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人人有权享有尽可能高水平身心健康问题特别报告员的报告阿南德·格罗弗

增编

对阿塞拜疆的访问(2012年5月16日至23日) *

内容 提要

2012 年 5 月 16 日至 23 日，人人享有尽可能高水平身心健康问题特别报告员走访了阿塞拜疆。访问期间，特别报告员本着对话和合作精神，审思了该国如何致力于落实健康权的问题。他尤其评估了下述相关问题：保健制度和资金筹措；肺结核病的预防、治疗和管控；以及监狱和拘留中心的卫生保健。

在本报告中，特别报告员赞扬了阿塞拜疆在减轻贫困、扩大卫生经费开支和解决孕产妇死亡率方面所取得的进展，以及该国承诺致力于实现健康权。然而，为使阿塞拜疆全面实现健康权，特别报告员鼓励政府，解决若干严重的挑战问题，尤其要考虑如何改善与上述几个健康议题相关领域的状况。为了便于致力开展这方面的工作，特别报告员在本报告中提出了一些建议。

Annex

[English 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 Azerbaijan (16–23 May 2012)

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I.Introduction

1.In the present report, the Special Rapporteur reports on his visit to Azerbaijan at the invitation of the Government from 16 to 23 May 2012. The purpose of the mission was to ascertain, in a spirit of dialogue and cooperation, how the country has endeavoured to implement the right to health, as well as the measures taken for successful realization of the right to health.

2.During the mission, the Special Rapporteur focused on the following issues: the health system and health financing; tuberculosis and multi-drug resistant tuberculosis (MDR-TB); and health care in prisons and detention centres. The Special Rapporteur visited Baku, Ganja, Yevlakh, Ujar and the Nakhchivan Autonomous Republic.

3.The Special Rapporteur held meetings with senior Government officials from the Ministries of Foreign Affairs; Health; Labour and Social Protection; Finance; and Justice; the State Committee for Family, Women and Children Affairs; Parliament Committees, the Office of the Ombudsman for Human Rights; as well as with senior officials from the Supreme Assembly and Ministry of Health of the Nakhchivan Autonomous Republic. He also held meetings with the representatives of civil society, international organizations, development partners, academics, legal experts and health professionals. The Special Rapporteur is grateful to the Government of Azerbaijan for its invitation and full cooperation during his visit. He also would like to thank all those who met with him, gave their time and extended cooperation to him during the mission.

II.Right to health

A.Background

4.After gaining independence in 1991, Azerbaijan experienced considerable political turmoil, including several military coups and rampant corruption. At the same time, the country was embroiled in a territorial armed conflict which ended with a 1994 ceasefire, which to date, remains in place. Social and economic development was effectively stalled during that tumultuous period. Over the last decade, however, Azerbaijan has experienced impressive economic growth, driven primarily by its oil and mineral wealth. The country's gross domestic product (GDP) increased from USD 7.3 billion in 2003 to 63.4 billion in 2011. GDP per capita increased during the same period from USD 884 to 6,916. Poverty in the country has been reduced significantly during this time, from 49.6 per cent in 2001 to 7.6 per cent in 2011.

5.A number of health indicators also improved during this time. Maternal mortality rates decreased considerably, from 81 deaths per 100,000 live births in 1995 to 43 in 2010. Additionally, the percentage of people using improved drinking-water sources has increased from 70 per cent in 1990 to 80 per cent in 2010, and the percentage of people using improved sanitation has increased from 62 per cent in 2000 to 82 per cent in 2010. However, health-related challenges and inequalities continue to persist. Infant and under-5 mortality rates remain high at 39 and 45 deaths per 1,000 live births respectively. Disparities in health indicators between the lowest and highest wealth quintiles in Azerbaijan are also of concern. For example, diphtheria-tetanus-pertussis immunization coverage among 1-year-olds in the lowest quintile (21 per cent) is less than half the coverage in the highest quintile (56 per cent). The disparity in children under 5 who are stunted in the lowest and highest quintiles is also a concern, at 33 and 15 per cent respectively. The Special Rapporteur urges the Government to direct a greater portion of its growing wealth toward addressing these health-related challenges and other socioeconomic inequities.

B.International and national legal framework

6.Azerbaijan is a party to a number of international human rights 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 two Optional Protocols 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, including the Optional Protocol thereto, the Convention on the Rights of the Child, including the two Optional Protocols thereto, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, and the Convention on the Rights of Persons with Disabilities, including the Optional Protocol thereto. In accordance with article 148 of the Constitution, international treaties are recognized as an integral part of the legislative system of Azerbaijan.

7.The Constitution of Azerbaijan contains a number of provisions relating to the right to health. Article 41 establishes the right of protection of health, including the right to medical care, and requires the Government to take all necessary measures for the development of all forms of health services, to guarantee sanitary-epidemiological safety, and to create possibilities for various forms of health insurance. Article 27 protects the right to life; article 31 provides for the right to live in safety; article 39 establishes the right to live in a healthy environment; article 35 protects the right to work in safe and healthy conditions; article 46 establishes the right to be free from torture and humiliating punishment and prohibits non-consensual medical, scientific and other experimentation; article 17 prohibits children's involvement in activities that threaten their lives or health.

8.Legislation in Azerbaijan related to the realization of the right to health include the Law on Protection of the Health of the Population (1997), Law on Prevention of HIV and AIDS (1997), Law on Medical Insurance (1999), the Law on Private Medical Practice (2000), the Law on the Control of Tuberculosis (2000), the Law on the Immunoprophylaxis of Infectious Diseases (2000), Law on Narcological Service and Control (2001), Law on State Care for Persons with Diabetes (2003), Law on State Care for Persons with Haemophilia and Thalassaemia (2005), Law on Blood and Blood Component Donors and Blood Service (2005), Law on Oncology Care (2006), Law on Patents (2009), Criminal Code (2010), as well as Presidential Decree on the Establishment of the State Agency on Mandatory Health Insurance (2007) and on the Concept for Health Financing Reforms and Introduction of Mandatory Health Insurance (2008).

