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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访问巴拉圭的报告*

秘书处的说明

秘书处谨向人权理事会转交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关于 2015 年 9 月 23 日至 10 月 6 日访问巴拉圭的报告。巴拉圭在落实健康权方面有所进展，特别是就改善基本的健康指标和按本国的国际人权义务协调规范框架而言。为使巴拉圭充分实现健康权，特别报告员鼓励该国政府应对若干严峻挑战，这些挑战主要涉及落实现有规范和政策框架，以及妇女和女童、儿童与青少年、男女同性恋、双性恋和跨性别者及艾滋病毒/艾滋病感染者等几个主要人群遭受的不平等待遇、歧视和暴力。本报告中，特别报告员论及心理健康和影响国家卫生体系的挑战，并提出若干建议。

* 本报告逾期提交，以反映最新动态。

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

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** Circulated in the language of submission and Spanish only.

I. Introduction

1. The Special Rapporteur visited Paraguay from 23 September to 6 October 2015 at the invitation of the Government. 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.

2. During his visit, the Special Rapporteur met with high-ranking government officials from the Ministries of Education and Culture, Foreign Affairs, Justice and Labour, Public Health and Social Welfare, and Women. He also met with high-ranking officials from the National Secretariat for Children and Adolescents, the Technical Planning Secretariat, the Secretariat for Social Action, the Social Security Institute, the National Institute of Indigenous Affairs, the National Preventive Mechanism, and the National Secretary for the Human Rights of Persons with Disabilities. He held meetings with the President of the Supreme Court of Justice and members of Congress. He also met with representatives of civil society, international organizations, development and United Nations partners, academics, legal experts and health professionals.

3. The Special Rapporteur visited several health facilities, family health units and schools in Asunción, including in various deprived neighbourhoods in Itagua, Coronel Oviedo and Ciudad del Este. He also visited the Psychiatric Hospital in Asunción, a prison and one educational detention centre for adolescents in Ciudad del Este.

4. The Special Rapporteur is grateful to the Government of Paraguay for its invitation and full cooperation during his visit. He appreciates the crucial support provided by the Human Rights Adviser of the Office of the United Nations High Commissioner for Human Rights (OHCHR) and her team. He is also grateful for the support provided by the United Nations country team, including by the Pan American Health Organization (PAHO), and by all those who contributed their time and experience.

II. Right to health in Paraguay

A. Background

5. In 1989, Paraguay emerged from over three decades of dictatorship under General Alfredo Stroessner and it is still a young democracy. However, the end of the autocratic regime did not bring political stability. In the following years, the country witnessed the assassination of a vice-president, and the contentious impeachment of the first President from the centre-left Patriotic Alliance for Change over the mishandling of a land eviction during which police officers and peasant farmers were killed.

6. With a population of almost 7 million, Paraguay is a multicultural country of vast natural resources marked by deep inequalities particularly affecting those living in rural areas, indigenous peoples, adolescents and young people, and women and girls. It is a landlocked lower-income country with 22.6 per cent of the population living in poverty and 10.5 per cent living in extreme poverty.[1] Although poverty has been reduced over the past decade, it still affects one in four Paraguayans, while extreme poverty affects one in ten.[2]

[1] Directorate-General of Statistics, Surveys and Censuses, Continuous Household Survey 2014, available in Spanish only.

[2] See www.worldbank.org/en/country/paraguay/overview.

The incidence of poverty and extreme poverty among indigenous communities far exceeds national averages (see A/HRC/30/41/Add.1, para. 49). Social spending per capita in Paraguay is one of the lowest in the region with US$ 147 invested in 2010.[3]

7. The country has made significant improvements in the life expectancy of certain sectors of the population, reduced maternal and child mortality rates over the past decades, and introduced successful vaccination campaigns nationwide. However, while under-five mortality has been halved since the 1990s, maternal mortality rates remain among the highest in the region, accounting for 110 deaths per 100,000 live births in 2013.[4] The main causes are preterm birth complications linked to early pregnancies, complications resulting from unsafe abortions, toxaemia, haemorrhages and sepsis (see DP/FPA/CPD/PRY/7, para. 6).

8. The commercialization of agriculture, population growth and forest clearances have led to a dramatic increase in the number of landless communities in Paraguay. Migration into urban areas and shanty towns from rural regions has burgeoned as a result.

9. The Paraguayan economy is small and open, with an average growth rate of 5 per cent over the past decade.[5] During that time, the country has made significant progress at the macroeconomic level, with strong results in fiscal and monetary aspects with the onset of major social reforms. Recent social reforms include free access to primary health care and secondary education, and the expansion of conditional cash transfer programmes benefiting populations in the most vulnerable situations.

10. The first National Development Plan (2014-2030) was prepared with the aim of eliminating extreme poverty and promoting the income growth of the poorest 40 per cent of the population. It includes a component to improve access to and the quality of social services, including health. The Plan supports a medium-term economic framework emphasizing sustainable fiscal policies, improved tax collection, increased effectiveness of social protection policies and their targeting, and broader financial inclusion.[6]

B. Legal and institutional framework

11. Paraguay is a founding member of the United Nations, a member of the Human Rights Council and has issued a standing invitation to the special procedures of the Council. It has ratified almost all the international human rights treaties. Currently, only the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights and the Optional Protocol to the Convention of the Rights of the Child on a communications procedure are pending ratification.

12. Paraguay has ratified all the regional human rights instruments except the Inter-American Convention against All Forms of Discrimination and Intolerance, and the Inter-American Convention against Racism, Racial Discrimination and Related Forms of Intolerance.

13. The constitutional and normative framework recognizes the right to health and other related rights. The National Constitution of the Republic of Paraguay (1992) provides for the right to health in connection to the rights to life, physical and mental integrity and quality of life in articles 4, 6, 7, 68, 69 and 70. Notably, article 68 establishes the responsibility of the State to protect and promote health as a fundamental right. It also

[3] See www.cadep.org.py/uploads/2015/10/EyS-17.pdf.
[4] See www.who.int/gho/countries/pry.pdf.
[5] See www.worldbank.org/en/country/paraguay/overview.
[6] Ibid.

prohibits discrimination in articles 46 to 48, including the obligation of the State to remove all factors that contribute to discrimination. Article 60 of the Constitution recognizes the right to a life free from violence.

14. There are a number of public policies, programmes and initiatives that stem from that framework, including relevant work on human rights indicators and the right to health, which should be continued.[7] The Government has developed a system to monitor the implementation of the recommendations from human rights mechanisms, which is considered a good practice and is being replicated by other countries.

