World Health Organization
REGIONAL OFFICE FOR Europe

# Towards a healthier Kyrgyz Republic

## Progress Report 2020 on Health and Sustainable Development

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**Abstract**

By bringing together 12 global health and development agencies, the Global Action Plan for Healthy Living and Well-being for All (GAP) represents a new commitment to advance collective action and accelerate progress towards health-related global Sustainable Development Goals (SDGs). This report supports the GAP country process in the Kyrgyz Republic by providing an overview of the status of health and well-being in the country related to realization of the health-related SDG targets. The report is based on a review of national strategic policy and programme documents, a trend and status analysis of more than 60 indicators related to SDG 3 (health and well-being) and interviews with national health experts. The report outlines opportunities for expanded intersectoral collaboration to advance health-related targets and concludes with specific recommendations on potential gaps where technical and financial support may be needed to realize the country's health priorities.

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# Abbreviations

| | |
|---|---|
| 2030 Agenda | United Nations 2030 Agenda for Sustainable Development |
| ADP | Additional Drug Package |
| GAP | Global Action Plan for Healthy Lives and Well-Being for All |
| GDP | gross domestic product |
| GIZ | Deutsche Gesellschaft für Internationale Zusammenarbeit |
| Global Fund | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| IHME | Institute for Health Metrics and Evaluation |
| IHR | International Health Regulations |
| MAPS | mainstreaming, acceleration and policy support [exercise] |
| MDG | Millennium Development Goal |
| MDR-TB | multidrug-resistant tuberculosis |
| MHIF | Mandatory Health Insurance Fund |
| MIC | Multiple Indicator Cluster [survey] |
| MSM | men who have sex with men |
| NCD | noncommunicable disease |
| NGO | nongovernmental organization |
| NSC | National Statistical Committee of the Kyrgyz Republic |
| ODCCP | Office of Drug Control and Crime Prevention (United Nations) |
| OOP | out-of-pocket [payment] |
| PHC | primary health care |
| PWID | people who inject drugs |
| SDG | Sustainable Development Goal |
| SGBP | state-guaranteed benefit package |
| STEPS | STEPwise approach to surveillance |
| TB | tuberculosis |
| UHC | universal health coverage |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |

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# Executive summary

Five years have passed since the 2030 Agenda for Sustainable Development (2030 Agenda) and its Sustainable Development Goals (SDGs) were adopted by all 193 Member States of the United Nations. The 2030 Agenda presents a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030. Health is both an enabler and a major outcome of sustainable development. Achieving SDG 3 (health and well-being for all at all ages) will only be possible in collaboration with action in other sectors and settings.

The WHO Regional Office for Europe developed a roadmap to implement the 2030 Agenda (the SDG roadmap) in consultation with Member States and with input from experts. Efforts to implement the 2030 Agenda, the SDG roadmap and WHO's 13th General Programme of Work are aligned and mutually reinforcing. Member States adopted the SDG roadmap in 2017. In 2019, the Global Action Plan for Healthy Living and Well-being for All (GAP) was endorsed by 12 global health and development agencies, presenting a new opportunity to advance collective action and accelerate progress towards health-related global SDGs.

This report is intended to support the acceleration of progress towards achieving the SDGs, through the SDG roadmap and the GAP. It provides an overview of the status of health and well-being in the Kyrgyz Republic related to realization of the health-related SDG targets and it provides indications on solutions and accelerator areas for joint cooperation with the support of multiple agencies.

The report is based on a review of national strategic policy and programme documents; a trend analysis of more than 60 indicators covering 12 SDG areas; interviews with national health experts and a high-level policy dialogue and technical workshop. The proposed actions contained in this report are intended as a starting point for a new round of policy discussions within institutions of the Kyrgyz Republic (Ministry of Health) and key stakeholders to explore new opportunities and to advance progress on health-related SDGs.

# Introduction

Five years have passed since the 2030 Agenda and its SDGs were adopted in 2015 by all 193 Member States of the United Nations *(1)*. The 2030 Agenda presents a universal call for action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030. Health is both an enabler and a major outcome of sustainable development. Achieving SDG 3 (health and well-being for all at all ages) will only be possible with action in other sectors and settings.

In consultation with Member States and with input from experts, the WHO Regional Office for Europe developed a roadmap to implement the 2030 Agenda, which was adopted in 2017 *(2)*. Efforts to implement the 2030 Agenda, the SDG roadmap and WHO's 13th General Programme of Work are aligned and mutually reinforcing. The GAP, which was endorsed by 12 global health and development agencies in 2019, presents a new opportunity to advance collective action and accelerate progress towards health-related SDGs *(3)*.

The aim of this report is to assess the current status of health and well-being in the Kyrgyz Republic in relation to achieving the goals and targets of the 2030 Agenda. This report will support the GAP country process in the Kyrgyz Republic by providing a starting point for new policy dialogues and development of future plans between the Ministry of Health of the Kyrgyz Republic, its development partners and stakeholders as they continue their work in partnership towards achieving the health-related SDGs in the Kyrgyz Republic.

## The 2030 Agenda

In September 2015, the Kyrgyz Republic was one of the 193 Member States of the United Nations that adopted the 2030 Agenda *(1)*. This historic global agenda built on the success of the Millennium Development Goals (MDGs), which covered the period 2000–2015. The 2030 Agenda strived to go further by addressing the root causes of poverty, recognizing the inherent need to balance economic growth with protection of the environment while ensuring equity and social inclusion for current and future generations.

The 2030 Agenda is built on three core principles that are particularly relevant to country level strategies and approaches to achieving health and well-being for all:

- **interconnectedness and indivisibility**: which are core features of all 17 SDGs;
- **leaving no one behind**: reaching out to all people in need and deprivation, wherever they are, in a manner that targets their specific challenges and vulnerabilities; and
- **inclusiveness**: participation of all segments of society, irrespective of their race, gender, ethnicity and identity, to contribute to implementation of the aims of the 2030 Agenda.

Efforts to achieve these goals of including all people and encouraging participation by all generate an unprecedented demand for local and disaggregated data to analyse outcomes and track progress. Taken together, the 2030 Agenda *(1)*, Health 2020: the European policy for health and well-being *(4)* and the WHO European SDG roadmap *(2)* define the role of health in sustainable development and provide a framework for country leaders to forge partnerships

with their development partners, national stakeholders and civil society as they work to ensure health and well-being for all while promoting prosperous societies.

## Health and well-being in the 2030 Agenda

The 2030 Agenda includes 17 SDGs with 169 targets that are broad in scope and intersectoral by design. The core health SDG is **SDG 3**: to ensure healthy lives and well-being for all at all ages. This SDG enshrines the global commitment to foster healthy societies and protect the rights of everyone to enjoy the highest attainable standard of physical and mental health. The SDG has 13 targets that are intended to address major health priorities, including reproductive, maternal and child health; communicable, noncommunicable and environmental diseases; universal health coverage (UHC); and access for all to safe, effective, quality and affordable medicines and vaccines. Health and well-being for all is also addressed directly and indirectly by many of the other sectoral SDGs under the 2030 Agenda.

Ensuring the health and well-being of the population is not only a specific goal for development it is also a necessary precondition for achieving sustainable development. Better health and well-being are heavily determined by economic, social and environmental conditions. Success in one SDG area heavily influences and is dependent upon success in other sectors.

Many of the non-health sector SDGs include targets that are both directly and indirectly related to health and well-being. For example, targets that directly impact the goal of health and well-being for all are found within **SDG 1** (poverty reduction), **SDG 2** (food security and nutrition), **SDG 4** (quality education), **SDG 5** (gender equality), **SDG 6** (clean water and sanitation), **SDG 8** (economic growth), **SDG 10** (reduction of inequality) and **SDG 11** (promotion of safe, sustainable cities). The challenge for policy-makers, therefore, is to develop an integrated approach to working towards health and well-being for all that covers both health and non-health sectors and recognizes the interdependencies between SDGs *(5)*.

## Methodology and development of the report

The following methods were used in the preparation of this report.

1. A desk analysis of national strategic policy and programme documents evaluated the extent to which SDG targets related to health and well-being were integrated into and addressed by national policies.

2. A trend analysis of available health-related SDG indicators was prepared using national and WHO statistics and epidemiological data from a variety of sources, including the Mandatory Health Insurance Fund (MHIF), the Ministry of Health, the National Statistical Committee of the Kyrgyz Republic (NSC) and international estimates. For each indicator, the primary data source was identified; where data were available, a trend analysis was performed to assess progress (data available on application). Where possible, data points were collected for 2000 and 2018. However, a trend analysis was not possible for many indicators because official definitions of indicators had changed over time. In addition, for some indicators, significant differences were noted between the Ministry of Health and NSC data and international estimates. The NSC is currently working on a formal process for verifying and finalizing sources and definitions of statistics that will be used for official SDG reporting. The figures and trends that appear in the body of the report reflect a collective best effort to portray progress, areas of concern and current state of health from available data and data sources.

3. Interviews were conducted with national health experts and United Nations bodies to identify the narrative, areas of progress and perceived gaps in addressing health-related SDGs. During interviews, participants were asked to provide examples of the ways in which the Kyrgyz Republic has already begun to advance the 2030 Agenda and put the core principles of the 2030 Agenda into action, namely interconnectedness, leaving no one behind and inclusiveness. These examples were not meant to be exhaustive but have been interspersed throughout the report to illustrate the commitment and level of effort already underway to advance the aims of health and well-being within the SDG framework in the Kyrgyz Republic.

4. A survey was carried out with GAP partner agencies using a questionnaire that covered ongoing and planned activities carried out in support of the health-related SDGs. Annex 1 summarizes responses to the questionnaire.

5. A high-level policy dialogue entitled A new approach to strengthen collaboration in health and sustainable development in Kyrgyzstan was organized by the WHO Regional Office for Europe and the WHO Country Office, in partnership with the Ministry of Health. The one-day meeting in October 2019 had around 70 participants, included representatives of the Presidential Administration and the Sustainable Development National Council, the Vice-Minister of Health, representatives from the MHIF and senior representatives from other government ministries (Ministry of Culture, Information and Tourism; Ministry of the Economy; Ministry of Education and Science; Ministry of Emergency Situations; Ministry of Foreign Affairs; Ministry of Internal Affairs; Ministry of Justice; Ministry of Labour and Social Development; and Ministry of Transportation and Roads), the NSC, the Office of the Government, the State Agency for Local Governance and Interethnic Relations and the State Agency for Youth, Physical Culture and Sports. Participants from GAP signatory country offices included representatives from the Global Action Plan Secretariat from WHO headquarters; the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund, represented by its Fund Portfolio Manager for the Kyrgyz Republic and its Eastern Europe/Central Asia Regional Manager); the Joint United Nations Programme on HIV and AIDS (UNAIDS); the United Nations Children's Fund (UNICEF); the United Nations Development Programme (UNDP); the United Nations Population Fund (UNFPA); and the World Bank. Other participants were the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), German Development Bank, German Embassy, International Organization for Migration, Japan International Cooperation Agency, Mercy Corps, Swiss Embassy, the Turkish Cooperation and Coordination Agency, the United Nations' Office of Drug Control and Crime Prevention (ODCCP) and the United States Agency for International Development (USAID). The policy dialogue was opened by the Deputy Minister of Health and other officials. This was followed by a presentation of the findings in the first draft of this report on the country's progress in health, a presentation on implementation of the SDG roadmap and an overview presentation on the GAP by the Global Action Plan Secretariat. This was then followed by discussion, a presentation about the country's voluntary national review preparations for 2020 and a panel discussion featuring the Deputy Minister of Health, Deputy Minister of Education and representatives from Mercy Corps, ODCCP, UNAIDS, UNDP, UNFPA and UNICEF. Closing remarks were provided by the Vice-Minister of Health and Dr Nazira Poolatovna Artykova, Head of the WHO Country Office Kyrgyzstan.

6. A collaborative technical workshop was organized with around 35 participants, including technical staff from the Ministry of Health and the MHIF and representatives of GAP signatory agencies (Global Fund, UNAIDS, UNICEF, WHO Global Action Plan Secretariat, regional and country offices and the World Bank) and several development partners (German Embassy, GIZ, International Organization for Migration and ODCCP). WHO outlined two key objectives of the workshop: (i) to discuss in small working groups how the GAP can add value at country level, looking specifically at four accelerator themes selected based on discussions during Day 1; and (ii) to identify how outputs from the workshop could inform national processes such as the common country assessments, the voluntary national review and joint annual reviews. Breakout groups were offered covering the four accelerators (sustainable financing for health; strengthen primary health care (PHC) and modernize public health; equity issues and regional disparities; and data and digital health). Workshop participants joined a group according to their expertise and which topic they wanted to discuss. The results of each group, including key bottlenecks and opportunities for progress, were presented to the rest of the participants. The discussions identified potential results and collaborative actions to achieve progress in these four areas over the next six months and by 2023. The conclusions are summarized in this report.

The results of the policy dialogue and the workshop informed the finalization and concluding set of recommendations of this report, which are aimed at stimulating further policy dialogues among key actors engaged in advancing a coordinated effort to improve health and well-being in the Kyrgyz Republic and accelerating achievement of the health-related SDGs in the 2030 Agenda.

# Health in sustainable development in the Kyrgyz Republic

## Sustainable development framework in the Kyrgyz Republic

The Kyrgyz Republic is strongly committed to implementing the 2030 Agenda, and its health sector is widely recognized as a leader in terms of aligning national priorities with SDG goals, working to adapt SDG indicators to the national context, integrating SDG goals and indicators into the state sector programme plan and following an intersectoral and whole-of-government approach to policy development as well as programme implementation.

In 2018 the Kyrgyz Republic launched important strategies: the new National Development Strategy for the Kyrgyz Republic 2018–2040 *(6)*, the accompanying five-year national implementation plan, and the Development Programme of the Kyrgyz Republic 2018–2022 – Unity. Trust. Creation *(7)*.

This was quickly followed by the release of the new health programme, the Programme of the Kyrgyz Republic Government on Public Health Protection and Health Care System Development for 2019–2030: Healthy Person – Prosperous Country (referred to hereafter as Health 2030) *(8)*. This detailed the country's health priorities and provided strategic direction for implementing health activities in the nation.

Importantly, these three strategic documents were developed over a two-year period beginning in 2016 during which there was a parallel process of national adaptation of the SDGs. As a result, as described in greater detail later in this report, the global SDG targets and indicators related to health and well-being were adapted for the national context. The SDG 3 targets and the nutrition-related components of SDG 2, in particular, are well integrated within Health 2030 *(8)*.

Taken together, these three documents articulate the policy framework and operational plan for advancing health and well-being in the Kyrgyz Republic within the larger context of the national framework for sustainable development.

## Governance for health within the broader national effort to advance the 2030 Agenda

Implementation of the 2030 Agenda in the Kyrgyz Republic is considered within the highest levels of Government under the National Council for Sustainable Development of the Kyrgyz Republic, which is chaired by the President. The Coordination Committee for SDG Achievement is responsible for oversight and implementation of the 2030 Agenda and includes representatives from Parliament, government agencies, line ministries, development partners and the NSC. The NSC has been granted authority to guide and oversee efforts to collect SDG-related data and build the evidence base (Fig. 1).

The process of national adaptation of global goals and indicators began in 2016. A national Coordination Committee on SDG Adaptation, Implementation and Monitoring was established under the direct supervision of the Prime Minister and included representatives from legislative bodies, ministries and government agencies, international organizations and nongovernmental organizations (NGOs). The Economics and Investment Division of the Government served as its

Secretariat. Under this body, a formal process of national adaptation of global SDG indicators began.

**Fig. 1. Policy framework for the 2030 Agenda in the Kyrgyz Republic**


The Ministry of Health made a significant contribution to the national SDG adaptation process by convening an interdepartmental technical working group to adapt SDG health-related objectives and indicators to the country context. A set of 45 suggested national indicators for health was developed; 32 of these were directly relevant to the targets expressed under SDG 3 while the other 13 were relevant for addressing health across other sectors. Passports were developed for each of these indicators defining data sources and baseline indicators for 2015 along with suggested targets for 2030 *(9)*.

Importantly, many, though not all, of these national health indicators were formally included in Health 2030 *(8)*. The national health indicator set continues to contribute to the NSC's ongoing national-level efforts to compile and report on the country's progress to achieving the SDGs.

In summary, there is high-level political leadership on implementation of the 2030 Agenda and the health-related SDGs in the Kyrgyz Republic; a history of multisectoral and multistakeholder collaboration in health; established national SDG and health coordination mechanisms; and coordination, commitment and investments among development partners to support implementation of the national health strategy.

Many of the ongoing activities build on existing coordination mechanisms. The Coordinating Council in Public Health was initially established in 2014 to support the implementation of the Public Health 2020 Health Protection and Promotion Strategy of Kyrgyzstan. It is led by the Vice Prime Minister responsible for social affairs and is tasked with coordinating intersectoral efforts on a government-wide basis to address public health throughout the country *(10)*.

There are other intersectoral committees and coordination mechanisms in place that address specific SDG health-related targets. For example, the Country Coordinating Mechanism for HIV/AIDS, Tuberculosis and Malaria, which was recently integrated with the Coordinating Council for Public Health, was established to secure and manage funding from the Global Fund. Membership of the Country Coordinating Mechanism includes representatives from government, the private sector, technical partners, civil society and communities living with the diseases, and one of

the two chairpersons is a member of civil society. The Country Coordinating Mechanism has become an important platform for fostering partnerships between government and civil society to address HIV and tuberculosis (TB). This model allows a strong voice for civil society to help to ensure that the needs of vulnerable and marginalized groups are addressed. With a large number of coordination committees for active disease or health-specific issues, there is potential for overlap and/or missed opportunities for broader intersectoral collaboration towards the achievement of health and well-being for all. Currently, WHO is collaborating with the Ministry of Health to conduct an assessment of governance for health that will examine possibilities for developing an approach that is both intersectoral and across levels of government.

## Development of the Kyrgyz State health programmes

In 2018, Health 2030 was approved by the Government of the Kyrgyz Republic *(8)*.

The Kyrgyz Republic has a history of using national programmes to guide long-term health reforms *(11)*. Since 1996, three consecutive reform programmes have been implemented: *Manas* (1996–2006) *(12)*, *Manas Taalimi* (2006–2011) *(13)* and *Den Sooluk* (2012–2016, then extended to 2018) *(14)*, all aiming at transforming the health system from a historical *Semashko* type of system towards a new model. The current Health 2030 was approved in 2018 and should be viewed as a continuation and acceleration of the ambitious health reform agenda the Kyrgyz Republic embarked upon in 1996. The country has been recognized for its efforts to undertake sweeping reforms of its public health system with the broad aims of strengthening PHC, restructuring the hospital sector and introducing a mandatory single payer system with the goal of safeguarding the public from financial risk and ensuring guaranteed provision of essential services.

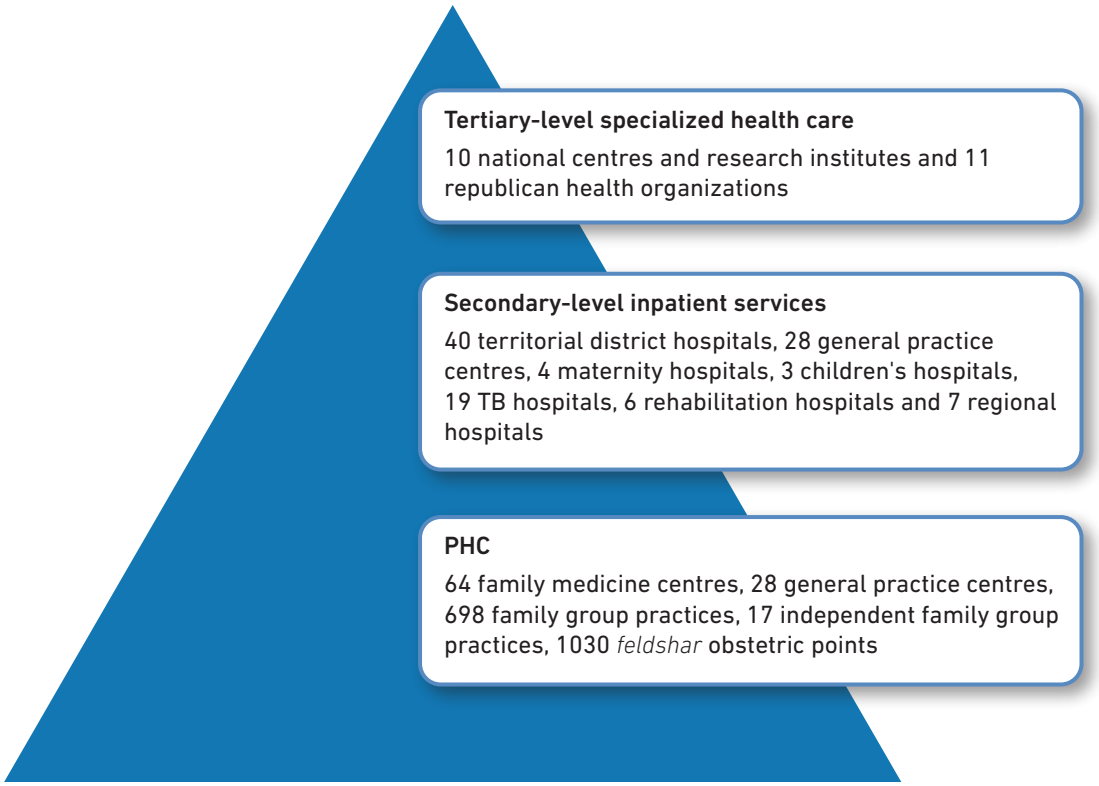
One of the most important early reforms was the introduction of a purchaser–provider split and the establishment of a single payer system for health services along with a state-guaranteed benefit package (SGBP). The SGBP sought to provide essential PHC services for all and free or reduced cost hospital services for certain groups of people while defining citizens' rights to free care. Responsibility for purchasing health services was consolidated under the MHIF while authority for health policy development and oversight was granted to the Ministry of Health. Since 2006, pooling of funds has been carried out at the national level (instead of the region (*oblast*) level) allowing a more equitable distribution for the SGBP and the Additional Drug Package (ADP). These mechanisms continue to form the basis of the health financing system and citizens' right to a guaranteed package of essential services today.

Similarly, early efforts to reorient the health-care system from providing costly, disease-oriented health care to providing less-expensive, prevention-oriented care within PHC led to the establishment of the structures and mechanisms that today serve as the foundation for delivery of PHC and community-based health promotion efforts. Under *Manas*, the family medicine model was introduced through the creation of the Family Medicine Institute and the establishment of a nationwide network of family doctors/group practices. Today, these service points and structures serve as the backbone of the PHC system.

Beginning in 2001, the Kyrgyz Republic and its development partners invested heavily in establishing a unique network of village health committees as a way to link population-based health promotion to delivery of individual health services. These committees are independent community-based organizations whose members work as volunteers.

They are trained by PHC staff to implement health promotion and prevention activities in their villages. By 2009, more than 1400 such committees were active in the country *(15)*. In 2019, there were 1800 village health committees covering almost 90% of all villages as well as many urban neighbourhoods (Fig. 2).

**Fig. 2. The Kyrgyz health-care delivery system**




The role of village health committees has evolved over time and is a hallmark of the health sector's efforts to engage civil society in public health activities. While the committees continue to play an important role in partnering with PHC service points to carry out community-based health prevention and promotion activities, they now also serve as a strategic partner at the national level through an association of village health committees. This association contributes to national health policy discussions and coordination with the Republican Health Promotion Centre in the planning, design and implementation of national prevention actions to address alcohol abuse, anaemia, brucellosis, goitre, hypertension and tobacco control, among others *(16)*.

Under *Manas Taalimi*, health became the first sectoral programme in the Kyrgyz Republic to integrate achievement of its global development commitments under the MDGs into state policy and national programmes. Tracking, measuring and reporting systems on MDG 4 (reducing child mortality), MDG 5 (improving maternal health), and MDG 6 (combating HIV/AIDs, malaria and other diseases) were incorporated into *Manas Taalimi*. This practice has continued and expanded with each subsequent national health programme.

