ACCESS TO HEALTH CARE IN HEALTH SYSTEMS AND POLICY IN CENTRAL ASIA: A CASE OF GENDER

Tatiana Chubarova, Natalia Grigorieva

Paper prepared for Conference on "Health Policy and Politics in Developing Societies: Asian and Global Issues" (28-29th November 2014, Kyoto, Japan)

Abstract

The paper deals with gender dimension of health system and health policy in modern societies. The five countries in Central Asia – Kyrgzstan, Kazakhstan, Uzbekistan, Turkmenistan, and Tajikistan – provide a good example to investigate the problem for several reasons. These countries have made a commitment to reform their health-care systems though are at varying stages of implementing changes involving financing and provision of health care during the transition from a centrally planned to a market economy. The existing evidence suggests that today population in countries in question experience problems in access to equitable healthcare. Besides, these countries find themselves at a crossroads in terms of their cultural identity as most of political aims of health reforms are based on values and mechanisms of the Western developed countries.

The paper investigates in what instances women across the region face barriers in assess to health care and how it affects their health status, what measures are undertaken by governments to address the situation. Particular attention is paid to maternal health and services as maternal mortality rates are still quite high in the countries in question.

The analysis revealed that the issue is poorly researched and definitely the potential of taking into account gender dimension is underestimated. The authors argue that gender

approach should become an integral part of health care polices in the countries of Central Asia based on understanding of importance of gender issues for the development of their societies. The idea of “gender points” is suggested to stress that gender approach in health system involves addressing health needs of both men and women as a way to increase the overall efficiency of health care systems.

Introduction

The Central Asian (CA) countries differ significantly in social and economic and political terms.(see table 1). The data shows for example the difference in GDP per capita - 10 770 PPP in Kazakhstan and only about 2 000 PPP in Kirgizstan, or almost 5 times less. According to WTO classification they fall into different income categories. Even more they had substantial differences when they were parts of the Soviet Union. In political terms each country has its own specifics as well - authoritarian modernization in Kazakhstan with its relative stability, civil war between various clans in Tadjikistan, political upheavals and instability of elites in Kirgizstan, «closed» posy-communist authoritarian regime in Turkmenistan and political stability under strong government in Uzbekistan.1

[1] Постсоветская Центральная Азия: потери и обретения. М: РАН. 1998.

Table 1
CA countries --key statistics

	Population 2012, end of the year mln	WTO classification	GDP per capita (inter.doll. PPP)	The life expectancy at birth, 2012		Probability of dying (per 1000 live births) up to 5 years	Probability of dying between the ages of 15-60 years (per 1,000).	
				men	women		men	women
Kazakhstan	16,9	Upper middle income	10,770	65	74	28	432	185
Turkmenistan	5,2 (2005)	Low middle income	7,490	60	67	53	380	212
Uzbekistan	29,9	Low middle income	3,110	66	71	49	220	139
Tajikistan	8,0	Low income	2,140	71	75	63	183	160
Kyrgyzstan	5,7	Low income	2,070	66	74	31	327	162

Source: Global Health Observatory, 2013

In demographic terms the steady population growth is to be noted in CA countries that is explained by high birth rates, high share of young generations and relatively low mortality

rates. In Tadjikistan annual population growth exceeds 2%, in Uzbekistan it amounts to about 1,7%, in Kirgizstan-1,3%. Only in Kazakstan there was a tendency for population to decline in 1990s but it was reversed in early 2000 and now the annual population growth is about 1,5%.

Oasis type of settlement leads to the fact that population density vary betweenn different parts of the country. For example in Uzbekistzn it reaches a maximum of 400-450 people / km2 (Andijan and Ferghana region of Uzbekistan) but and at the same time in a desert in the Navoi region there is no permanent population.

All CA countries had to go thought transition period that turned out to be quite painful for people. No country in the world had any experience before in moving from a centrally planned to a market economy. Definitely, modern health care reforms in CA countries are an integral part of the overall structural changes taking place in these countries that transform entire socio-economic system in society. Before the transition started as their health care was organized along the same rules as Semashko model.

The aim of this paper is to analyse in more detail gender aspect of health care as gender may affect assess to health care. It is suggested in the paper that health systems development and health policy formulation and implementation should take into account social status of men and women in the modern societies that is best of all reflected by the idea of gender. The aim is to secure gender equality in assess to health care.

