Alternative report
on the implementation of the CEDAW concerning women living with HIV, women who use drugs and sex workers in the Republic of Kazakhstan
for the 93rd session
of the UN Committee on the Elimination of Discrimination against Women
Geneva, Switzerland, 2026

Submitted by the Coalition of women-led organisations including the Eurasian Women's Network on AIDS, the Sex Workers' Rights Advocacy Network, Union of Legal Entities "Central Asian Women's Network "AMAL", Public Association "Protection of the Rights of Mental Health Service Users "Overcoming", Union of Legal Entities "Association Answer-Kazakhstan" and Public Association "Amelia"

Introduction

1. This Alternative Report evaluates the implementation of the Convention on the Elimination of All Forms of Discrimination against Women in the Republic of Kazakhstan regarding women living with HIV, women who use drugs, and sex workers. Submitted by a coalition of women-led civil society organisations—including the Eurasian Women's Network on AIDS, the Sex Workers' Rights Advocacy Network, Public Association "Amelia" (city of Taldykorgan), Union of Legal Entities "Central Asian Women's Network "AMAL" (city of Almaty), Public Association "Protection of the Rights of Mental Health Service Users "Overcoming" (city of Almaty) and Union of Legal Entities "Association Answer-Kazakhstan" (city of Almaty) — this document highlights critical implementation gaps between state commitments and the lived realities of key populations across Kazakhstan. These findings reaffirm and expand on the concerns already expressed in the CEDAW Committee's Concluding Observations to Kazakhstan in 2019, specifically the lack of shelter and crisis support for women with HIV, the discriminatory denial of services, mandatory testing and police harassment of women in prostitution. Despite existing gender mechanisms, structural barriers severely infringe upon women's human rights under CEDAW Articles 2, 5, 7, 12, 15, and 16:
    - HIV Criminalisation, Punitive Laws, and Law Enforcement Abuse [Articles 2, 15, GR No. 35 on gender-based violence]: Article 118 of the Criminal Code continues to penalise HIV exposure and transmission, weaponised by abusive partners to enforce silence and compliance. Furthermore, Article 449 of the Code of Administrative Offences (public solicitation), administrative drug laws, and arbitrary police databases are used by law enforcement officers to harass, extort, and arbitrarily detain sex workers and women who use drugs, while failing to protect them from violence.
    - Healthcare Discrimination and SRHR Violations [Articles 12, 16, GR No. 24 on women and health]: Institutional stigma, breaches of patient confidentiality, and hostile questioning are pervasive in medical settings. Women experience coercive pressures, including forced tubal ligation or sterilisation, forced HIV/STI testing without consent, discriminatory treatment in perinatal centres, and denial of trauma-informed care and essential pain management.
    - Exclusion from GBV Protections & Shelters [Articles 2, 5, GR No. 35]: Emergency shelters and "special social services" enforce rigid exclusionary criteria, treating HIV status as a medical contraindication for admission. A lack of monitoring, combined with severe stigma from shelter staff, leaves women living with HIV, women who use drugs, and sex

workers without refuge, forcing many to remain in life-threatening abusive environments.

- Harm Reduction Barriers, Regional Inequities, and Shrinking Civic Space [Articles 2, 7, 12, 15]: Women admitted to general hospitals are completely denied Opioid Agonist Therapy (methadone), forcing them to choose between receiving necessary hospital care and maintaining daily OAT clinic attendance. Furthermore, Naloxone — a life-saving medication used to reverse opioid overdoses — has been unregistered and completely unavailable in Kazakhstan since 2018, leaving patients with no access at all and significantly increasing fatal risks. Rural women face severe geographic and financial barriers to forensic medical examinations and legal aid under "Saltanat's Law", while local authorities systematically restrict civic space by denying permits for peaceful assemblies and March 8th rallies.

2. The Coalition urges the CEDAW Committee to call upon the Government of Kazakhstan to immediately decriminalise HIV exposure, sex work, and personal drug use; eliminate discriminatory admission barriers to GBV shelters; enforce strict healthcare accountability and confidentiality; expand rural legal aid and harm reduction; ensure access to overdose prevention and uninterrupted OAT during hospitalisation; and protect civic space and freedom of assembly.
3. The evidence is based on the focus group discussion comprising 19 women activists representing the communities of women living with HIV, women who use drugs and sex workers from the different cities of the Republic of Kazakhstan, as well as the data drawn from:
    - HIV Criminalisation Scan in the Countries of Eastern Europe and Central Asia[1];
    - How countries address barriers to HIV services for women living with HIV, sex workers and women who use drugs. Women-led gender assessment[2];
    - Types of Violence Against Women Living with HIV in Kazakhstan[3];
    - Express assessment of the impact of the Law of the Republic of Kazakhstan "On Ensuring Women's Rights and Children's Safety" on women from key populations[4];
    - Cases collected through kz.pereboi.net, a monitoring and reporting platform in Kazakhstan managed by community initiatives and NGOs, in collaboration with regional harm-reduction and treatment monitoring networks.

