

Gender Assessment in Kyrgyzstan

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List of abbreviations

DOT	Directly Observed Therapy
DR-TB	Drug Resistant Tuberculosis
GLEA	Gender and Legal Environment Assessment
HIV	Human Immunodeficiency Virus
MDR-TB	Multidrug-resistant tuberculosis
MHIF	Mandatory Health Insurance Fund
MoH	Ministry of Health
NGO	Non-Governmental Organization
PHC	Primary Health Care
PLHIV	People Living with HIV/AIDS
TA	Technical Assistance
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme

Executive summary

It is increasingly recognized that gender plays an important role in care-seeking and treatment access for tuberculosis (TB). The current technical assistance report, commissioned by the Stop TB Partnership contributes to the evidence base on which to build targeted TB interventions to better address gender-related barriers to health.

Kyrgyzstan's TB incidence, prevalence and mortality are disaggregated by gender. However, gender-disaggregated data on DR-TB and treatment outcome, particularly on those who are "lost to follow up", could have provided important additional information.

In the course of the gender assessment, we found no differences in TB treatment among men and women. Women and men stated that they did not experience any kind of discrimination or having been treated differently based on their gender. However, information from the focus groups leads to the conclusion that the health seeking behaviour differs substantially: women seek TB diagnosis at a later stage than men. Some of the factors contributing to delay among women were described as putting oneself as a woman in the least important position in the family, as well as fear of social isolation from the family or the community. Another factor the interviewees referred to was self-medication among women before seeking care at public services, especially if the socio-economic status of the family was low, fearing costs of diagnosis. This was not mentioned for men. Further research is needed to establish gender differences in the health seeking behaviour in cases of persons with TB symptoms is needed.

Stigma – among both genders - was described as a strong negative influence in the lives of people affected by TB. The stigma leads to the concealment of TB, potentially leading to a lack of TB awareness among the contacts of the TB patient thus contributing to the spread of TB. Many patients showed as well a very strong self-stigma. Self-stigma comprises the awareness of the stereotype, agreeing with it, and applying it to one self.

Further investigation into the extent and forms of stigma is strongly needed in order to understand the influence of it in the lives of the persons affected by TB and thus develop measures to act against it. The issue of stigma has to be addressed in order to ensure successful shift to ambulatory treatment.

During the expert interviews and the focus groups it was clear that the access to the health system is not influenced by gender. Women and men stated that they did not experience any kind of discrimination or having been treated differently based on their gender. It seems that the gender differences take place before the health system is contacted – the health seeking behaviour differs strongly, leading to women approaching TB diagnosis at a later stage than men.

The report identifies the need for additional data and follow-up studies with a more quantitative focus to fully understand how TB differently affects the lives of women and men and which gender specific barriers hinder access to TB diagnosis.

1 Gender and Legal Environment Assessment Approach and Methodology

The technical Assistance (TA) to conduct a Gender and Legal Environment Assessment (GLEA) in Kyrgyzstan has been supported by the Stop TB Partnership.

The assessment relied on primary and secondary research. The secondary research included a desk review of relevant studies, policy-related, regulatory and legal documents, especially the Kyrgyzstan's law "The law on the protection of the population against Tuberculosis", and the reports of the implementation of the ratified international conventions.

Primary research included two weeks of field data collection (semi-structured interviews and 15 focus groups in Bishkek and Chui provinces) and was preceded by an orientation. The aim of the orientation was to explain the basics of the assessment to the national stakeholders, introduce the assessment tool (UNAIDS and Stop TB Partnership Gender assessment tool for national HIV and TB responses) and form a consultative group for the assessment. A legal environment assessment questionnaire tool was developed specifically for the purpose of this assessment. The assessment team consisted of freelance consultants, Nonna Turusbekova and Samanta Sokolowski, accompanied and supported by members of the Kyrgyz Coalition against Tuberculosis.

The focus groups for the gender assessment were conducted mostly gender segregated, the ones for the legal assessment were mostly gender mixed. The focus group members shared their experiences of accessing diagnosis and treatment, their perceptions of differences between the genders, knowledge of their rights and possible breaches of these rights.

The key informants included representatives from the National Center for Phthisiatry, the national institutions and ministries involved in TB response, health care providers, international organizations, organizations providing technical assistance, civil society organisations and people affected by TB. A complete list of informants is provided in Annex A. At the end of the field collection a round table with various stakeholders was conducted in order to discuss and validate the data.

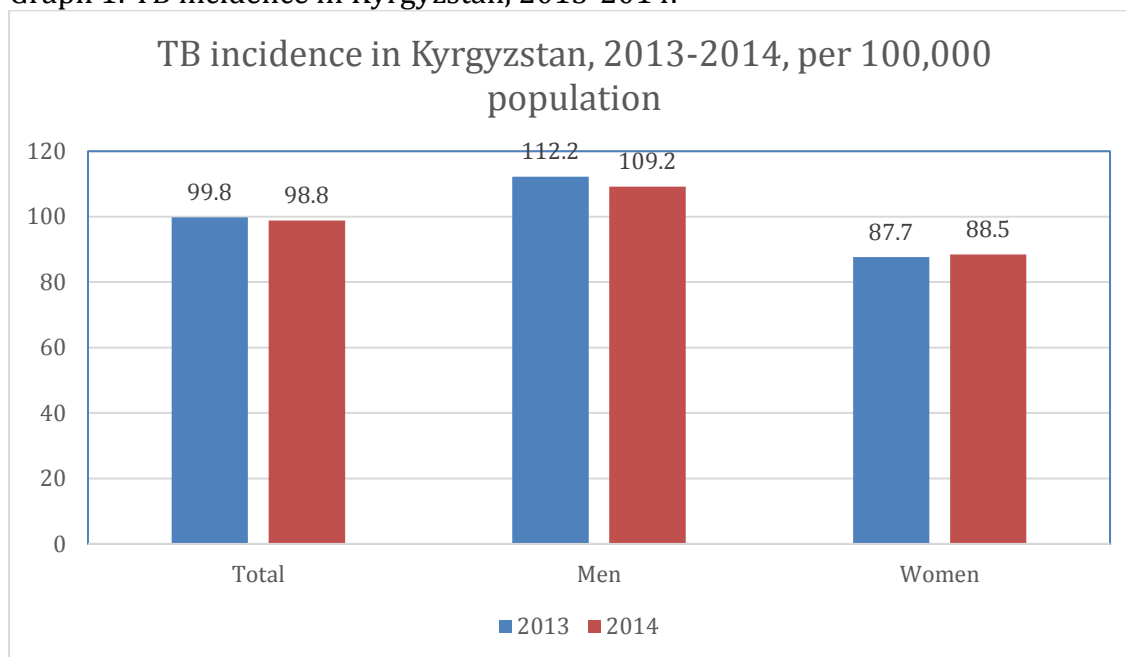
2 Findings

2.1 TB prevalence, incidence and behavioural information

TB prevalence in Kyrgyzstan is very high and it is among the WHO’s high burden lists for MDR-TB¹. Information about the country context is in Annex 2, information about Kyrgyzstan’s TB profile is in Annex 3.

From 2013 to 2014 there has been a slight decrease in the total number of people diagnosed with TB. The decrease is among the men, but among the women there is a very slight increase, as it can be observed in graph 1.

Graph 1: TB incidence in Kyrgyzstan, 2013-2014.

