



ASSESSMENT REPORT

INTEGRATING MENTAL HEALTH AND TB SERVICES INTO
PRIMARY HEALTH CARE IN KAZAKHSTAN: LESSONS LEARNED
AND FUTURE PROSPECTS FOR INTEGRATION OF HIV/AIDS
SERVICES INTO PRIMARY HEALTH CARE

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TABLE OF CONTENTS

Abbreviations.....	6
Acknowledgements.....	7
Executive summary.....	8
1. Introduction.....	11
1.1. Background to the assessment	11
1.2. Why integrating HIV/AIDS response into PHC is important.....	12
1.3. Kazakhstan’s PHC model.....	12
1.4. TB situation in Kazakhstan.....	15
1.5. Mental health situation in Kazakhstan.....	16
1.6. HIV/AIDS situation in Kazakhstan.....	18
1.7. Assessment objectives.....	20
2. Assessment Methods and approaches	21
2.1. Quantitative data collection.....	21
2.2. Qualitative data collection.....	22
2.3. Data collection methods.....	22
2.4. Data Quality Control.....	23
2.5. Data analysis.....	24
2.6. Ethical Considerations.....	24
2.7. Addressing research bias.....	24
2.8. Stakeholders’ involvement.....	24
2.9. Validation of the study findings.....	25
2.10. Management of the study.....	25
3. Integration at client level	26
3.1. Integration at policy and systems level.....	26
3.2. Integration at facility level.....	27
3.2.1. Interviews with PHC service providers.....	27
3.2.2. Interviews with service providers at AIDS Centers.....	36

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Antiretroviral drugs
BCG	Bacillus Calmette-Guérin, a vaccine primarily used against TB
CDC	Centre for Disease Control
CMIS	Comprehensive Medical Information System
DOT	Directly Observed Therapy
FGD	Focus Group Discussions
GP	General practitioner
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
IRB	Institutional Review Board
KII	Key Informant Interviews
MDR TB	Multidrug-resistant TB
MIS	Medical Information System
MMU	Mobile Medical Unit
MoH	Ministry of Health
MSM	Men who have sex with men
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organizations
NRBT	National Electronic Registry of TB Patients
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
SDGs	Sustainable Development Goals
SOPs	Standard Operating Procedures
SPSS	Statistical Package for Social Sciences
STIs	Sexually Transmitted Infections
TB	Tuberculosis
RK	Republic of Kazakhstan
TWGs	Technical Working Groups
WHO	World Health Organization
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
UNAIDS	Joint United Nations Program on HIV/AIDS

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EXECUTIVE SUMMARY

The assessment for HIV/AIDS integration in primary health care in Kazakhstan was undertaken in 2022. The overall objective of the assessment was to use findings and lessons learnt from TB and mental health integration to guide and support integration of HIV/AIDS into primary health care. A mixed methods approach combining both qualitative and quantitative assessment methods was used. In general, Kazakhstan has successfully integrated TB and mental health into primary health care. At policy level, the assessment identified that the policy environment is supportive of TB and mental health integration. In preparation for integration, relevant national health and primary health care policies were reviewed and revised to ensure that they adequately support integration. The organisation of the Ministry of Health in Kazakhstan provides an opportunity for HIV/AIDS integration into primary health care. Both primary health care and HIV/AIDS division are under the department of organization of medical care and report to the same director. At facility level, in all primary health care facilities covered as part of this assessment, TB and mental health services had been successfully integrated into primary health care services. Modifications undertaken in PHC health facilities to accommodate for integration of TB and mental health services include training of health workers, provision of additional health workers and improvement of infrastructure.

Models of integration used in delivery of TB and mental health services include:

- provision in same site and with same service provider;
- provision in same site and different provider;
- referral to different site but within the same facility;
- complete referral to another facility;

Voices from both service providers and clients indicate that provision of integrated services are preferred over vertical services. However, people living with HIV observed that it will be critical to train health workers on provision of quality HIV/AIDS services and address issues related stigma and discrimination as a prerequisite to integrating HIV/AIDS services into PHC. Integration of TB and mental health into PHC in Kazakhstan was associated with reduction in hospitalization of TB patients leading to lower transmission, bringing health services closer to the population, and improving competency for TB and mental health diagnosis and treatment among PHC service providers. Lessons learned from integration of TB and mental health into PHC indicate that for successful integration, there is need to create buy in from different stakeholders including clients, create necessary policy environment for integration, address health system bottlenecks and use a phased integration approach. Key challenges in integration of HIV/AIDS into PHC include: inadequate staffing (both in terms of skills and numbers) for provision of comprehensive and integrated TB and mental health services, weak financing, inadequate infrastructure, and stigmatization of patients with mental health disorders. Similar challenges are expected in the integration of HIV/AIDS into PHC and there is need for the country to address them for a successful integration. Based on lessons from integration of TB and mental health and experiences from other countries, this assessment makes the following recommendations for a successful integration of HIV/AIDS into primary health care:

- **a.** Implement a phased implementation of HIV/AIDS into PHC. To ensure learning from doing and as necessary health systems are strengthened, this assessment recommends a phased integration approach. This could start with integration of HIV prevention activities such as HIV testing and awareness creation and later HIV treatment and care. This assessment recommends that the country develops a clear plan and road map for integrating HIV/AIDS response into PHC. The plan should detail the vision for integration, the proposed integration models, the implementation timelines and milestones and reflect the required financial resources/costs.

- **b.** House AIDS treatment centres within PHC. Rather than PHC centres themselves providing HIV services, and as part of the phased implementation, the study recommends that HIV services be provided by AIDS centre housed within the PHC facilities. The AIDS centres will then build capacity of PHC service providers.
- **c.** Learn from phased integration and scale up. The country should put in place systems to document emerging lessons and best practices from phased implementation and scale up integration both in terms of coverage and intensity.
- **d.** Review and update existing national policy and strategic documents to ensure they adequately support integration of HIV/AIDS into PHC. Lessons from integration of mental health and TB into PHC indicate that policy support is critical for effective integration. This assessment recommends that the country reviews and updates national health and PHC documents to provide policy support for HIV/AIDS integration into PHC.
- **e.** Develop necessary guidelines, tools, regulations, and laws necessary to support integration of HIV/AIDS into PHC. In addition to the broader policy support, the assessment identifies the need to develop specific guidelines, tools, and protocols to guide PHC and HIV practioners on the 'how' of HIV/AIDS and PHC integration
- **f.** Create buy in for HIV/AIDS integration with different players including policy makers, implementers, communities, and people living with HIV/AIDS. For HIV/AIDS integration to be successful, it is critical to have buy in from various stakeholders especially people living with HIV. The assessment identified some misgivings by policy makers and people living with HIV on the country readiness and feasibility of integrating HIV/AIDS into PHC. The study recommends structured process for building buy in among various players on integration of HIV/AIDS into PHC.
- **g.** Build capacity of PHC service providers in provision of integrated HIV/AIDS services. Respondents interviewed identify those skills building for PHC service providers in provision of integrated health services is a pre-requisite for quality integration. The study recommends adoption of right training materials and training of service providers in HIV/AIDS and PHC integration.
- **h.** Review package of services offered at PHC facilities to ensure that PLHIV can get a comprehensive package of services. It is recommended that existing PHC package of services be revised accordingly to include a comprehensive package of integrated HIV/AIDS services.
- **i.** Build systems and implement activities to ensure quality of care in provision of integrated HIV/AIDS and PHC services. A key concern by respondents in this study was the possibility of reduced quality in provision of HIV/AIDS services following intergation into PHC. This study recommends that the MoH establishes systems in integrating PHC facilities to ensure high quality in provision of integrated services. This could include regular monitoring and supportive supervision as well as establishment of quality improvement teams in the PHC facilities integrating HIV/AIDS services. Quality standards for provision of integrated services will also need to be developed and disseminated.
- **j.** Implement actions to prevent stigma and discrimination for clients accessing integrated HIV/AIDS and PHC services. Interviews with people living with HIV identify fears for that integration will increase stigma and discrimination. To address this, this assessment recommends implementation of actions to mitigate possible stigma and discrimination in PHC facilities integrating HIV/AIDS services. This will include sensitizing health workers and developing legal frameworks to protect people living with HIV from stigma and discrimination. Working with people living with HIV to reduce self-stigma is also identified as an important intervention
- **k.** Financing for the delivery of integrated HIV/AIDS and PHC services. Lessons from integration of TB and mental health into PHC identify that provision of adequate financing is key to successful integration. To support the integration process, it is necessary to provide additional funding for the restoration/maintenance of primary healthcare infrastructure, strengthening of oversight,

filling gaps in staffing, etc. This study recommends that the country develops and finances a costed investment case for supporting integration of HIV/AIDS into PHC.

- **l.** Commodities and supplies and technologies including laboratory services. Ensuring adequate supplies including test kits, ARV drugs and other supplies is key to integrating HIV/AIDS into PHC. The study recommends that MoH strengthens capacity of integrating PHC facilities in appropriate forecasting and quantification to ensure all time availability of HIV/AIDS commodities and supplies to ensure seamless integration. Integrating procurement and distribution of PHC and HIV/AIDS commodities will need to be strengthened.
- **m.** Ensure appropriate infrastructural support for integration. This assessment identifies that there will be need to support the right infrastructure for provision of integrated services. Those interviewed identified the need to provide adequate space for HIV counselling and testing as part of ensuring client privacy and preventing possible stigma and discrimination.
- **n.** Develop systems and ensure monitoring and evaluation of integrated HIV/AIDS and PHC services. What gets measured gets done. The assessment recommends review of existing PHC monitoring and evaluation tools to ensure they can measure delivery of integrated services. This will also require the MoH to define and ensure regular reporting of indicators for integrating HIV/AIDS into PHC. This process should include the integration of information systems for data collection to eliminate discrepancies in statistical data and ensure access to unified data.
- **o.** It is unlikely that an overloaded healthcare system will be able to cope with the increased number of patients receiving antiretroviral therapy in the long term while maintaining service quality without revising the workload of service providers. Additional personnel may be required to achieve this task. Strategies for task shifting/delegation from doctors to nurses may also be useful in PHC facilities facing staff shortages
- **p.** Engage PLHIV and HIV communities at all stages of planning for the implementation of HIV integration into primary health care
- **q.** Conduct further desk research and visits to countries in the region that are already integrating HIV/AIDS into PHC. The assessment recommends further review to understand specifics on integrating HIV/AIDS response into PHC. It is recommended that that benchmarking visits could be made to countries in similar contexts who are integrating HIV response into PHC.

1. INTRODUCTION

1.1. Background to the assessment

This report is based on the findings of an assessment study conducted in the Republic of Kazakhstan at the request of the United Nations Children’s Fund (UNICEF). The assessment was conducted by a team of national and supported by an international consultant. The findings of the study, in particular the lessons learned, and recommendations set out in this report, are intended for a wide range of people including policy makers, program managers, implementers, health service providers and other professionals working on integration of traditionally vertical health programs into primary health care. Every year, the growing needs of clients require the provision of high-quality, affordable, and cost-effective health care. Based on client needs, an integrated health care model has been proposed in Kazakhstan. The approach entails bringing services closer to the people thus ensuring access to healthcare services. The model also ensures provision of integrated healthcare services that meet the needs of clients with various health needs.

Many reforms have been implemented in Kazakhstan’s healthcare system since independence, particularly starting in the 2000’s. Various targeted programs to reform and develop healthcare have been designed and continue to be implemented today. Kazakhstan is home to two international Primary Health Care (PHC) declarations. In the first declaration, adopted in Alma-Ata in 1978, the role of states in maintaining PHC was recognized for the first time as the basis for realizing the fundamental human right to health. Forty (40) years later, in Astana, 194 WHO member countries unanimously adopted the Astana Declaration on PHC. Member states have committed to provide a new impetus to PHC development as a cornerstone of sustainable health systems to reach universal health coverage (UHC) via strengthened primary health care and related Sustainable Development and Epidemiological Goals. The targets for achieving UHC, the SDGs and sanitary and epidemiological safety are ambitious, but practically feasible. Achieving these targets requires urgent acceleration of the effort, which can be based on PHC¹.

International experience shows that PHC is one of the most important links in the development of national health care systems in all countries. In many countries, all successful healthcare systems have achieved improved population health outcomes through the development of PHC. For the population, the importance of PHC is determined by easy access to health care, the possibility of examination and treatment without hospitalization, and often without having to take time off at work or at school². In recent years, the global public health community has paid increased attention to the integration of various health services into PHC. The Framework for Integrated, People-Centered Health Services, adopted by an overwhelming majority of Member States at the Sixty-ninth World Health Assembly, defines integrated health services as *“continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course”*³. The concept of providing “integrated care” involves intersectoral collaboration, joint goal setting and prioritization, and is focused on the involvement of stakeholders representing different areas of health care and on creating mechanisms for cooperation between them. Strong Primary Health Care systems together with the financial protection offered through UHC has been touted as the gold pathway to achieving health for all⁴.

In Kazakhstan, two specialized services, Tuberculosis (TB) and mental health, are currently integrated into PHC. The aim of this assessment was to explore the experiences, lessons learnt and challenges of integrating TB and mental health services into PHC, and then use this experience to support the integration of HIV/AIDS response into PHC.

¹ From WHO report on Primary health care, 1 April 2021, <https://www.who.int/news-room/fact-sheets/detail/primary-health-care>

² The concept of establishment and development of best-practice centers. The World Bank, SOFRECO, 2019.

³ World Health Assembly, 69. Framework on integrated, people-centered health services: report by the Secretariat. Geneva; World Health Organization; 2016 (<https://www.who.int/iris/handle/10665/252698>)

⁴ <https://www.oatext.com/Primary-health-care-and-universal-health-coverage-Achieving-health-for-all.php>

1.2. Why integrating HIV/AIDS response into PHC is important

In the context of this assessment, integration of HIV/AIDS into PHC is defined as colocation and sharing of services and resources for HIV care and primary care, such as clinic space, clinicians, health education, pharmacy, laboratory services, and training. Given that currently HIV/AIDS services are offered in specialised and vertical AIDS centres, integration means that HIV services are decentralised and provided together with other health services in primary health care facilities. Many studies have documented the benefits of integrating HIV/AIDS with other services and in primary health care. For the two programs, integration can help address the issue of skewed resource allocation and hence strengthen the broader health systems allowing people to access the health care they require regardless of HIV status. Where HIV/AIDS response is better funded than PHC, colocation of HIV and primary care services maximizes the use of available health facility structures and ensures that funds allocated for strengthening “HIV/AIDS” service facilities also benefit facilities that provide primary care health care services⁵.

Experiences in similar settings have shown that decentralising HIV services into primary health care facilities leads to greater acceptability of services, increased referrals, initiation, and retention into HIV care⁶. Additionally, integration has been associated with improved patient outcomes, and reduced cost of services⁷. Integrated HIV and PHC health systems such as human resources, monitoring and evaluation (M&E), supply-chain management and laboratory systems, and counseling services can also be shared when HIV services are integrated into primary care services which increases efficiency⁸. Programs decentralising and integrating HIV response into PHC have reported better improvements in access, quality of care, and efficiency in service delivery compared to centralised and verticalized HIV response⁹. In situations where HIV programs implement capacity building programs including in service training, integration has been associated with improved staff capacity at PHC facilities¹⁰. Given its emphasis on comprehensive, coordinated, continuous and people-centred care, PHC is best suited to offer service delivery points for people living with chronic diseases such as HIV and AIDS¹¹. Given the need to transition from donor financial support, there is need to put in place systems that ensure sustainability and availability of comprehensive services for people living with HIV. Integrating HIV/AIDS response with primary health care provides an opportunity for strengthening broader health systems and ensuring sustainability¹².

Integrating HIV/AIDS into PHC in Kazakhstan is expected to result in increased access, quality and improved health outcomes for people living with HIV.

1.3. Kazakhstan's PHC model

Primary health care is the first point of access to population-based health care, including prevention, diagnosis, treatment of diseases and conditions at the individual, family, and community levels. In Kazakhstan, as in the rest of the world, PHC is a priority area for the development of the healthcare system. Improving the health of the population based on an integrated approach to disease prevention and management has been and remains a key goal of government healthcare development programs in the past 10 years.

⁵ J. Pfeiffer, P. Montoya, A. J. Baptista et al., “Integration of HIV/AIDS services into African primary health care: Lessons learned for health system strengthening in Mozambique—a case study,” *Journal of the International AIDS Society*, vol. 1, article 3, 2010

⁶ M. Bedelu, N. Ford, K. Hilderbrand, and H. Reuter, “Implementing antiretroviral therapy in rural communities: the Lusikisiki model of decentralized HIV/AIDS care,” *Journal of Infectious Diseases*, vol. 196, supplement 3, pp. S464–S468, 2007.

⁷ A. T. Brennan, L. Long, M. Maskew et al., “Outcomes of stable HIV-positive patients down-referred from a doctor-managed antiretroviral therapy clinic to a nurse-managed primary health clinic for monitoring and treatment,” *AIDS*, vol. 25, pp. 2027–2036, 2011.

⁸ D. Coetzee, K. Hilderbrand, E. Goemaere, F. Matthys, and M. Boelaert, “Integrating tuberculosis and HIV care in the primary care setting in South Africa,” *Tropical Medicine and International Health*, vol. 9, no. 6, pp. A11–A15, 2004.

⁹ J. Pfeiffer, P. Montoya, A. J. Baptista et al., “Integration of HIV/AIDS services into African primary health care: Lessons learned for health system strengthening in Mozambique—a case study,” *Journal of the International AIDS Society*, vol. 1, article 3, 2010

¹⁰ A. T. Brennan, L. Long, M. Maskew et al., “Outcomes of stable HIV-positive patients down-referred from a doctor-managed antiretroviral therapy clinic to a nurse-managed primary health clinic for monitoring and treatment,” *AIDS*, vol. 25, pp. 2027–2036, 2011.

¹¹ El-Sadr WM, Goosby E. Building on the HIV platform: tackling the challenge of noncommunicable diseases among persons living with HIV. *AIDS*. 2018;32:S1–3.

¹² https://www.who.int/docs/default-source/primary-health-care-conference/aids.pdf?sfvrsn=189b259b_2

Over the past decades, primary health care in the country has undergone a lot of transformations and with varied results. Consumers of services (the population) have been at the central role in PHC reforms in the country. The overall purpose of reforms and transformations of the PHC system in the country is improving health care for all Kazakhstanis by maintaining people’s health, preventing diseases, reducing the need for inpatient services, and improving chronic disease management. Despite the significant achievements in Kazakhstan’s national health system and the success of reforms undertaken over the past two decades, the country’s PHC service delivery is under increasing stress from the growing burden of chronic diseases. The national PHC system is facing the challenge of refocusing the existing system on the needs of the individual and society, and on the development of patient-centered personalized medicine.

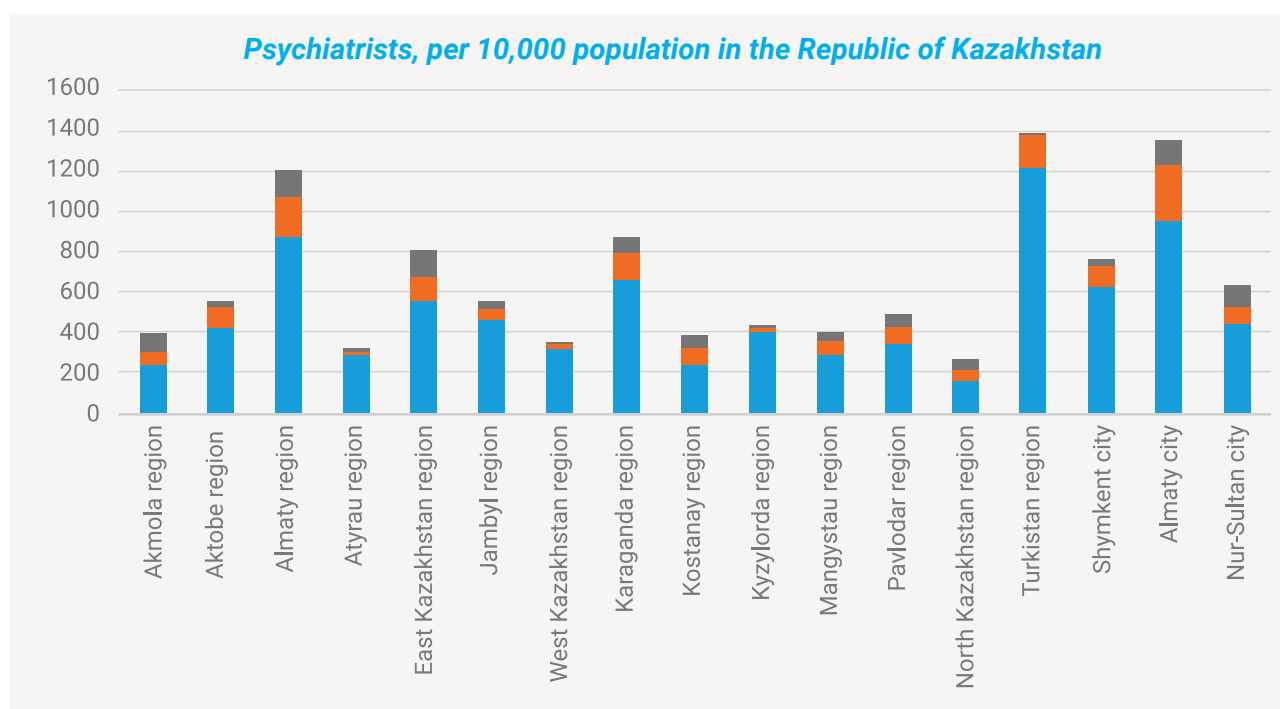
In Kazakhstan, currently (as of January 2022), there are a total of 609 public and private health facilities providing PHC services to their catchment populations. Of these, 384 (63%) are in urban areas while 225 (37%) operate in rural areas. 357 (70.4%) are state-owned and 252 (29.6%) are private. Table 1 shows the distribution of PHC health facilities in Kazakhstan by type and region.

