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Rapport du Rapporteur spécial sur le droit qu'a toute personne de jouir du meilleur état de santé physique et mentale possible concernant sa visite en Arménie

Note du secrétariat

Le secrétariat a l'honneur de transmettre au Conseil des droits de l'homme le rapport du Rapporteur spécial sur le droit qu'a toute personne de jouir du meilleur état de santé physique et mentale possible, M. Dainius Pūras, concernant la visite qu'il a effectuée en Arménie du 25 septembre au 5 octobre 2017.

L'Arménie a accompli des progrès importants pour ce qui est de la réalisation du droit à la santé depuis son indépendance. Il existe actuellement des perspectives encourageantes, mais des efforts supplémentaires sont nécessaires pour remédier aux problèmes structurels et systémiques, dans le droit comme dans la pratique. À cet égard, le Rapporteur spécial s'intéresse au système de santé national et au domaine de la santé mentale ; aux inégalités et à la discrimination dans le contexte de la lutte contre le VIH/sida et la tuberculose ; et à la politique relative aux stupéfiants et à l'accès aux médicaments réglementés. Il formule un certain nombre de recommandations.

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[*Anglais seulement*]

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Armenia*

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* Circulated in the language of submission only.

I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, visited Armenia from 25 September to 5 October 2017 at the invitation of the Government. The purpose of the visit was to ascertain, in a spirit of dialogue and cooperation, how the country implements the right to health.

2. He met with high-ranking Government officials, members of the parliament and the Constitutional Court and representatives of relevant health-related institutions at central, provincial and local levels. He also held meetings with representatives of the Office of the Human Rights Defender, international organizations and the diplomatic corps, and with a range of civil society actors, including professionals in the health-care sector.

3. The Special Rapporteur visited health facilities in Yerevan, Abovyan, Sevan, Dilijan, Vanadzor and Spitak, including polyclinics, medical centres and mental health-care institutions. He visited the national centre for AIDS prevention, the Narcological Centre, and the National Centre for Tuberculosis Control. He also visited a number of penitentiaries and primary and secondary schools, including those providing inclusive education programmes.

4. The Special Rapporteur is grateful to the Government of Armenia for its invitation and full cooperation during his visit. He appreciates the crucial support provided by the United Nations country team, including the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund and the World Health Organization (WHO).

II. Right to health in Armenia

A. Background

5. Armenia gained independence from the Soviet Union in 1991 amidst the Nagorno-Karabakh conflict, which remains unresolved to date. As a result of the conflict and its various consequences, including the lack of progress towards the peaceful resolution of the Nagorno-Karabakh conflict, economic growth, poverty reduction and development have been hampered, which has had a negative influence on the living standards of the population of the Republic of Armenia, especially its vulnerable groups, and on their social and economic rights.

6. Since 2000, economic growth has slowed, partly due to the weaker performance of the country's main trading partners and a slowdown in those countries that are sources of remittances. In 2009, as a result of the global economic crisis, gross domestic product (GDP) declined by 14.2 per cent, one of the deepest declines in the region.[1]

7. The incipient recovery of global commodity prices since 2010 has lifted the extractive industries sector and raised private consumption, which could facilitate the renewed growth of other sectors. Although poverty reduction has been impressive over the past few decades, a large proportion of the population remains vulnerable. Persistent geographic disparities require deep understanding of the root causes and possible solutions, particularly bearing in mind that the economy is still heavily reliant on mineral resources and the agriculture sector.[2]

8. During the first half of 2017, the Armenian economy showed renewed strength, as real GDP grew by 6 per cent more than in the same period in 2016, driven by industry, services and the retail trade. Growth and poverty reduction prospects over the medium term

[1] See United Nations Development Programme (UNDP), "Rapid integrated policy assessment in Armenia" (2017).

[2] World Bank, Armenia overview, available from www.worldbank.org/en/country/armenia/overview.

are positive (expected growth for 2017 is 4.5 per cent) but are subject to significant uncertainties, which are the risks on both the external and domestic political fronts.[3]

9. Since the 1990s, most indicators under the Millennium Development Goals have shown considerable improvement, with important achievements in life expectancy and a reduction in maternal and child mortality and in poverty. Public spending on social protection, education, infrastructure and health care has increased, although in absolute numbers it remains moderate.

10. Of the total of 65 indicators for the Millennium Development Goals, by 2015 Armenia had achieved 22; made good progress towards 10; and was still working on half of them. Areas showing considerable progress include child health protection, child and maternal health, and the fight against HIV/AIDS and other diseases. Progress was weak in poverty and hunger reduction, education, gender equality and governance, all of which contribute to the effective protection of human rights and to sustainable development. Overall, the principles of the Sustainable Development Goals are well reflected in national strategic documents. The Special Rapporteur was informed that one major challenge linked to the insufficiency of indicators to measure the attainment of policy goals and targets, was being addressed. An integrated website containing official statistics and metadata, publicly available and with access for user feedback, is reportedly expected to fill existing data gaps. The availability of relevant and timely data is critical for the formulation, monitoring, evaluation and review of public policy.

11. In 2015, the human development index value for Armenia was 0.743, placing the country in the high human development category, positioned at 84 out of the 188 countries and territories included in the index. Between 1990 and 2015, the human development index in Armenia increased by 17.2 per cent, life expectancy at birth increased by seven years and expected years of schooling by two years, while the gross national income per capita increased by approximately 122 per cent. The human development index is below average for both the totality of countries in the high human development group and the countries of Europe and Central Asia. Armenia is ahead of its neighbours when it comes to gender-based inequalities in reproductive health, empowerment and economic activity, with a gender inequality index value of 0.293, ranking sixty-first out of 159 countries reviewed.[4]

12. Over the last decade, maternal mortality has declined in Armenia (18.5 per 100,000 live births in 2014), however, progress has been slower than projected. Achievements have been made in addressing the factors behind maternal morbidity and mortality, including through the introduction of the “state maternity certificate” providing free maternal health-care services and ensuring the availability of skilled medical care for pregnant women and that there is an appropriate referral system in place. However, there remain major issues regarding quality of care to be addressed.[5]

13. Despite commendable efforts and investment, the availability of, access to and quality of health services remain a challenge in a country where poverty and inequalities persist and there are significant disparities between urban and rural areas. Improving the availability and quality of relevant health-related data, data management and institutional coordination will be crucial in this respect.

B. Normative and institutional framework

14. Armenia is party to all the international human rights treaties. It has yet to ratify the Second Optional Protocol to the International Covenant on Civil and Political Rights aiming at the abolition of the death penalty, but has ratified the Council of Europe Protocol No. 6 to the Convention for the Protection of Human Rights and Fundamental Freedoms concerning the abolition of the death penalty. Armenia has accepted the complaints

[3] Ibid.

[4] See UNDP, “Despite the progress in human development, vulnerable groups still left behind” (June 2017), available from http://un.am/en/news/590.