Access is an ill- defined concept because it its complexity. For the purpose of this paper it is understood as having "the timely use of personal health services to achieve

the best health outcomes".2 According to WHO accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economical accessibility (affordability) and information accessibility. 3

The paper consists of three sections. The first one provide general overview of health systems and reforms in the countries in question from the point of view of barriers to access, the second one deals with gender in health, the third section discusses gender issues in access to health care in CA countries with special reference on maternity services.

The paper has important limitation. There is a lack of both empirical and analytical comparative studies on gender and health in CA countries while statistical data available is often fragmented. In this paper we use WHO, Statistical Committee of the CIS and national governments health indicators database. Some CA countries provide gender statistics, three of them (Kazakhstan, Kyrgizstan and Tadjikistan) on the internet. Turkmenistan and Uzbekistan are more closed and statistic data is lacking on many gender and health indicators.

The most striking example is Turkmenistan, where Medecins Sans Frontieres (MSF) closed its office in 2010 after the Turkmen authorities failed to support its project proposals, thus making it impossible for the organization to carry out its work in the country. According to MSF final report, health care system in the country was not transparent and failed to

---

[2] Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. Access to health care in America. Washington, DC: National Academy Press; 1993

[3] WHO. The right to health. Fact sheet N°323. Reviewed November 2013

provide accurate data on population health status that may lead to a serious health crisis.

Health Systems and Reforms in CA: Barriers to Assess.

Being a part of the USSR affected very much the development of health systems in the region. Before 1990-s they have Semashko model and made a dramatic progress in health indicators and development of health systems infrastructure.

In the early 1920s the population, especially in rural areas, were mostly illiterate, and life expectancy was 40 years below. Over the next 70 years the region has achieved almost complete literacy, and life expectancy has risen to 68-70 years.

However, their health indictors were below USSR average that was reflected in mortality rates and life expectancy at birth. Child mortality rate (per 1000 births) was quite high though gradually decreasing with considerable variations among Republics. In 1989 it was in Turkmenistan - 54,7, Tatjikistan-43,2, Uzbekistan- 37,7, Kirgizstan-32,2, Kazakhstan-25,9. (to compare with in Belarus - 11,8, Ukraine -13,0, Russia - 17,8).

It should be noted that though countries in question made a remarkable advancement during Soviet power in their social and economic development they still lagged behind European Soviet republics in health indicators.

In early 1990s the five CA Soviet republics became independent states and started structural societal reforms to include health care systems. 4 The transition seriously affected

[4] Vardomsky L. 2012. New independent states: comparing outcomes of social and economic development. Research paper. Institute of Economics, Russian Academy of Sciences.

their economic and social development. Besides, as it was mentioned above some of them suffered from military conflicts and political upheavals that have had a serious impact on social situation.

CA countries implemented health reforms that establish market mechanisms in the health sector to various degrees. In early 1990s their health system were financed from general revenues, health services were provided by a public facilities infrastructure under central planning, physicians reimbursed based on salary. Since then, most countries adopted social health insurance, switched to fee-for-service or diagnosis-related groups (DRGs) for hospital payment. reimbursed primary care doctors by capitation, fee-for-service, or combination of the two. introduced patients' cost sharing and reorganised health services.

However in 2000 WHO ranked CA countries on such indicators as improving health status, health systems responsiveness to people expectations, fairness of financial contributions were quite low (see Table 2). Unfortunately, expectations that have been associated with the ongoing health reforms were not fulfilled.

Table 2

WHO 2000 ranking-CA countries

Country	WHO 2000 rank
Kazakhstan	64
Uzbekistan	117
Kyrgyzstan	151
Turkmenistan	153
Tajikistan	154

Source: World Health Report, 2000. Health systems, improving performance. Geneva, WHO. 2000.

Table 3
Central Asia in "The World's Healthiest Countries"

Rank	Country	Health grade	Total health score	Health risk penalty
1	Singapore	89,45	92,52	3,07
…….	….	…	…	…
84	Tadjikistan	38,27	43,50	5,22
85	Uzbekistan	37,89	41,67	3,79
101	Kyrgyz Republic	24,62	29,98	5,36
104	Turkmenistan	21,88	27,67	5,79
111	Kazakhstan	18,41	24,58	6,17

Source: BLOOMBERG RANKINGS. THE WORLD'S HEALTHIEST COUNTRIES, May 2012.

