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人人有权享有可达到的最高水准身心健康问题特别报告员阿南德·格罗弗的报告

增编

对塔吉克斯坦的访问(2012 年 5 月 24-31 日)* **

概要

人人有权享有可达到的最高水准身心健康问题特别报告员于 2012 年 5 月 24 至 31 日访问了塔吉克斯坦，访问期间，特别报告员本着对话与合作的精神考虑了该国如何能努力实施健康权、特别考虑了保健系统与供资问题，考虑了结核病和心理健康的预防与治疗问题。

本报告内，特别报告员赞扬塔吉克斯坦在减贫、增加保健开支和解决孕妇死亡率方面取得了显著的进展，并且赞扬塔吉克斯坦明确承诺实现人人享有可达到的最高水准身心健康的权利。为使该国彻底实现健康权，特别报告员鼓励该国政府解决若干严重挑战，在保健系统与供资、结核病预防、治疗与控制以及在心理健康照料与服务方面考虑具体的改进领域。为了加速这一艰巨任务，特别报告员提出了若干建议。

* 本报告概要以所有正式语文分发。载于概要附件的本报告本身以来文语文，仅以俄文分发。

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Annex

[English and Russian only]

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 mission to Tajikistan (24 – 31 May 2012)

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I. Introduction

1. The Special Rapporteur paid an official visit to Tajikistan, at the invitation of the Government, from 24 to 31 May 2012. The purpose of the visit was to consider, in a spirit of dialogue and cooperation, how the country had endeavoured to implement the right to health and the measures taken for the successful realization of that right.

2. During the mission, the Special Rapporteur paid special attention to the health system and health financing; tuberculosis and multi-drug resistant tuberculosis; and mental health. The Special Rapporteur visited Dushanbe, Khujand, Kulob, Rudaki and Vahdat.

3. The Special Rapporteur held meetings with senior Government officials from the Office of the President, parliamentary committees and the Ministries of Foreign Affairs, Health, Labour and Social Protection, Finance, and Justice; the State Pharmaceutical Certification Agency; and the Office of the Ombudsman for Human Rights. He also held meetings with representatives of civil society, international organizations, development partners, academics, legal experts and health professionals. The Special Rapporteur is grateful to the Government of Tajikistan for its invitation and full cooperation during his visit. He also thanks all those who met with him, gave their time and cooperated with him during the visit.

II. Right to health

A. Background

4. Soon after gaining independence in 1991, Tajikistan was engulfed in a civil war that lasted five years. During that time, Tajikistan endured a serious upheaval in its economy, which resulted in widespread poverty. The health of the population declined dramatically during the conflict, as witnessed by the increasing incidence of communicable and non-communicable diseases, poor quality health services, underfunded and deteriorating health infrastructure, a lack of health workers, and restricted access to health facilities, goods and services, especially for the poor.[1]

5. Since the cessation of the armed conflict, the Government of Tajikistan has made admirable progress in reducing poverty and rebuilding the country's health system. The rate of relative poverty declined from 83.4 per cent in 1999 to 51 per cent in 2009,[2] while extreme poverty decreased from 42 per cent in 2003 to 17 per cent in 2009.[3] The Government has also shown a laudable commitment to health since the conflict, as demonstrated by an increase in spending on health, which doubled as a percentage of gross domestic product (GDP) from 0.9 per cent in 2001 to about 2 per cent in 2012. More recently, budget allocations to health increased by more than four times, from $37.3 million in 2007 to $152.3 million in 2012. In addition, Tajikistan has achieved the Millennium Development Goal on improving maternal health. The maternal mortality rate decreased

[1] Ghafur Khodjamurodov and Bernd Rechel, Tajikistan: Health System Review, European Observatory on Health Systems and Policies, *Health Systems in Transition*, vol. 12, No. 2, (2010), pp. xv.

[2] Millennium Development Goals: Tajikistan Progress Report, 2010, p. 13. Available from www.untj.org/component/flexicontent/93-on-main-page/344-millennium-development-goals-tajikistan-progress-report.

[3] World Bank, Tajikistan: Country Brief 2011. See www.worldbank.org/en/country/tajikistan.

from 97 deaths per 100,000 live births in 2003 to 46.2 in 2009.[4] The Special Rapporteur commends the Government for these significant advances in reducing poverty, increasing spending on health and addressing maternal mortality. The Government should continue its efforts to reduce poverty and address health concerns.

6. A lack of adequate primary health care, however, has had a negative impact on all aspects of health, in particular on maternal and infant health. The situation is especially severe in rural and mountainous areas, where many people continue to lack access to basic health-care services, particularly during the winter months. This is a major concern, as up to 75 per cent of the population of Tajikistan live in rural and remote areas.[5] According to data compiled by the statistical agency of the office of the President received from the Government, infant mortality rates (34 deaths per 1,000 live births) and mortality rates for children under 5 years (43 deaths per 1,000 live births) are several times the average of the European and Central Asian region (12 and 13 deaths per 1,000 live births, respectively).[6] Children's health also presents a great concern in Tajikistan, especially the high rates of malnutrition in children: 29.1 per cent are stunted and 12.5 per cent are wasted.[7] During his visit, the Special Rapporteur learned that the Government only funded 30 per cent of the national immunization programme and relied on donor funding for the remainder. The State should continue to make improvements in these areas in order to realize the right to health for all people of Tajikistan.

B. International and national legal framework

7. Tajikistan is a party to a number of international treaties that recognize the right to health, including the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, including the first Optional Protocol thereto, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, including the first two Optional Protocols thereto, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. In accordance with article 10 of the Constitution adopted in 1994, international legal instruments that are recognized by Tajikistan become a constituent part of its national legal system.

8. The Constitution of Tajikistan contains a number of provisions relating to the right to health. Article 38 establishes the right to health care for all and to the protection of the environment for the promotion of health. Article 18 protects the right to life, including the right to be not subject to forced medical or scientific experiments, while article 17 ensures equality before the law and the courts. Legislation relating to the realization of the right to health in Tajikistan includes the Reproductive Health Act (2002), the Psychiatric Care Act (2002), the Emergency Services Act (2005), the Act on Child Nutrition (2005), the Act on the Fight against HIV/AIDS (2005), the Act on Protection from Tuberculosis (2006), the Act on Organ Transplants (2007), the Health Insurance Law (2008), the Law on Blood

[4] Tajikistan Progress Report (see footnote 2), p. 77.

[5] WHO/Europe, Tajikistan: facts and figures. Available from www.euro.who.int/en/where-we-work/member-states/tajikistan/facts-and-figures.

[6] See World Health Organization (WHO), World Health Statistics 2011 (Geneva, 2011), pp. 53 and 55. Available from www.who.int/whosis/whostat/EN_WHS2011_Full.pdf.

[7] WHO, "High food prices contributing to malnutrition in Tajikistan", 11 October 2011. Available from www.euro.who.int/en/where-we-work/member-states/tajikistan/news/news/2011/11/high-food-prices-contributing-to-malnutrition-in-tajikistan.

Donation (2009), the Act on the Medical and Social Protection of People with Diabetes (2009), the Act on Restrictions on Tobacco Products (2010), the Act on Drinking Water (2010), the Act on Food Safety (2010), the Act on Social Protection of People with Disabilities (2010), the Act on Family Medicine (2010), the Act on Immunization (2010) and the Act on Environmental Protection (2011).