[5] See UNFPA, *Public Inquiry into Enjoyment of Sexual and Reproductive Health Rights in Armenia*, (2016), p. 6.

procedures under the First Optional Protocol to the Covenant and the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women. Its accession to all complaints procedures under the international human rights treaties system would allow victims to access remedies and promote accountability for the respect, protection and fulfilment of the right to health.

15. In May 2006, Armenia issued a standing invitation to the special procedures mandate holders of the Human Rights Council and has since been visited by some of them. It has ratified the WHO Framework Convention on Tobacco Control and the main United Nations conventions related to drug control.

16. Armenia was evaluated under the universal periodic review in 2010 and 2015. The next review is scheduled for May 2020. During the most recent review in 2015, the efforts made to improve the health system were acknowledged. Concerns raised included discrimination and violence against women and lesbian, gay, bisexual, transgender and intersex persons and against persons living with HIV/AIDS, and regarding the level of awareness of the disease. Reforms outlined included those aimed at increasing access to, and the quality of, health services and steps to reduce corruption and eliminate informal payments, including by raising public awareness of the right to free health care and dismissing staff who demand such payments. The country received and accepted a number of recommendations relating to the right to health, including implementing the International Health Regulations and maintaining its commitment to guaranteeing access for the rural population to medical care and services (see A/HRC/29/11, paras. 29, 42, 81, 97, 120.164 and 120.165).

17. The transition from a semi-presidential system to a parliamentary republic is nearly complete. The constitutional amendments of December 2015 will enter into force on the day that the newly-elected President assumes office in April 2018. The new Constitution and the consequent normative and policy reform process will have an impact on the enjoyment of the right to health of the population.

18. Article 29 of the new Constitution prohibits discrimination on the basis of sex, race, skin colour, ethnic or social origin, genetic features, language, religion, world view, political or other views, belonging to a national minority, property status, birth, disability, age and other personal or social circumstances.[6] Additionally, a new and modern catalogue of fundamental constitutional rights has been introduced, with a distinction made between fundamental rights and freedoms (ch. 2), and social rights that are either to be further developed by law (ch. 3, arts. 82–85) or as State policy objectives whose promotion is an obligation of the public authorities (ch. 3, arts. 86–87).

19. Article 85 of the new Constitution establishes that the right to health care shall be defined by law, which should also establish the list of basic services that are free of charge and the procedures for their provision. Legislators have therefore been explicitly entrusted with the task of defining the right to health care, which will then depend on the adoption of specific legislation.[7]

20. The Law on Medical Assistance and Service to the Population (1996) is the main legal act regulating health care.[8] It sets out the right to receive medical care, irrespective of nationality, race, sex, or other status. The law distinguishes between two types of medical services: (a) primary medical care, guaranteed to be free of charge and requiring only basic methods and technologies and (b) specialized medical care, defined by the diagnostic methods and technologies it requires.[9] The law recognizes the rights to privacy and informed consent, the right to refuse treatment and the right of non-nationals to access health services (arts. 5, 8, 17 and 15 respectively).

[6] See www.translation-centre.am/pdf/Translat/RA_Constitution/Constitution_en.pdf.

[7] Venice Commission, "First opinion on the draft amendments to the Constitution of Armenia (chs. 1–7 and 10)", paras. 14–22 and 63–64.

[8] See www.translation-centre.am/pdf/Translat/HH_orenk/Bjshk_Ognut/bjshk_ognut_en.pdf.

[9] See Violeta Zopunyan, Suren Krmoya and Ryan Quinn, "Identifying the gaps: Armenian health care legislation and human rights in patient care protections", *Health and Human Rights*, vol. 15, No. 2 (December 2013).

21. The Ministry of Healthcare is the entity primarily responsible for health policy formulation, implementation and evaluation. It develops national health policies in line with the country's priorities, including strategies to achieve objectives, national health standards and norms, and quality control measures, and oversees State-funded programmes. Policy objectives are implemented through shared responsibilities with regional and local governance bodies and health institutions.[10]

22. The State Health Agency, established in 1998, has the role of planning in the health system, including through the allocation of financial resources. While it was originally established as an independent body, in 2002 it was transferred under the authority of the Ministry of Healthcare.

23. The Office of the Human Rights Defender was founded in 2004 by the Law on the Human Rights Defender. It has "A" status, which indicates compliance with the principles relating to the status of national institutions for the promotion and protection of human rights (Paris Principles) and is active on issues related to the right to health. It has highlighted various systemic challenges, including the lack of access to free medicine for people with disabilities, the lack of definition of rules of medical ethics and the lack of free access to health care in detention.[11]

C. National health-care system

24. As a post-Soviet State, Armenia inherited a centralized health-care system that guaranteed free medical care and access to a range of services for the population but with an excessive emphasis on hospital care and important geographical imbalances in terms of access and quality. In recent years, the system has undergone important reforms, including a rationalization process and the decentralization of services and transfer of health competencies to provincial and local authorities.

25. In 1996, the responsibility to provide primary and secondary care was transferred to provincial and local governments. Initially, the provincial governments were responsible for funding local health-care services, however that function was transferred to the State Health Agency in 1998. While provincial governments are no longer directly involved in the financing of health care, they retain planning and regulatory powers in the general governance of health services. However, lines of accountability between central, provincial and local authorities are reportedly opaque with few monitoring and evaluation initiatives to address this gap.[12]

26. In 2017, within the framework of the general programme of the Government to guarantee sustainable development between 2017 and 2022, a number of large-scale reforms in the health-care sector were announced. The main objectives included a gradual transition to a competitive market procurement model of health-care services; improving outcomes of treatment and the quality of medical services; establishing optimal numbers of health-care institutions, hospital beds and staff; and establishing quality management and comprehensive and integrated development of human resources through targeted spending, traceability and control over financial resources vis-à-vis the full use of a unified electronic system (E-HEALTH), which was launched in 2017. By the end of 2019, a draft law on public health will be elaborated and submitted to the National Assembly for approval.[13]

27. Despite important progress, the health sector faces serious challenges related to financing, access to quality primary care in rural areas and the workforce.

[10] European Observatory on Health Systems and Policies, *Health Systems in Transition — Armenia Health System Review*, vol. 15, No. 4 (2013), p. 16.

[11] See the annual report on the activities of the Human Rights Defender in 2013.

[12] European Observatory on Health Systems and Policies, *Health Systems in Transition*, p. 17.

[13] See Program of the Government of the Republic of Armenia, 2017–2022 (June 2017), available at www.gov.am/files/docs/2219.pdf.

Health sector financing: fulfilling the right to health

28. One structural challenge is the low level of public expenditure on health, which is below 2 per cent of GDP, one of the lowest in the world. Health expenditure per capita is among the lowest in the European region: in 2014 it was estimated at $215.[14]

29. The majority of the financing for public health-care institutions comes from out-of-pocket payments,[15] which account for over 50 per cent of health expenditures (2014)[16] affecting mainly inpatient care and access to medicines. The high level of such payments for accessing health care means that for certain sectors of the population, health care is considered unaffordable. That constitutes an important barrier to accessing care and can create inequalities in the health system. Moreover, an important part of the existing investment in health infrastructure, equipment and service provision is donor-based, which raises concerns about sustainability and ownership.