Health 2030 was envisioned as a larger cross-government exercise to develop a 20-year strategy for the country that was aligned with the 2030 Agenda *(17)*. A new approach was adopted from the very beginning in the development of this strategic document. The idea was to build consensus and gather input from as wide a range of intersectoral stakeholders as possible at the national, regional and local levels. The Ministry of Health established intersectoral and inclusive working groups that functioned at the national advisory and technical levels, with participation from parliamentarians; representatives from municipal and regional government, civil society, academia and professional medical associations; key ministries (e.g. Ministry of Economy, Ministry of Education, Ministry of Finance and Ministry of Labour and Social Development); public health experts; development partners; and the MHIF. The two-year process included policy dialogue forums and regional and local consultations as means to elicit input and garner support.

The consultative intersectoral process used to develop Health 2030 has important implications for future work related to advancing the health-related SDG agenda. Firstly, one of the goals in developing Health 2030 was to align national policy and programme priorities as closely as possible with the SDG health agenda. As a result, the country's main health priorities and the indicators that have been selected to track Health 2030 are well aligned with the SDG indicators.

Second, the approach demonstrated the commitment and the acknowledgment by the Ministry of Health that addressing the health needs of the nation requires an intersectoral approach as well as the involvement of civil society. The Ministry of Health has experience and an institutional tradition of working on an intersectoral basis to develop and implement health policy.

Lastly, including development partners as key stakeholders throughout the process instilled a shared vision of the country's health policy agenda and strong commitment among the development partners to support the aims of Health 2030. This commitment is evidenced by the official joint statement that was signed by 25 development partners in August 2019 pledging their support and collaboration to the Ministry of Health in implementing the current health strategy *(18)*.

## Priorities of Health 2030

Health 2030 focuses on working towards universal coverage of health services for all, reducing inequities in health, ensuring access to quality health services without financial hardship, and strengthening the emphasis on disease prevention and health promotion at the individual, community and health systems level (Box 1).

**Box 1. Main priorities of Health 2030**

- Public health
- Development of PHC
- Improvement and rationalization of the hospital system
- Drugs and medical services
- Health-care governance
- Human resources in health care
- Development of electronic systems for health
- Development of the financing system
- Management of implementation of the programme

### The main health targets addressed through national policies

Health 2030 was prepared in parallel with the broader national exercise for adaptation of the global SDGs. As a result, the national version of SDG targets and indicators associated with SDG 3 (health and well-being for all) and the nutrition-related targets from SDG 2 (zero hunger) are well integrated within the programme document.

Annex 2 lists the key laws, regulations and national programme plans underpinning the legal, regulatory and operational framework for implementation of Health 2030 and several health-related targets that fall outside the main purview of the Ministry of Health. This list is not intended to be exhaustive but it includes key laws, regulations and national programmes related to control and prevention of specific diseases; health promotion and protection; and health system improvements; plus non-health sector national programmes that are closely related to achieving SDG health-related targets.

## Monitoring and evaluation and the role of the Ministry of Health

Within the health sector, national adaptations of the global targets and indicators related to SDG 3 and the nutrition components of SDG 2 are well integrated into Health 2030 documents and will, consequently be monitored and evaluated as part of the country's existing system for compiling national and departmental health and health-care statistics and routinely assessing progress towards fulfilment of the country's strategic health plan.

Health 2030 presents baseline, interim and long-term targets for a defined set of national level indicators, many of which correspond to SDG 3 and the nutrition components of SDG 2. The interim and long-term targets for this set of indicators will be periodically reviewed and adjusted by the Ministry of Health. The first review is planned to take place after completion of the first five years of implementation of Health 2030.

### Existing systems for data collection

The Ministry of Health and the MHIF routinely collect data from all health facilities related to health statistics and the usage of health-care services. The MHIF collects hospital discharge data through its online platform. The Ministry of Health routinely collects data using a combination of paper forms and electronic data management systems through the Centre for e-Health and the NSC *(19)*. It should be noted, however, that existing data collection systems are not well integrated, which hampers the ease with which managers and policy-makers can regularly use monitoring data to inform policy and programme decision-making.

An electronic platform has been established expressly for compiling data on the quality of medical care. This system integrates quality of care information from the MHIF database and the Ministry of Health's database in the Centre for e-Health and will be used to track indicators related to quality of services. Data obtained using the electronic medicines prescription software system will be used to monitor prescription practices and usage of medicines covered by the ADP.

Some of the data with regard to the SDG-related indicators are obtained through specialized studies and population-based surveys such as the STEPwise approach to surveillance (STEPS) survey in 2013 (for NCDs), the Global Youth Tobacco Study 2014 *(20)* and the Multiple Indicator Cluster (MIC) surveys in 2014 and 2018. The Ministry of Health's ability to carry out these studies depends on securing external financial support.

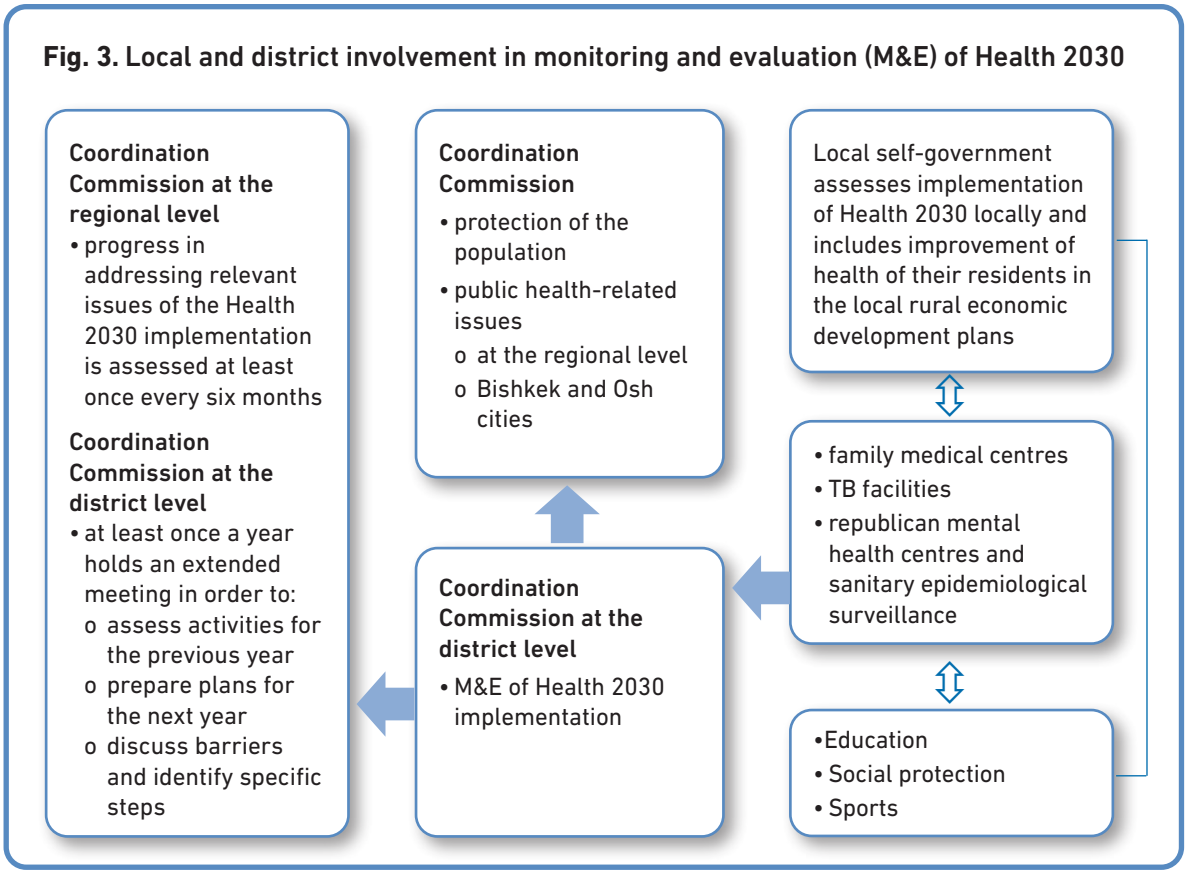
## Use of disaggregated data to track progress on reaching vulnerable and marginalized population groups

In comparison with other development sectors, the health sector generates a considerable amount of data through routine reporting systems and population-based surveys. These data can be disaggregated by health and demographic characteristics and used to help to identify at-risk populations and, potentially, track progress in improving health and well-being for underserved, at-risk or marginalized groups. Examples of such data sources include national statistical datasets on disease morbidity and mortality and associated risk behaviour; the 2018 MIC Survey *(21)*, which provided district-level data on a variety of maternal and child health indicators; and the 2016 Integrated Biological Behavioural Survey *(22)*, which provides detailed information related to prevention and control of communicable diseases among at-risk groups.

## Tracking progress in achieving national health priorities

Overall coordination of monitoring and evaluation of state health programmes is performed by the Ministry of Health with input from state bodies, local self-governments and other stakeholders, including development partners involved in health-care delivery and achievement of the nation's health targets. A regular feedback mechanism has been instituted to engage local, district and regional level officials in the monitoring and review of progress towards the national health priorities (Fig. 3). The Ministry of Health initially developed a health system monitoring and evaluation tool in 2002. This tool is used to assess country progress, on an annual basis, towards achieving the goals and targets set out in the national strategic health plan (e.g. the mid-term review of *Manas Taalimi* in 2008 *(23)*). The tool has been continuously updated to align with the goals and priorities of each new subsequent national health programme.

**Fig. 3. Local and district involvement in monitoring and evaluation (M&E) of Health 2030**



## Joint reviews with development partners

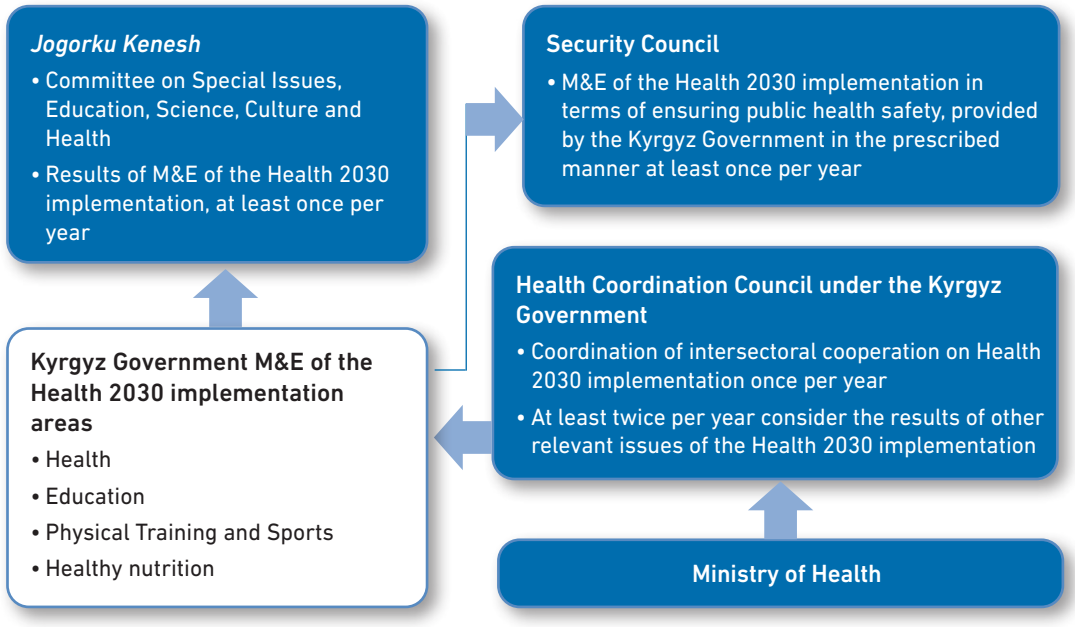
Within the Ministry of Health, the Department on Reforms and Implementation is responsible for conducting annual reviews of the overall progress towards realizing the targets set out in Health 2030. The Department is tasked with preparation and presentation of the annual progress report during the Joint Annual Review thematic weeks dialogue with the nation's health development partners, which is held within the One Monitoring Framework. The Joint Annual Review is an important institutional coordination mechanism that enables the Ministry of Health to work in close collaboration with the nation's health development partners to jointly assess annual progress, ensure that all financial support and project activities are supporting national health priorities and realign financial and project support as required.

## Monitoring health-related SDG progress at the national level

Underscoring the commitment by the Kyrgyz Republic to achieve the 2030 Agenda, sectoral progress towards achieving the SDGs will be monitored at the highest political level for the first time. Health sector progress towards achieving the SDGs will be reported to Parliament and presented to the national Security Council, which is chaired by the President of the Kyrgyz Republic. Under an amendment to the Decree on the Public Health Coordination Council under the Government of the Kyrgyz Republic, annual progress towards achieving health-related SDGs will be reported to the Government, Parliament and the Security Council (Fig. 4).

The NSC has been designated as the main entity responsible at national level for compiling data on national progress related to achievement of the 2030 Agenda across all sectors, including health. The NSC is currently developing an open-source data platform that will enable all stakeholders, including the public, to easily review and monitor the nation's progress in achieving the 2030 Agenda *(24)*.

**Fig. 4. Monitoring and evaluation (M&E) of Health 2030 implementation at the national level**



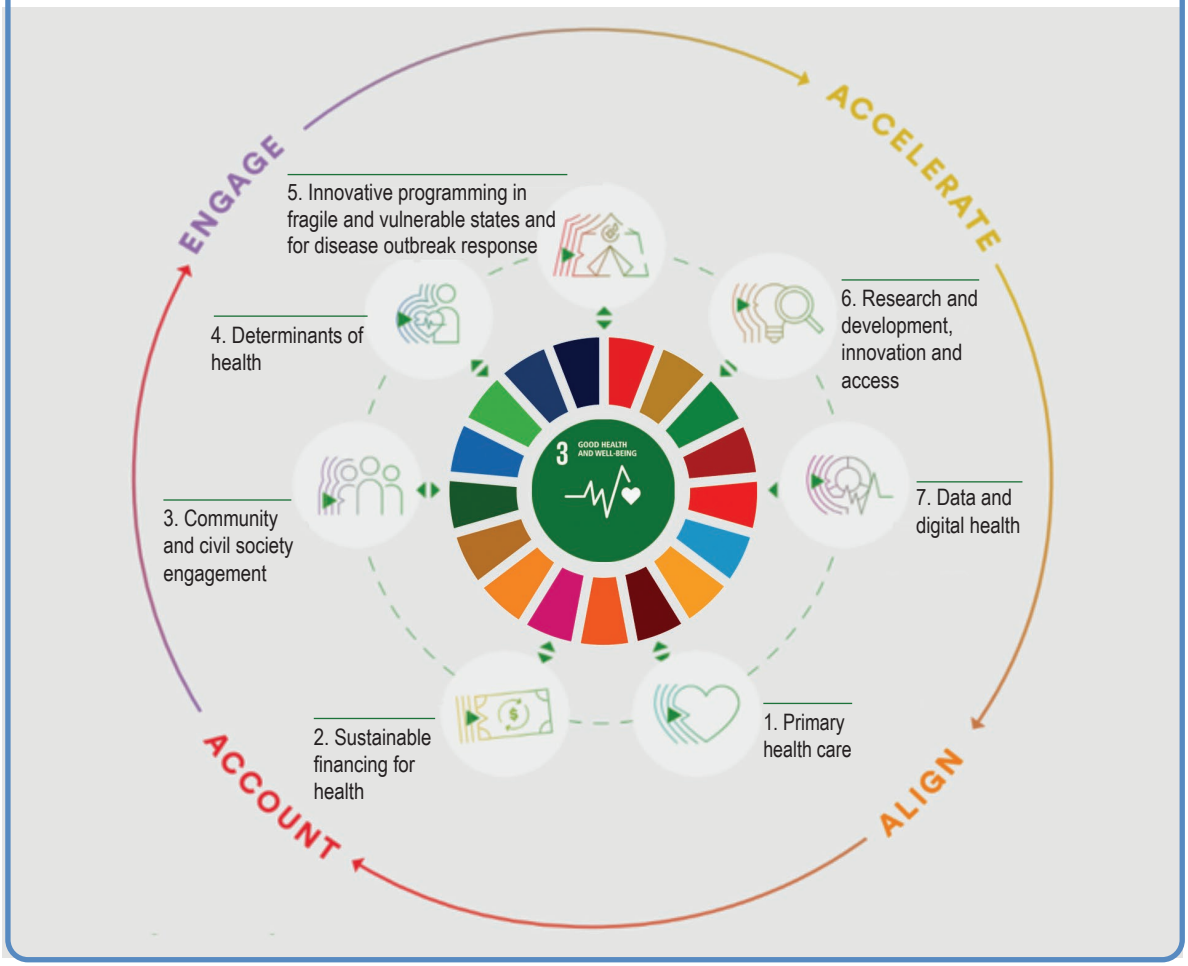
## Support for the 2030 Agenda in the Kyrgyz Republic

### The GAP strengthens collaboration and accelerates progress on health-related SDGs

The GAP represents a new opportunity to advance collective action towards the health-related SDGs. This joint initiative by 12 leading global health and development agencies is committed to supporting national efforts to achieve health-related SDGs. Signatories include the GAVI Alliance, the Global Fund, the Global Financing Facility, UNAIDS, UNDP, UNFPA, UNICEF, Unitaid, UN Women, WHO, the World Bank and the World Food Programme.

While focusing on health and well-being, the approach cuts across SDG sectors and commits global agencies to developing new ways of working together to maximize resources and measure progress in a more transparent way. Under the GAP, global health agencies will coordinate their approaches to support national plans and strategies by (i) identifying country priorities and implementing these together through engagement and dialogue; (ii) accelerating progress against health-related SDG targets by providing coordinated support under specific accelerator themes (Fig. 5); (iii) aligning and harmonizing operational and financial strategies, policies and approaches in support of countries to enhance effectiveness and efficiency; and (iv) shared

**Fig. 5. Key areas of collaboration in the GAP**



accounting for their actions by reviewing progress together. The GAP framework to advance collective action and accelerate progress towards the health-related SDGs was launched at a high-level political forum at the 74th session of the United Nations General Assembly in September 2019 and endorsed by resolution 74.4 *(25)*. Following the launch, the global process of country engagement officially began.

### United Nations support to implement the SDGs

The new GAP country engagement process to advance the health-related SDGs in the 2030 Agenda will take place within the broader context of larger efforts by the United Nations to support the Kyrgyz Republic in advancement of the 2030 Agenda. A key role of the United Nations Development System is to support the implementation of the commitment of the Kyrgyz Government in achieving the SDGs *(26)*.

In 2018 the United Nations Development System conducted a **mainstreaming, acceleration and policy support** (MAPS) exercise in the Kyrgyz Republic. The MAPS exercise was a United Nations system-wide undertaking carried out in collaboration with government ministers, technical specialists and representatives of the private sector and civil society. The goal of the exercise was to provide feedback on the alignment of national development strategies with the 2030 Agenda and to identify gaps and opportunities for working collaboratively to advance the 2030 Agenda *(27)*. The MAPS approach is intersectoral and takes a broad look at all of the 17 SDGs (including health) as well as national level coordination mechanisms for continuing and strengthening collaboration.

Following from the MAP exercise, the Kyrgyz Republic will carry out a **rapid integrated assessment** in the autumn of 2019, with technical support from UNDP, to help to define a national roadmap for implementation of the SDGs across sectors. The rapid integrated assessment is likely to include areas related to health although at the time this report was prepared, the sector focus had yet to be finalized.

The Kyrgyz Republic has also committed to prepare a **voluntary national review** on SDG progress by early 2020, with technical support from UNDP. The Government has already established a Secretariat to coordinate this, together with technical working groups. Health-related topics are also likely to be included.

### United Nations interagency, in-country working group on SDGs

The United Nations Development System within the Kyrgyz Republic has established an interagency SDG working group to coordinate United Nations efforts to advance the 2030 Agenda and advocate with government ministries, Parliament and other key stakeholders. Beginning in 2019, the SDG working group collaborated with the University of Central Asia to organize a series of high-level policy forums to promote the SDGs. The selected topics were highly relevant to advancing the 2030 Agenda. Policy forums were attended by a wide range of participants from government, academia, development partners and civil society and dealt with topics including nutrition and food security; strengthening emergency health preparedness; and developing a comprehensive strategy for migration. Policy briefs were published for each discussion *(28–30)*.

### Open-source online platform for reporting on SDGs

The NSC is currently participating in a project supported by the United Nations Statistical Division and the Department for International Development (United Kingdom) on SDG monitoring to make SDG data open and available to the widest possible audience. A prototype open-source data platform for the Kyrgyz Republic is under development, which will include health-related SDG indicators specific for the Kyrgyz Republic *(24)*.

### WHO support for health policy development and advancement of the 2030 Agenda

WHO plays a leading role in supporting the Ministry of Health in developing health policy and coordinating technical and financial support from development partners for the health sector. WHO has provided significant technical support to the Ministry of Health for the national adaptation of the SDG health targets and indicators as well as for the development of Health 2030.

In 2017, the Ministry of Health and WHO collaborated on the first-ever mapping of official development assistance for health in the Kyrgyz Republic using data from 2015 *(31)*. This exercise proved to be an invaluable tool for strengthening the efforts of the Ministry of Health and its development partners to ensure that development assistance in health was well aligned with national health priorities and that limited resources were used as catalysts to promote sustainability or scale up priority interventions. The second round of mapping of official development assistance was conducted in 2018–2019 based on data from 2017. The Development Partners' Coordination Council Health Sector Work Group, which is the main national level coordination mechanism for development partners working in the health sector, is chaired jointly by WHO and the World Bank, at the request of the Ministry of Health.

# Trends and status of the health-related SDGs in the Kyrgyz Republic

## Overview of the health of the population

With an estimated population of 6.3 million in 2018, the Kyrgyz Republic is one of the poorest countries in the WHO European and Central Asian Regions, with a gross domestic product (GDP) per capita of US$ 1281 *(32)*.

The population growth was 1.9% in 2018 *(32)* and, while the current population is relatively young, 36% are children and adolescents aged 0–17 years and 60% are adults of working age. Demographic projections predict ageing of the population by 2050, which will bring new challenges to the health-care system.

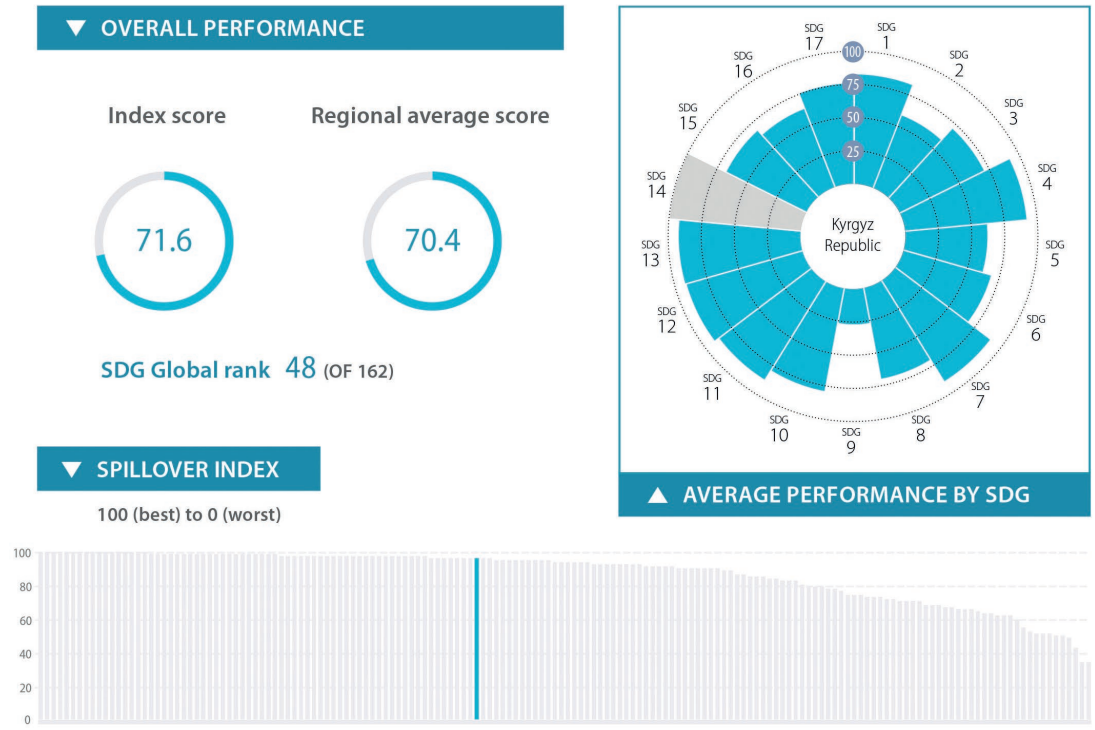
Health has traditionally been a priority in the Kyrgyz Republic and the country has achieved better health outcomes than seen in other countries with a similar income level. The Kyrgyz population experienced an increase in longer life expectancy, from 66.5 years in 1996 to 71 years in 2017 *(32)*, in part reflecting significant progress in reducing child mortality. The total mortality rate for the country in 2017 was 5.4 per 1000 population *(8)*. While improvements have been made in significantly reducing child and maternal deaths, infant and maternal mortality remain unacceptably high *(33)*. Moreover, disparities in health outcomes for women and children in rural compared with urban areas need to be addressed.

