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Visita a Kirguistán

Informe del Relator Especial sobre el derecho de toda persona al disfrute del más alto nivel posible de salud física y mental* **

Resumen

El Relator Especial sobre el derecho de toda persona al disfrute del más alto nivel posible de salud física y mental, Dainius Pūras, visitó Kirguistán del 22 al 31 de mayo de 2018. Kirguistán está en una situación idónea para seguir fortaleciendo sus políticas y servicios relacionados con la salud; sin embargo, para mantener esa situación será necesario enfocar la salud pública desde una perspectiva moderna y basada en los derechos humanos. En un contexto caracterizado por una firme voluntad política, sólidos avances en la formulación de políticas y buenas prácticas experimentales, el principal reto que habrá que afrontar para lograr la plena efectividad del derecho a la salud física y mental en Kirguistán será la aplicación efectiva y la sostenibilidad. Este reto está relacionado con la promoción de la transparencia y con la necesidad de combatir las prácticas corruptas e ineficaces que aún perduran. Para ello, el Gobierno debería elaborar una estrategia a largo plazo y asumir como propios los programas elaborados con la cooperación internacional, asegurando su continuación y sostenibilidad con la inversión de recursos nacionales. Entre las dificultades específicas que persisten figuran el disfrute de los diferentes derechos en materia de salud sexual y reproductiva, las prácticas discriminatorias en los servicios de atención de la salud y la necesidad de desinstitucionalizar progresivamente los servicios de salud mental y de asistencia social. La sociedad civil debería participar en esta labor en pie de igualdad con el Gobierno.

* El resumen del presente informe se distribuye en todos los idiomas oficiales. El informe propiamente dicho, que figura en el anexo, se distribuye únicamente en el idioma en que se presentó y en ruso.

** Se acordó publicar el presente informe tras la fecha de publicación prevista debido a circunstancias que escapan al control de quien lo presenta.

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Annex

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 Kyrgyzstan

Contents

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 Kyrgyzstan from 22 to 31 May 2018 at the invitation of the Government. The purpose of the visit was to ascertain, in a spirit of dialogue and cooperation, how the right to health is realized in the country.

2. During his visit, the Special Rapporteur met with high-ranking government officials and representatives of the relevant health-related authorities at the central and local levels. He also met with the Ombudsman and representatives of the national preventive mechanism, international organizations and a wide range of civil society groups, including health-care personnel.

3. The Special Rapporteur visited various health-care facilities in Bishkek, Jalal-Abad and Osh, including a psychiatric hospital, two prison hospitals, and health-care services at a pretrial detention centre and at a prison for women. He also visited a school, a number of primary health centres at the community and local levels and a psychoneurological institution.

4. The Special Rapporteur is grateful to the Government of Kyrgyzstan for its invitation and full cooperation during his visit. He appreciates the crucial support provided by the Regional Office for Central Asia of the Office of the United Nations High Commissioner for Human Rights and the useful assistance provided by the United Nations country team.

II. Right to health

A. Background

5. Kyrgyzstan was the first Central Asian republic to declare independence from the Soviet Union. It became an independent State in August 1991 when the Soviet Union dissolved. Since then, Kyrgyzstan has implemented reforms to become a market economy and a democratic society, including in the context of various economic, fiscal and political crises faced at different points in time.

6. In April 2010, civic unrest led to the establishment of an interim Government and a new Constitution, adopted by referendum in June of that year. The Constitution, inter alia, reduced presidential powers in favour of the parliament and the Prime Minister. Despite the outbreak of inter-ethnic violence in Jalal-Abad and Osh in June 2010, the country managed to return progressively to economic and political stability. Elections were held peacefully in 2015, 2016 and 2017. Some of the progressive measures included in the Constitution, however, were restricted through amendments approved by referendum in December 2016. The amendments were aimed to, inter alia, strengthen the executive branch, reduce the independence of the judiciary and restrict the constitutional oversight of the executive and legislative branches.

7. Since Kyrgyzstan gained independence, the economy has remained stable but highly dependent on other economies and is susceptible to global crises. The structure of the economy has in fact changed significantly over the years. In 1990, it was divided equally between agriculture, industry and services. The tertiary sector, however, has grown continually since then, at the expense of agriculture, accounting for approximately half of the workforce in 2013 and half of value added in 2014. The industry sector is far from its level in 1990.[1]

[1] Organization for Economic Cooperation and Development (OECD), *2018 Development Pathways: Social Protection System Review of Kyrgyzstan*, June 2018, p. 26.

8. Today, the economy largely relies on remittances from Kyrgyz migrants, including health-care personnel, who have left the country in search of work opportunities, particularly in the Russian Federation and Kazakhstan. In 2016, remittances accounted for 34.5 per cent of gross domestic product (GDP),[2] the highest proportion worldwide. Emigration has boosted domestic wages and reduced income poverty and income inequality, helping the country to make progress in achieving Millennium Development Goal 1 on eradicating extreme poverty,[3] the aim of which has continued in a strengthened form in Sustainable Development Goal 1, on ending poverty in all its forms everywhere. The percentage of individuals living below the poverty line dropped from 62.6 in 2000 to 31.7 in 2008. The percentage remained above 30 from 2008 until 2016, after which it fell to 25.4. Income inequality has also improved, with the Gini coefficient value falling from 0.54 in 1993 to 0.23 in 2015.[4]

9. The country has also made good progress in terms of its Human Development Index value, which rose from 0.618 in 1990 to 0.672 in 2017, placing Kyrgyzstan in the medium human development category. Between 1990 and 2017, life expectancy at birth increased (by 4.8 years), as did the number of years of schooling (by 2.3 years) and the expected years of schooling (by 1.4 years).[5] The two latter values are linked to Millennium Development Goal 2, on achieving universal primary education and Sustainable Development Goal 4, on ensuring inclusive and equitable quality education and promoting lifelong learning opportunities for all.

10. In 2015, the State was declared as having achieved Millennium Development Goal 4, on reducing mortality of children under 5 years of age. In recent years, Kyrgyzstan has paid special attention to the quality of care for children at first-level referral hospitals and introduced standards of care.[6] The under-5 mortality rate fell by two thirds between 1990 and 2016 and the neonatal mortality rate was halved, falling from 24 to 12 deaths in the same period.[7]

11. With regard to maternal health in the context of Millennium Development Goal 5 and target 3.1 of Sustainable Development Goal 3, on ensuring healthy lives and promoting well-being for all at all ages, Kyrgyzstan is gradually reducing the maternal mortality ratio. According to data from United Nations bodies and the World Bank, the ratio has fluctuated, with 74 per 100,000 births in 2000, 85 in 2005, 84 in 2010 and 76 in 2016.[8] This slow improvement has not prevented the country from having one of the highest ratios of maternal mortality in the Eastern Europe and Central Asia region.

