

Country Profile: Kyrgyzstan

Last Updated: 15 December 2023

Region: South-Central Asia



Identified policies and legal sources related to abortion:

- ✓ Reproductive Health Act
- ✓ General Medical Health Act
- Constitution
- ✓ Criminal / Penal Code
- Civil Code
- ✓ Ministerial Order / Decree
- Case Law
- ✓ Health Regulation / Clinical Guidelines
- ✓ EML / Registered List
- Medical Ethics Code
- Document Relating to Funding
- Abortion Specific Law
- Law on Medical Practitioners
- Law on Health Care Services
- ✓ Other

Related Documents

From Reproductive Health Act:

- [Law on reproductive rights of citizens amended, 2019](#)

From General Medical Health Act:

- [Law on Health Protection, 2005](#)

From Criminal / Penal Code:

- [Criminal Code amended, 2021](#)

From Ministerial Order / Decree:

- [Abortion procedure, 2009](#)
- [Position on abortion for medical indications, 2009](#)
- [Position on abortion for social indications, 2009](#)

From Health Regulation / Clinical Guidelines:

- [Clinical protocol on medical abortion in the first and second trimester, 2017](#)
- [Kyrgyzstan Clinical Protocol Medical abortion-in I and II trimester 2017](#)

From EML / Registered List:

- [Medabon registration, 2018](#)
- [Essential Medicines List, 2018](#)

From Other:

- [Law on National Strategy on Reproductive Health](#)



List of ratified human rights treaties:

- ✓ CERD
- ✓ CCPR
- ✓ Xst OP
- ✓ 2nd OP
- ✓ CESC
- CESCR-OP
- ✓ CAT
- ✓ CAT-OP
- ✓ CEDAW
- ✓ CEDAW-OP
- ✓ CRC
- ✓ CRC:OPSC
- ✓ CRC:OPAC
- CRC:OPIC
- ✓ CMW
- CRPD *
- CRPD-OP
- CED **
- Maputo Protocol

↓ [Download data](#)



Concluding Observations:

- [CEDAW](#)
- [CRC](#)
- [CESCR](#)
- [SR VAW](#)



Persons who can be sanctioned:

- A woman or girl can be sanctioned
- ✓ Providers can be sanctioned
- ✓ A person who assists can be sanctioned

Abortion at the woman's request

✓ Gestational limit: 12

Legal Ground and Gestational Limit

Economic or social reasons



Not specified

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:

- [Law on Health Protection, 2005](#)
- [Clinical protocol on medical abortion in the first and second trimester, 2017](#)
- [Abortion procedure, 2009](#)
- [Position on abortion for medical indications, 2009](#)
- [Position on abortion for social indications, 2009](#)
- [Law on reproductive rights of citizens amended, 2019](#)



WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Health grounds shall reflect WHO's definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2.

↓ **Source document:** [WHO Abortion Care Guideline \(page 16\)](#)



Additional notes

The Ministry of Health "Clinical protocol for medical abortion in the first and second trimesters of pregnancy" contains a list of social indications. These are: the presence of disability I-II group from his wife and / or her husband; death of the husband during the wife's pregnancy; detention in prison of the woman or her husband; presence of court decision on deprivation or restriction of parental rights; woman's or husband's official status as unemployed; woman's official status as a refugee or forced migrant; divorce during pregnancy; pregnancy as a result of rape; large family (five or more children); presence of a disabled child in the family; material insecurity (income per family member is less than the official living wage); the pregnant woman's age is below 18 years. The Protocol states that if a woman has grounds for abortion of a non-medical nature which are not listed, a decision on whether she may terminate the pregnancy will be taken on an individual basis by a commission at the primary health care centre level or by a consultation at the hospital level. The gestational limit is 22 weeks.

Related documents:

- <https://abortion-policies.srhr.org/documents/countries/02-Kyrgyzstan-Law-on-reproductive-rights-2007.pdf#page=4>
- [Law on Health Protection, 2005 \(page 18 \)](#)
- [Clinical protocol on medical abortion in the first and second trimester, 2017 \(page 11\)](#)

Foetal impairment

Yes

Related documents:

- [Clinical protocol on medical abortion in the first and second trimester, 2017 \(page 24\)](#)

Gestational limit

Weeks: 22

- [Law on reproductive rights of citizens amended, 2019 \(page 10\)](#)



WHO Guidance

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Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person.

Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available when carrying a pregnancy to term would cause the woman, girl or other pregnant person substantial pain or suffering, including but not limited to situations where the pregnancy is not viable. Grounds-based approaches that require fetal impairments to be fatal for abortion to be lawful frustrate providers and leave women no choice but to continue with pregnancy. Being required to continue with a pregnancy that causes significant distress violates numerous human rights. Abortion Care Guideline § 2.2.2.