The potential barriers to asses to health care that can be identified in CA countries are as follows.

1. The state of health care system changed dramatically during the transition to include shrinking health facilities especially in the state sector. The number of hospital beds has decreased substantially both in absolute and relative terms. In Kazakhstan the reduction was almost twofold – from 136 beds per 10000 of population in 1989 to 67 in 2012 (See table 4). The number of physicians decreased in the majority of CA countries as well, except Kazakhstan.

Table 4.
Selected health systems indicators in CA countries

	# of hospitals	# of policlinics 000	# of hospital beds		# of physicians		# of nursing staff	
			000	per 10000	000	per 10000	000	per 10000
Kazakhstan								
2000	938	3.2	107	72	49.0	33	106.	72
2005	1063	3.4	118	77	55.5	37	120.	79
2012	990	3.7	113	67	64.4	38	168.	100
Kyrgyzstan								
2000	321	0.6	36.6	75	14.3	29	37.0	76
2005	159	0.2	27.7	54	13.4	26	30.4	59
2012	177	0.2	27.7	49	13.4	24	32.3	57
Tajikistan								
2000	441	1.0	41.2	66	13.5	22	32.2	52
2005	454	1.2	40.6	59	13.3	19	28.9	42
2012	444	1.5	38.1	48	16.3	20	38.6	48
Turkmenistan								
2000	114	…	24.4	50	14.0	29	38.1	79
2003	125	….	26.6	53	14.0	28	34.1	69
Uzbekistan								
2000	1162	4.8	139	56	81.5	33	260.	105
2005	1159	5.5	142	54	76.5	29	271.	103
2008	…	….	137	50	71.3	26	…	…

Source: Statistics of CIS. 2012, №7. P. 79

The average length of stay in hospitals decreased during the transition period in all CA countries and is now comparable with the developed nations. In 2012 it amounted to 8 days in Uzbekistan and Turkmenistan, 12 days in Tajikistan and Kazakhstan, 13 days in Kirgizstan. Though the decrease was more dramatic as to 1989 indicators for Uzbekistan and Turkmenistan (by 50 %) than Kirgizstan (by 14%).

This trends are alarming when access is discussed especially taking into account the predominance of the rural population in CA countries. Its share is the lowest in Turkmenistan (55%), and the highest in Tajikistan - 72%. The urbal populations is concentrated usually in capital cities, for example Tashkent has nearly 2.5 million residents.

2. Under the conditions of economic crisis after transition on the background of disruption of economic links between the countries in questions health care financing both in terms of collecting and distributing funds available became a crucial issue for all of them.

Table 5
Health expenditures in CA countries, per capita

Member state	Total expenditure on health per capita at average exchange rate (U.S. $)				Total expenditure on health per capita (PPP int. Dollars)			
	2000	2007	2008	2011	2000	2007	2008	2011
Kazakhstan	51	253	333	458	198	405	446	534
Kyrgyzstan	13	46	54	71	62	130	123	152
Tajikistan	6	48	37	48	40	---	95	120
Turkmenistan	45	--	69	114	82	---	124	195
Uzbekistan	32	41	51	91	82	121	134	193

Member state	Public expenditure on health per capita at average exchange rate (U.S. $)				Public expenditure on health per capita (PPP int. Dollars)			
	2000	2007	2008	2011	2000	2007	2008	2011
Kazakhstan	26	167	195	265	101	268	259	309
Kyrgyzstan	6	25	26	42	27	70	27	91
Tajikistan	1	---	10	14	8	---	26	36
Turkmenistan	36	--	40	73	65		72	125
Uzbekistan	14	19	26	46	36	56	26	98

Source: World health statistics

Health expenditures (as a share of GDP) in these countries rangr from about 2 % in Turkmenistan to 6% in Kyrgizstan (see table 5). But the breakdown of these expenses is even more important (Table 6).