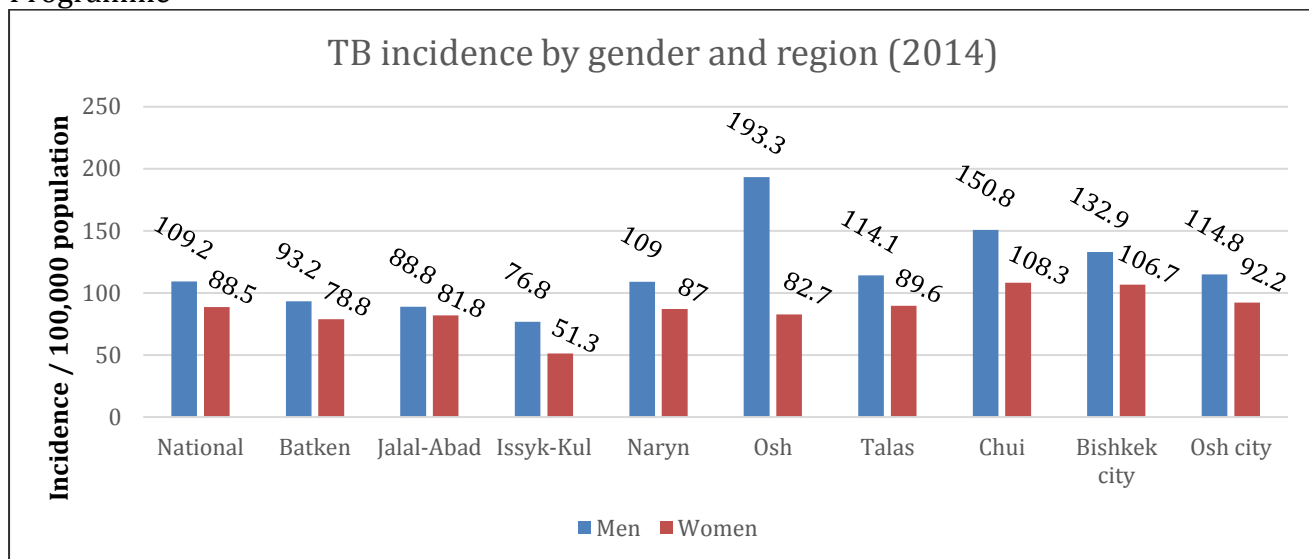


Source: National TB Programme

In graph 2 the 2014 incidence of TB, shows the differences between women and men, as well as between the provinces and two main cities (Bishkek and Osh). In all the regions we can see more men notified than women, but in the Osh province, not only the incidence is high, but the difference between genders is particularly stark. Possible explanations that were given in the course of the round table are that in the Osh province men migrate more to Russia and other countries, coming back with TB, hence the high number of TB notifications among men and that the society is more conservative toward women, so there can be higher stigma for women to seek TB diagnosis and treatment. Further research is needed to explain this difference.

¹http://www.who.int/tb/publications/global_report/high_tb_burden/countrylists2016-2020.pdf

Graph2: TB incidence by gender and region, 2014. Source: National TB Programme



The multidrug-resistant TB (MDR-TB) epidemic in the country is one of the most severe in the world². The Kyrgyz health care facilities add to the burden due to poor infection control measures- the hospitalisation periods are still very long and the quality of care is poor (idem). Primary health care (PHC) facilities are also challenged through TB. There is a need of improvement of the TB management at hospital and outpatient care levels³. A further difficulty for the health system is the lack of specialised TB doctors – there has been a significant “brain drain” of medical personnel, especially to Russia and the low attractiveness of pulmonary medicine for medical students. While medical schools remain able to attract students, retention of graduates at the health facilities remains a serious problem, and the system continues to lose qualified workers.⁴

Even though epidemiological data is disaggregated by age and gender, there is weak coordination of TB data management at institutions within the Ministry of Health (MoH) and other agencies. There is also insufficient support for directly observed therapy (DOT) at the PHC level. Infection control measures during diagnosis, treatment and isolation of smear-positive people affected by MDR-TB are inadequate. Adherence to MDR-TB treatment is a challenge, and monitoring and evaluation of drug-resistant people affected by TB needs to be improved.⁵. There has been an increase in TB/HIV coinfection. In 2013 alone, TB accounted for 53% of all deaths in people living with HIV/AIDS (PLHA).

² http://www.euro.who.int/_data/assets/pdf_file/0005/273308/HIV-Programme-Review-in-Kyrgyzstan.pdf?ua=1

³ <http://www.euro.who.int/en/health-topics/communicable-diseases/tuberculosis/country-work/Kyrgyzstan>

⁴ Khodjamurodov, Rechel 2010

⁵ <http://www.euro.who.int/en/health-topics/communicable-diseases/tuberculosis/country-work/Kyrgyzstan>

2.2 Gender equality in TB policies and programs

2.2.1 Access to services

Many laws guarantee equal access to health care and the national level (health) programs target health improvement for all (Annex 4). The “The law on the protection of the population against Tuberculosis” ensures free TB treatment and services. However, according to interviewees, informal (out-of-pocket) payments to purchase medicines from medical staff as well as direct payments to the doctors for services are a common practice. According to the affected people, these expenses apply to any medical service and are not specifically to TB treatment.

The Manas Taalimi⁶ program has identified control of TB and respiratory diseases as a priority area, suggesting that integration and delivery of TB services and securing of additional funding for TB control⁷ would be easy to achieve, but unfortunately this is not the case.

During expert interviews and in the focus groups it was clear that access to the health system is not influenced by gender. Women and men stated that they did not experience any kind of discrimination or differential treatment based on their gender. It seems that gender plays a role before the health system is contacted – the health seeking behaviour differs strongly as women receive TB diagnosis at a later stage than men⁸.

2.2.2 Social, cultural and economic factors

Economic hardship was named by all the respondents, especially in combination with their TB infection. Even though the TB treatment is free, additional medicines for the treatment of side effects, or dietary supplements are out of the reach of many persons affected by TB. The fact that women are more economically marginalised than men, further adds to the burden of disease for them. The diagnosis of further eventual complications, such as kidney or liver problems, is not provided for free, so often these complications are left untreated.

Women are more likely than men to be unemployed, regardless of their education level. In 2012, the overall unemployment rate was 8.4%, while the unemployment rate for women was at 9.5% percent, which is significantly higher than that of men (7.7%). Women also have a higher level of long-term unemployment (12 months or more) -13.6% against 12.3% for men (National

⁶ Kyrgyzstan has developed two major health reform programmes after becoming independent: Manas (1996 to 2006) and Manas Taalimi (2006 to 2010), introducing comprehensive structural changes to the health care delivery system with the aim of strengthening primary health care, developing family medicine and restructuring the hospital sector

⁷ Teitelbaum, Ibragimov, Akchurin, 2006 http://pdf.usaid.gov/pdf_docs/Pnadv492.pdf

⁸ In the small scale research that “Defeat TB” developed and carried out, the interviewed women did not show any difference in what??? to the men, but since there is no information on the sample, further research is needed.

Review of the Kyrgyz Republic in the framework of the Beijing Declaration and Platform for Action, 2014).

3 Comprehensive TB response

3.1 TB prevention

According to the respondents, information campaigns for TB prevention are urgently needed. Some donor funded posters were mentioned, but most respondents of the focus groups stated not having seen them, and even not having information on how to prevent TB. A respondent said *“every school child knows now how to prevent HIV and how it is transmitted, but no-one has an idea about TB”*.

It would be very important to have information especially targeted to migrants, according to some of the respondents, many of whom – both men and women - have had a history of being migrant workers in the Russian Federation or (fewer) in Kazakhstan. The respondents noted that if they would have known symptoms of TB, they would have sought a doctor earlier or they would have come back earlier. They also did not know their rights in the other country, many said to have been treated badly once the TB infection was known.

Mass media information campaigns for the general population would also be very important to reduce the existing stigma attached to TB. A young woman said *“I was in shock when I got diagnosed. I thought TB only existed in prisons”*. *“People need to be informed. I thought only bad people, people with bad life habits got TB”*. This widespread lack of information leads not only to stigma, but to internalized stigma, or self-stigma. Self-stigma comprises the awareness of the stereotype, agreeing with it, and applying it to one self. Many of the affected people believe that they are *“damaged for ever”*.