↓ **Source document:** [WHO Abortion Care Guideline \(page 64\)](#)

Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7.

↓ **Source document:** [WHO Abortion Care Guideline \(page 103\)](#)



Additional notes

Congenital anomalies and hereditary diseases in the foetus are included in the list of medical indications for termination of pregnancy. There is no gestational limit.

Rape

Rape is considered a social indication for abortion.



WHO Guidance

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Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available when carrying a pregnancy to term would cause the woman, girl or other pregnant person substantial pain or suffering, including but not limited to situations where the pregnancy is the result of rape or incest Abortion Care Guideline § 2.2.2.

↓ **Source document:** [WHO Abortion Care Guideline \(page 64\)](#)

Related documents:

- [Clinical protocol on medical abortion in the first and second trimester, 2017 \(page 11\)](#)

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| <p>Incest</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on Health Protection, 2005 • Clinical protocol on medical abortion in the first and second trimester, 2017 • Abortion procedure, 2009 • Position on abortion for medical indications, 2009 • Position on abortion for social indications, 2009 • Law on reproductive rights of citizens amended, 2019 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person.</p> <p>Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available when carrying a pregnancy to term would cause the woman, girl or other pregnant person substantial pain or suffering, including but not limited to situations where the pregnancy is the result of rape or incest. Abortion Care Guideline § 2.2.2.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 64)</p> |
| <p>Intellectual or cognitive disability of the woman</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on Health Protection, 2005 • Clinical protocol on medical abortion in the first and second trimester, 2017 • Abortion procedure, 2009 • Position on abortion for medical indications, 2009 • Position on abortion for social indications, 2009 • Law on reproductive rights of citizens amended, 2019 <p> Additional notes</p> <p>The woman's group I or II disability is included in the list of social indications for termination of pregnancy. The gestational limit is 22 weeks.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Clinical protocol on medical abortion in the first and second trimester, 2017 (page 11) |
| <p>Mental health</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on Health Protection, 2005 • Clinical protocol on medical abortion in the first and second trimester, 2017 • Abortion procedure, 2009 • Position on abortion for medical indications, 2009 • Position on abortion for social indications, 2009 • Law on reproductive rights of citizens amended, 2019 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>Health grounds shall reflect WHO's definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 16)</p> <p> Additional notes</p> <p>Abortion for medical reasons may be performed regardless of gestational age. The Ministry of Health "Clinical protocol for medical abortion in the first and second trimesters of pregnancy" contains a list of medical indications. For these indications there is no gestational limit.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Clinical protocol on medical abortion in the first and second trimester, 2017 (page 20) |

Physical health



Not specified

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:

- [Law on Health Protection, 2005](#)
- [Clinical protocol on medical abortion in the first and second trimester, 2017](#)
- [Abortion procedure, 2009](#)
- [Position on abortion for medical indications, 2009](#)
- [Position on abortion for social indications, 2009](#)
- [Law on reproductive rights of citizens amended, 2019](#)



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Health grounds shall reflect WHO's definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2.

↓ **Source document:** [WHO Abortion Care Guideline \(page 16\)](#)



Additional notes

Abortion for medical reasons may be performed regardless of gestational age. The Ministry of Health "Clinical protocol for medical abortion in the first and second trimesters of pregnancy" contains a list of medical indications. For these indications there is no gestational limit.

Related documents:

- [Clinical protocol on medical abortion in the first and second trimester, 2017 \(page 20\)](#)

Health



Not specified

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Related documents:

- [Law on Health Protection, 2005](#)
- [Clinical protocol on medical abortion in the first and second trimester, 2017](#)
- [Abortion procedure, 2009](#)
- [Position on abortion for medical indications, 2009](#)
- [Position on abortion for social indications, 2009](#)
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WHO Guidance

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↓ **Source document:** [WHO Abortion Care Guideline \(page 16\)](#)



Additional notes

The Ministry of Health "Clinical protocol for medical abortion in the first and second trimesters of pregnancy" states: "Medical indications for abortion are all clinical situations in which prolonged pregnancies pose a serious threat to the life and health of women." It contains a list of medical indications. It is unclear whether access to abortion in case of a serious threat to the life and health of the woman is limited to the listed medical indications. For these indications there is no gestational limit.

Life



Not specified

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:

- [Law on Health Protection, 2005](#)
- [Clinical protocol on medical abortion in the first and second trimester, 2017](#)
- [Abortion procedure, 2009](#)
- [Position on abortion for medical indications, 2009](#)
- [Position on abortion for social indications, 2009](#)
- [Law on reproductive rights of citizens amended, 2019](#)



WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person.


Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available where the life and health of the woman, girl or other pregnant person is at risk. Abortion Care Guideline § 2.2.2.

