

MIGRANTS' RIGHT TO HEALTH  
IN CENTRAL ASIA:

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# CHALLENGES AND OPPORTUNITIES



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International Organization for Migration (IOM)

The UN Migration Agency

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In its activities, IOM believes that humane and orderly migration responds to the interests of migrants and society as a whole. As a leading intergovernmental organization IOM is working with its partners in the international community, guided by the following objectives: to promote the solution of urgent migration problems, improve understanding of problems in the area of migration; encourage social and economic development through migration; assert the dignity and well-being of migrants.

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# CHALLENGES AND OPPORTUNITIES

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International Organization for Migration (IOM)  
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# FOREWORD

Ongoing trends of economic development and regional integration are currently intensifying migration flows in Central Asia. More than ever, the region's population is on the move in search of opportunities for employment, education and personal development. However, despite its many benefits, migration often leads to heightened health risks for those who undertake it.

Currently, legislation, policies and practices in both countries of origin and destination are not fully adapted to migrants' reality and health needs. Indeed, providing healthcare services to migrants meeting standards of quality and accessibility represents a considerable challenge for governments. The enhancement of legislative and policy frameworks allowing migrants to benefit from healthcare in destination countries requires a better understanding of the context-specific health impacts of migration, of migrants' experience in accessing healthcare and of the specific needs of the most vulnerable migrant sub-groups. The analysis contained in this report aims to fill this knowledge gap by providing stakeholders with information and recommendations for evidence-based policy-making aimed at the realization of migrants' right to health in Central Asia.

This report symbolizes IOM's commitment to promote migrants' health in Central Asia and assist governments in developing inclusive healthcare systems for the benefit of all, including migrants and their host communities.

**Dejan Keserovic**

IOM Coordinator for Central Asia and  
Chief of Mission in Kazakhstan, Kyrgyzstan,  
Turkmenistan and Uzbekistan



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# SUMMARY

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health – or simply “the right to health” – is explicitly formulated in an array of international law instruments, of which most Central Asian states are part. These instruments define states’ obligation to provide healthcare services for all, without discrimination based on health status, ethnicity, age, sex, disability, language, religion, national origin, income, social status or any other characteristic.

This right is particularly important to Central Asian migrants considering the significance of the migration phenomenon in the region. Indeed, the well-being of many households directly depends on migrants’ remittances. Moreover, ongoing processes of regional integration (such as the entry into force of the Eurasian Economic Union) as well as circumstantial factors (for instance the re-entry bans imposed by the Russian Federation on many Central Asian migrants) are intensifying mobility within the Central Asian region. These trends point to the need to address the health challenges of the most mobile and vulnerable groups of all: migrants.

Since their recent independence, Central Asian states have made significant progress towards the realization of migrants’ right to health, which represents a considerable challenge. They have acceded to many relevant international law instruments, while their legislation and policies are progressively adapting to this reality. However, much remains to be done to fully realize migrants’ right to health in Central Asia.

In terms of legislation (chapter one), Central Asian countries have developed frameworks guaranteeing the right of migrants to healthcare, irrespective of their legal status. However, this right is mainly reflected in overarching legislative documents such as constitutions, and is often absent in “lesser” policy documents such as bylaws, action plans, strategies and so forth. Moreover, clear implementation mechanisms of this right are often lacking in national legislations. Central Asian countries should thus pursue their efforts in enhancing legislative and policy frameworks in the area of migrants’ health, while striving to strengthen compliance with international norms and standards in the field.

Legislation and policies, however, do not always fully reflect migrants’ experience. The sociological research conducted within this project (chapter two) confirmed the oft-cited fact that migrants represent a particularly vulnerable group when it comes to health outcomes. Indeed, it was found that the migration experience significantly impacts migrants’ health, mostly in a negative way. Migrants’ health challenges, needs and obstacles hindering their access to healthcare are many and related to the different aspects of the migration experience.

An important factor determining the health impact of migration is the “cost minimization strategy” used by many migrants, who try to maximize the financial benefits of their journey by reducing expenses related to housing, nutrition and healthcare, all important determinants of health. For instance, housing arrangements of many migrants are characterized by overcrowded conditions leading to increased stress, weaker immune systems and increased risks of transmission of communicable diseases.

In addition to housing, working conditions significantly contribute to the negative health impact of mi-

gration. Occupational health risks are indeed high for migrants due to the fact that many are employed in the least regulated sectors of the labour market, where they perform hard physical tasks and undergo long work regimes often in the absence of safety training and equipment. Moreover, it is a common practice among migrants to work without formal employment contracts, a situation denying them the protection provided by labour legislation of host countries.

Of all the determinants of migration's health outcomes, legal status holds a central place. It was found that migrants with regular status enjoy a better access to healthcare in host countries. Conversely, irregular migrants' access is greatly impeded, whether by formal barriers of host countries' health systems or by migrants' reluctance to interact with them due to irregular status. The most frequent cause for irregular status is non-compliance with requirements related to registration at the place of residence. The absence of valid registration is mostly due to migrants' low level of knowledge about requirements and procedures, the use of intermediaries, frauds, registration systems not fully adapted to migrants' reality and a lack of trust towards state institutions in host countries.

Another important health determinant during migration is the degree to which migrants possess the required awareness and knowledge to navigate the legal environment and healthcare systems of host countries. It was found that migrants' knowledge is generally weak, a situation greatly aggravating the health impact of migration. Particular efforts should thus be devoted to increase migrants' awareness through innovative approaches.

In addition to these "general vulnerabilities", some migrant sub-groups are subject to specific vulnerability factors. Among those, many migrating women face acute challenges related to reproductive health. Indeed, pregnancy and/or childbirth during migration were mentioned by respondents as being particularly challenging and more likely to lead to negative health outcomes – both for mothers and children – than in countries of origin. Moreover, migrating women's experience in accessing reproductive health services appears to be highly variable due to the absence of clear procedures in host countries, thus making the "human factor" (the attitudes and actions of health professionals) an important determinant of health for migrating women with specific reproductive health needs.

In addition to migrating women, migrants' children are a particularly vulnerable group to the negative health consequences of migration (chapter four). Despite the fact that all Central Asian states acceded to the Convention on the Rights of the Child, issues with registration and absence of clear procedures hinder, in practice, migrants' children's access to healthcare. Moreover, children who are "left behind" by migrating parents often experience acute physical and mental health problems which require urgent attention from authorities in countries of origin.

In sum, it can be argued that migration's impact on health is significant and mainly negative. The inability and/or unwillingness to obtain healthcare services in host countries often lead to practices of self-treatment and self-medication, which in the absence of sufficient medical knowledge can bring about negative health outcomes.

The relationship between migration and health also concerns trends in migration of healthcare professionals such as physicians and nurses (chapter three). Indeed, the migratory behaviour of this group impacts the regional and national distribution of the health workforce, as well as the availability and quality of healthcare services in many regions. Overall, the migratory behaviour of healthcare professionals is dictated by general migration patterns in the Eurasian system. Wage differences and standards of living play an important role in migration decisions of healthcare students and medical personnel. However, other important factors such as personal aspirations, self-fulfilment, perspectives of professional growth, specialisation and further training are considered as important determinants of migration choices. In general, the state of development of the medical sector is a strong determinant of migration decision processes of healthcare professionals. The more developed the medical sector is, the less current or future health workers will be prone to migrate. This trend is well illustrated by the differences between the "Kyrgyzstan model" and the "Kazakhstan model".

Based on assessment results, recommendations were formulated to further realize migrants' right to health in Central Asia (chapter five). The underlying rationale of these recommendations is that addressing migration health issues is beneficial not only for migrants themselves, but also for the societies hosting them.

Based on assessment results, recommendations were formulated to further realize migrants' right to health in Central Asia (chapter five). The underlying rationale of these recommendations is that addressing migration health issues is beneficial not only for migrants themselves, but also for the societies hosting them. They aim to: 1) enhance legislative and policy frameworks; 2) reduce the impact of legal status on access to healthcare; 3) address specific vulnerabilities, in particular those related to gender, age and legal status; 4) raise migrants' awareness, knowledge and legal literacy about health impacting factors at the various stages of the migration journey; 5) strengthen migrants' trust in government institutions; 6) enhance the health workforce's knowledge and skills about migration health issues; 7) address occupational health risks through involvement of employers and the private sector; 8) establish post-return assistance and medical examination systems in countries of origin; 9) enhance the management of healthcare workers migration; 10) improve data collection and management systems, and 11) further involve migrants and host communities in migration health policy development.



# INTRODUCTION

The enjoyment of good health<sup>1</sup> is undoubtedly one of the most important underlying factors of human well-being. Recent developments in international law led to the establishment of the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health<sup>2</sup>” (further referred to as the “right to health”) as a universal and fundamental human right. From the Universal Declaration of Human Rights<sup>3</sup> to the International Covenant of Economic, Social and Cultural Rights, the right to health is now explicitly embedded in international law frameworks and defines the responsibility of states to provide adequate health services to all persons within their territory.

The right to health – important in and of itself – is closely related to an array of other human rights, of which it is a consequence or a precondition. Related rights include, but are not limited to, safe and potable water and adequate sanitation, adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, political participation and access to education.

The right to health and the promotion of physical and mental well-being are comprehensively reflected in international development frameworks, as shown by the central place they hold within the Sustainable Development Goals (SDGs). Goal 3, Ensure healthy life and promote well-being for all at all ages, proposes to “address all major health priorities, including reproductive, maternal and child health; communicable, non-communicable and environmental diseases; universal health coverage; and access for all to safe, effective, quality and affordable medicines and vaccines”. Among other targets, this goal aims to “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”. The right to health is also relevant to other SDGs, such as Zero Hunger (Goal 2), Gender Equality (Goal 5), Clean Water and Sanitation (Goal 6), Decent Work and Economic Growth (Goal 8) and Reduced Inequalities (Goal 10). In addition to the SDGs, the World Health Organization’s (WHO) Health 2020 policy framework for the European region – of which Central Asia is part – proposes to “significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality”. The project in the framework of which this report was produced is expected to contribute to these efforts by focusing on the health needs of a particularly vulnerable group: migrants.

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The realization of the right to health has made tremendous progress during the last decades. The WHO, in a 2014 report on Universal Health Coverage (UHC), states that “more people have access to essential

1 The WHO Constitution defines health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. This definition implies that the right to health has negative (the absence of illnesses) and positive (well-being) aspects, and should thus be considered in a holistic, comprehensive manner.

2 As stated in Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR).

3 The declaration of human right states that “[e]veryone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”. The term “everyone” clearly indicates that such characteristics as legal residence status should not impact on access to healthcare.



health services today than at any other time in history". Indicators measuring, for instance, vaccination, antiretroviral HIV therapy and antenatal care have consistently increased in the course of the last decade, including in Central Asia.

However, these positive developments in universal health coverage are far from being uniformly shared. Not only gaps between countries remain significant, but too often persons within a country do not enjoy equal access to healthcare. Indeed, for political, economic, financial or social reasons, it is often challenging for states to provide appropriate healthcare to all. Relatedly, the vulnerability to health problems and the access to healthcare services meeting standards of quality, availability, accessibility, acceptability and dignity, greatly differ from one group to another. Among the most disadvantaged and vulnerable groups, migrants and members of their family hold a central place.

Indeed, a combination of inherent characteristics and structural factors make migrants and members of their family particularly vulnerable to health problems. The migration experience – even though not in itself inevitably detrimental to health – often entails challenges and negative health consequences for those who undertake it, both during migration and upon return. Inherent characteristics include, among others, age, gender, education, social capital, financial assets and pre-migration health status. Structural factors mainly relate to working and living conditions, host countries' legal and social environments, cultural and language barriers, social norms and so forth.

Moreover, it is a proven fact that "with rare exceptions, migrants and ethnic minorities tend to occupy a less-favourable social position and research indicates that this is strongly linked to their health problems"<sup>4</sup>. Hence, not only does migration often negatively impact migrants' health, but their disadvantaged socio-economic status is often aggravated – or partly caused – by health problems, thus creating a self-reinforcing circle which is difficult to break.

If migrants as a generic category are highly vulnerable to the negative health consequences of the migration experience, distinct sub-groups show an even greater vulnerability. Among those, migrating women and children hold a critical place. Addressing female migration health issues is made urgent by the fact that women account for almost half of the Central Asian migrant population. For these women, migration represents a legitimate and valuable opportunity to gain independence, experience and skills. However, it is not devoid of risks and dangers. Indeed, persistent negative social norms, acts of violence, as well as specific reproductive health needs make this group particularly vulnerable to migration related negative health outcomes. Specific human rights law instruments were developed in response to this situation. In particular, the Convention on the Elimination of All Forms of Discrimination Against Women specifies that "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning" (Article 12). To contribute to this endeavour, the sociological component of this assessment was designed in a gender-sensitive manner allowing to investigate the specific vulnerability and needs of migrating women (section 2.5) and to formulate recommendations to address them (section 5.4).

Alongside women, migrants' children are highly prone to experience health problems and inadequate access to healthcare. Here again, specific international law documents explicitly formulate states' obligations in this area. Among those, Article 24 of the Convention on the Rights of the Child states that "Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services." In Central Asia, the health status and needs of migrants' children is understudied and relatively little is known about the realization of their right to health. Data gathered in the framework of this assessment point to the fact that migrants' children are generally disadvantaged when it comes to healthcare access, a situation often due to their parents' irregular status. The need to further understand and address migrants' children's health needs is the underlying rationale of chapter four.

<sup>4</sup> How health systems can address health inequities linked to migration and ethnicity. Copenhagen, WHO Regional Office for Europe, 2010.

Finally, it should be kept in mind that the migration experience does not only impact the health of those who actually migrate. Indeed, the well-being of migrants' family members who stay behind is also often impacted by migration. Households whose income is highly dependent on remittances can see their well-being affected if their breadwinners' health is in jeopardy. In addition, children "left behind" by migrating parents are subject to increased risks of physical and psychological health problems (sections 4.8 and 5.4).

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Addressing migrants' health is a pressing issue in Central Asia considering the scale and importance of the migration phenomenon in the region. Indeed, a recent IOM regional assessment<sup>5</sup> confirmed trends of increased mobility within Central Asia, as illustrated by the case of Kazakhstan, which in 2015 received almost 950,000 citizens from the Central Asian republics, a sharp increase compared to approximately 500,000 in 2011. Furthermore, ongoing processes of regional integration stimulate mobility among a wide range of population groups. The entry into force of the Eurasian Economic Union (EAEU) in 2015 has facilitated movements of goods and persons, lightened administrative procedures for labour migrants and led to increased mobility in the region. An evolving regional labour market and legal environment thus require a parallel evolution in legislation, policies and practices designed to realize the rights of those who embark on the migration journey.

In parallel to processes of regional integration, other developments point to the need for reinforced regional cooperation on migration health issues in Central Asia. One such development is the restructuring of migration dynamics following the re-entry bans that the Russian Federation is imposing on an increasing number of migrants, in most cases for minor administrative offenses related to registration procedures. The Russian Federation being by far the main destination for Central Asian labour migrants, re-entry bans are significantly impacting regional migration patterns. One effect is to make some countries more attractive to migrants, Kazakhstan being a case in point as it is increasingly becoming a destination country for labour migrants from Kyrgyzstan, Uzbekistan, Tajikistan and Turkmenistan. Considering these growing flows of migrants within Central Asia, increased attention should be given to their health needs, and efforts should be devoted to further mainstream migration health into national and regional governance frameworks.

As demonstrated by a strong body of evidence, addressing migrants' health can bring about significant benefits not only for migrants themselves, but also for the communities hosting them. Reducing structural barriers hindering migrants' access to healthcare can lead to positive repercussions on host countries' public health and, in the long run, reduce their financial burden. Moreover, «addressing the health needs of migrants can improve health status and outcomes; facilitate integration; prevent long-term health and social costs; contribute to social and economic development; and, most importantly, protect public health and human rights»<sup>6</sup>. If addressing migration health issues can prove challenging for governments, the advantages of doing so are many, as a healthy migrant population can significantly contribute to the well-being and dynamism of host communities.

The relationship between migration and health issues is not limited to migrants' access to healthcare. Indeed, not only does migration affect the health of those who undertake the journey, but the migratory behaviour of health workers such as doctors and nurses also impacts in significant ways the accessibility and availability of healthcare services. Indeed, human resources in the health sector is a crucial factor determining the capacity of health systems to address the needs of disadvantaged groups. However, some countries, as well as particular areas within countries – usually rural – see a significant portion of their health workforce leave in search of better professional opportunities and living conditions. A wide array of factors related to both places of origin and of destination determine migration decision processes of health workers in Central Asia, including working conditions, wage levels and opportunities for profes-

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5 IOM. 2016. *Migrant Vulnerabilities and Integration Needs in Central Asia: Root Causes, Social and Economic Impact of Return Migration*.

6 Pace, Paola. 2009. *Migration and the Right to Health: A Review of International Law*. International Migration Law #19. International Organization for Migration

sional growth. Despite its importance, health workers' migration and its impact on Central Asian states' health systems remain understudied, a situation which led to a targeted analysis of the topic presented in chapter three. It aims to further understand patterns of regional distribution of health workers, which are impacting health outcomes not only for migrants, but for the population as a whole.

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The project in the framework of which this assessment was produced represents a further step in IOM efforts to address the complex and pressing issue of migrants' right to health. It aims to update and deepen the state of knowledge on migration health issues specific to the Central Asian region. The analysis and recommendations contained in this report are intended for government and non-government stakeholders to assist them in increasing the degree of compliance of national legislations with international law and standards, strengthening regional cooperation and policy harmonization, further mainstreaming migration health into national legislation, plans, policies and strategies, as well as initiating concrete actions to increase the availability, accessibility and quality of healthcare services for migrants. Taken together, these efforts can reduce migrants' vulnerability to the negative outcomes of the migration experience, thus contributing to bring about a healthier society for the benefit of all.

Any efforts devoted to such a complex and multifaceted issue could not be successful without the active involvement of the many stakeholders playing a role in it, including governments, international and non-government organizations, civil society, host communities, diaspora organizations and migrants themselves. Thus, the outcomes of this project are expected to go beyond the mere production of this report as it also aims to strengthen multi-sectoral and regional cooperation in the area of migration health. To achieve this goal, a regional workshop was held in June 2017 in Bishkek, Kyrgyzstan, during which government and non-government actors with a migration health related mandate united to discuss the findings of the assessment, to exchange ideas and experience, and to provide input for the formulation of the recommendations presented in chapter five. This workshop represented an invaluable opportunity to give a voice to various stakeholders and establish a constructive dialogue about migration health issues in Central Asia.

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The structure of this report runs parallel to the project's different components and is designed to cover the various aspects of migration health. Chapter one presents the analysis of migration health related legislative and policy frameworks in the three participating Central Asian countries. It highlights current accomplishments, identify gaps and assesses the degree of compliance of national legislations with international law and standards.

To complement this desk-based review, chapter two adopts a qualitative sociological approach to investigate the concrete experience of migrants, mainly through in-depth interviews with current and returning migrants. This approach allowed to understand, among other topics, migrants' health status, the impact of the migration experience on migrants' health, migrants' degree of awareness and knowledge regarding their rights, their concrete experience in accessing healthcare services in host countries and the specific vulnerabilities of various migrant sub-groups.

In chapter three, the aforementioned issue of health workers' migration is examined in length in the context of external and internal migration trends in Kyrgyzstan and Kazakhstan. It brings a new light on patterns of distribution of healthcare personnel and on the migratory behaviour of this group.

Chapter four focuses on a particularly vulnerable group: migrants' children. As mentioned above, if migrants as a whole represent a particularly vulnerable group when it comes to their health, it is even more so with their children. This chapter thus presents an analysis of frameworks, policies and practices related to migrants' children's right to health and outlines paths for their enhancement.

Finally, chapter five sums up the assessment's main findings and formulates recommendations aimed at furthering the realization of migrants' right to health in Central Asia.

# 1

# LEGISLATION AND POLICY FRAMEWORKS

CHAPTER



This chapter reviews the legal and policy frameworks of the project's three participating Central Asian countries on migrants' right to health. It consists of three country sections reviewing the current state and prospects of the development of migration health related legislation of the Kyrgyz Republic, the Republic of Kazakhstan and Turkmenistan.

Each section takes into account the specificities of studied countries. At their end are listed country-specific illustrative indicators of migrants' right to the enjoyment of the highest attainable standard of physical and mental health, as well as relevant regulatory frameworks. The content of the chapter reflects stakeholders' input gathered during the Central Asian Regional Workshop on Migrants' Right to Health, held in Bishkek on 15–16 June, 2017.

The overall context of the present analysis takes into account the changes that followed the collapse of the Soviet Union in 1991 and the resulting independence of Central Asian states, which turned out to be a surprise for different sectors of the society, including local elites. Among these changes was the emergence of a fundamentally new type of migration, which took various forms and manifestations. Migration acquired a special urgency due to multiple factors typical to the region, such as:

- Ethnic minorities and ethnic groups deported in the 1940s and whose rights have not been fully determined;
- Unsettled administrative and territorial borders between states which occasionally resulted in the artificial division of ethnic groups;
- Armed conflicts in the region;
- Increasing socio-economic problems in these countries;
- Environmental degradation and disasters resulting in forced migration;
- Inadequate state border security contributing to weaker migration management systems;
- Large flows of labour migration from less economically developed to more developed countries.

Among the wide range of issues resulting from these trends, migrants' health requires special attention as it can impact public health in both sending and receiving countries. Despite a difficult social, political and economic situation, Central Asian states are devoting efforts to effectively address this issue. Consistent with their needs and capabilities, the Kyrgyz Republic, the Republic of Kazakhstan and Turkmenistan are taking measures to resolve migration-related issues in general and to ensure access to healthcare and social protection for migrants in particular. This chapter reviews how these efforts are reflected into national legislation, and what challenges await Central Asian countries in the path towards stronger legal frameworks guaranteeing migrants' right to health.



# KYRGYZ REPUBLIC



## 1.1 KYRGYZ REPUBLIC

### 1.1.1 Context and general situation

The realization of human rights and freedoms in modern society depends, above all, on its social and economic situation. Poverty, unemployment and social insecurity are the main obstacles to ensuring the human rights and freedoms, development and well-being. Since human rights and fundamental freedoms are indivisible and interdependent, the implementation, promotion and protection of civil and political, as well as economic, social and cultural rights should be paid particular attention. The implementation of economic, social and cultural rights can be achieved in different political environments; there is no unique path to their full realization. Successes and failures were observed in both market and non-market economies, and in both centralized and decentralized political systems. According to the International Covenant on Economic, Social and Cultural Rights (hereinafter referred to as ICESCR), the full realization of obligations in the field of economic, social and cultural rights can be achieved progressively. Nevertheless, the Kyrgyz Republic, like other ICESCR State parties, is legally bound to take immediate action to the maximum of its available resources to progressively achieve full realization of economic, social and cultural rights, irrespective of the current level of economic development of the country. Migrants' right to health should be at the forefront of these efforts.

However, the effective realization of migrants' right to health is faced by several challenges. The establishment and development of Kyrgyzstan's migration policy since its independence is characterized by instability and inconsistency. Despite recognizing external labour migration as an important and independent sector of the economy, at least since the 2000s weak institutional frameworks remain a key issue in the formation and implementation of an adequate migration policy. Over the past 20 years, the migration management function has been carried out by: the Department for Migration of Population (1993–1999), the State Agency for Migration and Demography (1999–2001), the Department of Migration Service (2001–2005), the State Committee for Migration and Employment (2005–2009), the Ministry of Labour, Employment and Migration (October 2009), the Department of External Migration (February 2012) and the Ministry of Labour, Migration and Youth (March 2013). Currently, migration issues are assigned to the State Migration Service under the Government of the Kyrgyz Republic. In addition, it should be noted that the Ministry of Health, as well as the state body for labour and social protection, which are engaged in health issues, have also been repeatedly reorganized.

Constant institutional re-organizations negatively affected the migration policy as the lack of stability has resulted in a weak institutional memory and insufficient capacity to adequately perform the assigned functions. The inadequate institutional framework has hindered the management of migration issues, which continues to be reactive rather than proactive. The transfer of migration issues to ministries with multiple parallel functions has resulted in the «dissolution» of migration issues among other priorities of these ministries. Despite the existence of a legal framework, issues of inter-departmental coordination related to the provision of healthcare services for migrants are still not fully resolved.



Today many companies, for various reasons, recruit foreign workers. However, few comply with requirements of national legislation on employment of foreign citizens and stateless persons in the territory of the Kyrgyz Republic. As a result, many migrants do not have access to healthcare services.

Despite existing gaps and ambiguities in the legislation on migration health of the Kyrgyz Republic, it is essential to know the existing legal provisions to prevent violations of rights.

## 1.1.2 International and regional legislation and norms

### International norms and instruments

Given its commitment to the main goals of the United Nations Charter, the rule of law, protection of human rights and democratic principles, Kyrgyzstan actively works on the protection of human rights at the international level. The country has ratified seven out of the nine universal international human rights instruments in the context of the United Nations.

Among international law instruments related to the provision of healthcare to migrants, we can note the following:

#### 1. The Universal Declaration of Human Rights of 10 December 1948

Every person has the right to a standard of living adequate to ensure his/her health and well-being of those of his/her family, including food, clothing, housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his/her control.

#### 2. Migration for Employment Convention, 1949 (No. 97)

Participating parties guarantee equal rights to healthcare and assistance in the event of illness, both to foreign migrants and to their own citizens.

#### 3. International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, 1990

According to the convention, migrant workers shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with citizens of the State party. Such emergency medical care shall not be refused on grounds of any irregularity with regard to stay or employment.

#### 4. International Covenant on Economic, Social and Cultural Rights of 16 December 1966

State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by the State Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; the creation of conditions ensuring to all medical service and attention in the event of sickness. The universally recognized principles and norms of international law are an integral part of the national legislation of the Kyrgyz Republic. In some instances, law enforcement practices are based on norms and principles set out in international legal instruments to which Kyrgyzstan is not a party, but which are recognized and applied by most developed countries of the world.

The latter trend is particularly relevant to addressing migrants' rights at the international level. For the first time, in September 2016, heads of state and governments came together to discuss issues related to migration and refugees at the global level within the framework of the UN General Assembly. This sent an important political message that migration and refugees issues have become priorities on the international agenda. In accepting the New York Declaration on Refugees and Migrants, 193 UN member states recognized the need for a comprehensive approach to the issue of human displacement and increased cooperation at the global level and pledged:



- To protect the security, dignity, human rights and fundamental freedoms of all migrants, regardless of their migration status and at any time;
- To support countries providing assistance and receiving large numbers of refugees and migrants;
- To take measures for the integration of migrants, which entails meeting their needs and providing opportunities, as well as the needs of host communities – this being done within frameworks of humanitarian and development assistance;
- Combat xenophobia, racism and discrimination against all migrants;
- Develop, as part of a state-led process, non-binding principles and voluntary guidelines for the treatment of migrants in vulnerable situations; and
- Strengthen the global migration management, including by including IOM into the UN family and by developing the UN Global Compact for Safe, Orderly and Regular Migration.

In annex II to the New York Declaration, a process of intergovernmental consultations and negotiations was adopted, as a result of which is planned the adoption of the a Global Compact during an inter-governmental conference on international migration in 2018. This international instrument is extremely relevant both for the Kyrgyz Republic and for the countries of the Central Asian region.

## Regional instruments

### 1. The CIS Agreement on cooperation in the field of labour migration and social protection of migrant workers dated 15 April 1994

Migrant workers shall be entitled to social protection and social security (except pension) in conformity with the legislation of the Party of Employment, if not otherwise provided by a special agreement. Their healthcare is provided at the expense of the employer of the Party of Employment on an equal footing as its citizens.

### 2. The CIS Agreement on the mutual recognition of workers' right for reparation for damages caused as a result of an injury, occupational disease or any other harm to health related to the performance of their duties of 9 September 1994

The Agreement establishes the procedure for reparation for damage caused to workers as a result of an occupational injury and other harm to health (including incapacity caused by an accident at a workplace related to the performance of duties by workers after the victim has moved to the territory of another State Party).

### 3. Agreement on the provision of medical assistance to citizens of member countries of the Commonwealth of Independent States of 27 March 1997

Unimpeded provision of first aid and emergency medical care for sudden acute conditions and illnesses that threaten the life of a patient or public health, as well as accidents, poisonings, injuries, childbirth and emergency conditions during pregnancy in the necessary amount and in all medical institutions (irrespective of a lack of possession of a health insurance policy) to citizens of the Commonwealth states who are not citizens of the country of a temporary residence.

### 4. Agreement on the mutual granting of equal access to first aid and emergency medical care to citizens of the Republic of Belarus, the Republic of Kazakhstan, the Kyrgyz Republic and the Russian Federation of 24 November 1998

Ensuring the provision of first aid and emergency medical care for workers from member states.

### 5. Convention on the legal status of migrant workers and members of their families adopted by the CIS member states of 14 November 2008

The Convention is intended to consolidate the fundamental rights of migrant workers including the right to free emergency medical assistance and paid healthcare services.

## 6. Treaty on the Eurasian Economic Union of 29 May 2014<sup>7</sup>

The EAEU Treaty is a highly detailed document which requires special attention. The Treaty establishes the right of workers – citizens of member states – to receive medical assistance in the EAEU countries. Firstly, workers and members of their families are entitled to receive free medical aid (in emergency and urgent cases) in member states of the Eurasian Economic Union on an equal footing with citizens of the state of employment and irrespective of a lack of possession of a health insurance policy. Secondly, in some member-countries workers have the right to healthcare services under the compulsory health insurance (for example in the Kyrgyz Republic, the Russian Federation and the Republic of Kazakhstan). Hence, the EAEU Treaty grants equal rights of access to healthcare services (in emergency and urgent cases) to workers and their family members enjoyed by the citizens of the state of employment, i.e. it provides for the so-called “national regime”. Healthcare expenses in such cases are covered by the state of employment.

In the event of continuation of treatment in a medical organization in the country of employment after elimination of immediate threats to life or to public health, the actual cost of healthcare services is paid directly by the patient at current prices. The patient pays the medical expenses him/herself from his/her own funds or from other sources not prohibited by the legislation of the member state.

The Treaty also addresses issues related to medical evacuation of patients to the state of permanent residence if required. If the patient requires medical evacuation to his/her country of permanent residence, the healthcare organization sends the information about his/her health status to the embassy and/or the authorized body (organization) of the state of permanent residence. The possibility and procedure of medical evacuation are defined by national legislations of the Union’s member states. The evacuation is carried out by mobile ambulance teams who can provide medical assistance during transportation, including the use of medical equipment. Evacuation-related costs are covered at the expense of the corresponding budget of the state of permanent residence.

### 1.1.3 National legislation

#### 1. Constitution of the Kyrgyz Republic

Article 47 establishes that everyone (including foreign citizens and stateless persons) has the right to health. The Government creates conditions to provide healthcare for everyone and takes measures to develop the state, municipal and private healthcare sectors. Free healthcare and medical services on preferential terms are provided within the limits of the State guarantees stipulated by legislation.

#### 2. The Law “On External Labor Migration” of 13 January 2006, No. 4

The law sets out that employers are responsible for provision of healthcare for their migrant workers and members of their families.

#### 3. The Law of the Kyrgyz Republic of 9 January 2005 “On the Health Protection of Citizens in the Kyrgyz Republic”, No. 6

Article 63 establishes that foreign citizens in territory of the Kyrgyz Republic, stateless persons permanently residing in the Kyrgyz Republic and refugees are guaranteed the right to healthcare in accordance with the legislation of the Kyrgyz Republic and international treaties signed by the Kyrgyz Republic. The procedure for provision of medical care for foreign citizens, stateless persons and refugees is determined by the designated healthcare authority of the Kyrgyz Republic.

#### 4. The Law of the Kyrgyz Republic of 17 June 1999 “On mental health services and guarantees of the rights of citizens in rendering these services”, No. 60

While receiving mental health assistance, foreign citizens and stateless persons residing in the territory of the Kyrgyz Republic enjoy all the rights established by this Law on an equal footing with citizens of the Kyrgyz Republic.

<sup>7</sup> Chapter XXVI «Labor Migration».

### 5. The Law of the Kyrgyz Republic of 18 October 1999 “On the medical insurance of citizens of the Kyrgyz Republic”, No. 112

Article 8 of the Law establishes that foreign citizens temporarily or permanently residing in the territory of the Kyrgyz Republic are subject to compulsory health insurance. Wherein, contributions for foreigners temporarily residing in the territory of the Kyrgyz Republic are paid by employers or by foreign citizens themselves in accordance with the legislation of the Kyrgyz Republic, unless otherwise provided by inter-state agreements.

### 6. The Law of the Kyrgyz Republic of 30 July 2003 “On the Single Payer system in financing of healthcare of the Kyrgyz Republic”, No. 159

The Law establishes the Single Payer system which consolidates the healthcare resources derived from the basic state health insurance and compulsory health insurance to ensure the subsequent single-channel funding of health and pharmaceutical services provided to the population by healthcare organizations. In the Kyrgyz Republic, the Single Payer system provides for a single healthcare funding agency with the authority to manage basic state medical insurance and compulsory health insurance.

### 7. The Order of the Government of the Kyrgyz Republic “On healthcare of foreign citizens” of 15 June 2000, No. 346

The Order approved the list of state healthcare institutions which deliver medical services to foreign citizens together with the official pricelist for services rendered by foreigners residing in the Kyrgyz Republic. However, this legal act does not specifically affect the category of migrants.

### 8. Order of the Government of the Kyrgyz Republic “On the Mandatory Health Insurance Fund” of 20 February 2012, № 133

The Order establishes the Mandatory Health Insurance Fund (MHIF) to ensure good quality medical and preventive care for citizens of the Kyrgyz Republic (as well as foreign citizens and stateless persons) under the State Guarantees Program on provision of healthcare for citizens of the Kyrgyz Republic and other compulsory health insurance programs.

### 9. Resolution of the Government of the Kyrgyz Republic of 28 February 2012 “On approval of the Regulation on the compulsory health insurance policy”, No. 151

The Resolution establishes the medical health insurance (MHI) policy, a document granting the right to healthcare under state compulsory medical insurance system programs, and gives the insurance status to those who are not covered by the compulsory health insurance system in the Kyrgyz Republic.

### 10. Order of the Ministry of Health of the Kyrgyz Republic and the Mandatory Health Insurance Fund under the Government of the Kyrgyz Republic of 19 February 2016 No. 123 “On approval of the Provisional Regulations on the procedure and conditions of implementation of the compulsory health insurance for foreign citizens and stateless persons temporarily staying or temporarily residing in the Kyrgyz Republic”

The Order establishes a mandatory procedure for health insurance for foreign citizens and stateless persons temporarily staying or temporarily residing in the Kyrgyz Republic. These individuals must present a compulsory health insurance policy to receive medical services under the State Guarantee Program in health institutions within the Single Payer system.

Thus, one of the healthcare frameworks in the Kyrgyz Republic also available for migrants is the compulsory medical insurance system. Citizens of the Kyrgyz Republic and foreign citizens, in cases stipulated by international treaties, are subjects to basic state healthcare insurance.

Mechanisms of the EAEU Treaty and the national legislation of Kyrgyzstan deserve further attention. Workers of EAEU member states have the right to receive healthcare services under the State Guarantees Programme on an equal basis with citizens of Kyrgyzstan if they have an employment contract with an employer and pay insurance premiums to the Mandatory Health Insurance Fund under the

Government of the Kyrgyz Republic. The implementation of the basic state medical insurance program is carried out by the executive body of the medical insurance system – the Health Insurance Fund and its territorial bodies. The program is financed by the republican and local budgets based on minimum social standards. The Compulsory Health Insurance Program consists of the basic and the supplementary programmes.

Foreign citizens temporarily or permanently residing within the territory of the Kyrgyz Republic are also subject to compulsory medical insurance. Insured persons have the right to receive medical, preventive, rehabilitation and health-improving services under the Compulsory Health Insurance Program throughout the territory of Kyrgyzstan in medical and preventive institutions contracted under the compulsory medical insurance. Insured persons are obliged to present documents confirming their right to receive medical and preventive care when applying for medical aid under the Compulsory Health Insurance Program. Insurance premiums for foreign citizens temporarily staying in the territory of the Kyrgyz Republic are paid by employers or foreign citizens themselves in accordance with the legislation of the country, unless otherwise stipulated by interstate agreements<sup>8</sup>. Employers pay insurance contributions to the Mandatory Health Insurance Fund at the amount of 2%<sup>9</sup>. Individuals can apply at the territorial office of the Mandatory Health Insurance Fund to purchase a compulsory medical insurance policy. Medical assistance under the Compulsory Health Insurance Program is provided to insured persons after identifying the patient in the database of the Mandatory Health Insurance Fund and determining the timing of contributions' payment<sup>10</sup>. The social security certificate serves as a proof that the person is insured. To receive medical services, insured persons must:

- Present documents for identification of their insurance status when applying for medical services under the compulsory medical insurance program;
- Take responsibility for the safety of insurance documents and do not transfer them to other persons to obtain medical services;
- In case of loss of the compulsory health insurance policy, individuals submit a written notification to the territorial administrative body of the Medical Insurance Fund that issued the policy in person or through the insurer.

#### 1.1.4 Conceptual foundations of Kyrgyzstan's migration policy

During the years of independence, Kyrgyzstan has adopted several conceptual frameworks in the field of migration:

- The State Demographic and Migration Policy Framework of the Kyrgyz Republic approved by the Decree of the President of the Kyrgyz Republic dated 28 April 2000, No. 102.
- The State Migration Policy Framework until 2010 approved by the Decree of the President of the Kyrgyz Republic dated 30 April 2004, No. 151.
- The State Program of Measures on Regulation of Migration Processes in the Kyrgyz Republic for 2007-2010.
- The Program on facilitation of employment and regulation of labor migration until 2020 approved by the Government of the Kyrgyz Republic on 6 September 2013.

In general, the analysis of conceptual framework (and particularly of the provisions on external labour migration) demonstrates that there were no significant conceptual innovations made over the past 10-15 years. It could be stated that conceptual frameworks reflected the understanding of economic and demographic issues of Kyrgyzstan, the limited choice of directions for emigration and the strong

8 The Law of the Kyrgyz Republic «On Tariffs of Insurance Contributions for State Social Insurance» of 24 January 2004, No. 8.

9 The Order of the Government of the Kyrgyz Republic on «Rules of the compulsory health insurance of citizens in the Kyrgyz Republic» of 9 March 2000, No. 121, items 8-7.

10 Ibid., item 14.

dependence on main recipient countries of labor migrants. Despite slight differences in emphasis, overall these documents reflect the logic of a labor exporting country.

Interestingly, none of the above conceptual frameworks contain regulations on ensuring migrants' rights to health. Furthermore, there is no interrelationship between programmatic documents in the areas of migration and healthcare.

### 1.1.5 Kyrgyz Republic: Conclusions and specific recommendations

Analysis of the legal framework of the Kyrgyz Republic and international commitments of the country within the context of universal human rights instruments, documents of the International Labour Organization and agreements of the Commonwealth of Independent States shows that the country has established a legal framework to ensure migrants' right to healthcare.

At the same time, a special law on migration processes<sup>11</sup> establishes the responsibility of economic entities to submit the information on healthcare support to the state migration authority and the labor migrant himself. It also stipulates that an employment agreement (contract) should contain provisions on organization of healthcare and medical insurance.

The existing gaps in legislation allow for the formulation of the following conclusions and recommendations:

1. The current legislation only regulates the provision of healthcare for migrants who are legally staying in the republic. Nevertheless, international obligations of the Kyrgyz Republic stipulate that the country must respect the human rights, and, specifically, the right to health care, including of those who illegally enter the country<sup>12</sup>. Thus, guarantees of these rights should be incorporated in the national legislation.
2. Provisions of the Law of the Kyrgyz Republic «On External Labor Migration» are of declarative nature in regard to the guarantees of migrants' right to healthcare. Provision of access to healthcare for migrants is outlined in the Order of the Ministry of Health of the Kyrgyz Republic and the Mandatory Medical Insurance Fund under the Government of the Kyrgyz Republic «On approval of the Provisional Regulations on the procedure and conditions of implementation of the mandatory health insurance for foreign citizens and stateless persons temporarily staying or temporarily residing in the Kyrgyz Republic» dated 19 February 2016, No. 1. However, this act is not a legal instrument and has the lowest status in the hierarchy of legal acts<sup>13</sup>. It is recommended to set out these issues in laws of the Kyrgyz Republic.
3. As indicated in paragraph 1 of this section, the Kyrgyz Republic is a party to agreements within the CIS which guarantee the rights of migrants to receive emergency medical care free of charge. However, this provision was not subsequently reflected in the legal acts of the state. Thus, it is necessary to implement these obligations in national legislation.
4. A significant gap is that programme documents adopted in the republic, such as concepts, strategies and programs, do not reflect the right of migrants to healthcare. So, it is recommended to include these issues in national migration and health concept papers.
5. It is also recommended to consider the accession of the Kyrgyz Republic to the International Labour Organization Convention concerning Equality of Treatment of Nationals and Foreigners and Stateless Persons in Social Security No. 118 of 1962 which establishes the framework in which each State Party may accept obligations in respect of certain branches of social security including medical care, sickness benefits, maternity benefits, etc.

11 The Law of the Kyrgyz Republic "On External Labor Migration".

12 The Universal Declaration of Human Rights, International Covenant on Social, Economic and Cultural Rights.

13 In accordance with the Law of the Kyrgyz Republic «On Legal Acts of the Kyrgyz Republic» of 20 July 2009, No. 241.

6. With a view to codifying legislation in the field of regulation of migration issues, it is necessary to work either on introducing amendments and additions to the current legislation or by developing a separate normative legal act that would take into account all aspects of migration taking into account human rights, fixed in both universal and regional international treaties.