III. Health system and financing

9. An effective and integrated health system, encompassing health care and the underlying determinants of health, that is responsive to national and local priorities and accessible to all is fundamental to the realization of the right to health.[8] The full realization of the right to health also depends on the availability of adequate, equitable and sustainable financing for health.[9] Despite a 280 per cent increase in the health budget in the past five years (according to data received from the Government after the visit of the Special Rapporteur), current Government expenditure on health in Tajikistan (2 per cent of GDP) is low by both international standards and when compared to the average of 5.7 per cent in other former Soviet republics in 2010.[10] Moreover, only 6 per cent of the national budget is allocated to health expenditure, which is well below the average for developing countries in Europe and Central Asia. Furthermore, in 2008, Tajikistan spent only $10.6 per capita on health, the lowest amount in the European-Central Asia region.[11] The estimated cost of providing key health services in low-income countries is, however, more than four times higher, at approximately $44 per capita.[12] During meetings with the Special Rapporteur, Government officials acknowledged that spending on health was too low. Increasing expenditure on health to meet international standards should therefore be of the utmost priority.

A. Primary health care

10. Many of the challenges that Tajikistan faces in developing its health system stem from the Semashko health system model inherited from the Soviet Union. The model relies on input-based financing and aims to provide a comprehensive set of health services. It traditionally focuses on infectious diseases and epidemic preparedness, which require large numbers of hospital beds and inpatient facilities staffed by specialized health workers. This results in the inefficient allocation of health funds to secondary and tertiary health care, and a health system that is unresponsive to the population’s health needs. It also leads to rigid budgetary allocation among health facilities, as authorities may not be able to transfer funds among facilities without transferring physical resources, such as hospital beds and staff.[13] Investment is thus directed towards specialized hospital institutions, leading to the underdevelopment of the primary health-care sector, excess capacity at the secondary and tertiary care levels, and the inefficient allocation of health funds and resources.

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[8] A/HRC/7/11, para. 15.

[9] A/67/302, para. 6.

[10] World Bank, Health expenditure, total percentage of GDP. See http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS.

[11] Khodjamurodov and Rechel, Tajikistan: Health System Review (see footnote 1), p. 133.

[12] WHO, World Health Report 2010: Health Systems Financing: The path to universal coverage (Geneva, 2010), p. 22. Available from www.who.int/whr/2010/en/index.html.

[13] John L. Mikesell and Daniel R. Mullins, “Reforming Budget Systems in Countries of the Former Soviet Union”, *Public Administration Review*, vol. 61, No. 5 (2001), p. 556.

11. States have a core obligation to ensure the satisfaction of minimum essential levels of the right to health, including available and accessible essential primary health care,[14] which is customarily defined as essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford.[15]

12. The primary health-care sector in Tajikistan remains, however, underdeveloped and underfunded, in part because primary care facilities do not feature a large volume of health system inputs (such as for hospital beds, costly medical equipment and staff), which largely determine the amount of funds allocated to health facilities by the Government. Consequently, the primary health-care sector is often perceived as providing poor quality services and thus underutilized. For example, the Government estimated in 2005 that up to 80 per cent of people bypass primary health care and go directly to hospitals.[16] Moreover, there is a shortage of trained primary health-care workers in Tajikistan. A variety of factors contribute to this deficit: the traditionally low status of primary health-care workers within the health sector; the fact that general practitioners receive less pay than specialists; and the absence of family medicine as a medical specialty in Tajikistan until only recently.[17]

13. The Special Rapporteur was pleased to note that the Government acknowledges the above-mentioned shortcomings and has embraced reforms to address them. According to a joint annual review for 2011 conducted by the Ministry of Health and the Ministry of Finance provided by the Government, qualifications in general and family medicine are now offered at State medical institutions, and doctors may be certified as family practitioners following a six-month retraining programme. Furthermore, basic benefits packages comprising basic medical services provided by primary health-care facilities have been introduced in three pilot districts. Tajikistan should increase investment in the primary health-care sector and ensure that expenditure on health does not disproportionately favour expensive curative health facilities, goods and services that benefit only a small sector of the population.[18]

B. Health financing reforms

14. In order to address the cases of inefficiency resulting from the country's highly centralized finance systems, the Government began the process of decentralization following independence. As a result of this process, health funds from the central Government are now disbursed directly to the finance department of each provincial administration, and provinces have greater discretion in formulating local district health budgets. In this way, district and local governments are able to respond more dynamically to population concerns and to bring health expenditure into line with local health needs and preferences.[19] Like many other former Soviet republics, however, decentralization was not

[14] Committee on Economic, Social and Cultural Rights, general comment No. 14 (E/C.12/2000/4), para. 43.
[15] See the Declaration of Alma-Ata of the International Conference on Primary Health Care, held in Alma-Ata from 6 to 12 September 1978.
[16] Khodjamurodov and Rechel, Tajikistan: Health System Review (see footnote 1), p. 99.
[17] Rifat Ali Atun et al., "Introducing a complex health innovation: primary health care reforms in Estonia", *Health Policy*, vol. 79, No. 1 (Elsevier Ireland Ltd., 2006), pp. 79-91.
[18] E/C.12/2000/4, para. 19.
[19] World Bank, Benefits and Challenges of Decentralization, 2011. Available from http://go.worldbank.org/23F15SL5I0.

accompanied by a coherent strategy to raise local managerial competence.[20] For example, the Special Rapporteur learned during the visit that the resistance of certain Government entities to the efforts made to increase the level of discretion and amount of funds pooled at the province level was due to concerns relating to transparency, accountability and managerial competence. While commending Tajikistan on having initiated the process of decentralization, the Special Rapporteur urges the Government to increase local stakeholder involvement in health-related decision-making in accordance with the right to health, and to build the capacity of local authorities in order to ensure efficient and transparent management of health funds and resources.

15. In order to increase funds for health, reduce out-of-pocket expenditures for the poor and promote access to health facilities, goods and services, the Government has introduced two pilot programmes: a fee-for-service programme in 236 health facilities, and a basic benefits package in eight districts. Out-of-pocket expenditures, namely payments for health goods and services made at the point of service delivery, including informal or ”envelope” payments, are prevalent throughout the health system in Tajikistan. Such expenditures accounted for 66.5 per cent of total spending on health in 2010, a large percentage of which for expenditure on pharmaceuticals.[21] Out-of-pocket expenditures for health goods and services have a disproportionate impact on the poor, who must pay a larger proportion of their income on health goods and services than other patients. As a consequence, poor households may experience financial difficulties and impoverishment, which discourages many from seeking health care in the first place.

16. The fee-for-service programme allows health facilities to charge a fee set by the State for certain hospital services. The programme has resulted in an increase in revenue for participating institutions, as well as an increase in the salaries of doctors, which has partially curbed the “brain drain” and financed the purchase of advanced medical equipment in participating hospitals. Increases in revenue under the programme have, however, been witnessed mostly in wealthy districts, particularly in Dushanbe. The vast majority of institutions have not seen the same benefits. Moreover, increases in doctors’ salaries have been inconsistent, even in participating hospitals. Forty per cent of all revenue from the programme remains in the department in which it is collected, and the departments that experience the greatest increases in revenue under the programme are highly specialized.

