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REPORT ON THE ASSESSMENT MISSION ON PRISON HOSPITAL SERVICES FOR PROPOSING EFFECTIVE MODELS OF MODERNISATION OF THE CURRENT SYSTEM

Within the framework of the Project

“Strengthening the health care and human rights protection in prisons in Armenia” funded by the European Union and the Council of Europe and implemented by the Council of Europe

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Executive Summary

This report is the result of an assessment mission carried out in March 2018 for evaluating new models of hospital care and other secondary health care services for prison inmates within the Project "Strengthening health care and human rights protection in Armenia" funded within the European Union and Council of Europe Partnership for Good Governance. The consultants wish to express their gratitude to all those involved in the assessment for their great support. The report and the resulting deliberations and recommendations are based on the assessment visit in March 2018, provided national data and documents and international documents.

Governance of penitentiary health care is still under responsibility of the Medical Service Unit of the Penitentiary Department but a recent Government Decision foresees to subordinate penitentiary health care under the direct responsibility of the Ministry of Justice.

The health care facilities in the penitentiary institutions are not licensed as it is the case for all health institutions in the country. In spite of several recent achievements such as training of health care professionals and upgrading of medical equipment there are still major deficiencies in primary health care that play an important role in planning improvement of hospital and secondary health care.

With regards to the legal basis for the provision of health care, the assessment identified several inconsistencies and need for harmonization of the norms and terms of the Law on Medical Assistance and Service to the Population and the specific legal acts regulating the provision of health care for arrestees and detainees (RA law on treatment of arrestees, detainees, Penitentiary Code, RA decision numbered 825-N of May 26, 2006). In addition, amendments are necessary for: i) restructuring hospital and other secondary health care, ii) approving standards, guidelines and procedures for the organization of state-guaranteed medical assistance and service and, iii) for licensing of these services in the penitentiary system that will allow for periodic control by Health Inspection operating within the Ministry of Health. In addition, the budget allocations for health care to penitentiary institutions currently are not completely distinguished from the general budgets of the institutions. With regards to the psychiatric care in the penitentiary system, the legislation needs substantial revisions and additions, among others to achieve professionally licensed, impartial and independent decisions of the Medical Commission in forensic psychiatric conclusions.

From the Public Health view, the importance of health care in prison including the conditions of detention, health prevention and promotion, primary health care and hospital and other secondary healthcare for the general public should not be underestimated. The data provided for 2017 show that the most frequent nosological reasons for transfers of inmates to hospitals were cardiovascular disorders followed by gastro-intestinal, respiratory, genitourinary, endocrinological, neurological, neoplastic and psychiatric disorders. However, there was a lack of detailed health care data on mental disorders of inmates, that would allow a more precise and comprehensive analysis.

The current management of in-patient secondary health care services for male inmates is based on the prison hospital in Yerevan which faces major deficiencies: poor material conditions and state of maintenance, inacceptable sanitary conditions, lack of barrier free access and elevators, lack of an anaesthetic recovery room and/or intensive care unit while major surgical interventions still are performed, lack of proper infection control and prevention, as well as lack of specialized staff during

nights and weekends. Therefore, in addition to economic and medical reasons, the consultants strongly recommend to close down the prison hospital and explore the option of hospital care of inmates in secured wards of civilian hospitals.

In-patient care for mentally severely disordered inmates needs, in addition to specialized and well-trained health care staff and psychopharmacological treatment, a therapeutic environment with non-pharmacological treatment options which are not available in the prison hospital. Non-pharmacological treatment need to be strengthened/established in the National Centre of Mental Health where all inmates in need of psychiatric hospital care should be treated, provided that the very poor condition of the premises and sanitary facilities of the Centre and the training of its security staff are improved. The importance of primary healthcare services, particularly the medical examination upon admission, for identifying inmates with mental disorders cannot be underestimated and stresses the need of proper training of primary health care professionals.

For out-patient secondary health care the consultants recommend strengthening and/or establishing a polyclinic model for all prisons by employing or calling in contracted specialists and equipping the medical units accordingly. In addition, pre- and postoperative care should be conducted under specialist surveillance and in cooperation with the surgical centre in well-equipped prison infirmaries, such as the Armavir medical unit, thus reducing expensive hospital stays.

The polyclinic model should include the availability of psychiatrists for each prison on a regular basis in order to care for the many mentally disordered patients who are not in need of psychiatric in-patient treatment.

For provision of health care services, the consultants provide the following proposals:

<u>Health care services to be performed in penitentiary institutions:</u>

- All primary health care including nursing care;
- Nursing care for disabled inmates;
- Out-patient secondary health care based on a polyclinic model organization;
- Care for patients with tuberculosis and resistant tuberculosis;

<u>Health care services to be performed in civilian hospitals in secured wards:</u>

- All major surgical interventions;
- All diagnostic, therapeutic and nursing interventions requiring equipment and/or medical expertise that cannot be made available in penitentiary institutions at an adequate qualitative level including in acutely or severely ill mental patients.

Detailed proposals and recommendations are provided at the end of the report.

Abbreviations

CME	Continuous medical education
CoE	Council of Europe
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment
ICU	Intensive care unit
MDR TB	Multidrug resistant tuberculosis
MoH	Ministry of Health
MoJ	Ministry of Justice
MSUoPD	Medical Services Unit of the Penitentiary Department
NCMH	National Centre for Mental Health
RA	Republic of Armenia
TB	Tuberculosis
ToR	Terms of Reference
UNODC	United Nations Office for Drugs and Crime
WHO	World Health Organisation

Introduction

This report is the result of an assessment mission carried out in March 2018 for evaluating new models of hospital care and other secondary health care services for prison inmates within the Project "Strengthening health care and human rights protection in Armenia" funded within the European Union and Council of Europe Partnership for Good Governance. Following the preceding phase of the project that focused on strengthening primary health care in prisons, the mission's aim was to analyse current practices of hospital and secondary health care in the penitentiary system and to examine possible future models of secondary healthcare on the basis of medical, structural and legal deliberations.

The authors are fully aware that, in spite of their efforts and the outstanding support of the authorities, in the short time available not all aspects of secondary health care may have been covered in this report. However, the consultants truly hope that the recommendations and proposals, all of them made on the basis of the assessed or observed facts and international experience, will serve the country in improving management of hospital and other secondary health care for prison inmates. The consultants wish to express their gratitude to all authorities, persons and institutions involved in the assessment, their understanding for the time-consuming meetings and visits, and their will to support the work of the assessment team.

Methodology

The assessment team consisted of one international medical consultant (J.P.), one national public health expert (R.B.) and one national legal expert (I.A.) and was constantly supported by the Senior Project Officer of the Council of Europe Office in Yerevan.

The methodology included: visits during the assessment mission on 19-20 March 2018 to the prison hospital in Yerevan, Medical Unit of the Armavir prison, the National Centre for Mental Health (NCMH) in Nubarashen and the Erebuni Hospital in Yerevan and interviews with the directors and senior physicians of these facilities; interviews with key stakeholders: Deputy Minister of Justice (MoJ), Deputy Minister of Health (MoH), Head of the Medical Services Unit of the Penitentiary Department (MSUoPD), Head of Medical Aid Policy Development Department of MoH, representatives of the Public Defender's Office (please see Agenda in Annex 2); desk review of a questionnaire assessment provided before the assessment visit and of additional statistical data provided by the MoJ and the MSUoPD; desk review of national and international documents (please see Annex 1).

Proposals and recommendations for future possible models of hospital care and other secondary healthcare for prison inmates were based on deliberations taking into account national law, medical and economic considerations and international experience. They were made not only upon the mission's Terms of Reference but also upon the explicit wish of representatives of the MoJ and the MSUoPD. Their listed sequence should not be understood as a sequence according to their importance as many of them are interrelated and one without the other might have little or no effect.

Current situation of secondary health care and hospital services for prison inmates

The structure and governance of health care services in prison have not undergone any major changes since the 2015 CoE Report on the needs assessment mission on health care in prisons in the Republic of Armenia was issued. Governance of penitentiary health care is still under responsibility of the MSUoPD. However, a recently issued Government Decision foresees to subordinate penitentiary health care under the direct responsibility of the MoJ, a structural change that, according to the Deputy Minister of Justice is expected to come into force latest by September 2018[1].

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

Primary health care facilities have been the target of a previous CoE assessment and proposals and recommendations for their improvement have been made in the 2015 CoE needs assessment report. Several CoE supported achievements such as training of health care professionals and upgrading of medical equipment have been implemented in the last two years. However, as examples of still prevailing deficiencies in primary health care, the consultants became aware that there is still no licensing of medical units in prison and, for instance, in the Vanadzor prison there is still no prison physician in service so that provision of primary health care relies fully on feldshers. As efficient primary health care is a prerequisite for appropriate planning of secondary health care, the consultants need to point to the importance of closing these gaps also in this report focusing on secondary health care.

Legal Bases of the Organization and Provision of Medical Assistance and Service for the Detainees and Convicts of the Republic of Armenia

In accordance with the second part of the third article of the Law of the Republic of Armenia on International Treaties, the RA international treaty, entered into force in accordance with the law, is a component part of the RA legislative system. The main international treaties of RA enshrining human rights, as well as the rights of the detainees and convicts, among which are the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, International Covenant on Civil and Political Rights, Convention on the Rights of Persons with Disabilities, the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, Children's Rights' and other treaties in the context of the above-mentioned are the constituent part of the RA legislative system.

The fundamental rights enshrined in them, such as the right to life, dignity, equality before the law, immunity, adequate standard of living, health care, including receiving medical assistance and service, discrimination, being threatened to scientific or medical experiments, torture, inhuman or degrading treatment or ban of punishment, are reflected both in the Constitution of the Republic of Armenia and in the main sectoral laws, such as in the Penitentiary Code, the Law of the Republic of

[1] RA Government Decision N 204-N "On Creation of the Penitentiary Medicine Center" State Non-Commercial Organization, March 1, 2018

Armenia on Treatment of Arrestees and Detainees, the Law of the Republic of Armenia on Medical Assistance and Service to the Population.

Nevertheless, it should be mentioned, that the realisation of the above-mentioned rights for the detainees and convicts was not secured at the same level and through the same mechanisms as within the public healthcare system. The regulations governing prison healthcare are non-interconnected and sometimes even contradictory.

The legislative provisions of the right to health care of detainees and convicts

According to Article 85 of the RA Constitution,

1. Everyone shall, in accordance with law, have the **right to health care**.

2. The law shall prescribe the list of free of charge basic medical services and the procedure for the provision thereof.

The 7th and 8th points of the 1st part of Article 86 define as follows: "The main objectives of state policy in the economic, social and cultural spheres shall be as follows: 7) implementing programmes for population's health care and improvement, creating conditions for effective and affordable medical services; 8) implementing programmes for disability prevention, treatment, rehabilitation of persons with disability, promoting the participation of persons with disability in public life."

In fact, according to RA Constitution, without any limitation or separation RA recognizes everybody's right to health care and enshrines the commitment of the State to implement the necessary programs for the proper enshrinement of that right and to establish appropriate conditions.

The **right to health care** and its legislative context for the penitentiary are enshrined in the RA Law on the Treatment of Arrestees and Detainees, and in the Penitentiary Code, with certain differences in those two laws. According to the Article 13 of the RA Law on Treatment of Arrestees and Detainees, "Rights of Arrestees and Detainees: to protect his/her health, including to receive sufficient food and urgent medical aid; as well as be examined by a doctor of his choice at his expense, and according to the Article 12 of the Penitentiary Code "the convict has a right of protection of health, including adequate food and medical care". In fact, the definitions show not only the apparent difference between the formulations, as well as the narrow context of the right to healthcare, which can predetermine the limitation of all spectral legal regulations. The current interpretation of the right to health care is much more comprehensive and includes not only physically accessible medical assistance and services, but also food, proper sanitation and hygienic conditions, safe environment[2]. Definition of legal content in line with comprehensive and up-to-date approaches to the right to health and definition of its legal regulations is a matter of fundamental importance in the Armenian legislation which will predetermine the whole spectrum of the realization of the right to medical assistance and service/volume, frequency, and other mechanisms.

[2] OHCHR, Facts Sheets, Right to health, available from http://www.ohchr.org/Documents/Publications/Factsheet31.pdf

Being the fundamental component of the right to healthcare, the **right to medical assistance and service** and its legislative context are defined in the RA Law on Medical Assistance and Service to the Population, the 1st part of the Article 1 of which defines that Medical assistance and service includes the provision of preventive medical assistance to the population; conduct of diagnostic examinations, rehabilitation treatment, medical expert examination; provision of paramedical and other nontherapeutic services. According to Article 12 of the same law the arrested, detained persons and those serving their punishment in places of imprisonment shall have the right to medical assistance and service in the manner prescribed by the legislation of the Republic of Armenia. So in accordance with the law, the arrested, detained persons and those serving their punishment in places of imprisonment equally with civilians have right to medical assistance and service.

However, the law sets reservation clearly defining that this right is subjected to realization in the scope of regulations prescribed by RA legislation.

Before addressing the regulations prescribed by the legislation, it is worth mentioning that the medical assistance and service of the arrested, detained persons and those serving their punishment in places of imprisonment is financed by the RA state budget by the annually approved law on the state annual budget. Moreover, taking the RA State Budget Law for 2018 as a basis, it should be mentioned, that the allocations of medical assistance and service for arrested persons and those serving their punishment in places of imprisonment are provided in the scope of the allocations in the provision “Prisons” of the state budget (2018 - 8 154 597 900 AMD). Moreover, medical expenses are not separated in the law, and the allocations for the civilian medical complexes for treatment of arrested persons, as well as those serving their punishment in places of imprisonment are presented in the part of medical services of the provision “Healthcare” along with socially insecure and other special groups. The allocation for providing drugs for the arrested persons and those serving their punishment in places of imprisonment for the penitentiary institutions is 150 000 000 AMD by the provision “Healthcare”. In fact, allocations to penitentiary institutions in general and health care are not particularly divisible at the level of the RA Law on “State Budget of 2018”, except for drugs which does not allow to understand the clear picture of health expenditures in penitentiary institutions.

Continuing the topic of legal regulations of medical assistance and service provided to the detained persons and those serving their punishment in places of imprisonment, the RA Government’s decision numbered 318-N of March 4, 2004 - Annex 1 defines the list of socially vulnerable and specific groups of people entitled to free and privileged medical assistance and services guaranteed by the state, including arrestees, detainees, and persons sentenced to imprisonment. It should be noted that the above-mentioned decision is the act of defining the procedures for the allocation of funds allocated to the “Healthcare” Section of the state budget and thus does not in any way regulate relations related to the provision of medical assistance and service by the relevant bodies of the penitentiary institutions, and the Annex 1 of the decision mentions the arrestees, detainees, and persons serving their punishment in places of imprisonment in the context of the right to receive medical assistance and service in civilian medical institutions.

