



ASSESSMENT OF BARRIERS RELATED TO THE LEGAL ENVIRONMENT, GENDER, STIGMA AND HUMAN RIGHTS FOR KEY POPULATIONS IN THE RESPONSE TO TUBERCULOSIS IN ALMATY CITY AND ALMATY OBLAST

2020

Almaty

Assessment of barriers related to the legal environment, gender, stigma and human rights for key populations in the response to tuberculosis in Almaty city and Almaty Oblast.

Project "Assessment of barriers in access to diagnosis and treatment of TB for key populations" within the framework of multi-country program "Advancing People-Centered Quality TB Care - From the New Model of Care Towards Improving DR-TB Early Detection and Treatment Outcomes" (TB-REP 2.0).

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Designations, abbreviations

ART	Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
WHO	World Health Organization
IDI	In-Depth Interview
FG	Focus Group
IKI	Interviews with Key Informants
PPSS	Public Procurement of Social Services
IIN	Individual Identification Number
STIs	Sexually Transmitted Infections
KazUnion of PLHIV	Kazakhstan Union of People living with HIV
KP	Key Populations
KSCDID	Kazakh Scientific Center of Dermatology and Infectious Diseases
PLHIV	People Living with HIV
PWTB	People with Tuberculosis
IUD	Injecting Drug Users
DR-TB	Drug-Resistant Tuberculosis
MIA RK	Ministry of Internal Affairs of the Republic of Kazakhstan - Ministry of Internal Affairs of the Republic of Kazakhstan
MH RK	Ministry of Health of the Republic of Kazakhstan
MHSD RK	Ministry of Health and Social Development of the Republic of Kazakhstan
MDR-TB	Multidrug-Resistant Tuberculosis
NRTBP	National Register of TB Patients
NSCP MH RK	National Scientific Center of Phthisiopulmonology of the Ministry of Health of the Republic of Kazakhstan
SI	Statutory Instrument
NGO	Non-Governmental Organization
OST	Opioid Substitution Therapy
UN	United Nations
PS	Psychoactive Substances
PHC	Primary Health Care
RK	Republic of Kazakhstan
RAP	Register of Attached Population
CRG	Communities, Rights and Gender
SRG	Stigma, Rights and Gender
AIDS	Acquired Immunodeficiency Syndrome
TB	Tuberculosis
CMCB	Centralized Medical Consultative Board
SDGs	Sustainable Development Goals
CAA PLHIV	Central Asian Association of People Living with HIV
XDR-TB	Extensively Drug-Resistant Tuberculosis

The purpose and objectives of the Assessment

The purpose of the CRG Assessment was to obtain strategic information to support interventions that transform the responses to TB and ensure that they are equitable, rights-based and people-centered.

CRG Assessment objectives:

1. To review TB normative and policy frameworks based on international regional and subregional conventions, systems and guidelines.
2. To identify which key sub-populations should be considered as key and vulnerable populations in the TB response.
3. To assess under what conditions and at what stages of TB care TB patients face stigma and its manifestations.
4. To evaluate how gender factors affect TB vulnerability, access to TB services and treatment outcomes.
5. To elaborate recommendations for improving the TB response, to develop an action plan with specific interventions in order to:
 - 5.1. ensure the provision of quality TB services that are acceptable to all key and vulnerable populations.
 - 5.2. change gender relations and be based on human rights.

Issues addressed by the Assessment,

Issues addressed by the Assessment relate to four areas of the survey: legal environment, gender, key populations and stigma.

1. Legal environment

- How does the current legal environment and policies affect access to TB-related health care or increase vulnerability and create barriers to access to TB-related health care?
- What legal program responses, including strengthening laws, policies, regulations, reducing stigma and discrimination, increasing access to justice, improving compliance with laws and policies might be taken to improve TB responses?

2. Gender

- How does gender influence the social dynamics of vulnerability to TB, access to care and treatment outcomes?
- What changes in program implementation could be made to change the nature of the response from one that is not gender-sensitive to one that is gender-responsive and eventually to one that changes gender relations?

3. Key populations

- Which potential population subgroups require further attention in case TB is eliminated?
- What is your opinion on the data gaps to ensure that TB programs address the risks, risk factors and barriers to service access experienced by key populations??

4. Stigmatization

- What is TB-related stigma and how does stigma affect the TB Journey?
- Where in the TB Journey and in what cases is there TB stigma?
- Which population subgroups need further attention to address TB stigma?

Principles for Evaluation

- **Responsibility:** Evaluation and responsibility rests with the countries implementing the evaluation.
- **Commitment:** Implemented with the commitment and support of national policy-makers, people affected by TB, civil society organizations and health professionals.
- **Participation:** People affected by TB, especially those in the focus of quality research, are actively involved in the development of the process and outcomes.

The importance of the assessment

The outcomes of this survey will contribute to a more comprehensive approach to TB programs and policies in Kazakhstan. The data received will improve the understanding of stakeholders, including communities affected by tuberculosis, of the possible impact of gender and human rights in the context of tuberculosis, so that they can assess how to improve existing approaches in TB prevention and treatment programs.

This survey will also contribute to acquiring knowledge and will respond to current gaps in TB-related policies, especially their interaction with gender and human rights. It would help future researchers, policy makers, program developers and health professionals.

Assessment scope and restrictions

Due to the financial and time restrictions, the Assessment was conducted only in Almaty city and Almaty Oblast. It is not intended to apply the data gathered in the Assessment to the entire country. However, the outcomes of the Assessment could provide an important basis for further research on gender, human rights and other related social determinants faced by communities affected by tuberculosis, which could contribute to the development and improvement of programs and policies.

Assessment methodology

1. The meeting of the core team and all stakeholders was held on October 1, 2019. In total, the Meeting was attended by 24 participants: 7 participants represented the public sector, 9 participants represented International Organizations and 8 participants represented non-governmental organizations (Annex 1 - The list of participants of the meeting).

The Meeting aimed at identifying the priority key populations in the RK to determine barriers to services.

Meeting objectives:

1. To outline the major features of the TV-REP 2.0 multi-country program, the purpose of the community, rights and gender (CRG) Assessment as part of the program and the further use of the Assessment results.
2. To present the results of the desk study on legal environment, human rights, gender and key populations (KP).
3. To present the community, rights and gender (CRG) Assessment approaches and practical tools that will be used to identify the key structural barriers that lead to people with TB not being provided with care and delaying treatment.
4. To foster a common understanding and prioritization of key, vulnerable and unreached populations as part of the TB response.
5. To coordinate with the participants of the Working group the methods of Assessment - priority key populations that are not yet reflected in the National Strategic Plan and/or underserved, and to discuss the importance of the desk study and related activities.

The preliminary results of the desk study were presented at the meeting, an exercise on prioritization of key populations and discussion of the assessment process were conducted.

2. Desk study

The objective of the desk study is to analyze the country situation with regard to access to TB prevention and treatment services in the context of legal environment, gender and communities.

Legal environment - an overview of legal barriers people with TB and key populations face in accessing TB and related health services.

Legal environment - an overview of the legal barriers to accessing care for people with TB and key populations.

Gender - an overview of possible gender barriers to accessing TB prevention and management services.

Key groups - an overview of the country situation in the context of coverage of key populations.

Within the assessment, the desk study examined the country context, public health priorities and health trends. The desk study also identified gaps to address in the course of the country's field research.

The desk study included a literature review, secondary data analysis, and the creation of a list of references.

Within the legal review of the desk study, the following documents were considered:

- Constitution of the Republic of Kazakhstan.
- Code of the Republic of Kazakhstan "On public health and health care system".
- Resolution of the Government of the Republic of Kazakhstan of December 15, 2009 No. 2136 "On approval of the list of statutory free medical assistance".
- Order No. 994 of the Minister of Health of the Republic of Kazakhstan of December 25, 2017 "On approval of the Instruction on organization of health care services for tuberculosis".

- Order No. 77 of the Minister of Health and Social Development of the Republic of Kazakhstan of February 2, 2016, "On approval of the Standard of organization of the delivery of health care services to the population in case of tuberculosis".
- Order of the Minister of Health of the Republic of Kazakhstan No. 481 of 30 September 2009 "On approval of the rules for medical examination to recognize a citizen as a person with a contagious form of tuberculosis".

As part of the desk study on gender, stigma and key populations, the following documents were examined:

- The legal and regulatory framework for tuberculosis.
- Official statistics.
- Country application to the Global Fund.
- Scientific publications in domestic and foreign sources (researches on social factors affecting the spread of TB in the country; poorly studied key groups).

3. Identification of priority key populations for assessment.

To identify priority key populations, an exercise on prioritization of key populations was conducted with all stakeholders at the meeting.

Prioritization of key populations was carried out:

- to accelerate efforts leading to the elimination of TB by improving the identification of undetected cases of TB among sub-populations facing significantly higher risks of TB or more vulnerable in relation to TB;
- to include in the assessment those subpopulations that are considered as "hidden";
- to provide maximum specific contexts and different levels of resource restrictions faced by different countries;
- to identify the most vulnerable and marginalized subgroups to help increase the effectiveness of targeting groups affected by TB.
- by using a multi-stakeholder approach to data triangulation between any available official statistics and the collective experience of stakeholders.

With the purpose of implementation of the prioritization exercise, existing TB data was collected from potential 30+ key populations recommended by the StopTB Partnership. The gathered data was summarized in a summary table showing the available statistics for each potential subpopulation.

A prioritization tool (Annex 2) and gathered statistics on key populations were provided to the meeting participants for prioritizing key populations. The participants of the meeting were divided into 4 groups, where discussions took place. All potential key populations were rated with points, including those groups with no official TB data. The points were based on the best assessment of the participants present.

Each group then rated each of the 5 key population groups that were identified for the group, based on the existing official TB data, the experience of the group members, and discussions about the risks/vulnerability and barriers faced by these key populations.

Group 1	Group 2	Group 3	Group 4
PLHIV	PLHIV	PLHIV	PLHIV
Internal migrants*	Internal migrants*	Migrants	Migrants
People Who Use Drugs	Rural Poor	Prisoners & Detainees	Prisoners & Detainees
Homeless	Homeless	Homeless	Homeless
Urban Poor	People with Alcohol	Urban Poor	Rural poor

	Dependency		
Rural poor		Rural poor	Family members of People Who Use Drugs
People with Diabetes		People with Diabetes	Miners
Oralmans ¹ (repatriants) *			

*key populations that are not on the 30+ Key Populations List recommended by the StopTB Partnership.