The country has a high burden of noncommunicable diseases (NCDs), accounting for 80% of the deaths in the country *(34)*. High rates of smoking, particularly among men, combined with a low level of public awareness about the connection between diet, lifestyle and health outcomes contributes to this problem. While the country has made progress in prevention and control of communicable diseases, recent trends demand an urgent response.

## The Kyrgyz Republic in the global SDG dashboard

The 2019 Global SDG index and dashboards report presents a revised and updated assessment of countries' distance to achieving the SDGs and also provides a ranking of countries by the aggregate SDG index of overall performance. According to the latest Sustainable Development Report, the Kyrgyz Republic occupies the 48th place among 162 countries (Fig. 6). Specific to SDG 3 (health and well-being), the country is assessed as having achieved close to 75% of its targets which is considered "moderately good progress" towards achieving the SDGs for health *(35,36)*.

**Fig. 6. SDG progress in the Kyrgyz Republic, 2019**




*Source*: Sustainable Development Solutions Network, 2019 *(36)*.

## Assessment of SDG 3 health targets

A review of available national data related to SDG 3 indicators and 67 health-related indicators from 11 SDG sectoral areas (SDG 1, SDG 2, SDG 4, SDG 5, SDG 6, SDG 8, SDG 10, SDG 11, SDG 12, SDG 13 and SDG 16) was conducted. For each indicator, the primary data source was identified and a trend analysis of the available data was performed to assess progress (data available on application).

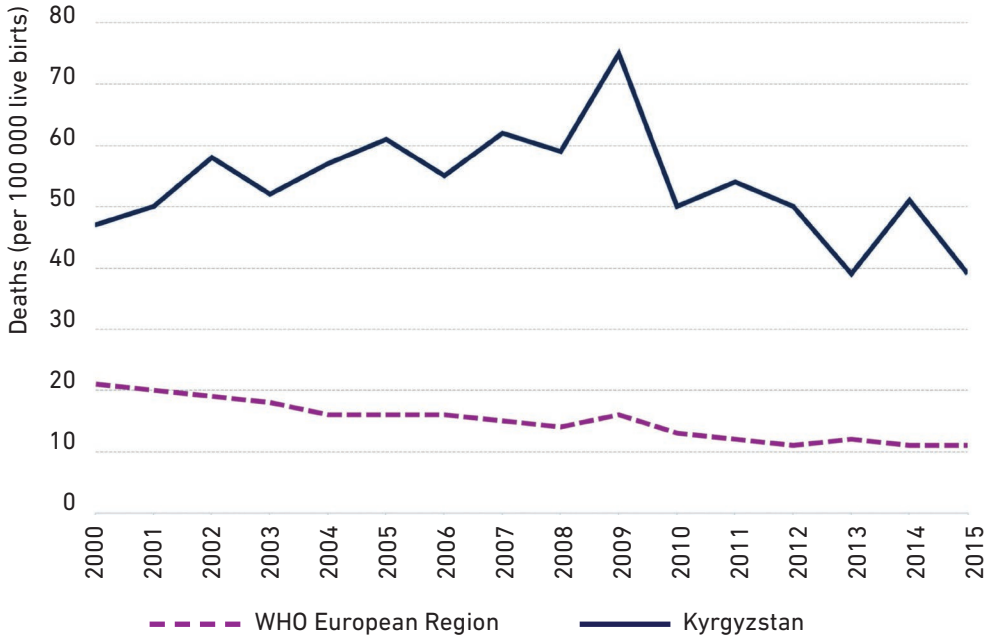
Based on the indicator analysis and the review of national policy and programme documents, the following section presents a discussion of the status and trends of health-related targets and indicators with a particular focus on progress related to SDG 3 (health and well-being). The subsequent section deals with health-related topics within the other SDGs, particularly SDG 2 (nutrition components), that are directly addressed within Health 2030.


### SDG 3.1. Reduce maternal mortality

While significant gains have been made in reducing maternal mortality, the maternal mortality ratio remains high in comparison to levels in the WHO European Region (Fig. 7). In 2018, the maternal mortality ratio was 24.5–28.6 deaths per 100 000 live births according to official statistics of the country (**SDG 3.1.1**) *(21)*. Global estimates suggest it may be considerably higher. The 2015 WHO/

UNICEF estimate was 76 deaths per 100 000 live births *(37)* while the 2017 estimate from the Institute for Health Metrics and Evaluation (IHME) was 39.4 deaths per 100 000 *(38)*.

**Fig. 7. Trends in maternal mortality rate, 2000 to 2015**




*Source*: WHO Regional Office for Europe, 2019 *(39)*.

Postpartum haemorrhage has been the leading cause of maternal mortality since the 2000s. Other main causes include extragenital pathologies, pre-eclampsia and sepsis. As early as 2006, the country began implementing WHO clinical audit tools as part of a "Beyond the Numbers" approach to preventing maternal deaths. The Confidential Enquiries into Maternal Deaths review is implemented at the national level and the Near-Miss Case Review at the hospital level. In 2018 a perinatal audit (mortality audit for stillbirths and neonatal deaths) was introduced in six pilot maternity departments around the country. The pilot initiative has been well received and the Ministry of Health is currently considering scaling this tool up as a strategy for reducing neonatal deaths.

Under *Den Sooluk* (2012–2018), improving maternal and child health outcomes (including reducing maternal deaths) was one of the four top health priorities. Between 2000 and 2018, the maternal mortality rate was reduced by 37%: from 45.5 deaths per 100 000 in 2000 to 24.5–28.6 in 2018 *(21)*.

Improving maternal and child health remains a national priority under Health 2030. Coverage of antenatal, skilled delivery and postnatal care services for pregnant women and new mothers is exceptionally high. In 2018 99% of pregnant women received at least one antenatal care visit; 100% had a skilled attendant at delivery (**SDG 3.1.2**) and 96% of new mothers received a postnatal care visit within the first two days after delivery. There were no significant regional differences in service coverage *(21)*.

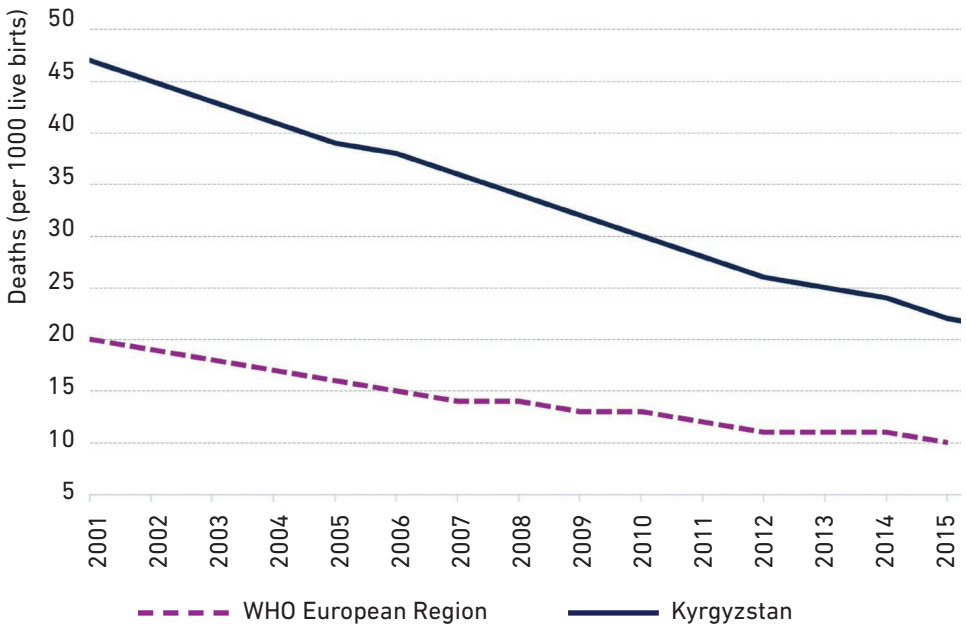
Unpublished monitoring data from the Ministry of Health suggest that maternal deaths may be occurring with more frequency among refugee and migrant women (both those moving into the country and those moving internally). These data require further investigation to understand whether refugee and migrant women are at higher risk and whether barriers to enrolment for services, inability of women and their families to recognize obstetrical emergencies in a timely manner or lack of emergency transport could be contributing to maternal deaths.

Continued high maternal mortality, against a backdrop of high coverage of antenatal, delivery and postnatal services, suggests possible underlying problems with the quality of care. To develop a clearer understanding of the dynamics that are contributing to maternal mortality, the Ministry of Health is collaborating with WHO to implement clinical audits according to the global "Beyond the Numbers" approach. Information from these audits will assist in developing measures to further reduce maternal deaths.


### SDG 3.2. End preventable deaths of newborns and children under 5 years of age

Since 2000 there has been a steady decline in the mortality rates for neonates, infants and children under 5 years of age (Fig. 8). In 2015 the Kyrgyz Republic achieved the MDG 4 target related to reducing child mortality. Under-5 mortality fell from 65 deaths per 1000 live births in 1990 to 21 in 2015 *(40)*. Findings from a recent situational analysis of newborn health, conducted with support of UNICEF (2019), confirmed substantial progress has been made in reducing neonatal mortality related to investments in PHC and efforts to address underlying social determinants of health.

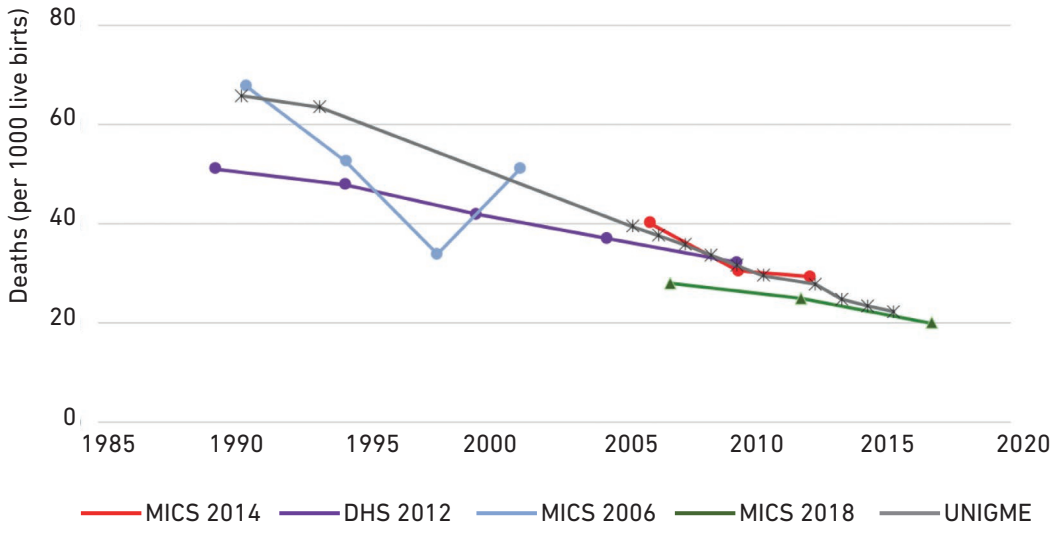
**Fig. 8. Trends in mortality for children under 5 years of age, 2000 to 2015**




*Source*: WHO Regional Office for Europe, 2019 *(39)*.

Despite impressive progress, child and neonatal mortality remain high in comparison with other countries in the WHO European Region. In 2018 the mortality rate for children under-5 was 20 deaths per 1000 live births (**SDG 3.2.1**) and neonatal mortality was 13 deaths per 1000 live births (**SDG 3.2.2**). Infant mortality was 17 deaths per 1000 live births during this same period (Fig. 9) *(21)*.

**Fig. 9. Trends in mortality for children under 5 years of age from different studies**




*Note*: data were taken from the final reports of the MICS surveys in 2006, 20212 and 2014 and the Demographic and Health Survey in 2012.
*Source*: NSC & UNICEF, 2019 *(21)*.

The MICS in 2019 revealed that disparities in child deaths exist. The mortality rate of children under-5 is higher in rural areas, among poor families in the lowest wealth quintile and among mothers with low levels of education *(21)*. This suggests targeted efforts are needed to improve access to quality services and address other factors affecting at-risk children both in rural areas and among vulnerable families in urban communities.

Postnatal home visits are an important existing mechanism for improving child health and delivering potential life-saving interventions. Despite reported high rates of postnatal home visits, information from UNICEF indicates that only a quarter of newborns are covered by home visiting services within two days after discharge from hospital. Health workers often lack sufficient capacity to provide quality primary care to save lives of newborns at risk, identify developmental delays in children and support caregivers in seeking essential health care, including immunizations and adopting healthy child-rearing practices. Efforts are underway to strengthen and expand home visiting services for promotion of child health.

### *Adolescent health*

Given the country's relatively young age structure, protecting and promoting adolescent health is critical to ensuring the long-term health and well-being of the population. WHO defines

adolescence as those aged 10–19 years and youth as those aged 15–24 years. There is no specific focus on adolescent health within the Health 2030 nor within the SDGs. Based on available data, the main causes of premature death during early adolescence are drowning, road injuries and lower respiratory infections. As adolescents grow older, road injuries, self-harm and violence become significant causes of death *(41)*. Early childbearing (the proportion of women aged 15–19 years who are pregnant or have given birth) is at 7% (5% among urban and 8% among rural adolescent girls) *(21)*.

More attention is needed to promote and protect the health of young people in the Kyrgyz Republic. Data disaggregated by relevant age strata to monitor health outcomes during the adolescent period are not readily available through the country's health management information system. Efforts are needed to modify existing data collection systems to better capture information on adolescent health and develop tailored programmes that address age-specific risks to their health and well-being.

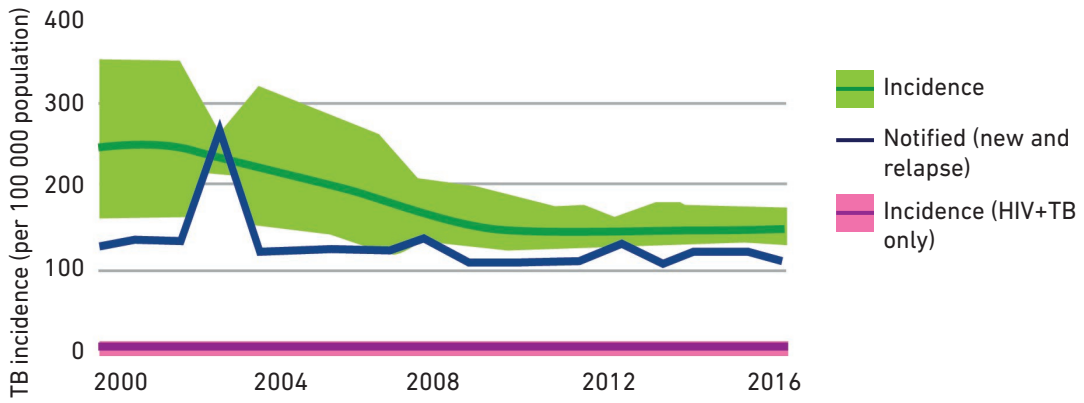

## SDG 3.3. End the epidemic of HIV/AIDS and TB and other communicable diseases

Prevention and control of communicable diseases, particularly TB, HIV/AIDS and viral hepatitis continue to pose challenges. The Ministry of Health collects data through its routine reporting system on diagnosis of new cases (proxy for incidence) for hepatitis B, HIV, malaria and TB. These data will be used as the basis for national SDG 3.3 indicator reporting on efforts to prevent and control communicable diseases.

### *TB*

As a result of a strong Government commitment to combat TB, the country has improved its modern diagnostic capabilities and quality of care, which has contributed to reductions in TB morbidity and mortality. Despite these efforts, the Kyrgyz Republic continues to experience high levels of TB incidence compared with other Member States in the WHO European Region and is one of 30 countries worldwide with a high burden of multidrug-resistant TB (MDR-TB; Fig. 10) *(42,43)*.

**Fig. 10. WHO estimated TB incidence in the Kyrgyz Republic, 2000 to 2016**



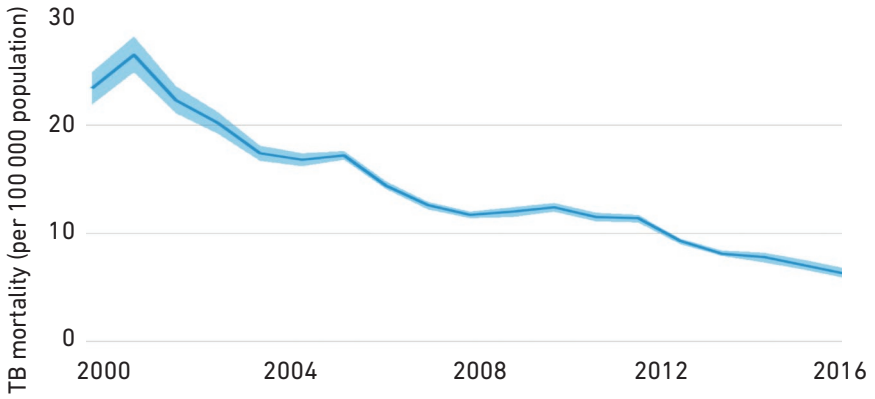

*Source*: WHO, 2017 *(43)*.

In 2017, the Kyrgyz Republic had the highest TB incidence in the WHO European Region, with 144 cases per 100 000 population (**SDG 3.3.2**). While there has been a slight decline in estimated incidence since the mid 2000s, the rate of decline has been relatively slow.

The growing proportion of MDR-TB among those with newly diagnosed TB is a cause for concern. It is estimated that 26% of all new cases of TB are either MDR-TB or rifampicin-resistant strains, while 61% of re-treated patients had both *(43)*. The country has developed an intersectoral national strategy to address antimicrobial resistance. WHO currently supports the country in strengthening the capacity of specialists in antimicrobial resistance.

TB mortality has declined steadily since 2001, with the current TB mortality rate estimated at 6.7 per 100 000 population in 2016 (Fig. 11) *(43)*. In contrast to TB, mortality for TB/HIV coinfection is rising. Between 2001 and 2017, TB/HIV mortality increased 10-fold: from 0.12 to 1.1 per 100 000 population *(43)*.

**Fig. 11. Decrease in TB mortality in the Kyrgyz Republic, 2000 to 2016**




*Note*: excludes HIV/TB coinfections.
*Source*: WHO, 2017 *(43)*.

The Kyrgyz Republic has worked steadily since 2013 to introduce a system of modern molecular methods for diagnosis and to update treatment approaches for the management of patients with TB, MDR-TB and TB/HIV. These efforts have enabled improvement in diagnostic services, an 82% treatment rate for those with new and relapsed TB and a 54% treatment rate for those with MDR-TB or rifampicin-resistant TB *(43)*.

In 2019 WHO supported an epidemiological assessment of TB surveillance, which provided a detailed picture of the TB burden for the country (unpublished data).

The current national programme on prevention and control of TB covers 2017–2021. The goal of the programme is to further reduce morbidity and mortality from TB and prevent a rise in the incidence of drug-resistant TB. The programme places a high priority on extending services to groups at high risk of developing TB, including contact children up to 5 years of age, individuals living with HIV infection, people with drug or alcohol dependency, refugees and migrants, ex-prisoners, medical personnel and people with chronic diseases associated with reduced immune

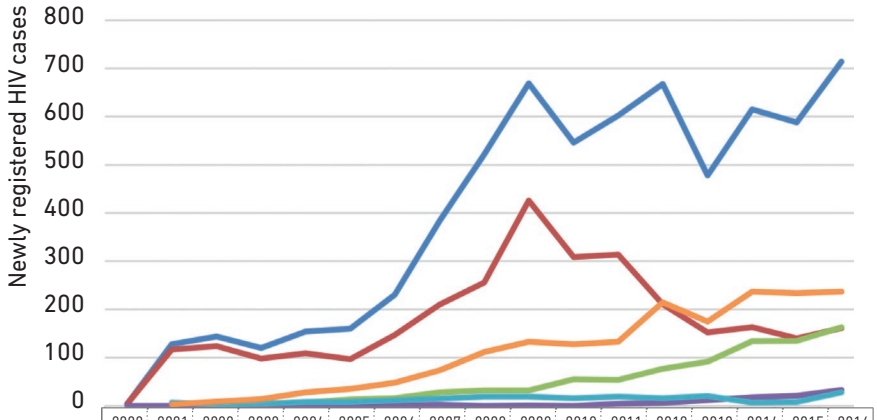
status. Efforts are underway to strengthen public partnerships with civil society towards the goal of better TB prevention and control.

TB treatment is covered under the SGBP. In anticipation of a reduction in external funding for the programme, a target has been established to cover 44% of the programme costs from the state budget.

### *HIV/AIDS*

The HIV epidemic in the Kyrgyz Republic is characterized as a low-burden, concentrated epidemic that affects key populations, including people who inject drugs (PWID), sex workers and men who have sex with men (MSM). The estimated HIV prevalence in the general adult population (aged 15–49 years) is 0.2% *(44)*. In comparison, prevalence among risk groups is estimated at around 12.4% for PWID, 11.3% for prisoners, 6.3% for MSM and 2% for sex workers. The number of children who have been newly infected with HIV through mother-to-child transmission is estimated at fewer than 100 per year, with a steady decrease from 6% in 2012 to 2.3% in 2019. The latest available data for 2019 showed 9288 people living with HIV, which included approximately 500 children and adolescents. Of these, 3804 (approximately 40%) are currently taking antiretroviral therapy (UNAIDS Country Representative, personal correspondence). In 2007, the country achieved significant progress with new measures to prevent mother-to-child transmission of HIV. Coverage with antiretroviral therapy for pregnant women living with HIV went from an estimated 19% in 2007 to 95% in 2008. In 2018, an estimated 88% of pregnant women living with HIV receive antiretroviral therapy (Fig. 12) *(45,46)*.

**Fig. 12. Number of newly registered HIV cases in the Kyrgyz Republic, 2000 to 2016**




| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Newly registered HIV cases, all cases | 4 | 128 | 144 | 120 | 154 | 160 | 231 | 384 | 522 | 669 | 546 | 602 | 668 | 478 | 615 | 588 | 714 |
| Men, drug injecting route | 4 | 117 | 124 | 98 | 109 | 97 | 147 | 210 | 256 | 426 | 309 | 314 | 211 | 152 | 163 | 140 | 161 |
| Men, sexual route (sex between man and woman) | | 1 | 8 | 4 | 7 | 13 | 16 | 28 | 32 | 32 | 55 | 54 | 77 | 92 | 134 | 135 | 163 |
| Men (same sex intercourse) | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 1 | 0 | 4 | 6 | 12 | 18 | 21 | 33 |
| Women, drug injecting route | | 7 | 3 | 4 | 8 | 8 | 11 | 15 | 19 | 19 | 16 | 19 | 16 | 20 | 7 | 8 | 28 |
| Women, sexual route (sex between man and woman) | | 3 | 9 | 14 | 28 | 35 | 48 | 74 | 112 | 133 | 128 | 133 | 215 | 175 | 237 | 234 | 237 |

*Source*: UNAIDS, 2016 *(46)*.

