BELARUSIAN HELSINKI COMMITTEE

BELARUSIAN MEDICAL SOLIDARITY FOUNDATION

THE RIGHT TO HEALTH

International Standards and the Belarusian Reality

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CONTENTS

INTRODUCTION

This report is devoted to the right to health and aims to promote a human rights–based approach to healthcare in Belarus. It was prepared jointly by the Belarusian Helsinki Committee and the Belarusian Medical Solidarity Foundation, which made it possible to develop a unified analytical framework in which international and national standards relating to the right to health are assessed through the lens of clinical expertise.

The research methodology includes desk-based analysis of the national regulatory framework, statistical data, and other publicly available sources, as well as relevant international instruments. For the first time, all recommendations of international mechanisms concerning the implementation of the right to health in the Republic of Belarus have been collected, analysed, and systematised within a single corpus. These include the legal positions and recommendations of the Human Rights Committee (HRC), the Committee on the Rights of Persons with Disabilities (CRPD), the Committee on the Rights of the Child (CRC), the Committee on the Elimination of Discrimination against Women (CEDAW), and the Committee on the Elimination of Racial Discrimination (CERD), as well as recommendations issued under the Universal Periodic Review (UPR), the Voluntary National Review of the Sustainable Development Goals (VNR), and the special procedures of the UN Human Rights Council.

In addition, a small-scale sociological survey was conducted. The survey does not claim to be nationally representative and, regrettably, coincided with the sentencing in a criminal case concerning sociological research, including research related to healthcare. This context further discouraged potential respondents from participation. Nevertheless, the responses obtained make it possible to gain a better understanding of people's behavioural attitudes and their perceptions of the right to health.

The authors would like to express their gratitude to the participants of the Belarusian Helsinki Committee's internship programme for their contribution to the initial data collection.

The report was prepared on the basis of legal sources and publicly available statistical data as of 5 December 2025.

I. THE CONCEPTUAL FRAMEWORK OF THE RIGHT TO HEALTH

International human rights standards proceed from the definition of the right to health as set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights, namely **«the right of everyone to the enjoyment of the highest attainable standard of physical and mental health»**. It is this international understanding of the right to health that forms the basis of the present report.

The substantive content of this right is elaborated in greater detail in General Comment No. 14 (2000). In this document, the Committee on Economic, Social and Cultural Rights emphasises that «the highest attainable standard of physical and mental health» is not confined to a «right to healthcare», but encompasses «a wide range of socio-economic factors that promote conditions in which people can lead a healthy life», and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment (para. 4).

The Committee further clarifies the content of the right to health (para. 8), noting that it includes both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, as well as the right to be free from interference, such as the right to be free from torture and from non-consensual medical or scientific experimentation. The entitlements derived from the right to health include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health. The fullest realisation of the right to health is possible only where the requirements of (1) availability, (2) accessibility, (3) acceptability, and (4) quality are met in respect of all aspects of this right. Their content is examined in greater detail below.

In Belarus, the right to «health protection», reflecting Soviet-era terminology, was constitutionally enshrined in Article 45 of the 1994 Constitution.[1] Subsequent amendments to the constitutional text have also affected this right. The formally operative version of the 2022 Constitution replaces, in Article 45,[2] the wording

[1] *The English version of Article 45 available at the referenced source does not reflect the aspect of «health protection» present in the Russian-language text. A more accurate translation of this provision of the 1994 Constitution would be: «Citizens of the Republic of Belarus shall be guaranteed the right to health protection, including free medical treatment in state healthcare institutions...»*

[2] *Citizens of the Republic of Belarus shall be guaranteed the right to health protection, including **free medical treatment at the expense of public funds, in accordance with the procedure established by law. Citizens shall take care of the preservation of their own health. The State shall create conditions for medical care that is accessible to all citizens**. The right of citizens of the Republic of Belarus to health protection shall also be ensured through the development of physical culture and sport, measures aimed at improving the environment, the opportunity to make use of health-improving facilities, and the enhancement of occupational health and safety.*

«free medical treatment in state healthcare institutions» with «free treatment **at the expense of state funds, in accordance with the procedure established by law»**. Moreover, the provision intended to guarantee a right of citizens has been supplemented by what is, in effect, an obligation: **«Citizens shall take care of the preservation of their own health.»**

That this formulation constitutes not a recognition of an individual entitlement, but rather an attempt to impose a constitutional duty on individuals, is confirmed by Constitutional Court judge A. Bodak. In her 2023 academic article on the content of the right to health protection, she argues for the need to establish «a clear and precise constitutional mechanism defining the required measure of individual conduct in the form of care for one's own health». One of the mechanisms for implementing such a duty on the part of citizens is likely to be «health preservation», a term introduced as a priority area in the state programme «Public Health and Demographic Security» for 2021-2025.

The revised version of the constitutional provision further specifies the State's positive obligations by stipulating that **«the State shall create conditions for medical care that is accessible to all citizens»**. While, on the one hand, this wording is consistent with international standards, which recognise accessibility as one of the core elements of the right to health, when viewed against the previous scope of the «right to health protection» it may be interpreted as an effective limitation of the right to «free» medical treatment set out in the first paragraph of the article, since it is evident that «accessible» is not synonymous with «free».

Further specification of the constitutional provision on the right to health is provided in the Law on Healthcare. Article 4 of that Law clarifies the meaning of «accessible medical care»,[3] one component of which is «free medical assistance». In turn, the latter is limited to the **«state minimum social standards in the field of healthcare»** (see the Law on State Minimum Social Standards, in force since 1999; the current list of basic free medical services for the provision of primary, specialised, high-technology, and palliative medical care was approved by a Regulation of the Council of Ministers in 2016).

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[3] *Citizens of the Republic of Belarus shall have the right to accessible medical care, which shall be ensured through:*
- *the provision of free medical assistance in state healthcare institutions on the basis of state minimum social standards in the field of healthcare;*
- *the provision of medical care in state healthcare organisations, non-state healthcare organisations, and by individual entrepreneurs carrying out medical activities in accordance with the procedure established by law, at the expense of individuals' own funds, the funds of legal entities, and other sources not prohibited by law;*
- *the availability of medicines;*
- *the implementation of measures aimed at ensuring the sanitary and epidemiological well-being of the population;*
- *the conduct of medical examinations.*

The draft Healthcare Code, which is currently at the final stages of revision,[4] introduces an additional element of the right to health, namely the **«quality»** of medical care. The content of the right to medical care, transferred to Article 4 of the draft Code[5] from Article 4 of the Law on Healthcare, is reproduced almost in its entirety, but is now formulated as the right to «accessible and **quality** medical care». The draft Code also provides a more detailed — arguably excessively detailed, as any institutional reorganisation would necessitate amendments to the Code — enumeration of state healthcare institutions and organisations in which free medical assistance may be obtained.

Among the definitions set out in Article 1 of the draft Code is that of «quality of medical care», defined as «the aggregate of characteristics of medical care reflecting its ability to meet the patient's needs, the timeliness of the provision of medical care, the degree of its compliance with clinical protocols and other regulatory legal acts in the field of healthcare, as well as the extent to which the planned outcome of medical care is achieved».

Thus, the «right to free medical treatment in state healthcare institutions», originally guaranteed by the Constitution as a key component of the right to health protection, has been transformed into a constitutional «right to free medical treatment at the expense of public funds in accordance with the procedure established by law» and, through legislation (and prospectively through the Healthcare Code), has been effectively reduced to a right to assistance «on the basis of state minimum social standards».

The evolution of the constitutional provision guaranteeing the right to health protection suggests a link between the transformation of the State's obligations and the gradual development of the non-state healthcare sector. The original 1994 Constitution enshrined a guarantee of free medical care specifically in state

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[4] *For an analysis of the draft Code and an assessment of the systemic deficit of public participation in the development of such a significant sector-specific instrument, which codifies a substantial body of legislation, see the project of the human rights organisation Doctors for Truth and Justice and the White Coats initiative.*

[5] *Citizens of the Republic of Belarus shall have the right to accessible and **quality medical care**, which shall be ensured through:*

- *the provision of free medical assistance at the expense of public funds, on the basis of state minimum social standards in the field of healthcare, in state healthcare organisations, university clinics, state social care institutions, and medical units of military formations and paramilitary organisations;*
- *the provision of medical care in state healthcare organisations, university clinics, non-state healthcare organisations, and by individual entrepreneurs carrying out medical activities in accordance with the procedure established by law, at the expense of individuals' own funds, the funds of legal entities, and other sources not prohibited by legislative acts;*
- *the availability of medicines;*
- *the implementation of measures aimed at ensuring the sanitary and epidemiological well-being of the population;*
- *the conduct of medical examinations.*

healthcare institutions, which corresponded to the nature of the system at the time: it was almost entirely state-run, reproducing the model inherited from the Soviet period. As the non-state segment of healthcare has expanded, one might speak of a gradual transition towards a different public health system in which the role of the State is transformed. This is not merely a technical adjustment of constitutional wording, but potentially a significant change in the model for the implementation of the right to health, involving a redistribution of the State's functions, duties, and responsibilities.

However, this transformation was not the subject of meaningful public debate at the time of the adoption of the 2022 constitutional revision. The absence of open and safe channels for the expression of professional and public views — particularly in the aftermath of the 2020 political crisis — has resulted in a significant legal transformation taking place without adequate stakeholder involvement. Similarly, the discussion of the draft Healthcare Code is currently being conducted within a very limited timeframe and largely in a closed format, which restricts opportunities for expert debate and public oversight.