Following the discussion and synthesis of the results of the prioritization exercise two groups were recommended for the CRG assessment:

- 1) people living with HIV;
- 2) internal migrants.

The group of internal migrants is not on the 30+ Key Populations List recommended by the StopTB Partnership and was selected specifically for Kazakhstan. According to the Government of the Republic of Kazakhstan², an internal migrant is a person who moves voluntarily within Kazakhstan with the intentions of settling, permanently or temporarily, at a new location. The major trend of internal migration is the urbanization processes that create centers of gravity, the village as a socio-economic element of the system is degraded - people in search of jobs and a better life "flee" to the cities. In most cases, internal migrants are people who do not have their own place of residence in the places of migration, a permanent source of income, social connections (relatives, friends) and without any social benefits and preferences due to lack of registration at the place of residence and/or lack of documents. All of the above-mentioned issues in the context of tuberculosis are reflected in access to health services in general and to TB-related services in particular.

4. Methods and procedures.

"Assessment of barriers related to legal environment, gender, stigma and human rights in the response to tuberculosis in Kazakhstan" is a qualitative study conducted through the following methods:

- **Desktop studies** for each area of assessment: legal environment, gender, key populations and stigma.
- **Key informants interviews** with experts and supporters in this area (Annex 3 - list of key informants).
- **In-depth interviews** with people affected by TB, community members.
- **Focus group discussions** with people affected by TB, community members. The issues related to the vulnerability of TB patients have been integrated into all methods.

Assessment participants

Criteria for the inclusion:

All participants (mentioned above) must meet the following criteria:

- Must be 18 years or older.

¹Oralman (Kazakh: Оралман), literally: "returnee") is an official term used by Kazakh authorities to describe ethnic Kazakhs who have immigrated to Kazakhstan since its independence in 1991

²https://tengrinews.kz/zakon/pravitelstvo_respubliki_kazahstan_premier_ministr_rk/konstitutsionnyy_stroy_i_osnovyi_gosudarstvennogo_upravleniya/id-P1100001427/.

- To be affected by tuberculosis in the last 5 years.
- To provide informed consent for inclusion of data into the assessment process.

Criteria for exclusion: People with TB who were not willing to participate in the assessment or those who could not or were not able to provide informed consent.

Assessment regions

Following the recommendation of the Meeting of Stakeholders held on October 1, 2019, Almaty City and Almaty Oblast were selected as target regions for the assessment.

Data collection for the assessment through key informant interviews, in-depth interviews, focus groups was conducted between December 2019 and January 2020.

Observance of ethical principles. Assessment tools have undergone ethical examination in the Local Ethics Committee of the Kazakh National Medical University, Minutes No. 10(89) of 27 November 2019.

Data collection plan for Almaty city and Almaty Oblast

	Data collection	Method	Number of participants
1	People with TB (PWTB) - general information (Almaty city).	In-depth interview	15 (gender and age balance) PWTB (gender balance) who have been diagnosed in the last 5 years
	PWTB – general information (Almaty Oblast)	In-depth interview	15 (gender and age balance) PWTB (gender balance) who have been diagnosed in the last 5 years
2	PWTB – general information (Almaty city)	Focus group discussions	11 (gender and age balance) PWTB who have been diagnosed in the last 5 years
	PWTB – general information (Almaty Oblast)	Focus group discussions	11 (gender and age balance) PWTB who have been diagnosed in the last 5 years
3	PWTB – women (Almaty city)	Focus group discussions	11 (age balance) women with TB who have been diagnosed in the last 5 years
	PWTB – women (Almaty Oblast)	Focus group discussions	11 (age balance) women with TB who have been diagnosed in the last 5 years
4	PWTB – men (Almaty city)	Focus group discussions	11 (age balance) men with TB who have been diagnosed in the last 5 years
	PWTB – men (Almaty Oblast)	Focus group discussions	11 (age balance) men with TB who have been diagnosed in the last 5 years
5	PWTB – PLHIV (Almaty city)	Focus group discussions	11 (gender and age balance) KP PWTB who have been diagnosed in the last 5 years

6	PWTB – PLHIV (Almaty Oblast)	Focus group discussions	11 (gender and age balance)KP PWTB who have been diagnosed in the last 5 years
7	PWTB – internal migrants (Almaty city)	Focus group discussions	11 (gender and age balance)KP PWTB who have been diagnosed in the last 5 years
8	PWTB – internal migrants (Almaty Oblast)	Focus group discussions	11 (gender and age balance)KP PWTB who have been diagnosed in the last 5 years

The selection of participants was held on the basis of the branch of the Unitary Enterprise based on the Right of Economic Management "Interdistrict TB Dispensary" at the address: 19a Namanganskaya Street, Almaty, Almaty Regional TB Dispensary, Talgar city, the Outpatient Clinic of Pokrovka village of the Central District Hospital of Ili district, PF " Revansh", PF " Doverie", PF Sanat Alemi, PF Crisis Center "Zabota". The healthcare organizations invited people with tuberculosis, NGOs invited representatives of key populations (PLHIV, internal migrants) recovered from TB to interviews and focus groups by calling their mobile phones. Participation in interviews and focus groups was stimulated by the presentation of a 5000 Tenge product card that can be used to purchase food products in the "Magnum" store chain.

Two specially trained interviewers conducted the interviews and focus-groups. The interviewers were trained by the international consultant from TBConsult (Samanta Sokolowski).

1. Desk study

Legal Environment Review

The Constitution of the Republic of Kazakhstan³, adopted in 1995, is the Fundamental Law of the country. The Constitution seeks to enshrine human and civil rights and freedoms. Article 14, paragraph 2, of the Constitution states that no one shall be subject to any discrimination for reasons of origin, social, property status, occupation, sex, race, nationality, language, attitude towards religion, convictions, place of residence or any other circumstances. Article 29 of the Constitution defines the right to health protection, and paragraph 2 of this article states that Citizens of the Republic shall be entitled to free, guaranteed, extensive medical assistance established by the Code of the Republic of Kazakhstan "On public health and health care system"⁴. The Code regulates public relations in the area of healthcare for the implementation of the constitutional right of citizens to health protection.

According to the Code, the State guarantees citizens of Kazakhstan (Articles 87 and 91): the right to health protection; and provision of **statutory free medical assistance**⁵; equal access to medical care; quality of medical care; availability, quality, efficiency and safety of pharmaceutical products; undertaking measures for the prevention of diseases and the formation of a healthy lifestyle and healthy nutrition; protection of privacy, protection of Private Health Information; freedom of reproductive choice, protection of reproductive health and respect for reproductive rights; sanitary and epidemiological, environmental well-being and radiological safety.

Issues related to the rights and guarantees for TBC patients are described in Chapter 18 "Provision of health and social care to TBC patients" of the Special Part of the Code. Thus, article 105, paragraph 1, "Providing medical care to TBC patients", guarantees:

- medical care and provision of medicines within the statutory free medical assistance;
- social and legal protection;
- **prevention any form of discrimination related to the nature of the disease;**
- the implementation of preventive measures to reduce the incidence of severe, acutely progressive forms of tuberculosis in children.

It should be emphasized that the subsequent provisions of the Code related to assistance to people with TB differ from the principles of the People-Centered Model of TB Care⁶. Thus, paragraph 2 of the same article 105 describing the rights of people with TB states: "Patients with contagious type of TB shall be subject to **compulsory hospitalization**, treatment and rehabilitation". The next article 106 of the Code describes the "Procedure for recognition of a citizen as a person with a contagious form of tuberculosis", which states that recognition of a citizen as a person with a contagious form of tuberculosis is based on the opinion of a health care organization with consideration of laboratory tests results. And that the procedure of medical examination for the purpose of recognition of a citizen

³ The Constitution of the Republic of Kazakhstan (adopted at the republican on August 30, 1995).

⁴ Code No. 193-IV of the Republic of Kazakhstan of 18 September 2009 ""On public health and health care system".

⁵ Order of the Minister of Health and Social Development of the Republic of Kazakhstan No. 344 of 13 May 2015

"On approval of the Rules for obtaining statutory free medical assistance by the citizens of the Republic of Kazakhstan, oralmans, and also foreigners and persons without citizenship permanently residing in the territory of the Republic of Kazakhstan".

⁶ http://www.euro.who.int/__data/assets/pdf_file/0020/342461/TB_Content_WHO_PRO2_rus-final-12_07_2017.pdf.

as infected with the contagious form³ of tuberculosis is established by the Ministry of Health of the RK⁷. This procedure is described in the Order of the Ministry of Health of the RK № 481 "On approval of the Rules for medical examination in order to recognize a citizen as a patient with a contagious form of tuberculosis", which also states that "a patient with a contagious form of tuberculosis is subject to **compulsory hospitalization** in the anti-tuberculosis organization to receive an intensive phase of medical treatment and rehabilitation". At the same time, this Order has a clause concerning the patient's rights: "14. A citizen recognized as a patient with a contagious form of tuberculosis and undergoing treatment shall enjoy all the rights of citizens of the Republic of Kazakhstan with restrictions related to the need to comply with the treatment regime of stay in the anti-tuberculosis organization". Nevertheless, it should be remarked here that the existence of this paragraph already indicates a significant restriction of the patient's rights. The Code further states that "a citizen recognized as a patient with a contagious form of tuberculosis may appeal the decision of the health care organization to a higher authority and/or a court. However, this paragraph does not make it clear how the complaints procedure shall be carried out and/or how health organizations shall act in case of a decision in favor of the patient. It's worth to remark that the Instruction on the organization of medical care for tuberculosis extends the principles of outpatient care, stating that outpatient care shall be also possible during the intensive phase of the treatment.

A separate article in the Health Code is devoted to the **coercive treatment of TB patients** (Article 107). This article of the Code is inconsistent with the provisions of the International Covenant on Civil and Political Rights⁸, adopted by the Republic of Kazakhstan⁹, where article 9 states, that "everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law." General comment No. 14, "The right to the highest attainable standard of health" (article 12 of the International Covenant on Economic, Social and Cultural Rights) of the Committee on Economic, Social and Cultural Rights also recognizes coercive treatment as a human rights restriction¹⁰.

