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Assessment of sexual, reproductive, maternal, newborn, child and adolescent health in the context of universal health coverage in Kazakhstan

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Abstract

Achieving universal health coverage (UHC) – meaning that everyone, everywhere can access essential high-quality health services without facing financial hardship – is a key target of the Sustainable Development Goals. Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) is at the core of the UHC agenda and is among the 16 essential health services that WHO uses as indicators of the level and equity of coverage in countries. In this context, WHO undertook an assessment of SRMNCAH in Kazakhstan. This report examines which SRMNCAH services are included in policies concerning UHC in the specific country context; assesses the extent to which the services are available to the people for whom they are intended, and at what cost; identifies potential health system barriers to the provision of SRMNCAH services, using a tracer methodology and equity lens; and identifies priority areas for action. A set of policy recommendations provides the basis for policy changes and implementation arrangements for better SRMNCAH services and outcomes in the context of UHC.

Keywords
SEXUAL AND REPRODUCTIVE HEALTH
MATERNAL, CHILD AND ADOLESCENT HEALTH
UNIVERSAL HEALTH COVERAGE
HEALTH CARE SYSTEM
QUALITY OF HEALTH CARE
DETERMINANTS OF HEALTH
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CORRIGENDUM

The following corrections have been incorporated into the electronic file on 13 May 2020:

- On the following pages iv; p.2 (twice); p.3; p.6 (twice); p.7 (in Fig.4 and once in the text); p.11; p.12 (3 times); p.24: "Ministry of Health and Social Development" is replaced with "Ministry of Health";
- On p. 12, the following text in the footnote "Order of the Minister of Health and Social Development" is replaced with "Order of the Minister of Health";
- On page 6, the following phrase before a footnote has been deleted: (a new version is currently under discussion);
- On page 16, a footnote is inserted and reads: OECD reviews of health systems: Kazakhstan 2018. Paris: OECD Publishing; 2018 (https://www.oecd.org/countries/kazakhstan/oecd-reviews-of-health-systems-kazakhstan-2018-9789264289062-en.htm, accessed 2 January 2020);
- On page 17, year 2015 is replaced with year 2017 and a footnote is inserted. The final sentence reads: "Antenatal care coverage remains very high (95%), and maternal mortality has decreased substantially over the last 15 years – in 2017 it was 10 per 100 000 live births[1], which is lower than the average in the WHO European Region.";
- On page 19, the following sentence is deleted "There are no official reliable data for other STIs." It is replaced with a new sentence: "According to key informants data on STI's is collected, but it was not available during the mission";
- On page 21 the text "photo of the baby" is replaced with the text "photo #2 attached to the e-mail";
- On page 22, a footnote is inserted and reads: Adolescent birth rate: data by country. In: WHO Global Health Observatory (GHO) data [database]. Geneva: World Health Organization; 2019 (http://apps.who.int/gho/data/view.main.1630AG, accessed 19 November 2019).

[1] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/maternal-mortality-ratio-(per-100-000-live-births), accessed 31 March 2020

Contents

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The authors' views expressed in this report do not necessarily reflect the views of WHO or the Ministry of Health of Kazakhstan.

Abbreviations

CSMI	compulsory social medical insurance
GDP	gross domestic product
GP	general practitioner
HPV	human papillomavirus
IMCI	Integrated management of childhood illnesses [WHO strategy]
OECD	Organisation for Economic Co-operation and Development
OOP	out-of-pocket [payment]
PHC	primary health care
SGBP	State-guaranteed Benefit Package
SRMNCAH	sexual, reproductive, maternal, newborn, child and adolescent health
STI	sexually transmitted infection
UHC	universal health coverage
UNICEF	United Nations Children's Fund

Executive summary

An assessment of sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) in the context of universal health coverage (UHC) was conducted in Kazakhstan on 25 February–4 March 2019. It included document reviews; interviews with policy-makers, health facility managers, service providers and clients; and visits to health facilities. Six SRMNCAH "tracer" interventions were investigated in greater depth, identifying barriers to access and utilization of services along the essential pillars of UHC.

Kazakhstan has been modernizing its health care system rapidly, with both demand- and supply-side reform. As reflected in national development strategies, Kazakhstan is seeking improvements in health status to be consistent with those found in Organisation for Economic Co-operation and Development countries.

The health of women, children and adolescents is given high priority. This is expressed in the intended full coverage of health services to pregnant women, women in delivery and postpartum and children aged 0–18 years, among others. Kazakhstan has made considerable progress in SRMNCAH during the past 10–15 years, particularly in bringing down maternal and under-5 mortality. Overall, coverage of essential interventions is relatively high, with the exception of some areas, such as adolescent sexual and reproductive health services and sexually transmitted infections.

The main challenges observed include proportionately low investment in health including SRMNCAH, despite rapid growth of gross domestic product; high out-of-pocket payments, particularly for medicines; considerable geographical differences in access to services and health outcomes; a focus on provision of services rather than health literacy and empowerment; limited access to sexual and reproductive health services for adolescents; and a primary health care system that does not always have the capacity to provide common SRMNCAH services as a "one-stop shop".

Recommendations to address challenges and barriers for SRMNCAH in the context of UHC are made at the end of the report. These include addressing the high out-of-pocket payments; reviewing the health benefit packages, including for SRMNCAH; focusing on reducing inequalities; implementing a broader approach to SRMNCAH beyond provision of services; improving service delivery models at the primary health care level, including addressing the skills and capacities of family doctors; and closing information gaps on SRMNCAH in the context of UHC, particularly with regard to data on equity and vulnerable populations.

Introduction

Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. This definition of UHC embodies three related objectives:

- equity in access, meaning that everyone who needs health services should get them, not only those who can pay for them;
- health services of good enough quality to improve the health of those receiving services; and
- protection against financial risk, ensuring that the cost of using services does not put people at risk of financial harm.

Achieving UHC is one of the targets the nations of the world set when adopting the Sustainable Development Goals in 2015.

Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) is at the core of the UHC agenda and is among the 16 essential health services in four categories that WHO uses as indicators of the level and equity of coverage in countries. Essential SRMNCAH services used as indicators for UHC are:

- family planning
- antenatal and delivery care
- full child immunization
- health-seeking behaviour for pneumonia.

An assessment of SRMNCAH in the context of UHC was conducted in Kazakhstan on 25 February–4 March 2019. Its specific objectives were to:

- delineate which SRMNCAH services are included in policies concerning UHC in the specific country context;
- assess the extent to which the services are available to the people for whom they are intended, and at what cost;
- identify potential health system barriers to the provision of SRMNCAH services, using a tracer methodology and equity lens;
- highlight good practices and innovations in the health system, with evidence of their impact on SRMNCAH services;
- identify priority areas for action and develop policy recommendations jointly with the country to address health system barriers to the provision of SRMNCAH services.

The assessment was carried out on behalf of the WHO Regional Office for Europe and it is intended that similar assessments will be conducted in other countries in the WHO European Region.

Methodology

A methodological approach was developed prior to the assessment and underwent several revisions. The visit to Kazakhstan was the fifth in a series, the first taking place in the Republic of Moldova in September 2018. The steps in the assessment included:

- a preliminary document review, including health policy and strategy documents, sexual and reproductive health and child and adolescent health strategy documents, UHC guiding documents, service package descriptions and similar;
- a country visit, including:
  - interviews with policy-makers from the Ministry of Health, health facility managers (primary health care (PHC) and hospital), service providers (doctors, nurses and others) and beneficiaries (patients, clients);
  - visits to health care facilities at primary, secondary and tertiary levels;
- a presentation and discussion of findings and recommendations with key stakeholders at the end of the visit.

Semi-structured questionnaires were developed to conduct interviews with key informants, including:

- representatives of the Ministry of Health;
- health facility managers (hospital and PHC);
- health workers including nurses, doctors and midwives, where applicable;
- patients and clients, including adolescents;
- partners and stakeholders, including representatives of the United Nations Children's Fund (UNICEF) and United Nations Population Fund.

Tracer interventions

To assess the extent to which services are available to the people for whom they are intended and at what cost, six tracer interventions were identified and analysed in depth. These were:

- antenatal care
- sexually transmitted infections (STIs) (excluding HIV)
- transport of sick neonates
- case management of common childhood conditions
- adolescent-friendly health services (sexual and reproductive health)
- immunization.

The findings are analysed and reported according to WHO's six building blocks of UHC (Fig. 1).

Fig. 1. The building blocks of UHC

Source: Universal health coverage [website]. Geneva: World Health Organization; 2019 (http://www.who.int/universal_health_coverage/en/, accessed 30 December 2019).

Limitations

The methodology aims to triangulate information through document reviews, visits to health facilities and interviews with policy-makers, health managers, providers and clients. The depth of the assessment depends on the completeness of documents provided by the Ministry of Health and partners, as well as to which extent the health facilities visited and key informants interviewed are representative and reflect the national context and situation. The appraisal of tracer interventions and health systems barriers and challenges represents the judgement of the assessment team, based on the information obtained.

Country context

Kazakhstan is an upper-middle-income country, which gained independence in 1991 following the dissolution of the Soviet Union. It is the second largest of the former Soviet republics (after the Russian Federation), covering 2.7 million km^2, but has one of the lowest population densities globally.[1] Table 1 sets out information on key indicators related to the SRMNCAH assessment.

Table 1. Key socioeconomic and health coverage indicators

Indicator	Value
Socioeconomic indicators	
Total population (2017)[a]	18.2 million
Life expectancy at birth: male/female (2016)[b]	67/75 years

[1] The World Bank in Kazakhstan [website]. Washington DC: World Bank Group; 2019 (http://www.worldbank.org/en/country/kazakhstan/overview#1, accessed 30 December 2019).