Table 1: PHC facilities by region

No.	Region/city	Total no. of PHC facilities	State-owned facilities		Private facilities	
			Urban	Rural	Urban	Rural
1	Akmola region	26	3	17	3	3
2	Aktobe region	37	11	13	12	1
3	Almaty region	39	4	20	4	11
4	Atyrau region	23	5	10	7	1
5	East Kazakhstan region	59	15	21	20	3
6	Jambyl region	28	6	10	10	2
7	West Kazakhstan region	29	7	15	7	-
8	Karaganda region	49	18	9	22	-
9	Kostanay region	31	10	16	5	-
10	Kyzylorda region	21	6	7	6	2
11	Mangystau region	25	4	8	11	2
12	Pavlodar region	30	6	10	14	-
13	North Kazakhstan region	17	3	13	1	-
14	Turkistan region	44	4	17	9	14
15	Shymkent city	43	14	-	29	-
16	Almaty city	72	40	-	32	-
17	Nur-Sultan city	36	15	-	21	-
	Totals	609	171	186	213	39

In terms of cadres, PHC services are offered by general practitioners (family doctors), pediatricians, paramedics, obstetricians, advanced practice (general practice) nurses, community (visiting) nurses, social workers, and psychologists. A gradual transition to general medical (family) practice is underway, and today the share of general practitioners among all PHC doctors is 76%. Figure 1 shows the distribution of doctors in PHC system by specialization.

Figure 1: Distribution of PHC doctors by cadre



The organization of PHC infrastructure is important in determining access to health services by the population. In Kazakhstan, the following structure of health facilities providing PHC is in operation.¹³

- a. **First-aid station:** established in a settlement (rural district) with a population of 50 to 500 people
- b. **Feldsher-obstetric station:** established in a settlement (rural district) with a population of 500 to 1500 people
- c. **Medical outpatient clinic:** established in a rural settlement with a population of 1500 to 5000 people or in a city with an assigned population of 1500 to 10000 people
- d. **PHC center:** established in a rural settlement with a population of 5000 to 30000 people or in a city with an assigned population of 10000 to 30000 people
- e. **District polyclinic:** established in an administrative center of a district as part of a district or multidisciplinary central district hospital
- f. **Numbered district polyclinic:** established as part of a district hospital in a district with rural settlements with a population of 30000 or more
- g. **City polyclinic:** established in an urban area with an assigned population of over 30000 people

The entities providing PHC operate based on the territorial model. A requisite number of territorial districts is formed and staffed with the relevant number of health workers (a PHC doctor and 2-3 nursing staff per district) to serve the population assigned to the clinic. A standard has been established for the average number of persons per general practitioner (1 general practitioner per 1700 enrolled population).

Kazakhstan is among countries operating a dispatch system in PHC (at the level of PHC doctors). As a rule, access to specialists requires a referral from a PHC doctor (a GP or another PHC cadre). A similar approach is used in Bulgaria, Spain, Italy, Lithuania, the Netherlands, Norway, Portugal, Romania, Slovenia, Great Britain, and Estonia. Furthermore, preventive medical examinations of target populations

¹³ Order of the Minister of Health of the Republic of Kazakhstan on October 15, 2020, No. KR DSM-133/2020

are carried out for early detection of behavioral risk factors at the PHC level. A set of measures is also being taken for prevention and active early detection of patients with mental and behavioral disorders in accordance with the standard for organization of the provision of medical and social assistance to the population of the Republic of Kazakhstan in the field of mental health¹⁴. PHC specialists also carry out a set of measures for prevention, active early detection, and diagnosis of TB in accordance with the regulations for carrying out activities for the prevention of tuberculosis¹⁵. PHC specialists also carry out dynamic monitoring of persons with chronic non-communicable diseases

PHC in Kazakhstan is provided within the guaranteed volume of free medical care to citizens of the Republic of Kazakhstan, kandas (repatriates), refugees, foreigners and stateless persons permanently residing in the Republic of Kazakhstan. It is funded from the state budget and includes preventive, diagnostic and therapeutic medical services with the highest proven efficacy, as well as drug coverage.

All these positive steps form a solid basis for the achievement of the goals and objectives set for further development of PHC.

1.4. TB situation in Kazakhstan

Over the past several decades, TB incidence in Kazakhstan has been steadily declining. Medical assistance for citizens suffering from socially significant diseases is provided within the framework of the guaranteed volume of free medical care and includes preventive, diagnostic and treatment services, medical rehabilitation, palliative and socio-psychological care. In 2015, the incidence rate of TB was 58.5 per 100,000 population. Thanks to the effective and systematic implementation of WHO recommendations, in 2020 it was 1.6 times lower, or 35.7 per 100,000 population. The number of registered new cases decreased by a factor of 1.5, from 10,255 cases in 2015 to 6,694 in 2020. The death rate per 100,000 population was 1.9 in 2020 versus 4.1 in 2015. The absolute number of deaths from TB was halved, from 721 in 2015 to 358 in 2020. In 2020 the number of patients with active TB decreased by 9333 to 10409 cases against 19742 at the end of 2015. The number of TB relapses is steadily decreasing as well: 2193 cases were registered in 2020 compared with 2541 in 2015. The prevalence rate of TB went down nearly by half, from 92.6 per 100,000 population in 2015 to 49.2 per 100,000 in 2020. The number of TB medical offices increased by a factor of 1.6, from 215 in 2015 to 359 in 2020. The number of beds for TB patients was halved, from 9922 in 2015 to 4363 in 2020, while the number of TB doctors decreased from 1140 in 2015 to 990 in 2020.

Kazakhstan is one of the few countries where the state has funded the introduction of the most advanced methods of early diagnosis, treatment, and prevention of TB in accordance with international standards, such as the WHO recommended Directly Observed Treatment Short-Course (DOTS). Today, early detection of TB is conducted at PHC health facilities regardless of their form of ownership, by medical personnel of all specialties by way of referral to fluorography screening. Preventive measures for TB begin at birth. To prevent TB in healthy newborns, in the absence of medical contraindications and according to the National Immunization Schedule vaccination with BCG vaccine is carried out 2-4 days after birth in the vaccination room of the perinatal facility (maternity ward). Healthy uninfected children are revaccinated with BCG at the age of 6.

Since 2016, innovative approaches to the treatment of TB have been introduced using new drugs recommended by WHO, including shortened treatment regimens with new and repurposed drugs that are highly effective and allow for a complete cure for TB. The effectiveness of treatment of TB patients in the country is among the highest in the world. In 2021, the treatment success rate among newly diagnosed patients with drug-susceptible TB was 87.5% (WHO standard is 85%), and 82.5% for multidrug-resistant TB (WHO standard is 75%).

¹⁴ Order of the Minister of Health of the Republic of Kazakhstan dated November 30, 2020 No. KR DSM-224/2020.

¹⁵ Order of the Minister of Health of the Republic of Kazakhstan dated November 30, 2020 No. KR DSM-224/2020.

During integration, a phased transfer of legal responsibility from TB to PHC service has been conducted for all dispensary departments and TB doctors' offices. This helps to ensure multidisciplinary case management of TB patients by PHC specialists, TB doctors, radiologists, nurses and other profile specialists. As mentioned above, further integration of TB services with the PHC network has been facilitated by the Comprehensive Plan for Combating Tuberculosis in the Republic of Kazakhstan for 2014-2020. As per this plan, an Integrated model of TB Control is being implemented where patients who do not excrete Mycobacterium tuberculosis and do not pose danger to others receive outpatient treatment in polyclinics at their place of residence.

At present, 2864 rooms have been set up at PHC facilities for conducting DOT (directly observed treatment) at the outpatient stage. As of the end of 2021, 7,584 patients are on outpatient treatment, including 3,172 patients (42.2%) with drug-susceptible TB and 4,412 patients (57.8%) with drug-resistant TB. Treatment is monitored daily by nurses responsible for DOT and supervised by TB doctors. Information about the treatment is entered into the "Medication Provision» information system and the National Electronic Registry of TB Patients (NRBT). For immobilized TB patients, mobile teams have been created, which include nurses from the DOT office. This group of TB patients is examined by PHC doctors once every 10 days.

In general, integration of TB into PHC included improving access to and quality of TB services for the population through the introduction of accelerated methods for diagnosing TB and including sustainable forms of effective treatment. Additionally, observing infection control measures at high-risk areas for TB, providing social services to vulnerable populations, creating conditions for increasing the motivation of TB patients for treatment, as well as professional and personal growth of medical workers, should contribute to the improvement of consultative and diagnostic assistance. Other contributing factors are improvement of the funding mechanism and the gradual increase of the number of district TB doctors at PHC institutions.

1.5. Mental health situation in Kazakhstan

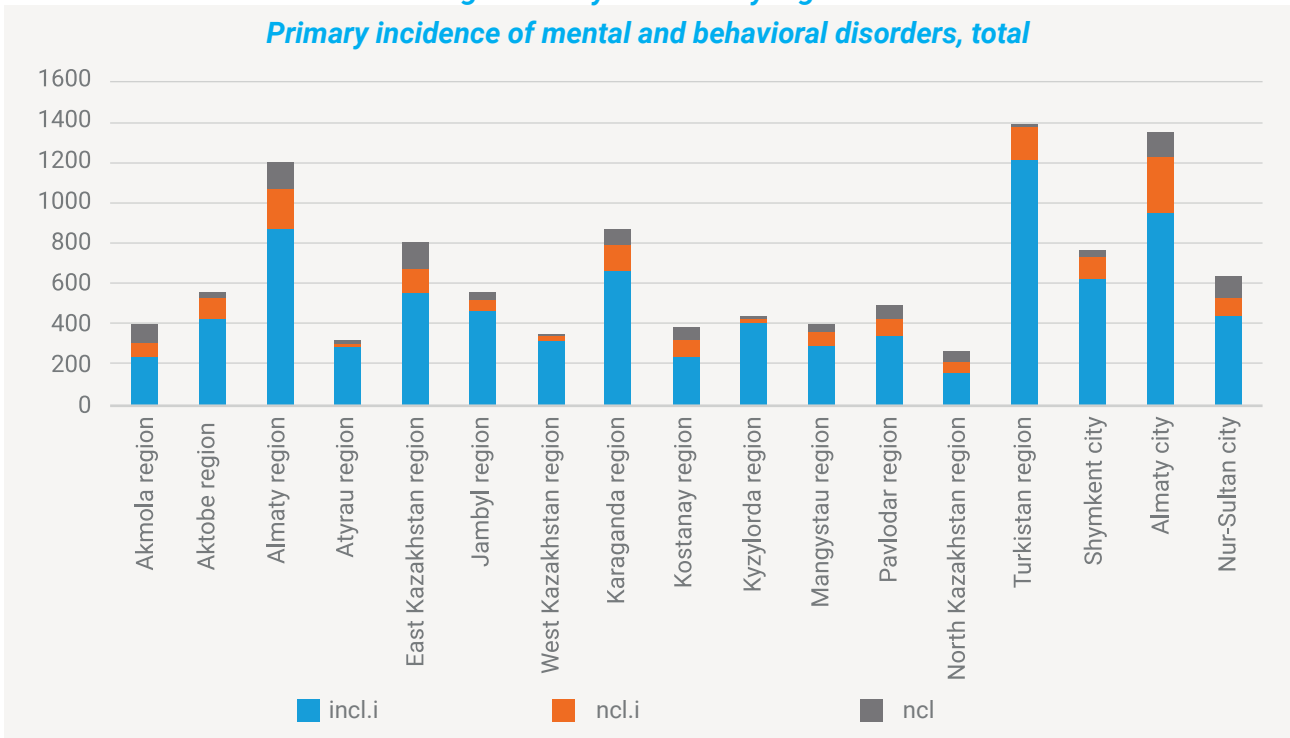
Approximately 23% of patients seeking PHC services have various borderline personality disorders. The most common mental illness is depression. Every year, mental depression is responsible for 140 thousand cases of suicide in the European region which includes Kazakhstan. Statistics show that women are more likely than men to attempt suicide, and recently a negative trend in this area has been observed among young people. The World Health Organization has identified 10 recommendations for the development of mental health services. These include the development of a national policy, programs, and legal framework, monitoring the mental health of the population, providing care in the community, providing health facilities with psychotropic drugs, and training personnel. Providing treatment at PHC facilities is among the WHO recommendations. In this regard, the Roadmap for the Development of the Mental Health Service of the Republic of Kazakhstan for 2017-2018, was developed, approved and implemented based on WHO recommendations.

Prevention and control of psychiatric and narcological diseases in Kazakhstan is also a priority for the MoH RoK. The basic principles of organizing and providing mental health and narcological services are set forth in the Regulations for the provision of medical and social assistance to citizens suffering from socially significant diseases¹⁶. As part of the Roadmap for the Development of the Mental Health Service of the Republic of Kazakhstan for 2017-2018, the national psychiatric and narcological services have been merged. As a result, unified Mental Health Centers have been established in the country since 2018. The main objectives of this initiative was to bring psychiatric and narcological care closer to the population as well as to combat stigma for these diseases in society.

In 2020, compared with 2019, there was a decrease in the absolute number of psychiatrists from 633 to 602. The number of psychiatrists per 10,000 population in 2020 was 0.3 versus 0.4 in 2019. Figure 3 shows the number of psychiatrists per 10,000 population across different regions.

¹⁶ Order of the Minister of Health and Social Development of the Republic of Kazakhstan dated April 28, 2015, No. 285.

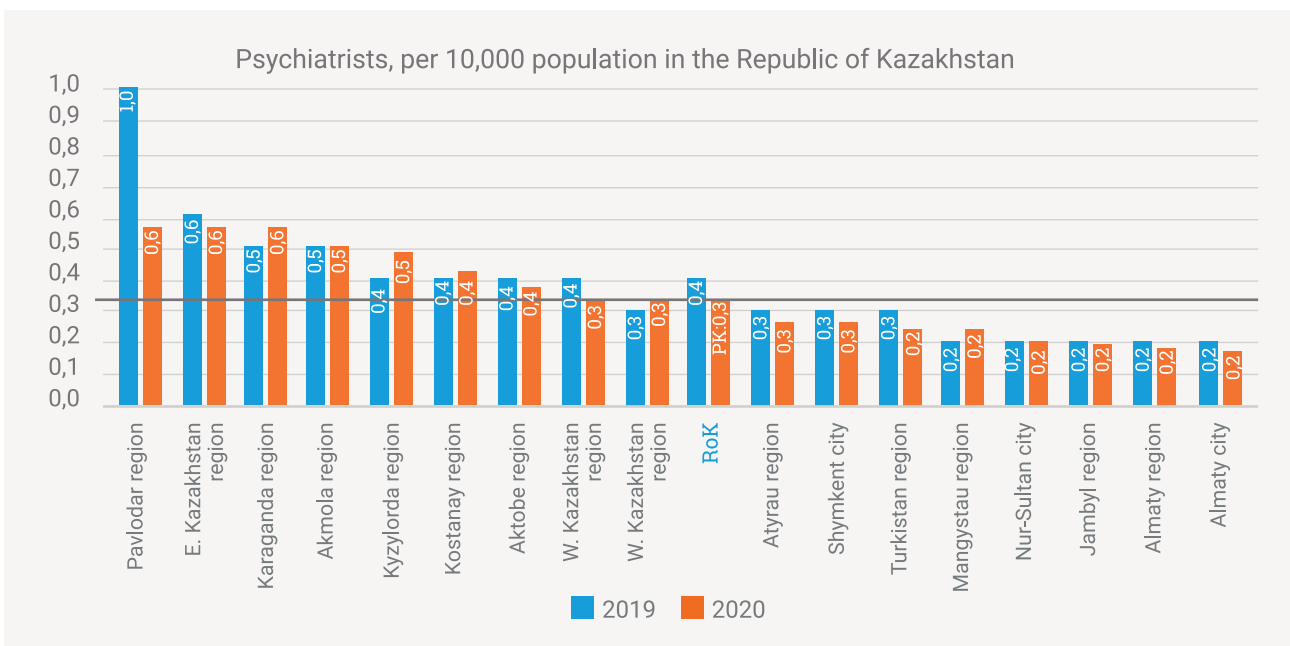
Figure 2: Psychiatrists by region



In 2020, the merger of legal entities – regional psychiatric and narcological organizations – was completed, establishing 17 Mental Health Centers as a result. In 2020, outpatient medical and social assistance to people with borderline personality disorders (BPD) was provided in 189 offices (219 in 2019). Around the end of 2020, a total of 74 Primary Mental Health Centers at the City Polyclinics at the different regions were introduced into the structure of mental health care.

The number of registered persons diagnosed with a mental or behavioral disorder (disease) for the first time in their life decreased from 9783 cases in 2019 to 8516 in 2020. Correspondingly, the primary incidence rate per 100,000 population in 2020 was 45.1 (52.5 in 2019). This indicator is higher than the national average in the city of Shymkent (66.8), Kostanay region (55.4) and Karaganda region (75.7), among others. Figure 3 shows the mental health situation by region.

Figure 3: Mental health situation by region



On January 15, 2016, the “Densaulyk” State Healthcare Development Program for 2016-2019” was approved by Decree of the President of the Republic of Kazakhstan No. 176. Among other areas, integration of mental health was included as part of the program.

During the implementation of the integration of mental health into the PHC system, psychiatrists and narcologists are merged into one specialty. Their activities are conducted in the primary mental health centers set up as part of city polyclinics. The establishment of the primary mental health centers has made it possible to bring the mental health services closer to the population. Today, psychiatrists conduct their activities in the polyclinics and closely interact with PHC doctors. Whereas earlier the population needed to seek psychiatric help in psychiatric dispensaries and narcological centers, now these organizations are merged into Mental Health Centers through integration. Along with this, and to effectively integrate this service into PHC, in 2017 and 2018, PHC doctors, in particular GPs, were trained in prevention, diagnosis and treatment of borderline personality disorders and the basics of conflict management. It was assumed that in the future these measures would increase the detection of borderline personality disorders.

1.6. HIV/AIDS situation in Kazakhstan

HIV remains a major global public health problem, with 36.3 million [27.2–47.8 million] deaths to date¹⁷. The Government of Kazakhstan supports the efforts of the world community in the fight against HIV/AIDS. Recognizing it as a major challenge, Kazakhstan is consistently implementing steps to curb the spread of HIV. Issues related to combating HIV are included in the Concept for Healthcare Development in the Republic of Kazakhstan until 2026.

The first cases of HIV in Kazakhstan were registered in 1987. The following eight years were characterized by low incidence rates: until 1995, only 30 HIV cases were recorded in Kazakhstan, and sexual transmission prevailed. In 1996, there was an outbreak among drug addicts in Temirtau, a city in the Karaganda region, with 36 registered cases. The infection was due to the sharing of needles and syringes by injection drug users. Since then, the number of new infections among drug addicts has steadily increased. Since 2006, the share of the parenteral route of transmission (through blood) has fallen from 55% to 29 %. The share of mother to child transmission of HIV decreased from 8.4 % to 0.6 %. Since 2011, the injection route has accounted for 46 % of all infections, and the sexual route for 50 percent. Kazakh experts report a tenfold increase in sexual transmission of HIV in the country over the past decade.

As at the end of 2021, 14,664 people had died in the country since the first case of HIV infection was detected. The AIDS-related mortality in Kazakhstan has been decreasing since 2018, from 1.5 per 100,000 population to 0.9 per 100,000 population in 2022¹⁸. The highest numbers of people living with HIV are recorded in Karaganda, Pavlodar, East Kazakhstan, and Almaty regions, and in the city of Almaty. As of early 2021, a total of 29,980 people were on treatment in both regional and city AIDS centers in Kazakhstan. According to national monitoring data, the HIV epidemic is at concentrated stage mainly among key populations: people who inject drugs, sex workers and men who have sex with men. Although according to WHO estimates Kazakhstan is in the group of countries with low HIV prevalence, infection rates are on the increase. There is a 10% increase in new HIV cases in Kazakhstan every year. In 2021, about 3 million voluntary and compulsory HIV tests (14% of the country’s population) were conducted detecting 3478 new HIV cases. More than 16,000 foreigners were also tested in 2021 where 0.2% of them tested positive. Figure incidence of HIV infection per 1000 uninfected population for 2015-2019 is shown in Figure 4.