In accordance with the Code, coercive treatment of citizens suffering from tuberculosis includes anti-tuberculosis and symptomatic therapy with isolation of patients in specialized anti-tuberculosis organizations and is financed through the budget. The grounds for the coercive treatment of citizens with tuberculosis are:

- 1) Refusal of a patient with TB diagnosis confirmed by a laboratory method to undergo treatment and absence of a positive result of all methods of his/her persuasion (psychologist's consultation, health education methods) documented in the patient's medical records;
- 2) Unauthorized leave and violation of therapy regimen in the form of unjustified skipping of seven daily doses of TB drugs within a calendar month, documented in the patient's medical records.

TB patients who have been subjected to coercive treatment, upon discharge from a specialized TB organization, are obliged to register with the TB organization at their place of residence. The decision on coercive treatment of citizens suffering from tuberculosis and avoiding the treatment shall be taken by a court upon the application of health organizations in compliance with the law of the Republic of Kazakhstan.

⁷Order of the Minister of Health of the Republic of Kazakhstan No. 481 of 30 September 2009 "On approval of the rules for medical examination to recognize a citizen as a person with a contagious form of tuberculosis".

⁸https://www.un.org/ru/documents/decl_conv/conventions/pactpol.shtml

⁹https://tengrinews.kz/zakon/prezident_respubliki_kazahstan/mejdunapodnyie_otnosheniya_respubliki_kazahstan/id-U030001227_.

¹⁰https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2f2000%2f4&Lang=en.

Article 108 of the Code explains the rights of TB patients receiving coercive medical treatment. For instance, in accordance with the Code, TB patients receiving coercive medical treatment enjoy all of the rights of citizens of the Republic of Kazakhstan with restrictions related to the requirement to comply with the regime of stay in a specialized anti-tuberculosis organization. It was also stated that referral to a specialized anti-tuberculosis organization for coercive treatment does not result in a record of conviction, a TB patient referred for coercive treatment shall hold a position of employment, and the period of the coercive treatment shall not interrupt the employment record and shall be included in the general labor experience.

The procedure of coercive treatment is described in the Order of the Ministry of Health of the Republic of Kazakhstan of March 30, 2019, No. KR DSM-14 "On approval of the Rules of providing medical care to TB patients referred to coercive treatment and invalidation of some orders of the Ministry of Health of the Republic of Kazakhstan"¹¹. This document contains provisions restricting the rights of TB patients. Coercive treatment of TB patients released from the institutions of the penal correction system with incomplete treatment shall be carried out in accordance with the "Rules for the organization of TB care in institutions of the penal correction system, approved by the Order of the Minister of Internal Affairs of the Republic of Kazakhstan of August 19, 2014 № 530"¹². If the previous Order of the Ministry of Health of the Republic of Kazakhstan contains criteria for referral for coercive treatment, according to the order of the Ministry of Internal Affairs of the Republic of Kazakhstan, referrals for coercive treatment are made to TB patients who are considered to be "danger to others" as stated in the document:

- 1) bacteriologically proven TB patients who have not undergone a complete course of TB treatment;
- 2) bacteriologically proven TB patients registered in TB Dispensary Group 1 "G" and receiving only symptomatic treatment in accordance with the Order № 994 of MH RK.

In this case the people-centered approach has not been applied. The MIA RK document also contains provisions restricting the rights of TB patients.

Social support for TB patients is essential to the success of treatment. The Health Code contains Article 111 "Social support for TB patients". According to this article, TB patients discharged from a specialized anti-tuberculosis medical organization upon completion of coercive treatment shall be provided with assistance by the local executive authorities only in their job and living arrangements. Article 105 of the Code also states that TB patients shall be guaranteed social and legal protection by the State.

According to the qualitative study conducted by the Kazakhstan Union of PLWH "Monitoring of access and quality of services implemented by the community of people affected by TB" (2016)¹³, despite the availability of TB treatment, there are serious shortcomings in the quality of treatment for PLWH, and more than a third of patients reported treatment interruption. Insufficient social support and side effects are cited as the main reasons. Lack of money for the fare, a permanent source of income, adequate nutrition and other factors may significantly affect the possibility of compliance with the treatment regime both under outpatient and inpatient treatment conditions. At the same time, despite the absence of a provision on social support for TB patients in the Code, some financial resources are allocated for social support at the level of

¹¹ https://tengrinews.kz/zakon/pravitelstvo_respubliki_kazahstan_premier_ministr_rk/zdravoohranenie/id-V1900018482/.

¹² http://mvd.gov.kz/portal/page/portal/mvd/mvd_page/mvd_norm_baza_current/mvd_norm_baza_prikaz/%D0%9F%D0%98-10614-%D0%9C%D0%92%D0%94%20%D0%A0%D0%9A-%E2%84%96574%20%D1%80%D1%83%D1%8104102018175316.pdf.

¹³ Findings report based on the survey conducted by the TB community, KazUnion PLHIV, 2016.

local executive authorities. Thus, according to an interview¹⁴ with M.M. Adenov, Director of the NSCP MH RK, "...social assistance to Kazakhstanis has increased by 2.5 times over the past four years. According to the results of 2017, it amounted to more than one billion tenge. That is to say, nearly 75% of outpatients receive cash subsidies, food packages and travel cards on a regular basis to ensure that they do not interrupt treatment".

The legal environment in Kazakhstan with regard to the right to labor for people with TB has been improved. At the present time, according to the Order of the Ministry of Health of the Republic of Kazakhstan¹⁵ № 994, TB patients in satisfactory condition with limited processes without bacterial excretion or with stable sputum smear conversion at the outpatient stage of the treatment and having high tolerability to TB drugs and adherence to the controlled medication intake are allowed to study or work in the course of the treatment regardless of the category and phase of the treatment.

At the same time, TB patients with: 1) bacterial excretion, destructive changes in the lungs, complications of a specific process, adverse TB drug reactions, low adherence to the controlled TB drug intake are not allowed to study or work in the course of the treatment;

2) Employees of perinatal centers (maternity units), children's hospitals (units), Neonatal pathology units and premature baby units; pre-school organizations (nurseries/kindergartens, children's homes, health camps) and junior schools, regardless of the form and diagnosis of tuberculosis.

It should be emphasized that this updating of the legal environment is a meaningful progress, as in previous versions of the orders of the Ministry of Health of the Republic of Kazakhstan there was a list of professions which persons with TB were not allowed to practice even after their recovery.

A particular issue of concern is the impossibility of providing social assistance to persons without passports and/or registration, residence permits and irregular migrants. The New Generation of Human Rights Defenders Coalition (2019)¹⁶, in its review of the human rights situation, states that the current situation in Kazakhstan with regard to the provision of health services to migrants is aimed only at keeping them alive "in the event of sudden acute conditions that threaten the life of the patient or the health of others", which is in no way consistent with the human right to "the highest attainable standard of health", and that minimum standards are not enshrined in Kazakhstani law, including the term "migrant worker", since Kazakhstan is not a party to the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.

In addition, the most part of departmental instructions approved by the orders of the Ministry of Health seek to systematize medical records, the completion of which does not affect the achievement of "possibly the highest level of health" by migrants and only contributes to improved statistical reporting. For example, the forms of medical records should contain the individual identification number (IIN) of a patient, which is impossible for most foreigners temporarily staying in Kazakhstan, and even more so for migrants with irregular status, which is a barrier to their access to health services. All these factors have a direct impact on reducing the life expectancy, quality of life and increasing mortality levels of migrants and indicate discrimination based on citizenship status.

¹⁴ <https://rezonans.kz/vlast/4383-kazakhstan-edinstvennyj-v-mire-effektivno-lechit-tuberkuljoz-ekspert>.

Order No. 994 of the Minister of Health of the Republic of Kazakhstan of December 25, 2017 "On approval of the

¹⁵ Instruction on organization of health care services for tuberculosis".

¹⁶ Joint Submission on the Human Rights Situation in Kazakhstan for the Universal Periodic Review, 34th Session of the UN Human Rights Council, 2019.

The review also indicates that "the Kazakhstani public health system does not ensure the right to the highest attainable standard of health without discrimination for vulnerable populations, such as people who inject drugs, migrants, people with disabilities". Violations are reflected in the physical and economic inaccessibility of medical services, lack of qualified personnel, health services and health care programs, including sexual and reproductive health and modern diagnostics. The standard of quality of medical care provided in remote populations is much lower than in urban areas. In breach of the law, medical personnel does not always inform patients about their right to free and informed consent to medical intervention. A low level of awareness of human rights, dignity, ethical standards leads to discriminatory practices". Meanwhile, the TB program uses the TB14/y form " Patient's consent to treatment" based on the informed consent of the patient¹⁷. Despite the fact that migrants in the regions do not have IINs, they are registered in IS NRTBP and receive treatment for both drug-sensitive TB and drug-resistant TB. Although the Centers for Physiopulmonology do not receive compensation for the costs associated with the treatment of migrants, persons without citizenship and persons without documents.

Conclusions:

1. Notwithstanding the provisions of the Constitution and the Public Health Code on the guarantees of human rights, there are also provisions restricting the rights of people with TB with respect to coercive treatment. The regulatory legal acts of the Ministry of Health of the Republic of Kazakhstan contain provisions that do not correspond to the people-centered model of TB care in terms of compulsory hospitalization of TB patients.
2. Within the framework of the assessment, it is recommended to address the issues of respect for human rights with respect to TB care, access to social assistance, access to diagnosis and treatment of TB for people without passports and/or registration, residence permits, and irregular migrants.

¹⁷ Order of the Minister of Health of the Republic of Kazakhstan of September 5, 2011 № 583 "On Amendments and Supplements to the Order of the Acting Minister of Health of the Republic of Kazakhstan of November 23, 2010 № 907 "On approval of the forms of medical source records of public health organizations".