Table 1. (contd)

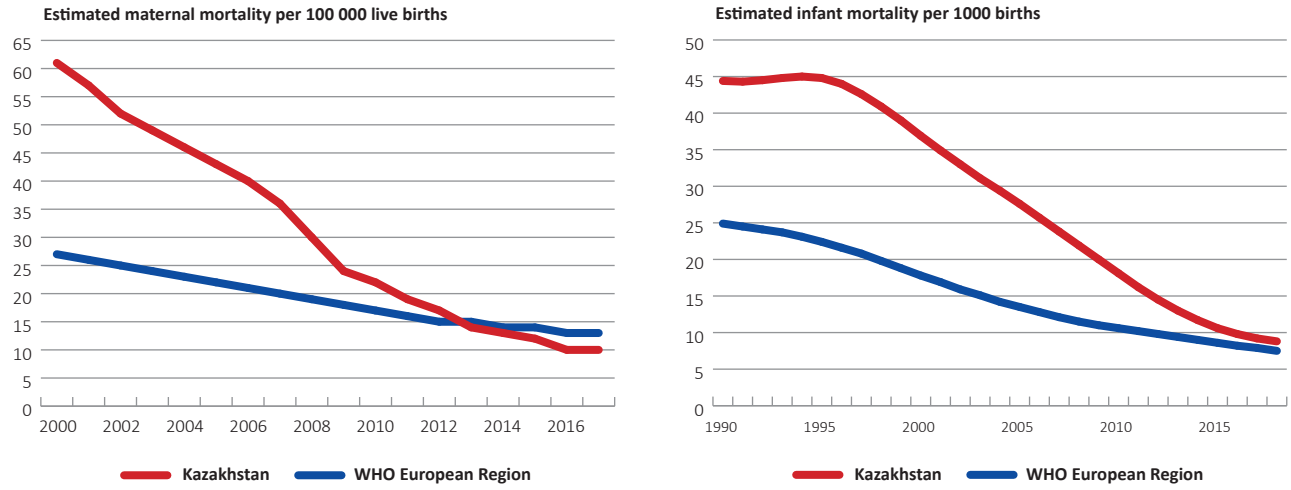
Indicator	Value
Current expenditure on health per capita (international $, reflecting purchasing power parity; 2017)[a]	820
Total expenditure on health as a proportion of gross domestic product (GDP) (2017)[a]	3%
Probability of dying under the age of 5 per 1000 live births (2018)[c]	9.9
Neonatal mortality rate per 1000 live births (2018)[c]	5.6
Maternal mortality rate per 100 000 live births (2015)[d]	13
Adolescent birth rate per 1000 women aged 15–19 years (2015)[e]	36
Health coverage indicators for tracer interventions	
Antenatal care coverage (at least four visits) (2015)[e]	95%
Proportion of women of reproductive age who have their need for family planning satisfied with modern methods (2018)[e]	79.4%
Proportion of diphtheria tetanus toxoid and pertussis vaccine administered (2018)[e]	98%
Proportion of children aged under 5 years with pneumonia taken to a health care provider (2011)[e]	81%

Sources:
[a] WHO Global Health Expenditure Database [online database]. Geneva: World Health Organization; 2019 (https://apps.who.int/nha/database);
[b] Kazakhstan. In: World Health Organization [website]. Geneva: World Health Organization; 2019 (https://www.who.int/countries/kaz/en/);
[c] Maternal, newborn, child & adolescent health data portal. In: World Health Organization [website]. Geneva: World Health Organization; 2019 (https://www.who.int/data/maternal-newborn-child-adolescent/indicator-explorer-new/mca/under-five-mortality-rate-(per-1000-live-births));
[d] Reproductive, maternal, adolescent & child health. In: WHO/Europe [website]. Copenhagen: WHO Regional Office for Europe; 2019 (https://gateway.euro.who.int/en/themes/reproductive-maternal-adolescent-child-health/);
[e] Global Health Observatory data repository. In: World Health Organization [website]. Geneva: World Health Organization; 2019 (http://apps.who.int/gho/data/node.home).
All accessed 9 January 2020.

Kazakhstan has made good overall progress on key indicators such as infant and maternal mortality rates during the past 15 years (Fig. 2). Although infant mortality rates had decreased markedly in all regions by 2015, however, regional inequalities persist. In 2015, the region with lowest infant death rate – Pavlodar – recorded approximately 7 deaths per 1000 live births, while in south Kazakhstan the rate exceeded 11. Maternal mortality also varies markedly between regions, revealing worrying inequalities.

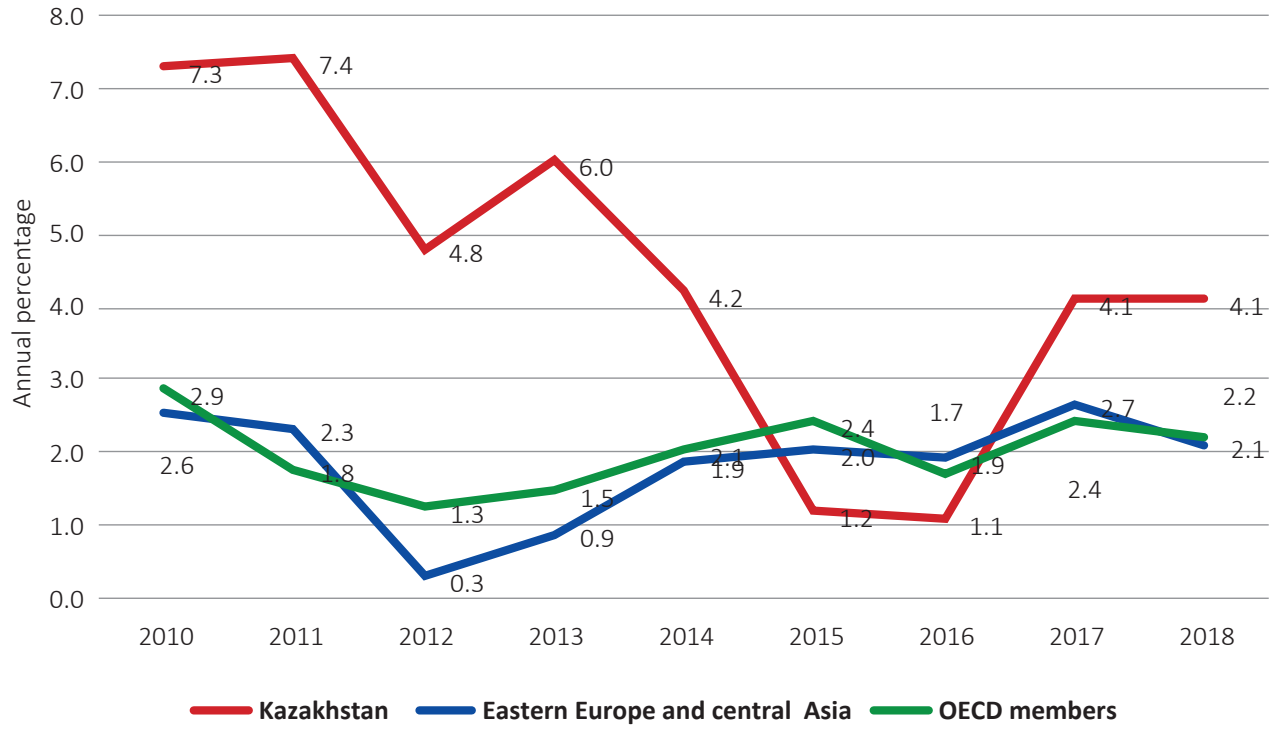
Kazakhstan transitioned from a lower-middle-income country to upper-middle-income country status in 2006, less than two decades after independence. GDP per capita has increased sixfold since 2002. In 2014 economic growth slowed because of the external environment, but in 2017 – thanks to more favourable terms of trade and increased oil production – the economy recovered and GDP growth was higher than the averages across eastern Europe and central Asian and Organisation for Economic Co-operation and Development (OECD) member countries (Fig. 3).

Fig. 2. Trends in maternal and infant mortality, Kazakhstan and WHO European Region



Source: European Health Information Gateway – Health for All explorer. In: WHO/Europe [website]. Copenhagen: WHO Regional Office for Europe; 2019 (https://gateway.euro.who.int/en/hfa-explorer/#s6Dx2vdvCl, accessed 9 January 2020).

Fig. 3. GDP growth



Source: World Development Indicators [online database]. Washington DC: World Bank Group; 2019 (https://databank.worldbank.org/source/world-development-indicators/, accessed 30 December 2019).

Health system governance for SRMNCAH

Policy-making in Kazakhstan is highly centralized in an executive-style government run by the president.[2] All strategic documents are developed at the national level and issues related to reproductive health are reflected to the extent that they are prioritized at that level, although there is no comprehensive reproductive health strategy. Service provision is the responsibility of local authorities, for which reproductive health is usually not a priority.[3]

At present, reproductive health policy – mainly on reproductive rights – is set out in the Code on Population Health and Health Systems, which was first adopted in 2009 and has undergone several amendments.[4] This brings together the main principles of health system and service provision setup, identifies priorities and responsibilities for each level of administrative authority and specifies financing mechanisms. A new version of the Code is currently under development and will also include issues of reproductive health policy and rights. It also includes regulations for the pharmaceutical sector on quality of drugs and other medical products. Reproductive health is one of the few concrete health issues mentioned in the Code beyond overall public health. It highlights the importance of reproductive health for young people, underlining the necessity of access to information and services. It also sets out the importance of youth health centres and the ability of adolescents to give informed consent independently for health services provided. The Code calls for a reduction in the age at which adolescents can seek care independently, which may increase access to reproductive health services.