It appears that the State lacks a strategic understanding of how medical care should be provided under the updated constitutional model — in particular, how the State's obligations to ensure free medical care in state healthcare institutions and overall accessibility are to be implemented in practice: whether through expanded reliance on non-state healthcare organisations supported by financial instruments, through the preservation of a predominantly state-based healthcare system, or through other mechanisms. Such changes require broad public and professional assessment. Otherwise, there is a growing risk that a new model for the implementation of the right to health will emerge without sufficient transparency, without analysis of its social consequences, and without due regard to the diversity of interests of patients, healthcare professionals, and other actors within the healthcare system

II. THE NORMATIVE FRAMEWORK OF THE RIGHT TO HEALTH

Constitutional provisions form the normative foundation of human rights, including the «right to health protection», and establish general guarantees of equality. More detailed regulation of the constitutional right to health protection is provided in the Law on Healthcare, which establishes the legal mechanisms for the provision of medical care, as well as in a number of other sector-specific laws. At present, the sectoral legislation is undergoing a process of codification into a single Healthcare Code.

The domestic legislation of Belarus is required to comply with international standards. Belarus is a party to the core universal human rights treaties, including the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, and the Convention on the Rights of Persons with Disabilities, and is also a Member State of the World Health Organization. Belarus has committed itself to the achievement of the Sustainable Development Goals, in particular SDG 3, «Ensure healthy lives and promote well-being for all at all ages».

Strategic directions for the development of the social sphere are set out in the National Sustainable Development Strategy of the Republic of Belarus until 2035. Paragraph 4.3 of the Strategy defines as a strategic objective «an increase in healthy and active life expectancy of the population and the provision of comprehensive coverage of all citizens, regardless of their place of residence, with quality medical care». Among the key objectives identified are strengthening the preventive orientation of medical care, ensuring full access to quality medical services through the optimisation of healthcare organisations, and, notably, «voluntary insurance», which is mentioned twice in consecutive paragraphs.

In addition to the National Strategy, sectoral programmes and regional planning documents are in force, defining priorities in the field of healthcare over the medium term. The principal policy document in the healthcare sector is the State Programme «Public Health and Demographic Security» for 2021-2025, approved by Regulation No. 28 of the Council of Ministers of the Republic of Belarus of 19 January 2021. The Programme is presented as comprehensive and intersectoral. The following priority areas are identified:

- the development of measures to strengthen reproductive health and to promote a culture of healthy lifestyles and health preservation;
- the improvement of the system of support for families with children, the enhancement of their living conditions, and the strengthening of the institution of the family;
- the development of outpatient and polyclinic services;
- the transition from line-item budgeting of healthcare organisations to a financing system based on achieved results;
- the introduction of a national system of medical accreditation for healthcare organisations;
- the development of regional healthcare, including interregional and interdistrict centres.

In assessing the outcomes of the previous State Programme for 2016-2020, the new Programme asserts that by 2020 the declared targets had been achieved in the areas of maternal and child health protection, family support, stabilisation of mortality rates, and improvements in certain population health indicators. It further claims «progress in fostering self-preservation behaviour and in reducing negative factors, including the prevalence of binge drinking [as phrased in the document], alcoholism, HIV infection, and tuberculosis».

The conclusion of the previous State Programme and the launch of the current healthcare programme coincided – conveniently for the authorities – with the period of the COVID-19 pandemic. As a result, reporting on the successful implementation of the previous programme was based on data that did not include the pandemic period («achieved by 2020»). A proper assessment of the state of the healthcare system in the post-pandemic period is further complicated by significant distortion and concealment of official data.

III. THE HEALTHCARE SYSTEM IN BELARUS TODAY

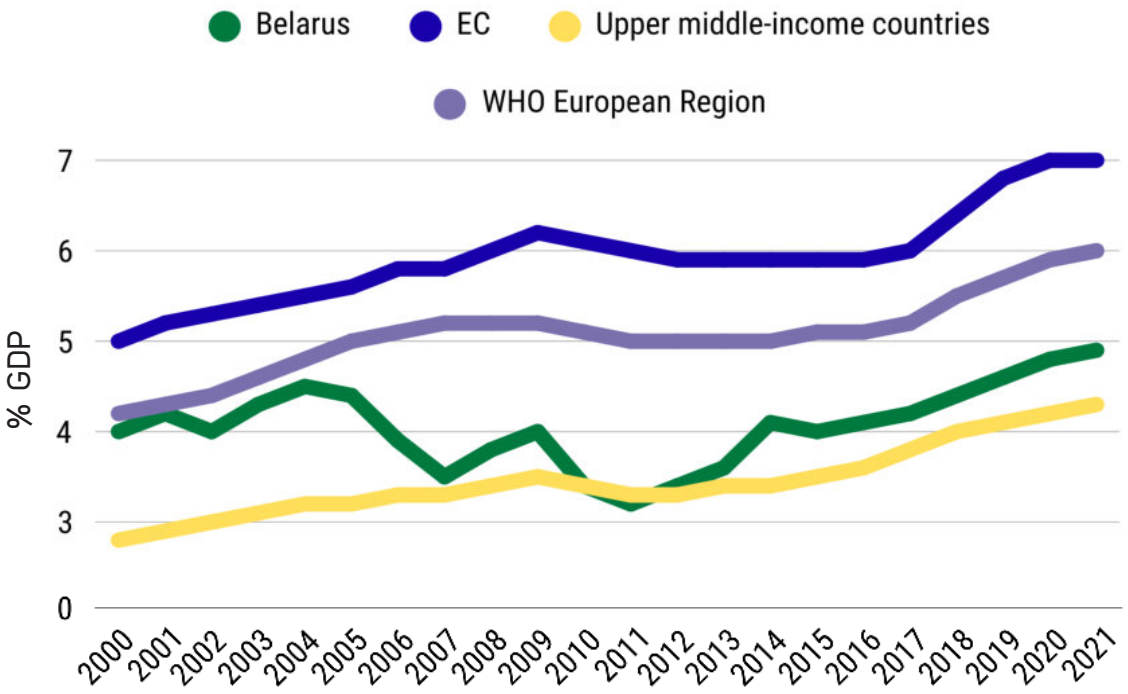
The healthcare system in Belarus is centralised. The Ministry of Health formulates policy and sets priorities, which are implemented at lower administrative levels (regional and district). Core medical services — including primary, specialised, high-technology, and palliative medical care, as well as medical and social assistance — are financed from the state budget and provided free of charge in state medical institutions, in accordance with the List of Basic Free Medical Services approved by a Regulation of the Council of Ministers in 2016.

According to WHO data, in 2021 approximately three-quarters of total health expenditure in Belarus was publicly funded, which corresponds to the level observed in upper-middle-income countries. At the same time, the share of household health expenditure has fluctuated. WHO data indicate that in the 2000s and 2010s the share of out-of-pocket payments in current health expenditure increased, reaching a peak of 36.2% in 2015. In 2016, this share fell sharply to 26.7% and has continued to decline since then, a trend that is likely linked to reduced use of private medical services during the COVID-19 pandemic. In 2021, out-of-pocket expenditure reached a minimum of 21.9%.

Current WHO recommendations do not establish a specific threshold for out-of-pocket health expenditure, but call for its minimisation through strengthened public financing and for its complete elimination for poor and vulnerable groups. A 2025 WHO–World Bank report on the state of universal health coverage notes that in more than one third of developed countries, out-of-pocket payments exceed 20% of total health expenditure, a level considered to be problematic and in need of policy response. As of 2021, Belarus, with an out-of-pocket share of 22%, exceeds this benchmark while having significantly lower overall health expenditure, creating a double barrier to access to medical care

According to WHO analysis, the structure of health expenditure in Belarus remains oriented towards inpatient care, despite efforts to strengthen primary healthcare, reduce the number of hospitals, and expand the outpatient network. At the same time, Belarus continues to record one of the highest levels of hospital capacity and bed availability in the WHO European Region. While this indicator may appear significant, it does not allow for an assessment of the effectiveness of healthcare delivery, since «beds» may be located in facilities lacking modern medical equipment

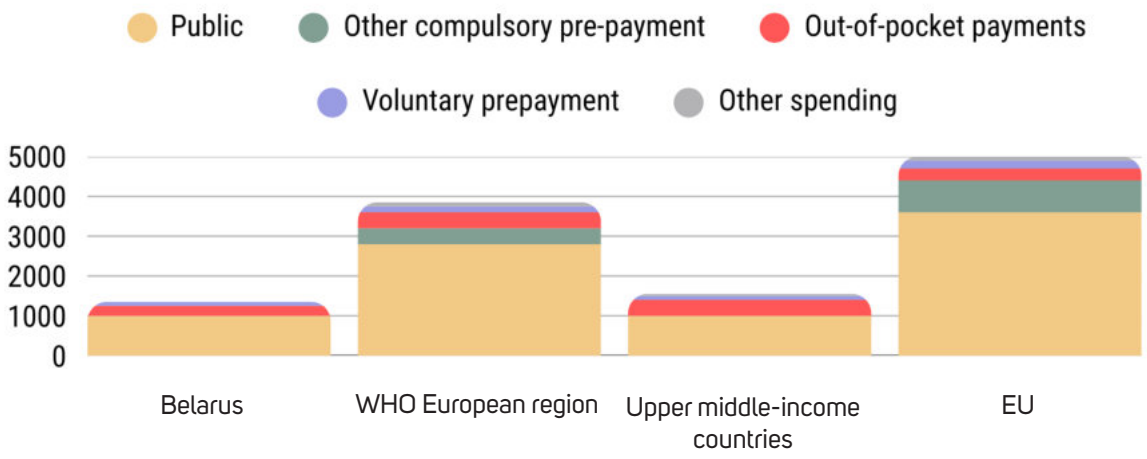
Public spending on health as a share of GDP (%)