Gender

The main legislative act in the area of gender policy is the Law of the Republic of Kazakhstan “On State Guarantees of Equal Rights and Equal Opportunities for Men and Women” adopted in 2009¹⁸. The law regulates social relations in the area of ensuring State guarantees of equal rights and equal opportunities for men and women and establishes the main principles and regulations relating to the creation of conditions for gender equality in all aspects of state and public life. Kazakhstan has become a party to the United Nations Convention on the Rights of Women, and more specifically: “Convention on the Elimination of All Forms of Discrimination against Women”, and the “Convention on the Political Rights of Women and Convention on the Nationality of Married Women”. **Kazakhstan has also signed a number of International Labor Organization instruments concerning the rights of women and children: “Equal remuneration for men and women workers for work of equal value” of 29 June 1951 (Law of the Republic of Kazakhstan No. 115-II of 14 December 2000 On ratification of the Convention concerning on equal remuneration for men and women workers for work of equal value); “On Forced or Compulsory Labor” of 28 June 1930 (Law of the Republic of Kazakhstan No. 120-II of 14 December 2000 “On the Ratification of the Convention on Forced or Compulsory Labor”); “Discrimination (Employment and Occupation) Convention” of 4 June 1958 (Law of the Republic of Kazakhstan No. 120-II of 14 December 2000 “On the Ratification of the Convention on Forced or Compulsory Labor”).**

The Concept of Family and Gender Policy in Kazakhstan until 2030 has been adopted currently¹⁹. According to the concept, the goal of the State gender policy is to achieve equal rights, benefits, obligations and opportunities for men and women in all spheres of society and to overcome all forms and manifestations of gender-based discrimination. The implementation of the concept will contribute to:

- creating conditions for women and men to enjoy their right to life without discrimination on the basis of sex.
- Strengthening the institution of gender equality through public regulation and the introduction of gender impact assessments in the state and budget planning system, as well as in the elaboration of regulatory legal acts.

In the country report²⁰ to the Committee on the Elimination of Discrimination against Women, Kazakhstan stated that activities to improve women's reproductive health are focused on improving access to family planning services, including infertility treatment, elimination of unsafe abortions and the control of sexually transmitted infections. In this connection, the modernization of primary health care is being carried out as a priority, providing for the development of universal, integrated, socially oriented, accessible and qualitative primary health care. National screening programs (cancer diseases, etc.) and an algorithm for screening women at their fertile age have been developed and implemented to improve reproductive health services, early detection of diseases, dispensary observation and health improvement.

Simultaneously, the Shadow Report on Discrimination and Violence against Women Living with HIV, Women Drug Users, Sex Workers and Women in Prison was prepared by civil society organizations²¹. This shadow report describes the situation of these groups in Kazakhstan. The report is based on studies and cases of rights violations registered by civil society organizations in 2015-2018 and official sources of information. The report contains information on

¹⁸ https://online.zakon.kz/document/?doc_id=30526983.

¹⁹ https://tengrinews.kz/zakon/prezident_respubliki_kazahstan/konstitutsionnyiy_stroy_i_osnovyi_gosudarstvennogo_upravleniya/id-U1600000384/.

²⁰ https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fKAZ%2fQ%2f5%2fadd.1&Lang=en.

²¹ https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCEDAW%2fCSS%2fKAZ%2f37320&Lang=en.

institutionalized discrimination against these populations, such as criminalization of marginalized groups of women, the violence and abuse they face in public institutions - law enforcement and health care institutions, violations of parental and reproductive rights, disclosure of status, lack of access to opioid substitution treatment for women who use drugs.

At the request of the UN-Women Multi-Country Office in Central Asia, a gender analysis of national HIV and AIDS policies was conducted in 2015 in Kazakhstan²². The goal of the gender analysis was to provide the foundation for the development and strategic planning of national HIV and AIDS programs based on gender approaches and the integration of HIV issues into the broad national gender agenda. The results of the gender analysis revealed, for example, that insufficient attention has been paid to protecting the rights of women and girls living with HIV, women who use drugs, sex workers and women prisoners. There is no public response to these problems. Many women experience rejection of HIV status by their surrounding communities, which leads, inter alia, to cases of domestic violence, violation of property and other rights as well as the loss of family and home. The State guarantees, by law, the accessibility and quality of medical examinations, medical surveillance, the provision of psychosocial, legal and medical consultations, medical care and medicine provision within the statutory free medical assistance guarantee, social and legal protection and the prevention of any form of discrimination because of the nature of the disease. On a practical level, models for the provision of health, social, legal and other services fail to recognize gender norms and stigmatization in society and by service providers, particularly in rural communities.

Nearly enough use been made of the potential of women affected by HIV and AIDS and key populations in the processes of developing, adopting and monitoring policies and strategies on HIV and AIDS, gender and violence; Nearly enough use been made of the potential of women affected by HIV and AIDS and key populations in the processes of developing, adopting and monitoring policies and strategies on HIV and AIDS, gender and violence; and in the preparation of country progress reports on implementing the Declaration of Commitment on HIV and AIDS, as well as national and shadow reports to the Committee on the Elimination of Discrimination against Women.

The issues of women prisoners in the context of gender and HIV remain insufficiently explored. The 2014 Country Progress Report on the implementation of the Declaration of Commitment on HIV and AIDS does not disaggregate rates (indicators) of access to the services in the penal system by age and sex, except for the HSS (HIV Sentinel Surveillance) data. The activities outlined in the Report are gender-neutral and do not reflect the objectives of the interventions and how they respond to the needs of the target group.

Female sex workers and people who inject drugs receiving prevention services indicate poor quality of services, as well as cases of stigma and discrimination on the part of service providers. Preventing HIV infection in couples is an important approach that can play a critical role in reducing the risk of HIV transmission from male IDUs to their sexual female partners who use and do not use drugs.

There are legal barriers (Code on Public Health and the Health System) that prevent female migrants from anonymously and voluntarily testing for HIV infection and from receiving a minimum health package including ART, OST, TB and STD treatment

However, no such gender analysis of TB policies has been conducted in Kazakhstan. However, given the fact that people living with HIV are one of the TB key populations in Kazakhstan, it is likely that the above gender-related issues may also be encountered in accessing TB services.

²² Gender Analysis of the National HIV and AIDS Policy in the Republic of Kazakhstan, CAA PLHIV, 2015.

The Country Gender Assessment²³ (Asian Development Bank, 2018) indicates that despite the steady positive trends, health indicators in Kazakhstan are relatively low compared to OECD and post-Soviet countries. There is a shortage of doctors throughout the country, with the exception of major cities - the availability of doctors in the oblasts is at least twice as low as in Astana and Almaty. This regional imbalance seriously prevents the implementation of commitments under Sustainable Development Goals 3 (SDG) to ensure a healthy lifestyle for the population, as well as SDG 5 on gender equality, since women in rural areas still do not have access to adequate health services. The Gender Assessment also indicates that infectious diseases such as tuberculosis and chronic diseases are a matter of concern. There are gender differences in susceptibility to these diseases, so an analysis of these gender specificities is needed to develop effective health strategies. It is noteworthy that the document itself does not provide any specific gender differences with regard to tuberculosis.

Termination of pregnancy is one of the gender barriers in the context of tuberculosis in Kazakhstan. Termination of pregnancy in women with pulmonary tuberculosis is regulated by the Order No. 626 of the Acting Minister of Health of 30 October 2009: "On approving realization rules in relation to artificial termination of pregnancy"²⁴. According to this document, all forms of active tuberculosis are medical grounds for artificial termination of pregnancy. However, it should be emphasized that the World Health Organization does not even mention tuberculosis as a therapeutic grounds for termination of pregnancy in its recommendations. WHO states that initiation of TB treatment is associated with better outcomes for mother and child than later initiation of treatment²⁵. At the same time, it should be remembered that the TB diagnosis during pregnancy can be complicated due to the uncertain, non-specific symptoms²⁶. It is important to note that the TB service in practice has proposed the removal of tuberculosis from the list of criteria for termination of pregnancy. At present, the decision on termination or maintenance of pregnancy is made by a pregnant woman after consultation with specialists. Quite a number of women maintain pregnancy, give birth to children and are successfully cured.

As previously stated, women from key populations are the most affected by violence, including domestic violence. There are 28 crisis centers for victims of domestic violence in Kazakhstan²⁷. But unfortunately, if a woman with TB comes to a crisis centre, she will be refused. The refusal will be based on the Order of the Minister of Health and Social Development of the Republic of Kazakhstan of December 21, 2016 № 1079²⁸ "On approval of the standard of special social services to victims of domestic violence", where TB in the active stage of the process is indicated among the reasons for refusal of services. Nowadays, supplements are being made to this order, where tuberculosis in the active stage of the process will be replaced by tuberculosis with bacterial excretion. In cases of domestic violence and when a woman is unable to find shelter, TB treatment is relegated to the background and there may be a risk of treatment interruption. The above provision of the Order No. 1079 must be considered as a gender barrier in the TB context.

Records of gender-related tuberculosis cases are kept in Kazakhstan. Thus, in 2017, the reported cases of tuberculosis were distributed as follows: 60.5 per cent men and 39.5 per cent women.

²³ Kazakhstan: Country Gender Assessment, December 2018. - Asian Development Bank

<https://www.adb.org/sites/default/files/institutional-document/501696/kazakhstan-country-gender-assessment-ru.pdf>.

²⁴ <http://adilet.zan.kz/rus/docs/V090005864>.

²⁵ <https://extranet.who.int/rhl/topics/preconception-pregnancy-childbirth-and-postpartum-care/antenatal-care/who-recommendation-tuberculosis-testing-pregnancy>.

²⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2813636/>.

²⁷ <https://eca.unwomen.org/ru/news/stories/2016/10/kazakhstans-nonstate-domestic-violence-crisis-centres-seek-funding>.

²⁸ https://tengrinews.kz/zakon/pravitelstvo_respubliki_kazahstan_premier_ministr_rk/bpak_i_semya/id-V1600014701/.

The ratio between men and women was 1.53 (in 2013-2016 the ratio ranged from 1.53 to 1.66). At the same time, we did not observe the analysis of other gender-specific indicators such as treatment coverage, treatment efficacy and other indicators in the the materials available. A number of scientific articles have also highlighted gender differences in tuberculosis prevalence. Thus, T.A. Maimakov et al. (2013)²⁹ have drawn a conclusion that there were adverse dynamics in the prevalence, morbidity and mortality rates of DR TB. TB morbidity and mortality are more often registered in men of working age. S. Hermosilla et al. (2017)³⁰ consider that the persistence of TB in Kazakhstan suggests the need to expand control efforts to address individual and social determinants of the disease. As a result of the study, the authors concluded that men with diabetes, alcohol dependence, in incarceration are associated with a higher chance of obtaining a smear-positive result. The authors believe that to stem the TB epidemic, screening, treatment and prevention policies should address these factors and significantly reduce TB transmission.