↓ **Source document:** [WHO Abortion Care Guideline \(page 64\)](#)














Additional notes








The Ministry of Health "Clinical protocol for medical abortion in the first and second trimesters of pregnancy" states: "Medical indications for abortion are all clinical situations in which prolonged pregnancies pose a serious threat to the life and health of women." It contains a list of medical indications. It is unclear whether access to abortion in case of a serious threat to the life and health of the woman is limited to the listed medical indications. For these indications there is no gestational limit.








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| <p>Other</p> | <p>Medical Indications</p> <p>Social Indications: the presence of disability I-II group from his wife and / or her husband; death of the husband during the wife's pregnancy; detention in prison of the woman or her husband; presence of court decision on deprivation or restriction of parental rights; woman's or husband's official status as unemployed; woman's official status as a refugee or forced migrant; divorce during pregnancy; pregnancy as a result of rape; large family (five or more children); presence of a disabled child in the family; material insecurity (income per family member is less than the official living wage); the pregnant woman's age is below 18 years.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 (page 10) • Law on Health Protection, 2005 (page 18) • Clinical protocol on medical abortion in the first and second trimester, 2017 (page 1) <p> Additional notes</p> <p>For medical indications included on the list there is no gestational limit.</p> <p>For social indications included on the list, the gestational limit is 22 weeks.</p> |
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Additional Requirements to Access Safe Abortion

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|---|---|
| <p>Authorization of health professional(s)</p> | <p>No</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Clinical protocol on medical abortion in the first and second trimester, 2017 (page 11) • Abortion procedure, 2009 (page 1) • Position on abortion for medical indications, 2009 (page 1) • Position on abortion for social indications, 2009 (page 1) <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women's access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 81)</p> <p> Additional notes</p> <p>For abortions for medical or social reasons after 12 weeks of gestation, a permit issued by a "Commission" is required. The "Commission" decides on the basis of a diagnosis of a disease or finding of a social factor by the doctor from whom the woman seeks a referral for abortion. The Ministry of Health "Clinical protocol for medical abortion in the first and second trimesters of pregnancy" states that if a woman has grounds for abortion of a non-medical nature which are not listed, a decision on whether she may terminate the pregnancy will be taken on an individual basis by a commission at the primary health care centre level or by a consultation at the hospital level. No further information was found on how the "Commission" is constituted or works. In the case of women receiving inpatient treatment and needing an abortion for medical reasons, the abortion permit is issued by a consilium of doctors treating facility. In the case of women being treated in a midwifery-gynecological hospital, an appropriate record is entered in the medical history, certified by the doctor's signatures according to the profile of the condition of the pregnant woman, the treating doctor and the head of the health organization (department).</p> |
| <p>Authorization in specially licensed facilities only</p> | <p>Yes</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 (page 10) <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>To establish an enabling environment, there is a need for abortion care to be integrated into the health system across all levels (including primary, secondary and tertiary) – and supported in the community – to allow for expansion of health worker roles, including self-management approaches. To ensure both access to abortion and achievement of Universal Health Coverage (UHC), abortion must be centred within primary health care (PHC), which itself is fully integrated within the health system, facilitating referral pathways for higher-level care when needed. Abortion Care Guideline § 1.4.1.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 52)</p> |
| <p>Judicial authorization for minors</p> | <p> Not specified</p> <p>When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on Health Protection, 2005 • Clinical protocol on medical abortion in the first and second trimester, 2017 • Abortion procedure, 2009 • Position on abortion for medical indications, 2009 • Position on abortion for social indications, 2009 • Law on reproductive rights of citizens amended, 2019 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 81)</p> |

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| <p>Judicial authorization in cases of rape</p> | <p>not applicable</p> <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>There shall be no procedural requirements to “prove” or “establish” satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information). These restrictions subject the individual to unnecessary trauma, may put them at increased risk from the perpetrator, and may cause women to resort to unsafe abortion.</p> <p>The Abortion Care Guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Abortion Care Guideline § 2.2.2.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 64)</p> |
| <p>Police report required in case of rape</p> | <p>not applicable</p> <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>There shall be no procedural requirements to “prove” or “establish” satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information). These restrictions subject the individual to unnecessary trauma, may put them at increased risk from the perpetrator, and may cause women to resort to unsafe abortion.</p> <p>The Abortion Care Guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Abortion Care Guideline § 2.2.2.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 64)</p> |
| <p>Parental consent required for minors</p> | <p>Yes</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 (page 10) <p>Can another adult consent in place of a parent?</p> <p>Yes</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 (page 10) <p>Age where consent not needed</p> <p>16</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 (page 10) <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>While parental or partner involvement in abortion decision-making can support and assist women, girls or other pregnant persons, this must be based on the values and preferences of the person availing of abortion and not imposed by third-party authorization requirements. Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women’s access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 81)</p> |
| <p>Spousal consent</p> | <p> Not specified</p> <p>When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on Health Protection, 2005 • Clinical protocol on medical abortion in the first and second trimester, 2017 • Abortion procedure, 2009 • Position on abortion for medical indications, 2009 • Position on abortion for social indications, 2009 • Law on reproductive rights of citizens amended, 2019 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>While parental or partner involvement in abortion decision-making can support and assist women, girls or other pregnant persons, this must be based on the values and preferences of the person availing of abortion and not imposed by third-party authorization requirements. Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women’s access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 81)</p> <p> Additional notes</p> <p>There is a spousal consent requirement for abortions on social grounds.</p> |