WHO, Health Systems in Action Insights: Belarus, 2024

Health Expenditure per Capita, US$ PPP

Data refer to 2021



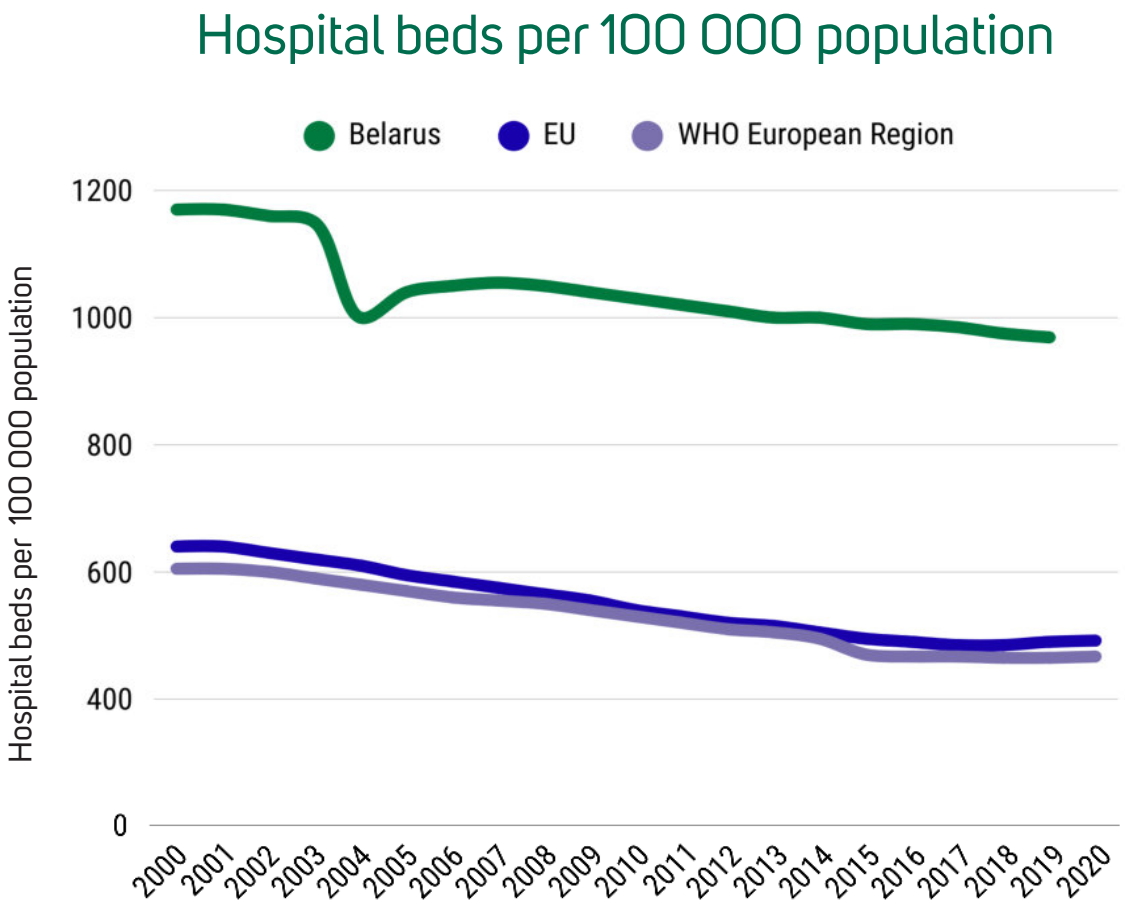
WHO, Health Systems in Action Insights: Belarus, 2024

Public refers to transfers from government budgets and social health insurance contributions. Other compulsory prepayment refers to premiums for mandatory health insurance schemes in Belgium, Finland, France, Germany, the Netherlands and Switzerland. Other refers to external funding and other marginal sources of funding

and therefore may not translate into improved access to or quality of medical care. In some cases, such inefficient bed capacity functions rather as a form of social burden on the healthcare system, providing heating, food, and accommodation for vulnerable individuals.

Belarus is also characterised by a paradoxically high density of physicians and nurses while simultaneously experiencing staffing shortages, particularly in rural areas, despite a growing number of places in medical universities and an increasing number of graduates. Explanations for this paradox include structural features of labour relations in the healthcare sector, notably systemic reliance on medical professionals working multiple posts, mandatory post-graduation placement, and targeted employment contracts.

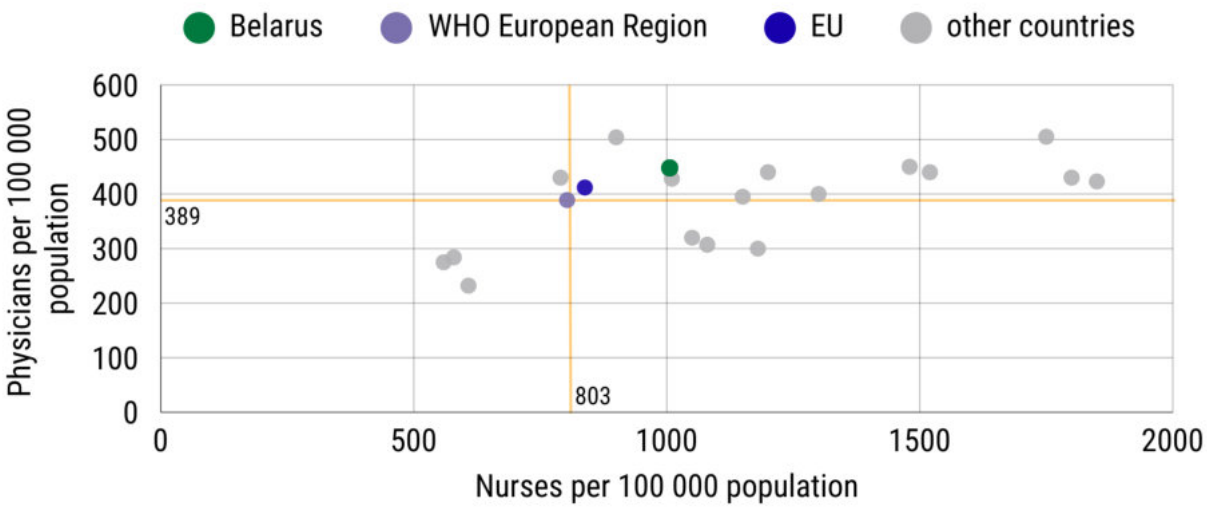
Key medico-demographic trends observed in the pre-COVID period include an increase in average life expectancy, a pronounced gender gap, and the dominance of non-communicable diseases, which account for more than 80% of all deaths, including a high level of premature mortality among men.



WHO, Health Systems in Action Insights: Belarus, 2024

Physicians and Nurses per 100 000 Population

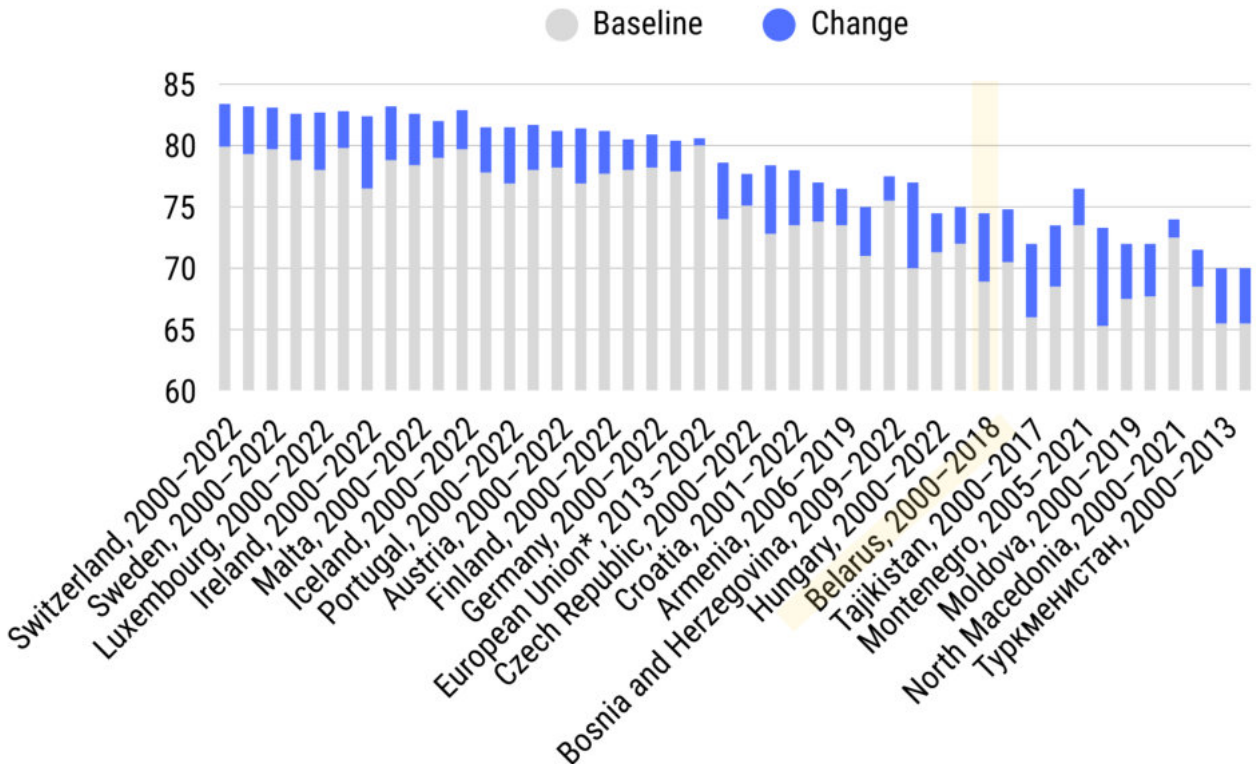
Data refer to 2020



WHO, Health Systems in Action Insights: Belarus, 2024

Note: The original WHO figure displays a larger set of countries

Life expectancy at birth (years)