Table 6

Health expenditures in CA countries

	Total expenditure on health as % of GDP				General government expenditure on health as % of total expenditure on health			
	2000	2007	2008	2011	2000	2007	2008	2011
Kazakhstan	4.2	3.7	3.9	3..9	51,0	66,1	58,5	57.9
Kyrgyzstan	4.7	6.5	5.7	6.2	44,3	54,0	48,4	59.9
Tajikistan	4.6	….	5.0	5.8	20,4	….	27,7	29.6
Turkmenistan	4.0		1.9	2.1	81.8			63.8
Uzbekistan	5.7	5.0	4.9	5.6	44,1	46,1	50.5	50.9

	Private expenditure on health as % of total expenditure on health				General government expenditure on health as % of total government expenditure			
	2000	2007	2008	2011	2000	2007	2008	2011
Kazakhstan	49,0	33,9	41,5	42.1	9,.2	11,2	8,3	10.5
Kyrgyzstan	55,7	46,0	51,6	40.1	8,3	9,8	11,5	11.6
Tajikistan	79,6	….	72,3	70.4	6,5	….	5,0	6.2
Turkmenistan	20,4		42.2	36.2	13,7		7,0	8.7
Uzbekistan	55,9	53,9	49,5	49.1	6.0	7,9	8,6	9.0

	External resources for health as % of total expenditure on health				Social security expenditures on health as % of total government expenditure on health			
	2000	2007	2008	2011	2000	2007	2008	2011
Kazakhstan	7,4	0,4	0,2	0.8	0	0	0	0
Kyrgyzstan	9,9	11,3	12,6	10.8	10.0	50.9	69.5	64.1
Tajikistan	2,3	….	10,5	14.3	0	0	0	0
Turkmenistan	1.4		0,4	1.1	6..5	….	6..5	6..5
Uzbekistan	6,2	1,6	2,4	2.0	0	0	0	0

	Out-of-pocket expenditure as % of private expenditure on health				Private health insurance as % of private expenditure on health			
	2000	2007	2008	2011	2000	2007	2008	2011
Kazakhstan	99.0	98.4	98,7	98.7	0.1	0,1	0.2	0.2
Kyrgyzstan	89.3	91,9	81.2	86.0	0	0	0	0
Tajikistan	99,0	….	95.1	85.4	0	….	0.1	0.1
Turkmenistan	100	100	100	100	0	0	0	0
Uzbekistan	97.0	98.0	98,0	94.0	0	0	0	0

Source: World health statistics

There is a steady increase in the volume of out-of-pocket payments both formal and informal. The share of out-of-pocket payments in private expenses exceeds 90% in Kazakhstan, Tajikistan and Uzbekistan, in Turkmenistan it amounts to 100%. It slightly decreased in Kyrgyzstan and Tajikistan (Table 6).

The practice of informal payments is widespread in the CA leading to formation of “shadow health economy”. They

include institutional or individual payments to suppliers, in kind or in cash, which are made outside the official channels or paid for services that should be covered by the health care system5. With the reduction of government spending and low wages paying medical staff directly has become almost a norm. In some cases, these payments may help to overcome waiting lists. Some countries have gone so far as to formalise such payments. This usually goes together with the introduction of a basic health package that formally includes services that are provided to the public free of charge and are funded by public means-- social security contributions or taxes. The peculiar feature is that fee for service may be charged officially by the state health establishments for services provided extra to such a guaranteed package 6.

An analysis of introduction of compulsory health insurance (CHI) turned out to be problematic. The statistics show that it might be intention rather than reallity. Data indicate that only in Kyrgistan social security contributions amount to a sizeble share of public health funds. Kazakhstan inroduced CHI in 1996 but later returned back to budget funding.

The expirience of the CA countries differs from that of the Western world as in these countries replaces free services provided by the state rather than private expences as it was the case in Western Europe.7 Perhaps this explains to a large extent why models of CHI developed in the region might not sit well with the countries' social and economic realities. At

---

[5] Lewis M. 2007. Informal Payments and the Financing of Health Care in Developing and Transition Countries. Health Affairs. 26: 4.

[6] "Rossiyskaya Gazeta" № 5906, October 10, 2012

[7] Kovalevsky M. Main guarantee of free medical care in the CIS members. Compulsory health insurance-legal issues/ federalbook.ru

the same time voluntary health insurance (VHI) is not developed in the CA countries amounting to less than 1% (Tajikistan – 0.1%, Kyrgyzstan – 0.2%).