According to the Article 21 of the RA Law on Treatment of arrestees and detainees and Article 83 of the Penitentiary code, the medical sanitary and preventive assistance of arrestees, detainees and convicts is organized in accordance with the legislation of the Republic of Armenia regulating the health sector.

The mentioned norm itself causes some issues and contradicts the legal regulations prescribed by the laws and other legal acts including:

1) First, the RA legislation does not have a legal definition of the term “legislation regulating the healthcare”. Secondly, the laws regulating healthcare of the Republic of Armenia do not apply the terms "Medical preventive” or "medical sanitary", which were most commonly used terms in the Soviet era and which are now completely out of the healthcare legislative vocabulary, thus making the articles legally unclear.

Even if we consider that “Legislation Regulating the Healthcare” is the legislation (laws, government decisions, normative decrees of the Minister of Healthcare) that regulates healthcare, medical assistance and service for civilian persons, the norms referred to are incorrect because the medical assistance and service for detainees and convicts are regulated in accordance with the penitentiary legislation (the RA law on Treatment of Arrestees and Detainees, Penitentiary Code, RA decision numbered 825-N of May 26, 2006 adopted on their basis, normative decrees of RA Minister of Justice). Such legislative norm is incorrect in terms of formulation, as well as in the sense of its content, as the provision of medical assistance and service of the detainees and convicts is significantly different from the regulations governing medical assistance and service of civilian persons, because of many features and exceptions (for example, differences in the volume and quality of medical assistance and service provided in penitentiary institutions of primary health care services, implementation of activities in accordance with other procedures of the services, particularly the requirement for licensing, lack of public healthcare oversight, etc.).

2) According to subpoint I of the 8th point of the RA Ministry of Healthcare Charter which was adopted by RA Government’s decision numbered 1300-N of August 15 of 2002 RA Minister of Healthcare develops and approves standards, guidelines and procedures for the organization of state-guaranteed medical assistance and service. As a result, currently the competence to approve the volume and content of state-guaranteed medical care and assistance is given to the RA Minister of Healthcare. The above-mentioned standards regulate the organization of the medical assistance and service of the arrestees, detainees and persons serving their punishment in places of imprisonment very briefly. They only regulate the organization of medical assistance and service in civilian medical institutions. Specifically, the decree numbered 71-N of November 18, 2016 of the RA Minister of Healthcare only defines issues of documentation related to the transfer from penitentiary institutions to civilian medical institutions. RA Minister of Healthcare decree numbered 57-N of September 28 of 2013, establishes a list of the most up-to-date and expensive services, with the exception of the principle of exclusion, which are chargeable for all categories of the population, including arrestees, detainees, and persons serving their punishment in the places of imprisonment. The normative decrees of the Minister of Healthcare of the Republic of Armenia do not specifically regulate the process of treatment of detainees and convicts in civilian medical institutions, which indicates the absence of discrimination in the level of legal acts. It becomes obvious that the regulatory acts of health sector do not do not take into account the peculiarities of medical assistance and service of detainees and convicts.

3) The main act regulating the procedure for medical assistance is the RA Government’s decision numbered 825-N of May 26, 2006 “On Approving the Procedure for Organizing Medical sanitary and Medical Preventive Assistance to Detainees and Convicts, using the medical institutions of healthcare

bodies and Involving Their Medical Staff for that Purpose" which was adopted pursuant to Article 21 of the RA Law on Treatment of Arrestees and Detainees, Article 83 of the Penitentiary Code. So, the main act on medical assistance of detainees and convicts is a part of penitentiary legislation, not healthcare as it states by laws.

Certainly, the RA legislation has other regulations set out in both the cited and other acts concerning the medical assistance and service of detainees and convicts but the main act regulating the medical assistance and service of detainees and convicts is the RA Government's decision numbered 825-N of 26 May 2006, which defines the structure, conditions and responsibilities of organization of medical assistance and service in penitentiary institutions.

The differences of the legal regulations of organization of medical assistance and service in penitentiary institutions and civilian medical complexes

Currently, the medical services of the penitentiary institutions of Armenia are at the stage of transformation, the beginning of which was the adoption of the Concept Paper modernization of medical services in penitentiary institutions approved by the RA Government Decision No 2 of January 19, 2017. In conformity with the proposed approaches, the RA Government on March 1, 2018 passed the Decision N 204-N "On Creation of the Penitentiary Medicine Center" State Non-Commercial Organization (according to which the organization will start its operations since July 1, 2018), which essentially resulted in the subdivision of the penitentiary institutions' medical services from the penitentiary service and the transfer to the Ministry of Justice and their integration into the overall healthcare system of the Republic of Armenia.

However, this process cannot be achieved at once, so the legal provisions (without narrow procedural regulations) of the organization of medical assistance and service in penitentiary institutions will be presented below comparing the legislative regulations for the medical assistance and service for the public, which will allow them to clarify the existing differences, aiming at their subsequent elimination in future.

Licensing, state control over healthcare system, standards on medical assistance and service, documentation

According to the 2nd part of the article 43 of The Law of the Republic of Armenia on Licensing medical assistance and service provided by organizations and citizens is subjected to licensing.

The licensing of the medical assistance and service in the Republic of Armenia hasn't limitation of time, is implemented by the RA Ministry of Healthcare in condition of meeting the professional, structural, technical and technological mandatory terms and requirements set by the RA legislation. The state supervision over the activities of licensed entities which are subjected to licensing are carried out by the health inspection operating within the structure of the Ministry of Health of the Republic of Armenia[3].

However, these regulations have not yet covered the penitentiary medical services because licensing and controlling legislation does not apply to them.

[3] http://www.arlis.am/DocumentView.aspx?docID=113099

Particularly, according to the Penitentiary Department's charter approved by the Government Decision No 1256-N of August 24, 2006, penitentiary institutions, including the prisoners' hospital, other medical service providing subdivisions, within the sense of RA Legislation are units within the Penitentiary Department's structure, but not organizations, so the legislation of licensing spectrum is not applicable to them. At the same time, it should be noted that the legislation does not define mandatory terms and requirements for technical, technological and professional capacity of penitentiary institutions providing medical services, including the prison hospital.

Civilian licensed medical organisations have structural, technical and technological capacity and professional competence defined by the legislation (appropriate staff, with the required number, trained in the last five years, or with CME certificate) and external state supervision over their activities is set up in the form of inspections, as a result of which in case of discovering breaches, sanctions prescribed by the law are applied.

Currently, there are no special requirements for the structure, technical and technological equipment of medical units in penitentiary institutions, and there is only an internal hierarchical control system The medical services of penitentiary institutions are components of a closed system, where external state supervision is excluded. There are no structural, personnel and technical-technological requirements corresponding to modern health care, as a result of which the constitution-guaranteed right to health care, medical assistance and services are not properly assured.

By the Government decision N 204-N about creating “Penitentiary Medicine Center” State Non-Commercial Organization, in fact, the area of medical assistance and service provided in penitentiary institutions is transferred to the field of civilian licensing and, hence, to the field of external supervision. However, it should be noted that, taking into consideration the sectoral distinctions, that there is a need for special legal regulations, which are currently absent in the existing legislation.

"Penitentiary Medicine Center" State Non-Commercial Organization, established by Decision N 204-N of March 1, 2018, to which the medical services of penitentiary institutions should be transferred, is subject to licensing under the current legislation of the Republic of Armenia and may operate only in if there is a license for the types of appropriate medical assistance and services. However, in this case, the actual licensing process is problematic as the legal acts defining its procedures are formed from the point of view of Civilian Medical Assistance and Service. The terms and requirements of the licensing of detainees and prisoners’ medical assistance and service should have a number of specific features that must be defined by separate legal regulations. Licensing will let the system:

1) have, if not the same as the civilian one, at least a very similar system of medical service, with structural, technical, technological and professional assurance;

2) have as much as possible professionally independent medical staff;

3) be subjected to periodic control by Health Inspection operating within the Ministry of Health, which will allow both preventing violation of sectoral legislation and disclosing and subjecting to responsibility those responsible for making violations.

In 2015 The RA National Assembly adopted the amendments and additions to the RA Law on Medical Assistance and Service to the Population, where, among other things, the concept of "professional activity in the field of public health" was first introduced, which is the work of medical practitioner carried out in accordance with his/her education, qualification and professional qualifications, in the scope of his/her jurisdiction by the laws of the Republic of Armenia, other legal acts, standards, clinical guidelines, protocols and his/her job responsibilities.

By the same amendments the concept of patient handling practices (protocols) were introduced including mandatory requirements for handling by the medical practitioner of disease or syndrome or clinical condition in the form of consultation, diagnosis and treatment. The jurisdiction of adopting protocols passed to the RA Minister of Healthcare. As of April 14, 2018, only seven protocols have been developed and adopted (according to Arlis legal informative system). However, according to a statement[4] posted on the website of the Ministry of Healthcare, more than 300 clinical guidelines, protocols and procedures have already been developed based on international best practice and are under discussion with the medical community expected to be finalized and adopted after final revisions and after the final amendments.

From the point of view of an appropriate assurance of medical assistance and service provided today by the penitentiary institutions and as well as those to be anticipated by “Penitentiary Medicine Center” state non-commercial organization, it is also important to simultaneously apply these protocols for the treatment of detainees and prisoners. It will essentially promote the improvement of the quality of treatment and will reduce the differences between provision of medical assistance and service in these institutions and civilian medical institutions.

According to the RA Government’s decision No. 1936-N of December 5, 2002, the RA Minister of Healthcare has competence to approve the forms of medical documents which are of mandatory use by the licensed entities. Based on that decision of the Government, there are currently more than a dozen types of medical approved documentation which are necessary during hospital and outpatient medical assistance and service. Taking into consideration the fact that medical assistance and service provided by penitentiary institutions is not subjected to licensing so far, approved forms of medical documents are not applicable for penitentiary institutions. Forms developed internally and not approved by prescribed manner are used there. In this regard, medical documentation of penitentiary institutions should be approved by legal act, of course, taking into account the peculiarities of penitentiary medical assistance and service.

<u>Primary Health Care</u> for people in freedom is guaranteed free of charge in point (a) of the article 2 of the RA law on medical assistance and service to the population and in the 3rd subpoint of the 12th point of the Appendix 2 of the RA Government’s decision N 318-N of March 4, 2004, to be organized in an outpatient manner when no hospital conditions are required for its implementation and to be provided to all groups of population free of charge (except for dental care services, which are only provided to socially insecure or specific groups at certain volumes) within the frames of the service packages set by the RA Minister of Healthcare. The volume of the free primary health care coverage is defined by the decree of the RA Minister of Healthcare No 47-N from September 13, 2013 and includes all scale of ambulatory-polyclinic medical assistance and service.

[4] http://moh.am/#1/1209

In contrast to the above mentioned decree, organisation of the primary healthcare of detainees and prisoners is defined by RA Government's decision numbered 825-N of May 26, 2006 with lacking or different definitions of the volume of provided primary health care, e.g. annual preventive examination is not envisaged, the concept of dispensary control is not clearly defined and the volume of provided services. Thus, it can be concluded, that despite the regulations of the Article 83 of Penitentiary Code, the primary health care of the detainees and convicts, its organization, volume and the proposed structural, professional and technical capabilities essentially differ from the process and scope of the primary health care organization for the persons who are in freedom.

At the same time, it should be noted that some common diseases among detainees and convicts, such as HIV and tuberculosis have specific regulations due to their risk of transmission. Thus, according to Decision 733-N of July 10, 2013, the terms and requirements of implementation of pre-test and post-referral consultation and research of HIV infected detainees and convicts by the medical practitioners are defined clearly and detailed. The sanitary rules and hygienic norms N 3.1.1-010-08 of Tuberculosis epidemiological surveillance in the Republic of Armenia, approved by the Decree of Minister of Healthcare No. 21-N of October 20, 2008 define that detainees and convicts are included in the risk group for tuberculosis and for any medical assistance, when applying, the service provider examines them in order to reveal any possible tuberculosis specific complaints.

Hospital (Inpatient) Medical Assistance and Service

According to point (b) of the article 2 of RA law on Medical Assistance and Service to the Population, specialised medical assistance, as a type of medical assistance and service, is based on diagnosis and special medical methods and sophisticated medical technologies. According to the article 3 of the same law, Medical assistance and service shall be organized in an inpatient manner when complex application of the following medical interventions is required: diagnosis, treatment, lasting and special care.

There is no compulsory health insurance system in the Republic of Armenia. Nonetheless, the state provides insurance packages for the public servants for the entire course of public service, while for some categories of employees also after the service, in accordance with the procedure and scope established by the law.

For socially vulnerable persons and special groups (including arrestees, detainees and convicts), the state guarantees free inpatient medical assistance and service, the scope and the procedure of provision of which are defined by the decrees of RA Minister of Healthcare. It should be noted that the 11th point of the decree of the RA Minister of Healthcare N 71-N of November 18, 2013 defines the content of state-guaranteed free-of-charge inpatient medical assistance and service, which can be carried out:

1) under daytime inpatient conditions,

2) "short-term or small-scale or low-cost medical assistance" under 24-hour control,

3) under conditions of long-term 24-hour control,

4) professional medical assistance under conditions not demanding 24-hour hospital control.

In terms of coverages, by the principle of exclusion, the decree of the RA Ministry of Healthcare establishes the services that are paid for socially vulnerable persons and special groups and for of the whole population with separate exceptions. They are the most up-to-date and high-tech medical services, the list of which is approved by the RA Minister of Healthcare Decree N 57-N of September 28, 2013[5].

The medical assistance and service for detainees and convicts are implemented twofold, namely by providing for inpatient medical assistance and service provided by penitentiary institutions, and medical assistance and service provided in civilian medical institutions.

No legal act provides the list of types of medical assistance and services provided in penitentiary institutions, including the prisoners' hospital, which, naturally, is problematic in terms of providing appropriate medical assistance and services, because it is not clear whether the provided services are adequate to health needs of detainees and convicts.

Inpatient medical assistance and service provided by penitentiary institutions, in turn, is provided by the corresponding services of the same penitentiary institutions or by the medical institution, namely prison hospital.

Medical care and service in penitentiary institutions is provided for up to 14 days, and for more than 14 days in the case of consultation with a qualified specialist, availability of a specialized department or by decision of medical working committee. In cases of insufficiency of medical assistance and care, or in case of the need of specialized or long-term treatment, the detainee or convict should be transferred to the prison hospital or civilian medical institution.