15. Paraguay is to be commended for the adoption in September 2015 of the Act on the health of indigenous people, which was developed in consultation with indigenous peoples. The Act should now be implemented with predictable and sufficient allocation of human and financial resources. In that connection, the Special Rapporteur was concerned to learn during his visit that the budget of the National Institute of Indigenous Affairs had been more than halved.

16. It is worth noting the existence of a National Plan for Human Rights, a National Plan on Education for Human Rights, and a recently approved National Action Plan for the Rights of Persons with Disabilities. In September 2015, the Act on Public Information Access was adopted as the result of collaborative efforts between the Government and civil society.

17. However, Paraguay is one of the few countries in the region that does not have the necessary normative framework to combat discrimination, which represents a historical debt to Paraguayan society.

18. Another issue of concern is the situation of the Office of the Ombudsperson, which suffers from institutional weakness and does not fully comply with the principles relating to the status of national institutions for the promotion and protection of human rights (the Paris Principles). Moreover, the mandate of the incumbent expired in 2008 and there has been no appointment to date.

C. Structural challenges and a human rights-based approach to health

19. Many of the challenges identified during the visit relate to structural and systemic factors that obstruct progress in many areas, including in the realization of the right to health. The main factors include deep and persistent inequalities associated with, inter alia, a regressive tax structure that does not allow for the necessary public investment. Discrimination is widespread and not properly combated owing to the lack of an appropriate normative and policy framework, and the absence of adequate social and educational programmes.

20. In accordance with Decree No. 19.966/98 on local health decentralization, health competencies have been being devolved to local authorities since the late 1990s. Responsibilities have been transferred to the local level, but the new system has failed to address endemic institutional weaknesses, significant budget constraints and prevailing corruption at different levels.

21. Moreover, the effective implementation of the existing normative framework is often hampered by the lack of an effective human rights-based approach to health, including to public budgets and information. That, combined with a non-inclusive model of

[7] See Red de Derechos Humanos del Poder Ejecutivo, “Indicadores de derechos humanos: el derecho a la salud”, 2012.

rapid economic growth, seriously undermines efforts made since the inception of democracy to promote and protect the right to health and related rights.

22. The Special Rapporteur highlights the importance of a human rights-based approach to health. The enjoyment of health and the exercise of human rights and fundamental freedoms are complementary. In order to fully exercise human rights and be able to participate in a State's civil, social, political, cultural and economic life, the enjoyment of the highest attainable standard of physical and mental health is necessary. At the same time, human rights and fundamental freedoms are essential to guarantee genuine physical and mental well-being.[8]

23. A violation of or a failure to respect human rights can adversely affect the physical, mental and social well-being of all people. Therefore, public health legislation, policy and planning can promote and protect basic human rights and freedoms, or, on the contrary, can hinder the exercise of basic rights related to physical and mental well-being.

24. The application of international human rights instruments in the context of the health of key populations and groups in situations of vulnerability is still in its infancy in the Latin American region. As PAHO member States have stressed, it is crucial for health legislation, policy and planning concerning those populations to take into account the existing international norms, especially international and regional standards and technical guidelines.

25. Paraguay has a good opportunity to reinforce the link between health and human rights but it should seize it effectively in order to address many cross-cutting challenges.

III. Right to health of key populations and groups

26. During his visit, the Special Rapporteur observed stark disparities and discrimination regarding the enjoyment of the right to health in Paraguay, and was concerned about retrogressive tendencies undermining previous achievements. The disparities mostly relate to barriers to availability, accessibility, acceptability and quality of health care, as well as the underlying determinants such as poverty, food and nutrition, safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information.

27. The lack of essential services in deprived neighbourhoods and in rural and remote areas of the country disproportionally affects groups in situations of poverty and peasant and indigenous communities. Certain key populations and specific groups face serious challenges in realizing their right to health, including women and girls, children and adolescents, lesbian, gay, bisexual and transgender persons, persons with disabilities and people living with HIV/AIDS.

A. Women and girls

Maternal mortality and morbidity

28. Women and girls face numerous barriers in the enjoyment of their right to health, particularly those from groups in situations of poverty and vulnerability, including indigenous women and those living in rural areas. The total fertility rate in Paraguay in 2013 was 2.9 births per woman, but in rural areas the rate was double the national average.

[8] See www.un.org/disabilities/documents/paho_mh_resolution.pdf.

29. The country faces significant challenges in reducing preventable maternal and neonatal mortality. It continues to be one of the countries with the highest maternal and neonatal mortality rates in the region, with a national average of 110 maternal deaths per 100,000 live births in 2013,[9] but that figure hides stark inequalities between rural and urban areas. The highest rates are found both in the poorest departments (Concepción, San Pedro and Caazapá) and in departments with large populations (Alto Paraná and Central). Also, while metropolitan areas such as Asunción and Central show a rate of 68.6, the Occidental or Chaco regions show rates as high as 135.7.[10] While the number of institutional births has increased, particularly in rural areas, there is still a lack of adequate prenatal care, especially among the poorest sectors of the populations.

30. Positive initiatives to address that include the National Plan for Sexual and Reproductive Health (2014-2018), the national mobilization for reducing maternal and neonatal mortality, and the campaign to reduce preventable maternal and neonatal deaths ("Zero Preventable Deaths").

31. Maternal mortality in Paraguay is mostly the result of preventable causes, mainly during deliveries or post-partum complications, including haemorrhage, post-abortion related complications and toxaemia. A high number of cases are associated with early and teenage pregnancy, many of which affect 10- to 14-year-old girls as a result of sexual abuse and violence. According to available data, teenage pregnancies account for 20 per cent of maternal deaths in the country.[11]

32. The situation is aggravated by an extremely restrictive normative framework for the interruption of pregnancies, which criminalizes abortion in all circumstances except when the life of the woman or girl is at risk (art. 109.4 of the Criminal Code). However, that exception is rarely used. As a result, abortions are performed in clandestine locations, causing grave health complications from which many girls and young women die every year in Paraguay.

33. In addition, women and girls who undergo an abortion, even if they were pregnant as a result of rape or incest, face imprisonment. According to article 352 of the Criminal Code, health professionals can be penalized for performing illegal abortions, with sentences ranging from two to eight years.

34. In an attempt to address that, the Ministry of Health passed resolution No. 146 in March 2012 establishing that health centres have an obligation to admit and assist all women, without discrimination, and to respect their right to privacy. The Ministry published guidelines on humane care for post-abortion patients. During the Special Rapporteur's visit, it was unclear to what degree the guidelines were being followed in the health-care sector. Certainly, more efforts are needed to ensure that health professionals are aware of their obligations to maintain their patients' privacy and integrity, and to ensure adequate emergency treatment for post-abortion patients.