17. The basic benefits package was designed to provide free access to primary health-care services for all and free hospital services for certain groups, while others pay a formal co-payment. According to information provided by the Government, the categories exempted of payment include the poor and individuals with particular medical conditions with important public health consequences and/or expected high health care costs, such as tuberculosis and diabetes.[22] Patients who are not exempt but have a referral from a primary health-care worker pay 30 per cent of the average cost of the required health service, while those without a referral pay 70 per cent.[23] Even though free primary health care under the programme is meant to be subsidized largely by the State through a specific budget allocation, such an allocation has not been included in the health budget, and funding for free primary health care has relied primarily on funds collected by means of co-payments

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[20] Carl Afford and Suszy Lessof, “The challenges of transition in CEE and the NIS of the former USSR”, *Human resources for health in Europe* (New York, Open University Press, 2006), chap. 11.

[21] See http://apps.who.int/nha/database/StandardReportList.aspx.

[22] Health Policy Analysis Unit and Ministry of Health, Tajikistan, The Basic Benefit Package and Patient Financial Burden at the Hospital Level: Results after 15 months of implementation, September 2009, p. 6.

[23] Ibid.

made for hospital services. This creates a problem, because revenue from such co-payments is earmarked for improving the quality of health services by securing an increase in doctors' salaries and raising the material and technical capacity of health facilities. According to a joint annual review for 2011 provided by the Government (see paragraph 13 above), in 2011, only 27 per cent of funds collected from co-payments were allocated to the salaries of health-care workers. The programme is also underutilized because of poor public awareness and a lack of understanding among health-care workers, and has thus been ineffective in increasing access to primary health-care services for the poor.

18. Both the fee-for-services and the basic benefit package programmes have failed significantly to reduce out-of-pocket expenditures, including informal payments. They have not substantially increased access to hospital services for the poor either. Even though the poor and other vulnerable groups are meant to be exempt from fees under both programmes, they are still required to produce a certificate issued by a local commission in order to obtain free services. During the visit, the Special Rapporteur heard reports that, in practice, the poor are often unable to obtain such certificates for various reasons. The fee-for-service programme is also being extended to include more health facilities and, in some instances, fees are charged for primary health-care services. This is a cause for concern, because it will lead to an increase in out-of-pocket expenditure, which may result in further underutilization of primary health-care services, particularly among the poor.

19. In 2011, pursuant to the national health sector strategy for the period 2010-2020, an inter-agency technical working group on health financing reached an agreement to implement a pilot programme in 2013 involving the pooling of health funds at the province level in Sughd province. Pooling funds for health allows for the cross-subsidization of financial risks associated with health care between different groups across large populations and the transfer of health funds from the wealthy to the poor and the healthy to the sick. Under the pilot programme, primary health care in each district would be funded from the province pool on a per capita basis through local taxes supplemented with national tax revenues in order to ensure equity between districts. Funds for primary health care would be allocated to the basic benefits package, providing a much-needed funding source for it. National tax revenues from the pool at the province level would be allocated to hospital facilities on a case-based payment rather than on the hospital-bed based method currently used. At the time of the visit, the programme was suspended owing to a number of concerns expressed by various stakeholders. The Special Rapporteur urges the Government to address these concerns urgently with a view to implementing the pilot programme in Sughd province.

C. Health-care quality and access to remedies

20. The prevalence of informal payments in Tajikistan is due in large part to the small salaries paid to doctors and other health-care professionals. The Special Rapporteur learned during his visit that the average monthly salary for doctors is approximately $85 and $50 for nurses. Small salaries also contribute to the poor quality of health services, often resulting in medical negligence, which is a critical concern throughout Tajikistan and contributes to a lack of public trust in the health system and the medical profession in general. Many health-care workers are poorly trained, and qualified professionals often choose to work abroad, attracted by higher wages and better working conditions, which contributes to a high turnover rates throughout the medical profession. According to data received during meetings with Government officials, the Government has increased salaries for doctors and other health-care professionals by 530 per cent since 2007. This is, however, insufficient, given that salaries were initially extremely small; in 2007, monthly salaries for health-care workers were as low as $12. The Special Rapporteur urges the Government to increase substantially salaries for doctors and other health-care workers in order to improve

the quality of health services and reduce the prevalence of informal payments throughout the health system. The quality of medical education in Tajikistan should be significantly improved and standards should be developed and implemented to ensure uniform qualifications throughout the health sector.

21. The right to health requires that everyone have access to quality health care and that the State provide a healthy environment. The lack of appropriate mechanisms to deal with any possible unjustifiable medical error (namely, those due to negligence or malpractice) not only denies those directly affected the compensation to which they should be entitled, but also prevent the State from identifying problematic patterns. It also prevents States from taking measures that could prevent repetition of such mistakes, which, in undermining the quality of available health care, would constitute a violation of the right to health. Anyone who is a victim of medical negligence or malpractice should thus have access to effective judicial or other appropriate remedies at the national level and should be entitled to adequate reparation, such as restitution, compensation, satisfaction or guarantees of non-repetition.[24] The health system in Tajikistan, however, suffers from a lack of remedies and accountability for medical malpractice, which further erodes the public's trust in the health system and the medical profession. During his visit, the Special Rapporteur met with a number of individuals with serious complaints relating to poor treatment resulting from medical negligence. In each case, the relevant authorities had not adequately investigated their complaints and the people affected lacked access to remedies under the law. In that context, the Office of the Human Rights Ombudsman in Tajikistan has an important role to play in addressing these concerns. According to the information received, however, the Office has to date lacked sufficient capacity and has not adequately fulfilled its mandate in this regard. The Special Rapporteur urges the Government to take immediate steps to ensure that victims of medical negligence and malpractice have access to appropriate legal remedies, including compensation for physical and emotional damages, and that the system set up also provides information allowing authorities to detect and address problematic patterns.

IV. Prevention, treatment and control of tuberculosis

22. Article 12, paragraph 2 (c) of the International Covenant on Economic, Social and Cultural Rights requires States to take measures to prevent, treat and control diseases, which includes an obligation to prevent, treat and control tuberculosis. The right to health also requires States to ensure that good quality health facilities, goods and services are available and accessible to all on a non-discriminatory basis, and in particular to those belonging to vulnerable or marginalized categories.[25] People living with tuberculosis are vulnerable as a result of stigmatization and discrimination, poverty and the greater likelihood that they are members of groups that are otherwise vulnerable, such as people living with HIV, migrant workers and people living in remote areas. The Special Rapporteur stresses the fact that States are required to ensure that health-care workers are trained to recognize and respond to the specific needs of vulnerable or marginalized groups, including people living with tuberculosis.[26]

23. The Government of Tajikistan has acknowledged that tuberculosis poses a serious challenge to the country. The rate of tuberculosis prevalence in Tajikistan (350 per 100,000

[24] E/C.12/2000/4, para. 59.
[25] Ibid., para. 43 (a).
[26] Ibid., para. 37.

people)[27] is very high compared with average levels in other high-burden countries (222 per 100,000 people),[28] and much higher than the regional average (170 per 100,000 people).[29] Tajikistan remains one of 27 countries with a high-burden of multidrug-resistant tuberculosis, with 13 per cent of all new cases of tuberculosis and 54 per cent of all retreatment cases having multidrug-resistant tuberculosis.[30] Furthermore, only 3 per cent of all newly notified cases of tuberculosis were tested for multidrug-resistant tuberculosis in 2010.[31] Approximately 4 per cent of all cases of tuberculosis in Tajikistan have a co-infection with HIV,[32] which is also a major concern that makes it difficult to lower the death rate from tuberculosis.