RA legislation provides a very general range of medical assistance and services in the prison hospital. These are complex medical examination and medical assistance, sufficient scale of care.

The volume of medical assistance provided in the prison' hospital is defined by the Government's Decision N 825-N of 26 May, 2006[6], according to which the detainees and convicts admitted to the medical correctional institution pass the required clinical laboratory, instrumental and other auxiliary examinations, as well as, depending on the diagnosis, appropriate preventive measures are assigned and taken. According to the same decision, the treatment of the detainees and convicts in the medical correctional institution is carried out in accordance with the requirements of modern medical science. During the treatment medication, dietary food is used, while there are applied physiotherapeutic treatment methods, therapeutic exercises, occupational therapy and other rehabilitation methods that contribute to the treatment process. There is no time limitation for the detainee or convict patient in need of care for getting inpatient treatment. In some cases, when there are no conditions for providing urgent professional medical assistance in the medical correctional institution (equipment, specialists), sick detainees and convicts are referred to medical institutions of healthcare bodies. The referral is given by the RA Minister of Healthcare based on the

[5] http://www.arlis.am/DocumentView.aspx?docid=87880

[6] http://www.arlis.am/DocumentView.aspx?docid=25105

petition presented by the Penitentiary Department. The period of treatment of a detainee or convict in civilian hospital facilities is not limited.

Psychiatric medical assistance and service for the detainees and convicts

In this section, the legal regulations of psychiatric medical assistance and services for detainees and convicts will be presented separately. The need to address these issues is conditioned by the peculiarities of psychiatric care and service, due to the more decisive role of the human factor in this type of health care (in particular, the psychiatrist's professionalism, knowledge and skills are more important in the diagnostic field since laboratory or instrumental studies are mainly not applicable), as well as the fact that persons with mental disorders are more vulnerable. This section does not discuss psychiatric medical assistance and service of persons released of the sentence and subjected to compulsory treatment under the judicial act, taking into account their status change.

According to the 2nd part of the Article 98 of the Criminal Code of the Republic of Armenia, the court can assign in addition to punishment an outpatient supervision by a psychiatrist and enforced treatment for those convicted for committal a crime in the state of mental disorder not ruling out sanity, but who need treatment against alcohol, drugs or mental disorder not ruling out sanity. According to the Article 99 of the same code, outpatient supervision by psychiatrist and enforced treatment can be assigned if the person in his mental state does not need to be admitted to a psychiatry hospital. According to the 7th part of Article 3 of the RA Law on Psychiatric Assistance, outpatient psychiatric assistance is the detection, recording and continuous control of patients with mental disorders or psychiatric examination or treatment or social rehabilitation in the outpatient conditions.

These legal norms, in addition to the definitions given by the Criminal Code, in some respects predetermine the scope of the definition of limited sanity, defining that in this case, outpatient supervision and compulsory treatment are imposed along with the sentence.

According to the 1st part of Article 123 of the Penitentiary code, outpatient supervision and compulsory treatment ordered by a psychiatrist with respect to persons who have been sentenced to a certain term or life imprisonment for a crime committed in a state of mental disorder not excluding sanity, and at the same time, need treatment from alcoholism, drug addiction, toxicomania, or mental disorder not excluding sanity, shall be applied in the institutions for serving the sentence in the form of imprisonment, and for those sentenced to other types of punishment-in health care institutions which provide outpatient psychiatric assistance. Those in need of treatment in a hospital setting, according to the logic of the same regulations, are subject to the conditions of the exemption and compulsory treatment at the hospital.

In the context of these regulations, the presence of convicts, recognised as sane, who have a mental disorder, serving an imprisonment sentence and being at the prison hospital on a basis of special care, issues a number of legal questions. According to the 6th part of Article 3 of the RA Law on Psychiatric Assistance, the hospital psychiatric assistance is an examination of mental disorder or diagnosis, treatment or psychiatric expertise of a person with mental disorder, which is organized whenever there is a need of immediate long-term supervision and care for her/him in hospital conditions. According to the 2nd part of Article 100 of the RA Criminal Code enforced treatment in

psychiatry hospital can be assigned, if the state of mental disorder of the person requires treatment, care, such conditions of keeping and supervision which can be implemented only in a psychiatry hospital. As it was mentioned above, the RA legislation does not envisage enforced treatment in psychiatry hospital in combination with imprisonment sentence. By the decision of the Government of the Republic of Armenia No. 350-N of April 1, 2010, the procedure for provision of psychiatric outpatient and inpatient psychiatric care was approved, whereby the scope of outpatient and inpatient psychiatric care is defined. However, the decision does not in any way refer to the procedure of psychiatric care and service in penitentiary institutions, its scope, and other issues related to the peculiarities of such an assistance. Similarly, the RA Government Decision No. 825-N of 26 May 2006 does not in any way determine the scope and conditions of provision of psychiatric assistance to convicts and detainees in penitentiary institutions. The decision only defines the frequency and progress of the supervision of persons undergoing the dynamic control. It should also be noted that the RA Government Decision N 350-N of April 1, 2010 regulates the procedure of outpatient enforced medical supervision in cases when a person is convicted of non-custodial sentence, meaning that he/she serves the sentence in freedom.

In this sense, the RA legislation needs substantial revisions and additions as they cannot be applied to persons detained in prisons because of common reasons, therefore, in terms of protection of human rights, the entire scope of psychiatric assistance and service in penitentiary institutions is subject to clear legal regulation.

Another problematic regulation is the procedure for recognizing persons held in penitentiary institutions as insane or partially sane, as well as the need to change the preventive measure for the detainee due to the mental health condition, or to release them from the sentence due to the mental illness, as well as to address procedural issues related to application of medical, psychiatric restraint measures. A motion to release from serving further sentence on the ground of a mental or other serious illness shall be submitted to the court by the head of the penitentiary institution. At the same time, together with the motion the conclusion of the relevant medical commission is presented. According to the RA Government's Decision N 1636-N of December 4, 2003, the mentioned Medical Commission is a permanent body, in which representatives of the Ministry of Healthcare of RA, Penitentiary Department of the RA Ministry of Justice, and the corresponding police division adjunct to the Government of the RA.

It turns out that the forensic psychiatric examination, which is subject to licensing, is carried out by a non-licensed body, by those who work in state bodies, so having certain constraints in terms of independence, impartiality and professional activity, upon whom there are not even imposed professional qualification requirements. Here, in some cases, corporate conflicts of interest may not let assure an impartial, reliable and objective examination during the expertise. The basis for returning to the penitentiary institution is the elimination of the need for further treatment.

Public Health Implications

"It is not sufficiently recognized that the prison service is a public service, meeting some fundamental needs of society, such as the need to feel safe and to feel that crime is sufficiently punished and reparations made. As with all public services, the extent and the quality of provision depend on a political decision. Political support for healthier prisons should be based on the recognition that:

- good prison health is essential to good public health;
- good public health will make good use of the opportunities presented by prisons; and
- prisons can contribute to the health of communities by helping to improve the health of some of the most disadvantaged people in society."[7]

The basic health related principles which should be maintained in prisons and emphasized by the WHO Europe for prisons' health are:

Equal Rights to Health and Quality of Care – It is in the first place, and the provision in Article 12 of the International Covenant on Economic, Social and Cultural Rights (United Nations, 1966)[8] establishes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". Right-based approach should be always a priority in patient-physician relationship, keeping with the spirit of Oath of Hippocrates. Considering the fact that the gaps and bottlenecks in prison health services will be definitely transferred into civil society and may create an additional burden to health sector, implementing and maintaining all standards applied in civil health care is imperatively important as the health of every citizen in the country.

Health Promoting – This is not just focusing on health of prisoners. It is important to focus on physical and psychological environment which definitely impact on mental health and well-being of prisoners. Other important aspects are prevention and healthy lifestyle, which is critical in prisons in terms of alcohol and drug abuse, smoking and nutrition, abusive relationships, sexual health, exacerbation of chronic diseases, spread of infectious and onset of non-communicable diseases (NCDs).

Imprisonment is never only about safety, security and discipline but, as the Council of Europe laid down in its 2006 Prison Rules, is always also about "... ensuring prison conditions which do not infringe human dignity and which offer meaningful occupational activities and treatment programmes to inmates, thus preparing them for their reintegration into society"[9]. Therefore, one of the most important principles that guide the deprivation of liberty is that prisoners remain bearers of all human rights insofar as they are not lawfully restricted or limited to an extent demonstrably necessitated by the fact of incarceration[10]. This also applies to their right to health, which is established on various foundations of fundamental human rights. Most important is Article 12 of the International Covenant on Economic, Social and Cultural Rights. In its General Comment No. 14 to give guidance to states, the United Nations Committee on Economic, Social and Cultural Rights laid out the scope and content of the right to health. With regard to its scope, the Committee states that "... the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health".

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[7] Health in prisons, A WHO guide to the essentials in prison health http://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf

[8] http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

[9] Recommendation Rec(2006)2 of the Committee of Ministers to member states on the European Prison Rules. Strasbourg, Council of Europe, Committee of Ministers, 2006 (https://wcd.coe.int/ViewDoc.jsp?id=955747

[10] Basic principles for the treatment of prisoners. United Nations General Assembly Resolution 45/111. New York, United Nations, 1990 (http://www. un.org/documents/ga/res/45/a45r111.htm)

With respect to prisoners, the following statements of the Committee are especially important. The first two refer to states' parties' obligations as to the right to health. They maintain that "States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including convicts or detainees ..., to preventive, curative and palliative health services", and that "States parties are also obliged to fulfil (provide) a specific right contained in the Covenant when individuals or a group are unable ... to realize that right themselves by the means at their disposal".

The European Prison Rules also reflect this special duty of care of the state: "Prison authorities shall safeguard the health of all prisoners in their care". The official comment on the European Prison Rules deduces the state's special duty of care from the right to health as enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights: ''Alongside this fundamental right, which applies to all persons, prisoners have additional safeguards as a result of their status. When a state deprives people of their liberty, it takes on a responsibility to look after their health in terms both of the conditions under which it detains them and of the individual treatment that may be necessary. Prison administrations have a responsibility not simply to ensure effective access for prisoners to medical care but also to establish conditions that promote the well-being of both prisoners and prison staff.''

Two fundamental consequences of this are that all imprisoned people must be offered a proper medical examination as promptly as possible after admission and that prisoners are entitled to care and treatment free of charge.

Demographic characteristics of prisoners. In Armenia the main part of prisoners are men. A considerable part of them derives from vulnerable and marginalized groups of society. Unsanitary, poor conditions and chaotic lifestyle, hypo nutrition, unavailability of access to normal medical aid are normal for many of them long before incarceration. According to the data provided (February 2018), there are 3549 people in penitentiary institutions of Armenia. 2180 of them are convicts and 1369 detainees. In Armenia more than 90 % of prisoners are men, 4-5 % of them women and juveniles.

Conditions of detention. Sanitary norms necessary for prisoners' health maintenance are defined by the UN Standard Minimum Rules for the Treatment of Prisoners. This key document defines the minimum standards for space, ventilation, lighting and equipment for living, industrial and sanitary premises in places of detention. Numerous publications describing the conditions of prisoners are done. The majority of them assess the sanitary and living conditions in places of detentions as extremely unfavourable[11].

The structure of organization of medical service and morbidity. High concentration of psychological diseases, drug abuse and infectious diseases is registered in places of detention of many countries. In 2017 cardio-vascular diseases have taken a lead in the structure of incidence in places of detention of the RA. The general picture was as follows.

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[11] Report on needs assessment mission of infection control and sanitary-epidemiological maintenance of healthcare units and hospitals in prisons in the republic of Armenia. Within the framework of the Project "Strengthening healthcare and human rights protection in prisons in Armenia" funded by the European Union and the Council of Europe and implemented by the Council of Europe.

In the penitentiary system of the RA medical aid and services are provided in 12 penitentiary institutions, including the 'Prison hospital' penitentiary institution. In contrast to other healthcare institutions in Armenia, the healthcare units which provide medical services within the framework of penitentiary institutions are not being licensed. Primary healthcare units of penitentiary institutions have practitioners (as a rule one of them is the head of the unit) and nurses depending on the size of the institution and the number of prisoners. Some penitentiary institutions have also inpatient care units. The secondary healthcare aid is provided in "Prison hospital" penitentiary institution which is unique one in the penitentiary system of the RA.

The equipment and staff density of the mentioned departments is presented in the corresponding chapter of the report.

If necessary imprisoned people are provided medical specialized aid in civil hospitals.

Number of prisoners referred to healthcare institutions from "Prison hospital" penitentiary institution and other penitentiary institutions of the Justice ministry of the RA

	Penitentiary institution		2013	2014	2015	2016	2017
1	Number of prisoners referred to "Prison hospital" penitentiary institution	In all	370	408	218	358	462
		In an urgent manner	116	99	61	97	97
2	Number of prisoners referred to healthcare institutions from penitentiary system	In all	422	708	778	912	1748
		In an urgent manner	117	113	171	-	-

There are primary healthcare units in all penitentiary institutions. In some of penitentiary institutions there are inpatient units. Healthcare units have practitioners (as a rule a general practitioner) and nurses, in some places heads of units or groups, depending on the size of the institution and the number of prisoners.

The hospital needs re-equipment and upgrading of the personnel. There is no department for intensive therapy, while it is a compulsory demand for the secondary healthcare institution. It is impossible to provide qualitative medical services in such poor conditions.

It is noteworthy that the CPT reports have also underlined the necessity of the re-equipment and the upgrading of the personnel, also improvement of building conditions of the "Prison hospital" for many times[12]. It should be taken into consideration that according to the 40.2 rule of the COE

[12] The CPT report (CPT/Inf (2004) 25) on their visit to Armenia, October 6-17, 2002. The CPT report (CPT/Inf (2011) 24) on their visit to Armenia, April 10-21, 2010.

“European Prison Rules”[13], “the healthcare policy in prisons should be in harmony with the national healthcare policy”.

Below are presented the data provided by the penitentiary department of the Ministry of Justice of the RA.

During 2013, 2014, 2015 no separate calculation has been done about the prisoners referred to healthcare medical institutions for treatment or examination. Data for 2016 and 2017 are given below.

