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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

## 对阿拉伯叙利亚共和国的访问*

内容提要

本报告载有人人有权享有可达到的最高水准身心健康(“健康权”)问题特别报告员于 2010 年 11 月 7 日至 14 日访问阿拉伯叙利亚共和国后所得的结论和建议。在此期间，特别报告员访问了大马士革、阿勒颇和哈塞克。

此次访问的目的是为了检视叙利亚努力落实健康权的方式，为成功实现该项权利所采取的措施，以及在国家和国际一级所遇到的障碍。访问的重点是享有保健服务的相关问题，特别是针对弱势、边缘化群体和被羁押人员；特别报告员还探讨了有关妇女健康的各项问题，包括产妇保健、计划生育和基于性别的暴力问题。在报告的最后部分，特别报告员就访问期间讨论的每一个领域提出了一套建议。

* 本内容提要以所有正式语文分发。报告载于内容提要后的附件，只以阿拉伯文和提交语文分发。

# Annex

## Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his mission to the Syrian Arab Republic

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# I. Introduction

1. At the invitation of the Government, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ("right to the highest attainable standard of health" or "right to health") visited the Syrian Arab Republic from 7 to 14 November 2010.

2. While the mission considered broadly a number of issues related to the enjoyment of the right to health, the focus was on access to health care, services, goods and facilities for marginalized group as well as on health systems in the realization of the right to health.

3. The agenda for the visit of the Special Rapporteur was prepared in close cooperation with the Ministry for Foreign Affairs and the Office of the United Nations Resident Coordinator. The mission included visits to the governorates of Aleppo and Al-Hasakah. The Special Rapporteur is grateful for the valuable cooperation and assistance received before, during and after the mission.

4. During the mission, the Special Rapporteur met with the Minister of Health, Dr. Rida Said; Vice Minister for Foreign Affairs, Faysal Mekdad; Deputy Minister for Higher Education, Nizar Al Daher; the Minister for Social Affairs and Labour, Diala Al Haj Aref, a number of senior Government officials, representatives of health professionals' organizations as well as with representatives of international and civil society organizations.

5. The Special Rapporteur expresses his sincere thanks to all those whom he met for their excellent cooperation.

# II. Background

6. The independent Arab Kingdom of Syria was established in 1920 following the partition of the Ottoman Empire at the end of the First World War. Syria gained independence from France in April 1946 and was established as a parliamentary republic shortly thereafter. In March 1963, the Arab Socialist Ba'ath Party re-established Syria as the Syrian Arab Republic, ruled by President Hafez al-Assad until his death in 2000, when his son, Bashar al-Assad, succeeded him as President. Today, Syria is a lower-middle-income country, with an economy based primarily on agriculture, oil, industry and tourism. Syria was ranked 111 out of 169 countries in the Human Development Index (HDI) in 2010[1] and has risen by 0.8 per cent annually between 1980 and 2010.[2] However, this still places Syria below the regional average of Arab States.

7. The 1973 Syrian Constitution obliges the State to provide welfare services. In the last decades, notable progress has been made in the provision of basic amenities, including health care, amongst nearly all key health indicators. Syria provides medical care virtually free of charge to its citizens at Government clinics and health centres, and imposes a ceiling on charges at private hospitals. This applies to all levels of care from emergency medicine to hospital admissions, surgeries, clinical follow-up, dialysis and surgery. Syria's public health programme is based on primary health care and is delivered at the village, district and provincial level. However, infrastructure and health services in rural areas remain inadequate. Expenditure on health care continues to be relatively low with only 3.2 per cent

[1] United Nations Development Programme (UNDP), *Human Development Report 2010: The Real Wealth of Nations: Pathways to Human Development* (New York, 2010).

[2] Ibid.

of the country's GDP being spent on health care in 2008.[3] Syria does not have a health insurance system, and people usually opt for private health care, if they can afford it. A social health plan for some 750,000 public servants was introduced in April 2010, which in future should be further extended to cover pensioners and the families of public servants.

8. The Special Rapporteur commends the Syrian Government for developing a long-term, five-year coordinated strategy to ensure that all Syrians receive access to high-quality health care. This plan aims to modernize the country's health sector, improve the provision and quality of health services, develop management and technologically update the health sector, and ensure greater planning and supervision.

# III. International and national legal framework

9. Syria has ratified several international human rights treaties recognizing the enjoyment of the right to health: the International Covenant on Economic, Social and Cultural Rights (ICESCR); the International Covenant on Civil and Political Rights (ICCPR); the Convention on the Elimination of All Forms of Racial Discrimination (CERD); the Convention on the Rights of the Child (CRC); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); and the Convention on the Rights of Persons with Disabilities (CRPD). It has acceded to, but not yet ratified, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families; and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

10. Syria's legal system is based on a combination of Ottoman and French civil law. As Syria is a dualist nation, international treaties need to be incorporated into domestic law through enactment of legislation, in order for them to be made enforceable.

11. Although it is encouraging that Syria has ratified the instruments listed above, many of these treaties were adopted with reservations which, in some instances, arguably undermined the spirit of those instruments under which the international obligations were undertaken. For example, the Syrian Government initially made various reservations to CEDAW, deeming particular provisions to be incompatible with domestic and Sharia law. It is encouraging to note that these have since been removed, particularly those reservations pertaining to article 2 of CEDAW, which relates to the State party's commitment to pursue the elimination of discrimination against women in all its forms.[4]

12. The Special Rapporteur was pleased to note that the Constitution of Syria, adopted on 13 March 1973, includes a provision relating to the enjoyment of the right to health. Article 46 guarantees health care for every citizen and his family in cases of emergency, illness, disability, orphanhood, and old age. The Government has an obligation to protect citizens' health and provides them with the means of protection, treatment, and medication.[5] The State also guarantees cultural, social, and health services, and especially undertakes to provide these services at the village level.[6] Moreover, it stipulates that the State must ensure the principle of equal opportunities for citizens,[7] which is imperative for the enjoyment of

[3] World Health Organization (WHO), national health accounts database, 2008, available from http://www.emro.who.int/emrinfo/index.aspx?Ctry=syr

[4] CEDAW, "Anti-Discrimination Committee Applauds Syria's Decision to Withdraw Reservations to Women's Treaty, Urges Amending Domestic Law to Reflect Commitments", press release, 24 May 2007 (Committee on Elimination of Discrimination against Women, 785th and 786th meetings).

[5] Syrian Arab Republic, Constitution of 1973, article 46.

[6] Ibid., article 47.