A. National tuberculosis programme

24. Efforts to prevent, treat and control tuberculosis in Tajikistan are funded largely by international donors. As a result of significant foreign assistance, the capacity of laboratories and polyclinics has been strengthened; some have been provided with the latest technology, including advanced diagnostic equipment.[33] Despite annual increases in State allocations, however, the State still does not allocate sufficient funds to meet the country's needs in the prevention, treatment and control of tuberculosis. As a result, Tajikistan is overly dependent on external funding, which could threaten the sustainability of efforts to prevent, treat and control the disease in the country.

25. A number of factors contribute to the high prevalence of tuberculosis and its multi-drug-resistant forms in Tajikistan: the underdevelopment of the primary health-care system; the less than comprehensive detection and incomplete collection of health information at the primary health-care level; the shortage of health-care workers in rural and remote areas; inadequate infection control and treatment in prisons; the interruption of prisoners' treatment on their release; a lack of coordination between the State and the health authorities of neighbouring countries to ensure access to treatment services for migrant workers; and the stigmatization and discrimination of people living with tuberculosis. The Special Rapporteur commends the Government for having implemented a pilot Directly Observed Treatment Short-course (DOTS) programme in 2002, and for subsequently extending it to all provinces and districts in 2007. In 2010, the Government also established a national tuberculosis control programme to combat multi-drug-resistant types of tuberculosis.

26. Under the national tuberculosis control programme, primary health care is intended to be the main level of detection for tuberculosis. Completing diagnostics and sputum

[27] TB country profile, Tajikistan, 2011,available from www.who.int/gho/countries/tjk/country_profiles/en/index.html.

[28] *Global Tuberculosis Report 2012* (WHO, Geneva, 2012) (available from www.who.int/tb/publications/global_report/en/), p. 11.

[29] Ibid.

[30] Ibid., p. 23.

[31] *Global Tuberculosis Control 2011* (WHO, Geneva, 2011) (available from www.who.int/tb/publications/global_report/2011/en/), p. 36.

[32] Ruhšona Ašurova, Cooperation between HIV and TB services in the Republic of Tajikistan: Scope, divisional manager, preventive treatment, National AIDS Centre, Ministry of Health of the Republic of Tajikistan (Almaty, May 2010), slide no. 18. Available from www.pptsearch365.com/tajikistan.html.

[33] Project HOPE, "Using Incentives to Improve Tuberculosis Treatment Results: Lessons from Tajikistan, March 2005, p. 8. Available from http://donate.projecthope.org/site/DocServer/Proj_Hope_Tajikistan_TB_case_study.pdf?docID=158.

collection at the primary health-care level in the community promotes early case detection, which lowers transmission rates, results in better health outcomes and reduces costs to patients who would otherwise incur transportation and accommodation expenses.[34] Given, however, that the primary health-care sector in Tajikistan is underfunded and underdeveloped, primary health-care workers tend to refer patients suspected of having tuberculosis to specialists rather than provide basic diagnostic services, such as collecting sputum and conducting smear microscopy tests. In accordance with the right to health, diagnostic services should be available in the community in order to promote early detection and ensure universal access, particularly for the poor and people living in rural and remote areas. The Special Rapporteur therefore encourages the Government to continue to develop the primary health-care system and to integrating tuberculosis detection efforts fully into primary health-care services.

27. Interrupted access to medicines for poor and physically isolated populations in the DOTS programme remains a major concern. The right to health requires that health facilities, goods and services be physically and economically accessible to everyone without discrimination, including socially disadvantaged groups.[35] The law requires that treatment services and medicines for tuberculosis be made available free-of-charge in Tajikistan.[36] According to health-care providers and persons living with tuberculosis in four districts of the country, however, the cost of health care is the main obstacle to access to testing and treatment for the disease.[37] Costs include out-of-pocket expenditure on treatment services, medicines, transportation and informal payments to health-care workers.[38] High transportation costs limit physical access to services provided at treatment centres, including primary health-care facilities.[39] The inability to afford or to have physical access to appropriate and uninterrupted treatment for tuberculosis has been shown to lower detection and adherence rates.[40] Moreover, in many cases, improper or interrupted treatment leads to the development of drug-resistant strains of tuberculosis, such as multi-drug-resistant tuberculosis and extensively-drug-resistant tuberculosis. Treatment services and medicines for the latter forms are more costly and less readily available than those for standard tuberculosis, the duration of treatment regimens are significantly longer, treatment side effects are more severe, and treatment success rates are substantially lower.[41] The greater financial burden associated with the treatment of such forms of tuberculosis is not only borne by people living with tuberculosis, but also by the State.

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[34] Stop TB Partnership and TB and Human Rights Task Force, Tuberculosis and Human Rights, working document on tuberculosis and human rights (available from www.stoptb.org/assets/documents/global/hrtf/Briefing%20note%20on%20TB%20and%20Human%20Rights.pdf), p. 3.

[35] E/C.12/2000/4, para. 12 (b).

[36] WHO/United Nations Development Programme (UNDP), Review of tuberculosis control in the Republic of Tajikistan (WHO, Denmark, December 2009) (available from www.euro.who.int/__data/assets/pdf_file/0015/126411/WHO_TB_Mission_TJK_April-2010-pdf.pdf), p. 7.

[37] Raffael Ayé et al., "Patient's site of first access to health system influences length of delay for tuberculosis treatment in Tajikistan", *BioMed Central Heath Service Research*, vol. 10, No. 10 (2010), p. 10.

[38] See Raffael Ayé et al., "Household costs of illness during different phases of tuberculosis treatment in Central Asia: a patient survey in Tajikistan", ibid., vol. 10, No. 18 (2010).

[39] F. Tediosi et al., "Access to medicines and out of pocket payments for primary care: evidence from family medicine users in rural Tajikistan", ibid., vol. 8 (2008), pp. 109-116.

[40] See Pirom Kamolratanakul et al., "Economic impact of tuberculosis at the household level", *International Journal of Tuberculosis and Lung Disease*, vol. 3, No. 7 (July 1999).

[41] See WHO, *Global Tuberculosis Control 2011* (see footnote 31).

B. Tuberculosis and migrant workers

28. According to some estimates, 620,000 Tajik citizens are migrant workers and one in every four households reports a family member involved in labour migration. Tajik migrant workers are vulnerable as a group owing to their often irregular legal status in host countries, the poor working and living conditions they endure and their limited access to affordable health services. In some cases, Tajiks living with tuberculosis migrate for work, and subsequently lack access to treatment services in the host country. In other cases, Tajik migrant workers contract tuberculosis in the host country and have no access to the necessary testing and treatment there.[42] Migrant workers living with tuberculosis are particularly vulnerable because of the stigma associated with the disease, the likelihood that they may lose their jobs if their status is revealed, and the threat of deportation from their host country.

29. Migration increases the risk of transmission of tuberculosis, particularly if migrants originate in countries with high rates of prevalence.[43] The high costs associated with the treatment of tuberculosis abroad coupled with poor awareness of disease prevention and transmission further increases the incidence of tuberculosis among migrant workers.[44] Studies have also shown that tuberculosis treatment adherence rates among migrant workers are lower than for other groups.[45] As a result, migrant workers constituted 10.2 per cent of newly registered cases of tuberculosis in Tajikistan in 2007.[46] The right to health requires States to pay particular attention to all vulnerable and marginalized groups, including migrant workers, in national health strategies.[47] The Special Rapporteur therefore urges the Government to take concrete steps towards addressing the heightened vulnerability of Tajik migrant workers to tuberculosis, including through targeted interventions and cooperation with host countries.