30. The right to health includes numerous entitlements, such as the availability of good-quality health facilities and access to essential medicines, and their realization requires public funding. Insufficient expenditure or misallocation of public resources may result in the lack of enjoyment of the right to health by individuals or groups, particularly those in vulnerable or marginalized situations, and amount to a violation of the State obligation to fulfil the right to health.[17]

31. There have been significant efforts to ensure access to services for the most vulnerable sectors of the population, including through the basic benefits package and the State certificate reforms (2010–2011) to ensure that women and children have access to affordable, quality maternity and paediatric services.

32. In 1997, the basic benefits package specified the public services that individuals would receive free of charge.[18] The package provides free medical services for certain types of care, including primary health care, emergency care, the treatment of certain infectious diseases and for socially vulnerable groups who are entitled to all health care free of charge. Services not paid for by the package have to be paid for out of pocket.[19] In 2004, the Government issued decree No. 318-N guaranteeing free medical services for a list of 20 groups in vulnerable situations. In 2006, the basic benefits package was broadened to include a package of primary care services for the whole population, although State funding remains insufficient, which has resulted in continued informal payments for primary care services.[20]

33. In 2008, the Government introduced the obstetric care State certificate to ensure all women have access to free, high-quality maternity services. Pregnant women start to receive their certificates and are eligible for such services from the twenty-second week of pregnancy. They use the certificates to pay for care at their chosen maternity hospital, with the State Health Agency paying a fixed fee, depending on the complexity of the delivery and the type of facility. In 2011, the child health State certificate was introduced on a similar basis to the obstetric care State certificate, as insufficient funding of inpatient paediatric services through the basic benefits package had led to a high level of out-of-pocket payments. The introduction of both certificate programmes has been successful in reducing informal payments, improving affordability and access to services, and contributing to patient satisfaction. Key factors for success have been a clear political

[14] See WHO, Global Health Expenditure Database, available from http://apps.who.int/nha/database/Select/Indicators/en.

[15] See Violeta Zopunyan, Suren Krmoya and Ryan Quinn, “Identifying the gaps: Armenian health care legislation and human rights in patient care protections”.

[16] See WHO, Global Health Expenditure Database.

[17] See Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 52.

[18] See WHO, “How does the introduction of co-payments for selected health services affect formal and informal out-of-pocket payments and utilization? Evidence from Armenia” (2017), p. 9.

[19] See WHO — Europe, “Voluntary health insurance in Armenia” (2007), pp. 10–11 and 15.

[20] See European Observatory on Health Systems and Policies, *Health Systems in Transition*, p. 77.

commitment, together with the associated financial commitment to covering the full cost of maternity and paediatric services.[21]

34. Armenia has a single risk pool and purchaser through the State Health Agency, which accords with global good practice. The country is moving towards a mandatory health insurance scheme that will involve private insurers as third-party administrators for a revised set of benefits for certain sectors of the population, mainly civil servants and socially disadvantaged groups. Involvement in private insurance in member countries of the Organization for Economic Cooperation and Development is often focused on covering complementary and supplementary insurance, not the mandatory basic benefits package. International experience suggests that competition among purchasers is technically more complex than a system with a single purchaser and involves higher transaction and administrative costs.[22] In the context of a broader universal health coverage reform, the approach of competition among purchasers could have significant implications regarding eligibility, coverage and financing of the system, and could potentially create inequities and inefficiencies if strong oversight and transparency are not ensured. The authorities should consider building on the existing system and support or modernize the purchasing efficiency of the State Health Agency.

35. While the engagement of private health practitioners within the public sector could be promoted to improve access to health-care services, in Armenia there are needs that should also be addressed. They include a definition of roles and functions at the different levels of government in the area of human resources for health and sector performance, an increase in the financing of the health sector and determining how health institutions could foster the effective participation of communities and service users.

Primary care to address the challenges of the system

36. In order to increase financial protection for users, national budget allocations for health should be increased and out-of-pocket payments reduced. However, increased investments in health-care systems only make sense if the system is efficient, transparent, friendly and responsive to those who use it. For health-care systems to be efficient, sustainable investment in primary care should be a first priority.

37. The Armenian health system retains an emphasis on inpatient services and despite efforts to reform primary care provision, hospital care continues to dominate. The inpatient system in Yerevan offers an oversupply of capacity and staff, and often provides services to patients who would be more appropriately treated elsewhere, either in regional hospitals or as outpatients at home. That remains a key challenge to improving efficiency.[23]

38. The Special Rapporteur observed that donors, including the Armenian diaspora, have contributed to the overreliance of the health system on specialized services based on expensive diagnostics and curative biomedical interventions. However, external support to the health system should be in line with modern public health principles, including investments in cost-effective outpatient health services and social care at the community level.

39. Recent policy efforts in primary care have focused on improving the productivity of primary care doctors through incentive payment programmes (results-based financing), which have reportedly been successful. Results-based financing in Armenia consists of two components: open enrolment and “pay for performance”. In 2015, the system covered all 363 public primary health-care facilities. It is financed through the State Health Agency, which also serves as the fund holder and verifier. General practitioners receive a mixture of capitation-based payments (open enrolment) and bonus payments (pay for performance).[24]

[21] Ibid, pp. 75–80.

[22] See WHO, “Analysis of options for purchasing market structure under the NHS: support to the health reform programme of the Government of Cyprus” (2015), p. 36.

[23] See European Observatory on Health Systems and Policies, *Health Systems in Transition*, pp. 91–92.

[24] See Varduhi Petrosyan and others (2017) “National scale-up of results-based financing in primary healthcare: the case of Armenia”, *Health Systems & Reform*, vol. 3, No. 2 (2017).

40. Nonetheless, significant challenges remain regarding equitable access to services and the quality of those services throughout the country, as well as a lack of good governance and incentives to manage the different levels of care to encourage the use of primary care.

41. The Government should invest in strengthening the role of general practitioners by building their capacities and competencies, as well as those of nurses, social workers and health assistants, through continuous learning programmes. It should consider establishing innovative incentives to consolidate the position of general practitioners as "gatekeepers" of the system. That is of special importance when it comes to the right to physical and mental health of women, children and groups in vulnerable situations, such as persons with disabilities, migrants and refugees.

42. The focus on reaching the poor, addressing financial exclusion and mitigating catastrophic expenditures, as provided by the basic benefits programme, are to be commended but should not divert attention from the structural and systemic challenges, which are discussed below. The best remedy against fraud and corruption, and altogether against discrimination, stigma, disparities and imbalances within the health-care system, is mutual trust between all participants of the universal health-care insurance system. Strengthening the quality of primary health care and investing in the trust of people in primary care remain crucial preconditions for the effectiveness of the health system.