¹⁷ <https://www.who.int/news-room/fact-sheets/detail/hiv-aids>

¹⁸ 2021 HIV Response Monitoring and Evaluation report

Figure 4: Incidence of HIV infection per 1000 uninfected population in 2015-2019¹⁹

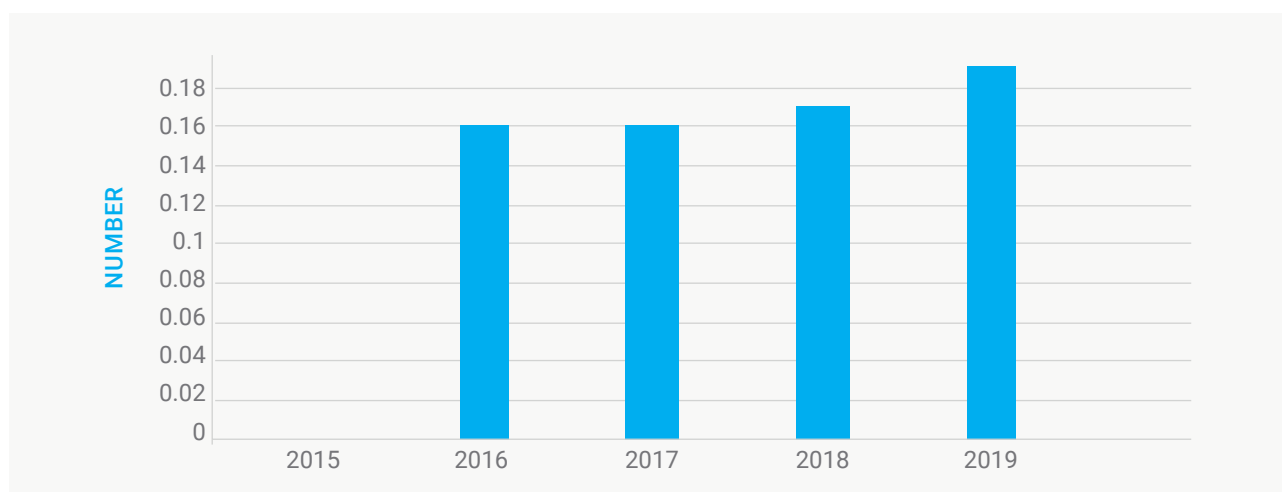
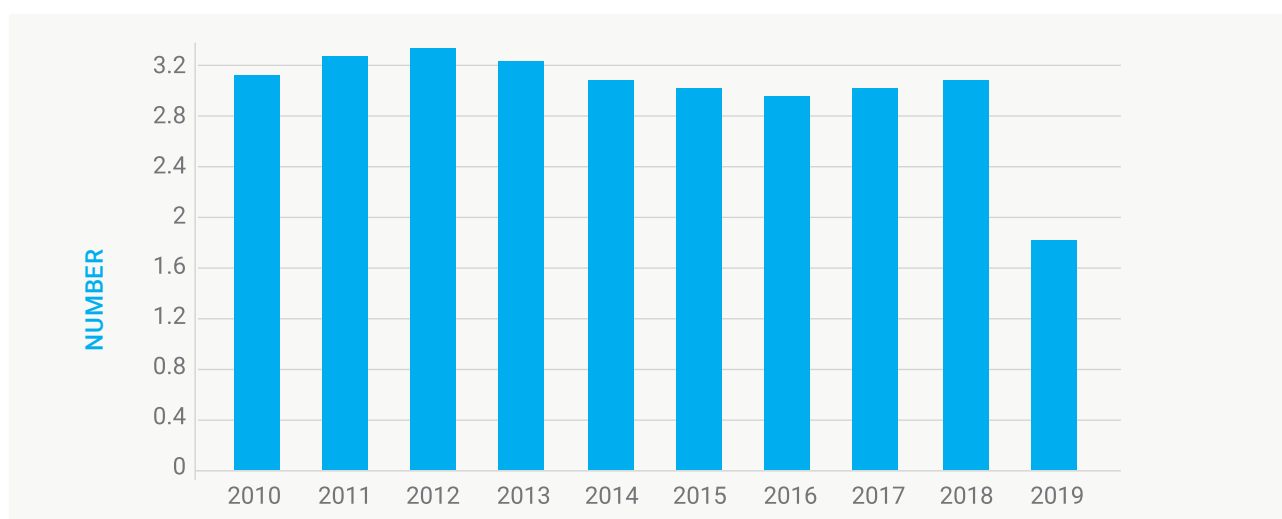


Figure 5 shows the trends in AIDS deaths between 2010 and 2019.

Figure 5: Trends in AIDS mortality per 100,000 population in 2010-2019 in Kazakhstan²⁰



In 2021, out of the registered 3478 cases, 1.2% were among students of colleges and universities, and 0.4% were among school students. A sociological study conducted by the Public Opinion Research Center with the support of UNFPA, aimed at assessing the level of awareness among young people aged 15-19 regarding HIV, AIDS, and STI prevention, revealed that:

91%

of young people are not sufficiently informed about HIV and AIDS.

66%

of respondents are not aware of prevention methods for unwanted pregnancy and HIV/STI transmission through condom use.

65%

of young people are not informed about the need for STI treatment.

2,6%

of young people with STI symptoms did not seek medical assistance for treatment at healthcare facilities.

¹⁹ Country Progress Report - Kazakhstan 2020.

²⁰ Country Progress Report - Kazakhstan 2020

This situation of low awareness among young people regarding sexual and reproductive health can lead to the development of future behavior with increased health risks.

In 2011, Youth Health Centers were established in Kazakhstan, where youth and adolescents can access various services and consultations, including those related to HIV infection. There are currently 191 Youth Health Centers operating in the country, providing comprehensive medical and psychosocial services to teenagers and youth.

In line with the global strategy, Kazakhstan is implementing the UNAIDS 95/95/95 strategy. In 2021, 81% of the estimated number of people with HIV knew their status, 79% of people with HIV were on antiretroviral therapy, and 86% of those on therapy had an undetectable viral load.²⁷ Kazakhstan is implementing the WHO recommendations for HIV/AIDS response including: testing and counseling, information and educational work, access to condoms, access to needles and syringes, prevention, post-exposure prophylaxis, application of the peer-to-peer principle in outreach work; prevention of mother-to-child transmission of HIV, and antiretroviral therapy for serodiscordant, HIV treatment, care and support.

PHC organizations provide the following services: primary screening for HIV; contraception for HIV-infected women of reproductive age within the framework of the National Reproductive Health Program; lactation suppression for HIV-infected mothers within the framework of the National Reproductive Health Program; provision of adapted formula milk for children born to HIV-infected mothers; annual fluorographic screening for early detection of tuberculosis among PLHIV (People Living with HIV). In collaboration with healthcare professionals engaged in HIV prevention activities, they carry out: dynamic monitoring of HIV-infected pregnant women and children born to HIV-infected mothers; providing information to pregnant or breastfeeding women on proper nutrition, family planning, pregnancy, and support for breastfeeding or artificial feeding; counseling on care for children born to HIV-infected parents; training in timely introduction and preparation of complementary foods; diagnosis and treatment of co-occurring and associated diseases; post-exposure prophylaxis of HIV infection among the population.

1.7. Assessment objectives

Overall objective

The overall objective of this assessment is to use findings from the TB and mental health integration to support integration of HIV/AIDS response into PHC.

Specific objectives

- a. Assess and document Kazakhstan's experience and status on integration of mental health and TB into PHC including integration packages, lessons learned, benefits and remaining challenges.
- b. Using the experience of the integration of mental and TB, develop feasible recommendations for the integration of HIV and AIDS prevention, treatment, care, and support into PHC.

²⁷ 2021 Country Report, www.kncdiz.kz

2. ASSESSMENT METHODS AND APPROACHES

This is a cross-sectional mixed methods assessment study utilizing both qualitative and quantitative methods. The assessment was conducted between January and May 2022. The assessment targeted three categories of respondents: policy makers and planners, service providers and clients accessing integrated PHC, mental health and TB services.

2.1. Quantitative data collection

Experiences from other rapid HIV integration assessments recommend purposive sampling of a representative number of health facilities across the different levels. A rapid assessment for integration of HIV into sexual and reproductive health services methodology guide recommends at least 15 service delivery sites²² for the assessment. Other studies recommend that at least 5% of the total number of health facilities is adequate sample for a rapid facility health assessment. Kazakhstan has a total of 613 PHC facilities spread over the country's 17 regions. A total of 30 PHC health facilities representing 5 % of the total number of health facilities were sampled for this assessment. Five out of the 17 regions were purposively sampled. The main criteria for the purposive sampling was to ensure representation of both urban and rural PHC facilities. The 30 sampled PHC facilities were then proportionately allocated to different PHC facilities across 5 sampled different regions. Additionally, in each of the visited regions, an AIDS centre was added bringing the number of participating health facilities to 35. The specific facilities were then randomly selected by the national assessment experts from an excel listing of all PHC health facilities from the 5 sampled regions. Table 2 provides sampled facilities for the 5 randomly selected regions.

Table 1. PHC organizations by region

№ n/n	Region	Total medical organizations providing PHC	State medical organizations		Private medical organizations	
			city	village	city	village
1	Akmola region	26	3	17	3	3
2	Aktobe region	37	11	13	12	1
3	Almaty region	39	4	20	4	11
4	Atyrau region	23	5	10	7	1
5	East Kazakhstan region	59	15	21	20	3
6	Zhambyl region	28	6	10	10	2
7	West Kazakhstan region	29	7	15	7	-
8	Karaganda region	49	18	9	22	-
9	Kostanay region	31	10	16	5	-
10	Kyzylorda region	21	6	7	6	2
11	Mangystau region	25	4	8	11	2
12	Pavlodar region	30	6	10	14	-
13	North Kazakhstan region	17	3	13	1	-
14	Turkistan region	44	4	17	9	14
15	Shymkent city	43	14	-	29	-
16	Almaty city	72	40	-	32	-
17	Nur-Sultan city	36	15	-	21	-
	Total	609	171	186	213	39

²² Rapid Assessment Tool for Sexual and Reproductive Health and HIV linkages. A generic Guide, prepared and published by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young positives, 2008 pg. 38

2.2. Qualitative data collection

For qualitative data collection, respondents were purposively selected at policy, systems, and service delivery level. Their selection was based on their knowledge and work experience in TB, mental health, HIV and PHC.

2.3. Data collection methods

Literature review

To understand PHC, TB, mental health, and HIV situation in Kazakhstan, desk review of relevant national policy and strategic documents was undertaken. The literature review further focused on understanding documented experiences, opportunities, and challenges for integrating TB, mental and HIV into PHC. The list of documents reviewed are referenced in this study report.

Key informant interviews with policy makers and planners

A total of 22 key informant respondents were reached at policy and systems level. Table 2 presents the number of respondents reached by category.

Table 2: Number of respondents targeted at policy and systems level.

Level	Respondent category	No. of respondents
Top MoH	High level MoH officials	3
Departmental bodies of the MoH RoK	Committee for Medical and Pharmaceutical Control	2
	Social Health Insurance Fund	1
National-level healthcare organizations subordinate to the MoH RoK	Republican Scientific and Practical Center for Mental Health	3
	National Scientific Center of Phthisiopulmonology	3
Non-governmental organizations	National Association "Primary Health Care"	6
	Association of Family Doctors of Kazakhstan	4
Totals		22

Key informant interviews with facility-based service providers

In line with the study protocol, a total of 30 health facilities providing PHC services were sampled for this study representing 5 % of the Kazakhstan total number of facilities. A random sample of 5 regions were selected to participate in the study. The 30 health facilities were then proportionately allocated to the 5 sampled regions. In addition, in each of the visited region, an AIDS centre was added bringing the number of participating health facilities to 35. Highlighted below are the sampled facilities for the 5 randomly selected regions. Using a pre-developed questionnaire, virtual interviews were held with service providers at integrated PHC, mental health and TB clinics and in the five AIDS centres. A total of 105 respondents were reached. Table 3 presents the total number of respondents reached by region.

Table 3: Sampled study facilities

No.	Region	No. of health facilities providing PHC services	Sampled facilities	Respondents
1	Akmola region	26	0	
2	Aktobe region	37	6	25
3	Almaty region	39	6	30
4	Atyrau region	23	0	
5	East Kazakhstan region	62	0	
6	Zhambyl region	28	0	
7	West Kazakhstan region	29	0	
8	Karaganda region	49	7	15
9	Kostanay region	31	0	
10	Kyzylorda region	21	0	
11	Mangystau region	25	0	
12	Pavlodar region	30	0	
13	North Kazakhstan region	17	0	
14	Turkistan region	44	7	26
15	Shymkent city	43	0	
16	Almaty city	73	9	9
17	Nur-Sultan city	36	0	
	Total	613	35	105

Client exit interviews with recipients of health services

Client exit interviews were held with recipients of health services at the sampled 30 PHC facilities. Ten clients (10) per facility representing a total of 300 respondents were interviewed. A client exit interview guide focusing on client experiences in excess of integrated PHC, TB and mental health services was used. The client exit interview guide is annexed to this report.

Focus group discussion with people living with HIV

As part of ensuring greater and meaningful involvement of PLWHA, a FGD was held with PLWHA in each of the 5 AIDS centres. A total of 5 FGDs were held each reaching 10 members. The group discussions focused on access to HIV/ADS services, levels of discrimination, perceived benefits and disadvantages of integration and recommendations for integrating HIV/AIDS response into PHC.

2.4. Data Quality Control

The following data quality control measures were taken during data collection, entry, and analysis

- **Data collection tools:** Data collection tools were pre-tested before the actual data collection to check for inconsistencies, ambiguity, or incomprehension. Identified challenges were addressed before the data collection exercise. In addition, the national experts who were responsible for data collection were trained to ensure uniform understanding and administration of each question in the data collection tools.
- **Supervision:** One national level expert was appointed to act as the assessment coordinator. The coordinator led the entire assessment exercise including data collection, data entry,

analysis and report writing. As part of data quality control, the assessment coordinator provided supervision for data collection, entry, and analysis. Data collection data collection spot checks were conducted to ensure quality.

- **Data entry and analysis:** The collected data was further cleaned during data entry and analysis.

2.5. Data analysis

Qualitative data was organized and analyzed thematically in alignment with the objectives of the study. Quantitative data was analyzed through Statistical Package for Social Sciences (SPSS). Simple frequency and cross tabulations were run to detect and correct any inconsistencies before the final descriptive analysis.

2.6. Ethical Considerations

This assessment adheres to the UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis and the principles for protection of human subjects. Informed consent was obtained within the standard operation procedures of the HML IRB. A study protocol for the research was developed and submitted to UNICEF HML Ethics Review Board who provided ethical review and clearance for the study. Written informed consent was obtained from each respondent. Collected information was kept confidential and no respondent name has been included in this report. Additionally, the national experts who conducted the interviews underwent training in research ethics including on gender and respect for human and child rights. The local experts signed commitment letters for adhering to the set ethical requirements including protection of child rights. To ensure confidentiality, the research assistants were trained on proper data handling. All filled questionnaires were handed over to the research at the end of each day. The questions were securely locked in a cabinet to prevent unauthorized access. All completed data collection tools will be destroyed after the finalization and approval of the assessment report. The authority to conduct the survey was also obtained from the MoH RoK and the management of health facilities that were sampled for the assessments. A copy of the informed consent documents was given to the participants for their records.

2.7. Addressing research bias

Targeted actions from design to study implementation, data analysis and report writing were implemented to address research biases. The use of quantitative and qualitative tools was useful in cross-checking responses and identifying any possible researcher biases. Data collection tools were piloted to identify any possible biases. Based on the pretest, study tools were revised to especially ensure clarity of questions and to eliminate any leading questions that can result in respondent bias. Research assistants were trained in interviewing skills and avoiding interviewer bias during data collection. Quality checks were done by the lead consultant after the end of each day to identify and address any possible bias. Validation of preliminary findings further helped to identify and address any possible findings that may have resulted due to research bias.

2.8. Stakeholders' involvement

The various study stakeholders at national and regional levels were involved at different ways in the design and implementation of this study. The various stakeholders including Ministry of Health HIV, TB, mental health and PHC units, research unit and UN agencies especially UNICEF were actively involved in the development of the study protocol. Additionally, the stakeholders were involved in sampling of study sites and respondents. Majority of the stakeholders further participated as key

informant respondents. National and regional stakeholders participated in the validation of the study findings. The final report will be disseminated to all stakeholders. To ensure confidentiality of the respondents as discussed under the section on study ethics, the report will not be presented in a way that can or directly links respondents to the study findings.

2.9. Validation of the study findings

Two one-day validation meetings were held with TB, mental health, HIV, PHC and broader health stakeholders from both national and sub-national levels. The first meeting was used to validate the study preliminary findings. Based on this first validation meeting, a draft PHC and HIV integration assessment report covering methodology, findings, conclusions, and recommendations was developed. The draft assessment report was further validated, and the inputs used to develop this final assessment report.

2.10. Management of the study

This study was commissioned by the Ministry of Health of the Republic of Kazakhstan. On behalf of the Republic of Kazakhstan, the National Research Centre for Health Development provided the overall leadership in the implementation of the research. UNICEF and UNAIDS provided technical as well as funding support for the study implementation. More importantly, UNICEF was responsible for the review of the study protocol to ensure adherence to globally acceptable ethical and human rights standards. The study was implemented by a team of national experts supported by an internal consultant. The international consultant was responsible for developing the study design including the tools, training local experts, and providing quality oversight and control in the implementation of the study, analysis and report writing. The local experts were responsible for conducting pretesting of the tools, conducting quantitative and qualitative data collection, analysis and draft report writing.

3. INTEGRATION AT CLIENT LEVEL

3.1. Integration at policy and systems level

Strong policy support is a pre-requisite to effective integration. Policy considerations for integration include the organization of the various departments within the ministry of health and how these facilitate or hinder integration, extent to which national health policy documents support integration and availability of guidance documents for integration. This assessment sought to understand the Kazakhstan policy environment for integration of HIV/AIDS integration. Additionally, the study assessed the policy changes that were implemented in the integration of mental health and TB into PHC.

In terms of organization, PHC in Kazakhstan is under the Department of outpatient care and emergency medical care, while HIV/AIDS, along with the mental health and TB service is coordinated by the Division of medical care for socially significant diseases. Both divisions are under the Department of organisation of medical care within the MoH and as such report to the same director. This assessment identifies that this organizational structure presents an opportunity for operationalizing integration of HIV/AIDS into PHC. Interviews with the policy makers identify that all divisions within the department of organization of medical care hold joint planning meetings presenting another opportunity for promoting integration.

Integration of TB and mental health into PHC provides useful lessons for supporting HIV/AIDS integration into PHC. The integration TB and mental health services into PHC began in 2014-2016. The “Densaulyk” State Healthcare Development Program for 2016-2019 and the Comprehensive Plan for Combating Tuberculosis, approved by the Government of the Republic of Kazakhstan provided the required policy backing for integration of TB into PHC. Lessons from integration of TB and mental health into PHC indicate that for successful integration of HIV/AIDS, there will be need to develop guidance documents including protocols and standards. Interviews with policy makers as part of this assessment identified that to support integration of TB and mental health into PHC, laws and regulations were revised, new standards, regulations and algorithms developed and approved, including the separation of the functionality of PHC and specialized care. Roadmaps containing measures to promote integration were developed and approved by order of the Minister of Health. Political pronouncements are an important catalyst for integration. In an address to the people, the President of the Republic of Kazakhstan focused called for the need to revise approaches to PHC, including in rural areas. As part of implementing the President’s instructions, the Order of the Vice Minister of Health No. 106 dated February 25, 2021 “On approval of the Action Plan to improve the availability of primary health care towards greater mobility and accessibility to a wide range of the population, including those living in rural areas for 2021- 2025” was developed and approved. Integration is a viable approach to actualizing this order.

This assessment identified various systems challenges that will need to be addressed to ensure effective integration. A robust and integrated health information system, monitoring and evaluation is key to successful integration of services. For TB, mental health and PHC integrated activities, monitoring of integrated activities is conducted by the subordinate national-level organizations of the MoH RoK responsible for the mental health and the TB services. A Committee for Medical and Pharmaceutical Control of the MoH oversees the process. A similar system will need to be established for monitoring integrated HIV/AIDS and PHC service delivery. Interviews with policy makers identified that HIV/AIDS and PHC health information systems as being vertical. The databases of the regional AIDS Centers and the Medical Information System (MIS) of medical organizations are not integrated with each other. Review of literature identifies that funding mechanisms are largely vertical which if not addressed can be an impediment to integration. The assessment identified that all laboratories of PHC facilities are adequately equipped. Adequate and skilled human resources for health is an important health system support for effective integration. Heavy workloads and frequent coupled with high staff shortages and transfers were identified as possible system challenges to integration. The table 4 summarizes the responses on human resources for health and integration.