12. More work is needed to achieve Millennium Development Goal 6, on combating HIV/AIDS, malaria and other diseases.

[2] World Bank, “Migration and remittances. Recent development and Outlook. Special topic: global compact on migration”, April 2017, p. 3.

[3] United Nations Development Programme (UNDP) *Kyrgyzstan, MDG Acceleration Framework: improving maternal health in the Kyrgyz Republic*, November 2013, p. 14.

[4] OECD, *2018 Development Pathways*, pp. 24 and 32.

[5] UNDP, “Human development indices and indicators. Briefing note for countries on the 2018 statistical update: Kyrgyzstan”, p. 2.

[6] A multi-country assessment of the realization of children’s rights in hospital care in 2012–2014, covering 11 Kyrgyz hospitals, revealed that Kyrgyzstan was the only State to have adopted, disseminated and implemented the Convention on the Rights of the Child. A second-round assessment showed an effective change in many of the gaps identified in the first round. See Fernandes Guerreiro et al., “Assessing and improving children’s rights in hospitals: case studies from Kyrgyzstan, Tajikistan, and Moldova”, *Harvard Health and Human Rights Journal*, vol. 18, No. 1 (June 2016).

[7] See www.unicef.org/kyrgyzstan/health-and-child-survival.

[8] World Health Organization (WHO), United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank and United Nations Population Division, *Trends in Maternal Mortality: 1990 to 2015* (2015), p. 73. The Republican Medical Information Center estimates lower ratios.

13. While overall poverty has decreased in recent years, most people in Kyrgyzstan continue to live just above the poverty line.[9] Despite the continued efforts to keep the social protection scheme that was in place under the Soviet Union, the standard of living, as measured by gross national income per capita, decreased between 1990 and 2017 by approximately 4.8 per cent.[10]

14. Access to economic and social rights, such as the right to health, is affected by elements other than income poverty alone, including location. In Kyrgyzstan, the level of deprivation (namely, the lack of basic necessities or assets that a person has been used to for a long period of time) continues to be high in rural areas, where services are often in place but underresourced.

15. A large degree of inequality exists between families with a low income and those with a high one. The mortality rate of children under 5 years of age is 1.6 times higher in rural areas than in urban areas, while the neonatal, infant and under-5 mortality rates in the lowest income quintile are more than double those of the highest income quintile.[11] Preventable child deaths are disproportionately concentrated in remote areas, with more than 80 per cent occurring in the first year of life as a result of diarrhoea, pneumonia or complications during the perinatal care period.

B. Normative and institutional framework

16. Kyrgyzstan is party to most international human rights instruments, including the complaints procedures under the International Covenant on Civil and Political Rights and the Convention on the Elimination of All Forms of Discrimination against Women. It has also accepted the inquiry procedures under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Convention on the Elimination of All Forms of Discrimination against Women.

17. Kyrgyzstan is in the process of ratifying the Convention on the Rights of Persons with Disabilities, which it signed in 2011, and is yet to ratify the complaints procedures under the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child. It has not signed or ratified the International Convention for the Protection of All Persons from Enforced Disappearance.

18. The Special Rapporteur highlights the ratification of the Convention on the Rights of Persons with Disabilities as a much needed step that will boost the work already begun in the progressive elimination of barriers faced by persons with disabilities. He was encouraged to learn that the ratification process was under way at the time of drafting the present report.

19. Kyrgyzstan has ratified the World Health Organization (WHO) Framework Convention on Tobacco Control and the main United Nations conventions relating to drug control. It has received visits from various special procedure mandate holders. The two most recent visits were by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (see A/HRC/19/61/Add.2) and the Special Rapporteur on the sale and sexual exploitation of children, including child prostitution, child pornography and other child sexual abuse material (see A/HRC/25/48/Add.1). Kyrgyzstan also received a follow-up visit by the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in September 2018.

20. Kyrgyzstan underwent a review in the context of the universal periodic review in 2010 and 2015; the next review is scheduled for January 2020. During the most recent review in 2015 (see A/HRC/29/4), Kyrgyzstan was commended for, inter alia, its readiness to cooperate with international human rights mechanisms, the reforms initiated to implement recommendations made at the previous review and establishing a human rights

[9] In 2015, 77 per cent of the population lived either below the poverty line or just above it (see OECD, *2018 Development Pathways*, pp. 27–28).

[10] UNDP, “Human development indices and indicators”, p. 2.

[11] See www.unicef.org/kyrgyzstan/health-and-child-survival.

coordinating council. Concerns raised included the increasing number of persons with HIV/AIDS, the growing number of children placed in care institutions owing to poverty, violence against women and against lesbian, gay, bisexual, transgender and intersex persons, early marriage, bride-kidnapping and limited progress towards the reconciliation of ethnic groups.

21. Kyrgyzstan accepted a number of recommendations made at the universal periodic review. Those relating to the right to health included improving access to adequate health care and treatment for HIV-positive mothers to prevent transmission from mother to child, and continuing the fight against domestic violence and violence against women, paying special attention to preventive and prophylactic measures (see A/HRC/29/4). The recommendation made by various States that Kyrgyzstan extend a standing invitation to all special procedures of the Human Rights Council was not accepted by the State.

22. The adoption of the Constitution in 2010 helped to strengthen human rights standards, although progress was restricted by the amendments approved in December 2016. The reference in article 6 to international human rights instruments taking precedence over other international instruments was removed, and article 16 was redrafted to suggest that fundamental rights and freedoms were part of the superior values of Kyrgyzstan, whereas previously they had been considered of superior value. In addition, the provision in article 36 allowing persons over the age of consent the right to marry and create a family was replaced with language suggesting that a family was created only upon the voluntary union of a man and a woman who had reached the age of consent and entered into marriage. This is a discriminatory and retrogressive provision that negatively affects the lesbian, gay, bisexual and transgender community.

23. Other human rights principles are still upheld in the amended Constitution, such as equality, including between women and men, and non-discrimination on various grounds (sex, race, language, disability, ethnic background, religion, age, political or other opinions, education, origin, property or other status, and other characteristics). The principle of the best interests of the child is upheld in the Constitution, including the protection of every child's right to an adequate standard of living for his or her physical, mental, spiritual, moral and social development.

24. The right to health, including provisions regarding its underlying determinants, is enshrined in the Constitution. Article 47 establishes everyone's right to health protection and the responsibilities of the State both to develop the health-care sector and to provide for free medical services within the bounds of State guarantees established in the law. Article 22 includes provisions on informed consent, such as the prohibition of medical, biological or psychological experiments on persons without their expressed and verified voluntary consent. Article 9 guarantees minimum levels of health and labour protection for citizens in socially vulnerable situations, while article 48 states that everyone has the right to a healthy environment and to compensation for damage to health or property as a result of environmental management.