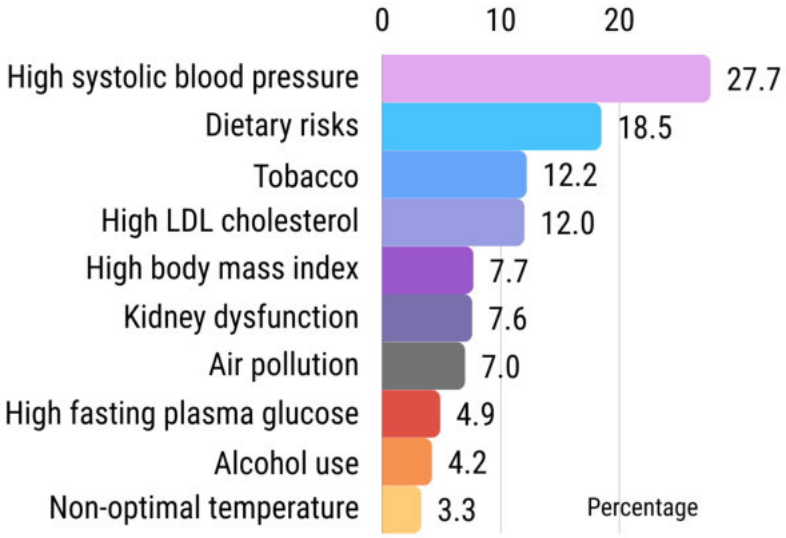


WHO, Health Systems in Action Insights: Belarus, 2024

Sources: Eurostat, 2024, WHO Regional Office for Europe, 2024.
*Notes: *averages are based on years with data available.*

Top 10 risk factors as a share of all deaths

Data refer to 2021



WHO, Health Systems in Action Insights: Belarus, 2024

Note: Percentage of all deaths attributable to risk factors for both sexes and all ages. Shares overlap and therefore add up to more thar 100%

According to WHO assessments, the healthcare system in Belarus faces significant behavioural risk factors that require strengthened prevention efforts, while at the same time demonstrating high immunisation coverage and the existence of vertical national programmes for tuberculosis and HIV. These objectives are likewise reflected in the National Strategy and the State Healthcare Programme, which emphasise strengthening the preventive orientation of medical care and enhancing efforts to establish an effective system for the prevention of socially significant diseases, including coverage of all citizens through preventive medical examinations.

IV. THE RIGHT TO HEALTH FACILITIES, GOODS AND SERVICES

In General Comment No. 14, the Committee on Economic, Social and Cultural Rights sets out the key interrelated elements of the implementation of the right to health that are relevant to all its aspects and at all levels:

- *the availability* of a sufficient quantity of functioning health facilities, goods, and services,[6] as well as relevant programmes*;*
- their physical, economic, and informational *accessibility* without discrimination;
- *acceptability* (compliance with the principles of medical ethics and cultural appropriateness);
- *quality* (scientific and medical appropriateness).

The application of these criteria must take into account the socio-economic conditions of a given society, as well as factors that may hinder the realisation of the right and that lie beyond the State's control.[7]

This section assesses the implementation of the right to health in Belarus through the prism of the above criteria, on the basis of recommendations issued by international mechanisms, official data, and assessments by national experts.

4.1. Availability of healthcare facilities, goods, and services

In describing the baseline situation regarding the implementation of the right to health in 2019, experts of the Belarus Human Rights Index (the Index) noted a «sufficient quantity of functioning healthcare facilities, goods, and services». Since 2019, the assessment of this criterion has steadily declined and, by 2024, had decreased by half.[8] Among the key factors identified are the healthcare system's response to the COVID-19 pandemic, as well as the large-scale repression that followed the 2020 elections and affected, inter alia, the healthcare sector.[9]

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6 *«They include, inter alia, safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs»: https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/GC14.pdf*

7 *Ibid, para. 12*

8 *[Decreased] from 7 to 3.5 points; see the «General principles» component in the assessment of the implementation of the right to health: https://index.belhelcom.org/en/*

9 *Right to Health 2023, Right to Health 2021*

At the same time, national experts emphasise the uneven nature of this trend: in some areas, the State has managed to maintain an adequate level of provision of healthcare goods and services, while in others the situation has deteriorated.

Availability of healthcare facilities

Between 2021 and 2024, experts of the Index consistently recorded a deterioration in the availability of functioning healthcare facilities for the population, drawing particular attention to, inter alia, the revocation of licences from private medical centres as a result of repressive measures,[10] as well as the widespread closure of healthcare facilities in small towns and rural communities.[11]

At the same time, experts underline that a formally high level of hospital bed capacity does not compensate for the shortage of modern, functional equipment and qualified personnel. This limits the ability of healthcare facilities not only to accommodate patients physically, but also to carry out the necessary diagnostic and therapeutic interventions within clinically appropriate timeframes.

Recommendations of international mechanisms likewise draw attention to the insufficient responsiveness of the healthcare system to the needs of vulnerable groups. In particular, repeated reference has been made to the shortage of crisis rooms and shelters for victims of domestic and gender-based violence,[12] as well as temporary shelters for victims of trafficking in human beings.[13] National experts have also noted, among other issues, the lack of a sufficient number of inpatient rehabilitation units for working with people with a history of dependency.

Availability of trained medical and professional personnel receiving domestically competitive remuneration

Restrictions on access to statistical data and on the conduct of independent research complicate the assessment of the staffing situation; nevertheless, the available evidence points to its steady deterioration. Independent studies indicate that official estimates of the number of practising physicians are overstated. According

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10 *Right to Health 2023*

11 *Right to Health 2021*, *Right to Health 2022*, *Right to Health 2023*. *By way of illustration of this problem, reference may be made to the «reorganisation» of the district hospital in the agrotown of Svetilovichi. In 2025, the inter-district early medical rehabilitation unit (20 beds), which had operated on the hospital's premises for many years, was transferred to the district hospital located approximately 30 km from the agrotown. Despite a formal increase in bed capacity at the new location, for residents of Svetilovichi and surrounding localities this effectively entails the loss of local access to inpatient rehabilitation care, as only outpatient services, nursing care, and an emergency medical post remain in place: https://news.zerkalo.io/life/113726.html, https://flagshtok.info/ru/naviny/oprovergaja-fejk-propagandisty-podtverdili-problemu-izvestnoj-bolnicy-v-gomelskoj-oblasti.html*

12 *CEDAW/C/BLR/CO/7 (2011), para. 20(f); CEDAW/C/BLR/CO/8 (2016), paras. 22(f), 23(c); CEDAW/C/BLR/CO/9 (2025), paras. 11-12; A/HRC/WG.6/50/BLR/2 (2025), para. 39.*

13 *CEDAW/C/BLR/CO/7 (2011), para. 22 (c-e); CERD/C/BLR/CO/18-19 (2013), para. 17*

to calculations by the Belarusian Medical Solidarity Foundation, the actual loss of mid-level medical personnel over recent decades amounts to approximately 40,000 specialists, pointing to the systemic nature of the problem.