Donors play important role in health reform especially in Kyrgyzstan and Tajikistan. However, their influence is not only financial but technical as well making foreign assistance even more important for health reforms. A recipient should implement important structural changes, some of them are controversial as they are typically based on certain ideological preferences of the donor while national (objective and subjective) conditions might not be given a due account 8.

The paradox of the situation is that the high share of private finance corresponds with a high share of population living in poverty. In Tajikistan where about 50% of population lives below national poverty line (2009) private health expenses amount to 70.4 %. The share of population living on less than 2 dollars per day amounts to 27,7 % in Tajikistan and 22% in Kirgizstan.

Important quality of life indicator for CA countries is access to good quality water. In rural areas only 57 % of population has access to water in Tadjikistan, 54 % in Turkmenistan, 81% in Uzbekistan and 85% in Kirgizstan.

3. Lack of public resources allocated to health care is likely not only to limit assess to health care but to change relevant policies. In Constitutions or relevant health care legislation in CA countries the right to health care is declared but the state is not in a position to secure it. Access is quarantined only within the certain limits (minimum) that are provided by the public system free (at the point of delivery)

[8] For details see: Global Social Policy, 1997

and private health services as well as fee-for service are now mentioned as elements of health system alongside free public health care.

Gender and Health: an Overview

Gender is an important structural determinant of health. Interacting with other determinants - age, marital status, education, occupation, income, etc., it influences the provision of health care at all levels - individual, group, or society. It reflects the material and symbolic position of women and men in the social hierarchy, and experience that defines their lives. As a social determinant, gender should be taken into account in explaining the differences in health status between men and women and formulating health policy.

The idea of gender is based on the social model of health and is informed by the social research in health and health care. Breakthrough for the promotion of the social model of health was fixed in the definition of the WHO, as it clearly emphasized that health is a state of complete social, psychological and physical well-being and not merely the absence of disease. It became quite obvious that to solve contemporary problems of health and health care the most extensive correlation between the socio-economic situation is needed. Equality in health care - is, first of all, justice and fairness of health care for all, including for such large social groups as men and women.

Gender mainstreaming is a tool using which guarantees for representation of the interests of both women and men at the level of formulating problems and decision-making in health care can be secured. However, the gender approach to the analysis of various aspects of health is not yet a well developed issue in gender studies. This is due to the fact that gender in relation to health is a complex web of problems associated with both the biological and physiological differences between the sexes, and social component of

inequality between men and women. Gender theory addresses issues of health and health care rather than health policy takes into account gender aspects of health.

The gender dimension of health is based on the fact that social and cultural factors, as well as relations between men and women in society, play an important role in health systems. Hence, it is nessesary to identify those areas in which the health of women and men is at risk because of the distribution of their gender roles. The task of the gender approach in health care - to identify the impact of a disease or intervention on the health of men and women, as well as their social consequences, in other words, to show how access to resources affects the differences in health status and access to health care.

Gender mainstreaming in the health sector means addressing the role of social, cultural and biological factors that influence health outcomes, and therefore, improve efficiency, coverage and equity of health programs.

It should be noted that at present still gender approach is not widely used for the analysis of health status and monitoring and evaluation of health systems in the post-Soviet space. Very few studies on this topic, mainly covering specific sectors, for example, reproductive health or HIV infection 9.

In 2002, a practical guide to gender mainstreaming in the New Independent States (second edition, 2005) was prepared by the Regional Center of UNDP, that formulated the main objectives of promoting gender mainstreaming in health, namely:

liquidation of life expectancy gap between women and men;

comprehensive record of the incidence of diseases and other health problems (sex-disaggregated data on the number

---

[9] Grigorieva N. Gender and Health // Gender problems in Russia (national Publications 2008-2012) M., 2013.

of diseases and ailments, the development of prevention and treatment based on gender, overcoming the barriers that make one sex more vulnerable than others);

ensuring the highest standard of sexual and reproductive health, guarantees of the complete information about the services of all women and men throughout the life cycle;

understanding of the gender impact of health sector reform and their consideration in the implementation and monitoring of reforms;

ensuring full and equal access to both men and women in all health care
adoption of measures to prevent violence and ensure the care of victims of violence from a gender perspective.10

The CA countries special laws on gender were adopted. It was influenced much by the model law on that was adopted by the Interparliamentary Assembly of members of the Commonwealth of Independent States in 2005. Tajikistan (2005); Kyrgizstan (2008), Turkmenistan (2007) и Kazakhstan (2009). In Uzbekistan the relevant norms were fixed in article 46 of Constitution, and in 2002 was accepted by the Cabinet of Ministers of the Republic of Uzbekistan "On additional measures to improve the health of women and the younger generation" (2002).