C. Tuberculosis in the penitentiary system

30. Tuberculosis among prisoners is a matter of great concern in Tajikistan. The State has an obligation to ensure the enjoyment of the right to health of prisoners by, inter alia, refraining from denying or limiting their access to health services.[48] Moreover, prisoners living with tuberculosis are a particularly vulnerable as a result of the stigma associated with the disease and their complete dependence on access to health facilities, goods and services. In 2008, the DOTS programme was fully implemented within the penitentiary system and access to testing and treatment for tuberculosis improved. Treatment for multi-drug-resistant tuberculosis has been available in prisons since 2009. The prevalence of tuberculosis and multi-drug-resistant tuberculosis has not, however, decreased significantly since the implementation of the programme. The incidence of tuberculosis and mortality

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[42] Christopher Gilpin et al., “Exploring TB-Related Knowledge, Attitude, Behaviour, and Practice among Migrant Workers in Tajikistan”, Hindawi Publishing Corporation, *Tuberculosis Research and Treatment*, vol. 2011, p. 1.

[43] José Figueroa-Munoz, Pilar Ramon-Pardo, “Tuberculosis control in vulnerable groups”, *Bulletin of the World Health Organization*. Available from www.who.int/bulletin/volumes/86/9/06-038737/en/index.html.

[44] See Gilpin, “Exploring TB-Related Knowledge” (see footnote 42).

[45] Xu Weiguo et al., “Adherence to anti-tuberculosis treatment among pulmonary tuberculosis patients: a qualitative and quantitative study”, *BioMed Central Health Services Research*, vol. 9, No. 169 (2009), p. 3.

[46] WHO/UNDP, Review of tuberculosis control (see footnote 36), p. 13.

[47] E/C.12/2000/4, para. 43 (f).

[48] Ibid., para. 34.

rates in prisons was 15 and 30 times higher, respectively, than in the general population.[49] A lack of timely testing and treatment in the penitentiary system exacerbates the burden of tuberculosis in prisons. In some cases, treatment starts as late as six to eight weeks after detection.[50] Moreover, during his visit, the Special Rapporteur learned that the prevalence of tuberculosis in prisons rose from 165 in 2007 to 195 in 2011, and that the prevalence of multi-drug-resistant tuberculosis dropped only slightly, from 22 in 2010 to 19 in 2011. The Special Rapporteur was also informed that the prevalence of HIV/tuberculosis co-infection in prisons rose from eight cases in 2010 to 21 in 2011, and that the prevalence of multi-drug-resistant tuberculosis was 44 during the first five months of 2012. The Special Rapporteur urges the Government to take concrete steps to increase the availability and accessibility of testing and treatment for tuberculosis in prisons.

31. The penitentiary system lacks an effective monitoring system and integrated electronic database to keep records of prisoners and recently released prisoners living with tuberculosis in order to ensure continued treatment upon transfer inside the penitentiary system or after release from prison.[51] The transfer of prisoners living with tuberculosis inside the penitentiary system and a lack of coordination between prison and local health authorities thus results in interrupted treatment and raises the risk of multi-drug-resistant tuberculosis among prisoners, former prisoners and the general population. The lack of accurate medical records may also prevent health workers from providing appropriate treatment for prisoners living with tuberculosis who are transferred or released from prison.[52] Moreover, lack of accurate information concerning the tuberculosis states of prisoners is an obstacle to effective infection control in prisons. The obligation of the State to prevent, treat and control disease includes the responsibility to use and improve epidemiological surveillance. The Special Rapporteur calls on the Government to ensure an appropriate monitoring and medical records system is devised and implemented within the penitentiary system in order to prevent any interruption of treatment for current and former prisoners living with tuberculosis.

D. Stigma and discrimination

32. The Special Rapporteur is seriously concerned about the stigmatization and discrimination associated with people living with tuberculosis and HIV/tuberculosis co-infection in Tajikistan. During his visit, the Special Rapporteur was repeatedly informed that the stigma surrounding tuberculosis was a significant concern and that people living with HIV/tuberculosis co-infection had occasionally been denied treatment for tuberculosis in certain facilities. Stigma and discrimination discourage people living with tuberculosis from seeking testing and treatment, which in turn impedes prevention, treatment and control efforts.

33. Stigmatization in Tajikistan is rooted in poor public awareness of the prevention and transmission of tuberculosis. The Government should therefore increase its efforts to raise public awareness through mass, social and other media. The Special Rapporteur was pleased to learn that, in some instances, the Government had involved people living with tuberculosis and those who had recovered from the disease in awareness-raising campaigns along with other stakeholders, civil society and religious leaders. The participation of affected communities is central to the realization of the right to health and is necessary to

[49] Tajikistan Progress Report (see footnote 2), p. 86.
[50] WHO/UNDP, Review of tuberculosis control (see footnote 36), p. 41.
[51] Ruhšona Ašurova, Cooperation between HIV and TB services in the Republic of Tajikistan (see footnote 32), slide no. 37.
[52] WHO/UNDP, Review of tuberculosis control (see footnote 36), p. 7.

ensure sustainable and effective prevention, treatment and control of tuberculosis in Tajikistan. The Government should ensure the right of people living with the disease to have personal health data treated with confidentiality, including information concerning testing and treatment. Ensuring the right to confidentiality promotes the utilization of testing and treatment services by those who might otherwise fear stigmatization. The Special Rapporteur therefore urges the Government to facilitate meaningful participation of people living with tuberculosis and other relevant stakeholders in all aspects of prevention, treatment and control efforts, and to protect the right to confidentiality in testing and treatment information in order to reduce the stigmatization of and discrimination against people living with the disease.

V. Mental health

34. Given that mental health is an essential component of the right to the enjoyment of the highest attainable standard of health, the State should ensure that good quality mental health facilities and goods and services are available, accessible and culturally appropriate for all. The obligation to fulfil the right to health requires the State to adopt and implement a national public health strategy and plan of action, which includes promoting and supporting the establishment of institutions providing counselling and mental health services.[53] Moreover, the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care support the right of every person living with mental illness to be treated and cared for, as far as possible, in the community in which he or she lives.[54]

35. In 2005, Tajikistan signed the Mental Health Declaration and Action Plan for Europe, which called upon States Members of the World Health Organization (WHO) to establish mental health policies, programmes and legislation based on current knowledge and considerations regarding human rights, in consultation with all stakeholders in mental health.[55] Tajikistan still lacks a comprehensive national plan addressing mental health. The Law on Psychiatric Care of 2002, the primary law governing the provision of mental health services in Tajikistan, has not been fully implemented and many of its provisions are outdated. During his visit, the Special Rapporteur was pleased to learn that the Government was considering amending the law and adopting a national mental health strategy. He encourages the Government to move promptly towards the adoption of the strategy and a comprehensive mental health policy based on the right to health and to ensure the active and informed participation of all relevant stakeholders, including people living with mental illness, in the decision-making process.

A. Mental health financing

36. During his visit, the Special Rapporteur learned that Tajikistan currently allocates only 1.5 per cent of the health budget to mental health. There is no separate budget line item for psychiatric care in the health budget.[56] This may indicate low prioritization of mental health in the country. By one estimate, budget allocations for mental health cover

[53] E/C.12/2000/4, paras. 36 and 43 (f).