Implementation of Article 2: Legal Reform

4. Article 118 of the Criminal Code of the Republic of Kazakhstan[5] criminalises the intentional transmission of or 'knowing exposure' to HIV. In practice, this punitive provision is weaponised by abusive partners who leverage threats of police reports to enforce compliance, silence survivors, and deepen women's socio-economic and emotional dependency.
5. Empirical evidence and women-led research demonstrate that HIV criminalisation fails to reduce transmission rates; instead, it reinforces structural inequality, heightens vulnerability to GBV, and deters women living with HIV from seeking essential sexual and reproductive healthcare services[6].

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[1] EWNA, HIV Criminalisation Scan in the Countries of Eastern Europe and Central Asia (2023), available at: https://academy.hivjustice.net/wp-content/uploads/2023/04/EWNA-HIV-Criminalization-Scan-2023_eng.pdf

[2] EWNA, How countries address barriers to HIV services for women living with HIV, sex workers and women who use drugs. Women-led gender assessment (2023), available at: https://ewna.org/wp-content/uploads/2023/07/ewna-gender-assessment-report_2023_eng-1.pdf

[3] EWNA, Types of Violence Against Women Living with HIV in Kazakhstan (2023), available at: https://ewna.org/wp-content/uploads/2024/01/ewna_gbv-clm-final-report_kazakhstan_2023_eng-1.pdf

[4] PA "Equal to Equal Plus", EWNA, Express assessment of the impact of the Law of the Republic of Kazakhstan "On Ensuring Women's Rights and Children's Safety" on women from key populations (2024), available at: https://ewna.org/wp-content/uploads/2024/12/eo_ravnyj-ravnomu-plyus_kazahstan_2024-2.pdf

[5] Available at: https://adilet.zan.kz/rus/docs/K1400000226

[6] EWNA, HIV Criminalisation Scan in the Countries of Eastern Europe and Central Asia (2023), available at: https://academy.hivjustice.net/wp-content/uploads/2023/04/EWNA-HIV-Criminalization-Scan-2023_eng.pdf

6. Although sex work per se is not explicitly criminalised, legal and institutional barriers effectively criminalise sex workers. Specifically, the Code of Administrative Offences (Article 449[7]) imposes fines for solicitation/engaging in prostitution, which increases women's vulnerability, while anti-trafficking frameworks and Criminal Code provisions on involvement and mediation are applied selectively to pressure communities. Furthermore, amendments to the Law on Advertising restrict sex workers' access to online platforms, depriving them of safe communication and earnings channels. Targeted municipal policing tactics further drive them underground, increasing their exposure to extortion, physical or sexual violence, and depriving them of effective legal recourse.
7. Similarly, the punitive approach to drug policy provides for criminal and administrative liability for non-medical consumption of narcotic drugs, their illicit possession without intent to distribute, as well as appearing in public places in a state of intoxication (Article 296 of the Criminal Code, Articles 440 and 440-1 of the Code of Administrative Offences), prioritising measures of punishment and control over public health and harm reduction.
8. These punitive statutes perpetuate systemic stigma, obstruct access to life-saving harm reduction, and violate marginalised women's rights under Articles 2 (Policy Measures), 12 (Health), and 15 (Equality Before the Law) of the CEDAW Convention, as well as General Recommendations No. 24 (Health) and No. 35 (Gender-Based Violence Against Women).

Implementation of Article 12: Intersectional Discrimination and Violence Against Women in Healthcare Settings

9. Women living with HIV, women who use new psychoactive substances (NPS), and sex workers face intersectional discrimination within primary and specialised healthcare settings in Kazakhstan. CLM conducted by EWNA reveals that fear of mistreatment and stigma deters women living with HIV from seeking healthcare[8]. Medical personnel routinely breach confidentiality, subject marginalised women to degrading interrogations, and deny trauma-informed care. For instance, in Temirtau, a woman visiting a pre-examination room was interrogated by a gynaecologist asking, *"Where did you catch it?"*, while another patient disclosing her HIV status to a general practitioner was aggressively silenced out of fear of public exposure – *"Be quiet, the door is open!"*. In Pavlodar, a woman undergoing a routine examination was subjected to hostile questioning regarding visible injection marks, and a pregnant woman living with HIV who used NPS was pressured by an attending physician at the regional AIDS Centre to undergo tubal ligation rather than receiving prenatal care and harm reduction support.
10. These practices violate Article 12 (Health) and Article 16(1)(e) (Reproductive Rights) of the CEDAW Convention. They directly breach General Recommendation No. 24, which mandates that healthcare services must be acceptable—meaning delivered with full respect for confidentiality, dignity, and informed consent. Furthermore, verbal abuse, stigma, and pressure toward coerced sterilisation in medical settings constitute gender-based violence, violating General Recommendation No. 35. According to findings from EWNA's above-mentioned CLM, among women living with HIV who experienced gender-based violence, only 19% were aware of specialised medical assistance available for survivors of violence, highlighting a severe systemic failure in offering accessible, trauma-informed medical support.
11. Severe state budget cuts and logistical deficits in major urban centres have crippled healthcare access for women with dual diagnoses, particularly those who use drugs and experience co-occurring mental health disorders or complex somatic conditions such as cancer. In Almaty, severe funding cuts have made inpatient drug dependence treatment virtually inaccessible for women with psychiatric comorbidities; patients seeking care at the Republican Scientific and Practical Centre for Mental Health are routinely turned away without basic consultation. In