**LIST 1****International legal instruments joined  
by the Kyrgyz Republic in the field  
of migrants' right to health**

1. The Universal Declaration of Human Rights of 10 December 1948.
2. The International Labour Organization Convention on Migrant Workers No. 97, 1949.
3. The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990.
4. The International Covenant on Economic, Social and Cultural Rights of 16 December 1966.
5. The CIS Agreement on Cooperation in the Field of Labour Migration and Social Protection of Migrant Workers of 15 April 1994.
6. The CIS Agreement on the mutual recognition of the workers' right for reparation for damages caused as a result of an injury, occupational disease or any other harm to health related to the performance of their duties of 9 September 1994.
7. Agreement on the provision of medical assistance to citizens of the member countries of the Commonwealth of Independent States dated 27 March 1997.
8. Agreement on the mutual granting of equal access to the first medical aid and emergency medical care to citizens of the Republic of Belarus, the Republic of Kazakhstan, the Kyrgyz Republic and the Russian Federation of 24 November 1998.
9. Convention on the legal status of migrant workers and members of their families adopted by the CIS member states of 14 November 2008.
10. Treaty on the Eurasian Economic Union of 29 May 2014.

**LIST 2****Regulatory legal acts of  
the Kyrgyz Republic related or relevant  
to migrants' right to health**

1. The Constitution of the Kyrgyz Republic.
2. The Law "On External Labour Migration" of 13 January 2006, No. 4.
3. The Law of the Kyrgyz Republic of 9 January 2005 "On the Health Protection of Citizens in the Kyrgyz Republic", No. 6.
4. The Law of the Kyrgyz Republic of 17 June 1999 "On the mental health services and guarantees of the rights of citizens in rendering these services", No. 60.
5. The Law of the Kyrgyz Republic of 18 October 1999 "On the medical insurance of citizens of the Kyrgyz Republic", No. 112.
6. The Law of the Kyrgyz Republic of 30 July 2003 "On the Single Payer system in financing of the healthcare of the Kyrgyz Republic", No. 159.
7. The Order of the Government of the Kyrgyz Republic "On the healthcare of foreign citizens" of 15 June 2000, No. 346.
8. Order of the Government of the Kyrgyz Republic "On the Mandatory Health Insurance Fund" of 20 February 2012, № 133.
9. Order of the Government of the Kyrgyz Republic of 28 February 2012 "On approval of the Regulation on compulsory health insurance policy", No. 151.
10. Order of the Ministry of Health of the Kyrgyz Republic and the Mandatory Health Insurance Fund under the Government of the Kyrgyz Republic of 19 February 2016 No. 123 "On approval of the Provisional Regulations on the procedure and conditions of implementation of the compulsory health insurance for foreign citizens and stateless persons temporarily staying or temporarily residing in the Kyrgyz Republic".



**TABLE 1** **Illustrative indicators of migrants' right to the enjoyment of the highest attainable standard of physical and mental health – Kyrgyz Republic: Structural factors**

Structural indicators	International treaty, convention or National statutory act
International human rights treaties relevant to the right to the highest attainable standard of physical and mental health ratified by the State	<p style="text-align: center;"><b>YES</b></p> <ul style="list-style-type: none"> <li>• The Universal Declaration of Human Rights of 10 December 1948.</li> <li>• The International Labour Organization Convention on Migrant Workers No. 97, 1949.</li> <li>• The International Covenant on Economic, Social and Cultural Rights of 16 December 1966.</li> <li>• The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990.</li> </ul>
National/regional/local legislation that recognizes the equal right to health for all individuals under state jurisdiction, without discrimination based on prohibited grounds	<p style="text-align: center;"><b>YES</b></p> <p>(Relevant national legislation is listed in List 2.)</p> <p>Regional legislation:</p> <ul style="list-style-type: none"> <li>• The CIS Agreement on Cooperation in the Field of Labour Migration and Social Protection of Migrant Workers of 15 April 1994.</li> <li>• The CIS Agreement on the mutual recognition of the workers' right for reparation for damages caused as a result of an injury, occupational disease or any other harm to health related to the performance of their duties of 9 September 1994.</li> <li>• Agreement on the provision of medical assistance to citizens of the member countries of the Commonwealth of Independent States dated 27 March 1997.</li> <li>• Agreement on the mutual granting of equal access to the first medical aid and emergency medical care to citizens of the Republic of Belarus, the Republic of Kazakhstan, the Kyrgyz Republic and the Russian Federation of 24 November 1998</li> <li>• Convention on the legal status of migrant workers and members of their families adopted by the CIS member states of 14 November 2008</li> <li>• Treaty on the Eurasian Economic Union of 29 May 2014.</li> </ul>

Structural indicators	International treaty, convention or National statutory act
Recognition of migrants' right to health in law, including its scope based on type of health service (e.g., emergency only) and migration or residence status	<p style="text-align: center;"><b>NO</b></p> <p>The legislation lacks the concept of migrants' right to health. Migrants are viewed as foreign citizens and stateless persons temporarily staying or temporarily residing in the Kyrgyz Republic. Thus, migrants have the right to healthcare on an equal basis with Kyrgyz citizens.</p>
Inclusion of migrants within public health policy and programs, as a particular target group, including those aiming to reduce health inequalities and inequities and address the social determinants of health	<p style="text-align: center;"><b>NO</b></p> <p>Migrants are not included in existing national health programs as a separate category or a specific target group such as, for example, the National Program for Health Care Reform of the Kyrgyz Republic «Den sooluk» for 2012-2016.</p>
Mechanism for gathering and publishing periodic data on health conditions and health services, disaggregated by migration or residence status, age, gender, sex, ethnic origin, nationality, nationality of parents, place of residence, length of residence, and socio-economic status	<p style="text-align: center;"><b>NO</b></p> <p>Current legislation does not contain such requirements.</p>
Date of entry into force and coverage of domestic law for implementing the right to health of migrants, including prohibition of direct or indirect discrimination by public or private actors nullifying or impairing access to health	<p style="text-align: center;"><b>YES</b></p> <p>(A complete list of legal acts is given in list 2.)</p>
Existence of case law on the right to health of migrants, disaggregated by their migration or residence status	<p style="text-align: center;"><b>NO</b></p> <p>The current legislation does not contain such requirements.</p>
Mechanisms aimed at data gathering for evaluating causes of higher prevalence of health problems in the migrant population, in relation to nationals.	<p style="text-align: center;"><b>NO</b></p> <p>The current legislation does not contain such requirements.</p>

**TABLE 2** Illustrative indicators of migrants' right to the enjoyment of the highest attainable standard of physical and mental health – Kyrgyz Republic: Processes and outcomes

Accessibility of Health Facilities, Goods and Services	Cultural Acceptability of Health Services	Natural and Occupational Environment	Sexual and Reproductive Health	Child Health Care
<p>Legislation that does not oblige health workers and civil servants to detect migration or residence status to provide goods and services and report irregular migrants to migration authorities.</p> <p><b>There is no such requirement.</b></p> <p>Measures meant to remove formal and practical obstacles that hinder or prevent the enjoyment of the right to health, such as requiring a residence permit, or additional fees based on nationality or migration or residence status, and reporting migrants in irregular status to migration authorities.</p> <p><b>There are no such special measures; migrants are equated with citizens of the Kyrgyz Republic.</b></p>	<p>Legislation that prohibits any act of xenophobia at health facilities.</p> <p><b>There is no specific legislation. The Constitution prohibits any discrimination.</b></p> <p>Public institutions developing intercultural health policies, programs and services.</p> <p><b>The authorized body is the Ministry of Health of the Kyrgyz Republic.</b></p> <p>Legal framework and policies aimed at removing language and cultural barriers at health facilities and services.</p> <p><b>Legislation provides for the provision of services to patients in the language they understand.</b></p>	<p>Legal protection of the right to adequate housing, including access to water and sanitation services, without discrimination based on nationality and migration or residence status.</p> <p><b>There is no specific prohibition of discrimination on these criteria.</b></p> <p>Application of regulations and/or existence of case law on the rights of tenants, disaggregated by their migration or residence status.</p> <p><b>None.</b></p> <p>Application of legislation on occupational safety and health, including workers' rights and protections, to all workers regardless of status.</p> <p><b>Reflected both in legislation and in international agreements.</b></p>	<p>Legal protection of migrants' right to sexual and reproductive health services, regardless of nationality and migration or residence status, equal to nationals.</p> <p><b>There are no special provisions in legislation on migration and healthcare. However, international legal instruments that are part of the country's legislation provide these guarantees.</b></p>	<p>Legal protection of children's right to health, regardless of their migrant status or their parents';</p> <p><b>Provided for by the Convention on the Rights of the Child and the Children's Code of the Kyrgyz Republic.</b></p> <p>Legal recognition of the right to birth registration, regardless of the migration or residence status of parents.</p> <p><b>Provided for by the Convention on the Rights of the Child and the Children's Code of the Kyrgyz Republic.</b></p>

Accessibility of Health Facilities, Goods and Services	Cultural Acceptability of Health Services	Natural and Occupational Environment	Sexual and Reproductive Health	Child Health Care
<p>Policies directed at periodically ensuring equitable qualitative and quantitative conditions at health facilities.</p> <p><b>Reflected in legislation including, for example, Temporary Regulations* or Government decree of the KR of 20.02.2012, No.133</b></p>	<p>Policies aimed at including intercultural, rights-based approach to migration in medical training curricula.</p> <p><b>None.</b></p> <p>Health services aimed at addressing mental health problems related to migration.</p> <p><b>Not specified in legislation.</b></p>			

\* The Order of the Ministry of Health of the Kyrgyz Republic and the Mandatory Health Insurance Fund under the Government of the Kyrgyz Republic "On approval of the Provisional Regulations on the procedure and conditions of implementation of the compulsory health insurance for foreign citizens and stateless persons temporarily staying or temporarily residing in the Kyrgyz Republic" dated 19 February 2016, No. 123.





# REPUBLIC OF KAZAKHSTAN



## 1.2 REPUBLIC OF KAZAKHSTAN

### 1.2.1 Context and general situation

Four main phases can be highlighted in the development of immigration and emigration processes in Kazakhstan since its independence (1992 – present):

1. The 1990s was a decade of major crisis for the country's socio-political and socio-economic development, which was associated with migration "donation" (emigration). During this period, migration outflows surpassed insignificant immigration numbers by several times, leading to substantial reduction of the "Russian-speaking component" of Kazakhstan's population. During this phase, migration processes were spontaneous in nature despite the Decree of the President of Republic of Kazakhstan "On the legal status of foreign citizens in the Republic of Kazakhstan"<sup>14</sup> of 1995.
2. The end of the 1990s were marked by the first attempts to regulate migration processes by the adoption of legislation (the Law «On Migration of the Population» in 1997<sup>15</sup>) and the creation of the Agency for Migration and Demography<sup>16</sup>. For the first time, the Law «On Migration of the Population» had officially established criteria for granting the oralman status (persons returning to Kazakhstan as their "historical homeland"). Additionally, the Concept of repatriation of ethnic Kazakhs to their historical homeland was adopted in 1998<sup>17</sup>.
3. The first half of the 2000s was a period of socio-economic stability and economic growth (both in an "absolute sense" and in comparison with other Central Asian countries), significant reduction of emigration and gradual rise of immigration (mainly from other Central Asian countries) including ethnic immigration (inflow of ethnic Kazakhs into the country within programmes supporting their return to the «historic homeland»). During this phase, Kazakhstan became a recipient country for migrants (although in absolute terms the positive migration balance is small, these dynamics can be traced very clearly). Contributing to this trend was the fact that the emigration potential of the "Russian-speaking" population was largely exhausted by that time.

<sup>14</sup> President of the Republic of Kazakhstan. Decree having the force of law "On the Legal Status of Foreign Citizens in the Republic of Kazakhstan" of June 19, 1995, No. 2337.

<sup>15</sup> Republic of Kazakhstan. The Law "On Migration of the Population" of 13 December 1997, No. 204. // Vedomosti of the Parliament of the Republic of Kazakhstan. – 1997. – № 24. – Article 341.

<sup>16</sup> President of the Republic of Kazakhstan. Decree On establishment of the Agency on Migration and Demography of the Republic of Kazakhstan of 8 December 1997, No. 3783 – 1997. – № 52. – Article 475.

<sup>17</sup> The Government of the Republic of Kazakhstan. Resolution "On the Concept of Repatriation of Ethnic Kazakhs to Their Historical Homeland" of 16 September 1998, No. 900.

During this period, several amendments<sup>18</sup> were introduced to the Law “On Migration of the Population”, and the Migration Policy Programme of the Republic of Kazakhstan for 2001–2010<sup>19</sup> entered into force. The Conception of Migration Policy of the Republic of Kazakhstan<sup>20</sup> and the Conception of Migration Policy of the Republic of Kazakhstan for 2007–2015<sup>21</sup> were adopted in 2000 and 2007, respectively.

4. In the second half of the 2000s and 2010s, Kazakhstan was affected by the economic crisis triggered by the global financial and economic crisis of 2008, and later by the decline of raw material prices. In 2011, a new version of the Law «On Migration of the Population»<sup>22</sup> was adopted. The country discontinued the implementation of the Concept of Migration Policy of the Republic of Kazakhstan for 2007–2015<sup>23</sup> and the «Nurly Kosh» Program for 2009–2011, which was aimed at rational resettlement and provision of integration assistance to ethnic immigrants.

In 2016, the government introduced amendments<sup>24</sup> to the Law «On Migration of the Population» which linked migration (both external and internal) and threats of terrorism and extremism, and with the aim of creating an «integrated system of migration control»<sup>25</sup>.

During the existence of Kazakhstan as a sovereign and independent state, it has not signed basic universal international documents concerning the social protection of migrants. At the same time, Kazakhstan is signatory of almost all agreements regulating migration processes in the post-Soviet space.

Today, Kazakhstan is considered as a host country for migrants within the Central Asian migration sub-system. Consequently, issues related to the legal status and social security – including healthcare – of migrants in this country represent a key aspect of migration processes in Central Asia.

18 See Republic of Kazakhstan. Law of 27 March 2002 No. 313-2. On introducing amendments and additions to the Law of the Republic of Kazakhstan «On migration of the population» // Vedomosti of the Parliament of the Republic of Kazakhstan. - 2002. - No. 6. - Art. 76.

19 The Government of the Republic of Kazakhstan. Decree “On approval of the sectoral Migration Policy Program of the Republic of Kazakhstan for 2001 – 2010” of 29 October 2001, № 1371.

20 The Government of the Republic of Kazakhstan. Decree “On the Concept of the Migration Policy of the Republic of Kazakhstan” of September 5, 2000 No. 1346.

21 President of the Republic of Kazakhstan. Decree “On the Concept of the Migration Policy of the Republic of Kazakhstan for 2007-2015” of August 28, 2007 No. 399.

22 The Republic of Kazakhstan. Law “On the migration of the population” of July 22, 2011, No. 477-IV // Kazakhstanskaya pravda. - 2011. - 6 August.

23 President of the Republic of Kazakhstan. Decree of May 23, 2011 No. 88 On the recognition of invalidity of the Decree of the President of the Republic of Kazakhstan of August 28, 2007 No. 399.

24 The Republic of Kazakhstan. Law “On Amendments and Additions to Certain Legislative Acts of the Republic of Kazakhstan on Countering Extremism and Terrorism” of 22 December 2016, No. 28-VI // Kazakhstanskaya pravda. - 2016. - December 27.

25 Meeting of the Security Council under the chairmanship of the Head of the State // The official website of the President of the Republic of Kazakhstan «Ak Orda». - 2016. - 10 June // [http://www.akorda.kz/ru/events/akorda\\_news/zasedanie-soveta-bezopasnosti-pod-predsedatelstvom-glavy-gosudarstva-4](http://www.akorda.kz/ru/events/akorda_news/zasedanie-soveta-bezopasnosti-pod-predsedatelstvom-glavy-gosudarstva-4)



## 1.2.2 International and regional legislation and norms

### International norms and instruments

In accordance with the Constitution of the Republic of Kazakhstan (Article 4, paragraph 3) «International treaties, ratified by the Republic, shall have priority over its laws. The order and terms of action of international treaties of which the Republic is a party, in the territory of the Republic of Kazakhstan, shall be defined by the legislation of the Republic».

As a member of the United Nations and supporting the goals of the UN Charter, Kazakhstan shares the objectives of the Universal Declaration of Human Rights of 10 December 1948, which provides that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”. However, since this declaration is not a legally binding instrument, it does not impose any obligations on Kazakhstan; it only forms the context of the country’s legal system.

### Regional instruments

Kazakhstan is a signatory to several regional international instruments developed within the framework of the Commonwealth of Independent States (CIS), which determine the state’s position with respect to migrants. These include:

- The CIS Agreement on cooperation in the field of labour migration and social protection of migrant workers of 15 April 1994 which provides that migrant workers shall be entitled to social protection and social security (except pension) in conformity with the legislation of the Party of Employment, if not otherwise provided by a special agreement. Healthcare is provided at the expense of the employer of the Party of Employment on an equal footing as its citizens.
- The CIS Agreement on the mutual recognition of the workers’ right for reparation for damages caused as a result of an injury, occupational disease or any other harm to health related to the performance of their duties of 9 September 1994. The Agreement establishes the procedure for reparation for damage caused to workers as a result of an employment injury and other harm to health (including incapacity caused by an accident at a workplace related to the performance of duties by workers after the victim has moved to the territory of another State Party).
- Agreement on the provision of medical assistance to citizens of the CIS member states of 27 March 1997 which stipulates full provision of first medical aid and emergency medical care to citizens of the CIS states who are not citizens of the country of temporary residence, in all medical institutions (irrespective of a lack of possession of health insurance policy) for sudden acute conditions and illnesses threatening the life of patients or public health, as well as accidents, poisonings, injuries, childbirth and emergency conditions during pregnancy.
- The Convention on the legal status of migrant workers and members of their families adopted by the CIS member states of 14 November 2008, which establishes fundamental rights of migrant workers, including the right to free emergency medical assistance and paid healthcare services.

Kazakhstan is also a signatory to the Agreement on the mutual granting of equal access to first medical aid and emergency medical care to citizens of the Republic of Belarus, the Republic of Kazakhstan, the Kyrgyz Republic and the Russian Federation of 24 November 1998, which ensures provision of first medical aid and emergency medical care for workers from member states.

Currently, the key instrument determining the position of labour migrants is the Treaty on the Eurasian Economic Union of 29 May 2014, and specifically the section XXVI «Labor migration». The Treaty (Article 96) establishes the following definitions:

- «Worker of a member state» is a person – citizen of a member state who is legally staying and legally carrying out labour activities in the territory of the state of employment of which he/she is not a national and which is not a country of his/her permanent residence;
- «Family member» are persons married to the worker of the member state, their dependent children and other persons recognized as members of their families in accordance with legislation of the state of employment;
- «Social security (social insurance)» is compulsory insurance for temporary disability and maternity insurance, compulsory insurance for occupational accidents and diseases, and compulsory medical insurance.

In accordance with Article 98, workers of member states and their family members have the right to social security (social insurance) under the same conditions as the citizens of the state of employment. They are also entitled to free emergency medical care (urgent and emergency types). The article stipulates that additional medical assistance is subject to the legislation of the state of employment and international treaties of which it is a party.

Issues related to medical assistance for workers of member states and their family members are specified in the Protocol on provision of medical assistance to workers of the member states and members of their families (Appendix 30 to the Treaty on the Eurasian Economic Union). The protocol establishes the following definitions:

- «Emergency medical care (in urgent cases)» is a set of medical services provided in case of sudden acute diseases, conditions, exacerbation of chronic diseases without obvious threats to the life of the patient;
- «Emergency medical care (in emergency cases)» is a set of medical services provided in case of diseases, accidents, injuries, poisonings and other conditions that threaten the life of the patient;
- «Medical evacuation» is the transportation of patients to save their lives and preserve their health, including patients with life-threatening conditions needing to be treated beyond available health facilities, and patients affected by emergency situations and natural disasters, as well as those suffering from diseases that present a threat to others.

The protocol stipulates that state and healthcare institutions of the state of employment provide emergency medical care (in both urgent and emergency cases) to workers from the member states and their family members free of charge and irrespective of a lack of possession of a health insurance policy. If the patient's treatment continues in the healthcare institution of the state of employment after elimination of immediate threats to his/her life or health of others, the actual cost of services is paid by the patient or from other sources not prohibited by the legislation of the state of employment at the set tariffs or contractual prices. The cost of medical evacuation of the patient to the state of permanent residence is covered by the state of permanent residence or other sources not prohibited by the legislation of the state of permanent residence.

Kazakhstan also has bilateral agreements regulating the social protection of labour migrants. One example is the Agreement between the Government of the Republic of Kazakhstan and the Government of the Republic of Azerbaijan on employment and social protection of citizens of the Republic of Azerbaijan temporarily working in the territory of the Republic of Kazakhstan and citizens of the Republic of Kazakhstan temporarily working in the territory of the Republic of Azerbaijan (approved by the Decree of the Government of the Republic of Kazakhstan dated 26 July 2000, No. 1123).

### 1.2.3 National legislation

The legislation of the Republic of Kazakhstan on the legal status of non-citizens is based on the Constitution of the Republic of Kazakhstan and defines the main rights and duties of non-citizens, procedure of their entry to the Republic of Kazakhstan, stay and movement within the territory of the country and departure from the Republic of Kazakhstan in accordance with the Constitution.

### 1. The Constitution of the Republic of Kazakhstan (adopted at the Republic referendum on 30 August 1995 with amendments and additions on 10 March 2017)

Issues related to the stay of foreign citizens on the territory of Kazakhstan are addressed in Article 12, which stipulates that “foreigners and stateless persons enjoy the rights and freedoms as well as bear responsibilities established for citizens, unless otherwise stipulated by the Constitution, laws and international treaties”. Although the Constitution does not directly refer to the issue of health protection of foreigners and stateless persons, this article allows to consider that the entitlement of citizens of Kazakhstan to “free, guaranteed, extensive medical assistance established by law” enshrined in Article 29 can be applied not only to the citizens, but to all persons in the territory of the country.

### 2. The Law of the Republic of Kazakhstan dated 19 June 1995 No. 2337 «On the legal status of foreigners» (with amendments and additions as of 22 December 2016)

The law (Article 4) defines the two groups of foreign citizens and stateless persons in the territory of Kazakhstan: (1) permanently residing in Kazakhstan (those who have received an authorization and a residence permit which is subject to confirmation of their solvency in line with a procedure and in the amount defined by the Government of the Republic of Kazakhstan) and (2) temporarily residing.

According to Article 7, «foreigners and stateless persons staying in the territory of the Republic of Kazakhstan shall enjoy the rights and freedoms and bear responsibilities established for the citizens in the field of healthcare, unless otherwise provided by the legislation of the Republic of Kazakhstan and international treaties». It is highlighted that “foreigners temporarily staying in the Republic of Kazakhstan are provided with medical assistance according to the procedure defined by the health authority of the Republic of Kazakhstan”. This procedure is currently outlined by the Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011, No. 665 «On approval of the rules for provision of medical assistance to immigrants».

### 3. The Law of the Republic of Kazakhstan No. 477-IV of 22 July 2011 «On Migration of the Population» (with amendments and additions as at 22 December 2016)

The law (Article 3) establishes five types of immigration:

- For the purpose of return to historical homeland;
- For the purpose of family reunification;
- For education purposes;
- For employment purposes;
- On humanitarian and political grounds.

According to Article 5, immigrants shall have the right to health and social assistance in the manner established by the legislation of the Republic of Kazakhstan. This procedure is currently regulated by the Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011, No. 665 «On approval of rules for provision of medical assistance to immigrants».

In accordance with Article 12, the authorized body in the field of healthcare service, the Ministry of Health, approves the procedure of medical assistance to immigrants (Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011 № 665 «On approval of rules for provision of medical assistance to immigrants») and the list of diseases that prohibit foreign citizens and stateless persons suffering from them to enter the Republic of Kazakhstan (the Order of the Minister of Health of the Republic of Kazakhstan “On approval of the list of diseases that prohibit foreign citizens and stateless persons suffering from them to enter the Republic of Kazakhstan» of 30 September 2011 № 664).

Ethnic Kazakhs and members of their families resettling to Kazakhstan as their historical homeland (Oralmans) are entitled to healthcare according to the legislation of the Republic of Kazakhstan in the field of healthcare service (Article 23).

Immigrants entering Kazakhstan for the purpose of family reunification must have a medical insurance to obtain an entry visa (Article 28).

Immigrants entering Kazakhstan for education purposes are requested to submit a medical report stating they do not suffer from illnesses preventing them from studying the selected subject, and must have a valid medical insurance (Article 31).

Foreign employees entering the country for independent employment or engaged by employers, business-immigrants and seasonal foreign workers must have a medical report confirming they do not suffer from illnesses preventing them from working in the chosen area of specialization, and must have a medical insurance (Articles 35, 39, 41).

The law does not specify required medical conditions for the stay of immigrants entering Kazakhstan on humanitarian and political grounds.

Immigrant can be denied access to Kazakhstan on medical grounds (if they have a disease which is contraindication for entry into Kazakhstan) (Article 48). This can also be grounds for denial or annulment of permanent residence permit in the Republic of Kazakhstan (Article 49).

#### **4. The Law of the Republic of Kazakhstan of 16 November 2015 No. 405-V «On the compulsory social health insurance» (with amendments and additions as of 22 December 2016)**

The law regulates the system of compulsory social health insurance with the aim to realize the constitutional right of citizens to healthcare. According to Article 2, «foreigners and stateless persons permanently residing in the territory of the Republic of Kazakhstan and oralmans enjoy the rights and bear responsibilities in the compulsory social health insurance system on an equal basis with citizens of the Republic of Kazakhstan, unless otherwise specified by this Law».

In accordance with Article 5 (which will be effective from 1 January 2018), citizens have the right to healthcare under the compulsory social health insurance system if they made payments (contributions) for at least two months in the last twelve calendar months before the month they sought medical help. Article 7 (will be introduced from 1 January 2018) stipulates that the compulsory social health insurance system provides:

- Outpatient care (except for treatment of socially significant diseases and diseases that threaten lives of others according to the list defined by the authorized body), including primary health care and consultative and diagnostic assistance through referral of primary healthcare specialists and specialized professionals;
- Inpatient care (except for medical treatment of socially significant diseases and diseases that threaten lives of others according to the list defined by the authorized body) through referral of primary healthcare specialists or a medical organization, within the planned hospitalization quota established by the authorized body;
- Alternatives to inpatient care (except for medical treatment of socially significant diseases and diseases that threaten lives of others according to the list defined by the authorized body) through referral of a primary healthcare specialist or a medical organization;
- High technology medical services.

#### **5. The Code of the Republic of Kazakhstan of 18 September 2009 No. 193-IV «On public health and the healthcare system» (with amendments and additions as of 27 February 2017)**

Article 34 establishes the guaranteed volume of free healthcare provided to citizens of the Republic of Kazakhstan and Oralmans subsidized by budget funds. It includes:

- Emergency care and air ambulance;
- Outpatient care (primary healthcare and consultative and diagnostic assistance through referral of primary healthcare specialists or specialized professionals);

- Inpatient medical assistance through referral of a primary healthcare specialist or a medical organization within the planned hospitalization quota established by the authorized body (referral is not mandatory for emergency treatment);
- Alternatives to inpatient care through referral of primary healthcare specialists or medical organizations;
- Recovery treatment and medical rehabilitation;
- Palliative and nursing care for population groups defined by the Government of the Republic of Kazakhstan.

According to Article 88, foreign citizens are entitled to receive guaranteed free medical care only for acute diseases posing threat to others. The list of socially significant diseases and diseases posing threat to others is determined by the authorized body, the Ministry of Health (Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 1 April 2015 No. 194 «On approval of the list of acute diseases posing threat to others for which foreign citizens and stateless persons in the territory of the Republic of Kazakhstan are entitled to receive guaranteed volume of free medical care»). Refugees and asylum seekers are entitled to preventive, diagnostic and therapeutic medical services in the order and volume defined by the authorized body (Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 21 May 2015 No. 368 “On approval of the order and volume of preventive, diagnostic and therapeutic medical services with the highest proven efficiency for refugees and asylum-seekers”).

The Code establishes (Article 156) that individuals in the territory of the Republic of Kazakhstan are entitled to be vaccinated against infectious and parasitic diseases within the guaranteed volume of free medical care. Per Article 35, other paid medical services shall be provided based on a contract between the patient and the healthcare subject which delivers the services.

According to Article 115 citizens of the Republic of Kazakhstan and oralmans have the right to undergo a voluntary anonymous and/or confidential medical examination and counseling on HIV free of charge. The rights and obligations of foreign citizens and stateless persons are not completely defined in this matter, but it is stated that “in case of refusal to undergo medical HIV testing they shall be deported from the Republic of Kazakhstan”.

According to Article 155, employers shall arrange and fund timely mandatory periodic medical examinations for their workers who are subject to examination in line with the legislation of the Republic of Kazakhstan on healthcare. They shall also create conditions for conduction of preventive medical examinations for workers who are subject to examination in accordance with the list of the guaranteed free medical care approved by the Government of the Republic of Kazakhstan. Individuals who do not undergo medical examinations or who are unfit for health reasons are allowed to work.

The code remains unclear regarding children of foreign citizens. Article 89, dedicated to the rights of children, does not specify whether it concerns the children of Kazakhstani citizens only or any children.

#### **6. Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011, No. 665 «On approval of rules for provision of medical assistance to immigrants»**

The Order was prepared in line with the Law of the Republic of Kazakhstan «On Migration of the Population» (Article 12). In accordance with the Order, an immigrant is «a foreign citizen or a stateless person who entered the Republic of Kazakhstan for temporary or permanent residence». The rules, in terms of medical care, define two groups of immigrants:

- Immigrants who entered the Republic of Kazakhstan for the purpose of return to historical homeland (oralmans, ethnic Kazakhs) receive free healthcare on an equal basis with citizens of the Republic of Kazakhstan in accordance with the List approved by the Decree of Government of the Republic of Kazakhstan of 15 December 2009 № 2136 «On approval of the list of the guaranteed free healthcare»;

- Immigrants entering the Republic of Kazakhstan for the purpose of family reunification, education or employment must have a valid health insurance.

Immigrants entering the Republic of Kazakhstan for the purpose of return to historical homeland or on humanitarian and political grounds much undergo free medical examination, which includes x-ray examination of the chest and HIV testing. All other immigrants who do not have medical report with HIV and tuberculosis test results issued by their country of residence must undergo a medical examination on a fee basis.

All immigrants in the territory of Kazakhstan have the right to free healthcare for acute diseases which pose threat to others within the framework of the guaranteed free medical care. In other cases, health-care is provided for a fee. If the immigrant is unable to pay for the planned medical care after elimination of the threat to life, he/she will be sent to the country of his/her permanent residence assisted by the State Migration Service for continuation of treatment.

Persons are denied entry to Kazakhstan if they suffer from illnesses included in the list of diseases that prohibit foreign citizens and stateless persons suffering from them to enter the Republic of Kazakhstan (Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011, No. 66).

#### **7. Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011 № 664 “On approval of the list of diseases that prohibit foreign citizens and stateless persons suffering from them to enter the Republic of Kazakhstan»**

The order was prepared in line with the Law of the Republic of Kazakhstan «On Migration of the Population» (Article 12). It defines the list of diseases that prohibit foreign citizens and stateless persons suffering from them to enter the Republic of Kazakhstan and, in accordance with article 49 of the same law, are grounds for denial or annulment of the permanent residence permit. The list includes: drug addiction; mental disorders (diseases); tuberculosis; leprosy (Hansen’s disease); sexually transmitted infections: syphilis, venereal lymphogranuloma (donovanosis), chancroid; acute infectious diseases (except for acute respiratory viral infections and influenza).

#### **8. Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 1 April 2015 No. 194 «On approval of the list of acute diseases posing threat to others for which foreign citizens and stateless persons in the territory of the Republic of Kazakhstan are entitled to receive the guaranteed volume of free medical care»**

The order was prepared in line with the Code of the Republic of Kazakhstan of 18 September 2009 «On public health and the health care system» (Article 88) and defines the list of diseases for which foreigners and stateless persons on the territory of the Republic of Kazakhstan have the right to receive a guaranteed volume of free medical care. The list includes: diphtheria; measles; rubella; whooping cough; scarlet fever; chickenpox; parotitis; paratyphes A, B, C; polio; atypical forms of influenza; meningococcal infection; cholera; typhoid fever; tuberculosis; pulmonary form of anthrax; plague; haemorrhagic viral fevers; viral hepatitis A, E; malaria.

#### **9. Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 21 May 2015, No. 368 «On approval of the order and volume of preventive, diagnostic and therapeutic medical services with the highest proven efficiency for refugees and asylum-seekers»**

The order was prepared in line with the Code of the Republic of Kazakhstan of 18 September 2009 «On public health and the health care system» (Article 88). It defines the rules and the volume of healthcare services for refugees and asylum seekers. Medical assistance to refugees and asylum seekers is delivered free of charge in accordance with the list of the guaranteed free healthcare.



## 1.2.4 Republic of Kazakhstan: Conclusions and specific recommendations

The legal framework of Kazakhstan covers issues related to both the management of migration processes and to healthcare. There are main two mechanisms of healthcare provision in the country (including to migrants):

- Free healthcare – the minimum guaranteed volume is determined by the legislation and depends on the status of the migrant;
- Health insurance – all persons in the territory of Kazakhstan are subject to the health insurance.

Main identified gaps in Kazakhstan’s migrants’ right to health related regulatory framework are the following:

- Only migrants with regular legal status have access to free healthcare (including for the treatment of infectious diseases that present a danger to the population);
- Only migrants from CIS countries have access to free healthcare in emergency situations;
- The situation of migrant children in regard to medical services remains uncertain.

The issue of the limited access of migrants (especially labour migrants) to paid medical services should be reviewed, as this limited access is determined by the very nature of their migration. Indeed, labour migration is caused by economic motives, and migrants aim to minimize their expenses in destination countries, which is often done at the expense of health insurance. Thus, it is expedient for the Government of Kazakhstan to take the following actions:

1. To ensure the right to healthcare for migrants with irregular status and illegal migrants in national legislation.
2. To consider provision of free healthcare for all migrants in emergency cases.
3. To introduce clarity and address ambiguity in the legal regulation of the situation of migrant children in relation to healthcare.
4. To consider the accession of the Republic of Kazakhstan to the following key international legal instruments which are directly related to the situation of migrants in the country:
  - The UN International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, adopted by General Assembly resolution 45/158 of 18 December 1990;
  - Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, adopted by UN General Assembly resolution 63/117 of 10 December 2008;
  - International Labour Organization Migration for Employment Convention No. 97 (Revised 1949), (Geneva, 8 June 1949);
  - International Labour Organization Migration for Employment Recommendation No. 86 (revised in 1949) (Geneva, 1 July 1949);
  - International Labour Organization Convention Migrant Workers (Supplementary Provisions) Convention No. 143 (Geneva, 24 June 1975);
  - International Labour Organization Migrant Workers Recommendation No. 151 (Geneva, 24 June 1975);
  - International Labour Organization Domestic Workers Convention No. 189 (Geneva, 1 June 2011);
  - International Labour Organization Domestic Workers Recommendation No. 201 (Geneva, 16 June 2011).

### LIST 3

## International legal instruments joined by the Republic of Kazakhstan in the field of migrants' right to health

1. The Universal Declaration of Human Rights of 10 December 1948.
2. The International Covenant on Economic, Social and Cultural Rights of 16 December 1966.
3. The CIS Agreement on Cooperation in the Field of Labour Migration and Social Protection of Migrant Workers of 15 April 1994.
4. The CIS Agreement on the mutual recognition of workers' right for reparation for damages caused as a result of an injury, occupational disease or any other harm to health related to the performance of their duties of 9 September 1994.
5. Agreement on the provision of medical assistance to citizens of the member countries of the Commonwealth of Independent States dated 27 March 1997.
6. Agreement on the mutual granting of equal access to the first medical aid and emergency medical care to citizens of the Republic of Belarus, the Republic of Kazakhstan, the Kyrgyz Republic and the Russian Federation of 24 November 1998.
7. Convention on the legal status of migrant workers and members of their families adopted by the CIS member states of 14 November 2008.
8. Treaty on the Eurasian Economic Union of 29 May 2014.



**LIST 4****Regulatory legal acts of  
the Republic of Kazakhstan related  
or relevant to migrants' right to health**

1. The Constitution of the Republic of Kazakhstan (adopted at the Republic referendum on 30 August 1995 with amendments and additions as at 10 March 2017).
2. The Law of the Republic of Kazakhstan dated 19 June 1995 No. 2337 «On the legal status of foreigners» (with amendments and additions as at 22 December 2016).
3. The Law of the Republic of Kazakhstan No. 477-IV of 22 July 2011 «On Migration of the Population» (with amendments and additions as at 22 December 2016).
4. The Law of the Republic of Kazakhstan of 16 November 2015 No. 405-V «On the compulsory social health insurance» (with amendments and additions as at 22 December 2016).
5. The Code of the Republic of Kazakhstan of 18 September 2009 No. 193-IV «On public health and the healthcare system» (with amendments and additions as at 27 February 2017).
6. Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011, No. 665 «On approval of rules for provision of medical assistance to immigrants».
7. Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011 № 664 “On approval of the list of diseases that prohibit foreign citizens and stateless persons suffering from them to enter the Republic of Kazakhstan».
8. Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 1 April 2015 No. 194 «On approval of the list of acute diseases posing threat to others for which foreign citizens and stateless persons in the territory of the Republic of Kazakhstan are entitled to receive the guaranteed volume of free medical care».
9. Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 21 May 2015, No. 368 «On approval of the order and volume of preventive, diagnostic and therapeutic medical services with the highest proven efficiency for refugees and asylum-seekers».