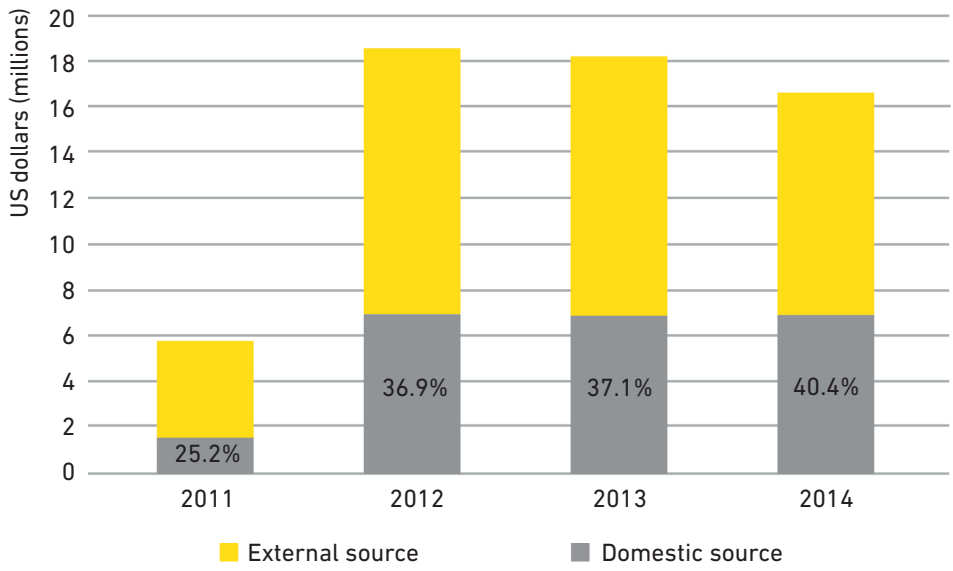
Despite improvements in ensuring access to and enrolment in antiretroviral therapy, the rising number of new HIV cases and relatively low levels of sustained enrolment in antiretroviral therapy programmes are a serious concern. In 2016, the estimated rate of new HIV diagnoses reached 13 per 100 000 *(47)*.

Injection drug use is the main driver of HIV transmission in the Kyrgyz Republic, where the epidemic is concentrated in parts of the population, with at least 50% of HIV infections occurring in PWID. Recent data from national HIV surveillance suggest an increasing role of heterosexual sex in HIV transmission. HIV incidence among women is rising. Results of the cross-sectional survey among sex partners of PWID suggest that sexual transmission of HIV in the Kyrgyz Republic remains closely related to injection drug use and transmission from PWID *(22)*.

HIV prevention and control activities are carried out under the Programme of the Government of the Kyrgyz Republic on countering HIV infection in the Kyrgyz Republic for 2017–2021. The overall aim of the Programme is to reduce new HIV infections and AIDS-related deaths by 50% from 2015 levels by the year 2021. This is a step towards ending the HIV epidemic in the Kyrgyz Republic by 2030, in line with the SDG goals. The current Global Fund grant for HIV activities covers 2019–2021. In 2020, the country will simultaneously begin development of both a new national five-year plan for HIV along with a national application for a new round of Global Fund financing.

The government's share of financing of the overall national response to the epidemic has been gradually increasing (Fig. 13). The cost of providing antiretroviral therapy represents a large portion of the total programme costs. Under the terms of the Global Fund grant, the country has committed to increasing its share of the costs associated with procurement of antiretroviral medicines to 30% by 2021, and it appears to be on track to meet this budgetary target.

**Fig. 13. Financing of the State HIV/AIDS Programme**




*Source*: USAID, 2015 *(48)*.

The country's approach to addressing HIV/AIDS is an important example of the ways in which public partnerships with civil society can advance disease prevention and control objectives. Through the Country Coordinating Mechanism (see above), the Ministry of Health has established strong partnerships with civil society. Groups representing key affected populations, including PWID, sex workers and MSM, are actively involved in the development of national plans and the design and monitoring of programmes. This approach, combined with a data-driven decision-making processes, has enabled the country to adjust programme strategies continuously in an effort to be effective in reaching those at highest risk and to achieve its prevention and disease control objectives. For example, the Government recently initiated an HIV rapid testing programme for people at higher risk of HIV and launched an adherence programme for people living with HIV based on mobile technology. Self-testing is to be piloted in MSM groups before scaling it up countrywide. The country is also planning to scale up coverage of opioid substitution therapy by making this service more friendly and accessible for stable and adherent clients (five-day dosage to take home).

Despite progress, stigma and discrimination related to HIV within the general population and health-care professionals remain major obstacles to HIV prevention and control efforts. In a recent survey, 67% of women stated that they would refuse to buy vegetables from an HIV-positive vendor and believe that children with HIV should not be allowed to attend school with other children *(21)*. Disparaging attitudes, disclosure of HIV-status, refusal to provide medical services and threats or perpetration of violence have been identified as major obstacles to prevention and control of the epidemic.

### *Malaria*

In 2016, the Kyrgyz Republic received the WHO certification of malaria elimination.

The country had faced a major malaria epidemic in 2002, following a massive influx of Kyrgyz labourers returning from neighbouring malaria-endemic countries. The Government has established a comprehensive plan of action to guard against the reintroduction and transmission of malaria and continues to collect data on malaria cases through its routine reporting systems.

### *Hepatitis*

The Kyrgyz Republic is considered to be a country with a relatively high burden of viral hepatitis. In 2016, at the request of the Ministry of Health, WHO supported a technical mission to assess hepatitis surveillance and national policies and services related to hepatitis prevention and control *(49)*.

It is estimated that half a million people in the Kyrgyz Republic in 2016 had chronic hepatitis B infection and nearly 100 000 had chronic hepatitis C *(49)*. There have been no population-based studies to measure the prevalence of chronic infections with hepatitis B or C in the country. The best available data come from the testing database of the Republican AIDS Centre, but this is not representative of the population. The Ministry of Health collects data on new cases of diagnosed hepatitis B infection through the routine data collection system (data available on application).

Since 2000 the vaccine for hepatitis B virus has been included in the country's national childhood immunization programme. Reported coverage rates for the dose at birth and the third dose are high, 97% in 2015.

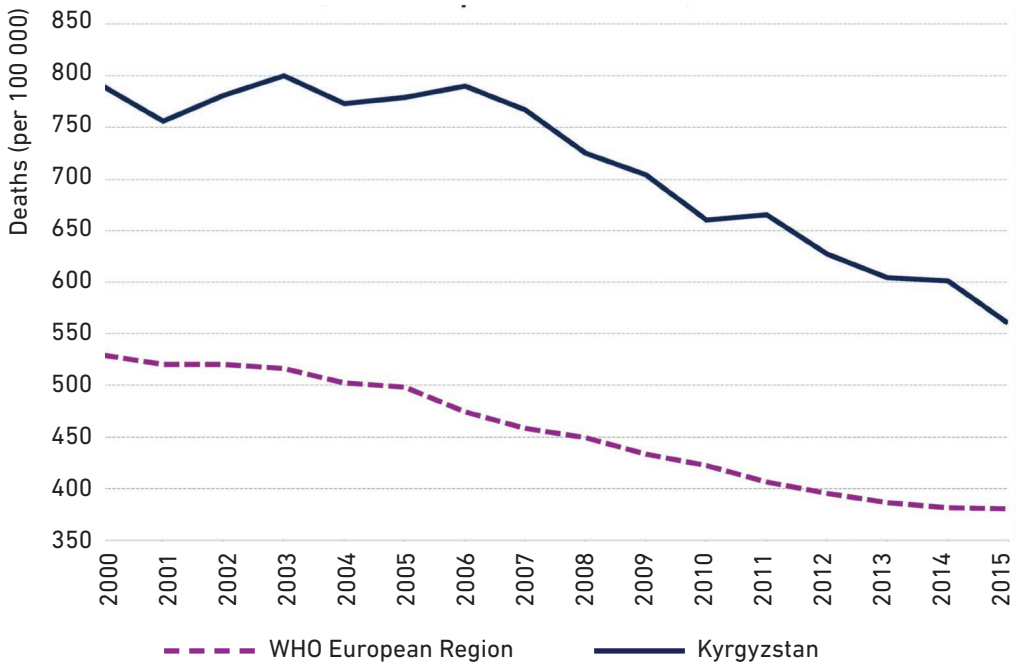
There is no national strategy for routine hepatitis B vaccination for adults who are in higher risk groups, including health workers, military personnel, commercial sex workers, PWID, MSM and people living with HIV or chronic hepatitis C infection. Vaccination for adults is not covered by the SGBP and must be covered by out-of-pocket (OOP) payment.

National clinical protocols for diagnosis, treatment and prophylaxis of hepatitis B and C were developed in 2014. The guidelines are not, however, aligned with current WHO guidelines *(49)*.


## SDG 3.4. Reduce mortality from NCDs

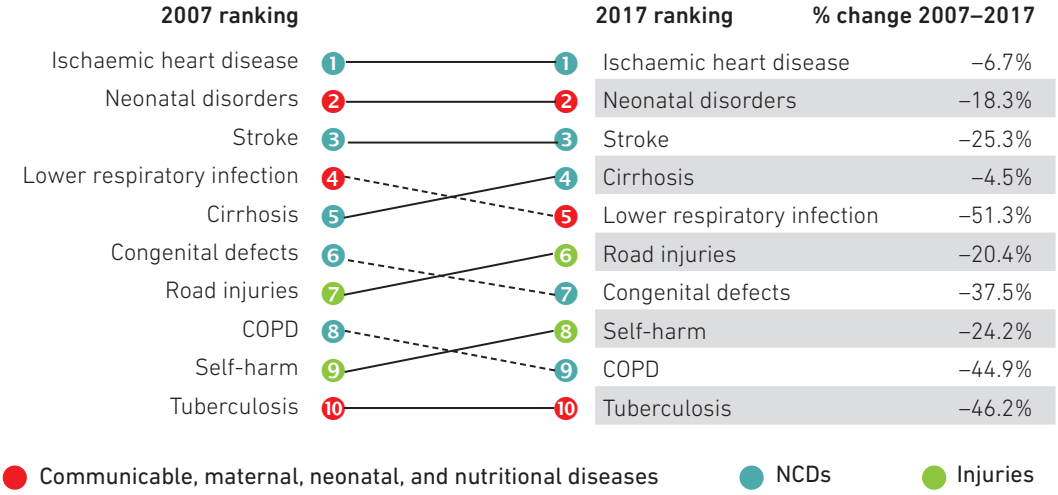
The Kyrgyz Republic faces a high burden of NCDs. While the NCD mortality rate has steadily declined since 2000 (Fig. 14), NCDs are responsible for 80% of all deaths in the country. More than half of these (51%) are related to cardiovascular diseases (Fig. 15). The probability of premature death (death before the age of 70 years) from one of the four major NCDs was one in four in 2015. The majority of risk factors contributing to NCD morbidity and mortality are behavioural and, therefore, potentially avoidable. These risk factors include unhealthy diets, physical inactivity, exposure to tobacco smoke and the harmful use of alcohol. Almost half of the adult population (43%) has hypertension and 79% of these are not taking antihypertensive medication. Among adult men, 48% smoke tobacco (**SDG 3.a.1**) and 20% of the population is obese (Kyrgyz Republic STEPS 2013, unpublished data). Alcohol use was the fourth most common risk factor contributing to premature death in 2017 (Fig. 16) *(45)*; 44.8% of men and 17.7% of women reported drinking alcohol at least once per month in 2018 *(8)*.

**Fig. 14. Trends in mortality rate for major NCDs, 2000 to 2015**



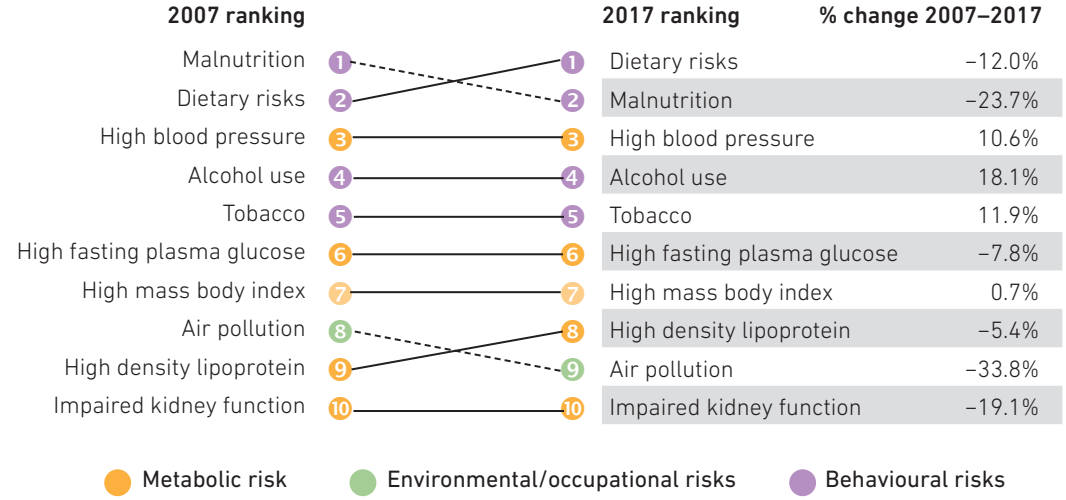

*Note*: deaths as standardized deaths for those aged 30–69 years.
*Source*: WHO Regional Office for Europe, 2019 *(39)*.

**Fig. 15. Most common causes of death in the Kyrgyz Republic, 2007 and 2017**




*Note*: COPD, chronic obstructive pulmonary disease.
*Source*: IHME, 2019 *(50)*.

**Fig. 16. Most common risk factors for premature death in the Kyrgyz Republic, 2007 and 2017**




*Source*: IHME, 2019 *(50)*.

A recent economic burden analysis concluded that losses associated with NCDs are equivalent to 3.9% of GDP *(51)*.

A trend analysis of NCD-related mortality from 2008 to 2012 revealed a gender gap, with NCD-related mortality rates for men being almost twice as high as for women *(52)*. This suggests that prevention and care services are not reaching men at the necessary levels.

The Kyrgyz Republic plans to report on five indicators related to SDG 3.4 (mortality from NCDs). Data are collected by the NSC. These include mortality linked to cardiovascular diseases, neoplasms, diabetes, chronic respiratory diseases and suicide (mental health) (**SDG 3.4.1**).

**Cardiovascular diseases**: according to national statistics, there has been a 15.2% decrease in the overall mortality rate from cardiovascular diseases between 2000 and 2018. In 2018 the mortality rate for cardiovascular diseases was 265.7 per 100 000 population.

**Cancer**: based on national statistics, there has been a 6.8% increase in the overall mortality from neoplasms between 2000 and 2018. In 2018 the mortality rate from neoplasms was 65.6 per 100 000 population.

**Diabetes**: the mortality rate from diabetes has remained stable from 2000 to 2018. In 2018, the mortality rate from diabetes was 7.3 per 100 000 population.

**Chronic respiratory disease**: national statistics show that mortality from chronic respiratory disease has declined dramatically by 64.3%, or 2.8 times, during 2000–2018, primarily among children under-5; this has been achieved through strengthening of prevention measures (implementation of the pneumococcal vaccine) and improvement in early detection and treatment at PHC and hospital levels. The mortality rate from chronic respiratory disease in 2018 was 16.3 per 100 000.

**Suicide**: from 2000 to 2018, the mortality rate from suicide decreased by 42.3% or 1.7 times. The suicide mortality rate for 2018 was 6 per 100 000 population. The rate of attempted suicide is much higher in all years (indicator data available on application).

### *Mental health*

While suicide represents only a fraction of the mental health problem, there are important shortcomings of the health-care and social system that should be noted. Service systems for delivery of mental health services are highly fragmented and are not patient centred. There are parallel mental health systems in the health-care, social protection and educational institutions, as well as the State Penitentiary Service under the Government of the Kyrgyz Republic and the Ministry of Internal Affairs. Each of these systems is funded and accountable to their respective departments without coordination or a holistic vision of individuals needs for mental health services. Institutional linkages between the government mental health service systems and non-profit-making organizational providers are generally limited and depend on the availability of funds rather than being based on identified priorities and the needs of individuals requiring mental health services and their families.

Guidelines and standardized practices related to the provision of psychological services are not well defined. Linkages are poorly regulated between psychiatric services under the Ministry of Health and other state bodies and local self-government; health-care, education, social protection and child protection agencies; and psychosocial services at the local level.

In 2017, a new model for provision of comprehensive health-care services, including mental health, was piloted in a number of districts and coordinated through family medicine centres. A multidisciplinary team including psychiatrists, psychologists, social workers and nurses provide comprehensive services to people with severe mental disorders. This approach reduced the frequency of hospitalizations in the target group by almost 44%.

Based on this pilot, a new state Programme on protecting the population's mental health (2018–2030) was developed with the goals of strengthening mental well-being, preventing mental disorders, providing affordable medical care, accelerating recovery, respecting human rights and reducing the mortality, morbidity and disability of people with mental disorders. The Programme is being implemented under the framework of Health 2030; however, according to experts, more than 80% of the activities planned for 2018 were not implemented through lack of effective management of the Programme by the state bodies.

### *Addressing NCDs*

NCDs are addressed through the Programme and action plan on noncommunicable diseases 2013–2020. The goals of this Programme are to prevent and control NCDs by (i) reducing morbidity, premature mortality and disability from NCDs; (ii) reducing the prevalence of risk factors; (iii) reducing the social and economic burden of NCDs through an intersectoral approach to controlling major risk factors; and (iv) improving the evidence base on the quality of health care.

Early detection of NCDs at the PHC level is not well developed. Similarly, health promotion and disease prevention activities and follow-up related to NCD risk factors are poorly organized *(53)*. There is a low level of public awareness about the connection between lifestyle and risk for NCDs, and there is not a strong tradition among patients or providers in engaging patients in promotion and protection of their personal health. For example, health-care facilities at the PHC level offer a range of nutritional services: nutritional status is assessed and dietary changes are advised for patients with cardiovascular diseases or diabetes, but follow-up measures to assess progress achieved by patients are limited. Clinical guidelines on smoking cessation were developed in 2012 and training was provided for some PHC providers. Screening for smoker status, however, is not universally implemented at the PHC level.

More training and support are needed to engage both the public and providers of PHC in health promotion and disease prevention related to NCDs.


### SDG 3.5. Strengthen prevention and treatment of substance abuse

Harmful consumption of alcohol and abuse of narcotic drugs are risk factors for disease and are associated with a wide range of adverse health outcomes. In the short term, excessive alcohol use and use of narcotics is associated with injuries (motor vehicle crashes), violence (homicide, suicide, sexual assault and intimate partner violence), alcohol and narcotic poisoning, and risky sexual behaviours. In the longer term, sustained heavy drinking has been shown to contribute to chronic disease, including high blood pressure, cardiovascular diseases, stroke, liver disease, some types of cancer, mental health problems and social problems such as lost productivity, unemployment and family conflict.

Prevention and treatment of substance abuse, including narcotic substances and alcohol, is an important public health strategy to reduce the population's risk for morbidity and mortality related to both communicable diseases and NCDs and to protect the health and safety of the broader public.

The Kyrgyz Republic currently collects data on the number of people per 100 000 population diagnosed with drug addiction and the number diagnosed with alcohol addiction; these do not

correspond directly to the global SDG 3.5 indicators, which are intended to measure coverage of treatment services (among those in need of treatment).

### *Alcohol consumption patterns and approaches to treatment and prevention*

In 2014 the total adult alcohol per capita consumption per year was 5 litres. This was relatively modest compared with the average for the WHO European Region of 10.7 litres per year *(54)*. Nevertheless, alcohol consumption in the country has increased since 2000 when the per capita consumption per year was 3.6 litres, and alcohol is ranked as the fourth most common risk factor contributing to premature deaths in the country *(50)*. Treatment for alcohol addiction is available through the Republican Centre for Addiction and through private providers.

Within the context of the Programme and action plan on prevention and control of NCDs, the Kyrgyz Republic has already instituted a number of measures to reduce the harmful use of alcohol, which include increased taxes on alcohol for domestic products; limits on advertising of alcoholic beverages (including sponsorship of events using alcohol logos); prohibitions on the sale of alcohol in public transport, government offices, parks and city squares as well as institutions for children, education, health, sports and culture; and enactment of stricter legislation on blood alcohol levels for driving (maximum of 0.3 g/l). At the request of religious leaders, the sale of alcohol has been strictly prohibited in a number of communities and villages.

Nevertheless, a review of some of these measures revealed loopholes and weaknesses in enforcement. For example, 40% of alcohol consumed is imported or illegally produced and is, consequently, unaffected by alcohol tax increases.

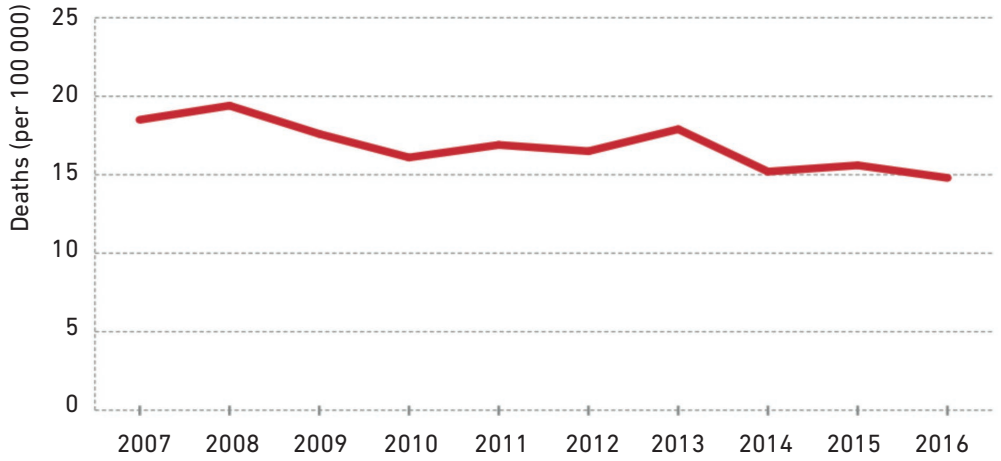
### *Use of narcotics and approaches to prevention and treatment*

The total number of PWID was estimated at 25 000 in 2013 *(55)*. Treatment for drug abuse is provided through the Republican Centre for Addiction and through private providers. Opioid substitution therapy is available through harm reduction programmes for injecting drug users as part of the Programme on prevention and control of HIV.


## SDG 3.6. Reduce deaths and injuries from road traffic accidents

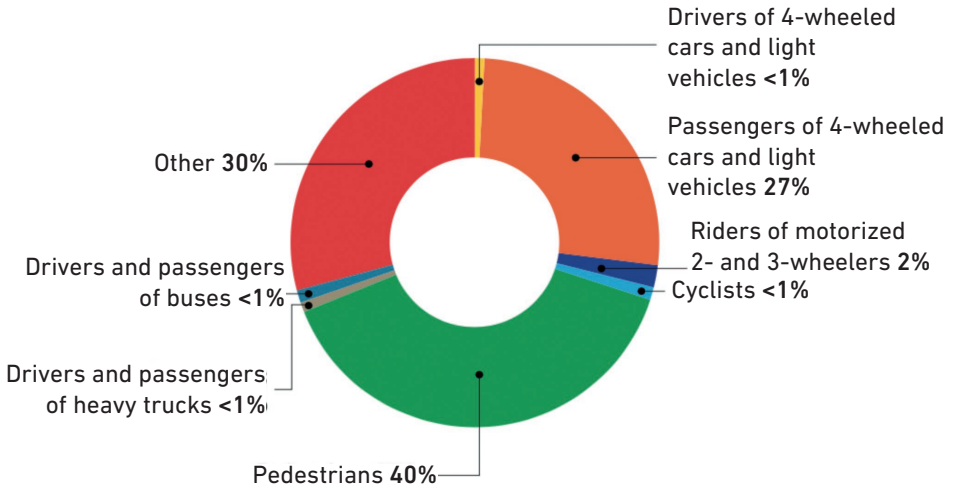
Between 2015 and 2018, mortality related to road traffic accidents declined by 29% from 15.6 to 11 deaths per 100 000 (**SDG 3.6.1**), with 812 reported fatalities in 2018 *(21)*. Despite the positive trend, the road-traffic-related death rate remains among the highest in the WHO European Region *(56)* and traffic-related deaths and injuries remain a major concern (Fig. 17). Economic growth has contributed to an expanded network of roads, increased numbers of vehicles and a trend toward urbanization. All of these factors converge to increase the risk of road traffic accidents involving vehicles and pedestrians. Pedestrians account for 40% of all road traffic deaths *(56)*. More efforts are needed to ensure road safety.The Department of Road Safety in the Ministry of the Interior has overall responsibility for road safety. The Ministry of Transport and Communications is the leading transport agency in the Kyrgyz Republic and is responsible for transport and communications policy, regulation, planning and road infrastructure development. The Commission for Road Safety, under the chairmanship of the Deputy Prime Minister, is responsible for collecting and analysing road traffic crash data (e.g. for categories of road users, deaths; Fig. 18) and coordinates prevention initiatives across government agencies.