The Ministry of Health is responsible for development of national health policies. The strategic planning process is set out in the Ministry's development plan and the State Health Development Programme "Densaulyk" is in place for the period 2016–2019. The government has begun the process of developing an updated programme, a draft of which has been agreed with all state bodies. "Densaulyk" aims to:

- promote public health to ensure sustainable socioeconomic development of the country;
- implement a new public health policy based on an integrated approach to disease prevention and management;
- modernize the national health system, focusing on efficiency, financial sustainability and support for socioeconomic growth.

As in previous health sector development plans, it reflects the direction set by the president in the country's development strategies Kazakhstan 2030 and Strategy 2050.[5] All development strategies highlight the importance of health, setting the direction for improvement of the nation's health and health system performance. In particular, maternal and child health and rights are given high priority, to the extent that maternal and infant mortality rates are indicators for not only health system performance but overall government performance, and are tracked very closely.

Since independence, the government has launched several waves of reforms aimed at empowering local authorities, reorganizing service delivery and encouraging private service provision. The Ministry of Health has also gone through several reorganization processes; its current structure is shown in Fig. 4.

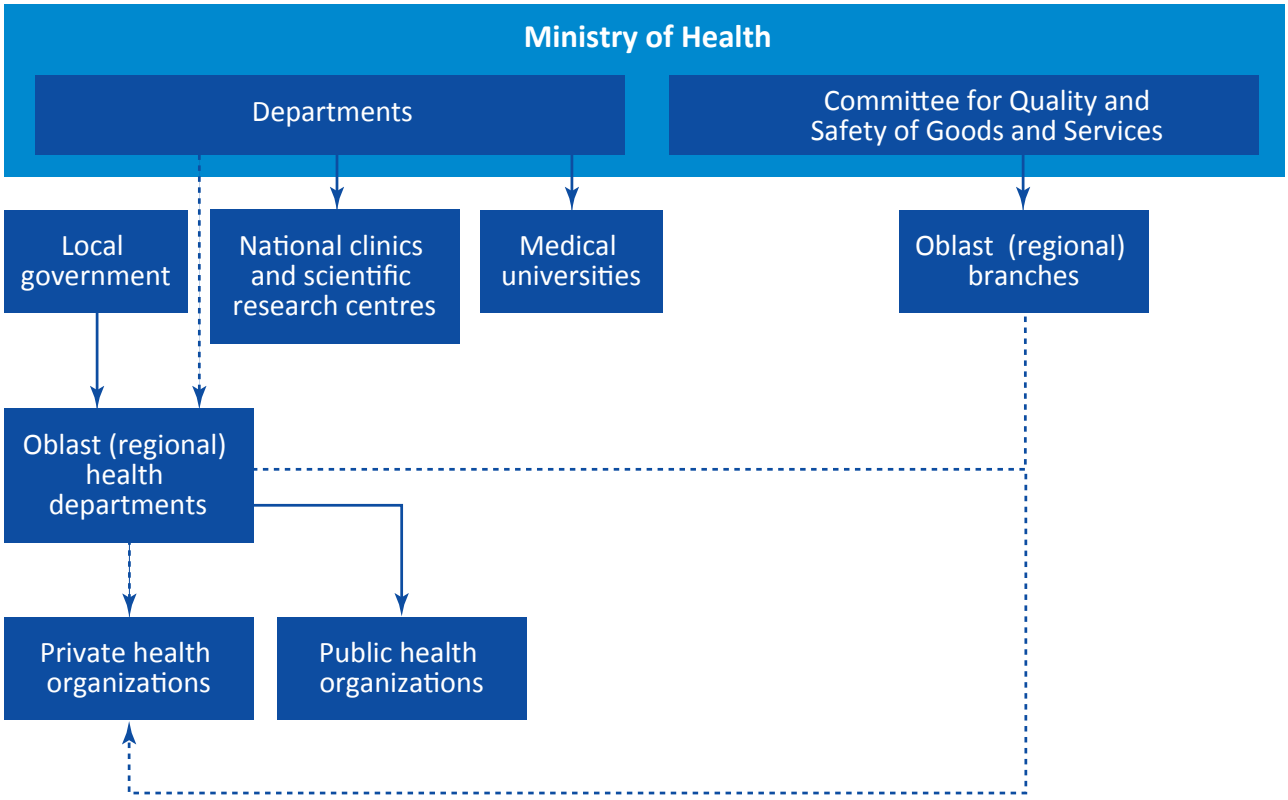
[2] Katsaga A, Kulzhanov M, Karanikolos M, Rechel B. Kazakhstan: health system review. Health Syst Transit. 2012;14(4)1–154.

[3] Tanirbergenov S, Abuova G. Situation analysis: reproductive health in Kazakhstan 2008–2014. Astana: United Nations Population Fund in Kazakhstan; 2015.

[4] Code of the Republic of Kazakhstan on population health and health systems. Nur-Sultan: Ministry of Justice; 2019 (http://adilet.zan.kz/eng/docs/K090000193_, accessed 30 December 2019).

[5] Strategy 2050 [website]. Astana: KazContent JSC; 2019 (https://strategy2050.kz/en/page/multilanguage/, accessed 30 December 2019).

Fig. 4. Organization and governance of the health system in Kazakhstan



Note: Dotted lines indicate regulatory oversight; solid lines indicate direct administration and reporting.
Source: Katsaga A, Kulzhanov M, Karanikolos M, Rechel B. Kazakhstan: health system review. Health Syst Transit. 2012;14(4)1–154.

Not all planned reforms have been implemented; in fact, some – such as radical decentralization – have been reversed. With the introduction of the concept of a unified national health care system, the authority of the Ministry of Health has been increased, financing and payment functions recentralized and the Ministry has become the main public purchaser of hospital services (Fig. 5).[6]

Fig. 5. Selected milestones of health system development in Kazakhstan

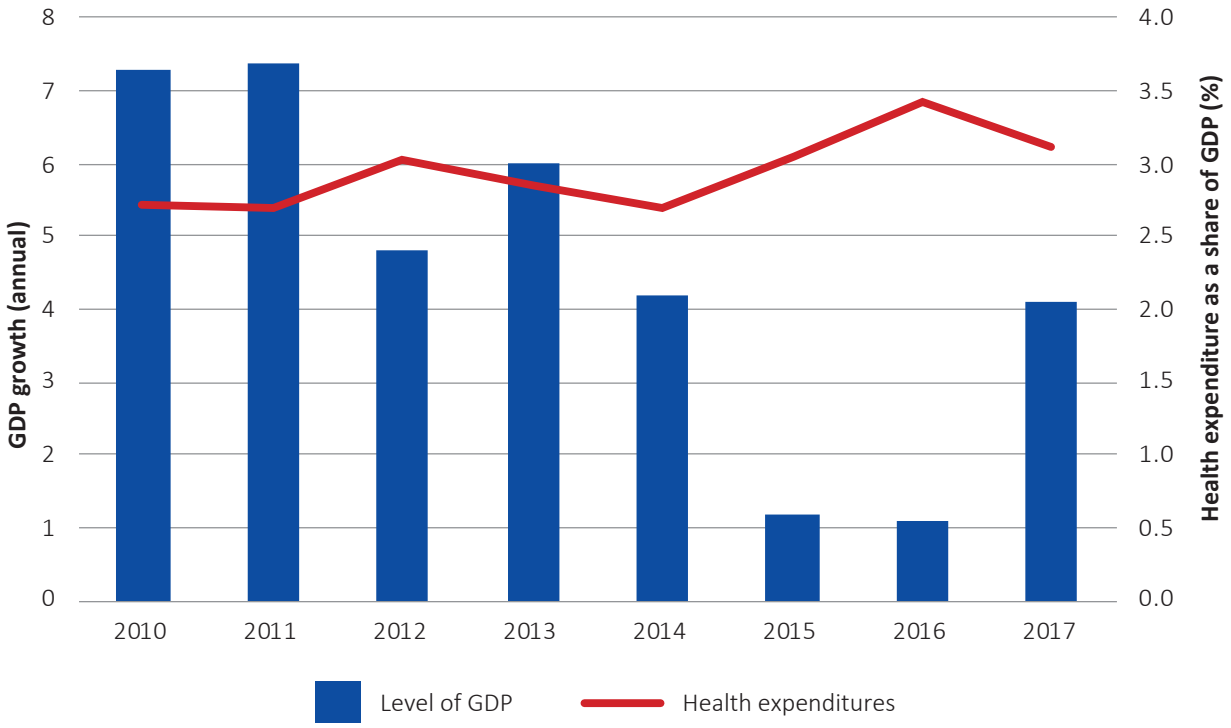
2004	• Adoption of the National Programme for Health Care Reform and Development 2005–2010 • Introduction of the State-guaranteed Benefit Package
2009	• Adoption of the concept of a unified national health care system, based on free choice of provider and development of competition and transparency in the health care system • Adoption of the Code on Population Health and Health Systems
2010	• Adoption of the State Health Development Programme "Salamatty Kazakhstan" for 2011–2015
2018	• Adoption of the State Health Development Programme "Densaulyk" for 2016–2019, reapproved in 2018 to reflect changed realities

[6] Katsaga A, Kulzhanov M, Karanikolos M, Rechel B. Kazakhstan: health system review. Health Syst Transit. 2012;14(4)1–154.