III.Health system and financing

9.An effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities and accessible to all, is fundamental to the realization of the right to health. Full realization of the right to health is further contingent upon the availability of adequate, equitable and sustainable financing for health. States should therefore take all necessary steps to raise adequate revenue and mobilize resources for health and ensure that health financing is correspondingly prioritized in national and subnational budgets.

10.The Government of Azerbaijan has increased expenditures on health significantly in recent times. The budget for health has increased to more than fifteen times the size of the budget at the time of independence, including an 18 per cent increase from 2011 to 2012. Capital investment in the health sector has also increased: allocations for government investment in health in 2012 rose by 40 per cent since 2011, 400 health facilities have been renovated or newly built, and 53 additional facilities have been identified for renovation. Per capita government expenditure on health has also risen substantially, from USD 6 in 2000 at average exchange rate to 65 in 2009. Per capita spending on health is thus in line with World Health Organization (WHO) estimates, according to which low-income countries will need to spend more than USD 60 per capita by 2015 in order to reach the health-related Millennium Development Goals and to ensure access to critical interventions, including for non-communicable diseases. The Special Rapporteur commends the Government on these advances.

11.Although current Government expenditure on health is increasing, expenditure on health in Azerbaijan has not kept pace with the country's economic growth, much of which has been spent on large capital investment projects. Azerbaijan currently spends only 1.5 per cent of the country's GDP on health, down from almost 6 per cent in 2010. This is very low by international standards: lower than the 2010 averages in the Americas (8.1 per cent), Europe (7.4 per cent), the former Soviet republics (5.7 per cent), and Africa (3 per cent). Moreover, in 2012 only 3.9 per cent of Azerbaijan's State budget was allocated to health. By contrast, the European average was 15.3 per cent in 2010. During meetings with the Special Rapporteur, the Government acknowledged that spending on health is still low. Increasing expenditure on health to meet international standards should be of the utmost priority in order to ensure that the country's considerable wealth is used to improving the health of its people and to meet the country's obligations under the right to health.

A.Primary health care

12.Like the other former Soviet republics, Azerbaijan inherited what is known as the Semashko health system model from the former 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 model thus prioritizes inpatient hospital care, investment in physical health infrastructure, financing based on inputs, such as hospital beds and staffing, and specialized secondary and tertiary care. This leads to an inefficient allocation of health funds and resources throughout the health system, as investment is directed toward specialized health facilities, leading to excess capacity at the secondary and tertiary-care levels and the underdevelopment of the primary health-care sector.

13.In Azerbaijan, this has resulted in a considerable excess of hospital beds and an underutilization of health facilities throughout the country. In meetings with the Special Rapporteur, the Government acknowledged the problem and indicated that it was taking steps to address it, including through a proposed 40 per cent decrease in the number of health facilities and a 50 per cent decrease in the number of hospital beds in the country. However, Government spending on health continues to be directed towards investment in large-scale physical health infrastructure, specialized secondary and tertiary care, and advanced medical equipment. This was evident during meetings with experts and visits to health facilities throughout the country.

14.States have a core obligation to ensure the satisfaction of minimum essential levels of the right to health, including available and accessible primary health care. Primary health care 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.As a result of its continued reliance on the Semashko health system model, the primary health-care system in Azerbaijan remains underdeveloped and underfunded. This is especially acute in rural and remote areas, where clinics are often inaccessible and understaffed and the quality of services is low. Individuals living in rural and remote areas affected by poverty face the greatest challenges in accessing quality primary health-care services. The Government has acknowledged this problem and, in cooperation with development partners, has begun to invest in the construction and improvement of primary health-care facilities in rural areas. However, in order to ensure access to and availability of primary and preventative health-care facilities, goods and services for all, particularly groups living in rural or remote areas, the Special Rapporteur urges Azerbaijan to increase its efforts and funding substantially to strengthen the country's primary health-care system. This should include, among other things, the training and utilization of general medical practitioners (e.g., family doctors), the continued construction and improvement of primary health-care facilities throughout the country, and the use of preventative health-care campaigns to address hygiene, sanitation, and communicable and non-communicable diseases. Strengthening the primary health-care system is necessary for full realization of the right to health in

Azerbaijan and will ensure Government expenditures on health are more efficiently spent in directly improving the population's health.

B.Input-based and alternative financing models

16.Input-based financing allocates funds throughout the health system based on overhead expenses incurred by health-care providers, such as the number of hospital beds, health worker salaries and medical equipment. Input-based financing provides incentives for health facilities to increase their capacity in order to obtain more budgetary funds without consideration of actual needs of the populations they serve. As a result, health facilities maintain excess staff, expensive medical equipment and a large number of hospital beds, which often go unused. Such facilities offer expensive curative care, but do not provide affordable primary and preventative health-care goods and services. Input-based financing also leads to rigid budgetary allocation between health facilities, as authorities may not be able to transfer funds between facilities without transferring physical resources, such as hospital beds and staff.

17.Shifting to a system of financing based on populations' health needs, demographic and socioeconomic indicators and performance outputs will promote a more equitable and efficient allocation of health funds and resources in Azerbaijan, as required under the right to health. Such financing systems often rely on capitation funding, which focuses on individuals and allocates funds based on certain characteristics, such as age, sex, health status, economic circumstances, geographic location and employment status. Funding may thus be scaled to provide more financial support to health-care facilities and providers that service groups needing the most assistance. This in turn would increase equity throughout the health system. Health financing may also be performance-based, whereby funds are allocated to health facilities and providers in accordance with the quantity and quality of the health care they provide. Performance-based financing increases levels of accountability among health workers because they must monitor the quality of the services they provide and respond to patients' needs, encouraging patients to utilize available health services. Capitation and performance-based financing models allow Governments to allocate funds for health with greater sensitivity to regional differences and local needs. This in turn promotes efficiency throughout the health system because health budgets are more closely tailored to the needs of communities rather than based upon health inputs.