Table 4: Human resources for health and integration

1.	What human resources for health challenges have you encountered in integrating PHC services into HIV prevention and control services? How did you overcome them?	Shortage of personnel at PHC facilities. The AIDS Centers are practically fully staffed.
		A shortage of specialists, since only 3-4 specialists work in AIDS Centers, and in PHC specialists are not trained on HIV.
2.	Based on your experience, what human resources-related health challenges do you think a country will face when integrating HIV/AIDS prevention and control services into PHC services? How would you recommend addressing these challenges?	Currently there are not enough infectious disease doctors for each PHC facility.
		Lack of and incompetence of PHC staff. The personnel situation is difficult throughout the country.
		Solution: staff training, salary increases for PHC specialists due to increased workload.
3.	If Kazakhstan moves towards integrating HIV/AIDS prevention and control services into PHC services, what would you recommend in the field of human resources for health in terms of strengthening medical capacity in the provision of integrated PHC and HIV/AIDS prevention and control services?	Training of infectious disease doctors and epidemiologists for each PHC facility on providing AIDS prevention and control services.
		Use the capacity of existing specialists at AIDS Centers.
		Leave HIV services in AIDS centers.

3.2. Integration at facility level

3.2.1. Interviews with PHC service providers

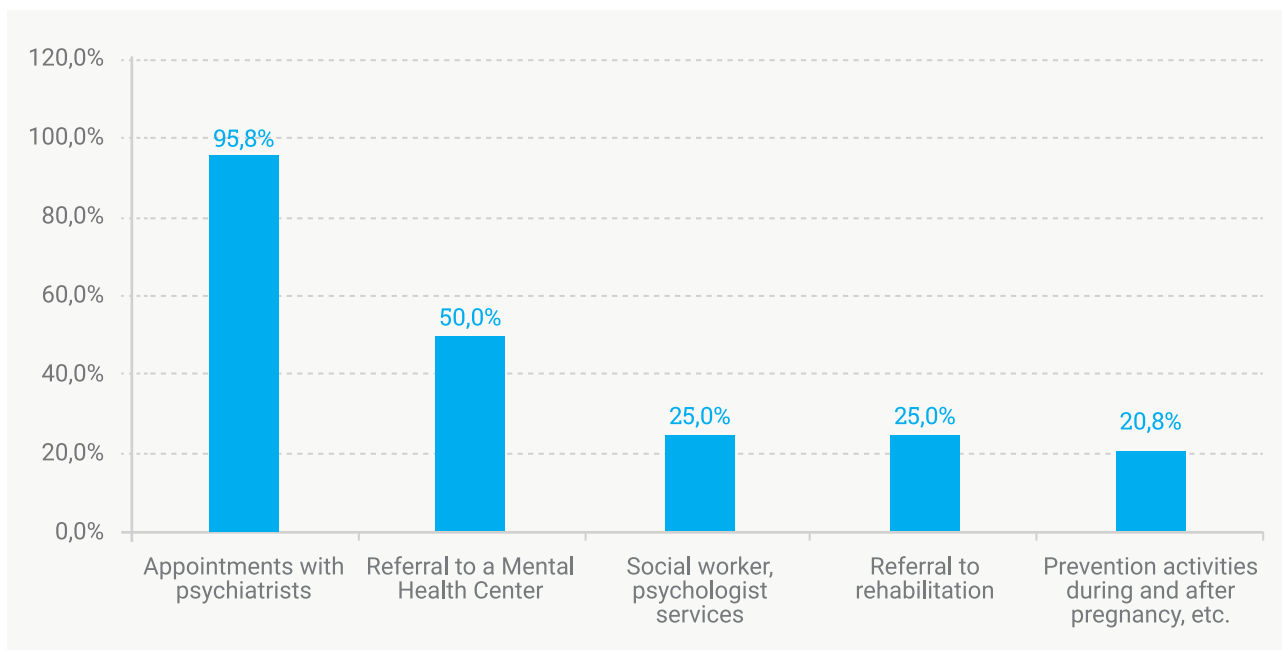
What to integrate into- PHC services offered in the visited health facilities

Understanding what PHC services are offered in the different facilities is key in determining what HIV/AIDS services to integrate into which PHC services. All visited facilities reported offering an entire range of services except treatment of STI services. About 17 % of respondents from the 5 PHC facilities indicated that they do not treat STI which is subcontracted to private dermatology and venerology clinics.

Integrating mental Health into PHC

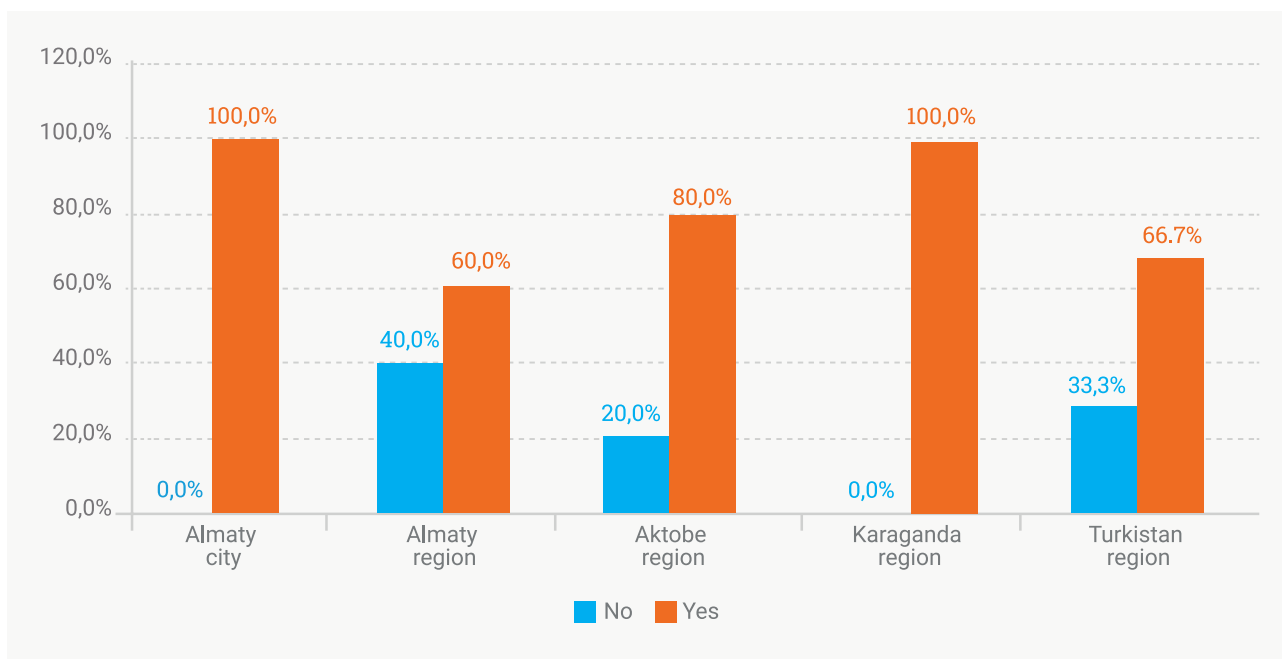
Mental health services had been successfully integrated in all the visited health facilities with 97 % of the respondents reporting that mental health services were offered in their PHC facilities. The most common mental health services provided included appointments with psychiatrists (95 %) with other services offered including referral services (50%), counselling with a social worker/psychologist (25%), and prevention activities during and after pregnancy (21%). Figure 6 provides the mental health services provided at the visited health facilities.

Figure 6: Mental health services provided in health facilities



Understanding what modifications were made in integrating mental health services into PHC is important in helping plan for HIV integration. Health workers were asked to report on what modifications in service delivery that were done to accommodate mental health integration. On average, 81.34% of respondents reported that some modifications were done. Figure 7 provides the percentages interviewed staff who reported some modifications in service delivery by region.

Figure 7: Respondents reporting modifications in service delivery



Models for integrating mental health into PHC

Across the regions, different models of integration had been used to integrate mental health services into PHC. Almost in all facilities, mental health was offered in same facility with no referral to a different facility. Only 25 % reported any referral to a different facility. Differences exist by regions. Table 5 presents the “how” of integrating mental health into PHC.

Table 5: Models of integrating mental health into PHC

Responses	Yes	No
Located in same site/room with same service provider	15 (50%)	15 (50%)
Located in the same service site/room but with different provider	15 (50%)	15 (50%)
Referral in a different site/room but in same facility	25 (83.3%)	5 (16.7%)
Referral to a different facility	18 (60%)	12 (40%)

Although equal number of participants reported Yes and No to the question on whether mental health services were available in the same room with other PHC services and offered by the same provider, region wise, Almaty city (75%) had more respondents reporting same room same provider integration of mental and PHC services. Turkistan region had the lowest % (16.7%) reporting same room same provider integration of mental and PHC services. Table 6 provides the various types of integration by region.

Table 6: Models of integration by region

Responses	Almaty city		Almaty region		Aktobe region		Karaganda		Turkistan	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Located in same site/room with same service provider	75%	25%	20%	80%	60%	40%	67%	33%	17%	83%
Located in the same service site/room but with different provider	50%	50%	20%	80%	80%	20%	67%	33%	33%	67%
Referral in a different site/room but in same facility	100%	0%	60%	40%	100%	0%	67%	33%	83%	18%
Referral to a different facility	0%	100%	100%	0%	0%	100%	50%	50%	33%	68%

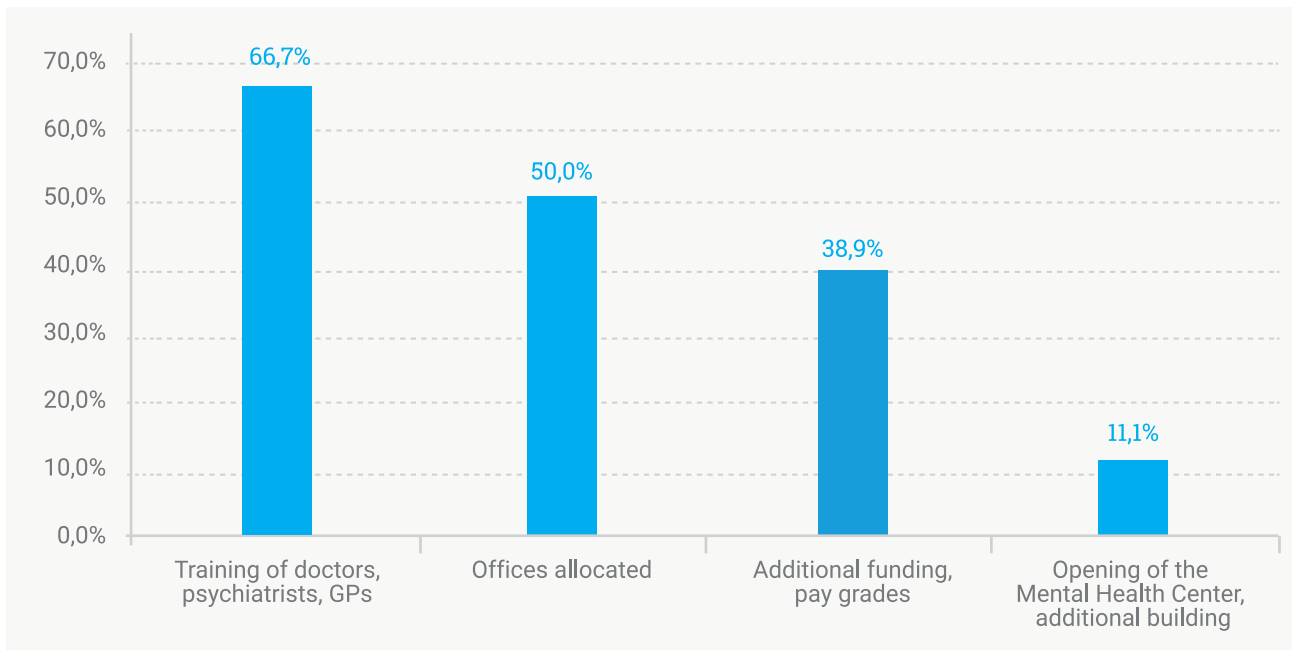
Mental health services were offered across all the PHC services. All respondents were on the affirmative on whether mental health services were integrated with PHC services ranging from FP, antenatal care, delivery and child health services to treatment of common diseases.

Thus, the integration of mental health into PHC primarily aimed to improve accessibility. All preventive services were delegated to PHC, which included an additional set of 8 diagnoses for observation by PHC physicians. For all other psychiatric issues and diagnoses, including dynamic monitoring and observation of patients with mental disorders, substance abuse, etc., observation by a psychiatrist was envisaged. One of the main advantages of integration is that patients no longer need to travel to a psychiatric dispensary, as the service underwent reorganization, resulting in the establishment of Primary Mental Health Centers (PMHCs) within the polyclinics (1 PMHC per 60,000 population).

Reorientation of PHC services to accommodate integration

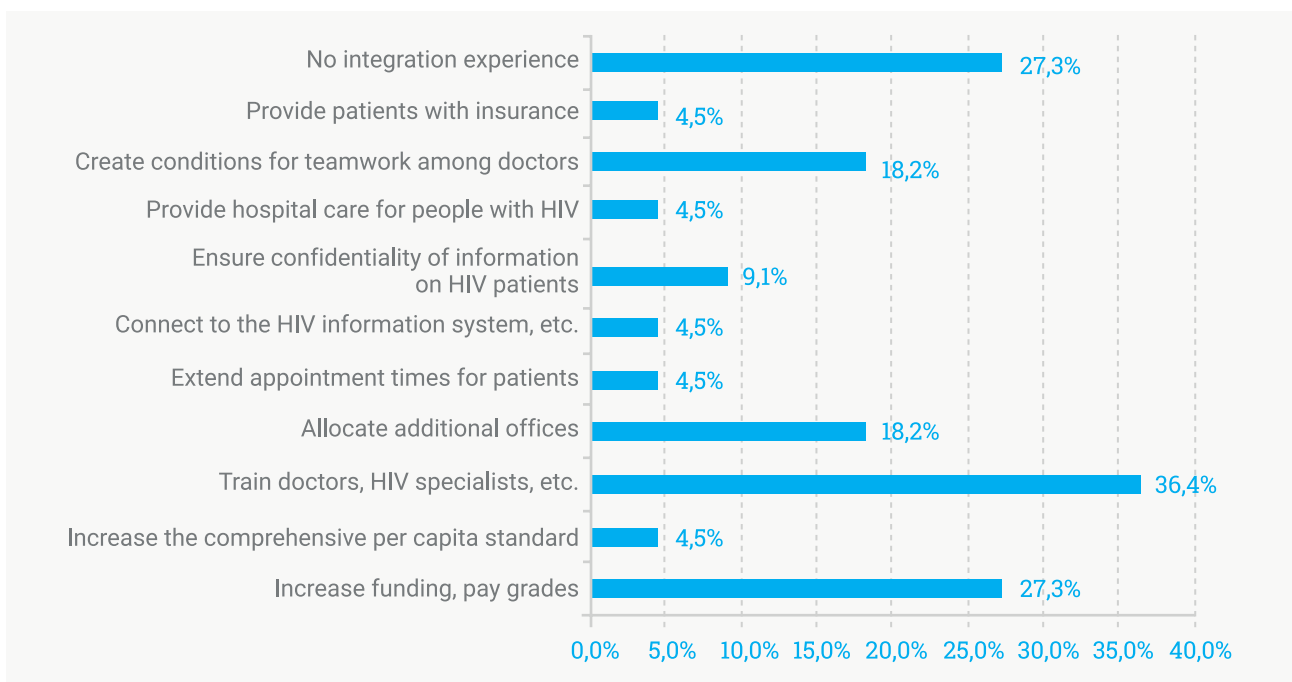
To provide for integration, this study identified that various re-orientation actions were undertaken to PHC service delivery pointing that the same may apply in preparation for integration of HIV/AIDS into PHC. The commonest re-orientation was the training of doctors (67%) and allocation of offices (50%). Figure 8 shows the various ways in which PHC was re-oriented to accommodate for integration.

Figure 8: PHC reorientation to integrate mental health services



Agreeing with the experiences from integration of mental health into PHC, most respondents identified key areas where re-orientation was needed to support HIV integration into PHC, as training of health workers (36.4%), increasing funding (27.3%) and creating conditions for teamwork amongst health workers (18.2%). This is shown in figure 9.

Figure 9: Reorienting PHC to support HIV integration



From this assessment, mental health has been successfully integrated into PHC and that using lessons from this experience and with some re-orientations, HIV/AIDS response can also be feasibly integrated into PHC. Despite this finding, some respondents identify that integrating HIV/AIDS into PHC will be complex and may negatively impact on access to HIV services by introducing stigma. Emphasizing these complexities and what needs to be done, health workers noted:



Past experience with mental health service has shown that the process of integration itself is difficult, as it involves not only financial costs but also psycho-emotional stress both for PHC specialists and for psychiatrists. How quickly the problems will be solved depends on how well-equipped the organization is, on its leadership and on the staff morale. Our opinion is that the AIDS service should be left where it is. It is more convenient for them that way, they feel better when they are more separate, they should have their own territory. Psychologically, both the staff and the patients feel more secure when the AIDS service is autonomous. We believe that the AIDS service is more serious than mental health and tuberculosis. There are more risks.

Other health workers feared that integration will lead to stigma and discrimination and possible breach of confidentiality. Additionally, probably due to lack of awareness, health workers also report that integration may increase staff risk to infection. On this, health workers observed:

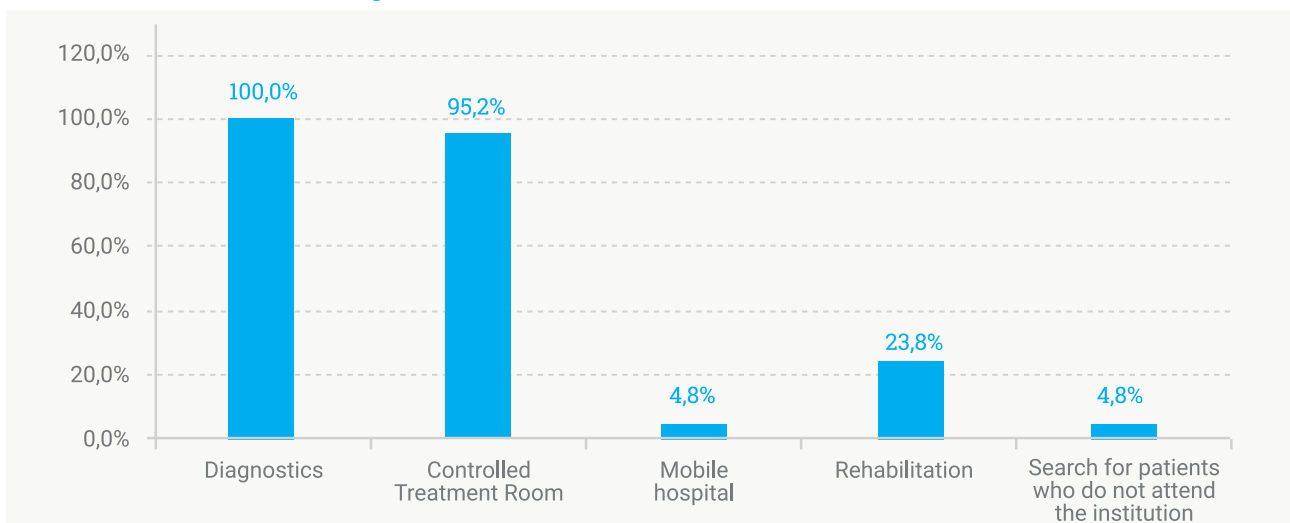


There is no desire for the AIDS service to become part of PHC. We believe that it will lead to many confidentiality issues. It will be necessary to allocate separate premises, otherwise they will be in front of everyone. The prescription of medicines in the “Medication provision” information system will be visible, and thus it will be clear who has AIDS. Thus, confidentiality will be breached. It will also put a burden on procedure rooms, and the risk of infection of medical personnel will increase. We think it’s better to leave it as it is, it will be better for the patients.

Integrating TB into PHC

All visited PHC health facilities had integrated TB services. TB services offered in the visited facilities included diagnostics (100%), directly observed treatment (95.2%), rehabilitation (23.8%) and defaulter tracing (4.8%). Figure 10 presents the TB services offered in the visited PHC facilities.

Figure 10: TB services offered in PHC facilities



Models of integrating TB into PHC

This assessment sought to understand the models for integrating TB into PHC. All regions reported using multiple models of integration probably due to the various needs that TB clients may have. Models utilised ranged from: same site and same service provider, same site and different provider, referral

to different site but within the same facility, and complete referral to another facility. Only 25% and 20 % of the respondents in Almaty and Turkistan region respectively reported not have same site same service provider model. Almost all service providers from all regions except Turkistan region reported referring TB clients outside their facility. This may be to have the clients access services that are not offered in their facilities. This scenario points to the fact that several models will need to be applied in integrating HIV/AIDS into PHC. Table 7 shows the various models used in integrating TB into PHC.