3.2 Testing and treatment

Currently, the Kyrgyz health sector is financed from the following main sources of funds: general budget revenues (republican and local); contributions to the Mandatory Health Insurance Fund (MHIF); the Public Investment Program; out-of-pocket payments; and external sources (including funds from donors and lenders).

All TB services should be provided free of charge to all population categories, according to the regulations. However, while most of the interviewed persons could confirm this, some reported irregularities where doctors had asked to be paid to perform surgeries. Here, no differences in the answers between men and women could be established. A female respondent, telling about a friend who had to be operated due to extra-pulmonary TB stated that *“the first operation, on the right X⁹, was for free, but the doctor told her that she would have to pay to get the second side done”*.

⁹ In order to preserve the anonymity of the respondent, the authors opted to use an X.

The people affected by TB that were not compliant to the treatment reported to have had difficulties to get back to receiving TB drugs: *“The doctor asked me for 300 USD to get back on the treatment”*.

In the male focus groups the subject of surgical treatment of pulmonary TB was repeatedly discussed. Several of the men stated that doctors are *“very fast in telling you that you need a surgery, and they of course want money for it”*. The need for a *surgery* was not brought up in the female groups.

Even though the TB treatment is available and free of charge, X-ray diagnosis is not. According to several sources, the required X-ray costs around 120 Som (around 1.20 USD), all contacts of persons affected by TB were asked to get an X-ray. Even though this is in general perceived as a small sum of money, this could be a barrier to TB diagnosis, especially for women. One interviewed woman said *“120 Som is not a lot of money, but if you have four children it adds up”*.

Men and women said that the level of attention and information of the PHC level was very poor and it was too cumbersome to reach the points of care in order to receive the TB medicine. Women stated that the household chores and taking care of the children made it very difficult to make the daily trip to the doctor’s office, the men said that it was difficult for them to *“have a job to feed my family and still find the time to go to the doctor”*.

3.3 Prison settings

In the focus groups *“prison”* was named as a reason why men are more represented in the TB statistics of the country. Kyrgyzstan has improved the situation of TB in prisons dramatically in the past years. At the moment, from a total of 8,162 prisoners in the country, there are 250 people affected by TB (of which 126 are DR-TB patients). Only one of the persons affected by TB in the prison is a woman. This means a prevalence of 3063 per 100,000 or that approximately 3% of the prison population suffers from TB.

Prisoners are screened every year, as well as in detention facilities pending trial. The prison system has introduced a pilot project of the International Red Cross consisting of a special TB screening questionnaire and this helps detect TB cases at an early stage. There is a needle exchange programme as well as access to methadone and ARV therapy in the prison.

In one of the focus groups a man who had been in prison stated *“when I hear all the problems that my civilian population colleagues have had with being diagnosed and getting treatment I am always astonished. I was in prison and they took really good care of me”*.

During the interview with the prison authorities they were asked to explain possible reasons of the big difference among the level of TB in female and male prisons. The answers indicated the prevailing male/female stereotypes in the society – the women are more hygienic; they take more care of themselves. Men

have riskier behaviour patterns, they use drugs and alcohol. A further point is that male prisons are more crowded than female ones.

The confiscation of passports as a result of imprisonment and the absence of a registered residency address upon release mean that ex-prisoners face difficulties to register for and continue TB or HIV treatment or any other medical services. Officially, there is a programme funded by the Red Cross that should help avoid these problems, but according to the interviewed patients, this difficulty remains and the continuity of treatment is a challenge.

4 Stigma and discrimination

Analysing the information provided by the focus groups, as well as by the expert interviews, two central topics that affect how men and women suffer from TB were identified. The first one is economic hardship, and the second one is stigma and discrimination in all levels of their life.

Stigma destroys a person's dignity; marginalizes affected individuals; violates basic human rights; markedly diminishes the chances of a stigmatized person of achieving full potential; and seriously hampers pursuit of happiness and contentment.

Stigma prevents individuals from getting tested for TB, seeking medical care and adhering to treatment and follow up. Fear of social abandonment and losing partners prevents many with TB from sharing the diagnosis with their family members, friends and colleagues.

Men and women suffering from TB and TB survivors shared their experiences with stigma and discrimination from friends, families, health personnel, classmates, colleagues and neighbours.

The stigma of TB in the society leads persons with TB to not take infection control measures, such as wearing a surgical mask, to avoid discrimination in public transportation and shops.

Even though stigma was named by all the interviewed persons as a barrier to diagnosis and treatment of TB, it was noted that this stigma is even stronger for women and girls.

Women expressed their fears for their reproductive health: *"how will I ever become a mother?", "I will not be able to give birth to a healthy child", "I am afraid that TB is genetic, I do not want to pass this on to my child", "my genes will be changed now"*. Finding a partner was also an issue, TB might severely affect the marriage perspectives: *"if someone knows, I will never find a husband"*.

Women will usually try to hide a possible TB disease as long as possible due to the fear of stigma that might result in being thrown out of the household, either by the husband or by her in-laws. Relating to this, an interviewed woman said

“who needs a sick wife?” Many of the women from the focus groups had been left by their husbands and their children had been taken away.

Similar fears were expressed by men, but the fear was not so much related to finding a spouse as to protect the current family: *“when I come out of here healed, I will not go back to my family to protect them from me. I will rent a separate flat”, “I will want my own set of plates, and glasses and cutlery. I don’t want them to get infected”*.

The patients are worried about the future in general- they are worried that they will not find work, specifically that they cannot work in education, with children and that their families will turn away from them. One man even said *“my friends were so afraid of me that one was even afraid to pick up the phone when I called him”*.

There is a great need of further research of the implications of TB stigma in Kyrgyzstan. It is paramount to understand the different dimensions of stigma in general for the patients, and especially to understand how the stigma differs between men and women, boys and girls and how differently it affects the everyday life of the affected population.

The USAID funded project “DefeatTB” conducted a short basic survey, comprising eight questions, to assess the stigma experiences of 129 women in Bishkek, Chui and Jalalabad Oblasts. In order to have a comparison with men, the Kyrgyz Coalition used the same tool to interview 129 men in the same regions. The filled in surveys were analysed in cooperation with DefeatTB and a short analysis can be found in the Annex of this report (Annex 5).

5 Gender considerations

The laws in Kyrgyzstan guarantee in general equal opportunities for men and women, mainly in accordance with international requirements and does not discriminate between the sexes. However, the existing social practice is dictated by traditional understandings based on patriarchal structures, practices, stereotypes and views. These understandings form and influence the social roles of the respective genders, creating expectations in behaviour patterns that can result in unequal and even discriminatory outcomes.

5.1 Gender stereotypes

An important challenge lies in the fact that the general attitude and prevailing perception in the broader society is that existing gender roles present no problem and women and men are equal and emancipated. The interviewed persons had very strong gender stereotypes and patriarchal attitudes, emphasizing certain roles and establishing specific behaviours for men and women, particularly within the family and the household.

Women are expected to be mothers and family caretakers, men have the decision-making role in the household and are expected to be the breadwinners.

As a female respondent put it *“men are the ones to bring in the money”*. There was consensus that in the situations in which the women have to work to additionally support the family due to a low wage of the husband or even unemployment *“is where all the conflicts in the family begin. The woman will want to have a say in the family and that is not the way it is supposed to be”*. These men cannot serve the stereotype of masculinity – linked to sexual power, material wealth and authority, and are subject to psychological pressure. This can be an explanation for the high suicide rate among men in Kyrgyzstan, which is four times higher than among women. (UNDP Kyrgyzstan 2010).

These stereotypes limit women’s rights, radius of participation and their decision-making power. This influences directly the health seeking behaviour of women. In the focus groups it was repeatedly mentioned that the women will prioritize the other members of the family in the case of illness, especially if the financial resources are scarce. *“I am the last of the line”, “first I will see to it that my husband and children are treated, I can wait”*. Women will resort to traditional methods of healing first, then actually go for TB diagnosis. This can be a possible explanation for the statistical discrepancy between male and female cases of TB. At the same time, this would mean a delay in the diagnosis, but the cases would be reflected in the numbers. Further research is needed to understand this difference better.