Official statistics[14] do not reflect the mass outflow of specialists, which accelerated as a result of the State's post-2020 repressive policies. Experts of the Index have consistently recorded a qualitative deterioration in the availability of medical professionals to the population. At the same time, the measures adopted by the State fail to address the root causes of the staffing deficit, which are linked to harsh working conditions for healthcare professionals, non-competitive remuneration, a reliance on coercive approaches in policies aimed at retaining personnel in the country, and the persecution of dissent, which, inter alia, results in restrictions on the labour rights of medical workers.[15]

National experts also note a formalistic approach to staffing adequacy, which leads to the deployment of insufficiently qualified specialists at the local level; in rural regions, cases have been documented in which specialists with the required qualifications are entirely absent.[16]

International mechanisms have drawn attention to the shortage of qualified personnel capable of working with vulnerable groups, including children,[17] persons with disabilities,[18] victims of gender-based violence,[19] and women in detention,[20] as well as to the persistent lack of qualified and impartial medical staff in places of detention. The latter concern has been raised by various mechanisms across multiple reporting cycles.[21]

Availability of healthcare infrastructure, medicines and equipment

For several years, national experts have consistently documented deficiencies in the physical infrastructure and medical equipment of the healthcare system, including the use of outdated equipment — particularly in healthcare facilities in rural areas — and a tendency to economise on the maintenance of medical equipment.[22]

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14 *See Section 6.1, «Key health indicators», in the official statistical publication of the National Statistical Committee of the Republic of Belarus: https://www.belstat.gov.by/upload/iblock/3f3/5xvzuaapkxahc813whcc53fniit7yeuz.pdf*

15 *The Belarusian Medical Solidarity Foundation is aware of at least 299 healthcare workers who were subjected to politically motivated repression between 2020 and the end of 2024; among them are highly demanded specialised medical professionals: https://www.belhalat.news/articles/itogi-2024-go-chast-chetvertaya; for information on politically motivated dismissals, the creation of obstacles to subsequent employment, mass arrests of medical professionals, and the resulting staffing shortages, see Right to Health 2020-2024: https://index.belhelcom.org/en/*

16 *Right to Health 2023, Right to Health 2024*

17 *CRC/C/BLR/CO/3-4 (2011), n. 21; КПР/C/BLR/CO/5-6 (2020) nn. 32, 34(d), 39(f)*

18 *CRPD/C/BLR/CO/1 (2024), n. 49*

19 *A/59/38 (2004), n. 348*

20 *CEDAW/C/49/D/23/2009 (2011), n. 7.9(2)(e); CEDAW/C/BLR/CO/9 (2025), nn. 53-54*

21 *A/HRC/15/16 (2010), para. 138.228; paras. 62, 88; CEDAW/C/49/D/23/2009 (2011), para. 7.9(2)(e); A/HRC/44/55 (2020); CEDAW/C/BLR/CO/9 (2025), paras. 53-54.*

22 *Right to Health 2019, Right to Health 2021*

Limited availability of a number of medicines has also been noted.[23] The policy of «import substitution» has resulted in a predominant reliance on domestically produced alternatives, the quality and registration of which are overseen by the Ministry of Health, which is simultaneously responsible for their promotion. Certain international assessments indicate[24] a medium-to-high level of population coverage with essential medicines. At the same time, national experts have identified, among other issues, problems with access to foreign chemotherapy medicines,[25] shortages of drugs used for immunotherapy and cancer treatment,[26] and the lack of access to foreign COVID-19 vaccines (with the exception of Russian and Chinese vaccines).[27]

At the same time, cases have been reported in which patients lack access to modern, high-cost therapies. In particular, patients with rare diseases, such as children with spinal muscular atrophy and patients with cystic fibrosis, do not receive the necessary high-cost medicines funded by the state. The absence of a well-developed system of comprehensive early intervention, as well as the lack of modern diagnostic and corrective methods and tools for certain childhood conditions, forces parents to take their children abroad in order to obtain medicines, vaccines, and treatment that are unavailable in Belarus.[28]

International mechanisms have drawn attention to the need to ensure a sufficient number of inpatient and mobile units, as well as qualified specialists, to enable universal access to mammography; to ensure the provision of qualified psychological support, rehabilitation, and reconstructive surgery for women with breast cancer[29]; as well as to guarantee the timely diagnosis, treatment, and patient support for multidrug-resistant tuberculosis in line with WHO recommendations.[30]

4.2. Physical, economic, and informational accessibility

Accessibility of healthcare facilities, goods, and services without discrimination

International mechanisms have consistently emphasised the need to ensure equal access to healthcare facilities, goods, and services, which includes, inter alia,

[23] *In assessing this parameter, it is important to bear in mind that data on actual access to medicines remain fragmented.*
[24] *See the study on the availability of chemotherapy medicines: https://dam.esmo.org/image/upload/ESMO23-Insights-in-essential-medicine-availability-and-accessibility-Nathan-Cherny.pdf; see also the study on the availability of cancer medicines: https://pmc.ncbi.nlm.nih.gov/articles/PMC11656608/pdf/12885_2024_Article_13247.pdf*
[25] *Right to Health 2019*
[26] *Ibid.; in 2023-2024, prices for anticancer and immunomodulatory medicines increased by 22% amid overall moderate inflation: https://investigatebel.org/en/investigations/zakupka-lekarstv-u-brata-shakutina-dorogo*
[27] *Right to Health 2021, Right to Health 2022*
[28] *Right to Health 2019*
[29] *CEDAW/C/BLR/CO/7 (2011), para. 38*
[30] *E/C.12/BLR/CO/4-6 (2013), para. 26*

addressing the accessibility of healthcare for[31] women (including older women, women with disabilities, LBTI women,[32] and women involved in prostitution[33]), children (including those in situations of migration and stateless children[34]), persons living with HIV,[35] persons with disabilities,[36] persons of Roma origin,[37] and LGBTIQ+ people.[38]

With regard to detention conditions and access to healthcare in places of deprivation of liberty, specific recommendations have been formulated for juveniles convicted of drug-related offences,[39] women in detention,[40] and other vulnerable groups[41]. National experts have likewise consistently documented the dire situation regarding access to medical services, medicines, and health-related information in places of deprivation of liberty, particularly where such restrictions are associated with politically motivated persecution.[42]

Physical accessibility

Uneven distribution of healthcare facilities, goods, and services between large cities and rural areas has been consistently noted by both national experts[43] and international mechanisms. In addition to the above-mentioned problem of an insufficient number of healthcare facilities in small towns and rural communities, national experts point to limited transport accessibility[44] of existing healthcare facilities for residents of such areas, a restricted range of specialised services and medical specialists, and limited access to emergency high-technology care outside major urban centres.[45]

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31 *More detailed recommendations on the implementation of the right to health with regard to specific vulnerable groups are presented below.*

32 *CEDAW/C/BLR/CO/7 (2011), para. 34; CEDAW/C/BLR/CO/8 (2016), paras. 42–43; CEDAW/C/BLR/CO/8 (2016), para. 48*

33 *CEDAW/C/BLR/CO/9 (2025), paras. 35, 36(b)-(f)*

34 *CRC/C/BLR/CO/3-4 (2011), para. 53; CRC/C/BLR/CO/5-6 (2020), para. 18(c)*

35 *A/HRC/44/55 (2020), paras. 60-61; E/C.12/BLR/CO/7 (2022), paras. 39-40;*

36 *CRPD/C/BLR/CO/1 (2024), paras. 22, 24, 49-50; A/HRC/WG.6/50/BLR/2 (2025), paras. 50-54;*

37 *A/HRC/44/55 (2020), paras. 90-91; A/HRC/WG.6/50/BLR/2, para. 21; Report on the Implementation of International Convention on the Elimination of All Forms of Racial Discrimination by the Republic of Belarus, para. 26*

38 *Alternative Report by the Civil Society Organization TG House, Universal Periodic Review, Belarus, 2025.*

39 *CRC/C/BLR/CO/5-6 (2020), para. 42(g)*

40 *CEDAW/C/BLR/CO/7 (2011), para. 40*

41 *A/HRC/WG.6/50/BLR/2 (2025), paras. 74-75*

42 *See expert commentaries on the right to health: https://index.belhelcom.org/en/*

43 *For disparities in access to medicines provided free of charge between large cities and rural areas, see Right to Health 2019; for overall availability of healthcare facilities, goods, and services in the regions, see Right to Health 2019 and Right to Health 2022.*

44 *By way of illustration of challenges related to the physical accessibility of services, national experts have drawn attention, inter alia, to the reduction of the network of maternity wards. While such measures may be economically justified, in practice – given existing infrastructure constraints – they lead to increased distances to maternity facilities for residents of a number of regions.*

45 *Right to Health 2019; In particular, in a number of regions there is no capacity to provide timely coronary angiography in cases of myocardial infarction, emergency CT scans and thrombolysis in cases of ischaemic stroke requiring urgent intervention. The absence of a fully developed air ambulance service limits the possibility of rapid transport of critically ill or injured patients from small towns and rural communities to large specialised centres capable of providing medical care at a modern standard.*

Many recommendations of international mechanisms place particular emphasis on vulnerable groups — especially girls and women[46] — living in rural areas and therefore being in a particularly disadvantaged position. There remains a persistent need to address the physical accessibility of healthcare for persons with disabilities[47]: national experts note the «overall inaccessibility or only partial accessibility» of the healthcare system for such individuals.[48]

Economic accessibility

The above-mentioned recommendations of international mechanisms on ensuring access to healthcare for specific groups also encompass the dimension of economic accessibility. Additional emphasis on this aspect is reflected in recommendations calling for economically accessible safe, modern contraceptives (including hormonal methods);[49] guarantees of free medical care for all children — including foreign nationals and stateless persons holding temporary residence permits;[50] and the provision of economically accessible, non-discriminatory medical services for women engaged in prostitution.[51]

National experts likewise point to economic disparities in access to medicines, particularly affecting vulnerable groups.[52]

Informational accessibility: the right to seek, receive, and impart information and ideas related to health

The broader authoritarian trend of restricting access to information of public importance, filtering and manipulating data, and imposing unjustified limitations on the dissemination of information also extends to the healthcare system in Belarus. In assessing informational accessibility in 2019, experts of the Index

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46 *CEDAW/C/BLR/CO/7 (2011), para. 36; CRPD/C/BLR/CO/1 (2024), para. 50 (b)*