[7] Ibid., article 25(4).

all human rights. However, it must be noted that an Emergency Law has been in effect since 1963, effectively suspending many constitutional safeguards for Syrians including those critical to the formation of community and other civil society groups, both of which are crucial in the development of effective, rights-based health policies.

13. The analysis in this report is based on article 12 of ICESCR, which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". This implies ensuring that health facilities, goods and services are available, accessible, acceptable and of good quality for everyone.

14. General comment 14 details the obligations of States parties under the right to health. States are required to respect, protect, and fulfil the right to health. The requirement to respect obliges States not to interfere with the right to health, while the requirement to protect calls upon States to prevent third-party interference with the right to health. The requirement to fulfil the right to health encompasses the concept of "progressive realization", requiring State Parties to undertake appropriate measures to advance the right to health moving forward, and includes the critical principle of non-retrogression, that prohibits States from engaging in activities that would result in reversal of gains already achieved in relation to the right.

15. Non-discrimination and equal treatment are fundamental elements of international human rights law, including the right to the highest attainable standard of health. States must ensure that the health system is accessible to all, without discrimination. At the same time, it must be responsive to the particular needs of women, children, older people, persons living in poverty, etc. By applying these two basic human rights principles, of equality and non-discrimination, States ensure equal access to health care for both the advantaged and the disadvantaged.

16. In order to address groups that are deemed vulnerable and those which may be discriminated against, there must be adequate information identifying these groups and their health-related vulnerabilities. This requires the collection of data disaggregated in an appropriate manner along the lines of ethnicity, gender, age, etc., in order to allow for identification of possible discrimination. The Syrian Government's commitment to providing health care to all citizens on a non-discriminatory basis is commendable. However, whilst the available health indicators may be positive, a lack of disaggregated data has prevented a complete assessment of the Syrian health sector. Without access to such data it is virtually impossible to identify whether particular problems exist.

17. The Special Rapporteur strongly believes that data collection should be more comprehensive and should include a broader range of demographic indicators to ensure the provision of health services in a non-discriminatory manner. The collection of such data, in and of itself, does not appear to contravene the provisions of the Syrian Constitution, which prohibits discrimination on the basis of race or ethnicity. Such data collection would rather allow the Government to obtain a clearer picture of whether such discrimination is occurring, and take steps to address it.

18. Community participation and consultation is an essential component of the right to health. While national health strategies and plans of action should respect, inter alia, the principles of non-discrimination and people's participation,[8] in order for communities to have genuine, measurable input into policymaking, it is necessary that such communities are able to voice their opinion on issues that they deem important and provide feedback to the Government. It is in the long-term interest of any State to include these voices, in order

[8] E/C.12/2000/4, para 54.

to improve delivery of health services, and ultimately realize its obligation to fulfil the right to health.

19. Due to the continuation of the state of emergency declared by the Government in the 1960s, the freedoms of assembly, association and expression are restricted within Syria, which inevitably has a significant impact on the enjoyment of the right to health. Members of civil society or community-based organizations that are wholly independent from the Government are rarely invited to participate in the development of health policies and programmes. The problem of insufficient community participation is particularly acute in relation to vulnerable groups such as women and ethnic minorities. This is also a particular concern in relation to HIV/AIDS, an illness for which patient empowerment and participation are particularly necessary, notwithstanding the fact that the prevalence of the disease fortunately remains low in Syria.

20. Syria's legal guarantees for the provision of the highest attainable standard of health, in terms of constitutional protections outlined above, are commendable. It is one of only four countries in the world that ensures access to medicines in its Constitution. In general, advances have been made across nearly all key health indicators, including substantial reductions in infant and maternal mortality rates which are on target to meet the respective Millennium Development Goals.[9] However, the Special Rapporteur urges the Government to take further, practical steps to ensure that the principles of non-discrimination and participation – central to realization of the right to health – are effectively promoted and adhered to.

# IV. Health system

21. Enjoyment of the highest attainable standard of health is not only a human rights issue – health is also a fundamental element of sustainable development, poverty reduction and economic prosperity. By building and strengthening effective and integrated health systems, which are instrumental for the enjoyment of the right to health, States would secure sustainable development, poverty reduction, and improved health for individuals, including the right to the highest attainable standard of health. While health systems give rise to a number of technical issues, the right-to-health approach places the well-being of individuals, communities and populations at its heart, and is interested not only in processes, i.e. providing access to medicines, or water and sanitation, but also in its processes and outcomes – how to ensure non-discrimination, participation, transparency, respect for cultural difference, etc.

22. In the last three decades, the Syrian Government has undertaken considerable work to improve the health system as a whole. The Government operates a network of clinics and health centres that provide health care free of charge to all citizens. As a result, the rate of access to health-care services among the population is very high. It is reported that close to 100 per cent of the population has access to health-care services, both urban and rural, and there is one primary health-care unit per 10,000 people. Moreover, physical accessibility of health services is impressive; the Special Rapporteur was informed that no more than an hour's drive is required to access any of the 19 hospitals in Syria, even throughout remote and rural areas.

[9] UNDP, *Syrian Arab Republic Third Country Millennium Development Goals Report 2010; see* http://www.undp.org.sy/files/FINAL253.pdf.

23. Nevertheless, expenditure on health care is still relatively low and has been decreasing in recent years, falling from 4.6 per cent of GDP in 2005 to 3.2 in 2008.[10] This is clearly becoming insufficient, particularly in light of the population growth rate, which remains at approximately 2.45 per cent annually; additionally, around 550,000 refugees seek health care in Syria, which creates a further burden on resources. Although it is commendable that the Syrian Government has been so willing to receive and accommodate refugees, and social issues are clearly considered a high priority by the Government, continuing improvement in health outcomes for both citizens and non-citizens is unlikely to occur without sufficient funding. The Special Rapporteur hopes that funding for this sector will be revised in the upcoming five-year plan, as he was informed during his mission.

24. One of the concerns noted about Syria's health-care system is maintaining health-care services of sufficient and consistent quality to its citizens. Although health-care services are very accessible because they are free of charge, this constitutes a challenge to maintenance of an acceptable quality of health-care delivery. Currently, neither hospital accreditation nor continuous medical education is required in Syria, and the growth of the largely unregulated private sector continues to outstrip that of the public sector.[11]

25. The proposed introduction of health insurance, initially only for public service officials, may serve to increase access to health-care goods and services, although some concerns have been voiced in respect of its introduction. These include the fact that out-of-pocket private expenditure is already capped at certain rates, which renders private health care relatively affordable for those that prefer to utilize it and have the means to do so, and reduces the pressure on the public system.[12] This effectively obviates the need for insurance in most cases, other than in respect of unforeseeable and costly medical events, for which insurance could be used effectively as a supplement. It remains to be seen how introduction of comprehensive insurance would effectively increase access to services, as well as improve the quality of services available.