When asked about possible reasons of the difference between the sexes in the TB statistics, men and women in the interviews and the focus groups were quick to point out that the reason why men were more affected was because *“men drink [alcohol], smoke and “go out””, “they do not take care of themselves, they behave unresponsively”* and as well *“men get infected in the prisons”*.

In general, the status of men’s health is alarming and the Government of Kyrgyzstan has emphasized it in its National Gender Strategy, which runs up to 2020¹⁰.

The stereotype of a strong man influences directly the health of the male population – a real man is always healthy, should not pay attention to any illness and go to doctors (Government of the Kyrgyz Republic 2012).

The societal pressure on men to be the breadwinner of the family was thematised in the focus groups: *“I have to bring in the money for the family. Now I am too weak to work”*. A male respondent even said *“as my wife saw that I was not bringing money home and was too sick, she left me”*.

Alcohol use was identified by the interviewees as a main reason why men are overrepresented in the TB statistics. Alcohol use belongs to the stereotype of being male, but it does not mean that women do not drink. Compared to 2005, in 2009 the morbidity rate from alcohol addiction increased by 12% throughout the country. Alcohol dependency is encountered more often among men than women (National Statistical Committee of the Kyrgyz Republic 2010). Besides

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http://www.kg.undp.org/content/kyrgyzstan/en/home/library/womens_empowerment/follow-your-voice1.html

possible economic losses through the husbands' probable inability to work or unemployment due to his dependency, further negative and (psychological and physical) health-related effects for women and children of alcohol dependency is the worldwide researched and recognized interconnection of alcohol and interpersonal violence.

In the interviews, alcohol use was closely linked to homelessness. Homeless persons are very stigmatised individuals. Even though officially they have access to diagnosis and treatment of TB, interviewees stated that health care personnel avoided treating them.

6 Gender based violence

Gender-based and sexual violence in Kyrgyzstan is connected with the overall discriminatory practices against women and children, such as bride kidnapping, early and forced marriages, sexual and domestic violence in the family. According to the National Statistical Committee of the Kyrgyz Republic for the period from 2004 to 2011 the number of appeals in cases of domestic violence has increased almost fourfold. (UNDP 2013)

Ambulance service annually registers more than 600 people with physical injuries or other types of health disorders resulting from domestic violence. In most of these cases, the victims are female. (UNDP 2013) Each year, the police in Kyrgyzstan receives more than 7000 calls related to domestic violence with severe consequences. (UNDP 2013)

Many of the interviewed women have experienced physical/ emotional/ sexual violence by current or former husbands/partners, a female respondent even said *"of course our husbands are violent, mine beat me, especially when he found out that I had TB. He then left me and took away my child"*. The issue of domestic violence as a problem was also acknowledged by the men: *"yes, there is violence"*.

Many women of the focus groups mentioned severe violations of their sexual reproductive rights. Several of them had been talked into having abortions by their doctors, without proper counselling or information. *"They told me that my child would be mentally handicapped or that it would have 3 arms or no legs"*.

7 Recommendations

Recommendations for stakeholders:

- Further research on stigma is urgently needed to understand how stigma affects women and girls living with TB *more, less or differently* than men and boys. Recognise that this is rooted in entrenched gender dynamics and inequalities that often make females significantly more vulnerable to the impact of stigma at all levels.
- In order to address the stigma attached to TB, information materials that address the different needs of the respective actors should be developed. These materials should address the issue of gender in the family and the gender stereotypes that affect the health seeking behaviour.
- Gender and social aspects of TB response, particularly the aspects that influence equity in accessing diagnosis, need to be considered by all the involved stakeholders when designing interventions
- Link necessary capacity development on gender and rights to other acceptable topics. The approach should be not to necessarily mention gender or human rights as a concept, but to “piggyback” them to more accessible topics, such as health and wellbeing
- Strengthen the capacity of the PHC facilities to include the concept of gender in their work. Develop their capacity on gender-sensitive perspectives, messages (effective delivery), gender stereotypes, interactive training and teaching methods and alternative approaches.

- Recommendation to the Civil Society:
 - Use the platform for informal education of men and women on gender, which is to be established in 2015-16 by the Ministry of Labor and Social Development; delegate at least one advocate to the two-day advocates training if possible. Whereas a guidance for documenting the cases of gender-based violence is more relevant to cases of violence, it can possibly be used for documenting discrimination
 - Establish community-based monitoring to collect and analyse information on the influence of gender in the diagnosis of TB
 - Collect and analyse information about stigma suffered by people affected by TB.
 - Stigma in the families
 - Stigma in the medical facilities
 - Stigma in the public sphere
 - Stigma in the media
 - Self-stigma
 - Address the subject of stigma when possible to create awareness of the problem

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Annex 1 List of persons met

Организация	Должность	Имя Фамилия
Organisation	Position	Name
Национальный центр фтизиатрии (НЦФ)	Директор	Кадыров Абдуллат Саматович
National TB Centre (NTC)	Director	Kadyrov, Abdulat Samatovich
Национальный центр фтизиатрии (НЦФ)	Юрист	Петрова Ольга
National TB Centre (NTC)	NTC Lawyer	Petrova, Olga
Федеральный фонд обязательного медицинского страхования (ФОМС)	Председатель Фонда	Калиев, Марат Темирбекович
Compulsory medical insurance Fund under the Government of the Kyrgyz Republic (FOMS)	Chairman of the Fund	Kaliev, Marat Terimbekovich
Федеральный фонд обязательного медицинского страхования (ФОМС)	Главный специалист отдела стратегического развития	Кешикбаева Анара Асылбашевна
Compulsory medical insurance Fund under the Government of the Kyrgyz Republic (FOMS)	Senior Specialist of the Department of Strategic Development	Keshikbaeva, Anara Asylbashevna
Омбудсмен Кыргызской Республики	Омбудсмен	Оторбаев Кубат Табалдиевич
Ombudsman of the Kyrgyz Republic	Ombudsman	Otorbaev, Kubat Tabaldyevich
Офис Омбудсмен Кыргызской Республики	Зав.отд. по защите населения в семье и гендерной дискриминации	Турдамаматова Махабат
Office of the Ombudsman of the Kyrgyz Republic	Head of the Department of Protection of Families	Turdamamatova, Makhabbat

	and Gender discrimination	
Жогорку Кенеш , комитет по правам человека Kyrgyz Parliament, Human Rights Committee	Зав. сектором прав человека Head of the Human Rights sector	Авасканова Гульмира Avaskanova, Gulmira
Жогорку Кенеш , комитет по социальным вопросам Kyrgyz Parliament, Social Affairs Committee	Комитет по социальным вопросам, Депутат Social Affairs Committee, Member of Parliament	Никитенко Наталья Владимировна Nikitenko, Natalia Vladimirovna
Правозащитный центр «Граждане против коррупции» Human Rights Center "Citizens against corruption"	Директор Director	Исмаилова Толекан Асаналиевна Ismailova, Tolekan Asanalyevna
Международный фестиваль документальных фильмов по правам человека International Human Rights Documentary Film Festival	Координатор Coordinator	Абдыллаева Жылдыз Abdyllaeva, Zhyldyz
Министерство Социального развития и труда (МСТ) Ministry of Social Development and Labour	Заведующая отделом гендерной политики Head of Section of Gender Policy	Бакирова Нургуль Жакыповна, Bakirova, Nurgul Zhakypovna
Министерство Социального развития и труда (МСТ) Ministry of Social Development and Labour	отдел гендерной политики Gender Policy Section	Сатыбалдиева Бегаим Ашимовна Satybaldyeva, Begaim Ashymovna
Государственная служба исполнения наказаний (ГСИН) State Penitentiary Service	Начальник Управления организации медико-санитарного обеспечения Head of the organization of health care provision	Асанов Акылбек Авазович Asanov, Akylbek Avazovich