Health workforce: human rights education and research

43. Since 1991, the number of people working in the health system has contracted. Although the total number of specialist doctors and dentists has actually increased, the number of mid-level personnel per capita has fallen. Furthermore, there is a shortage of doctors serving in rural areas, while there is a surplus in Yerevan.[25]

44. According to WHO, the density of skilled health professionals is 75.3 per 100,000 (2005–2013), which is above the Sustainable Development Goal threshold of 44.5 skilled health professionals per 100,000.[26] As with several other countries in the region, the health-care workforce in Armenia is largely female; for example, in 2013, 69 per cent of physicians in Armenia were female.[27]

45. There are over 40 professional medical associations but, traditionally, they have not played a significant role in decision-making. Over the past few years, there has been an attempt to enhance the role of professional organizations, particularly in licensing and registration, and in postgraduate education, but this has not been supported by the authorities.[28]

46. The Ministry of Education and Science is responsible for undergraduate and postgraduate medical education, including nursing. It is also responsible for setting educational standards for the undergraduate training of health-care personnel, but the curriculum is developed in close cooperation with the Ministry of Healthcare. Yerevan State Medical University is the only State institution that offers undergraduate and postgraduate medical education.

47. Existing regulations require doctors and nurses to take education courses every five years. Continuous medical education is shared between the Ministry of Education and Science and the Ministry of Healthcare. According to available data, 60 per cent of doctors and 40 per cent of nurses receive such training. The training and retraining programme for family medicine is now in line with international standards. Nurses, midwives, dental nurses and physiotherapists are trained at State or private nursing colleges for three or four years. The specialist training of nurses for different disciplines is not well developed and

[25] WHO European Observatory on Health Systems and Policies, *Health Systems in Transition*, p. 49.

[26] See WHO, *World Health Statistics 2016: Monitoring Health for the SDGs*. The term skilled health professionals refer to the latest available values (2005–2013) in the WHO global health workforce statistics database (http://who.int/hrh/statistics/hwfstats/en/) aggregated across physicians and nurses/midwives.

[27] See WHO, "Core health indicators in the WHO European region 2015".

[28] WHO European Observatory on Health Systems and Policies, *Health Systems in Transition*, p. 18.

consists of short courses and projects delivered as part of development assistance through international partners.[29]

48. Medical education and research for other health professionals is based on the model of diagnosing and treating diseases, which does not fully reflect the modern approach of investing in human resources in health. In training health professionals, more attention should be paid to the role of the social determinants of health (poverty, violence, discrimination, etc.), human rights in patient care, the principles of medical ethics and new approaches in providing services for persons with disabilities.

49. It is reported that few psychiatrists receive refresher training in the rational use of drugs or in psychosocial interventions and child/adolescent mental health issues. Staff members working in mental health do not receive such training. Additionally, many health-care workers at mental health facilities do not have specific training in mental health. For example, nurses working in psychiatry are often not trained as psychiatric nurses and there are no geriatric specialists among psychiatrists and psychologists to provide professional care for the elderly. Child mental health services are underdeveloped, although in most countries in the region and globally, child and adolescent mental health is an established field in health services, represented by teams of different mental health professionals. The number of non-medical health-care workers, such as social workers, is very limited in Armenia and most of them do not receive specific training in mental health.[30]

50. Job descriptions for mental health personnel have not been clearly established and there are no legal documents on the procedure for establishing a job description in medical institutions, nor a code of conduct for health workers in such institutions. Reportedly, low salaries and inappropriate working conditions do not make the profession of psychiatrist very attractive for young specialists.[31]

51. The Special Rapporteur met with various professional associations and learned that they were in the process of establishing themselves as independent organizations. They were discussing their guiding principles and whether they should take over some responsibilities from the Ministry of Healthcare and other authorities through mechanisms of self-regulation. For example, the Armenian Psychiatrist Association has developed a code of ethics and submitted it for endorsement to the Ministry of Healthcare. The Special Rapporteur wishes to emphasize that medical professional associations should be independent and exercise self-regulation, particularly when it comes to conduct and ethics in the profession.

III. Mental health

Background

52. According to official sources, in 2015 mental health and behavioural conditions accounted for 0.05 per cent of the causes of mortality in Armenia.[32] Other research indicates that 5–10 per cent of youth suffer from various mental health conditions, suggesting that official estimates may not be accurate and that many children and youth with mental health conditions may not be registered.[33] A sample survey questionnaire by the Ministry of Healthcare in 2016 indicated that about 40 per cent of the population suffered from mild depression, 2.9 per cent from moderate depression and 0.1 per cent from

[29] Ibid., pp. 58–59.

[30] See WHO and the Ministry of Health, "WHO-AIMS report on mental health system in Armenia" (2009), pp. 7 and 21.

[31] See Helsinki Citizens' Assembly Vanadzor, "Human rights situation in mental health facilities in Armenia" (2011), p. 20.

[32] Ministry of Health, *Health for Health Care: Armenia Health System Performance Assessment* (2016), tables 2 and 8, available at www.moh.am/uploads/HSPA%202016_%20English_final.pdf.

[33] Association of Child Psychiatrists and Psychologists, annual report 2008, p. 5, available at http://acpp.armdex.com/documents/ACPP_Report_2008.pdf.

severe depression. The survey also found a strong link between depression and wealth, age, gender and educational attainment.[34]

53. The ratification of the Convention on the Rights of Persons with Disabilities by Armenia in 2010 led to amendments and increased efforts in the provision of mental health services. Since 2011, the Government has endeavoured to transfer the mental health-care system from being exclusively inpatient to a system that focuses on the provision of medical care and assistance at the community level. Nonetheless, psychiatric care is still mainly provided in specialized mental health institutions, including hospitals and large social care residential institutions. Although psychotropic medicines appear to be available, other services such as psychosocial and community-based support are mostly lacking.

54. Only 3 per cent of government health-care expenditure is devoted to mental health and over 80 per cent of all mental health expenditure is invested in mental hospitals. Mental health care, including essential psychotropic medicines, is included in the basic benefits package, which means it is offered free of charge. All severe and some mild mental conditions are covered by social insurance schemes. Patients with chronic mental health conditions are able to register as persons with disabilities and receive disability benefit payments.[35]

Normative and policy framework

55. Mental health in Armenia is regulated by the Law on Psychiatric Assistance, which was adopted in 2004 and last amended in 2013. While the law provides for the protection of the rights of persons with mental health conditions, it allows for involuntary placement and treatment through court orders. According to section 22, in order to subject a person to involuntary placement, he or she must first be examined by the psychiatric commission of a mental health institution. If the commission estimates that the person represents a danger to him/herself or others, or that a failure to provide treatment (or its termination) may worsen the health condition, and if the person refuses to undergo treatment or demands its termination, the commission immediately informs the head of the institution, who must in turn apply to a court within 72 hours for authorization to subject the person to placement and involuntary treatment. The law still lacks the basic safeguard of a provision for the periodic review of involuntary civil hospitalization at least once every six months.[36]

56. Section 6 of the Criminal Code regulates measures of medical enforcement. Article 97 stipulates that medical enforcement measures can be applied to: (a) a person who has committed a crime in an "insane state" (or a state of "limited insanity"); (b) a person who develops a mental condition which makes the application of a given punishment impossible; and (c) a person who has committed a crime and has been recognized as being in need of treatment against alcohol or drug-taking. The types of medical enforcement measures allowed in the above-mentioned cases are outpatient supervision by psychiatrists and forced treatment; forced treatment in general psychiatric hospitals; and forced treatment in specialized psychiatric hospitals (art. 98).