26. Irrespective of whatever model of health insurance is proposed, the Special Rapporteur urges that the most poor and marginalized members of the community are proactively provided for. For instance, he was informed that primary health care will continue to be provided free of charge, which is a welcome decision. Ultimately, the introduction of insurance or otherwise will not obviate the need to introduce consistent quality-control mechanisms to both the public and private sector.

27. The pharmaceutical industry is one of the success stories in Syria. In 1970, only 6 per cent of drugs were manufactured locally and 94 per cent were imported. In 2005, however, 90 per cent of drugs were manufactured locally and 10 per cent were imported.[13] Syria is now a major exporter of essential medicines to the Middle Eastern and North African region. However, Syria has just begun initial negotiations to join the World Trade Organization (WTO). Accession to the WTO will require Syria to change its intellectual property law to be compliant with the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The Syrian Government must ensure that during this process it avails itself of all the appropriate flexibilities in its new intellectual property law in order to

[10] World Bank, Expenditure on Health (percentage of GDP), World Development Indicators database, see http://data.worldbank.org/data-catalog/world-development-indicators.

[11] H. Bashour and A. Abdulsalam, "Syrian Women's Preferences for Birth Attendant and Birth Place", *Birth*, vol. 32, No. 1 (2005), pp. 20-26.

[12] B. Al-Khatib, "Can Private Health Insurance Improve Health Care in Syria?" Indiana University School of Medicine (2006), p. 30.

[13] B. Al-Khatib, "Health Profile of Syria, 2006", Indiana University School of Medicine, 2006. p. 34.

assure that its current generics sector is not weakened and continues to provide high-quality, low-cost medicines within Syria, and the wider region.

# V. Women's and children's health

## A. Women's health

28. The right to health, as it pertains to women, is provided for in various international instruments, including CEDAW. Article 12 obliges States Parties to take all appropriate measures to eliminate discrimination against women in order to ensure access to health-care services, including those related to family planning, and further urges States to ensure women are provided with appropriate services in connection with pregnancy, as well as adequate nutrition during pregnancy and lactation.

29. General comment 14 of the Committee on Economic, Social and Cultural Rights also notes the need to implement a comprehensive national strategy for promoting women's right to health, and to eliminate discrimination against them. This strategy should include interventions concerning prevention and treatment of diseases affecting women, as well as policies concerning access to high-quality and affordable health care, including sexual and reproductive health services. Furthermore, the general comment notes that the State should protect against particular female health risks, especially maternal mortality and domestic violence, and should remove barriers relating to education and information, including in the area of sexual and reproductive health.

30. Sexual and reproductive health rights are considered to be integral elements of the right to health.[14] Following the 1994 International Conference on Population and Development in Cairo, and the 1995 Fourth World Conference on Women held in Beijing, the right to reproductive health is considered to include the ability to have a satisfying and safe sexual life, alongside the capability to reproduce and the freedom to decide if, when and how often to do so.

31. Syria's Constitution provides that "citizens are equal before the law in their rights and duties" (article 25), and explicitly guarantees women "all opportunities enabling them to fully and effectively participate in the political, social, cultural, and economic life" (article 45). Despite this constitutional guarantee, and the fact that men and women are equally paid for equivalent work in Syria, the Special Rapporteur remains concerned that problems concerning the investment in, and empowerment of, women in Syria persist and ultimately have health-related implications.

32. The right to health also depends upon the realization of other human rights, such as the right to education, and its attainment is strongly correlated to poverty risk in Syria. Nearly 20 per cent of the poor population is illiterate, and in turn, poverty is most severe in the illiterate population, with more pronounced rates in rural areas.[15] There is a vicious cycle in Syria, and worldwide, wherein poverty leads to lower educational attainment, and vice versa, which is particularly pronounced amongst women. The interaction between poverty and gender results in low school enrolment rates amongst poor girls, and high rates of illiteracy.[16]

[14] Commission on Human Rights resolution 2003/28.
[15] UNDP, *Poverty in Syria: 1996-2004* (Damascus, 2005), p 1.
[16] Ibid., p 2.

33. Young women in Syria are also less than half as likely to participate in the labour force compared to young men, and are nearly twice as likely to be unemployed.[17] By age 29, some 73 per cent of women are economically inactive. However, activity rates amongst women who have completed primary and post-secondary education are significantly higher (36 per cent and 80 per cent, respectively).[18] These figures indicate just one area in which the importance of educational attainment for women is paramount.

34. These circumstances ultimately have a harmful impact on the health of women in a myriad of ways including, inter alia: reducing the ability to obtain and comprehend health-related information; limiting the financial resources available to access health-care goods and services; curtailing the ability of the State to broadly deliver appropriate sexual and reproductive education, and so forth. A relative lack of sexual and reproductive education has also been linked to high rates of maternal mortality, early marriages and sexually transmitted infections. Concern has been expressed that young people in Syria are less informed regarding these matters than their counterparts in other countries of the region.[19]

35. The low rates of school enrolment amongst women are particularly concerning in light of the fact that sexual and reproductive education is more likely to occur in the context of the school system. The reluctance of young people in the region to seek information about sexuality and reproduction from their parents, and a lack of preparedness on the part of parents to discuss sexuality makes school-based sexual education even more important.[20] This is also relevant in respect of other health-related information, particularly that concerning food and nutrition, which will be discussed in the context of children's health (see para. 45).

## B. Maternal health

36. It is encouraging to note that Syria's maternal mortality rate was estimated at 58 deaths per 100,000 births in 2008, a significant decrease from the rate of 130 estimated by interagency groups in 2005.[21] Although Syria is on target to achieve Millennium Development Goal 5, the greatest room for improvement is in regard to Syria's high fertility rate. This remained at 3.8 births per woman in 2008, although the general trend is towards further reduction. A high fertility rate represents an independent risk for increased maternal mortality rates,[22] and failure to contain the total fertility rate in Syria jeopardizes progress in further reducing the maternal mortality rate. Moreover, the adolescent fertility rate remains at 59.5 births per 1,000 women between the ages of 15-19, which is higher than the regional average.[23]

37. Additionally, a divide between urban and rural centres persists in respect of all health-related outcomes, but is particularly evident in the area of maternal health. By way of example, in Al-Raqqa, the highest maternal mortality rate for the country is recorded, at 78.25 deaths per 100,000 live births, whereas the lowest rate is recorded in the governorate

[17] N. Kabbani and N. Kamel, "Youth Exclusion in Syria: Social, Economic, and Institutional Dimensions", *Middle East Youth Initiative Working Paper*, No. 4 (September 2007), p. 6.