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| <p>Ultrasound images or listen to foetal heartbeat required</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on Health Protection, 2005 • Clinical protocol on medical abortion in the first and second trimester, 2017 • Abortion procedure, 2009 • Position on abortion for medical indications, 2009 • Position on abortion for social indications, 2009 • Law on reproductive rights of citizens amended, 2019 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>The right to refuse information, including the right to refuse viewing ultrasound images, must be respected. The Abortion Care Guideline recommends against the use of ultrasound scanning as a prerequisite for providing abortion services for both medical and surgical abortion. Abortion Care Guideline § 3.3.5.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 85)</p> |
| <p>Compulsory counselling</p> | <p>Yes</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 (page 10) <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>While counselling should be made available and accessible, it should always be voluntary for women to choose whether or not they want to receive it. The right to refuse counselling when offered must be respected. Where provided, counselling must be available to individuals in a way that respects privacy and confidentiality.</p> <p>Counselling should be person-centred and may need to be tailored according to the needs of the individual; young people, survivors of sexual and gender-based violence or members of marginalized groups may have different information or counselling requirements.</p> <p>The content of and approach to counselling will need to be adjusted depending on the reason for seeking abortion services. Therefore, it is important for the counsellor to be aware of and sensitive to the individual's situation and needs. Abortion Care Guideline § 3.2.2.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 77)</p> |
| <p>Compulsory waiting period</p> | <p>No</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Clinical protocol on medical abortion in the first and second trimester, 2017 (page 15) <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>Mandatory waiting periods delay access to abortion, sometimes to the extent that women's access to abortion or choice of abortion method is restricted. The Abortion Care Guideline recommends against mandatory waiting periods for abortion. Abortion Care Guideline § 3.3.1.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 79)</p> |
| <p>Mandatory HIV screening test</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on Health Protection, 2005 • Clinical protocol on medical abortion in the first and second trimester, 2017 • Abortion procedure, 2009 • Position on abortion for medical indications, 2009 • Position on abortion for social indications, 2009 • Law on reproductive rights of citizens amended, 2019 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>Regulatory, policy and programmatic barriers – as well as barriers in practice – that hinder access to and timely provision of quality abortion care should be removed. Abortion Care Guideline § Box 2.1.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 59)</p> <p> Additional notes</p> <p>Blood tests for RW, HIV, coagulogram (platelets, blood clotting), blood type and Rh factor are not necessary before a medical abortion, but the Clinical Protocol on Medical Abortion specifies that due these tests are necessary in the case of surgical abortion. In health organizations, where all women conduct laboratory tests to exclude STIs, in the absence of clinical signs of infection, induced abortion should not be postponed until the results of these tests are obtained.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Clinical protocol on medical abortion in the first and second trimester, 2017 (page 7) |

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| <p>Other mandatory STI screening tests</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on Health Protection, 2005 • Clinical protocol on medical abortion in the first and second trimester, 2017 • Abortion procedure, 2009 • Position on abortion for medical indications, 2009 • Position on abortion for social indications, 2009 • Law on reproductive rights of citizens amended, 2019 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>Regulatory, policy and programmatic barriers – as well as barriers in practice – that hinder access to and timely provision of quality abortion care should be removed. Abortion Care Guideline § Box 2.1.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 59)</p> <p> Additional notes</p> <p>Blood tests for RW, HIV, coagulogram (platelets, blood clotting), blood type and Rh factor are not necessary before a medical abortion, but the Clinical Protocol on Medical Abortion specifies that due these tests are necessary in the case of surgical abortion. In health organizations, where all women conduct laboratory tests to exclude STIs, in the absence of clinical signs of infection, induced abortion should not be postponed until the results of these tests are obtained.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Clinical protocol on medical abortion in the first and second trimester, 2017 (page 7) |
| <p>Prohibition of sex-selective abortion</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on Health Protection, 2005 • Clinical protocol on medical abortion in the first and second trimester, 2017 • Abortion procedure, 2009 • Position on abortion for medical indications, 2009 • Position on abortion for social indications, 2009 • Law on reproductive rights of citizens amended, 2019 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>In situations where abortion is restricted for sex selection purposes, terminating a pregnancy for this reason is likely to involve an unsafe procedure carrying high risks. Any policies or guidelines on the use of technology in obstetric and fetal medicine should take into account the need to ensure women’s access to safe abortion and other services - efforts to manage or limit sex selection should also not hamper or limit access to safe abortion services. Preventing gender-biased sex selection: an interagency statement.</p> <p>↓ Source document: Preventing Gender-Biased Sex Selection (page 17)</p> |
| <p>Restrictions on information provided to the public</p> | <p>No data found</p> <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>Dissemination of misinformation, withholding of information and censorship should be prohibited.</p> <p>Information should be accessible and understandable, including formats catering to low-literacy and differently abled populations. Different modalities exist for the provision of information on abortion, e.g. remote access via hotlines and telemedicine, and through approaches such as harm reduction and community-based outreach, as well as in-person interactions with health workers. Abortion Care Guideline § 3.2.1.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 74)</p> |
| <p>Restrictions on methods to detect sex of the fetus</p> | <p>No data found</p> <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>A woman is entitled to know the status of her pregnancy and to act on this information. Prenatal tests and other medical diagnostic services cannot legally be refused because the woman may decide to terminate her pregnancy. Safe Abortion Guidelines § 4.2.1.4.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 103)</p> |
| <p>Other</p> | |