**Fig. 17. Trends in reported road traffic deaths in the Kyrgyz Republic, 2007 to 2016**




*Source*: WHO, 2018 *(56)*.

**Fig. 18. Deaths by road user category in the Kyrgyz Republic**




*Source*: WHO, 2018 *(56)*.

National road safety plans were approved by decree in 2017 (No. 546) and in 2018 (No. 504) to outline measures for road safety, reduce the number of road accidents, improve road infrastructure and reduce risks for pedestrians. Road safety targets are included in the National Strategy for Sustainable Development 2040, and road safety indicators will be reported as part of the country's efforts to implement the 2030 Agenda. The Kyrgyz Republic is a member of the Central Asia Regional Economic Cooperation Programme, a group of countries that have established a target to reduce the number of deaths in their road corridors by 50% by 2030, compared with 2010.

WHO has been supporting the Government's intersectoral efforts to address road safety on behalf of the United Nations system. WHO provided technical input and recommendations on the development of the 2018 National Road Safety Plan and has supported participation by representatives from the Ministry of Interior, Ministry of Health and the Parliament in regional training seminars on road traffic safety and regional safety forums.


### SDG 3.7. Ensure universal access to sexual and reproductive health-care services

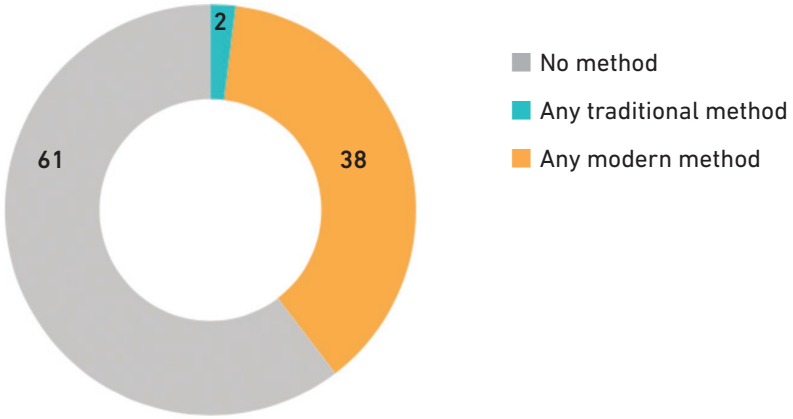
Ensuring universal access to reproductive health services is one measure of a country's success in achieving UHC for the population. Reproductive health services, including family planning, are part of WHO's global list of 16 essential services that all countries should strive to provide for the population.

Access to and use of an effective means to prevent pregnancy helps women and their partners to exercise their rights to decide freely and responsibly on the number and spacing of their children. Meeting demand for family planning with modern methods contributes to maternal and child health by preventing closely spaced or unintended pregnancies, which are at higher risk for poor obstetrical outcomes. Preventing births very early in a woman's life is a key strategy for ensuring healthy outcomes for women and children.

The contraceptive prevalence rate in the Kyrgyz Republic has declined substantially since the mid 1990s, from 60% in 1997 to 36% in 2012 *(57)* with modest gains to 42% reported in the 2014 MICS *(21)*.

In 2018 only 38% of women of reproductive age reported using a modern method of contraception. Women living in urban areas, those with higher levels of education and those with higher incomes were more likely to use modern methods (Fig. 19) *(21)*.

**Fig. 19. Family planning methods**




*Note*: percentage of women currently unmarried or not in union who are using (or whose partner is using) a contraceptive method.
*Source*: data from NSC & UNICEF, 2019 *(21)*.

Low rates of modern contraceptive use are related to a variety of factors including insufficient funding under the SGBP to provide quality family planning services that could ensure greater access to services, particularly for underserved populations such as poor women living in rural areas.

In 2018 the Kyrgyz Republic joined the global Family Planning 2020 movement as a new commitment-making country. The country declared its intent to accelerate progress towards ensuring the rights of people to access family planning services, including contraception, by expanding state funding for the purchase of contraceptives to cover the needs of women at high medical and social risk for maternal mortality; taking measures to improve the quality of family planning services; and reducing barriers to expand the variety of modern contraceptives available in the market. Two types of contraceptives (intrauterine devices and oral contraceptives) have been included in the list of drugs and medical devices eligible for reimbursement under the ADP/SGBP programme.

### *Family planning needs*

**SDG 3.7.1** measures the proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods. The figure for this indicator was 68% in 2018 *(21)*. The significance of this indicator should be interpreted with caution, however, given the low use and access to family planning services among women in the country.

### *Adolescent birth rate*

In 2018, the adolescent birth rate (**SDG 3.7.2**) was 50 per 1000 women aged 15–19 years in the population. The adolescent birth rate is two times higher in rural areas than in urban settings (64 in rural areas and 32 in urban areas) *(21)*. The birth rate among adolescents has declined since 2014, when the overall adolescent birth rate was 65 per 1000 with a similar trend of higher rates in rural than in urban areas (75 in rural areas and 45 in urban areas) *(21)*.

The adolescent birth rate derived from data in the country's routine reporting systems is considerably lower (data available on application).

Despite efforts to reduce pregnancies in adolescence, adolescent fertility rates remain high compared with those in other Member States of the WHO European Region. A total of 3% of women aged 20–24 years reported having given birth before the age of 18 *(21)*. Regional differences and patterns of early births among ethnic minorities suggest a more targeted approach is needed to further reduce pregnancies during the adolescent period.

Within the framework of Health 2030, a national programme for sexual reproductive maternal and child health is currently under development. The new programme will follow a life-course approach to providing reproductive and maternal and child health services and promoting health for women and children.


## SDG 3.8. Achieve UHC

UHC refers to a country's ability to ensure that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship *(58)*.

Achieving UHC is a high priority for the Kyrgyz Republic, which is a member of the UHC 2030 International Health Partnership and a signatory of the Global Compact for Progress towards UHC.

To understand the progress and challenges the country faces in terms of achieving UHC, it is helpful to consider two specific aspects related to the goal of UHC:

- access to basic health services and quality of basic health services in relation to measurable improvements in the population's health outcomes; and
- sustainable financing, including long-term financial viability of the systems in place to achieve UHC, and financial risk protection, particularly for the most vulnerable and impoverished segments of the population (SDG 3.c, and discussed below).

UHC means also ensuring that all individuals and communities have equitable access to a defined package of essential health services without suffering financial hardship. WHO recommends 16 essential services that should be included in a country's essential package of services. These are grouped in four categories: reproductive, maternal, newborn and child health; infectious diseases; NCDs; and service capacity and access. Assessing progress towards achieving UHC requires measuring the country's ability both to provide the population with a defined package of essential services (coverage) and to minimize financial hardship in the population when obtaining these essential health services.

Health 2030 includes a number of indicators related to tracking **coverage** of essential health-care services included in the SGBP that relate to reproductive, maternal and child health as well as communicable diseases and NCDs. In addition, the Programme includes indicators intended to measure the **financial burden** on patients by tracking the overall coverage of the population with health insurance and direct expenditure for provision of health care to patients as a percentage of government expenditure. Data for these indicators will be derived from a combination of routine reporting systems and special studies.

In the context of UHC, measurable improvements in population-based health outcomes are an indicator of the quality of health care and prevention services. As countries gain traction in ensuring the population's access to basic health services, a corresponding improvement in key health outcomes is an indication that the quality of PHC and prevention services is at a sufficient level to protect and improve the health of the population.

*Den Sooluk* (2012–2018) emphasized improving health outcomes in four priority areas: control of cardiovascular diseases; promotion of maternal and child health; control and prevention of TB; and control and prevention of HIV/AIDS. The country has made significant progress in reducing mortality related to cardiovascular diseases, strokes, TB and child mortality (see above). More can be probably achieved through strengthening PHC and public health.

In the Kyrgyz Republic, the basis for UHC rests upon the single payer system for health services operated by the MHIF and the SGBP and the accompanying ADP, which were established during the early periods of health-care reform *(59)*. Beginning in 1997, a payroll tax earmarked to finance health care was introduced. Funds are invested in a mandatory health insurance programme, managed by the MHIF, which is intended to complement domestic and external budget support for health-care services.

Entitlements of the population to health-care services are defined by the SGBP and the ADP. The SGBP follows a universal approach as it applies to all citizens and defines a basic package of

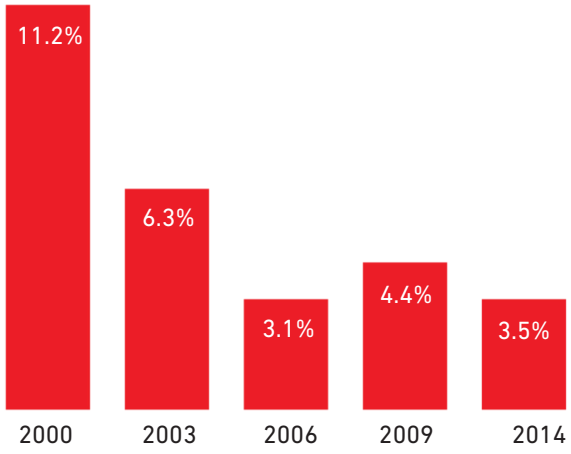
health services that is publicly funded and made available to the entire population. Under the SGBP, emergency care and PHC, including a limited selection of medicines, are provided free of charge to all citizens. To receive PHC, patients must enrol with a family group practice although they are allowed to change their practice freely.

Secondary care by referrals is provided for a flat copayment, with generous exemption categories. Inpatient and specialized outpatient care are provided with appropriate referrals, but with copayments. Exempt categories, which are intended to cover vulnerable populations as well as people with special medical conditions or diseases, pay no copayment or pay a reduced copayment. To receive a reduced copayment for inpatient and specialized outpatient care, patients must provide a valid referral from a primary physician in a family group practice. Without a proper referral, a patient must pay the full cost of the services, regardless of their insurance status. This mechanism was intended to encourage greater utilization of PHC.

The ADP regulates entitlement to outpatient medicines for those who pay mandatory health insurance contributions and for those where the government pays contributions. The ADP currently includes 61 medicines, up from 34 when it was introduced in 2001 *(59,60)*.

Since enacting the SGPB and mandatory health insurance systems, overall access to basic health services for the population has improved, with notable exceptions in remote and rural areas (Fig. 20) *(61)*. Access in these areas is hampered by service delivery problems, including persistent shortages of health-care workers, limited availability of ambulances and lack of specialized and higher levels of care and laboratory diagnostic services.

**Fig. 20. Reasons given for not accessing health care among those who needed care, 2000 to 2014**




*Source*: WHO Regional Office for Europe, 2019 *(60)*.

Throughout the country, gaps in coverage are related to weaknesses in enforcing the collection of mandatory health insurance contributions (payroll tax) and the system for awarding benefit exemptions, which is not sufficiently targeted at those in poverty. Securing contributions to the MHIF among people who work in the agricultural sector, self-employed people, those working in temporary or irregular jobs and those in the shadow economy is problematic. In 2017 the

enrolment rate was 73.6%. This means that a quarter of the population does not benefit from reduced copayments and has limited entitlement to publicly financed outpatient medicines.

The number of groups eligible for exemption from SGBP hospital copayments has grown from 29 in 2001 to 46 in 2016. However, eligibility for exemption is based on sociodemographic and disease-based criteria and is not tied to income and poverty level. As a result, poor people may inadvertently be excluded from the system *(61)*. Introducing a means-tested exemption requires a joint approach between the Ministry of Health and the Ministry of Labour and Social Development, which has not yet occurred *(60)*.

The country is currently in the process of identifying the specific indicators that will be used to report on its progress in achieving UHC within the 2030 Agenda. Two indicators are under consideration: **SDG 3.8.1**, related to coverage of essential services, and **SDG 3.8.2**, related to the financial burden on the population to obtain health care.

At the global level, the IHME has developed an index measure to help countries to assess their progress towards achieving UHC. The index number is a rating of the country's progress in achieving UHC related to nine tracer interventions and risk-standardized death rates or mortality-to-incidence ratios from 32 causes amenable to health care. The 2017 IHME estimated UHC index for the Kyrgyz Republic is 68.6 (on a scale of 0 to 100, with 100 being total achievement of UHC) *(38)*.


### SDG 3.9. Reduce deaths and illness from hazardous chemicals and pollution

Globally, air pollution is the largest single environmental risk to health and is responsible for more than 500 000 premature deaths in the WHO European Region each year *(62)*. Even at relatively low concentrations, particulate matter can produce adverse effects on health and is an associated risk factor for cardiovascular diseases, chronic obstructive pulmonary disease, acute lower respiratory infection and lung cancer. WHO has established air quality guidelines for particulate matter, and addressing air pollution levels is linked to achieving health-related SDG targets.

In the Kyrgyz Republic, establishing guidelines for acceptable air pollution levels and monitoring air quality fall under the joint responsibilities of the Ministry of Agriculture's State Environmental and Forestry Agency and the Ministry of Emergency Situation's State Hydrometeorological Agency. Efforts on behalf of the Government to assess or address the impact of air pollution on the health of the population could not be identified within the scope of this review.

For the purpose of SDG reporting, four national indicators are considered for SDG 3.9, where pollution includes air, water and soil pollution and each indicator is measured as mortality rate per 100 000 population:

- carbon monoxide (0.8 in 2018)
- intestinal infections (0.8 in 2018)
- typhoid fever (0.0 in 2018)
- unintentional poisonings (6.3 in 2018).


## SDG 3.a. Strengthen tobacco control under the WHO framework

The Kyrgyz Republic has a high rate of smoking among men; 48.2% of men are smokers compared with 2.7% of women *(63)*. The high rate of smoking among men is one of the main contributing factors to cardiovascular, cancer and chronic respiratory morbidity and mortality in the country. WHO estimates that without further strengthening of tobacco control measures, premature deaths attributable to smoking could be as high as 213 000 among the 426 000 smokers alive today *(63)*.

Smoking among youth and exposure to second-hand smoke is also a concern for health. One quarter of adults (24%) in 2013 reported being exposed to second-hand smoke at home while 23% reported exposure in the workplace (Kyrgyz Republic STEPS 2013, unpublished). Among adolescents, 12% of boys and 5% of girls aged 13–15 years used tobacco products in 2014 *(20)*.

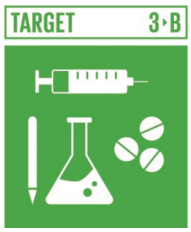
Country-specific data on smoking prevalence is only available through special studies, most recently the STEPS study, which was conducted in 2013, and the 2014 Global Youth Tobacco Survey *(20)*. Therefore, it is not possible to conduct a trend analysis for this indicator. Based on data from 2013, the overall prevalence of tobacco use among people aged 15 years and older is 25.7% (**SDG 3.a.1**) (Kyrgyz Republic STEPS 2013, unpublished). This statistic does not provide an adequate picture of the health burden and associated risk for NCDs since, as described above, the smoking rate among men is significantly higher than that for women, a reflection of gendered cultural norms related to smoking behaviours.

The Kyrgyz Republic ratified the WHO Framework Convention on Tobacco Control in 2003 and in 2006 enacted a law protecting the health of citizens against the harmful effects of tobacco. Smoking is prohibited in educational institutions; organizations for recreation for children; health organizations; some public venues, including cinemas, theatres, sports facilities, circuses and concert halls; as well as intercity buses and fixed-route taxi vans. However, so far smoking bans have not been well enforced. The country has also enacted limited bans on advertising and adopted warning labels for cigarette packages.

The country's strategy for tobacco control is integrated into the national Programme on NCDs and through the Programme for protecting citizens' health against the harmful effects of tobacco use (2008–2015). Targeted education awareness campaigns have been carried out but these have been curtailed through lack of funding.

A new tobacco control strategy has been drafted but has not yet been endorsed by the Government, partly because of ongoing policy debates related to the health and economic impact of tobacco taxation policies.

The organization in 2018 of the 3rd biennial World Nomad Games in Kyrgyzstan as a smoke-free event, for the first time ever, is an important example of an Ministry of Health-led effort to engage a whole-of-government approach to health promotion *(64)*. With support from WHO, the Ministry of Health galvanized the support of the Vice Prime Minister and the Organizing Committee of the Games to designate the Games as an official tobacco-free event. This effort required sensitization and collaboration with a host of non-health sector government, private sector and civil society groups, including local village health committee representatives. This successful effort serves as a model for future engagement in intersectoral collaboration with civil society to promote health.




## SDG 3.b. Provide access to affordable essential medicines and vaccines

Immunization is a proven and cost-effective public health intervention, saving the lives of millions of children and protecting millions more from illness and disability. Historically, the country has enjoyed high rates of childhood immunization through the national programme. Following a measles outbreak in 2015 and increasing vaccine hesitancy in parts of the country, the country has renewed its efforts to achieve – and sustain – universal routine immunization to protect children against deadly, but easily preventable, diseases. The Ministry of Health is being supported in this effort by the GAVI Alliance, UNICEF and WHO together with NGOs.

The latest data shows that 76.7% of children aged 12–23 months and 81.7% of those aged 24–35 months have been vaccinated according to the country's national vaccination schedule *(21)*.

Preliminary data from a new WHO-supported survey suggest that variations in coverage rates may be related to internal migration. Relocation by families may disrupt their ability to access immunization services in a timely fashion that prevents any compromise of vaccine efficacy. Release of the study results is anticipated later in 2020.


## SDG 3.c. Increase health financing and the recruitment, development and retention of the health workforce

### *Health workforce*

Ensuring adequate staffing with qualified health personnel who have the requisite skills and motivation to perform their responsibilities is a critical issue for a country. Many sections of this report return to the issues of staffing: disparities in the geographic distribution of essential health personnel, insufficient skills in technical areas related to functional responsibilities and systemic problems with recruitment and retention of qualified staff. These are persistent challenges that affect the functional performance of the entire health-care system, including public health and PHC.

Health 2030 identified human resources in health care as a top national priority. Six areas were identified to address the human resource challenges in the health sector:

- improve the human resource management system in health care with improved interdepartmental and intersectoral linkages;
- increase the availability of medical personnel in remote regions particularly family doctors, public health and emergency medical aid staff;
- complete the process of reforming the system of higher medical education;
- reform nursing education to reflect heath needs and new requirements;
- improve the mechanisms for regulating the professional activity of health workers through the involvement of professional medical associations and continuous professional development; and
- promote the development of scientific research in the field of health for the scientific substantiation of policies and practices.

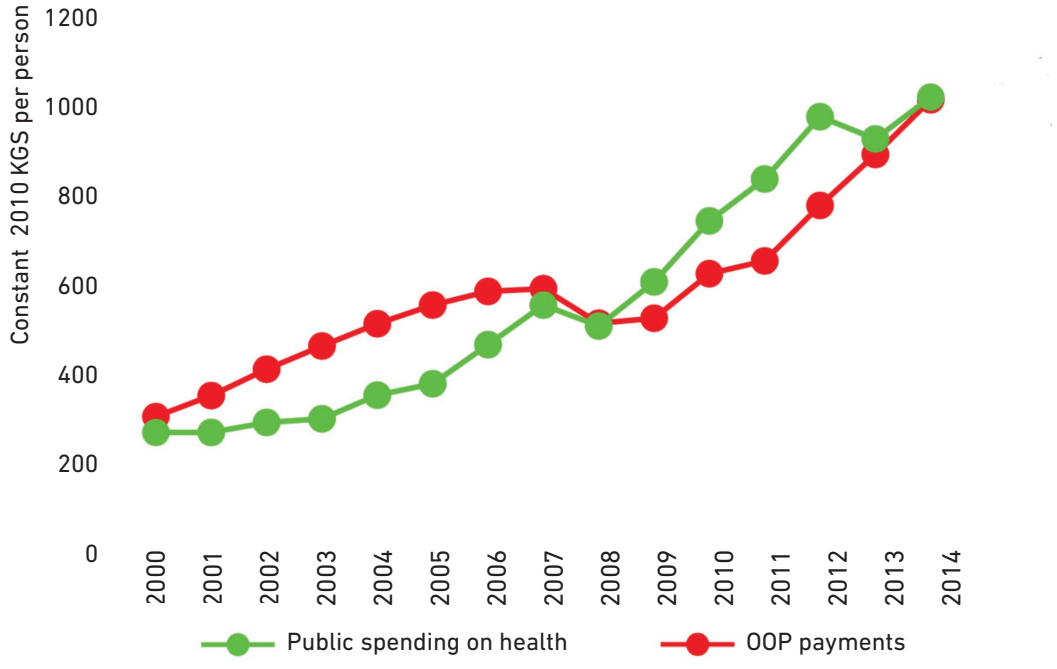
For SDG reporting purposes, the number of doctors and mid-level medical workers per 10 000 population (**SDG 3.c.1**) will be used, which in 2018 was 22 doctors and 56 mid-level medical workers *(21)*. These figures do not, however, provide an adequate picture of the disparities that exist in adequately staffing PHC service points, particularly in rural and remote areas.

### *Health financing*

National Health Accounts data show that public spending on health along with OOP payments increased in real terms between 2000 and 2014 *(65)*. This increase was in part caused by a 2006 agreement between the Government and its development partners to increase spending on health by 0.6% a year to reach a target of allocating 13% of the Government budget to health. This target was achieved in 2013 and has remained in place since then *(60)*.

Despite increased state funding for health, available funds are insufficient to cover the cost of delivering the SGBP (Fig. 21).

**Fig. 21. Spending on health per person by financing scheme in real terms, 2000 to 2014**




*Note:* public spending excludes budget support from development partners.
*Source*: WHO Regional Office for Europe, 2019 *(60)*.

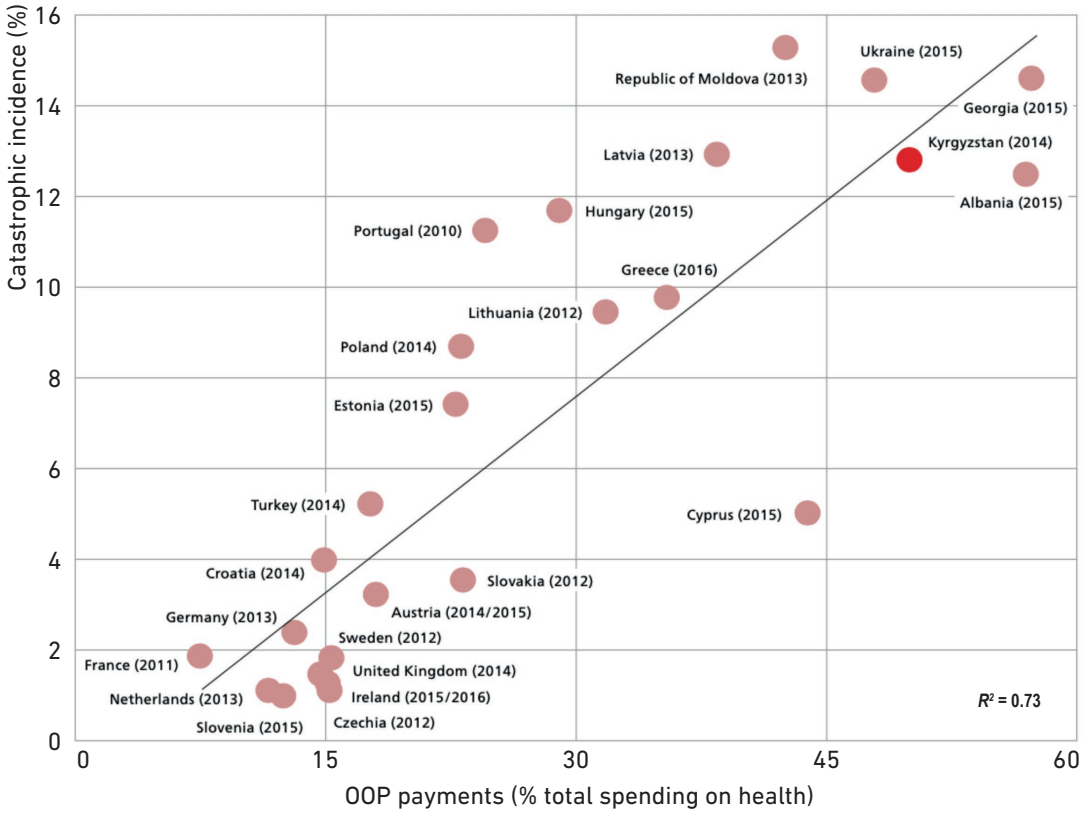
The persistent funding gap, is related to rising costs associated with meeting the state obligations under the SGBP, which have outpaced increases in the contributions of budgetary, copayment and MHIF contributions intended to cover the cost of health services.