[18] Ibid., p 6.

[19] J. DeJong et al,, "Young People's Sexual and Reproductive Health in the Middle East and North Africa", *Population Reference Bureau*, 2007, p. 2.

[20] Idem.

[21] WHO, *World Health Statistics 2010* (Geneva, 2010), p. 68.

[22] C. Ronsmans and W. Graham, "Maternal Mortality: who, when, where and why" *Lancet,* vol. 368, No. 9542 (2006), p. 1189.

[23] World Bank, "World Development Indicators", 2008, see http://data.worldbank.org/data-catalog/world-development-indicators.

of Damascus, at 33.08 deaths.[24] Some of the reasons noted for this difference in outcomes include economic and educational levels, as discussed in the former section, and a higher ratio of home births, and births attended by traditional midwives. Similarly, in Tartus 100 per cent of births are attended by skilled health personnel, in comparison to around 80 per cent of births in Hasakeh.[25] These figures are encouraging, but indicate that more work remains to be done, including the promotion of birth spacing and other methods of family planning.

38. The Special Rapporteur was pleased to note the increase in the uptake of prenatal care amongst pregnant women. Currently, around 84 per cent of women attend at least one prenatal visit before delivery, whereas surveys conducted in Syria in 2001 and 1993 showed that 70.9 per cent and 50 per cent of women respectively had attended such visits.[26] However, only 42 per cent of women were recorded as attending at least four prenatal visits over the 2000-2009 period.[27] This indicates a need for more comprehensive coverage, and may require a re-examination of the systems employed in ensuring all pregnant women are appropriately followed up throughout the period of pregnancy.

39. The Special Rapporteur is also concerned that, despite the intention to ensure increased access to prenatal care, and promotion of adequate health care during pregnancy, the postpartum period does not receive as much attention, and more needs to be done to ensure the continuing health of mother and child after birth. There is currently a paucity of data around the birth weight of children; although 70.4 per cent of children are now delivered in institutional facilities, only 47.9 per cent of children are weighed at birth.[28] There is a need to develop and use more indicators related to post-partum health care, as well as to collect disaggregated data in this regard (for instance, relating to the nutritional status of the mother). The Special Rapporteur would particularly welcome the development of programmes within communities for new mothers, which would result in empowerment of these women, and ensure that their health is not neglected due to the increased focus on their children in the post-partum period.

40. Some particularly promising initiatives have been undertaken by the Syrian Women's Union, including establishment of 26 health centres specifically for women, a number of which are located in rural areas. The Syrian Government should consider taking additional steps to improve maternal health such as fortification of flour with folic acid, along with the current iron fortification programme, and promotion of other methods to combat anaemia, which remains a significant problem in the region. Despite efforts to tackle it, the prevalence of iron-deficiency anaemia amongst women of child-bearing age remains at around 40 per cent,[29] which poses a risk in relation to post-partum haemorrhage (one of the major causes of maternal mortality) alongside its general health implications.

41. The Special Rapporteur is concerned about a great number of early marriages in Syria. As of 2006, around 18 per cent of married women were married before the age of 18. However, this rate has decreased, and the proportion of women between the ages 15-19

[24] Syrian Arabic Republic, "Syrian Arab Republic Third Country Millennium Development Goals Report" (2010), p. 27; see http://www.undp.org.sy/files/FINAL253.pdf.

[25] Syrian Arabic Republic, "Syrian Arab Republic Third Country Millennium Development Goals Report" (2010), p. 28; see http://www.undp.org.sy/files/FINAL253.pdf.

[26] B. Al-Khatib, "Health Profile of Syria, 2006", Indiana University School of Medicine, 2006. p. 26.

[27] WHO, *World Health Statistics 2010* (Geneva, 2010), p. 94.

[28] Central Bureau of Statistics & UNICEF, "Syrian Arab Republic Multiple Indicator Cluster Survey 2006" (February 2008), pp. 5, 32.

[29] K. Bagchi, "Iron Deficiency Anaemia – an old enemy" *La Revue de Santé de la Méditerranée orientale,* vol 10, No. 6 (2004), p. 756.

who are currently married is now around 10 per cent,[30] which is a commendable development. Nevertheless, the health implications of child and early marriages include early pregnancy (which, in turn, may result in social isolation and compromised development) and curtailed educational and vocational opportunities which both directly and indirectly hinder the full enjoyment of the right to health.

42. Furthermore, the Special Rapporteur was informed of some consideration of lowering the marriage age limit for females to 15 years. At present, Syria's Law of Personal Status sets the minimum age of marriage as 18 years for males and 17 for females. However, the Special Rapporteur is concerned that marriages may be entered into under these ages upon application to a judge (at 15 or 13 respectively).[31] Article 16 of CEDAW, related to the right to protection from child marriage, stipulates that "The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage." However, Syria's reservations concerning this Article still remain, and the Special Rapporteur strongly encourages the Government to urgently withdraw this reservation.

## C. Family planning

43. Contraceptive prevalence amongst married women stands at 58.3 per cent, which is higher than the regional average. Uptake varies significantly between governorates –highest in Sweida (74.9 per cent) and lowest in Al-Raqqa (33.7 per cent) – and is also strongly correlated with educational attainment level. Some 70 per cent of women who have completed higher education use contraceptives, in contrast to 65.3 per cent of women having completed secondary education, 57.5 per cent primary education, and 45.2 per cent with no education.[32] These figures demonstrate the importance of education and confirms that more needs to be done in respect of promoting family planning and methods of birth control.

44. The current unmet need for contraceptives stands at approximately 11 per cent.[33] To successfully increase utilization of family planning services throughout the country, the State must note women's preferences, and promote culturally appropriate interventions. For instance, the most popular method of contraception amongst married women in Syria is the intra-uterine device, used by 25.7 per cent of women, with the combined oral contraceptive pill accounting for 12.9 per cent of contraceptive usage amongst married women.[34] The Government should facilitate active participation of women in developing appropriate family planning services.

## D. Gender-based and family violence

45. The Special Rapporteur is very concerned by the lack of awareness regarding gender-based violence within the Government and wider community. Although it may

[30] Central Bureau of Statistics & UNICEF, "Syrian Arab Republic Multiple Indicator Cluster Survey 2006" (February 2008), p 52.