<p>Государственная служба исполнения наказаний (ГСИН)</p> <p>State Penitentiary Service</p>	<p>УОМСО Старший инспектор</p> <p>Senior inspector organization of health care provision</p>	<p>Куканова Гульсара Каныбековна</p> <p>Kukanova, Gulsara Kanybekova</p>
<p>ЮСАИД</p> <p>USAID</p>	<p>Специалист по управлению программ здравоохранения</p> <p>Health Programs Management Specialist</p>	<p>Камарли Чинара</p> <p>Kamarli, Chinara</p>
<p>ЮСАИД</p> <p>USAID</p>	<p>Специалист по управлению проектами, отдел по развитию демократии</p> <p>Project Management Specialist , Department for Development of Democracy</p>	<p>Алымкулова Махаббат</p> <p>Alymkulova, Makhabbat</p>
<p>UNION/ЮСАИД</p> <p>UNION/SAID project in Kyrgyzstan</p>	<p>Старший технический советник</p> <p>Senior Technical Advisor</p>	<p>Базиков Тимур</p> <p>Bazikov, Timur</p>
<p>ВОЗ</p> <p>WHO</p>	<p>Координатор по программе ИППП/ВИЧ/СПИД</p> <p>Coordinator of the STI/HIV/AIDS Programme</p>	<p>Карымбаева Салия</p> <p>Karymbaeva Saliya</p>
<p>ВОЗ</p> <p>WHO</p>	<p>медицинский сотрудник ТБ</p> <p>TB Medical Officer</p>	<p>Насидзе Николоз</p> <p>Nasidze, Nikoloz</p>
<p>МСФ «Врачи без границ»</p>	<p>Сотрудник по коммуникации</p>	<p>Шигайбаева Гуляим</p> <p>Shygaybaeva Guliaim</p>

MSF- Doctors without borders	Communication Officer	
МСФ «Врачи без границ» MSF- Doctors without borders	Помощник руководителя миссии Head of Mission Assistant	Керималиева Раушан Kerimalyeva Raushan
ПРООН UNDP	Координатор программ по туберкулезу Группы управления грантами Coordinator of the Tuberculosis Control Programme, Grant Management division	Щелокова Ирина Shelokova, Irina
ОО «Социум» NGO „Sotsium“	Исполнительный директор Executive Director	Эстебесова Батма Абибовна Estebesovna Batma Abibovna
KNCV Branch Office in the Kyrgyz Republic	Директор Director	Бакыт Мырзалиев Bakyt Myrzaliev
ОЮЛ "Ассоциация СПИД-сервисных НПО КР "АнтиСПИД" Association of Legal Entities "Association of AIDS service NGOs of the Kyrgyz Republic " Anti-AIDS "	Исполнительный директор Executive Director	Бакирова Чынара Абдыгуловна Bakirova Chinara Abdygulovna

Annex 2. Context

Context

The Kyrgyz Republic is a small, land-locked Central Asian country covering some 198,500 square kilometers. It borders Kazakhstan to the north, Uzbekistan to the west, Tajikistan to the southwest, and the People's Republic of China to the south and southeast. The capital, Bishkek, is located close to its northern border. The Kyrgyz Republic became an independent State in August 1991.

With a population of 5.834 million¹¹ people, it is an ethnically diverse nation. Of the non-Kyrgyz nationalities found in Kyrgyzstan, the largest ethnic groups are Uzbek (13.8%) and Russians (12.5%). About one percent or less of the population is Ukrainian, Tatar, Dungan, Uigur, Turkish, Korean, and German (Kolpakov, 2001)

Even though the government is secular, Islam is the main religion (75%), followed by Russian Orthodoxy (20%). Demographically, Kyrgyzstan is a young nation – almost half (48,6%)¹² of the population are 24 years old and younger. There are slightly more women than men, with a ratio of 0.96 male(s) to every female in the total population.

The country has a mostly rural population, with only 35,6% concentrated in urban spaces(<http://hdr.undp.org/en/countries/profiles/KGZ>).

Since independence, the Kyrgyz Republic has gone through a difficult phase of economic, social, and political transition. The Kyrgyz Republic is categorized as a “lower middle income country” by the World Bank¹³ and in 2015, the United Nations Human Development Index ranked the Kyrgyz Republic 120th in the world, out of 188 assessed countries¹⁴.

The last years have been economically challenging for the country. The government achieved a gross domestic product (GDP) growth of estimated 2,0% in 2015 and 3,6% in 2014, very low in comparison to the 10,9% level of 2013¹⁵. However, the headcount index of absolute poverty declined from 44.4% in 2002 to 30,6% in 2014 (idem). Sustaining these achievements, underlined by a continued program of economic reform, will be a key challenge for the Kyrgyz Republic in the future.

The economic growth is based on a large service sector (52%), followed by 25% in agriculture and forestry and 23% from industrial goods and services.

Kyrgyzstan, as opposed to other countries in the region, has scarce natural resources and possesses only minor quantities of oil and gas. Its only important resource is gold, responsible for 10% of the GDP. Foreign companies mainly access the gold reserves. In the medium-term, the country will remain dependent on financial support by international donors.

As elsewhere in the former USSR, the transition to a market economy and many aspects of the reforms to social provision that have taken place in the region since 1991 have had a negative impact on women. Traditional or customary practices have been bolstered and patriarchal ways of management, cultural stereotypes and practices that discriminate against women and limit their role in

¹¹ <http://data.worldbank.org/country/kyrgyz-republic>

¹² http://www.indexmundi.com/kyrgyzstan/demographics_profile.html

¹³ <http://data.worldbank.org/country/kyrgyz-republic>

¹⁴ <http://hdr.undp.org/en/composite/HDI>

¹⁵ <http://data.worldbank.org/country/kyrgyz-republic>

society have (re)emerged. Most noticeable in the region is a growing acceptance (and justification) of women's economic dependence, domestic violence, and abduction for forced marriage, particularly in rural areas (Deerberg 2013: 5).

Annex 3. WHO tuberculosis profile of Kyrgyzstan 2014

Estimates of TB burden * 2014	Number (thousands)	Rate (per 100 000 population)
Mortality (excludes HIV+TB)	0.65 (0.63-0.67)	11 (11-12)
Mortality (HIV+TB only)	0.055 (0.042-0- 07)	0.94 (0.71-1.2)
Prevalence (includes HIV+TB)	11 (5.4-20)	196 (93-336)
Incidence (includes HIV+TB)	8.3 (7.3-9.3)	142 (126-160)
Incidence (HIV+TB only)	0.18 (0.16-0.2)	3.1 (2.7-3.5)
Case detection, all forms (%)	77 (68-87)	
87)		
Estimates of MDR-TB burden * 2014	New	Retreatment
% of TB cases with MDR-TB	26 (23-31)	55 (52-58)
MDR-TB cases among notified pulmonary TB cases	1100 (960-1300)	850 (800-900)

Source:

https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Report_s%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=KG&outtype=pdf
accessed on 10.02.16

Annex 4. Health-related Laws and National Programs in Kyrgyzstan

The Law of the Kyrgyz Republic “On public health protection”, the Law of the Kyrgyz Republic “On reproductive rights and guarantees of their implementation”, and National Strategy for protection of reproductive health of the population of the Kyrgyz Republic until 2015, approved by the Governmental Decree #185 on April 24, 2008, Health Care Reform Program “Den Sooluk” for 2012-2016 approved by the Governmental Decree #309 of the Kyrgyz Republic on May 24, 2012, all guarantee equal access to health care for all citizens, both male and female.

The improvement of the health status of the population is targeted through the implementation of the National Health Reform Program of the Kyrgyz Republic “Manas Taalimi” for 2006-2010 and the new health care reform program “Den Sooluk” for 2012-2016, developed on the basis of a broad sectoral approach. These programmes prioritize maternal and child health, access to health care and reducing the financial burden on the most vulnerable groups (National Review of the Kyrgyz Republic in the framework of the Beijing Declaration and Platform for Action, 2014).