57. The Law on the Child's Rights stipulates that the State must guarantee professional, psychological and pathological care and assistance to children with physical or mental disabilities free of charge. The State must also ensure that such children have the opportunity to gain a professional education, in accordance with their employability, provide for social rehabilitation, promote self-confidence and facilitate their participation in public life (art. 26).[37]

[34] Ministry of Health, *Health for Health Care: Armenia Health System Performance Assessment*, pp. 48–54.http://www.moh.am/uploads/HSPA 2016_ English_final.pdf

[35] WHO and the Ministry of Health, "WHO-AIMS report on mental health system in Armenia", p. 6.

[36] See Council of Europe, "Report to the Government of Armenia on the visit carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment" (2015), p. 68.

[37] The Law on Child's Rights, available at www.ombuds.am/resources/ombudsman/uploads/files/agreements/2d25331b2ad440a56d9e450a307813f3.pdf.

58. In September 2013, the Government approved the "Action Plan of the concept on provision of alternative care and social services to persons with mental health problems" for the period 2013–2017, to be implemented under the auspices of the Ministry of Labour and Social Affairs. In April 2014, the "Strategy on preserving and improving mental health in the Republic of Armenia" for the period 2014–2019 was adopted. The Action Plan was aimed at the introduction of community-based services, while the Strategy and a list of actions envisaged normative and institutional activities, such as improvements in the compliance of legislation with the Convention on the Rights of Persons with Disabilities; the training of specialists; raising public awareness; and the design, implementation and evaluation of a community-based pilot project.

59. There is no mental health authority in Armenia apart from the Ministry of Healthcare. There is, however, a Chief Psychiatrist, appointed by the Ministry, who provides advice to the Government on mental health policies and legislation and on service planning, service management and coordination.[38] While important efforts over the past decades have encouraged the adoption of internationally recognized approaches to mental health, old-fashioned and outdated practices, reflecting mainly the neurobiological paradigm, remain widely used in Armenia.[39]

Challenges and opportunities: children and adults with psychosocial and intellectual disabilities

60. The successful implementation of the ambitious reforms of the health-care system can only be achieved if all elements of a modern approach to mental health are properly addressed. The most important of such elements are: (a) increased investment in the area of mental health services through the promotion of mental health and the prevention of common mental health problems among children and adults; (b) the integration of mental health into primary care; (c) the development of community-based services for children and adults with intellectual and psychosocial disabilities; and (d) a fundamental change in attitudes, among both the general population and health professionals.

61. A great deal of mental health promotion can be done in schools and educational settings, including the prevention of bullying and other forms of violence against children. The Special Rapporteur visited a number of primary and secondary schools and through his conversations with teachers and children, he was able to see that more effort is needed to ensure awareness of issues such as bullying, which exists in all countries. The sooner such issues are identified and properly addressed, the more effective investment in mental health at the school level will be.

62. However, mental health in school settings is also about inclusive education, not only crucial for the integration of children with disabilities but for the promotion of the emotional well-being of all children and society at large. The Special Rapporteur visited kindergarten No. 92 in Yerevan and considers it an example that needs to be replicated throughout the country. However, for the moment, it is the only kindergarten with such an approach in Armenia. The Special Rapporteur hopes that amendments in progress to the State programme on the development of education for the period 2017–2025 will allow the effective transition to an inclusive education system by 2025. He trusts that good pilot initiatives will be mainstreamed with the necessary additional investment.

63. The Special Rapporteur also visited the Spitak care centre, which provides community-based services to adults with psychosocial disabilities based on the existing mental health strategy. He was impressed by how services are provided with a human rights and evidence-based approach to guarantee the dignity and autonomy of users. He strongly recommends the prompt implementation of mental health reforms and the scaling-up and replication of such community services in all marzes or provinces.

64. Armenia is able and ready to follow good international practices in mental health and abandon the legacy of outdated policies and services reliant on large psychiatric

[38] See WHO and the Ministry of Health, "WHO-AIMS report on mental health system in Armenia", p. 12.

[39] Association of Child Psychiatrists and Psychologists, annual report 2008, p. 4.

hospitals and long-term care institutions. However, good pilot initiatives are, for the moment, only exceptions. Strong political will is needed to replicate modern community-based services throughout the country. Promising signs include the Action Plan for the provision of alternative care and social services to persons with mental health problems for the period 2013–2017, the Strategy on mental health for the period 2014–2019 and the first-time public funding of the Spitak care centre in 2018. Political will is needed to consolidate pilot initiatives and mainstream modern services as central components of the system.

65. The Armenian mental health system still contains elements of outdated models and practices, including easy and frequent hospitalization of people with mental health conditions, overmedication and long-term confinement based on labels such as "chronic patients". The Special Rapporteur warns against the risk that funding for mental health reform is invested in the renovation and expansion of the segregated psychiatric institutions that dominate the mental health-care system.

66. The Special Rapporteur visited a number of psychiatric institutions and was able to interview staff working there at different levels, as well as a number of service users. Living conditions could be qualified as basic in most places, although some buildings had recently been renovated. In both old and new buildings, it was common to find rooms without doors, which does not allow for privacy. Most activities seemed to be ad hoc and to consist of simple games, handicrafts, music and walks outside. Treatment seemed to consist mainly of medication and often, in the absence of structured activities during the day, many residents were either wandering the halls or lying on their beds at the time of the visits. The Special Rapporteur noted that in a number of the institutions, there were patients who had been confined for long periods of time, sometimes for 10–15 years, not because they needed to be hospitalized but owing to the lack of adequate care structures at the community level.

67. During conversations with managers and professionals in the mental health sector, the view that many residents of such institutions were too seriously affected by mental conditions to live an independent life was repeatedly conveyed. The Special Rapporteur wishes to stress that the "deterioration" in their condition is to a large extent likely to be the effect of institutionalization and disempowerment by discriminatory and stigmatizing attitudes that prevail in an ineffective and harmful mental health-care system.

68. Financial and other incentives need to be in place to expand community-based services that empower people with psychosocial or intellectual disabilities, integrate them into communities, support their needs and fulfil their right to live independently in society. In that respect, Armenia has received many good recommendations from international organizations, which should be implemented, including from the Committee on the Rights of Persons with Disabilities (see CRPD/C/ARM/CO/1, in particular paras. 6, 8, 12, 24, 32 and 43–44).