25. An extensive legislative national framework governs the national health-care system. The framework includes laws on public health, food safety and water safety, and a number of government decrees and orders by the Ministry of Health. The most important pieces of legislation governing the national health system are the law on the protection of the health of citizens (January 2005), the law on the organization of health care (August 2004) and the law on public health (July 2009). Additional laws relevant to the realization of the right to health include the laws on the reproductive rights of citizens; on measures for preventing harm to children's health and physical, intellectual, mental, spiritual and moral development; on the sanitary and epidemiological well-being of the population; on the protection of citizens' health from the harmful effects of tobacco; on labour protection; and on mental health.[12]

[12] WHO Regional Office for Europe and Ministry of Health of Kyrgyzstan, *Results of the self-assessment of essential public health operations in the Kyrgyz Republic: April–September 2016* (Bishkek, 2017), p. 1.

26. The Ministry of Health is the primary body responsible for policies on health protection, including policy formulation, implementation and evaluation, in the areas of health care and health promotion, sanitary and epidemiological welfare, health financing and economics, staffing in the health-care system, the provision of medicines to the population, medical science and education, and compulsory medical insurance. The Ministry participates in the planning process, taking into account socioeconomic, demographic, epidemiological and other data. Although the health-care system is a funding priority, it is still underfunded, health-care infrastructure is underdeveloped, and facilities are ageing, characterized also by a lack of modern equipment and fixed assets depreciating in value. Furthermore, the implementation, monitoring and accountability mechanisms in health-related policies are not appropriately developed.

C. National health-care system

27. Kyrgyzstan inherited a centralized health-care system from the Soviet Union that guaranteed free medical care and access to a range of services for the population. It also inherited, however, a system that prioritized hospital care and curative rather than preventive services, and significant geographical imbalances in terms of access and quality. Since Kyrgyzstan became independent, the health-care system has undergone three main reform programmes: Manas (1996–2005), Manas Taalimi (2006–2010) and Den Sooluk (2012–2016, later extended to 2018). The Special Rapporteur was informed that, at the time of the visit, the State was working towards a fourth generation health sector strategy that would address the new challenges posed by the increasing prevalence of non-communicable diseases, while accelerating progress towards universal health coverage.

28. In the recent past, Kyrgyzstan has been depicted as a pioneer in health reforms for its early establishment of a single payer system (the mandatory health insurance fund), its establishment of a basic benefit package (the State-guaranteed benefits package), its promotion of family medicine and the priority given by the State to the health sector in terms of funding.

29. The health reforms have shifted the focus from hospital care to outpatient care, and to primary health-care services in particular. Family medicine centres have been created and family physician groups established as the first point of contact with the health-care system. Many hospitals have also been restructured. As a result, inpatient care discharges per 100 persons, for example, dropped from 25.8 in 1988 to 14.1 in 2015.[13] Child hospitalization and overtreatment are still, however, issues of concern that require further action.

30. The reforms also introduced a mandatory health insurance contribution, the mandatory health insurance fund and a single-payer system. In 2001, Kyrgyzstan introduced a State-guaranteed benefits package to clarify health-care entitlements, co-payment for particular services and tests, and an exemption mechanism. The mechanism currently covers 16 medical categories, including HIV, tuberculosis and maternal care, and 30 socially vulnerable groups, including children under the age of 5 and persons over 70, households with a "social passport",[14] recipients of State benefits and beneficiaries of monthly cash payments. More transparency is needed in order for citizens to be more aware of their entitlements.

31. The health reforms initially reduced out-of-pocket expenditure on health-care services. After 2009, however, out-of-pocket spending began to grow at an increased rate and faster than the growth of the total household budget per capita. The main driver of out-of-pocket expenditure is medicine for outpatients. Moreover, informal payments made during hospitalization, although not a significant portion of out-of-pocket spending, also

[13] OECD, *2018 Development Pathways*, p. 54.

[14] A document issued to a low-income family to demonstrate that it meets guidelines with regard to poverty. The passport also contains a range of demographic information about the holder, including general financial status (income and property), educational status, gender, age, physical status (noting any disability hindering income generation) and social mobility potential (i.e., the ability to move to a higher social level).

increased. These patterns led the World Bank and WHO to recommend a review of the State-guaranteed benefit package and better control of the pharmaceutical market in the country.[15] The recommendations, particularly on a review of the State-guaranteed benefit package, were taken into consideration by the State during the development of the "healthy person – prosperous country" health strategy for 2019–2030.

32. The national health-care system currently offers three types of insurance: the State-guaranteed benefits package[16] covers free access to primary health care for the entire population and defines co-payment exemptions; the mandatory health insurance programme covers specific co-payments and contributing members; and voluntary health insurance with private insurers covers limited specialist services and provides types of insurance other than health insurance. Both the State-guaranteed benefits package and the mandatory health insurance programme are managed by the mandatory health insurance fund. There is no opt-out of the fund; voluntary health insurance schemes are therefore unlikely to expand.

33. Primary health-care facilities in Kyrgyzstan[17] include family group practices (or feldsher obstetrical ambulatory points) and family medicine centres. Family medicine centres are separate from hospitals and provide free health-care services to all individuals assigned to them. In some districts, family medicine centres are still connected to hospitals, in which case they are called general practice centres. In the districts that have family medicine centres, hospitals do not usually provide outpatient services, but on the rare occasions that they do, they are provided through co-payment.

34. Free primary health-care services include access to laboratory testing and medical advice, including on breastfeeding. Primary health care also includes the provision of some medicines through an additional programme.

35. The Special Rapporteur confirms that there is a continuing political will to focus on investing in primary health care and efforts have been made to keep the entire health-care system sustainable. Progress in this direction is shown by the reduction in child mortality and the prevention and treatment of communicable diseases, in particular tuberculosis. Although government funding has been increasingly directed to family primary health-care services, the services still face the challenge of retaining health-care workers, particularly in rural areas.

1. Transparency in the health-care system and role of health-care personnel

36. The Special Rapporteur was informed, throughout his visits to health-care facilities and in most of his meetings with government officials and stakeholders, that informal payments in exchange for health-care services are still common practice in Kyrgyzstan. Groups in vulnerable situations suffer disproportionately from this system, as they have the most difficulty affording informal payments.

37. Addressing remaining corrupt practices and improving transparency at all levels of the health-care system is a key factor in the realization of the right to physical and mental health. Lack of transparency, compounded by unclear rules in the provision of services, reduces trust between health-care users, health-care providers and policymakers.

38. To address these issues, there is a clear need to invest significantly more in human resources, which should be a priority. Health-care personnel play an indispensable role in the realization of the right to health. They help to document and provide redress for human rights violations, such as violence and torture. In some cases, they are, intentionally or unintentionally, complicit in certain types of human rights abuses, for example when

[15] World Bank and WHO, "Den Sooluk national health reform programme: joint review summary note", April 2017.

[16] The State-guaranteed benefits package provides for primary health care, outpatient emergency care, emergency consultation services (air ambulances), specialized outpatient health care, inpatient health care, health-care services financed by the high-tech medical care fund, dental care, medicines and vaccines, and immunization. See OECD, *2018 Development Pathways*, p. 89.