[7] Available at: https://adilet.zan.kz/rus/docs/K1400000235

[8] EWNA, Types of Violence Against Women Living with HIV in Kazakhstan (2023), available at: https://ewna.org/wp-content/uploads/2024/01/ewna_gbv-clm-final-report_kazakhstan_2023_eng-1.pdf

another case from Almaty, an oncology patient who uses drugs was systematically shuttled between clinic rooms without receiving an official diagnostic confirmation, resulting in the polyclinic refusing to dispense necessary pain management and oncology medications. Fear of criminalisation prevented her from seeking legal recourse. Additionally, the complete absence of municipal or state temporary childcare services within addiction treatment facilities across the region forces mothers to forgo residential drug rehabilitation, creating an insurmountable structural barrier to recovery.

12. This structural neglect violates Article 12 and Article 5(a) (Gender Stereotypes and Prejudices). It breaches General Recommendation No. 24, which obligates States Parties to allocate adequate budgetary resources to guarantee health services for vulnerable groups of women. EWNA's research indicates that 57% of surveyed women living with HIV emphasized the need for systemic information and support systems that are specifically sensitive to HIV issues in cases of violence and healthcare delivery. Furthermore, denying essential medical care and pain management based on drug use status constitutes intersectional discrimination in violation of General Recommendation No. 28 and amounts to inhuman and degrading treatment under General Recommendation No. 35.

Implementation of Article 2: Duty to Establish Legal Protection Against Discrimination and Modify Discriminatory Enforcement Practices

13. Despite previous recommendations by the CEDAW Committee (CEDAW/C/KAZ/CO/5, para. 28) calling on Kazakhstan to register, investigate, and prosecute discrimination and gender-based violence against women in prostitution, state authorities have escalated punitive measures. Law enforcement agencies actively track, register, black-list, and blackmail sex workers and transgender women. Rather than protecting sex workers from violent crimes, police officers exploit their criminalised status to commit acts of extortion, administrative abuse, and degrading treatment, completely undermining access to justice for marginalised women.
14. In Temirtau, sex workers report routine police harassment, with officers issuing threats such as *"You better work off your debt for us"* or *"I'll lock you up right now and frame you for drug possession".* Following the law enforcement crackdown on the online platform "Kazdarnet", police detained site administrators and systematically tracked registered users, forcibly subjecting them to mandatory HIV and STI testing and using their medical status for blackmail.
15. In a severe case of institutional violence, a sex worker in Temirtau went to a police station to report that her cohabitant had severely beaten her and stolen her property. Upon arrival, officers ignored the violent crime, mocked her status, stating, *"Oh, you're a prostitute, you are on our registry".* Police officers forcibly required her to take an HIV test and refused to allow her to change her feminine hygiene products during hours of detention. Wearing white clothing that became visibly soiled, the survivor suffered severe psychological trauma, shame, and humiliation. Police completely failed their duty to perform their obligation to investigate the assault and theft, using their authority instead to abuse and re-traumatise the victim.
16. These police abuses violate Article 2(c), 2(f), and Article 15, and breach General Recommendation No. 35 (Gender-Based Violence Against Women) and General Recommendation No. 33 (Women's Access to Justice). The practice of forced HIV and STI testing by law enforcement explicitly violates previous CEDAW Concluding Observations on Kazakhstan (2019, para. 28(e)), which demanded an immediate end to forced testing and police harassment of women in prostitution.
17. Until mid-2023, women living with HIV were legally excluded from access to crisis centres. Although this clause was repealed in June 2023 and despite the adoption of landmark domestic violence legislation in Kazakhstan (popularly known as "Saltanat's Law"), structural and regulatory barriers continue to prevent marginalised women from accessing life-saving protection. In major urban centres such as Almaty and Astana, crisis centres routinely turn away women living with HIV or restrict their stays to brief, informal arrangements. For instance, a pregnant woman living with HIV who was escaping domestic violence contacted an emergency

crisis centre seeking refuge; shelter staff explicitly refused her admission, stating: *"We have crawling children and mothers here, and you'll be here with HIV..."*