[31] J. Nasir, *The Islamic Law of Personal Status,* 2nd ed. (London, Graham & Trotman, 1990) p. 48.

[32] Central Bureau of Statistics & UNICEF, "Syrian Arab Republic Multiple Indicator Cluster Survey 2006" (February 2008), p. 42.

[33] Central Bureau of Statistics & UNICEF, "Syrian Arab Republic Multiple Indicator Cluster Survey 2006" (February 2008), p. 42.

[34] Central Bureau of Statistics & UNICEF, "Syrian Arab Republic Multiple Indicator Cluster Survey 2006" (February 2008), p. 42.

involve persons of any gender, gender-based violence directed towards women is defined by the United Nations as "any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".[35] Family violence is more broadly defined, and can involve older persons and child abuse as well as violence caused by intimate partners.

46. Although the prevalence of "honour killings" and other extreme violence directed towards women is lower in Syria than throughout the region, it is estimated that 40 to 200 honour killings are still committed annually in Syria.[36] Due to the lack of official data, it is difficult to estimate the extent of these problems, even though their presence is widely acknowledged. A study conducted by UNDP in 2006 revealed that nearly one in four married women in Syria has been physically abused.[37] It is disturbing that little to no attention has been paid to these issues. The Special Rapporteur notes with regret that, throughout the mission, when the topic of gender-based violence was raised, the responses of various actors were often misguided or ill-informed.

47. During the mission, the Special Rapporteur was advised that establishment of a Family Protection Unit has been considered, alongside governorate-based observatories for domestic violence, but that little progress has been achieved in this area. It remains unclear which Governmental department should take responsibility for its creation and administration, as well as prepare a plan devised to raise awareness of its operation. A mechanism to report violence and take action needs to be established as a matter of urgency. Alongside this, legislative reform is clearly called for, given the number of lacunae and inconsistencies within the present legislation.

48. Although the Penal code of 1949 currently provides for the protection of women from verbal and physical harassment and violence, there are few provisions which protect women from violence in the domestic sphere, or other intimate or familial relationships. The Special Rapporteur is pleased to note that Article 548, regarding the waiver of punishment where alleged misconduct on the part of the woman in question led to the perpetrator's actions, has recently been abolished, and a provision enacted relating to "honour crimes", allowing for a prison sentence of 7 years. However, the replacement article still allows for mitigation of punishment, which is troubling, and other articles still remain concerning violence occuring in a situation where a contract for marriage is concluded with the perpetrator, wherein there is room for no charges to be laid, or a sentence commuted or reduced.

49. In order to comprehensively address the issue of gender-based violence, much more than legislative change is required to ensure the protection of women. Long-term changes in attitude can only be brought about when the problem is recognized as such. Adequate attention must be given to prevention, treatment and rehabilitation of both victims and perpetrators of gender-based violence. Access to justice for victims must be ensured through establishment of processes to address this issue directly, and promotion of educational initiatives designed to raise awareness of gender and family-based violence and its broader implications. The Special Rapporteur strongly believes that issues related to gender-based and family violence should be urgently addressed and urges the Government to do so.

[35] A/RES/48/104.
[36] Human Rights Watch, "Syria: No exceptions for 'Honour Killings'", 28 July 2009.
[37] K. Zoepf, "Syria's First Study of Violence Against Women Breaks Taboo", *New York Times*, 10 April 2006.

## E. Children's health

50. Children's health in Syria has seen some important advances over the recent decades. The under-five mortality rate was most recently estimated at 16 deaths for every 1,000 live births,[38] falling from a previous rate of 41.7 in 1993.[39] The infant mortality rate currently stands at 14 deaths per 1,000 live births, which has fallen from 30 in 1990,[40] and is estimated to have decreased by 75 per cent since 1980. These achievements are all in line with the Millennium Development Goals concerning children's health, adopted in September 2000, and the Plan of Action of A World Fit for Children, adopted by 189 Member States of the United Nations in May 2002. The most pressing concerns regarding children's health in Syria are again related to the underlying determinants of health, most particularly, access to food and food security.

## F. Nutrition

51. One of the major problems concerning children's health is that of malnutrition and stunting. The prevalence of these issues has risen largely as a result of the recent drought, Syria's worst drought in over four decades, which is now heading into its fourth consecutive year. Although the problem is largely concentrated in rural areas of Syria – over 95 per cent of those affected are from the governorates of Al-Hassake, Dayr az Zawr and Al-Raqqa[41] – it is nevertheless an issue that needs to be addressed nationwide. Rising food and fuel prices, alongside the continuing effects of the global financial crisis, place the most vulnerable people outside these governorates at risk as well.

52. In areas directly affected by the drought, food shortages have led to insufficient food intake and poor diet. The food intake of 80 per cent of families assessed by the United Nations was comprised solely of bread and sweetened tea, and meals for children reduced to two per day.[42] Some 42 per cent of children in Al-Raqqa between the ages of six to 12 months were recorded as anaemic.[43] Moreover, in drought-affected areas, there has been an increase in the number of children attending medical centres for treatment of waterborne diseases, as well as nutrition-related illnesses.[44] According to medical professionals consulted during the mission, the incidence of marasmus and kwashiorkor (diseases resulting from inadequate nutrition and protein intake, respectively) has also risen markedly since the beginning of the drought. The longer-term health-related sequelae of malnutrition and these associated illnesses are profound, and include, inter alia, immune compromise, growth retardation, and delayed mental development.

53. Throughout Syria, around 10 per cent of children under the age of five are currently recorded as being underweight.[45] In 2006, the prevalence of moderate stunting was 22 per cent, and 10 per cent of children were considered as severely stunted for their age.[46] These

[38] WHO, *World Health Statistics 2010* (Geneva, 2010), p. 24.
[39] Syrian Arabic Republic, "Syrian Arab Republic Third Country Millennium Development Goals Report" (2010), p. 21; see http://www.undp.org.sy/files/FINAL253.pdf.
[40] WHO, *World Health Statistics 2010* (Geneva, 2010), p. 55.
[41] United Nations, "Syria Drought Response Plan 2009-2010: Mid-Term Review" (February 2010), p. 1.
[42] Ibid., p 5.
[43] United Nations, "Syria Drought Response Plan 2009" (August, 2009), p. 9.
[44] United Nations, "Syria Drought Response Plan 2009-2010: Mid-Term Review" (February 2010), p. 11.
[45] WHO, *World Health Statistics 2010* (Geneva, 2010), p. 23.
[46] Central Bureau of Statistics & UNICEF, "Syrian Arab Republic Multiple Indicator Cluster Survey 2006" (February 2008), p. 25.