Table 7: Models of integrating TB into PHC services

Responses	Almaty city		Almaty region		Aktobe region		Karaganda region		Turkistan region	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Located in same site/room with same service provider	75%	25%	100%	0%	100%	0%	100%	0%	80%	20%
Located in the same service site/room but with different provider	50%	50%	100%	0%	100%	0%	100%	0%	83.3%	16.7%
Referral in a different site/room but in same facility	87.5%	12.5%	100%	0%	100%	0%	100%	0%	100%	0%
Referral to a different facility	100%	0%	100%	0%	100%	0%	100%	0%	83.3%	16.7%

The situation regarding the integration of TB into PHC service differs somewhat from the integration of the mental health service. Previously, phthisiologists provided consultations in polyclinics, but most patients suspected of having TB underwent all diagnostic services at the TB dispensary. Over time, the approach to treating TB patients has changed, and now a large number of people receive outpatient treatment. In this regard, it was decided to transfer phthisiologists from the consultative departments of dispensaries to polyclinics. They were relocated to the polyclinics, but at the same time, the functions of PHC physicians were expanded to include diagnostic responsibilities, in addition to prevention and detection. The diagnosis is confirmed by a phthisiologist, and subsequent treatment and monitoring are carried out by PHC physicians. Additionally, with phthisiologists now located in the same building, they are involved in monitoring the provision of care to TB patients.

Stigma and discrimination in provision of TB services

Qualitative data from respondents identify that although stigma was prevalent at the beginning, this died off as the service provision continued. TB patients are satisfied with the services and reported that integration helped increase access to TB services. On this, a national level policy maker observed:

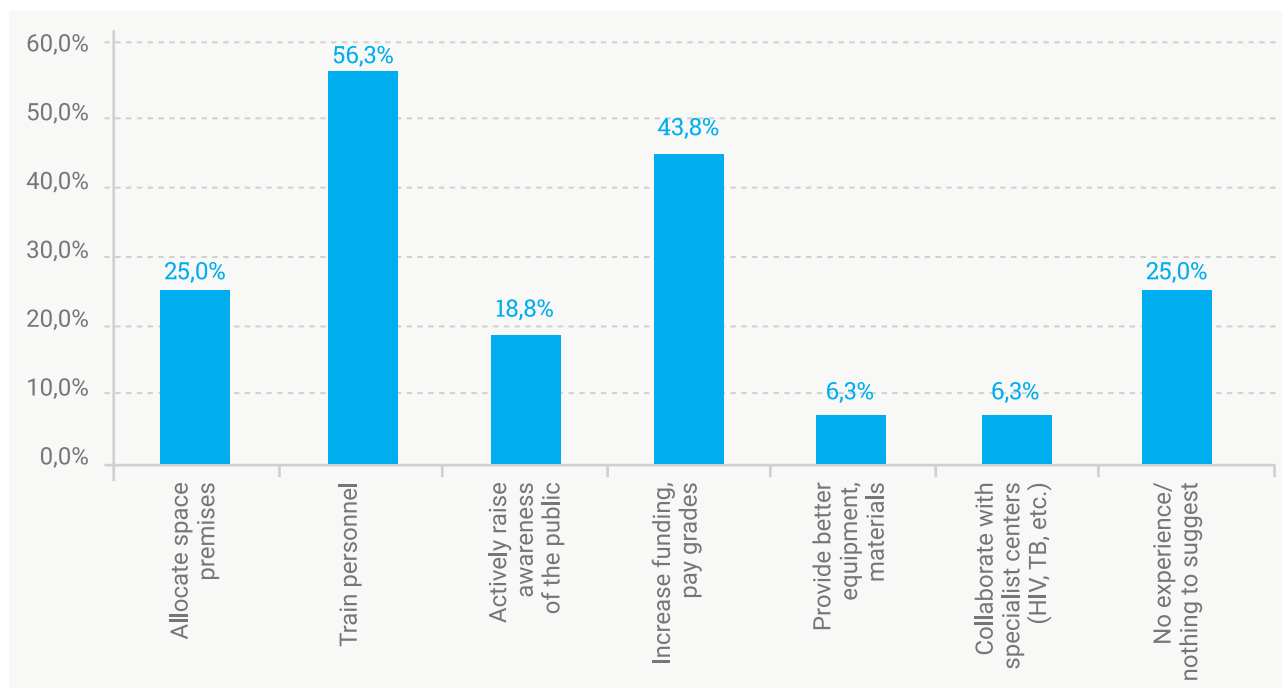


“In the beginning, there were challenges on the part of [regular] patients: they did not take it very well that TB patients began to go to the general network for health services. This especially applies to mothers with children and pregnant women. There was a lot of stigma. A decision was made to split the reception into streams in order to solve this problem. It has become easier for TB patients; they no longer have to go to the TB dispensary for services but receive them within walking distance. Therefore, they are more willing to receive treatment. And it became easier for doctors that TB doctors are nearby, they can consult them at any time.”

Re-orienting PHC services for integration of HIV services

Using their experiences in integrating TB into PHC, services providers were asked areas where PHC service delivery will need to be re-oriented to strengthen integration of HIV into PHC. Key areas reported for PHC re-orientation for HIV integration included: training of personnel (56.3%), increasing funding (43.8%), allocating space for provision of integrated services (25%) and actively raising public awareness (18.8%). Figure 11 provides this information.

Figure 11: Reorienting PHC to integrate HIV



Tracking clients and referrals

Where provision of integrated services involve referral to another facility, effective referrals and follow ups to ensure clients access referred services is critical. All visited facilities reported that they had follow up systems in place to ensure clients referred for integrated are able to access services they are referred for. Follow up methods ranged from calling patients through mobile phones, door to door visits, use of police to locate them and racking through medical health records. Calling by general practioners was the most common used method at 83%. Interestingly follow up by police has considerable use at 39%. The following are some quotes from interviewed health workers on methods of tracking and follow up of clients.



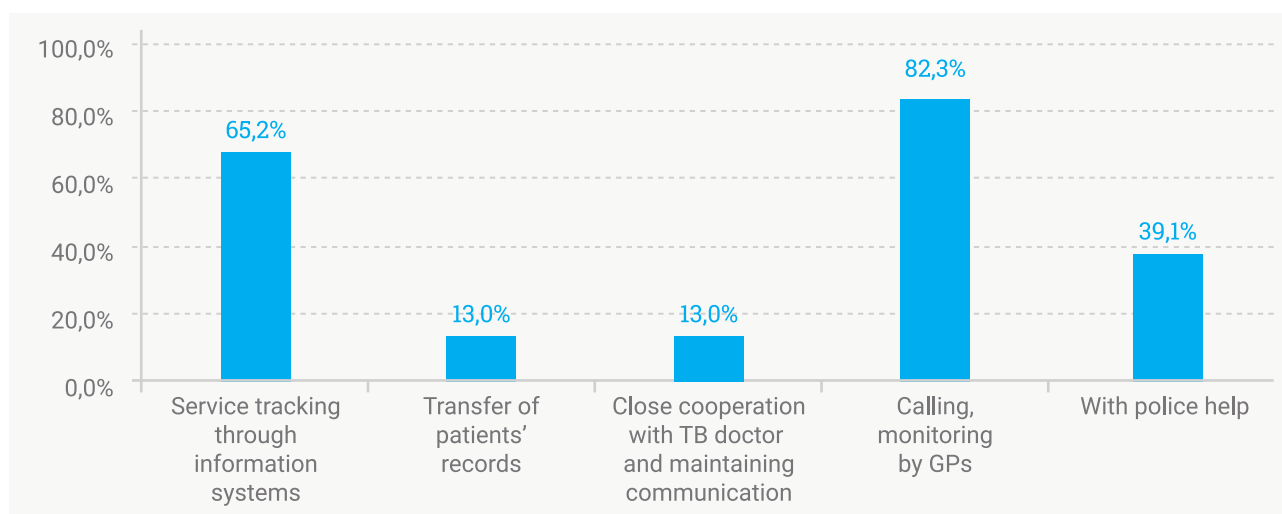
Subsequently, accessing services is monitored through information systems, by calling patients and inviting them for examinations, as well as by door-to-door visits. If necessary, they are located with the help of the police.



Constant communication between GPs, psychiatrists and TB doctors, transfer of records upon discharge from the hospital, and tracking patients in the medical information system". Additionally, we are constantly in touch with them by phone; we also check using the information system. If a patient disappears, we report that to their local PHC facility so that the nurse finds out the reason.

Figure 12 presents the methods used in tracking TB clients.

Figure 12: Tracking TB clients



Constraints in integrating HIV into PHC

Understanding possible constraints to integration is important for designing appropriate strategies for addressing them. Using their experiences in integrating TB into PHC, using several health systems variables, service providers were asked to rate whether those are likely to be a large, medium, small, or not a constraint at all. Inadequate data collection tools (60%), lack of appropriate guidelines (57%) and shortage of drugs and supplies (53%) were identified as large constraints by majority of the respondents. Possible breach of confidentiality, stigma and discrimination and lack of coordination were reported as “other” possible constraints. Some respondents felt that integration will significantly increase workload among health workers and make them leave practicing. On this, interviewed service providers observed:



“It is not easy for the PHC to integrate HIV/AIDS service: they now have the TB and mental health TB services incorporated; emergency care was also added to their responsibilities. There were serious financial challenges with payments and billing. From July 1, prisons will be handed over to PHC as well... Recommendation: first and foremost, address funding and confidentiality. In general, we do not recommend integrating HIV and AIDS into PHC.

Table 8: Predicted constraints of integrating HIV into PHC

Variable	Not a constraint	Small	Medium	Large
Shortage of equipment	11 (36,7%)	9 (30%)	5 (16,7%)	5 (16,7%)
Shortage of space	9 (30%)	3 (10%)	10 (33,3%)	8 (26,7%)
Shortage/lack of drugs and other supplies	2 (6,7%)	4 (13,3%)	8 (26,7%)	16 (53,3%)
Shortage of adequate staff	3 (10%)	6 (20%)	7 (23,3%)	14 (46,7%)
Inadequate training	2 (6,7%)	3 (10%)	10 (33,3%)	15 (50%)
Low staff motivation	4 (13,3%)	6 (20%)	10 (33,3%)	10 (33,3%)
Weak supervision	3 (10%)	7 (23,4%)	10 (33,3%)	10 (33,3%)
Lack of data collection tools	3 (10%)	5 (16,7%)	4 (13,3%)	18 (60%)
Lack of appropriate guidelines	5 (16,7%)	5 (16,7%)	3 (10%)	17 (56,6%)

Impact of integrating mental health into PHC

To anticipate possible impact of integrating HIV/AIDS into PHC, using various variables, service providers were asked to state whether integration of mental health services was associated with decrease, increase or no change in the stated variable. Majority of the respondents reported that mental health integration was not associated with any change in cost of services (93.3%) and time spent on the client (53.3%). A significant percentage of respondents (43.3%) reported reduced stigmatization of mental health clients. Table 9 shows the impact of integrating mental health into PHC.

Table 9: Impact of integrating mental health into PHC

Service	Decrease	No change	Increase	Don't know
Cost of services (for facility)	-	11 (36.7%)	10 (33.3%)	9 (30%)
Cost of services (for client)	-	28 (93.3%)	-	2 (6.7%)
Efficiency of services	3 (10%)	6 (20%)	18 (60%)	3 (10%)
Stigmatization of mental health clients	13 (43.3%)	9 (30%)	2 (6.7%)	6 (20%)
Workload for providers	1 (3.3%)	10 (33.3%)	19 (63.3%)	-
Time spent per client	6 (20%)	16 (53.3%)	8 (26.7%)	-

Impact of integrating HIV into PHC

Using their experiences in integrating mental health into PHC, service providers were asked to predict the impact of integrating HIV/AIDS into PHC. A significant percentage (90%) of health workers felt that integration of HIV will increase workload for service providers. On a positive side, more than half of the respondents (53%) reported that integration HIV services will increase efficiency in delivery of services. Table 10 shows perceptions of service providers on impact of integrating of HIV/AIDS on PHC.

Table 10: Impact of integrating HIV/AIDS services into PHC

Service	Decrease	No change	Increase	Don't know
Cost of services (for facility)	-	8 (26,7%)	15 (50%)	7 (23,3%)
Cost of services (for client)	1 (3,3%)	23 (76,7%)	1 (3,3%)	5 (16,7%)
Efficiency of services	3 (10%)	4 (13,3%)	16 (53,3%)	7 (23,3%)
Stigmatization of HIV clients	6 (20%)	9 (30%)	8 (26,7%)	7 (23,3%)
Workload for providers	-	-	27 (90%)	3 (10%)
Time spent per client	1 (3,3%)	10 (33,3%)	12 (40%)	7 (23,3%)

Recommendations for integrating HIV/AIDS response into PHC

Using their experience from integrating mental health and TB into PHC, service providers were asked to provide recommendations for success integration of HIV into PHC. The following is a listing of the recommendations provided:

- Ensure confidentiality
- Provide adequate staffing with trained specialists
- Ensure availability of medication at all time
- Provide adequate staffing for provision of integrated services
- Provide adequate funding for provision of integrated services
- Develop clear client flow for access of integrated services
- Start with and learn from a pilot project
- Ensure communities and clients are sensitized and prepared for integrated services

3.2.2. Interviews with service providers at AIDS Centers

Integration of PHC into AIDS centres

Normally, HIV/AIDS services in Kazakhstan are offered in specialized sites referred to as AIDS Centres. This study interviewed service providers in all the five (5) AIDS Centres. The assessment sought to understand the HIV/AIDS and PHC services offered at the centers. Additionally, the assessment sought opinions of the service providers at the AIDS centers on integration of HIV/AIDS into PHC facilities. All the centres reported providing comprehensive HIV/AIDS information and services ranging from prevention, to treatment, care, and support. Additional services provided included TB diagnosis and treatment. Asked whether the AIDS centres were integrating PHC services all the centres were affirmative. A further discussion on what PHC services were offered, this assessment identified that all the centres (100%) provided STI services while reproductive, maternal, newborn health services including family planning, antenatal care services, delivery and maternity and postnatal care services were offered in 4 out of the total 5 centres (80%). Least integrated services included immunization, treatment of childhood illnesses and adolescent health, with only 2 centres (20%) integrating those services. Table 11 summarizes this information.

Table 11: PHC services offered at AIDS centers

Service	Yes	No
Family planning	4 (80%) ¹	1 (20%)
Antenatal care services	4 (80%)	1 (20%)
Delivery/maternity services	4 (80%) ²	1 (20%)
Postnatal care services	4 (80%)	1 (20%)
Immunization services	2 (40%) ³	3 (60%)
Treatment of childhood illnesses	2 (40%) ⁴	3 (60%)
Adolescent health services	2 (40%)	3 (60%)
Treatment of STIs	5 (100%)	
Treatment of Non-Communicable Diseases (NCDs)	3 (60%)	2 (40%)
Diagnosis and treatment of TB	3 (60%)	2 (40%)
Mental health services	2 (40%)	3 (60%)
General outpatient services	4 (80%)	1 (20%)

Recommendations for integrating HIV/AIDS into PHC

Using their experience in integrating PHC into AIDS centres, health service providers at the centers provided their recommendations on what reorientations need to be done to integrate HIV/AIDS services into PHC. While participants from 2 centres (40%) did not support the integration and therefore did not offer any suggestions, the rest noted that there will be need to train PHC staff on management of HIV including administering ARV drugs. In addition to training on HIV and AIDS management, respondents mentioned the need for sensitizing health workers on promoting zero stigma and discrimination in provision of services. Provision of additional space for provision of HIV counselling services at PHC service delivery points was also recommended. Provision of effective referrals is important in ensuring PLHIV adhere and are retained on treatment. All the 5 centres reported referring clients to other clinics for accessing services not available at the centres. Methods of follow up to ensure those referred access services included calling and tracking the patients through existing information systems.

Possible barriers to integration- perspectives from AIDS Centre service providers

Based on their experience in integrating PHC into AIDS centers, service providers were asked rate different possible barriers as either not a constraint/barrier, small, medium or large constraint. Lack of equipment and shortage of drugs were identified by majority of respondents (60%) as being significant (large) constraints to integration of HIV/AIDS response into PHC. Majority of respondents did not identify weak supportive supervision as a constraint to integration. Fear of breach of confidentiality and high levels of stigma as were also mentioned as being possible constraints to integration of HIV/AIDS response into PHC. Table 12 presents AIDS service providers rating on possible constraints of integration.

Table 12: Rating on possible constraints of integration

Possible constraints/barriers	Not a constraint	Small	Medium	Large
Lack of equipment for the provision of integrated services	-	-	2 (40%)	3 (60%)
Shortage of premises for the provision of integrated services	-	1 (20%)	2 (40%)	2 (40%)
Shortage/absence of drugs and other supplies for the provision of integrated services	2 (40%)	-	-	3 (60%)
Lack of sufficient staff for the provision of integrated services	2 (40%)	-	1 (20%)	2 (40%)
Insufficient staff training for the provision of integrated services	1 (20%)	-	2 (40%)	2 (40%)
Low staff motivation	1 (20%)	2 (40%)	2 (40%)	-
Weak supervision	3 (60%)	-	-	2 (40%)
Lack of data collection tools	1 (20%)	-	3 (60%)	1 (20%)
Lack of proper guidelines/standard operating procedures	2 (40%)	-	2 (40%)	1 (20%)

Understanding the possible positive and negative impact of integration is key to designing appropriate strategies to address the negative impact while at the same time maximizing on the benefits. To understand this, the assessment sought to understand the perceptions of the AIDS service providers on the possible effect of integrating HIV/AIDS response into PHC. Although several respondents indicated don't know on most of the variables, a sizeable percentage of AIDS service providers were more inclined to HIV/AIDS integration into PHC having negative impacts. Majority of the respondents (60%) reported that HIV/AIDS integration will increase workload for service providers. Forty percent (40%) reported that cost of services, stigmatization and time spent per patient will increase. A significant percentage (80%) reported that integration will lead to decrease in quality of services to the clients. Table 13 shows perceptions by AIDS service providers on possible impact of integrating HIV/AIDS into PHC.

Table 13: Impact of HIV/AIDS integration into PHC

Elements	Decrease	No change	Increase	Don't know
Cost of services (for facility)	-	1 (20%)	1 (20%)	3 (60%)
Cost of services (for client)	-	1 (20%)	2 (40%)	2 (40%)
Efficiency of services	1 (20%)	1 (20%)	1 (20%)	2 (40%)
Stigmatization	2 (40%)	-	2 (40%)	1 (20%)
Workload for providers	-	1 (20%)	3 (60%)	1 (20%)

Elements	Decrease	No change	Increase	Don't know
Time spent per patient	1 (20%)	1 (20%)	2 (40%)	1 (20%)
Quality of service to client	4 (80%)	-	1 (20%)	-
Service quality	3 (60%)	-	2 (40%)	-
Integrated nature of services received	3 (60%)	2 (40%)	-	-

Other potential negative impact of integrating HIV/AIDS response into PHC as identified by service providers at the AIDS center include possible increase in opportunistic diseases such as TB and hepatitis B & C, weak adherence to treatment which can result to increased HIV transmission rates.

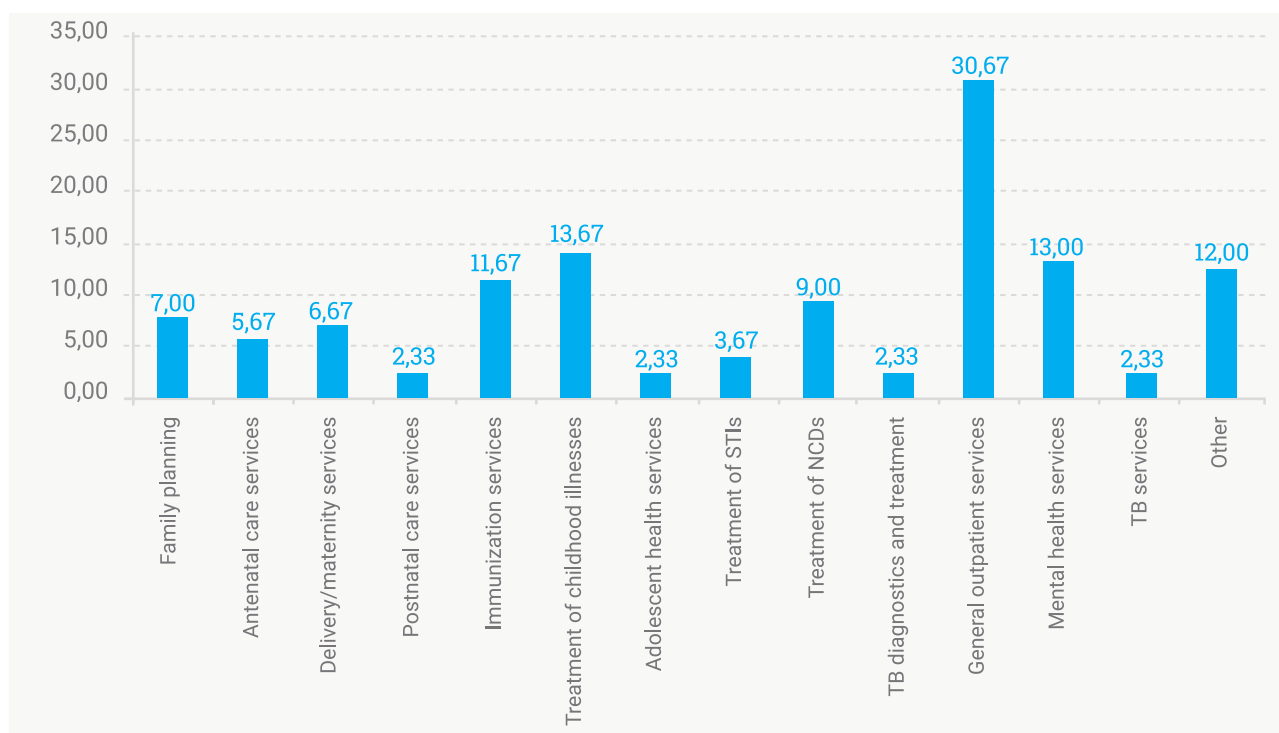
3.3. Integration at client level

3.3.1. Client exit interviews at PHC facilities

Services sought at PHC

In response to the question “What services did you come for today?”, most of the patients (30.67%) reported coming for general outpatient services. Those who reported having come for mental health services were a sizeable percentage (13%), indicating that mental health had been integrated into PHC. Other commonly accessed services include treatment for childhood illnesses (14%), immunization (12%) and others (12%). Figure 13 shows the services the clients had sought.