18. This systemic exclusion is driven by secondary regulations and service standards issued by the Ministry of Labour and Social Protection of the Population, whose regulatory criteria for providing "special social services" include broad medical contraindications regarding infectious diseases. These lower-level administrative orders directly contradict higher-level legislative acts, constitutional guarantees of equal protection, and the core intent of domestic violence protection laws. As a result, victims of severe intimate partner violence are forced to conceal their HIV status to secure shelter.
19. Although AIDS was removed as an explicit contraindication for crisis centres, the broad category of "infectious diseases" remains, allowing staff to deny shelter to women living with HIV. Additionally, Order No. 230 governing Special Social Services (inpatient, semi-inpatient, and home care) explicitly retains AIDS as a contraindication for Special Social Services, barring elderly women or women with disabilities living with HIV from receiving care. This drives severe intersectional discrimination. A documented case highlights a woman living with HIV and a psychiatric diagnosis who was forced into homelessness and subjected to abuse for seven years because she was legally barred from receiving required inpatient social services due solely to her HIV status.
20. The existence of medical restrictions on access to services is acknowledged in the State party's Sixth Periodic Report under Article 6 (Exploitation of women); however, the report fails to address how these restrictions impact women living with HIV and their practical ability to receive support.
21. The systemic exclusion of women living with HIV from domestic violence shelters violates Article 2(f) and Article 12 (Health). It directly breaches General Recommendation No. 35, which explicitly requires States Parties to ensure that crisis shelters, hotlines, and protection orders are accessible to all women without discrimination based on health or HIV status. Furthermore, the disclosure of medical confidentiality by social service employees violates Article 16 and General Recommendation No. 24.
22. Monitoring and express assessment[9] conducted by PA "Equal to Equal Plus" and EWNA confirm that crisis centre personnel—ranging from technical and maintenance staff to facility directors—frequently lack basic medical literacy regarding HIV transmission routes and confidentiality standards. Social workers regularly disclose clients' HIV status within shelters, sparking internal stigma and harassment from other residents. Unsupported, humiliated, and fearing for their safety, women are forced to return to their abusers, only to suffer repeated and escalating physical violence. Additionally, women with substance dependencies face systemic prejudice and are routinely denied admission to state-funded shelters due to intersecting stigma and strict abstinence mandates.
23. Abusers frequently weaponise legal frameworks and medical stigma against women living with HIV. In another documented incident from Astana, after a financially self-sufficient woman living with HIV filed a legal petition for unpaid alimony as entitled by law, her former partner retaliated by attempting to gain custody of their child. He weaponised her HIV status by claiming it rendered her unable to continue working in the medical field, asserting she was consequently incapable of supporting the child financially. The failure of law enforcement and social protection systems to prevent abusers from using medical stigma and bad-faith custody claims against HIV-positive mothers violates General Recommendation No. 33 on women's access to justice.

Implementation of Articles 2 and 12: Overdose and the Right to Life: Fear of Criminalisation as a Barrier to Emergency Healthcare

[9] PA "Equal to Equal Plus", EWNA, Express assessment of the impact of the Law of the Republic of Kazakhstan "On Ensuring Women's Rights and Children's Safety" on women from key populations (2024), available at: https://ewna.org/wp-content/uploads/2024/12/eo_ravnyj-ravnomu-plyus_kazahstan_2024-2.pdf

24. In Kazakhstan, emergency medical calls for drug overdoses are systematically linked to the automatic involvement of law enforcement agencies. The absence of a legally binding 'Good Samaritan Law' forces witnesses—predominantly women—into a life-threatening dilemma where they must choose between seeking emergency medical help and risking arrest, interrogation, registration on state drug registries, or criminal prosecution.
25. Mothers who use drugs are disproportionately impacted by this punitive system, as police involvement directly threatens them with the loss of parental rights and child apprehension. A 46-year-old woman from Temirtau highlighted this reality: *"When the overdose happened, I didn't call for help right away... I was thinking about what would happen to me and my children if the police arrived. No woman should have to choose between saving a life and the fear of punishment".* In another documented incident from Temirtau, a young mother experienced a severe opioid overdose; fearing police raids, prosecution, and loss of custody, those present refused to call emergency services. Lacking access to take-home naloxone and basic first-aid training, bystanders spent nearly three hours attempting ineffective manual resuscitation. She survived, later reflecting: *"If I had died then, [my child] would have been left without me. It's terrifying to realise that people were more afraid of calling an ambulance than of losing me".*
26. Consequently, emergency medical requests are dangerously delayed, or overdose victims are abandoned in public spaces to evade police detection. As a 45-year-old woman from Almaty noted: *"When the person stopped breathing... calling doctors can mean the arrival of the police. That fear can cost a person their life".* This structural risk is further exacerbated by the widespread lack of community-accessible Naloxone—the standard life-saving opioid antagonist—and a complete absence of gender-sensitive overdose response training. A 50-year-old mother from Rudny described waiting in agony for help without access to medical tools: *"When my daughter's lips turned blue and she lost consciousness... we called an ambulance, but while waiting, we couldn't do anything... Those minutes felt like eternity".*
27. These systemic barriers violate Article 12 (Health) and Articles 2(e) and 2(f) of the CEDAW Convention, which require States Parties to eliminate discrimination by public authorities and modify laws that perpetuate gender-based harm. The deliberate creation of legal and enforcement barriers that impede access to life-saving emergency medical treatment breaches General Recommendation No. 24, which explicitly obligates States Parties to ensure timely, non-discriminatory access to emergency health services without fear of criminal sanctions. Furthermore, denying access to basic harm reduction tools like Naloxone violates the State's duty to guarantee women's fundamental right to life and bodily integrity under General Recommendation No. 35.