69. Primary care should have a role in psychiatric care in Armenia. Primary health structures and general practitioners and their teams should become an essential piece in the mental health system. Doctors working at primary care level should have sufficient training and interest in mental health care to identify, treat or refer mental health patients. An integrated approach is needed to continue building the capacity of health structures in all regions of the country towards community-based services, and support them with substantial budget allocations, adequate training of the workforce and the empowerment of persons with psychosocial disabilities

70. Armenia should fully integrate a human rights perspective into mental health and community services, and adopt, implement and monitor all existing laws, policies and practices, with a view to eliminating all forms of discrimination, stigma, violence or social exclusion in that context. Furthermore, it should take concrete measures to recognize the importance of addressing mental health by, inter alia, promoting prevention and training programmes for social, health and other relevant professionals, integrating mental health services into primary and general health care and providing mental health and other community-based services that protect, promote and respect the enjoyment of the rights to

liberty and security of person, to live independently and be included in the community, on an equal basis with others.[40]

IV. Communicable diseases: HIV/AIDS and tuberculosis

71. The Special Rapporteur observed inequalities in barriers to the enjoyment of the right to health in Armenia affecting access to quality essential services, particularly for people living with HIV/AIDS and with tuberculosis. Those communicable diseases mainly affect groups and key populations in situations of poverty and/or social exclusion who face stigma, discrimination and specific challenges in realizing their right to health.

A. HIV/AIDS and the right to health of key populations

72. The registration of HIV cases in Armenia started in 1988. In 2016, the estimated total number of people living with HIV was 3,300, the prevalence rate for adults aged 15 to 49 was 0.2 per cent, the number of women aged 15 and over living with HIV was less than 1,000 and deaths due to HIV/AIDS were fewer than 200.[41]

73. The main modes of HIV transmission in 2015 were heterosexual practices (65 per cent) and injecting drug use (26 per cent). Transmission through heterosexual practices affects women disproportionately, with almost all of them infected this way (96.7 per cent). About half of males are infected through sexual transmission (52.5 per cent) and 37 per cent through injecting drug use.[42]

74. Armenia is strongly committed to fighting HIV/AIDS, has joined all the international initiatives in this field and has provided access to testing and treatment for persons living with the disease. In 2016, Armenia became one of the only four countries in the world to have eradicated mother-to-child transmission of HIV.[43] Armenia was also awarded first prize in the category for innovation and excellence in delivering health services at the United Nations Public Service Forum 2017, held in The Hague in June 2017.

75. The prevalence of HIV/AIDS remains concentrated among certain key populations, particularly migrants and people who inject drugs, including prisoners. Since 2004, most new cases have been infected through heterosexual contact and are linked to the migration experience of male Armenians who leave the country to work abroad, mainly in the Russian Federation. These key populations are exposed to heightened risks and face barriers to exercising their right to health, both in law and in practice, as well as stigma and discrimination when accessing testing and treatment services.

76. Armenian legislation criminalizes HIV exposure and transmission, and there are serious concerns about respect for the right to confidentiality of HIV/AIDS patients.[44] According to the Criminal Code, knowingly subjecting another person to the obvious danger of HIV infection is punishable by imprisonment of up to one year (art. 123 (1)); infection of another person with HIV by someone who knows they are infected is punishable by imprisonment of up to five years (art. 123 (2)); and HIV transmission resulting from the professional negligence of medical professionals is punishable by imprisonment (art. 130 (2)).

77. Criminalization of HIV exposure and transmission does not comply with international obligations under the right to health. It acts as a serious barrier to the enjoyment of the right to health of those at risk, driving them away from the services they need and increasing health-related risks for them and for society as a whole. Armenia

[40] See Human Rights Council resolution 36/13, paras. 5 and 7.

[41] See www.unaids.org/en/regionscountries/countries/armenia.

[42] UNAIDS, “AIDS response progress report” (2016) available at www.unaids.org/sites/default/files/country/documents/ARM_narrative_report_2016.pdf.

[43] See www.unaids.org/en/resources/presscentre/featurestories/2017/july/20170706_armenia.

[44] See Violeta Zopunyan, Suren Krmoya and Ryan Quinn, “Identifying the gaps: Armenian healthcare legislation and human rights in patient care protections”.

should restrict liability for HIV transmission to cases where the infected person is aware of his/her condition and if he/she wilfully wanted to infect or has infected another person.

78. Regarding immigrants, in 2009 an amendment to the law "on the prevention of disease caused by the human immunodeficiency virus" was passed and repealed a provision requiring foreign citizens and stateless persons applying for entry visas for more than three months to present an HIV test certificate. A provision allowing for the deportation of HIV-positive foreign or stateless citizens was also removed. There are reportedly no legal obstacles for people living with HIV to travel or immigrate to Armenia.

79. Armenia has taken important steps to fight HIV/AIDS and the main objectives of the national programme on the response to the HIV epidemic for the period 2017–2021 are to achieve the UNAIDS 90–90–90 targets, maintain the validation of the elimination of mother-to-child transmission and strengthen surveillance systems.

80. The country coordination mechanism for HIV/AIDS, tuberculosis and malaria programmes, established in 2002 and reformed in 2011, is a multisectoral commission including representatives of the Government, academia, local and international NGOs, faith-based organizations, United Nations agencies and bilateral development partners, the private sector, and people living with the disease. The mechanism manages grants and serves as an important coordinator between all relevant actors, including civil society, that have taken an active part in developing proposals and activities to strengthen the response to HIV/AIDS, tuberculosis and malaria.[45]

81. HIV testing in Armenia is voluntary. It is only mandatory for blood and organ donors and children of HIV-positive mothers and since 2005, access to antiretroviral treatment is free of charge. Counselling and testing is available in State-owned outpatient health centres and self-testing will be introduced shortly.

82. As for other health-related services, there is a gap between access in major cities and in rural areas. To address that situation, a mobile medical team has been created to make HIV/AIDS treatment, care and support accessible in the marzes. Antiretroviral treatment and substitution treatment have been introduced for prisoners.[46]

83. However, most public health efforts to fight HIV/AIDS are funded by external donors, which raises concerns about the sustainability and ownership of those initiatives. The activities implemented by the national programme on the response to the HIV epidemic are mainly funded by the Global Fund to fight AIDS, Tuberculosis and Malaria, the Government and other donors. In 2015, the total spend on AIDS amounted to a bit more than 2 million drams (about $4,130). The sum of allocations from the State budget made up 36.1 per cent of the total spend on AIDS in 2015.[47]

84. Awareness and access to information remain at a low level, including in relation to sexually transmitted diseases and modern contraceptive methods, among the general population, youth and adolescents, and the key target groups of people in situations of poverty and/or social exclusion who face specific challenges in realizing their right to health. That is particularly important for women and girls.

85. Additionally, reports and testimonies gathered during the visit indicate that stigma and discrimination in health-care settings are major barriers to accessing treatment and services for key populations. Consequently, they tend to avoid the health services.