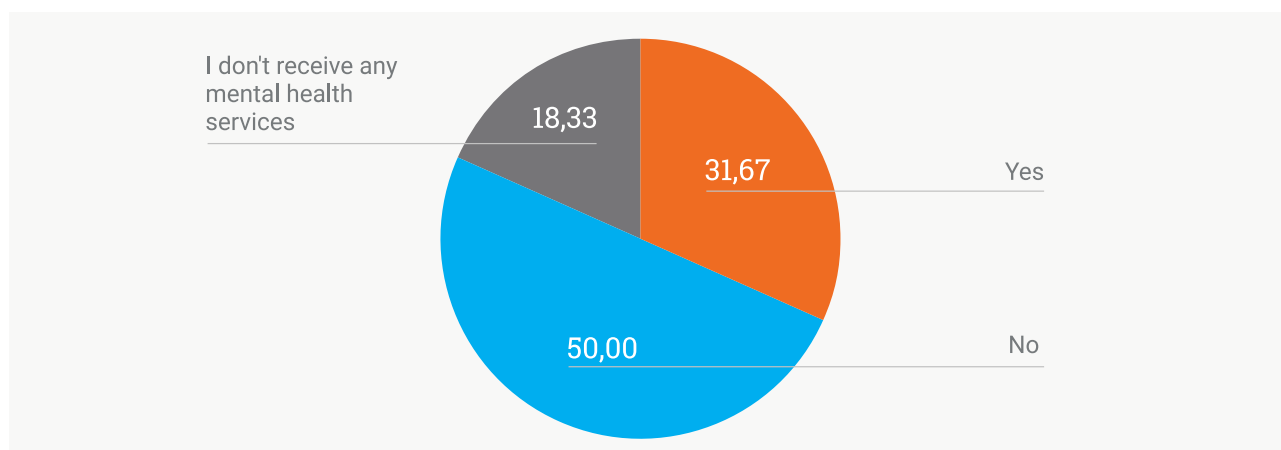
Figure 13: Services clients sought in PHC facilities



Close to half (48%) of the respondents attending PHC services reported that they had been offered mental health information or services at the visited facilities.

As with mental health, 43 % of clients visiting PHC facilities reported having been offered TB services or information. A good percentage of respondents (30%) access mental health services at the same point where they access their PHC services. This is shown in figure 14.

Figure 14: Clients accessing TB services at PHC facilities



Majority of the mental health clients visited the PHC facilities on the referral. Other reasons included for counselling with the psychologists on their mental wellbeing and that of their child, depression, and anxiety counselling and pre and postnatal consultation and psychologist.

Models of integrating TB and mental health into PHC as reported by clients

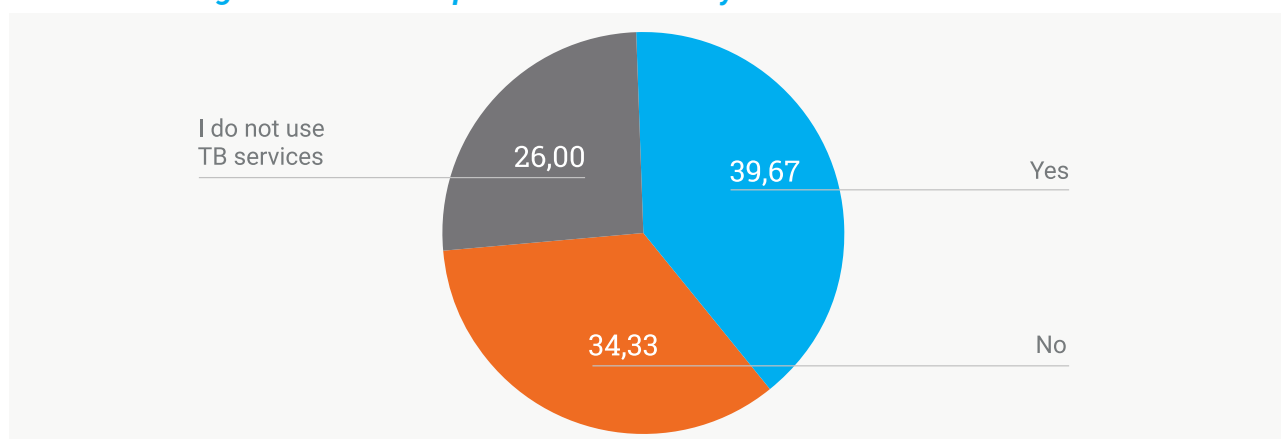
Integration of health services can happen at different levels and in different ways. This assessment sought to understand how TB and mental health were integrated into PHC in the perspectives of the clients. The most mentioned model of integration for both mental health (29%) and TB (39%) was “different site but within the same facility”. On the other hand, same site same service provider was the least used model with 13% for mental health and 20% for TB. Table 14 presents results on how TB and mental health was integrated into PHC.

Table 14: Models of integrating TB and mental health into PHC as reported by clients

Mode of integration	Mental health		TB	
	Yes	No	Yes	No
Located in same site with same service provider	13%	87%	20%	80%
Located in same site but with different service provider	28%	72%	21%	79%
Different site but within the same facility	29%	71%	39%	61%
Referral to different facility	11 %	89%	7%	93%

More than half of the clients (40% of total including those not accessing) who were accessing TB services reported that they access them at same site where they accessed other PHC services. Figure 15 shows the responses to the question on the question “Is this the usual health facility where you access your TB services?”.

Figure 15: Client responses on where they access TB and PHC services

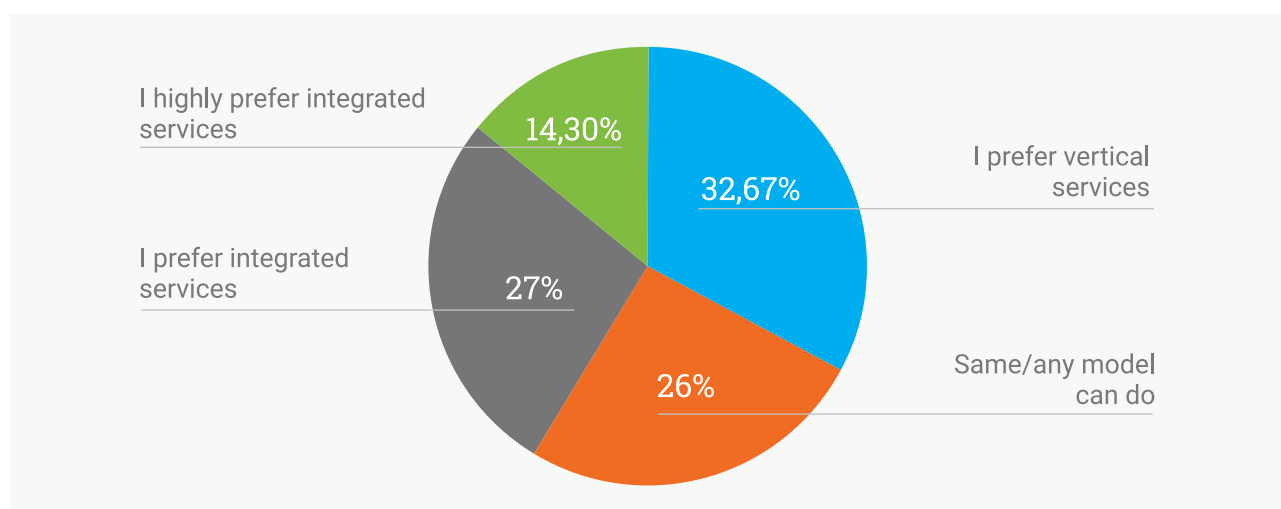


TB services accessed from the PHC facilities included TB screening and diagnosis for children and adults including Mantoux, sputum test and fluorography and treatment for those testing positive.

Client preferences on integrated versus vertical services

Understanding client services for integrated services is an important consideration in planning for integration of HIV/AIDS into PHC services. This assessment sought to understand whether clients prefer integrated or vertical services. Asked to rate their preferences on either vertical or integrated services, a slightly higher % of clients reported (41.3 %) reported that they would prefer integrated services compared to 32.6% who reported their preference for vertical services. Additionally, 26% reported that they highly prefer integrated services. Figure 16 shows respondents rating for integrated versus vertical services.

Figure 16: Client preferences on vertical versus integrated services



Impact of integrating TB and mental health into PHC

Using lessons from TB and mental health integration into PHC, this study sought to understand the possible impact of integrating HIV/AIDS into PHC. Respondents were asked to rate whether in their opinion integration of TB and mental health into PHC resulted into decrease, no change or increase in variables such as cost of services, efficiency, time spent in accessing services, quality, stigma, client privacy and confidentiality. Table 15 presents the impact of integrating TB and mental health into PHC as reported during the client exit interviews.

Table 15: Impact of integrating TB and mental health into PHC as reported by clients

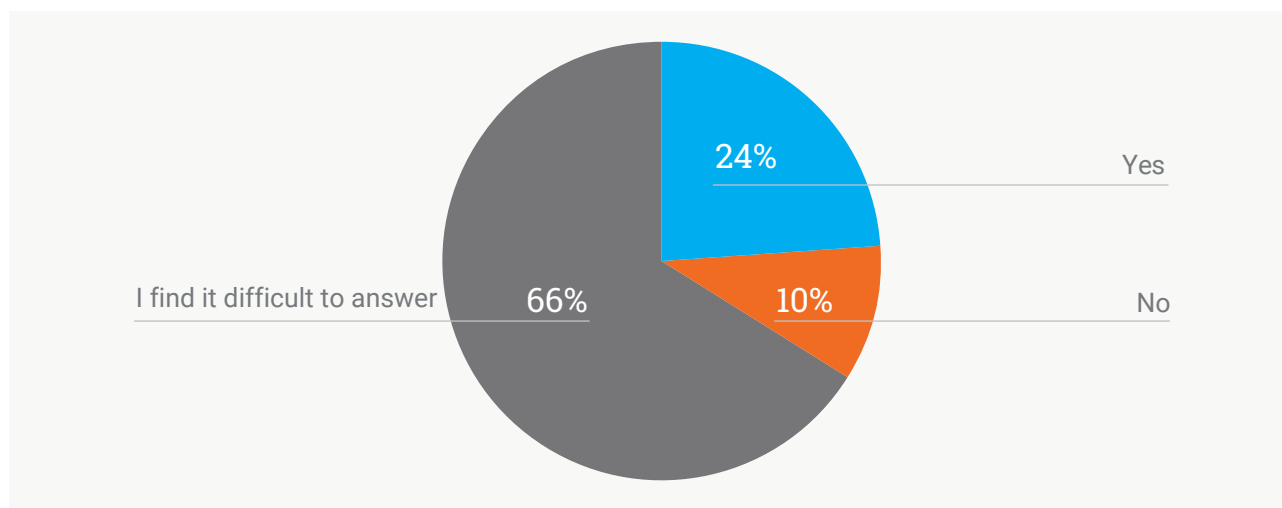
Variable	Mental health				TB			
	Decrease	Increase	No change	Don't know	Decrease	Increase	No change	Don't know
Cost of services	3%	15%	36%	46%	2%	8%	40%	50%
Efficiency	3%	38%	35%	24%	1%	31%	38%	30%
Time spent in accessing services	13%	26%	39%	22%	13%	28%	34%	25%
Perceived quality of services	5%	20%	33%	42%	4%	16%	42%	39%
Privacy and confidentiality	1%	20%	34%	45%	1%	17%	37%	45%
Stigma	11%	6%	23%	60%	9%	6%	25%	60%

Almost all the service providers (99%) reported no challenges in integrating TB and mental health into PHC. Only one (1) respondent identified that inadequate nurses and doctors were a challenge to integration of integrated mental and TB services.

Client opinions on benefits and disadvantages of integrating HIV/AIDS into PHC

This assessment sought opinions of clients on the Kazakhstan MoH plan to integrate HIV/AIDS into PHC. On direct question on their opinion on this plan, majority of the respondents (66%) did not provide any opinion. For the few who responded to this question, majority approved the idea (24%) as opposed to those who opposed the plan to integrate (10%). Figure 17 presents the clients opinions on HIV/AIDS integration into PHC.

Figure 17: Clients opinions on integrating HIV/AIDS into PHC



Asked on what benefits will be accrued from integration, clients cited: saving time for clients due to provision of services in one place and improved access and quality of the integrated services. Reported disadvantages included: Increased workload among PHC doctors, inadequate equipment and supplies, lack of space for provision of integrated services and possible breach of confidentiality.

Recommendations for successful integration from client perspectives

Asked to provide their recommendations for successful integration in their perspectives, clients provided the following suggestions:

- Reduce queues and waiting times for doctors' appointments.
- Provide adequate space for provision of integrated services
- Create awareness among the general population
- Training health workers on provision of HIV/AIDS services
- Provide adequate salary to service providers
- Ensure confidentiality and privacy and prevent stigma

3.3.2. From the perspectives of those who live it: Findings from FGDs with PLHIV

Focus group discussions with PLHIV identify that they currently most of their health care services including "PHC services" from AIDS centres. Those interviewed reported that they rarely visit PHC clinics unless referred for some special services by their AIDS Centre physicians. Some of the reasons cited for their poor access to PHC facilities include their lack of knowledge on which PHC facilities

they should visit and their perception that the PHC health workers have no adequate knowledge and skills for management of HIV patients. Those interviewed report that health workers at PHC clinics treat PLHIV with full understanding and consideration of their HIV status. Another reason cited for poor access to PHC services by PLHIV is the lack of comprehensive package of services for PLHIV. With some package of services like diagnostics being available to only those that are insured, PLHIV reported that they were facing challenges accessing those services unlike in AIDS centres where all services are provided to them.

Although PLHIV identify that integrating HIV services in PHC is feasible and cost effective, they further identify that some pre-conditions must be met including re-training health workers at the PHC clinics, ensuring the PHC facilities are stigma free and that a comprehensive package of services are available to PLHIV for free. According to PLHIV, if HIV/AIDS services are to be integrated into PHC, there is need to ensure health workers are trained and PHC centres are devoid of stigma and discrimination. On this point, a PLHIV respondent noted: “It is important that there is no queue, that drugs are given, that the doctor is competent, knows what treatment to prescribe, although in practice we encounter incompetence at the PHC level. Therefore, it is dangerous and scary to go to primary health care facilities because they cannot even make a diagnosis. It is also important that there is no stigma and discrimination.” People living with HIV observe that cases of health facility stigma exist but further add that what may be more critical is to address self-stigma among PLHIV. On health facility related stigma, a PLHIV discussant observed: “when a PLHIV come to them with certain complaints, the doctors may say: “What did you expect, you are diagnosed with HIV, so that’s how it will be for you,” thus showing their attitude towards these patients and violating their rights”. To address issues of self-stigma, the PLHIV discussants note that it is critical to strengthen pre- and post-test counselling once an individual tests positive for HIV.

In addressing this, the PLHIV noted that there is need for an overall systems change to address HIV related stigma including through creating awareness among health service providers. Making a recommendation on addressing stigma, FGD discussants with PLHIV observed:



“In order for patients to want to go to a PHC facility, it is necessary to change the approach and management in general. We have discrimination not only towards HIV patients, but towards everyone. It is necessary to radically change the PHC facilities, starting from the entrance, from the technical staff. The clinic should greet everyone in a friendly manner. And PHC facilities should adopt a policy, like they do abroad, to treat everyone equally regardless of status”.

With strengthened capacity and with health facilities being stigma free, PLHIV observe that integration is a feasible and cost-effective approach. The discussants noted:



“In fact, AIDS centers are not needed, as they are a separate entity that eats up the budget. And it would be good to receive all the relevant services at the PHC facility. Abroad, there is experience in obtaining ARV drugs in private clinics, why not do this in our country? But we have monopolization”.

3.4. Achievements and lessons learned

3.4.1 Achievements

Reduction in hospitalization of TB patients leading to reduced costs and lower transmissions. Due to ongoing integration of TB services into PHC, there has been a reduction in hospital beds for TB patients. Whereas 100% of TB patients used to be subject to hospitalization, thanks to integration now only epidemiologically dangerous patients are subject to inpatient treatment. The budget funds thus saved are directed towards the purchase of equipment, repair work, purchase of protective equipment and for other purposes. Patients with drug susceptible forms of TB are treated on an outpatient basis. As a result, there is a decrease in the number of patients with resistant forms of TB. Directly observed therapy is conducted in PHC facilities. Patients receive a single dose of the necessary drugs daily and take it on the spot, in the presence of a nurse.

Bringing mental health services closer to the population. Bringing outpatient psychiatric and narcological services closer to the people has reduced stigma and increased accessibility. This has a great potential for optimizing budget funds and human resources (psychiatrists and narcologists). In the future, these measures will improve the detection rate of mental disorders.

Skills and competency building for PHC service providers. Over time, the integration of TB and mental health services has helped build skills among PHC service providers in TB and mental health diagnosis and management.

3.4.2 Lessons learned

Phased approach works in integrating specialized services into PHC. The experience of integrating TB and mental health services has shown that integration of specialized services into PHC should be done systematically and allow time to learn as integration goes on. A phased and gradual approach helps to ensure emerging lessons and challenges are document and disseminated before scaling up.

Addressing systemic bottlenecks is a prerequisite to effective integration. As part of supporting integration process, it is key to conduct an analysis to understand health systems bottlenecks. Based on this understanding, it is key to ensure strategies are put in place to address those bottlenecks before integration. Priority health systems support required as part of integration includes staff training, development of relevant guidance policy and strategy documents and planning for and ensuring consistent availability of essential commodities and supplies for provision of integrated services.

Creating buy among stakeholders including clients is key. To ensure a successful integration, it is critical to inbuild a system of creating awareness and buy in among stakeholders at all levels including policy makers and planners, service providers and clients.

3.5. Gaps and Challenges

Lack of comprehensive services. Even with most TB interventions having been integrated into PHC, still not all TB services are available in the PHC facilities. The available services do not cover the needs of all sputum smear-negative and multidrug-resistant TB patients. Rapid molecular diagnosis of multidrug-resistant TB patients and drug-susceptibility testing services are not yet available to all patients. This could imply that as the country integrates, it's still useful to have a few specialized centers where referral services can be accessed.

Inadequate staff for provision of integrated TB and mental health services. Even in a fully integrated program like TB, staff capacity both in terms of numbers and skills continue to challenge service provision. There are inadequate doctors at PHC clinics challenging provision of integrated services.

Due to high workloads, and insufficient training in TB and MDR-TB issues, the doctors are not able to provide proper care to TB patients receiving outpatient treatment. A certain burden falls on the nurses for directly observed treatment (DOT).

Inadequate financing for delivery of integrated services. The Comprehensive Plan for Combating Tuberculosis in the Republic of Kazakhstan for 2014-2020 states that “Over the past three years, the number of beds in the country’s TB facilities has been reduced by 17.8%. However, the financial resources saved by reducing the number of beds did not translate into strengthening outpatient care due to a lack of appropriate redistribution mechanism. The funds were simply automatically reduced”. The challenges of the outpatient stage of treatment are primarily related to the lack of funding. The existing system of funding TB care in the country is based on an inpatient bed-day, and not the entire course of treatment for a TB patient.

Inadequate capacity of personnel, funding and infrastructure for provision of quality mental health services. Just like in integration of TB into PHC, inadequate capacity of health workers both in numbers and skills is a big impediment to provision of quality integrated mental health services. In most cases, one psychiatrist-narcologist is responsible for several PHC facilities. This high workload affects the quality of care provided. There are PHC facilities in which the integration of mental health services is at an early stage due to the lack of premises and funding to hire a psychiatrist-narcologist. Even though general practitioners have been trained in the diagnosis and treatment of anxiety and depression, capacity to detect these conditions in PHC is still weak. The low salaries of psychologists in PHC facilities makes it impossible to attract more experienced psychology specialists to PHC facilities.

Stigmatization of mental health disorders. There is still some level of stigmatization of patients with mental disorders which negatively affects service delivery.