There has been a steady expansion in the number of categories of people who are entitled to receive preferential services under the SGBP. At the same time, enforcement of payroll

contributions to the MHIF remains problematic. This problem is exacerbated by the large number of citizens who have migrated outside of the country for employment and do not contribute to the MHIF system. The rising price of medicines in an unregulated drug market is also a contributing factor. Inefficiencies in the health-care delivery system, such as unjustified hospitalization and overprescribing practices, also contribute to the rising cost of health care.

Financial protection improved from 2000 to 2006 but deteriorated between 2009 and 2014, largely because of increased OOP spending required for outpatient diagnostics, medicines and medical products *(61)*. The incidence of catastrophic OOP payments increased substantially from 2009 to 2014 in all except the poorest quintile (Fig. 22).

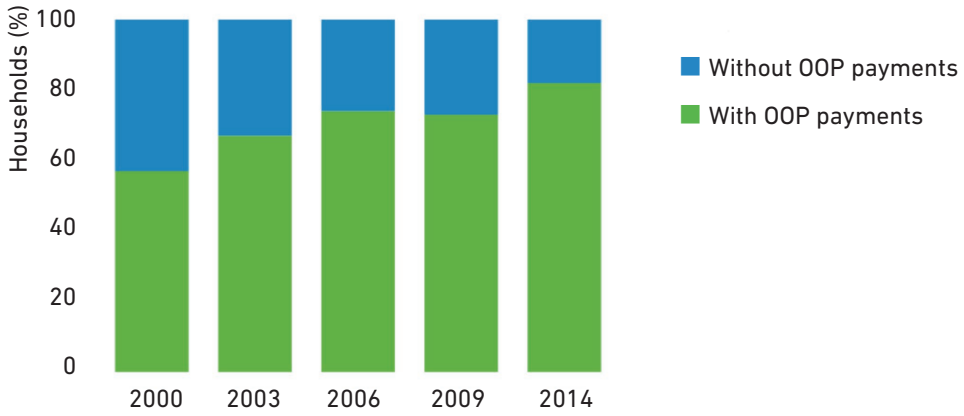
**Fig. 22. Incidence of catastrophic health spending and OOP payments as a share of total health expenditure in selected Member States of the WHO European Region, latest available year**




*Source*: Cylus et al., 2018 *(66)*.

The share of households making OOP payments has increased substantially over time, rising from 57% of households in 2000 to 82% in 2014. This is largely because of increased spending on outpatient medicines (Fig. 23). Greater OOP spending on medicines is related to two trends: higher market prices for medicines associated with the absence of price and mark-up regulation and spending on medicines issued without prescriptions. Informal payments are also a persistent problem that places a disproportionate financial burden on the poor *(60)*.

**Fig. 23. Percentage of households with and without OOP payments, 2000 to 2014**




*Note*: results are for all households not just those reporting use of health services.
*Source*: WHO Regional Office for Europe, 2019 *(60)*.

Improving the regulation of and management of drug circulation and increasing the coverage by the MHIF to provide financial protection of the population are two stated priorities within Health 2030.

Notably, the Kyrgyz Republic has already begun to take measures to address the rising cost of medicines. In 2017 three new laws on the regulation of medicines and health technologies were implemented. In 2018 new legislation was introduced to establish a regulatory framework, which will contribute to making medicines and medical devices more affordable and meet the requirements of accession to the Eurasian Economic Union and its common market. For the first time, the new laws will allow the Government to regulate the prices of medicines and medical devices. These changes were complemented by the revision of the national essential medicines list in 2018 and an initiative to update ADP pricing, with a focus on medicines addressing areas of high disease burden *(60)*.


## SDG 3.d. Strengthen health emergency preparedness

Health emergency preparedness refers to a country's readiness to respond to a wide range of public health emergencies including disease outbreaks, food safety and natural and human-generated disasters (e.g. landslides, floods, earthquakes, exposure to chemicals or radioactivity).

Protecting the health and safety of the population in an emergency situation requires a coordinated whole-of-government approach that cuts across the responsibilities of various ministries and involves joint efforts with regional and district level authorities. In this regard, the Ministry of Emergency Situations and the Ministry of Health have historically worked together to respond to disease outbreaks and natural disasters.

The Kyrgyz Republic is a signatory to the international treaty on International Health Regulations (IHR), which provides an international legal framework to all countries to protect their citizens

from epidemics and other health emergencies. Under this framework, countries are encouraged to routinely assess their public health emergency preparedness capabilities.

Beginning in 2016, the Kyrgyz Republic has been actively working to evaluate and strengthen its capacity for public health emergency response. A joint external evaluation of the Kyrgyz public health emergency preparedness and response capacities was carried out in 2016 and a report from this provided a comprehensive overview of the status of IHR country capacity *(67)*. The evaluation found that basic public health service structures and mechanisms for fielding a multisectoral response at the national, regional and district levels were in place, but that more attention was needed in:

- clarifying roles and responsibilities across various sectors (ministries, inspectorates, agencies and departments) and levels (central, regional and district) in the context of IHR implementation; and
- skills training and incentives to retain qualified staff across all essential areas related to health emergency response (epidemiology, chemicals/radioactivity, safety, nutrition and provision of emergency medical services).

The Ministry of Health was officially designated as the country's focal point on IHR in 2017 (Decree No. 236), with the Department of Disease Prevention and State Sanitary- Epidemiological Surveillance in charge of carrying out functional responsibilities (Ministry of Health Order No. 695).

In 2018 the country conducted seven simulation exercises, with support from WHO and other United Nations bodies.

The country participates in the Electronic State Parties Annual Reporting Tool platform *(68)*. Countries voluntarily report their annual progress towards implementation of 10 IHR core capacity requirements. This web-based monitoring tool generates a capacity achievement rate for each of 10 core IHR areas *(68)*. In 2018 the Kyrgyz Republic's strongest area of IHR capacity was in surveillance (80% achievement of global requirements in this area). The IHR areas where the country still lags behind are risk communication and food safety, where the country achieved just 40% capacity against the global IHR requirements in these core areas.

Within Health 2030, activities at national level to strengthen health emergency response capabilities fall under the broader goal of strengthening the public health system. Establishing a single national system for assessing and managing population health risks is a national priority that encompasses efforts to strengthen emergency response capabilities in the areas of better defined roles and responsibilities across sectors and levels of government; improved information systems for surveillance and communication in the event of a health emergency; provision of training to strengthen skills of essential personnel; and harmonization of trans-border policy within the framework of the IHR.

For the purpose of SDG reporting, data on the number of health quarantine points organized in line with IHR will be reported for **SDG 3.d.1.** In 2018 there were 14 of these health quarantine points (data from the Department of State Sanitary and Epidemiological Surveillance 2018 and available on application).

## Assessment of health-related targets in other SDGs

The following text discusses the targets within the other SDGs that have particular relationship to health and well-being.



### SDG 1.2 and 1.3. Reduce poverty and ensure social protection for all

Poverty reduction efforts (**SDG 1.2**) and expansion of social protection to cover vulnerable groups (**SDG 1.3**) are closely linked to improvements in health and well-being of the population. After independence in 1991, the Kyrgyz Republic experienced an economic downturn, with GDP declining by half in the mid 1990s *(8)*. In the period after 2000, the Kyrgyz Republic experienced economic growth, transitioning from a low-income to a lower-middle-income country in 2014 and joining the Eurasian Economic Union in 2015. The Kyrgyz Republic had a human development index of 0.672 in 2018, which was below the world average (0.728) and ranked the country at 122 *(69)*. For its 6.4 million inhabitants, GDP per capita has increased by 60% since 2000, reaching US$ 3283 in 2017 *(45)*. According to the latest available information, gross national income per capita was US$ 3255 in 2011. Income inequality has also decreased, with a GINI coefficient of 26.8 in 2018 *(8)*.

The percentage of households living below the basic needs line fell significantly from 14% in 2000 to 3% in 2014 *(60)*. In 2017 approximately 25% of adults were living below the national poverty line (data from the NSC). Rates of child poverty are estimated to be higher. In 2015 UNICEF estimated that 40.5% of those living in poverty were children *(70)*. Children living in poverty are at greater risk of missing out on pre-school, school education and health care and suffer disproportionately from malnutrition and poor health outcomes. The poorest children live mainly in rural areas; many belong to families with three and more children and families with unemployed adults *(70)*.

UNICEF is currently supporting the development of a multidimensional poverty assessment tool that will be used to periodically review progress in addressing interrelated dimensions of childhood poverty that affect health outcomes, educational prospects and the social development of children. Introduction of this tool presents unique possibilities for intersectoral collaboration towards improving SDG targets related to reducing poverty and improving health outcomes for children.


### SDG 2.2. Achieve food security and improve nutrition

Adequate nutrition is essential for the health of the population and has a direct impact on the incidence of child and maternal mortality. Trends regarding the nutritional health status of the population are contradictory. Overall, domestic food security and the nutritional health of the population have improved but malnutrition among children remains an issue, particularly for those in rural areas or from poor families. Stunting (too short for age; **SDG 2.2.1**) is moderately high at 12% of children under-5, with the highest rates among rural children (13.2%) and children in the poorest households (14%). Notably, the latest available data on wasting (too thin for height) and underweight (**SDG 2.2.2**) are within the biological norms, less than 5%, for children under-5 *(21)*. These data suggest that efforts to improve nutrition for children must be targeted to children in rural areas and from poor families.

Although it is not an SDG reportable indicator, persistently high levels of iron-deficiency anaemia among women of reproductive age, particularly pregnant and parturient women, are a concern and a risk factor for poor obstetrical outcomes and newborn health. Data on anaemia are collected through special studies and routine reporting systems. According to national statistics, 37% of pregnant women and 51.7% of parturient women had anaemia in 2018 (Ministry of Health data). Reducing high rates of anaemia among pregnant and parturient women is a stated objective of Health 2030.

Against these issues, health officials are concerned about a newly emerging trend toward overweight and obesity among both children and adults. Overweight and obesity are known risk factors for NCD-related morbidity and mortality. Given the country's high burden of NCD-related morbidity and mortality, this trend is troubling for the health of adults and for future generations. This problem is being addressed within the framework of the country's Programme and action plan on NCDs. This trend is related to an increase in consumption of ultra-processed, energy-intensive, cheap and affordable foods high in fat, salt and sugar and an accompanying relatively low level of regular physical activity *(28)*. Data on overweight and obesity are scant and comes from specialized studies. In 2018, 7% of children under-5 were classified as overweight *(21)*. According to the 2013 STEPS survey (unpublished), 56% of the adult population had body mass index greater than 25 (overweight) and for 23% it was over 30 (obese).


### SDG 4.2. Ensure all children have access to quality early development to be ready for primary education

Ensuring children are provided with a stimulating, nurturing environment in their early years has a lasting impact on their health and development. Early childhood exposure to poverty, high levels of family and environmental stress (including violence, abuse and exploitation), inadequate care and lack of learning opportunities contribute to poor health and can have a lasting impact on a child's health and development.

In the Kyrgyz Republic, early stimulation and responsive care for children aged 2–4 years is carried out primarily by an adult outside of a formal setting. Attendance at early education programmes is higher for children in urban areas and among families with higher incomes. Participation is higher among girls than boys *(21)*.

A multisectoral approach that takes in more than just the health sector is needed to ensure all children are provided with a healthy start in life.


### SDG 5.2 and 5.3. Eliminate all forms of violence against women and girls and early and forced marriage

Violence against women and girls is associated with a range of poor health outcomes, including injury; increased risk of unwanted pregnancies and miscarriage; infection with sexually transmitted diseases (including HIV); depression; harmful drug and alcohol use; and chronic health problems associated with prolonged stress *(71)*. Reducing all forms of violence against women and girls (**SDG 5.2**) including early and forced marriage (**SDG 5.3**) is directly related to ensuring the health and well-being of the population.

Intimate partner and family violence are the most common forms of violence against women and girls in the country, with 25% of women reporting experiencing physical or sexual violence by an intimate partner over their lifetime *(57)*. In comparison, 0.1% reported sexual violence by a non-partner *(57)*.

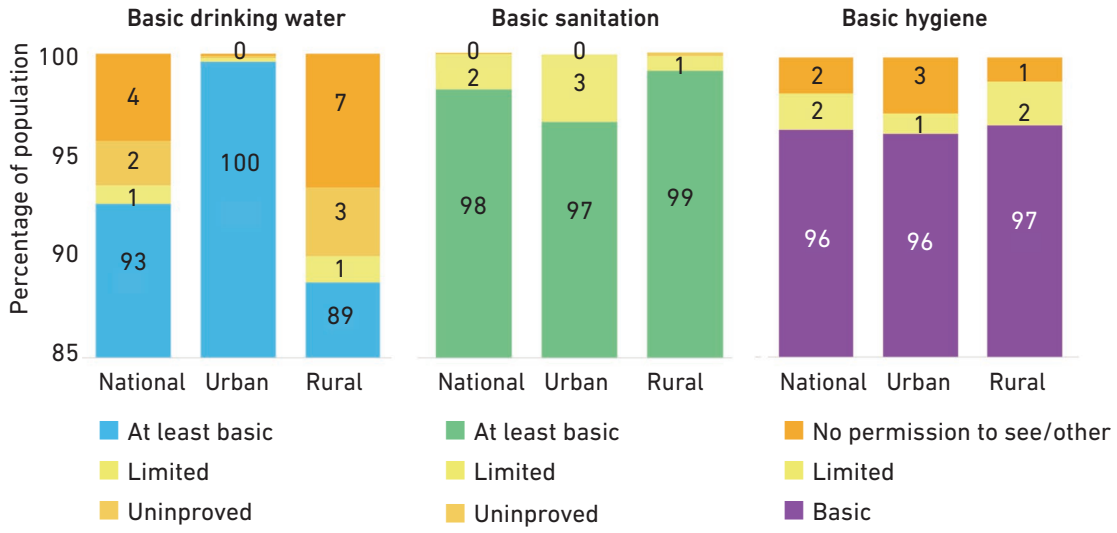
Nationally, 13% of women marry before 18 years of age, with higher levels of early marriage common in rural areas *(21)*. Although reliable data on forced marriage (known as bride kidnapping) are limited, anecdotal reports suggest that the practice is on the rise. Early and forced marriage reduce educational opportunities for young women and girls and place them at higher risk for intimate partner violence, which, in turn, negatively affects their overall health and well-being and that of their children.

More effort is needed to engage the health sector in supporting multisectoral approaches to prevention and response to violence against women and girls. There is an urgent need to improve the availability of reliable, population-based data on the prevalence of violence against women and children and the consequences of this violence on their health and well-being.


## SDG 6.1 and 6.2. Achieve universal access to safe drinking water, sanitation and hygiene

Availability of basic drinking water, sanitation and hygiene services is relatively high although there are significant disparities in rural areas (Fig. 24) *(21)*. Many health facilities and residents in rural areas do not have adequate water, sanitation and hygiene services. Addressing this basic need is essential to promoting the health and well-being of the population and ensuring health facilities are able to deliver quality services.

**Fig. 24. Availability of basic drinking water, sanitation and hygiene services**




*Note:* some figures will not add up to 100% because of rounding up.
*Source*: NSC & UNICEF, 2019 *(21)*.



### SDG 8.7 and 8.8. Eradicate forced labour, eliminate hazardous child labour and promote safe working environments

In the Kyrgyz Republic, 27% of children are engaged in child labour. The prevalence is higher for boys (34%) than for girls (19%) and is almost three times more common in rural than in urban areas. The share of children involved in hazardous working conditions is higher among those from the poorest families *(21)*.

Child labour and the safety of work environments have a direct impact on the health and well-being of the population. These issues fall under the responsibilities of multiple ministries and require a coordinated multisectoral response.



### SDG 10.2 and 10.3. Empower and promote social inclusion and equal opportunities for all, and remove discriminatory practices

Reducing stigma and addressing discrimination against socially marginalized groups (including those who are lesbian, gay, bisexual, transgender and queer/questioning; PWID and commercial sex workers) are essential to achieving disease prevention and the SDGs. Addressing stigma and discrimination within the health-care system among health-care professionals as well as by the public in society at large is crucial to protecting the health of individuals and the population.

There are an estimated 180 000 individuals living with disabilities living in the Kyrgyz Republic, including 30 000 children who were registered with the Government in 2018 (about 1% of all children) *(72,73)*. This number does not include all children with disabilities, only those who are registered and receive cash assistance. For this reason, the actual number of adults and children with disabilities is expected to be higher.

Many of these individuals lack access to the essential health, educational and social services they require to reach their full potential and maintain their health and well-being. In 2018 the Kyrgyz Republic ratified the Convention on the Rights of Persons with Disabilities. This committed the country to adopting a number of laws to create a more physically accessible environment and work towards more inclusive educational, cultural and economic opportunities for all. Within this context, there may be new opportunities for cross-sectoral cooperation to promote the health and well-being of all those with disabilities. This presents a new opportunity for the health sector to develop systematic approaches to early identification of children with developmental delays and difficulties in order to provide early intervention services in collaboration with other sectors such as the education and social service sectors.


### SDG 11. Make cities and communities inclusive, safe, resilient and sustainable

The Kyrgyz Republic is rapidly urbanizing and has identified urban and regional development as national priorities under the 2040 strategic development policy framework.

In 2018 the Kyrgyz Republic became the first country in central Asia to establish a National Healthy Cities Network under the broader alliance of the WHO Healthy Cities Network for Europe. In 2018 a conference was held that brought together more than 30 city mayors of republican, regional and local municipalities from across the country *(74)*. City mayors, together with political representatives, line ministries and WHO technical experts on health and well-being examined the role of cities, municipalities and regions in achieving UHC at the national level.

Currently, two cities have been identified as being of importance at the national level, 12 at the regional level and 17 at the district level. A number of challenges to address and opportunities to leverage to improve health and well-being in cities and municipalities across the country have also been identified. The Healthy Cities Network potentially provides new opportunities to expand cross-sectoral collaboration to improve the health and well-being of the population.


### SDG 16.2. End abuse, exploitation, trafficking, violence and torture of children

An estimated 700 000 Kyrgyz citizens are working abroad *(75,76)*. Although the majority of labour migrants are male, there has been a trend towards feminization of labour migration. Nearly 40% of Kyrgyz migrants in the Russian Federation in 2018 were women *(76)*. Nine percent of all children in the country do not live with their biological parents; this percentage is higher in the southern regions of the country *(21)*. The number of children living without their parents in settings that increase their vulnerability to deprivations of care, reduced access to health and educational services and exposure to abuse, exploitation and violence is rising.

Another issue of concern for the well-being of children is the widespread use of physical punishment of children in the home. Nearly 50% of children are exposed to physical punishment in the home and 5.4% suffer severe physical punishment *(21)*.

More research is needed to understand the extent and dimensions of these risks to the health and well-being of children in the Kyrgyz Republic.

# Solution space: action areas

Global SDG targets, particularly those related to SDG 3 (health and well-being) and the nutrition-related targets of SDG 2 (food security and nutrition) are well integrated into Health 2030. Representatives from multilateral health organizations, development partners and civil society stakeholders were heavily consulted during the development of the Programme. As a result, there is a relatively solid level of awareness at the national policy level regarding the ways in which technical and financial support from development partners will contribute to national health policy priorities and associated SDG health-related targets within the Programme framework.

Moving forward, more discussion is needed at the national level to address two broad areas:

- to identify potential gaps where technical and financial resources and stronger engagement across levels of government and by intersectoral and civil society partners may be needed to realize the country's national health priorities (and by extension achievement of SDG 3 targets and the nutrition-related SDG 2 targets) within Health 2030; and
- to develop a unified vision for achieving health and well-being of the population that extends beyond the framework of Health 2030 and encompasses health-related targets across SDG sectors, including poverty alleviation (SDG 1); education (SDG 4); gender (SDG 5); water and sanitation (SDG 6); economic growth and decent, safe working conditions (SDG 8); reduction of social inequalities (SDG 10); promotion of safe sustainable cities (SDG 11); and peace and justice (SDG 16).

Specific action areas were identified for achieving the health-related SDGs: strengthening awareness and support at the operational level (regions (*oblasts*) and districts (*rayons*)), expanding intersectoral collaboration, addressing health inequities and sustaining commitment on specific areas of health provision.

## Strengthen awareness and support at the operational level

Within the regions and districts, where operational activities are concentrated, awareness and support are needed to work towards achieving the health-related SDGs. more efforts are needed to convey the important role played by district and local level health authorities and managers within the public health and PHC systems in achieving the SDG health-related goals.

## Expand intersectoral collaboration

Work towards achieving the health policy priorities set out in Health 2030 needs to encompass all sectors, not just the health sector, and broader engagement across sectors should be fostered for achieving health-related SDG targets. The Ministry of Health has considerable experience in leading intersectoral approaches to health policy development and operationalization of health priorities. Examples include intersectoral engagement of stakeholders in the development of Health 2030 and coalition building to organize a tobacco-smoke-free World Nomad Games in 2018 *(64)* as part of the broader policy objective of fulfilling the state's commitment to the WHO Global Framework for Tobacco Control.

Intersectoral collaboration is needed to address the underlying determinants of good health and well-being and is essential to strengthening national emergency response preparedness.

Specific opportunities should be identified to serve as focal points on which to build and expand intersectoral support and collaboration for advancing the SDG health agenda. During this review, a number of potential entry points for enhanced cooperation were identified.

- **Reduce violence and abuse against women and children** (**SDG 5 and SDG 16**): intersectoral collaboration is needed to build a stronger evidence base on the prevalence of violence against women and children and to develop and strengthen violence prevention and response strategies for all forms of violence against women and children. These include intimate partner violence, forced marriage, trafficking, abuse and violence against children in the home and in schools, and reducing vulnerability for children of labour migrants. Home visiting for young children by health providers is an available platform to identify children and women in need of protection and support services by providers from different sectors, including local self-government.
- **Address the link between poverty and health** (**SDG 1**): the development of UNICEF's new multidimensional poverty assessment tool will provide a unique opportunity to establish an intersectoral approach to improving the health and well-being of children.
- **Reduce the impact of air pollution on health** (**SDG 3**): the Ministry of Health can play an important role in building the evidence base on the effects of air pollution on the health of the population and in advising regulatory branches of government on ways to minimize harm to the population's health.
- **Reduce inequality** (**SDG 10**): the country's recent adoption of the Convention on the Rights of Persons with Disabilities offers new possibilities for intersectoral engagement to improve the health and well-being of this segment of the population.
- **Promote healthy cities** (**SDG 11**): the new Healthy Cities Network offers many possibilities for cross-sectoral collaboration to improve the health and well-being of the population.

## Address health inequities

A two-pronged approach is needed to address health inequities in relation to access to essential services and poor health outcomes. Continued support is needed for system-wide improvements to the quality of care *(77)*, the costs of pharmaceuticals *(65)* and the extension of SGBP benefits to those from the poorest families. At the same time, innovative targeted efforts are required to address the underlying causes of persistent inequities among vulnerable groups.

### Promote intersectoral collaboration, strengthen coordination of platforms and increase health sector capacity

- The state migration service would benefit from more training and strengthened operational mechanisms (e.g. cross-border approaches) to address migrant health needs, including TB, and provision of strengthened health content in migrant information platforms (centres, apps, hotlines, the Guide for Migrants).
- Non-health ministries could be encouraged to participate in national health coordination platforms, in particular to address NCDs and structural determinants of health inequities.
- A multisectoral platform on food security and nutrition could be implemented/strengthened.