**TABLE 3**                      **Illustrative indicators of migrants' right to the enjoyment of the highest attainable standard of physical and mental health – Republic of Kazakhstan: Structural factors**

Structural indicators	International treaty, convention or National statutory act
International human rights treaties relevant to the right to the highest attainable standard of physical and mental health ratified by the State	(See List 3 above).
National/regional/local legislation that recognizes the equal right to health for all individuals under state jurisdiction, without discrimination based on prohibited grounds	<p><b>National legislation:</b></p> <ul style="list-style-type: none"> <li>• The Constitution of the Republic of Kazakhstan (adopted at the Republic referendum on 30 August 1995 with amendments and additions as at 10 March 2017)</li> <li>• The Law of the Republic of Kazakhstan dated 19 June 1995 No. 2337 «On the legal status of foreigners» (with amendments and additions as at 22 December 2016)</li> <li>• The Law of the Republic of Kazakhstan No. 477-IV of 22 July 2011 «On Migration of the Population» (with amendments and additions as at 22 December 2016)</li> <li>• The Law of the Republic of Kazakhstan of 16 November 2015 No. 405-V «On the compulsory social health insurance» (with amendments and additions as at 22 December 2016)</li> <li>• The Code of the Republic of Kazakhstan of 18 September 2009 No. 193-IV «On public health and the healthcare system» (with amendments and additions as at 27 February 2017)</li> <li>• Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011, No. 665 «On approval of rules for provision of medical assistance to immigrants»</li> </ul>

Structural indicators	International treaty, convention or National statutory act
	<ul style="list-style-type: none"> <li>• Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011 № 664 “On approval of the list of diseases that prohibit foreign citizens and stateless persons suffering from them to enter the Republic of Kazakhstan»</li> <li>• Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 1 April 2015 No. 194 «On approval of the list of acute diseases posing threat to others for which foreign citizens and stateless persons in the territory of the Republic of Kazakhstan are entitled to receive the guaranteed volume of free medical care»</li> <li>• Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 21 May 2015, No. 368 «On approval of the order and volume of preventive, diagnostic and therapeutic medical services with the highest proven efficiency for refugees and asylum-seekers».</li> </ul> <p><b>Regional legislation:</b></p> <ul style="list-style-type: none"> <li>• The CIS Agreement on Cooperation in the Field of Labor Migration and Social Protection of Migrant Workers of 15 April 1994</li> <li>• The CIS Agreement on the mutual recognition of the workers’ right for reparation for damages caused as a result of an injury, occupational disease or any other harm to health related to the performance of their duties of 9 September 1994</li> <li>• Agreement on the provision of medical assistance to citizens of the member countries of the Commonwealth of Independent States dated 27 March 1997</li> <li>• Agreement on the mutual granting of equal access to the first medical aid and emergency medical care to citizens of the Republic of Belarus, the Republic of Kazakhstan, the Kyrgyz Republic and the Russian Federation of 24 November 1998</li> <li>• Convention on the legal status of migrant workers and members of their families adopted by the CIS member states of 14 November 2008</li> <li>• Treaty on the Eurasian Economic Union of 29 May 2014</li> </ul>

Structural indicators	International treaty, convention or National statutory act
<p>Recognition of migrants' right to health in law, including its scope based on type of health service (e.g., emergency only) and migration or residence status</p>	<p style="text-align: center;"><b>YES</b></p> <p>Although the legislation does not specifically define the concept of «migrants' right to health», and that migrants are considered as foreign citizens and stateless persons temporarily staying or temporarily residing in Kazakhstan, migrants still enjoy the right to medical care.</p> <ul style="list-style-type: none"> <li>• The Constitution of the Republic of Kazakhstan (adopted at the Republic referendum on 30 August 1995 with amendments and additions as at 10 March 2017)</li> <li>• The Law of the Republic of Kazakhstan dated 19 June 1995 No. 2337 «On the legal status of foreigners» (with amendments and additions as at 22 December 2016)</li> <li>• The Law of the Republic of Kazakhstan No. 477-IV of 22 July 2011 «On Migration of the Population» (with amendments and additions as at 22 December 2016)</li> <li>• The Law of the Republic of Kazakhstan of 16 November 2015 No. 405-V «On the compulsory social health insurance» (with amendments and additions as at 22 December 2016)</li> <li>• The Code of the Republic of Kazakhstan of 18 September 2009 No. 193-IV «On public health and the healthcare system» (with amendments and additions as at 27 February 2017)</li> <li>• Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011, No. 665 «On approval of rules for provision of medical assistance to immigrants»</li> <li>• Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011 № 664 "On approval of the list of diseases that prohibit foreign citizens and stateless persons suffering from them to enter the Republic of Kazakhstan»</li> <li>• Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 1 April 2015 No. 194 "On approval of the list of acute diseases posing threat to others for which foreign citizens and stateless persons in the territory of the Republic of Kazakhstan are entitled to receive the guaranteed volume of free medical care"</li> </ul>

Structural indicators	International treaty, convention or National statutory act
	<ul style="list-style-type: none"> <li>Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 21 May 2015, No. 368 "On approval of the order and volume of preventive, diagnostic and therapeutic medical services with the highest proven efficiency for refugees and asylum-seekers"</li> </ul>
<p>Inclusion of migrants within public health policy and programs, as a particular target group, including those aiming to reduce health inequalities and inequities and address the social determinants of health</p>	<p style="text-align: center;"><b>NO</b></p> <p>Exceptions:</p> <ul style="list-style-type: none"> <li>Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011, No. 665 «On approval of rules for provision of medical assistance to immigrants»</li> <li>Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011 № 664 "On approval of the list of diseases that prohibit foreign citizens and stateless persons suffering from them to enter the Republic of Kazakhstan»</li> <li>Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 1 April 2015 No. 194 «On approval of the list of acute diseases posing threat to others for which foreign citizens and stateless persons in the territory of the Republic of Kazakhstan are entitled to receive the guaranteed volume of free medical care»</li> <li>Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 21 May 2015, No. 368 «On approval of the order and volume of preventive, diagnostic and therapeutic medical services with the highest proven efficiency for refugees and asylum-seekers»</li> </ul>
<p>Mechanism for gathering and publishing periodic data on health conditions and health services, disaggregated by migration or residence status, age, gender, sex, ethnic origin, nationality, nationality of parents, place of residence, length of residence, and socio-economic status</p>	<p style="text-align: center;"><b>NO</b></p> <p>Current legislation does not contain such requirements.</p>
<p>Date of entry into force and coverage of domestic law for implementing the right to health of migrants, including prohibition of direct or indirect discrimination by public or private actors nullifying or impairing access to health</p>	<p style="text-align: center;"><b>YES</b></p> <ul style="list-style-type: none"> <li>The Constitution of the Republic of Kazakhstan (adopted at the Republic referendum on 30 August 1995 with amendments and additions as at 10 March 2017)</li> </ul>

Structural indicators	International treaty, convention or National statutory act
	<ul style="list-style-type: none"> <li>• The Law of the Republic of Kazakhstan dated 19 June 1995 No. 2337 «On the legal status of foreigners» (with amendments and additions as at 22 December 2016)</li> <li>• The Law of the Republic of Kazakhstan No. 477-IV of 22 July 2011 «On Migration of the Population» (with amendments and additions as at 22 December 2016)</li> <li>• The Law of the Republic of Kazakhstan of 16 November 2015 No. 405-V «On the compulsory social health insurance» (with amendments and additions as at 22 December 2016)</li> <li>• The Code of the Republic of Kazakhstan of 18 September 2009 No. 193-IV «On public health and the healthcare system» (with amendments and additions as at 27 February 2017)</li> <li>• Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011, No. 665 «On approval of rules for provision of medical assistance to immigrants»</li> <li>• Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011 № 664 "On approval of the list of diseases that prohibit foreign citizens and stateless persons suffering from them to enter the Republic of Kazakhstan»</li> <li>• Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 1 April 2015 No. 194 «On approval of the list of acute diseases posing threat to others for which foreign citizens and stateless persons in the territory of the Republic of Kazakhstan are entitled to receive the guaranteed volume of free medical care»</li> <li>• Order of the Minister of Health and Social Development of the Republic of Kazakhstan of 21 May 2015, No. 368 «On approval of the order and volume of preventive, diagnostic and therapeutic medical services with the highest proven efficiency for refugees and asylum-seekers»</li> </ul>
<p>Mechanisms aimed at data gathering for evaluating causes of higher prevalence of health problems in the migrant population, in relation to nationals</p>	<p style="text-align: center;"><b>YES</b></p> <ul style="list-style-type: none"> <li>• The Constitution of the Republic of Kazakhstan (adopted at the Republic referendum on 30 August 1995 with amendments and additions as at 10 March 2017).</li> </ul>

Structural indicators	International treaty, convention or National statutory act
	<ul style="list-style-type: none"> <li>• The Law of the Republic of Kazakhstan dated 19 June 1995 No. 2337 «On the legal status of foreigners» (with amendments and additions as at 22 December 2016)</li> <li>• The Law of the Republic of Kazakhstan No. 477-IV of 22 July 2011 «On Migration of the Population» (with amendments and additions as at 22 December 2016)</li> <li>• The Law of the Republic of Kazakhstan of 16 November 2015 No. 405-V «On the compulsory social health insurance» (with amendments and additions as at 22 December 2016)</li> <li>• The Code of the Republic of Kazakhstan of 18 September 2009 No. 193-IV «On public health and the healthcare system» (with amendments and additions as at 27 February 2017)</li> <li>• Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011, No. 665 «On approval of rules for provision of medical assistance to immigrants»</li> <li>• Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011 № 664 “On approval of the list of diseases that prohibit foreign citizens and stateless persons suffering from them to enter the Republic of Kazakhstan»</li> </ul>
Mechanisms to collect data for assessment of reasons for high prevalence of health problems among migrants compared to citizens	<p style="text-align: center;"><b>NO</b></p> <p>Current legislation does not contain such requirements.</p>

**TABLE 4** Illustrative indicators of migrants' right to the enjoyment of the highest attainable standard of physical and mental health – Republic of Kazakhstan: Processes and Outcomes

Accessibility of Health Facilities, Goods and Services	Cultural Acceptability of Health Services	Natural and Occupational Environment	Sexual and Reproductive Health	Child Health Care
<p>Legislation that does not oblige health workers and civil servants to detect migration or residence status to provide goods and services and report irregular migrants to migration authorities. <b>There is no such requirement.</b></p> <p>Measures meant to remove formal and practical obstacles that hinder or prevent the enjoyment of the right to health, such as requiring a residence permit, or additional fees based on nationality or migration or residence status, and reporting migrants in irregular status to migration authorities. <b>Legislation establishes the differentiation of migrants by status.</b></p>	<p>Legislation that prohibits any act of xenophobia at health facilities. <b>No specific legislation.</b> <b>The Constitution prohibits any discrimination.</b></p> <p>Public institutions developing intercultural health policies, programs and services. <b>The authorized body is the Ministry of Health.</b></p> <p>Legal framework and policies aimed at removing language and cultural barriers at health facilities and services. <b>Legislation provides for delivery of healthcare to patients in the language they understand.</b></p>	<p>Legal protection of the right to adequate housing, including access to water and sanitation services, without discrimination based on nationality and migration or residence status. <b>There is no specific prohibition of discrimination on these criteria.</b></p> <p>Application of regulations and/or existence of case law on the rights of tenants, disaggregated by their migration or residence status. <b>None.</b></p>	<p>Legal protection of migrants' right to sexual and reproductive health services, regardless of nationality and migration or residence status, equal to nationals. <b>There are no special provisions in legislation on migration and medicine.</b></p>	<p>Legal protection of children's right to health, regardless of their migrant status or their parents'; <b>Legislation contains uncertainties in this area.</b></p> <p>Legal recognition of the right to birth registration, regardless of the migration or residence status of parents. <b>Specified in legislation.</b></p>



Accessibility of Health Facilities, Goods and Services	Cultural Acceptability of Health Services	Natural and Occupational Environment	Sexual and Reproductive Health	Child Health Care
<p>Policies directed at periodically ensuring equitable qualitative and quantitative conditions at health facilities.</p> <p><b>Defined in legislation.</b></p>	<p>Policies aimed at including intercultural, rights-based approach to migration in medical training curricula.</p> <p><b>None.</b></p> <p>Health services aimed at addressing mental health problems related to migration.</p> <p><b>Not specified in legislation.</b></p>	<p>Application of legislation on occupational safety and health, including workers' rights and protections, to all workers regardless of status.</p> <p><b>Stipulated both in legislation and by international agreements.</b></p>		



# TURKMENISTAN



## 1.3 TURKMENISTAN

### 1.3.1 Context and general situation

The Government of Turkmenistan recognizes and strives to facilitate the beneficial impact of migration, and specifically the contribution of international migrants to the country's economic growth. In addition, it heavily invests in healthcare infrastructure and modern medical technology, which reflects its commitment to ensure a healthy population.

Migrants have a positive economic impact both on host countries and countries of origin. Turkmenistan's rapid and dynamic economic growth attracts more and more global and regional companies and international migrants to the country. The Government of Turkmenistan regards migration and healthcare as a priority areas of cooperation and is committed to fulfil its obligations to provide healthcare services to migrants. In order to do so, it is committed to bring its national legislation in line with international standards on migrants' right to health.

Turkmenistan has adopted a number of programmes to advance the well-being and health of migrants:

- 15 January 2016 – National Human Rights Action Plan for 2016–2020
- 22 January 2015 – National Action Plan for Gender Equality for 2015–2020
- 18 March 2016 – National Action Plan to Combat Trafficking in Human Beings for 2016–2020

In March 2017, the Mejlis (Parliament) of Turkmenistan has elected the country's first Ombudsman (Commissioner for Human Rights). The Ombudsman will annually report to the President of Turkmenistan on his/her activities on the human rights situation in the country. This report will be publicized annually<sup>26</sup>.

Turkmenistan has a status of an upper middle-income country and implements a number of programmes aimed at improving the life quality of the population. All measures carried out by the state are outlined in the State Programme «Saglyk», the National Programme of Social and Economic Development for 2011–2030 and the National Program of the President of Turkmenistan on changing the social conditions in villages, towns and regional centres for the period until 2020.

The main objective of the latter is to provide the rural population with high-quality social conditions close to urban standards. During 2008–2012 the state budget has allocated 4.8 billion US dollars for implementation of large-scale projects in rural areas. Despite the Government's efforts to improve the well-being of citizens, there are still differences between urban and rural areas, as well as between regions<sup>27</sup>. Almost half of the country's workforce is engaged in agriculture, although it accounts only for 8 percent of GDP<sup>28</sup>.

<sup>26</sup> [www.turkmenistan.ru](http://www.turkmenistan.ru), 21 March 2017.

<sup>27</sup> Partnership Framework for Development (PFD) between the Government of Turkmenistan and the United Nations, 2016–2020, section 1.3, item 29.

<sup>28</sup> UNDP in Turkmenistan and the Government of Turkmenistan. Document of the Project: «Strengthening Disaster Risk Management Capacity (DRM) in Turkmenistan for the period 2014–2016» Ashgabat, 2013.

### 1.3.2 International and regional legislation and norms

Turkmenistan has acceded to several core human rights instruments and optional protocols. The country has intensified its efforts at the international level to fulfil its obligations on human rights, including issues of migrants, refugees and stateless persons<sup>29</sup>. In recent years, the country has accumulated a vast experience in reduction of statelessness. The main international law instruments related to migration health of which Turkmenistan is part are the following:

#### 1. The Universal Declaration of Human Rights of 10 December 1948

The Declaration proclaims common standards of achievement for all peoples and all nations of the UN who should take progressive measures, national and international, to promote social progress and improve living conditions.

#### 2. The International Covenant on Economic, Social and Cultural Rights of 16 December 1966

The state parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The state parties recognize that in line with the Universal Declaration of Human Rights, the ideal of a freedom can only be achieved if conditions are created whereby everyone can enjoy civil and political rights, as well as economic, social and cultural rights.

#### 3. The International Covenant on Civil and Political Rights of 16 December 1966

Despite its name, the rights enshrined in the Covenant on Civil and Political Rights are not limited to «civil and political» ones. Article 26, which stipulates a prohibition of discrimination, is broad and covers social, economic and cultural spheres as well. Article 27 protects the rights of minorities.

All these universally recognized principles and norms of international law are an integral part of the national legal system of Turkmenistan on the protection of migrants' rights to health.

### 1.3.3 National legislation

Foreign citizens and stateless persons in Turkmenistan can enjoy a network of health facilities and medical services on the basis and in order established by the legislation of Turkmenistan.

#### 1. Article 9 of the Law of Turkmenistan "On the Legal Status of Foreign Citizens in Turkmenistan" (Gazette of the Mejlis of Turkmenistan, 2011, No. 1, Part II, Article 13)

- States that foreign citizens enjoy the same right to healthcare and bare the same responsibilities as citizens of Turkmenistan.

#### 2. The Constitution of Turkmenistan

- The principal law of Turkmenistan, which guarantees the implementation of the conventions and all other international agreements to which Turkmenistan has acceded. The Constitution of the country includes such rights as the right to an adequate standard of living, education and health security, work and leisure, free expression of opinion and awareness, protection of honour and dignity, life and development. Article 11 of the Constitution of Turkmenistan guarantees equal rights to foreign citizens and stateless persons.

#### 3. The Law on Migration

- Legal procedures for healthcare provision to migrants is regulated by the Law on Migration, with amendments and additions of the Laws of Turkmenistan No. 399-IV of 4 May 2013, No. 453-IV of 09.11.2013, No. 90-V of 13.06.2014, No. 204-V of 28.02.2015, No. 367-V of 26.03.2016 and No. 437-V of 12.09.2016). Equality of rights and freedoms to receive healthcare for non-citizens and citizens is based on norms set out in international legal instruments. The rights of foreign citizens and stateless persons to healthcare are equal to those of citizens of Turkmenistan.

29 Report of the Working Group on the Universal Periodic Review: Turkmenistan, Human Rights Council, 24th session, p. 5.

#### 4. The Civil Code of Turkmenistan (Dated 17 July 1998, effective 1 March 1999 – Gazette of the Mejlis of Turkmenistan, 1998, No. 2, Article 39, 2003, No. 4, Article 36, 2007, No. 1, Article 40, 2010, No. 3, Article 63, 2012, No. 1, Article 7)

- The Civil Code governs civil legal relations, civil rights and obligations and their implementation and protection. It defines the concept of an individual, his legal capacity, place of residence, compensation for harm, etc.

#### 5. The Social Security Code of Turkmenistan

- The Social Security Code defines the legal, economic and organizational basis of social security and protection of the interests of mothers and children, persons with disabilities and other categories of citizens.

#### 6. The Labour Code of Turkmenistan

- The Labour Code governs employment relations of individuals working in businesses, organizations and institutions irrespective of form of ownership and legal status, as well as for individuals under the conditions of an employment contract. It protects the interests of mothers and children and other categories of citizens in terms of health security and social well-being.

#### 7. The Law of Turkmenistan «On Combating Trafficking in Human Beings», adopted 15 October 2016 (hereinafter referred to as the «New Law»)

- The Law of Turkmenistan «On Combating Trafficking in Human Beings» of 15 October 2016 (hereinafter referred to as the «New Law») came into effect on 1 January 2017. This is the new edition of the earlier Law of Turkmenistan «On Combating Trafficking in Human Beings» of 14 December 2007. The New Law was enriched by norms that significantly expand the range of measures that must be taken in the country to protect persons affected by human trafficking. Thus, the New Law contains a special Article 13 «The national referral mechanism for victims of human trafficking» (NRM), which obliges the Cabinet of Ministers of Turkmenistan to determine the order of NRM operations. This mechanism is based on cooperation of state bodies that carry out counteraction to human trafficking with public, international and other non-governmental organizations, in accordance with signed agreements.

#### 8. The Sanitary Code of Turkmenistan

- The Sanitary Code defines the legal, economic and social conditions to ensure the sanitary and epidemiological well-being of the population and to implement and protect the right of citizens to a healthy environment.

#### 9. The Law of Turkmenistan «On the Protection of Public Health» (Dated 25 October 2005 (the new edition as amended by the Law of Turkmenistan (LT) of 18 April 2009 No. 32-IVB, 23 May 2015)

- The law governs the relations in the area of health protection and aims to ensure the constitutional right of citizens to healthcare.

#### 10. The Law of Turkmenistan «On the State Guarantees of Women’s Equality»

- The Law is aimed at strengthening the rights and freedoms of all women in political, economic, social, cultural and other fields based on gender equality.

#### 11. The Law of Turkmenistan «On narcotic drugs, psychotropic substances, precursors and measures to counter their illicit trafficking» (Of 9 October 2004 (as amended by the LT No. 192-III of 18.04.2008 and No. 32-IV of 18.04.2009)

- The Law is aimed at protecting human, state and public safety and it regulates trafficking in narcotic drugs, psychotropic substances and precursors.

## 12. The Law of Turkmenistan «On Pharmaceutical Activity and Supply of Pharmaceuticals» (Of 5 July 2002 (as amended by the law of 18 April 2009, No. 32-IV))

- The Law regulates the pharmaceutical business and supply of pharmaceuticals to the population of Turkmenistan.

## 13. The Law of Turkmenistan «On Psychiatric Care» (Dated 1 October 1993, amended by the law of 18 April 2009 No. 32-IV)

- This Law guarantees the provision of psychiatric assistance to the population of Turkmenistan and governs the relevant legal aspects.

## 14. The Law of Turkmenistan «On the Preventing the Disease Caused by the Human Immunodeficiency Virus (HIV)»

- The Law defines the legal framework for protection of public health, prevention, diagnosis and treatment of HIV/AIDS.

**The Law «On migration» and the Law «On protection of public health in Turkmenistan».** The Law «On migration» (with amendments and additions made by Laws of Turkmenistan № 399-IV of 05.04.2013, № 453-IV of 09.11.2013, № 90-V of 13.06.2014, № 204 -V of 28.02.2015, № 367-V of 26.03.2016 and № 437-V of 12.09.2016) and the Law «On protection of public health in Turkmenistan» (with amendments as at May 23, 2015) are in line with the Constitution and, based on the universally recognized norms of international law, provide equal human and civil rights and freedoms irrespective of the nationality, skin colour, sex, origin, property and official status, place of residence, language, attitude religion, political opinions or other circumstances.

According to Article 3 of the Law “On the legal status of foreign citizens in Turkmenistan”, foreign citizens in Turkmenistan enjoy the rights and freedoms as well as bear responsibilities established for the citizens unless otherwise stipulated by the Constitution of Turkmenistan, this Law and other legal acts of Turkmenistan<sup>30</sup>.

Provision of high-quality healthcare services is a public policy priority. The main principles of the state health policy are:

- Equality of citizens’ right for safe and quality healthcare;
- Accessibility of healthcare and medical services.

Over the recent years, the country has successfully implemented the State Programme of the President of Turkmenistan «Saglyk» («Health»), the National Programme of Socio-Economic Development of Turkmenistan for 2011–2030, the National Transformation Programme of the President of Turkmenistan aimed at improvement of social and living conditions of the population in settlements, villages and city centres until 2020, the State Programme of Turkmenistan On Public Health Development for 2012–2016, the National Programme for the Development of Sanatorium and Health Resort Services, the National Programme On Healthy Nutrition of the Population 2013–2017, the National Strategy on implementation of the Ashgabat Declaration objectives on prevention and control of non-communicable diseases in Turkmenistan for in 2014–2020, the National Programme on Early Childhood Development and Pre-primary Education for 2011–2015, the National Strategy on Reproductive Health in Turkmenistan for 2011–2015, the National HIV Program of Turkmenistan for 2012–2016, the National Strategy and Action Plan on Maternal, Newborn, Child and Adolescent Health in Turkmenistan for 2015–2019 and the National Action Plan on Combating Trafficking in Human Beings for 2016–2020 dated 18 March 2016.

One of the main objectives of the policy of the President of Turkmenistan is the protection of health of women, adolescents and children, including reproductive health. Turkmenistan provides women with equal free access to healthcare resources that concern their health and family planning matters, and takes regard of special needs of women in the field of health security.

30 The Law of Turkmenistan «On the legal status of foreign citizens in Turkmenistan» (2011).

The legislation of Turkmenistan provides women and children in the country with all opportunities for full enjoyment of all rights and achievement of good health: the Law of Turkmenistan «On Protection of Public Health» (23 May 2015), the Law of Turkmenistan «On State Guarantees of Equal Rights and Equal Opportunities for Women and Men» (new edition of 18 August 2012) and the Law of Turkmenistan «On State Guarantees of the Rights of the Child» (new edition of 3 May 2014).

**Freedom of Movement.** According to Article 49 of the Constitution of Turkmenistan in the new edition, “Every individual has the right to work and to freely choose his profession, type of employment and place of work at their own discretion, and for safe and healthy working conditions”<sup>31</sup>.

The Order of the President of Turkmenistan «On registration and accounting of persons arriving in Ashgabat for employment» (of 13 February 2016, No. 14606) is intended to regulate the migration flows within the country and the employment of citizens in Ashgabat.

According to the new order individual employment in Ashgabat is permitted only with special authorization. Citizens of Turkmenistan who are not registered or do not have a residence permit in Ashgabat and foreign citizens and stateless persons are permitted to work (carry out independent work) in the city of Ashgabat only with officially registered permit of the Ministry of Labour and Social Protection of Turkmenistan.

If the employer is a state-owned enterprise, his/her application to the Ministry of Labour and Social Protection of Turkmenistan for permission to hire a non-resident should be agreed in writing and endorsed by a higher-level organization, the ministry or city administration.

The Ministry of Labour and Social Protection reviews the employer’s application and the supporting documentation and submits them to the Inter-Departmental Group on Registration of Individuals. The permit is issued for a period of one year.

**Emergency healthcare.** Article 36 of the Law «On Health» stipulates that emergency healthcare is provided to citizens and stateless persons in case of illnesses, accidents, injuries free of charge. In the event of circumstances that pose a danger to human life and health, medical personnel can use all necessary means of communication and any kind of available vehicle free of charge to transport the person to the nearest ambulance service or a medical and preventive institution<sup>32</sup>.

**Mandatory HIV/AIDS test.** On 31 March 2012, a new law «On Migration» came into force, different from the previous document adopted on 7 December 2005. According to Article 11, in addition to reasons related to international and national security, foreign citizens or stateless persons may be denied a visa to Turkmenistan if he/she is infected with a disease included by the Ministry of Health and Medical Industry of Turkmenistan into the List of diseases that are harmful to the health of the population of Turkmenistan.

According to Article 11 (item 6) of the Law on Migration, foreign citizens and stateless persons must undergo an HIV/AIDS test for obtaining a visa. Foreign citizens must undergo this examination if the term of his/her stay exceeds one month. The following reasons can be grounds for entry denial: if he/she is infected with the human immunodeficiency virus (HIV infection), a venereal disease, suffers from drug addiction or other illness included by the Ministry of Health and Medical Industry of Turkmenistan in the List of diseases that are harmful to the health of the population of Turkmenistan.

### 1.3.4 Turkmenistan: Conclusions and specific recommendations

Health protection is recognized as a human right in Turkmenistan through international and national instruments and inter-governmental agreements.

The legal status of migrants receiving healthcare is regulated by the Law on Migration with amendments

31 Answers of Turkmenistan to the list of questions, List of Questions Related to the Second Periodic Report of Turkmenistan (Addendum), Human Rights Committee, 119th Session, 6-29 March 2017 CCPR/C/TKM/Q2/Add.1.

32 Law «On protection of public health in Turkmenistan», Article 13, 23 May 2015.



and additions of the Laws of Turkmenistan No. 399-IV of 4 May 2013, No. 453-IV of 09.11.2013, No. 90-V of 13.06.2014, No. 204-V of 28.02.2015, No. 367-V of 26.03.2016 and No. 437-V of 12.09.2016) and the Law «On the Protection of Public Health in Turkmenistan» (the new edition dated 23 May 2015) in line with the Constitution of Turkmenistan. The Constitution guarantees the equality of human and civil rights according to the universally recognized norms of international legal instruments.

Article 11 of the Constitution of Turkmenistan guarantees equal rights to foreign citizens and stateless persons: «Foreign citizens in Turkmenistan enjoy the rights and freedoms as well as bear responsibilities established for the citizens unless otherwise stipulated by the Constitution of Turkmenistan». Thus, the rights of foreign citizens and stateless persons to healthcare are equal to citizens of Turkmenistan.

In general, the country has a legal framework on management of migration processes and healthcare. There is a mechanism for provision of healthcare (including to migrants) and the volume of free healthcare is defined by law.

The main issues of the legal framework arise from the differentiated approach to issuing of entry permits to migrants which is based on the length of their stay in the country. The HIV/AIDS test is compulsory only for migrants who plan to stay in the country for more than a month. This requirement does not apply to migrants coming for the period of up to one month. It is recommended to revise the legislation and remove this contradiction.

When applying for healthcare assistance, citizens and migrants are required to present a valid identification document. Voluntary health insurance allows citizens to receive health services on a preferential basis and to use the network of medical institutions. Migrants also have the right to obtain a voluntary health insurance.

Despite the fact that the law provides equal rights for migrants and stateless persons, there are no specific provisions in the bylaws specifying migrants' entitlements to healthcare. Thus, it is important to develop and implement adequate policies and legal frameworks for provision of healthcare for migrants. A multi-sectoral approach should be applied and coordinated at all levels, as migration health is also linked to issues such as food security, housing, freedom of movement, sanitation, education, etc.

Migration health issues were repeatedly discussed by the Government of Turkmenistan. Two project phases were implemented in Turkmenistan within the framework of the programme on migrants' right to health. A delegation from Turkmenistan participated in a study tour to Portugal to learn from experience on ensuring the rights of migrants to healthcare. Several work meetings were held on this issue with various ministries. Participants of the Workshop on Migration and Health (26–27 May 2015 in Ashgabat, Turkmenistan) organized within the framework of the project on «Resolving migration issues in Turkmenistan» have identified a number of priority areas for improving the legislative and regulatory framework of the country.

Drawing on the results of the analysis of the regulatory legal documents of Turkmenistan, it would be beneficial to introduce improvements in the following areas:

1. Build the capacity and knowledge of healthcare, migration and social workers in the field of migration health;
2. Consider amending the current legislation to bring it in line with the WHA Resolution «On the Health of Migrants» of 2008;
3. Since its independence, Turkmenistan did not sign the basic universal international documents on social protection of migrants. At the same time, Turkmenistan is a signatory to virtually all agreements in the area of regulation of migration processes. This discrepancy should be resolved in the legislation;
4. Further build the capacity of the working group on issues related to internal migration and the rights of migrants to healthcare through involvement of stakeholders. Include relevant government bodies in the working group on internal migration which, at present, does not exist,



- and extend its mandate to migration and health care issues including the collection of data on migrants;
5. Submit for discussion to the Mejlis of Turkmenistan a proposal on compulsory healthcare insurance for international migrants working in Turkmenistan;
  6. Develop guidelines and standards on migrants' rights to health based on international best practices;
  7. Adopted policy documents, such as concepts and strategy, do not reflect the issue of ensuring migrants' right to health. This gap should be addressed through incorporation of these issues in national migration and health concept papers;
  8. Study the experience of other countries on regulation of movement of HIV-positive migrants;
  9. It is recommended to consider the accession of Turkmenistan to the following key international legal instruments which are directly related to the situation of migrants in the country:
    - The UN International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, adopted by General Assembly resolution 45/158 of 18 December 1990;
    - Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, adopted by UN General Assembly resolution 63/117 of 10 December 2008;
    - ILO Migration for Employment Convention No. 97 (Revised 1949), (Geneva, 8 June 1949);
    - International Labour Organization Migration for Employment Recommendation No. 86 (revised in 1949) (Geneva, 1 July 1949);
    - International Labour Organization Convention Migrant Workers (Supplementary Provisions) Convention No. 143 (Geneva, 24 June 1975);
    - International Labour Organization Migrant Workers Recommendation No. 151 (Geneva, 24 June 1975);
    - International Labour Organization Domestic Workers Convention No. 189 (Geneva, 1 June 2011);
    - International Labour Organization Domestic Workers Recommendation No. 201 (Geneva, 16 June 2011).

**LIST 5****International legal instruments  
joined by Turkmenistan in the field  
of migrants' right to health**

1. The Universal Declaration of Human Rights of 10 December 1948.
2. The International Covenant on Economic, Social and Cultural Rights of 16 December 1966.
3. The International Covenant on Civil and Political Rights of 16 December 1966.
4. Convention on the Rights of the Child.
5. The Convention on the Elimination of All Forms of Discrimination against Women.
6. The Convention on the Rights of Persons with Disabilities.
7. The Cooperation Agreement between the Ministry of Internal Affairs of Turkmenistan and the Ministry of Internal Affairs of the Russian Federation of 25 March 2009.
8. Agreement between Turkmenistan and the People's Republic of China on Cooperation in Combating Terrorism, Separatism and Extremism of 3 April 2006.
9. The Convention on Legal Aid and Legal Relations in Civil and Family Criminal Cases (22.01.1993, Minsk).
10. Agreement between Turkmenistan and Georgia on Mutual Legal Assistance in Civil and Criminal Cases (1996).
11. Agreement between Turkmenistan and the Republic of Uzbekistan on Legal Assistance and Legal Relations in Civil, Family Criminal Cases (1996).
12. Agreement between Turkmenistan and the Republic of Armenia on Legal Assistance and Legal Relations in Civil, Family Criminal Cases (2000).
13. Agreement between the Government of Turkmenistan and the Government of the Islamic Republic of Iran on Mutual Legal Assistance in Criminal Cases (2005).
14. Agreement between Turkmenistan and the Republic of Turkey on Legal Assistance in Civil and Criminal Cases (2012).
15. Agreement between the Government of the Republic of Latvia and the Government of Turkmenistan on Terrorism and Organized Crime\*.
16. Agreement between the Government of Turkmenistan and the Government of the Russian Federation on Reciprocal Visa-Free Travel of Citizens (with a list of documents for entry, exit and movement of citizens) – 17.07.1999.
17. Agreement between the Government of Turkmenistan and the Government of the Republic of Kazakhstan on Mutual Trips of Citizens (01.03.2001).

\* <https://m.likumi.lv/doc.php?id=262882>

**LIST 6****Regulatory legal acts of Turkmenistan  
related or relevant to migrants’  
right to health**

1. The Constitution of Turkmenistan.
2. The Law on Migration.
3. The Civil Code of Turkmenistan.
4. The Social Security Code of Turkmenistan.
5. The Family Code of Turkmenistan.
6. The Labor Code of Turkmenistan.
7. The Sanitary Code of Turkmenistan.
8. The Law of Turkmenistan on Guarantees of the Rights of the Child.
9. The Law of Turkmenistan « On the Protection of Public Health» .
10. The Law of Turkmenistan «On Pharmaceutical Activity and Supply of Pharmaceuticals.
11. The Law of Turkmenistan «On Psychiatric Care».
12. The Law of Turkmenistan «On the Preventing the Disease Caused by the Human Immunodeficiency Virus (HIV)».

**TABLE 5**                      **Illustrative indicators of migrants' right to the enjoyment of the highest attainable standard of physical and mental health – Turkmenistan: Structural factors**

Structural indicators	International treaty, convention or National statutory act
<p>International human rights treaties relevant to the right to the highest attainable standard of physical and mental health ratified by the State</p>	<ul style="list-style-type: none"> <li>• The Universal Declaration of Human Rights of 10 December 1948</li> <li>• The International Covenant on Economic, Social and Cultural Rights of 16 December 1966</li> <li>• The International Covenant on Civil and Political Rights of 16 December 1966</li> </ul>
<p>National/regional/local legislation that recognizes the equal right to health for all individuals under state jurisdiction, without discrimination based on prohibited grounds</p>	<p><b>National legislation</b> is listed in list 6.</p> <p><b>Regional legislation:</b></p> <ul style="list-style-type: none"> <li>• The Cooperation Agreement between the Ministry of Internal Affairs of Turkmenistan and the Ministry of Internal Affairs of the Russian Federation of 25 March 2009</li> <li>• Agreement between Turkmenistan and the People's Republic of China on Cooperation in Combating Terrorism, Separatism and Extremism of 3 April 2006</li> <li>• The Convention on Legal Aid and Legal Relations in Civil and Family Criminal Cases (22.01.1993, Minsk)</li> <li>• Agreement between Turkmenistan and Georgia on Mutual Legal Assistance in Civil and Criminal Cases (1996)</li> <li>• Agreement between Turkmenistan and the Republic of Uzbekistan on Legal Assistance and Legal Relations in Civil, Family Criminal Cases (1996);</li> <li>• Agreement between Turkmenistan and the Republic of Armenia on Legal Assistance and Legal Relations in Civil, Family Criminal Cases (2000);</li> <li>• Agreement between the Government of Turkmenistan and the Government of the Islamic Republic of Iran on Mutual Legal Assistance in Criminal Cases (2005);</li> <li>• Agreement between Turkmenistan and the Republic of Turkey on Legal Assistance in Civil and Criminal Cases (2012)</li> </ul>

Structural indicators	International treaty, convention or National statutory act
Recognition of migrants' right to health in law, including its scope based on type of health service (e.g., emergency only) and migration or residence status	<p style="text-align: center;"><b>NO</b></p> <p>The legislation lacks the definition of the right of migrants to health but they are viewed as foreign citizens and stateless persons temporarily staying or temporarily residing in Turkmenistan. Thus, migrants have the right to medical care on an equal basis with Turkmenistan citizens.</p>
Inclusion of migrants within public health policy and programs, as a particular target group, including those aiming to reduce health inequalities and inequities and address the social determinants of health	<p style="text-align: center;"><b>NO</b></p> <p>Migrants are not included in existing national health programs as a separate category or a specific target group.</p>
Mechanism for gathering and publishing periodic data on health conditions and health services, disaggregated by migration or residence status, age, gender, sex, ethnic origin, nationality, nationality of parents, place of residence, length of residence, and socio-economic status	<p style="text-align: center;"><b>NO</b></p> <p>Current legislation does not contain such requirements.</p>
Дата вступления в силу и охват внутренним законодательством реализации права на здоровье мигрантов, в том числе, запрещение прямой или косвенной дискриминации со стороны государственных или частных субъектов путем нарушения доступа к здоровью	<p style="text-align: center;"><b>YES</b></p> <p>A complete list of legal acts is given in list 6. There is no direct prohibition of discrimination in the legislation.</p>
Existence of case law on the right to health of migrants, disaggregated by their migration or residence status	<p style="text-align: center;"><b>NO</b></p> <p>The current legislation does not contain such requirements.</p>
Mechanisms aimed at data gathering for evaluating causes of higher prevalence of health problems in the migrant population, in relation to nationals	<p style="text-align: center;"><b>NO</b></p> <p>The current legislation does not contain such requirements.</p>

# 2

# MIGRANTS' RIGHT TO HEALTH IN PRACTICE

CHAPTER



This chapter presents the results of a sociological research, which was conducted with the aim of complementing the legal analysis by assessing the concrete, day-to-day realization of migrants' right to health in Central Asia through the understanding of migrants' experience. Indeed, if analysing legislation and policies represents a first logical and necessary step, it is not sufficient to capture migrants' daily reality and experience in accessing healthcare services in destination countries. Hence, this chapter uses migrants' experience as a "raw material" for analysis and strives to make migrants' voices accessible to readers.

The research was designed to review the entire migration process, from pre-departure to return, with a focus on the health aspects of these different stages. Topics of investigation include the main "drivers" of Central Asian labour migration (both individual and social), pre-departure preparedness, migrants' overall health status, the health impact of migration, occupational health, treatment and prevention among migrants, migrants' experience in accessing healthcare, the impact of legal status on healthcare access, female migration and specific vulnerabilities, migrants' knowledge and awareness, return migration, medical insurance and non-government health support.

A qualitative approach was used to investigate these topics. It entailed individual, in-depth semi-structured interviews with migrants and key informants in the field of migration health, as well as group discussions with migrants. Questionnaires for individual interviews were designed to investigate the experience of both current and returning migrants. Data was coded and analysed by the IOM research team. Targeted respondents included:

- Migrant workers engaged in labour migration at the time of the survey;
- Migrant workers who returned to their homeland at the time of the survey, either temporarily or permanently;
- Experts and key informants in the field of migration health, including representatives of embassies and consulates, non-government organizations, medical institutions, ethno-cultural centres and diaspora organizations.

Data collection was conducted on the territories of Kyrgyzstan and Kazakhstan from February to April 2017. Respondents included 59 migrants (44 individual in-depth interviews and two focus group discussions with a total of 15 respondents) and seven experts. Respondent selection was made on the basis of a non-random, targeted and «snowball» sampling method. Interviews and group discussions were conducted in Kyrgyz, Kazakh and Russian languages. During the entire research process, respondents' confidentiality and anonymity was protected, informed consent was ensured and "do not harm" principles were enforced. Research methodology and protocol were approved by the Central Committee on Ethics of the Republican Centre for Health Development under the Ministry of Health of the Republic of Kazakhstan.

The analysis presented in this chapter reflects qualitative data from a non-representative sample, and does not pretend to be statistically representative of all aspects and issues of the complex migration dynamics of Central Asia. Its objective is not to present numbers and statistics, but rather to provide readers with a "living snapshot" of migrants' concrete experience, with a focus on the health aspects of migration. For this reason, anonymous quotes from interviews are presented throughout the chapter to illustrate the investigated topics. It is thus hoped that migrants' own words will allow readers to better grasp their reality and understand the challenges they face in a more profound manner.

## 2.1 RESPONDENTS' CHARACTERISTICS

Despite its non-representativeness, the research's sample quite accurately reflects the Central Asian labour migrant population as a whole. Among the relevant elements to take into consideration, we can note that at the moment of the survey, most respondents already possessed a rich migration experience. On average, respondents migrated four times in the course of their life. This explains why, in their narrative, migration experiences in Kazakhstan – our primary focus in this research – are often intertwined with those of stays in the Russian Federation, the latter being the primary destination for Central Asian migrants.

Respondents were aged from 23 to 61 years old. The average of 35 and median of 28 point out to the fact that Central Asia's migrant population is overall quite young, especially when considering that most of these young respondents have had one or several previous migration experiences at the time of the survey.

Respondents included 23 men (55 percent) and 21 women (45 percent). Most respondents (26 out of 44) had children, although not all were married at the time of the survey (four were divorced and three lived in civil union and/or cohabitation).

Most respondents (39 percent) migrated for the first time between 2006 and 2010 and travelled abroad on average four times, which illustrates the tendency, confirmed by numerous studies, of young Central Asians using migration as an early life livelihood strategy.

Respondents' countries of origin included Belarus (2), Ukraine (2), Kazakhstan (3), Kyrgyzstan (24), Moldova (1), Russia (2), Tajikistan (1), Turkmenistan (1), Uzbekistan (6) and two not indicated. The high proportion of respondents from Kyrgyzstan is deliberate, as the focus of this study was put on countries taking part in the project in the framework of which this research was conducted.

## 2.2 THE PRE-DEPARTURE STAGE

The first step towards understanding the health impact of the migration experience is to study the circumstances and conditions in which it takes place. It is also important to understand that the migration experience starts before departure, while migrants are still in their homeland and preparing for the journey. Indeed, their level of preparedness, knowledge and awareness, the presence of social capital and networks, and their sources of information about aspects related to their destination such as housing, employment opportunities, legal and administrative procedures, are all contributing to determine the outcomes of the migration journey, as well as its health consequences.

### 2.2.1 Drivers of migration

Assessing the health impact of migration requires an understanding of its primary motivations. In other words, what are the characteristics of both countries of origin ("push factors") and of countries of destination ("pull factors") determining migration decision processes? Understanding push and pull factors is important, as they can shed light on the socio-economic motivations and resources of migrants, which in turn partly determine the health outcomes of their migration experience.

Interview data point out to a wide range of motivations for migration. Among push factors mentioned by respondents, socio-economic reasons are predominant and include:

- Low or insufficient salaries in home country
- Debts and inability to repay credit
- Unemployment and lack of work opportunities in line with professional specialisation
- Desire to provide children with quality education by means of financial resources acquired during migration



- Unsatisfying housing arrangements leading to the desire to buy or build housing with financial resources acquired during migration.

What were the reasons [for migrating]? Where did you work before migrating?

The [main reason is] low salary, 7000 soms [per month]. Friends [who worked in Russia] came back [in Kyrgyzstan] for a month and I spent some time with them. During this month, they spent two or three times the amount of my annual salary. Later they invited me to work in Russia. Apart from a small salary, I migrated because I wanted to see other countries.

Can you explain the reasons [for which you migrated]? What prompted you to leave your home and go work there [in Kazakhstan and Russia]?

Well, I just could not find a job here.

You are a teacher by profession, did you want to find work according to your training?

I didn't manage to find work at all, in my field or not.

What motivated you to go there [in Kazakhstan and Russia], to leave your home?

The reason is simple: the hardships of life. I wanted to build a house, to make money for my family.

Tell me, why did you decide to leave Kyrgyzstan and start working abroad?