National guidelines for induced abortion

Yes, guidelines issued by the government

Related documents:

- [Clinical protocol on medical abortion in the first and second trimester, 2017 \(page 1\)](#)



WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

National standards and guidelines for abortion care should be evidence based and periodically updated and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines. Abortion Care Guideline § 1.3.3.

↓ **Source document:** [WHO Abortion Care Guideline \(page 50\)](#)

Methods allowed

Vacuum aspiration

Not specified

Abortion by means of a surgical technique is used as an alternative in case of failure of medical abortion.

- [Clinical protocol on medical abortion in the first and second trimester, 2017](#)
- [Clinical protocol on medical abortion in the first and second trimester, 2017 \(page 11\)](#)

Dilatation and evacuation

Not specified

Abortion by means of a surgical technique is used as an alternative in case of failure of medical abortion.

- [Clinical protocol on medical abortion in the first and second trimester, 2017](#)
- [Clinical protocol on medical abortion in the first and second trimester, 2017 \(page 11\)](#)

Combination mifepristone-misoprostol

Yes (22 WEEKS)

Medical abortions up to 71 days from the first day of the menstrual period can be performed in primary health care facilities and hospitals. After 71 days they may be performed only in hospitals.

- [Clinical protocol on medical abortion in the first and second trimester, 2017 \(page 10\)](#)

Misoprostol only

Not specified

- [Clinical protocol on medical abortion in the first and second trimester, 2017](#)

Other (where provided)



WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Vacuum aspiration is recommended for surgical abortions at or under 14 weeks to be provided by traditional and complementary medicine professionals, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners.

The Abortion Care Guideline recommends against the practice of dilatation and sharp curettage (D&C), including for sharp curette checks (i.e. to “complete” the abortion) following vacuum aspiration. Abortion Care Guideline § 3.4.1.

↓ **Source document:** [WHO Abortion Care Guideline \(page 101\)](#)

Dilatation and evacuation (D&E) is recommended for surgical abortions at or over 14 weeks to be provided by generalist medical practitioners and specialist medical practitioners. Vacuum aspiration can be used during a D&E. Abortion Care Guideline § 3.4.1.

↓ **Source document:** [WHO Abortion Care Guideline \(page 103\)](#)

The recommended method for medical abortion is mifepristone followed by misoprostol (regimen differs by gestational age). Abortion Care Guideline § 3.4.2.

↓ **Source document:** [WHO Abortion Care Guideline \(page 106\)](#)

The Abortion Care Guideline recommends the use of misoprostol alone, with a regime that differs by gestational age. Evidence demonstrates that the use of combination mifepristone plus misoprostol is more effective than misoprostol alone. Abortion Care Guideline § 3.4.2.

↓ **Source document:** [WHO Abortion Care Guideline \(page 106\)](#)

Country recognized approval (mifepristone / mife-misoprostol)

Yes

Related documents:

- [Medabon registration 2018 \(page 1 \)](#)
- [Essential Medicines List, 2018 \(page 51\)](#)

Pharmacy selling or distribution



Not specified

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

- [Medabon registration 2018](#)
- [Essential Medicines List, 2018](#)



WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

Inclusion in the NEML is one important component of ensuring that quality medicines are available.

For induced abortion, Mifepristone (200 mg) and misoprostol (200 µg), are recommended in the WHO EML. The EML specifically mentions the following co-packaged formulation: 1 tablet mifepristone (200 mg) + 4 tablets misoprostol (200 µg).

Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system. Abortion Care Guideline § 1.4.4.

↓ **Source document:** [WHO Abortion Care Guideline \(page 55\)](#)

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

Inclusion in the NEML is one important component of ensuring that quality medicines are available.

For induced abortion, Mifepristone (200 mg) and misoprostol (200 µg), are recommended in the WHO EML. The EML specifically mentions the following co-packaged formulation: 1 tablet mifepristone (200 mg) + 4 tablets misoprostol (200 µg).

Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system. Abortion Care Guideline § 1.4.4.

↓ **Source document:** [WHO Abortion Care Guideline \(page 55\)](#)

Country recognized approval (misoprostol)

Yes, indications not specified

Related documents:

- [Essential Medicines List, 2018 \(page 51\)](#)

Misoprostol allowed to be sold or distributed by pharmacies or drug stores



Not specified

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

- [Essential Medicines List, 2018](#)



WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

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Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system. Abortion Care Guideline § 1.4.4.





↓ **Source document:** [WHO Abortion Care Guideline \(page 55\)](#)





Additional notes

The Essential Medicines List specifies that Misoprostol is for: "treatment of incomplete abortion and miscarriage; prevention and treatment of postpartum hemorrhage where oxytocin is not available or cannot be safely administered."



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| <p>Where can abortion services be provided</p> | <p>Related documents:</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 (page 10) • Abortion procedure, 2009 (page 1) <p>Primary health-care centres</p> <p>Yes</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 (page 10) • Abortion procedure, 2009 (page 1) <p>Secondary (district-level) health-care facilities</p> <p>Yes</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 (page 10) • Abortion procedure, 2009 (page 1) <p>Specialized abortion care public facilities</p> <p>Not specified</p> <ul style="list-style-type: none"> • Abortion procedure, 2009 • Law on reproductive rights of citizens amended, 2019 <p>Private health-care centres or clinics</p> <p>Not specified</p> <ul style="list-style-type: none"> • Abortion procedure, 2009 • Law on reproductive rights of citizens amended, 2019 <p>NGO health-care centres or clinics</p> <p>Not specified</p> <ul style="list-style-type: none"> • Abortion procedure, 2009 • Law on reproductive rights of citizens amended, 2019 <p>Other (if applicable)</p> <p>Healthcare organizations licensed for artificial termination of pregnancy</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 (page 10) • Abortion procedure, 2009 (page 1) <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 48)</p> |
| <p>National guidelines for post-abortion care</p> | <p>Yes, guidelines issued by the government</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Clinical protocol on medical abortion in the first and second trimester, 2017 (page 1) <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>National standards and guidelines for abortion care should be evidence based and periodically updated and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines. Abortion Care Guideline § 1.3.3.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 50)</p> |











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| <p>Where can post abortion care services be provided</p> | <p>Primary health-care centres Not specified</p> <ul style="list-style-type: none"> • Abortion procedure, 2009 • Law on reproductive rights of citizens amended, 2019 <p>Secondary (district-level) health-care facilities Not specified</p> <ul style="list-style-type: none"> • Abortion procedure, 2009 • Law on reproductive rights of citizens amended, 2019 <p>Specialized abortion care public facilities Not specified</p> <ul style="list-style-type: none"> • Abortion procedure, 2009 • Law on reproductive rights of citizens amended, 2019 <p>Private health-care centres or clinics Not specified</p> <ul style="list-style-type: none"> • Abortion procedure, 2009 • Law on reproductive rights of citizens amended, 2019 <p>NGO health-care centres or clinics Not specified</p> <ul style="list-style-type: none"> • Abortion procedure, 2009 • Law on reproductive rights of citizens amended, 2019 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>The Abortion Care Guideline recommends the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion services in whole or in part. Telemedicine services should include referrals (based on the woman’s location) for medicines (abortion and pain control medicines), any abortion care or post-abortion follow-up required (including for emergency care if needed), and for post-abortion contraceptive services. Abortion Care Guideline § 3.6.1.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 133)</p> |
| <p>Contraception included in post-abortion care</p> | <p>Yes</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Clinical protocol on medical abortion in the first and second trimester, 2017 (page 8) <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>All contraceptive options may be considered after an abortion. For individuals undergoing surgical abortion and wishing to use contraception, Abortion Care Guideline recommends the option of initiating the contraception at the time of surgical abortion. For individuals undergoing medical abortion, for those who choose to use hormonal contraception, the Abortion Care Guideline suggests that they be given the option of starting hormonal contraception immediately after the first pill of the medical abortion regimen. For those who choose to have an IUD inserted, Abortion Care Guideline suggests IUD placement at the time that success of the abortion procedure is determined. Abortion Care Guideline § 3.5.4.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 126)</p> |
| <p>Insurance to offset end user costs</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • https://abortion-policies.srhr.org/documents/countries/02-Kyrgyzstan-Law-on-reproductive-rights-2007.pdf • Law on Health Protection, 2005 <p>Other (if applicable)</p> <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>Where user fees are charged for abortion, this should be based on careful consideration of ability to pay, and fee waivers should be available for those who are facing financial hardship and adolescent abortion seekers. As far as possible, abortion services and supplies should be mandated for coverage under insurance plans as inability to pay is not an acceptable reason to deny or delay abortion care. Furthermore, having transparent procedures in all health-care facilities can ensure that informal charges are not imposed by staff. Abortion Care Guideline § 1.4.2.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 53)</p> |