The National Strategy for Reproductive Health in the Kyrgyz Republic for 2006-2015 has as priorities safe motherhood, adolescent reproductive health, cancer of the reproductive system, combating HIV/AIDS as well as prevention and combating of violence.

The State Guarantees Program (SGP) is annually approved by the government to provide healthcare to the citizens of the Kyrgyz Republic, within the framework of which the provision of care during pregnancy, childbirth, postpartum and to children under five years of age is free.

The program provides that domestic workers, pregnant women, children under five years, people who are in social shelters, nursing homes, orphanages, hostels of educational institutions, private educational schools with accommodation, injecting drug users, commercial sex workers, homeless persons, people affected by tuberculosis, people living with HIV/AIDS, and persons released from prison are all registered with the medical facility, regardless of residence¹⁶.

The National Gender Equality plan 2015-17 does not have any specific activities regarding safeguarding the rights to health. However MoH is quoted as (co)-responsible for (1) participation in the (to be established) Inter-Agency working group to review legislation related to gender discrimination and access to justice

¹⁶ Joint Order: #358 of the Ministry of Health on 26 June 2013, and Mandatory Health Insurance Fund (HIF) under the Government order #126 on June 26, 2013 “On Approval of the Rules of Registry of the population of the Kyrgyz Republic to groups of family doctors”

in end 2016-2017; (2) publishing the cases of gender discrimination on the official websites, including MoH starting from the 1st quarter of 2016; (3) to conduct an analysis of the national statistical reports on gender discrimination and submit recommendations to the National Council of Gender development in quarters 2-4 of 2016; (4) MoH is expected to have an action plan for a guidance for documenting the cases of gender-based violence by 1st quarter of 2016, have training for staff on the use of this guidance and monitor its implementation (5) be involved in information sessions for population about gender. In quarter 1 of 2016, national legislative acts are to be reviewed for compliance with principles of non-discrimination based on gender.

MoH is also expected to send statistical staff in each of the regions to a seminar on gender discrimination to be conducted in 2017; a two-day training is planned for advocates on issues of gender discrimination, focusing on women from vulnerable groups (responsible Ministry of Labor and Social Development and Ministry of Justice) from 1st quarter of 2016. (National Gender Equality plan 2015-17)

Annex 5: DefeatTB Survey

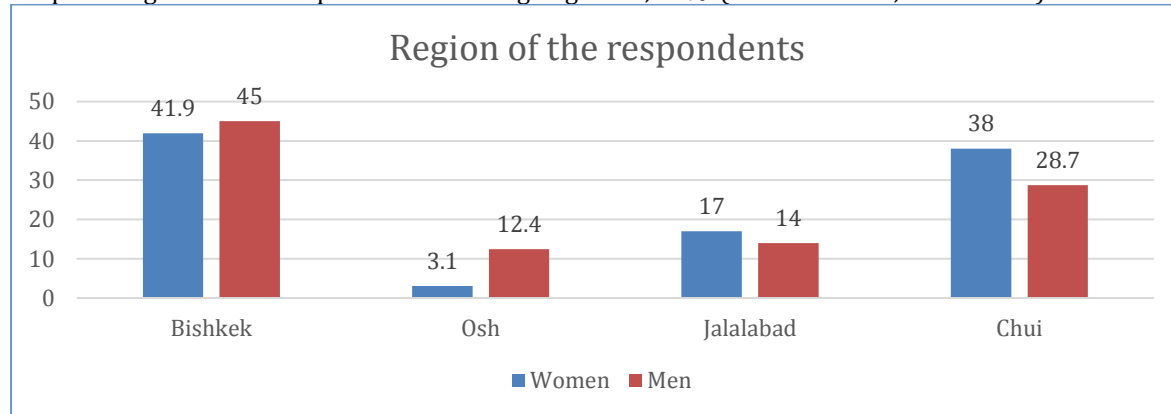
The „Defeat TB“Project, funded by USAID, decided to take first steps in the analysis of the stigma suffered by TB patients. The project developed independently a short questionnaire (Annex 6), comprised of 11 questions, and interviewed 129 women in four regions: Bishkek, Osh, Chui and Jalalabad Oblast. In the frame of the mission for the Gender and Legal Assessment of the TB response in Kyrgyzstan, the consultants learned about these questionnaires and decided, with the help of the “Coalition against TB”, to additionally interview 129 men in order to be able to have a comparison between genders, using the same instrument and assisting DefeatTB with the analysis.

The analysis of the in total 258 questionnaires has to be seen as a first step in the understanding of the stigma that is suffered by men and women suffering from TB in Kyrgyzstan and should be continued with further in-depth research. The data was analysed using the program GNU PSPP, a free replacement of the statistical program SPSS, and only descriptive statistics were used.

Basic demographic data

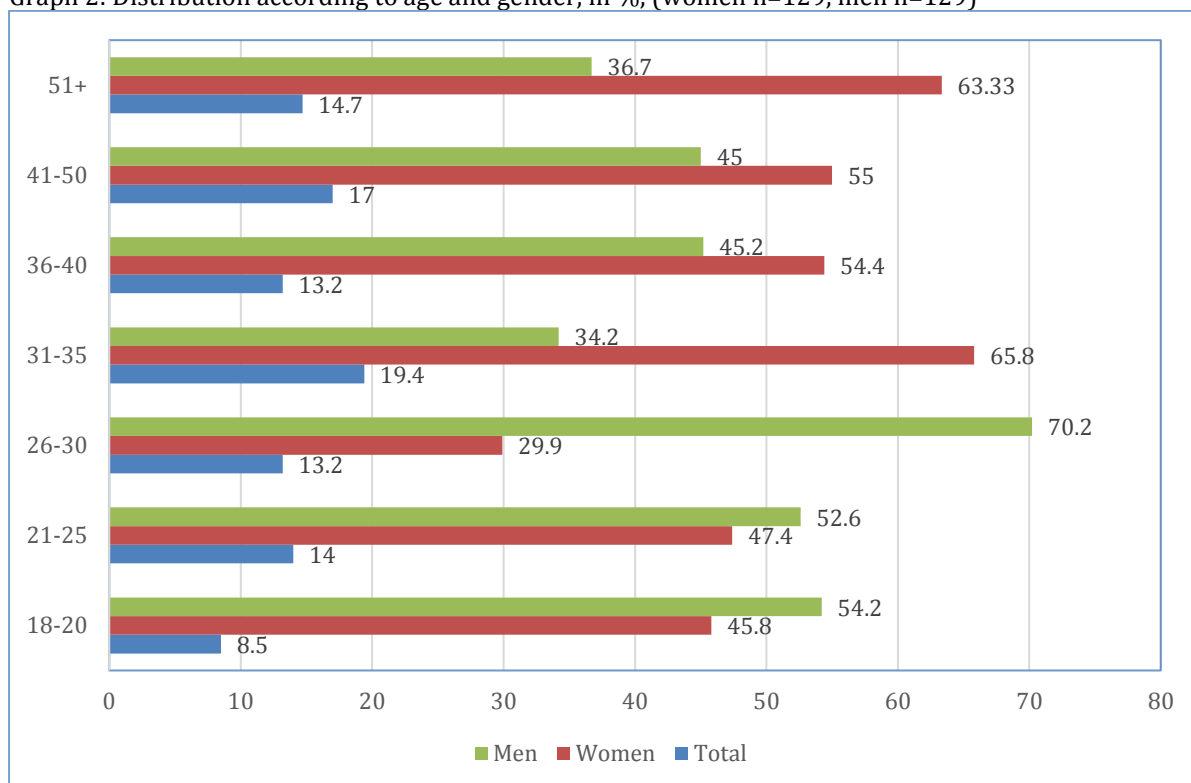
The respondents come from four regions: Bishkek, Osh, Chui and Jalalabad. The following table shows the distribution according to the gender of the respondents:

Graph 1: Regions of the respondent according to gender, in %. (women n=129, men n=129)



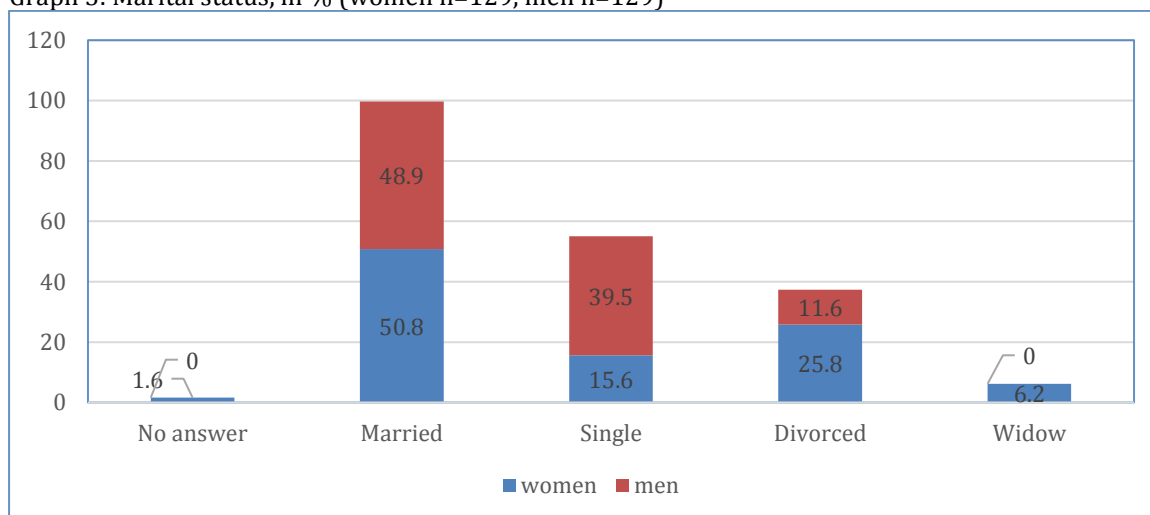
Almost half of the total of the respondents live in Bishkek. Looking at the distribution according to age and gender (Table 2), even though in total sample the age groups are relatively well distributed, there are more men than women in the age groups until 30 years old, and more women in the group older than 31 years old.

Graph 2: Distribution according to age and gender, in %, (women n=129, men n=129)



Looking at the marital status of the respondents, most of the women are married or divorced, whereas men are mostly married or single, as seen in Table 3.

Graph 3: Marital status, in % (women n=129, men n=129)

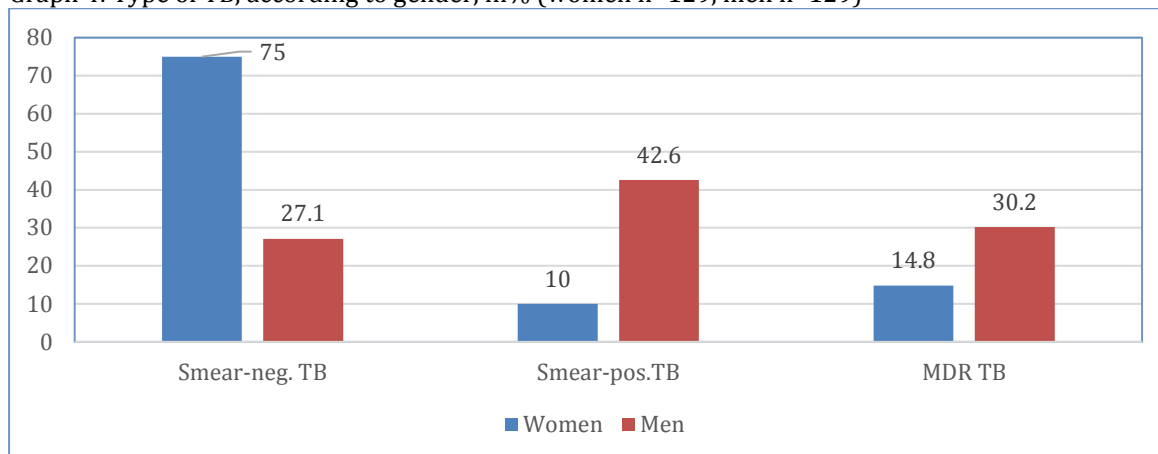


Looking at the regions, more women and men are married in the Jalalabad region, what was to be expected following our focus groups discussions.

Questions on TB

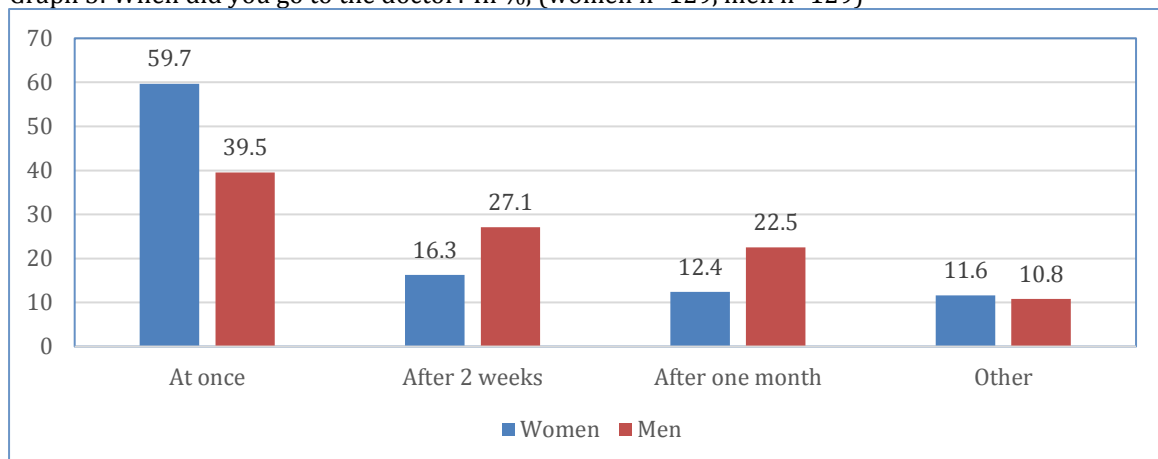
There is a difference between the genders of the respondents according to the type of TB they had- smear-negative pulmonary TB, smear-positive or MDR TB.

Graph 4: Type of TB, according to gender, in% (women n=129, men n=129)



The respondents were asked when did they go to the doctor after they started feeling any symptoms. The next graph shows (Graph 5) that more women than men went at once to the doctor. This fact is very interesting, because it apparently contradicts the findings of the assessment. In the focus groups discussions and in the expert interviews the view was that women do not go at once to the doctor, but send their children and husband first, putting themselves as “last in the line”. However, there is no question in the instrument that asked if anyone in their family showed any symptoms as well – if the interviewed women were the only ones in the family that showed signs of TB, then maybe there was no threshold of going at once to the doctor. This question should be further researched.

Graph 5: When did you go to the doctor? In %, (women n=129, men n=129)



Looking at the regions, most of women in all of them say to have gone at once to the doctor. In the focus groups we were told that there would be a great difference in the health seeking behaviour of the women in the South, in the Jalalabad region. Here, the women would not go to the doctor due to societal pressure. From the sample of 22 women (a small sample), 77% went to the doctor at once. When asked why the respondents did not contact the doctor (44 answers) at once, the most given answer was thinking that “it was something else”, not knowing it could be TB (33 answers), and fear of the diagnosis (11). The relation between the genders is even in these answers.

Looking at the age groups, it is interesting to see that men who are younger than 35 tend to go at once to the doctor or up to two weeks after they feel any symptoms- 73,26% of the men do so. Among the women such a tendency cannot be observed.