Implementation of Article 12: Access to Opioid Agonist Therapy and Gendered Barriers

28. As of June 1, 2026, 4,598 patients with opioid dependence are under dynamic observation in the Republic of Kazakhstan. Among them, 378 patients (8%) receive Opioid Agonist Maintenance Treatment (OAMT) provided through the state-guaranteed volume of free medical assistance. As of 2026, the programme operates across 17 sites in 21 regions of the country, with women accounting for approximately 20% of service users. Despite the programme's long-standing operation, women's participation remains low, highlighting persistent gender-specific barriers to accessing treatment[10].
29. Women face unique institutional barriers to treatment. Enrolling in state addiction services frequently triggers automatic reporting to child protection authorities, exposing mothers to the immediate threat of losing child custody. Furthermore, OAT clinics operate in isolation without integrating sexual and reproductive healthcare, family planning, psychological support, or services for survivors of GBV. Rigid treatment protocols also deny take-home medication, causing

[10] Data compiled by CSOs from the Electronic Register of Patients of the Republican Center for Mental Health (RCMH) of the Ministry of Health of the Republic of Kazakhstan (as of June 2026), and CLM reports by the Kazakh Union of People Living with HIV and regional harm reduction monitoring networks (kz.pereboi.net)

severe physical suffering for women with mobility issues or co-occurring health problems. As Sveta from Ust-Kamenogorsk noted: *"I can't get up, severe pain from a pinched sciatic nerve... The treatment protocols and laws are structured so that while we treat one thing, we cripple another... I can't ease the withdrawal, I can't stand up, I can't get pain relief".*

30. In 2025-2026, the programme was severely destabilised by a methadone supply crisis driven by breakdowns in state procurement and logistics. This left patients across multiple regions facing critical uncertainty, with CSOs documenting widespread risks of forced treatment interruption. Interruptions escalate the risk of returning to illicit opioid use, fatal overdose, severe mental health decline, and degrading inpatient conditions. Anna from Kostanay described the toll of government neglect: *"They promised us from the first of the month... but in the end, nothing... Everyone thinks, 'They're addicts, they won't die!' But why did I start taking it? To get a normal life back... It's like telling a diabetic, 'We'll give you insulin in a week, just wait'".* Where local methadone ran out, inpatient options proved punitive; Zhanna from Taraz reported: *"There is no Methadone in Taraz... To get 2 ml of Tramadol, you have to cause a scene... I was there for 11 days and almost died... It's a concentration camp; executioners work there, not doctors".*
31. These severe gender disparities violate Article 12 (Health) of the Convention by failing to provide accessible, non-discriminatory, and gender-responsive healthcare. Pervasive social and institutional stigma against women who use drugs breaches Article 5(a), which requires States to eliminate discriminatory social patterns. Threatening a woman's family unit or parental rights due to her engagement in healthcare violates Articles 16(1)(d) and 16(1)(f). Furthermore, state procurement failures leading to forced withdrawal breach General Recommendation No. 24 (Health) and constitute state-directed ill-treatment under General Recommendation No. 35.

Implementation of Article 12: Lack of OAT Continuity During General Inpatient Hospitalisation

32. Kazakhstan currently lacks any regulatory framework or clinical routing protocol to guarantee the continuous provision of OAT when a patient is admitted to a general, surgical, or maternity hospital. When a woman receiving OAT requires planned or emergency hospitalisation for a somatic condition or childbirth, she is forced to choose between receiving treatment for her physical illness or maintaining her addiction therapy. Consequently, women frequently delay essential medical procedures, endure forced withdrawal while hospitalised, or discharge themselves against medical advice to avoid acute suffering. This structural deficiency directly breaches World Health Organisation guidance[11] establishing OAT as an essential health service that must never be interrupted during hospital transfers.
33. Elena from Kostanay explained the impossible dilemma women face when seeking general medical care: *"When the doctor told me I needed hospitalisation, my first thought wasn't about the illness, but about methadone. I knew that if I went into the hospital, they most likely wouldn't give me the medication. So, to treat one illness, I have to give up treatment for another. No woman should have to make that choice".*
34. The systemic failure to ensure continuous OAT during general hospital admissions violates Article 12 of the Convention, which guarantees women continuous, quality healthcare across all medical settings without discrimination. Abruptly denying OAT to women admitted for acute illnesses, surgical interventions, or reproductive care breaches Article 12(2), which explicitly mandates that States Parties ensure appropriate, non-discriminatory care in connection with pregnancy and the post-natal period. Forcing pregnant women into sudden opioid withdrawal places both maternal and foetal survival at grave risk. Furthermore, denying essential maintenance therapy in healthcare settings violates General Recommendation No. 24 (Health) and subjects women to severe, preventable physical suffering, amounting to ill-treatment under General Recommendation No. 35.