18.The Special Rapporteur is pleased to note that the Government has begun to reform the country's health financing system. He encourages the Government to continue to implement financing reforms in order to promote the equitable and efficient use of health funds and resources and to ensure that health facilities, goods and services meet the needs of the community and are available and affordable within the community.

C.Out-of-pocket payments and compensation for health workers

19.Health services are legally required to be provided free of charge in public health facilities in Azerbaijan. Despite this, out-of-pocket payments, or payments for health goods and services made at the point of service delivery, including informal or so-called "envelope" payments, are pervasive throughout the health system. In 2010, out-of-pocket payments accounted for up to 70 per cent of the total spending on health in the country. The actual percentage, however, is likely to be considerably higher, given the difficulty in measuring informal payments and incomplete reporting from the private sector, including private health-care providers and pharmacies. A large percentage of out-of-pocket payments comprise expenditures on outpatient pharmaceuticals. The cost of pharmaceuticals is particularly high due to the absence of a comprehensive regulatory regime to regulate prices and facilitate the introduction of more affordable medicines, such as generic medicines, into the market.

20.The prevalence of out-of-pocket payments is due in part to extensive corruption throughout the health system. It is also a consequence, however, of the low salaries paid to doctors and other health workers. According to Government data, the average monthly salary for health workers in 2011 (164 manats) was less than half the average salary for all workers in the country (364 manats). Moreover, during his visit, the Special Rapporteur learned that doctors' salaries are often just above the national minimum wage (93.50 manats). In order to supplement insufficient salaries, doctors and health workers, as a matter of uniform practice, collect informal payments from patients in return for health goods and services. The result is an informal, unregulated system of fee-for-services. The cost of health care under a system that relies on unregulated fee-for-services paid out-of-pocket is likely to be regressive. Out-of-pocket payments for health goods and services thus disproportionately impact the poor, who must spend considerably larger proportions of their income on health care than wealthy patients. As a result, poor households may experience financial catastrophe and impoverishment due to out-of-pocket payments, resulting in a chilling effect that discourages many from seeking health care in the first place (A/67/302, para. 2). This in turn leads to the underutilization of health services throughout the health system.

21.Low salaries for health workers also contribute to low quality of health services, which erodes the population's confidence in the health system. During meetings with the Special Rapporteur, the Government acknowledged that salaries for health workers are too low, contributing to high out-of-pocket payments and low confidence in the health system among the population. The Special Rapporteur urges the Government to substantially increase salaries and reconsider existing incentive structures for health workers.

D.Mandatory health insurance

22.In order to address excessive out-of-pocket payments and increase funding for health, the Government enacted the Law on Medical Insurance in 1999. Among other things, the law provides a legal framework for a mandatory health insurance programme. The implementation of the programme, however, was initially delayed in order to avoid increased taxation of individuals and businesses during the economic reconstruction. In 2007, the State Agency on Mandatory Health Insurance was established by a presidential decree. The following year, the Concept for Health Financing Reforms and Introduction of Mandatory Health Insurance was introduced. A coordinating council of senior government officials was also established by the order of the Cabinet of Ministries. However, the mandatory health insurance programme has not yet been implemented, despite the fact that funding for the programme has been made available. Regrettably, during meetings with officials from relevant agencies, the Special Rapporteur was unable to ascertain how and when the programme will be implemented.

23.In order to ensure adequate, equitable and sustainable funding for health as required by the right to health, the Special Rapporteur encourages Azerbaijan to pool health funds collected through prepayment schemes. The mandatory health insurance programme represents one such scheme. Pooling allows for the cross-subsidization of financial risks associated with health care among different groups across large populations and reduces out-of-pocket payments for health goods and services. Cross-subsidization of financial risks protects the sick and the poor from catastrophic health expenditures and promotes universal access to good quality health facilities, goods and services that may otherwise be financially inaccessible. Prepayment schemes for health should be funded progressively through universal mandatory contributions, based on individuals' and families' ability to pay, with absolute exemptions for the poor.

24.The mandatory health insurance programme should ensure that a minimum set of health goods and services are available and universally accessible based on need under the programme. Benefits packages should be responsive to the disease burden and health needs of the population. At a minimum, they should contain effective, community-based primary health-care goods and services and safe, effective and affordable drugs, including essential medicines and generic drugs. The Special Rapporteur strongly urges the Government to prioritize the implementation of the mandatory health insurance programme in line with the right to health.

IV.Prevention, treatment and control of tuberculosis

25.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 therefore includes an obligation to prevent, treat and control tuberculosis. The control of tuberculosis includes efforts to make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, and implement or enhance immunization programmes and other strategies of infectious disease control. The right to health also requires States to ensure good-quality health facilities, goods and services are available and accessible to all on a non-discriminatory basis, particularly for vulnerable or marginalized groups. People living with tuberculosis are vulnerable as a result of stigmatization and discrimination, the high levels of poverty amongst those affected by the disease, and the greater likelihood that people living with tuberculosis are members of groups that are otherwise vulnerable or marginalized, such as prisoners and detainees and persons living with HIV. The right to health further requires the participation of affected individuals and communities in all decision-making processes impacting their health during the formulation, implementation, monitoring and evaluation of health-related laws and policies.