35. The Special Rapporteur was extremely concerned to learn that the mothers of young girls who are pregnant are almost systematically criminalized, facing charges for failing in their duty of care. As a result, pregnant girls are confined to homes, isolated from their families and disconnected from their friends and school environment until they give birth. The State has a duty to protect the girls' rights to liberty, privacy and physical integrity,

[9] See www.who.int/gho/countries/pry.pdf.

[10] United Nations Children's Fund (UNICEF), "Situación del derecho a la salud materna, infantil y adolescente en Paraguay", 2013, p. 9.

[11] Ibid., p. 9.

since they are children. In doing so it must balance the girls' best interest with their evolving capacities and the importance of their family ties.

36. In the view of the Special Rapporteur, the existing legal, policy and institutional framework is failing to protect very young girls who have been victims of sexual abuse and are then forced to continue high-risk pregnancies and motherhoods with long-lasting impacts on their physical and mental health.

37. The Mainumby case, widely reported in the media, is an example of a systemic challenge and a structural problem. The case triggered reactions from international experts, precautionary measures from the Inter-American Commission on Human Rights,[12] and a declaration from the European Parliament.[13] That case is, however, just one of the hundreds of cases of 10- to 14-year-old girls who are victims of sexual violence, and are forced into unwanted pregnancies and motherhoods every year.

38. That is a human rights protection issue and a public health concern that must be addressed without delay through changes in legislation, policies and practices based on scientific evidence and a human rights-based approach. Existing legislation should be reviewed to decriminalize abortion and guarantee the therapeutic interruption of pregnancy through access to services, at the least, when the pregnancy is the result or rape or incest, in cases of fetal impairment, and when the life and the health of the mother is in danger.

39. Evidence shows that criminalizing abortion only leads to clandestine and unsafe practices and exposes women and girls to additional dangers, violence and stigma that negatively affect the full enjoyment of their right to health.

Sexual and reproductive health rights

40. According to reports, about 40 per cent of girls aged between 15 and 19 report having had sexual relations, of which 43 per cent did so before the age of 16. More than half of those relations occurred without any planning, 28 per cent engaged on a voluntary basis and 12 per cent were forced. Early sexual relations are more common in rural areas. Most girls use modern contraceptive methods such as condoms (40 per cent), the contraceptive pill and injectable contraceptives, but some still resort to traditional methods. There are no data about the behaviour of adolescent boys.[14]

41. The Special Rapporteur acknowledges the formulation of national plans and programmes, such as the National Plan for Sexual and Reproductive Health, to ensure coordinated delivery of health-care services to that group of the population. However, in 2008, a bill on sexual and reproductive health was introduced with the aim of recognizing sexual and reproductive health as part of the right to health, but it did not progress owing to strong resistance from religious and conservative sectors of society.

42. During his visit, the Special Rapporteur noted that women and girls faced significant barriers to the full enjoyment of their right to health, particularly their sexual and reproductive health rights.

43. The reproductive health services most needed by girls and young women include access to safe, reliable and good quality contraception, comprehensive maternal health services, safe abortion and treatment for complications from unsafe abortion, and prevention and treatment of sexually transmitted infections and HIV/AIDS (see

[12] See www.oas.org/es/cidh/decisiones/pdf/2015/MC178-15-ES.pdf.

[13] See www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+TA+P8-TA-2015-0230+0+DOC+PDF+V0//EN.

[14] UNICEF, "Situación del derecho a la salud", p. 56.

E/CN.9/2014/4, paras. 68-77). However, the right to health requires more than service provision, and attention should be paid to social determinants such as violence, poverty and discrimination, which are reinforced by patriarchal gender norms and stereotypes.

44. Paraguay faces significant shortcomings in the provision of comprehensive sexual and reproductive information and education for children and adolescents in schools, in families and in other settings Some families are reticent to address those issues and the media often portrays the issues in a sensationalist way.[15]

45. Evidence and information gathered during his visit led the Special Rapporteur to conclude that violence against women and girls can be considered as an epidemic in Paraguay. Sexual abuse and other forms of violence, including domestic violence, are widespread. The main challenges in addressing violence against women include the fact that it is widely underreported owing to prevailing patriarchal gender norms and associated stigma, and that the scope and enforcement of the existing legal provisions remains unsatisfactory.

46. Proactive measures need to be taken to address violence against women and girls. Violence against women should be seen as a human rights protection issue as well as a public health concern, since it is directly associated with adverse consequences on the physical and mental health of the women and girls who are affected. The Special Rapporteur welcomes the draft law on comprehensive protection for women against all forms of violence, which was passed on first reading in Parliament in December 2015. He trusts it will be adopted and implemented without delay.

47. During his visit, the Special Rapporteur received reports of acts of intimidation and harassment against individuals, non-governmental organizations, human rights defenders and lawyers working on women's rights and gender issues, including violence against women and sexual violence. He expressed his concern about that and underlined that in a democratic and open society, it is not acceptable. Those people are playing a crucial role, working to promote and protect the right to health and other rights; they should be able to do so in a safe and enabling environment.

B. Children and adolescents

48. About one third of the population of Paraguay (32 per cent) is composed of adolescents and children, most of them under 15 years of age.[16] Childhood and adolescence are critical moments in life to strengthen resilience and combat illness and morbidity in later life.

49. Paraguay has made improvements in the reduction of infant and child mortality over the past few years, including by expanding the coverage of child immunization programmes. However, neonatal and adolescent (15-19 years old) mortality represent 43 per cent and 20 per cent of the total number of deaths in the 0-19 age group, respectively.[17] Malnutrition still affects many children, particularly indigenous children among whom the chronic malnutrition rate is 41.7 per cent, compared to the national average of 17.5 per cent (see A/HRC/30/41/Add.1, para. 49).

[15] UNICEF, "Situación del derecho a la salud", p. 10.
[16] See www.who.int/gho/countries/pry.pdf.
[17] UNICEF, "Situación del derecho a la salud", p. 9.

50. Paraguay acceded to the Convention on the Rights of the Child in 1990, but has yet to ratify the Optional Protocol thereto on a communications procedure in order to allow effective access to justice and redress for violations.

51. The Code on Children and Adolescents, established in Act 1680/01 of 2001, is the main legal instrument concerning the right to health of the two groups. The Code guarantees the right to information and provides for sexual and reproductive education for children and adolescents (art. 14). It also establishes the obligation of the State to provide sexual educational services and programmes according to the evolving capacities of the child and his or her cultural and family background. Services for those groups should guarantee confidentiality, free and informed consent, and the holistic development of the children's and adolescents' personalities.