Health system financing for UHC of SRMNCAH

Despite being a policy priority, investment in health remains modest and is dominated by hospital expenditure. Rapid GDP growth has not been followed by increased spending on health. According to the WHO Global Health Expenditure Database, health expenditure as a share of GDP was highest for last decade in 2016, at 4% (although according to the Republican Centre for Health Development it was around 3%) (Fig. 6).

Fig. 6. GDP growth versus expenditure on health as a proportion of GDP



Source: WHO Global Health Expenditure Database [online database]. Geneva: World Health Organization; 2019 (https://apps.who.int/nha/database, accessed 30 December 2019).

Even though almost 60% of total health expenditure is government spending, out-of-pocket (OOP) payments represent 36% (Fig. 7). That is lower than in the majority of former Soviet republics, but still higher than the WHO estimate for adequate financial protection of 20% or lower. The largest proportion of OOP payments is on pharmaceutical expenditure (63% of OOP payments and 40% of total health expenditure).[7]

A breakdown of expenditure by type of service shows that 74% of total health expenditure was on curative care and only 6% on prevention in 2017. Accordingly, the breakdown by provider is 43% paid to hospitals, 31% to ambulatory care providers and only 6% to preventive care providers.[8]

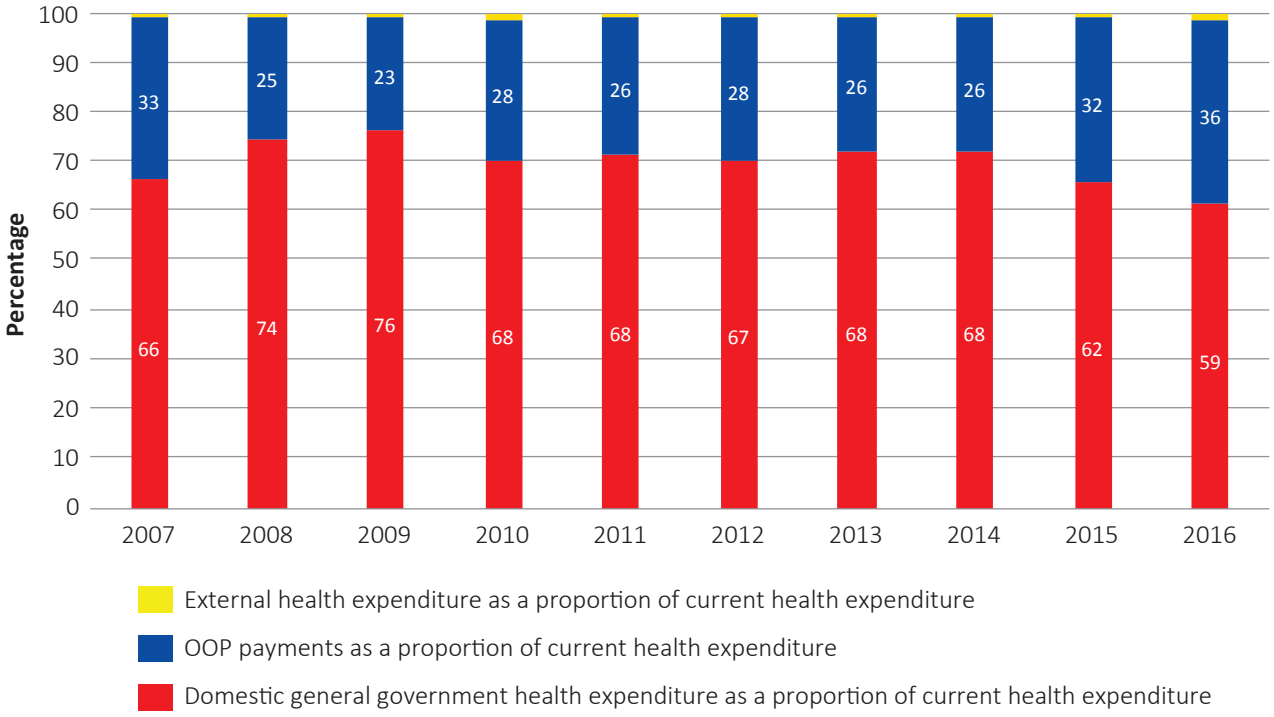
Health is funded from the state budget and is based on general taxation. The sector is financed through two main sources – national and local budgets. The national budget covers:

- hospital care (except tuberculosis, infectious diseases, mental health, HIV/AIDS and STIs) and highly specialized care;
- ambulatory care (PHC and specialist), hospital care in rural settings and medical care for oncological patients.

[7] Information provided by the National Health Accounts team of the Republican Centre for Health Development during interviews.

[8] National Health Accounts of Kazakhstan. Astana: Republican Centre for Health Development; 2017 (http://www.rcrz.kz/index.php/en/for-chiefs/national-health-accounts-nha, accessed 10 January 2020).

Fig. 7. Government expenditure on health versus OOP payments



Source: WHO Global Health Expenditure Database [online database]. Geneva: World Health Organization; 2019 (https://apps.who.int/nha/database, accessed 30 December 2019).

According to Government Decree No 2136 of 15 December 2009, the State-guaranteed Benefit Package covers ambulance and medical aviation, which is funded from the national budget.

The local budgets cover:

- emergency medical care;
- tuberculosis, infectious diseases, mental health, HIV/AIDS and STIs;
- healthy lifestyle programmes;
- pharmaceuticals at the PHC level for defined beneficiary groups.

Provision of services funded by the state is regulated by the State-guaranteed Benefit Package and compulsory social medical insurance, which will be implemented from January 2020.

State-guaranteed Benefit Package

The State-guaranteed Benefit Package (SGBP) is fairly comprehensive and covers:

- emergency care and transportation;
- ambulatory/polyclinic care, including PHC and consultative-diagnostic care on referral from a PHC doctor or specialist;
- hospital care on referral from a PHC professional or specialist in the framework of the planned volumes determined by the authorized body in the field of health care according to emergency indications;
- rehabilitation care;
- palliative care.

Medicines are provided free of charge at the outpatient level in the framework of the SGBP, in accordance with the approved list of medicines and medical supplies. They are provided for defined categories of citizens with certain diseases or conditions, and specialized medical products are provided according to indications and prescriptions of PHC specialists.

From SRMNCAH services, almost everything is covered (see Table 2) except contraceptives: pills and other family planning methods are not covered. Local governments, if they have resources available, procure limited amounts of contraceptives that are provided free of charge to socially vulnerable groups (including adolescents).[9] The government is responsible for providing counselling and performing procedures (such as intrauterine device insertion), but pills and intrauterine devices have to be procured by clients.

Table 2. Services included in the SGBP

Benefits of SGBP	PHC	Specialized ambulatory care	Hospital care
Antenatal care following recommendations	6 visits	Yes (according to local authority regulations)	Yes
WHO micronutrient supplements	Yes	Yes	Yes
Vaginal delivery/ caesarean section	No	No	Yes
Postpartum care	Yes	Yes	Yes
Home visits for postpartum/postnatal care	Yes	No	No
Family planning	Consultations, intrauterine device insertion, injection of injectable contraceptives	Consultations	Consultations
Emergency contraception	No	No	No
Abortion (including medical abortion)	No	No	Yes
STI diagnosis	No	Syphilis testing (Wassermann reaction)	Yes
STI treatment	No	Yes	Yes
Human papillomavirus (HPV) immunization	No	No	No
Cervical cancer screening	Yes	Yes	Yes
Cervical cancer treatment	No	No	Yes

[9] Tanirbergenov S, Abuova G. Situation analysis: reproductive health in Kazakhstan 2008–2014. Astana: United Nations Population Fund in Kazakhstan; 2015.

Compulsory social medical insurance

The draft decree on the introduction of compulsory social medical insurance (CSMI) defines the scope of services to be provided and identifies all citizens of Kazakhstan, including foreign citizens and their family members living in the country, as beneficiaries of CSMI. Services to be provided, as listed in the draft decree, are:

- consultative-diagnostic assistance by referring to the specialist in PHC and/or specialized assistance;
- day care (instead of hospitalization, with the exception of treatment for diseases under the SGBP via referral of a primary care specialist or medical organization);
- planned hospitalizations, with the exception of treatment of diseases within the framework of the SGBP, via referral of a specialist in PHC or a medical organization within the planned annual number of hospitalizations (defined by the Ministry of Health);
- medical rehabilitation and rehabilitation treatment.

The draft decree states that services already included in the SGBP will not be covered by CSMI, to avoid duplication and overspending. Provision of medical services to children under 18 years of age will be carried out within both the framework of the SGBP and the CSMI system, since children are among those whose contributions are provided by the state. Other interventions, such as nutrition for breastfeeding mothers during a stay in hospital (to take care of hospitalized baby), also are included in the CSMI package. Few details were available during the assessment period, so close monitoring will be required when the implementation process starts.

The relationship between the benefit packages and available funding needs to be managed carefully by the government, to ensure access to declared entitlements to all, while keeping the package financially feasible and avoiding duplication.

Table 3 sets out a summary of the assessment's findings on health system financing.

Table 3. Summary of findings on health system financing

Attribute	Rating	Criteria for rating
Inclusion in SGBP for UHC	Some need for improvement	All strategic documents are developed at the national level and issues related to reproductive health are reflected to the extent that they are prioritized at that level, even though the country has no comprehensive reproductive health strategy. At the service provision level, which is the responsibility of local governments, it is usually not a priority. For instance, the SGBP covers family planning counselling only; actual methods are the responsibility of local authorities, who usually have limited resources allocated for this purpose. Further, the authorities procure commodities (if at all) only for socially vulnerable groups, including adolescent girls. Kazakhstan is planning to introduce CSMI from 2020. The package to be covered is not yet defined, so the process of introduction needs to be monitored closely to make sure that current coverage under the SGBP is maintained and implemented.