26.Over the last two decades, Azerbaijan has taken a number of important steps toward combating tuberculosis in the country. In accordance with WHO recommendations, in 1995 the Ministry of Health adopted the Directly Observed Treatment, Shortcourse (DOTS) programme, later expanding it to cover all provinces and districts. In the same year, the Ministry of Justice, in cooperation with International Committee of the Red Cross, instituted a pilot tuberculosis programme in the central penitentiary hospital in Baku. The programme was later expanded to cover all prisoners and detainees in the penitentiary system, in part through funding from international donors, including the Global Fund to Fight AIDS, Tuberculosis and Malaria. In 2000, Azerbaijan adopted the Law on the Control of Tuberculosis, which forms the basis for the national tuberculosis control programme. In 2005, the Ministry of Health initiated the programme "Management of Drug-Resistant Tuberculosis". In 2008, the Research Institute for Lung Diseases of Azerbaijan began developing a network of diagnostic laboratories responsible for sputum microscopy of suspected tuberculosis cases with the Institute's central laboratory in Baku acting as a reference laboratory responsible for drug-sensitivity testing. In 2010, the Government adopted a new national tuberculosis programme for 2010–2015, under which the Strategic Action Plan for 2011–2015 was adopted.

27.However, tuberculosis, multi-drug-resistant tuberculosis (MDR-TB) and extremely drug-resistant tuberculosis (XDR-TB) continue to pose a serious threat to health and human rights in Azerbaijan. WHO has designated Azerbaijan a high tuberculosis priority country within the European region. While the tuberculosis prevalence rate (177 per 100,000) is only slightly above the global average (170 per 100,000), it is more than three times the WHO regional average (56 per 100,000). More alarmingly, Azerbaijan has amongst the highest burdens of MDR-TB in the world. WHO has categorized Azerbaijan as one of 27 high MDR-TB burden countries. The estimated rate of new tuberculosis cases with MDR-TB is 22 per cent, the sixth highest in the world, and it is estimated that over half of previously treated tuberculosis cases have MDR-TB, again one of the highest proportions in the world. The gap between current diagnostic capacity and available MDR-TB and XDR-TB treatment is as high as 56 per cent, which means that treatment is unavailable for over half of people diagnosed with MDR-TB or XDR-TB in the country. Azerbaijan also has one of the highest proportions of MDR-TB cases with XDR-TB in the world in the Baku city subnational area. Moreover, it is one of only six countries that still rely on drug resistance surveillance information collected from a small set of subnational areas, despite plans to begin nationwide surveys in 2013.

28.Commendably, tuberculosis notification rates increased between 2001 and 2010 from 59.8 to 69.5 per 100,000 people, which suggests improved detection and registration. National detection of MDR-TB began in 2005 and data from the reference laboratory in Baku gained acceptance within the international community, following its inauguration in 2009. From 2010 to 2011, as the accessibility of MDR-TB and XDR-TB diagnosis increased, the number of MDR-TB and XDR-TB cases diagnosed rose dramatically from 584 to 987. However, such a drastic increase may instead indicate an increase in the number of MDR-TB and XDR-TB cases in absolute terms. This interpretation is further supported by the fact that detection and treatment success rates, only 62 and 77 per cent, respectively, remain below both WHO targets and global averages.

A.High prevalence of tuberculosis, MDR-TB and XDR-TB

29.A number of factors contribute to the high prevalence of tuberculosis, MDR-TB and XDR-TB in Azerbaijan: a lack of availability and accessibility of diagnostic and treatment services; interrupted or discontinued treatment regimes, particularly for former prisoners; inconsistent quality of diagnostic and treatment services under the DOTS programme; inadequate infection control; incomplete integration of tuberculosis services into the primary health-care system; a lack of validated epidemiological data; and stigmatization and discrimination of people living with tuberculosis.

30.The right to health requires good-quality health facilities, goods and services to be physically and economically accessible to everyone without discrimination, especially for vulnerable or marginalized groups. Diagnostic and treatment services and medicines for tuberculosis are required by law to be available free-of-charge. However, during his visit, the Special Rapporteur learned that in practice informal payments for health goods and services, including for tuberculosis treatment and medicines, are pervasive. As a result, health goods and services remain financially inaccessible for many. The inability to afford or physically access appropriate and uninterrupted treatment for tuberculosis has been shown to lower detection and adherence rates. Improper or interrupted treatment also leads to the development of drug resistant strains of tuberculosis, such as MDR-TB and XDR-TB. This is particularly a concern for prisoners living with tuberculosis who may experience interruptions in their treatment after release, as discussed below. As compared to tuberculosis, treatment services and medicines for MDR-TB and XDR-TB are more costly and less readily available, the duration of treatment is significantly longer, treatment side effects are more severe, and treatment success rates are substantially lower. The increased financial burden associated with the treatment of MDR-TB and XDR-TB further reduces financial accessibility and increases overall system costs to the Government.

31.Although the DOTS programme achieved 100 per cent coverage in 2005, the Special Rapporteur remains concerned about the quality of testing and treatment available under the programme. For example, while protocols on detection, treatment, prophylaxis, childhood tuberculosis, surgical interventions and treatment side effects are in place, some have been approved without meeting international standards as defined by WHO. Additionally, some tuberculosis medicines procured by Government funds are loose and incomplete single-drug formulations, which may contribute to the development of MDR-TB and XDR-TB. Infection control guidelines have also not been updated according to international recommendations, and criteria for the hospitalization and discharge of people living with tuberculosis do not adequately consider infection control.

32.The integration of tuberculosis prevention, treatment, and care into the primary health-care system is very limited. Primary health care provided in a community setting, in small clinics or in homes, by general practitioners and nurses may be administered in a more socially and culturally acceptable manner. Patient-centred primary health-care services are especially important for communicable diseases such as tuberculosis because appropriate methods of prevention and treatment of the disease are often misunderstood and people living with tuberculosis are frequently stigmatized. There are many health-care workers with specialized knowledge of tuberculosis in Azerbaijan, but very few of them are trained in primary health-care delivery. The skills of many health-care workers working on tuberculosis have also not been updated and some workers do not follow diagnostic protocols or apply incorrect treatment regimes, contributing to the inconsistent implementation of DOTS in primary health care.