52. The Act against Domestic Violence (1600/00) establishes protection for all persons who suffer physical, psychological or sexual abuse or violence in the domestic environment, including children.

53. The National Policy on Children and Adolescents is the main reference for the implementation of the normative framework, together with the national plan for comprehensive early childhood development, aimed at guaranteeing and promoting the rights of children aged between 0 and 8, the national plan to promote quality of life and health with equity for children (2010-2015) and the national plan to promote quality of life and health with equity for adolescents (2010-2015).

54. Over the past few years, there have been commendable efforts to ensure accountability and transparency in the implementation of public policies, including those targeting children. That has been done through the development of indicators, including health-related indicators, and culminated with the development of the 20 commitments to improve the quantity and efficiency of investment in childhood and adolescence.[18]

55. However, serious threats and barriers remain to children's right to holistic development. Violence against children and adolescents is a prevailing challenge in Paraguay. Six out of ten children suffer from some form of violence in their families.[19] Also, six out of ten deaths of adolescents are the result of external causes such as traffic accidents, homicides and suicides.

56. The way in which the authorities are addressing the health and protection of children and adolescents in vulnerable situations, who are exposed to multiple adversities, is an example of ineffective policies and practices. Shortcomings at different levels of policy formulation and implementation hinder the accomplishment of good practices and the implementation of recommendations made by human rights monitoring bodies, international organizations and other stakeholders. There is a need to address the right to health of children and adolescents in a holistic manner and with a multisectoral approach. That means going beyond medical services and addressing the root causes of violence as well as the social and environmental determinants.

57. In Paraguay, there is a lack of adolescent-friendly health services and confidential counselling, as well as poor access to essential services, in particular for indigenous children and adolescents using drugs and alcohol, including in detention. There is also a lack of sustainable investment in promoting children's holistic development, including their emotional and social development.

[18] See www.unicef.org/paraguay/spanish/20_compromisos_ninez.pdf.

[19] UNICEF, "Situación del derecho a la salud", p. 12.

58. The level of drug use and alcohol consumption among adolescents is alarming in Paraguay. About 18 per cent of adolescents consume some type of drug or substance, most commonly alcohol. One out of four adolescents has consumed alcohol before the age of 14, with on average 40 per cent of adolescents aged 14 to 17 and about 25 per cent of those below 14 years old consuming alcohol.[20] The increasing prevalence of HIV/AIDS among adolescents over the past few years is also a source of concern, with an average of 7 new cases every month. Since 2005, that has mostly affected girls aged between 15 and 19.[21]

59. Furthermore, the high rate of early pregnancy in the country reflects the serious protection gap in children's rights, including their right to physical and mental health and integrity, their right to be free from all forms of violence and their right to receive adequate information and health education. The prevalent approach is to consider sexuality only in connection to reproduction, thus ignoring the fact that sexuality is an intrinsic human activity that has multiple personal and social dimensions.[22]

60. Comprehensive sexual education is not properly integrated in school curricula in Paraguay. Confessional groups and ideas have a strong influence on the school system, in which students are being provided with unscientific and inaccurate information about their health. Related education programmes are often not based on evidence and place strong emphasis on abstinence, rather than providing evidence-based information and education to allow students to make free and informed decisions about their sexuality.

61. That certainly contributes to the high prevalence of unwanted pregnancies among girls and of unsafe abortions, and the high risk of the spread of sexually-transmitted diseases, including HIV/AIDS. Evidence shows that access to comprehensive sexual education has a positive impact on the knowledge and health-related behaviours of adolescents and young people (see E/CN.9/2014/4, para. 68).

62. The Special Rapporteur urges the authorities to implement the National Plan on Human Rights Education at the school level, with emphasis on sexual education and information. The 2010 Pedagogical Framework for Comprehensive Sexual Education was a commendable initiative, but was never implemented. The Framework could serve as inspiration for the development of new measures in that area.

Children deprived of liberty

63. Most adolescents who are deprived of their liberty are in pretrial detention, which is in itself a major problem in Paraguay owing to the excessive resort to detention-based measures in the criminal system. The Ministry of Justice, through the Adolescent Offenders Welfare Service, is responsible for the so-called "educational detention centres".

64. There are seven such centres in the country with a population of about 450 adolescents, boys and girls, 90 per cent of whom are detained without having been convicted. The main issues range from the lack of legal personnel during hearings to impose pretrial measures, the lack of inter-institutional coordination among all the authorities involved and other stakeholders, and the lack of qualified staff, such as community psychologists, social workers, paediatricians, ophthalmologists and psychiatrists.

65. The detention conditions in such centres have been a matter of concern for national and international bodies (see CCPR/C/PRY/CO/3, para. 21), and reportedly include overcrowding, the poor quality of the food provided, insufficient potable water and hygiene

[20] UNICEF, "Situación del derecho a la salud", p. 54.
[21] Ibid., p. 58.
[22] Ibid., p. 62.

products, and the lack of basic medicines, including painkillers, antibiotics and anti-inflammatories. Reports also indicate that adolescents placed in those centres have restricted access to their family members, which can have a detrimental effect on their development and social learning. In addition, there have been serious allegations of ill-treatment inside the centres, including corporal punishment and humiliating treatment

66. The Special Rapporteur visited one educational detention centre in Ciudad del Este where, at the time, about 56 children who had committed mostly minor offences were placed. During his visit, he was able to confirm some of those concerns, in particular the lack of programmes to address key issues such as drug use.

67. All efforts made to improve the situation in those centres are compromised by the fact that the majority of the adolescents there should not be deprived of liberty. Alternative non-custodial measures should be put in place. Punitive measures such as deprivation of liberty are a form of institutional violence and only reinforce the cycle of injustice, exclusion and hopelessness in society. They have a detrimental impact on the enjoyment of the right to health, particularly of children.

Right to health in schools

68. Paraguay has made progress over the past decades with regard to the enrolment of children in schools, but significant disparities remain with regard to the situation of girls, those living in poverty and indigenous children.[23]

69. The Special Rapporteur visited schools in several locations during his visit and found it to be one of the most inspiring parts of his visit. He was able to determine that children, in general, enjoy attending school and most teachers are doing their best, despite inadequate salaries, scarce resources and often poor infrastructure.

70. Schools offer excellent opportunities as spaces in which to promote the health and well-being of children, including through nutrition programmes and the provision of health-related education and evidence-based information. However, in Paraguay those opportunities are not always adequately utilized. The health-related information provided is not always evidence-based and the progress in implementing inclusive education for children with disabilities has been limited. In addition, there are almost no measures in place to address bullying and other forms of violence against children in a systemic way in the school setting.