In all countries, soon after independence, the national mechanisms for the advancement of women were established (they are called in different ways), as well as special national institutions (mostly Commitions or Comittees on womens' issues) responsible for carrying out the strategy of gender equality. For example, in Kazakhstan, from the moment of creation in 1998, and until 2006 it was called the National Commission on Family and Women Affairs under the

---

[10] Gender Mainstreaming in Practice: A Handbook UNDP Regional Centre for Europe and the CIS. UNDP RBEC. 2nd edition, 2005.

President of the Republic of Kazakhstan. In 2006 its name was changed to the National Commission on Family Affairs and Gender Policy. Since 2012 it is called the National Commission on Women's Affairs and Family and Demographic Policy. At the same time, the National Action Plan on Gender Equality for 2006-2016 includes gender mainstreaming in education, health, etc. to eliminate first of all gender stereotypes.

In Kazakhstan and Kyrgyzstan, gender rules are formulated in laws on the state guarantees of equal rights and equal opportunities for men and women, ie we can say that this is above all laws to ensure the advancement of women. Often in the official documents gender equality is implied rather than stated explicitly.

The specifics of gender in relation to health systems and policy in CA countries flow from both their Sovet past and modern health systems development 11. In fact under the Semashko model men and women were treated equally and had equal access and thus equal status in health system. Probably women had a higher gender status as protection of mothers health was separated as a independent stream of health policy starting from 1918. As a result the necessity to introduce gender approach in health care in its western understanding became important only when reforms started in the begging of 1990s. Decline in living standards, lack of access to material and financial resources, employment problems, reduced social support, that is the whole complex of social and economic problems affected primarily women, their social status in society and forced to talk about their discrimination.

---

[11] Chubarova Tatiana and Grigorieva Natalia (2013) Patterns of Health Care Reforms in Economies under Transition: The Case of Russia // Health Reforms in Central and Eastern Europe: Options, Obstacles, Limited Outcomes. J.W.Biorkman, J. Nemec (eds.). Eleven International Publishing. Hugue.

One of the most widely used indicators in gender statistics is life expectancy at birth. Gender gap reflects the difference in life expectancy between women and men. For example, in Kazakhstan in 2004 the life expectancy was for women - 67.0, men - 56.0, that is, women do not live to 70 years and men to 60 . Thus, gender gap was 11 years. By 2012 these indicators improves - 70 and 59,0, respectively. But gender gap remained the same - 11 лет; at that the number of women in total population increased approximately the same as men (from 8.110,0 in 1995 to 8 750,0 in 2012г., or by 640 thousand; мужчины с 7 565,8 в 1995г. до 8 158,9 в 2012 г., т.е. на 693,1).

In Kyrgizstan for the same period life expectancy at birth was 63 years (67.0 for women and 59 for men) thus making gender gap of 12 years. In 2012 these indicators somewhat improved (women – 70.0, men – 63.0) but gender gap slightly increased to 13 years.

The situation in other CA countries is better. In Tajikistan life expectancy at birth increased for the period of 2004-2014 from 64 to 69 for women and from 62 to 66 for men. The gender gap is only 3 years that corresponds with good international standards. In Turkmenistan Туркменистан – from 65 to 67 for women and from 56 to 60 for men, gender gap improved from 9 to 7 years. In Uzbekistan – from 71 to 74 for women and from 66 to 70 for men, gender gap 5 years.

If to take the GDP per capita into account it is to be noted that Kazakhstan has the highest GDP per capita in the region but one of the biggest gender gaps of 11 years while Tajikistan has a 5 times less GDP per capita but gender gap is only 3 years. Besides life expectancy in these countries differ widely in different regions within a country. Which again suggests that the lives of men and women can have a strong influence differences in the environment, traditions, and, above all, the economic and social gender roles, which took over the men and women in a particular country.