problems concerning nutrition illustrate that the right to health is closely related to, and dependent upon many rights, but in particular to the realization of the right to food. An adequate supply of safe food and nutrition is vital to achieve this right. However, this is not simply a matter of ensuring that an adequate quantity of food is supplied to persons in need. More efforts need to be taken to ensure the education of families, particularly mothers, around infants' and children's nutritional requirements. Data indicates that children of mothers who have attended secondary or higher education are the least likely to be underweight and stunted, in comparison to children whose mothers received no education.[47]

54. The Special Rapporteur also notes that more needs to be done to promote infant nutrition, particularly breastfeeding for infants up to the age of six months. It is of particular concern that a number of common misconceptions result in repeated patterns of malnutrition amongst children: for instance, the practice of drinking tea from infancy onwards.[48] The percentage of children who are adequately fed from birth up to 11 months is only around 25 per cent, and only 29 per cent of infants aged less than six months are exclusively breastfed in Syria.[49] Again, marked differences in outcomes are noted between governorates, with Lattakia recording the best outcomes for adequate feeding between 0 and 11 months (37 per cent), and Hassake the worst (16 per cent).[50] It is encouraging that a nutrition surveillance programme has been recently established, but efforts need to be made to expand its reach to allow for comprehensive recording of the problem, particularly in the north-eastern governorates.

# VI. Right to health and stateless persons, and refugees

55. Syria is home to dozens of ethnic, linguistic, and cultural groups. While ethnic Arabs constitute about 80 per cent of the population, many other groups, such as Syrian Kurds, Turks, and Druze, make up substantial minority populations. Along with these minority groups who are considered to be Syrian nationals, Syria is currently home to millions of refugees from the occupied Palestinian territories, Iraq, Somalia, and elsewhere.

56. The principle of non-discrimination requires that all health services, goods and facilities must be accessible to all, including refugees, internally displaced persons, minority populations, and stateless persons. However, the Special Rapporteur received personal testimonies that alleged discrimination based on ethnic origin or status.[51]

57. This section will discuss two such groups: approximately 300,000 Syrian of stateless approximately and millions of Iraqi refugees who fled to Syria in the aftermath of the 2003 United States-led invasion of Iraq. The Constitution of Syria guarantees equal status to all people, regardless of their background, and does not allow for discrimination on any grounds when it comes to the provision of health goods and services. The Special Rapporteur notes with regret that in some instances due to their status a number of non-citizens persons do not have equal access to health care, goods and services as Syrian nationals.

[47] Central Bureau of Statistics & UNICEF, "Syrian Arab Republic Multiple Indicator Cluster Survey 2006" (February 2008), p 26.

[48] R. Sixsmith, "Alongside Syrian health workers, UNICEF battles varied causes of malnutrition", 18 August 2010. Available from http://origin-www.unicef.org/infobycountry/syria_55611.html

[49] Central Bureau of Statistics & UNICEF, "Syrian Arab Republic Multiple Indicator Cluster Survey 2006" (February 2008), pp. 29-30

[50] Central Bureau of Statistics & UNICEF, "Syrian Arab Republic Multiple Indicator Cluster Survey 2006" (February 2008), p. 30.

[51] E/C.12/1/Add.63, paras. 13, 15, 23.

## A. Syrian Kurds

58. The Special Rapporteur was informed that there are somewhere between 25-30 million Kurds around the world, and they constitute one of the largest ethnic groups in the Middle East and North African region. The 1923 Treaty of Lausanne partitioned the former Ottoman Empire, and left the Kurdish population without a self-governed State. As a result, sizeable Kurdish minorities exist in modern-day Iran, Iraq, Turkey and Syria.[52] In Syria, disaggregated date based on ethnicity is not officially collected by or available from the Government, and as a result it is difficult to obtain accurate numbers concerning the number of Syrian Kurds or any other minority group. However, estimates indicate that the Kurds in Syria account for approximately 8 to 15 per cent of the population.[53]

59. Over the course of the mission, the Special Rapporteur was told on numerous occasions by Government officials that, generally, Kurds in Syria are treated no differently than other Syrians. However, at the same time, many of these sources acknowledge that a sizeable group of stateless Kurds often face great difficulties in accessing health care, goods and services due to their statelessness, primarily because they lack proper forms of identification or have identification that makes clear their status as stateless.

60. In the 1960s, the Government began a process known as "arabization", which sought to expand the influence and assert the primacy of Arab linguistic cultural traditions throughout the whole of Syria. As a complement to this process, in 1962, the Government mandated an impromptu census, unofficially known as the "Hasakah Census".[54] As a result of this census, somewhere between 120,000 and 150,000 Kurds were divested of their Syrian citizenship and effectively rendered stateless.[55] The Syrian Government's justification for doing so was to claim that this particular population of Kurds illegally entered Syria from Turkey and were therefore not Syrian nationals. However, there are numerous examples from immediately after the Hasakah Census where, even within nuclear families, people were given differing citizenship status. Today, this group's numbers have grown to approximately 300,000; this is only an estimate.[56]

61. Within Syria, there are two groups of stateless Kurds, known as *ajaneb and maktumeen*.[57] The *ajanib*, consisting of approximately 200,000 people, have been given red identity cards, which allows them a degree of access to medical facilities, goods, and services generally similar to that of other Syrian citizens. Of greater concern is the remaining group of approximately 100,000 people, *maktumeen*, who have no form of identification at all, and therefore their access to health care, goods and services is limited. As previously stated, due to the lack of disaggregated data, assessing the real size of the affected population is very difficult.

62. Reports regarding whether identification is necessary to access health goods and services are often contradictory. While it does not seem that identification must be presented to receive emergency care in public health centres, beyond this initial acceptance, specialized treatments (i.e. treatment for chronic diseases, cancer etc.) and care are often reported to be inaccessible. In visits to primary care facilities in Aleppo and Al-Hassake, the Special Rapporteur repeatedly asked staff whether any identification was necessary for

[52] Refugees International, *Buried Alive: Stateless Kurds in Syria*, January 2006, p.1.
[53] Ibid.
[54] Harriet Montgomery, *The Kurds of Syria: An Existence Denied, European Centre for Kurdish Studies*, 2005, p. 9.
[55] Ibid.
[56] See A/HRC/16/49/Add 2, para. 48.
[57] Ibid.

the purposes of treatment, and on all occasions the staff said it was not. While identification may not be required for the purposes of accessing treatment in Syrian public health-care centers per se, at various points the lack of such identification may pose a significant obstacle to access health care. For example, in the case of a traffic accident an identification document will be required in order to access health care and file a report. People without identification are therefore easily identified as Kurds and "non-Syrians" and to that extent are vulnerable to discrimination, as would be the case for many minority populations.