	Penitentiary institution	2016		2017	
		Treatment	Examination	Treatment	Examination
1	Prison hospital	62	70	87	63
2	Nubarashen	62	146	88	272
3	Vardashen	21	24	12	51
4	Yerevan-Kentron	3	17	4	7
5	Goris	1	22	1	35
6	Abovyan	22	55	12	65
7	Hrazdan	20	116	8	112
8	Sevan	0	59	3	63
9	Vanadzor	71	114	9	234
10	Artik	58	96	58	96
11	Kosh	0	75	5	119
12	Armavir	0	118	49	295
In general		320	912	336	1412

In 2017 no nosological record has been kept on prisoners referred from penitentiary institutions to civil hospitals. Below approximate data are presented.

	Penitentiary institution	Cardio-vascular diseases	Respiratory illnesses	Gastrointestinal diseases	Neurogical diseases	Urinary system diseases	Endocrinological diseases	Psychological diseases	Cancer
1	Prison hospital	28	21	62	5	11	6	5	12
2	Nubarashen	142	37	67	22	40	26	6	20

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

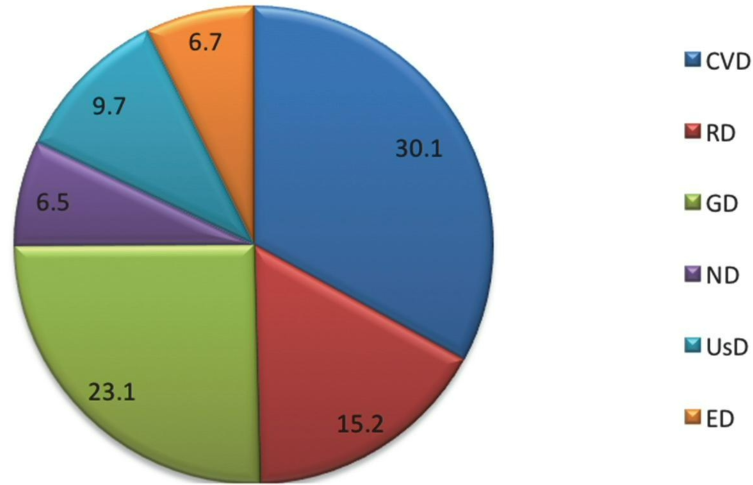
3	Vardashen	9	23	16	6	2	2	-	5
4	Yerevan-Kentron	2	6	-	3	-	-	-	-
5	Goris	3	10	8	4	8	2	-	1
6	Abovyan	16	21	17	4	5	10	1	3
7	Hrazdan	33	26	30	11	8	7	3	2
8	Sevan	16	10	16	7	5	5	3	4
9	Vanadzor	65	23	57	23	27	13	21	14
10	Artik	52	22	22	12	9	15	9	13
11	Kosh	47	18	34	5	4	6	3	7
12	Armavir	114	48	74	12	51	25	11	9

More often detainees and arrestees are referred to “Erebuni”, “Saint Grigor Lusavorich”, “Astghik”, “Armenia” medical centers and provincial medical centers for examination and treatment.

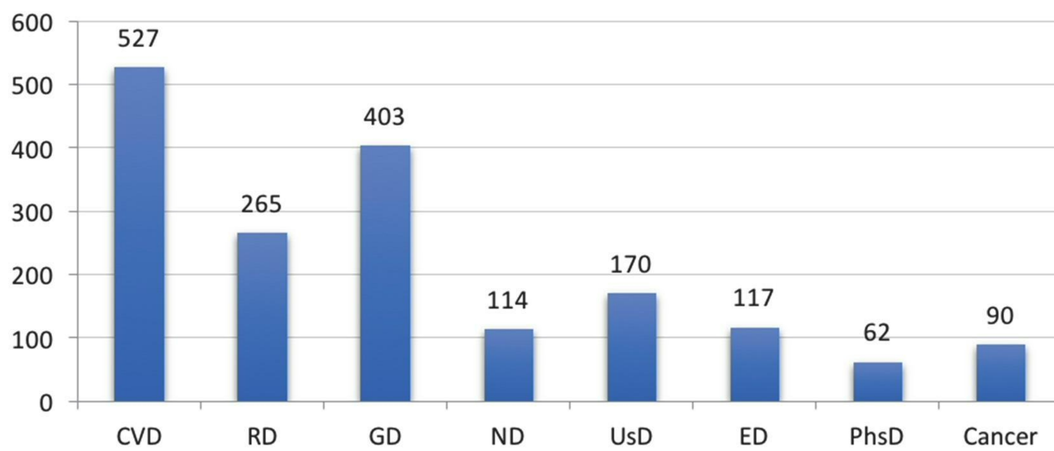
While assessing the risks for health a big problem should be solved: in order to have more precise and comprehensive analysis it is necessary to collect personal and not generalized data. Gathering generalized data hinders the analysis process. It doesn’t allow to analyse the state of health of detainees and arrestees and the extent of the examinations done per one person. Nevertheless, taking into account the approximate nosological data on referrals from penitentiary institutions to healthcare institutions, the following conclusions can be made:

1. The majority of referral cases from penitentiary institution to healthcare institutions – 30%- are conditioned by cardiovascular diseases.
2. Conditioned by cardiovascular system disorders comparatively more referral cases were registered in “Nubarashen”, “Artik”, “Kosh”, “Armavir” penitentiary institutions.
3. The ratio of gastrointestinal and respiratory illnesses is also high- correspondingly 23% and 15 %.
4. The 40% of referrals from “Prison hospital” to healthcare institutions were conditioned by gastrointestinal diseases. This can mean two things: first, “Prison hospital” needs specialists of that profile, second, there are no corresponding technical conditions to do operations. It can be also concluded that the high percentage of that diseases is conditioned by the food.
5. Comparatively more cases of referrals to healthcare institutions conditioned by respiratory diseases were registered in “Vardashen”, “Goris”, “Abovyan”, “Hrazdan” penitentiary institutions.

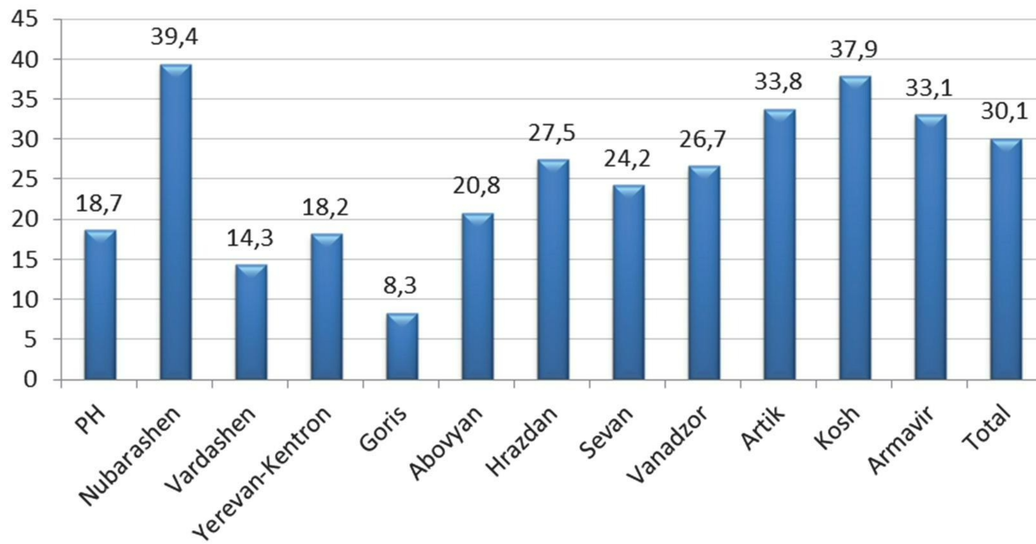
The referrals from penitentiary to healthcare institution for examination or treatment in 2017 (according to nosologies (%)



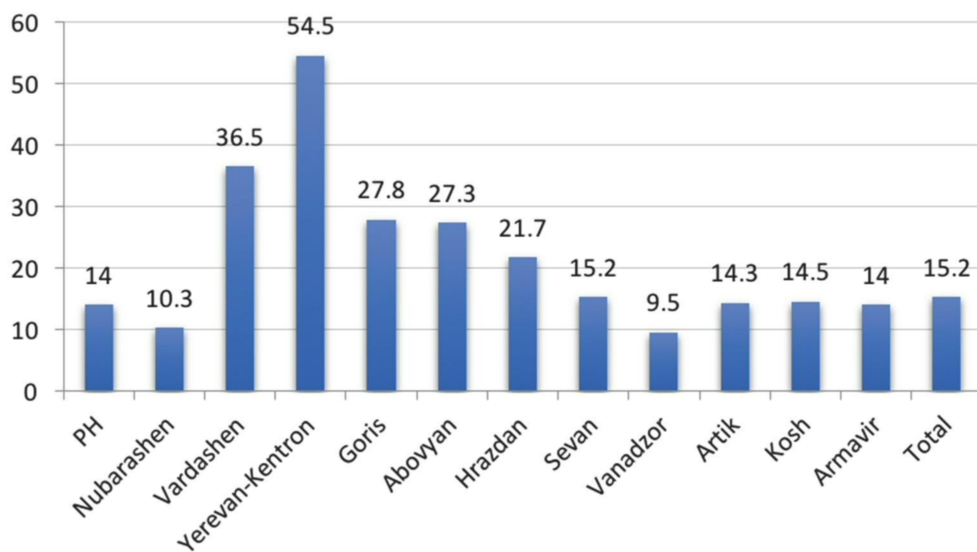
The referrals from penitentiary to healthcare institution for examination or treatment in 2017 (in numbers)



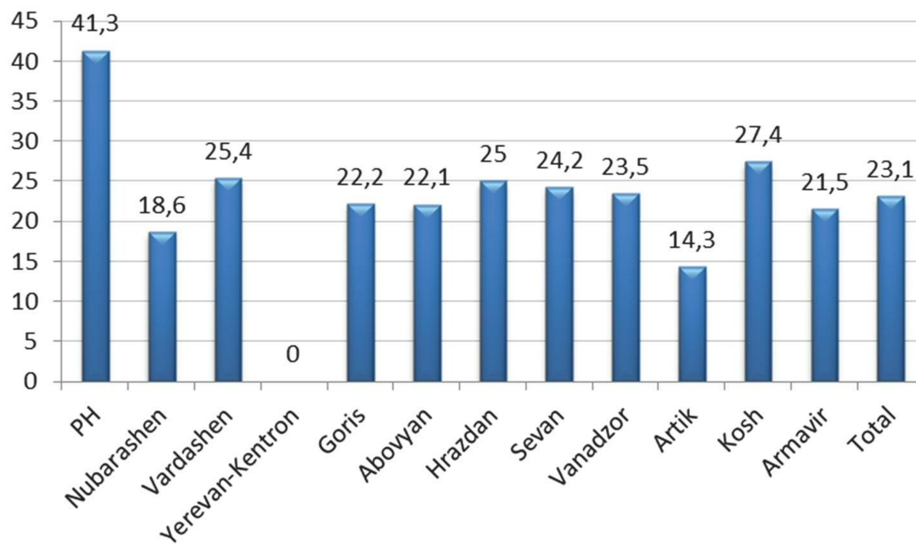
The referrals from penitentiary to healthcare institution conditioned by cardiovascular system diseases in 2017 (according to penitentiary institution (%)



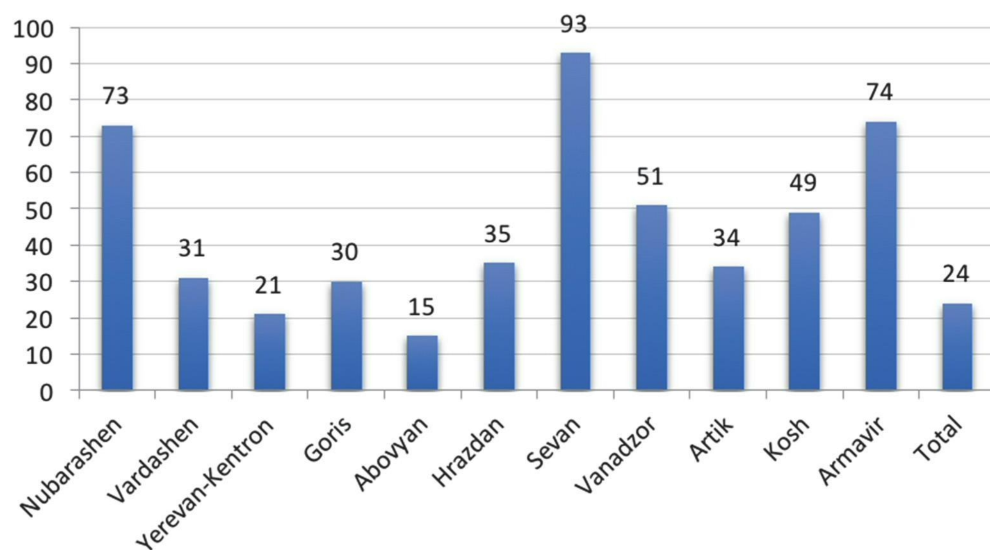
The referrals from penitentiary to healthcare institutions conditioned by respiratory system diseases in 2017 (according to penitentiary institution (%)



The referrals from penitentiary to healthcare institutions conditioned by gastrointestinal diseases in 2017 (according to penitentiary institution (%)



Sufficiency of doctors in penitentiary institutions (number of detainees and arrestees per one doctor)



Number of major surgeries (=laparotomies and/or other surgeries with general anaesthesia) in 2017: not registered

Number of emergency admissions of prisoner patients: not registered

Number of outpatient services for prisoner patients: not registered

Duration of prisoner patients' stay in days, range, median not registered

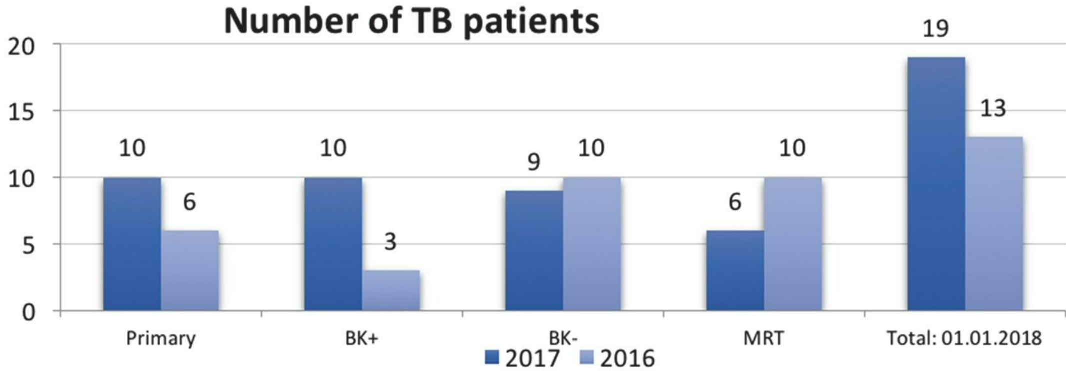
Number of deaths of prisoner patients in civil hospitals: 7

Mental diseases. According to penitentiary service data, places of detention are overcrowded with people who have mental disorders. The indicator of the disease spread exceeds the analogical indicator among the civil population for several times. Unfortunately, there is no statistics which

could help to know how many people need psychological treatment. When attending the “Detainees’ hospital”, 10 people were registered receiving corresponding treatment. But it can be surely said that the spread of the disease is much more. There can be some explanations about the large-scale spread of the disease.