71. The Special Rapporteur witnessed young mothers attending school with their babies and raised the issue of children who drop out of school, many of them girls owing to early pregnancies.

Children with disabilities

72. Although not directly addressed during the visit, the Special Rapporteur notes with concern the situation of children with disabilities. The National Programme of Comprehensive Care for Children and Adolescents with Disabilities is limited solely to the prevention and early detection of disability characteristic of the medical model, and does not take account of the full range of rights recognized to children with disabilities (see CRPD/C/PRY/1/CO, para. 19).

73. Moreover, the scarcity of resources available for the implementation of a public policy on inclusion of children with disabilities is also a source of concern. The number of children with disabilities enrolled in school is very low and most of them are in special

[23] See www.unicef.org/paraguay/spanish/children_16444.htm.

schools. Moreover, the persistent use of terminology drawn from the medical model of disability when assessing educational standards is also worrying.

C. Lesbian, gay, bisexual and transgender persons

74. The Special Rapporteur was pleased to note that the situation and rights of lesbian, gay, bisexual and transgender persons have become more visible in Paraguay over the past few years. The National Plan on Sexual and Reproductive Health includes non-discrimination on the basis of sexual orientation and gender identity.

75. However, lesbian, gay, bisexual and transgender persons face significant barriers in the full enjoyment of their right to physical and mental health. The barriers are connected to deeply entrenched discriminatory attitudes in society at large, which generate stigma, violence and abuse, including in the health system.

76. The Special Rapporteur received testimonies and evidence that lesbian, gay, bisexual and transgender persons face extreme forms violence on the basis of their sexual orientation and gender identity and expression. The violent deaths of at least 34 transgender persons between 1989 and 2013 are evidence of that.[24] During his visit, the Senate held a debate about the situation of transgender persons, and he met with a number of high-ranking government officials who were aware of the specificities and challenges faced by that group.

77. The situation of lesbian, gay, bisexual and transgender persons living outside the main urban areas, some of whom met with the Special Rapporteur, is of particular concern as they are isolated from the main support networks, live and work in very difficult environments and face violence from the community.

78. Lesbian, gay, bisexual and transgender persons face discrimination and rejection from health-care personnel and a lack of comprehensive health services tailored to their needs, particularly when it comes to access to treatment and services for HIV/AIDS. Moreover, confidentiality is not always guaranteed in the provision of health services.

79. Information gathered during his visit allowed the Special Rapporteur to conclude that many lesbian, gay, bisexual and transgender persons do not use health services for fear of stigma and rejection, which can drive many health issues underground with negative consequences for the health of the persons concerned and that of society at large.

D. People living with HIV/AIDS

80. There are approximately 17,000 persons living with HIV in Paraguay,[25] which represents about 0.25 per cent of the total population. On average, there are three new cases of infection every day. Most of the cases are concentrated in Asunción and the Central department, and the most affected groups are men who have sex with men, and sex workers.

81. The Government has taken effective measures to reduce the spread of HIV/AIDS through an evidence-based approach, including access to free testing, distribution of condoms and free provision of antiretroviral treatment. However, in recent years, Paraguay has seen a surge in HIV/AIDS infections resulting from sexual transmission, increasingly affecting young people and adolescents, mainly women and girls.

[24] See www.panambi.org.py/publicaciones/16.

[25] See www.unaids.org/en/regionscountries/countries/paraguay/.

82. The Constitution enshrines the right to health and public health care (art. 68). Additionally, it establishes the right to equality and the principle of non-discrimination for all persons (arts. 46, 47 and 48). The normative and institutional framework includes the Act on rights, obligations and preventive measures in relation to the effects of HIV/AIDS (No. 3.940) and a National AIDS Control Programme. The Ministry of Public Health and Social Welfare is the authority responsible for those instruments.

83. Articles 8.1 and 8.2 of Act No. 3.940 contain provisions that promote sexual abstinence and mutual fidelity as some of the bases for preventing HIV/AIDS, which implies a strong moralistic approach to law-making that does not comply with human rights standards and is not evidence-based. Those provisions should be removed and the section on prevention should be reviewed accordingly.

84. The real challenge lies in the operationalization of the framework. At the institutional level, the division of responsibilities between the Ministry of Public Health and Social Welfare and the National AIDS Control Programme is not always clear, which undermines the implementation of policies and programmes. The responsibilities are also centralized in an ineffective manner, affecting local capacities to prevent and treat HIV cases in rural areas.[26]

85. Persons living with HIV/AIDS in Paraguay suffer from various forms of public and private discrimination, including arbitrary limitations on access to health services.[27] That is exacerbated by the fact that there are no specific programmes or protocols targeting key populations, such as children and adolescents, lesbian, gay, bisexual and transgender persons, indigenous peoples, persons in detention and persons with disabilities.

86. People living with HIV/AIDS are also exposed to discrimination in educational and workplaces, but there is little information, dialogue or awareness-raising about that, as the Special Rapporteur confirmed during his meetings with relevant authorities.

87. Compulsory HIV testing in the workplace is not authorized, but the Special Rapporteur received reliable reports that it is, nonetheless, common practice. In addition, there are established practices in the health sector in response to financial constraints, such as shared transport services for users in remote locations to access treatment, which violate the right to privacy, and should be reviewed without delay.

88. The National Centre for the Treatment of Addictions cannot cope with the existing demand. It should be extended and should adapt its programmes to the needs of those in the most vulnerable situations, including those with less resources, and children and adolescents.

E. Right to mental health: priorities and the way forward

89. Data from 2011 show the following disability distribution among the population at large: mobility, 26 per cent; mental, 25 per cent; speech, 11 per cent and hearing, 6 per cent. The most frequent types of disability among children under 9 years old are paralysis of some sort and Down syndrome, while most children and adolescents between 10 and 19 years old with disabilities reportedly have intellectual disabilities, paralysis of some sort or

[26] PAHO, *Evaluación para el fortalecimiento de la respuesta del sistema de salud al VIH en Paraguay* (Asunción, 2009), p. 16-18.

[27] Fundación Vencer, *Perspectiva comunitaria sobre estigma y discriminación en personas que viven con VIH y sida en Paraguay* (Asunción, 2010).