[11] WHO, New guidance on maintaining opioid agonist maintenance treatment as an essential health service (2025), available at: https://www.who.int/news/item/16-12-2025-who-s-new-guidance-on-maintaining-opioid-agonist-maintenance-treatment-as-an-essential-health-service?utm_source=chatgpt.com

Implementation of Article 12: Access to SRHR Services

35. Women who use drugs and women living with HIV in Kazakhstan face severe violations of their SRHR, characterised by reproductive coercion, medical neglect, age- and status-based stigma, and gross breaches of bodily autonomy. Primary healthcare and specialised perinatal facilities routinely delay or refuse services to vulnerable women by exploiting administrative procedures. Medical professionals routinely exercise subjective bias, pressuring women into unwanted reproductive decisions through degrading language, ageism, and status-based shaming. According to the People Living with HIV Stigma Index[12], 51 women reported being advised to terminate their pregnancy due to HIV.
36. Community-led research on obstetric violence reveals pervasive mistreatment during maternity care[13]. A woman describing her caesarean section shared: *"The anaesthesiologist constantly asked questions about my status, like what I had used, why, and how my husband lived with me without being afraid... When an injection was needed, he refused to administer it into my arm... and instead made me strain my neck to inject there, joking, 'Why are you scared? You've injected yourself before...'"* In another documented case from Astana, a pregnant woman living with HIV was systematically denied enrolment for dynamic prenatal surveillance at a regional perinatal centre, leaving her without official maternal healthcare monitoring. Similarly, in Astana, a woman suffering from severe gynaecological pain was turned away and shuttled between clinic departments for two years, with doctors refusing diagnostic procedures and telling her: *"You need to go to a private clinic"*. In Almaty, a woman seeking care was discouraged from pregnancy with staff asking: *"Are you planning to give birth? You are old, and don't forget about your diagnosis"*.
37. Furthermore, within obstetric and gynaecological settings, healthcare providers treat marginalised women—particularly those with visible injection marks—as subjects of medical curiosity rather than patients deserving of dignity. Unconsented exposure to medical trainees, refusal of basic pain management, and obstetric violence remain routine practices across facility levels. In Pavlodar, a woman undergoing a pregnancy termination at 12 weeks was subjected to a severe violation of medical ethics and bodily autonomy. Male medical interns entered the procedure room without her knowledge or consent and examined her injection sites like a *'museum exhibit'*, violating her privacy and dignity during a vulnerable medical procedure.
38. These systemic practices directly violate Article 12 (Health) of the CEDAW Convention, which guarantees equal access to healthcare, including services related to family planning and maternal care. Denying prenatal care, coercing women into pregnancy termination, and subjecting women to humiliating treatment breach General Recommendation No. 24 (Health), which requires healthcare services to be acceptable, respectful of dignity, and delivered with full informed consent. Furthermore, obstetric violence, unconsented medical procedures, and denial of pain relief constitute forms of gender-based violence in medical settings, directly violating General Recommendation No. 35.

Implementation of Article 15: Access to Justice

39. Despite the criminalisation of domestic violence under recent legislative reforms (commonly known as "Saltanat's Law"), the state system does not ensure equal protection and access to justice for marginalised women. A profound geographic divide exists between regional administrative centres and rural villages. Express assessment[14] reveals that rural women must travel tens or hundreds of kilometers to regional centres to undergo official forensic medical

[12] People Living with HIV Stigma Index (Kazakhstan), available at: https://www.stigmaindex.org/
[13] EWNA, Community-Led Research: Obstetric Violence Against Women Living with HIV in Eastern Europe and Central Asia (2025), available at: https://ewna.org/wp-content/uploads/2026/01/ewna-obstetric-violence-report-2025_eng.pdf
[14] PA "Equal to Equal Plus", EWNA, Express assessment of the impact of the Law of the Republic of Kazakhstan "On Ensuring Women's Rights and Children's Safety" on women from key populations (2024), available at: https://ewna.org/wp-content/uploads/2024/12/eo_ravnyj-ravnomu-plyus_kazahstan_2024-2.pdf

examinations. The high cost of transport, combined with strict village social norms that normalise male violence, forces rural women to stay with their abusers without legal or medical documentation of their injuries. In rural communities, entrenched patriarchal dynamics treat the male household head as supreme—even when intoxicated or abusive—leaving women isolated and without institutional protection.