Self-harm. It is characteristic for all penitentiary institutions for all over the world the high level of self-aggression and self-harm. In penitentiary institutions of the RA most typical manifestations of the disease are swallowing foreign objects, fracture of limbs, etc. Officially no statistical report is done. But in average 20-50 cases of self-harm are registered every year.

Airborne, droplet infections. The overcrowding of penitentiary institutions is a problem for the whole world which potentially creates conditions for quick spread of airborne and droplet infectious diseases. Traditionally, places of detentions have always been associated with high level of tuberculosis. But during the last 3-4 years the situation with tuberculosis spread has been improved which is explained with the fact that anti tuberculosis services are provided with first-line agents.



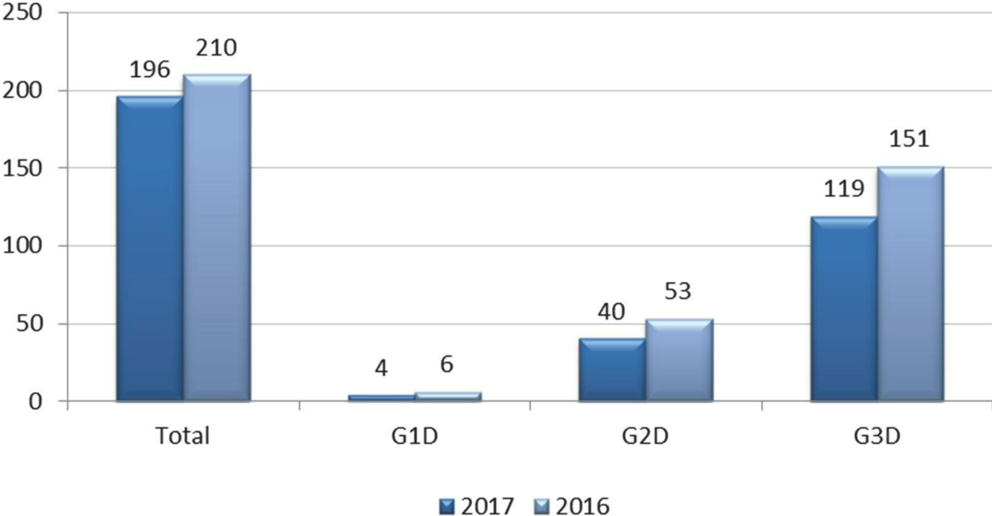
Sexually transmitted and blood-borne infections. It is characteristic for places of detention the large-scale spread of sexually transmitted infections. The situation with the HIV/AIDS and blood-borne infections in prisons is highly determined by the peculiarities of the epidemiology in the country.

According to HIV research results in penitentiary system 2016[14], the overwhelming majority (94%) of prisoners has heard about HIV/AIDS. 31.7 % of the respondents excluded, 54.4 % of them viewed unlikely the possibility to be infected with HIV. During the last 12 months 54.4 % of the respondents were given contraceptives (condoms) within the framework of preventive programs. Though 83.7 % of respondents stated the accessibility of consultations and examination services, only 50.4 % of them has been examined on HIV, 89.3 % has been informed about the exam results during the last 12 months. 85.1 % of the examined has done the examination free-will. The inclusion rate in preventive programs has been 80.7 %.

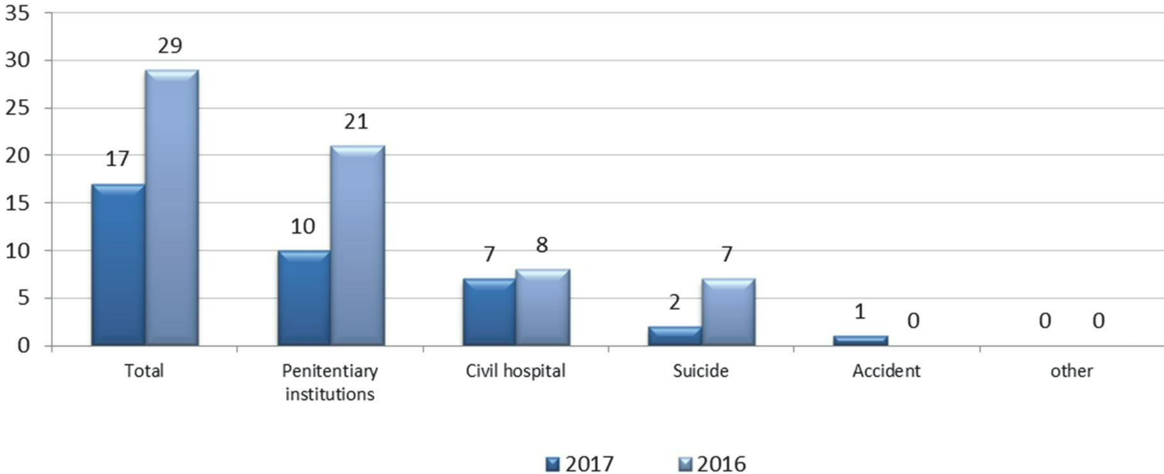
Infectious hepatitis is an essential issue in penitentiary system. It has a large-scale spread and epidemiological potential. Hepatitis is the main cause of death conditioned by liver pathology. There are no statistical data on this issue in Armenia.

[14] http://www.armaids.am/images/pdf/BBS_PRISONERS_ARM_REPORT_FINAL_2016_arm.pdf

The disabled. Though the incarceration should be implemented only as an extreme measure especially when talking about disabled people, there are disabled people in penitentiary institutions. Among them- people with physical, psychological, mental disorders. They face numerous problems in penitentiary institutions, as they have no proper conditions to meet the needs of disabled people.



The death picture in penitentiary institutions is as follows:



Interrelation with healthy society. Penitentiary institutions have direct and indirect effects on the health of the society in whole. Very often the prisons have immediate impact on the epidemiological situation in society.

WHO strongly recommends that prison and public health care be closely linked. The Moscow Declaration on Prison Health as a Part of Public Health (WHO Regional Office for Europe, 2003)[15] elaborated on some of the reasons why close working relationships with public health authorities are so important.

- Penitentiary populations contain an overrepresentation of members of the most marginalized groups in society, people with poor health and chronic untreated conditions, drug users, vulnerable people and those who engage in risky activities such as injecting drugs and commercial sex work.
- The movement of people already infected with or at high risk of disease to penitentiary institutions and back into civil society without effective treatment and follow-up gives rise to the risk of the spread of communicable diseases both within and beyond the penitentiary system. Prevention and treatment responses must be based on scientific evidence and on sound public health principles, with the involvement of the private sector, nongovernmental organizations and the affected population.
- The living conditions in most prisons of the world are unhealthy. Overcrowding, violence, lack of light, fresh air and clean water, poor food and infection-spreading activities such as tattooing are common. Rates of infection with tuberculosis, HIV and hepatitis are much higher than in the general population. The Declaration makes a series of recommendations that would form the basis for improving the health care of all detained people, protecting the health of penitentiary personnel and contributing to the public health goals of every Member State in the European Region of WHO.

Prisons are closely linked to communities. Prisoners go on leave, receive visitors and sometimes attend outside work placements or health care facilities. The vast majority of prisoners will eventually leave prison and reintegrate into society. Prison personnel constantly oscillate between prisons and their communities. Thus, prisons also affect public health in the wider community. Even though reporting of health-related data from prisons is rather poor, evidence indicates that outbreaks of TB in prisons have caused increased TB in local communities[16].

Prison settings thus present a challenge to public health. According to a recent scientific review of how prisons affect public health, prisoners whose physical and mental illnesses are not adequately dealt with during incarceration may "... act as reservoirs of infection and chronic disease, increasing the public health burden of poor communities". Consequently, "tackling the mental and physical illness of prisoners will improve public health"[17].

It is noteworthy that according to WHO statistics the main cause of morbidity and mortality in world are non-communicable diseases, in particular blood circulatory system diseases, cancer, pancreatic diabetes, lung diseases, mental diseases, fractures and intoxication. In Armenian society the burden

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[15] http://www.euro.who.int/__data/assets/pdf_file/0007/98971/E94242.pdf

[16] Stuckler D et al. Mass incarceration can explain population increases in TB and multidrug-resistant TB in European and central Asian countries. *Proceedings of the National Academy of Sciences of the United States of America*, 2008, 105:13280–13285.

[17] Good governance for prison health in the 21st century. A policy brief on the organization of prison health, WHO, UNODC. http://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf

of mortality from the non-communicable diseases is approximately 80%. Blood circulatory system diseases are on the top position – 48%. It is the same in penitentiary institutions. On the second position is cancer – 20.6%, then pancreatic diabetes – 4.8%, fractures, intoxications and external reasons – 4.7%, lung chronic diseases – 3.6%.

The primary health care is the fundament of all medical services in prisons. The full set of the functions in prisons' health units includes not only clinical care, but also diseases' prevention, supervision of sanitary condition, hygiene, food safety and security, and health promotional activities. The previous CoE needs assessment report[18] focused on the importance of improvement of PHC including the gate keeper function for secondary and hospital care.

Hospital care

In civil health care system around 90% of all medical cases are managed on primary health care level, and about 10-12% are referred to secondary and tertiary care level. Considering the high prevalence of infections, traumas and injuries and other surgical and specialized care requiring cases among prisoners and overall deteriorated health condition of prisoners in comparison with civilians' health the number of referred to hospital cases is higher.

In regard of specialized (secondary) health care in the penitentiary system it is stated by the assessment mission that the physical condition as well as the equipment of the prison hospital are completely inadequate to meet the basic requirements of a hospital: the material conditions of the building causing severe sanitary/hygienic deficiencies pose a health threat to patients and the lack of minimal requirement such as availability of an Intensive care unit (ICU) with monitoring, life supporting and modern resuscitation equipment preclude the required licensing as hospital with a major surgery department. It is strongly suggested to re-organize the secondary health care structure within the penitentiary system. The recommendation regarding non-surgical secondary health care departments currently available in prison's hospital is to reallocate them to newly constructed facilities such as the large Armavir health care unit. The latter has having 120 beds capacity and satisfactory material conditions adequate to hospital care.

In case of surgical and other cases requiring specialized care, it is recommended to refer patients to the civil hospitals, which have the capacity to provide the security and separation for those patients. There are many factors and points for justification of full re-organization of the secondary health care in penitentiary system. One of them is absence of the surgeon in prison's hospital for a pretty long period of time; other essential elements for provision of continuity and quality of care are other staff turnover issues in the hospital, absence of ICU, unsatisfactory material and physical condition of the building, growing tendency in referrals to the civil hospitals. In order to finalize and prove the effectiveness of maintaining hospital prison versus its re-organization cost-benefit analysis is recommended.

[18] Vladimir Ortakov, Jörg Pont, Roza Babayan, Naira Gharakhanyan, Davit Khachaturyan:
Report on the assessment mission on health care in prisons in the Republic of Armenia, July 2015

Current Medical Management

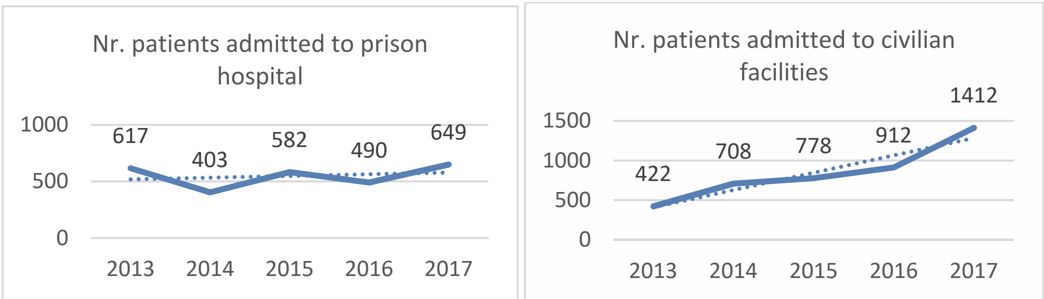
The Prison Hospital

Currently, there is one prison hospital in the country under the rule of the MSUoPD. The prison hospital cares only for male adult inmates, all female and juvenile inmates in need of hospital care are transferred to civilian hospitals. It is located in Yerevan. The premises were built in 1828. Their poor material conditions and state of maintenance, sanitary conditions and the lack of barrier free access and of elevators in the one-storied buildings do in no way comply with contemporary prerequisites for hospital buildings. Therefore, already in the Report of a Council of Europe Expert Visit to Evaluate the Prison Health Services in Armenia from May 2000 (The Arpo/Ekeid Report) the authors recommended “that all patients in the Central Prison Hospital should be transferred forthwith to civilian hospitals and/or the Hospital of the Ministry of Interior, pending either a full and thorough rehabilitation of the buildings or the building/finding of new accommodation for the central prison hospital.” For the same reasons, the 2015 CoE assessment report recommended to close down the prison hospital and see for hospital care of inmates in other facilities.