33.The prevention and control of tuberculosis is impeded by a lack of validated epidemiological data, which is a major problem throughout the health system in Azerbaijan. Dissonance between Government statistics and data from independent sources makes it difficult to ascertain the true extent of progress made toward combating tuberculosis. This lacuna was evidenced during the visit of the Special Rapporteur and further demonstrated by the incomplete information available on tuberculosis in Azerbaijan in the WHO *Global Tuberculosis Repor t 2012* . Data from the country is unavailable for many of the indicators in the report. In particular, data concerning the prevalence of HIV/tuberculosis co-infection as well as information regarding the treatment of HIV/tuberculosis co-infection is notably unavailable. This is despite the fact that tuberculosis is a leading cause of death globally for people living with HIV. During official meetings, the Special Rapporteur was informed that the rate of new tuberculosis cases with MDR-TB in 2011 was 11 per cent. This is half the official rate reported by WHO for the same year (22 per cent), illustrating the substantial dissonance between Government and independent data. The use of epidemiological surveillance and data collection is critical to the control of tuberculosis and necessary to the realization of the right to health. The Special Rapporteur calls upon the Government to improve its epidemiological surveillance of tuberculosis and to make the data available and accessible for all, as required by the right to health.

34.The stigmatization of people living with tuberculosis in Azerbaijan is a serious concern. Stigmatization is partly rooted in low public awareness about the prevention and transmission of tuberculosis. In some instances, even health-care workers have adopted practices that contribute to stigmatization, such as disinfecting surfaces in the homes of the people living with tuberculosis, which is unnecessary to prevent the transmission of the disease. Stigmatization infringes upon the dignity of affected individuals and often leads to discrimination, interfering with the realization of their right to health. Stigmatization discourages people from being tested for tuberculosis and inhibits people living with tuberculosis from seeking treatment. The magnitude of stigmatization in Azerbaijan is often so great that people living with tuberculosis hide that fact even from their loved ones. The Special Rapporteur also learned during his visit that some individuals obtain medicines illicitly from private pharmacies and discretely engage in self-treatment in order to avoid registration on the national tuberculosis programme. Self-treatment lowers cure rates and increases chances of acquiring MDR-TB.

35.The Special Rapporteur was pleased with efforts to use the media to reduce stigma surrounding tuberculosis and to encourage testing for the disease. In particular, he notes a campaign to promote awareness and reduce stigma through a national television advertising campaign. The programme produced two public service announcements for television and a variety of other educational materials, including a video. The Special Rapporteur encourages the Government to continue its support for these activities. However, the participation of affected communities, including people living with tuberculosis and people formerly affected by tuberculosis, in such activities is still limited. The Special Rapporteur would like to emphasize that the participation of people living with tuberculosis and former tuberculosis patients is necessary to ensure sustainable and effective interventions toward eliminating the stigmatization of tuberculosis in Azerbaijan.

B.Tuberculosis in prisons

36.In contrast to the prevention, treatment and control of tuberculosis in the general population, Azerbaijan has achieved notable success combating tuberculosis in the penitentiary system. As mentioned above, the Government established a pilot programme in 1995 to address tuberculosis and later MDR-TB in prisons. The programme rigorously implemented DOTS and later DOTS-Plus, increased access to diagnostics and treatment, improved infection control and trained and employed local staff. Through technical and financial assistance from external partners, the initiative has since been expanded to cover all prisoners and detainees. Treatment and medicines for tuberculosis and MDR-TB are provided free-of-charge under the programme. As a result, the penitentiary system in Azerbaijan has one of the highest tuberculosis cure rates globally. The number of deaths due to tuberculosis in prisons has been

reduced dramatically from 465 in 1998 to 25 in 2010, and the number of prisoners with tuberculosis has decreased by almost 50 per cent from 1,012 in 2001 to 521 in 2010. The Special Rapporteur commends the Government for these achievements.

37.The administration of the tuberculosis programme in prisons was transferred to the Ministry of Justice in March 2011. In order to carry on the programme's success and ensure continued realization of the right to health for prisoners and detainees, the Government should: maintain universal availability and accessibility of diagnostics and treatment for tuberculosis and MDR-TB in prisons; ensure transparent monitoring and evaluation of the programme; and preserve existing compensation and incentive structures to retain and recruit qualified medical professionals. The Special Rapporteur, however, is concerned that the Government has not made sufficient plans to ensure adequate and sustainable funding for the programme is available following the cessation of grants from external partners. A significant decrease in funding would impact the availability of medicines, particularly for MDR-TB, and threaten the programme's ability to retain and recruit qualified personnel, which is critical to maintaining high-quality testing and treatment for tuberculosis and MDR-TB in the penitentiary system.

38.The interruption or cessation of tuberculosis treatment for prisoners after their release is a significant concern. Interruption and discontinuation of tuberculosis treatment negatively impacts infection control and leads to the development of MDR-TB and XDR-TB. A lack of coordination between prison and civilian authorities increases the incidence of MDR-TB and XDR-TB amongst former prisoners and contributes to the spread of tuberculosis and the development of MDR and XDR-TB in the general population. In order to address this problem, in 2009 the Government concluded a tripartite agreement between the Red Cross, the Ministry of Justice and the Research Institute for Lung Diseases aimed at ensuring the continued treatment of prisoners living with tuberculosis after their release from prison. Upon the departure of the Red Cross in 2011, a domestic non-governmental organization (Support to Health) was designated to continue these activities. The Special Rapporteur is encouraged by these developments and the involvement of civil society in particular. However, in order to ensure continued treatment for prisoners living with tuberculosis after their release, the Government should develop and implement a coordinated national strategy involving close cooperation between prisons, national and province-level tuberculosis hospitals and laboratories, and district-level polyclinics.