47 *«with a specific emphasis on the sexual and reproductive health of women and girls with disabilities, as well as on accessible information and communication for persons with autism, persons with psychosocial disabilities and/or intellectual disabilities, persons with a visual disability, deaf persons and persons who are hard of hearing in general treatment in the health-care system»: CRPD/C/BLR/CO/1 (2024), para. 50*

48 *Among the key problems identified are the lack of reasonable accommodation and individual support; a shortage of objective information on diagnoses and treatment methods; stigma and prejudiced attitudes on the part of medical personnel; and instances of refusal to provide life and health insurance: Civil Society's written contribution for the review of the Republic of Belarus by the Committee on the Rights of Persons with Disabilities, 2024; Right to Health 2019*

49 *A/55/38 (2000), para. 374; A/59/38 (2004), para. 356; CEDAW/C/BLR/CO/8 (2016), paras. 36-37; CEDAW/C/BLR/CO/9 (2025), paras. 45-46; A/HRC/WG.6/50/BLR/2 (2025), para. 35*

50 *CRC/C/BLR/CO/3-4 (2011), para. 54*

51 *CEDAW/C/BLR/CO/9 (2025), paras. 35, 36 (b,c,f)*

52 *Right to Health 2019*

already noted the falsification of statistics «in virtually all areas of healthcare».[53] Data manipulation or the absence of data, alongside the continuous reduction in the volume of publicly available information on healthcare, have been documented consistently in subsequent years.[54]

Data provided by official sources are often incomplete or internally inconsistent. In particular, from 2020 until April 2025, no official information on birth and death rates was published;[55] figures on the number of hospital beds and medical personnel are inconsistent;[56] and there is a lack of clear data on public expenditure on the healthcare system. Within the «health statistics» section of the website of the National Statistical Committee, 34% of indicators have not been updated since at least 2020. Among the specific manifestations of a broader systemic lack of transparency are the withholding of information on the scale of disease outbreaks[57] and epidemics,[58] the falsification of vaccination[59] and child mortality statistics,[60] and interruptions in the supply of vaccines and medicines, including those resulting from non-transparent public procurement procedures.

International mechanisms have placed particular emphasis on the right of the public, especially vulnerable groups, to seek and receive accurate and accessible health-related information. Recommendations addressed to Belarus in this regard have included: expanding HIV awareness and information campaigns;[61] introducing evidence-based and age-appropriate sexual and reproductive education into school curricula;[62] and ensuring the accessibility of information and communication within the healthcare system for persons with autism, psychosocial and intellectual disabilities, as well as for persons with visual and hearing impairments.[63]

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53 *Ibid.*

54 *Right to Health 2019-2024: https://index.belhelcom.org/en/; https://news.zerkalo.io/economics/8037.html*

55 *Even the data that have been published omit the period from 2019 to 2024, making it impossible to draw conclusions about natural population change during this time on the basis of official data: https://dataportal.belstat.gov.by/osids/indicator-info/10101200001, https://dataportal.belstat.gov.by/osids/indicator-info/10101200003, https://dataportal.belstat.gov.by/osids/indicator-info/10101200019*

56 *Official statistics overstate the number of healthcare professionals in the country by approximately 20%; https://civicmonitoring.health/post/hospital-availability-2023/; https://t.me/belhalat_by/9290*

57 *In particular, see the situation in 2024 relating to the hepatitis A outbreak: https://t.me/belhalat_by/9361, and the increase in the incidence of whooping cough: https://charter97.org/ru/news/2024/6/27/600668/*

58 *See the concealment of statistical data at the height of the COVID-19 epidemic: https://news.zerkalo.io/economics/8037.html*

59 *https://t.me/belhalat_by/9299; Right to Health 2019, Right to Health 2022.*

60 *Over several decades, cases have been documented of falsification of infant mortality statistics, including the registration of miscarriages as abortions; forced medical interventions — such as the artificial induction of miscarriage or stimulation of labour without the woman's informed consent; and the prescription of medical procedures aimed at meeting performance indicators rather than safeguarding the health of the mother and child: Right to Health 2019*

61 *CRC/C/BLR/CO/3-4 (2011), para. 60; CEDAW/C/BLR/CO/7 (2011), para. 36*

62 *CRC/C/BLR/CO/5-6 (2020), para. 34(b); CEDAW/C/BLR/CO/9 (2025), paras. 39(e)-40(e)*

63 *CRPD/C/BLR/CO/1 (2024), para. 50(a)*

It is important to note that restrictions affect not only access to information of public importance, but also the ability to disseminate such information[64] and to participate independently in decision-making on healthcare matters at various levels. The liquidation of specialised non-governmental organisations (see below), the use of «anti-extremism» legislation, including for the purpose to restrict access to platforms for grassroots mobilisation,[65] and Belarus's withdrawal from the Aarhus Convention have further narrowed an already limited space for independent initiative and for influencing decision-making in the healthcare sector.

Restrictions on access to information also affect the medical profession, particularly in cases involving international professional engagement. Participation in international conferences and other professional events that facilitate training and the exchange of experience requires authorisation at the ministerial level.

4.3. Acceptability[66]

Observations by national experts and recommendations of international bodies concerning acceptability converge on the necessity of applying a human rights-based approach, especially with regard to vulnerable groups. In particular, the need has been noted to apply this approach to the treatment of persons with alcohol dependence or who use drugs;[67] to establish a person-centred system for persons with disabilities;[68] to guarantee women non-coercive pre-abortion counselling, as well as to ensure women's ability to make free and informed decisions regarding their bodies and their right to abortion, without interference from partners, family members, or religious actors.[69]

Experts also point to persistent problems related to the lack of a humane approach towards persons with mental health conditions, the use of the healthcare system as a tool of repression,[70] and ongoing risks of violations of the confidentiality of medical information.[71]

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64 *See unlawful restrictions on freedom of expression within a systemic and large-scale policy of suppressing dissent: Belarus Human Rights Index, Right to freedom of expression (2020-2024)* https://index.belhelcom.org/en/

65 https://spring96.org/ru/news/118154; https://t.me/belhalat_by/9308

66 *All healthcare facilities, goods, and services must be respectful of medical ethics and culturally appropriate, that is, respectful of the culture of individuals, minorities, peoples, and communities, sensitive to gender and life-cycle requirements, and designed to respect confidentiality and improve the health status of those concerned*

67 *E/C.12/BLR/CO/4-6 (2013), para. 25;* Right to Health 2019

68 *CRPD/C/BLR/CO/1 (2024), paras. 49-50;* Right to Health 2019

69 *CEDAW/C/BLR/CO/9 (2025), paras. 45-46*

70 Right to Health 2019, Right to Health 2021, Right to Health 2022; https://www.belhalat.news/articles/bel-psychiatry-04

71 *With regard to sexually active adolescent girls and people living with HIV, see:* Right to Health 2019.

4.4. Quality[72]

In assessing healthcare facilities, goods, and services in Belarus in 2019, national experts noted their overall acceptability from a scientific and medical perspective. At the same time, shortcomings were identified, including insufficient qualifications among a portion of medical personnel, the use of outdated treatment protocols for certain conditions, and the limited effectiveness and scientific adequacy of a number of domestically produced medicinal products.[73] Problems have also been noted with the scientific reliability of information disseminated by healthcare institutions.[74]

International mechanisms, in their conclusions and recommendations, have drawn attention, inter alia, to the need to improve the quality of medical services provided to children, including obstetric care;[75] to ensure quality medical care for members of the armed forces;[76] to enhance the accessibility and quality of medical equipment and services for persons with disabilities;[77] and to improve the quality of home-visiting services within the primary healthcare system through the introduction of child development monitoring.[78]

The impact of unlawful restrictions on freedom of expression and freedom of assembly on the implementation of the right to health

The mass liquidation of specialised non-governmental organisations and initiatives as part of the State's repressive policies, along with other unlawful restrictions on freedom of association and freedom of expression — despite repeated recommendations by international mechanisms to strengthen cooperation with relevant organisations and to increase their funding[79] — has further narrowed the scope for the realisation of the right to health **across all its key components**.

Expert assessments consolidated in the Index demonstrate deterioration across the dimensions of availability, accessibility (to a significant extent, informational

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72 *Healthcare facilities, goods, and services, in addition to being culturally appropriate, must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and appropriate medicines and medical equipment, safe drinking water, and adequate sanitation.*

73 *Right to Health 2019*

74 *Inter alia, serious factual errors have been identified on the official websites of a number of healthcare institutions in materials relating to vaccination against the human papillomavirus (HPV), including unsubstantiated claims regarding modes of HPV transmission; examples are available here: https://drive.google.com/drive/folders/1LXNbE_vTkQUhnURYPqtKImi_t6UTAvAh*

75 *CRC/C/BLR/CO/5-6 (2020), para. 60(b)*

76 *A/HRC/44/55 (2020), para. 65*

77 *CRPD/C/BLR/CO/1 (2024), para. 49(a)*

78 *A/HRC/WG.6/50/BLR/2, para. 39(c)*

79 *CEDAW/C/BLR/CO/7 (2011), para. 20(f); A/HRC/46/5 (2021), para. 97.6; CEDAW/C/BLR/CO/9 (2025), para. 33–34 (b,d). CRPD/C/BLR/CO/1 (2024), para. 22.*

accessibility), quality, and acceptability of healthcare facilities, goods, and services, following the liquidation of organisations that had, in certain areas, assumed functions otherwise incumbent upon the state. The adverse consequences of the mass liquidation of specialised organisations have affected, inter alia, persons with experience of dependency,[80] survivors of domestic violence,[81] children and adolescents,[82] children with autism spectrum disorders,[83] people living with HIV,[84] and other groups.