Down syndrome. The most frequent causes of disabilities in that age group are complications at birth (64 per cent), accidents (7 per cent) and illness (20 per cent).[28]

90. For a number of years now, about 40 per cent of those attending mental health consultations have been adolescents and young persons. The most common conditions were linked to drug abuse, depression, suicide attempts, anxiety, and behavioural, developmental and personality disorders.[29]

91. Paraguay ratified the Convention on the Rights of Persons with Disabilities in 2008, and has since made significant efforts to harmonize and strengthen its normative, policy and institutional framework. It has, for example, adopted the Inclusive Education Act (No. 5136/13) and the Act on Accessibility of the Physical Environment for Persons with Disabilities (No. 4934/12). Those efforts need to continue in order to bring the existing legal, policy and institutional framework in line with the Convention.

92. The National Plan on the Rights of Persons with Disabilities was adopted shortly after the Special Rapporteur's visit. It could be considered a good practice since it was developed in a participatory manner, involving relevant institutions and civil society organizations.[30]

93. However, during his visit, the Special Rapporteur ascertained that, as health professionals and other stakeholders are not aware of some of the recommendations made by the Committee on the Rights of Persons with Disabilities, the recommendations are not properly implemented.

Mental health policy

94. Paraguay has a history of mental health services closely linked and limited to assisting users of mental health services, including persons with disabilities, through institutionalization in the only public psychiatric hospital in the country, the Psychiatric Hospital in Asunción.

95. Paraguay does not have a specific legal framework to protect and promote the rights of users of mental health services and those with mental health conditions and disabilities in terms of their admission to psychiatric institutions. Neither the Constitution nor disability-related laws or national regulations include due process guarantees for the admission into psychiatric institutions or provisions for periodic reviews of involuntary institutionalization. Article 267 of the Civil Code addresses admission to and treatment in such institutions, referring to admission "subject to guardianship" in "adequate establishments", and "under judicial orders" when either the "person's own security", "the security of third parties" or "his/her recuperation" needs to be ensured.

96. Since the 1970s, there have been important initiatives trying to move away from long-term institutionalization and towards community-based services for users of mental health services and persons with mental health conditions, including developmental and psychosocial disabilities. However, good initiatives have been fragmented and have lacked sustainability and adequate backing with human and financial resources.

97. The issue of institutionalization reached the Inter-American Commission on Human Rights, which granted precautionary measures on behalf of the patients of the Psychiatric Hospital in 2003 and 2008. Paraguay was called to protect the life and physical, mental and moral integrity of the 458 patients, paying particular attention to the situation of women and

[28] UNICEF, "Situación del derecho a la salud", p. 69.
[29] Ibid., p. 54.
[30] See www.ohchr.org/SP/NewsEvents/Pages/DisplayNews.aspx?NewsID=16819&LangID=S.

children. In response, Paraguay started a thorough restructuring of its mental health-care services with the support of the World Health Organization/PAHO, including through the drafting of a mental health bill, which is still under way. In July 2010, the Inter-American Commission on Human Rights lifted its two precautionary measures.

98. The first National Policy on Mental Health was issued in 2002 and was followed by the current one, which covers the period from 2011 to 2020. Its overall goal is to establish a holistic and community-based approach that takes into consideration each individual and promotes mental health through actions that are preventive, healing, educational, rehabilitative, promoting community-based participation, while avoiding stigma, confinement and uprooting.

99. In 2008, the substitute homes scheme was launched as a transitional structure to facilitate services supporting independent living in the community. That was a positive initiative, but it has not been extended, which has led to systemic violations of the rights of users of mental health services, such as the right to live in the community.

100. During his visit to the Psychiatric Hospital and in different meetings on mental health, the Special Rapporteur observed that the mental health-care system remains strongly dependent on the outdated model based on long-term institutionalization and excessive use of biomedical interventions such as psychotropic medication and electroconvulsive therapy. The Hospital is poorly integrated in the community and the general health-care system.

101. All of that points to a lack of political will to shift the approach to mental health services and public investments to the community, based on quality services and the empowerment of users, and on human rights and modern principles of mental health policy. An illustration of that is the plan to construct a new building within the premises of the Psychiatric Hospital, with a budget of 2,500 million guaraníes. Such an investment would reinforce the outdated model of specialized psychiatric institutions for long-term care, and would add further barriers to the effective reform of the mental health system. The Special Rapporteur urged the authorities to reconsider that decision and use the opportunity to invest existing and planned resources to expand and reinforce community-oriented services with a human rights-based approach.

Way forward

102. A comprehensive reform of the mental health-care system, based on the principles of non-discrimination and respect for the dignity and all rights of users of mental health services, could be successful in Paraguay. It is of utmost importance to make decisions with regard to two aspects.

103. Firstly, a mental health bill could be considered as an appropriate step but with the necessary precondition that the law is in line with the provisions of the Convention on the Rights of Persons with Disabilities. That also means that the new law should not list numerous exceptions to justify restrictions of the human rights of users of mental health services, in particular those with psychosocial disabilities. It should include measures allowing the empowerment of all stakeholders of mental health services, including users of services, their relatives, and service providers such as health professionals, managers and policymakers. That should pave the way to effectively implement the Convention on the Rights of Persons with Disabilities and thus eradicate the legacy of systemic violations of human rights in psychiatry.

104. Second, public investments should be directed not to support psychiatric hospitals or institutions for long-term care, which should be progressively closed, but to community-oriented mental health services. Those services should be mainstreamed within the general health-care services, substitute homes in the community, and inclusive education of children with developmental and psychosocial disabilities.

105. Paraguay is well placed to move in that direction, particularly as it does not have a high rate of persons in residential institutions and psychiatric hospitals compared with many other countries. However, key stakeholders, including the leadership of professional groups, appear not to be ready to seriously consider a real shift in the provision of mental health services. That is why an effective transition should be undertaken in phases. However, in order for that to succeed, real political commitment and will is needed to encourage, guide and engage all stakeholders in a meaningful public debate on how to ensure the full realization of the right to mental health.

F. National health-care system

106. The normative framework establishing the national health system stems from the Constitution, which enshrines the right to health and related rights in its articles 6, 7, 68, 69, and 70. The Ministry of Public Health and Social Welfare was established in 1936 and by means of public law, though a Decree in 2001. The Ministry is responsible for organizing the health system and services in the country and for promoting the health of the general public.

107. The Health Code was promulgated in 1980 through Act No. 836/80 and contains provisions on mental health (arts. 43-48) and health for sport (arts. 49-54), and promotes community participation in the preservation and improvement of health services (arts. 236-238). However, the Code includes a chapter on the "control of the health of individuals" which establishes compulsory health testing before marriage with the aim of identifying illnesses that could threaten the health of one of the spouses (arts. 61), and the requirement to obtain a premarital medical certificate, without which the marriage will not take place (art. 63). That could have discriminatory implications and could violate the right to privacy and family life.