C.Financing for tuberculosis

39.Government funding for tuberculosis is increasing, in part due to the establishment of the Tuberculosis Action Fund in 2010. However, the large majority of funding for tuberculosis in Azerbaijan comes from international donors, including the Global Fund, the United States Agency for International Development and UNITAID. Dependence on external funding sources threatens the sustainability of the national tuberculosis programme. Since 2011, the Government has procured first-line tuberculosis drugs for use in the civilian sector. However, the Global Fund currently provides virtually all funding for second-line treatment for MDR-TB and XDR-TB in the civilian and penitentiary sectors, as well as all funding for first-line drugs in prisons. According to WHO, little external funding will be available for the national tuberculosis programme beyond 2013. During his visit, the Government informed the Special Rapporteur that plans are in place to account for decreases in external funding. However, the Special Rapporteur heard concerns that these plans were not fully developed. The Special Rapporteur urges the Government to take measures to ensure adequate and sustainable domestic funds are available for tuberculosis upon the departure of international funders.

V.Right to health of prisoners and detainees

40.The right to health of prisoners and detainees is protected and elaborated upon in a number of international instruments. General comment No. 14 of the Committee on Economic, Social and Cultural Rights, interpreting article 12 of the International Covenant on Economic, Social and Cultural Rights, establishes the obligation of States to refrain from denying or limiting prisoners' and detainees' access to preventive, curative and palliativehealth services (para. 34). The 1955 Standard Minimum Rules for the Treatment of Prisoners provide for standards related to the availability and accessibility of health care in prisons as well as the underlying determinants of health, such as food, sanitation and hygiene. The 1990 Basic Principles for the Treatment of Prisoners and the 1988 Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment provide for free and non-discriminatory access of prisoners to the health services available outside the penitentiary system in the place of detention or imprisonment. And the 1982 Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment declare that health workers in prisons have a duty to provide prisoners with treatment of the same quality and standard that is afforded to those who are not imprisoned or detained (principle 1).

41.The Human Rights Committee has stated that States' obligations under the International Covenant on Civil and Political Rights include "the provision of adequate medical care during detention". The Committee against Torture has declared that allegations that prisoners were not provided medical treatment amount to cruel and degrading treatment under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

42.The Special Rapporteur was informed that the Government, as part of reforms in the judicial system, has replaced the medical service of the Ministry of Justice with the newly established General Medical Department. According to information received from the Government following the visit, the Department carries out regular sanitary and epidemiological assessments in places of detention and imprisonment, and every prisoner has a right "to consult a doctor of his/her own choice" and "to be examined in one of the leading, fully equipped hospitals of the Ministry of Health". Despite this, the Special Rapporteur is concerned that these policies have not been fully implemented in places of detention and imprisonment.

43.In 2010, the penitentiary system in Azerbaijan housed approximately 37,000 individuals, amounting to a prison population rate of approximately 407 prisoners per 100,000 people. The prison population has grown considerably over the past decade, almost doubling during the last five years. Because the penitentiary system in Azerbaijan remains largely opaque, however, making an accurate assessment of the health status of the prison population presents a challenge. Based on available information, overcrowding in prisons and detention facilities throughout the country remains a significant problem and should be of concern to the Government.

Prisons are operating at over 30 per cent above over their capacity, which impacts negatively on prisoners' health, especially as relates to the spread of infectious and communicable diseases, such as tuberculosis.

44.The Government has taken steps to renovate and build new prison facilities, such as Baku Remand Prison, in an effort to alleviate overcrowding and increase prisoners' access to health services. In the last six years, the Government has also built two new medical-sanitary units in two prisons and renovated 12 Soviet-era prisons in order to meet modern standards. Following the visit, the Government reported that a number of new laboratory units had been established and old laboratories repaired and equipped with new diagnostic and surgical equipment. The Special Rapporteur commends the Government for these initiatives, but cautions against focusing too narrowly on investments in physical infrastructure and medical equipment, as it may lead to an inefficient allocation of funding, underutilization of health facilities and neglect of other financing concerns, such as compensation for health workers in the penitentiary system.

45.The understaffing of medical units in the penitentiary system is a concern in Azerbaijan. It negatively impacts the health of prisoners and detainees because it reduces the availability and accessibility of health goods and services. It further indicates that the penitentiary health system does not provide the same quality and standard of health care as is provided to the general population, as required under the right to health. Understaffing in prisons is due in large part to the insufficient compensation and incentive structure available for health workers. The recruitment and retention of qualified personnel is made more difficult by the fact that many prisons and detention centres are located in remote and difficult-to-access areas. This is compounded by the poor conditions that prevail in the penitentiary system generally. The Special Rapporteur advises the Government to increase salaries for health workers in the penitentiary system and to develop incentive structures, including education subsidies and paid living expenses, to encourage qualified personnel to enter into the field.

A.Mental health care

46.Article 12 of the International Covenant on Economic, Social and Cultural Rights recognizes that enjoyment of the highest attainable standard of mental health is central to realization of the right to health. The 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care reiterate that all persons, including persons serving sentences of imprisonment, have the right to the best available mental health care and that there shall be no discrimination on the grounds of mental illness (principle 20). States should therefore ensure equal and timely access to appropriate mental-health treatment and care for prisoners and detainees.

47.WHO has reported that mental disorders and suicide are highly prevalent in prisons and multiple factors associated with imprisonment are harmful to the mental health of prisoners. Mental health care in prisons in Azerbaijan, however, is virtually non-existent. When prisoners require mental health care, they must be transferred to external facilities or obtain care through the Ministry of Health. On two separate occasions during the mission, high-level prison administrators informed the Special Rapporteur that mental health was not a concern in prisons because inmates in their facilities do not suffer from mental illness. Moreover, during a visit to a prison, the Special Rapporteur was informed that mental-health workers were employed only as part-time staff.