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| <p>Who can provide abortion services</p> | <p>Related documents:</p> <ul style="list-style-type: none"> • https://abortion-policies.srhr.org/documents/countries/02-Kyrgyzstan-Law-on-reproductive-rights-2007.pdf • Law on Health Protection, 2005 <p>Nurse Not specified</p> <ul style="list-style-type: none"> • Law on Health Protection, 2005 • Clinical protocol on medical abortion in the first and second trimester, 2017 <p>Midwife/nurse-midwife Not specified</p> <ul style="list-style-type: none"> • Law on Health Protection, 2005 • Clinical protocol on medical abortion in the first and second trimester, 2017 <p>Doctor (specialty not specified) Not specified</p> <ul style="list-style-type: none"> • Law on Health Protection, 2005 • Clinical protocol on medical abortion in the first and second trimester, 2017 <p>Specialist doctor, including OB/GYN Not specified</p> <ul style="list-style-type: none"> • Law on Health Protection, 2005 • Clinical protocol on medical abortion in the first and second trimester, 2017 <p>Other (if applicable) Medical abortion is conducted by a specially trained medical professional (certificate).</p> <ul style="list-style-type: none"> • Clinical protocol on medical abortion in the first and second trimester, 2017 (page 12) <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>The Abortion Care Guideline recommends against regulation on who can provide and manage abortion that is inconsistent with WHO guidance. Abortion Care Guideline § 3.3.8.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 97)</p> |
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| <p>Extra facility/provider requirements for delivery of abortion services</p> | <p>Referral linkages to a higher-level facility No data found</p> <p>Availability of a specialist doctor, including OB/GYN No data found</p> <p>Minimum number of beds No data found</p> <p>Other (if applicable)</p> <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>There is no single recommended approach to providing abortion services. The choice of specific health worker(s) (from among the recommended options) or management by the individual themselves, and the location of service provision (from among recommended options) will depend on the values and preferences of the woman, girl or other pregnant person, available resources, and the national and local context. A plurality of service-delivery approaches can co-exist within any given context. Given that service-delivery approaches can be diverse, it is important to ensure that for the individual seeking care, the range of service-delivery options taken together will provide access to scientifically accurate, understandable information at all stages; access to quality-assured medicines (including those for pain management); back-up referral support if desired or needed; linkages to an appropriate choice of contraceptive services for those who want post-abortion contraception. Best Practice Statement 49 on service delivery. Abortion Care Guideline § 3.6.1.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 132)</p> |
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Conscientious Objection

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| <p>Public sector providers</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 • Criminal Code amended, 2021 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>The Abortion Care Guideline recommends that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection. It is critical that States ensure compliance with regulations and design/organize health systems to ensure access to and continuity of quality abortion care. If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible. Abortion Care Guideline § 3.3.9.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 98)</p> |
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| <p>Private sector providers</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 • Criminal Code amended, 2021 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>The Abortion Care Guideline recommends that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection. It is critical that States ensure compliance with regulations and design/organize health systems to ensure access to and continuity of quality abortion care. If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible. Abortion Care Guideline § 3.3.9.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 98)</p> |
| <p>Provider type not specified</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 • Criminal Code amended, 2021 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>The Abortion Care Guideline recommends that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection. It is critical that States ensure compliance with regulations and design/organize health systems to ensure access to and continuity of quality abortion care. If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible. Abortion Care Guideline § 3.3.9.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 98)</p> |
| <p>Neither Type of Provider Permitted</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 • Criminal Code amended, 2021 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>The Abortion Care Guideline recommends that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection. It is critical that States ensure compliance with regulations and design/organize health systems to ensure access to and continuity of quality abortion care. If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible. Abortion Care Guideline § 3.3.9.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 98)</p> |
| <p>Public facilities</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 • Criminal Code amended, 2021 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 48)</p> |
| <p>Private facilities</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 • Criminal Code amended, 2021 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 48)</p> |

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| <p>Facility type not specified</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 • Criminal Code amended, 2021 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 48)</p> |
| <p>Neither Type of Facility Permitted</p> | <p> Not specified When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</p> <p>Related documents:</p> <ul style="list-style-type: none"> • Law on reproductive rights of citizens amended, 2019 • Criminal Code amended, 2021 <p> WHO Guidance</p> <p>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</p> <p>Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.</p> <p>↓ Source document: WHO Abortion Care Guideline (page 48)</p> |

Indicators

Country specific information related to sexual and reproductive health indications. As data for the Sustainable Development Goal (SDG) indicators related to sexual and reproductive health become available, these will be provided, through periodic updates.