The number of systemized beds in the prison hospital is 424, however according a statistic from December 5, 2016, only 366 beds were available for actual use. In 2017 the average number of occupied beds/day was only 89 and has been steadily decreasing over the last 5 years (Fig.1):

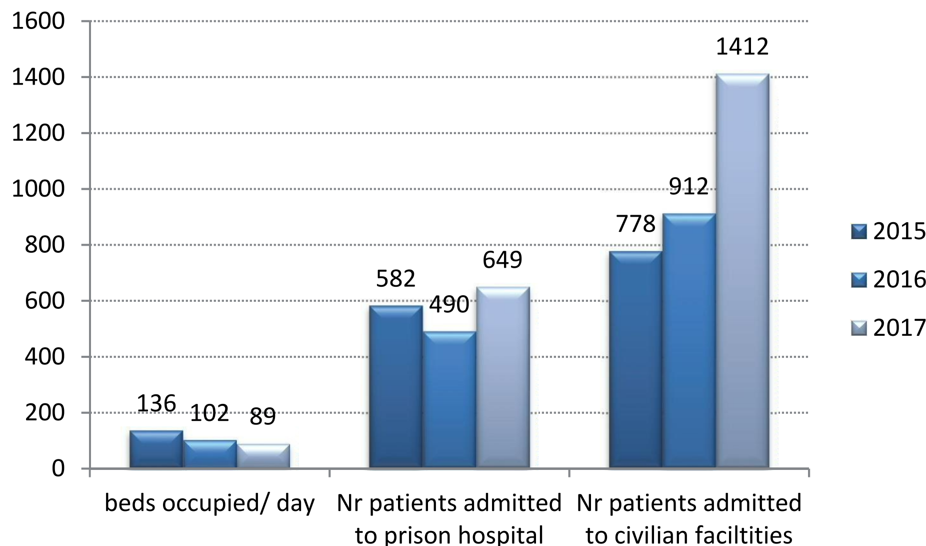
The number of inmate admissions to the prison hospital in 2017 was 646 and has been showing a stable trend over the last 5 years whereas the number of inmate patients admitted to civilian hospitals, transferred from prisons and from the prison hospital, more than tripled over the last five years (see below Civilian hospitals, Fig. 2a and b).

Figure 2a, b



The median duration of patients’ stays in the prison hospital in 2017 was 89 days which is an excessively long hospitalisation figure in comparison to median patients’ stays in community hospitals that requires explanation of the underlying causes.

The development of bed occupancy and the number of patients admitted in the prison hospital and the number of patients admitted in civilian hospitals over the last three years is shown in the following graph:



It can be seen that, despite the fact that the bed fund in the prison hospital has maintained the same, by 2017 the number of detainees and convicts conveyed to civilian hospitals has been twice more than in 2016, and the average beds occupancy rate in the prison hospital decreased to 89 of 366 available beds.

According to data provided in the questionnaire on the prison hospital, there are the following 10 department systemized, in addition to the head department (staff: 3) and the medical group on duty (staff: 12):

- therapeutic department (actual beds: 35, medical staff: 5);
- surgical department (actual beds: 34, medical staff: 11);
- department for infectious diseases (actual beds: 0, medical staff: 6);
- tuberculosis (TB) department (actual beds: 95) with sections for regular TB (staff: 3), multidrug resistant tuberculosis (MDR TB) (staff:3) and bacteriological laboratory group;
- psychiatric department (actual beds: 41, staff: 8);
- narcological department (actual beds: 12, staff: 5);
- clinical and biochemical laboratory department (staff: 3);
- department of functional diagnostics and physiotherapy (staff: 4);
- X-ray department (staff: 2);
- dental department (staff: 3).

However, the department for infectious diseases is since 2016 not in function and patients with infectious diseases are therefore treated in the therapeutic department.

From the total systemized medical staff of the prison hospital, n=74 (38 doctors, 22 nurses and 14 medical technicians), 8 posts were vacant at the time of the assessment visit. In addition, 1 trained pharmacist is running the hospital pharmacy. During nights and weekend, 1 doctor and 1 nurse are

on duty for the whole hospital, i.e. if specialized emergency expertise is needed at these times, a specialist has to be called in (11 times in 2017) or emergency transfers to civilian hospitals are arranged (56 transfers in 2017).

In addition to the medical staff, 160 non-medical staff (143 custodial staff and 17 administrative staff) is employed at the prison hospital.

The 2017 annual budget of the prison hospital was 700 million AMD, consisting of 573 million for staff, 8 million for medical equipment and medication and 199 million for maintenance (heating, electricity, cleaning, refurbishment, repairs…).

The dentistry department is, according to the dentist, appropriately equipped and cares on average for 6 patients each working day. Jaw surgery is conducted in cooperation with the surgical ward, dental X-ray is performed by the general X-ray device of the hospital.

The intervention part of the surgical ward, located in the first floor of an old building without elevator, has two theatres, one for aseptic and one for septic operations, a wound care room, a manipulation room and an endoscopy room, all of them very basically equipped but, according to the specialist surgeon, functioning including the outdated looking anaesthesia machines. There is no anaesthetic recovery room and no intensive care unit (ICU). Most frequent major interventions are performed for gastrointestinal bleeding, hernias and paraproctitis. Occasionally, cholecystectomies are also performed but, according to the head of the MSUoPD, should not be performed because there is no back up by an ICU in case of post-operative complications. An anaesthesiologist who works in a civilian hospital is on the pay roll of the prison hospital and is called in if required. In 2017, 51 major surgeries (i.e. laparotomies and/or other surgeries with general anaesthesia) have been performed. Removal of swallowed foreign bodies is all the time done by laparotomies because the gastroscopist lacks a device for retrieving them endoscopically.

The General Diagnostic Unit is equipped with an old 1-channel ECG, a very old sonography device, a first-generation echocardiography machine without ejection fraction calculation and Doppler technique and a device for electro-physiotherapy.

The most frequent conditions treated in the therapeutic department are peptic ulcers, hypertension, diabetes mellitus, ischemic heart disease and oncological diseases that are cared for under guidance of oncological centres in community hospitals. Although formally existing, the infectious diseases department currently is not in function. Therefore, non-tuberculous infectious diseases currently are cared for in the therapeutic department. The interior of the patient rooms in the therapeutic department look more like normal prison dormitories and the sanitary units of the ward are in an extremely poor condition.

The consultants got the impression that a majority of patients in the therapeutic department with chronic conditions such as arterial hypertension and diabetes mellitus not necessarily were in need of hospital care but easily could be treated in primary health care units of prisons provided well trained primary health care physicians and/or specialist consultants care for them or supervise their treatment.

The same is true for the psychiatric ward located in the second floor of the same building. The most frequent diagnoses to be treated in this ward are personality disorders, organic psycho-syndromes, reactive psychosis and only rarely bipolar and schizophrenic disorders. The senior psychiatrist reports that, in contrast to three years ago at the consultant's last visit, there is now access to second generation atypical neuroleptics but there is still no non-pharmacological treatment available such as occupational therapy for mentally disordered patients because of lack of space and lack of appropriate staff.

The tuberculosis (TB) department consists of separated units for non-infectious patients, infectious drug sensitive and infectious drug-resistant patients. The TB lab provides smear microscopy and, since April 2017, is in possession of a GeneXpert machine. Specimens for conventional TB culture and sensitivity testing are sent to the National TB Centre. Currently there are 5 MDR patients, 3 of them on bedaquiline or delamanide combination treatment within a national program for XDR patients. Two patients have been treated for HIV plus TB infection.

The radiologist of the X-ray department of the prison hospital assesses the regular 6-monthly fluoroscopic chest images for active case finding that are sent to him from all prisons on CDs. The X-ray department is in possession of a digital X-ray device, however, due to a lack of an appropriate interface for an X-ray data base, radiological images still are developed by wet chemistry and stored as hard copy films.

The clinical and biochemical laboratory department provides blood counts and basic biochemical blood and urine tests and hepatitis B and C antibody rapid tests but no HIV rapid tests. Whenever additional lab tests are required specimens are sent to labs of civilian facilities.

In the narcological department currently 12 patients were on methadone maintenance treatment and 7 patients underwent detoxification treatment supported by low doses of tramadol.

According to the answered questionnaire, the hospital infection control is carried out by Hygienic-Epidemiological Centre of RA Police Medical Department. However, according to the Report on Needs Assessment Mission of Infection Control and Sanitary-Epidemiological Maintenance of Healthcare Units and Hospitals in Prisons in the Republic of Armenia from November 2017, pages 9 – 12, many deficiencies regarding prevention of hospital infection, hospital infection surveillance and control as well as non- compliance with legal requirements, particularly the orders of the Ministry of Health No. 3023-A and 24/03/08 N03-N, N2.1.3-3. have been identified in the prison hospital.

Civilian hospitals

The number of inmate patients admitted to civilian hospitals, transferred from prisons and from the prison hospital, more than tripled over the last five years (Fig. 2b)._As of services for inmates in civilian hospitals in the year 2017, 1748 were requested directly from prisons and 150 from the prison hospital. All female inmates and juveniles in need of hospital care have been admitted to civilian hospitals because the prison hospital in Yerevan has no department for women and juveniles.

The prisons with the highest referral numbers to public health care facilities in 2017 were Armavir (49 for treatment and 295 for examination), Nubarashen (88 for treatment and 272 for examination),

and Vanadzor (9 for treatment and 234 for examination). Nearly a quarter of all patients admitted to the prison hospital (150/649) was further transferred from the prison hospital to civilian hospitals (87 for treatment and 63 for examination).

Of all 12 penitentiary institutions including the prison hospital 1748 inmates underwent in 2017 health care services in civilian hospitals, 336 for treatment and 1412 for examination.

The most frequent nosological reasons for transfers to civilian health care facilities in 2017 were cardiovascular disorders (527) followed by gastro-intestinal (413), respiratory (265), genitourinary (172), endocrinological (119), neurological (114), neoplastic (90) and psychiatric disorders (61).

Most transfers to civilian hospitals were covered by Erebuni Hospital, Saint Grigor Lusavorich, Astghik, Armenia medical centers and regional medical centers.

National Centre for Mental Health

The national Centre for Mental Health (NCMH), formerly the Nubarashen Mental Hospital, is the largest psychiatric facility and 6th largest hospital in the country. It is run under the responsibility of the MoH including the forensic units which are completely separated from the "civilian" wards by a concrete wall. The Centre has a total capacity of 410 beds, currently there are 367 patients including the patients in the forensic units. In the forensic unit there were currently 4 inmates on forensic assessment in the assessment ward with a capacity of 10 beds in addition to outpatients on assessment (on the day of the visit n=7) and patients on compulsory treatment in ward with a capacity of 60 patients. The Centre currently is staffed with 22 doctors and 2 clinical psychologists. Of great concern to the assessment team was that, while external security is guaranteed by police officers, the internal security is managed by "orderlies", employees with no specialized education or training for their difficult job. According to the director of the Centre, for pharmacological treatment all second- generation atypical neuroleptics are available but rarely used by the doctors because of their conservative attitude and lack of training which keeps them using the old drugs they are familiar with. There is virtually no non-pharmacological treatment such as occupational therapy available. The very poor condition of the premises of the Centre, the very poor sanitary conditions of the patient wards and the completely insufficient facilities for non-pharmacologic psychiatric treatment such as occupational therapy appeared to the consultants to be in striking contrast to the new policies and programs of the Centre as expressed by the new director, i.e. a focus on research, occupational therapy, de-stigmatisation, and normative reform of mental health care. He also stressed that legal reforms are urgently needed that, inter alia, should set new rules on compulsory treatment, for psychologists' job profiles and for licensing of forensic expertise.

Secondary out-patient health care

Out-patient secondary health care comprises all health care that needs specialist medical expertise without needing admission to a hospital facility. For the purpose of this report we define dental care as part of primary health care and do not include it into secondary health care, particularly as, according to the 2015 CoE assessment report, it seems to be comparatively well-arranged in Armenian prisons. Out-patient secondary health care for prison inmates can be provided by specialists employed in prisons, contracted specialists coming into the prison (polyclinic structure) or

by escorting prison inmates to specialists practising outside prisons e.g. to outpatient departments of civilian health care facilities.

Currently, in a few prisons there are specialists full-time employed such as in the Nubarashen prison (neurologist, psychiatrist, gastroenterologist, surgeon, phthisiatrist) and in the Abovyan prison (gynaecologist), who in part cover also primary health care. However, their certification of continuous medical education (CME) is unclear or lacking. In 4 of the 6 prisons visited at the 2015 CoE assessment report there were no specialists employed and, as mentioned before, in the Vanadzor prison there was no physician at all employed.

The polyclinic option with contracted specialists coming regularly and/or ad hoc to prisons seems to be not or not well developed. Even in the Armavir prison where reportedly a full range of specialists are under contract, the number of escorts to outside medical facilities in the year 2017 was around 400, each escort requiring two custodial officers to guard the patient.

Of greatest concern is the lack of psychiatrists. According to CPT, a doctor qualified in psychiatry should be attached the health care service of each prison, and some of the nurses employed there should have had training in this field[19] . At the time of the 2015 CoE assessment visit, in 5 of the 6 visited prisons no regular psychiatric service was available apart from the regular 6-monthly

visits of the Medical Working Commission. This situation is all the more alarming in light of the high prevalence of mental disorders within the prison population and the modest level of training of medical generalists in Armenia in the field of mental health care.

Deliberations for Options of Improvement

Prison health care governance

The recent decision by the Government of the Republic of Armenia to take the responsibility for prison health care away from the Penitentiary Department and subordinate it directly under the MoJ is a step to be commended as it is a step towards independence of prison health care from penitentiary administration and is in line with CoE and other international recommendations[20] [21] [22]. The accompanying administrative change offers at the right time a good opportunity for restructuring prison health including hospital and other secondary health care which is the target of this report.

Primary health care as gatekeeper for hospital and other secondary health care

[19] Health care services in prisons. Extract from the 3rd General Report [CPT/Inf (93) 12] 41.

[20] WHO, UNODC: Good governance for prison health in the 21st century. A policy brief on the organization of prison health, 2013. http://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf?ua=1

[21] CoE, WHO: Strasbourg conclusions on health and prisons, 2014. http://www.euro.who.int/__data/assets/pdf_file/0005/252563/Strasbourg-Conclusions-on-Prisons-and-Health.pdf?ua=1

[22] Pont J, Enggist St, Stöver H, Williams B, Greifinger R, Wolff H: Prison healthcare governance: guaranteeing clinical independence. American Journal of Public Health 108(4) 472-476, 2018

A basic prerequisite for proper planning of secondary health care is to have appropriate and efficient primary health care structures in place that function as gate keeper for secondary health care and reduce inappropriate use of expensive hospital and other secondary health care facilities. This is, why in the framework of the ongoing "Strengthening health care and human rights in prisons in Armenia" project, the CoE's preceding efforts in supporting the country focused on improving primary health care services in prison. In addition to the proposed and ongoing efforts for improvement of primary healthcare such as proper staffing, training and qualifying of health professionals and of refurbishment and updating equipment of primary health care units in prison, in the frame of primary health care the establishment or strengthening of efficient nursing care in well-equipped prison infirmaries and/or day clinics is able to decrease undue use of secondary health care structures considerably. Such units can appropriately treat inmates with minor infections or other minor acute disorders and many chronic disorders not in need of a hospital care under the supervision of primary health care staff and/or guidance of specialist consultants. Like all other medical units, they need to be licensed for their purpose by the health authorities of the country.

Likewise, mobility-disabled inmates should be cared for in barrier-free primary health care facilities with adequately equipped sanitary installations and toilets that meet their needs as it was shown to be done already now in the Armavir prison.