As a result, independent professional medical associations and patient organisations are virtually absent in Belarus. Existing organisations are, in practice, integrated into the state system and do not perform functions that, in European practice, are traditionally entrusted to independent professional bodies, including the development of diagnostic and treatment standards, participation in the formulation of clinical protocols, and the organisation of postgraduate medical education, among others.

80 *Right to Health 2021*
81 *Right Not to Be Subjected to Torture, Cruel, Inhuman or Degrading Treatment or Punishment 2023*
82 *Right to Health 2021*
83 *https://www.belhalat.news/articles/rasstroystva-autisticheskogo-spektra-v-belarusi*
84 *Right to Health 2021*

V. INTERNATIONAL RECOMMENDATIONS ON THE RIGHT TO HEALTH

The systemic problems outlined in the previous section — relating to the availability of healthcare facilities, goods, and services, their accessibility, acceptability, and quality — as well as the continued deterioration of the situation as a result of repressive state policies affecting, inter alia, the healthcare sector, **have a disproportionately severe impact on vulnerable groups within Belarusian society**. In this context, particular significance attaches to the assessments and recommendations of international mechanisms, which accord priority attention to the protection of the rights of these groups.

For the purposes of this report, 37 documents adopted by international human rights mechanisms in relation to the situation in Belarus were analysed. From these documents, 188 quotations (extracts) relating to the right to health were selected. The material covers the entire period of Belarus's independence, from 1991 to 2025.

Among these recommendations, certain achievements are acknowledged and efforts by Belarus are recognised, a pattern primarily characteristic of the Universal Periodic Review and the Voluntary National Reviews of the Sustainable Development Goals. A significant factor contributing to Belarus's positive international image has been its declared commitment to the principles of the social State, in particular the provision of free healthcare to the population (UPR 2015, 2021). In the field of sustainable development, reductions in child mortality, the protection of motherhood, and effective efforts to combat the spread of HIV/AIDS among young people have been highlighted (UPR 2021). Positive assessments have also been given to measures aimed at the rehabilitation of territories affected by the Chernobyl nuclear accident (UPR 2021).

At the same time, an analysis of the recommendations of UN treaty bodies and special procedures reveals a range of long-standing **systemic problems** in the realisation of the right to health, encompassing a broad spectrum of issues — from access to services for vulnerable groups to conditions of detention in closed institutions.

5.1. Most frequently raised concerns

Access to healthcare and conditions of detention in places of deprivation of liberty

One of the most frequently raised concerns relates to the health status of detainees and the quality of medical care within the penitentiary system. International bodies have expressed serious concern about prison overcrowding and the lack of adequate

and timely medical care, which has, in a number of cases, resulted in the deaths of detainees. The Human Rights Committee has repeatedly referred to reports of suicides and deaths in custody attributable to the absence of appropriate medical assistance and has called for conditions of detention to be brought into line with the Nelson Mandela Rules.[85]

The Special Rapporteur on the situation of human rights in Belarus has noted[86] a shortage of qualified and independent medical personnel in places of deprivation of liberty, leading to deterioration of detainees' health and, in some cases, to disability. The Committee on the Elimination of Discrimination against Women and the Committee on the Rights of Persons with Disabilities have drawn attention to unsatisfactory sanitary and hygienic conditions for women in detention and to cases of deaths of persons with disabilities in custodial settings.[87]

Sexual and reproductive health and rights

Issues relating to sexual and reproductive health are regularly raised in recommendations, primarily by the Committee on the Elimination of Discrimination against Women. Concerns relate both to the accessibility of services and to the level of public awareness.

Over many years, the Committee on the Elimination of Discrimination against Women has called on the state to expand access to modern and affordable methods of contraception in order to reduce the number of abortions. At the same time, it has expressed concern about the growth of the anti-abortion movement and the introduction of mandatory pre-abortion counselling, which may undermine women's autonomy.[88]

The Committee on the Rights of the Child and the Committee on the Elimination of Discrimination against Women have emphasised the need to introduce compulsory, comprehensive, and scientifically accurate sexuality education into school curricula, with a view to improving adolescents' awareness of reproductive health, contraception, and the prevention of sexually transmitted infections.[89]

The Committee on the Elimination of Discrimination against Women has also expressed concern about the increasing incidence of cancer among women and has recommended the adoption of measures to ensure universal screening for breast and cervical cancer, particularly for women living in rural areas.[90]

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85 *CCPR/C/BLR/CO/5, 2018*
86 *A/HRC/44/55, 2020*
87 *CEDAW/C/BLR/CO/8, 2016; CRPD/C/BLR/CO/1, 2024*
88 *A/55/38, 2000; CEDAW/C/BLR/CO/8, 2016; CEDAW/C/BLR/CO/9, 2025*
89 *A/59/38, 2004; CRC/C/BLR/CO/5-6, 2020*
90 *CEDAW/C/BLR/CO/7, 2011; CEDAW/C/BLR/CO/8, 2016.*

In practice, a problem has been identified in relation to the late provision of information to young women with oncological diagnoses about the possibility of fertility preservation. Patients often learn about oocyte cryopreservation programmes only after the initiation of aggressive chemotherapy, at a point when reproductive potential has already been irreversibly reduced. Such practice violates the right to timely and comprehensive medical information and effectively deprives women of the opportunity to exercise their reproductive rights.

HIV/AIDS policy and combating stigma

Despite progress in addressing the spread of HIV, international mechanisms have pointed to a number of legislative and policy barriers that hinder effective prevention and treatment. Key concerns include the criminalisation of HIV transmission and mandatory testing for certain population groups,[91] as well as insufficient safeguards for the confidentiality of medical data.[92] These factors contribute to an environment of fear and stigma, thereby discouraging individuals from seeking medical assistance and undergoing testing.

Mental health and approaches to the treatment of dependencies

Recommendations in the area of mental health address both systemic shortcomings and treatment approaches. Particular concern has been expressed regarding the high rate of suicide among adolescents, which underscores the need to strengthen psychological support services within schools.[93] The Committee on the Rights of Persons with Disabilities has raised concerns about the practice of involuntary hospitalisation and treatment of persons with psychosocial disabilities.[94]

Special attention has also been drawn to the practice of referring persons with alcohol or drug dependence to so-called medical-labour treatment facilities. The Committee on Economic, Social and Cultural Rights has characterised this practice as a form of forced labour rather than treatment, constituting a serious violation of human rights.[95] The Committee has called for the abolition of this system and a transition to approaches grounded in respect for human rights, including voluntary treatment and harm-reduction programmes.[96]

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91 *A/HRC/46/5, 2021*
92 *E/C.12/BLR/CO/4-6, 2013; CEDAW/C/BLR/CO/9, 2025*
93 *CRC/C/BLR/CO/5-6, 2020*
94 *CRPD/C/BLR/CO/1, 2024*
95 *E/C.12/BLR/CO/4-6, 2013; E/C.12/BLR/CO/7, 2022*
96 *E/C.12/BLR/CO/4-6, 2013; E/C.12/BLR/CO/7, 2022*

5.2. Chronic and systemic issues

An analysis of the body of recommendations makes it possible to identify a set of «chronic issues», namely those that appear in the earliest available recommendations (from the 1990s) and continue to recur in reports over many years, often decades. This persistence indicates their deeply entrenched, systemic nature, as well as the limited progress in addressing them.

Health consequences of the Chernobyl nuclear accident

The health impact of the Chernobyl disaster is among the oldest and most persistent issues identified in international recommendations. In the 1990s, the Committee on the Rights of the Child and the Committee on Economic, Social and Cultural Rights expressed general concern about the health status of the population, particularly children living in contaminated areas. By the 2010s, the focus of recommendations had shifted towards more specific and long-term consequences. The Committee on the Rights of the Child and the Committee on the Elimination of Discrimination against Women began to highlight increases in specific conditions, such as thyroid cancer among children and oncological diseases among women, and called for strengthened measures for early diagnosis and specialised treatment.

Right to health in the penitentiary system

The problem of ensuring the right to health in places of deprivation of liberty is likewise chronic in nature. Complaints concerning the failure to provide adequate medical care and instances of ill-treatment have been documented for more than a decade. As early as 2010, the Human Rights Committee, in its Views on an individual communication, found a violation of the rights of a detainee who had not received the necessary medical treatment following a stroke. This issue continues to feature in the recommendations of various mechanisms up to 2024–2025, encompassing a broad range of violations — from torture and the absence of qualified medical personnel to deaths in custody of persons with disabilities and political prisoners.[100]

Persistent issues in the area of gender equality and reproductive health

Recommendations of the Committee on the Elimination of Discrimination against Women demonstrate a high degree of continuity in the framing of concerns. Calls to ensure broad and affordable access to modern contraception, to criminalise

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97 *CRC/C/15/Add.17, 1994; E/C.12/1/Add.1/Rev.1, 1996*
98 *CRC/C/BLR/CO/3-4, 2011; CEDAW/C/BLR/CO/7, 2011*
99 *CCPR/C/99/D/1502/2006*
100 *CRPD/C/BLR/CO/1, 2024; A/HRC/WG.6/50/BLR/2, 2025*

domestic violence, and to establish a sufficient number of shelters for women affected by violence have been raised since 2000[101] and have been repeated almost verbatim in each subsequent reporting cycle — in 2004, 2011, 2016, and 2025.