### Expand the engagement of civil society and community organizations in health promotion and disease prevention activities

- The village health committees represent a nationwide network whose potential is underutilized.
- Successful partnerships with community-level organizations and patient advocacy groups have been forged by the HIV and TB programmes. Lessons learned from these partnerships can be applied to other health areas such as prevention of NCDs.

### Invest in and build capacity for a modern health-care workforce

- The ongoing reorientation of the health-care system towards a people-centred approach that prioritizes health promotion and disease prevention is dependent on capacity-building and adequate finance.
- Other opportunities to strengthen and leverage the PHC workforce include:
    - curriculum and regulatory reform;
    - incentives and more effective engagement and capacity-building with civil society and the community;
    - assistance in identifying who is being left behind and why and how to tailor services appropriately;
    - promotion of models for integrating NCD prevention and health promotion; and
    - support for implementation of digital technology to increase efficiencies.

### Sustain commitment at the political and development partner levels to strengthen financial risk protection

- The reduction of the population's financial burden related to obtaining essential health-care services forms part of the country's efforts to work towards UHC.
- Eligibility for SGBP benefits could be extended to the poorest families.
- Measures could be put in place to increase efficiency and reduce costs associated with delivery of essential health services, in particular as it relates to the cost of medicines covered under the ADP.
- The current system of per capita financing and state guarantees should be reviewed to improve the payment mix in primary care, promote transparency and increase public understanding about what services are covered by the public health system.
- Funding issues could be considered through a meeting of GAP signatories and other development partners, or a World Bank working group, to explore opportunities for closer collaboration to support implementation of World Bank/bilateral financing and identify funding gaps, technical assistance needs and potential to leverage other donor and domestic financing, including for human resources.

### Address the persistent funding gap related to the state's obligations under the SGBP

- Action should be taken to raise awareness across government sectors of health as an investment in sustainable development and promote greater prioritization of public health, including prevention, in national budgets.
- Functional analysis of prevention and treatment costs would support ongoing MHIF/WHO work.

- Public–private partnerships could be explored as a potential pathway for investment in health infrastructure.
- Improvement of incentives for medical staff and task-shifting would support more efficient use of mid-level staff.
- Digital systems could be implemented to strengthen public financial management and optimize expenditure.
- Efficiency of tax collection could be improved to generate revenue.
- More intense discussions with the Ministry of Finance related to health financing would allow exploration of funding contributions to PHC from other ministries.
- The case for investment in health-related SDGs could be linked with the development of a national health financing strategy in order to improve the efficiency of spending, increase the fiscal space for health, extend state insurance coverage and widen the group of health financiers in the country, consistent with Health 2030.
- Implementation of digital technology would strengthen public financial management.

## Sustain commitment on specific areas of health provision

### New focus on prevention and control of NCDs

The heavy burden of NCDs on the health of the population necessitates the priority focus on prevention and control of NCDs in Health 2030. However, while this focus is essential, it should not diminish continued efforts to improve reproductive, maternal and child health and to prevent and control communicable diseases, particularly HIV and TB.

### Reorganization of the public health system

Sustained political commitment and development partner support are essential to complete the transformation of the public health system. Successful structural reorganization of the public health system plus reorientation and strengthening of its functions are essential to the country's vision of creating a health-care system that is focused on health promotion and disease prevention. Citizens should be made aware of the role they can play in ensuring their own health and well-being.

### Development of evidence-informed approaches to policy development and programme implementation

More support is needed for data-driven, evidence-informed approaches to policy development and programme implementation.

- Capacity-building at the national, district and local levels would support health officials and managers of health programmes to use existing data as a tool to continuously review progress and adjust programme strategies towards achieving national health priorities and the SDG health-related targets.
- The establishment of an integrated e-monitoring platform and a portal of databases for SDG indicators would make data available across the health system and beyond.

- Disaggregation of data for vulnerable populations (e.g. migrants) and improvement of postmortem diagnosis and stillborn data would allow a better use of the information collected.
- Coordination of donor assistance through a central database is needed to avoid duplication of efforts.

### Implementation of technology

Coverage and quality of basic health services could be expanded through the use of technology.

- Cooperation among GAP signatory agencies, other development partners and the Ministry of Health is needed to identify current challenges and explore entry points for closer collaboration to support digital health components of the national health policy and identify funding gaps and technical assistance needs.
- Implementation of initiatives already underway (e.g. e-card for patients, e-queuing at PHC facilities, and e-med-prescriptions) should be supported.
- Other initiatives include the development of an integrated database on medicines linked to the state procurement portal, the implement electronic medical records and their integration into PHC and the rollout of the Ministry of Health's cashless payment initiative.

### Strengthen collaboration among multilateral health organizations

Government, Ministry of Health and United Nations-led coordination mechanisms and processes are already in place for advancement of the national health priorities and the overall 2030 Agenda. Any efforts to strengthen collaboration among multilateral health organizations to accelerate country progress on health-related SDGs should take care not to duplicate these efforts.

# Opportunities for joint action in four accelerator theme areas to improve health and well-being for all at all ages

The accelerator areas presented in this section are intended to support the new GAP country process in the Kyrgyz Republic for strengthening collaboration among multilateral health organizations to accelerate country progress on the health-related SDGs.

## Sustainable financing for health

Sustainable financing for health, as one of the seven accelerator themes of the GAP, was highlighted as an opportunity for the Kyrgyz Republic to accelerate progress towards the health-related SDG targets during the discussions at the high-level policy dialogue and collaborative workshop at the end of October 2019 in Bishkek. Discussions emphasized that funding from the Ministry of Health, MHIF and external sources does not address the country's health needs and will not do so given costs and anticipated population growth. The fiscal space for health and the Ministry of Health's influence in budget decisions are limited and there is no separate health financing strategy.

Activities should be carried out in three areas to support the implementation of Health 2030:

- improve the efficiency of public financial management in the health sector;
- develop strategic purchasing of health services; and
- increase the coverage of mandatory health insurance to provide financial protection to the population.

Increasing the coverage of the MHIF to provide financial protection for the population and improving the regulation of and management of drug circulation are two stated priorities within Health 2030.

While public spending on health has grown and state funding for health increased, available funds are insufficient to cover the cost of delivering the SGBP. The persistent funding gap is related to rising costs associated with meeting the state obligations under the SGBP, which have outpaced increases in the contributions of budgetary, copayment and MHIF contributions intended to cover the cost of health services. There has been a steady expansion in the number of categories of people who are entitled to receive preferential services under the SGBP. At the same time, enforcement of payroll contributions to the MHIF remains problematic. This problem is exacerbated by the large number of citizens who have migrated outside the country for employment and do not contribute to the MHIF system.

The rising price of medicines in an unregulated drug market is also a contributing factor. Inefficiencies in the health-care delivery system such as unjustified hospitalization and overprescribing practices also contribute to the rising cost of health care. The Kyrgyz Republic has already begun to take measures to address the rising cost of medicines. In 2017, three new laws on the regulation of medicines and health technologies were implemented. In 2018, new legislation was introduced to establish a regulatory framework, which will contribute to making medicines and medical devices more affordable and meet the requirements of accession to the Eurasian Economic Union and its common market. For the first time, the new laws will allow the Government to regulate the prices of medicines and medical devices. These changes were

complemented by the revision of the national essential medicines list in 2018 and an initiative to update ADP pricing, with a focus on medicines addressing areas of high disease burden *(60)*.

The current level of external development assistance in the health sector is approximately 7% of total health expenditures *(18)* and despite efforts to increase health financing from domestic sources, the Kyrgyz Republic remains dependent on external support for critical needs such as procurement of drugs for TB and HIV as well as for infrastructure improvement.

## Strengthen PHC and modernize public health

### *Strengthen PHC*

PHC is another one of the seven GAP accelerator themes that was flagged as priority during the discussions at the high-level meeting at the end of October 2019. Development of an upgraded high-quality PHC system is a priority under Health 2030. PHC serves as the foundation of the health-care system envisioned by the Kyrgyz Republic. Since 1996, the country has invested heavily in building a strong base for the delivery of PHC services and while much progress has been made, there is wide recognition that additional efforts are required.

Strengthening PHC provider capacity to focus on health promotion and prevention is essential to this effort. With support from UNICEF, the country recently developed a PHC model for promoting child health through home visits. The initiative focuses on improving health and development outcomes for young children who are vulnerable because of developmental delays or unsafe home environments that put them at risk for violence or deprivation of parental care. Home visits are conducted by family medicine doctors and nurses according to quality standards established by the Ministry of Health. The MHIF provides bonus payments for home services based on specific evaluation criteria. Under Health 2030, the home visit programme will be expanded nationwide, and efforts are underway to strengthen referral linkages with social service providers at the community level.

Despite efforts at the national policy level to integrate health promotion and disease prevention with delivery of PHC services, these components are not well developed in relation to NCDs at the PHC level. There are few national guidelines or protocols to guide PHC staff on how to integrate health promotion, early disease detection and engagement of patients in self-care, and PHC staff have received limited training in this area.

A recent review of the health service delivery system characterized doctor–patient interactions as paternalistic, with most patients excluded from decision-making regarding their health. This problem is exacerbated by factors on both the patient and the provider sides. On the patient side, significant barriers to health prevention that must be overcome are low levels of health literacy, persistent misconceptions about the impact of diet and lifestyle on health, poor treatment adherence, high levels of self-medication (without prescriptions) and a cultural preference towards hospitalization and injections. On the provider side, a shortage of family medicine doctors, particularly in rural areas, combined with a heavy patient load and limited training and support for carrying out health promotion and prevention activities means that PHC staff are largely focused on clinical care *(78)*. Given the high burden of NCDs in the country, as well as the continued need to address HIV and TB and improve maternal and child health, a stronger focus on health promotion and prevention is urgently needed within PHC.

A second critical area that needs to be addressed is ensuring access to health care for those living in underserved geographical areas, poor families and marginalized groups. Overall, there is a shortage of clinical providers trained in family medicine. The number of family practice doctors has declined dramatically since the mid 2000s. The Ministry of Health estimates that in 2019 there were only half as many family-practice doctors as needed. The situation is even more dire in rural and remote areas where an estimated 79% of family physicians are at or nearing retirement age. Low salaries are a major obstacle in recruitment and retention of family medicine specialists. In addition, the status of nurses is low and their overall role in proving patient care, health promotion and diseases prevention services is underutilized.

There is a geographical imbalance between rural and urban areas in terms of both availability of qualified staff and availability and quality of essential health services. The number of physicians per 10 000 population is highest in Bishkek and Osh cities (22.8 and 24.1, respectively) while in some rural and remote areas the ratio is under 7 per 10 000. A 2017 survey identified the main challenges in underserved rural and remote areas as clinic hours that are not convenient for working residents; poor qualifications and shortages of clinic staff; transportation costs associated with reaching clinics from remote areas; and limited availability of laboratory diagnostic facilities, ambulance service and specialized treatment at secondary and tertiary facilities *(8)*. Referrals networks for maternal and child health services also need strengthening. These disparities need to be addressed.

Throughout the country, the quality of care across the PHC system is uneven. This is reflected in stagnant or declining levels of improvement in population health statistics, particularly in relation to maternal mortality, access to reproductive health services and morbidity/mortality related to NCDs. The absence of a holistic management and supervision system that focuses on the quality of health services plus a weak referral system linking primary, secondary and tertiary care also contribute to the problem.

To address these problems, Health 2030 outlines four key objectives related to strengthening the PHC system in the country:

- create an efficient model of PHC that includes prevention, early detection of diseases and case management (e.g. the home visiting programme for young children);
- improve coordination of referrals between PHC and secondary and tertiary health-care institutions;
- improve the quality and coverage of PHC services that result in improved health outcomes and equitable access to care for the entire population; and
- strengthen staff capacity to deliver PHC services.

A new project, the Primary Health Care Quality Improvement Programme (2019–2024) (Box 2), will be launched in 2020 with funding support from the World Bank and bilateral donors (Swiss and German). The Programme will establish and strengthen systems for quality of care monitoring, purchasing and governance in order to build and strengthen foundations for sustainable systemwide quality improvement.

**Box 2. Primary Health Care Quality Improvement Programme**

The Programme's activities will be directed towards improving health outcomes and the quality of services, reducing inequities in health outcomes, and improving financial protection. In alignment with Health 2030, the Programme will focus on three areas that are essential to improving the quality of PHC services.

**Result area 1** focuses on integrating sustainable quality improvement mechanisms into service delivery in order to establish and strengthen systems for quality care reporting and monitoring as foundations for sustainable quality improvement.

**Result area 2** covers strengthening strategic purchasing for quality services and improving coverage for selected priority conditions.

**Result area 3** aims to establish a national-level structure and mechanism for coordinated efforts to improve quality of care in the country through strengthened health sector stewardship and governance for quality improvement.

### *Modernization of the public health system*

Modernization and reform of the public health system is a stated national priority within Health 2030. The earlier sections of this report have described the steady reform trajectory in the Kyrgyz Republic intended to shift the focus of the entire health-care system to a more preventive health approach. Attempts to reform the public health system under past national health programmes did not achieve the desired transformation to a modern public health system.

The structure and functions of the public health system remain rooted in outdated approaches characterized by fragmentation and uncoordinated efforts that are not responsive to the country's burden of disease. The system suffers from insufficient financial and human resources, which results in a weak technical base. Competencies of the public health personnel do not correspond to the country's public health needs and challenges. An ageing workforce and inability to recruit and retain young professionals, coupled with an absence of adequate university and professional training programmes in modern approaches to public health, including laboratory services, pose significant challenges.

The vertical programme structure of the current public health system hinders efforts to establish the intersectoral and interagency collaboration that is necessary to protect the health and safety of the population. The technical and institutional capacity to engage on a broad range of public health concerns (e.g. environmental and occupational health, road safety, tobacco control, food safety or emergency response to natural disasters or disease outbreak) is lacking.

Leadership and engagement on population-based health promotion and disease prevention remain weak because of inadequate financing, low technical capacity of personnel and a lack of institutionalized coordination with the PHC system. The proportion of state budget funds allocated for preventive services at the population level is extremely low. Consequently, development and implementation of health and safety promotion activities are dependent on external donor support, which impedes efforts to design longer-term population-based health promotion and disease prevention strategies.

Health 2030 outlines four key areas for modernization of the public health service:

- establish a single national system for assessing and managing the population health risks to ensure effective management of public health;
- modernize the public health service by extending its main functions and assuring the quality of services for prevention, surveillance, health protection and health promotion;
- formulate an integrated system of surveillance for priority infectious diseases and NCDs, including hazardous and socially significant diseases, with packages of preventive services at the population level; and
- develop the health promotion system based on modern communication approaches that use technology and engage local government and community level nongovernmental partners.

Within the framework of cooperation between WHO and the Ministry of Health, WHO has been supporting the country's efforts to assess the capacity of its public health system and develop a plan for reform since 2011.

Based on WHO's global methodology for conducting country self-assessments of the 10 Essential Public Health Operations *(79)*, the Kyrgyz Republic carried out two self-assessments of public health services in 2011 and 2015. These reviews helped to identify the technical and organizational strengths and weaknesses of the current system.

In 2018 the Ministry of Health renewed its efforts to transform the public health system. A technical working group and an advisory group, comprising national public health experts, were established by the Ministry of Health to guide the process and provide input on the plan for modernization and restructuring of the public health system. In September 2018 the Ministry of Health launched a consultative review process, with technical support from WHO, to elicit input from a wide range of national, regional and city-level stakeholders including representatives from government, civil society, academia and international development partners. Based on this input, a set of recommendations for developing a plan to transform and modernize the public health system was developed.

Successful reorganization of the structures along with reorientation and strengthening of the functions of the public health system are essential to the country's vision of creating a health-care system that is focused on health promotion and disease prevention with active participation and awareness among the public on the role they can play in ensuring their own health and well-being. A revitalized public health system will fill a critical role in supporting this vision by providing evidence-informed guidance for policy development and programme implementation to safeguard and promote the health of the population.

## Equity issues and regional disparities

Health equity means that everyone in society has a fair and equal opportunity to be as healthy as possible. This requires removing obstacles to achieving good health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care *(80)*.

Health equity is a cross-cutting challenge that requires particular attention across all national priority health areas: PHC, NCDs, TB/HIV and maternal, child and reproductive health. Inequities occur when there are systematic differences in the health status of different population groups. These inequities have significant social and economic costs for both individuals and societies.

National data on health outcomes suggest systematic health disparities between rural and urban residents. Certain populations are also particularly vulnerable to poor health outcomes through poverty, discrimination, gender, lifestyle factors or limited access to services. Some specific focus might be required to ensure access for refugees and migrants and those with vulnerabilities related to TB.

Health equity, as part of the GAP accelerator determinants of health, was another opportunity for acceleration of progress towards the achievement of the health-related SDG targets identified and discussed during the high-level meeting at the end of October 2019. The National Strategy for Sustainable Development 2040 includes a stated priority for improving accessibility and quality of social services (particularly health and education services), while eliminating regional differences and inequalities between different income and cultural layers of society. The 2040 Strategy has three main objectives: economic well-being of the people, social well-being and security, and an enabling environment for citizens.

Within the framework of the 2040 Strategy, a specific regional development strategy and action plan was developed that identified several priority areas, including human capacity development, the cornerstones of which are education, health care and social protection. In accordance with the Decree of the President of the Kyrgyz Republic, the Government of the Kyrgyz Republic declared 2018 the Year of Development of the Regions and Digitalization of the Country.

Against this background, the Government adopted Health 2030 *(8)*, which acknowledges geographical disparities in health-care delivery and health outcomes, system failures that have inadvertently excluded access to the SGBP, and the unmet health needs of vulnerable and at-risk groups. Addressing these health and service delivery inequities is identified as a priority area within Health 2030.

## Data and digital health

As one of the seven GAP accelerator themes, data and digital health was another area of emphasis during the high-level meeting at the end of October 2019. The national policy is to digitize government institutions across the country (Digital Kyrgyzstan 2023–2040 contains action plan and activities). The Year of Digitization and Development of the Regions in 2019 saw various e-platforms being introduced but as yet many are not well integrated. Overall, there is a lack of resources for professional staff in informational technology and related systems management. Infrastructure is not well developed and there are some Internet connectivity issues in remote areas. Data exchange between sectors and on health-related SDG indicators, particularly from non-health sectors, is limited. There is also a lack of capacity to use health data to inform decision-making.

Health 2030 identifies three priorities for electronic health:

- to form a health information system that can provide unified and centralized data processing, information security, access to information systems in real time and cost-effectiveness assessments;
- to ensure the integration and interaction of a unified health information system with the information systems of other sectors; and
- to ensure proper management of information systems in electronic health.

# Key bottlenecks and problems in implementation

At the macro level, a number of factors pose potential bottlenecks or challenges to successful implementation.

**Periodic political instability** continues to pose a challenge that could potentially reduce political commitment to health reforms and continuity in the implementation of planned targets. Notably, however, the Ministry of Health's practice of establishing high-level intersectoral technical working groups to help to guide and formulate national policy and programmes has proved successful in maintaining a steady course toward health reform even during periods of political transition.

**Low level of knowledge about and commitment to SDGs at the operational level** among those implementing national health priorities can limit moves towards their achievement. While the SDG targets and indicators have been well integrated into Health 2030, hospital administrators or heads of family medical centres may be less familiar and have little understanding of how their work contributes to advancing the health agenda. More effort is needed to build a high level of awareness and strengthen the base of support for achieving SDGs throughout all levels of the heath system.

**Limited vision of health and well-being issues across the whole 2030 Agenda** may prevent effective collaboration on a broad range of health-related issues. While health and well-being are widely understood as the targets within SDG 3 and the nutrition-related targets of SDG 2, other SDGs have a direct and indirect impact on the health of the population, and their achievement requires intersectoral stakeholders to collaborate on a broad range of health-related issues.

**A persistent funding gap** prevents state obligations under the SGBP and activities proposed under Health 2030 to be achieved. Available financial resources from the state budget, MHIF and external sources are insufficient to meet the country's health needs and state obligations. PHC is inadequately funded and the per capita funding approach does not generate sufficient funds to cover state obligations. The Ministry of Health has limited influence in budget decisions and there is no separate health financing strategy. External support is also decreasing as a consequence of the country's change in status from low income to low middle income.

**The increase in OOP expenditure for health care** places a financial burden on the poorest households. By 2005 UHC had nearly been achieved for all citizens through insurance or budgetary funds, with specified vulnerable groups entitled to essential services at no charge *(15)*. In subsequent years, there has been a reversal of this trend, which has been linked to increased spending on pharmaceuticals *(65,81)*. Low-income users of health services face the heaviest financial burden of health-related OOP expenditure.

**Health worker retention and preparedness at the PHC level** have been identified as a major threat to efforts to improve health. Low remuneration for health-care workers has historically been a problem in recruitment and retention of these professionals. In 2018, the Ministry of Health adopted new performance-based salary increases for family medicine doctors as a step towards addressing this challenge. The ageing of the current health workforce, inability to attract and retain young people to the family medicine specialty and an uneven distribution of PHC staff (particularly in rural areas) pose significant challenges.

**The quality of health-care services is uneven across the PHC system** with many PHC facilities in poor condition and lacking adequate water, heating, equipment and technology (including Internet access). In practice, few providers follow a patient-centred approach to care, and the focus on health promotion and disease prevention remains limited. The regulatory system for medical staff is rigid and does not facilitate task shifting, leading to the underutilization of nurses. Mental health services and counselling is neglected in PHC. Collaboration between practitioners in PHC and public health care is not well developed and there is limited focus on prevention and health promotion.

**People-centred continuum of care** is hampered by the relatively weak referral systems throughout the health-care system and the vertical structure of most disease programmes. Referral systems within and between levels of the health-care system are underdeveloped, which further hampers efforts to develop good case management and person-centred approaches to care.

**Significant challenges to achieving health equity and poor health outcomes in sections of the population** arise from health determinants such as poverty, gender, stigma, discrimination, lifestyle factors and limited access to services. Although data are limited, anecdotal reports suggest external migration may increase risk of TB infection and reduce opportunities for diagnosis and treatment. High levels of stigma related to TB and discrimination against patients with TB contribute to reluctance to seek diagnosis and treatment and many refugees and migrants lack knowledge of their rights (including rights to health care). Addressing these factors will require the development of intersectoral approaches and stronger partnerships with civil society and communities.

**Reforms to the public health system** may fail to get needed political commitment because of the focus on strengthening PHC. Continued rationalization and modernization of the hospital system is essential for the transformation of the health system to a more prevention-oriented approach.

**Additional resources will be needed to finance special surveys** to track certain indicators related to achieving health-related SDGs.

**Limited capability for using health data** to design and manage health promotion and disease prevention policies and programmes impedes efforts at the national, regional and local service delivery levels to routinely review progress and adjust programme implementation strategies.

**National IHR implementation** is impeded by a lack of whole-of-government, all-hazards approach. The fragmented distribution of roles and responsibilities between various sectors impedes the formulation of emergency planning and effective response. Availability of quality specialist IHR training related to epidemiology, laboratory diagnosis, chemical and radioactive safety and emergency medical assistance is limited and retention of qualified staff, as in other health areas, is problematic.

**Corruption** is still deemed as one of the serious problems affecting the public sector. The Kyrgyz Republic ranks at 135 among 180 countries in terms of corruption according to the 2017 Global Corruption Index *(82)*. Informal payments are a persistent problem in the health-care sector and contributes to inefficiencies and higher costs to the patient.

# Conclusions

The health sector has been a leader in terms of integration and alignment of SDGs within Health 2030 *(83)*. It has establish an institutional precedence for intersectoral and broad stakeholder participation in policy development and programme design across all levels of government (district and local) and with civil society (including patient and citizens' rights groups, academia and private sector entities). It has also created strong coordination mechanisms for working with development partners in a collaborative manner to achieve national health policy priorities.

Significant progress has been made towards realigning the health-care system as a whole to a more prevention-oriented approach that emphasizes health promotion and disease prevention. While more efforts are needed, Health 2030 should be understood as a long-term commitment to and acceleration of reforms that began in the 1990s to transform the health-care system.