Secondary out-patient health care

A large part of secondary health care, i.e. health care that needs medical expertise beyond primary health care, can be provided in outpatient settings with the involvement of specialists, thus sparing expensive stationary hospital treatment. For the penitentiary situation, this can principally be organized either by escorting inmate patients to specialists practising in the community or in outpatient departments of civilian hospital facilities or by employing specialist in prisons or calling in contracted specialists to the prison, i.e. the polyclinic model. Escorting inmate patients to outside health care facilities needs at least two custodial staff throughout the transport and the stay in the facility in addition to the transport logistics and the vehicle. Therefore, the polyclinic model, i.e. employed or contracted specialists practising in equipped medical rooms in prisons at scheduled visits and whenever urgently needed in the prison is to be preferred both in terms of security as well as in terms of custodial staff saving and cost efficiency. This stays true, certainly in the long run, even if specialized non-portable diagnostic equipment such as ultrasound and echocardiography machines need to be procured upon carefully calculated needs assessment in cooperation with the specialists. Diagnostic laboratory services needed for out-patient specialist care can be obtained from contracted civilian medical laboratories or laboratories of regional hospitals by transporting specimens (in respect of national law on transporting biological material) to the outside lab facilities rather than escorting inmate patients.

A good part of conservative (i.e. non-operative) treatments that result from specialist diagnostic services can safely be applied as outpatient treatment in prison or in prison infirmaries or day clinics under the guidance of specialists as outlined above. Examples include those diagnoses patients currently are most frequently treated for in the therapeutic department of the prison hospital such as diabetes mellitus, arterial hypertension, chronic cardiovascular disease, peptic ulcers etc. It holds true also for infectious diseases that are not or not anymore transmissible through ordinary social contacts such as HIV disease, hepatitis B and C, tuberculosis in the continuation phase of treatment

and others. In addition, pre-operative care such as preparatory diagnostic checks for fitness for general anaesthesia and preparation for the surgical intervention as well as post-operative care and rehabilitation that does not need any more hospital care can be conducted under specialist surveillance and in cooperation with the surgical centre in prison infirmaries, thus reducing the time of hospital stays for these patients.

In order to optimally link specialist outpatient services with hospital in-patient care if needed, contracts with specialists working in regional civilian hospitals might be preferable rather than contracting specialists not linked to hospitals.

A matter of consideration are the specialist doctors employed in the penitentiary system who currently provide primary health care. On the one hand they do not have the qualification/license as general practitioners or family doctors as needed for primary healthcare, on the other hand their specialist training could and should be deployed for secondary health care services provided it is regularly updated by CME. Re-organizing health care professionals working in prison should foresee that qualification/licensing of health care professionals matches with their medical job profile and job description.

The above delineated polyclinic model for out-patient secondary health care is already established rudimentarily in a few Armenian prisons as described above in Current Medical Management/Out-Patient Secondary Health Care. However, the high number of escorts (>400 from the Armavir prison in 2017) shows the need to strengthen and expand this model considerably.

Hospital care

Hospital care for prison inmates principally can be provided in penitentiary hospitals or in civilian hospitals. In Armenia, as in several other European countries, both options are in use because prison hospitals do and cannot cover all the expertise and technical equipment that may be required for contemporaneous state-of- the art medical care of all patients. In a CoE survey from 2014, 29 out of 45 CoE member states/Länder ran prison hospitals whereas 16 countries did not (Table 1)[23]. The median capacity ratio of available prison hospital beds/number of prison inmates in the 29 countries was 1/54 with a wide-spread range. Armenia showed in this survey to have the greatest hospital bed capacity with 1 prison hospital bed for each 7 prison inmates. The survey also showed that countries with prison hospitals reported on higher yearly hospitalisation rates of inmates (18%) than countries without prison hospitals (7%) and considerably longer hospital stays in prison hospitals than in civilian hospitals.

Table 1:

Countries/Länder with prison hospitals: 29/45

[23] Pont J: General overview of the structure, organisation and management of prison health care services in Council of Europe member states. Presentation at the Multilateral Meeting on Organisation and Management of Prison Health Care, Strasbourg, 12-13 October 2017, Council of Europe

	median	range
capacity ratio beds/inmates:	1/54	1/7 – 1/3381
inmates hospitalized 2013:	11%	1% - 39%
duration of stay, days	30	1 – 424
hospitalized in civilian facilities:	7%	1 – 20%
Countries/Länder without prison hospitals:	**16/45**	
hospitalized in civilian facilities	7%	6 – 16%
duration of stays, days	4	2 – 22

Examples of European countries running prison hospitals include Albania, Austria, Azerbaijan, Bulgaria, Czech Republic, Denmark, Estonia, Finland, Georgia, Greece, Latvia, Lithuania, Moldova, Portugal, Romania, Slovakia, Spain, Turkey, some Swiss cantons and eight of the 16 German Länder, whereas Bosnia Herzegovina, Cyprus, Iceland, the Former Yugoslavian Republic Macedonia, Malta, Montenegro, Norway, Slovenia, Sweden, the United Kingdom and 8 of the German Länder provide all hospital care for prison inmates in civilian facilities. The wide variety of organisation structures for hospital care of prison inmates in various European countries may be illustrated by the following examples:[24]

In France, hospitalization is organized either in the neighbouring hospital (for hospitalisation<48h), or in the UHSI (8 Unités Hospitalières Sécurisées Interrégionales, 182 beds) (hospitalisation>48h) or, for forced psychiatric hospitalization in the UHSA (7 Unités Hospitalières Spécialement Aménagées, 340 beds).

In Scotland, secondary health care services are partially provided within the prisons through in-reach provision by specialists. If necessary, healthcare staff is entitled to refer prisoners to second line services outside prisons. The Scottish Prison Service is responsible for organizing the transfers. Utilization of "Telehealth" in prison is under development, with one of the objectives being to reduce transfers to hospitals through support to decision making and triage. Videoconferencing equipment is in place in 7 out of the 15 prisons (as of April 2016) - delivering "a range of services from forensic psychiatry to Teleneurology" - and the provision of Cognitive Behavioural Therapies delivered by phone in 10 prisons.

In Switzerland, in an emergency or complex treatment situation, detainees are transferred to hospital. In French-speaking Switzerland, prisoners requiring special safety conditions are placed in a hospital cell unit, such as in the Cantonal Hospital of Geneva. In Switzerland, there are two medical prison wards, one in Geneva and one in Bern. The High Security Ward (BEWA) of the Inselspital in

[24] Data derived from: Dubois C, Linchet S, Mahieu C, Reynaert J-F, Seron P. Organization models of health care services in prisons in four countries. Health Services Research (HSR) Brussels: Belgian Health Care Knowledge Centre (KCE). 2017.KCE Reports 293. D/2017/10.273/69.

Bern is part of the Clinic for General Internal Medicine with 13 beds. The High Security Ward is built both as a prison and as an emergency hospital. The medical staff and guards are specially trained for working with prisoners.

In the Netherlands, if primary healthcare offered inside the prison is not sufficient, prisoners can be sent to the medical care centre (56 beds) of the prison of Scheveningen. The Scheveningen Medical care centre seemed unable to meet the need for secondary care coming from all the Dutch prisons. The hospital does not always have sufficient bed space, or the required expertise. As a result, many prisoners are transferred directly to a civilian hospital.

When principally weighing advantages of prison hospitals against having all hospital care conducted in civilian facilities, the most obvious argument for prison hospitals seems to be safety and security, because of the prison-specific security provisions. In this context it was remarkable for the consultants to hear that the free movement of patients inside the prison hospital was regarded as a security risk.

Concentrating on medical and medical-ethical reasoning, there is little if any advantage of prison hospitals in comparison to hospital services for inmates in civilian facilities. As far as major surgery is concerned, there is scientific evidence that the low frequency of major surgical interventions in prison hospitals in comparison to large civilian hospitals is disadvantageous for patients because of a clear relationship between higher surgical volume and lower postoperative mortality in larger hospitals.[25,26] In addition, the professional expertise and equipment needed in order to guarantee the same level of surgical safety and quality as in community hospitals are rarely if ever affordable in the penitentiary system, e.g. if intensive care unit (ICU) care becomes necessary postoperatively. This holds true also for non-surgical intensive medical interventions in need of highly specialised expertise and equipment such as in acute coronary heart disease, acute vascular brain disease etc. Disregarding these arguments risks the violation of the medical ethics principle of equivalence of care[1].

A different approach may be justified for inmate patients with infectious diseases contagious by ordinary social contact such as infectious TB: The need to separate contagious TB patients from other inmate patients (and contagious MDR TB patients from treatment sensitive contagious patients) may pose less challenges in the prison setting than in civilian hospitals. In addition, the high prevalence of TB in prison populations has led to an accumulated clinical and radiological expertise on this disease in phthisiatrists/pulmonologists working in penitentiary systems in well-functioning close cooperation with the National TB Centre. This specialized expertise should continue to be used.

The current condition of the prison hospital in Yerevan, as described above in Current Medical Management does in many ways not comply with the minimum requirements of a hospital including the poor material conditions and state of maintenance of its premises; the unacceptable conditions of the sanitary rooms and toilets; the lack of barrier free access and lack of elevators in the one-storied buildings; the lack of an anaesthetic recovery room and or ICU while major surgical

[25] Luft HS, Bunker JP, Enthoven AC. Should operations be regionalized? The empirical relation between surgical volume and mortality. N Engl J Med 1979;301:1364-1369

[26] Urbach DR. Pledging to eliminate low-volume surgery. N Engl J Med 2015;373:1388-1390

interventions still are performed; deficiencies regarding the prevention of hospital infection and infection control; lack of specialized staff during nights and weekends. Therefore, like in the previous CoE assessments, the consultants strongly recommended to close down the prison hospital and see for hospital care of inmates in other facilities.

The recent 2017 data on the prison hospital in Yerevan as delineated above in Current Medical Management show the low and decreasing occupancy rate and unexplained excessive duration of hospital stays in the prison hospital in contrast to the dramatic increase of admissions of inmates in civilian hospitals including the high rate of transfers of inmate patients from the prison hospital to civilian hospital facilities. This development gives the impression that the penitentiary health care authorities in the country have already taken into account to a certain extent the above-mentioned reasoning. However, as currently there are no secured wards for prison inmates established in civilian hospitals, inmate patients each need to be guarded by two security officers for the duration of their hospital stay causing considerable consumption of custodial staff resources as well as frictions with civilian patients and staff in civilian hospitals.

Establishing secured wards for prisoner patients fully integrated in the clinical service of civilian hospitals but with separate entrance and fenced from civilian patients and guarded by a small team of security officers assigned for the custody of prisoner patients in the hospital would allow for equivalent clinical care of inmate patients and for providing security by less custodial staff than with the current practice and for avoiding frictions with the “civilian” part of the hospital.

From an economic point of view, the common use of human resources, premises and equipment of a large hospital facility, be it a private one or a state owned, for both civilian and prison inmate patients should be more cost efficient for the state than running separate hospital institutions for the comparatively small number of prisoner patients who are in real need of hospital care. As mentioned above in Out-Patient Secondary Health Care, a major part of patients currently treated in the prison hospital can be taken care of in out-patient settings, infirmaries and day clinics of medical units of prisons provided that the above delineated polyclinic model of outpatient secondary health care will be strengthened and expanded. Given these prerequisites, the head of the MSUoDP together with the consultants estimate that, based also on international experience, not more than a total of 25 beds in two or three secured wards of civilian hospitals should be sufficient.

In the CoE assessment report from 2000 (Arpo/Ekeid Report) as well as during the current assessment team’s visit to the MoH, the Hospital of the Ministry of Interior was taken into consideration as a possible option of a civilian hospital that could serve for hospital care of prison inmates. As the consultants didn’t visit it during their assessment, they cannot have an opinion whether this hospital, form a medical point of view, would suit for this purpose and has all the needed specialist departments. However, caring for law enforcement officers and offenders under one and the same hospital roof gives cause for concern in addition to the possible challenge of involving an additional ministry.

For treatment and separation of contagious TB/MDR TB patients it seems reasonable to keep a small central TB hospital unit inside the penitentiary system, possibly within the spacy Armavir prison medical unit, whereas non-contagious or not anymore contagious TB patients can receive DOTS treatment and care in penitentiary outpatient settings.

When planning the needed number of beds for hospital care of inmates it should be assured that each emergency case can be admitted immediately whereas for planned hospital interventions such as selective surgical interventions a transparent waiting list should be established. The electronic waiting list for hospital admissions in the Georgian penitentiary system may serve as an example of good practice in this regard as it prevents undue preferences of certain inmates. Likewise, the duration of hospital stays of patients' needs to be decided and documented exclusively on traceable medical grounds in order to keep capacity for emergency cases and to avoid undue hospital stays.

Care for mentally disordered inmates

The care for mentally disordered patients poses extraordinary challenges to health care in prison because of their high prevalence and the lack of health professionals trained and specialized in this field. The importance of primary healthcare services, particularly the medical examination upon admission, for identifying inmates with mental disorders cannot be overestimated and stresses the need of proper training of primary health care professionals.

The care of patients with acute and severe mental disorders such as acute psychosis, major depression, acute suicidality is incompatible with detention in a prison and must be conducted in specialized institutions[27] with specialized staff and a therapeutic environment providing proper pharmacological and non-pharmacological treatment. Currently, these patients are treated in the psychiatric ward in the Yerevan prison hospital and in the NCMH in Nubarashen. As described in Current Medical Management, both institutions have specialized staff and access to state of the art psychopharmacologic treatment but provide little if any non-pharmacologic treatment options such as occupational treatment and the condition of the premises and sanitary facilities of both institutions are in a very poor state that do not comply with minimal requirements of a psychiatric hospital and would need major renovation and refurbishment.

As of international practices, there are different models of organisation of the penitentiary mental health care services for the persons in need of in-patient psychiatric treatment[28]. On the one hand, there is a model with completely separated forensic psychiatric institutions, where the persons who committed crimes and seek in-patient psychiatric treatment, both the ones declared criminally irresponsible after the conviction and the ones who seek psychiatric treatment for different reasons while in prison, are treated in completely separated institutions from the mental health institutions for general population. Usually, the forensic mental health services in this case are under the jurisdiction of the Ministry of Justice.