Conclusions:

1. The Gender Equality Strategy has been officially recognized and adopted in Kazakhstan.
2. Data on gender barriers to access to TB prevention and treatment services are poorly studied in Kazakhstan.
3. The “Shadow Report on Discrimination and Violence against Women Living with HIV, Women Drug Users, Sex Workers and Women in Prison” in Kazakhstan provides evidence of institutionalized discrimination against women who use drugs, women living with HIV, sex workers and women prisoners, such as criminalization of marginalized groups of women, the violence and abuse they face in public institutions - law enforcement and health care institutions, violations of parental and reproductive rights, disclosure of status, access to opioid substitution treatment for women who use drugs.
4. It is recommended to consider issues of access to TB diagnosis and treatment services for women from key populations as part of the Assessment.

²⁹ Maimakov T.A., Kurakbaev K.K., Buleshov M.A. Prevalence and Dynamics of Drug Resistant Tuberculosis Morbidity Rate in Southern Kazakhstan. - Vestnik KazNMU, №4(1).

³⁰ Hermosilla S. et al. Identifying risk factors associated with smear positivity of pulmonary tuberculosis in Kazakhstan.-PLOS ONE | DOI:10.1371/journal.pone.0172942 March 1, 2017.

Key populations

The Global Plan to End TB describes TB key populations as groups of vulnerable people facing higher risk of TB due to the conditions in which they live and work, people with limited access to quality-assured TB services, or biological or behavioral factors, and people at risk due to biological or behavioral factors³¹.

The Standard for tuberculosis care for the population³² identifies "risk groups" as key populations: people living with HIV, injecting drug users, close contacts, homeless people, migrants and prisoners. The Standard points out that TB detection and diagnostics among the "risk group", children and adolescents, extrapulmonary tuberculosis shall be performed according to diagnostic algorithms.

A number of the orders of the MOH of the Republic of Kazakhstan contain selected groups of specific interventions. Thus, the Instruction on organization of providing TB medical care³³ (paragraph 75) contains a list of population groups with high risk of exposure to disease that are subject to obligatory annual fluorographic examination for TB. Among them:

- Persons in contact with a TB patient, regardless of the bacterial excretion;
- Persons with chronic obstructive pulmonary disease subject to regular medical check-up;
- Persons with diabetes;
- Persons with alcohol dependence;
- Persons with drug addiction;
- Persons with human immunodeficiency virus/acquired immune deficiency syndrome and those receiving immunosuppressive therapy;
- Persons with residual effects of any etiology in the lungs;
- Persons released from prison.

The information system "National register of tuberculosis patients" (NRTB) monitors the following risk groups and risk factors: TB contact person, MDR-TB contact person, LDR-TB contact person, diabetes mellitus, drug addiction, alcohol abuse, detention for the last 2 years, HIV positive diagnosis. The Country Proposal 2020-2022 to the Global Fund (TB component) indicates that among the activities to be implemented by non-governmental organizations support will be provided for TB and DR TB case detection, case management and prevention among vulnerable and socially disadvantaged groups such as PLHIV, IUDs, migrants, prisoners, ex-prisoners and homeless people. Within the desk study, data on TB detection/prevalence by key populations were further searched. Unfortunately, the statistical digest "Statistical review of tuberculosis in the Republic of Kazakhstan for 2017"³⁴ does not contain information on TB statistics among key populations, except for the group of convicted persons. The only source of data on some of the key populations is the Country Application on TB to the Global Fund³⁵. The Application indicates that, for the group of prisoners/convicts, the annual number of cases of active TB in detention facilities and pre-trial detention centers decreased by 4.8 and 2.5 times respectively between 2008 and 2017 (4.2 in total). The rate of all TB cases per 100,000 prisoners during the same period decreased from 5,406 to 2015 (2.7 times), and was 25 times

³¹ http://www.stoptb.org/assets/documents/global/plan/GlobalPlanToEndTB_TheParadigmShift_2016-2020_StopTBPartnership.pdf.

³² Order No. 77 of the Minister of Health and Social Development of the Republic of Kazakhstan of February 2, 2016, "On approval of the Standard of organization of the delivery of health care services to the population in case of tuberculosis".

³³ Order No. 994 of the Minister of Health of the Republic of Kazakhstan of December 25, 2017 "On approval of the Instruction on organization of health care services for tuberculosis".

³⁴ <https://www.nncf.kz/upload/2017.pdf>.

³⁵ <http://ccmkz.kz/upload/KAZ%20TB%20Proposal%202020-2022.rar>.

higher compared to the national level. For the PLWHIV group, the following data are presented. In 2017, almost all (98%) TB patients undergoing treatment were tested for HIV, and 87% of PLHIV registered at AIDS centers were screened for TB by different methods. The number of reported cases (all forms) of HIV-associated TB in 2017 was 734, compared to 736 in 2016 and 781 in 2015. The TB/HIV prevalence rate among all TB cases in 2017 was 5.0% (4.7% in 2015 and 4.9% in 2016). According to the results of the GF project, 2014-2017, which was implemented by Project HOPE, the following data are presented for the group of labor migrants: more than 44,000 migrants gained access to TB screening, more than 1,600 TB patients were detected (3.6% of the detected cases); More than 145,000 migrants received critical information about tuberculosis as a result of outreach work. Under the Program, most of these migrants with tuberculosis (internal and external) received monthly motivational support during the course of outpatient treatment.

Conclusions:

1. Official reporting documents on the TB situation do not contain data on some key populations: injecting drug users, homeless people, migrants.
2. Publications on TB epidemiology in Kazakhstan contain data only on PLHIV, convicted persons.

³⁶ <https://www.tbcoalition.eu/2018/04/20/in-three-years-over-44000-labor-migrants-in-kazakhstan-were-examined-for-tuberculosis-with-the-assistance-of-the-international-organization-project-hope/>.

Stigma

As already pointed out in the section "Legal Environment Review", the Constitution states that no one may be subjected to any discrimination on the grounds of origin, social, official or property status, sex, race, nationality, language, attitude towards religion, beliefs, place of residence or any other circumstances. This is also addressed in the Public Health Code, where the chapter on assistance to TB patients states that no form of discrimination due to the nature of the disease is allowed. The Stop TB in Kazakhstan National Partnership has been established in Kazakhstan.. The Partnership's main mission is to consolidate the efforts of public, non-governmental and private organizations in the fight against the disease so as to improve the quality and accessibility of modern aid and reduce stigma and discrimination against people affected by tuberculosis and HIV. Recently the country has implemented projects to combat stigma against people with TB. However, unfortunately, to date there are no data available on the stigma and discrimination against people with TB.

A study on stigma and discrimination in Kazakhstan was conducted as part of the People Living with HIV Stigma Index. This study was conducted in 2015 by the Central Asian Association of People Living with HIV (CAA PLHIV). Based on the main findings of the study, one in four PLHIV in Kazakhstan faced disclosure of their HIV status in a medical facility, one in three PLHIV did not receive consultations related to their reproductive capabilities, and one in four received recommendations from health-care workers not to have children. The Internalized stigma of PLHIV in Kazakhstan is primarily reflected in feelings of guilt and shame. One in ten PLHIV had suicidal thoughts.

In addition, in 2017, CAA PLHIV conducted an assessment of stigma and discrimination against PLHIV and key populations in health care facilities in Pavlodar and Ust-Kamenogorsk. The results of the assessment revealed that the level of anxiety among medical workers due to fear of HIV infection is very high. The assessment results also demonstrated that the attitude of health-care workers towards PLHIV and key population groups is negative in general. 45.2% (the answers are 'fully agree' and 'agree') of respondents agree with the statement that people become HIV infected through irresponsible behavior, 34% of respondents believe that the majority of people living with HIV had many sexual partners, 23.3% of respondents believe that people living with HIV should be ashamed of themselves, 56.7% of health care workers say that the majority of people living with HIV do not care what happens if they infect other people.

Conclusions:

1. Kazakhstan has no data on stigma and discrimination against people affected by TB, but there have been studies on stigma and discrimination against people living with HIV.
2. Based the Assessment of Stigma and Discrimination against PLHIV and Key Populations in Health Care Facilities of Pavlodar and Ust-Kamenogorsk, there are preconditions for stigma and discrimination against key populations by health care workers.
3. It is recommended as part of the Assessment to consider the stigma and discrimination against people with TB by health care workers throughout the TB Journey.

³⁷ <http://qaztbstop.kz/>.

1. Results of the CRG Assessment based on the ID, FG and IKI

The CRG Assessment is a qualitative study that has been carried out among people affected by tuberculosis. The TB Journey is the core methodology applied in conducting focus groups and in-depth interviews with TB affected people. The TB Journey consists of 7 steps:

1. Recognition of symptoms.
2. Contact to a health facility
3. Obtaining a precise diagnosis.
4. Initiation of treatment.
5. Receiving assistance in compliance with the treatment regime.
6. Completion of treatment.
7. Receiving further services after treatment.

The study was designed to find out if people affected by tuberculosis have encountered any barriers or barriers to cure in the context of rights, gender, stigma and key communities, and how these barriers have influenced or could have influenced the outcomes of TB treatment.

Legal barriers

As part of the Assessment, legal barriers were considered to be those barriers that prevented access to or provision of services due to existing regulatory legal acts (RLAs), structural barriers in the public health care system, barriers to service delivery due to non-compliance with and/or lack of awareness of existing RLAs.

The main legal barriers pointed out by PWTB practically in all interviews are:

- issues of registration with PHC facilities;
- limited access to social assistance;
- In a number of cases, patients with a job and patients with children had to visit medical facilities every day for outpatient treatment, which was not in line with a patient-centered approach to service delivery;
- lack of qualified psychological aid at all stages of treatment, social workers do not perform their functions to support TB patients.

In accordance with the Rules of registration of citizens with primary health care organizations, approved by the Order of MSHD RK № 281 of 28.04.2015, registration of citizens with PHC organizations is carried out at the place of permanent or temporary residence, work, training, with the right of free choice of doctor, and medical organization within the same administrative division, except for citizens living in border areas, who, under the right of free choice of a health care organization, shall be registered at a nearby outpatient clinic located in another administrative division.