I wanted to buy a house and live separately from my husband's parents. (...) The first time [I migrated], while the documents [working permits and registration] were being prepared, my brother arranged work for me in a restaurant with his friend's help. I washed dishes in this restaurant. I worked there for a month or two. It was very difficult and I worked for very long hours. When my documents were ready, I settled down in a cafe as a waitress. There the conditions were better.

Did you go with your husband? And did he had the same reasons for leaving?

Yes, I left with my husband and yes, he had the same reasons for leaving: work.

Pull factors (related to countries of destination) mentioned by respondents are more varied than push factors. They include:

- Interest in seeing other countries;
- Employment opportunity with conditions perceived as advantageous;
- Obtain education for oneself and for one's children;
- Acquire specialized skills and experience;
- Obtain specialized healthcare services unavailable in the home country.

Tell me, why did you decide to leave and start working outside Kyrgyzstan?

I don't know really. I finished my studies here [in Kyrgyzstan], started working but I wanted something which would be my own, something new and interesting. I found a school on the Internet in Kazakhstan. But after going there, the school turned out to be too expensive. I could not study there and started working. I liked it there and decided to stay.

In some instances, personal and circumstantial reasons are the main drivers of migration. For example, respondents mentioned:

- A divorce or the loss of a partner became an impetus for migration
- Short-term visits becoming long-term stay for personal reasons
- Family reunion

What decided you to leave?

My husband went there [to Kazakhstan] for work, and since he had to cross [the border] frequently and had problems with his visa, we had to both come here.

The above indicated motivations demonstrate how migration is used as a livelihood strategy adapted to the specificities of people's life, needs and aspirations. The success of this strategy depends on a wide range of factors, not always within the control of migrants. Cases of unsuccessful attempts to enhance one's conditions through migration are frequent. For instance, a respondent who engaged in labour migration with the specific goal of acquiring the financial resources to build a house in his home country, turned out to be unsuccessful. Such scenarios often cause frustration, a feeling of failure and can negatively affect migrants' mental and physical well-being.

What was your reason for migrating?

Well, we needed money to repay loans.

And did it help? Did working abroad allowed you to repay your loans?

No.

How did you manage to repay your loans?

Well, relatives helped.

So, the fact that you migrated did not help you repay your loans?

No, it did not help.

## A circumstantial factor: The re-entry bans into the Russian Federation

An important and relatively recent phenomenon affecting Central Asian migrants' trajectory and decision making processes is the re-entry bans into the Russian Federation – the so-called «black list». This policy forbids a large number of Central Asian migrants – most often for committing minor administrative offences related to registration procedures – to re-enter the territory of the Russian Federation (by far the main destination country for Central Asian labour migrants) for a determined period usually lasting a few years.

Many interviewed respondents learned that they were on the re-entry bans list only when they tried to enter the territory of the Russian Federation from the Kazakh border. Unable to afford transportation costs to return home, they had to remain in Kazakhstan and find work there. These “stranded migrants” find themselves in a particularly difficult situation, as they are not prepared for a stay in Kazakhstan: they lack reliable contacts and information about local conditions, employment opportunities, housing, legal issues and other important aspects. In those cases, the negative health impact of this “unplanned migration” can be particularly high.

Overall, the re-entry bans have led to a partial redirection of migration flows from Russia to Kazakhstan, as migrants unable to work in Russia can still do so in Kazakhstan, a country enjoying a relatively dynamic economy. Considering this current – and probably future – increase in labour migration to Kazakhstan, the issue of the provision of social services to migrants becomes more relevant than ever.

Before [coming to Kazakhstan], where did you go to work?

To Russia, I worked a lot there.

You said you came to Kazakhstan last year. Why did you started to go to Kazakhstan instead of Russia?

Because I'm now banned from going to Russia.

Why?

I was deported, I don't know why exactly. After that, when I tried to enter Russia, they told me at the border that I was not allowed to travel to Russia, so I decided to stay here [in Kazakhstan].

You left home to work in Russia?

Yes, but at the border, at the customs they told me that I would be deported, that I'm not allowed to enter Russia.

And what is the reason for that?

I don't remember exactly, I think it's because of registration.

Would you go to Russia if you could, instead of staying in Kazakhstan?

Yes.

So, you came here by accident, you wanted to go to Russia but you stayed here [in Kazakhstan] because you were not allowed to cross the border. You had no money to get back home so you started looking for a job here, is that correct?

Yes. I found work in a car wash. There was a Kyrgyz man there, I explained to him my situation, he understood and took me to work. It was a relief when I earned my first 1000 tenge, which I spent on food. It was possible to eat something. The Kyrgyz man registered me immediately.

### 2.2.2 Preparing for the migration journey

How migrants plan their journey and how they find information about work opportunities, required legal procedures and the availability of social services can indirectly tell us about their overall strategy and mentality, and is thus worth studying within a research investigating migrants' health.

**Sources of information.** In general, accounts from other migrants are the main source of information for future migrants. Such narratives are often a decisive factor encouraging migrants to undertake the migration journey. This occurs both in a direct way (when acquaintances share concrete migration stories) and in an indirect way, when ambient migration related narratives and norms affect individual behaviour («everyone around me is leaving, so I should try myself»).

Moreover, interview data show that the starting point of nearly all migration journeys is a trusted contact person, located either in the destination country or in the country of origin and possessing experience and networks perceived as valuable. This contact person usually provides future migrants with practical information about transportation, housing and, most importantly, employment opportunities. Reliable contact persons are often considered as an assurance of the migration journey's success.

Did anyone help you to find work like relatives, neighbours or fellow villagers?

I had a classmate there [in destination country] and I went to her.

She called you?

No, when I was preparing to leave, I wrote to her to ask if we could meet, if she could help me find a place to live.

She agreed?

Yes, she agreed.

However, if personal contacts are generally effective in providing migrants with useful information about housing, employment opportunities and other practical issues, these sources often fail to equip migrants with accurate and updated information related to legal issues and administrative procedures such as registration, work permits, employment contracts, social services and migrants' rights and entitlements. Indeed, this information – which is paramount for successful migration – is often acquired by contact persons through personal experience, by "trial and error" and from a variety of unofficial sources such as fellow migrants, relatives and friends with previous migration experience. As a result, the transmitted information is often inaccurate, outdated and unreliable. As we will see later, such "low quality" information can negatively affect migrants' ability to navigate the administrative environment in destination countries, thus hampering their access to healthcare.

Did someone help you find work the first time you migrated?

Yes, my cousin helped.

Did he tell you about the work you would have there, about the conditions, working hours, etc.?

Actually, the landlady of the apartment where we lived, she worked there herself [in a restaurant]. With her help, my brother arranged work for me there [as a dishwasher].

And did you know what work conditions would be like before starting?

I thought I knew, but I did not imagine it would be so hard. I spent long hours standing, hands in the water and in washing liquids. Dirty dishes were brought endlessly to us. We also had to throw garbage out. Because I was the youngest, when the cleaning lady did not come to work, I had to do her tasks also. Cleaning was very hard as they would check my work constantly, God forbid that there remains a stain somewhere. It was especially hard to clean the men's restroom, as people there were sometimes harsh. But for them it's normal, they are used to see «blacks» ... That's what we are for them.

«Blacks»? They called you that?

Yes.

They said this between them?  
How do you know they called you that?

Well, they call all the Tajiks, Uzbeks and Kyrgyz people this way.

Regarding employment – the primary motivation behind migration – migrants most often leave home knowing that a particular work awaits them, which was organized at the pre-departure stage through personal contacts networks. Others are “invited” by acquaintances without previously organized employment, but with the hope that upon arrival a job would be found easily. In rarer cases, migrants travel abroad “blindly”, without personal contacts and with little operational information about employment opportunities, housing and legal issues in destination countries. These different degrees of preparedness, social capital, legal literacy and knowledge affect the overall migration experience, partly determine its health consequences and migrants' access to healthcare in the host country.

**Transit and “migratory debts”.** For most migrants, travelling to destination countries entails considerable expenses and represents a difficult stage of the migration process. To afford transportation by bus, train or plane, migrants usually spend a part of their own and/or their family's savings, borrow money from acquaintances or from a bank, or sell property (selling livestock to cover such expenses in a common strategy in rural areas). Transportation expenses are considered as an investment to be repaid by wages acquired during migration. Thus, in many cases migrants commence their migration journey with a “migratory debt”. This debt often increases upon arrival due to initial expenses related to housing and services of intermediaries which facilitate legal procedures such as registration, acquisition of work per-

mits, "patents" and the like. These debts generally have a negative, albeit indirect impact on migrants' health, as the necessity to repay them lead migrants to avoid expenses that would otherwise contribute to their health and well-being such as quality food, appropriate housing and clothing, and of course healthcare services and drugs.

How did you get there [to your intended destination]?

By bus.

Who paid for the trip and how?

I paid myself, I took a loan.

And where did you say you will live [in destination country]?

In a friend's apartment. I came by plane, they met me when I landed. The ticket from Bishkek was expensive for me.

Did your parents give you this money?

We sold cattle and with this money I bought a ticket. We sold our last bull to buy this ticket, now there are no bulls left at home.

How did you get to your destination the first time?

The first time I went with my uncle by plane. My uncle paid for it, but after that I paid myself for the trip.

Did you borrow any money to pay for the trip?

No, I paid with my savings.

**The role of employment centres.** Some migrants plan their trip through government or non-government employment centres. Interview data show that migrants who do so are generally the most informed and prepared to face the challenges awaiting them. This was clearly the case with respondents



from Kyrgyzstan who organized their journey through employment centres. They had employment contracts concluded before departure, underwent preliminary medical examination and obtained useful medical certificates, their transportation expenses were sometimes subsidized, and all of them were properly registered and obtained valid work permits. For these respondents, the migration experience was generally easier, the success rate higher and the negative health consequences lesser. Moreover, working conditions, salary, housing arrangements and other aspects of their experience more or less coincided with their initial expectations, thus preventing dissatisfaction and frustration. This points out to the potential of an extended and more efficient network of employment centres in countries of origin to indirectly but efficiently contribute to the realization of migrants' right to health in Central Asia.

**Conclusions.** The above results demonstrate the importance of the pre-departure stage in determining the outcomes of the migration journey, including in terms of health. Reliable information, pre-departure employment and legal arrangements, as well as migrants' overall preparedness can greatly contribute to minimise the health consequences of migration and to increase migrants' ability to navigate the administrative environment of destination countries. Detailed recommendations related to the pre-departure stage can be found in chapter five.

## 2.3 THE HEALTH IMPACT OF MIGRATION

### 2.3.1 Migrants' health status

Assessing the health status of migrants is a difficult task. On the one hand, reliable data and statistics about migrants' health are scarce. On the other, many migrants tend to hide illnesses, injuries and health problems due to the fear of losing employment opportunities. What follows is merely the "big picture" of health issues mentioned by respondents, which provides a general understanding of the health impact of migration and of the health challenges migrants face.

It is worth noting that the majority of respondents rated their current health status as "average" or "good". However, interview data revealed that migrants suffer from a wide range of health problems and diseases, including:

- Common cold and influenza (frequent)
- Toothache (frequent)
- Tuberculosis
- Joints pain (frequent)
- Stomach pain (frequent)
- Deterioration of vision
- Back pain
- Gastritis
- Kidneys problems (frequent)
- Low haemoglobin count
- Fungus infection
- Haemorrhoids
- Sinusitis (frequent)
- Female reproductive health problems
- Severe weight loss.

[Name], how is your health at the moment?

When I arrived here [in destination country], I weighted 82 kilograms. Look at me now.

How much do you weigh now?

I think 60 kilograms. I have not weighed myself for a long time.

Why [did you lose so much weight]?

Because of poor nutrition. And poor living conditions. And unpaid work. If I would have earned something, everything would have been fine. I could have bought food for myself.

In addition to the temporary and/or circumstantial health problems listed above, a range of chronic conditions were also identified by respondents. It is however difficult to divide temporary health problems from chronic conditions, as migrants themselves often fail to make such distinction and both categories can be intertwined. Indeed, during interviews many respondents replied negatively when asked if they suffered from chronic health problems; however, during the course of the conversation many mentioned health problems that have been affecting them for a long time, and which are sometimes not entirely curable. The following chronic diseases were mentioned by respondents:

- Chronic joints pain and disease (frequent)
- Diseases of the gastrointestinal tract
- Osteochondritis
- Chronic bronchitis
- Chronic sore throat
- Chronic diseases of the genitourinary system
- Chronic kidney diseases
- Tuberculosis
- Eye diseases
- Chronic tonsillitis (frequent)
- Hernia, spine displacement, protrusion of discs (frequent)

Of course, not all the above mentioned health issues are caused by migration; it is often difficult to link their origin directly to the migration experience. However, the nature of many health problems mentioned by respondents illustrate the specific challenges faced by migrants, as they can be traced back to:

- Overcrowded, unhygienic, and/or cold housing conditions contributing to the spread of infectious or transmissible diseases such as tuberculosis, gastritis, common cold and influenza;

- Employment conditions characterized by long working regimes, performance of hard physical tasks sometimes carried out without appropriate security measures and safety equipment, and sometimes involving exposure to toxic chemicals without protection equipment;
- The common migration strategy consisting in limiting expenses in destination country to maximise the financial benefit of the stay, which entails cutting expenses on quality food (causing vitamin deficiency leading to weakened immune system and increased prevalence of diseases and health problems), on medications and drugs, and on healthcare services.

It is also important to note that many young migrants (under 30 years old) complained of health problems that usually appear at a much later age. For instance, young respondents mentioned suffering from chronic joint pain, chronic stomach diseases, kidney dysfunctions, chronic sinusitis and haemorrhoids, all of which can be at least partly attributed to circumstances specifically related to the migration experience. Indeed, young migrants are often the most eager to maximise the financial benefits of their journey. More than older migrants, they are willing to work longer hours in more difficult and sometimes dangerous conditions, often perform multiple jobs simultaneously, have insufficient and irregular sleep and neglect their nutrition. Young migrants are also the most likely to have risky sexual behaviour leading to sexually transmissible diseases.

Why do you think you fell ill with jaundice?

I think it's because of the cold, I was constantly ill during winter. Maybe because I worked on a construction site and had to carry heavy objects 15-16 floors up, like cement, sand, tiles, etc. A wheelbarrow was provided to make it easier, but it was still hard. (...) I think that when it gets warmer I will go to the hospital for a check-up and to be treated. Probably because of the stress, my hair and beard began to turn grey, even though I'm only 32 years old.

How did this schedule [long work hours] affect your body, did you feel any changes?

Well, I think I got ill from the cold, I also had a chronic gastritis. This is probably because of [bad nutrition], I only ate snacks at work and dry food at home.

Sometimes, diseases are contracted prior to migration, either in countries of origin or during previous migration experiences. However, it is not uncommon that circumstances of migration worsen pre-existing conditions or prevent their effective treatment. In other cases, health problems and diseases appear after migration, but can be traced back to its circumstances.

Would you say that your health has improved or deteriorated because of migration?

It has deteriorated.

Why?

Well, it was cold there, the food was poor. At the end of the winter we did not eat properly, we lived in metal trailers, without heating, it's very cold, you imagine, in the middle of winter. After that, stomach and kidneys began to hurt.

Finally, some migrants acquire disability during migration. One respondent, after a heavy object fell on his head on a construction site, is now partly paralyzed one side of his body.

Despite the inherent difficulties in assessing migrants' health status, interview data demonstrate that practically all migrants suffer from some kind of health problems. True, the same could be said regarding the general population, and not all health problems are attributable to the migration experience. However, the nature of the health problems experienced by respondents, their frequency and the age of those experiencing them point to a specific health impact of migration, which will now be examined through the lens of some important aspects of the migration experience.

### 2.3.2 Housing and health

Migrants' housing arrangements are varied and depend on the specific circumstances of their stay. Typically, migrants will rent rooms in apartment, entire apartments or live in a dormitory. Others (including some of our respondents) live in more difficult conditions: at the workplace, in unheated wooden cabins, in tents on the street or in basements.

Among the various housing related difficulties faced by migrants, the most common is overcrowding, which most often derives from the financial inability to afford proper housing and from the cost minimisation strategy in use by many migrants. The most vivid example was told by a respondent who lived with about 30 people in a three-room apartment: as some of the occupants worked on night shifts and others on day shifts, they shared the place accordingly.

In 2012, a lot of people lived in the apartment. (...) Five persons lived in one room. But I did not live there for long: through a friend I found a job in a restaurant and left this apartment. It's just that work was very far away: it took 1,5 hours to get there. I worked on my feet for 12 hours a day. So, I moved to an apartment closer to work, but there I also lived with a lot of people: there were about 30 persons living in a three-room apartment.

And [how was the] housing?

First I lived with a classmate who rented an apartment with her friends. We were five living in a one-room apartment.

If not all migrants live in such extreme situations, the majority of respondents nonetheless stated that overcrowded housing arrangements are very common and negatively affect their life quality and health. Significant stress is caused by the difficulties inherent to sharing space with a large number of people, sharing responsibility for domestic tasks, managing conflict between tenants, the fear of theft and insufficient and poor-quality sleep.

And what about the living conditions?

I had a 3-room apartment, which I shared with other Kyrgyz, from the south, from Osh I think. The apartment was in very bad condition, there was no washing machine, we washed clothes by hand. We took turn to hang them to dry on the balcony [because there was not enough space]. There were problems with the kitchen too. There were many people living there but there was only one small kitchen with one gas stove. Everyone cooked for his family and I had to wait [for my turn]. We all came back from work at the same time. When the bathroom is occupied, you go to the kitchen, but there are already women cooking, you have to sit and wait. The first time I went [to the destination country], we were ten persons living in the flat, including my husband and me. In another room lived my brother with his family. And in another – the landlord herself, with her children and husband.

The most significant health risk of overcrowded housing is the facility with which infectious diseases can spread due to constant physical proximity of potentially infected persons, frequent unhygienic conditions and weakened immune systems due to stress, lack of sleep, poor nutrition and hard work regimes. Tuberculosis is a case in point.

Most often, migrants cover housing expenses themselves. More rarely, employer cover these costs, especially when accommodation is provided at the workplace. As mentioned, migrants display a high employment mobility and change jobs frequently. Relatedly, they also often change housing, sometimes from one part of the city to another, in order to live as close as possible to the workplace, which saves time and money and reduces the risks of being checked by the police.

It is common for migrants to live with people from their home country (in some cases, migrants even live with people from their town or village). Others live with nationals of other countries and of the host country. When travelling with family and children, migrants tend to rent a room for themselves or, if they can afford it, a whole apartment or house.

Most respondents indicated that they feel safe at their place of residence. However, some mentioned a feeling of insecurity caused by:

- The general “fear of the unknown” related to moving to another country;
- Perceived insecurity and crime in the neighbourhood;

- When accommodation is provided at the workplace, fear of employer's misconduct;
- Fear of unexpected police raids.

Finally, respondents stated (from personal experience or observation) that cases of domestic violence tend to be more frequent during the migration period. Cited reasons include jealousy of one of the partners, disagreement on financial management, as well as an increased level of overall stress caused by exhaustion and difficult living and working conditions.

Overall, it can be said that housing conditions are an important determinant of the health outcomes of the migration experience. Migrants' "cost minimization strategy" often leads to inappropriate housing which is directly or indirectly conducive to health problems, some of which can be of a serious nature such as tuberculosis.

### 2.3.3 Occupational health

The main purpose of the majority of Central Asian migrants is work. Typically, the workplace is where migrants will spend most of their time. As such, work is probably the aspect of the migration experience having the greatest impact on migrants' health. This section outlines the employment patterns and work regime of Central Asian migrants, the most frequent occupational illnesses and injuries, employers' role in providing medical assistance, as well as other work-related issues. It aims to assess the overall health impact of the work-related aspects of migration.

**Employment patterns.** The first thing to note about migrants' employment patterns is that in the course of their migration journey, many will work on different jobs, for different employers and in various fields. This is especially true for male migrants, who seem to be more mobile when it comes to employment. For instance, some respondents indicated that they changed jobs up to five times during a migratory stay of a few months.

In general, as can be seen in table 6 below, most migrants are employed as low-skilled workers. We can observe a quite clear distinction by sex, as women will generally be employed in the services sector as waitresses, dishwashers, cleaners and sellers, and most men in the construction and commercial sectors. It is worth noting that few migrants benefit from upward mobility: most of them remain in low-skilled positions despite many years of experience in a particular field. In the present study, only one respondent mentioned having benefited from upward mobility.

**TABLE 6** Employment of respondents

Code	Age	Sex	Respondents' employment during migration
KGAS01	24	Male	Electrician
KGAS02	25	Female	Waitress
KGAS03	28	Female	Dish washer – Cleaner – Waitress
KGAS04	47	Female	Seller in small shop – Dish washer – Baker – Security guard
KGAS05	28	Female	Seller in "container shop"
KGAS06	25	Female	Nanny
KGAS07	40	Male	Construction worker – Plumber
KGAS08	30	Female	Cook – Cleaner – Dish washer
KGAS09	28	Female	Dish washer
KGAS10	30	Female	Seller in "container shop"

Code	Age	Sex	Respondents' employment during migration
KGAS11	39	Male	Sales manager – Sales representative – Company founder/director
KGAS12	31	Female	Beauty salon employee – Seller – Store clerk
KGKJ01	54	Male	Security guard – Construction worker – Wholesale intermediary – Construction overseer – Driver
KGKJ02	29	Male	Construction worker – Loader in brick factory – Electrician
KGKJ03	28	Male	Worker in cardboard factory – Railroad worker – Warehouse worker – Window washer – Office loader
KGKJ04	32	Male	Loader – Construction worker – Taxi driver – Small weekend jobs
KGKJ05	28	Male	Barista in cafe
KGKJ06	26	Male	Seller – Construction worker
KGKJ07	27	Male	Warehouse worker – Driver
KGKJ08	51	Male	Security worker – Taxi driver
KZRS01	26	Male	Car washer – Construction worker
KZRS02	33	Male	Shop loader
KZRS03	23	Male	Repairer
KZRS04	47	Male	Taxi driver
KZRS06	61	Male	Security guard – Wholesale shop employee – Unemployed
KZRS07	39	Male	Construction worker – Worker in tire shop
KZRS08	41	Male	Security guard – Electrician
KZRS10	43	Female	Cook
KZRS11	47	Female	Cleaner in medical clinic – Worker in sewing factory
KZRS12	56	Male	Construction worker – Welder
KZRA01	32	Female	(Victim of human trafficking, sexual exploitation)
KZRA02	25	Female	Cashier
KZRA04	32	Male	Tiler
KZRA06	31	Female	Milkmaid – House worker
KZRA07	49	Male	Construction worker
KZRA08	33	Female	House worker
KZRA09	36	Female	Cleaner
KZRA10	47	Female	Cleaner
KZRA12	24	Female	Cleaner

As previously mentioned, in their search for work migrants are most often assisted by friends, relatives or acquaintances, whether in destination or origin countries. However, it is common for migrants to be dissatisfied with conditions and salary of jobs provided by personal contacts. In such case, many are looking for alternative employment opportunities through ads, contacts or employment centres in destination countries.

In some cases, employers themselves approach migrants, both in countries of origin or destination, to offer jobs. It is common that when migrants are recruited in the country of origin, employers cover transportation expenses, which are then deducted from their salary when they start working. In such cases, “debt relationships” are often created between migrants and employers, which can be problematic in the absence of employment contracts. Indeed, without clear and formal agreement on working hours, wages, provision of food, housing and other aspects of the employment relationship, the value of performed work is often not accurately included in the repayment of the debt. As a result, some migrants spend several months repaying their initial debts to their employer, which prevents them to save money to send home – the very objective of the migration journey.

**Work regime.** The typical work regime of Central Asian migrants is characterized by long hours. As a rather extreme example, a female respondent stated that she worked in a confectionery shop in Moscow from 7am to 3am. After a month, not able to maintain this regime, she quit this job and became a dishwasher. In her new job, conditions were slightly better, but she still worked 12 hours each night, from 21pm to 9am. She then changed job once more and started working as a room cleaner with a similar regime of 12 hours (from 8am to 8pm).

Migrants employed in the construction sector work on average from 10 to 12 hours a day. In all cases recorded during this research, employers did not pay for overtime if the amount of work required additional hours to the initial agreement, whether formal or informal.

Finally, it is not uncommon for migrants – especially the young – to seek additional employment opportunities on the days off their regular job, as part of the strategy to maximise the financial benefits of their journey.

Such dense work regimes allow for little time to look after one’s health, to get enough sleep and a healthy diet. Sleep deprivation and physical exhaustion affect migrants’ health in a significant way, as it weakens the immune system, thus increasing risks of illnesses and diseases. Exhaustion also increases risks of occupational injuries, as we will see below.

It is important to note that such work regimes should not be attributed solely to employers’ behaviour. Migrants’ overall mentality and desire to make the most of the migration journey in terms of financial benefits also lead to hard and long work regimes. However, many respondents stated that they would work less hours per day if they could, but that it was generally not possible due to practices in the employment sectors where the majority of migrants work.

**Occupational injuries and illnesses.** Migrants generally perform low-skilled, physical labour entailing significant health risks. Among frequent cited risks of occupational injuries, respondents mentioned:

- Risks of falling from heights, especially when working on rooftops and when washing windows;
- Risks of falling objects, especially in warehouses and on construction sites, aggravated by the fact that many migrants are not provided with appropriate protection equipment such as helmets;
- Risks of electric shocks;
- Risks of skin injuries due to contact with industrial chemicals (aggravated by the frequent absence of appropriate protection equipment such as rubber gloves and masks);
- Risks of car accidents, especially for taxi drivers in winter;
- Risks associated with insufficient skills to manipulate dangerous construction tools;
- Risks of respiratory illnesses caused by industrial chemicals such as glue.



Did you have the feeling that some parts of your work were dangerous?

In some way, there was danger everywhere. You get security equipment only if you manage to work officially [with an employment contract and other appropriate documents]. Then you get a safety briefing and you learn the technique, everything is as it should be. But if you work for a private employer [without a formal employment contract and legal protection], then where [do you get the safety equipment and briefing]? You must insure yourself. That's how it works.

Actual work-related injuries and accidents experienced by respondents include:

- Cuts from sharp objects;
- Crushed fingers or limbs from falling objects;
- Burns;
- Dislocations and fractures;
- Cramps and limb numbness;
- Falls from vehicles, rooftops and other high places;
- Injuries caused by fighting at the workplace.

Of course, these risks are not faced by migrants alone: many locals also perform work entailing risks of occupational injuries. However, migrants are generally overrepresented in low-skilled labour, making them a particularly vulnerable group. This vulnerability is further aggravated by the fact that being non-citizens and often in an irregular situation, they do not benefit from social services entitlements as nationals, just as they often lack support networks helping to alleviate the impact of health problems.

**Employers' role in migrants' health.** Considering the importance of work in the migration experience, employers' actions and attitude towards migrants' health significantly influence the health impacts of migration. According to interview data, the role of employers in migrants' health issues greatly varies on a spectrum ranging from indifference and carelessness to consideration and active assistance. In some cases, employers cover expenses related to the treatment of occupational injuries or illnesses, or contribute to the treatment in non-financial ways. For example, when a respondent had his fingers crushed by a safe, the employer covered medical expenses and compensated the migrant for missed work days. In another case, when a respondent working in a remote location (where access to medical facilities was difficult) was injured, the employer provided first aid assistance and arranged further treatment in a hospital.

Have you ever been ill while working here?

Yes.

Could you describe what health problems you had?

My kidneys hurt.

Did you receive any medical help?

Yes, I received medications, the doctor gave me some.

Where did you get medical help?

At the polyclinic.

And who paid for it?

My employer paid.

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Did you receive any treatment? Did you go to the hospital?

No, but I received medicine.

And who prescribed the medicine for you then?

A doctor in a clinic.

Was it a private clinic?

No, a public one.

Did the company [for which the respondent was working] pay for it?

Yes.

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So, you missed work days because of your illness? Were these missed days taken from your salary?

No, they were not. On the contrary, [my employer] helped, gave money for treatment in the hospital. The brigadier himself visited me in the hospital, he also helped.

At the opposite end of the spectrum, respondents mentioned cases where themselves or fellow migrants were injured or fell sick at work, but employers did not allow them to recover and forced them to continue working by threatening to fire them if they wouldn't. Such situations – and countless variations – are especially frequent in cases of labour exploitation and human trafficking. Interview data also show that employers most often do not compensate migrants for working days missed because of occupational injuries or illnesses.

Overall, employers' role in migrants' health depends to a great degree on their subjective mood and attitude. However, the presence of formal legal arrangements (valid registration, work permits if applicable and employment contracts) is usually a good indicator of employers' attitude towards occupational health: respondents with formal employment arrangements stated an overall greater health support from employers than those without it.

Occupational health risks are often aggravated by the fact that many migrants, when getting injured or falling ill, hide their conditions from employers. Respondents also reported to hide chronic conditions, a behaviour caused by the fear of missing working days and thus salary. It is telling that many migrants prefer to endure their health problems and continue working instead of being treated. Most respondents stated that they would stop working only upon very serious health problems. Even if they do interrupt work for treatment, they will often get back to it as soon as the first signs of relief appear, before having fully recovered. Most often, this practice is attributable to the will of migrants themselves, not because the employer forbids treatment. Here again, the reason can be traced back to the "cost minimization migration strategy". Following this logic, every missed working day implies lost resourcefulness and an overall less "successful" migration journey.

Some respondents stated that in the presence of injuries and illnesses requiring urgent treatment, they would take a few hours off work to undergo tests, buy medicines, apply bandages and so on. In order to not take leave from work, they would often agree with acquaintances (most often fellow migrants) for temporary replacement.

**Violence at work.** In addition to injuries and illnesses caused by the work itself, violence among workers – either fellow migrants or locals – is not uncommon and sometimes leads to injuries. Such situations are rendered more frequent due to the stress triggered by difficult and/or dangerous working conditions, as well as by increased irritability caused by exhaustion. Interview data show that cases of violence at workplace are related to the following factors:

- Situations directly related to the work process;
- Alcohol intoxication of colleagues;
- Sexual harassment;
- Expressions of nationalism and/or racism causing conflict;
- Extortion and racket by criminal groups;
- Disagreement with employers;
- Violent encounters with the police.

What are the most significant problems [you encountered at work]?

Well, sometimes the employers used to beat us.

Can you tell me in detail what happened exactly?

Well, he just got drunk and started harassing me, he wanted to rape me, but I didn't let him. After that, I was very afraid of him, but everyone is afraid of him.

So, there were people [at work] threatening and humiliating you and your family?

There were guys who came for my husband asking for money.

Why?

They said it was for "protection", he didn't really have a choice but to accept.

Has anyone threatened or humiliated you at work?

Yes, there was one administrator.

What did he say and did he do?

Sometimes he would just hit me or make fun of me. I would not say anything.

And when he hit you, what did he say?

He said, "you're a Kirghiz, you're cunning".

Have you received any other injuries [at work]?

Yes, once there was a conflict, with the Nazis [nationalist groups] and [the respondents got injured during a fight].

**Climate and health.** An additional factor impacting migrants' health is climate. This factor is particularly important in cities such as Astana, Kazakhstan's capital, where winter temperature can drop to 50 degrees below zero. Migrants coming from warmer regions are often unprepared and ill-equipped to deal with such temperatures. Those working outdoors (bazaar traders, construction workers, handlers, taxi drivers, etc.) are most likely to report the negative impact of climate on their health. Furthermore, many migrants are not willing to afford warm clothing because of the necessity to save money.

Working in cold conditions without appropriate clothing often causes common colds, influenza, and other diseases, while worsening some chronic conditions, weakening the immune system and increasing vulnerability to infectious diseases.

Is it colder there than in Bishkek?

It's colder. During the summer it's very hot in containers [where the respondent lived at the workplace], and in winter, on the contrary, it's very cold. If the temperature outside is minus 20 degrees, then in the container it's even colder.

You think this is harmful to your health?

Yes, of course, it is. Money is good, but you lose your health.

## Conclusion

The overwhelming majority of respondents (all but two) indicated that migration is having a significant impact on their health, and that this impact is mostly negative. Many factors such as housing arrangements, nutrition, legal status, work conditions and climate interact in a complex manner to determine the health outcomes of the migration experience. In the conditions in which most Central Asian migrants currently undertake the migration experience, it can be concluded that migration has generally a negative impact on migrants' health.

It is worth noting that despite this negative assessment of the health consequences of migration, most respondents remained convinced that overall, migration is an effective livelihood strategy as it allows – at least when it is “successful” – to make rapid financial gains and acquire experience, new skills and further personal development.

## 2.4 MIGRANTS' EXPERIENCE IN ACCESSING HEALTHCARE

### 2.4.1 Treatment and prevention

The first step in grasping migrants' experience in accessing healthcare is to understand the different treatment methods they use when falling ill or getting injured, as their behaviour in such situations is telling about both their attitude towards the health consequences of migration and their relationship to host countries' health systems.

**Self-treatment.** Interview data show that upon illnesses or injuries – even quite serious ones – most migrants will first engage in self-treatment. The first recourse is often the local drugstore, where they expect to obtain advice and drugs that will bring a quick resolution to the problem. This method is perceived by migrants as the most affordable form of treatment. However, in some cases, poor level of health-related knowledge and unwillingness to seek proper medical treatment lead to dangerous self-medication practices. As an example, a respondent engaged in self-medication to treat an advanced case of hepatitis. After about a week, his condition worsened to an alarming degree and he decided to seek medical help.

And when you got sick there [at work in destination country], what did you do? Did you go to the doctor?

No, I treated myself. I bought drugs and everything. Once, only when I got very sick, my neighbours took care of me a little. I was lying and felt very ill. I was coughing hard.

The effectiveness of self-medication is also hampered by poor compliance with drug dosage and instructions. Many respondents stated that they tend to use drugs until symptoms start to disappear rather than complying with instructions and undergoing the complete treatment, a practice often leading to the reappearance of symptoms. This is particularly dangerous when antibiotics are used, as drug-resistance is created and more potent forms of viruses and microbes appear. The frequent non-compliance with drug dosage and instructions is greatly contributing to the current outburst of multidrug resistant tuberculosis in the Central Asian region.

Who does the injections?

We do it ourselves. There are girls without medical education, but they are good at injections.

When you take medicines, do you adhere to instructions, or when the pain goes away you stop taking them?

As soon as the pain passes I stop taking them.

Interview data show that this behaviour is not only due to migrants' poor health knowledge: this practice is also embedded in the cost minimization strategy, as migrants prefer keeping remaining tablets for later use instead of continuing to use when symptoms disappear. This phenomenon is further encour-

aged by a common practice in Central Asia upon which, at the request of the client, pharmacists will sell a few tablets instead of the entire medicine box. In such cases, customers often do not receive drug instructions as they remain in the box.

Conversely, some respondents stated that to heal more quickly, they took doses of medicine well above those prescribed, which can also be detrimental to health.

As we will see later in more details, a common reason for self-treatment among migrants is irregular status and lack of documentation. Many respondents think that their irregular status would prevent them from obtaining healthcare services in public (or even private) healthcare institutions. In addition, some feared that irregular status might cause problems upon interaction with the public health system, including the fear of deportation.

[When you were ill], did you go see a doctor, did you seek medical help?

No, I did not.

What did you do?

You just have to be patient and endure, what to do? I have no documents so what can I do?

Other frequently mentioned reasons for self-treatment is insufficient financial resources to afford private healthcare and lack of time. As an example, a female respondent suffering from hernia for several years stated that she never had the time nor the money to undergo proper treatment, as she felt the need to work without interruption to provide for members of her family who stayed at home. These can be directly attributed to the specific circumstances of the migration experience.

And you needed medical care, right?

Yes, of course, there were severe pains, but what can you do? I continued to work. I made myself an anaesthetic injection and worked. (...)

So, why did you not ask for help? You did not have enough money, or could you just not physically go to the hospital?

Yes, I could not physically go, and also, I could not afford it, I had to work.

**Host countries' health institutions.** When self-treatment proves unsuccessful and their health condition deteriorate, some migrants – both regular and irregular – will turn to local medical institutions. In the absence of clear instructions for healthcare personal to deal with migrants with various legal statuses,

healthcare services obtained by migrants greatly vary and depend on a range of factors, including the nature of the medical institution, the health condition for which migrants seek assistance and the subjective assessment and “mood” of healthcare personnel interacting with migrants.

And who paid [for healthcare services], your employer?

No, I paid myself. The employer does not pay. My health is very important for me.

And did you go to a public or a private hospital?

Public.

And the medicines you needed were officially prescribed?

Yes. The doctor wrote [a prescription] and I myself bought them at the pharmacy.

As an example, a respondent suffering from jaundice, after unsuccessful attempts at self-treatment, decided to visit the local hospital even though her legal status was not settled and she did not have all the required documents. The doctor, not paying attention to her legal status, provided diagnostic and drug prescription free of charge and without asking “uncomfortable” questions. However, even though carrying out a blood test would have been the ordinary procedure to validate the diagnostic, the doctor did not do so. We can infer that the reason for this is related to the necessity to use registration information for the blood test, which the migrant did not possess. Other such cases narrated by respondents point out to the highly unpredictable outcomes of migrants turning to local medical institutions for healthcare services and treatment, in which the human factor plays a considerable role. However, it should be noted that according to respondents’ experience, public medical institutions almost always treat children and pregnant women.

Were there anyone among you who went to the hospital?

Yes, I got an ultrasound, I was asked 4 000 tenge. For foreigners, they [healthcare services] are all expensive. There was a case when a 15-year-old girl with a kidney attack called an ambulance. The ambulance took her away, she had ultrasound and other tests, the payment was 15 000 tenge even though the diagnosis could not be established. It was impossible to stay at the hospital, because inpatient treatment is very expensive, it costs 15 000 tenge per day. The girl had to be treated at home.



Did you go to see doctor there [in destination country]?

Yes, I went.

Because of the hernia?

Yes, or for other reasons.

To a private or public clinic?

To a private. In the public clinic, they don't accept [undocumented migrants]. When I was pregnant I was accepted though. I was even put on the register there.

Although you are not a citizen of Kazakhstan?

Yes. Pregnant women are accepted.

**Private healthcare services.** Another method of treatment is to go to private health clinics. Interestingly, migrants with a regular status, as well as those who have obtained permanent residence or citizenship in host countries, admitted that they preferred obtaining healthcare services in private clinics, despite their eligibility to (some) free healthcare services in public medical institutions. The two main mentioned reasons included saving time (as queues are usually much shorter in private than in public institutions) and a perceived higher quality of services in private clinics.

Irregular and unregistered migrants also stated a preference for private clinics, which present the significant advantage of providing anonymity and not "asking questions" related to legal status, registration and the like (excepting for tests for HIV, syphilis and some other diseases, for which doctors are required by law to ask for an identity card and report cases). Respondents also mentioned that it is common for them to pay for private dentistry and gynaecology services in host countries.

I'm pregnant but I work anyway. I'm not on the register yet. Once I went to the [public] polyclinic, but when they found out a Kyrgyz [citizen], I did not even get an ultrasound scan. You need to have friends and contacts there. In the end, I had to go to a private clinic and pay for my ultrasound(...)

Private clinics provide good services and advice and prescribe medicines, but they're very expensive. Just registering there costs five thousand tenge. Therefore, we are trying to be treated in Kyrgyzstan.

Most migrants expressed a preference to obtain healthcare services in destination countries. In their view, the quality of healthcare is higher than in their country of origin. However, as mentioned above, several factors often prevent them to do so, which are generally of a financial and administrative nature.

Indeed, prices of healthcare services determine to a large extent migrants' choice of treatment strategy. Healthcare services in both public and private health facilities are estimated by migrants to be expensive, sometimes hardly affordable. It is thus very common for migrants to choose the least expensive treatment option, or to neglect treatment altogether, even if detrimental to health. When suffering from a condition requiring urgent treatment, some migrants often decide to return to their homeland to be treated there, as healthcare is often less expensive and they can benefit from entitlements as citizens.

Did you have any injuries at work?

No, thank God. On the medical side, I tried not to be treated at all in Almaty.

Why?

Well, first of all, it's more expensive there.

When you had problems with your kidneys, did you go to a hospital or a polyclinic?

No, I didn't.

Why did you not go?

Because it's very expensive. And I didn't have documents yet. But mostly because of it's too expensive.

**Emergency medical assistance.** In cases of acute illness or serious injury, migrants often call an ambulance to obtain emergency medical assistance on location. According to migrants' own experience and those of acquaintances, in all cases emergency assistance was provided free of charge. In cases requiring subsequent in-patient treatment, migrants are taken to the hospital to receive specialized services, analysis, radiography and so on. Respondents mentioned that they had to pay themselves for these services. It is worth noting that respondents stated being satisfied with the provided emergency medical assistance.

**Non-government organizations and consular support.** Non-government actors such as local and international NGO, as well as international organizations, play an important role in migration health in terms in advocacy, policy development and direct assistance to migrants in need. The present section will focus of the latter field of action. First, migrants' expectations towards non-government organizations are telling about their specific needs and overall experience. Respondents mentioned that in their opinion, these actors can or should help them with the following:

- Assist in the search for employment, especially in cases when migrants must leave their job while already in the host country and find alternative employment;
- Assist in registration related procedures and provide practical information about legal requirements, where they should apply and so on;
- Provide legal advice to migrants, especially to those poorly knowing the language of the host country;
- Provide direct assistance when migrants fall victim to various kinds of fraud, deception and exploitation, and provide them with an "emergency fund" to cover their basic expenses in the most desperate cases;
- Assist in the process of documentation and regularization of children born during migration;
- Help to restore documents when they are lost or stolen;
- Raise migrants' overall level of knowledge and awareness about migration regulations, procedures and the risks of frauds and exploitation.