[17] Until 2018, primary health care in Bishkek was still funded by the budget for the Bishkek municipality.

providing non-discriminatory services to all, including lesbian, gay, bisexual and transgender persons or migrants and refugees.

39. The capacity of well-trained health workers should be strengthened by, inter alia, integrating a human rights-based approach into the health-care education curriculum. A human rights-based health-care curriculum should encourage a change within the system, moving away from paternalistic, top-down medicine, compounded by an excessive focus on the tertiary level and biomedical technologies, towards increased partnership between health-care providers and users.

40. Medical education and research should also pay more attention to the role of the social determinants of health (such as poverty, violence and discrimination), to human rights in patient care, to the principles of medical ethics and to new approaches in providing services for persons with disabilities.

41. The Special Rapporteur learned that the salaries of physicians and other health-care personnel are unacceptably low, below the national average and below the average salaries in other sectors. According to data provided by the national statistics committee, in June 2018, the gross average salary of a health-care or social services worker was 10,566.90 som (approximately $150), while the national gross average salary was 15,994 som ($230). The gross average salaries of an education worker, a professional, scientific or technical worker, and a financial or insurance worker were 11,599.90 som ($166), 19,203.80 som ($275) and 33,227.10 som ($476) respectively.[18]

42. The low salaries of health-care personnel have a negative impact on the quality of services and provide incentives for informal payments. They also contribute to the brain drain of medical personnel, not only to other countries but from the public to the private sector, including the pharmaceutical industry.

43. The State should make a greater effort to train, recruit and retain health-care personnel, and to protect their rights and guarantee decent living wages and working conditions, job security and rewards for good performance and conduct. It could also develop non-biased and evidence-based treatment guidelines in order to reduce the possibility of corruption.

44. It is equally important that the State strengthen the mechanisms of self-governance within the medical profession, to encourage health-care personnel to develop ownership over their profession and to adhere to ethical standards when providing health-care services.

2. Groups in vulnerable situations

45. Overall, any health-care system should address discrimination, which can undermine the full realization of the right to physical and mental health. The Special Rapporteur learned about many cases of stigmatization and discriminatory attitudes based on different grounds among society at large, and among health-care personnel in particular. One particular example of discrimination related to sexual orientation and gender identity. Lesbian, gay, bisexual and transgender persons are subjected to psychological violence, sexual abuse and physical harm by family members, law enforcement officials and health-care personnel. This significantly affects their physical and mental integrity.

46. Such discriminatory practices are the result of a strongly patriarchal and conservative society, where issues that differ from the socially approved traditional norms, including those linked to sexual orientation and gender identity, are not accepted by social institutions, families or even government officials. This attitude is further reflected in the lack of national programmes specifically addressing the rights of lesbian, gay, bisexual, transgender and intersex persons and, in some cases, in the reluctance of public officials to cooperate with civil society organizations representing this community.

[18] See www.ceicdata.com/en/kyrgyzstan/gross-average-salary/gross-average-salary-nace-2-health-care-and-social-services.

47. In 2017, Kyrgyzstan made a commendable step forward by issuing the *Manual on Provision of Medical and Social Care for Transgender, Transsexual and Gender Nonconforming Persons*,[19] for use by medical professionals at all levels of the national health-care system and at other national institutions. The aim of the manual is to help medical professionals to provide medical and psychological care and assessments, psychotherapeutic and social support and specialized medical care to transgender, transsexual and gender non-conforming persons to maximize their overall physical and mental well-being. It also includes guidance on changing gender expression and making gender-affirming changes to the body, which may involve masculinization or feminization. Importantly, the manual stresses the need to change the gender marker in identity documents to give legal recognition to transgender, transsexual and gender non-conforming persons, and the need to assist them in their social readaptation.

48. While the manual sets one of the most progressive standards in the Central Asian region, it is yet to be fully disseminated among health-care personnel and is yet to be effectively used in health-care centres. Testimonies gathered by the Special Rapporteur indicated that the most pressing challenges related to changing the gender marker in identity documents and addressing the remaining discriminatory attitudes among health-care personnel. Informal payments may sometimes help to remove the barriers faced by transgender, transsexual and gender non-conforming persons in their access to health-care facilities, although they can rarely afford the high prices that are demanded.

49. The Special Rapporteur reiterates the recommendation made by the Committee on the Elimination of Racial Discrimination in its concluding observations on the combined eighth to tenth reports of Kyrgyzstan to adopt comprehensive anti-discrimination legislation (CERD/C/KGZ/CO/8-10, para. 11). He joins the Committee in welcoming the readiness of the Government to work with United Nations agencies in drafting an anti-discrimination law,[20] and further encourages the full implementation of that law.

50. Refugees and minority groups also face difficulties in gaining access to health-care services. Refugees who are recognized by the State hold identity documents issued by the State and one-year renewable residence and work permits. The majority of them have access to their livelihoods, but they can only gain access to public services by paying a rate applicable to foreigners, which is almost 10 times higher than the rate for persons who are not foreigners. These higher payments are not compatible with the 1951 Convention relating to the Status of Refugees, according to which fees should be moderate and commensurate with the fees charged to nationals for similar services (art. 25 (4)).

51. Refugees who are yet to be recognized by the State, but who are recognized by the Office of the United Nations High Commissioner for Refugees (UNHCR), hold UNHCR certificates that are not formally recognized by the State. While they are not expelled from the country, they are not entitled to work or to hold residence permits. They may gain access to health-care services, mainly through costly, informal payments, but they cannot purchase health insurance policies. Their access to health-care services is therefore very limited.

52. The vast majority of refugees, either recognized by the State or solely by UNHCR, are culturally and socially well integrated into society in Kyrgyzstan; they speak the language and have developed personal networks. Kyrgyzstan should strengthen its efforts to find local integration solutions with alternative protection measures and arrangements that effectively protect the rights of all refugees, including their right to physical and mental health.

53. Some ethnic Uzbeks, despite having been born in Kyrgyzstan, may also have to resort to paying the same rate for foreigners in order to gain access to health-care services. The lack of documents among the Uighur and Lyuli communities (Central Asian Roma) also prevents their access to health care. Populations with no State documents may be provided certain health-care services, although only through informal payments that are more costly.

[19] Available from www.labrys.kg/ru/library/full/27.html.

[20] See www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=22996&LangID=E.

54. Children with disabilities are another group in a vulnerable situation. According to the most recently available data provided by the Ministry of Labour and Social Development, there were 29,000 registered children with disabilities in 2017.[21] However, this number only includes those children who have been registered by the Ministry as eligible for monthly social benefits, and not the "invisible" children with developmental disabilities. All children with disabilities, whether registered by the Ministry or not, have poor access to quality care services that meet their needs. The current care system in Kyrgyzstan continues to focus on the medical model of disability, which rarely provides for appropriate support at a young age through early identification and targeted family support measures, putting children with disabilities at a significant risk of exclusion and discrimination.