Registration with the outpatient clinic is based on an application in no particular form and an identification document (ID card, passport, birth certificate or other document issued in accordance with the procedure established by the legislation of the Republic of Kazakhstan). Under these rules, a citizen shall be registered and provided with health-care services only in one PHC organization.

Accordingly, the absence, for any reason, of registration in the outpatient clinic is a barrier for PWTB to further access to health-care services. The PWTB just will not pass through the registration office of the outpatient clinic and he/she will waste time for registration in the outpatient clinic. If PWTB is registered at an outpatient clinic in another region, then according to focus group participants the process of registration in new outpatient clinic takes much longer.

Lack of documents:

Woman, Almaty, focus group with internal migrants:

"I from Semipalatinsk, I had no residence permit, I had an active form of TB, EMS did not pick me up, they constantly asked me to leave for the place of residence in Semipalatinsk, they didn't pick me up four times, and only for the fifth time they came from TB dispensary and immediately hospitalized me. I had a problem with the registration at the PHC facility, my main residence registration was in the Oblast, and my temporary registration was in the city, because I was a student and I had a temporary registration at the student outpatient clinic. They sent me to the Oblast. The PHS facility did not want to admit me and I had to look for a place in Almaty where I could make the residence registration. Then I found some place to make my registration in Almaty. I didn't even know, and the doctors didn't tell me that I was a student and that I was registered at the student outpatient clinic, so they had to admit me to the student outpatient clinic".

It is important to emphasize that the problem of registration relates only to PHC facilities, in case PWTB goes directly to the TB dispensary, he/she will receive healthcare services without any delay and obstacles, even if a person has no identity documents.

As it was noted in the desk study, social assistance is provided to the PWTB in the form of money allowances, food packages, travel cards and other types of assistance. There are no unified standards for PWTB social support in Kazakhstan. This is the responsibility of local executive bodies, and the procedure for receiving, size and types of social support is subject to approval by local executive bodies. The assessment results indicated that the process of receiving social support is over-administered. PWTB has to make considerable efforts to receive social support and many of the PWTB involved in the assessment report that they received social support during the latter stages of the treatment or refused it at all. Also, one of the concerns reported by PWTB is that health workers provide insufficient information about available support. People report that they found out about the availability of social support too late and accidentally. The procedure for receiving social support requires the collection of a certain document package and, consequently, the absence of any of the documents is also a reason for refusal of social support. According to PWTB, the lack of permanent income in the course of the treatment, dependence on family members, absence of documents and the associated vulnerability influence the treatment outcomes. PWTB also reported that there is an inequality in the provision of social assistance. Thus, patients in Almaty Oblast receive much less social support than in Almaty city.

Man, Almaty, in-depth interview:

"There is social support from the state, but it is impossible to get it, because there is such a bureaucratic system, you need to collect a lot of documents, to go through the "seven circles of hell", and if you are sick, you just felt discouraged from applying for this targeted social support. In order to get this targeted social support, you still have to bring the family income certificate, what does the family have to do with it? The family will not say that they do not want to support me".

Outpatient clinics are the first medical facilities where people seek a medical attention when first symptoms of any disease appear. It is known that 90% of TB patients with primary disease go to PHC facilities. As part of the assessment, PWTB reported that referral to an outpatient clinic, even in the presence of DPT and related TB symptoms would not result in immediate actions by health-care workers with regard to the algorithms of TB diagnostics. Outpatient clinics are characterized by endless redirection from one office to another, the so-called "football", when the patient in the hope of receiving a diagnosis is wasting precious time. PWTB point out that in

most cases, general practitioners are not suspicious about tuberculosis, and even in the presence of classic TB symptoms, doctors have not referred patients for TB diagnosis, the patient has to put out considerable effort and expend time in obtaining a diagnosis.

Woman, Almaty, female focus group with TB patients:

"During the diagnostics, I was faced with clinical negligence/incompetence. I requested an appointment for X-ray/fluorography examination in the summer, but they did not refer me to this type of diagnosis, mistaking my TB symptoms for osteochondrosis, neuralgia, and even in case of emergency, they released me by prescribing analgine with dimedrol. Later it has been found that they had added a note to my clinical record, that they detected TB in spring, in March (i.e. before my first visit to the hospital). Even when I applied for a paid medical consultation, another diagnosis was determined there. Only when my husband got involved they made an X-ray and detected TB, so it had been 7-8 months since my first visit to the hospital and my request to make X-ray examination".

Outpatient treatment of tuberculosis in Kazakhstan has gradually shifted to a patient-centered approach over the past three years. However, some of PWTB who participated in the assessment reported that outpatient treatment was not tailored to their needs and requirements. Thus, the requirement to visit a health-care facility on a daily basis to receive outpatient treatment was inconvenient for workers, patients' students, patients with small children or those residing far from the health-care facility. In each of the above cases, PWTB has reported the risk of becoming unemployed, or to be expelled or experiencing family and domestic problems. In general, in the case of a true patient-centred approach, the effectiveness of outpatient treatment may have been considerably higher and more attractive to patients.

Woman, Almaty, in-depth interview:

"When I was hospitalized again as a result of secondary disease, the doctors and nurses exerted moral pressure, humiliated me, abused me and ill-treated me. The stress over children also influenced the treatment process. It was difficult to get TB drugs daily, I often walked with a breastfeeding child, I had to walk on foot a distance of 4 bus stops. The community nurse who administered the medicines concealed the possibility of providing the medicines for several days and taking them via video call. There were cases when there was partial and short-term memory loss in association with the medicines".

Since issues of stigma and self-stigma are particularly sensitive for tuberculosis, PWTB need psychological counseling. As part of the Assessment, PWTB reported that qualified psychological aid in the course of the treatment was not available in those tense moments when it was particularly required. It is also known that TB is associated with many social problems in PWTB, such as lack of some required documents, unemployment, inability to get social support, and other problems. In this respect, PWTB were in need of social support.

PWTB also reported that strong side-effects of TB drugs made an impact on their health status and medical adherence, with no treatment for side-effects in PHC facilities. For PWTB who resided in the Oblast, the barrier to services was the distant location of the regional hospital. After completion of treatment, some PWTB faced problems when applying for employment and/or training.

Gender barriers

The assessment results revealed that there are certain gender barriers to services in the TB context.

The PWTB report that women are more vulnerable to tuberculosis during pregnancy and after giving birth. Women later seek treatment because of their children, especially young children. A woman with TB should collect a large number of documents to place children at the Baby House during treatment. Also one of the reasons for late treatment was the vulnerable situation in the family (the traditional role of a daughter-in-law), physical abuse by the spouses, sexual partners. During TB illness, a woman is more likely to experience family breakdown, husbands distance themselves from their wives, close relatives also distance themselves and there is a high level of within-family discrimination. Owing to psychological abuse from husbands and sexual partners, women refused to treat tuberculosis. Stigmatization of women from vulnerable groups by health-care personnel was also one of the barriers.

Woman, Almaty, in-depth interview:

"Right after the birth, I had fluorography examination, I had had my 2nd baby, and it has been found that I had TB. They invited phthisiotherapists, I had sputum analysis and tomography, and the diagnosis was confirmed. I was immediately isolated from my baby. The next day, an ambulance took me to the TB dispensary for hospitalization. I'm really not sure why I got TB, perhaps during pregnancy, when a woman is more vulnerable, the immune system is weakened. On one hand, it is good thing that TB was not detected at the beginning of the pregnancy, otherwise I would probably have been sent to termination of pregnancy, I have met many women who were prescribed an abortion in the early stages of pregnancy".

Woman, Almaty Oblast, focus group with female TB patients:

"In the maternity unit everyone immediately becomes aware of your TB diagnosis. Doctors and a nurse and junior staff, they say it out loud so that everyone knows we have TB. While you are packing your things to be transferred to the TB Dispensary, everyone in the maternity clinic already knows that you have TB, there is no confidentiality among the maternity clinic personnel.

The gender role of men as "supporter of the family" influences men's late referral to health-care facilities regarding tuberculosis for fear of having lost their earnings. Men are more likely to seek self-treatment and therefore seek medical attention for more complicated cases of tuberculosis. Men are more likely to have addictions (drugs, alcohol) and this also affects their medical adherence.

Man, general focus group with PWTB, Almaty Oblast:

"TB therapy is very severe, it also affects the mental health, and there are side effects in both women and men, but women find it harder to tolerate the treatment. Women are more responsible about the therapy; they probably do not miss the treatment, and try to recover quickly. But for some reason, women recover more quickly. Men, who often use drugs and alcohol, it happens that they miss treatment. Treatment is difficult for everyone, especially for the 4th category and tolerance of the drugs. There are moments when the body simply refuses to accept treatment".

Key populations

Internal migrants are faced with rental housing problems. After being diagnosed with tuberculosis, the Sanitary and Epidemiological Service visits the dwelling place of an internal migrant to undertake epidemiological investigation and disinfection of the premises. During such

visits, the landlord usually terminates the rental agreement with the internal migrant with no explanation and forces him and his family out into the street. Later on, it is difficult for an internal migrant to find accommodation. In the absence of social relations in places of residence, internal migrants do not have sufficient access to information on where to go at the first TB symptoms and on the services available. And a major barrier for an internal migrant to seek treatment is that he/she will lose his/her source of income and the opportunity to support his/her family. Thus, the internal migrant will constantly put off the moment of seeking health care. While receiving diagnostic services, internal migrants at the PHC level experience endless redirections from one office to another, so patients may not be able to complete the procedures for disease diagnosis. In the course of treatment, internal migrants are faced with the problem of receiving social support in the absence of the required documents. After completion of treatment, the requirement to provide the employer with the Certificate No. 086 is a barrier for the internal migrant, which often prevents him or her from being employed because of the TB diagnosis indicated in the Certificate No. 086 or in case the former patient is still on the TB record. PWTB internal migrants report that it is quite uncomfortable for working patients being in outpatient phase of treatment to come daily for pills as there is a risk of losing their job because of systematic late attendance.