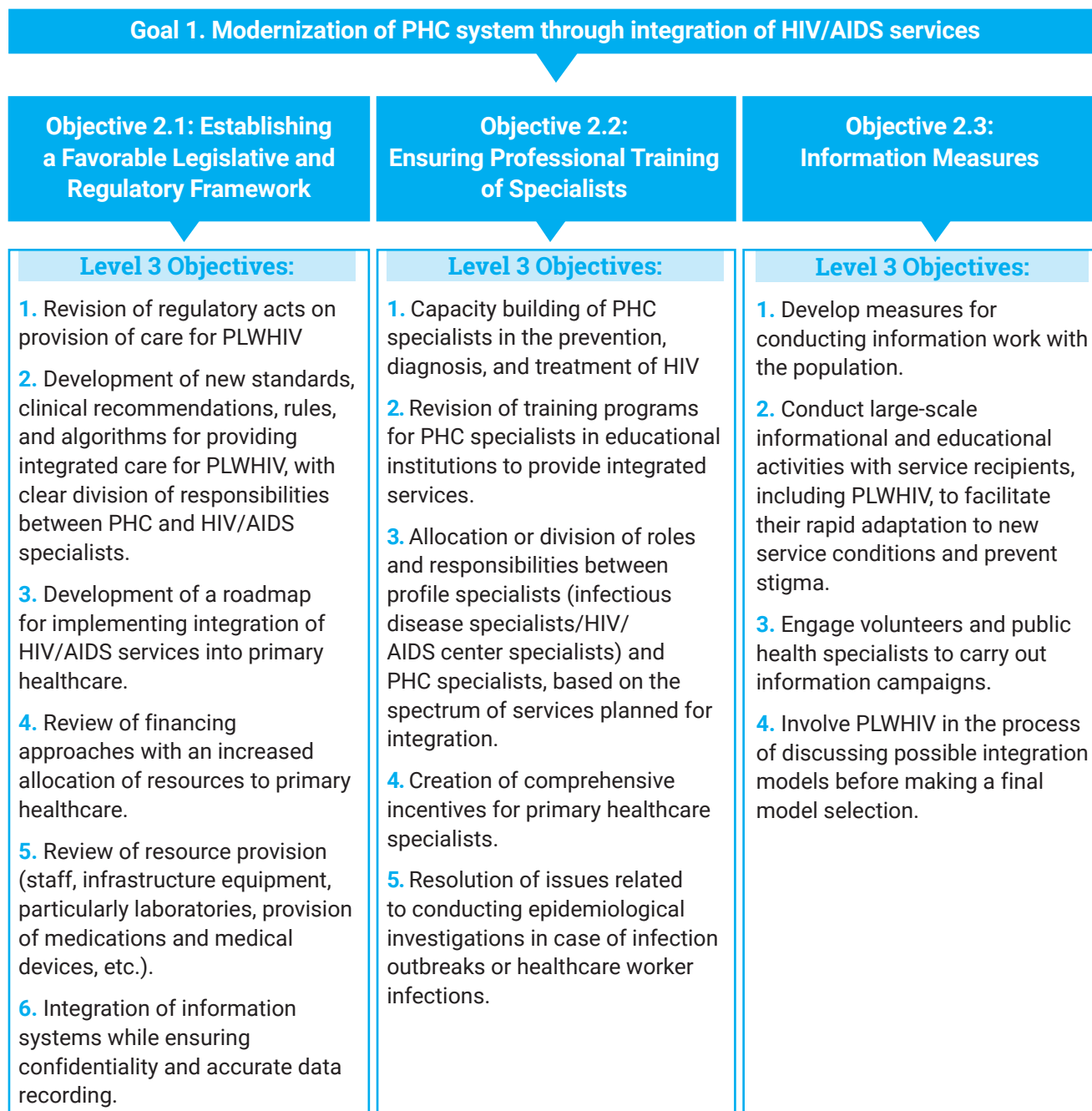
3.6. Unintended and unexpected findings

This assessment did not have many unexpected findings. However, although the study focus was on integration of HIV/AIDS services, it was interesting to learn some experiences on integration of PHC services into AIDS centers. The unexpected finding that AIDS Centres had successfully integrated PHC services point to the bidirectionality of integration and presents lessons on the possibility of promoting and strengthening integration of PHC services into the already existing AIDS centres.

4. DISCUSSION AND LIMITATIONS OF THE ASSESSMENT

The integration of HIV/AIDS services into primary healthcare is possible under certain conditions. At the current stage, the country's healthcare system requires extensive preparatory work. Based on the literature review and taking into account international experience in this field, as well as the results of the conducted cross-sectional assessment study, the following goal tree (Table 16) has been developed.

Table 16. Goal Tree for Integration of HIV/AIDS Services into Primary Healthcare



Possible models of integrating HIV/AIDS services into PHC:

- Model 1:** Cross-Referral between PHC organizations and AIDS Centers (lowest level of integration). This model involves maintaining the provision of services to PLWHIV largely as it currently exists. However, it includes integrating innovative methods to enhance service delivery
- Model 2:** Partial Integration. This model entails transferring some functions of AIDS Centers to PHC, allowing for a partial integration of services
- Model 3:** Full Integration of HIV/AIDS services into PHC. This model involves the complete integration of HIV/AIDS services into PHC

At all stages of integrating HIV/AIDS services into PHC, methodological support is necessary, including consultative assistance from HIV/AIDS specialists. Integrating HIV/AIDS services into PHC presents a more complex task compared to integrating mental health or tuberculosis services, as it involves more risks and nuances. Therefore, the integration of HIV/AIDS services into PHC requires thorough preparation and consideration of various risks, such as breaches of confidentiality, inadequate laboratory equipment, the unique nature of providing services to PLWHIV, increased risk of infection for healthcare professionals, insufficient training of PHC specialists in providing treatment and care to PLWHIV, and population-specific factors.

Experience from the integration of other services into PHC has shown that the integration process itself is challenging. Apart from financial costs, it also entails significant psychological and emotional strain for both PHC specialists and specialized professionals. Moreover, there has been a noted high level of stigma, particularly towards TB patients, which required the separation of patient flows to address this issue. It is anticipated that there will be even higher stigma towards PLWHIV from the population.

At the initial stage, it is necessary to integrate the HIV/AIDS service into PHC through a pilot project in 1-2 selected regions.

Additionally, to support the integration, a methodological center should be established to assist PHC in providing treatment and care for PLWHIV with the involvement of HIV/AIDS specialists.

Importantly, for an effective integration process of the HIV/AIDS services into PHC, it is crucial to consider the preferred integration model by the clients themselves.

Limitations of the study:

- Despite drawing lessons from the integration of TB and mental health, it is acknowledged that integrating HIV/AIDS has its own specific challenges. For instance, stigma and discrimination related to HIV may be higher compared to TB and mental health. Additionally, considering the prevalence of HIV, the number of trained PHC providers in HIV/AIDS treatment may be significantly lower.
- The study was unable to survey clients with mental disorders and TB to capture their experiences.
- The scope of the current assessment did not allow gathering information on the experience of integrating HIV response services into PHC in countries similar to Kazakhstan. This is recommended for future research.

5. ASSESSMENT CONCLUSIONS AND RECOMMENDATIONS

5.1. Conclusions

This assessment concludes that Kazakhstan has successfully integrated TB and mental health into PHC. This has not been without challenges and still there is still more to be done in strengthening integration of the two conditions. Using experiences from integration of TB and mental health, this assessment identifies that it is possible to integrate HIV/AIDS response into PHC. However, given the high levels of stigma and discrimination associated with HIV and possibly requiring more advance skills, its integration into PHC may require better preparation. Policy makers, planners and service providers identify that HIV/AIDS integration into PHC may result into increase workload among health workers and reduce quality of care. People living with HIV fear that integration could lead to reduced confidentiality and hence potential for increased stigma and discrimination. On the positive side, integration of HIV/AIDS into PHC may improve efficiency in the delivery of services. Health systems constraints to integration abound and these must be addressed as a prerequisite to integration. Having considered the experiences from integration of TB and mental health into PHC and based on advice from policy makers and planners, this assessment concludes that Kazakhstan should move to integrate HIV/AIDS into PHC. However, this should be preceded by adequate preparation and should be implemented gradually both in geographic scale and the HIV/AIDS programs/interventions to be integrated.

5.2. Recommendations

To ensure strong and sustainable integration of HIV/AIDS into PHC, based on findings from this assessment, the study makes the following recommendations to the Ministry of Health and other stakeholders involved in PHC and HIV/AIDS response in Kazakhstan. The assessment team recommends that consultations be held with stakeholders to prioritise these bottlenecks and establish clear timelines for their implementation.

- a. Implement a phased implementation of HIV/AIDS into PHC. To ensure learning from doing and as necessary health systems are strengthened, this assessment recommends a phased integration approach. This could start with integration of HIV prevention activities such as HIV testing and awareness creation and later HIV treatment and care. This assessment recommends that the country develops a clear plan and road map for integrating HIV/AIDS response into PHC. The plan should detail the vision for integration, the proposed integration models, the implementation timelines and milestones and reflect the required financial resources/costs.
- b. House AIDS centers within PHC. Rather than PHC centres themselves providing HIV services, and as part of the phased implementation, the study recommends that HIV services be provided by AIDS centers housed within the PHC facilities. The AIDS centers will then build capacity of PHC service providers.
- c. Learn from phased integration and scale up. The country should put in place systems to document emerging lessons and best practices from phased implementation and scale up integration both in terms of coverage and intensity.
- d. Review and update existing national policy and strategic documents to ensure they adequately support integration of HIV/AIDS into PHC. Lessons from integration of mental health and TB into PHC indicate that policy support is critical for effective integration. This assessment recommends that the country reviews and updates national health and PHC documents to provide policy support for HIV/AIDS integration into PHC.

- e. Develop necessary guidelines, tools, regulations, and laws necessary to support integration of HIV/AIDS into PHC. In addition to the broader policy support, the assessment identifies the need to develop specific guidelines, tools, and protocols to guide PHC and HIV practitioners on the 'how' of HIV/AIDS and PHC integration
- f. Create buy in for HIV/AIDS integration with different players including policy makers, implementers, communities, and people living with HIV/AIDS. For HIV/AIDS integration to be successful, it is critical to have buy in from various stakeholders especially people living with HIV. The assessment identified some misgivings by policy makers and people living with HIV on the country readiness and feasibility of integrating HIV/AIDS into PHC. The study recommends structured process for building buy in among various players on integration of HIV/AIDS into PHC.
- g. Build capacity of PHC service providers in provision of integrated HIV/AIDS services. Respondents interviewed identify those skills building for PHC service providers in provision of integrated health services is a pre-requisite for quality integration. The study recommends adoption of right training materials and training of service providers in HIV/AIDS and PHC integration.
- h. Review package of services offered at PHC facilities to ensure that PLHIV can get a comprehensive package of services. It is recommended that existing PHC package of services be revised accordingly to include a comprehensive package of integrated HIV/AIDS services.
- i. Build systems and implement activities to ensure quality of care in provision of integrated HIV/AIDS and PHC services. A key concern by respondents in this study was the possibility of reduced quality in provision of HIV/AIDS services following integration into PHC. This study recommends that the MoH establishes systems in integrating PHC facilities to ensure high quality in provision of integrated services. This could include regular monitoring and supportive supervision as well as establishment of quality improvement teams in the PHC facilities integrating HIV/AIDS services. Quality standards for provision of integrated services will also need to be developed and disseminated.
- j. Implement actions to prevent stigma and discrimination for clients accessing integrated HIV/AIDS and PHC services. Interviews with people living with HIV identify fears for that integration will increase stigma and discrimination. To address this, this assessment recommends implementation of actions to mitigate possible stigma and discrimination in PHC facilities integrating HIV/AIDS services. This will include sensitizing health workers and developing legal frameworks to protect people living with HIV from stigma and discrimination. Working with people living with HIV to reduce self-stigma is also identified as an important intervention
- k. Financing for the delivery of integrated HIV/AIDS and PHC services. Lessons from integration of TB and mental health into PHC identify that provision of adequate financing is key to successful integration. To support the integration process, it is necessary to provide additional funding for the restoration/maintenance of primary healthcare infrastructure, strengthening of oversight, filling gaps in staffing, etc. This study recommends that the country develops and finances a costed investment case for supporting integration of HIV/AIDS into PHC.
- l. Commodities and supplies and technologies including laboratory services. Ensuring adequate supplies including test kits, ARV drugs and other supplies is key to integrating HIV/AIDS into PHC. The study recommends that MoH strengthens capacity of integrating PHC facilities in appropriate forecasting and quantification to ensure all time availability of HIV/AIDS commodities and supplies to ensure seamless integration. Integrating procurement and distribution of PHC and HIV/AIDS commodities will need to be strengthened.
- m. Ensure appropriate infrastructural support for integration. This assessment identifies that there will be need to support the right infrastructure for provision of integrated services. Those interviewed identified the need to provide adequate space for HIV counselling and testing as part of ensuring client privacy and preventing possible stigma and discrimination.

- n. Develop systems and ensure monitoring and evaluation of integrated HIV/AIDS and PHC services. What gets measured gets done. The assessment recommends review of existing PHC monitoring and evaluation tools to ensure they can measure delivery of integrated services. This will also require the MoH to define and ensure regular reporting of indicators for integrating HIV/AIDS into PHC. This process should include the integration of information systems for data collection to eliminate discrepancies in statistical data and ensure access to unified data.
- o. It is unlikely that an overloaded healthcare system will be able to cope with the increased number of patients receiving antiretroviral therapy in the long term while maintaining service quality without revising the workload of service providers. Additional personnel may be required to achieve this task. Strategies for task shifting/delegation from doctors to nurses may also be useful in PHC facilities facing staff shortages
- p. Engage PLHIV and HIV communities at all stages of planning for the implementation of HIV integration into primary health care
- q. Conduct further desk research and visits to countries in the region that are already integrating HIV/AIDS into PHC. The assessment recommends further review to understand specifics on integrating HIV/AIDS response into PHC. It is recommended that that benchmarking visits could be made to countries in similar contexts who are integrating HIV response into PHC.

6. ANNEXES

Annex 6.1. Informed Consent Form

Consent to participate in the assessment.

I have read the above information, or it has been read to me. I have had the opportunity to ask questions about it and the questions asked to have been answered to my satisfaction. I voluntarily consent to be a participant in this assessment.

Name of participant: _____

Signature: _____

Date: _____

Name of interviewer: _____

Signature: _____

Date: _____

Annex 6.2.

KII guide for policy makers, planners and programmers at national level

Preliminary Data

Name of the Respondent: _____

Respondent department/Unit/organization: _____

Respondent Title/Cadre: _____

Date of the interview: _____

Name of interviewer: _____

Signature of the interviewer: _____

Key thematic Blocks	Responses
Policy Level: Political Positions, national guidelines/policies, funding/budgetary support	
1. I would WANT to understand the different departments within the Ministry of Health in Kazakhstan and how these are linked:	
Which department is responsible for PHC?	
Which department is responsible for mental health?	
How are mental health and PHC departments linked? In your opinion do you think the way the two departments are linked facilitates or hinders integration of TB into PHC? Please explain your responses.	
Which department is responsible for TB services?	
How are TB and PHC departments linked? In your opinion do you think the way the two departments are linked would facilitate or hinder integration of TB services into PHC? Please explain your responses.	
Which department is responsible for HIV/AIDS response?	
How are HIV AIDS and PHC departments linked? In your opinion do you think the way the two departments are linked would facilitate or hinder integration of HIV/AIDS services into PHC?	
2. From your experience in integrating mental health and TB services into PHC, what are your recommendations on reorientations/structural changes that need to be made within the organization of the MoH RoK to ensure successful integration of HIV/AIDS response into PHC?	
3. I would like to have more understanding the PHC program in Kazakhstan.	
Does the country have a policy/strategic document that guides PHC in the country? What is the name of the policy document?	
According to the policy document what levels of service delivery constitute PHC?	
What is the package of services offered at PHC?	
Do the PHC policy documents call for integrated service delivery? If yes, do they call for integration of mental health and TB? What about for HIV/AIDS services?	

Key thematic Blocks	Responses
To support integration of mental health and TB services, did the Ministry have to make any review and adjustments to accommodate integration of mental health and TB into PHC? Please provide details on the changes/review that was done?	
As part of supporting integration of mental health and TB into PHC, did the country develop any policy/strategy, or SOP to guide the integration? If yes, please provide details of how this was done, and lessons learned from this process. Learning from this, do you think there will be need to develop a similar document to support integration of HIV/AIDS into PHC? Please provide details.	
Based on your experience in integration of mental health and TB at policy level, what are your policy recommendations on policy review/changes that need to be introduced to support integration of HIV/AIDS response into PHC	
4. I would like to understand the funding for PHC and other programs facilitates or hinders integration.	
What are the main sources of funding for PHC program in Kazakhstan? Are PHC funds being used to support implementation of integrated mental health and TB services?	
What are the main sources of funding for mental health? Can mental health funding be used to implement PHC services?	
What are the main sources of funding for TB services? Can TB funding be used to support implementation of PHC services?	
In your opinion, are donors including government facilitative or a hindrance to integrated financing? Please explain. How can donor support for integrated financing be strengthened.	
As part of supporting financing of integrated mental health and TB services, what funding changes has the country made on PHC, mental health and TB services?	
What are the sources of funding for HIV/AIDS response?	
In your opinion what would be the challenges of financing integration of HIV/AIDS services into PHC?	
Based on financing of PHC integrated mental health and TB services, what would be your recommendations for strengthening financing of integration of HIV/AIDS services into PHC?	
Systems level: Planning, HRH, laboratory, monitoring and evaluation	
5. I would like to understand planning for PHC, mental health, TB and HIV/AIDS in the country and how that facilitates or hinders integrated programming:	
Please explain to me PHC planning in the country in terms of frequency, levels and stakeholders who are involved?	
What about planning for TB and mental health in terms of frequency, levels and stakeholders who are involved?	
Is there joint planning for PHC, mental health and TB? Please provide details. If not, please explain how the country ensures integrated planning for PHC, mental health and TB.	

Key thematic Blocks	Responses
Based on your experience in integrating mental health and TB, what are your recommendations for strengthening joint planning for PHC and HIV/AIDS response?	
6. I would like to know about networks of PLHIV in Kazakhstan, how well they are involved in HIV/AIDS response and how their involvement can help strengthen integration?	
Are there networks of people living with HIV in the country? Are they organized in any national forum/association? If yes what is the name of this forum?	
Are they involved in HIV/AIDS response in the country? If yes, how are they involved?	
What would be your suggestions for improving involvement of PLHIV in integration of HIV/AIDS response into PHC?	
7. I would like to learn more about PHC human resources for supporting integrated service delivery:	
What would be your general comment on the HRH situation in the country in terms of numbers, skills, motivation and distribution? Do you think the HRH situation as it is ready for integrated service delivery?	
What HRH challenges were experienced in integrating mental health and TB into PHC?	
How were the challenges addressed? What HRH changes were introduced to strengthen integration of mental health and TB into PHC?	
Based on experience in integrating mental health and TB into PHC, what are your recommendations for strengthening HRH to support integration of HIV/AIDS into PHC?	
8. I would like to understand health commodity security and management in the country and how this facilitates or hinders delivery of integrated health services:	
Please describe to me the procurement and distribution of PHC commodities and supplies in the country	
What about procurement and distribution of mental health and TB commodities?	
Is there an integrated procurement and distribution of PHC, mental health and TB commodities? If yes, please provide details on how these are integrated. If no, please provide details on the challenges to integrated procurement and distribution systems?	
What commodity and supplies related challenges did your experience in supporting integration of mental health and TB services? How did you address those challenges?	
What about procurement and distribution of PHC and HIV/AIDS commodities and supplies? Are these integrated or vertical?	
Based on your experience integrating mental health and TB, what are your recommendations on strengthening commodity and supplies to ensure efficient integration of HIV/AIDS response into PHC services?	

Key thematic Blocks	Responses
9. I would like to understand the Kazakhstan laboratory management system and how this supports delivery of integrated TB and HIV services:	
Please describe to me the Kazakhstan Laboratory management system? How are labs organized in the country?	
Does PHC laboratory system integrate TB testing and screening? If yes, please provide details.	
Did you have any laboratory related challenges in integrating TB into PHC? If yes what were the challenges and how did you address them?	
Did you implement any laboratory management reforms in integrating TB into PHC? If yes, what reforms did you introduce?	
Based on your experience in integrating TB into PHC, what are your recommendations on how laboratory management systems will need to be strengthened to ensure effective integration of HIV/AIDS into PHC?	
10. I would like to get your views on the national data collection, reporting, monitoring and evaluation systems and how these facilitate or hinder integrated service delivery:	
Please describe to me the national PHC monitoring, reporting and evaluation systems (Probe on DHIS 2, registers and other data collection and reporting tools)	
Does the system integrate mental health and TB reporting, monitoring and evaluation? If yes, please provide details.	
What challenges did you experience in integrated PHC, mental health and TB reporting? How did you address those challenges?	
What changes did you introduce in the national PHC monitoring, reporting and evaluation systems to support efficient data collection, reporting and monitoring of integrated mental health and TB services	
Based on your experience in integrating mental health and TB into PHC, what would be your recommendations for strengthening integrated HIV/AIDS and PHC data collection, reporting, monitoring and evaluation?	
11. In conclusion, are there any other policy and systems issues for supporting integration of HIV/AIDS response into PHC that you may want to share with me?	