Table 3. (contd)

Attribute	Rating	Criteria for rating
Financing mechanisms for health providers	Considerable need for improvement	The country's financing mechanisms are very complex. Funding schemes for different medical facilities vary: they are case-based in hospital settings in big cities, but per capita at the PHC level in cities and for all in rural settings, including hospitals. This creates inequality in availability of resources for health facilities and increases inequity for population groups in access to services. Shortages of resources at the facility level automatically lead to OOP payments; this may prevent citizens from seeking timely care. The only exception may be maternal and child health services, which do not have any funding ceilings, according to stakeholders.

Essential medicines and health products for SRMNCAH

The list of pharmaceuticals provided free of charge under the SGBP at the ambulatory level is extensive and approved by a Ministry of Health decree, which defines conditions and population groups covered.[10] It also sets out drugs that must be provided free of charge – in general, these are for management of chronic conditions (heart diseases; lung diseases; endocrinological problems, including diabetes; mental health conditions; and oncology). The list also includes drugs for management of common childhood conditions, including pneumonia in children under 18 years, newborn conditions (not specified) and hepatitis B. Contraceptives and drugs for treatment of STIs are not included in the list – except those for syphilis, which is treated free of charge. The SGBP does not cover emergency contraception.

No specific studies on the perceived affordability of drugs in Kazakhstan are available but, despite the comprehensive list of drugs that should be provided free of charge, almost 63% of OOP payments in 2017 were on pharmaceuticals. Alongside the high OOP payments, government expenditure on pharmaceuticals is also high, at 40% of total health expenditure in 2017. In response, the Ministry of Health issued a decree that regulates caps on prices of drugs procured under and provided via the SGBP.[11] Why OOP payments are still high, despite all the efforts to control government expenditure on pharmaceuticals and provide them free of charge to the population, is thus unclear. One explanation may be shortages of drugs at health facilities towards the end of the year, forcing patients to buy them in pharmacies, as explained by key informants.

To ensure the quality and effectiveness of the drugs provided through SGBP and CSMI, the Ministry of Health has developed a positive list (formulary), which uses the British list as a reference, developed based on evidence of effectiveness and quality.[12]

[10] Order of the Minister of Health No. 666 of 29 August 2017. Registered with the Ministry of Justice on 19 September 2017, No. 15724.

[11] On approval of marginal prices for medicines and medical products in the framework of the State-guaranteed Benefit Package and compulsory social health insurance funds. Order of the Minister of Health No. 112 of 16 March 2018. Registered with the Ministry of Justice on 29 March 2018, No. 16672.

[12] Order of the Minister of Health No. 369 of 22 May 2015. Registered with the Ministry of Justice on 24 June 2015, No. 11429.

Service delivery and safety for SRMNCAH

A national joint quality committee approves all protocols. It is planned that this will become a more self-regulating entity and more autonomous, so that guidelines are developed based on professional rather than political decisions – particularly as their implementation becomes increasingly expensive. Reviewing the tracer interventions, protocols and legislation in general follow WHO guidelines, where those exist. Coverage for key interventions, except for adolescent-friendly services is also high, thanks to a very comprehensive system for maternal and child health.

There is, however, scope to deliver services more efficiently. As also observed in an unpublished WHO report of 2015 on an assessment of quality of outpatient antenatal and postpartum care for mothers and newborn babies in Kazakhstan in 2014, there is:

> *no rational distribution of tasks between general practitioners, midwives, obstetrician-gynaecologists and other specialized physicians. Antepartum care, even for women without any risk factors, continues to be offered mostly by specialist obstetrician-gynaecologists (only one facility was an exception). These specialists are overburdened by the huge number of physiological pregnancies they should care for. Additionally, pregnant women have to be examined many times during pregnancy by general practitioners and other specialists. The consequences of this situation are multiple: long delays in diagnosis and treatment of some conditions/complications; overdiagnosis and overmedicalization of other conditions (urinary tract infections, threatened abortion or preterm labour); insufficient focus on and quality of information and counselling component of antepartum care; increased cost of services.*

In addition to the key interventions, violence against women and sexual abuse was mentioned by health workers as an issue that may be underreported. According to the 2018 Kazakhstan country gender assessment, 16.2% of women reported experiencing physical violence during their lifetime and 4.5% reported such incidents in the past 12 months.[13] Some "patronage" nurses – specialist nurses who monitor the growth and development of children under 5 years and provide parenting and feeding advice – have been trained to deal with these cases. Reasons for underreporting include the fact that cases are coded as external causes, so no official statistics are available.

Interviewees also mentioned that perpetrators are rarely prosecuted. The Committee on the Elimination of Discrimination Against Women's 2014 report noted that violence against women – including domestic violence, sexual violence and rape – is largely underreported due to a culture of silence perpetuated by persistent societal stereotypes.[14] Further, the Kazakh Criminal Code includes a distinction regarding acts of violence against women that are amenable to settlement when the alleged perpetrator reconciles with the victim; it also states that prosecution of acts of violence can be undertaken only when a victim lodges a complaint.

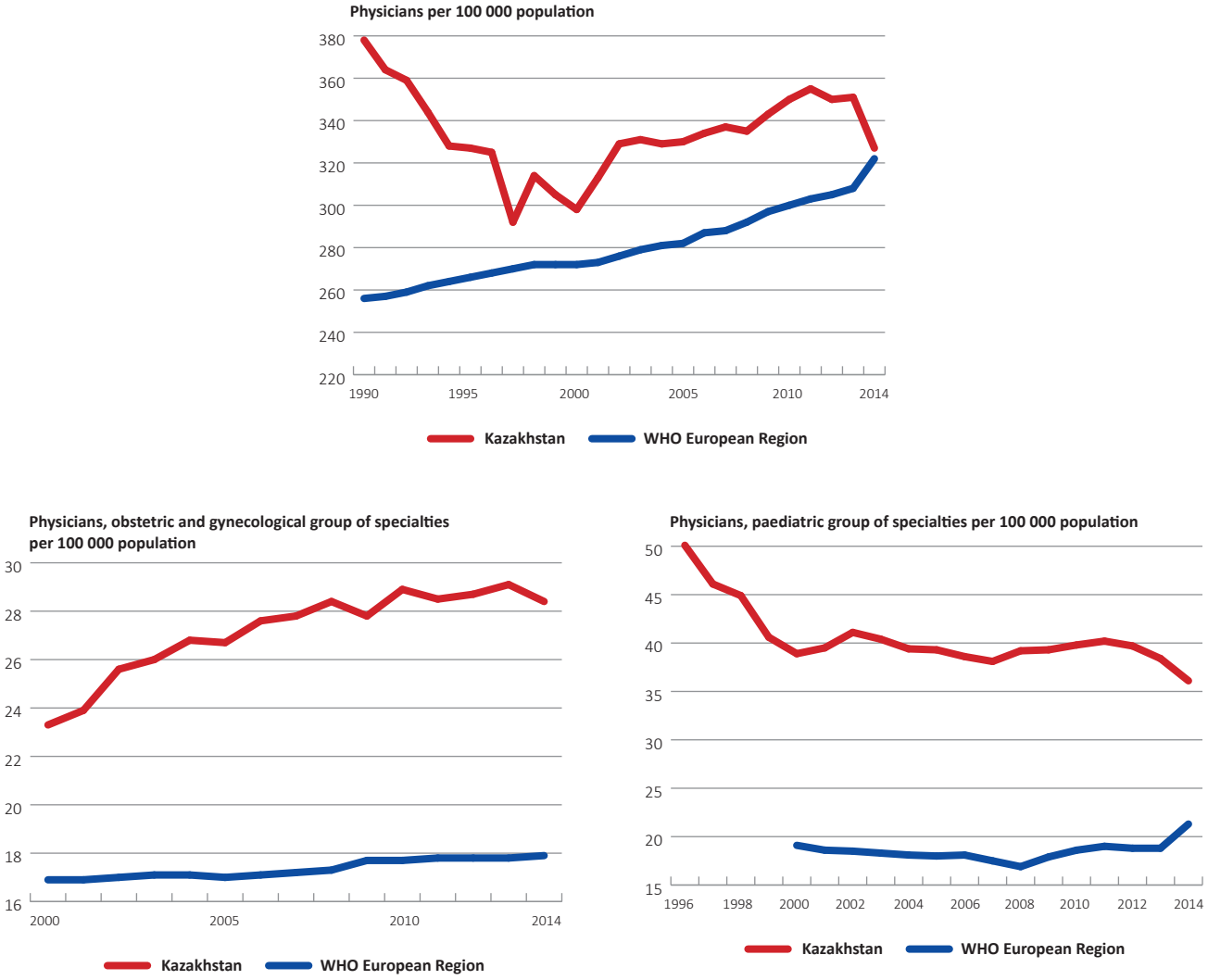
[13] Kazakhstan country gender assessment. Manila: Asian Development Bank; 2018 (https://www.adb.org/documents/kazakhstan-country-gender-assessment-2018, accessed 2 January 2020).

[14] Concluding observations on the combined third and fourth periodic reports of Kazakhstan. New York: Committee on the Elimination of Discrimination Against Women; 2014 (CEDAW/C/KAZ/CO/3-4; https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/KAZ/CO/3-4&Lang=En, accessed 2 January 2020).