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

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[27] European Prison Rules, CoE Rec(2006)2, Basic principles 12.1

[28] Extracted from: Vladimir Ortakov, Jörg Pont, Roza Babayan, Naira Gharakhanyan, Davit Khachaturyan: Report on the assessment mission on health care in prisons in the Republic of Armenia, July 2015

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

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

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

The current state of organisation of penitentiary mental health services in the Republic of Armenia is closest to the model described as semi-separated. The persons sentenced to imprisonment in need of inpatient psychiatric care currently are placed either in the medical units of different prisons or in Yerevan Prison Hospital, whereas the NCMH provides mental health care for persons sentenced with a measure for compulsory psychiatric treatment. The consultants recommend that, in line with the recommended practice for patients with somatic disorders in need of hospital care, severely and acutely ill mental patients to be treated in an appropriate secured ward of a civilian specialized facility, e.g. the NCMH, provided that its sanitary conditions and non-pharmacological treatment facilities will be up-graded as envisaged. This includes also prison inmates in a state of acute suicidality.

Many patients with chronic or less severe mental disorders do not need hospital care but can be cared for by a regularly visiting psychiatrist or in a protected out-patient setting or day clinics under close surveillance of psychiatrists and other health care staff trained in psychiatric disorders. In the Armenian prison context, such protected units could be established in the spacy Armavir prison medical unit provided that psychiatric health care staff is employed or contracted to be present regularly, best on a daily basis and, in addition to psycho-pharmacological treatment non-pharmacological treatment options such as psychotherapy, group therapy and occupational therapy are provided.

Likewise, narcological treatment such as methadone maintenance treatment and most detoxification treatments, at the time of the assessment visit in 12 and 7 patients applied in the narcological department of the prison hospital, does not need hospital care and easily can be conducted in specialized medical units of prisons.

Following these considerations, the number of psychiatric patients to be treated under hospital care would be reduced considerably and could be taken care of by capacities of the NCMH or any other civilian psychiatric hospital.

Proposals and recommendations

The majority of recommendations as made by the consultants of the CoE Report on the Assessment Mission on Health Care in Prisons in the Republic of Armenia, June/July 2015, have not yet been put into reality. They covered the whole of health care in prison and in particular the wide range of primary health care issues and the consultants regard these recommendations three years later still as valid and equally important. In keeping with the ToR of the present report, the following recommendations focus on hospital and other secondary health care for which proper primary health care management is an indispensable prerequisite. Therefore, the consultants strongly recommend the reader also to resort to the recommendations of the 2015 report. The listed sequence of the following recommendations should not be understood as a sequence according to their importance as many of them are interrelated and one without the other might have little or no effect.

Proposals:

Health care services to be performed in penitentiary institutions:

- All primary health care including nursing care in well-equipped prison infirmaries and/or day clinics (dependent whether a nurse or feldsher is present at night and at weekends).
- Nursing care for mobility-disabled and other disabled inmates in specially equipped rooms or wings (barrier-free, appropriately equipped sanitary units).
- Out-patient secondary health care based on a polyclinic model organization, i.e. that specialists come regularly and/or ad hoc to the penitentiary institutions and conduct their services, provided that the necessary equipment is available in the penitentiary institution and the expertise of the specialist is sufficient; This includes the taking of diagnostic tests to be sent outside to contracted laboratories; the treatment of most chronic diseases that are not in need of hospital care; infectious diseases that are not any more contagious through normal social contact (TB patients in the continuation phase of treatment); psychiatric patients not or not anymore in need of hospital treatment but in need of regular psychiatric out-patient care; and the pre- and postoperative care under surveillance and co-operation of the civilian surgical centre.
- Care for patients with tuberculosis and resistant tuberculosis should be treated in penitentiary TB units, given the need to separate contagious TB patients from other inmate patients (and contagious MDR TB patients from treatment sensitive contagious patients) which may pose less challenges in the prison setting than in civilian hospitals. In addition, the high prevalence of TB in prison populations has led to an accumulated clinical and radiological expertise on this disease in phthisiatrists/pulmonologists working in penitentiary systems in well-functioning close cooperation with the National TB Centre. This specialized properly.

Health care services to be performed in civilian hospitals in secured wards:

- All major surgical interventions.

- All diagnostic, therapeutic and nursing interventions requiring equipment and/or medical expertise that cannot be made available in penitentiary institutions at an adequate qualitative level including in acutely or severely ill mental patients.

Legal recommendations

- Define by amendment of the RA government's decision N 825-N of May 26, 2006 that the patient treatment procedures (protocols)approved by the Minister of Healthcare of RA are equally applied during the treatment of arrestees and detainees.
- Define the legal content of the right to health care in the Penitentiary Code and in the law of the Republic of Armenia on Treatment of arrestees and detainees in the same way and precisely.
- Issue a Decree of the Minister of Healthcare of RA for sanitary mandatory norms and rules for medical assistance provided in the penitentiary institutions.
- Define separately the number of allocations of medical assistance and services provided by the "Penitentiary Medicine Center" state non-commercial organization of detainees and arrestees in the annually approved state budget laws.
- Define the mandatory terms for structural, technical, technological and professional requirements for the license for provision of penitentiary medical assistance and services intending the inclusion of new healthcare providers/ on the basis of contract or invitation by amendment of the RA Government's decision numbered 1936-N of December 5, 2002 or by a new governmental decision.
- Amend and make additions to the RA Government's decision numbered 825-N of May 26, 2006 defining the types and volumes of hospital and outpatient medical assistance provided by "Penitentiary Medicine Center" state non-commercial organization in the penitentiary centers and in the "Penitentiary Medicine Center" bringing them closer to the volumes provided by civilian medical institutions.
- Define that outpatient secondary health care assistance is provided either by civilian polyclinic services or by invited specialists, and on the prison hospital part exclude the performance of all major surgical interventions and medical interventions in need of highly specialized expertise and equipment by amendment of the RA Government's decision numbered 825-N of May 26, 2006. By the same governmental decision, for patients in need of major surgical interventions and medical interventions in need of highly specialized expertise and equipment define a new requirement of transferring them all to civilian hospitals.
- Define a new requirement for secured wards in civilian multi-profile hospitals for the medical assistance and service of arrestees and detainees in need of major surgical interventions and medical interventions in need of highly specialized expertise and equipment with the provision of appropriate security infrastructure and regulate the process for the detention of detainees and the custodial patients by the penitentiary servant in the civilian hospital while providing the patients' medical care integrated in the clinical management of the civilian hospital by amendment of the RA Government's decision N 1936-N of December 5, 2002.
- Define the volumes of psychiatric outpatient medical care, including dispensary control in penitentiary institutions identifying or at least at the largest scale bringing it closer to the

volumes of psychiatric outpatient medical care provided to the citizens in freedom by amendment of the RA Governmental decision N 825-N of May 26, 2006.

- Exclude provision of clinical psychiatric medical assistance and service by "Penitentiary Medicine Center" state non-commercial organization establishing an exception for organizing care service of people with mental disorders by amendment of the RA Government's decision N 825-N of May 26, 2006
- Re-regulate legally and clearly the procedure for the operation of the expert commissions to resolve the issues related to the release of the sentence, the expediency of changing the remedies because of the detainee's mental health condition and the application of compulsory psychiatric measures including the procedure of decision-making, excluding the involvement of state representatives in the implementation of such expertise by establishing an impartiality of experts and effective guarantees of impartiality by amendment of the Penitentiary Code, the Criminal Procedure Code and the law of the Republic of Armenia on treatment of detainees and convicts.

<u>Recommendations for healthcare management</u>

- Remedy the still prevailing deficiencies in primary health care, such as insufficient staffing, training and CME accreditation for primary health care as family health care professionals in order to have primary health care including prevention and health promotion efficiently functioning as gate keeper for hospital and other secondary health care. Strengthen further the training of primary health care professionals in mental health in order to improve identification of mental health disorders upon admission and during imprisonment.
- Establish and/or strengthen primary health care units with well-equipped and staffed infirmaries and day clinics in prisons allowing for efficient nursing care of inmates with minor infections or other minor acute disorders and many chronic disorders not in need of a hospital care under the supervision of primary health care staff and/or guidance of specialist consultants licensed for their purpose by the health authorities of the country. These units are able to decrease unnecessary use of secondary health care structures considerably.
- Set up an out-patient polyclinic service for prisons by employing and/or contracting medical specialists, preferably from regional hospitals who regularly and upon need visit prisons and examine and treat patients in need of their services and/or provide consultancy to primary health care professionals. Equip the medical units in prisons with those non-portable medical devices that, upon cooperation with the specialists, are needed for out-patient secondary health care. Contract regional medical laboratories, preferably those in regional hospitals, for laboratory services.
- Employ and/or contract for each prison a psychiatrist to be available on a regular and upon need basis in accordance with CoE and CPT recommendation.
- Establish, preferably in the spacy Armavir prison medical unit, intermediate care departments for:
    - pre- and postoperative care supervised by specialists of the polyclinic service in cooperation with the surgical department of civilian hospital allowing for reducing the duration of hospital stays in civilian hospitals;
    - protected care of less severe or chronic mental disordered patients not or not anymore in need of mental hospital care supervised and managed by psychiatrists and nursing staff trained in mental health care.

- Close down the Yerevan prison hospital given the current low occupancy rate, the poor condition of its premises, infrastructure and facilities not complying with contemporaneous hospital requirements.
- Perform all major surgeries and medical interventions in need of highly specialized expertise and equipment in civilian hospitals appropriately staffed and equipped for these interventions.
- Establish secured wards for prisoner patients in civilian hospitals suited for the above requirements fully integrated in the clinical service of civilian hospitals but with separate entrance and fenced from civilian patients and guarded by a small team of security officers assigned for the custody of prisoner patients in the hospital.
- Set up a transparent waiting list for planned hospital interventions such as selective surgical interventions in order to maintain bed capacity for each emergency case while avoiding undue preferences of non-emergency patients. Control strictly that admission and duration of hospital stays are decided and documented exclusively on traceable medical grounds in order to keep capacity for emergency cases and to avoid undue hospital stays.
- Transfer the TB department from the Yerevan prison hospital to a separated department of the medical unit in the Armavir prison. The number of beds can be reduced significantly if only contagious and drug-resistant patients are cared for in this department, whereas non-infectious or not anymore infectious TB patients are treated in out-patient medical units of other prisons under the supervision and care of phthisiatrists/pulmonologists.
- The care of patients with acute and severe mental disorders such as acute psychosis, major depression, acute suicidality that is incompatible with detention in a prison should be taken over by a civilian mental health care hospital. The NCMH might suit for this purpose, provided that its premises are renovated and refurbished, non-pharmacological treatment options are introduced and inner security is maintained by appropriately trained staff.
- Introduce obligatory CME and their documentation for all health care professionals caring for prison inmates both in primary health care as well as in hospital and other secondary health care.
- See that all health care units in prison and caring for prisoners are fully compliant with the national laws and national and international recommendations on prevention of hospital infection and infection control as already recommended in detail in the CoE Report on Needs Assessment Mission of Infection Control and Sanitary-Epidemiological Maintenance of Healthcare Units and Hospitals in Prisons in The Republic of Armenia.

Annex 1: Documents

National Documents:

Constitution of Republic of Armenia

Penitentiary Code

Criminal code

Law on the Treatment of Arrestees and Detainees

Law on Medical Assistance and Service to the Population

Law on Licensing

Law on Psychiatric Care

Government’s decision No 318-N of March 4, 2004 On State-provided free medical care and aid

Government’s decision No. 350-N of April 1, 2010 On Inpatient and outpatient mental health care

Government’s decision No 733-N of July 10, 2013, On approving of procedure of provision by health care workers pre- and post- counselling and testing for HIV to detainees and convicts

Government’s decision No 825-N of May 26, 2006 On Approving of procedure for arranging medical and sanitary, as well as medical and prophylactic assistance for detainees and convicts

Government’s decision No 1301-N of August 15, 2002 On Approving of charter of Ministry of Health

Government’s decision N 1636-N of December 4, 2003 On Creation of intersectoral medical committees

Government’s decision No 2 of January 19, 2017, On Modernization of prisons’ healthcare

Government’s decision No 204-N of March 1, 2018, On Creation of the “Penitentiary Medicine Center" State Non-Commercial Organization

Government’s decision No 1256-N of August 24, 2006, On Approving of charter of Penitentiary Department's charter

Government’s decision No. 1936-N of December 5, 2002, On mandatory requirements and conditions for licensing of medical entities

Health Minister’s decree No 47-N of September 13, 2013, On State-provided outpatient healthcare

Health Minister’s decree No 71-N of November 18, 2013, On State-provided inpatient (hospital) healthcare

Health Minister’s decree No 57-N of September 28 of 2013 On approving of state provided list of the most up-to-date and expensive medical services

Health Minister’s decree No 68-N of October 31, 2013, On state-provided dispensary medical assistance and services

Health Minister’s decree No. 21-N of October 20, 2008 On approving of Sanitary rules of epidemiological control of tuberculosis

<u>CoE Documents:</u>

Vladimir Ortakov, Jörg Pont, Roza Babayan, Naira Gharakhanyan, Davit Khachaturyan: Report on the assessment mission on health care in prisons in the Republic of Armenia, July 2015

Gohar Simonyan, Olivera Vulić: Report on mental healthcare issues in the penitentiary institutions of the Republic of Armenia, May 2017

Lilit Avetisyan, Romella Abovyan: Report on needs assessment mission of infection control and sanitary-epidemiological maintenance of healthcare units and hospitals in prisons in the Republic of Armenia, November 2017

Report of a Council of Europe Expert Visit to Evaluate the Prison Health Services in Armenia (The Arpo/Ekeid Report), May 2000

CPT Report on the periodic visit to Armenia in October 2015 and response of the Armenian authorities CPT/Inf(2016)31 and CPT/Inf(2016)32

Annex 2: Agenda of the assessment visit

19 March 2018

09:30 – 10:30 Meeting with Mr Krmoyan, Deputy Minister of Justice of the RA

10:30 - 17:00 Site visit to the Prison Hospital

17:00 – 18:00 Meeting with Mr Hovhannisyan, Head of Medical Service of Penitentiary Department of MoJ

20 March 2018

09:30 – 10:30 Meeting with Mr Khachatryan, Deputy Minister of Health of RA and Mr Melik-Nubaryan, Head of Medical Aid Policy Development Department of MoH

11.00 – 13.00 Meeting with Mr Manukyan, Executive director of Erebuni hospital

Site visit Erebuni hospital, Yerevan

13:30 – 14:30 Meeting with Mr Mirinjanyan, Head of National Center for Mental Health (former Nubarashen psychiatric hospital), Site tour to Center's facility for detained persons

15:00 – 15:30 Meeting with representatives of the Public Defender's Office

16.00 – 18.00 Site visit to Armavir prison, Armavir region