Annex 6.3. Interview guide for facility-based service providers

Respondents: Health facility in charge; Health service providers in PHC facilities

Date of the interview: _____

District: _____

Facility name: _____

Level of the facility: _____

Interviewee number: _____

Cadre/title of the interviewee: _____

Name of interviewer: _____

Signature of the interviewer: _____

Question	Responses			
	Yes	No		
1. What PHC services are offered in this health facility? (Read all and mark Yes or No where appropriate)				
1a. Family planning				
1b. Antenatal care services				
1c. Delivery/maternity services				
1d. Postnatal care services				
1e. Immunization services				
1f. Treatment of childhood illnesses				
1g. Adolescent health services				
1h. Treatment of STIs				
1i. Treatment of Non-Communicable Diseases (NCDs)				
1j. Diagnosis and treatment of TB				
1k. General outpatient services				
1l. Others (specify)				
2. Are mental health services provided in this facility?				
3. If yes, please list the mental health services that are provided in this facility (List the services as mentioned by the respondent)				
4. If mental health services are integrated in this facility, please state how the services are integrated into PHC services? (Tick Yes or NO for what applies, multiple responses may apply if different mental health services are provided through different models).				
4a. Located in the same service site/room with the same provider				
4b. Located in the same service site/room but with different provider				
4c. Referral in a different site/room but in same facility				
4d. Referral to a different facility				
5. If mental health services are integrated into PHC services in this facility, please state whether the mental health services are integrated in each of the specific PHC services offered in this facility (Tick Yes or No for what applies, multiple responses are allowed).				

Question	Responses			
	Yes	No		
5a. Family planning				
5b. Antenatal care services				
5c. Delivery/maternity services				
5d. Postnatal care services				
5e. Immunization services				
5f. Treatment of childhood illnesses				
5g. Adolescent health services				
5h. Treatment of STIs				
5k. Treatment of NCDs				
5l. Diagnosis and treatment of TB				
5m. General outpatient services				
5n. Others (specify)				
6. Has provision of PHC services in this facility been oriented in any way to accommodate provision of mental health services?				
7. If yes, please provide details on how provision of PHC services in this facility have been reoriented to accommodate provision of mental health services?				
8. Based on your experiences on integration of mental health, what are your recommendations on how PHC service provision in this facility will need to be reoriented to accommodate integration of HIV/AIDS prevention, treatment, care and support services?				
8. Are TB services provided in this facility?				
9. If yes please list the specific TB services that are integrated into PHC in this facility				
10. If TB services are integrated into PHC in this facility, how have these been integrated into PHC services?				
10a. Located in the same service site with the same provider				
10b. Located in the same service site but with different provider				
10c. Referral in a different site but in same facility				
10d. Referral to a different facility				
11. If TB services are integrated into PHC services in this facility, please state whether the TB services are integrated in each of the specific PHC services offered in this facility (Tick Yes or No for what applies, multiple responses are allowed)				
11a. Family planning				
11b. Antenatal care services				
11c. Delivery/maternity services				
11d. Postnatal care services				
11e. Immunization services				
11f. Treatment of childhood illnesses				
11g. Adolescent health services				
11h. Treatment of STIs				
11i. Treatment of NCDs				

Question	Responses			
	Yes	No		
11j. Diagnosis and treatment of TB				
11k. General outpatient services				
11l. Others (specify)				
12. Has PHC services in this facility been reoriented in any way to accommodate provision of TB services?				
13. If yes, please state how the PHC services have been reoriented to accommodate provision of TB services in this facility.				
14. Based on your experience on integration of TB into PHC, what are your recommendations on how PHC services will need to be reoriented to support provision of HIV/AIDS prevention, treatment, care and support services in this facility?				
14. Are there cases where clients are referred for TB and or mental health services outside this facility?				
15. If yes, is there any follow up done to ensure clients go for and receive the services they are referred for?				
Yes				
No				
Don't know				
16. If yes, please explain how the follow up is done.				
17. If yes, is there any referral form that is used?				
Yes				
No				
Don't know				
18. Based on your experience in integrating mental health and TB into PHC, please rate each of the following as to how large the following are expected to be a constraint in integrating HIV/AIDS response into PHC in this facility. Would you say it is not a constraint, a small, a medium, or a large constraint?	Not a constraint	Small	Medium	Large
18a. Shortage of equipment for integrated services				
18b. Shortage of space for provision of integrated services				
18c. Shortage/lack of drugs and other supplies for provision of integrated services				
18d. Shortage of adequate staff for offering integrated services				
18e. Inadequate training among staff for provision of integrated services				
18f. Low staff motivation				
18g. Weak supervision				
18h. Lack of data collection tools				
18i. Lack of appropriate guidelines/SOPS				
18j. Other constraints (please specify)				
19. What has been the impact of integrating mental health and TB services into PHC on the following service dimensions. Did it decrease, increase or not change (Read each dimension below)?	Decrease	No change	Increase	Don't know

Question	Responses			
	Yes	No		
19a. Cost of services (for facility)				
19b. Cost of services (for client)				
19c. Efficiency of services				
19d. Stigmatization of mental health clients				
19e. Workload for providers				
19f. Time spent per client				
19g. Space and privacy				
19h. Lack of data collection tools				
19i. Lack of appropriate guidelines/SOPS				
19j. Other constraints (please specify)				
20. Based on your experience in integrating mental health and TB into PHC, what do you think will be the impact of integrating HIV services into PHC on the following service dimensions. Will it decrease, increase or not change (read each dimension below)?	Decrease	No change	Increase	Don't know
20a. Cost of services (for facility)				
20b. Cost of services (for client)				
20c. Efficiency of services				
20d. Stigmatization of HIV clients				
20e. Workload for providers				
20f. Time spent per client				
20g. Space and privacy				
20h. Lack of data collection tools				
20i. Lack of appropriate guidelines/SOPS				
20j. Other constraints (please specify)				
21. Generally, what would be your recommendations for strengthening integration of HIV into PHC in this facility?				

Annex 6.4. Focus group discussion guide

Target respondents: People living with HIV and AIDS

Thematic area	Guiding Questions/Probes
Access to HIV prevention, treatment and care services including where they access services and challenges, they experience in accessing services	<p>a. Tell me about your HIV prevention, treatment, care and support needs? (Guiding questions: What HIV/AIDS services do you usually seek?)</p> <p>b. How is access to HIV and AIDS prevention, treatment, care and support services in your area/region? (Guiding questions: Are there challenges in access to services or are you satisfied with the current situation?)</p> <p>c. Where do you access HIV/AIDS prevention, treatment, care and support services in this area? (Probe to know whether they are in AIDS centers, how far these are? How do they travel there)</p> <p>d. Are there some services that are more difficult to access than others? Please list those services for me.</p> <p>e. What are some challenges that you experience in accessing those services? (Probes: Transport, sometimes services not being there, quality, stigma and discrimination, others)</p> <p>f. What are your recommendations on how those access challenges can be addressed? (Probe to see whether integration/decentralization of services is mentioned as one of the recommendations?)</p>
HIV and AIDS related stigma and discrimination	<p>a. I would like to discuss with you issues of HIV related stigma and discrimination in your area or where you access your services, is this common? Have you ever experienced stigma and discrimination? If yes, please explain.</p> <p>b. Or have you heard of someone living with HIV and AIDS who ever experienced HIV related stigma and discrimination in your area/or where you access your HIV/AIDS services? Please describe.</p> <p>c. What are some forms of stigma and discrimination that PLHIV experience in this community? (Probes: Stigma at health facility, discrimination in provision of services, self stigma etc.)</p> <p>d. How does the stigma and discrimination affect your access to services?</p> <p>e. What are your recommendations on how HIV related stigma and discrimination can be addressed? (Probe to see whether decentralization and integration into PHC is mentioned as a solution to addressing stigma and discrimination)</p>
Preferences on vertical versus integrated (into PHC) HIV prevention and care services	<p>a. Please tell me about the clinics where you access HIV and AIDS services, are they stand alone clinics, or do they offer other services? (Probes: If they offer other services, please tell me what other services are offered?)</p> <p>b. If no other services are offered, please tell me what you do when you want to access other services apart from HIV/AIDS services? (Probes: If you want to access TB services, FP services, immunization for children etc.)</p>

Thematic area	Guiding Questions/Probes
	<p>c. Do you prefer to access HIV services in stand-alone (vertical) or in integrated clinics? (Note: provide details to respondents on what vertical (standalone) and integrated clinics are)</p> <p>d. Please tell me why you would prefer access HIV and AIDS prevention, treatment, care and support services in a stand-alone/vertical clinic?</p> <p>e. Please tell me why you would prefer access HIV and AIDS prevention, treatment, care and support services in an integrated clinic?</p>
Perceived benefits and disadvantages of integrating HIV into PHC services	<p>a. Do you think there are any benefits in having HIV and AIDS services integrated and decentralized at PHC clinics? What do you think are the benefits? (Probes: Increasing access, addressing stigma and discrimination, ease of getting other services, reducing costs, reducing time spent in accessing services etc.)</p> <p>b. And do you think there are any disadvantages in having HIV/AIDS prevention, treatment, care and support services BEING integrated/ decentralized in PHC clinics? If yes what are some of the disadvantages? (Probe on their views on whether it increases stigma and discrimination)</p>
Recommendations for integrating HIV into PHC services	<p>a. What are your recommendations for strengthening integration/ decentralization of HIV prevention, treatment, care and support into PHC? What do you think needs to be done to ensure the integration works well?</p> <p>b. What are your suggestions on involvement of PLHIV to strengthen integration of HIV/AIDS prevention, treatment, care and support into PHC?</p>

Annex 6.5. Client Exit Interview Questionnaire

Date of the interview: _____

District: _____

Facility name: _____

Level of the facility: _____

Interviewee number: _____

Name of interviewer: _____

Signature: _____

Question	Responses			
	Yes	No		
1. What services did you come for today? (Read and tick all that apply, multiple responses possible)				
1a. Family planning				
1b. Antenatal care services				
1c. Delivery/maternity services				
1d. Postnatal care services				
1e. Immunization services				
1f. Treatment of childhood illnesses				
1g. Adolescent health services				
1h. Treatment of STIs				
1i. Treatment of Non-Communicable Diseases (NCDs)				
1j. Diagnosis and treatment of TB				
1k. General outpatient services				
1l. Mental health services				
1m. TB services				
1n. Others (specify)				
2. If you came for PHC services (1a to 1k) did health workers offer you any information or services on mental health services?				
3. If yes, what information did they offer to you?				
4. If you came for PHC services (1a to 1k) did health workers offer you any TB related information or services?				
5. If TB information and services was offered, please list for me what was offered				
6. Is this the facility where you normally access your mental health services?				
Yes				
No				
I don't access any mental health services				
7. If yes, please list the mental health services that you access from medical facility				

Question	Responses			
8. From your experience, how are mental health services integrated into PHC in this medical facility? (Tick what applies, multiple responses may apply if different mental health services are provided in different models)				
8a. Located in the same service site with the same provider				
8b. Located in the same service site but with different provider				
8c. Referral in a different site but in same facility				
8d. Referral to a different facility				
9. Is this the usual health facility where you access your TB services?				
Yes				
No				
I don't access TB services				
10. If yes please list the specific TB services that you usually access in this health facility				
11. From you experience, how are TB services integrated into PHC services in this medical facility? (Tick what applies, multiple responses may apply if different TB services are provided in different models)				
11a. Located in the same service site with the same provider				
11b. Located in the same service site but with different provider				
11c. Referral in a different site but in same facility				
11d. Referral to a different facility				
12. I would like to hear your rating on integrated compared to vertical service delivery models (Notes: Explain correctly and ensure respondents understand the difference between integrated and vertical service delivery models. Tick response that applies- only one response is allowed)				
I prefer vertical services				
Same/any model can do				
I Prefer integrated services				
I highly prefer integrated services				
13. As a client what would you say has been the impact of integrating mental health into PHC on the following service dimensions. Did it decrease, increase or not change (Read each dimension below)?	De-crease	No change	In-crease	Don't know
13a. Cost of accessing services				
13b. Efficiency of services				
13c. Time I spent at the facility				
13d. Perceived quality of services				
13e. Privacy and confidentiality				
13f. Stigma at facility level				
13g. Other impacts (specify and rate)				
14. As a client what would you say has been the impact of integrating TB into PHC on the following service dimensions. Did it decrease, increase or not change (Read each dimension below)?	Decrease	No change	Increase	Don't know
14a. Cost of accessing services				
14b. Efficiency of services				

Question	Responses			
14c. Time I spent at the facility				
14d. Perceived quality of services				
14e. Privacy and confidentiality				
14f. Stigma at facility level				
14g. Other impacts (specify and rate)				
15. Generally speaking, do you experience any challenges in receiving mental health and TB services in this medical facility?				
Yes				
No				
16. If you do, please list those challenges				
17. What are your recommendations on how those challenges can be addressed?				

18. The Kazakhstan Ministry of Health plans to integrate HIV/AIDS response into PHC, based on your experience in accessing integrated services, we would like to hear your opinions on this:

- a. Do you think it will be beneficial?
- b. If yes, what will be the benefits?
- c. If no, why do you think it will not be of benefit?
- d. What are your recommendations on what will need to be done to ensure successful integration of HIV/AIDS prevention, treatment, care and support into PHC? (Probe on any health systems issues that will need to be addressed)

19. Do you have any other issue you may want to share?

Annex 6.6. KII guide for Service Providers at the AIDS Centers

Date of the interview: _____

District: _____

Name of the Center for the Prevention and Control of AIDS: _____

Interviewee number: _____

Cadre/title of the interviewee: _____

Name of the interviewer: _____

Signature of the interviewer: _____

Question	Responses			
	Yes	No		
1. What HIV/AIDS prevention and control services are offered at this AIDS Center? (Read all answers and check Yes where applicable)				
1a. General HIV testing and counseling				
1b. Provision of condoms				
1c. HIV information and education				
1d. Provision of ARV drugs				
1e. Treatment of opportunistic infections				
1f. HIV/AIDS prevention and control services for IDUs				
1g. HIV prevention and control services for MSM and other key populations (list services offered)				
1h. PMTCT services				
1i. Viral load testing				
1j. Early diagnosis for infants				
1k. Other (Please specify)				
2. Does this AIDS Center provide any PHC services?				
3. If yes, what PHC services are offered in this health facility? (Read all and mark Yes or No where appropriate.)				
3a. Family planning				
3b. Antenatal care services				
3c. Delivery/maternity services				
3d. Postnatal care services				
3e. Immunization services				
3f. Treatment of childhood illnesses				
3g. Adolescent health services				

Question	Responses			
3h. Treatment of STIs				
3i. Treatment of Non-Communicable Diseases (NCDs)				
3j. Diagnosis and treatment of TB				
3k. Mental health services				
3l. General outpatient services				
4. If PHC services are integrated into this AIDS Center, how are they integrated into HIV/AIDS prevention and control services? (Check "Yes" or "No" where applicable. Multiple answers may apply if different PHC services are integrated using different models)				
4a. Located in the same service site with the same provider				
4b. Located in the same service site but with different provider				
4c. Referral to a different site but in same facility				
4d. Referral to a different facility				
5. Has the AIDS prevention and control service in this facility been reoriented in any way towards PHC services?				
6. If yes, please describe in detail how the provision of AIDS prevention and control services in this facility has been reoriented towards integrating AIDS prevention and control services?				
7. Based on your experience in integrating PHC services into AIDS Centers, what would you recommend for ways to reorient PHC clinics to support the integration of HIV/AIDS prevention and control services?				
8. Are there cases when clients are referred for PHC services to another facility?				
9. If so, are there any follow-up actions taken to ensure that clients refer to and receive the services they are referred to?				
Yes				
No				
Don't know				
10. If yes, please explain how the follow-up actions are carried out?				
11. If yes, is there any referral form that is used?				
Yes				
No				
Don't know				
12. Based on your experience in integrating PHC services into HIV prevention and control services, please rate each of the following activities in relation to how significant barriers to integrating HIV/AIDS prevention and control services into PHC services may be. Could you say that this is not a constraint, or is a constraint, either small, medium or large?	Not a constraint	Small	Medium	Large
12a. Lack of equipment for the provision of integrated services				

Question	Responses			
12b. Shortage of premises for the provision of integrated services				
12c. Shortage/absence of drugs and other supplies for the provision of integrated services				
12d. Lack of sufficient staff for the provision of integrated services				
12e. Insufficient staff training for the provision of integrated services				
12f. Low staff motivation				
12g. Weak supervision				
12h. Lack of data collection tools				
12i. Lack of proper guidelines/standard operating procedures				
12j. Other constraints (please specify)				
13. How has the integration of PHC services with HIV/AIDS prevention and control services at this AIDS Center affected the following service levels? Did they decrease, increase or remain the same (answer each item below)?	Decrease	No change	Increase	Don't know
13a. Cost of services (for facility)				
13b. Cost of services (for client)				
13c. Efficiency of services				
13d. Stigmatization				
13e. Workload for providers				
13f. Time spent per client				
13g. Quality of service to client				
13h. Service quality				
13i. Integrated nature of services received				
13j. Other impacts/outcomes (please specify)				

14. I would like to understand how you plan to provide services for the prevention and control of HIV/AIDS and PHC services in this facility:

- Do you carry out joint planning of HIV/AIDS prevention and control services and PHC services? If yes, please describe in detail how this is done?
- Do you have joint plans for the provision of HIV/AIDS prevention and control services and PHC services? If yes, ask for a copy of joint plans for the provision of HIV/AIDS prevention and control services and PHC services?
- What difficulties do you face in joint planning of HIV/AIDS prevention and control services and PHC services? How do you deal with these difficulties?
- In the event that Kazakhstan moves towards integrating HIV/AIDS prevention and control services into PHC services, what would you recommend on how the country can improve joint planning?

15. I would like to understand how you are reporting, monitoring and evaluating the delivery of HIV/AIDS prevention and control services and PHC services:

- Do you jointly collect data on HIV/AIDS prevention and control services and PHC services, or do you collect data vertically for each stream? Please explain your answer.
- Do you use integrated data collection tools/registers for HIV/AIDS prevention and control services and PHC services? Please explain your answer (Research: If integrated, ask for details on integrated data items). If not integrated, explain why (ask to see a copy of the registries)
- What reporting, monitoring and evaluation challenges do/have you encountered in integrating PHC services into HIV prevention and control services? How did you overcome them?
- Based on your experience, what challenges do you think will be associated with integrating HIV/AIDS prevention and control services into PHC services? What would you recommend to address them?
- In the event that Kazakhstan moves towards integrating HIV/AIDS prevention and control services into PHC services, what would you recommend to improve reporting, monitoring and evaluation of the integrated response?

16. I would like to know about your medical staff who provide integrated HIV/AIDS prevention and control and PHC services:

- Do the same health care providers provide both HIV/AIDS prevention and control and PHC services? Or are the services provided by different providers? Please explain your answers.
- How have you strengthened the capacity of your medical staff to provide both HIV/AIDS prevention and control and PHC services?
- What human resources for health challenges have you encountered in integrating PHC services into HIV prevention and control services? How did you overcome them?
- Based on your experience, what human resources-related health challenges do you think a country will face when integrating HIV/AIDS prevention and control services into PHC services? How would you recommend to address these challenges?
- In the event that Kazakhstan moves towards integrating HIV/AIDS prevention and control services into PHC services, what would you recommend in the field of human resources for health in terms of strengthening medical capacity in the provision of integrated PHC and HIV/AIDS prevention and control services?

17. I would like to understand how you manage medicines and consumables for the provision of integrated HIV/AIDS prevention and control and PHC services:

- Where do you get HIV/AIDS medicines and other consumables? What about PHC? Are their sources and distribution channels integrated or do they come from vertical sources? Please explain your answers.
- I would like to understand what challenges you faced related to medicines and consumables for the provision of integrated HIV/AIDS prevention and control and PHC services: How did you overcome them?
- What difficulties do you think the country will face as it moves towards integrating HIV/AIDS prevention and control services into PHC? How would you recommend to address these difficulties?
- Overall, in the event that Kazakhstan moves towards integrating HIV/AIDS prevention and control services into PHC services, what would you recommend in terms of strengthening procurement, distribution and management of medicines and consumables to ensure successful integration HIV/AIDS prevention and control and PHC services?

18. In general, would you support the country's policy decision to integrate HIV/AIDS prevention and control into PHC services?

19. If yes, what are your reasons for recommending it? What are the benefits of integration?

20. If not, why would you NOT recommend it? What will be the disadvantages of integrating HIV/AIDS prevention and control services into PHC? (Research on the quality of services, stigmatization and discrimination, etc.)

21. Do you think the country's PHC system is ready for integration of HIV/AIDS prevention and control services into PHC? Please explain your answer.


22. What would you recommend on ways to strengthen PHC services to ensure effective integration of HIV/AIDS prevention and control services?

23. What role do you think AIDS Centers can play in supporting the country to effectively integrate HIV/AIDS prevention and control services into PHC? (Investigation of the role in conducting trainings, etc.)



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