Health workforce for SRMNCAH

Overall, the number of physicians per 100 000 population in Kazakhstan has shown a slight decline since 1990 and is now close to the average in the WHO European Region. In contrast, the numbers of paediatricians and gynaecologists/obstetricians per 100 000 remain well above the European average, although the number of paediatricians has decreased over the last 20 years (Fig. 8).

Fig. 8. Proportions of health professionals, Kazakhstan and WHO European Region



Source: European Health Information Gateway – Health for All explorer. In: WHO/Europe [website]. Copenhagen: WHO Regional Office for Europe; 2019 (https://gateway.euro.who.int/en/hfa-explorer/#s6Dx2vdvCI, accessed 9 January 2020).

As of 2016, primary care physicians in Kazakhstan probably accounted for between 7% and 16% of the physician workforce. This is considerably lower than the average among OECD countries, where the proportion of physicians in PHC is 32%.[15] At the oblast (regional) hospital visited, only 30% of the anaesthesiologist and intensive care specialist posts and 70% of the gynaecologist and neonatologist posts were filled. There was also a lack of neonatal cardiologists.

[15] OECD reviews of health systems: Kazakhstan 2018. Paris: OECD Publishing; 2018 (https://www.oecd.org/countries/kazakhstan/oecd-reviews-of-health-systems-kazakhstan-2018-9789264289062-en.htm, accessed 2 January 2020).

To ensure sufficient health staffing at the rayon (district) level, a national programme supporting health staff going to work in rural areas includes housing support and a lump sum. In addition, the district visited during the assessment supports doctors for training.

General practitioners (GPs) are the intended backbone of the PHC level for SRMNCAH services. The role of GP was officially introduced into the Kazakh health system in 2005. Following a period of intensive re-training and an increasing number of medical graduates entering general practice, the number of GPs grew to 920 in 2006 and to 2233 in 2010, reaching 5071 in 2016, corresponding to a nearly fivefold increase. According to the 2018 OECD review, however, the number of doctors varies across regions, and rural and remote areas suffer from a shortage of qualified health personnel.[16] In 2016, the highest numbers of doctors were found in the cities of Astana (84.4 per 10 000 population) and Almaty (76.1 per 10 000 population). At the other end of the spectrum were regions such as Almaty, Kostanay and Jambyl, all with fewer than 27 doctors per 10 000 population, or around one third of the number found in cities. In addition, many doctors prefer working at the hospital rather than the PHC level, and incentives to work as a GP at the PHC level are not considered sufficient, according to key informants.

In the region visited, there were about 1700 people per GP and per three nurses, of which one is a patronage nurse. There is one gynaecologist to each 2–3 GPs, meaning that each gynaecologist covers approximately 1500 women of reproductive age. Many common conditions seen by GPs, including family planning services, are referred to a specialist level; this causes fragmentation of services. Key informants at the regional polyclinic level noted that the quality of new graduate GPs needs to be improved to deal adequately with a wider range of SRMNCAH services. This view was supported in the 2018 *Review of Integrated management of childhood illnesses (IMCI) in Europe*, which found skills and knowledge of graduates from medial universities to be insufficient.[17]

Specific implications for SRMNCAH are the following.

- SRMNCAH services in Kazakhstan are typically provided at the PHC level by GPs. The fact that rural and remote areas often suffer from a shortage of qualified health personnel is concerning, as it may impair universal access to services.
- Skills and competencies of GPs in providing SRMNCAH services may not always be sufficient, resulting in multiple referrals and/or inadequate treatment.

Health statistics and information systems for SRMNCAH

The health information systems in Kazakhstan, including patients records, are being digitized.

Official statistics, including civil registration and vital statistics, comply with survey-based data (such as Multiple Indicator Cluster Surveys and Demographic and Health Surveys), indicating that the data are reliable. Annual statistics are published on the web.

[16] OECD reviews of health systems: Kazakhstan 2018. Paris: OECD Publishing; 2018 (https://www.oecd.org/countries/kazakhstan/oecd-reviews-of-health-systems-kazakhstan-2018-9789264289062-en.htm, accessed 2 January 2020).

[17] Review of Integrated management of childhood illness (IMCI) in Europe. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/en/publications/abstracts/review-of-integrated-management-of-childhood-illness-imci-in-europe-2019, accessed 30 December 2019).

One main purpose of the health information system, however, relates to financial reimbursement and budgets rather than informed policy-making, and the multiple data registries are not used in conjunction. According to the 2018 OECD review, information-sharing among providers at different levels is limited, representing a critical barrier to deeper integration and coordination of care.[18] This was confirmed by key informant interviews, which indicated few formal mechanisms and limited capacity for data analysis at lower levels.

It is possible to extract data disaggregated for sex, age, rural/urban population, wealth, ethnicity and others, but, according to key informants, this is not done systematically.

Although there is a process for accreditation of health facilities based on standards and quality of care, only about 30% of facilities are accredited and it is not a requirement but a competitive advantage in obtaining contracts with the health insurance fund.[19] The 2018 OECD review also noted that quality improvement initiatives should prioritize further modernization of health information systems – in particular the completion of the electronic health passport – to integrate health care data and promote continuity of care for patients. In addition, reporting on and rewarding quality of care rather than taking punitive action would also help to increase health care professionals' engagement and thereby inculcate a culture of quality assurance.

Specific implications for SRMNCAH are the following.

- A major issue is the lack of disaggregated data. In the case of morbidity, no disaggregation is done for age (only below and above 18 years), sex, rural/urban population, wealth, ethnicity or other factors. Without data disaggregation, it is difficult to monitor trends along the continuum of care. Further, health information and data are submitted to the central/national level, with no formal mechanisms and limited capacity for analysis and use of data for policy development at lower levels.
- Improved reporting on quality of care is key to SRMNCAH, but the multiple health registries are not used in conjunction for integration of health care and promotion of continuity of care for patients.

Findings on tracer interventions

Six tracer interventions were examined in particular detail during the assessment. This section provides a description and analysis of each, concluding with summary tables reviewing different dimensions or attributes, with colour codes based on a traffic-light system:

- red – considerable need for improvement or equating to service not being provided/totally inadequate care/potentially life-threatening practices;
- yellow – some need for improvement to reach standards;
- green – good practice or showing little need for improvement.

The attributes of the tracer interventions were reviewed using the following themes and associated questions.

- Protocols and legislation: do protocols and legislation exist for the intervention package and are they in line with WHO recommendations?

[18] OECD reviews of health systems: Kazakhstan 2018. Paris: OECD Publishing; 2018 (https://www.oecd.org/countries/kazakhstan/oecd-reviews-of-health-systems-kazakhstan-2018-9789264289062-en.htm, accessed 2 January 2020).

[19] OECD reviews of health systems: Kazakhstan 2018. Paris: OECD Publishing; 2018 (https://www.oecd.org/countries/kazakhstan/oecd-reviews-of-health-systems-kazakhstan-2018-9789264289062-en.htm, accessed 2 January 2020).

- Scope of services: are the services provided within the intervention package adequate and in line with WHO recommendations?
- Population coverage and/or access: what is the population coverage of the intervention package or the proportion of the target population that has access to the intervention package?
- Quality of services: is the quality of provision of the intervention package adequate?

Antenatal care

Women of reproductive age are called for regular routine check-ups and divided into different groups according to whether they intend to become pregnant or not. If wanting to become pregnant, they are divided into possible risks groups, such as presence of genital diseases, extragenital diseases, social vulnerability and so on. During these check-ups, women are also counselled regarding family planning, folic acid and nutrition.

New guidelines for antenatal care have been adopted and include at least eight points of contact. In practice, however, numbers of points of contact are much higher, even often for normal pregnancies, according to key informants.

Antenatal care coverage remains very high (95%), and maternal mortality has decreased substantially over the last 15 years – in 2017 it was 10 per 100 000 live births[20], which is lower than the average in the WHO European Region. The district visited during the assessment had a population of 77 000 and approximately 2000 deliveries a year. According to the authorities' statistics, the number of pre-eclampsia cases diagnosed in 2018 was 29; no cases of eclampsia were diagnosed – the last one was seen in 2016. Approximately 76% of pregnant women delivered at the district hospital, the remainder at the regional or national level.

Interviews with clients revealed general satisfaction with services, although queues and multiple referrals were seen as problems. Sometimes patients chose to pay private clinics to avoid queues and get laboratory investigations. Clients also informed the assessment team that they sometimes had to pay for medicines when "free" medicines were out of stock; this often happens towards the end of the year. The reason, according to health facility managers, was that each facility has to predict which medicines are needed for the year and in what quantities, based on current patient load. OOP payments for antenatal care services are rare.

The assessment team visited the Perinatal Centre at City Hospital No 2 in Nur-Sultan, where screening of congenital malformations had been centralized. All pregnant women living in Nur-Sultan now have to be screened at the nineteenth week of gestation. The Perinatal Centre has the ability and capacity to operate on all malformations except heart problems, for which pregnant women are referred to the National Centre for Cardiac Surgery. Stakeholders underlined that this system has sufficiently decreased newborn deaths caused by congenital malformations (from 34% to 16%)

Interviewees also mentioned the regionalization of perinatal care in Kazakhstan, for which three-level service provision has been organized across the entire country. Having extensive infrastructure but moderate resources, the original system was not able to maintain equal conditions in every maternity unit, so the decision was made to integrate primary level maternity units into secondary level units at the district level and to integrate secondary level units into tertiary level facilities in regional centres. According to stakeholders, this has improved the quality of perinatal services, even though staff in those facilities are overstretched.