Goal 1. End poverty in all its forms everywhere

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|--|---------|
| 1.1.1 Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural) | No data |
| 1.3.1 Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable | No data |
| 1.a.2 Proportion of total government spending on essential services (education, health and social protection) | No data |

Goal 3. Ensure healthy lives and promote well-being for all at all ages

| | |
|--|------------------|
| 3.1.1 Maternal mortality ratio | 60 (2017) |
| 3.1.2 Proportion of births attended by skilled health personnel | No data |
| 3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods | No data |
| 3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group | 38.1 (2015-2020) |
| 3.8.2 Number of people covered by health insurance or a public health system per 1,000 population | No data |
| 3.c.1 Health worker density and distribution | No data |

Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

| | |
|---|---------|
| 4.1.1 Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex | No data |
|---|---------|

Goal 5. Achieve gender equality and empower all women and girls

5.1.1 Whether or not legal frameworks are in place to promote, enforce and monitor equality and nondiscrimination on the basis of sex

No data

5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age

No data

5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence

No data

5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18

No data

5.3.2 Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age

No data

5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

No data

5.6.2 Number of countries with laws and regulations that guarantee women aged 15- 49 years access to sexual and reproductive health care, information and education

No data

5.a.1 (a) Proportion of total agricultural population with ownership or secure rights over agricultural land, by sex; and (b) share of women among owners or rights-bearers of agricultural land, by type of tenure

No data

5.b.1 Proportion of individuals who own a mobile telephone, by sex

No data

Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

8.5.2 Unemployment rate, by sex, age and persons with disabilities

No data

Goal 10. Reduce inequality within and among countries

10.2.1 Proportion of people living below 50 per cent of median income, by age, sex and persons with disabilities

No data

10.3.1 Proportion of the population reporting having personally felt discriminated against or harassed within the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law

No data

Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

16.1.3 Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months

No data

16.2.2 Number of victims of human trafficking per 100,000 population, by sex, age and form of exploitation

No data

16.2.3 Proportion of young women and men aged 18-29 years who experienced sexual violence by age 18

No data

16.3.1 Proportion of victims of violence in the previous 12 months who reported their victimization to competent authorities or other officially recognized conflict resolution mechanisms

No data

16.5.1 Proportion of persons who had at least one contact with a public official and who paid a bribe to a public official, or were asked for a bribe by those public officials, during the previous 12 months

No data

16.6.1 Primary government expenditures as a proportion of original approved budget, by sector (or by budget codes or similar)

No data

16.6.2 Proportion of the population satisfied with their last experience of public services

No data

16.7.1 Proportions of positions (by sex, age, persons with disabilities and population groups) in public institutions (national and local legislatures, public service, and judiciary) compared to national distributions

No data

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|---|---------|
| 16.9.1 Proportion of children under 5 years of age whose births have been registered with a civil authority, by age | No data |
| 16.10.1 Number of verified cases of killing, kidnapping, enforced disappearance, arbitrary detention and torture of journalists, associated media personnel, trade unionists and human rights advocates in the previous 12 months | No data |
| 16.b.1 Proportion of population reporting having personally felt discriminated against or harassed in the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law | No data |

Goal 17. Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

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|---|---------|
| 17.8.1 Proportion of individuals using the Internet | No data |
|---|---------|

Additional Reproductive Health Indicators

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|---|-----------------------|
| Percentage of married women with unmet need for family planning | 18 (2012) |
| Percentage of births attended by trained health professional | 98.4 (2014) |
| Percentage of women aged 20-24 who gave birth before age 18 | 2 (2009-2013) |
| Total fertility rate | 3.3 (2018) |
| Legal marital age for women, with parental consent | No data |
| Legal marital age for women, without parental consent | 18 (2009-2017) |
| Gender Inequalities Index (Value) | 0.39 (2017) |
| Gender Inequalities Index (Rank) | 91 (2017) |
| Mandatory paid maternity leave | yes (2020) |
| Median age | 26 (2020) |
| Population, urban (%) | 36.35 (2018) |
| Percentage of secondary school completion rate for girls | 0.98 (2013) |
| Gender parity in secondary education | 1 (2018) |
| Percentage of women in non-agricultural employment | 68.69 (2018) |
| Proportion of seats in parliament held by women | 19.2 (2017) |
| Sex ratio at birth (male to female births) | 1.06 (2018) |