Impressive achievements of CFA countries to include relatively good human development outcomes and high literacy rates including female set them apart from their neighbors of comparable income. Besides after the decay of the USSR these countries were included into European commission as a result they are often discussed within European context not within regional context.

As Access to Health Care in CA Countries: From Maternity to Gender data demonstrates, HDI for female in all CA countries except Kazakhstan is slightly less than for male. It is important to note that HDI for female is higher in CA countries relatively to the average for medium human development countries. These countries are ranking better on gender inequality index than on general HDI.

One of the gender health indicator is maternal mortality rates that is quite high in CA countries though national statistics report their steady decline in 2000s. In 2012 materenal mortality ratio per 100000 of live birth was 13 in Kazakhstan, 49 in Kirgizstan, 20 in Tajikistan (2009).

It should be admitted that the Central Asian countries devote considerable effort to maternal and child health. They all have special governmental programmes targeted on maternal and reproductive health.

In many ways it's a tradition, as maternal and child health was a priority health policy priority in the USSR. At the same time, in the 1990s, all countries experienced a sharp decline in almost all indicators of the health of pregnant women, mothers and children. In addition, the state of health of mother and child is one of the key indicators of the Millennium Development Goals, countries reports to CEDO Committee on Women and Human development index.In addition, after the collapse of the USSR declines in this sphere was in a sharp contrast with what it was before 1990s. As a result all ccountries pay attention to mother and child health

issues and a positive dynamics in maternal mortality is observed.

A case of Kazakhstan is instructive: the situation there is most favorable of all CA republics, and whrere leadership sets ambitious social and economic goals. It managed to reduce the number of abortions in the whole country, and what is especially important - among girls aged up to 18 years. However, the proportion of pregnant women among HIV-infected increased - from 11% in 2008 to 17.0 in 2012. Especially alarming fact is a growing number of youth HIV infection among women aged 15-29 years. And at the same time as a positive fact, it should be noted decrease in the number of HIV infection among young men aged 15-29 from 28.0 in 2008 to 17.1 in 2012.

In obstetric care the number of antenatal, obstetric and gynecological surgeries wards increased from 877 in 2008 to 1,018 in 2012 while numbers of gynecologists remain approximately the same (10.2 per 1,000 live births in 2008 and 10.3 in 2012), and the number of beds for pregnant women, women in childbirth and postpartum women decreased from 28.2 in 2008 to 25.0 in 2012.

In the analysis of the state of health draws attention to a whole different kind of reduced complications during pregnancy and childbirth, but at the same time increased the number of premature births (14.3 in 2008 and 22.3 in 2012), some of which might be explained purely social reasons.

However, new risks are to emerge that require specific attention on the part of health policy. They are connected to the fact that position of women in CA countries is likely to deteriorate.

Women constitute the majority of the poor in the countries of Central Asia, they earn almost 1.6-2 times less than men, and their avarage pension is approximately 60% of men.

The structure of employment changed, and today the number of women who are employed only in unpaid domestic work increased. In market conditions it replaces a large number of social services previously provided by the state (nursing, children, etc.). The society does not recognize the economic value of women's unpaid wor, including child care, and unequal distribution of household responsibilities is considered a form of discrimination against women.

The Central Asian states are in accordance with the provisions of its constitution, secular ones. However, in the past years the position of Islam has significantly improved. There is a significant influence of religious confessions on people in gender morality. An increasing number of Muslim schools and colleges where teaching is conducted from the perspective of the traditional view of women's status in the family and society.

In some cases, for example women may refuse the help of a male doctor. In areas of Kazakhstan with strong Muslim influence (in these same areas was apparent decline of women of marriageable age, and as a consequence of early pregnancy) there is a strong trend towards home birth. Muslim women prefer not to use the services of male doctors. In primary care work mostly female gynecologists, while in hospitals significantly the number of male gynecologists, as well as the men who carry out various diagnostic procedures. In the future, such situation may gradually change the composition of health professionals working in the field of maternal health.