40. For sex workers and women who use NPS, access to police protection is virtually non-existent due to pervasive fear of criminalisation and secondary victimisation. When marginalised women attempt to report intimate partner violence or sexual assault, police officers routinely exploit their drug use or sex work status to discredit their claims, threaten them with administrative detention, or reverse legal victim-offender roles. Fearing police retaliation and lacking legal literacy, vulnerable women are frequently coerced into accepting administrative liabilities or dropping complaints, leaving perpetrators completely unpunished. As one woman involved in sex work who uses NPS expressed regarding legal recourse: "Where would I even go? Everyone knows I'm a sex worker and that I use drugs".
41. Most marginalised women remain unaware of their legal rights or available support services, and no formal state mechanism exists to help them navigate legal, social, or medical systems. Peer support services and community navigators are neither officially recognised nor integrated into state protection schemes, leaving women feeling isolated, unprotected, and unable to seek redress due to a lack of accurate information and trained, non-judgmental staff.
42. These systemic failures violate Article 2(c), 2(f), and Article 15 of the CEDAW Convention, which guarantee women equality before the law and an effective system of legal protection. The geographic and financial barriers faced by rural women directly conflict with General Recommendation No. 34 (Rural Women), which mandates that States Parties ensure equal access to justice, legal aid, and health services, including regional forensic facilities. Furthermore, institutional bias, threats of administrative sanctions against victims, and the refusal to process complaints from sex workers and women who use drugs violate General Recommendation No. 33 (Access to Justice) and General Recommendation No. 35 (Gender-Based Violence), which strictly prohibit police misconduct, secondary victimisation, and the discriminatory enforcement of penal laws.

Implementation of Article 7: Participation in public and political life

43. The systemic denial of peaceful assembly for women's rights organisations and feminist activists in Kazakhstan represents a severe violation of civic space, curtailing public advocacy for all women—particularly those from double-marginalised populations, including women living with HIV, women who use drugs, and sex workers, who rely on public platforms to demand systemic reform.
44. Local government authorities (*akimats*), particularly in Almaty, systematically refuse to grant permits for the annual International Women's Day (March 8th) feminist rallies and marches[15]. Multiple refusals were issued again in 2026. For consecutive years, municipal authorities have deployed generic, unsubstantiated justifications for these bans, citing *"threats to public order during peaceful assemblies"*, risk of *"potential public unrest"*, or claiming that all designated public assembly spaces are pre-booked. The authorities provide no empirical evidence or factual grounds to support these safety claims. The year 2022 remains the sole instance in the history of independent Kazakhstan where city authorities approved a peaceful feminist walking march in Almaty[16]. These arbitrary restrictions severely limit the visibility of key populations; when civic space is closed, community-led organisations representing women living with HIV, sex workers,

[15] March 8th Almaty Rally and March Instagram page, available at: https://www.instagram.com/8marchkz?igsh=MXY4ZzMyNGhsMHdzcA%3D%3D
[16] March 8th Almaty Rally Organisers, Press Release, available at: https://www.instagram.com/p/DVsnNkmiLAn/?img_index=1

and women who use drugs are stripped of rare public opportunities to raise demands regarding state violence, healthcare discrimination, and criminalisation.

45. Member of the March 8th Organising Committee emphasizes the broader discriminatory impact of these arbitrary bans, noting: "*A huge number of people attend our rallies. They want to speak about women's rights, show solidarity, and celebrate March 8th in this exact way. I believe the akimat's refusals are not only discrimination against me as a feminist, but also discrimination against hundreds of people who come every year and want to attend the March 8th rallies and march*"[17]. This exclusion acutely impacts community advocates and civil society groups representing key populations, for whom public assemblies serve as vital platforms to demand healthcare access, bodily autonomy, and protection from police harassment without fear of administrative retaliation.
46. This state practice directly breaches Article 7 of the CEDAW Convention, which obligates States Parties to eliminate discrimination against women in the political and public life of the country, guaranteeing their right to participate in non-governmental organisations and public associations. Denying women the right to assemble peacefully and express public solidarity also violates Article 2(e) and 2(f) and conflicts directly with General Recommendation No. 23 (Political and Public Life), which underlines that full equality requires an enabling environment where women and feminist organisations can advocate publicly without state obstruction or fear of administrative retaliation. Furthermore, arbitrary restrictions on women's civic space breach General Recommendation No. 28, which details the core legal obligations of States Parties to respect, protect, and fulfill women's human rights.

Recommendations

We ask the CEDAW Committee to recommend to the Government of the Republic of Kazakhstan to:

47. Repeal Article 118 of the Criminal Code to fully decriminalise HIV exposure and transmission [Articles 2, 12, 16].
48. Enact comprehensive anti-discrimination legislation that explicitly protects people based on HIV status, drug use, and engagement in sex work [Article 2(f), GR 28].
49. Repeal or amend Article 449 of the Code of Administrative Offences to decriminalise sex work, eliminate administrative penalties for prostitution, and ensure it is not used as a basis for police harassment, extortion, or arbitrary detention [Articles 2(f), 15, GR 35].
50. Abolish police databases and registries that target sex workers [Article 2(f), CEDAW/C/KAZ/CO/5].
51. Stop the practice of forced HIV and STI testing conducted by law enforcement officers [Articles 2(f), 12, GR 24].
52. Transition national drug policies from criminal prosecution toward a human-rights-based, gender-responsive harm reduction model [Articles 2, 12, GR 24].
53. Ensure widespread, non-prescription community access to Naloxone (including nasal spray formulations) and provide systematic, gender-sensitive overdose response training for women who use drugs and their peers [Article 12, GR 24].
54. Issue a binding directive from the Ministry of Health strictly prohibiting public healthcare institutions, including regional perinatal centres and polyclinics, from refusing registration, diagnostic procedures, or treatment to women based on their HIV status, age, or drug use history [Article 12, GR 24].
55. Enforce mandatory written informed consent requirements across all medical and academic healthcare facilities, prohibiting the presence or examination of patients by medical trainees or unauthorised personnel without explicit, voluntary consent [Article 12, GR 24, GR 35].
56. Ensure non-discriminatory access to healthcare and social services for sex workers, women who use drugs, and women living with HIV, including targeted gynaecological, oncological, sexual and reproductive health, and HIV prevention programs [Articles 12, 14].