55. Many children and adults in vulnerable situations live in residential institutions, which continue to exist in Kyrgyzstan under the management of different ministries. The Ministry of Health manages institutions for children under the age of 3 and their parents, the Ministry of Education and Science is in charge of institutions for orphaned children and adolescents, and the Ministry of Labour and Social Development is responsible for institutions for persons with disabilities, both children and adults, and institutions for older persons, in coordination with local governments. It has annually increased its expenditure on the institutions under its responsibility.[22]

56. Increased funding for institutions managed by the social sector should not be aimed at expanding the institutional care of children and adults with disabilities and in other vulnerable situations. Although more funding may be needed to improve the conditions and quality of life for those who are already living in institutions, allocating increased funding to institutional care would also suggest that this type of care is the priority over community-based alternatives. This practice in the social sector is contrary to the progress made by the health sector, which has prioritized family medicine centres. Kyrgyzstan should continue to move away from dependency on costly and ineffective institutional care in the health, social and education sectors, and should increasingly invest in community-based alternatives.

III. Mental health

57. Health-care services in Kyrgyzstan are still based on a narrow and outdated biomedical model, which is why health insurance coverage includes mainly biomedical interventions. It is important to recall that, globally, modern health care has incorporated new priorities with a holistic approach, such as mental health services for children and adults with disabilities, services for older persons, medical and psychosocial rehabilitation and palliative care. Kyrgyzstan should modify its health-care system so that resources are used not only for medication and hospital treatment, but also for other types of health-related intervention, which may not necessarily be only biomedical. This is particularly important when planning and developing policies and services to address mental health, an area increasingly becoming a global priority.

58. The Special Rapporteur visited a pilot outpatient mental health centre in Jalal-Abad that provides mental health services in compliance with WHO recommendations. It is a promising initiative based on a modern approach to health care and will, it is hoped, become part of the national strategy. Similar initiatives should be replicated throughout the country, and funded and supported by the Government to allow for their sustainable integration into the general health-care system.

59. If the right to mental health is to be fully realized, strategic changes must be made to the entire system. Primary care should take mental health as seriously as it does physical health. To be effective, primary care must be supported by mental health specialists working as consultants at the outpatient and day-care levels. However, these services, with some exceptions in larger cities, are not available to the majority of persons who need them.

[21] See www.unicef.org/kyrgyzstan/children-kyrgyzstan.

[22] OECD, *2018 Development Pathways*, p. 135.

The field of child and adolescent mental health is particularly underdeveloped, with only a few specialists working in this important field in the two largest cities.

60. The Special Rapporteur was informed about the issue of adolescent suicide, a sensitive issue of increasing concern that is linked to religious and cultural beliefs and therefore largely underreported. Death as a result of suicide is sometimes disguised as having had another cause. Consequently, the data available on the issue differ from source to source, even though there is a general consensus that the suicide rate among adolescents is increasing, and that the rate among young men is higher, but is increasing at a faster pace among girls.

61. The Special Rapporteur emphasizes that child and adolescent psychiatry is an established medical specialty and that it should be developed in Kyrgyzstan to address adolescent suicide and other child and adolescent mental health issues. Furthermore, services for children and adults with intellectual and psychosocial disabilities, which mainly require non-biomedical interventions, should be developed at the community level. Autism is an excellent example of a condition that cannot be effectively addressed through the biomedical model. Children and adults with autism face barriers that should be removed through a broader approach, which involves health, education and social services and a good level of cooperation between those three sectors.

62. A comprehensive long-term strategy ought to be developed in order to lower and eventually eliminate reliance on large, segregated institutions, including psychiatric hospitals and residential institutions. At the present time, Kyrgyzstan does not seem ready to order an immediate full closure of all such institutions, which is why they should provide at least the minimum conditions to protect the dignity and human rights of the persons living in them. At the same time, capacity at community-based centres should be built and strengthened to eventually care for those currently living in institutions. Throughout this process, independent mechanisms should continue to monitor institutions to ensure that they provide decent conditions to allow children and adults to live in dignity, with no space for abuse or violations of their human rights.

63. National and international investments in health and social care should start to be directed, as a priority, at the establishment and strengthening of community-based outpatient services that effectively serve the particular mental health needs of persons in the communities in which they live. The Special Rapporteur was informed by the relevant authorities about two government-led investment initiatives to improve the premises of two psychoneurological institutions, one of which he visited. Although the management team at the Belovodsk psychoneurological institution is working well to address the needs of the children through improved facilities and qualified and committed staff, the Special Rapporteur stresses that the ultimate responsibility of promoting and protecting the rights of persons with intellectual, cognitive and psychosocial disabilities lies with the State.

64. A long-term vision requires investment, as a priority, in community-based services, with a family-focused approach to services for children in need. The health, social welfare and education sectors should develop early intervention services for children with disabilities and their families, inclusive education in schools and child mental health services at the community level. The same principle applies to the development of mental health services for adults, including older persons.

65. Such a long-term vision requires a move away from excessive reliance on institutional care and treatment with psychotropic medication. Mandatory health insurance must cover psychosocial interventions, as they are equally as needed and effective as medication. As a recent WHO study[23] revealed, such a strategy requires close collaboration between policymakers and specialists, with educational programmes to help specialists to move in the same direction.

[23] See WHO Regional Office for Europe, *Mental health, human rights and standards of care: Assessment of the quality of institutional care for adults with psychosocial and intellectual disabilities in the WHO European Region*, 2018.

IV. Health in detention: tuberculosis and drug use

66. Before 2014, persons in temporary detention centres in Kyrgyzstan could only receive emergency medical assistance, until the International Committee of the Red Cross (ICRC), together with the Ministry of the Interior and the Ministry of Health, agreed that detainees should have regular access to doctors from civilian hospitals. As at April 2018, approximately 70 per cent of detainees in temporary detention facilities had access to regular medical care.[24]

67. The Special Rapporteur visited health facilities at pretrial detention centres and various prisons with the initial aim of following up on recommendations made by previous special procedure mandate holders and to observe how tuberculosis is treated. During the visits, he was impressed by the effort made to provide additional care for drug users.

68. Tuberculosis in detention centres must be addressed, precisely because the risk of transmission is higher in centres and the disease could potentially have a harmful effect on the wider community. It is estimated that a person with tuberculosis who has not been treated will transmit the disease to an average of 15–20 people per year. This rate increases significantly in detention centres owing to a combination of factors, such as overcrowding, unsanitary conditions, including poor ventilation and poor air exchange, and restricted access to adequate medical care.

69. Tuberculosis is a curable but potentially fatal disease if not treated correctly. Multi-drug resistant tuberculosis is a strain of the disease that is highly resistant to two or more of the common drugs that are used in combination to treat the infection. Kyrgyzstan is among the 30 States with the highest rate of multi-drug resistant tuberculosis.