108. During his visit, the Special Rapporteur learnt that the Health Code is in the process of being reviewed, with the technical assistance of PAHO. He welcomed that and hoped that the Code would be updated and reviewed to address all relevant issues from a human rights perspective.

Priorities for strengthening the health-care system

109. The national health system was established in 1996 through Act No. 1032/96, which defines its purpose and organization, including the coordinating role of the National Health Council. The Council is a public-private inter-institutional coordinating body, with regional and community level subcouncils, which meet regularly and include civil society representatives. In June 2012, there were 224 health councils, 211 local health councils and 13 regional health councils present in 87 per cent of the country's districts.[31]

110. However, the National Health Council has not been effective. It has only been convoked once, in October 2014, and historically has not fulfilled its role as coordinator and evaluator of public policies. During his visit, the Special Rapporteur met with staff of the local health council in Coronel Oviedo and was discouraged to learn that it discharges its mandate by simply ensuring the availability of supplies to the local hospital. He was also discouraged by the evident lack of resources and the council's lack of visibility within the community.

111. Health councils, both at national and municipal levels, should adopt modern public health and human rights-based approaches, including health promotion and prevention at

[31] UNICEF, "Situación del derecho a la salud", p. 85.

the community level. In order to achieve that, health councils should actively involve all stakeholders.

Structure and financing of the national health-care sector

112. The national health system in Paraguay is currently composed of a combination of public, private and mixed subsystems that are fragmented and lack coordination and integration mechanisms. The basic structure comprises a central public health system, which includes the Ministry of Public Health and Social Welfare and military and police health systems. There is also a decentralized public health system that includes the Social Security Institute, which covers people who are in salary-based insurance schemes, the National University of Asunción with the Clinical Hospital, and the Maternal and Infant Clinic. The private sector includes non-governmental organizations and cooperatives, and the lucrative prepaid medical services sector, and the mixed component is represented by the Paraguayan Red Cross.

113. That constellation of different subsystems facilitates the persistence of significant and inefficient asymmetries in resource allocation and coverage.[32] For instance, the Ministry of Health and Social Welfare has to cover almost 80 per cent of the population with a budget of about 2.3 per cent of gross domestic product, while the Social Security Institute covers about 18 per cent of the population with a budget of about 1.3 per cent of gross domestic product.[33] Both the Ministry of Health and the Social Security Institute cover about 95 per cent of the population, while the private sector provides services to about 7.5 per cent of the population.[34]

114. It is reported that the endemic lack of coordination between the different elements of the national health system and the high degree of concentration of services in the capital and the Central department[35] is having a direct impact on the quality of the services provided, multiplying costs, and protracting diagnosis and treatment.

115. Initiatives such as the integrated health services network are commendable efforts to tackle the excessive fragmentation and lack of coordination. However, more should be done, which requires political commitment from the highest levels of governance.

116. Public investment in the national health system in Paraguay is among the lowest in the Americas region. According to data from 2011, total health expenditure was 8.1 per cent of gross domestic product, but general government expenditure on health was only 11.2 per cent of total government expenditure.[36] The budget allocated to the health sector was progressively increased between 2007 and 2011 in the framework of human rights oriented policies, but from 2012 onwards the increase has slowed down. One recurrent problem affecting the national health system is the low level of budgetary execution, that is, actual spending of the allocated budget, which has decreased in the past few years. That could imply a lack of capacity to manage existing allocations and could have had a significant impact on out-of-pocket expenditure for families.

[32] See www.cird.org.py/salud/docs/Paraguay_Health_Service_Delivery.pdf.

[33] Coordinadora por los Derechos Humanos del Paraguay, *Derechos Humanos en Paraguay 2014* (Asunción, 2014), pp. 202-217.

[34] See Red de Derechos Humanos del Poder Ejecutivo, "Indicadores de derechos humanos", pp. 84 and 154.

[35] María Cristina Guillén, "Paraguay: sistemas de salud en Sudamérica: desafíos hacia la integridad y equidad", (Ministerio de Salud Pública y Bienestar Social, 2011), p. 27.

[36] See www.who.int/gho/publications/world_health_statistics/EN_WHS2014_Part3.pdf?ua=1.

117. The main sources of financing for the health system are the public budget, social security, out-of-pocket expenditure to private insurance schemes, employer and company contributions to the Social Security Institute, and external sources, which include international cooperation through multilateral or bilateral sources. Out-of-pocket payments are very high, representing almost 90 per cent of the total private expenditure on health in 2011, and have increased over the past decade, particularly affecting the poorest quintiles of the population.[37] That is a source of concern since the ability to pay should never affect an individual's decision whether to access the necessary health goods and services.

118. One crucial element to be considered is the fact that Paraguay lacks a national tax system based on revenue, with most of the taxes being imposed indirectly, which is by definition an unfair system that does not protect those with fewer resources or those in situations of poverty.

Primary care and universal health coverage

119. Decentralization and a policy of universal comprehensive health care were instituted in 2008 as primary strategies for the National Health Plan, which also included human resources for health as one of the central pillars of the health system.

120. The development of family health units since 2009 is a good example of efforts in the direction of ensuring universal health coverage through the primary care system. It is part of the national strategy to promote quality of life and health with equity and to combat poverty. The family health units are meant to be the gatekeepers of the national health system and their main objectives are to detect ailments and avoid illnesses in a timely fashion, to solve health problems close to where people live, and to promote health and a culture of health prevention at the community level.

121. Currently, there are about 790 family health units in operation, each of them providing services to between 3,500 and 5,000 individuals. It is estimated that, in order for the primary health-care system to have a minimum of coverage at the national level and reach out to the 3.9 million people currently without coverage, it would be necessary to establish about 1,300 family health units.[38]

122. After the initial, promising stage of establishing the units, the Special Rapporteur observed that the network requires more resources and more personnel, and that very few new units have been created over the past two years. In addition, there have been significant gaps in addressing the health needs of key populations such as women and children, indigenous communities, and persons with disabilities.

123. The effective decentralization of health competencies following a human rights-based approach is crucial to reducing inequalities and contributing to social cohesion. It is also a key step towards progressively achieving universal health coverage as part of the Sustainable Development Goals. Therefore, it is of utmost importance to use the current momentum to reinforce the expansion and quality of the network of family health units by increasing the number of units and the number of health personnel available, including health promoters, improving the infrastructure and providing for the needs of key groups and populations.

[37] See www.who.int/gho/publications/world_health_statistics/EN_WHS2014_Part3.pdf?ua=1.

[38] See www.mspbs.gov.py/planificacion/informe-de-monitorero-2012/.