Table 4 sets out a summary of the assessment's findings on antenatal care.

[20] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/maternal-mortality-ratio-(per-100-000-live-births), accessed 31 March 2020.

Table 4. Summary of findings on antenatal care

Attribute	Rating	Criteria for rating
Protocols and legislation	Good practice/ little need for improvement	The protocols for antenatal care are in line with WHO recommendations, including eight points of contact with a physician during pregnancy.
Scope of services	Good practice/ little need for improvement	All WHO-recommended antenatal care interventions are included in the protocol and in the SGBP.
Population coverage and/or access	Good practice/ little need for improvement	Antenatal care coverage is high (95%), and all women of reproductive age are called for regular check-ups and counselling.
Quality of services	Some need for improvement	The services are sometimes fragmented, and pregnant women may have to see many different providers with multiple referrals. These multiple check-ups could be organized more efficiently.

STIs (excluding HIV)

Testing and diagnostics for STIs are covered by the SGBP. For pregnant women, STI treatment is free of charge; for other patients, only treatment of syphilis and HIV is covered. Due to the high coverage of antenatal care, in which testing for syphilis is part of the routine check-up, coverage of testing and treatment for syphilis is presumed to be high. Furthermore, syphilis in pregnant women was an "Akimat" (administrative unit in Kazakhstan) performance indicator in the district visited. According to key informants data on STI's is collected, but it was not available during the mission.

According to health workers interviewed, many patients prefer private clinics owing to confidentiality issues and perceived better treatment, despite services being offered free of charge in public facilities. In recent years, a number of beds for STIs at the hospital level have been closed and only day care beds remain.

Adolescents need parental consent for testing and treatment for STIs. At the adolescent-friendly health centre visited, only testing could be done – a referral was needed for treatment. In general, referrals are required for management of STIs, resulting in some fragmentation of services at the PHC/GP level. Rapid tests were reportedly not available for any STIs.

Table 5 sets out a summary of the assessment's findings on STIs.

Table 5. Summary of findings on STIs

Attribute	Rating	Criteria for rating
Protocols and legislation	Some need for improvement	Legislation regarding management of STIs, particularly on parental consent for adolescent patients, needs updating.
Scope of services	Some need for improvement	Only syphilis and HIV testing and treatment are fully covered for all citizens. For all other STIs, testing and treatment are only free for pregnant women; others pay, particularly for treatment.

Table 5. (contd)

Attribute	Rating	Criteria for rating
Population coverage and/or access	Some need for improvement	Coverage is presumed to be high for syphilis, but no reliable data are available for other STIs.
Quality of services	Considerable need for improvement	No treatment is available at the PHC/GP level: referrals to specialists are required for all STIs, resulting in fragmentation of services. No rapid tests are available.

Neonatal transport

Transport of sick neonates seemed well organized in the region and district visited by the assessment team. Overall, neonatal mortality rates for Kazakhstan decreased to a relatively low level of 5.3 per 100 000 live births in 2017. Transport is done by Sanaviation, which has both a plane and a car in the district visited; interviewees confirmed that the situation is similar across the country. At the regional level an emergency team is available, which can follow the plane or car to the district.

Surfactant is available in all districts, and the cars and planes are fully equipped with transport incubators, ventilators and so on. Telemedicine is available and often is used to decide treatment and/or referral. The district visited had a neonatologist, who could deal with sick neonates. Transport can be initiated at short notice, depending on the neonate's condition. In the region visited, 169 referrals of sick neonates were done to districts in 2018, including transport and stabilization of the neonate prior to and during transport. Outreach to 151 neonates, of which 55 were referred to the regional hospital, and transport of 18 pregnant women was also included.

Table 6 sets out a summary of the assessment's findings on neonatal transport.

Table 6. Summary of findings on neonatal transport

Attribute	Rating	Criteria for rating
Protocols and legislation	Good practice/ little need for improvement	Clinical protocols for management of preterm and/or severely sick neonates are available.
Scope of services	Good practice/ little need for improvement	Planes and cars are available for transport and equipped with incubators and ventilators. Surfactant is available at the district level. An emergency team follows the plane or car. Telemedicine is available.
Population coverage and/or access	Good practice/ little need for improvement	A system of referral (in-utero transport) for at-risk pregnancies prior to delivery is in place. All districts are said to be covered by transport.
Quality of services	Good practice/ little need for improvement	The response time is short when required; planes and cars are fully equipped. An emergency team and telemedicine are available.

Case management of common childhood conditions

Kazakhstan was the first country in the WHO European Region to introduce and adapt IMCI as a national strategy. National standard child health records have been amended in line with IMCI, including care for development/early childhood development. Training coverage of IMCI reached 69% of PHC physicians and medical assistants and 60% of nurses in 2015, according to WHO's 2018 *Review of Integrated management of*

childhood illness (IMCI) in Europe.[21] Overall training coverage is, however, said to have decreased to about 50% among all health workers that deal with sick children in recent years.

During visits to health facilities, there were clear indications that IMCI charts and the WHO Pocket book of hospital care for children were known, and national records were adapted to IMCI.[22] However, health workers interviewed noted that the guidelines were not always followed, even for very common conditions such as pneumonia. The same observation was made in the 2018 WHO review.

[21] Review of Integrated management of childhood illness (IMCI) in Europe. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/en/publications/abstracts/review-of-integrated-management-of-childhood-illness-imci-in-europe-2019, accessed 30 December 2019).

[22] Integrated Management of Childhood Illness: chart booklet. Geneva: World Health Organization; 2014 (https://www.who.int/maternal_child_adolescent/documents/IMCI_chartbooklet/en/, accessed 3 January 2020); Pocket book of hospital care for children: guidelines for the management of common childhood illnesses, second edition. Geneva: World Health Organization; 2013 (https://www.who.int/maternal_child_adolescent/documents/child_hospital_care/en/, accessed 3 January 2020).

Medicines included under IMCI are free of charge. UNICEF is supporting a project on improving patronage nurse availability in the region visited. The patronage system also includes addressing social aspects. At the facility level, weekly nutrition sessions are conducted for mothers on feeding their babies and children.

Table 7 sets out a summary of the assessment's findings on case management of common childhood conditions.

Table 7. Summary of findings on case management of common childhood conditions

Attribute	Rating	Criteria for rating
Protocols and legislation	Good practice/ little need for improvement	IMCI and the WHO Pocket book are adopted; national protocols follow international evidence-based standards.
Scope of services	Good practice/ little need for improvement	Management of common childhood conditions is included in the SGBP.
Population coverage and/or access	Some need for improvement	Coverage of IMCI training is relatively high but has decreased over recent years.
Quality of services	Some need for improvement	Despite good training coverage, IMCI guidelines are not always followed, leading to potential overhospitalization and polypharmacy.

Adolescent-friendly sexual and reproductive health services

The concept of adolescent-friendly health services or youth health centres was introduced in Kazakhstan in 2006. Originally, they were part of healthy lifestyle centres, but they have recently been privatized, resulting in a decreased number. Most regions have youth-friendly services as part of PHC centres, despite the fact that experience indicates that adolescents rarely visit PHC centres. At the district level, youth services are covered by a family doctor, a psychologist and a nurse. The regional adolescent health centre visited in Kyzylorda provided an example of how youth-friendly services can be organized, but the assessment team was informed that there are no similar centres in other regions. The team was, however, told that an additional 17 regional adolescent health centres are planned to be established.

The adolescent birth rate is high in Kazakhstan (in 2015 it was 36 women aged 15–19 years per 1000 women in that age group)[23]. The age of consent is 18 years, which means that adolescents under 18 years cannot receive treatment without their parents' involvement. The team was informed that a new package of laws is in the pipeline that will decrease the age of consent to 16 years, except for abortions.

Adolescents have limited access to sexual and reproductive health information, including in schools, according to key informants. Contraceptives are included in the SGBP, but need to be bought at pharmacies. STIs can be diagnosed by youth-friendly health services, but referral is needed for treatment. Clients at the regional adolescent health centre visited indicated – through an anonymous feedback box – that they felt it important that a fuller range of services, including provision of contraceptives, should be provided at the centre without referral.

Table 8 sets out a summary of the assessment's findings on adolescent-friendly sexual and reproductive health services.

[23] Adolescent birth rate: data by country. In: WHO Global Health Observatory (GHO) data [database]. Geneva: World Health Organization; 2019 (http://apps.who.int/gho/data/view.main.1630AG, accessed 19 November 2019).

Table 8. Summary of findings on adolescent-friendly sexual and reproductive health services

Attribute	Rating	Criteria for rating
Protocols and legislation	Considerable need for improvement	Adolescents below 18 years cannot access individual services and treatment without parental consent.
Scope of services	Considerable need for improvement	Services are limited, even in the few existing adolescent-friendly centres – they do not include treatment, testing or provision of family planning. Sexuality education is also limited.
Population coverage and/or access	Considerable need for improvement	Access and coverage are limited. Healthy lifestyle centres have been privatized, resulting in adolescent health services disappearing.
Quality of services	Considerable need for improvement	Adolescents lack access to sexual and reproductive health information, including in schools and colleges. The majority of existing services are not targeted and do not fulfil standards for high-quality health services for adolescents.

Immunization

Overall, immunization coverage remains very high (95%). The immunization schedule is in line with WHO recommendations, except for HPV vaccination, which is not included. HPV vaccines were part of the schedule a few years ago, but due to resistance – a campaign saying that they would cause cervical cancer – they were removed. Now only at-risk groups, including patients who already have HPV, are offered the vaccine. It is not offered to adolescent girls.