[54] General Assembly resolution 46/119, principle 7 (1).

[55] Mental Health Declaration for Europe: Facing the Challenges, Building Solutions, WHO European Ministerial Conference on Mental Health, January 2005 (EUR/04/5047810/6), para. 4.

[56] WHO and Ministry of Health, Tajikistan, WHO-AIMS Report on Mental Health System in the Republic of Tajikistan, Dushanbe, 2009 (available fromwww.who.int/mental_health/tajikistan_who_aims_report.pdf), p. 10.

only 30 to 50 per cent of the actual needs of mental health facilities, and 70 per cent of the facilities do not receive funding for the procurement of equipment or municipal service payments.[57] International donor funding has also been generally unavailable for mental health, which exacerbates the funding and resource shortage. The Special Rapporteur urges the Government to increase funding for mental health substantially as a matter of priority, and to allocate a greater proportion of mental health funds and resources to community-based mental health facilities and services.

37. Moreover, the existing mental health physical infrastructure in Tajikistan is in disrepair and in need of substantial rebuilding. Owing to limited public funding, many psychiatric care facilities are unable to undertake even the most basic repairs.[58] The Special Rapporteur is concerned at the poor conditions in mental health facilities, which often include a lack of basic sanitation and hygiene. Poor hygiene and lack of drinking water and food have contributed to the deteriorating physical health of hospitalized patients.[59] Prolonged electricity shortages are common, and patients in some psychiatric hospitals have died owing to deficient heating systems during the winter.[60] Mental health facilities should be fitted with the necessary physical resources and equipment to meet basic sanitary standards and the diverse needs of people living with mental illness. The Special Rapporteur urges the Government to take immediate steps to improve sanitation and hygiene in mental health facilities and to address physical infrastructure problems.

38. Inadequate budget allocation to mental health has severely restricted the availability and accessibility of culturally acceptable and good-quality mental health facilities, goods and services. The mental health system in Tajikistan relies too heavily on the institutionalization of people suffering from mental illness, including children, in mental hospitals, which make up the vast majority of the mental health infrastructure. Indeed, 84 per cent of all Government spending on mental health goes to mental hospitals.[61] The Government has started to reduce the number of hospital beds and to emphasize outpatient treatment in accordance with other health sector reforms. There are, however, no functional community health services available in the mental health field in Tajikistan.[62] During his visit, the Special Rapporteur learned that community-based facilities were unable to obtain licenses to operate owing to an outdated and inefficient licensing system. Community-based treatment allows people living with mental illness to remain in their communities while receiving treatment. It involves the participation of the community in treatment and rehabilitation, and is more cost-effective than inpatient treatment and hospitalization. Moreover, community-based treatment will contribute significantly to the reduction of the stigmatization of mental illness in Tajikistan. The Special Rapporteur calls upon the Government to take concrete steps to establish community-based treatment facilities and services for people living with mental illness in accordance with international medical and human rights standards.

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[57] Pharmaciens Sans Frontières Comité International (PSFCI), Assessment of psychiatric institutions in the Republic of Tajikistan (2006), slide 15.

[58] Hamid Ghodse, *International Perspectives on Mental Health* (London, Royal College of Psychiatrists, 2011), pp. 208, 210.

[59] Ibid., p. 208; PSFCI, Assessment of psychiatric institutions (see footnote 57), slide no. 13.

[60] PSFCI, Assessment of psychiatric institutions (see footnote 57), slides 14, 16; Ghodse, *International Perspectives on Mental Health* (see footnote 58) p. 210.

[61] WHO, WHO-AIMS Report (see footnote 56), p. 5.

[62] Ibid., p. 12.

B. Psychiatric medicines and quality of mental health care

39. Under the right to health, States have an obligation to provide access to safe, efficacious and affordable medicines, and to ensure such access for vulnerable populations. Psychiatric medicines, such as antidepressants and antipsychotics, are, however, rarely available in mental health facilities, particularly in poor and remote communities. The situation became particularly acute after the provision of free psychotropic treatment was discontinued in 2010.[63] As a result, there has been an increase in self-medication and the use of traditional healers.[64] Shortages in psychiatric medicines have also increased out-of-pocket expenditures for patients, who must pay higher costs for treatment when they are not made available free of charge in mental health facilities.[65] The widespread shortage of psychiatric medicines has further distanced psychiatry and the treatment of mental illness from mainstream medicine, disproportionately affecting people living with mental illnesses. This is in contrast to those who suffer from physical illness, for whom health goods and services are comparatively more accessible. The Special Rapporteur urges the Government to improve the supply of psychiatric medicines in Tajikistan through the adoption of laws and policies that ensure that safe, efficacious and affordable medicines are available for people living with mental illness.

40. The primary factor limiting the availability of good-quality mental health services in Tajikistan is the lack of qualified mental health workers. There are only 1.8 psychiatrists per 100,000 people in Tajikistan,[66] which is extremely low when compared with the situation in other countries in the region. Moreover, there are almost no psychologists and social workers in the country.[67] Only 2 per cent of training for medical doctors and 1 per cent for nurses is devoted to mental health.[68] As a result, there is a complete lack of psychosocial staff working in outpatient facilities, community-based psychiatric inpatient units and mental hospitals.[69] The shortage of qualified mental health workers is even more acute in rural and remote areas, where psychiatrists are four times fewer than in urban areas.[70] Moreover, given that mental health workers are not adequately remunerated, younger medical professionals are reluctant to work in mental health.[71] Ten per cent of mental health workers leave the country within five years following graduation to pursue higher paying positions.[72] The situation is more serious in the penitentiary system. During his visit, the Special Rapporteur learned that the prison health system does not have any trained mental health workers on staff and relies, on a consultancy basis, solely on one doctor trained in mental health. The Special Rapporteur urges the Government to raise salaries for mental health workers, to develop substantially incentive structures to promote

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[63] Alisher Latypov, "Healers and psychiatrists: the transformation of mental health care in Tajikistan", *Transcultural Psychology*, vol. 47, No. 3 (July 2010), pp. 419-451.
[64] Khodjamurodov and Rechel, Tajikistan: Health System Review (see footnote 1), p. 115.
[65] WHO, WHO-AIMS Report (see footnote 56), p. 10.
[66] Maya Semrau et al., "Lessons learned in developing community mental health care in Europe", *World Psychiatry*, vol. 10, No. 3 (October 2011), pp. 217–225, table 1.
[67] WHO/Europe and Ministry of Health Tajikistan, Mental Health Policy and Strategy, Republic of Tajikistan (2010) (available from the secretariat of the Office of the United Nations High Commissioner for Human Rights), p. 10.
[68] WHO, WHO-AIMS Report (see footnote 56), p. 21.
[69] Ibid., p. 23.
[70] Ibid., pp. 23-24.
[71] WHO/Europe, Tajikistan: Mental Health. See www.euro.who.int/en/where-we-work/member-states/tajikistan/areas-of-work/mental-health.
[72] WHO, WHO-AIMS Report (see footnote 56), p. 27.

mental health work and retain mental health professionals, and to improve working conditions in mental health facilities.