63. Lack of identification documents often negatively affects enjoyment of other rights that are closely related to the enjoyment of the right to health. In reporting to the Committee on Economic, Social, and Cultural Rights the Syrian Government indicated that in order for children to enroll in primary school proof of the parents' citizenship or legality of stay in Syria is needed. [58] Moreover, stateless persons are not allowed to work in Syria. Restrictions and limitations on education, work, and other relevant factors obviously have a detrimental impact on the enjoyment of the right to health. Moreover, the Special Rapporteur notes that, under international customary law, everyone has a right to nationality and a right not to be arbitrarily deprived of his or her nationality[59].

64. The Syrian Government, in particular its President, has repeatedly acknowledged the situation regarding persons without any form of identification and has also signalled his intention to resolve the situation.[60] The Special Rapporteur commends these commitments, and hopes that concrete action is immediately taken to improve the situation of many persons whose enjoyment of fundamental rights has been impeded. In the Special Rapporteur's opinion, this situation would take little time to correct, but would have a tremendous positive impact on the full enjoyment of human rights, including the right to health, of hundreds of thousands of people.

## B. Refugees

65. Historically, Syria has been very welcoming to refugees such as Palestinian and Somali refugees. Since the middle of the 20th century, the country has been home to over a million Palestinian refugees and many other groups. Since the United States-led invasion of Iraq in 2003, it is estimated that over a million Iraqis have fled Iraq for Syria.[61] In each of these instances, and in particular after the 2003 Iraq War and ensuing sectarian conflict, Syria has done a commendable job ensuring the enjoyment of the right to health of these groups considering the limited resources at its disposal.

66. The Office of the United Nations High Commissioner for Refugees (UNHCR) has currently registered approximately 126,000 Iraqi refugees.[62] This number is, of course, down from peak numbers, which were much higher five to six years ago. However by most accounts, the current registration number greatly underreports the actual number of Iraqis that remain in Syria. Borders between the two countries are still rather porous, leading to

[58] E/C.12/2001/SR.34, para. 30

[59] Art. 15 of the Universal Declaration of Human Rights, Yean and Bosico v. Dominican Republic, Inter-American Court of Human Rights, judgement of 8 September 2005, Series C, No.130.

[60] Bashar al-Assad, second inaugural speech, July 17, 2007.

[61] Ashraf al-Khalidi, Victor Tanner, and Sophia Hoffmann , "Iraqi Refugees in the Syrian Arab Republic: A Field-Based Snapshot," Brookings Institution-University of Bern Project on Internal Displacement, 11 June 2007.

[62] UNHCR, "2011 UNHCR country operations profile - Syrian Arab Republic, 2011 UNHCR planning figures for the Syrian Arab Republic".

ongoing movement of peoples between the two nations, although almost entirely from Iraq to Syria.

67. The size of the refugee population in Syria poses problems for the Government. These problems are, in part, alleviated by an extensive network of international support. The Syrian Arab Red Crescent (SARC) and UNHCR have been providing Iraqi refugees with health services at local centres established, in part, just for this purpose. Care at these facilities is largely subsidized by UNHCR and Iraqis, so long as they are registered with UNHCR, pay only 25 Syrian pounds (approximately 50 US cents) per consultation. The Special Rapporteur was told by staff at these centres that Iraqis could also seek out care at Syrian public health-care facilities in the same manner as Syrian nationals would.

68. Moreover, although the primary health-care system provides a temporary solution to many primary health problems, longer-term solutions to the situation are still very much lacking. For example, work permits are not given to refugees and asylum seekers in Syria, making them completely dependent on international assistance for their basic needs.[63] The Iraqi refugee population in Syria is now mostly urbanized and no longer live in camps. Their inability to work creates a serious obstacle to access and community integration.

69. While delivery of primary health-care services may be handled adequately, many expensive, but necessary medical procedures, goods and medical devices are often not covered by the UNHCR and SARC centers. There are many examples of refugees needing prosthesis and other costly medical devices or procedures that must rely on charity and donation because such services and goods are too expensive to be covered by international assistance programmes.[64]

70. In general, the support of the Syrian Government in providing health care, goods and services for the very large Iraqi population living in Syria has been commendable. Not only has the State provided logistical support for these persons through assistance and facilitation of the SARC/UNHCR centers, but it also claims to allow Iraqis to be treated in Syrian public health-care facilities in the same way that Syrians are largely free of charge.

71. Due to continuing instability and violence in Iraq, the number of Iraqis returning home remains at a very low rate. Regardless of the cause, if Iraqis continue to remain in Syria, long-term solutions need to be found to ensure their access to health care. Coupled with Syria's extremely high fertility rates, the permanent addition of Iraqis to the national population will place an additional burden on an already strained public health system.

# VII. Right to health and persons in detention

72. The Special Rapporteur would like to thank the Syrian Government for facilitating the visit to Adara prison in Damascus, and its medical facilities. It is of great importance that the Syrian prison system is becoming gradually open to international scrutiny. Remaining in the scope of his mandate, the Special Rapporteur will confine his comments and analysis only to the enjoyment of the right to health of persons in detention. That said, the Special Rapporteur would like to encourage the Syrian Government to extend invitations and allow other special procedure mandate holders similar opportunities in the future.

[63] World Food Programme/United Nations High Commissioner for Refugees/Syrian Arab Red Crescent/Syrian State Planning Commission Joint Mission, Refugees in Syria, June 2009, p. 3.

[64] IRIN news service, "SYRIA: Iraqi refugees face painful wait for artificial limbs," 10 December 2010.

73. The enjoyment of the right to health implies that incarcerated persons are not to be discriminated against, and should receive special care in light of their vulnerability. General comment 14 indicates that the State has a specific legal obligation to respect the rights of prisoners, detainees, and other incarcerated persons, which includes abstaining from enforcing or promoting discriminatory practices. As prisoners are under complete control of the State, this applies to them during the entire period of incarceration.

74. The Standard Minimum Rules for the Treatment of Prisoners, an internationally agreed-upon set of guidelines regarding persons held in prisons and other forms of custody, also indicate the standard of health care which those incarcerated should receive.[65] Rules 22 through 26 make clear that prisons should follow certain procedures and provide certain services. The rules provide for the attendance of qualified medical and dental professionals servicing the institution; examination of prisoners upon admission, and whenever necessary thereafter; reporting of prison conditions by doctors to the director; and other similar matters.