Despite these high expectations, slightly less than half of respondents were not aware of non-government organizations providing assistance to migrants. In addition to non-government organizations, respondents stated a relatively high level of trust towards embassies and consular representatives of their country of origin. In their opinion, embassies and consulates should assist them for the following:

- To conduct "arrival briefings" for new migrants, during which they could obtain practical, reliable and updated information about all important aspects of host countries, including required procedures for migrants, laws, labour market, available social services and other issues;
- Provide a voucher for migrants proving the absence of criminal records (to be presented to potential employers during search for employment);
- In cases of loss of documents, frauds or exploitation causing desperate situations, providing emergency assistance and help establish contact with relatives at home who could assist them;
- Make the above mentioned information available online, as well as employment opportunities and contact information of diaspora organizations, ethno-cultural centres and non-government organizations able to provide assistance in different types of situations.

**"Traditional" remedies.** To overcome the main financial and legal barriers preventing them to access healthcare, many migrants use "traditional" or "home" remedies, such as infusion, ointments and massages. However, poor knowledge about the health consequences of some of those methods lead to negative and dangerous health outcomes. As an illustrative example, a mother admitted giving cognac to her two-year-old child as a medicine against common cold and cough. This points out to the need to increase basic health knowledge of migrants already in host countries.

**Conclusions on migrants' choices of treatment methods.** Empirical evidence shows that the choice of a treatment method depends on a wide variety of factors, including the nature of health problems, migrants' financial resources, legal status, legal literacy, knowledge and awareness, social capital, networks and perceptions about the health system of the host country.

It is telling that some migrants choose to neglect treatment altogether despite serious health problems. For instance, a respondent admitted that despite suffering from chronic cough for more than a year, he did not undergo testing for tuberculosis. He stated that "Maybe I was ill but I did nothing, I just worked as usual».

Common mentioned reasons for neglecting treatment include:

- Lack of money;
- Necessity to work (no time to spend on treatment);
- Lack of knowledge about where to go to receive treatment;
- Irregular status and absence of documentation;
- Not being a citizen of host country;
- The desire to save money;
- Preference to wait for a trip home and be treated there;
- Carelessness.

And [what do you do] when you get sick?

Well, we buy medicines at the pharmacy and treat at home, we consult the pharmacist or friends. [Explanation that they do not go to public medical institutions because they are undocumented]. There are private medical centres, but they are very expensive. If we have a very serious illness, we must go home.

## 2.4.2 Legal status and its impact on healthcare access

Work permits, employment contracts and registration are the main documents giving migrants the legal right to stay and work in host countries. Their possession or absence affect the migration experience in a significant way, and can often be the main determinants of its success or failure. Relatedly, the level of migrants' knowledge about these issues, legal literacy and preparedness also determine to a great extent the access of migrants to social services, including healthcare. The following section will thus examine how migrants interact with the legal environment of host countries, and how this interaction affects their access to healthcare services.

**Registration.** Registration at place of residence is probably the single most important procedure for labour migrants, and a significant determinant of their legal status.

In Kazakhstan, migrants' registration should officially be handled by the inviting party, who is responsible for registering the migrant at the address of permanent residence. However, in practice many migrants obtain registration through intermediaries, who in exchange for payment register migrants at their address, even when they do not actually live there. This practice is mainly explained by migrants' difficulty to find a landlord willing to register migrants at their address, and by the overall low degree of legal literacy of migrants. Moreover, migrants' high mobility (many move frequently during the courses of their migration journey) is another element preventing registration at the actual place of residence. Interviewed experts and key informants were unanimous in the opinion that the current registration system is not adapted to migrants' reality.

Has the employer concluded a contract with you, an employment contract?

Yes, they did. I had a work permit also, and therefore I was taken to work. I had registration at the place of residence too.

Did you register at the place where you lived, or at another address?

At another address.

Does your registration coincide with your place of residence?

No, it doesn't. It doesn't for 90% of migrants.

Registration evidences a legal stay, but does not give the right to work. However, many migrants manage to find employment without any additional documents, especially in the least regulated employment sectors such as construction, small businesses (bazar), transportation (taxi) and some services (cleaning and restauration).

Registration is usually valid for a determined period. Therefore, it is a common practice for migrants to temporarily leave the host country when registration expires, and immediately re-enter. However, many migrants stay in the host country after expiry of registration, thus rendering their status irregular and potentially creating legal problems, including in terms of access to social services such as healthcare.

Migrants' compliance with registration requirements is often verified by authorities (the police or the State Migration Service). According to respondents, raids in apartments where migrants live are frequent. When verifying registration, attention is paid to the correspondence of the registration address with the actual address of residence. If they correspond, authorities will usually verify the presence of a rental agreement (lease), on which the same address and the migrant's name should be indicated. According to respondents' narratives, if about ten migrants live in an apartment, it is usually only possible for about two of them to be registered at this particular address, the rest being registered at other addresses. Registration is also verified on the street, on the workplace and at border checkpoints.

Many respondents mentioned that intermediaries who "sell" their address to register migrants often provide fake registrations. This problem is aggravated by the inability of many migrants to distinguish a genuine registration from a fake one.

In some cases, registration rules and procedures become an instrument for labour exploitation. For instance, respondents mentioned cases where employers provide migrants with accommodation at the workplace, take migrants' passports for registration, but without actually doing the registration procedure. Migrants thus find themselves without registration – and sometimes without passport – a situation which greatly limits their freedom of movement, access to social services and capacity to negotiate with employers. Migrants falling into such traps can easily become victims of labour exploitation, are subject to manipulation and are often afraid to contact authorities because of the very absence of documents and registration.

Both in Russia and in Kazakhstan, expired registration is one of the most common reasons for administrative punishment, including deportation and, in the case of Russia, inclusion to the re-entry bans list.

## Changes brought by the Eurasian Economic Union (EAEU)

The Eurasian Economic Union was signed in 2014 and entered into force in 2015. As of August 2017, it comprises of Russia, Kazakhstan, Belarus, Kyrgyzstan and Armenia. Among other changes, it introduced lightened administrative procedures for migrants of member states, thus encouraging and facilitating labour mobility. Although many recent studies have been produced to assess EAEU's impact on migration trends and migrants' experience, it is still early to have a complete and clear picture of its impact. Within this study, migrants from Kyrgyzstan either neutrally or positively assessed EAEU's impact. They cited the following advantages:

- Registration periods are longer;
- Work permits are not needed anymore;
- It is easier for migrants to find work, as the administrative burden to hire migrants from EAEU countries on the employers' side is lightened;
- Crossing borders of EAEU countries became easier and faster.

**Work permits and employment contracts.** Alongside registration, work permits and employment contracts are also important determinants of migrants' legal status and can greatly influence their access to social services such as healthcare. According to interviewed experts, the conclusion of employment contracts is highly beneficial to migrants when it comes to accessing social services in general, and healthcare in particular. Indeed, migrants in possession of a valid employment contract fall under the action of national labour legislation, which regulates labour relations. Thus, when a migrant is injured in the workplace, he/she is generally entitled to receive compensation from the employer, as stipulated by law. In theory, migrants could still receive compensation in the absence of employment contracts; however, this necessitates proof that the injury is labour related, which often requires a long, difficult and costly process in which migrants are often unwilling or unable to engage. Ultimately, valid employment contracts are a strong legal protection for migrants.

Conversely, the consequences of not having formal and valid employment documents can be serious and negatively affect the outcomes of the migration experience. As an example, among respondents was a young man from Kyrgyzstan who travelled to the city of Almaty with a group of 12 other migrants to work in a brick factory. The employer did not formalize their documents, and a week after their arrival, a police inspection took place at the workplace and the whole group was deported for not possessing valid employment documents and registration. In addition to the stress and frustration caused by the incident, the respondent and his companions could not fully reimburse the initial costs of their migration journey.

Many respondents mentioned similar cases, when absence of employment documents or invalid/expired documents led to fines, detention and deportation. It is worth mentioning that migrants often do not pay fines out of carelessness or lack of financial resources to do so.

And why was your wife deported?

She was fined for not having a work permit, but she did not pay, [that is why she was deported].

Some respondents stated that after negative employment experience, they regretted that they had not concluded an employment contract. Most have a clear understanding of how contracts can protect them in the future.

Similarly to registration, interview data show that migrants are generally ill-informed about procedures surrounding work permits and employment contracts. Most often, they will use the services of intermediaries who, for a price, will arrange the necessary “package” of documents allowing them to work legally. This practice, as we’ve seen earlier, is hindering the development of a much needed legal literacy culture among migrants. In addition, many migrants, thinking that using an intermediary’s services is the only way to obtain documents, are not able to afford them. Indeed, the costs of such services can be expensive for some migrants, especially in capitals and major cities where they tend to be higher. Thus, it is a common practice for migrants to work with only registration at the place of residence, without work permit or employment contract.

Did you have an employment contract?  
Did your employer know about this?

No, I did not know this before, I’ve learned about this only recently. I now know that everything should be indicated in the contract, including how many hours I should work.

Do you have a registration or a work permit?

No.

Are you working currently?

Presently yes.

And do you have an employment contract  
with your employer?

No.

Have you ever concluded an employment contract  
with an employer?

No, no.

Did you have any official permission to work?

Only the first time when I worked in a cafe. And that's all. Then the next two times I did not have a work permit. I even lost all my documents once. I lost everything when I lost my bag with my documents and my phone. I took the documents of a friend and I worked with these documents for a while in a restaurant.

And in what cases do you conclude an employment contract? Can you work without it?

You can. Now I think that I spent this money [the fees of an intermediary who arranged a work permit] for nothing. I just did not know, people said it was necessary [to have a work permit].

And in your opinion, is this work permit like a labour contract or are they two different things?

I don't know.

The accession of Kyrgyzstan to the Eurasian Economic Union (EAEU) has changed the rules for migrants from Kyrgyzstan working in Kazakhstan. One of the major changes is that work permits are not anymore required for Kyrgyzstani citizens to work in Kazakhstan. However, it remains necessary to conclude employment contracts with employers and register this agreement (together with a request from the employer) with the State Migration Service, which then registers the migrant for the period stipulated in the employment contract. According to migrants' feedback, this greatly simplified the procedures to ensure legality of stay and employment.

Kyrgyzstan joined the Eurasian Economic Union in 2015. Since then, has anything changed for Kyrgyz labour migrants?

Because of the changes, I am more willing to go. Now we can work [in these countries] more like [the local population]. It became easier with the documents.

An important point to which attention should be paid is the information indicated by migrants in the "purpose of the trip" section of the migration card, which every non-citizen must fill when crossing the border. According to experts and officials, even if migrants indicate "private visit" as the purpose of the trip, it is still possible to register an employment contract during the stay. However, some respondents stated that in practice, when the purpose of the visit is specified as "private" (or as another reason not related to employment) they experienced problems with employment contract and subsequent registration. They were told by government employees that they should have indicated "work" on the migration card when crossing the border. However, as we have seen some migrants leave their homeland without having formally organized employment in the destination country. In such cases, respondents who in-



licated "work" as their purpose were asked specific details about employment by border guards, which they could not provide, and thus experienced difficulties crossing the border. This points out to the need to adapt such procedures to the concrete reality of migrants.

It is worth noting that migrants usually travel several times to destination countries and that within the same trip, they can change jobs many times. A typical migrant who had, say, three stays abroad and worked on average for three employers during each stay will have had nine jobs. For some of these jobs, contracts will be concluded, for others not. Respondents cite the following reasons for the absence of employment contracts:

- Poor knowledge and low level of awareness (migrants are not informed of the rules related to employment contracts);
- Self-employment (for example for unofficial taxi drivers and retail sellers in bazars);
- Unwillingness of employers to arrange contracts to avoid paying taxes;
- Employers' fear that registering migrants as employees will lead to police inspections;
- Employers' opinion that employment contracts will make them legally responsible for migrants, thus rendering them unwilling to do so;
- Migrants' opinion that employment contracts do not provide any guarantees of social services provision;
- Migrants work using the identity of a person possessing a valid employment contract, but who does not actually work;
- Migrants concluded an employment contract for his/her first job, but did not for subsequent jobs due to carelessness or lack of knowledge;
- The employer is an acquaintance, a relative, a fellow countryman and the relationship of trust renders contract unnecessary in migrants' opinion;
- Migrants possessing previous positive work experience without having concluded a contract rely on this experience and do not see the necessity to conclude a contract;
- Employers' unwillingness or inability to formalize a contract due migrants' absence of documents;
- Very short period of employment, not leaving sufficient time to conclude a contract;
- When hiring domestic workers and nannies.

The employer hired you only with registration? He didn't ask for anything else?

Yes, only registration. He didn't ask for anything else.

And is there an employment contract?

No, he took a copy of my passport and that's it. We didn't conclude an employment contract.

Did you have a contract with the employer?

No, we didn't.

It was a verbal agreement then, right?

Well, he [the employer] is my friend, we grew up together [so I trust him].

Has the employer concluded an employment contract with you?

No, no.

Why in your opinion?

Because when they [the employers] make contracts, they have to pay taxes for us, they become responsible for us. But he [the employer] treated us very well.

In addition, it is not uncommon that migrants possessing valid documents will not renew them when they expire. There are reported cases when migrants found work with the documents of other migrants. Respondents noted that this was particularly common in the Russian labour market.

Interviewed experts noted that many employers have concerns about the health of the migrants they recruit. Some employers, before concluding a contract (or even if they don't conclude a contract at all) require migrants to obtain a medical certificate proving absence of hepatitis, tuberculosis, HIV and other diseases. This is a common practice for housekeepers, nannies and nurses. Migrants often have to go to private clinics to obtain medical certificates, which represents a significant expense seldom covered by employers.

According to interviewed experts, the proportion of migrants having employment contracts and valid documents is currently increasing. In the particular case of Kyrgyz migrants, experts attribute this change to the effect of EAEU, which lightened the administrative burden for migrants.

**Deception and fraud.** Migrants in living and working in foreign countries are particularly vulnerable to various kinds of fraud and deception, which are unfortunately common and can impact to an important degree the outcomes of the migration experience. Some forms of deception can result in migrants involuntarily changing jobs, moving from one city to another, deportation and, in the most unfortunate cases, to labour exploitation. Migrants can be deceived by employers, by intermediaries offering "packages" of documents, as well as by fellow migrants and colleagues.

The most common form of deception is underpayment by employers from performed work. For instance, an employer who has not concluded a contract with a migrant can orally promise to the latter

free accommodation at the workplace, but at the time of payment deduct part of the agreed salary for provided accommodation. Migrants without alternative housing options, relatives or money, are often forced to agree with this arrangement.

Things did not exactly go as we wanted [during migration].

Why?

We became the victims of a deceiver. My uncle was acquainted with him. He found a job for us and transferred the money from the employer to us. But after a while we found out that he only gave us half the money he should have, he was keeping the rest for himself. (...) Therefore, I decided to return [home].

What was your relationship with your employer?

There was no problem, everything seemed good, but when I left he didn't count my last days of work and wouldn't pay me for them.

Another very common type of fraud on the part of employers is the gradual expansion of types of work and workload. Migrants are required to perform tasks that were not previously agreed on and for which they are often not qualified and/or provided with the necessary protection equipment, thus increasing risks of occupational injuries

How much did you earn on average?

Very little. I did not have enough to rent a room. I had to accept a room in the basement [at the workplace].

You worked as an electrician there. Did they [the employers] ask you to do other tasks?

Yes, then began to force me to do all sorts of things. Clean the porch, for example.

Another form of deception from employers is for them to intentionally give migrants inaccurate information about salary prior to employment. For example, an employer will promise that the salary will be piece-rate based, which in some cases can be advantageous for the employee. However, when work is starting, the migrant is in fact paid at a fixed wage, which is generally quite low.

Yet another form of deceit consists in employers taking migrants' passport and promising to arrange formal contract and registration, but without actually doing it, which puts migrants in very difficult situations. Moreover, they often fear that reporting the situation to authorities will lead to additional problems due to the very absence of registration caused by the employer's fraudulent behaviour. Finally, as mentioned earlier, migrants can be deceived by intermediaries who provide their services for registration. It is not uncommon that these intermediaries will register migrants at non-existent addresses or make fake registrations. As noted earlier, many migrants, especially those who undertaking their first migration experience, are unable to distinguish a fake registration from a genuine one.

These various forms of fraud and deceptions make it clear that valid work permits, employment contracts and registration are strong protection mechanisms for migrants and can partly determine the health impacts of the migration experience. However, for reasons mentioned above – mostly related to migrants' low level of awareness and knowledge and to an administrative system not fully adapted to migrants' reality – many migrants cannot enjoy these benefits. It is thus important to strengthen mechanisms and procedures allowing migrants to work legally.

### Conclusion

As the above data clearly demonstrate, migrants' legal status significantly impacts the overall migration experience. Regular status is much more likely to result in the "success" of the migration journey, to allow greater access to healthcare and other social services, and to contribute to reduce risks of negative health outcomes. Conversely, the consequences of irregular status can be serious and detrimental to migrants' well-being and health.

Unfortunately, many migrants cannot enjoy the benefits of regular status for a variety of reasons, including: the general low level of knowledge, awareness and legal literacy; the frequent use of intermediaries and the fraud and deception associated with it; lack of financial resources; lack of trust towards government institutions in destination countries and the low effectiveness of informational material targeted for migrants.

In general, would you rate your migration experience as positive or negative?

You know, if I had correctly legalized the documents, I would have done very well... But it turned out be quite different from what I expected.

## 2.5 GENDER VULNERABILITIES, REPRODUCTIVE HEALTH AND CHILDREN'S HEALTH

Not all migrants have the same level of vulnerability when it comes to the health consequences of the migration experience. Among particularly vulnerable groups are migrating women, who are subjects to a variety of social norms directly impacting their life, and who face particular health challenges. This section presents an overview of issues related to migrating women's experience.

### 2.5.1 Social norms surrounding female labour migration

Interview data show that both among the general population and the migrants sub-group in particular, we can observe a whole spectrum of social understandings and norms related to the differences

between men and women in regard to migration. These norms are important to investigate as they indirectly tell us about women's migration experience and the challenges they face. Norms mentioned by respondents include the following:

- With regards to migration, women gradually gained more rights than men;
- In general, men leave the homeland to work abroad, while women stay home and receive money;
- Recently, women have become more independent and less vulnerable, including during migration;
- Migration is easier for women, as they have specific resources and abilities that men do not possess;
- Migrating women are often engaged in prostitution;
- Migrating women enjoy too much freedom;
- Migrating women often cohabit with members of other nationalities in destination countries, which is a bad thing;
- It is easier for migrating women to obtain permanent residence or citizenship in destination countries because they can, more easily than for men, marry local people;
- It is easier for women to find employment;
- Migrating women generally work harder and better than men;
- Migrating women can find a "common language" more easily and are better than men at negotiating;
- Migrating women are less often checked by the police than men;
- Migrating women's wages are generally lower than migrating men's;
- In the workplace, migrating women are more vulnerable and more easily manipulated by employers (they cannot fight back if necessary, as men would);
- Migrant women generally suffer more during the migration process;
- Women suffer from additional hardships because of children left at home (they worry about them and miss them more than men do);
- Men generally have more ambitious migratory objectives than women;
- Men are more prone than women to work on the black market;
- Men are more likely than women to solve problems through money.

Is it easier to migrate for women or men?

It's difficult to say because it's easier for women to get a job, but their salary is usually lower than men's.

Is it worth noting that these opinions are not shared by all respondents, and correspondingly do not reflect the entire population's mindset. Indeed, a significant proportion of respondents did not see any significant differences in the migration experience of men and women. Rather than gender, such factors as personal character, language skills, knowledge of laws and education were considered as the most important in determining the migration experience and its success.

In addition to being subject to social norms which affect their daily life, migrating women face the additional challenge of gender-based violence during migration. Both male and female respondents stated that gender-based violence – which in the majority of cases is directed towards women – tended to be more frequent during migration. Aggravating factors mentioned by respondents included the overall stress inherent to the migration experience, disagreement about financial management and jealousy caused by increased feeling of freedom experienced by some migrants who are less subject to social pressures of their usual environment.

Have you ever experienced violence during migration?

Well, yes, it happened with my husband. After that [the violent conflict], I could not go to work for five days.

What happened, did he beat you?

Well, I had a black eye after.

And after [this event], did you [continue to] live with him?

Yes, we still live together.

Did you forgive him?

Well, he's changed now. And then there are our three children anyway. Especially since he wanted a boy. I gave him a boy. (...)

And what were the causes of the conflicts with your husband [during migration]?

Well, for example, he used to go out with a friend to drink beer late at night. And I told him: «We did not come here for this.»

So, he did not work, but spent your money?

Well, he didn't spend a lot of money on beer, but I just didn't like his behaviour. He is a jealous person – maybe because of this.

In addition to increased risks of being victim to gender-based violence, migrating women also face the danger of a particular kind of social violence, when men of the same nationality seek to control their sexual behaviour and prevent them from engaging in relationships with men from other nationalities. Some cases of this type of violence were much publicized, when migrating women from Kyrgyzstan were physically assaulted by fellow migrants because they allegedly had relationships with men of other nationalities.

## 2.5.2 Reproductive health

One of the most critical challenge faced by women during their migration journey – and probably the most important factor vulnerability – is reproductive health. Far from their traditional support networks of family and community, pregnant migrant women often face particular hardships. So are women giving birth in host country, and those with young children<sup>33</sup>.

The issue of reproductive and child's health is rendered particularly important considering that many Central Asian migrants have children, some of them having had their pregnancy, and in some cases have given birth, during migration. For example, among respondents, more than half (27 out of 44) had at least one child, the average being two and the maximum six. Even more telling, among the 20 female respondents, 9 have had pregnancy during migration.

The main result that can be inferred from interview data is that women's experience related to reproductive health in host countries is very diverse, and that the services they receive depend in a great measure on ad-hoc factors, in which the "human element" plays a considerable role. Indeed, the absence of clear procedures for the provision of reproductive health services to non-citizens creates an unpredictable environment, in which most migrants find it difficult to navigate.

For instance, if some female respondents mentioned that they benefited from free healthcare during pregnancy in Kazakhstan, others stated that they had to pay for the same kind of services. These differences were noted even when respondents visited the same type of healthcare institutions and had the same legal and residency status. However, among respondents, most pregnant women who visited healthcare institutions in host countries to obtain reproductive health services stated that they paid for them.

However, medical assistance during childbirth was mostly provided free of charge. Among respondents, five women gave birth to children in Kazakhstan (one respondent gave birth three times in this country). Out of these five, three received free healthcare services during childbirth. One woman had a caesarean section, which was also carried out free of charge. The remaining two female respondents provided ambiguous information, making it difficult to understand if childbirth medical assistance was provided for free or not.

According to respondents, it is a common practice for pregnant women to temporarily go back to their homeland to give birth. One respondent went home twice to give birth. In addition to a better availability of post-natal healthcare services, the main mentioned reasons were related to the absence of family support during and after childbirth in host countries.

<sup>33</sup> For a more detailed analysis of children's right to health in Central Asia, the reader can refer to chapter four of the present report, which is specifically dedicated to this topic. The information contained in this section is thus complementary to the content of chapter four.

Abortions are also common among female migrants: according to respondents, they are more frequent among migrating women than among the general population. Among the 20 female respondents, three mentioned having had abortion. Two interrupted pregnancy during migration due to financial difficulties and fear of not being able to take care of their children. The other had abortion upon return home and mentioned health reasons directly related to the migration experience: according to her, heavy physical work, stress, long work hours and poor nutrition during migration contributed to the death of the foetus. These reasons behind the decision to abort pregnancy point out to the specific vulnerabilities of female migrants and to migration's impact on health.

Where you ever pregnant here [in host country]?

Yes. But I interrupted [the pregnancy].

Can you explain why you decided to interrupt the pregnancy?

Because of financial hardship [not enough financial resources to take care of a new-born baby].

The second time I became pregnant was in Moscow. I thought: keep it [the baby] or not? It's just that my daughter was still small. I went to the Kyrgyz polyclinic; there, a simple consultation costs 500 roubles. I asked about all this [the reproductive health services and their costs during pregnancy in the host country], if I need to come every month, if I need any tests? And if I give birth, is it possible do to all this here in Moscow? She explained to me that in general all this cost one thousand dollars. I thought and decided to take a pill to have a miscarriage. Three tablets cost me five thousand roubles.

Female migrants generally try to minimise the impact of childbirth and rearing on the "efficiency" of their migration journey. Giving birth and bringing up children were mentioned as bringing about financial and logistical challenges, often conducive to less "successful" migration. For instance, respondents mentioned that female migrants, whether giving birth in the host country or temporarily returning home to do so, tend to resume work as soon as possible, despite the possible health consequences, both for the mother and the child.

In addition, all respondents with children mentioned that taking care of their health during migration is particularly problematic, as migrating parents usually possess less financial means, time and contextual knowledge to address their children's health problems. This is aggravated by the fact that migrants' children tend to be particularly vulnerable to health problems considering the living conditions of many migrants, which are prone to the spread of infections and communicable diseases.

**Documentation of migrants' children.** Similarly to the provision of reproductive health services to female migrants, there seems to be a certain ambiguity in the practices of documentation of migrants' children, especially those born in host countries. For instance, among respondents, two women could not obtain birth certificates for their children born in Kazakhstan. Another woman, who gave birth to



three children in Kazakhstan, could obtain a birth certificate for only one of them; the two others remain undocumented. Despite ambiguities in migrants' children documentation practices, it is worth noting that all respondent stated that doctors are always trying to help with their children's health issues, irrespective of the children's or their parents' status. However, interview data clearly demonstrate that migrants' children's health is heavily affected by their parents' legal status in host countries. Migrants with an irregular status (in terms of registration, employment contract and work permit if applicable) are less prone to seek medical assistance to solve their children's health problems due to the fear of interacting with government representatives. Hence, realizing migrants' children's right to health represents another powerful argument to take measures to ensure that all migrants have a regular status in host countries.

Although their children are most often registered in public institutions, in some cases migrants with sufficient financial means turn to private clinics to solve their children's health issues. At the other end of the spectrum, the most financially vulnerable migrants frequently use home remedies, with more or less success. In some cases, migrants' children's health suffers from these remedies and the poor level of their parents' health knowledge. For instance, a female respondent, when her child suffered from persistent cough, gave him cognac, thinking that it would help.

## 2.6 MIGRANTS' KNOWLEDGE AND AWARENESS

The overwhelming volume of gathered data points out to the fact that among all the factors affecting migrants' experience – both the overall experience and its specific health consequences – migrants' level of knowledge and awareness are probably the most decisive. The ability to find and use information, both during migration and at the pre-departure stage, about such topics as the legal requirements for regular stay and employment in host countries, registration procedures, work permits, employment contracts, about the availability, accessibility and entitlements to social services, as well as about the work market, housing and society of host countries, is paramount to a successful migration journey and to the minimisation of its negative health consequences.

However, despite the importance of information, interview data show an overall low level of awareness by migrants. The degree of knowledge about migration related laws and regulations offers a good example. Indeed, out of the 44 interviewed respondents, 18 admitted that they do not know migration regulations at all; 13 mentioned that their knowledge is low, and five found it difficult to answer the question. Out of 46 respondents, only eight (18 percent) noted that they have a good knowledge of migration regulations.

Tell me about what you know concerning your rights [as a migrant] and about the laws of the country where you left to work?

Yes, I know.

What exactly?

I know that documents should be in order. And if you don't bother anyone you will not be bothered yourself. The police checks your documents, and if they are okay, then they let you go. If you don't smoke and don't drink, and if you're quiet in your apartment, then nobody will bother you. You should consider that you're in a foreign country and act accordingly.

What do you know about the rights and regulations for workers in this country?

Very little. I don't know much about this.

How well do you think you know about your rights as a migrant?

Well, I know about this, but the police will always find something.

Participants in focus group discussions also demonstrated an overall low level of knowledge and awareness about migration regulations and the requirements they should observe. Interestingly, this low awareness was observed even in respondents who possessed extensive migration experience, not only in Kazakhstan but also in the Russian Federation and sometimes in other countries. During discussions, participants asked the moderator to fill their knowledge gaps about topics such as:

- The required correspondence between registration address and address of actual residence;
- The kind of information required to be indicated in the "purpose of trip" line of the migration card;
- The procedure to extend registration to prolong stay and employment;
- Penalties in cases of expired documents;
- Entitlements of the police and other government authorities;
- The actions they should take when being subject to intimidation and illegal behaviour (bribes) by government authorities.

Did you notice any changes after Kyrgyzstan joined the Eurasian Economic Union?

No, my friends did everything for me. I don't understand this at all.

It is important to note that despite this low level of knowledge, almost all respondents understand the importance of possessing reliable and accurate information. Indeed, they tended to link their lack of information with the problems they face during migration. In any case, explaining this low degree of knowledge and awareness entails understanding migrants' most common sources of information about topics relevant to the migration experience.

The most common source mentioned by respondents is simply personal experience. The latter is particularly important for migrants as knowledge acquired in this way tends to settle deeply in memory. However, the acquisition of knowledge through personal experience has its limits, especially when related to a very important part of the migration process: registration. Indeed, as we have seen earlier, many

migrants use the services of intermediaries to fulfil registration procedures, to acquire work permits, obtain permanent residence or citizenship and so on. These intermediaries are most often citizens of host countries or firms related to diasporas. As migrants using these services do not acquire any first-hand experience in these procedures, this greatly impedes the overall development of a legal literacy culture among migrants. Indeed, practices show that many migrants stay and work for several years in host countries without acquiring reliable and accurate legal information.

In rare cases, migrants acquire legal knowledge during legal counselling, for instance when contesting a court's decision.

Employment centres are an important source of information and offer a considerable potential to strengthen migrants' legal literacy. Indeed, employment centres in countries of origin present the valuable advantage of transferring knowledge to migrants at the pre-departure stage, when they have more time and attention to devote to these issues, as they are not yet experiencing the challenges of migration proper.

Government authorities of host countries – most notably the agencies responsible for migration management – also have the potential to act as an efficient and reliable source of legal information for migrants. However, migrants are generally distrustful of host countries' government authorities and often try to minimise their contact with them. Somewhat ironically, this lack of trust is most often due to irregular status deriving from a lack of legal knowledge, thus creating of self-reinforcing circle of misinformation and mistrust.

Some migrants will seek information in the media and on the internet. Online resources have indeed an important potential for disseminating legal information among migrants. However, interview data show that the most used resources are not always official and sometime contain inaccurate information.

Can you tell me if you know your rights [as a migrant] and the laws of that country?

Now I know. Before I didn't. About 10 years ago. Previously, no one told me.

How did you find out then?

Well, on the internet. And from friends.

And what kind of things did you learn?

How do I make a work permit and other documents, what documents I need to collect, where to go, whom to call, how much should I pay, etc.

Finally, informational material produced by government and non-government organizations (leaflets, brochures and other types of documents made available in bus and train stations, airports, border crossing points and other public places) seems to have a limited effect on migrants' knowledge according to respondents' opinion. Both respondents and experts stated that few migrants take the time to read this material. Instead, they tend to rely on information provided by their contacts and networks in

host countries. However, these contacts, which themselves frequently use intermediaries, often do not possess accurate information.

Do they read it [informational material targeted for migrants]?

If they would read it, there wouldn't be so many problems. The fact is that no one reads it [the informational material]. And then they [migrants] come here [in Kazakhstan], they believe everyone who comes across and offers their registration services. Some deceive [provide fake registration or no registration at all], some do it but too late...

*Representative of Tajik diaspora*

Considering the importance of migrants' knowledge and awareness for the realization of their right to health, special attention is devoted to this issue in recommendations (chapter five).

## 2.7 HEALTH INSURANCE AND MEDICAL EXAMINATIONS

Interview data show that acquiring a health insurance policy is not a common practice among migrants, regardless of their migration objectives, length of stay or legal status. Indeed, among the 44 respondents, only two possessed voluntary medical insurance (provided by their employer) at the time of the study. The reason most frequently invoked for not acquiring a health insurance policy is directly related to the specific circumstances of the migration journey, namely the "cost minimisation strategy". Indeed, most respondents stated that they prefer to avoid the expense of a health insurance policy in order to be able to send more money home. Most considered the potential health consequences of the migration experience to be not serious enough to acquire health insurance. Relatedly, many consider that upon injury or illness, self-treatment will be sufficient. Finally, it is a widespread opinion that in case of serious injury or illness, a health insurance policy will not be of any substantial help. In Kazakhstan, this situation will most likely change since the adoption, in July 2017, of the mandatory health insurance policy for all persons staying in the country's territory, including migrants. At the moment of writing this report, this policy just entered into force, and it is yet too early to assess its impact on the realization of migrants' right to health.

Unlike health insurance, many migrants undergo medical examination prior to employment, most often while already in the host country. Most of them do not undergo examination voluntarily, but to fulfil requirements related to migration regulations or upon employers' demand. For example, some respondents underwent medical examination prior to the acquisition of a work permit, permanent residency status, military registration, and so on. Medical examinations are more frequent in certain employment sectors, such as public catering, healthcare and domestic work. In most cases, migrants cover examination costs themselves. Migrants usually undergo medical examinations in clinics specified by employers or authorized bodies. Just as falsified (fake) registrations are often provided to migrants by intermediaries in exchange for money, respondents mentioned the possibility to buy fake medical examinations in host countries.

Finally, it is worth noting that often, migrants who are the most in need of a medical examination are not those who undergo it. Some migrants with chronic health problems have not been examined for years, including a respondent suffering from chronic cough for more than a year, but who was never tested for tuberculosis.

## 2.8 RESPONDENTS' ADVICE TO FUTURE MIGRANTS

An interesting way to learn about migrants' experience is to ask them what advice they would give to potential future migrants. Thus, interviewed respondents were asked what they would say to people from their homeland who consider undertaking the migration journey. The many given answers can be summarized by the following general advices:

- Migrating for work can be beneficial in different ways (financial, personal, professional), but it entails many challenges, difficulties and potentially hardships. Be aware of this before you leave your homeland to live and work abroad.
- Before you leave, prepare yourself by obtaining all the necessary information about the place you are going to. To be successful and to avoid problems, you need to be familiar with the labour market of your destination, with legal requirements for migrants, with migration regulations and procedures and with your rights and entitlements as a migrant.
- Be sure to make your status regular, to have all your documentation in order and with you at all times.
- Before starting a job, be sure that you conclude a valid employment contract recognized by law and that all the aspects of the job are clear and mutually agreed upon (salary, work regime and conditions, provision of accommodation, food and protection equipment if applicable, etc.)
- If you can arrange employment before departure through an employment centre, all procedures will be simpler, work conditions will be better and you might avoid problems.

## 2.9 CONCLUSIONS

This chapter provided readers with an overview of the migration experience at its different stages, with a specific focus on its health aspects. It showed the various ways through which the migration journey can impact migrants' health, as well as their experience in accessing healthcare in host countries.

The health outcomes of migration are determined by several sets of factors. The first set is inherent to the very rationale underpinning labour migration. Indeed, as the main criterion against which the success of the migration journey is assessed is economic, the "cost minimisation strategy" used by most migrants leads to limiting expenses during stay in host countries. The first expenses that are "cut" in order to be able to send more money home are usually related to housing and nutrition, two important determinants of health. The frequent absence of health insurance policies is also a result of this strategy, which is economically rational but can aggravate migration's health outcomes.

The second set of factors determining the health impact of migration is related to characteristics of host countries. Among many such factors, we can mention housing arrangements characterized by overcrowding and conditions leading to the spread of communicable diseases; labour markets in which most migrants perform low-skilled jobs entailing long work regimes, difficult conditions and high risks of occupational injuries and illnesses; and a legal environment not fully adapted to migrants' reality, thus complicating their access to healthcare.

To this, we can add circumstantial factors such as the re-entry bans list in the Russian Federation, creating the phenomenon of "stranded migrants" who find themselves compelled to stay in Kazakhstan, where they most often lack the networks, support and information necessary to guarantee the journey's success and to prevent its negative health consequences.

Finally, the third set of factors is related to inherent characteristics of migrants themselves. Firstly, migrants generally show a high level of employment mobility which can increase the potential negative health consequences of migration. Secondly, the overall low level of migrants' knowledge and awareness

about the legal environment of host countries significantly hinders their ability to navigate their health-care systems, and thus limit their access to healthcare. Finally, specific vulnerabilities – such as reproductive health needs of migrating women – represent an additional challenge which needs to be addressed by both countries of origin and destination.

Labour migration is a legitimate and necessary livelihood strategy for millions of Central Asians, and is deeply embedded in the social and cultural fabric of the region. It provides many with not only opportunities of financial gains, but also of personal and professional growth. However, the conditions in which migration currently takes place are often conducive to significant hardships and negative consequences, including on the health of those who undertake it. Based on this analysis, recommendations (chapter five) were formulated for both government and non-government actors aimed at reducing the negative health impact of migration and at improving migrants' access to healthcare in host countries.



# 3

# MIGRATION OF HEALTH WORKERS

CHAPTER





Both Kazakhstan and Kyrgyzstan are integral parts of the Eurasian migration system<sup>34</sup>, which sets trends and patterns determining internal and external migration at the system-wide level and within national boundaries of its member states. Migration of healthcare workers is also affected by these trends and patterns. Within the national boundaries of Kazakhstan and Kyrgyzstan, healthcare workers predominantly leave rural areas and small towns for larger cities, especially capitals. Regarding external migration, the main trend is the outflow of people with higher education and secondary vocational education (including medical education) to Russia and other countries. While Kyrgyzstan is a distinctly migrant-sending country, Kazakhstan has a dual status in terms of migration: it is a migrant-sending and transit country within the Eurasian system on the one hand, and on the other a migrant-receiving country within the Central Asian sub-system. These factors underline specific challenges for the two countries: Kyrgyzstan is mainly faced with the issue of outflow and, therefore, lack of healthcare workers, while Kazakhstan, in addition to this challenge, also has to manage the reception and adaptation of immigrant healthcare workers.

Within the framework of this project, the research team has conducted a study of migration attitudes among focus groups, which includes medical students and healthcare workers of both countries in higher medical institutions in Bishkek (the Kyrgyz State Medical Academy named after I.K. Akhunbaev, May 2017) and Almaty (the Kazakh National Medical University named after S.D. Asfendiyarov, April 2017). Taking into account the growing mobility of young people and students in Central Asia, the behavioral models of these groups are particularly relevant for understanding the geographical distribution and the quality of medical personnel. Investigating the migratory behaviour of healthcare workers and medical students allowed to identify the specificities of “healthcare migration” and forecast the further development of healthcare services in these two countries, as the migration trends of these groups will, in the near future, be one of the factors affecting the quality and accessibility of healthcare services in Kazakhstan and Kyrgyzstan.

### 3.1 MAIN MIGRATION TRENDS AND TENDENCIES: EXTERNAL MIGRATION IN KYRGYZSTAN AND KAZAKHSTAN

The different positions of Kazakhstan and Kyrgyzstan in the Eurasian migration system and its Central Asian sub-system define trends of external migration in these countries<sup>35</sup>.

During the past few years, we observed a significant outflow of population from the Kyrgyz Republic. The highest negative migration was recorded in 2007 and 2010 (minus 50,600 people or almost one percent of the total population of the country), which coincided with political transformations that took place in the country in 2005 and 2010. In 2012, there was a sharp decline in the number of people leaving the country for permanent residence and net migration has dropped to 7,500 people. This figure remained constant until 2015 when net migration has increased to minus 4,200 people (Figure 1). Authorities of Kyrgyzstan attribute the sharp decrease in emigration to the termination of the bilateral inter-governmental agreement on simplified acquisition of citizenship between Kyrgyzstan and the Russian Federation, to changes in the migration legislation of Russia and to economic crisis in post-Soviet countries<sup>36</sup>.

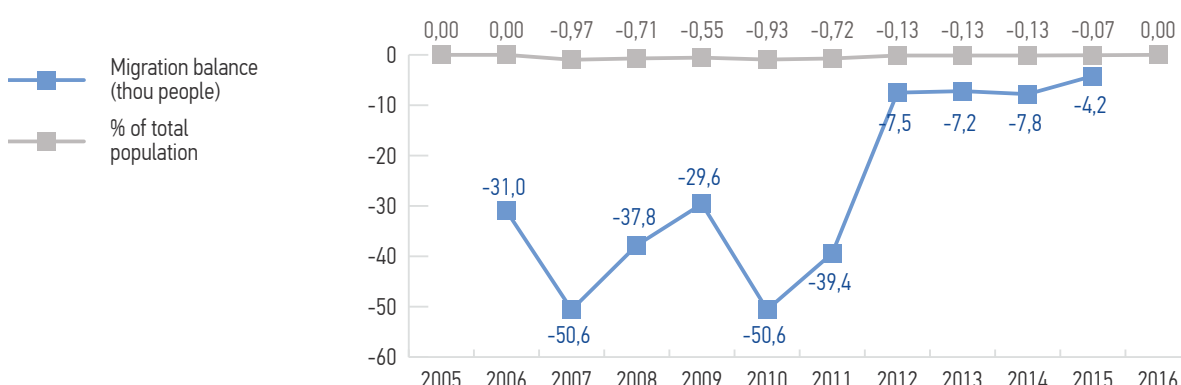
34 Ivakhnyuk I. V. Two migration systems in Europe: development trends and prospects for cooperation // Internet portal «Archipelago». 2003// [http://www.archipelago.ru/agenda/povestka/povestka-immigration/strategii/dve\\_sistemi/](http://www.archipelago.ru/agenda/povestka/povestka-immigration/strategii/dve_sistemi/)

35 This analysis only considers official data on people who have left or entered the country for permanent residence.

36 Social Trends of the Kyrgyz Republic: 2011-2015. - Bishkek, National Statistical Committee of the Kyrgyz Republic, 2016. – P. 30.