The urban-rural differences in life conditions for women and men are also important. The population who lives in the remote rural areas maintains more traditional views on gender and sexuality.

As a consequence, despite the official recognition of the importance of gender policy, there is a subconscious resistance to the idea of gender equality. Active use of concepts of "mother-woman", "female homekeeper" stress first of all women role in the family, strongly emphasize the priority of the home of their reproductive role. A revival of gender stereotypes and their consolidation in the new social conditions. In addition, there is a hidden rejection of gender equality in various social groups, including those who have the status to put gender issues into practice.

The problem of violence against women is on the rise. For example, in Kazakhstan in 2005 it accounted for one in four crimes committed in the country. Half of the women who experienced violence, do not apply to law enforcement agencies.

The growth in fee-for services in health care affects first of all those who by virtue of the economic situation has fewer resources, mostly - women, especially in rural areas. Household spending on health services is incresing as well - in the Republic of Kazakhstan in 2008, they accounted for 2.176 tenge per capita, and in 2012 was almost 2 times more - 4285 tenge. The prices for certain types of medical services raised roughly in the same proportion (primary physician visit 592 tenge in 2008, and 1153 in 2012).

However gender means not only women but men health as well. Mortality rates reflect problems with men's health (Table 7).

Table 7

Mortality rates in Kazakhstan in 2012

	Total, numbers			Per 100 000		
	total	female	male	total	female	male
Total	142563	64142	78421	848,90	737,93	967,96
including						

from						
cardio-vascular diseases	43143	18613	24530	256,93	241,16	302,84
accidents and trauma	16416	3561	12855	97,76	40,97	158,70
neoplasms	17674	8242	9432	105,26	94,83	116,44
respiratory diseases	9719	3446	6273	57,88	39,65	77,44
digestive diseases	9924	3895	6029	59,10	44,81	74,43
infectious diseases	2009	596	1413	11,96	6,86	17,44

In general, the situation in the health sector in CA countries does not give grounds for fixing the strong gender problems in access to health care. Or, to be presice acceess barriers lay outside health system. But it is a sphere, which makes the society to pay attention to overcoming gender inequalities in health indicators of both men and women rather than only paying special attention to improving women's health.

We suggest that it might be useful to identify "gender points" in health systems – that means to define areas where health system should address specific health need of men and women in order to increase efficiency of health care.

Literature

Ahmedov M, Azimov R, Alimova V, Rechel B. Uzbekistan: Health system review. Health Systems in Transition, 2007; 9(3): 1–210

Ibraimova A, Akkazieva B, Ibraimov A, Manzhieva E, Rechel B. Kyrgyzstan: Health system review. Health Systems in Transition, 2011; 13(3):1–152.

Health Systems in Transition, Turkmenistan. 2000, European Observatory on Health Care Systems.

Katsaga A., Kulzhanov M., Karanikolos M., Rechel B.Kazakhstan: Health system review. Health Systems in Transition. 2012

Khodjamurodov G, Rechel B. Tajikistan: Health system review. Health Systems in Transition, 2010, 12(2):1–154

Gender and HIV/AIDS In Eastern Europe and Central Asia

UNAIDS, 2013. HIV in Asia and the Pacific. UNAIDS report 2013

World Bank. 1996. A survey of health reform in central Asia. WB technical paper 344.

Rechel B., Ahmedov M., Akkazieva B., Katsaga A., Khodjamurodov G., McKee M. Lessons from two decades of health reform in Central Asia. Health Policy Plan. 2012 Jul;27(4):281-7.

Ulikpan A., Mirzoev T., Jimenez E., Malik A., Hill PS. Central Asian Post-Soviet health systems in transition: has different aid engagement produced different outcomes? Glob Health Action. 2014 Sep 16;7

Health Care in Central Asia Ed. by M. McKee, J. Healy and J. Falkingham European Observatory on Health Care Systems Series Open University Press. Buckingham, Philadelphia. 2002

Economic Transition and Health Care Reform: The Experience of Europe and Central Asia. Prepared by A. Leive. IMF Working Paper Fiscal Affairs Department. March 2010

UNDP, 2005. Central Asia Human Development Report. Bringing down barriers: regional cooperation for human development and human security. The UNDP Regional Bureau for Europe and the Commonwealth of Independent States. 2005