70. Treatment for persons with multi-drug resistant tuberculosis can take up to two years, as those affected must be monitored from diagnosis to cure. Since 2007, ICRC has supported Kyrgyzstan in addressing the disease, mainly in two of its prisons: Colony 31 (since 2013) and SIZO-1 (since the beginning of 2015).[25] The focus has been on infection control through early detection and treatment to prevent transmission. Infrastructure has been created or renovated and the capacity of health-care services and personnel and of prison authorities has been strengthened to improve diagnosis, treatment and care. Care may also include psychological and social support, as necessary. Detainees have access to diagnosis and rapid treatment in ad hoc facilities through standard bacteriology laboratory diagnostic services. Detainees with tuberculosis are separated according to their infectiousness to avoid transmission.

71. Following his visit to the hospital at Colony 31, the Special Rapporteur was able to confirm that its practices, developed with international cooperation, were exemplary in terms of control and treatment of tuberculosis. He also learned, however, that ICRC was planning to withdraw its support by 2020 as Kyrgyzstan is now a middle-income country. Sustainability has therefore become an issue of concern; the Government must continue its efforts and investments to control and treat the disease. The Special Rapporteur learned that other international bodies were also planning to withdraw their support; he therefore stresses that the authorities must take ownership of the projects implemented through international cooperation to ensure their sustainability, and that any results achieved are not reversed.

72. During his visit to Colony 31, the Special Rapporteur also learned about the treatment and rehabilitation available to drug users through the Atlantis programme. This prison-based programme follows the “clean zone” 12-step model developed by Pawel Moczydlowski, a Polish criminal justice expert. In accordance with the model, methadone therapy is followed by voluntary entry into a therapeutic abstinence-based community, although entrants must pledge to participating in group therapy sessions for up to 18 months. Participants also sign a written pledge to reject all psychoactive substances, including medication linked to any mental health conditions. Upon completion of the

[24] See ICRC, “Kyrgyzstan: improving access to health-care for detainees”, 16 April 2018.

[25] See ICRC, “Combating tuberculosis in detention”, 24 March 2015.

programme, the detainee may return to his or her prison unit or be transferred to the "clean zone", in which commitment to a drug-free lifestyle is compulsory.

73. The Special Rapporteur also observed the ongoing establishment of the Atlantis programme in Colony 2 for women, and improvements in the health-care services and facilities at the pretrial detention centre SIZO-5 in Osh. His visit to Colony 47 revealed the contrast between the detention facilities that have benefited from international cooperation and those that have not, which are deteriorating. He also visited the psychiatric hospital in Kyzyl-Jar, which hosts persons with mental and psychosocial disabilities, committed with or without a court sentence.

74. During his visit to detention centres, the Special Rapporteur noted the progress made in the implementation of the recommendations made by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment after his country visit to Kyrgyzstan in 2011 (see A/HRC/19/61/Add.2). The Special Rapporteur on health paid special attention to recommendations on health-care personnel, awareness and the implementation of the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol), detainees' access to independent medical examination, and the number of qualified health-care personnel in temporary and pretrial detention facilities. In the detention centres that the mandate holder visited, detainees had good access to independent medical examination, particularly in cases of tuberculosis.

75. The Special Rapporteur was also encouraged to learn that most doctors had received training on the Istanbul Protocol. He urges health-care personnel in detention centres to continue to report alleged cases of torture or ill-treatment and to work in cooperation with the relevant authorities to improve and streamline existing reporting processes. Health-care personnel have an ethical and legal duty to document alleged cases of torture and other ill-treatment, and play a fundamental role in helping the State to fulfil its human rights obligations in this regard.

76. Medical personnel and the relevant authorities agreed that the jurisdiction of health-care workers at detention facilities should be transferred to the Ministry of Health. The Special Rapporteur not only agrees with this approach but also strongly recommends that the Government find suitable ways and effective incentives to integrate prison health-care services into the national health system under the Ministry of Health.

V. Sexual and reproductive health rights

77. Kyrgyzstan continues to face significant challenges in terms of empowering women to enjoy their sexual and reproductive health rights, including access to and use of family planning services. The percentage of married women who use modern contraceptive methods (around 28–30 per cent) has remained unchanged in recent years, and these methods continue to be ineffective, as shown by the large percentage of women who give birth within less than three years (18.6 per cent) and less than one year (9 per cent) after having given birth to their previous child. Furthermore, a large percentage of women (approximately 19 per cent in 2014)[26] do not have their needs met in terms of family planning, and the overall fertility rate is relatively high at 3.1 births per woman. Abortion continues to be one of the primary methods of birth control.

[26] Kyrgyzstan, National Statistics Committee, "Kyrgyzstan multiple indicator cluster survey 2014: key findings", December 2014, p. 11. The survey was carried out as part of the global multiple indicator cluster survey programme developed by UNICEF in the 1990s to collect internationally comparable indicators on the situation of children and women.

78. According to the multiple indicator cluster survey of 2014,[27] although one out of three women of reproductive age expressed a desire to space their births or limit the number of children they had, the majority did not use contraception owing to the lack of interest in family planning, a lack of information, or religious and cultural considerations, including opposition from partners, families or communities. Modern contraceptive methods in Kyrgyzstan are not affordable, available, of high quality or physically accessible. There is insufficient information to allow people to make informed decisions regarding their reproductive health, and the capacity of health-care personnel to provide quality family-planning services is inadequate and their counselling skills are poor.[28] The Special Rapporteur was informed that the supply of contraceptives provided by international development partners had recently stopped. There is an urgent need for Kyrgyzstan to assume its responsibility as the duty bearer in the promotion and protection of sexual and reproductive health rights given the ongoing need for family planning and for quality sexual and reproductive health services.

79. When their sexual and reproductive health needs are not met, women are exposed to a greater risk of abuse and violence, sexually transmitted diseases, including HIV, and unwanted pregnancies. Moreover, research has shown that giving women access to modern methods of contraception in Kyrgyzstan would prevent 113,000 unintended pregnancies, 34,000 unsafe abortions and 60 maternal deaths.[29]

80. Following his visits to health-care facilities, the Special Rapporteur was able to confirm that positive efforts had been made to address maternal and infant health issues. Despite the progress made, however, better quality emergency obstetric care is still needed to prevent maternal deaths and to improve conditions for healthy newborn babies.

81. The official data available indicate that the leading causes of maternal deaths are post-partum haemorrhage and septic complications, and that most maternal deaths occur in hospitals at the secondary and tertiary levels. A key factor associated with maternal deaths is the poor quality of Caesarean sections, a procedure that has become more frequent in recent years, to the point that it is now the most common surgical procedure. More emphasis should be made on developing practical skills at all stages of training for medical specialists to effectively improve the delivery of good quality care to pregnant women and newborns.