75. Multiple Government ministries are responsible for the provision of health-care goods and services for the prison system. The Ministries of Interior and Health provide medical personnel and the Ministry of Social Affairs provides services of social workers. All information regarding the prison's health-care workers was provided to the Special Rapporteur directly by the staff.

76. The prison that the Special Rapporteur was allowed to visit – the Adara prison, in Damascus – generally accommodates between 7000 and 8000 persons at any given time. There are 25 medical professionals on site. The breakdown of these health-care workers is as follows: two general physicians, three dentists, and 16 nurses are provided for by the Ministry of Interior; two doctors are allotted by the Ministry of Health; and a rotating group of specialists all work in the facility. The specialists include a cardiologist, ophthalmologist, psychologist, and others, all of whom visit the hospital separately on different days of the week.

77. Additionally, the prison has three lab technicians and a radiology unit for in-house diagnosis. In case of emergencies, the prison has four ambulances that take prisoners to the nearby health center for treatment. There is also an emergency doctor on prison grounds at all times. It is reported that there were generally between 15 – 25 emergencies daily. The Ministry of Social Affairs provides five social workers on-site to cover needs of the prison population on a daily basis.

78. Certain conditions and situations as described by the prison medical staff were cause for concern, especially in light of the Standard Minimum Rules. For example, there is no routine examination provided to the prisoners upon admission. In the Special Rapporteur's opinion, such a routine check is necessary, in order to accurately and adequate determine the incarcerated persons' health needs. Furthermore, people who use drugs were kept in unnecessary isolation from the rest of the prison population. Moreover, in cases of homosexual detainees, prison staff follow an isolation procedure, during which time these prisoners receive psychological "treatment" and are kept apart from the rest of the prison population for no reason besides their sexual orientation or gender identity. In each of these cases stigma is reinforced, vulnerable detainees are discriminated against, and there is a resulting deprivation of the enjoyment of the right to health without meaningful public health benefit.

79. Very little information is available concerning the health conditions in Syrian prisons. The facilities that the Special Rapporteur was allowed to see, however limited,

[65] United Nations, *Standard Minimum Rules for the Treatment of Prisoners*, 30 August 1955,

were in generally good condition. Patients were being given appropriate treatment in general alignment with the right to health. It should be noted that no discussion with prisoners was conducted in conditions guaranteeing confidentiality. In general, the Special Rapporteur would like to encourage the Syrian Government to conduct a more thorough assessment of the realization of the right to health in Syrian prisons.

# VIII. Conclusions and recommendations

80. **The Special Rapporteur was impressed with the advances that have been made in maternal and child health, particularly given the resource constraints faced by the Government, alongside challenges such as the continuing drought. The gains in respect of child mortality are particularly notable, and exceed the targets set for the Millennium Development Goals. However, it remains clear that there is more to be done, particularly in key areas such as nutrition, family planning and women's empowerment.**

81. **Community participation in decision-making, an essential element of the right to health framework, is of great importance in achieving long-term gains in core areas, and in particular to further lower the maternal and child mortality rates. Community guided and led initiatives to raise awareness of these problems, and combat them through culturally appropriate methods, are vital. This is particularly true in to address the continuing discrepancy in outcomes between rural and urban centres. The Special Rapporteur urges the Government to consider the following recommendations pertaining to the health-care system in its entirety:**

**(a) Collect comprehensive, disaggregated data, to ensure that no specific ethnic or minority groups are disadvantaged or discriminated against in respect of access to health-care services;**

**(b) Enable community participation in health-care service delivery through active engagement of civil society organizations in health-related policy-making at all levels of government;**

**(c) Reconsider the need to maintain a state of emergency, which has remained in place since the 1960s, in view of its negative effects on the organization and participation of civil society in health-related policy-making;**

**(d) Ensure that access to medicines is protected by developing a plan to integrate and make use of all the appropriate TRIPS-flexibilities in light of possible accession to the WTO;**

**(e) Conduct impact assessments of the proposed private insurance scheme with the assistance of international partners.**

82. **The Special Rapporteur urges the Government to consider the following recommendations in the area of women's and children's health:**

**(a) Develop and implement a consistent, nation-wide sexual and reproductive health education curricula, to be delivered through late primary and early secondary schools;**

**(b) Increase efforts to close the gap between male and female enrolment rates throughout the entire education system;**

**(c) Engage in legislative reform concerning early marriage, and initiate programmes designed to raise public awareness of this issue;**

**(d) Increase efforts to contain the national fertility rate, particularly through implementation of comprehensive family planning services which include women in their design;**

**(e) Seek to increase the number of ante-natal visits attended by woman during pregnancy, and consider establishment of a mechanism to ensure patients are given appropriate follow-up;**

**(f) Invest increased resources in provision of health care during the post-natal period, and develop mechanisms allowing for community involvement in establishing programmes that engage and empower women;**

**(g) Seek immediate amendment of the Penal code provisions which discriminate against women, particularly those relating to instances of gender-based or family violence;**

**(h) Conduct research into the prevalence and nature of gender and family-based violence nationwide, with a view to discovering the extent of the problem and taking steps to redress it;**

**(i) Take urgent steps to address the issues relating to malnutrition throughout the country, particularly in children, through provision of food to the most marginalized and vulnerable groups affected by the drought, and through establishment of nation-wide education programmes concerning infant and child nutrition.**

83. **The Special Rapporteur urges the Government to consider the following recommendations in the area of vulnerable and marginalized groups:**

**(a) Grant all stateless Syrian Kurds citizenship to guarantee, inter alia, unhindered access to health-care services, and in the interim period ensure that all stateless persons are given forms of ID sufficient for them to access all health-care services they require;**

**(b) Change requirements to allow Iraqis to work, at least temporarily in Syria, to reduce the burden on the State and international organizations;**

**(c) Seek assistance in obtaining increased external funding to ensure that the needs of the refugee population can be met, particularly in respect of expensive, non-elective medical procedures for refugees;**

84. **The Special Rapporteur urges the Syrian Arabic Republic to consider the following recommendations in respect of incarcerated persons and prison health:**

**(a) To urgently ratify the Convention Against Torture and its Optional Protocol;**

**(b) To collect and publicly release comprehensive data relating to prisoners' health, and the health-care services with which they are provided; and**

**(c) To allow a more thorough assessment of the situation in prisons and other detention centres in Syria by inviting relevant special srocedures mandate holders.**