41. Coupled with the lack of mental health workers and severe shortages in psychiatric medicines, the poor quality of existing mental health services results in a system that fails to serve even the most basic needs of people living with mental illness in Tajikistan. People living with mental illness are often subject to restraints or seclusion as part of their treatment: 8.2 per cent of patients admitted to the republican psychoneurological hospital and 6 to 10 per cent of patients in community-based psychiatric inpatient units were found to have been restrained or secluded at least once,[73] despite international principles holding that physical restraint or involuntary seclusion should be employed "only when it is the only means available to prevent immediate or imminent harm to the patient or others".[74] Prevention, detection, diagnosis and monitoring of mental illness are also lacking at the primary health-care level. Primary health-care workers do not receive training in mental health; for this reason, many mental illnesses, such as depression, go undetected at the primary health-care level.[75] This deficit further contributes to the mental health burden in Tajikistan and increases system-wide costs by failing to prevent more expensive, specialized hospital care.

C. Discrimination, abuse and informed consent in mental health care

42. The Special Rapporteur was distressed to hear reports of abuses perpetrated against people living with mental illness in mental health facilities in Tajikistan. These include reports of sexual violence against patients by mental health workers and other patients, and acts of humiliation whereby patients were given narcotics and forced to perform for hospital staff and other patients. Such acts, if substantiated, amount to egregious violations of the right to health and infringements on the dignity and autonomy of people living with mental illness. The Special Rapporteur calls upon the Government to investigate immediately these reports, to implement safeguards to prevent the abuse of people living with mental illness, and to ensure that all perpetrators of abuse are held accountable under the law.

43. The stigmatization of and discrimination against people living with mental illness in Tajikistan are a serious concern. Stigma and fear of discrimination discourage people living with mental illness from seeking treatment for fear of being identified as mentally ill. Their families are reluctant to participate in community-based programmes because of the stigma attached to acknowledging that a family member is mentally ill within the community. In some cases, families choose to abandon family members living with mental illness in mental health facilities.[76] A family's primary objective is often to disassociate itself from the stigma rather than seek appropriate treatment for the family member. Stigma surrounding mental illness is further generated and perpetuated by the registration system of people who receive treatment in mental health facilities. The Special Rapporteur learned that registration information is shared with employers, educational institutions and other State agencies. In some cases, the availability of such information results in discrimination against people living with mental illness, despite the requirement envisioned by the Law on Psychiatric Care on the confidentiality of mental health records. The right to be free from discrimination based on health status is a core component of the right to health. The registration system, as it is currently implemented, undermines the right to have personal

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[73] Ibid., p. 15.
[74] General Assembly resolution 46/119, principle 11, para. 11.
[75] WHO, WHO-AIMS Report (see footnote 56), p. 6.
[76] WHO/Europe, Tajikistan: Mental Health (see footnote 71).

health data treated with confidentiality and infringes on the dignity of people living with mental illness. The Special Rapporteur urges the Government to eliminate the stigma associated with mental illness through public awareness and education campaigns, and to review its mental health registration system by assessing its impact on the rights of people living with mental illness.

44. During his visit, the Special Rapporteur observed that patients were admitted to mental health facilities and received treatment without their explicit and informed consent, even though it is required by law in Tajikistan. In a visit to a mental health facility, the Special Rapporteur was informed that the consent of relatives of those living with mental illness was accepted as a substitute for the consent of the patients themselves. This problem is compounded by the implementation of the Law on Psychiatric Care, which results in the characterization of involuntary admissions as emergency hospitalizations rather than involuntary ones.[77] Moreover, people living with mental illness are often not informed of their health condition or diagnosis, nor involved in discussions about treatment plans nor given the opportunity to request alternative psychiatric examination.[78] The right to health requires that the informed consent of all those who possess legal capacity be obtained prior to the administration of medical treatment. Securing the informed consent of people living with mental illness is fundamental to respect for their personal autonomy, self-determination and human dignity. Adults, including those living with mental illness, are presumed to possess legal capacity and thus have the right to consent to, refuse, or choose an alternative medical intervention.[79] Involuntary admission and treatment should only be allowed in exceptional circumstances, subject to specific and restrictive conditions, respecting best practices and applicable international standards.[80] The Special Rapporteur calls upon the Government to ensure that the informed consent of all people living with mental illness is obtained prior to admission into mental health facilities or the administration of treatment.

D. Mental health of women and domestic violence

45. According to one estimate, up to 50 per cent of women in Tajikistan experience physical, psychological or sexual violence perpetrated by their husbands or other family members.[81] Tajikistan has no comprehensive health strategy to address the negative impact of domestic violence on physical and mental health of women. Doctors and health-care workers are not trained to screen and document instances of domestic violence. Tajikistan also lacks a functioning cross-referral system between health facilities and support services to protect victims of violence.[82] As a result, the limited number of programmes that offer psychological counselling and temporary protection are not sufficiently integrated into the health system and fail to cover the majority of women in need.[83] Women from rural and

[77] See WHO, WHO-AIMS Report (see footnote 56), p. 15.
[78] Ghodse, *International Perspectives on Mental Health* (see footnote 58) p. 211.
[79] See A/64/272, para. 10.
[80] E/C.12/2000/4, para. 34. See General Assembly resolution 46/119.
[81] Amnesty International, “Violence is Not Just a Family Affair: Women Face Abuse in Tajikistan” (London, 2009) (available from www.amnesty.org/en/library/asset/EUR60/001/2009/en/59bb6e9b-727d-496b-b88d-1245a750d504/eur600012009en.pdf), p. 5.
[82] Ibid., p. 6.
[83] UNDP, Strengthening Early Recovery Capacities in Tajikistan programme (available from www.undp.tj/site/images/Docs/Early_Recovery_Rollout_Tajikistan__Early_Recovery_Capacities_Project_Document.pdf), p. 6.

remote communities, who account for the majority of women in Tajikistan,[84] are especially vulnerable owing to their limited access to health facilities and services when compared with their urban counterparts.[85] In accordance with to the right to health, Tajikistan should take special measures to protect the physical and mental health of women who are victims of or at risk of violence.[86]

46. The Special Rapporteur is concerned about reports of a correlation between high rates of domestic violence against women and rising levels of suicide among women and young people in Tajikistan. The gender ratio for suicide in the Sughd region is one to one male to female, as against the four to one male to female ratio in developed countries.[87] According to WHO, gender-based violence is a significant predictor of suicide in women.[88] A survey in Tajikistan found that 70 per cent of women who had suicidal thoughts and 70 per cent of those who had attempted suicide reported experiencing physical violence from their husbands.[89] Another study found that women from families that believe a woman should be beaten if she talks to a man who is not a relative are twice as likely to be suicidal than those from other families.[90] The societal perception that domestic violence is a private family matter is also a driving factor in female suicide and impairs the ability of mental health workers to assess and treat victims of domestic violence appropriately.[91] Other factors affecting the incidence of suicide in Tajikistan include forced marriage, child abuse and regressive notions of gender roles.[92] The lack of mental health services and early detection of mental illness at the primary health-care level contribute substantially to this problem.

47. Following her mission to Tajikistan in 2008, the Special Rapporteur on violence against women, its causes and consequences, pointed to the lack of a protective infrastructure and practices by law enforcement and judicial bodies as a reason for underreporting of violence against women in the country.[93] Health professionals are nonetheless required by law to report cases of domestic violence to law enforcement authorities in Tajikistan. While reporting requirements are professedly protective, they infringe upon a woman's right to have personal health data treated with confidentiality, and generate and perpetuate stigma surrounding victims of domestic violence.[94] Reporting is also thought to deter some women from seeking help from health services.[95] Furthermore,

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[84] State Statistics Committee of the Republic of Tajikistan, "Women and Men in the Republic of Tajikistan", UNIFEM, Dushanbe, 2007 (available from www.tojikinfo.tj/en/download/files/MenWomen_eng.pdf), p. 3.