82. At the community level, the Special Rapporteur was informed about many cases of pregnant women delaying visits to primary care facilities or purposefully concealing health problems before delivery,[30] preventing the provision of proper prenatal care. He also heard about the good work carried out by village health committees at the community level and by health-care personnel at primary care facilities, involving regular visits to families to provide information and follow-up on maternal care. Awareness-raising among women about the importance of receiving quality health care and having access to referral services in order to address the right to health for women in Kyrgyzstan is vital.

83. An additional challenge being faced is teenage pregnancy and the adolescent fertility rate, which is high in Kyrgyzstan. Kyrgyzstan holds the second highest adolescent fertility rate in the Eastern Europe and Central Asian region, with the highest number of pregnancies in the provinces of Batken, Jalal-Abad and Talas. The rate is also higher among girls from rural areas, from the lowest wealth quintile and from minority families of Uzbek ethnicity. Most adolescents give birth between 15 and 19 years of age.

[27] See Kyrgyzstan, National Statistics Committee, *Multiple Indicator Cluster Survey in the Kyrgyz Republic 2014: Final Report* (June 2016).

[28] Kyrgyzstan, Ministry of Health, *Mid-Term Review Report: National Health Reform Program of the Kyrgyz Republic "Den Sooluk" for 2012–2016* (12 June 2016), p. 14.

[29] See Family Planning 2020, Kyrgyzstan core indicator summary sheet: 2017–2018 annual progress report.

[30] According to the second report on the confidential investigation into maternal deaths in Kyrgyzstan for 2014–2015, more than 40 per cent of women did not cooperate with health-care providers, often pregnant women purposefully concealed health problems and did not visit primary care centres before delivery (see https://kyrgyzstan.unfpa.org/ru/publications (in Russian only)).

84. In 2015, the adolescent birth rate in Kyrgyzstan was 42 per 1,000 women.[31] There are, however, no programmes that target the reproductive health needs of adolescents and young people owing to the sensitivity of the issues in terms of socioeconomic, cultural and religious backgrounds. It is also a common practice for primary care providers to report the pregnancy of any unmarried adolescent girl to the police, which is a violation of the girl's rights. All adolescents must have guaranteed access to confidential, age-sensitive and non-discriminatory sexual and reproductive health information, services and goods, including family planning, modern forms of contraception and counselling (A/HRC/32/32, para. 90). These measures will, inter alia, help to reduce reliance on abortion as the primary method of birth control. Although statistics are often unreliable owing to underreporting or a lack of availability, according to the Republican Medical Information Centre 7.5 per cent of all abortions recorded in 2017 were carried out on adolescents.[32]

85. Access to safe abortion for adolescents is a key element in the realization of the right to health, but it should not replace the need for access to modern contraceptive methods or to information on sexual and reproductive health at schools and health-care facilities at the community, local and national levels. Measures should be taken to raise adolescents' awareness of their rights to sexual and reproductive health and to the relevant services and goods. Furthermore, age-appropriate, comprehensive and inclusive education on sexuality, based on scientific evidence and human rights, should be part of the mandatory school curriculum. Special attention should be paid to relationships, sexuality, gender equality and identity and sex characteristics, including non-conforming gender identities, responsible parenthood and sexual behaviour, and preventing early pregnancy and sexually transmitted infections.

86. Adolescent girls in Kyrgyzstan are less aware about HIV than women belonging to older age groups. While 90 per cent of women between the ages of 25 and 29 know where to get tested for HIV, only 43 per cent of girls between 15 and 19 years old know where to go. Similarly, 22 per cent of older women have comprehensive knowledge of HIV, compared to 17 per cent of adolescent girls. Approximately 65 per cent of older women have comprehensive knowledge of mother-to-child transmission, compared to 50 per cent of teenagers.[33] The lack of knowledge of HIV among adolescents is compounded by the high rate of adolescent pregnancy, as these two factors combined increase the risk of transmitting HIV from mother to child.

87. During his visit to public school No. 85 near Bishkek, the Special Rapporteur observed that sex education was still a sensitive issue in Kyrgyzstan, linked to misconceptions, a prevailing patriarchal system and conservative societal attitudes, which are yet to be overcome. He welcomes the introduction of sex education as part of the "healthy lifestyle" curriculum, optional in school programmes and mandatory in the vocational education system. This, however, is not enough, and he encourages stakeholders to make more effort and find the political will to implement the curriculum effectively. During his visit to the school, the Special Rapporteur noted the effective implementation of traditional measures to promote physical health and healthy food. More is needed, however, to promote a broader approach and to address new challenges, such as sex education, the integration of children with disabilities and bullying.

88. The Special Rapporteur welcomes the President's endorsement of the law on reproductive rights in July 2015. The law includes relevant provisions on sexual and reproductive health rights. Article 13 provides for access to sexual and reproductive health information and services without the consent of a legal guardian for all persons above 16 years of age and access to any medical intervention during pregnancy following the written consent of the pregnant woman. The Special Rapporteur stresses the need for regular monitoring of the effective implementation of the law to ensure the enjoyment of sexual and reproductive rights for women and adolescents.

[31] See www.unfpa.org/sites/default/files/SWOP-2016.xlsx.

[32] The Republican Medical Information Center reported that 6.4 per cent of abortions were carried out on adolescents in 2015.

[33] See Kyrgyzstan, National Statistics Committee, *Multiple Indicator Cluster Survey in the Kyrgyz Republic 2014*, pp. 195–196, 199 and 203–204.

89. At the end of his visit, the Special Rapporteur was appalled by media reports of the alleged murder of a victim of bride-kidnapping, reportedly by the abductor inside a police station. This event shows that bride-kidnapping continues, in breach of the right to enter into marriage with the free and full consent of both parties.[34] In particular, child, early and forced marriage is a violation of the victim's sexual and reproductive health rights, including the right to control one's health and body. Sexual violence, including forced marriage, is a serious breach of sexual and reproductive freedoms, and is a fundamental and inherent violation of the right to health.

90. According to the United Nations entities present in Kyrgyzstan, 13.8 per cent of women under 24 years old are married through some form of coercion.[35] The Special Rapporteur acknowledges that legal steps must be taken to prohibit religious child marriages and calls for a greater effort to prevent and prosecute perpetrators of human rights violations and to protect victims. All appropriate measures should be taken to stop the practices of bride-kidnapping and forced marriage.

HIV/AIDS

91. While fewer cases of tuberculosis have been reported,[36] there has been a rapid increase in cases of HIV through sexual transmission, as opposed to parental transmission. According to information provided by the United Nations country team in Kyrgyzstan, the number of registered cases of HIV was 8,158 in April 2018, and cases of sexually transmitted HIV now represent approximately 60 per cent of all new cases. In contrast, parental transmission is only responsible for 44 per cent of all infections. While the transmission of HIV to newborns has dropped, the proportion of women among people with HIV has increased, rising from 30 to 42 per cent between 2011 and 2013.