Asked about whom did they tell about the TB infection- unfortunately the question was too broadly asked, we do not know if they told these people first, and parents and relatives were clustered in one answer option. Looking first at the women, 66% of the married women told their husbands and 33% to their relatives. Of the single women, 75% told their relatives. 90,6 % of the divorced women told their relatives. A very interesting fact is that very few women told a friend about the infection- a fact that pinpoints to a strong fear of stigma. Among the men, even though the parents and relatives play an important role, friends were told in 11% of the cases of the married men, almost 10% among the single men and even 20% among the divorced.

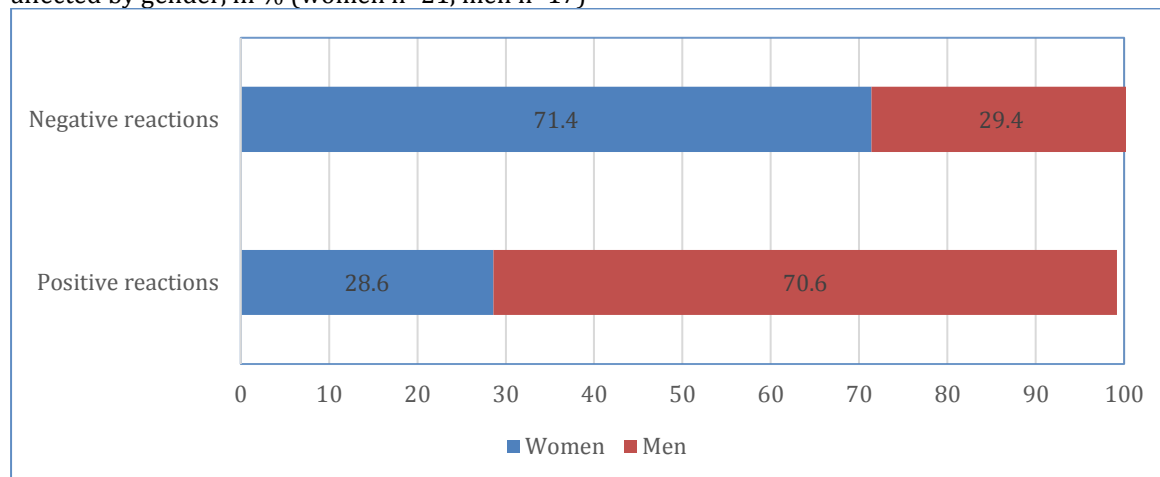
The questionnaire asked how did the relative take the news that the respondent is affected by TB. This question is only centred in the reaction of the relatives, not specifying which relative or reaction and not asking the reaction of other persons that can provide support, such as friends.

Clustering the answers given, more women than men received negative reactions, such as being badly treated, being feared, being turned away and even divorced. Almost one third of the women (30,5%) reported being treated negatively by the relatives. 26,33% of the men reported the same. The author would have expected a higher difference between the men and the women, but for a better assessment of the stigma perceived by the different genders more detailed questions would have been necessary.

40,3% of the men said to be treated “well” by the relatives, whereas 30,2% of the women stated the same.

Analysing the answers by the regions, a very interesting fact comes to light. In the focus groups it had been mentioned that the situation for women affected by TB is more difficult in the south, and the answers of the questionnaire respondents corroborate this. In all the regions the ratio between the genders of being positively or negatively treated by the relatives is very similar, but in the next graph (graph 6) the differences in the southern, more conservative region, of Jalalabad are depicted.

Graph 6: Positive and negative reactions of the relatives at the news that the respondent is TB affected by gender, in % (women n=21, men n=17)



In the graph we can clearly observe that women in Jalalabad suffer more from negative reactions from the relatives that men do.

Looking at the influence of marital status in the reaction of the relatives, among the men the distribution is even, but among the women, while 25% of the married women say to have had negative experiences, 43,75% of the divorced and 42,86% of the widowed women stated the same.

The type of TB- if it is smear positive, negative or MDR TB - has an influence in the reactions of the relatives, this influence is much stronger among the women. Among the women with smear negative TB, 28% said to have negative experiences, but among the ones affected by smear positive TB, this number climbs to 50%, and it is 42,1% for the women with MDR TB.

Among the men, 25,4% of the ones with smear negative TB had negative experiences, 37,3% with smear negative TB and 35,2% with MDR TB.

The last question was if the respondents think that one should communicate the fact that one is affected by TB. Unfortunately, the question does not specify to whom. Here, 72% of the men said that it should be communicated, but only 55% of the women say so. The region where the respondents were asked does not have any influence in the answer.

Conclusion and recommendations

This questionnaire is a first attempt into the research of TB related stigma, and it should be seen as such. It gives a first insight in the differences of how stigma is suffered by women and men. In the conducted focus groups in the frame of the Gender Assessment, conducted independently from this questionnaire, the differences between the genders were more visible. Some of the answers in this survey seem contradictory to the results of the focus groups, but this can lay in the quality of the sample and the questions asked.

The results of this survey support the theory that women are more affected by TB stigma than men, and especially women in the south, in the region of Jalalabad.

Further research is needed to understand the influence and consequences of stigma in the lives of people affected by TB in Kyrgyzstan and thus to develop measures, such as information campaigns, to reduce the discrimination that they are subjected to.

There is a very successful tool that has been developed to measure and quantify stigma suffered by people living with HIV – the People living with HIV stigma index (<http://www.stigmaindex.org/>). Adapting the tool for TB and carrying out the survey in Kyrgyzstan would be an important step forward for improving the situation of people suffering from TB in the country.

Annex 6: DefeatTB Tool

Анкета/*Questionnaire*

Заполняется интервьюером/*To be filled in by the interviewer*

Место опроса (регион/район): _____ Дата интервью: _____

Place of interview(region, rayon)/ Date of interview

ФИО интервьюера(*Name of interviewer*): _____

Интервью проведено в соответствии с инструкцией _____ (подпись интервьюера)

The interview was carried out according to the instructions (Signature of interviewer)

Анкетирование проводится среди мужчин больных ТБ с целью - выявить по каким причинам происходит стигма и дискриминация по отношению мужчинам больным ТБ.

Ваше мнение и ответы очень важны для нас. Мы гарантируем сохранение конфиденциальности Ваших ответов. Ваши ответы будут обработаны вместе с другими ответами, и результаты будут использованы только в обобщенном виде.

The survey is being carried out among men/women affected by TB with the purpose of analysing the reasons why stigma and discrimination occur towards men (women) affected by TB.

Your opinion is very important for us. We guarantee the confidentiality of your answers. Your answers will be added to other answers and the results will only be used in a generalised way.

Спасибо за понимание и поддержку ! *Thank you for your understanding and your support!*

1. Сколько вам полных лет: (*how old are you*) _____

2. Ваше семейное положение: (*your marital status*) _____

а) Женат (в т.ч. гражданский брак) *Married* б) Холостой *Single* в) Развелся/Вдовец *divorced/widowed*

3. Категория *Category*: а) 1. б) 2. в) МЛУ *MDR*

4. После того как обнаружили туберкулез, через какое время вы обратились к врачу /*After discovering you had TB, how soon did you go tot he doctor*

а) Сразу/*At once*

б) Через 2 недели/*after 2 weeks*

в) Через месяц/*after a month*

г) Другое/other

д) Если не обратились сразу, то почему/If you did not go at once, why?

5. Когда (через какое время) вы рассказали о своем заболевании родственникам и близким? /when did you tell about the diagnosis to you close ones/relatives?

6. Кому вы рассказали о своем заболевании? *whom did you tell about your infection?*

а) Родители (родственники) Parents/relatives

б) Жена Wife/Husband

в) Другьям /Friends

г) Не сказала никому/Did not tell anyone

7. Как отнеслись ваши родственники к вам ? *How did your relatives treat you?*

8. Как вы думаете нужно ли сообщать о своем заболевании родственникам и близким? *What do you think- should one tell the relatives and close ones about the infection?*