5.3. Evolution of approaches within international human rights mechanisms

Over time, not only have the challenges facing Belarus evolved, but so too have the approaches of international human rights mechanisms themselves. Recommendations have developed from general observations into more detailed and legally precise requirements, reflecting the progressive development of international human rights standards. The body of recommendations relating to the right to health may be provisionally divided into three stages.

The early stage (the 1990s to the early 2000s) is characterised by a focus on basic needs and the consequences of the transition period. During this phase, recommendations were more general in nature. They centred on the consequences of the dissolution of the USSR, the economic difficulties of the transition period, and the Chernobyl nuclear disaster. Primary attention was given to the development of primary healthcare, reducing the number of abortions through family planning, and the promotion of breastfeeding.[102]

The mid-2000s to the 2010s marked a period in which recommendations became more specific and targeted. Detailed analysis emerged of issues related to the spread of HIV and tuberculosis, adolescent mental health, violence against women, and conditions in places of detention. At this stage, a divergence in tone became apparent: treaty bodies (notably the Committee on the Elimination of Discrimination against Women and the Human Rights Committee) formulated increasingly critical and detailed observations, while within the Universal Periodic Review more general and encouraging recommendations by other States continued to prevail.

The contemporary stage (late 2010s – present). At the contemporary stage, a definitive shift towards a human rights-based model can be observed, particularly in the recommendations of the Committee on the Rights of Persons with Disabilities, which calls for the abandonment of the medical model of disability and of practices of involuntary treatment.[103] An intersectional approach is increasingly applied, analysing how multiple and overlapping grounds of discrimination intersect (for example, in relation to women living in rural areas or women with disabilities).

[102] *CRC/C/15/Add.17, 1994; E/C.12/1/Add.1/Rev.1, 1996*
[103] *CRPD/C/BLR/CO/1, 2024*

In addition, following the political crisis of 2020, violations of the right to health are increasingly linked to the broader political context. Recommendations have emerged addressing the health of political prisoners and the persecution of women human rights defenders, including threats of forced hospitalisation. Calls have also been made for decriminalisation (of HIV transmission and drug use) and for the introduction of harm-reduction programmes

VI. KEY FINDINGS OF THE SURVEY ON PERCEPTIONS OF THE RIGHT TO HEALTH

The survey allows preliminary conclusions to be drawn regarding perceptions of the right to health, attitudes towards the healthcare system, and barriers to the realisation of this right. Despite the limited sample size, the data obtained reflect characteristic trends in public attitudes and individual priorities.

Understanding of health and the right to health

The majority of respondents associate health not only with the absence of illness, but also with physical and emotional well-being, sufficient vitality, and the ability to lead an independent life. This understanding is consistent with the international definition of health as a state of physical, mental, and social well-being.

Participants most frequently associate the concept of the «right to health» with the obligation of the state to ensure the accessibility and quality of medical care, as well as with respectful treatment and non-discrimination within the healthcare system.

At the same time, the right to participate in decision-making and the right to receive information about medical services are mentioned considerably less frequently (16% and 8%, respectively).

Health-seeking behaviour and prevention

More than half of respondents prefer to manage deteriorations in their health independently, using painkillers, traditional remedies, or rest (67%). Only 18% seek medical assistance immediately. At the same time, 54% reported undergoing preventive medical check-ups on their own initiative, which may indicate trust in diagnostic procedures but a lack of trust in medical treatment. This combination points to a widespread lack of trust and a tendency to minimise contact with the formal healthcare system.

Accessibility and quality of medical care

Approximately 33% of respondents assess the economic accessibility of medical services as insufficient. Only 16% of respondents reported no difficulties related to territorial or organisational access (including waiting times, distances, and conditions for older persons and persons with disabilities). The quality of medical services is assessed even more critically: 66% selected «satisfactory», while 24% rated it as «poor» or «very poor». It can therefore be concluded that, even where trust in individual medical professionals is maintained, the healthcare system as a whole is perceived as inefficient and inconvenient.

Awareness and seeking redress

Only 16% of respondents report good awareness of the list of free medical services, while the majority (66%) are only partially aware of it. Half of the respondents believe that submitting complaints or feedback regarding the functioning of medical institutions is pointless. This indicates a low level of trust in feedback and complaint mechanisms and a perception of such mechanisms as ineffective.

Sources of information and horizontal practices

The main sources of information on medical services remain the internet and personal contacts. A total of 69% of respondents obtain information via the internet and messaging applications, while 30% rely on acquaintances. At the same time, 66% of respondents consider the exchange of experience between individuals and mutual peer support on health-related issues to be useful.

Approximately one third of respondents are aware of the existence of patient initiatives and communities but do not participate in them, while more than half are not aware of such initiatives at all. This confirms both the importance of informal channels of information exchange and their potential as mechanisms for accessing information in contexts of low trust in official sources.

Inequality and individualised approach

Only one third of respondents reported not having encountered instances of unequal treatment within the healthcare system. Unequal or unfair treatment was associated with age (30%), health status (30%), income level (30%), or place of residence (23%). Only 16% indicated that doctors took their individual characteristics into account when prescribing treatment. These findings point to the persistence of discriminatory practices and formalistic approaches in the provision of medical care.

Trust and self-censorship

Some respondents refrained from answering sensitive questions (relating to age, place of residence, assessment of the healthcare system, and other issues) or selected neutral options such as «difficult to answer». In a context of restricted freedom of expression and documented practices of persecution for participation in surveys, such responses may reflect not the absence of an opinion, but caution and a lack of trust in guarantees of anonymity.

CONCLUSION

- The evolution of the normative framework governing the right to health indicates a gradual narrowing of the scope of state obligations. The shift of constitutional guarantees of free medical care into the realm of legislatively defined minimum social standards — as one of the forms of accessible medical care — together with the absence of open and inclusive discussion of the draft Healthcare Code, creates risks of reduced accessibility of medical care and diminished predictability of the model for its provision.

- The key components of the right to health — availability, accessibility, acceptability, and quality — are characterised by systemic deficiencies. International bodies and national experts consistently document shortages of qualified personnel, uneven distribution of healthcare infrastructure, the use of outdated equipment, limitations in access to modern medicines and high-cost therapies, and the lack of adapted services for vulnerable groups. Survey data reflect similar trends: the majority of respondents assess the quality of medical services as unsatisfactory or moderate, a significant proportion prefer self-treatment, and both economic and territorial accessibility are perceived as limited.

- The scale and nature of unequal treatment point to insufficient implementation of the principle of non-discrimination. While healthcare in Belarus is often perceived as formally universal, international recommendations consistently express concern regarding access to medical care for women, children, persons with disabilities, LGBTIQ+ people, people living with HIV, residents of rural areas, and persons deprived of liberty. Survey findings confirm the existence of practices of unequal treatment, primarily associated with age, health status, income level, and place of residence.

- Restrictions on access to information and the contraction of civic space undermine mechanisms of accountability and public participation in decision-making. The liquidation of specialised organisations and restrictions on freedom of expression weaken the ability of the population and experts to influence health policy, which, inter alia, is likely to have an adverse impact on the quality of the Healthcare Code currently under development.

- Chronic issues have persisted for decades despite repeated international recommendations since the 1990s. These include access to healthcare in

places of deprivation of liberty, the health consequences of the Chernobyl accident, access to contraception and sexual education, efforts to combat HIV-related stigma, and conditions affecting women and children.

- A human rights–based approach is a necessary precondition for strengthening the healthcare system. The core elements of the right to health — availability, accessibility, acceptability, and quality — together with the general principles governing the implementation of human rights (non-discrimination, access to information, transparency, and accountability), are implemented in Belarus in a fragmented and inconsistent manner.

An analysis of the legal positions of international monitoring bodies on the right to health in Belarus, of Belarusian legislation, and of the practical functioning of the healthcare system makes it possible to formulate a number of recommendations that would ordinarily be addressed to the state. However, in a context of authoritarian closure, the authors of the report consider it particularly important to draw the attention of Belarusian civil society to the most essential components of the right to health:

- In order to ensure compliance of national legislation with international human rights obligations — including the fullest possible implementation of the content of Article 12 of the International Covenant on Economic, Social and Cultural Rights and General Comment No. 14 (the human rights-based approach to the right to health) in law and in practice — it is important, where opportunities exist, to engage with the state, which bears the primary responsibility for the realisation of the right to health. At the same time, efforts to raise awareness among rights-holders of the human rights-based approach to the right to health are of critical importance.

- Broad public discussion of the constitutional and legislative framework governing the right to health would help to reduce uncertainty regarding the scope of state obligations to ensure free medical care and to establish clear criteria for accessibility, quality, and acceptability.

- In the absence of a transparent and inclusive process for the drafting and discussion of the Healthcare Code, it is essential to make use of all advocacy and public engagement mechanisms available to civil society in order to raise public awareness of the right to health in general and to influence the content of the draft Code in particular.

- In a situation of limited opportunities for participation by the public, professional medical associations, and patient communities in decision-making, it is important to employ tools of public oversight and monitoring of the implementation of the right to health, with a focus on a human rights-based approach and, in particular, on the criteria of availability, accessibility, acceptability, and quality of medical services.