92. The HIV epidemic in Kyrgyzstan is predominantly concentrated among key population groups that have a higher risk of becoming infected.[37] Therefore, in order to respond to the epidemic effectively, measures should be taken to empower these key population groups at the community level and to address stigma and discrimination, and the social and structural barriers they face in their realization of rights, including access to health-care services.

93. The Special Rapporteur collected testimonies of abuses committed by law enforcement officials, including harassment, extortion, arbitrary arrests and detention, violence, rape and a failure to protect persons from violence. To guarantee that HIV prevention services cover all key population groups, it is crucial to ensure an enabling environment and remove punitive laws and practices.

94. The State has developed an ambitious new programme for 2017–2021 that seeks to reduce the number of persons affected by HIV and to eliminate the infection by 2030. The programme is focused on reaching the 90-90-90 targets of the Joint United Nations Programme on HIV/AIDS.

95. The implementation of the above-mentioned programme will certainly require the strengthening of sex education and reproductive health services in order to prevent the sexual transmission of HIV. A human rights-based approach requires quality, integrated sexual and reproductive health and HIV services, free from stigma and discrimination, with a focus on primary care.

[34] The right to enter into marriage with the free and full consent of both parties is enshrined in the International Covenant on Civil and Political Rights (art. 23), the International Covenant on Economic, Social and Cultural Rights (art. 10) and the Convention on the Elimination of All Forms of Discrimination against Women (art. 16), all of them ratified by Kyrgyzstan.

[35] See www.unicef.org/kyrgyzstan/press-releases/un-statement-bride-kidnapping-and-child-marriage.

[36] See https://data.worldbank.org/indicator/SH.TBS.INCD; see also WHO, "Kyrgyzstan tuberculosis country profile 2017".

[37] See Global AIDS monitoring, "Country progress report: Kyrgyzstan", 2018.

VI. Conclusions and recommendations

96. **Kyrgyzstan is in a good position to continue to strengthen its health-related policies and services; for this position to remain strong, however, a human rights-based and modern approach to public health should be ensured in the formulation and implementation of policies.**

97. **In a context where there is strong political will, solid policy developments and good pilot practices, the main challenge to the full realization of the right to physical and mental health in Kyrgyzstan lies with effective implementation and sustainability. The challenge is linked to the promotion of transparency and the need to address persisting corrupt and ineffective practices. To this end, the Government should develop a long-term strategy and take ownership of the programmes developed with international cooperation, ensuring their continuation and sustainability with the investment of national resources.**

98. **Specific challenges to be addressed include the enjoyment of different sexual and reproductive health rights, persisting discriminatory practices in health-care services and the need to progressively deinstitutionalize mental health and social welfare services through a long-term strategy in which investments are directed, as a priority, to family-focused and community-based services, with a human rights-based approach.**

99. **The role of civil society at the national and local levels must be encouraged in this process. The vibrant civil society groups in Kyrgyzstan are a real asset and should be regarded by the Government as equal partners, not only in the formulation of guidelines and policy measures but also in the implementation of such measures, which in many cases have proven to be better implemented with the support of civil society partnerships.**

100. **The Special Rapporteur recommends that the authorities in Kyrgyzstan:**

(a) **Complete the process of ratifying the Convention on the Rights of Persons with Disabilities;**

(b) **Ensure adequate, equitable and sustainable financing to the health sector, improving the availability and accessibility of health services in all regions;**

(c) **Increase investments to train, recruit and retain health-care personnel by protecting their rights and providing incentives and career development options, particularly for personnel in rural areas;**

(d) **Strengthen the capacity of well-trained health-care workers and integrate a human rights-based approach into the health-care education curriculum, with a focus on the social determinants of health (such as poverty, violence and discrimination), human rights in patient care, the principles of medical ethics, new approaches in providing services for persons with disabilities and the partnership between health-care providers and users;**

(e) **Strengthen self-regulatory practices and capacity-building activities within the health-care profession to promote the best practices in medicine and prevent ethical misconduct and human rights violations;**

(f) **Develop non-biased and evidence-based treatment guidelines to minimize opportunities for corruption;**

(g) **Address the practice of informal payments in the health-care sector by ensuring decent living wages and working conditions, job security and rewards for good performance and conduct;**

(h) **Ensure monitoring and accountability in the health sector through the establishment of well-resourced and independent anti-corruption and fraud agencies, as well as accessible and effective accountability procedures for health-care users who encounter corrupt practices;**

(i) **Raise awareness of the negative effect that all forms of corruption in the health sector, including informal payments, have on individual and societal health and well-being;**

(j) **Disseminate and effectively implement the *Manual on Provision of Medical and Social Care for Transgender, Transsexual and Gender Nonconforming People* among medical professionals at all levels of the health-care system and among other institutions;**

(k) **Adopt comprehensive anti-discrimination legislation;**

(l) **Effectively protect the rights of all refugees and migrants, including their right to physical and mental health;**

(m) **Develop a comprehensive long-term strategy to reduce and eventually eliminate reliance on large, segregated institutions; and ensure the minimum conditions to protect the dignity and human rights of the people living within them, without expanding the institutions;**

(n) **Strengthen independent mechanisms to monitor residential institutions in order to guarantee decent conditions for those within them to live in dignity, with no space for abuses or violations of human rights;**

(o) **Establish community-based services for children and adults with intellectual and psychosocial disabilities, which predominantly provide non-biomedical intervention, with the involvement of and a good level of cooperation between the health, education and social sectors;**

(p) **Provide primary care facilities with mental health specialists working as consultants at the outpatient and day-care levels;**

(q) **Direct national financial resources to maintain the sustainability of the Atlantis programme and tuberculosis treatment in places of detention;**

(r) **Continue to support health-care workers in their compliance with the Istanbul Protocol in detention centres and their medical investigation into, and reporting of, alleged cases of torture and ill-treatment; and work with health-care personnel to find avenues to improve and streamline existing reporting procedures;**

(s) **Find suitable ways and effective incentives to integrate prison health-care services into the national health system under the Ministry of Health;**

(t) **Strengthen sex education and reproductive health services to particularly address the sexual transmission of HIV, and ensure a human rights-based approach that guarantees quality, integrated sexual and reproductive health and HIV services, free from stigma and discrimination, with a focus on primary care;**

(u) **Strengthen the capacity of health-care services and health-care personnel to provide quality sexual and reproductive health services;**

(v) **As part of quality sexual and reproductive health services, provide quality family planning and counselling; modern contraceptive methods, including through increased budgetary allocations and spending of public funding; better quality emergency obstetric care; awareness-raising on the importance of receiving proper prenatal care; programmes that target the reproductive health needs of adolescents and young people, free from stigma and aiming to increase their knowledge of the sexual transmission of HIV;**

(w) **Strengthen efforts to address all forms of sexual violence, including child, early or forced marriage.**