**FIGURE 1**

**Absolute and relative values of net external migration in Kyrgyzstan**



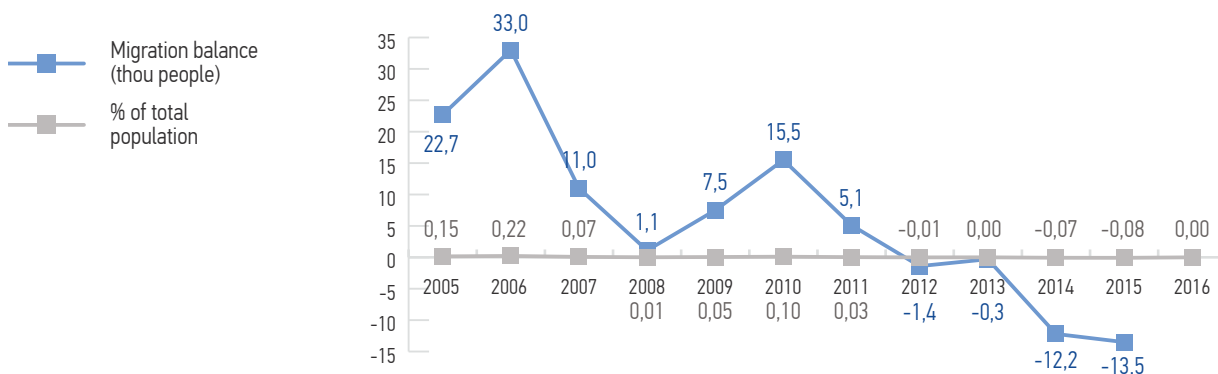
Source: Demographic Yearbook of the Kyrgyz Republic. 2011-2015 – Bishkek: National Statistics Committee of the Kyrgyz Republic, 2016. – P. 277

The research project Youth of Central Asia, implemented by the Representative Office of the Friedrich Ebert Foundation in Central Asia, has revealed that 56.1 percent of interviewed young people in Kyrgyzstan do not intend to leave the country under any circumstances, 2.4 percent plan to move in the near future, and 11.7 percent plan to migrate sometime in the future. Russia is the most appealing destination country (41.8 percent). Young people have indicated the quality of life (44.7 percent) and material reasons (41.1 percent) as the main reasons for external migration<sup>37</sup>.

Kazakhstan was subject to large migration influx in the 2000s and early 2010s, related to economic growth associated with high prices of raw materials exported from the country and implementation of the state programme which supported immigration of ethnic migrants (oralmans)<sup>38</sup>. For the first time, negative net migration was recorded in 2012 (minus 1,400 people) and since then this trend continues to increase (Figure 2).

**FIGURE 2**

**Absolute and relative values of net external migration in Kazakhstan**



Source: Demographic Yearbook of Kazakhstan, 2013. – Astana, 2013. – P. 786; Demographic Yearbook of Kazakhstan, 2015. – Astana, 2015. – P. 246; Results of migration of the population of the Republic of Kazakhstan for 2015. – Astana, 2016. – P. 5.

According to data gathered within the project on Youth of Central Asia, 66.9 percent of interviewed young people in Kazakhstan do not intend to leave the country under any circumstances, 2.7 percent plan to migrate in the near future, and 7.9 percent plan to move sometime in the future. Russia is the

37 Youth of Central Asia. Kyrgyzstan. Based on a sociological survey. - Almaty: Representation of the Friedrich Ebert Foundation in Kazakhstan, 2016. - P. 125-126.

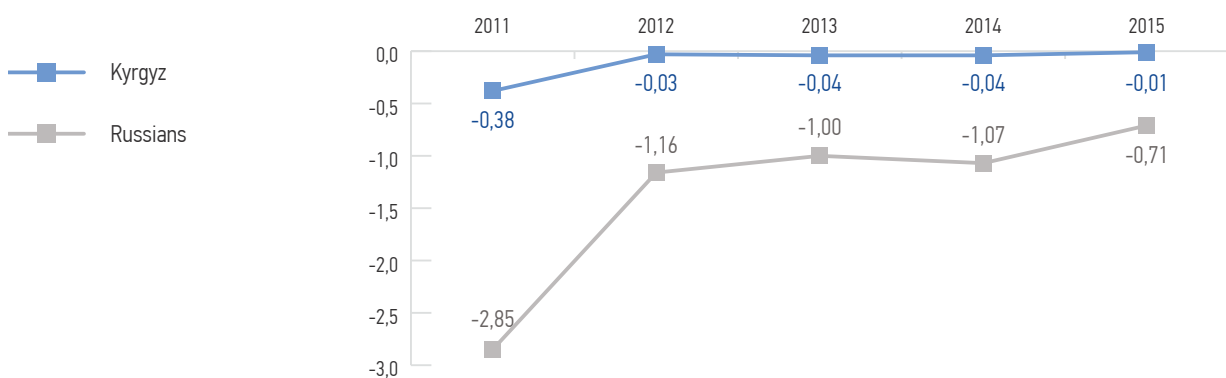
38 A similar program exists in Kyrgyzstan, but the low standard of living in the country significantly limits the attractiveness of resettlement for ethnic Kyrgyz.

most appealing destination country (54.7 percent). Young people have indicated personal reasons (32.1 percent), quality of life (29.2 percent) and career goals (19.8 percent) as the main reasons for external migration<sup>39</sup>.

Emigration from Kazakhstan is mostly typical of the Russian-speaking population. The main reasons for departure are related to the socio-economic circumstances such as dissatisfaction with living standards and lack of prospects for self-fulfilment, including on the professional plan<sup>40</sup>. Programmes carried out by the Russian government to attract compatriots also impact migration processes of both countries. The influence of the ethnic factor on external migration processes in Kyrgyzstan is also confirmed statistically: the relative emigration volume of the Kyrgyz population is much lower than emigration of Russians (Figure 3).

**FIGURE 3**

### Relative net external migration in Kyrgyzstan (percentage of migration balance of the total size of ethnic groups)



Source:

Data of the official website of the National Statistical Committee of the Kyrgyz Republic.

It is difficult to systematically assess emigration volumes of healthcare workers from Kyrgyzstan and Kazakhstan, as there are no statistical data on migrants by professional sectors in these countries. Selected data was retrieved from various publications or obtained at the request of the IOM Coordination Office for Central Asia. For example, according to the Kazakhstani edition of «Vlast», 810 people with higher medical education left the country in 2014, and 911 people in 2015<sup>41</sup>. According to information from the Ministry of Health of the Republic of Kazakhstan, 935 medical workers left the country in 2016, of which 354 had higher medical education and 581 secondary professional medical education<sup>42</sup>.

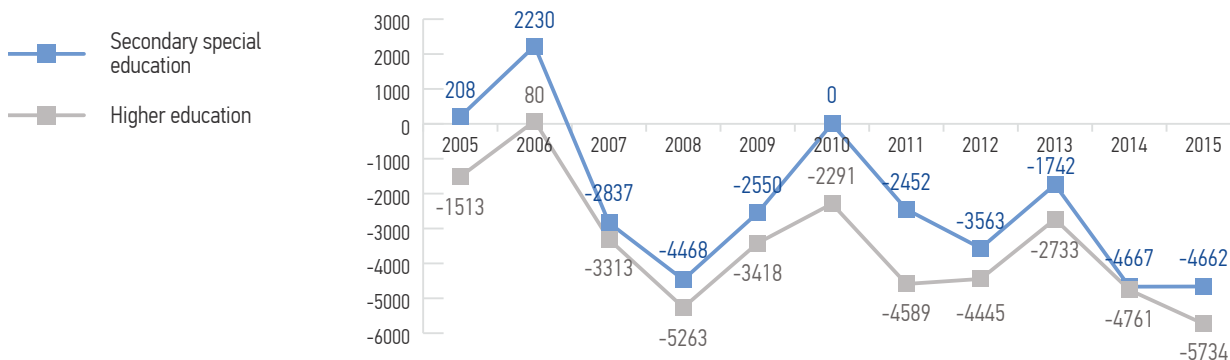
Studying these trends is also impeded by the lack of data on external migration in the context of education in Kyrgyzstan. Given that the balance of migration of persons with higher and secondary special education in Kazakhstan throughout the entire second half of the 2000s was negative (Figure 4), this trend can be extrapolated to healthcare workers. Thus, it is highly probable that the number of healthcare workers with higher and secondary special education leaving Kyrgyzstan and Kazakhstan for permanent residence exceeds the number of people with equal qualifications arriving to these countries.

39 Youth of Central Asia. Kazakhstan. Based on a sociological survey. - Almaty: Representation of the Friedrich Ebert Foundation in Kazakhstan, 2016. – P. 247-248.

40 O. Simakova. Emigration of Russians: an invitation for meditation // Kazakhstan-Spectrum. – 2016. – № 1. – P. 107.

41 D. Moldabekov Kazakhstan or the rest of the world? // Vlast. - 2017. – 15 February // <https://vlast.kz/obshestvo/21802-kazakhstan-ili-ostalnoj-mir.html>

42 Data of the Ministry of Health of the Republic of Kazakhstan received at the request of the IOM Coordination Office for Central Asia.

**FIGURE 4****Net migration of persons with higher education and secondary specialized education in Kazakhstan (persons)**

Source:

Demographic Yearbook of Kazakhstan, 2006. – Almaty, 2007. – P. 352, 354; Demographic Yearbook of Kazakhstan, 2007. – Almaty, 2008. – P. 719, 720; Demographic Yearbook of Kazakhstan, 2008. – Almaty, 2009. – P. 899, 901; Demographic Yearbook of Kazakhstan, 2009. – Almaty, 2010. – P. 496, 497; Demographic Yearbook of Kazakhstan, 2010. – Almaty, 2011. – P. 562, 566; Demographic Yearbook of Kazakhstan, 2012. – Astana, 2012. – P. 819, 820; Results of migration of the population of the Republic of Kazakhstan for 2013. – Astana, 2014. – P. 49; Results of migration of the population of the Republic of Kazakhstan for 2014. – Astana, 2015. – P. 49; Results of migration of the population of the Republic of Kazakhstan for 2015. – Astana, 2016. – P. 49.

In Kazakhstan, the need to attract qualified healthcare workers from abroad was formulated at the official level. Certain categories of doctors (those with scientific degree and rank, medical research of international standard, international certificates, knowledge of advanced diagnostics and treatment methods in the field of obstetrics and gynaecology, angioplasty, anaesthesiology, resuscitation, cardiosurgery, neurosurgery, oncology, oncohematology, otorhinolaryngology, radiology, transplantology, pharmacology and clinical pharmacology, maxillofacial surgery) are included in the list of professions subject to simplified citizenship granting procedure in the Republic of Kazakhstan<sup>43</sup>. However, this arrangement remains nominal. In reality, in accordance with Article 16 of the Law “On Citizenship of the Republic of Kazakhstan”<sup>44</sup>, simplification of citizenship granting procedure for this category of specialists only means a reduction of the five-year residence requirement in the country (in case of marriage to a citizen of Kazakhstan, three-year period). It is noteworthy that the list of professions has not changed since the adoption of the decree in 2005.

Kazakhstan, as a host country within the Central Asian migration sub-system, receives a large number of labour migrants who can be grouped into three categories according to their legal status:

- Irregular migrants, the number of which cannot be determined;
- Labour migrants from the CIS countries working for private entrepreneurs, and who must pay a duty in the amount of two minimum calculation indices (approximately USD 12). The volume of these immigrants is steadily increasing: in 2015 a total of 141,000 permits were issued for this type of labour activity, and in 2016 the number has increased to 210,000<sup>45</sup>;
- Foreign workers contracted within quotas allocated by the government of Kazakhstan. According to experts, the quoted labour force accounts for 5 to 10 percent of total labour migration flow<sup>46</sup>,

43 President of the Republic of Kazakhstan. Decree of 6 June 2005 No. 1587 “On approval of the list of professions and requirements for persons in relation to whom a simplified procedure for admission to the citizenship of the Republic of Kazakhstan is established”.

44 The Republic of Kazakhstan. Law of 20 December 1991 “On Citizenship of the Republic of Kazakhstan”.

45 Bocharova M. In 2016, most labour migrants left Kazakhstan for China // Internet magazine Vlast. 2016. – 20 September// <https://vlast.kz/novosti/19354-v-2016-godu-bolsinstvo-trudovyh-migrantov-iz-kazhastana-uezzalo-v-kitaj.html>

46 Sadovskaya E. Kazakhstan in the Central Asian migration sub-system. P. 293.

which represents about 1 percent of the economically active population of Kazakhstan. The number of this group of labour migrants is estimated at 60,000 to 70,000 people<sup>47</sup>.

Qualified migrants working in medical institutions fall into the third group, although there are no clear estimates of their total numbers. Kazakhstan also hosts a rather large number of foreign students who study in medical higher educational institutions. As at May 2017, there were 2,622 medical students in the country who mostly come from India (1933 people), Uzbekistan (259 people) and Afghanistan (182 people)<sup>48</sup>.

The inflow of foreign migrant workers in Kyrgyzstan is seriously limited both by the domestic economic situation and the quota mechanism. In 2015, the officially approved labour migration quota was 12,990 people<sup>49</sup>. However, only 12,012 specialists were actually granted work permits (92.5 percent of the quota)<sup>50</sup>. Five percent of them were employed in the education and healthcare sectors<sup>51</sup>. The quota for 2016 entailed the employment of 14,490 specialists, including 875 in the healthcare, education, science, culture and art sectors (6 percent). There is lack of data on foreign students studying in higher educational institutions of Kyrgyzstan<sup>52</sup>. In the academic year of 2014-2015, a total of 8,466 students receiving higher education in Kyrgyzstan arrived from the CIS countries and 4,257 students were from other countries. The largest number of students were citizens of Kazakhstan (4,800 people) and India (2,500 people)<sup>53</sup>. Since the 2011-2012 academic year, the share of foreign medical students, especially from India and Pakistan, has been steadily increasing<sup>54</sup>.

Thus, the lack of statistical information presents the major challenge for identification of trends and tendencies of external migration of healthcare workers in Kazakhstan and Kyrgyzstan: authorities of both countries either do not track migration movements with disaggregated data on professional backgrounds of migrants, or do not make such data available to the public. Therefore, external migration trends of healthcare workers at the macro level can only be extrapolated from the overall demographic of Kazakhstan and Kyrgyzstan.

External migration processes in Kazakhstan and Kyrgyzstan developed in different directions: while there was a decline in the number of people leaving Kyrgyzstan for permanent residence, the number of people permanently departing from Kazakhstan has increased. The outflow of qualified labour from the country, including healthcare workers, was observed in Kazakhstan. This trend can be extrapolated to Kyrgyzstan as it is a sending country. Despite expressing the need for qualified healthcare workers, neither country offers effective measures to attract skilled labour from abroad. Indeed, foreign students educated in these countries generally plan to return to their homeland upon completion of their studies.

47 Zhussupova A. New tendencies in the migration policy of Kazakhstan // Institute of World Economy and Politics. - 2016. - 15 December // <http://iwep.kz/ru/kommentariy-eksperta/2016-12-15/novye-tendencii-v-migracionnoy-politike-v-kazahstane>

48 Data from the Ministry of Health of the Republic of Kazakhstan, received at the request of the IOM Coordination Office for Central Asia.

49 The Government of the Kyrgyz Republic. Order No. 58 of 13 February 2015 "On establishment of the labor migration quota for the maximum number of foreign citizens and stateless persons arriving in the Kyrgyz Republic with labor purposes by economic sectors and regions of the Kyrgyz Republic for 2015".

50 A single report on migration in the Kyrgyz Republic. - Bishkek: State Migration Service under the President of the Republic of Kyrgyzstan, 2016. - P. 29.

51 Ibid. - P. 30.

52 The Government of the Kyrgyz Republic. Order No. 85 of 1 March 2016 "On establishment of the labor migration quota for the maximum number of foreign citizens and stateless persons arriving in the Kyrgyz Republic with labor purposes by economic sectors and regions of the Kyrgyz Republic for 2016".

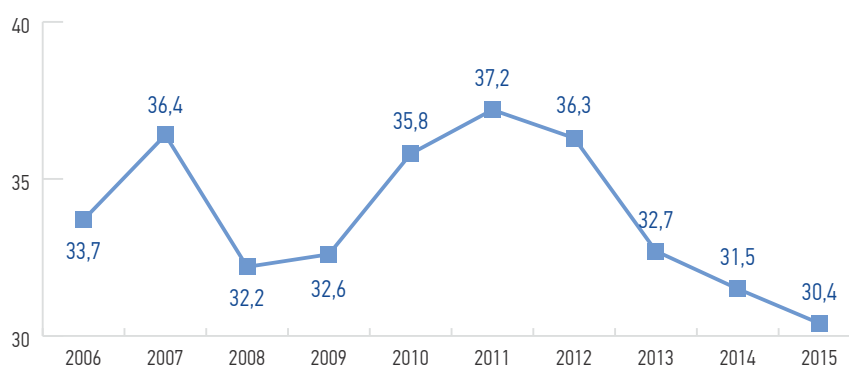
53 Kyrgyzstan. Extended migration profile: 2010-2015. - Bishkek: International Organization for Migration, 2016. - P. 53.

54 Ibid. - P. 54.

## 3.2 INTERNAL MIGRATION IN KAZAKHSTAN AND KYRGYZSTAN AND DISTRIBUTION OF HEALTHCARE PERSONNEL

Both internal and external migration processes in Kazakhstan and Kyrgyzstan show multi-directional dynamics. In the 2000s and 2010s, there were two peaks of internal migration in Kyrgyzstan (2007 and 2011) following political transformations that took place in the country in 2005 and 2010. Since 2011, internal migration volumes have declined (Figure 5). In 2015, internal migration processes involved more than 30,000 people or 0.52 percent of the country's population.

**FIGURE 5** Volume of internal migration (by number of departures) in Kyrgyzstan in 2000-2015 (thousand of people)



Source:

Demographic Yearbook of the Kyrgyz Republic. 2011-2015 - Bishkek: National Statistics Committee of the Kyrgyz Republic, 2016. – P. 313.

The main destinations for internal migrants (Figure 6) were the city of Bishkek (net migration for the year was 4,513 people) and the Chui region (2,731 people). Negative net internal migration was recorded in all other regions.

Statistical data for Kyrgyzstan correlates with findings of the project Youth of Central Asia, which reveal that 82.6 percent of interviewed young people in Kyrgyzstan do not intend to move to another city or village<sup>55</sup>.

Since 2000 and 2010, internal migration in Kazakhstan is characterized by a steady upward trend (Figure 7). In 2015, internal migration processes affected more than 455,000 people or 2.61 percent of the country's population, almost five times more than in Kyrgyzstan. The bulk (75.29 percent) of migrants are of working age: 16 to 62 years old (up to 57 for women).

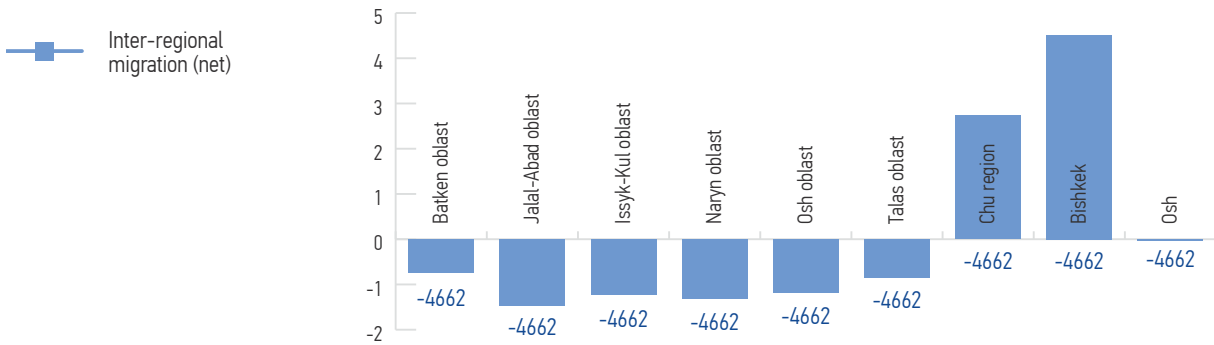
Despite increasing internal migration flows, young people in Kazakhstan and Kyrgyzstan are not inclined to move inside the country. According to the project on Youth of Central Asia, 81.3 percent of interviewed young people did not want to change their place of residence<sup>56</sup>.

<sup>55</sup> Youth of Central Asia. Kyrgyzstan. Based on a sociological survey. - Almaty: Representation of the Friedrich Ebert Foundation in Kazakhstan, 2016. – P. 123.

<sup>56</sup> Youth of Central Asia. Kyrgyzstan. Based on a sociological survey. - Almaty: Representation of the Friedrich Ebert Foundation in Kazakhstan, 2016. – P. 247.

**FIGURE 6**

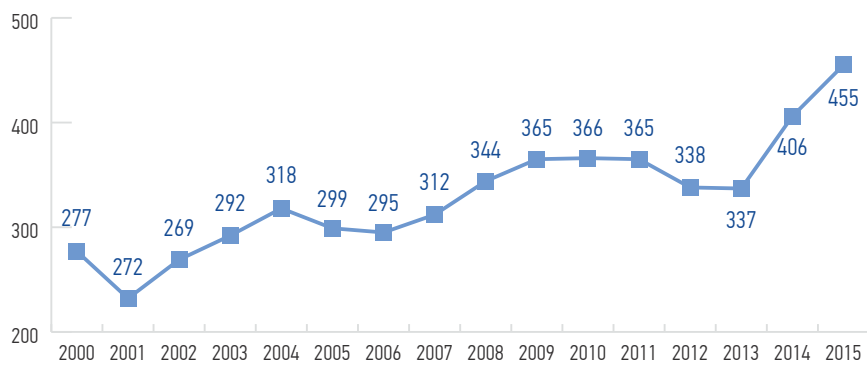
**Volume of internal migration by administrative units of Kyrgyzstan in 2015** (thousand of people)



Source: Demographic Yearbook of the Kyrgyz Republic. 2011-2015 - Bishkek: National Statistics Committee of the Kyrgyz Republic, 2016. – P. 277.

**FIGURE 7**

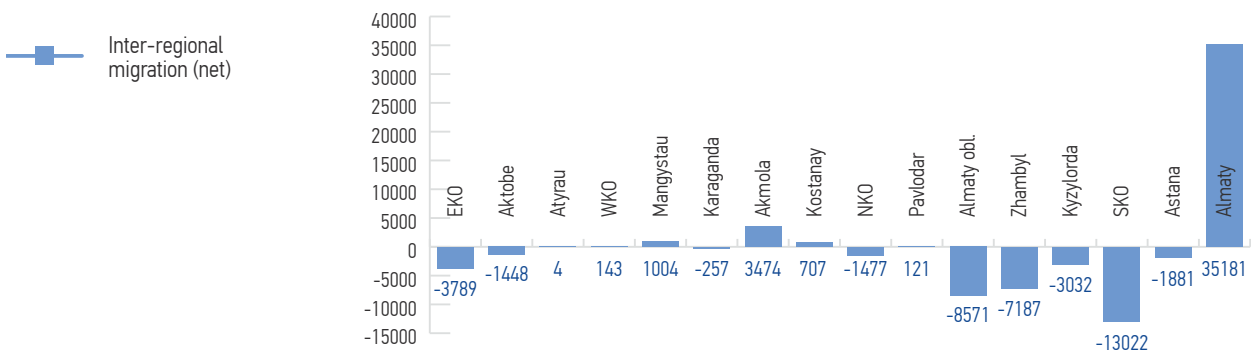
**Volume of internal migration in Kazakhstan in 2000-2015** (thousand of people)



Source: Results of migration of the population of the Republic of Kazakhstan for 2015. - Astana, 2016. – P. 103.

**FIGURE 8**

**Volume of internal migration by administrative units of Kazakhstan in 2015** (thousand of people)

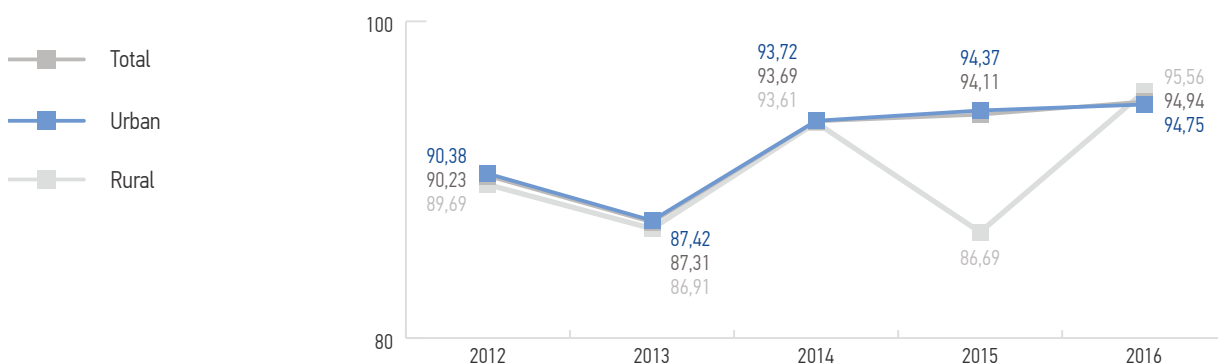


Source: Migration of the population of the Republic of Kazakhstan for 2015. – Astana, 2016.



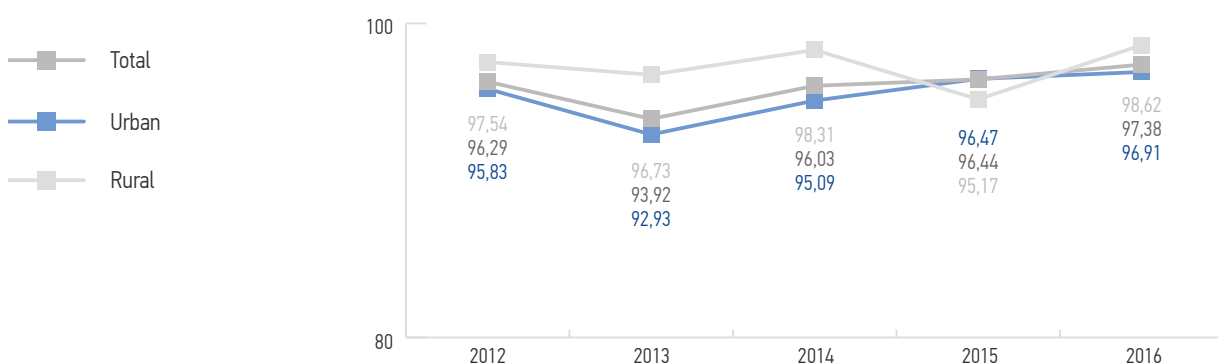
Major internal migration flows (Figure 8) were directed to the city of Almaty (net migration for the year was 35,181 people), Akmola region (3,474 people) and Mangistau region (1,004 people). The largest population outflows were recorded in the country's southern regions: South-Kazakhstan (net migration was minus 13,022 people), Almaty (minus 8,541 people), Zhambyl (minus 7,187 people) and Kyzylorda (minus 3,032 people), as well as in East-Kazakhstan region (minus 3,783 people). Most migration flows were from rural areas to cities. In 2015, the net migration to cities in Kazakhstan was 66,142 people.

**FIGURE 9** Staffing levels for doctors in medical organizations of Kazakhstan in 2012-2016 (%)



Source: Ministry of Health of the Republic of Kazakhstan.

**FIGURE 10** Staffing levels for mid-level medical personnel in medical organizations of Kazakhstan in 2012-2016 (%)



Source: Ministry of Health of the Republic of Kazakhstan.

There is no systematic data available in Kyrgyzstan nor Kazakhstan on internal migration of healthcare workers and their distribution by regions, as well as in terms of territorial aspects (rural/urban). Nevertheless, authorities of both countries base their national healthcare system development plans on the assumption of a shortage of healthcare workers in small towns and rural areas. For instance, the section on “Formation of healthcare system resources” of the National Healthcare Reform Programme of the Kyrgyz Republic “Den Sooluk” for 2012–2016<sup>57</sup> outlines that “shortage of healthcare human resources in rural areas and remote locations of the Kyrgyz Republic continues to grow”, and the situation in remote and inaccessible areas is classified as critical. At the same time, this problem cannot be resolved by simply increasing numbers of trained personnel, as rural areas remain unattractive for young specialists in terms of social and economic conditions.

57 National Healthcare Reform Program of the Kyrgyz Republic «Den Sooluk» for 2012-2016.



According to authors of the Programme, “at present, specialists choose their place of work based on two main factors: housing (social package, degree of development of social infrastructure) and salary”.

The same problem was outlined in the State Healthcare Development Programme of the Republic of Kazakhstan “Densaulyk” for 2016–2020<sup>58</sup>. The section on “Analysis of the current situation” emphasizes that “the existing problems associated with uneven geographical and territorial distribution and structural staff imbalances are compounded by insufficient qualification of available personnel which often underlie the poor quality of medical services”. According to the Programme, the ratio of qualified doctors in the overall structure of medical personnel is 48 percent in urban areas, and 39.3 percent in rural areas, and the ratio of physicians of pre-retirement and retirement age is 22.7 percent and mostly observable in rural areas. At the same time, official statistics look less negative (figures 9 and 10). Staffing levels for mid-level medical personnel in rural healthcare institutions is generally higher than that of urban.

The disproportionate distribution of healthcare workers in urban and rural areas can be seen as a fundamental problem, which was outlined in all healthcare development programmes in both countries. In Kyrgyzstan, a series of programmes on healthcare system reform were implemented since 1996: the National Healthcare Reform Programme of the Kyrgyz Republic «Manas» for 1996–2005, the National Healthcare Reform Programme of the Kyrgyz Republic «Manas Taalimi» for 2006–2011<sup>59</sup>, the National Healthcare Reform Programme of the Kyrgyz Republic «Den Sooluk» for 2012–2016<sup>60</sup> and the Strategy on Protection and Promotion of Health of the Population of the Kyrgyz Republic until 2020 (Health 2020)<sup>61</sup>. Since 2005, Kazakhstan has implemented the State Programme on Healthcare Reform and Development for 2005–2010, then the State Programme of Healthcare Development of the Republic of Kazakhstan «Salamatty Kazakhstan» for 2011–2015<sup>62</sup> and the National Healthcare Development Programme of the Republic of Kazakhstan «Densaulyk» for 2016–2020<sup>63</sup>.

Both in Kyrgyzstan and Kazakhstan, these programmes aimed to address the problem of the disproportionate distribution of healthcare workers. For example, the National Healthcare Reform Programme of the Kyrgyz Republic «Den Sooluk» for 2012–2016 was aimed at «universal (overall) provision of quality healthcare and preventive services to the population regardless of their social status, gender differences and insurance status». The State Healthcare Development Programme of the Republic of Kazakhstan «Densaulyk» for 2016–2020 was designed to «promote sustainability and dynamic development of people-centred national healthcare, in accordance with principles of universal coverage, social justice, access to quality medical care and joint responsibility for health».

In recent years, excluding the factor of unequal distribution of medical resources, Kyrgyzstan observed a stabilization in the number of doctors and nurses at the levels of 23 and 57 respectively per 10,000 people. At the same time, there was a marked decrease in the number of hospital wards (Figure 11).

58 The State Healthcare Development Program of the Republic of Kazakhstan «Densaulyk» for 2016-2020.

59 The Government of the Kyrgyz Republic. Decree No. 100 of 16 February 2006 “On the National Healthcare Reform Program of the Kyrgyz Republic «Manas Taalimi» for 2006-2010”.

60 The Government of the Kyrgyz Republic. Decree No. 309 of 24 May 2012 “On the National Healthcare Reform Program of the Kyrgyz Republic «Den Sooluk» for 2012-2016”.

61 The Strategy on Protection and Promotion of Health of the Population of the Kyrgyz Republic until 2020 (Health 2020).

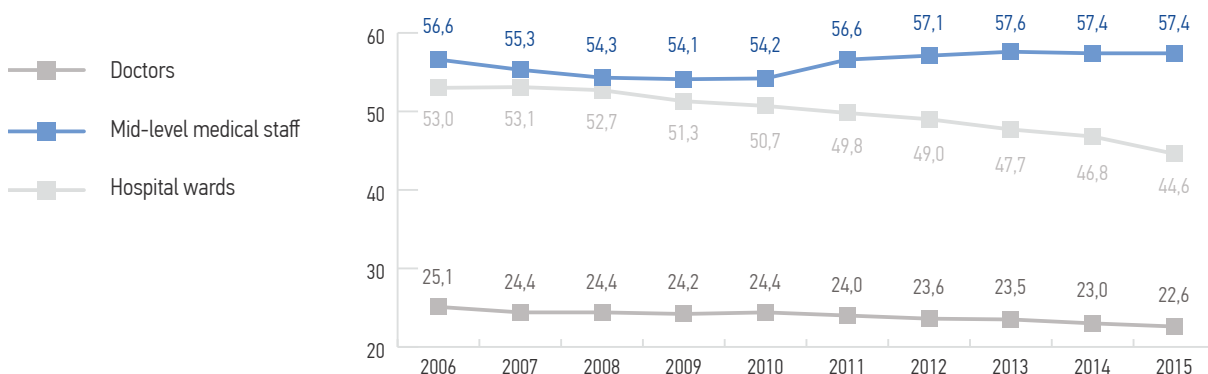
62 President of the Republic of Kazakhstan. Decree of 29 November 2010 No. 1113 “On approval of the State Program on Healthcare Development of the Republic of Kazakhstan «Salamatty Kazakhstan» for 2011-2015”.

63 President of the Republic of Kazakhstan. Decree of 15 January 2016 No. 176 “On approval of the State Healthcare Development Program of the Republic of Kazakhstan «Densaulyk» for 2016-2020”.

**FIGURE 11**

**Healthcare resources in Kyrgyzstan**

(per 10 thou population)



Source:

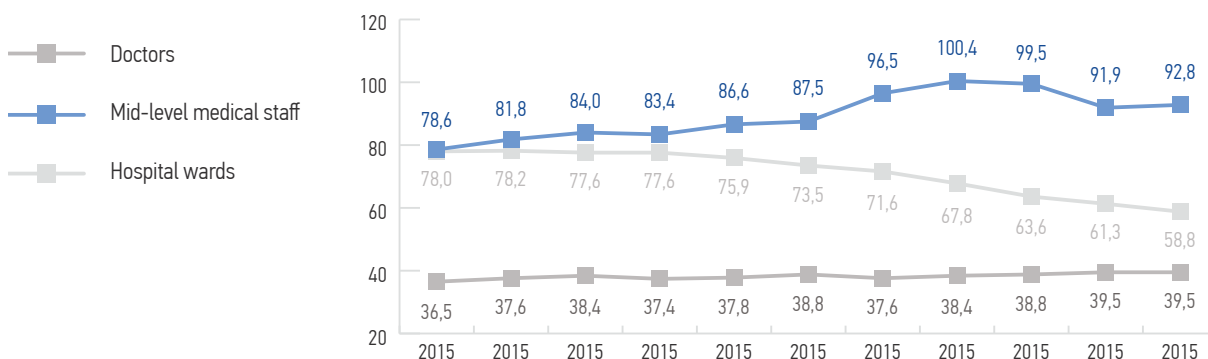
Social Trends in the Kyrgyz Republic: 2011-2015. - Bishkek, National Statistical Committee of the Kyrgyz Republic, 2016. - P. 100.

Kazakhstan enjoys a better position in terms of healthcare resources (Figure 12). In 2015, the total number of doctors was 39.5 per 10,000 people (1.7 times higher than in Kyrgyzstan), and a slight upward trend was recorded for this indicator. After growth in 2011-2013, the total number of mid-level medical personnel has decreased to 92.8 per 10,000 people (1.6 times higher than in Kyrgyzstan). As in Kyrgyzstan, the number of hospital wards in Kazakhstan has gradually decreased to 58.8 wards per 10,000 people in 2015 (1.3 times more than in Kyrgyzstan).

**FIGURE 12**

**Healthcare resources in Kazakhstan**

(per 10 thou population)



Source:

Information of the official website of the Committee on Statistics of the Ministry of National Economy of the Republic of Kazakhstan (<http://www.stat.gov.kz>).

Healthcare problems in Kyrgyzstan and Kazakhstan (poor medical infrastructure, disproportionate distribution of healthcare workers in urban and rural areas, staffing of medical institutions, low wages, etc.) were confirmed by interviews with students of the Kazakh National Medical University named after S. D. Asfendiyarov and the Kyrgyz State Medical Academy named after I. K. Akhunbayev. Most of interviewed medical students in both countries were unenthusiastic at the prospect of working in small towns or rural settlements after graduating from a higher education institution.

Kyrgyz students were more critical than Kazakhstani students and demonstrated a total unwillingness to work in rural medical centres. The primary reasons for this decision include lack of housing provided on preferential terms, lower wages in rural areas than in cities and the necessity to perform functions of mid-level medical personnel due to understaffing. It is significant that movements of young people to the countryside contradict the main motives for internal migration of the Kyrgyz and Kazakh youth which were identified under the project Youth of Central Asia. Main incentives include the desire to improve economic standards of living (this factor was indicated by 55.6 percent of respondents from Kyrgyzstan

and 41.6 percent of respondents from Kazakhstan), obtain more opportunities for employment (40 percent and 38.7 percent respectively), receive a higher quality of education (23.1 percent and 23.7 percent) and have access to a greater cultural diversity (21.3 percent and 26.6 percent)<sup>64</sup>.

We are forced to go to work in villages but there are no conditions at all. There is lack of medical staff, one doctor often works for ten. We have no housing and it is not provided, salaries are even lower than in the city. As students of state funded departments we must work for two years anywhere the government posts us. I will have to work, I'm a "budget-funded student". After completion of this work I will definitely return to Bishkek although working in the countryside or in a small town is always well-respected and is a good experience. People know and appreciate you... Healthcare workers do not enjoy any privileges in rural areas.

*Interview with Akbar, second year student of the "General Medicine" faculty (Bishkek, Kyrgyzstan)*

Now they say that all graduates of medical schools are required to work in the countryside regardless of the department they have completed, budgetary (state funded) or commercial. I strongly oppose this! My parents pay for me, the tuition fees are 50,000 soms per year. I do not understand why I have to work in the village? There are no conditions in rural hospitals. No one guarantees your housing there. Salaries are not enough to survive and you have to work from morning till late night.

*Interview with Kanat, third year student of the "General Medicine" faculty (Bishkek, Kyrgyzstan)*

Overall, most Kazakhstani medical students, while expressing their unwillingness to work in rural regions, do not rule out such possibility for building their careers. They consider the prospect of working in a small town as an opportunity to obtain professional practice and unique experience in difficult conditions.

I do not rule out the possibility of working in the countryside or in regions. This is an invaluable experience that you can get only by working in such difficult or even extreme conditions. You can learn everything and try everything there. Certainly, it is a great responsibility and it can even be scary because we are still young specialists and do not have a great deal of practical knowledge, only theoretical. But this will be an invaluable experience which will later help us. This is the only way to become a qualified doctor! (...) Honestly, I would not want to work in the village all my life, but 3-5 years is ok. Then I would need to leave for a big city, Astana or Almaty, where there are more prospects and opportunities.

*Interview with Dana, second year student of the "General Medicine" Faculty (Almaty, Kazakhstan)*

<sup>64</sup> Youth of Central Asia. Kyrgyzstan. Based on a sociological survey. - Almaty. Representation of the Friedrich Ebert Foundation in Kazakhstan, 2016. - P. 124; Youth of Central Asia. Kyrgyzstan. Based on a sociological survey. - Almaty. Representation of the Friedrich Ebert Foundation in Kazakhstan, 2016. - P. 247.

According to the legislation of Kyrgyzstan, students who receive scholarships from public funds are obliged to work for two years in locations assigned by the government. The Kazakhstani legislation has a similar norm and students who have government-funded education can be posted to work in an assigned location for three years after completion of their studies. In addition, there is a so-called «rural quota» in Kazakhstan which provides preferential treatment to applicants from rural areas for admission to medical institutions. However, such students must return to work to locations of their origin upon completion of education. This category of students, acknowledging the requirement to work in the countryside, explore opportunities of either avoiding it through informal practices or returning to big cities after completion of the assignment to pursue their medical careers.

I guess I haven't got much choice, I had a scholarship to fund my education and now I have to complete the compulsory work assignment to get my diploma. Let's see what conditions they will offer. But I know that to grow professionally one should work either in Astana or in Almaty. If I have a chance I will leave.

*Interview with Daniyar, third year student of the "General Medicine" faculty (Almaty, Kazakhstan)*

Analysis of data on behaviour of medical students allows to conclude that problems in the healthcare sector in rural areas and small towns will continue to remain in the short and medium terms. At least, there will be a continuous «turnover» of personnel.

The analysis of the distribution of healthcare personnel across regions of Kazakhstan and Kyrgyzstan and in the context of cities and countryside is hindered by the lack of comprehensive statistical data. Furthermore, official statistics sometime provide conflicting data: there are discrepancies between official statistics on staffing of medical institutions with professional personnel and the fact that the distribution of healthcare personnel across the country remains uneven.

In both Kazakhstan and Kyrgyzstan, skilled workers aim to migrate to larger settlements: Almaty and Astana in Kazakhstan and Bishkek in Kyrgyzstan.