Man, Almaty, focus group with internal migrants:

"The absence of support and of the opportunity to share problems with relatives at the right time. A small circle of acquaintances in a strange city or even their absence when the going gets tough. Lack of knowledge of whom and where to turn in such a situation. Often such circumstances lead and drive to despair and outburst that do not characterize a person to the community at its best".

Man, Almaty Oblast, in-depth interview:

"In everyday life, to survive, one has to work two jobs to support oneself and a small child".

Man, Almaty Oblast, focus group with internal migrants:

"If a person has come to another city to earn money, and has no support from his family, it is difficult to recover the lost documents, because when you are physically weak you often find yourself without the opportunity to earn money and pay rent, without communication, almost on the street in a critical situation".

People living with HIV who have gone through TB reported that they were faced with the problem of late TB diagnosis due to the clinical features of the disease course in case of HIV infection. People living with HIV who have gone through TB reported that they were faced with the problem of late TB diagnosis due to the clinical features of the disease course in case of HIV infection. The process of TB diagnostics in people living with HIV is time consuming. Doctors at PHC level and phthisiotherapists should maintain a high vigilance for TB/HIV.

Woman, Almaty Oblast, focus-group with PLHIV:

"I had a sore throat, I had fever, and the therapist treated me haphazardly. I was in a day hospital, then they put me in the village hospital again, then they sent me to the oncology center on Abay street in Almaty, they took a biopsy and I had all the symptoms of TB, I lost 16 kg., I already had a huge swollen neck, had a fever, and no one in all the hospitals could detect TB. In Kaskelen, the doctor made X-ray and fluorography examinations, he found spots on the X-ray photograph and

immediately sent me to the TB dispensary. Only after that they placed in intensive care and I was so sick, I lost a lot of weight, and I didn't have the strength to walk and all this time they couldn't detect TB".

Stigma

Stigma and discrimination are among the major barriers to TB services. PWTB report that when diagnosed with TB they were psychologically depressed; they were looking for causes of contamination, blaming themselves. Self-stigma is a barrier to seeking medical attention. The absence of psychological counseling in the initial stages of the disease, the lack of support from the surrounding community. Moreover, family, relatives and surrounding communities are sources of discrimination for PWTB.

The assessment results demonstrated that while there are regulations that do not allow for any form of discrimination, discrimination against PWTB does exist, especially in the PHC network and especially against key populations. This is expressed in negative attitudes, disclosure of diagnosis to others, as well as in service delivery. There is also the problem of stigma and discrimination on the part of employers. If an employee has TB diagnosis, the employer will in most cases dismiss the employee for whatever reason. Continuous delays in work during outpatient treatment will also be a reason for dismissals.

In most cases, the problem of stigma and discrimination is related to the fact that PWTB do not know their rights and therefore cannot defend themselves if their rights are violated.

Man, Almaty, in-depth interview:

"Our rights are being violated pretty often. We do not know the algorithms of access to diagnostics, where to go, they send us from one office to another, from one medical institution, to another, we do not know what benefits, and social assistance we are supposed to receive, everything is being deliberately hidden from us. Sometimes, they talk about your diagnosis, both HIV and TB, right in the hallways".

8. Summary results (for 7 stages of TB Journey) approved by the meeting of all stakeholders

The Validation Meeting to assess the barriers to accessing the diagnostics and treatment of TB in the area of SRG (stigma, rights, gender) among key populations and develop an action plan to address the barriers was held on February 18, 2020. The purpose of the meeting was to present the preliminary results of the assessment of the barriers to accessing the diagnostics and treatment of TB in the area of SRG and to develop an action plan on eliminating the barriers in Almaty city and Almaty Oblast. The validation meeting was attended by representatives of the NSCP MH RK, TB dispensaries of Almaty and Almaty Oblast, other governmental entities, staff members of international and non-governmental organizations, people affected by TB.

The preliminary results of the SRG Assessment were discussed at the validation meeting. The participants were invited to discuss and prioritize the identified barriers to TB services throughout the TB Journey and recommendations to address the identified barriers. The barriers that were prioritized as the most important to address in the SRG Assessment results are presented below.

TB Journey barriers on human rights, gender, key populations, stigma

Stages of TB Journey						
Step 1. Recognition of symptoms.	Step 2. Health encounter	Step 3. Obtaining a precise diagnosis.	Step 4. Initiation of treatment	Step 5. Receiving assistance in compliance with the treatment regime	Step 6. Completion of treatment	Step 7 Receiving further services after treatment
Legal barriers						
- Insufficient awareness of tuberculosis among key populations and general population; - The absence of PHCF registration in the Register of Attached Population and the absence of documents in patients.	- Insufficient awareness of tuberculosis among key populations and general population; - The absence of PHCF registration in the Register of Attached Population and the absence of documents in patients.	- Lack of social support in the PHCF service; - Inadequate quality of services at the PHC level; - The absence of PHCF registration in the Register of Attached Population and the absence of documents in patients. - unavailability of information for patients;	- patients don't know their rights; - restricted access to social support; - The absence of TB patients' consultations provided by PHC staff on the TB progression, treatment outcomes, infection control; - Limited patient-centered approach; - The absence of RAP and time-consuming	- lack of qualified psychological counseling at all stages of treatment; - weak patient-centered approach, patient needs are not always considered; - lack of information about TB in patients; - TB diagnostics services are not integrated into the	- Poor quality of medical services in the penal system; - the remote location of the district hospital from the patients' place of residence; - the absence of Treatment Monitoring by Video; - lack of access to treatment of side effects at the PHC level (issue at the	- Poor coordination between TB and HIV services and drug treatment services; - the remote location of the district hospital from the patients' place of residence.

Stages of TB Journey						
Step 1. Recognition of symptoms.	Step 2. Health encounter	Step 3. Obtaining a precise diagnosis.	Step 4. Initiation of treatment	Step 5. Receiving assistance in compliance with the treatment regime	Step 6. Completion of treatment	Step 7 Receiving further services after treatment
		- Lack of knowledge among PMTCT health-care workers (TB, TB/HIV, counseling skills, KP management); - Insufficient involvement of NGOs in the TB service delivery (inadequate funding, PPSS mechanism needs to be improved); - Poor quality control of TB services; - Weak interaction between TB and HIV services (the absence of information sharing, feedback).	- process of registration to PHC facilities; - Lack of awareness among physicians on TB/HIV management; - Poor (still) coordination between TB and HIV services.	drug treatment service.	stage of decision, order No 666).	
Gender barriers						
		- Gender-specific approaches are not distinguished (there is no gender mainstreaming, women are more vulnerable).	- a woman with TB needs a lot of paperwork to put her babies in the Baby House; - TB is an indication for pregnancy termination;		- psychological abuse by spouses and sexual partners against women (coercion to refuse treatment because of religious convictions).	- psychological abuse by spouses and sexual partners against women (coercion to refuse treatment because of religious convictions).

Stages of TB Journey						
Step 1. Recognition of symptoms.	Step 2. Health encounter	Step 3. Obtaining a precise diagnosis.	Step 4. Initiation of treatment	Step 5. Receiving assistance in compliance with the treatment regime	Step 6. Completion of treatment	Step 7 Receiving further services after treatment
			- men are more likely to break the treatment regimen because of addictions.			
Barriers related to key populations (PLHIV and internal migrants)						
- Lack of programs on prevention and support in the context of tuberculosis within the PSS for NGOs at the local level; - Lack of awareness among physicians on TB/HIV management.	- Lack of programs on prevention and support in the context of tuberculosis within the PSS for NGOs at the local level; - Lack of awareness among physicians on TB/HIV management.			- the presence of addictions in the patient (psychoactive substances, alcohol).		
Stigma and discrimination						
- self-stigma.	- self-stigma.	- Stigma and discrimination.		- self-stigma.		- Stigma and discrimination by employers (problems when applying for employment).

Action Plan for the CRG Assessment

Action plan goal:

To remove barriers to TB diagnosis and treatment services related to rights, gender, stigma and key populations.

Objectives:

1. To facilitate allocation of funds by the local executive authorities within the framework of the Public Procurement of Social Services to provide social support services for people with tuberculosis in Almaty city and Almaty Oblast by the end of 2021.
2. To facilitate a dialogue with primary health care services and social services to strengthen the assistance of social workers to people with tuberculosis in Almaty city and Almaty Oblast by the end of 2020.
3. The adoption by the NSCP MH RK the gender-sensitive algorithm for case management by the end of 2020. To combat stigma and discrimination associated with tuberculosis, the STOP TB Partnership should create the Platform for Monitoring and Respecting the Rights of People with TB by June 2020.
4. To facilitate the creation of the TB/HIV Standing Interdisciplinary Working Group at the MOH RK level until September 2020.

Justification for objectives 1 and 2. The barriers identified within the CRG Assessment are related to lack of case management for people with TB and the absence of systematic work by PHC facilities that have social workers on their staff. Accordingly, addressing the barriers related to rights is possible through the implementation by NGOs of the projects under the the Public Procurement of Social Services and enhancement of the work of social workers of PHC facilities in relation to TB.

Rights-related barriers:

- The absence of RAP and time-consuming process of registration to PHC facilities;
- Restricted access to social support (absence of support, insufficient support, lack of information on the support available), lack of income and dependence on family members, the absence of documents;
- Poor quality of services provided at the PHC level (endless redirection from one office to another, lack of alertness of general practitioners ("football")), unwillingness of PHC facilities to register TB so that they can keep their stats up);
- outpatient treatment does not involve a patient-centered approach (Treatment Monitoring by Video is not sufficiently offered as an alternative method; visits to a medical organization are required on a daily basis);
- Lack of psychological assistance at all stages of treatment, social workers do not perform their functions to support TB patients.

Justification for objective 3:

Gender-related barriers are mostly not perceived by NTCP (National Tuberculosis Control Program), TB specialists, PHC doctors and patients as actual barriers that may affect access to TB services. Therefore, there is a necessity for developing a comprehensive document that would include a gender-sensitive algorithm of case management. This document will provide guidelines for assisting women from key populations with tuberculosis in terms of their vulnerability during pregnancy and childbirth, the presence of children, and gender-based violence.

Gender-related barriers:

- Women are more vulnerable during pregnancy and after childbirth;
- Late medical treatment of women owing to the presence of children, particularly young children;
- Late medical treatment of women because of their vulnerable situation in the family (daughter-in-law), physical violence.
- Late medical treatment of men for fear of income deprivation;
- Men are more likely to breach the regime of treatment because of addictions.