Human resources for health and participation

124. The National Health Policy (2015-2030) includes human resources for health as one of the central pillars of the health system. However, Paraguay has traditionally suffered from poor development of human resources in the health-care sector, resulting in inadequate availability and composition of the health workforce, particularly those required for essential services. For instance, there is an endemic lack of health professionals focused on the needs of adolescents, and the theme is not present in the curriculum of paediatricians. In addition, the health system is not well equipped to provide services to adolescents or to respond to their needs.

125. Although there are reportedly 22.5 health workers per 10,000 population nationally, inequitable geographic distribution of health workers linked to poor infrastructure and limited incentives to work in rural areas has resulted in 70 per cent of health workers concentrated in the area around Asunción, where 30 per cent of the population lives.[39]

126. The active involvement of all key stakeholders in the functioning of the health system, including users of services and the health-care workforce, is crucial to ensure trust, transparency and accountability. Currently, key stakeholders, including professional medical organizations, non-governmental organizations representing civil society, users of health services and their relatives do not feel that they are participating in the process of health policy decision-making.

127. In order to address that, the self-regulation of professional health groups should be promoted and the role of health councils at all levels should be reinforced. The quality of medical education and the education of related professions need to be strengthened so that beyond clinical skills, other knowledge and skills are promoted, including human rights, ethics, health management and communication skills.

IV. Conclusions and recommendations

128. **The Special Rapporteur notes the progress made in Paraguay with respect to the right to health. In particular, he notes the significant advances made in health-related indicators and the expansion of primary care. He commends efforts made towards the harmonization of the normative framework and the commitment to bring it into line with the international human rights system and framework.**

129. **However, during his visit, the Special Rapporteur observed serious challenges to the realization of the right to health connected to the implementation of the existing normative and policy framework, and the prevalence of inequalities, discrimination and violence against key populations, particularly women and girls, children and adolescents, lesbian, gay, bisexual and transgender persons, persons with disabilities and people living with HIV/AIDS.**

130. **The Special Rapporteur would like to reiterate that the right to health should be promoted and protected not only through access to health-care services, supplies and facilities, which should be available, affordable, appropriate and of good quality. The right to health is also realized through the design and implementation of cross-sectoral programmes that address socioeconomic, cultural and environmental factors. Such policies or programmes should be guided by a human rights-based approach with strong emphasis on the principles of equality and non-discrimination, participation and empowerment, and accountability.**

[39] See www.who.int/workforcealliance/countries/pry/en/.

131. **The Special Rapporteur recommends that the State:**

(a) **Ratify the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights and the Optional Protocol to the Convention of the Rights of the Child on a communications procedure, in line with the recommendations made during the universal periodic review in 2016 (see A/HRC/WG.6/24/L.5);**

(b) **Pass the bill on comprehensive protection for women against all forms of violence and adopt without further delay a law against all forms of discrimination;**

(c) **Continue and strengthen cooperation with OHCHR and the United Nations system to ensure that the normative and policy framework is guided by a human rights-based approach, including when it relates to the enjoyment of the right to health;**

(d) **Follow up effectively on the implementation of the National Plan on Human Rights Education and on the work done on human rights indicators, particularly on the right to health, that was carried out previously with the technical assistance of OHCHR;**

(e) **Address neonatal mortality and morbidity, including by using the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age (A/HRC/27/31), which was produced by OHCHR in collaboration with WHO;**

(f) **Address the high rates of early pregnancy, including among very young girls, through changes in legislation, policies and practices based on scientific evidence and a human rights-based approach;**

(g) **Create an enabling environment to ensure that every woman and girl has access to safe abortion and post-abortion care, including by ending criminalization and ensuring access to services, at least when the pregnancy is the result or rape or incest, in cases of fetal impairment, and when the life and the health of the mother is in danger, as well as by providing the information and training necessary to relevant health professionals and key groups of women and girls at risk, and by addressing the stigma associated with seeking abortion services or treatment for post-abortion complications;**[40]

(h) **Ensure that barriers to girls' and women's sexual and reproductive rights are removed, including by providing sexual and reproductive health information, services and goods, in particular comprehensive, age-sensitive and inclusive sex education in schools;**

(i) **Ensure that all acts of intimidation, harassment and violence against individuals, civil society organizations and lawyers working on women's rights and gender issues are properly addressed by publically supporting their work and guaranteeing access to justice, protection and redress for victims;**

(j) **Protect children from all forms of violence, including from intrafamily violence and bullying in schools; make sure that non-custodial measures are widely applied to children in conflict with the law, and find suitable alternatives to detention, always bearing in mind the best interest of the child;**

[40] World Health Organization, "Safe abortion: technical and policy guidance for health systems" (Geneva, 2012).

(k) **Promote the well-being and autonomy of children by providing them with conducive environments and services, particularly in the health and education sectors; and by ensuring their meaningful participation in all decisions affecting them, particularly in the areas of sexual and reproductive rights and drug and substance use;**

(l) **Prohibit violence and any discrimination on the basis of sexual orientation and gender identity and expression in all services, including health, education, employment and access to public services; and prosecute perpetrators of violence against lesbian, gay, bisexual and transgender persons, protect victims, and ensure access to justice and remedies;**

(m) **Eliminate discriminatory provisions towards people living with HIV/AIDS in the policy and legal framework, such as those contained in Act No. 3.940, and ensure that health services are available, accessible, acceptable and of good quality, including by eliminating practices that may infringe on the right to privacy;**

(n) **Address new trends in the HIV/AIDS epidemic with adequate policies and comprehensive educational and information campaigns, particularly among adolescents and young people;**

(o) **Start a gradual comprehensive reform of the mental health-care system based on the principles of non-discrimination, participation and respect for the dignity and all rights of users of mental health services;**

(p) **Develop a system of user-friendly community-oriented services for children and adults with mental health conditions, including persons with developmental and psychosocial disabilities, and ensure that their rights are respected, promoted and protected;**

(q) **Progressively close the Psychiatric Hospital in Asunción and move towards an effective integration of mental health services in general health care and community life;**

(r) **Continue the reform and revision of the Health Code by working closely with PAHO and OHCHR, and remove compulsory health testing as a precondition to marriage;**

(s) **Strengthen the health-care system and ensure adequate, equitable and sustainable financing for health by increasing national budget allocations for health, and ensure that the health system is funded progressively through universal contributions, based on individuals' and families' ability to pay, and that it foresees exemptions for the poor;**

(t) **Address the excessive fragmentation of the health-care system with a view to integrating existing elements and decentralizing competencies in an effective manner following a human rights-based approach. In the same vein, reinforce health councils at all levels, and expand family health units, ensuring the quality of the services provided.**