[17] EWNA, The Story of One Women's March: Why Is the State Against Feminists? (2025), available at: https://ewna.org/2025/03/07/istoriya-odnogo-zhenskogo-marsha-pochemu-gosudarstvo-protiv-feministok/

57. Provide mandatory training for all law enforcement officers, healthcare personnel, and social service providers on medical ethics, non-discrimination, gender-based violence, and trauma-informed care [Article 12, GR 24].
58. Enforce strict administrative and legal penalties for health workers and officials who breach medical confidentiality, strictly prohibiting the disclosure or transfer of patient medical data to third parties or law enforcement [Article 12, GR 24]
59. Explicitly prohibit healthcare providers from pressuring women living with HIV or women who use drugs into forced tubal ligation, forced sterilisation, or forced abortions [Article 12, GR 24, GR 35].
60. Establish a legal mechanism to guarantee that OAT is never interrupted during planned or emergency hospital stays [Article 12, GR 24].
61. Issue binding protocols ensuring that pregnant women receiving OAT are protected from forced withdrawal during childbirth and post-natal care [Article 12(2), GR 24].
62. Secure uninterrupted national procurement and supply chains for methadone and OAT medications to prevent treatment stockouts [Article 12, GR 24].
63. Allocate public funding to expand gender-responsive, voluntary drug dependency treatment facilities [Article 12, GR 24].
64. Guarantee equal access to essential pain management and oncology medications regardless of a patient's drug use status or registry record [Article 12, GR 24].
65. Establish state-funded temporary childcare services for mothers undergoing inpatient drug treatment or rehabilitation [Article 12, GR 24].
66. Amend Order No. 230 to completely remove AIDS/HIV from the list of medical contraindications for receiving Special Social Services across all formats, ensuring women living with HIV who have disabilities or are elderly have equal access to state social support.
67. Amend all Ministry of Labour and Social Protection regulations to explicitly stop using HIV status as a medical reason to turn women away from crisis shelters [Articles 2(f), 12, GR 35].
68. Enforce domestic violence legislation ("Saltanat's Law") equally so that protection orders and crisis shelters are accessible to sex workers, women who use drugs, and women living with HIV [Articles 2(c), GR 35].
69. Implement mandatory training for all social centre and shelter staff on HIV transmission, privacy, and non-discriminatory care [Article 12, GR 24, GR 35].
70. Ensure the meaningful participation of women living with HIV, women who use drugs, sex worker community representatives in the development, implementation, and evaluation of national strategies on women's rights, public health, and gender equality [Article 7, GR 28].
71. Implement public awareness campaigns to combat HIV-related stigma and discrimination, especially in rural and remote areas [Articles 5, 14].
72. Support and institutionalise peer-led services for women living with HIV, including psychosocial support and assistance in navigating protection systems [Articles 2, 12].
73. Ensure that women living in rural and remote areas have equal and timely access to healthcare services, forensic medical examinations, legal aid, crisis centres, shelters and other protection services for survivors of GBV, including by expanding the availability of services at the local level and removing geographic and financial barriers [Articles 12, 14, 15, GR 34, GR 35].
74. Mobile forensic teams and localised medical examination protocols should be established within district polyclinics and rural health centres to eliminate financial and geographic barriers that prevent rural women from documenting domestic and sexual violence injuries [Article 15, GR 34, GR 35].
75. State-funded legal literacy campaigns and free legal aid services should be expanded into rural areas and key population networks, ensuring women are informed of their rights under "Saltanat's Law" and equipped to access protection orders and legal remedies [Article 15, GR 33, GR 34].

76. Create an independent mechanism to investigate police officers guilty of extortion, violence, or refusing to protect sex workers and women who use drugs [Article 2(c), GR 33, GR 35].
77. Allocate state funding to train and deploy community paralegals from key populations to help marginalised women navigate legal and social service systems [Article 2(c), GR 33].
78. Design and fund rights-literacy programmes for vulnerable women to help them recognise and safely report domestic abuse and reproductive coercion [Articles 5(a), GR 33].
79. Guarantee the right to peaceful assembly by instructing local city authorities (*akimats*) to stop arbitrarily denying permits for March 8th feminist rallies [Article 7, GR 23].
80. Ensure that feminist activists, harm reduction workers, and advocates can operate publicly without fear of police harassment or administrative retaliation [Article 7, GR 28].