[85] WHO Multi-country Study on Women's Health and Domestic Violence against Women (Geneva, 2005) (available from www.who.int/gender/violence/who_multicountry_study/en/), pp. 55-62.

[86] E/C.12/2000/4, para. 21.

[87] UNICEF-Tajikistan and Columbia University, Study of prevalence and dynamics of suicide among children and young people (12-24 years of age) in Sughd Region, Tajikistan (New York, February 2012), p. iii.

[88] WHO, Department of Mental Health and Substance Dependence, "Gender disparities in mental health". Available from www.who.int/mental_health/media/en/242.pdf.

[89] Amnesty International, "Violence is Not Just a Family Affair" (see footnote 81), p. 16.

[90] UNICEF, Study of prevalence and dynamics of suicide (see footnote 87), p. v.

[91] WHO, WHO-AIMS Report (see footnote 56), p. 32.

[92] United Nations Integrated Regional Information Network, "Our bodies – their battle ground: gender-based violence in conflict zones", September 2004 (available from www.irinnews.org/pdf/in-depth/GBV-IRIN-In-Depth.pdf), p. 25.

[93] A/HRC/11/6/Add.2, para. 66.

[94] *Domestic Violence in Tajikistan* (Minneapolis, The Advocates for Human Rights, 2008) (available from www.stopvaw.org/uploads/tajikistan_3_6_07_layout_-_final_mc.pdf), p. 46. See also Amnesty International, "Violence is Not Just a Family Affair" (see footnote 81), p. 25.

[95] A/HRC/11/6/Add.2, para. 71.

such laws have a chilling effect on the provision of mental health services. Mental health workers fearing criminal prosecution may be unwilling to treat victims of domestic violence, and victims of violence may be deterred from seeking mental health services out of the fear of public exposure and further domestic abuse. These laws thus restrict the availability and accessibility of mental health services and expose women to a greater risk of suicide. Health workers should therefore not be required by law to report cases of domestic violence to law enforcement authorities. The Special Rapporteur encourages the Government to consider adopting a legal regime that is protective of victims, enabling them to quickly obtain protective orders, and that integrates counselling and treatment for negative physical and mental health outcomes resulting from domestic violence.

VI. Conclusions and recommendations

48. **The Special Rapporteur notes with appreciation the progress made in Tajikistan since the cessation of civil conflict in 1997. In particular, the Government of Tajikistan should be commended for having significantly reduced poverty in the country and for having recently initiated health sector reforms. The Special Rapporteur encourages the Government to continue health sector reforms in accordance with the right to health, to ensure universal access to good-quality health facilities, goods and services for all. In that context, the Special Rapporteur notes with appreciation the Government's communication after his visit that a plan of action had been prepared for the implementation of his recommendations, and encourages the Government to ensure effective participation of civil society and community representatives in the implementation and monitoring of the plan.**

49. **The Special Rapporteur recommends that the Government of Tajikistan, with regard to its health system and health financing:**

(a) Increase national budget allocations for health to ensure adequate, equitable and sustainable financing for health;

(b) Reduce excess capacity at the secondary and tertiary care levels, including by addressing excess staff, hospital beds and medical equipment;

(c) Redirect resources towards and increase funding for the primary health-care sector;

(d) Increase investment in training of general practitioners and family doctors, including through the expansion of educational concentrations in general medicine, and to develop a comprehensive benefits and incentives programme to encourage individuals to pursue such training;

(e) Continue to develop and refine programmes such as the fee-for-service and basic benefits package programmes to reduce out-of-pocket expenditures, particularly for the poor;

(f) Raise public awareness and understanding among health workers of health financing reforms in order to increase their effectiveness;

(g) Implement the pilot programme to pool funds in Sughd province as a basis for developing a national pooling system comprising mandatory, progressive prepayments, such as taxes and insurance contributions, based on the ability to pay, in order to reduce out-of-pocket payment for health and ensure access to good-quality health facilities, goods and services;

(h) Continue to increase salaries for all health-care workers.

50. **The Special Rapporteur urges the Government to consider the following recommendations in its efforts to prevent, treat and control tuberculosis:**

(a) Increase funding for tuberculosis prevention, treatment and control in order to ensure sustainability of the national tuberculosis programme;

(b) Integrate testing and treatment services for tuberculosis fully into the primary health-care sector;

(c) Ensure that testing and treatment for tuberculosis are available free-of-charge, including all incidental goods and services as required by national laws, and that such services are physically accessible for rural and remote populations;

(d) Ensure, in cooperation with international donors, the availability of the most up-to-date diagnostic services, including drug-susceptibility testing for multi-drug-resistant tuberculosis;

(e) Protect the right to confidentiality to personal health data for people living with tuberculosis, particularly information concerning testing and treatment;

(f) Coordinate with receiving countries to ensure that migrant workers have uninterrupted access to testing and treatment for tuberculosis both in Tajikistan and during their stay in host countries;

(g) Ensure timely access to testing and treatment for tuberculosis for all prisoners and implement a monitoring and medical records system within the penitentiary system in order to, inter alia, prevent interrupted treatment for prisoners and former prisoners living with tuberculosis;

(h) Implement public awareness and education campaigns about the prevention and transmission of tuberculosis with a view to reducing the stigma associated with the disease, and informing people about the importance of testing and treatment.

51. **With regard to the area of mental health, the Special Rapporteur recommends that the Government of Tajikistan:**

(a) Adopt a comprehensive mental health policy and plan of action based on the right to health, and to ensure the active and informed participation of all relevant stakeholders, including people living with mental illness, in the decision-making process;

(b) Increase budget allocations for mental health in the national health budget substantially and to allocate a greater proportion of mental health funds and resources to community-based mental health facilities and services;

(c) Establish community-based treatment facilities and services for people living with mental illness in accordance with international medical and human rights standards;

(d) Improve sanitation and hygiene in mental health facilities and to address existing shortcomings in physical infrastructure;

(e) Develop a national procurement and pricing policy to ensure that safe, efficacious and affordable medicines are available and accessible for people living with mental illness;

(f) Establish incentives for health-care workers to pursue a career in mental health, especially in rural and remote areas, including substantial increases in salaries for mental health workers;

(g) Expand evidence-based training for mental health at education institutions, particularly for psychologists and psychosocial workers;

(h) Implement mechanisms to investigate reports of abuse of people living with mental illness in mental health facilities, to implement safeguards to prevent such abuse, and to ensure that perpetrators of such abuse are held accountable under the law;

(i) Implement public awareness and education campaigns to eliminate stigmatization of and discrimination against people living with mental illness;

(j) Strengthen the protection of the right to confidentiality with regard to personal mental health records;

(k) Review the mental health registration system in order to assess its impact on the rights of people living with mental illness;

(l) Ensure the informed consent of all people living with mental illness is obtained prior to admission into mental health facilities or the administration of treatment;

(m) Develop a comprehensive system to respond to domestic violence, including through the implementation of community-based programmes that provide women, particularly in rural and remote areas, with counselling and support services and respect their right to confidentiality. Such programmes should also include training of doctors and other health-care workers on domestic violence and appropriate treatment of victims of domestic violence.