Population of Kyrgyzstan and Kazakhstan are generally unwilling to move permanently, which is typical both for external and internal migration. The main limitations for internal migration are poor infrastructure and the dominant "settled residence" mind-set among the population.

When planning their professional career, medical students take into account the poor infrastructure and lack of staff in medical institutions in rural areas and small towns. Moreover, they all share the belief that living standards in rural areas are significantly lower than in large cities, and there is little trust in state programmes supporting young professionals posted to work outside large cities.

### 3.3 PUSH AND PULL FACTORS OF HEALTHCARE WORKERS' AND MEDICAL STUDENTS' MIGRATION: BEHAVIOURS AND MODELS

Migratory behaviours of healthcare workers (doctors and nurses) and students, as well as the dynamics of migration in this sector are determined by the general migration patterns of the Eurasian migration system and «standard» push and pull factors such as:

- Cultural and historical factors (common languages, sustained socio-economic and family ties, similarity of cultural traditions and values, etc.);
- Political and legal factors (stable political partnerships between the Central Asian countries and

Russia, visa-free travel of migrants, simplified rules of legalization of labour migrants from member states of the Eurasian Economic Union, Programmes on resettlement of compatriots to Russia);

- Socio-economic factors (typical push factors for Central Asian countries are lack of jobs and high unemployment levels, relatively low wages, widespread poverty, uneven distribution of labour resources in the region, etc.).

During interviews and focus group discussions with Kazakh and Kyrgyz medical students and healthcare workers, all these aspects, to varying degrees, were identified as factors affecting migration behaviour. Most interviewees in both countries mentioned that healthcare development depends on the country's socio-economic and political circumstances. At the same time, respondents in Kyrgyzstan, far more than respondents in Kazakhstan, mentioned socio-economic issues hindering their country's development and emphasized the low economic development rates and, consequently, high unemployment and low salaries.

Does the economic and political situation affect the status of healthcare? Yes, of course, it does. Most of us want to leave, all my friends often talk about migrating from the country. However, the question is whether it would be possible to leave? When people have small salaries or they are unemployed, they cannot afford proper treatment; medical tests and drugs are costly. The lesser money people have, the more limited their access to medical services would be, especially to paid services. And the state healthcare sector is unsatisfactory!

*Interview with Akbar, second year student of the "General Medicine" faculty (Bishkek, Kyrgyzstan)*

Yes! The level of economic and political development of the country certainly affects the status of healthcare! Everything is falling apart here! And the healthcare sector is in a deep crisis.

*Interview with Zhuldyz, third year student of the Faculty «General Medicine» (Bishkek, Kyrgyzstan)*

The economic situation greatly affects the healthcare sector and has an impact on our income. We, dentists, depend on the financial well-being of our patients. If a patient does not have money, he does not come receive medical treatment. It costs from 500 to 700 soms to pull a tooth in Bishkek, and up to 1500 soms to fix a root canal.

*Interview with Asezim, dentist (Bishkek, Kyrgyzstan)*

Along with the above-mentioned «typical» factors, other specific factors determine the migration potential of medical personnel as well as the migratory attitudes of medical students. The «specific» factors cannot be explicitly referred to as push or pull factors. While some were push factors for a respondent, the same were identified as pull factors by others. For example, one of the factors outlined during the interviews was the underdevelopment of the healthcare sector in the country (more applicable to the situation in Kyrgyzstan). Most respondents consider it as a push factor because it results in limited prospects for professional advancement, skills development, etc. At the same time, other respondents consider it as an opportunity for self-realization in extreme conditions and obtaining a unique work experience.

The main identified problems in the healthcare sectors of Kazakhstan and Kyrgyzstan are:

- Low wages and social insecurity of health workers;
- Lack or a weakly developed skills advancement system for medical personnel;
- Limited internship and training opportunities for medical students;
- Lack or insufficient number of clinics with up-to-date modern equipment;
- Insufficient number of medical personnel and low level of qualification.

Our earnings are very low: from 5,000 to 10,000 soms. They pay more in private clinics but they usually do not hire people without experience. It is difficult to find a job in a good place, in a good hospital. You need connections, relatives who can help. For example, finding a job in any clinic is only possible if you know someone working there who comes from your hometown (home-town association). I know that the [medical institution X] usually hires southerners, and the hospital [X] – mostly northerners from Naryn. .... Another problem is that students have limited access to a full-fledged practice. For example, you need to practice to become a surgeon, but nobody wants to train us.

*Interview with Akbota, third year student of the "General Medicine" faculty (Bishkek, Kyrgyzstan)*

The market is oversaturated with professionals, unemployment is high and it is difficult to find a job in your field. Hospitals lack the necessary equipment or staff are not sufficiently qualified to operate this equipment. Salaries in hospitals are very low: the average wage is around 8,000 to 10,000 soms per month. It is not much. Salaries in the private medical sector are higher but it is very difficult to find a job there and they do not hire without experience.

*Interview with Azamat, second year student of the "General Medicine" faculty (Bishkek, Kyrgyzstan)*

We have a lot of problems in the healthcare sector: wages are not very high and passing an exam to acquire a professional qualification is a whole story. You need to pay for training to improve your qualifications, but salaries are too low... Diagnostic equipment in hospitals is outdated, and there is nobody sufficiently qualified to operate the new equipment. Staff requires training. The situation in Astana is a lot better. There are many new well-equipped clinics with a developed infrastructure. Many good doctors came to Astana from Almaty. But there are very few modern hospitals in other regions and cities of Kazakhstan.

*Interview with Lyazzat, ENT doctor (Almaty, Kazakhstan)*

Most medical students consider the underdevelopment of the healthcare sector as a migration push factor. At the same time, Kazakhstani students, more often than students from Kyrgyzstan, consider educational migration to advance their professional qualifications, and plan to subsequently return back home to contribute to the development of the healthcare sector in their country.



I would leave Kazakhstan to continue my studies. I always wanted to have an internship in St. Petersburg where schooling is great. However, I will definitely return home after completion of my training. I'm from Astana and I want to work there, we have several high-quality medical centres where you can have a career and I hope I will be in demand there!

*Interview with Aigerim, third year student of the "General Medicine" faculty (Almaty, Kazakhstan)*

Healthcare workers (especially aged 50 and above) indicate that the poorly developed healthcare system and lack of systematic and regular training funded by the state or medical institutions made them less competitive compared to medical professionals in potential host countries. This is a factor restraining emigration for a given social group.

Where will I go? I will retire in a few years, maybe we will then move to Russia. At the moment, everything is fine. I'm an experienced doctor, I have my clients whom I have treated and consulted for many years. In a new country I would have to start all over again, confirm my qualifications, prove that I'm a professional doctor. (...) Other countries might have different quality standards and qualification requirements.

*Interview with Rufina, First Category Therapist (Almaty, Kazakhstan)*

I work in the pharmaceutical sector and teach at the Academy where I have graduated several years ago. Salaries in the country are low, including in the healthcare sector. Yet, the competition for admission into institutions grows annually and the tuition fee for the pharmacology faculty is 45,000 soms per year. Professors leave the academy... There are no prospects here, including in my area of specialization. We do not have a pharmaceutical industry; drugs are mostly imported. There are no scientific developments, no laboratories, no pharmaceutical plants. I plan to move to Moscow and take a post-graduate course. I already have a scientific director there. The education is paid and my parents will support me, they will help me financially. If I undergo an internship in Russia and have a diploma, I will be able to get a job quicker. Moreover, earnings are high there.

*Interview with Aliya, teacher, pharmacologist (Bishkek, Kyrgyzstan)*

I want to leave Kyrgyzstan. I'm not satisfied with the standard of living in our country, it is impossible to afford anything with our salaries. Many of my colleagues have two jobs to be able to earn something! I'm a young specialist, I do not have my own dental practice, I need to «develop» my clientele and try to gain experience. So, I don't care where to start, here or in another country.

*Interview with Asezim, dentist (Bishkek, Kyrgyzstan)*

Thus, students and young medical professionals who have recently obtained basic medical education consider the weak healthcare system as a push factor; for middle and senior health workers, especially of pre-retirement age, this factor limits their motivation for emigration.

Language is another “specific” factor affecting the migration potential of medical students and personnel. Since independence, there has been a growing demand for knowledge of state languages (Kazakh and Kyrgyz, respectively) by all workers in the services sectors of Kazakhstan and Kyrgyzstan. This practice extends to the healthcare systems of these countries, where medical staff interacting with patients must speak both the state language and Russian. This, on the one hand, is a push factor, especially for medical workers who do not have sufficient knowledge of the state language, since they will not experience “language pressure” in a new place (especially in Russia).

I know that my colleagues call me a «Russian doctor» behind my back because I’m not able to provide qualified services to patients in Kazakh. Yet, I have patients who only want an appointment with me as a specialist. Many of them are Kazakh speakers. But they are interested in my qualifications, not in the language I speak. Nobody openly blames me for not knowing Kazakh, but I feel some pressure and discomfort. Sometimes there are difficulties with patients who speak only Kazakh, then colleagues help with translation. I feel that the Russian-speaking space is gradually shrinking and there is a risk to lose a profession someday. I consider the possibility of emigration in the future. Most likely it will be Russia.

*Interview with Svetlana, therapist (Almaty, Kazakhstan)*

Also, this aspect, to some extent, is a push factor for medical students studying in Russian. Interviews with students of the Kyrgyz State Medical Academy named after I.K. Akhunbayev confirmed the relevance of studying in Russian because a good knowledge of the language would be an advantage for finding employment in Russia. It is noteworthy that only one out of the 28 groups of the second year of the «General Medicine» faculty was lectured in Kyrgyz. All other groups were lectured in Russian.

Specific factors limiting emigration of health workers from Kazakhstan and Kyrgyzstan, as well as immigration of healthcare specialists to Kazakhstan, are:

- Requirements to confirm medical qualifications (procedure for recognition and validation of the diploma) in the host country;
- Loss and/or downgrading of professional status of medical migrants in host countries in cases of prolonged recognition and validation or rejection of medical diploma or degree.

Graduates of foreign educational institutions must present the following documentation for validation of diploma of higher medical education in Kazakhstan<sup>65</sup>:

- Copies of educational certificates and its annexes, certified by public notary (documents must be translated into Kazakh or Russian) with the list of academic courses, completed academic disciplines and internships, final grades, course works, final qualification papers and other components of the educational process. The education certificate and all supporting documents must be apostilled or legalized. Otherwise the applicant has to present an archival certificate issued by the institution which confirms that he/she has completed the studies and obtained the educational certificate;

<sup>65</sup> Minister of Education and Science of the Republic of Kazakhstan. Order of 10 January 2008 No. 8 “On rules for the recognition and validation of educational certificates”. See also: Minister of Education and Science of the Republic of Kazakhstan. Order of 25 June 2016 No. 405 “On amendments to the Order of the Minister of Education and Science of the Republic of Kazakhstan of 10 January “On approval of rules for the recognition and validation of educational certificates”.



- Identity document of the educational certificate holder, for non-residents a notarized copy of his/her identity document with a translation into Kazakh or Russian. If the holder of the educational certificate has changed his/her first, last or patronymic names after completion of the education, he/she is required to present a notarized copy of the certificate confirming the entry in the civil registry of changes of his/her first, last or patronymic names, or a certificate of marriage or divorce;
- A copy of the license or certificate of accreditation of the academic institution that issued the educational certificate stamped by the academic institution (translated into Kazakh or Russian). If such documents cannot be presented, the applicant must provide the information about the academic institution which issued the educational certificate (with references to websites or other sources).

I am in demand here, I am a doctor of the first category. Yet, I don't know how I will manage to settle in Russia. Will I have the same level of professional fulfilment that I have now?(...) I know it's difficult to pass the certification to upgrade my category. I think in Russia they have similarly complicated procedures. But as far as I'm aware, I also need to validate my diploma there.

*Interview with Svetlana, therapist (Almaty, Kazakhstan)*

This process is bureaucratized. It requires a lot of paperwork, references, time and effort. Moreover, they unexpectedly come up with new requirements to provide additional documents. You get an impression that nobody is interested although doctors are in demand everywhere. At a certain point I was ready to give up and even agree to work as a nurse in a hospital despite being a certified doctor... It was a long time ago, but I still remember the unpleasant feeling because of what I had to go through.

*Interview with Zumrat, therapist who moved to Kazakhstan from Tajikistan 7 years ago (Almaty, Kazakhstan)*

Requirements are even more complex for migrant healthcare workers holding a foreign degree in medical sciences. To confirm their degree in Kazakhstan, they must meet the current requirements for students enrolled in PhD programs. Namely, they must have at least three publications in scientific papers recommended by the Education and Science Control Committee under the Ministry of Education and Science of the Republic of Kazakhstan; and one of the scientific works should have been published in a scientific paper which has a non-zero impact factor per the ISI Web of Knowledge/Thomson Reuters, or needs to be a member of the Scopus database<sup>66</sup>. In most cases, it is extremely difficult or almost impossible to meet these criteria.

In each specific case, various configurations of the above-described factors determine people's decision to stay in the country of origin or to migrate permanently. Migration is influenced by the subjective perception of a wide range of push and pull factors and by non-measurable personal circumstances, such as the "need for self-realization and professional growth", "lack of prospects", "gaining a new high-quality experience", "poor medical infrastructure in the country of residence", etc. The confluence of such factors when obvious and objective "push events" emerge (degradation of the economic or political situation in the country of residence, opportunities to study abroad, job offer, availability of a start-up capital) triggers both internal and external migration movements.

<sup>66</sup> Minister of Education and Science of the Republic of Kazakhstan. Order of 31 March 2011 No. 127 "On Approval of the Rules for Awarding of Academic Degrees".

Kazakhstan poses unrealistic demands. To confirm my academic degree, I had to provide an archival certificate from the place of my education. It's fine if my institution still exists... I have a post-graduate degree from the Second Tashkent State Medical Institute but all medical institutions in Uzbekistan were merged into one academy. It took me six months to get a certificate because all archives of these institutions were also merged. It's good that Tashkent is not too far away, I could travel there and resolve the issue on the spot. But what if you need to get papers from a non-CIS institution? Kazakhstan requires a copy of the license to conduct an educational activity from the institution where I defended my academic thesis. Such licenses don't exist in Uzbekistan. It's just bureaucracy... To validate my degree, I need to have three publications in Kazakhstani scientific journals. There are only eight medical journals in the country and there is a long queue for publications. Moreover, you have to pay from 5,000 to 10,000 tenge for each publication. I also need to make a publication on the topic of my research in a journal with a high impact factor. I defended my thesis twenty years ago, my research has lost its relevance by now; who will publish it and why is it needed?

*Interview with Bakhtiyor, surgeon who moved to Kazakhstan from Uzbekistan 5 years ago (Almaty, Kazakhstan)*

Despite the subjective configuration of various push and pull factors, it is nevertheless possible to make certain generalizations and define two distinct models of migratory behaviour: the Kazakhstan model and the Kyrgyzstan model. In other words, research data highlight the specific characteristics of the migratory mind-set of medical students and healthcare workers in Kyrgyzstan and Kazakhstan. These models and mind-sets are affected by the overall differences in the attitudes of citizens of these countries towards emigration and labour migration. In particular, the specificities of Kazakhstan's economic development (higher standard of living) make its residents less prone to emigration and labour migration, while this message has been relayed in the public discourse.

The main characteristics of **Kazakhstan's model** of migratory behaviour are:

- Students educated in Russian or English tend to be more prone to emigration from Kazakhstan;
- Students of Kazakh educational groups (usually students from rural areas or small towns) are usually inclined to resettle internally and express a desire to stay in the city and not return to the village;
- A significant majority of students consider temporary relocation to the countryside as an opportunity to acquire medical work experience; they wish to subsequently return to one of the larger cities (Almaty or Astana) to continue their medical career;
- There is a widespread inclination towards educational migration among students (mainly ethnic Kazakhs): they wish to temporarily go abroad to continue their medical education and subsequently return home after gaining experience. The main destinations for educational migration are Russia, the United States and several European countries;
- Attitudes of young health workers are comparable to the attitudes of students; health workers of the senior and pre-retirement age are less inclined to relocate and consider the possibility of migration only after retirement.

Respondents in Kazakhstan consider external and internal migration as an opportunity to advance their professional qualifications and gain work experience (in case of external migration by learning innovative

technologies, and in case of internal migration by working in unique and “extreme” conditions).

The main characteristics of **Kyrgyzstan’s model** of migratory behaviour include:

- Almost all interviewed medical students expressed a desire to move abroad;
- Medical students who study in Russian are more willing to emigrate from Kyrgyzstan (many of them are ethnic Kyrgyz). There is a demand for medical education in Russian as it opens more prospects for employment in Russia;
- Kyrgyz students often view educational migration as a way to stay in the country of education in the future. Main destinations for educational migration are Turkey and Germany. Russia is a less desirable destination because students generally believe that Russians exhibit xenophobic behaviour towards migrants from Central Asia;
- Work in the countryside (even short term) is not considered as a desirable option for medical career;
- Attitudes of young health workers are similar to attitudes of students; health workers of senior and pre-retirement age are less inclined to relocate and consider the possibility of migration only after retirement.

Respondents in Kyrgyzstan view external and internal migration as a way to improve their economic and social situation, and do not consider it as an opportunity to advance their professional qualifications.

# 4

CHAPTER

## MIGRANTS' CHILDREN'S RIGHT TO HEALTH:

LEGISLATION, POLICIES  
AND PRACTICES



Children are the most vulnerable and unprotected group of our society and they should not be deprived of their rights. The state must take care of them.

*Nursultan Nazarbayev, President of Kazakhstan*

## 4.1 INTRODUCTION

Since the collapse of the Soviet Union, labour migration became a major source of income and a livelihood strategy for many Central Asian households. Alongside creating new opportunities, this phenomenon also led to new vulnerabilities. Among the most affected are migrants' children who are particularly vulnerable as a result of their parents' migratory behaviour, whether they accompany them during migration or not.

The goals of this component are three-fold. Firstly, it aims to understand the impact of the migration experience on the health and well-being of migrants' children, both those who accompany the parents and those who are left behind. Secondly, it analyses and assesses legislative and regulatory frameworks related to the health of migrants' children, as well as their implementation mechanisms. Thirdly, it studies the health needs of migrants' children and proposes targeted recommendations to address them through a comprehensive multi-sectoral approach.

The present component focuses on three Central Asian countries: Kazakhstan, Kyrgyzstan and Tajikistan. Taking into account their respective migratory dynamics, Kazakhstan was studied as a host country (or destination country), while Kyrgyzstan and Tajikistan were considered as migrant sending countries (or countries of origin).

Methods used for this component include literature review, analysis of legal frameworks and other documents relevant to the studied topics (conventions, laws, regulations, declarations, international and national reports, studies, presentations, etc.), semi-structured and informal interviews with key informants in the fields of migration management, healthcare, child labour and protection, as well as focus group discussions with non-governmental organisations.

The analysis of legal and regulatory frameworks was focused on the review of the following documents:

- International law instruments defining universal human rights and child's rights, including the best interest of the child, the principles of nondiscrimination and social protection;
- International conventions defining the rights of migrants and members of their families;
- Regional and national legal and strategic documents on migration management and migrants' health, laws, resolutions, programmes, and decrees issued by ministries and agencies;
- Reports, presentations, and project documents of stakeholders involved in the areas of migration and migrants' children's health.

In addition to this desk based analysis, discussions and information exchange were conducted during the assessment's period. Preliminary results and conclusions were presented and discussed with stakeholders in the framework of the Central Asian Regional Workshop on Migrants' Right to Health, held in Bishkek, Kyrgyzstan on 15–16 June 2017. Stakeholders' input gathered during this event contributed to the formulation of recommendations.

### Summary of main findings

- Migrants' children – both those who accompany their parents on the migratory journey and those who stay behind – are a particularly vulnerable group when it comes to their health;

- The main obstacles facing the realization of migrants' children's right to health in host countries are the frequent absence of an individual identification number (IIN), the inability to navigate the health systems of host countries, insufficient information on available services, lack of financial resources, and fear of interacting with government agencies due to irregular status;
- Despite the existing legal and regulatory frameworks governing the issue of migrants' children's health in Central Asia, their implementation mechanisms should be strengthened to increase effectiveness. In particular, it is imperative to create mechanisms allowing children of irregular migrants to access healthcare services in host countries;
- In countries of origin, child protection systems should be strengthened to allow identification of and assistance to children left behind. Moreover, national registration systems need to be simplified to facilitate internal migrants' children's access to healthcare.

The scope and comprehensiveness of this assessment were limited mainly by a dearth of reliable data and statistics on migrants' children issues (both in countries of destination and origin). Moreover, the qualitative data collected during the interview process with key informants present risks of bias, including: selective memory, telescoping, attribution and exaggeration.

## 4.2 THE CHALLENGE OF DATA AND STATISTICS

**TABLE 7** Number of labour migrants from Tajikistan who left the country for economic reasons (people)

	Total	Age			
		Under 18	18-29	30-59	Over 60 years old
Both gender					
2013	799 698	23 681	316 935	454 778	4 304
2014	670 806	2 129	260 719	407 586	372
2015	552 596	324	214 417	337 605	250
2016	517 308	1 101	208 157	308 002	48
Males					
2013	693 355	18 276	279 114	392 876	3 087
2014	564 390	1 850	214 129	348 068	343
2015	487 929	304	188 776	297 813	190
2016	435 457	723	174 500	259 399	38
Females					
2013	100 094	5 405	35 570	57 902	1 217
2014	106 416	279	46 590	59 518	29
2015	64 667	20	25 641	38 796	60
2016	81 851	378	33 657	47 806	10

Source:

Second periodic report of the Republic of Tajikistan to the Committee on the Rights of Migrant Workers, 12 May 2017.

As mentioned above, one of the greatest challenges in addressing the issue of migrants' children's health is related to the lack of comprehensive and reliable data on the topic. In particular, most of the information on irregular migrants' children is anecdotal. Moreover, there is no comprehensive statistics on migrants' children and no government agency is working on this topic on a formal and systematic basis. Even though separate statistics exist in various sectors in all three countries, there are no comprehensive statistics on migrants' children. Current main instruments of data collection in Kazakhstan are: the electronic system of data collection within the Ministry of Health, EMIS (Education Management of Information System) within the Ministry of Education, the State Statistics Agency which collects information on children without parental care, TransMonEE<sup>67</sup>, and the respective national statistical agencies in Tajikistan and Kyrgyzstan.

Hence, the number of migrants' children covered by basic social services is not known and not reflected in official statistics. Moreover, official statistics often mask significant inequalities among different vulnerable migrant sub-groups.

### 4.3 RATIONALE TO ENSURE MIGRANTS' CHILDREN'S ACCESS TO HEALTHCARE

There is overwhelming evidence that the foundations of child's life are laid during the very first years of their existence. If these early years are hindered by ill-health, this can have a permanent and detrimental impact on child's long-term development. Indeed, the child's future choices, attainments and well-being are greatly affected by quality of life and care during childhood. Evidence shows that good quality healthcare services in the early years have an important and positive impact on children's long-term health outcomes. Investing in child's health – including for migrants' children – can thus bring significant economic benefits to countries<sup>68</sup>.

Conversely, ignoring or not investing in migrants' children's health is not only contrary to international law, but also detrimental to countries' socio-economic development. To effectively compete in a globalised world in which information technologies and higher education are increasingly valued, children need to have the necessary skill sets. As the foundation of life is built during childhood, the rights of migrants' children cannot be ignored.

In addition, investing in migrants' children's health can contribute to limit the spread of infectious diseases. Therefore, supporting migrant sensitive policies and legislation with the aim of realizing migrants' children's right to health can have an important impact not only on children's future, but on public health outcomes in both countries of origin and destination.

### 4.4 SOCIO-ECONOMIC CONTEXT OF STUDIED COUNTRIES

**The Republic of Kazakhstan.** Starting from 2001 and onwards, Kazakhstan experienced rapid economic growth. Until recently, the country had one of the largest and fastest expanding economies in Central Asia. Kazakhstan is the second migration destination choice after the Russian Federation and attracts many migrants to live and work with their families and children.

There are additional factors contributing to make Kazakhstan an attractive destination for migrant labourers. Firstly, it became a member of the Eurasian Economic Union on 29 May 2014, which came into force on 1 January 2015. This lightened administrative procedures for migrants and facilitated mobility in the region in general and to Kazakhstan in particular. Secondly, the Russian Federation's policy of re-en-

<sup>67</sup> TransMonEE database: data for understanding the situation of children in Central and East European countries and the Commonwealth of Independent States.

<sup>68</sup> Dr. Jim Yong Kim, President of the World Bank, Rethinking Development Finance, LSE lecture, 11 April 2017.

try bans (the so-called “black list”) affect many migrant workers from Central Asia, preventing them from entering Russia and thus making Kazakhstan an important alternative destination.

The migration policy of Kazakhstan is quite favourable for migrant workers from Kyrgyzstan to work and live there with their families. Kyrgyz migrants and their families can exercise their rights as members of the Eurasian Economic Union area. Since 1 January 2017, citizens of Tajikistan can visit Kazakhstan without a visa for up to 90 days.

Tolerance towards migrants has become a decisive factor in ensuring the peace, stability, and economic progress in Kazakhstan. For the Kazakh people, the principle of tolerance is not only a norm inherent to its political culture, but also one of the key principles of the state. During interviews, the majority of the respondents reacted positively to the question of migration from neighbouring countries and demonstrated a tolerant attitude towards migrants.

Kazakhstan is a multicultural nation. For generations, Kazakh people used to live together with other nationalities in peace and prosperity. The Kazakh people are tolerant towards migrants.

*NGO Representative, Kazakhstan*

**The Republic of Tajikistan.** After independence in 1991, civil and political conflict plagued Tajikistan from 1992 to 1997, causing major disruption and physical destruction. The 2008–2009 global economic crisis adversely affected Tajikistan’s economy with a 30 percent decline in inward remittances as a result. In general, migrants are more likely to come from poorer households in rural areas. Despite recent improvements, these households are disadvantaged by limited access to basic healthcare services.

Every fourth child under five years old is chronically malnourished and the rates of acute malnutrition and underweight among children have increased substantially since 2009, remaining at 9 and 17 percent, respectively.

Whilst mortality rates have been reduced to 63.3 per 1,000 live births for infants and to 52.8 per 1,000 live births for children under five, these are still amongst the highest in the region<sup>69</sup>.

**The Kyrgyz Republic.** Kyrgyzstan declared its independence from the Soviet Union in 1991. Its population recently reached six million, with nearly 2 million under 18 years of age. Due to scarce financial resources, child protection and access to healthcare have been hampered. High unemployment rates among youth lead to important outflows of labour migration to neighbouring countries.

The World Bank estimates Kyrgyzstan’s economy to be highly dependent on remittances (as they amounted to as much as 31 percent<sup>70</sup> of the gross domestic product in 2016). Moreover, the 2008–09 global economic crisis adversely affected Kyrgyzstan’s economy.

## 4.5 INTERNATIONAL STANDARDS ON CHILDREN’S RIGHT TO HEALTH AND THEIR IMPLEMENTATION IN KAZAKHSTAN

Migrants’ children’s right to health results from international human rights policies of which the Republic of Kazakhstan became part. The United Nation Convention on the Rights of the Child (UNCRC) was adopted in 1989 and signed unanimously by almost all countries of the world. Kazakhstan, Kyrgyzstan, and Tajikistan all committed to the advancement of children’s rights and ensurance of the best interest of the child.

69 United Nations Development Assistance Framework (UNDAF) for Tajikistan, 2016–2020.

70 World Bank. Online at <http://data.worldbank.org/indicator/BX.TRF.PWKR.DT.GD.ZS>



The UNCRC – the provisions of which the Government of Kazakhstan reflected in its legislation – imposes binding legal obligations on participating states, upon which the rights stated in the Convention should be respected for all children within the state's jurisdiction, without discrimination of any kind and irrespective of the child's or his/her parents' or legal guardian's status<sup>71</sup>. The UNCRC further states that the best interests of the child must be a primary consideration in decision-making processes (Article 3) and that “non-rights-based arguments such as those relating to general migration control, cannot override the best interest consideration<sup>72</sup>.” Article 19 of the UNCRC sets out that concrete measures that states should take to ensure protection of the child: “all appropriate legislative, administrative, social, and educational measures ... to provide necessary support for the child ... as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment, and follow-up of instances of child maltreatment<sup>73</sup>.” Kazakhstan ratified the UNCRC in 1994 and committed to international norms regarding protection of children. The UNCRC established a comprehensive system of measures to ensure social and legal guarantees for all children.

The umbrella framework for the protection of the rights of migrant workers and their families is further strengthened by International Labour Organization (ILO) conventions No. 97, 102, 143, ILO Recommendation 202, and the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (2003). Kazakhstan has yet to ratify the latter.

Finally, the World Health Assembly 2008 resolution On the Health of Migrants promotes migrant sensitive policies and encourages state parties to undertake measures to ensure the introduction and implementation of comprehensive and coordinated migrant-sensitive policies into national strategies and plans.

However, in practice, not all children enjoy protection and fulfilment of rights without discrimination. UNICEF conducted a regional monitoring on social protection for child rights and well-being in Central and Eastern Europe, the Caucasus, and Central Asia in 2015<sup>74</sup>. The report found that, along with other children in vulnerable situations, children of migrant workers face significant barriers to the realization of their rights. These barriers may include unfamiliarity with navigating the healthcare systems of host countries, inadequate information about available services, poverty, and fear of interacting with state institutions due to irregular status. It is also stated that countries may not have the capacity to effectively put legislation into practice and deliver services at the local level. Secondary legislation is far less developed in the region than primary legislation and policies often do not come with adequate action plans or guidance for implementation.

## 4.6 LEGISLATION AND PRACTICES ON MIGRANTS' CHILDREN'S RIGHT TO HEALTH IN KAZAKHSTAN

### 4.6.1 Legal and policy frameworks

The Constitution of the Republic of Kazakhstan and the Law on the Rights of the Child guarantee equal rights to migrants' children, including access to healthcare and other social services. According to domestic law, children are treated as nationals of Kazakhstan in the country of destination of migrants and

71 UN General Assembly, Convention on the Rights of the Child, 20 November 1989, United Nation's Treaty Series, vol.1577, Article 2.

72 UN Committee on the Rights of the Child, General Comment Number 6 (2005), 'Treatment of Unaccompanied and Separated Children Outside their Country of Origin', 1 September 2005, CRC/GC/2005/6, para 86. at: [http://www.jus.uio.no/smr/english/people/aca/birgsc/working-papers/Schlutter\\_April.pdf](http://www.jus.uio.no/smr/english/people/aca/birgsc/working-papers/Schlutter_April.pdf)

73 UNCRC Article 19 (2)

74 UNICEF. Social Monitor: Social protection for child rights and well-being in Central and Eastern Europe, the Caucasus and Central Asia. Available from [https://www.unicef.org/ceecis/Social\\_Monitor\\_Regional\\_Report.pdf](https://www.unicef.org/ceecis/Social_Monitor_Regional_Report.pdf) (accessed 7/02/2017)

as citizens of their own country of origin. They enjoy equal rights and bear equal responsibilities according to legislation of their respective countries.

The Law on the Rights of the Child establishes equality of rights between citizen and non-citizen children and prohibits any restriction of those rights. All children – citizens or not – enjoy equal rights and full protection. Article 2 guarantees that:

*A child who is not a citizen of the Republic of Kazakhstan enjoys rights and freedoms in the Republic and bears responsibilities established for citizens unless otherwise provided by the Constitution of the Republic of Kazakhstan, laws of the Republic of Kazakhstan, and international treaties ratified by the Republic of Kazakhstan.*

Article 3 stresses the importance of international law in this field:

*If an international agreement ratified by the Republic of Kazakhstan establishes rules other than those contained in this Law, the rules of the international treaty shall apply, except when it follows from the international treaty that it requires the publication of the law of the Republic of Kazakhstan.*

According to the Public Health Code (No. 193-IV of 18 September 2009) and the Law on the Rights of the Child, children up to the age of 18 shall receive healthcare services within the guaranteed amount of free medical care, skilled, specialized, and tertiary care, as well as treatment abroad.

Finally, article 14 (paragraph 2) of the Constitution ensures nondiscrimination in access to healthcare and education to all, including to migrants' children.

There has recently been significant improvements in Kazakhstan's legislative and policy frameworks regarding provision of healthcare, which are constantly improving to align with the most important international legal documents defining basic requirements for state policy on children. For example, on 10 February 2016, by Decree of the President of the Republic of Kazakhstan, the Commissioner for the Rights of the Child was established. The Commissioner monitors the situation of all children in the country. To address the challenges in the implementation of UNCRC, the Commissioner established a Platform for Dialogue which gathers on a regular basis representatives of the Government, non-government organisations, the UN and development partners.

To ensure the best interest of the child in the field of healthcare, a system of free medical care for children and paediatric services was established and is continually improved. Children under the age of 18 with certain health conditions (including children with disabilities) are treated free of charge on an outpatient basis and are provided with medicines according to the approved list of medicines and medical products by the Ministry of Health.

In accordance with Article 88 (paragraph 5) of the Code of the Republic of Kazakhstan On Population Health and Healthcare System (18 September 2009), foreign citizens have the right to receive a guaranteed amount of free medical care, but only for acute diseases that pose a danger to others. The list of diseases posing a danger to others is determined by the Ministry of Health (Order of the Minister of Health and Social Development of the Republic of Kazakhstan dated 1 April 2015 No. 194.).

Article 156 of the Code On Population Health and Healthcare System establishes that individuals located in the territory of the Republic of Kazakhstan are entitled to receive preventive vaccinations against infectious and parasitic diseases within the guaranteed volume of free medical care. Finally, according to Article 88, primary medical care (in emergency and urgent situations) and sanitary care is provided regardless of immigration status and length of stay.

Thus, there are clearly defined legal frameworks in Kazakhstan guaranteeing migrants' children's right to health. However, weak or undefined implementation mechanisms of these laws, lack of reliable data, absence of clear guidelines and bi-laws, and lack of inter-ministerial collaboration hampers the actual realization of migrants' children's right to health. The child protection system and related services provided by the Government of Kazakhstan are not sufficiently developed, at their current stage, to meet

international standards as stipulated in adopted international conventions. In addition, healthcare and social workers have limited skills to work with migrants' children. As a result, policy responses to support members of this vulnerable sub-groups are fragmented and inconsistent.

Thus, despite relatively strong macroeconomic indicators and considerable progress in building civil society in Kazakhstan, numerous challenges remain in delivering healthcare services to migrants' children and their families. These challenges are mainly related to contradictory laws and regulations, confusion from both service providers and beneficiaries and lack of reliable information on migrants' children's health status and needs. Considering the above, the Republic of Kazakhstan still needs to formulate detailed guidelines and bi-laws on how to provide healthcare services to migrants' children.

### 4.6.2 Registration, individual identification numbers and health insurance

The Government introduced individual identification number (IIN) and compulsory health insurance, which also impact migrants' children's access to healthcare.

The Law on National Registers of Individual Identification Number (dated 12 January 2007, No. 223) obliges everyone in Kazakhstan to have an IIN, including migrants, and requires everyone to present that document while using state provided services. The Law states that foreign citizens and stateless persons permanently residing in Kazakhstan who do not have an indicated IIN in their residence permit should visit the internal affairs agency at the place of residence to reissue the document. However, in practice many migrants, especially those in irregular situation, do not possess an IIN, which greatly hinders their access – and the access of their children – to healthcare, as an IIN is required upon obtaining medical services from public health institutions.

Beginning on 1 July 2017, the Republic of Kazakhstan introduced a system of compulsory health insurance, which ensures joint responsibility of the state, employers and citizens. The Law of the Republic of Kazakhstan No. 405-V of 16 November 2015 On Mandatory Social Health Insurance requires compulsory health insurance and affect both citizens and non-citizens, including migrants.

According to article 28, children, mothers with large families, students, people with disabilities and the unemployed are exempt from payment of contributions to the medical insurance fund. Article 5 of the same law grants citizens who have not made contributions to the fund the right to free medical healthcare, in accordance with guaranteed amounts of free medical assistance as defined in the Code of the Republic of Kazakhstan On Public Health.

## 4.7 BARRIERS TO HEALTHCARE FOR MIGRANTS' CHILDREN

In recent years, Kazakhstan has made considerable progress in the field of child health. Infant mortality was reduced from 45.8 per 1,000 live births in 1990 to 16.7 in 2012. Similarly, maternal mortality has decreased from 55 per 100,000 live births in 1990 to 12.6 in 2013<sup>75</sup>. The country has also made significant progress in the area of nutrition, breastfeeding, vaccination and access to healthcare services. However, these positive numbers do not reflect the situation of some vulnerable groups, including migrants' children, who are invisible in statistics.

Central Asian migrant families most often work and live in difficult conditions in host countries, which lead to an overall low level of health status of migrants' children. In addition, children whose parents have irregular legal status have severely restricted access to state healthcare and can rarely afford private healthcare services. Migrants face significant financial access barriers to healthcare, partly because of out-of-pocket payment systems. Although national legislation ensures equal access of migrants' children to healthcare, non-realization of their rights to health occurs for various reasons.

**TABLE 8** Legal regulations relating access of migrants' children to healthcare services in Kazakhstan

Group	Medical Examination	Ambulance and emergency assistance	Regular medical services/ specialised healthcare services	TB	HIV/AIDS
Migrant workers from countries with visa-free regime, including citizens of Kyrgyzstan and Tajikistan	Payment is required	Free-of-charge until the condition is stabilised. Further services are charged for. If there are no financial resources to pay for services, patients are referred to the country of origin with the help of migration services.	Paid	Diagnosis conducted through compulsory medical insurance or voluntary medical insurance or is charged for. Treatment and assistance are free-of-charge.	Diagnosis conducted through compulsory medical insurance or voluntary medical insurance. If HIV is detected, it is recommended to return to the country of origin for getting free ARVT treatment.  ARV medicine is not available for foreign nationals living with HIV.

**Frameworks:**

- Agreement on the provision of medical assistance to citizens of CIS countries.
- Agreement between the Government of Republic of Tajikistan (RT) and the Government of Republic of Kazakhstan (RK) on employment and protection of rights of migrant workers – citizens of RT, working temporarily in Kazakhstan and on employment and protection of rights of migrant workers – citizens of Republic of Kazakhstan, working temporarily in Tajikistan (as of May, 2006)
- The Order of the Minister of Health of Republic of Kazakhstan “Regulations for the provision of healthcare services to immigrants” (as of 30 September 2011, № 665).
- The Order of the Minister of Republic of Kazakhstan “On approval of the list of diseases which prevent entry of foreigners and stateless persons to Kazakhstan” (as of 30 September 2011; № 664)
- The Code of RK on population’s health and healthcare system (as of 10 January 2015):
- The Order of the Ministry of Health and Social Development of RK “On approval of instructions for organization and implementation of TB prevention activities” as of 22 August 2014; № 19)
- The Resolution of the Government of Republic of Kazakhstan “On the order of provision of guaranteed basic free medical care to citizens” (as of 19 November , 2009; №1887)

- The Resolution of the Government of Republic of Kazakhstan “Regulations for the provision of primary healthcare services and regulations on registration of citizens with PHC facilities” (as of 1 November 2011; № 1263)
- The Order of the Minister of Health and Social Development of Republic of Kazakhstan “On the approval of the list of acute diseases posing threat to others, which guarantee foreigners and stateless persons residing in Kazakhstan the right to receive the guaranteed volume of free medical care in Kazakhstan” (as of 1 April 2015 № 194).
- The Code of the Republic of Kazakhstan “On Population Health and Health Care System,” (as of 18 September 2009, paragraph 5 of the article 88)
- The Code of the Republic of Kazakhstan “on children” guarantees free medical services to all children up to the age of 18, however there is no clear guidelines on servicing migrants’ children

**Source:**

Table modified from Rapid Situational Analysis of the Access of Migrants and Members of their Families to Comprehensive TB, MDR-TB, and TB/HIV Services in Tajikistan.

USAID/IOM Project, Dushanbe 2016.

Migrants’ children with temporary registration (up to three months) are not entitled to the full package of government-provided healthcare services. In cases when long-term treatment is required, they are normally advised to return to their homeland. Moreover, most migrants cannot afford treatment in private clinics in Kazakhstan<sup>76</sup>.

Regarding reproductive health, childbirths are considered as emergency cases and thus free of charge. However, pregnant female migrants are not entitled to free routine preventive care and treatment. Upon serious pathologies or the need for surgical intervention, health insurance is required, which migrating women often do not have. In most cases, treatment is still carried out upon doctors’ will and judgement, which entails risks upon verification by fiscal authorities.

According to the results of the “Situation of labour migrants from Kyrgyzstan in Kazakhstan”<sup>77</sup>, migrants’ social rights are frequently infringed, in particular the right to the full package of state-provided health services. More than 20 percent of respondents reported always experiencing problems when applying to health facilities, and 60 percent stated experiencing problems “in some cases”.

One of the most significant obstacle to migrants’ children’s access to healthcare is probably their parents’ legal status. Indeed, many migrants work without employment contract and sometimes stay in the territory of Kazakhstan without valid registration, which prevents them from enjoying full access to the healthcare system. Even though the state, in principle, covers basic healthcare services and emergency care, migrant’s children can technically be denied access to healthcare services without an individual identification number, which itself depends on a valid registration. Thus, the absence of clear regulations and mechanisms for the provision of healthcare services to irregular migrants’ children represents an important obstacle standing in the way of the realization of migrants’ children’s right to health in Central Asia.