Despite the high coverage, outbreaks of measles have been seen. Apart from the misinformation regarding HPV, there is not a very active anti-vaccination lobby in the country. UNICEF supports and procure vaccines, while the government pays for them.

Table 9 sets out a summary of the assessment's findings on immunization.

Table 9. Summary of findings on immunization

Attribute	Rating	Criteria for rating
Protocols and legislation	Some need for improvement	The national immunization schedule is in line with WHO recommendations for routine immunization, but does not include HPV.
Scope of services	Some need for improvement	HPV vaccine was taken out of the immunization schedule due to misinformation that it could cause cancer. It has not yet been reinstated. Other vaccines are included and available.
Population coverage and/or access	Good practice/ little need for improvement	Coverage for included vaccines is high (95%).
Quality of services	Good practice/ little need for improvement	Patients are called for regular immunizations.

Policy recommendations

Kazakhstan has been modernizing its health care system rapidly, with both demand- and supply-side reform. Since 2010 the Ministry of Health has pursued the concept of a unified national health care system, pooling funding for hospital services at the national level and connecting payments to an individual patient, rather than a health care provider. As reflected in national development strategies, Kazakhstan is seeking improvements in health status to be consistent with those found in OECD countries. These reforms are not yet fully implemented.

The health of women, children and adolescents is given high priority. This is expressed in the intended full coverage of health services to pregnant women, women in delivery and postpartum and children aged 0–18 years, among others. Kazakhstan has made considerable progress in SRMNCAH during the past 10–15 years, particularly in bringing down maternal and under-5 mortality. Overall, coverage of essential interventions is relatively high, with the exception of some areas, such as adolescent sexual and reproductive health services and STIs.

Strengthening governance, health literacy and multisectoral action for SRMNCAH

Policy-making in Kazakhstan is highly centralized and heavily regulated. An extensive number of regulatory documents complicate follow-up for service providers, and beneficiaries may not always have a clear understanding of their entitlements. All strategic documents are developed at the national level.

Reproductive health is a priority at the national level, but service provision is the responsibility of local authorities, where the same priorities are not always reflected. This may weaken the governance process. Maternal and newborn mortality are used as performance indicators. This may be helpful, but if used in a punitive way it may cause demotivation of staff and add to pressure on local authorities. Intersectoral coordination boards exist at the district level, but may not be fully utilized in promoting intersectoral collaboration in the area of SRMNCAH. Health literacy initiatives exist – such as a programme on infant feeding – but they may not be systematically applied for SRMNCAH.

The assessment team recommends the following.

- The system of issuing regulatory acts should be reviewed in the area of SRMNCAH, with the aim of reducing the number and simplifying the system for both providers and clients.
- Existing performance indicators for effectiveness and efficiency for the health system in the area of SRMNCAH should be reviewed.
- Health literacy programmes and initiatives (such as those providing information on access to contraception, sexuality education, promotion of early detection of cervical cancer and HPV immunization) should be reviewed in order to standardize them and obtain full coverage, including for the most vulnerable population groups. A starting-point could be adolescent-friendly sexual and reproductive health services.
- Multisectoral collaboration in the area of SRMNCAH should be analysed, with the aim of identifying and optimizing the most important entry points for action – for example, sexuality education, prevention and responses to gender-based violence.
- Rights-based approaches to health, achieving equity and "leaving no one behind" should become explicit objectives for all SRMNCAH policies, including implementation and monitoring/evaluation activities. This would include:
  - involving a broad range of partners within and outside government, including representatives of the populations concerned, in the formulation of strategies and action plans to provide services to population groups with specific needs;
  - setting policy targets to close equity gaps – for example, between geographical areas and population groups – presenting all SRMNCAH data disaggregated for sex, age, geographical location, ethnicity and wealth, and monitoring the data over time to ascertain that equity gaps are closing;
  - targeting SRMNCAH services to population groups with specific needs, including people with lower socioeconomic status and other vulnerable, disadvantaged and hard-to-reach groups, and ensuring that the services are provided free of charge and accessible.

Orienting health financing to improve support for SRMNCAH

Despite being a stated government priority, the health sector is proportionally underfunded and is dominated by hospital-level expenditure. Funding mechanisms for hospital care in urban and rural settings are different. Hospitals receive per capita funding in rural settings but are paid according to case-load in urban areas. In some cases this leads to underfunding of rural hospitals, contributing to high OOP payments among the population, which affects equity and ability to access timely health care services. As a result, despite all the efforts and some improvements, health indicators in Kazakhstan are not comparable to those in OECD countries.

The assessment team recommends the following.

- Funding for the health care sector should be increased to ensure a reduction of OOP payments.
- Existing SRMNCAH services and supplies covered by the SGBP should be reviewed for cost–effectiveness, feasibility, affordability, equity dimensions and other relevant parameters, with the aim of achieving progressive realization of universal SRMNCAH. Examples include provision of family planning services (specifically emergency contraception) for adolescents and STI diagnostics and treatment.
- Clear criteria and transparent processes should be developed to ensure inclusion of SRMNCAH and other interventions in the SGBP, the contents of which should be clearly communicated to health service providers and the public. The services included should reflect the epidemiological situation, potential costs associated with treatment/management of the condition and, more importantly, the real needs of women, children, adolescents and other vulnerable groups.

- Payment mechanisms for health facilities should be reviewed to ensure adequate funding for PHC so that the quality and quantity of services provided are satisfactory for beneficiaries.

Reducing OOP payments for essential medicines and health products for SRMNCAH

The overall system for monitoring the quality and prices of pharmaceuticals provided under the SGBP and CSMI is effective and well regulated. The list of medicines provided free of charge is comprehensive and covers almost all common chronic conditions; nevertheless, almost 63% of OOP payments and 40% of total health expenditure in 2017 were on pharmaceuticals.

The assessment team recommends the following.

- All SRMNCAH essential drugs, including contraceptives, should be fully compensated; access to these should be made easy at the point of care.
- The process of forecasting at the facility level should be improved so that no stock-outs occur at the end of the year, and beneficiaries do not have to buy drugs in private pharmacies.

Developing a more effective model of service delivery, improving coordination between providers and strengthening evidence-based practice

The review of tracer interventions shows that protocols and legislation in general follow WHO guidelines, where those exist. Coverage of key interventions, except for adolescent-friendly services, is also high due to a very comprehensive system for maternal and child health. There is, however, scope for delivering services more efficiently. For example, antenatal care – even for women without any risk factors – continues to be offered mostly by specialist obstetrician-gynaecologists (only one facility was an exception). Further, pregnant women are examined many times during pregnancy by GPs and other specialists. In addition to the key interventions, violence against women and sexual abuse were mentioned by health workers as issues that may be underreported, and only some patronage nurses have been specifically trained to deal with these cases. At the PHC level, services are often fragmented, resulting in multiple referrals.

The assessment team recommends the following.

- Guidelines/protocols for routine examination, particularly for women of reproductive age, should be reviewed to ensure that resources, including specialized care, are used for those women in need of treatment rather than multiple visits for healthy women.
- Access to high-quality comprehensive sexual and reproductive health services at the PHC level should be strengthened, as core services should be provided at that level. For example, the system for STI treatment should be reviewed in the light of advances in rapid tests moving towards point-of-care testing and treatment, with the aim of avoiding multiple referrals and fragmentation.
- Adolescent sexual and reproductive health services should be strengthened, including increasing access to services for those aged less than 18 years and establishment of additional adolescent health centres.
- Violence against women and sexual abuse should be addressed at the PHC level, following the WHO guidelines for health sector response to partner and sexual violence against women.[24]

Strengthening human resources to provide SRMNCAH services

GPs are the intended backbone of PHC for SRMNCAH services, but the number of doctors varies across regions, and rural and remote areas suffer from a shortage of qualified health personnel. The skills and competencies of

[24] Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 (https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/, accessed 3 January 2020).

GPs in the field of SRMNCAH may not always be adequate, causing multiple referrals and fragmentation of services.

The assessment team recommends the following.

- The role of family doctors in providing SRMNCAH should be reviewed and strengthened. This should include an assessment of:
  - skills, competencies, training and supervision/mentoring needs;
  - professional development related to recertification and incentives for working in rural areas (accommodation, education for children, professional development);
  - incentives for providing a core package of SRMNCAH services – currently referral is the "easy" choice;
  - other factors that may undermine the perception of family doctors and their competencies, including highlighting the health system function from community to family doctor to hospital and the roles of specialists versus generalists.
- Human resources and financing policies should be reviewed to expand the scope of health promotion and prevention. They should also include task-shifting to nurses, who could assume monitoring, check-ups and provision of basic interventions in SRMNCAH**.**

Using health information and performance monitoring systems to improve outcomes and accountability

A well functioning health information system is a prerequisite for informed decision-making at all levels. Although improvements have been made, the system in Kazakhstan still suffers from fragmentation and a lack of analytical capacity. For SRMNCAH services, disaggregation of data – particularly for age and sex, but also for other parameters such as rural/urban locations, wealth and others – is essential to understand and address equity issues.

The assessment team recommends the following.

- A major effort should be made to ensure that sex and age disaggregation at minimum are done for all reported data in the health information system. Integration of the multiple databases would be important in that regard.
- Information gaps on SRMNCAH in the context of UHC should be reviewed, particularly with regard to data on equity and vulnerable populations.
- Existing data on SRMNCAH status, quality and performance of health service providers should be used in conjunction for analysis and generation of actionable information for policy-making and programming at all levels.

The WHO Regional Office for Europe

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