B. Tuberculosis

86. Tuberculosis is an important public health concern in Armenia, which has one of the highest incidence rates in the European region. Between 2005 and 2006, prevalence peaked at 118 cases per 100,000 of the population but then fell by an average of 6.3 per cent per

[45] See UNAIDS, "Aids response progress report", p. 11.
[46] Ibid, p. 14.
[47] Ibid, p. 13.

year to 79 cases per 100,000 of the population in 2012[48] and 45 cases per 100,000 of the population in 2014. From 1990 to 2006, mortality increased from 4.4 to 8.7 per 100,000 of the population, but since 2008 the mortality rate has been declining.[49]

87. The low treatment success rate of 78.1 per cent is below the WHO target of 85 per cent, which is increased to 90 per cent in the Global Plan to end tuberculosis for the period 2016–2020 of the Stop TB Partnership.[50] That is partly explained by the high prevalence of the multidrug-resistant form of tuberculosis and by high levels of stigmatization of patients, which can negatively impact on adherence.

88. Armenia is one of the 27 countries in the world with the highest level of multidrug-resistant tuberculosis cases, with a burden of 11 per cent of new cases in 2016.[51] Nonetheless, control of multidrug-resistant tuberculosis appears to have been improving in recent years. In 2014, pulmonary cases made up 25.4 per cent of all cases and of all multidrug-resistant cases enrolled in treatment in 2012, only 44.3 per cent were successfully treated.[52] One reason for the low treatment outcome in Armenia is adherence, as not all patients are properly followed up.

89. Control of tuberculosis is prioritized at the highest political level in the Ministry of Healthcare. It was included in a health system development concept paper for the period 2013–2020, taking into consideration the recommendations of the 2011 review of the national tuberculosis control programme. In 2014, the national control programme and the Republican TB Dispensary were merged into the National Centre for Tuberculosis Control, which has strengthened its roles in policy development and implementation and in the coordination of work among relevant stakeholders.[53]

90. As mentioned, treatment of tuberculosis has traditionally not been patient-friendly and has relied excessively on hospitalization owing to a reverse incentive system, which discouraged ambulatory care. Although there have been important efforts to address this, including through the introduction of a performance-based financing model in primary care, essential community-based tuberculosis care and treatment centres have yet to be fully developed. Diagnostic services should be brought closer to patients at the primary care level and new rapid diagnostic techniques are needed.

91. In 2013, the Ministry of Healthcare decided to modify the "per-bed occupation" funding scheme to move towards a more modern outpatient, performance-based scheme (governmental decision No. 1515N, December 2013, and governmental protocol No. 21 May 2013). By 2015, the number of tuberculosis beds in dispensaries was to be reduced by 30 per cent, while an additional 12 per cent decrease in the total number of hospital beds was planned. The reorganization aimed to improve the levels of both detection and successful treatment by achieving financial savings, improving the satisfaction levels of both tuberculosis specialists and patients, and gradually shifting experienced tuberculosis doctors from hospitals to outpatient services.

92. People living with HIV are at heightened risk for tuberculosis, meaning that discrimination against people with HIV/AIDS increases their vulnerability. Information and education campaigns related to tuberculosis are not widespread and there are no specially designated places in tuberculosis facilities at any level to display information, education and counselling materials for patients and the general population.

93. Overcrowding and unsanitary conditions in prisons and the lack of meaningful access to physicians and health services are reportedly acting as a vector for the spread of tuberculosis. The Special Rapporteur visited a number of prisons and discussed relevant

[48] See WHO, *Extensive Review of Tuberculosis Prevention, Control and Care in Armenia* (2014).

[49] See WHO, *World Health Statistics 2016: Monitoring Health for the SDGs.*

[50] See Stop TB Partnership, *The Global Plan to End TB: the Paradigm Shift 2016–2020* (2015),

[51] For a definition and information on multidrug-resistant tuberculosis (MDR-TB) see WHO, available from www.who.int/mediacentre/factsheets/fs104/en/. See also, WHO, Tuberculosis country work summary (2010) and WHO, Tuberculosis Country Brief: Armenia (2016).

[52] WHO and European Centre for Disease Prevention and Control, *Tuberculosis Surveillance and Monitoring in Europe 2016*, p. 159.

[53] See WHO, *Extensive Review of Tuberculosis Prevention, Control and Care in Armenia*, pp. 12–13.

issues with prison authorities, health professionals and inmates. He wishes to underline that more attention, investment and creative thinking is needed to address the situation in Armenian prisons regarding tuberculosis, HIV/AIDS and other issues related to the right to health.

V. Drug policy and access to controlled medicines

94. Throughout its history, as part of the Union of Soviet Socialist Republics and for nearly two decades after it gained independence in 1990, Armenia enforced a "zero tolerance" approach to illegal drugs, with harsh criminal sentences for use and possession. In 1993, it ratified the three United Nations conventions on drug control.

95. In 2014, it was estimated that over 12,000 people in Armenia used drugs and the adult HIV prevalence among people who used drugs was 6.3 per cent. The rapid increase in HIV/AIDs among the prison population in the Eurasia region over the past decades has led to opioid substitution therapy being available to prisoners, but access to sterile injecting equipment remains rare.[54]

96. In 2008, amendments to the Armenian normative framework resulted in a significant policy shift. Drug use and possession statutes were removed from the Criminal Code and replaced by article 44 of the Administrative Code, which provides that possession of small quantities of illegal drugs without intent to sell faces only administrative liability. However, the level of fines established can result in a backdoor criminalization of drug users, with those caught in possession of drugs for the first time facing fines set at 100 to 200 times the minimum wage, which many cannot pay.[55]

97. Under the law, individuals who seek assistance or treatment in relation to drug use at medical facilities are exempt from administrative liability. Research suggests that the decriminalization of drug possession has led to a greater number of people who use drugs accessing treatment.[56] Nonetheless, the approach to drug control in Armenia, including drug use and access to controlled medicines for pain relief, remains excessively punitive and restrictive, undermining the enjoyment of the right to health of people who use drugs and of those in need of palliative care.

98. The national health-care system provides for opium substitution therapy, including methadone substitution therapy, but treatment is not always voluntary and can be imposed through court orders, in addition to prison sentences for drug-related offences. Needle exchange programmes are available but reportedly not in prisons.

99. Access to methadone for injecting drug users is based on existing clinical guidelines, which include an agreement depriving users of access to health care in case of non-compliance, for instance through the use of substances containing narcotics without the permission of a physician. It is reported that the police have permanent access to patients' medical records without requiring their consent.

100. Services related to drug use and HIV/AIDS remain insufficient. There is late diagnosis of HIV among drug-injecting users and the HIV testing rate among people who inject drugs in Armenia is only 25 per cent.[57] That indicates low levels of trust in the health system owing to the lack of balance between law enforcement responses and the health and social strategies aimed at addressing drug use. Additionally, there are low levels of awareness and access to other harm-reduction services.

101. The Special Rapporteur was informed that health structures providing harm-reduction services did not cater for the needs of specific populations, such as adolescents

[54] Data from Harm Reduction International, Eurasia regional overview, available from www.hri.global/eurasia.

[55] Ari Rosmarin and Niamh Eastwood, "A quiet revolution: drug decriminalization policies in practice across the globe" (2012), p. 17, available at www.opensocietyfoundations.org/sites/default/files/release-quiet-revolution-drug-decriminalisation-policies-20120709.pdf.

[56] Ibid.