Justification for objective 4:

Stigma-related barriers in the context of CRG Assessment results are systemic in nature and mainly related to the lack of information on TB and the fear associated with it among the surrounding community of people with TB, the general population, health care workers. NTCP through the Integrated TB Plan and Global Fund projects, have invested heavily in combating stigma and discrimination. Another dimension associated with this challenge is the lack of awareness of the rights of people with TB and NTCP. The creation of the Platform for Monitoring and Respecting the Rights of People with TB will therefore fill this gap.

Stigma-related barriers

- self-stigma;
- Stigma and discrimination by family, relatives and surrounding communities;
- Stigma and discrimination by health-care workers, in the PHC network, especially against women from vulnerable groups;
- Stigma and discrimination by employers.

Justification for objective 5: Barriers related to internal migrants can be addressed under objectives 1 and 2, where social assistance and/or social workers can assist internal migrants to access TB services. In relation to the group of people living with HIV, the Assessment highlighted barriers that are related to lack of coordination between HIV and TB services. In this context, it is essential to establish a standing interdisciplinary TB/HIV working group at the MoH level, which could enhance the TB/HIV co-infection management component in the country.

Barriers related to key populations:

- lack of available information on TB for internal migrants, PLHIV (especially on Isoniazid Prevention Therapy);
- the problems with renting accommodation after being diagnosed with TB due to pressure from SES (Sanitary and Epidemiological Service), internal migrants with TB are deprived of income and housing;
- Insufficient awareness among doctors on TB/HIV management.

Objective 1: To facilitate allocation of funds by the local executive authorities within the framework of the Public Procurement of Social Services to provide social support services for people with tuberculosis in Almaty city and Almaty Oblast by the end of 2021.

Indicator to measure progress towards objective 1: Allocation of funds under the Public Procurement of Social Services to provide social support services for people with TB for at least one PPSS project in Almaty and Almaty Oblast.

Action / step	Target audience	Expected outcome and indicator	Time of execution	Implementing Agency
1. Organization of a working meeting with the NSCP, NGOs and other stakeholders to discuss PPSS issues and coordinate activities. 2. Conducting a panel discussion with representatives of local executive and legislative authorities on the role of NGOs and civil society in TB response and the possibility of the allocation of funds under the PPSS. 3. Conducting a working meeting with NGOs and community representatives on assessing needs and drafting the Terms of Reference for the PPSS. 4. Conducting advocacy among decision-makers in Almaty city and Almaty Oblast. 5. Participation in public hearings, community councils to discuss budgets of public health service and social assistance.	Local executive authorities (internal policy department, public health department, social welfare department), maslikhat of Almaty city and Almaty Oblast (local legislative bodies) NSCP, inter-district TB dispensaries, NGOs.	Terms of Reference for PPSS bid formation have been developed. Bids are announced. Service NGOs participate in the tender.	August 2020	Stop TB Partnership

6. Conducting a panel discussion with all stakeholders to discuss cooperation on implementation of PPSS projects in Almaty city and Almaty Oblast.				
Objective 2: To facilitate a dialogue with primary health care services and social services to strengthen the assistance of social workers to people with tuberculosis in Almaty city and Almaty Oblast by the end of 2020.				
Indicator to measure progress towards objective 2: Access to social assistance (social workers, social support) for people with TB has been improved.				
Action / step	Target audience	Expected outcome and indicator	Time of execution	Implementing Agency
1. Conducting regular round tables to discuss social assistance for people with TB with the participation of Heads of PHC facilities, Heads of District Social Welfare Departments, Heads of Health Departments. In total 9 round tables are scheduled according to the number of districts of Almaty city and Almaty Oblast. City districts: Almalinskiy, Bostandykskiy, Zhetysuskiy, Nauryzbaiskiy, Medeuskiy, Turksibskiy, Auezovskiy. Oblast: Iliyskiy, Talgarskiy, Karasayskiy. 2. Manufacturing and printing of a pamphlet for people affected by TB containing all legal information about their rights and the assistance they are entitled to.	Heads of PHC facilities, Heads of District Social Welfare Departments, Heads of Health Departments NSCP, inter-district TB dispensaries, NGOs.	Round tables were held, a protocol was prepared.	June 2020	Stop TB Partnership
Objective 3: The adoption by the NSCP MH RK the gender-sensitive algorithm for case management by the end of 2020.				
Indicator to measure progress towards objective 3: The gender-sensitive algorithm for case management is adopted by NSCP MH RK.				
Action / step	Target audience	Expected outcome and indicator	Time of execution	Implementing Agency

1. To approve the NNCF working group on the development of the gender-sensitive algorithm for case management 2. To develop and coordinate the Terms of Reference for the development of the gender-sensitive algorithm for case management. 3. To hold a competition to select two experts for the development of the gender-sensitive algorithm for case management 4. To coordinate the draft gender-sensitive algorithm for case management with the NSCP. 5. To conduct a round table with all stakeholders to discuss the gender-sensitive algorithm for case management. 6. To approve gender-sensitive algorithm for case management in the NSCP. 7. To print and disseminate the algorithm.	NSCP, International Organizations, NGOs.	A working group has been created. The algorithm to help women with TB from KP has been developed.	May-July	Stop TB Partnership
Objective 4: With the aim of combating TB-related stigma and discrimination, KazUnion PLHIV should create Platform for Monitoring and Respecting the Rights of People with TB by June 2020.				
Indicator to measure progress towards objective 4: The Platform for Monitoring and Respecting the Rights of People with TB has been created and is fully functional.				
Action / step	Target audience	Expected outcome and indicator	Time of execution	Implementing Agency
1. To conduct a working meeting with all stakeholders to discuss the rights of people with TB and the framework of the Platform for Monitoring and Respecting Human Rights. 2. To organize a series of trainings among NGOs on monitoring and observance of human rights in the context of TB. 3. To organize a series of trainings for PHC specialists on human rights, tolerance, including standards for disclosure of status with regard to PWTB and key populations.	NSCP, International Organizations, NGOs.	A working meeting has been held. Training sessions have been organized. An algorithm for providing assistance in case of violation of	May-August	Stop TB Partnership

4. To develop an algorithm for NGOs for providing assistance in case of violations of PWTB rights.		PWTB rights has been developed.		
Objective 5: To facilitate the creation of the TB/HIV Standing Interdisciplinary Working Group at the MOH RK level until September 2020.				
Indicator to measure progress towards objective 5: The TB/HIV Standing Interdisciplinary Working Group at the MOH RK level has been has been created and is fully functional.				
Action / step	Target audience	Expected outcome and indicator	Time of execution	Implementing Agency
1. To hold a working meeting (kickoff meeting) to discuss the issues of TB and HIV services interaction. 2. To draft an application letter to the MOH RK justifying the need for the TB/HIV Standing Interdisciplinary Working Group at the MOH level. 3. Develop an operational plan for the TB/HIV Standing Interdisciplinary Working Group 4. To hold at least 2 meetings of the TB/HIV Standing Interdisciplinary Working Group by the end of 2021.	MH RK, NSCP MH RK, KSCDID.	The Working Group has been set up An operational plan for the TB/HIV Standing Interdisciplinary Working Group has been developed 2 meetings have been held.	September	Stop TB Partnership

ANNEXES:

Annex 1

List of participants and all stakeholders attending the **Meeting of the Core Team** held on October 1, 2019

LIST OF PARTICIPANTS

Meeting

“Country Consultation on the Development of an Assessment Approach and Priority Key Populations (KP) in the Republic of Kazakhstan”.

Date: October 01, 2019.

Venue: Almaty, KazZhol Hotel (127/1 Gogolya Street)

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Annex 2

Prioritization Tool for Key Populations

Key populations to be considered	Score 1	Score 2	Score 3	Score 4	Score 5	Subtotal of assessment on risk, barriers and new understanding (Sum of scores 1-5) Max. 5	Score 6	Combined scores to facilitate discussion on prioritization	
	Risks of exposure Exposure to infected persons/high concentration of bacilli 0 – Low 0.5 – Average 1 – High	Biological Risks Probability of immunosuppression/liability to the risk of progression to active tuberculosis 0 – Low 0.5 – Average 1 – High	Barriers to accessing assistance Gender, legal, social and structural barriers 0 – Low 0.5 – Average 1 – High	Barriers to treatment completion Stigma, life circumstances, difficulties in continuing access to treatment 0 – Low 0.5 – Average 1 – High	Probability of new understanding Social dynamics is not sufficiently clear. 0 – Low 0.5 – Average 1 – High		Permissible (and/or official data, if available) Proportion of the TB burden in the country (Cases of active TB of all forms) 1 - very low (<1%) 2 - low (1-3%) 3 - average (3-5%) 4 - high (5-10%) 5 - very high (> 10%)	Final score (Sum of scores 1-5) Max. 10	Discussion of priorities and justification of priority key populations.
Enter the pre-selected KP									

Annex 3

List of key informants:

1. Ismailov Sh. Sh., Manager of the Global Fund Project Implementation Unit for “Tuberculosis” component, NSCP MH RK.
2. Auezova S.N., "Center of Physiopulmonology" of the Department of Public Health of the city of Almaty, Head of Dispensary Department.
3. Bashieva G.K., Iliysk Central District Hospital, Tuberculotherapist.
4. Akhmetova G.M., Kazakh Scientific Centre of Dermatology and Infectious Diseases of MH RK, Infectious Disease Physician of the Clinical Monitoring Department.
5. Bokhazhanova A.T., UNAIDS Office in Kazakhstan, National Program Officer.
6. Pak S., KNCV Representative Office in Central Asia, Director.
7. Dudnik R., PF AIDS Foundation East-West in Kazakhstan, Executive Director.
8. Rsaldinova A., Central Asian branch of non-profit corporation Popular Services International - PSI USAID HIV Flagship Project Coordinator.
9. Amanzholov N., Central Asian Association of PLHIV, President.
10. Dzhazylbekova P.M., NSCP MH RK, Head of Monitoring, Planning and Epidemiology Department.
11. Vorontsova, L., Central Asian Association of PLHIV, Gender specialist.
12. Demeuova R., Country Coordinating Committee, Secretariat Coordinator.