48.Many factors contribute to the heightened need for mental health care in prisons: the tendency to incarcerate people with mental disorders based on a misconception that they are a danger to the public; the failure of treatment and rehabilitation or the lack of mental health care outside of prisons; and conditions within the prison environment, including experiences of violence and lack of meaningful activity, that negatively affect mental health. The lack of qualified mental-health-care professionals in prisons leads to mental illnesses remaining undiagnosed and untreated. This reduces the likelihood that prisoners suffering from mental illness will be successfully integrated into the prison population and reintegrated into the community after their release.

49.The Ministry of Health allocates only 3 per cent of its budget to mental health, of which 85 per cent is allocated to mental-health hospitals. This leaves very little funding for mental health in the penitentiary system. Moreover, there is no governing authority on mental health in Azerbaijan, which leads to a lack of coordination and oversight of the provision of mental-health care in the country. However, non-governmental organizations have recently been contracted to provide psychological consultations as part of a pilot programme in the main prison in Baku. The Special Rapporteur urges the Government to scale up such activities and develop a comprehensive mental-health strategy to enhance its understanding of and capacity to respond to the mental-health needs of prisoners in Azerbaijan. Such a strategy should involve close cooperation with community-based organizations to ensure continuity of treatment and facilitate the reintegration of prisoners into the community after their release.

B.External health facilities

50.The lack of mental health services in prisons is demonstrative of a more systemic problem within the penitentiary system: the acute need for improved access to specialized treatment for prisoners. The Special Rapporteur learned during his visit that prisoners often face difficulties in obtaining transfers to external health facilities in order to receive specialized treatment, even though the law in Azerbaijan requires such transfers under many circumstances. In some instances, prisoners in need of specialized treatment must arrange for and bear the costs of the treatment outside of prison and provide their own transportation and accommodation.

51.Prisoners and detainees are especially vulnerable due to their complete reliance on the State for food, shelter and access to health goods and services. The right to health requires States to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable groups. General comment No. 2 (2007) of the Committee against Torture on implementation of article 2 by States parties also declares the right of all persons deprived of their liberty to promptly receive independent medical assistance (para. 13). The Special Rapporteur encourages the Government to guarantee compliance with existing laws and policies in order to ensure that prisoners and detainees in need of specialized treatment unavailable in prison health facilities receive such treatment in external facilities.

C.Hygiene and sanitation

52.In spite of investments in physical infrastructure, poor sanitation and unhygienic conditions in prisons generally, and in prison health facilities in particular, remain key areas of concern in Azerbaijan. The obligation to fulfil the right to health requires States to ensure access to the underlying determinants of health, such as food and nutrition, safe water and adequate sanitation and living conditions. Prisoners and detainees are at particular risk in this regard because they lack control over their environment and must rely exclusively on the State to ensure access to underlying determinants of health. The Standard Minimum Rules for the Treatment of Prisoners recognize the importance of good hygiene and sanitation in prisons and directs health workers to regularly inspect and advise prison officials upon the hygiene, cleanliness and sanitation of the institution (para. 26 (1)). Poor sanitation and hygiene, particularly in the light of overcrowding, negatively impacts the health of prisoners and detainees, contributing to the spread of communicable and infectious diseases such as HIV and tuberculosis. Clean water supply, effective sewage and waste disposal, hygienic food preparation and general hygiene practices are all essential to a clean, healthy prison environment and to preventing and controlling the spread of disease.

53.During visits to a number of prisons, the Special Rapporteur observed that health facilities lacked basic provisions for hygiene and sanitation. Many prison latrines, including those in medical units, were unclean and in a state of disrepair, with soaps or disinfectants often absent. Poor cleanliness in prison dormitories and common areas was observed along with inadequately ventilated medical units and living spaces. Appropriate and clearly marked waste disposal protocols, including those for medical waste, were not observed in some prisons and prison health facilities. The Special Rapporteur encourages the Government to develop and implement comprehensive plans to ensure and monitor hygiene and sanitation in prisons. This should include regular inspections undertaken in a transparent way by appropriately trained personnel. Prison health workers should be utilized in this regard to inform and advise prison management on matters of hygiene and sanitation. In addition, prisoners and detainees should have access to education and basic information on hygiene and sanitation and be encouraged to report on such matters, as they are best situated to monitor and report on their own living conditions.

D.Drug use and treatment

54.The Special Rapporteur learned during meetings with Government officials that 35 per cent of prisoners in Azerbaijan are incarcerated on drug-related charges. Treatment services are available for some, but a comprehensive treatment programme has not been implemented. The Special Rapporteur was pleased to note that in one prison in Baku a needle exchange pilot programme for injecting drug users had been developed. The programme, however, had not yet been implemented at the time of his visit. The Special Rapporteur was also encouraged to learn during the visit that a draft law on HIV prevention and harm-reduction in prisons was in circulation. Harm-reduction interventions, including needle and syringe programmes and opioid substitution therapy or maintenance programmes, aim to reduce the adverse health, social and economic harms associated with the use of psychoactive drugs. WHO acknowledges the strength of evidence in favour of opioid substitution therapy in reducing drug use, criminal activity, HIV risk behaviours and transmission, as well as overall mortality. The Special Rapporteur encourages the Government to make harm-reduction services, such as needle and syringe programmes and opioid substitution therapy, available within the penitentiary system.

55.According to the national legislation, a court may order, on the basis of a report from an expert on drugs, compulsory treatment for a person who is found guilty of a crime and requires treatment for drug dependence. Such treatment is imposed in addition to penal sentence, rather than as an alternative to imprisonment, and is provided in a specialized medical institution in prison. According to the 2000 Penal Code, if drug dependency is discovered during imprisonment, the penitentiary institution may seek a court order for compulsory treatment.