[57] See UNAIDS, "Aids response progress report".

and youth. It is reported that stigma and discrimination remain an important barrier to accessing treatment and services for drug use and dependency, including HIV prevention, treatment and care.

102. As a result of the advocacy and support of external donors and partners, Armenia has developed a palliative care concept for the period 2012–2016 and a palliative care strategy for the period 2017–2019, to integrate palliative care into the national health system. The authorities are to be commended for those initiatives. However, many patients with life-limiting illnesses and chronic pain still end their days in unbearable suffering, which goes against international standards on pain management, represents a violation of the right to health and creates a risk of cruel, inhuman or degrading treatment.[58]

103. Morphine is the main medication for the treatment of moderate to severe pain. WHO has included it in its model list of essential medicines (twentieth edition, 2017), which contains the minimum essential medications that should be available to all who need them.[59] However, reports and available data show that morphine has not been available in Armenia in sufficient quantities. Oral morphine was registered in 2017 for the first time and it is scheduled to be included in the tender for medication purchase in 2018. Shortly after his visit, the Special Rapporteur was pleased to learn that the Ministry of Healthcare had placed the first order for 2,500 boxes of oral morphine, which should be available in early 2018.

104. There were other positive developments in the area of palliative care after the visit of the Special Rapporteur, particularly regarding the removal of complex procedures and bureaucratic barriers for prescribing opioids. On 8 November 2017, a decree was issued allowing family doctors and treating doctors, irrespective of their specialty, to prescribe opioids for people in need of palliative care. Reportedly, there will be no standing commission to make a decision on prescription, which will be made by the treating doctor based on pain assessment protocol requirements. Prescriptions of narcotic drugs have been extended to cover 10 days versus the 3 days of previous practice and are valid for 10 days. The drugs can be prescribed at a health institution and at home during a home visit by the treating doctor. The drugs can also be received by a legal representative of a patient.

105. However, the Special Rapporteur was concerned to learn that oncologists routinely provide written reports to the police about patients who receive opioid medication, with information that violates the right to privacy and confidentiality, which are crucial elements of the right to health. The Data Protection Inspectorate of the Ministry of Healthcare issued a decision indicating that this practice is not based on existing legislation, is not proportionate according to article 5 of the Law on Personal Data Protection,[60] and violates patient confidentiality.[61] It remains unclear whether that decision has been implemented.

106. Moreover, health professionals are not properly trained and certified to provide palliative care services, including psychosocial support and counselling, and access to palliative care medication is not available throughout the country. In 2018, it is planned that 20 polyclinics will provide palliative care services, 10 in Yerevan and 10 in the regions. However, such services are to be privately paid for, which could have devastating consequences for an important sector of the population and their families.

107. Palliative care and services should be further developed and provided through the national health system and policy reform is needed to ensure their availability, as is the education of health workers to provide adequate and ethical services.

[58] See, for example, World Health Assembly resolution WHA67.19 (2014).

[59] Available from www.who.int/medicines/publications/essentialmedicines/20th_EML2017_FINAL_amendedAug2017.pdf?ua=1.

[60] Available at www.foi.am/u_files/file/Personaldataprotectionlaw_ENG.pdf.

[61] Human Rights Watch, "'All I can do is cry': cancer and the struggle for palliative care in Armenia" (2015), p. 3.

VI. Conclusions and recommendations

108. **There are good opportunities for achieving the progressive realization of the right to health in Armenia but the public authorities need to step up efforts to address structural and systemic challenges, both in law and in practice, in order to fulfil the obligations of the State under international law to promote and protect human rights.**

109. **The best way to implement the 2030 Agenda for Sustainable Development and the Sustainable Development Goals, including Goal 3 (ensure healthy lives and promote well-being for all at all ages), is by guaranteeing the protection and promotion of human rights for all. To move forward, Armenia should make use of the recommendations made by various regional and international bodies, particularly in the field of human rights.**

110. **Challenges in Armenia to the realization of the right to health can only be effectively addressed if all elements and principles of the right to health framework are mainstreamed in health policy formulation and implementation. They include non-discrimination, accountability, participation and empowerment, informed consent, and the need to go beyond the narrow biomedical model so that holistic, equitable and ethical care is provided to all.**

111. **The Special Rapporteur recommends that the authorities in Armenia:**

(a) **Consider ratifying the Second Optional Protocol to the International Covenant on Civil and Political Rights and the remaining optional protocols on individual complaints procedures of the international human rights treaties;**

(b) **Effectively implement legal provisions against all forms of discrimination, including in regard to health status, sexual orientation and gender identity, introducing public awareness-raising campaigns and education programmes to combat all forms of discrimination;**

(c) **Strengthen the health-care system and guarantee adequate, equitable and sustainable financing by substantially increasing national budget allocations for health, and continue to improve the availability and accessibility of health services in all regions;**

(d) **In the process of moving towards a mandatory health insurance scheme, consider carefully all risks related to involving private insurers as third party administrators and adopt all necessary measures to ensure that strong oversight and transparency mechanisms are in place;**

(e) **Reduce inherited reliance on specialized and hospital care, including in the capital city, through rational investments in health infrastructure throughout the regions, with a particular focus on primary care and the increasing role and competences of general practitioners and their teams;**

(f) **Introduce explicit provisions in the law to protect the right to non-discrimination on the basis of health status, particularly tuberculosis and HIV status, including in the Law on Medical Care, and establish a system of community-based care and treatment of tuberculosis with the full engagement of people with, and survivors of, the disease and those at heightened risk of contracting it, including prisoners, migrants, refugees and non-citizens;**

(g) **Restrict liability for exposure to and transmission of HIV/AIDS and ensure effective outreach to those most at risk, including by providing access to quality evidence-based services and working closely with key affected populations. Address widespread misconceptions about HIV/AIDS through evidence-based public awareness, education and information campaigns;**

(h) **Further develop and provide palliative care and services through the national health system and adopt a national strategy for palliative care. Facilitate registration of oral opioid painkillers and make sure oral morphine is available at all**

levels of care. Continue removing restrictions to the prescription of opioids, reducing unnecessary bureaucratic requirements, and put an end to excessive police interference in the process;

(i) **Increase investment in prevention, education and information programmes about drug use, especially among adolescents and youth. Ensure that the health and related sectors are proactive in promoting evidence-based prevention, services and treatment for people who use drugs, while respecting their autonomy, dignity and privacy;**

(j) **Take targeted and concrete measures to radically reduce coercion in mental health-care services, with a view to ending all forced psychiatric treatment and confinement, and seek technical assistance from the WHO Quality Rights initiative to make this process successful and effective;**

(k) **Stop prioritizing investments in large psychiatric hospitals and residential institutions for people with mental health conditions and scale up investments in alternative mental health services and support models that respect the dignity and autonomy of users of services and empower them;**

(l) **Develop a comprehensive infrastructure of health care and educational and social welfare services for children with developmental disabilities and mental health conditions, so that those children and their families receive all the services they need at the community level, to prevent their placement in institutional care and the excessive use of biomedical interventions.**