76 Alternative Report on the implementation of the Convention on the Rights of the Child.

77 Alternative Report on the implementation of the Convention on the Rights of the Child.

## 4.8 MIGRANTS' CHILDREN'S HEALTH IN COUNTRIES OF ORIGIN

Issues related to the health of migrants' children should not be examined only in host countries. Indeed, countries of origin have an important role in ensuring that their citizens under 18 – as well as citizens of other countries staying on their territories – can enjoy the highest attainable standard of health. In this view, the following section examines legislation and policies in Kyrgyzstan and Tajikistan, as well as specific issues related to the health of “children left behind”.

### 4.8.1 Legislation and policies

Tajikistan and Kyrgyzstan are members of the Commonwealth of Independent States, the United Nations and the World Health Organization. The provisions of the charters of these organizations are binding for participating countries. The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICPMW) is one of the basic UN documents for the protection of migrants' rights. The Republic of Tajikistan ratified this document and the Kyrgyz Republic is one of the first countries to have acceded to it. The Convention aims at protecting migrant workers and members of their families and serves as a guide for the promotion of migrants' rights. Tajikistan and Kyrgyzstan are party to core UN human rights treaties and optional protocols to these treaties, including the UNCRC, which is the main document for the protection of the rights of children.

The Constitutions of both Tajikistan and Kyrgyzstan, as well as their healthcare sector legislation, guarantee the protection of the health of all children. However, state programmes and legislations of both Tajikistan and Kyrgyzstan are targeted for registered citizens and their families, who participate to the formal labour market. Officially registered internal or external migrants are entitled to basic social services packages, including state provided healthcare. However, an important proportion of migrants do not have registration documents in their temporary place of residence, and thus cannot benefit from these entitlements in practice.

Indeed, a study conducted by the Centre for the Protection of the Children of Kyrgyzstan revealed major barriers in access to healthcare services. The most common problems of migrants' children for obtaining medical services are the lack of registration at the place of residence and of registration with a medical institution, absence of documents (passport, birth certificates), frequent changes of residence, low incomes, and legal illiteracy. All these factors represent barriers for migrants' children to access healthcare services.

In addition, some segments of the population, including children, are disadvantaged in terms of access to healthcare. This concerns people living in remote areas and those not employed in the formal labour market, which cannot access state provided benefits and basic services.

Finally, while the law formally provides protection for children at risk of abuse, neglect, or exploitation in both countries, practice shows that concrete and effective implementation mechanisms are lacking on such important issues as identification, referral and assistance<sup>78</sup>.

### 4.8.2 Children left behind and their access to healthcare in Kyrgyzstan and Tajikistan

In addition to children undertaking the migration journey with their parents, children who are “left behind” while their parents are working abroad also face potential health risks and challenges. Studies conducted on the children left behind phenomenon show that alongside creating financial benefits for families, migration can greatly affect the psychological and physical well-being of children left behind<sup>79</sup>.

78 Professor Carolina Hamilton, Review of Child Protection System of Tajikistan, 2008.

79 Impact of Labour Migration on “Children Left Behind” in Tajikistan, UNICEF/Oxford Policy Management, November 2011; A Portrayal of Absence: Households of Migrants in Kyrgyzstan, UNICEF/HelpAge International 2012.



When their parents migrate, those children often live in families headed by grandparents or older children, in extended families or are sent to boarding schools. Situational analysis shows an increased vulnerability of these children to ill-treatment and neglect in their families and communities, as well as an increased propensity for violence against them. The health impact on children left behind is rendered especially salient due to the lack of adequate resources to respond to broad public health, social, and child protection issues linked to these increased vulnerabilities.

In order to address the specific vulnerabilities of children left behind by migrating parents, there is a need to adapt and strengthen systems of social services provision, to build the health workforce's capacity (including psychologists) and to develop a coordinated plan based on international best practices.

In recent years, Central Asian Governments have taken steady steps in developing social services and social protection systems. For example, in the case of Kyrgyzstan, the Government adopted a resolution and guideline dated June 22, 2015 № 391 on the procedure for identifying children and families in difficult life situations (DLS). The regulation describes the interaction between the territorial units of the child protection authorized body, territorial state bodies and executive bodies of local government. It determines the procedure for the identification of children and families in difficult life situations in order to provide appropriate support and services.

In accordance with this regulation, the district and city social development departments, together with the executive bodies of local government, conduct on a regular basis the early identification of children and support children and families in difficult life situations.

There is a procedure described for identifying and assisting all categories of children in the regulation:

- Children left without parental care;
- Children with disabilities;
- Children involved in the worst forms of child labour;
- Children in conflict with the law;
- Children, who were subjected to cruel and degrading treatment (violence);

The procedure determines responsibilities for conducting a comprehensive assessment of the situation of the child and family in DLS. After the assessment, district employees and city social development departments develop an individual child protection plan (ICPP) or an individual family work plan (IFWP), if necessary. In accordance with the developed and approved ICPP and IFWP, through the provision of appropriate state and social services, measures are undertaken to assist the child and the family to get out from a difficult life situation.

It is worth noting that employees of district and city social development departments, jointly with the employees of Internal Affairs and local authorities, conducted a household survey in 2015 to identify disadvantaged families and children of external and internal migrants. Thus, a total of 316,680 households were surveyed, where 61,405 migrant children were identified, including 5752 children of internal migrants and 56,462 children of external migrants. According to approved individual child protection plans, 673 children of external migrants were transferred to guardianship, 136 children were sent to residential children's institutions, and 55,653 children live with relatives (grandparents, uncles, aunts). In 2016, 925 children were placed under guardianship, 95 percent of these children are under the custody of relatives. The total number of children transferred for adoption were 1,000. Similar work has been initiated and is currently in progress in Tajikistan.

Despite these positive developments, social services provision remains insufficient to meet the health needs of children left behind due to the heavy workload of social workers and the lack of professionals with relevant specialised training. The lack of adequate resources to respond to broad public health, social, and child protection issues related to increased vulnerabilities in migrant families can lead to cascading reverse impact on the society as a whole.

## 4.9 CONCLUSIONS AND RECOMMENDATIONS

Labour migration is, at least for the time being, an inevitable part of life in Central Asia. Despite the economic benefits it can bring to families, it also poses a number of threats to children's health. Therefore, the issue of migrants' children's health requires particular attention from both government (especially in the areas of migration management, healthcare and education) and non-government actors.

The analysis of legal frameworks, policies and practices revealed a number of challenges related to the realization of migrants' children's right to health in Central Asia. In order to overcome them, the following recommendations were formulated on the basis of the four pillars of the operational framework proposed by WHO and IOM to further the realization of migrants' right to health<sup>80</sup>: 1) policy and legal frameworks; 2) partnerships, networks and multi-country cooperation; 3) migrants' health monitoring; and 4) migrant sensitive healthcare systems.

### 4.9.1 Policy and legal frameworks

#### Kazakhstan

- Examine the possibility to accede to the the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (2003) and reflect provisions of this Convention into national legislation;
- Revise current migration related legislation in order to bring it in line with the ILO Convention concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour;
- Consider the establishment of a mechanism of healthcare provision to irregular migrants' children through the issuance of temporary/permanent documents or individual identification numbers;
- Develop, disseminate and enforce clear guidance for healthcare practitioners on the provision of healthcare services to migrants' children;
- Advocate with the Commissioner for the Rights of the Child through regular consultations, the Platform for Dialogue and inter-agency coordination meetings to promote the issue of migrants' children's health and to position it at the top of the political agenda.

#### Kyrgyzstan and Tajikistan

- Review public health institutions' registration systems to facilitate internal migrants' access to healthcare services and simplify children's registration procedure by rendering it location-independent (migrants' children's registration should not be linked to parents' registration as many live with relatives);
- Support targeted outreach to identify and assist families where carer, siblings and other relatives bear responsibility for migrants' child;
- Develop training programmes for social workers on social and psychological support to migrants' children and families and increase their skills to address the specific challenges families face with children left behind;
- Define the minimum package of social services required to satisfy the needs of families considering the best interest of the child, and develop standards and indicators to measure results;
- Develop a legislative basis for the implementation of special programmes aimed at ensuring access to social services for migrants' children and children left behind;
- Develop and implement programmes of pre-departure preparation for labour migrants, which

80 WHO and IOM. 2010. Health of Migrants – The Way Forward. Report of a Global Consultation.



would include advice on host countries' legal environment, employment, health insurance and healthcare. The possibility of pre-departure medical examinations for labour migrants and their families (in a health risks assessment perspective) should also be considered.

#### 4.9.2 Partnerships, networks and multi-country cooperation

- Promote effective interagency cooperation and coordination related to access to healthcare services for migrants' children;
- Ensure the dissemination of high quality information among migrants' families on children's health in host countries through a network of sources, including embassy and consular websites, international organizations, host countries' government networks, NGOs and social media;
- Strengthen cooperation with local authorities for the protection of the rights of children, particularly in terms of monitoring and emergency response to violations;
- Support healthcare institutions in host countries for the dissemination of informational material on reproductive health, sexually transmitted infections, HIV and safe motherhood in national Central Asian languages.

#### 4.9.3 Migrants' health monitoring

- Establish partnership and collaboration with UNICEF to include migrants' children's health into Multiple Indicator Cluster Surveys;
- Involve the Commissioner for the Rights of the Child and a network of non-governmental organizations for conducting monitoring of the situation of migrant's children health status and needs, and their access to healthcare;
- Develop indicators to monitor migrants' children's health in the framework of existing laws and policies;
- Work with the Ministries of Health to collect data on migrants' children's health.

#### 4.9.4 Migrant sensitive healthcare systems

- Align national legislations in the areas of migration management, healthcare and child protection with the World Health Assembly 61.17, while taking into consideration the needs of migrants in Kazakhstan, Kyrgyzstan, and Tajikistan;
- Develop mechanisms creating conditions for the acquisition of affordable health insurance policies for migrant families in host countries;
- Organize regular information campaigns and trainings for diaspora organizations, ethno-cultural centres, migrant centres, NGOs and migrants themselves with the aim of increasing the legal literacy of these actors on migration health issues, with a component on children's health;
- Include a course on migration health (which would include a component about migrants' children' health) in curricula for physicians, nurses and other relevant healthcare professionals. The course should include such topics as: migration legislation, international human rights law, migrants' vulnerability analysis, culturally sensitive social services and epidemiological profiles of countries of origin.

# 5

## CONCLUSIONS AND RECOMMENDATIONS

CHAPTER



## 5.1 RATIONALE FOR THE REALIZATION OF MIGRANTS' RIGHT TO HEALTH

The right to health is a complex and comprehensive human right and is closely intertwined with other rights. Indeed, the right to health, if important by itself, is in fact a precondition to the enjoyment of other rights, such as education, political participation and many others. Central to the rationale of this right is the principle of non-discrimination, a foundation of international human rights law architecture. The principle of non-discrimination carries special relevance when migrants are concerned, as their status in host countries often leads to differentiated treatment and entails particular vulnerabilities which need to be addressed.

Just as the right to health is related to – or a precondition to – the enjoyment of other rights, its realization brings about benefits extending beyond the sphere of health. Indeed, establishing the required conditions for its realization can lead to “collateral benefits”: it facilitates integration in host communities, increases the chances of success of the migration journey and allows migrants to truly gain from the migration experience in terms of self-fulfilment, skills and knowledge.

But the benefits of realizing migrants' right to health are not limited to migrants themselves. The findings of this assessment – as well as of many research investigating other contexts – point to the fact that the realization of this right can bring about numerous benefits for host countries as well. Ensuring that a country's migrant population is healthy can not only lead to positive public health outcomes such as the prevention of communicable diseases: it can also allow migrants to contribute in positive and constructive ways to host countries' economy, social life and culture. Hence, migrants' health should not only be viewed as an issue of human rights, but also as an issue of public health and socio-economic development.

Conversely, neglecting to take measures to realize migrants' right to health is likely to bring about negative outcomes for both migrants and host societies. For migrants, these include heightened risks of migration resulting in temporary or permanent health problems, harm related to various methods of self-treatment and self-medication, and increased risks of different types of exploitation.

This assessment has demonstrated that Central Asian countries have made considerable progress since their recent independence in the areas of migration management and healthcare. They have acceded to many international human rights law instruments and have realized important steps in reflecting their provisions into national legislation. Moreover, practices and policies are increasingly taking into account migration not only as an inevitable phenomenon requiring appropriate management, but as a positive tool for development in the economic, social and cultural areas.

However, despite these significant steps forward, the impact of migration on migrants' health remains important, and many of them experience significant problems in accessing healthcare services in host

countries. Indeed, the realization of migrants' right to health represents a considerable challenge – not only for Central Asian countries, but also for the world's most developed. States often face an array of economic, social and political difficulties, in the midst of which ensuring the provision of healthcare for their own population – let alone for migrants – is a challenge. Moreover, tenacious “toxic narratives” about migrants, xenophobia and violent expressions of nationalist ideologies complicate the practical realization of this right. Finally, inclusive healthcare systems can be perceived by some segments of the society as conflicting with states' security imperatives.

However great these challenges, they do not free states from the obligation – defined by international law instruments of which they are part – to realize the human rights of all, including migrants. These obligations should however not be misinterpreted and the need to avoid a common misconception should be stressed: the right to health should not be considered as the right to be healthy, which states cannot fully guarantee. Rather, states' responsibility is to create the conditions in which both citizens and non-citizens can enjoy the highest attainable standard of physical and mental well-being.

Based on the results of this assessment, recommendations were formulated to assist Central Asian countries on the difficult but rewarding path of realizing migrants' right to health. They are intended for both government and non-government actors whose mandate is primarily related to healthcare and migration management, as well as to education, social protection, labour and other areas.

These recommendations were framed within the rationale of the 2008 resolution of the World Health Assembly 61.17 “On the health of migrants” and are founded in the four action points of the global operational framework on migrants' health: 1) monitoring migrant health; 2) policy and legal frameworks; 3) migrant sensitive health systems; and 4) partnerships, networks and multi-country frameworks. They aim to contribute to the main migration health goals, including the promotion and protection of migrants' health rights, the reduction of excess mortality and morbidity, the reduction of disparities in health status and healthcare access, and the minimization of migration's negative health outcomes. These recommendations are expected to contribute to IOM's response on promoting health of migrants, which entails: 1) advocating for migrant-inclusive health policies; 2) delivering technical assistance; 3) enhancing the capacity of governments and partners to provide migrant-friendly services; and 4) providing evidence for policy change.

Among other goals, these recommendations aim to remove or reduce the limitations and conditionality of provision of healthcare services for migrants. The underlying logic is that reducing structural barriers for migrants may minimize the impact of the migration experience on their health, while reducing the financial burden for host countries.

## 5.2 LEGISLATION AND POLICIES<sup>81</sup>

As demonstrated by the analysis of legislation (chapter one), the Kyrgyz Republic, the Republic of Kazakhstan and Turkmenistan possess a relatively thorough national legislative framework related to the provision of healthcare services to migrants. Moreover, it is a positive development that Central Asian countries have joined most regional and international conventions directly or indirectly related to migration health (see chapter one for details). However, despite positive progress, important gaps remain regarding the comprehensiveness of migrants' right to health in national legislations. Several paths could be taken to bridge them:

1. Firstly, provisions of international law instruments signed and/or ratified by Central Asian states are not all comprehensively and accurately reflected in national legislations, especially when their mechanisms of implementation are concerned. States should thus pursue their efforts to bring national legislation in compliance with international standards in the field of migrants' health.

81 The legislative and policy related recommendations presented in this chapter are of a general character. For country-specific recommendations, please refer to chapter one.

2. In parallel, the possibility to join international instruments that they have not yet signed and/or ratified should be examined. It should be noted that states can take measures to initiate the implementation of such instruments by progressively integrating their provisions into national legislation. This path is particularly relevant for several conventions of the International Labour Organization directly relevant to migrants' right to health, which Central Asian states could join in the near future as part of their efforts to strengthen their human rights frameworks in general, and those related to migrants' right to health in particular.
3. Another path towards strengthening national migration health legal frameworks is to further reflect the issue in "lesser" policy documents. Indeed, despite the presence of general migration health related provisions in overarching legislative documents such as constitutions, instruments such as concepts, strategies and action plans often do not comprehensively and accurately reflect migration health issues. Further development of national legislation would thus benefit from the mainstreaming of migration health issues in such policy documents, in accordance with international instruments and with support from international organizations with a migration and/or health mandate.
4. One of the most significant gaps in legislative frameworks is related to the impact of legal status on access to healthcare. Indeed, current laws and regulations are mostly aimed at providing healthcare services to migrants whose residence status is regular. However, within the framework of their international obligations, Central Asian states are also compelled to realize the human rights, including the right to health, of people whose residence status is irregular. The actual realization of migrants' right to health thus requires formal laws and mechanisms for the provision of healthcare to migrants with irregular status.
5. Finally, on a more long-term basis, it is desirable for Central Asian states to pursue and expand their involvement in regional and international migration management initiatives, especially in the framework of the United Nations. In September 2016 the UN General Assembly adopted the New York Declaration for Refugees and Migrants, which calls for the development of a Global Compact on migration through intergovernmental negotiations. Central Asian states should make the most of this momentum and actively engage in regional and international consultations in support of the negotiations, including, where possible, within existing consultative processes and mechanisms. This participation should be inter-sectoral and involve high-level representatives of Ministries of Health, migration management agencies and non-government actors (civil society, private sector, diasporas and migrant organizations).

### 5.3 REDUCING THE IMPACT OF LEGAL STATUS ON ACCESS TO HEALTHCARE

The sociological research included in this assessment demonstrated that one of the most important factors impeding migrants' access to healthcare is their legal status. Indeed, many irregular migrants cannot enjoy the benefits of the healthcare services that they would normally receive if their status was regular. This can be due to: 1) health systems formally not allowing irregular migrants to obtain healthcare; 2) the absence of regulations causing unpredictable outcomes for irregular migrants seeking medical assistance, in which the "human factor" plays an important role; and 3) the fear on irregular migrants' side that interacting with the health system will lead to legal problems such as fines or, in some cases, deportation. However, international law instruments of which Central Asian states are part (see chapter one) clearly state that the right to health should be enjoyed independently from legal status, and that discrimination based on this factor is forbidden by law.

As showed in chapter two, many migrants cannot enjoy the benefits and security provided by regular status because of circumstances not entirely within their control. In Central Asia, procedures related to registration – which are not always adapted to migrants' concrete reality and high mobility – are most

often the cause of irregular status (section 2.4.2). The inefficiency of registration procedures is further aggravated by an overall low level of migrants' knowledge and awareness, leading to low compliance with requirements (see sections 2.6 for analysis and 5.4 for recommendations). Finally, many migrants work in host countries without valid and formal employment contracts, a fact complicating the regularization of their status and, relatedly, their access to social services, including healthcare. Host countries should thus consider reviewing registration procedures with the aim of adapting them to migrants' reality (see section 2.4.2). They should also design policies aimed at ensuring that healthcare workers can assist undocumented patients without fear of prosecution.

However, if registration procedures and other mechanisms of "movement management" should be adapted to migrants' reality with the aim of ensuring their access to healthcare, they also should take into account the legitimate concerns and needs of governments. Indeed, effective tracking mechanisms of both internal and international migrants are important for governments to plan and regulate welfare systems and to protect public health through the monitoring of communicable diseases. Moreover, governments' legitimate security concerns should be taken into consideration when reviewing registration mechanisms. It is thus necessary to find a balance between public health and security concerns on one side, and protection of migrants' rights on the other.

## 5.4 ADDRESSING SPECIFIC VULNERABILITIES

The health consequences of migration are experienced differently by various migrant sub-groups. Inherent characteristics make some individuals more vulnerable than others. Gender, age and legal status are among the most important. As issues surrounding legal status were addressed in the previous section, the following will focus on the particular health challenges faced by migrating women and children.

The sociological research identified specific health challenges faced by female migrants, especially in terms of reproductive health (section 2.5.2). Considering the high vulnerability of this group, governments of host countries should take measures to ensure the provision of reproductive health services for women at the different stages of pregnancy. Neglecting to address the reproductive health needs of migrating women can lead to serious consequences not only to their health, but also to the well-being of their children – and in some cases to their very survival. As we have seen, cases of abortion caused by the impossibility or unwillingness to undergo pregnancy and give birth in host countries are not uncommon.

Research results show that pregnant migrating women, including those with irregular status, were most of time provided with free healthcare services. However, these services were provided out of health workers' "good will" as there are no clearly formulated mechanisms guaranteeing the provision of reproductive health services for migrating women. Host countries should thus take measures to bridge this gap in legislation and practices.

In addition to these needed actions from host countries' side, countries of origin should also be actively involved in measures aimed at reducing risks of negative health outcomes for migrating women. In particular, efforts of government and non-government actors could be articulated around General Recommendation No. 26 on women migrant workers made by the Committee on the Elimination of Discrimination against Women during its 42nd session in 2008, which calls on countries of origin to:

*deliver or facilitate free or affordable gender and rights-based predeparture information and training programmes that raise prospective women migrant workers' awareness of potential exploitation. These should include: rights and entitlements in countries of employment, procedures for invoking formal and informal redress mechanisms; information about safety in transit including airport and airline orientations and information on general and reproductive health, including HIV/AIDS prevention.*

In addition to women's, migrants' children's vulnerabilities are also high. Indeed, the analysis on migrants' children (chapter four) showed that in Kazakhstan – the main studied destination country within this project – there are no clearly formulated procedures regulating the provision of healthcare services for migrants' children. Even though in practice, most doctors provide healthcare to migrants' children, the absence of clear regulations is conducive to many children lacking specialized medical services, especially in the early stages of their development. Host countries should thus develop, disseminate and enforce clear procedures intended for the health workforce related to the provision of health services to migrants' children. In particular, it would be desirable to determine procedures and mechanisms under which children of irregular migrants could receive healthcare services in the absence of a health insurance policy or individual identification number. In parallel, measures should be taken to increase the accessibility and quality of information intended to migrants on children's health issues during migration.

Addressing migrants' children's health issues, however, should not be the sole responsibility of host countries. Indeed, massive labour migration in Central Asia has led to the "children left behind" phenomenon, which negatively affects the health of many children in countries of origin (section 4.8.2). The children left behind phenomenon, unfortunately, was until recently a much neglected topic, and is only beginning to receive the attention it deserves. Paths of action to address the health vulnerabilities of this particularly at-risk group include:

- The creation of a structure of intervention with active involvement of governments, private sector partners, civil society, academia and migrants themselves to identify and provide assistance to children left behind;
- The development of an integrated system of social services provision for vulnerable children in migrant families based on international experience and best practices;
- The strengthening of the system of psychological assistance for children left behind, with the aim of minimizing the negative psychological consequences of parental migration;
- In relation to the previous point, increase the number of skilled professionals providing psychological assistance to migrants' children, and provide training to adapt and enhance their skill sets.

## 5.5 RAISING MIGRANTS' AWARENESS, KNOWLEDGE AND LEGAL LITERACY

The overwhelming amount of data gathered during the sociological research demonstrates that one of the most important factors determining migrants' health status, access to healthcare and general well-being is the "informational capital" they possess upon embarking on the migration journey (sections 2.2.2 and 2.6). Migrants with thorough and accurate information are better equipped to face the many challenges of migration, and its negative health impact is often lesser. Relevant information is particularly related to the legal environment of host countries, legal requirements for migrants (including conditions of stay and registration procedures), labour market and employment formalities, availability and accessibility of healthcare and other social services in host countries, and rights and entitlements of different categories of migrants.

Conversely, uninformed migrants are ill-equipped to navigate the environment of host countries, which can lead to a multitude of negative outcomes on their well-being and health. Indeed, the dearth of knowledge about rights can prevent their bearers to enjoy them fully.

Evidence confirms that in Central Asia, the degree of knowledge regarding the above mentioned elements is low among migrants and generally insufficient to contribute to the realization of their rights. Indeed, interviewed representatives of NGOs, diaspora organizations, consular personnel, as well as migrants themselves, expressed that migrants' knowledge level is generally low despite various initiatives to



disseminate information among them. In particular, many respondents stated that informational material such as leaflets and booklets made available for migrants in airports, train stations and other public places have limited impact on the overall level of migrants' knowledge. Indeed, the opinion was repeatedly expressed that migrants have little time and energy to get acquainted with such material in migration related situations often involving high levels of stress and fatigue (border crossings, long journeys, difficult working conditions, etc.).

Finally, the importance of enhancing migrants' knowledge and awareness about the above mentioned issues is rendered clear from migrants' own words. An interesting method, used within this research, to understand the challenges migrants face is to ask them what advices they would give to future migrants about to undertake the migration journey. One of the most common answers to this question was related to the need to possess thorough and accurate information about required legal procedures for migrants and about regulations and practices in the labour market.

Considering the utmost importance of information in determining the outcomes – including the health outcomes – of the migration experience, there is a dire need to increase migrants' informational capital, both at the pre-departure stage (in countries of origin) and in host countries. There is no easy way to do so, as shown by the frequently expressed opinion that information material has limited impact on migrants' knowledge. However, several paths could be undertaken to tackle this pressing issue:

**1. Support diaspora organizations, ethno-cultural centres and migrants' organizations in host countries.** The crucial role of diaspora and other migrant organizations in outreach and "norms setting" among migrant communities cannot be understated. Indeed, these organizations are often based on vast informal networks in host countries, and administered by community leaders possessing a strong influence on migrant communities. Because of these characteristics, diaspora organizations offer a tremendous potential to raise migrants' level of knowledge and awareness. Establishing formal cooperation between diaspora organizations on one side, and governments and international organizations on the other, is however challenging considering that the formers mostly work on an informal basis. Local NGOs, usually more "rooted" in communities, would probably have more success in realizing the potential of diaspora organizations to raise the level of awareness and knowledge of migrants. Strengthened partnerships between governments, international and local organizations and diaspora organizations should thus be developed to tackle the issue of migrants' awareness.

**2. Strengthen the use social networks.** The sociological component showed that Central Asian migrants increasingly rely on social networks to find the information they consider necessary to the success of their migration journey. NGOs and international organizations are already making use of these channels for informational and outreach purposes. The mobile application developed by IOM, which allows migrants to access a wide range of migration related information, is a good example of such initiatives. Considering the potential of social networks to raise migrants' awareness and knowledge, existing initiatives should be strengthened, and new ones should be developed after careful assessment of the most effective methods.

**3. Support government efforts.** Governments – both in host countries of countries of origin – are the most legitimate actors to disseminate comprehensive, reliable and accurate information about migrants' responsibility in complying with legal requirements in host countries, as well as about the availability of social services. Thus, international organizations and other actors should pursue and extend their support to relevant government institutions with the aim of increasing migrants' knowledge. Ministries of education, health, labour, and social protection and migration agencies should thus coordinate for the development of targeted programmes to increase migrants' awareness and knowledge with support from international organizations and other non-government actors.



## 5.6 STRENGTHENING MIGRANTS' TRUST IN GOVERNMENT INSTITUTIONS

Trust is a fundamental element determining the quality of the relationship between a state and the people located on its territory, be they citizens or not. Indeed, the level of trust determines to a large extent the outcomes of interactions between individuals and government institutions. This dynamic is particularly decisive in migrants' experience in accessing healthcare. As demonstrated in chapter two, many migrants have a relatively low level of trust towards state institutions in host countries, sometimes leading to the fear of interacting with their representatives. This attitude can be due to previous negative experiences with government representatives and/or to certain beliefs and perceptions.

The issue of registration is a case in point demonstrating the importance of trust between migrants and host countries' state institutions. Indeed, it was showed in section 2.4.2 that an important and common factor preventing migrants from complying with registration procedures – and thus to access health-care services – is the reluctance of interacting with government structures. However, this attitude also prevents migrants from fulfilling their legal obligations, as this implies interacting with state bodies, in particular those responsible for migration management. This creates a self-reinforcing cycle of mistrust and non-compliance which hinders migrants' well-being and access to healthcare, and which in addition complicates the work of migration management agencies in host countries.

Hence, carefully designed measures aimed at strengthening trust between migrants and state institutions could significantly contribute to the realization of migrants' right to health. This could be done by different ways, including: 1) conducting training for government representatives interacting on a daily basis with migrants on migrant-sensitive practices; 2) conducting informational campaigns to promote increased trust between migrants and host countries' governments; 3) and, most importantly, by actively involving migrants in the development and implementation of policies directly affecting them (see recommendation 5.12 below).

## 5.7 ENHANCING THE HEALTH WORKFORCE'S MIGRATION HEALTH KNOWLEDGE, SKILLS AND ATTITUDES

Health workers – nurses, doctors, pharmacists and other health professionals – are at the frontline of migration health issues. During the research process leading to this report, researchers witnessed many cases where their professionalism and devotion made a significant difference in migrants' health, well-being and life in general.

Despite the devotion and good will of health workers, many are not properly equipped in terms of knowledge and skills to provide migrant-sensitive healthcare services, both in host countries and countries of origin. Thus, an effective path to further realize migrants' right to health in Central Asia is to provide the health workforce with the appropriate knowledge, skills and tools to deal with migration health issues.

An efficient method to reach this objective is to develop, disseminate and enforce standardized procedures for healthcare workers – nurses, doctors and other specialists – to deliver services to various categories of migrants while taking into account their specific experience, different statuses, and in a culturally sensitive manner. As the sociological component of this assessment showed, in the absence of clear procedures for the provision of healthcare services to migrants, the outcomes of their interactions with host countries' health systems greatly depend on the "human factor" (the attitude and actions of healthcare workers). Introducing and enforcing standardized procedures would thus contribute to reduce the impact of this unpredictable factor on migrants' access to healthcare.

However, such initiatives would have limited effect without the health workforce possessing the appropriate knowledge, skills and competency to put them into practice. It is thus recommended to conduct targeted training for the currently active health workforce, as well as to include a component (course) on migration health in medical curricula for future doctors and nurses. The content and format of training and courses could be inspired from IOM material developed in other contexts, which could be adapted to the Central Asian context with minimum effort and resources. Curricula for training and courses should aim at the acquisition of the following knowledge, skills and competencies by the health workforce in host countries and countries of origin:

- Appropriate intercultural competence, language and communication skills;
- Know-how to manage change, cultural diversity and values;
- Being sufficiently knowledgeable of other cultures and customs to develop professional practice with respect to the autonomy, beliefs and culture of the patient;
- Understand migrants' health determinants and be able to contribute to reduce social and health inequalities;
- Recognize the disease profile of migrants and its epidemiology;
- Manage competently the clinical manifestation of disease in different ethnic and population groups;
- Know the rights of migrants to healthcare services;
- Be able to advise migrants on how to access and what to expect of healthcare services<sup>82</sup>.

These education initiatives directed towards the health workforce should be complemented by trainings on migration health for relevant government representatives. Overall, such initiative would greatly contribute to develop the capacity of healthcare human resources to face migration health challenges.

Finally, it is worth adding that in the Central Asian context, pharmacists have a particularly important role to play in migration health issues considering the frequency with which migrants use self-medication treatment methods. Indeed, because of insufficient financial means to obtain appropriate healthcare services and/or the fear of interacting with the public healthcare system due to irregular status, many migrants turn to self-medication, thus putting pharmacists at the frontline of migrants' health issues. As many migrants tend to rely on pharmacists for medical advice – that in a “normal” context doctors would provide – pharmacists' role and responsibility increase. This is particularly relevant considering the common practice of selling drugs “piece-by-piece” to clients (including migrants) instead of a full treatment (see section 2.4.1). This practice often leads to non-compliance with treatment instruction and contribute to the spread of drug resistant diseases such as multi-drug-resistant tuberculosis. Training programmes aimed at the development of the health workforce's capacity to deal with migration health issues should thus also target pharmacists.

## 5.8 ADDRESSING OCCUPATIONAL HEALTH RISKS

Central Asian migrants spend most of their time at work, the latter being the main reason of their journey. As we have seen, occupational injuries and diseases are among the greatest challenges of migration (section 2.3.3). Such risks are aggravated by the fact that most migrants are employed in low-skilled, physical labour sectors and that many – especially those with irregular status – work in dangerous environments with little protection, whether in the form of training or safety equipment. Considering this situation, targeted measures should be taken to reduce occupational health risks. In doing so, particular attention should be paid to the least regulated sectors of host countries' labour market, and those where occupational health risks are the greatest (such as the construction sector).

82 IOM. 2009. Developing a Public Health Workforce to Address Migrant Health Needs in Europe. Background paper for Assisting Migrants and Communities project.

Employers' involvement is paramount to achieve this goal, as without it and the private sector's participation in general, migration health issues will be difficult to resolve. As demonstrated in chapter two, one of the main mechanisms of migrants' protection is the conclusion of formal and legally valid employment contracts. Indeed, migrants working with such contracts fall under the action of labour legislation, which provides a range of protection mechanisms for workers, be they citizens or migrants. They also guarantee – at least in theory – that migrants will work under safe conditions. However, many migrants cannot enjoy this protection as they do not conclude employment contracts, a situation that can be attributed to the negligence of both employers and migrants themselves. Several possible paths exist to tackle this problem.

Firstly, simplifying registration procedures by adapting them to migrants' reality could greatly contribute to solve the issue of absence of employment contracts in particular, and occupational health risks in general. Indeed, as employers are often reluctant to conclude employment contracts with unregistered migrants, an increased number of registered migrants could contribute to higher rate of employment contracts.

Secondly, the sociological research made clear the fact that a frequent reason for the absence of employment contracts is poor information from migrants' side, as many do not see the necessity of concluding a contract, are not aware of the procedures to do so, or think that it does not bring any benefits. This topic should thus hold a central place in initiatives aiming to raise migrants' awareness and level of knowledge (see recommendation 5.5 above).

Finally, labour inspection mechanisms should be improved and strengthened to allow more effective identification and prosecution of violations from employers' side.

## 5.9 POST-RETURN ASSISTANCE AND MEDICAL EXAMINATIONS

The health consequences of the migration experience are not confined to the period of "active" migration. As demonstrated in chapter two, many health problems acquired by migrants during migration continue to affect their health upon return in the homeland. Moreover, despite a general preference to have their health problems treated in host countries – where the quality of healthcare is perceived as higher – many choose to return home to receive medical care (as they cannot afford it in host countries or because their irregular legal status does not allow them to be treated there). Health problems which are "brought back home" can be all the more serious that many migrants tend to neglect to treat them while in host countries, thus creating an "accumulated negative health capital" whose consequences can often last several years.

Countries of origin thus have an important responsibility and role in mitigating the health impact of migration. Indeed, just as host countries should ensure the realization of the right to health of migrants located in their territory, countries of origin, considering the importance of labour migration for their economic well-being, should pay particular attention to the health status of returning migrants.

In this regard, medical examinations could play an important role. It is thus proposed to create a system of accreditation of medical centres in both countries of origin and destination in order to manage medical examinations for migrants in a reliable and effective manner. This could be done by the development and adoption of a multilateral agreement regulating accreditation of medical clinics, which would enjoy the authority of the healthcare system of other countries participating in the agreement.

Migrants could thus undergo a pre-departure medical examination in an accredited clinic in the country of origin, the results of which would be officially recognized in countries of destination. This would resolve the issue of the lack of trust from authorities and employers of host countries in results of medical examinations conducted in countries of origin. It would also allow migrants to undergo medical examination in a familiar environment and at a lesser cost than in countries of destination, as well as prevent

“duplication” (undergoing a second examination in the host country).

Within this system, accredited clinics could also conduct medical examination on a systematic basis for returning migrants, which would allow to identify health problems and develop targeted intervention plans. Such a system could greatly contribute to the identification and prevention of communicable diseases related to migration, such as tuberculosis and HIV. Finally, this system would represent an invaluable opportunity to identify migrants’ vulnerabilities at the pre- and post-migration stages, as well as for the overall monitoring of migrants’ health and the collection of data.

## 5.10 MIGRATION OF HEALTHCARE WORKERS

In chapter three were presented the results of a research investigating migratory behaviours of healthcare workers, an understudied topic deserving more attention from government and non-government stakeholders. Healthcare workers’ migratory behaviour is impacting – and will impact in the future – the overall structure of healthcare systems in Central Asia, both in sending and receiving countries. Devoting attention to the issue is thus necessary to prevent a personnel crisis in the healthcare sector, which would affect not only health outcomes for migrants, but for the entire population. Considering the above, the following measures are proposed:

1. The first obstacle standing in the way of managing the impact of healthcare workers’ migration on the health system is to further our understanding of the issue through the enhancement of data collection and management systems. Indeed, the lack of comprehensive statistical information on migration processes – and the unavailability of data on migrants’ professional status in particular – stresses the need for improvement and automation of the migration data processing system and reduction of paper-based records (for example, introduction of an electronic migration card). It is also recommended to create a single register at the national level to record the actual population residing in the country (citizens and migrants). This register should contain data on the person’s status (citizen or non-citizen), and for migrants information on their employment status and field of activity. For more efficiency and to bolster regional cooperation, the development and implementation of a single statistical methodology to record migratory movements using unified categories could be extended to all Central Asian countries. It is also recommended to collect data on the professional status of external and internal migrants and include this information in national statistical reports on countries’ demographic situation.
2. To attract health workers to rural areas and small towns in Kazakhstan and Kyrgyzstan, it is necessary to design and implement targeted programmes aimed at healthcare sector development in rural areas and the creation of favourable conditions for medical personnel moving to rural areas for employment purposes on a long-term basis. Such programmes should include clearly defined and guaranteed conditions and incentives, such as:
  - Provision of housing which can be privatized after five years of service;
  - Introduction of increasing coefficients and wage supplements linked to work experience in rural areas;
  - Guaranteed training opportunities in national and/or foreign medical educational centres (at least once a year after two years of work in rural areas);
  - Guaranteed social and medical insurance including application of the multiplying index to the joint pension component;
  - Establishment of scholarships for children of health workers for studies in higher education institutions.
3. Upon assessment and revision of migration related legislation, emphasis should be put on the simplification of registration procedures for migrating health workers. This would create incen-

tives for health workers to settle in needed areas, while ensuring full compliance with departmental regulatory documents.

4. When setting quotas for foreign workforce, governments should include medical workers in a separate category, without merging them with other professional groups.
5. Procedures for granting citizenship and residence permits to health workers moving to Kazakhstan and Kyrgyzstan for permanent residence should be simplified. For example, Kazakhstan has developed the list of priority professionals in these areas who are entitled to acquire the citizenship through simplified procedure. This list has not been updated since 2006 and establishes rather high criteria for specialists. Simplification of citizenship granting procedures could entail, for instance, the reduction of the term of permanent residence requirement to one year. At the same time, more serious restrictions for admission to citizenship of Kazakhstan (such as the requirement to relinquish citizenship of the country of origin) should be re-examined through the prism of their impact on health workers mobility.
6. Recognizing the right of each state to protect its citizens against incompetent health professionals, it is recommended to develop a transparent and “intuitively understandable” mechanism for confirmation of qualifications and education by health workers who have obtained their qualifications and education in foreign educational institutions.
7. Relatedly, it would be beneficial to institutionalize processes of validation of foreign medical qualifications and education. Currently, validation of foreign diplomas entails complex procedures for migrating health workers, alongside creating risks of corruption. For instance, transferring the responsibility to validate professional qualifications and level of education to medical institutions who are inviting foreign migrant workers could significantly improve the efficiency of these procedures.

## 5.11 DATA COLLECTION AND MANAGEMENT

Comprehensive and reliable data related to all relevant aspects of migration processes are essential to their management. Relatedly, the realization of migrants’ right to health is not possible without effective data collection and management systems. Interventions aiming to enhance the general health status of migrants require appropriate data and information. However, disaggregated data on this topic are not always available, a problem further complicated by the irregular status of many migrants, which are not included in statistics. Thus, in order for government and non-government actors to design evidence-based policies supported by comprehensive and reliable data, it is recommended to:

- Strengthen existing data collection and management mechanisms in countries of origin and destination and reinforce interdepartmental and inter-sectorial cooperation in this field;
- Promote the creation of a regional online platform on migration data and management which would involve representatives of civil society, governments and international organizations. This platform should be articulated around a unified methodology for statistical recording of migration movements, which should be developed jointly by government and non-government actors. This database should collect information on migrants according to WHO criteria, with clearly determined health indicators.

## 5.12 INVOLVING MIGRANTS AND HOST COMMUNITIES

National health systems are usually designed to meet the needs of the country’s majority population: its citizens. If this tendency is comprehensible, it also entails risks of neglecting the needs of marginalized groups, including migrants. Addressing the specific vulnerabilities of these groups is, however, not an

easy task. One of the greatest challenges faced by host countries' governments is the difficulty to comprehend migrants' health needs and design appropriate measures to meet them.

An effective way to overcome this obstacle is to involve migrants themselves, as well as host communities, in the process of designing and implementing migration health policies. The underlying rationale is simple: migrants know better than anyone else about their needs and the measures that could be taken to minimize the negative health consequences of migration. Moreover, representatives of host communities – among which employers stand in the frontline – are also primary witnesses and actors of migrants' experience. Thus, establishing a formal, constructive and participative dialogue between governments, migrants and host community representatives could contribute not only to design migration health policies better adapted to migrants' concrete reality, but also to lessen the social and political tensions often surrounding migration health issues, which in some contexts can be particularly sensitive. Ultimately, such participative mechanisms would contribute to the establishment of participative health-care systems and to the realization of migrants' right to health.

Participative processes could take the form of ad-hoc and/or periodic consultations and should involve, in addition to migrants and relevant governments agencies, non-government organizations with a mandate related to migration health, diaspora organizations, ethno-cultural centres and international organizations. These consultations would allow to reach a mutual understanding of the various actors' points of views and concerns related to migrants' health, and to discuss how health sector reforms could tackle health inequities while addressing social determinants of health in a multi-sectoral perspective.



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