56.As there is no specific regulation on voluntary drug dependence treatment in prisons, all drug dependence treatment in prisons appears to be carried out on a compulsory basis. Moreover, internal regulations provide for the possibility of compulsory drug testing of prisoners. According to the Medical Department of the penitentiary system, 2,865 prisoners were registered as receiving compulsory treatment for drug dependency in 2010. The Special Rapporteur emphasizes that the right to health includes the right to be free from non-consensual medical treatment and requires the informed consent of all who possess legal capacity be obtained prior to the administration of medical treatment. In addition, he notes that while drug dependence is a chronic, relapsing disorder that involves psychosocial and biological factors, including altered brain function, drug use alone, by contrast, is not a medical condition and may not require treatment at all. The Special Rapporteur calls on the Government to ensure the informed consent of all prisoners is obtained prior to the administration of any medical test or treatment, including for drug dependence.

VI.Conclusion and recommendations

57. The Special Rapporteur notes with appreciation the progress made in Azerbaijan since independence , i n particular, the significant reduc tion of poverty and the Government's commitment to improving the health of its people . He encourages the Government to continue health sector reforms in accordance with the right to health in order to ensur e universal access to good - quality health facilities, goods and services .

58. With regard to the health system and financing , t he Special Rapporteur recommends that the Government of Azerbaijan :

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

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

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

(d) Continue to implement financing reforms, including capitation, needs-based and/or performance-based financing models, in order to promote the equitable and efficient use of health funds and resources and to ensure health goods and services that meet the needs of the community are available and affordable within the community ;

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

(f) Develop and refine programmes to reduc e out-of-pocket expenditures, particularly for the poor ;

(g) Develop a comprehensive regulatory regime for medicine prices and facilitate the introduction of more affordable medicines , including generic medicines , into the market ;

(h) Increase salaries substantially and improve incentive structures for all health workers, in particular for health workers in rural and remote areas, in order to reduce informal payments and incentivize health workers to work in rural and remote areas ;

(i) Prioritize the implementation of the mandatory health insurance program me and ensure that : (i) it is funded progressively through universal mandatory contributions, based on individuals' and families' ability to pay, with absolute exemptions for poor, and (ii) it offers a minimum set of health goods and services, including community-based primary health care and safe, effective and affordable drugs, including essential medicines and generic drugs .

59. With regard to its efforts to prevent, treat and control tuberculosis , t he Special Rapporteur recommends that the Government:

(a) Increase funding for tuberculosis , MDR- TB and XDR-TB prevention, treatment and control in order to ensure sustainability of the n ational TB p rogram me;

(b) Ensure testing and treatment for TB, MDR- TB and XDR-TB are available free-of-charge and accessible to all, including rural and remote populations ;

(c) Ensure uniform, good quality testing and treatment services are available under the DOTS program me , including appropriate multi-drug formulations ;

(d) Ensure all tuberculosis , MDR- TB and XDR-TB protocols meet international standards ;

(e) Improve infection control by, among other things, updating guidelines in accordance with international standards and strengthening criteria for hospitalization and discharge of the people living with tuberculosis ;

(f) Integrate diagnostic and treatment services for tuberculosis fully into the primary health - care sector and ensure health workers with specialized knowledge of tuberculosis , MDR- TB and XDR-TB are trained in primary health - care delivery ;

(g) Improve the epidemiological surveillance of tuberculosis , MDR- TB and XDR-TB and make all data available and accessible in order to effectively to monitor and evaluate the national tuberculosis program me ;

(h) Take immediate steps to eliminate stigma attached to tuberculosis , MDR- TB and XDR-TB through public awareness and education campaigns about the prevention and transmission of tuberculosis , MDR- TB and XDR-TB with the participation of affected communities, including people living with tuberculosis and former tuberculosis patients ;

(i) Ensure continued success of the tuberculosis program me in prisons through universal availability and accessibility of diagnostics and treatment for tuberculosis and MDR-TB in prisons, transparent monitoring and evaluation, and preservation of existing compensation and incentive structures for health professionals under the program me;

(j) Ensure prisoners receiving tuberculosis , MDR- TB and XDR-TB treatment continue their treatment uninterrupted after release through the development and implementation of a national policy on transitioning prisoners living with tuberculosis from prisons into society ;

(k) Implement measures to ensure adequate and sustainable domestic funds are available for tuberculosis , MDR- TB and XDR-TB upon the departure of international funders.

60. With regard to the right to health of prison er s and detainees, t he Special Rapporteur recommends that the Government:

(a) Reduce overcrowding in prisons through a balanced approach that allows for the creation of additional physical infrastructure without affecting other aspects of health in prisons ;

(b) Ensure prison health facilities are adequately staffed with qualified health workers by increasing salaries, providing incentives, such as education subsidies and paid living expenses, and improving work conditions ;

(c) Develop a comprehensive mental health strategy with the participation of prisoners to respond to the mental health needs of prisoners ;

(d) Ensure the availability and accessibility of mental - health goods and services in the penitentiary system, through

increased funding for mental health and scaling-up existing pilot program me s, such as those through which non-governmental organizations are contracted to provide psychological consultations ;

(e) Ensure prisoners and detainees in need of specialized treatment un available in prison health facilities receive such treatment in external facilities free-of-charge , including subsidization of incidental expenses ;

(f) Develop and implement comprehensive plans for providing and monitoring hygiene and sanitation in prisons, including regular inspections undertaken transparently and by appropriately trained personnel ;

(g) Ensure harm-reduction services, such as needle and syringe program me s and opioid replacement therapy, are available within the penitentiary system ;

(h) Ensure the informed consent of all prisoners and detainees is obtained prior to the administration of any medical test or treatment, including for drug dependence.