Successful achievement of the national priorities expressed in Health 2030 will result in realization of the 2030 Agenda, particularly for the targets outlined under SDG 3 and those related to nutrition under SDG 2. These are the targets most closely aligned with the objectives and planned activities of Health 2030.

Ensuring better health and well-being for the population requires a whole-of-government approach with strong engagement by civil society. It is also dependent on successful realization of the SDG health-related targets across other sectors particularly those related to poverty alleviation (SDG 1), education (SDG 4), gender (SDG 5), water and sanitation (SDG 6), economic growth and decent, safe working conditions (SDG 8), reduction of social inequalities (SDG 10) and promotion of safe sustainable cities (SDG 11). More efforts are needed to identify opportunities for broader intersectoral collaboration to achieving health-related targets within these areas.

The health sector generates a considerable amount of data through routine data collection systems, special studies and periodic large-scale population-based surveys. These data are useful in developing a picture not only of the health and well-being of the population as a whole but also of the needs of the most vulnerable and those who have been left behind. Health 2030 acknowledges geographic disparities in health-care delivery and health outcomes, system failures that have inadvertently excluded access to the SGBP and the unmet health needs of vulnerable and at-risk groups. Addressing these health and service delivery inequities is a priority area within Health 2030.

The Ministry of Health enjoys strong partnerships with its development partners and has established effective coordination mechanisms for continuous review and realignment of support towards achieving the nation's health priorities. Over the coming years, technical and financial support from development partners will be directed towards assisting the country to achieve its goal of "strengthening people-centered health systems that ensure public health and deliver quality services throughout life aimed at maximum improvement in health outcomes for the population, reducing health inequities, and providing financial protection".

Moving forward towards realization of the health-related SDGs within the framework of Health 2030, will require coordinated approaches to addressing a number of challenges.

- **A persistent funding deficit exists for meeting state obligations under Health 2030 and the SGBP**. This deficit will require actions addressing the spiralling cost of drugs, rationalizing drug-prescribing practices among physicians and exploring possibilities for increasing state budget allocations for health.
- **The health workforce is ill-equipped to respond to the needs of a modern public health and PHC delivery system.** Development of rational staffing plans, adequate remuneration for long-term retention and recruitment, and training and support for personnel at all levels throughout the health-care system are essential.
- **The population has little active engagement in health promotion and disease prevention efforts.** Greater awareness about lifestyle risk factors related to NCDs must be generated and there should be a shift towards a more patient-centred approach to service delivery that encourages active patient/client involvement in improving and safeguarding personal health.
- **There are pockets of resistance to reform and a weak unified vision of the role of the public health and the PHC delivery systems in achieving the defined goals of Health 2030.** Both awareness raising and advocacy are needed throughout the system at all levels to ensure that the SDG health agenda and the broader national goal of transformation of the health-care system towards a public health orientation are achieved.
- **Persistent health inequities relate to accessing essential health services and health outcomes.** Both a systems-wide approach to improving quality of care and an expansion of access to essential services for vulnerable and poor populations are needed. Targeted approaches should address the underlying causes of health inequities. Civil society groups can potentially play an important role in promoting health and well-being among vulnerable populations.
- **Data-driven evidence-informed approaches to policy development and programme implementation are little used.** Capacity-building is needed to assist managers at the national, district and local levels to make greater use of available data as a tool for periodically assessing progress and refining implementation strategies towards achievement of the national health priorities and SDG goals.

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# Annex 1. Summary of questionaire on GAP partner agency activities supporting achievement of the health-related SDGs

The following tables summarize the information obtained from the questionaires.

**Table A1.1. Health-related SDG target area covered by agency**

| SDG target | UNICEF | UNFPA | FAO | WHO | UNDP |
|---|---|---|---|---|---|
| 1. No poverty | | | 1.2, 1.3, 1.4, 1b | | X |
| 2. Zero hunger | X | | 2.1, 2.2, 2.3, 2.4, 2.5, 2a | | |
| 3. Good health and well-being | X | 3.1, 3.2, 3.3,3.7.1, 3.7.2,3.8.1 | | 3.1,3.2,3.3,3.4,3.5, 3.6,3.7,3.8,3.a,3.b, 3.c,3.d | 3.3 |
| 4. Quality education | | X (sexuality education family planning) | | | |
| 5. Gender equality | X | 5.2.1, 5.2.2, 5.3.1, 5.6.1, 5.6.2 | 5.4, 5a, 5b | | X |
| 6. Clean water and sanitation | | X (dignity kits for women in disasters) | | | X |
| 7. Affordable and clean energy | | | | | X |
| 8. Decent work and economic growth | | | 8.2 | | X |
| 9. Industry innovation, infrastructure | | | | | |
| 10. Reduction of inequality | | X (reduction of inequality services; prevent gender-based violence; promote gender equality in vulnerable communities including migrants and disabled) | | | |
| 11. Sustainable cities and communities | | | | X | X |
| 12. Consumption and production | | | | | X |

contd.

| SDG target | UNICEF | UNFPA | FAO | WHO | UNDP |
|---|---|---|---|---|---|
| 13. Climate action | | | 13.1, 13.2 | | X |
| 14. Life below water | | | | | |
| 15. Life on land | | | | | |
| 16. Peace justice and strong institutes | | X (address vulnerability to violence, sexual and other, in emergency situations) | | | 16.6 |
| 17. Partnership for the goals | | X (support for population surveys) | 17.4, 17.18 | | |

FAO: Food and Agriculture Organization.

### Table A1.2. Accelerator area: PHC

| Agency | Strengthen quality of services | Strengthen staff capacity and motivation | Improve access to essential drugs | Support for monitoring and supervision |
|---|---|---|---|---|
| UNICEF | • PHC pilot on adolescent health<br>• Integration of nutrition counselling (mother and child) into home visiting and baby friendly hospital programmes | Training for PHC providers: home visiting services for newborns | — | — |
| UNFPA | • Development of standard operating procedures for PHC specialists on postpartum care<br>• Development of clinical protocols on eclampsia, pre-eclampsia of a severe degree, ectopic pregnancy<br>• Development of state standards on management of pregnancy, obstetric and gynaecology services at the primary and secondary levels (under approval process) | • Clinical training on insertion/removal of interuterine devices at secondary health-care level including regions<br>• Training for PHC providers in 10 areas of high HIV prevalence to strengthen linkages with sexual and reproductive health services at PHC level | • Work with MHIF to improve access to modern contraceptives through the ADP<br>• Monitor prescription of contraceptives at PHC level | • Developed monitoring tool on Reproductive Health and Rights Law; tested in regions<br>• Development of monitoring tool on family planning services approved by State Medical Postgraduate Institute |
| FAO | N/A | N/A | N/A | N/A |

contd.

| Agency | Strengthen quality of services | Strengthen staff capacity and motivation | Improve access to essential drugs | Support for monitoring and supervision |
|---|---|---|---|---|
| UNDP | • Provision of equipment and reagents for rapid TB diagnostics (Genexpert platform)<br>• Expand sputum transportation system from 5 to 7 regions for TB services<br>• Motivation payments to MDR-TB outpatients to improve treatment compliance | • Training for PHC providers on TB diagnostics, logistics and supervision<br>• Results-based payments to doctors in family medicine centres for services for people living with HIV | • Provision of second-line TB drugs<br>• Partial provision of antiretroviral drugs | • Monitoring and supervision for TB and HIV service provision under Global Fund grant |
| WHO | • Conducted technical review of quality of health care focusing on hospitals and PHC centres<br>• Review of the health service delivery system; identification of systems bottlenecks<br>• Assessment of SRMNA<br>• Assessment of adolescent reproductive health<br>• Beyond the Numbers assessment of measles, mumps, rubella vaccine<br>• Update guidelines on surveillance of immunization adverse events<br>• T/A to strengthen immunization cold chain<br>• T/A for HIV roadmap to improve services<br>• Development of viral hepatitis clinical protocols and national strategy<br>• Development of TB roadmap to improve services | • Under Better Labs for Better Health: technical support for assessments, planning and mentoring for lab accreditation<br>• T/A for development of new SRMNA programme<br>• Training for health workers on reproductive health and monitoring and evaluation<br>• Training on immunization<br>• Polio outbreak simulation<br>• National seminar on antiretroviral therapy guidelines<br>• Training on prevention, care, and management of viral hepatitis | • T/A on development of pharmaceutical regulation; revision of clinical protocols to promote rational use of antibiotics | • Revision of viral hepatitis surveillance system |

FAO: Food and Agriculture Organization; T/A: technical assistance.

### Table A1.3. Accelerator area: sustainable financing for health

| Agency | Analysis to identify gaps in coverage | Advocacy for increased government financing and improved financial management | Support for improved strategic purchasing of health services and commodities |
|---|---|---|---|
| UNICEF | Bottleneck analysis of service gaps related to maternal and child health, nutrition and immunization services | – | – |
| UNFPA | • Ongoing tracking and analysis of government expenditures for family planning and advocacy on transparency of national health accounts<br>• Development of draft Costed Implementation Plan for 2019-2030 to increase contraceptive prevalence rate and protect health of women, newborns, children, and adolescents | Support for development of Ministry of Health's 5-year plan to increase state budget to cover contraceptives for 50% of women at medical and social risk for maternal mortality by 2023 | Regional workshop on procurement and quality assurance of reproductive health commodities |
| FAO | N/A | N/A | N/A |
| UNDP | – | Advocacy for financial support of social contracting; increased state financing for HIV and TB services and TB and antiretroviral drugs | – |
| WHO | Studies on the financial burden of health-care use | – | • T/A to support draft of price regulations for essential medicines<br>• T/A for revision of case-based payment to improve strategic purchasing for hospital services. |

FAO: Food and Agriculture Organization; N/A: not applicable; T/A: technical assistance.

**Table A1.4. Accelerator area: community and civil society engagement**

| Agency | Capacity-building | Strengthening civil society networks | Engagement of civil society and community in health promotion |
|---|---|---|---|
| UNICEF | Information and awareness to community groups on identification of danger signs and timely health service referral for pregnant women and infants | – | – |
| UNFPA | Collaboration with State Committee on Religious Affairs, Muftiyat and civil society organizations: meetings with 170 religious women and men on family planning and contraceptive use in Islam | – | • Partnerships with faith-based organizations and civil society to promote reproductive health for youth<br>• Development of reproductive health toolkit for Madrasah students and stepping stones module for religious leaders with brochures on safe motherhood, sexually transmitted infections/ HIV, family planning and reproductive health for youth |
| FAO | – | – | Pilot of community-led nutrition education<br>• Development of training guide engagement of village health committees, women's councils, social workers and health workers |
| UNDP | • Training for trustee board of state medical institutions (AIDS and NTC) to strengthen TB and HIV prevention, treatment, and care services<br>• Training for civil society organizations on project development to participate in social contracting tenders | • Support for NGO networks to create enabling environment for social contracting within the HIV/TB programme<br>• Support for the Association Partner Network to strengthen collaboration between state entities, health-care providers and civil society and TB community organizations to improve coverage and quality of TB prevention and treatment | Support for NGO-based centres for people living with HIV to serve those who experience sigma or discrimination related to HIV (legal aid, temporary shelter) |
| WHO | – | – | – |

FAO: Food and Agriculture Organization.

**Table A1.5. Accelerator area: determinants of health, equity, leave no one behind**

| Agency | Identification of risk factors and health inequities | Support for initiatives to better reach vulnerable populations | Capacity-building |
|---|---|---|---|
| UNICEF | • Perinatal mortality audits<br>• Bottleneck analysis of service gaps related to maternal and child health, nutrition and immunization services | Prioritization of newborn home visiting services for most vulnerable families | – |
| UNFPA | – | – | Sensitivity training on HIV stigma and discrimination for medical personnel serving key populations |
| FAO | – | – | • Multistakeholder engagement in analysing elements of food system on malnutrition<br>• Support for improved policy and nutrition analysis, stakeholder dialogue to formulate policies that better address underlying risk factors for poor nutrition |
| UNDP | – | • Motivation payments to MDR-TB outpatients to improve treatment compliance<br>• Support for patient-oriented approach to home-based TB treatment (DOTs) for 80 vulnerable patients in Bishkek City<br>• Motivation payments for children and adolescents living with HIV<br>• Support for NGO-based centres for people living with HIV who experience sigma or discrimination related to HIV (legal aid, temporary shelter) | Training for case managers in regional TB centres to implement patient-oriented approach to addressing the social and psychological needs of patients with drug-resistant TB |
| WHO | – | – | • Supported National Healthy Cities Network Meeting to examine role of cities and municipalities in achieving UHC<br>• Support for Kyrgyz participation in regional meetings on road traffic safety, alcohol as a risk factor |

FAO: Food and Agriculture Organization.

**Table A1.6. Accelerator area: innovative programming in fragile and vulnerable settings and for disease outbreak**

| Agency | Technical support for policy and planning | Capacity-building |
|---|---|---|
| UNICEF | Development of a communications framework for disease outbreak under immunization imperatives | – |
| UNFPA | Integration of minimum initial services package on sexual and reproductive health and services for victims of gender-based violence into national contingency and preparedness plans in collaboration with the Ministry of Emergency Situations | Simulation workshop to test a tool for minimal initial service package for reproductive health, maternal health, HIV, family planning and gender-based violence with the Ministry of Health, Ministry of Emergency Situations, National Red Crescent Society and health-care providers |
| FAO | N/A | N/A |
| UNDP | N/A | N/A |
| WHO | • With FAO promotion of food standard CODEX; high-level policy seminar to promote implementation of international CODEX on food safety standards<br>• T/A for drafting of new food safety strategy<br>• T/A for drafting of intersectoral pandemic preparedness action plan<br>• Conduct strategic assessment with Ministry of Health, Ministry of Emergency Situations to identify and prioritize hazards by risk level<br>• Under One Health Framework, workshop to strengthen linkages between sectors to prevent zoonotic outbreaks | • Training with US Centers for Disease Control and Prevention on influenza vaccine programme<br>• Provide essential medicine supply kits for 20 000 people for emergency planning and response. |

FAO: Food and Agriculture Organization; N/A: not applicable; T/A: technical assistance.

**Table A1.7. Accelerator area: research and development, innovation and access**

| Agency | Population-based health surveys | Clinical audits and epidemiological assessments | Operations and behavioural research | Policy research |
|---|---|---|---|---|
| UNICEF | • National Integrated Micronutrient Survey<br>• MIC survey (2018) (UNICEF, USAID, UNFPA) | • Trend analysis of neonatal mortality<br>• Perinatal mortality audits | • e-health, telemedicine review and analysis<br>• Review of procurement systems for immunization services | – |
| UNFPA | MIC survey (2018) (UNICEF, USAID, UNFPA) | Situational analysis of sexually transmitted infections among key populations (2018); results showed increase in sexually transmitted infections and need for stronger linkages between services for sexually transmitted infections, sexual and reproductive health and HIV | Knowledge, attitude, practice (KAP) survey among health-care workers and women of reproductive age on family planning; KAP survey will also examine existing family planning services and client satisfaction among vulnerable groups | Comparative economic analysis for providing modern contraceptives for a 3-year period: free of charge to women at sociomedical risk vs 50% subsidized to all insured women<br>• Support on CEDAW and Beijing +25 Reports (2019) |
| FAO | N/A | N/A | N/A | N/A |
| UNDP | N/A | N/A | N/A | N/A |
| WHO | • National survey on food and beverage marketing to children<br>• NCD risk factor survey<br>• COSI survey (on child obesity) | Maternal Sepsis Study<br>• Perinatal mortality audit (with UNICEF) | • Studies on financial burden of health care use<br>• Assessment of sexual, reproductive, maternal, newborn, child and adolescent services in the context of UHC | 2nd assessment of external aid (ODA)<br>• T/A for development of Health 2030 |

FAO: Food and Agriculture Organization; N/A: not applicable; T/A: technical assistance.

### Table A1.8. Accelerator area: data and digital health

| Agency | Improve technology infrastructure | Strengthen health data | Development of e-health software | Expansion of distance learning for health professionals |
|---|---|---|---|---|
| UNICEF | – | • Neurotube deficiency register in progress<br>• National Integrated Micronutrient Survey conducted | – | Telemedicine review and analysis |
| UNFPA | – | • Revision of forms at Centre for Electronic Health to capture contraceptive usage data for women from medical and social risk groups<br>• Development of a monitoring tool for a logistic management information system to support contraceptive procurement planning | With MHIF, developed specialized interface of SimBase software for electronic prescription of medicines including contraceptives; roll out nationally by 2020 | Collaboration with Postgraduate Training Institute to promote online platform for continuing education on evidence-informed family planning |
| FAO | – | Support to the NSC on methodology for adaptation and calculation of SDG food- and nutrition-related indicators (2.1.1, 2.3.1, 2.3.2) according to international standards; future support will cover Producer Price Index calculation and related SDG 2.c.1 indicator | – | – |
| UNDP | Procurement of 215 sets of computers and printers for TB surveillance and electronic TB patient record systems in hospitals and PHCs (country-wide) | – | – | – |
| WHO | | • Support for EVIPNet policy dialogue<br>• Support for e-registration of newborn births and deaths<br>• T/A for NCD monitoring<br>• Establish cancer registry<br>• T/A for PEN 4 Protocol | | |

FAO: Food and Agriculture Organization; T/A: technical assistance.

# Annex 2. Key national policy and programme strategy documents and laws related to health and well-being in the Kyrgyz Republic

| Document title | Details of normative legal acts | Priority focal areas | Related SDGs |
|---|---|---|---|
| Development programme of the Kyrgyz Republic for the period 2018–2022. Unity. Trust. Creation | Decree of the Jogorku Kenesh of the Kyrgyz Republic of 20 April 2018, No. 2377-VI | • A compact, mobile, and open model of public administration in the system of executive power structures should be formed to match the adopted and approved development model of the country and should be aimed at a sustainable increase of the country's citizens' well-being; ensuring dynamic economic growth and stable increase in the population's income and, consequently, poverty reduction<br>• Increase productivity and develop the labour market<br>• State–private partnership is one of the meaningful mechanisms of ensuring economic growth through consolidation of state and private resources to implement joint investment projects<br>• An individual and citizen of the Kyrgyz Republic should always be in the very centre of planning, implementation and assessment of development efforts<br>• The system of education begins to prepare a new generation in the country in a productive and competent way in accordance with the society's, state's and market's demands<br>• Activities aimed at ensuring UHC and meeting the needs of socially vulnerable population groups (e.g. young, elderly, people with disabilities) are being implemented within the scope of the Programme<br>• Involvement of other sectors in issues of protecting and strengthening the population's health<br>• Revision of the approach to social assistance as a narrow-sector area of responsibility and subsequent transition to an integrated approach to the needs of the socially vulnerable target category; this means covering the entire range of needs: social services, financial assistance and benefits, access to education, health care, public transportation, housing, justice and economic opportunities<br>• Urban development must be structured and should meet the main needs of citizens, including not just critically important areas, but also leisure, physical culture, and socialization<br>• Long-term development planning for each settlement, in the context of nationwide goals, mobilization of opportunities available to local self-governments and local communities<br>• Ensure gender parity in both decision-making and participation in the implementation of the set fields, elimination of pre-conditions for gender discrimination and empowerment in all areas of human activity<br>• Build a unified intersectoral policy on introducing and advancing resource-saving, low- and non-waste technologies for rational environmental management | 1–12, 16, 17 |

contd.

| Document title | Details of normative legal acts | Priority focal areas | Related SDGs |
|---|---|---|---|
| Development programme of the Kyrgyz Republic for the period 2018–2022. Unity. Trust. Creation | contd.Decree of the Jogorku Kenesh of the Kyrgyz Republic of 20 April 2018, No. 2377-VI | • Application of information, communication and digital technologies to increase productivity in public administration, improve quality of services, increase transparency, accountability and human capacity-building; all mandatory conditions for achieving the set goals in economic, social and public fields | 1–12, 16, 17 |
| Environmental Safety Concept of the Kyrgyz Republic | Order of the President of the Kyrgyz Republic of 23 November 2007, No. 506 | • Integration of environmental aspects into sectoral policy<br>• Rational (sustainable) consumption of renewable natural resources that eliminates their degradation<br>• Mandatory environmental review, environmental impact assessment during an expert review of practical projects<br>• Develop parameters and conducting an assessment of ecosystems' restorative capacities, as well as implement accounting procedures for these parameters when planning social and economic development of the country<br>• Attract domestic and foreign investment in prevention and mitigation of negative economic impacts on ecosystems | 6, 7, 13, 15 |
| National Development Strategy of the Kyrgyz Republic for 2018–2040 | Order of the President of the Kyrgyz Republic of 31 October 2018, No. 221 | • Health care that responds to human needs<br>• A quality system of education and science<br>• Youth's capacity<br>• Equal opportunities for every citizen<br>• Decent work and dignified old-age<br>• Human capacity and labour market<br>• Quality infrastructure<br>• Environment, climate change adaptation and mitigation of disaster risks<br>• Development of the country's regions<br>• Balanced system of governance; rule of law and law enforcement | 3, 4, 6–11, 16,17 |
| Regional Policy Concept of the Kyrgyz Republic for the period 2018–2022 (2017) | Decree of the Government of the Kyrgyz Republic of 31 March 2017, No. 194 | • Ensure accelerated social and economic development of the Republic's regions in order to increase the population's well-being and quality of living through focused assistance to the development of supporting territories, which include development centres and relevant ayil aimaks (rural districts) | 11 |
| The programme of the Kyrgyz Republic Government on public health protection and health care system development for 2019–2030: healthy person – prosperous country | Decree of the Government of the Kyrgyz Republic of 20 December 2018, No. 600 | • Strengthen systems, centred on human needs, that ensure the health of the population; lifelong provision of quality services aimed at a maximum improvement of population's health-care indicators; reduce inequality in health, ensuring financial protection | 3 |

contd.

| Document title | Details of normative legal acts | Priority focal areas | Related SDGs |
|---|---|---|---|
| Programme of the Government of the Kyrgyz Republic on eliminating HIV infection in the Kyrgyz Republic for 2017–2021 | Decree of the Government of the Kyrgyz Republic of 30 December 2017, No. 852 | • Reduce HIV incidence rate to a minimum through a 50% decrease in morbidity and mortality from HIV infection by 2021, in comparison to 2015, as a stage in eliminating HIV infection in the Kyrgyz Republic by 2030 | 3 |
| Programme and action plan on prevention and control of noncommunicable diseases, 2013–2020 | Decree of the Government of the Kyrgyz Republic of 11 November 2013, No. 597 | • Reduce rates of morbidity, premature mortality and disability from NCDs among citizens of the Kyrgyz Republic<br>• Reduce the prevalence of NCD risk factors<br>• Reduce the social and economic burden of NCDs using the principles of intersectoral cooperation through integrated actions on controlling the main NCD risk factors and increasing the quality of health care that builds on evidence-informed medicine | 3 |
| Programme of the Government of the Kyrgyz Republic on Protecting Population's Mental Health for 2018–2030 | Decree of the Government of the Kyrgyz Republic of 1 March 2018, No. 119 | • Strengthen mental health, prevent mental illness, ensure accessible medical care and develop a system of responsive, integrated mental health protection services at the local level; accelerate recovery, observe human rights and decrease mortality, morbidity and disability among people with mental disorders | 3 |
| Anti-narcotics Programme of the Government of the Kyrgyz Republic | Decree of the Government of the Kyrgyz Republic of 27 January 2014, No. 54 | • Decrease demand for illegal narcotics, reduce illegal supply and harm from consuming narcotics | 3 |
| On Approving the Plan of Action for Implementing a Set of Measures to Reform the System of Road Safety in the Kyrgyz Republic for 2018–2019 | Decree of the Government of the Kyrgyz Republic of 29 October 2018, No. 504 | • Reduce the number of road traffic accidents and hazardous road sectors<br>• Improve road infrastructure<br>• Reduce the risk of road traffic accidents involving pedestrians | 3, 11 |
| Programme of the Government of the Kyrgyz Republic: development of youth policy for 2017–2020 | Decree of the Government of the Kyrgyz Republic of 10 August 2017, No. 471 | • Create favourable conditions for public, social and economic self-realization and comprehensive development of new generations of young Kyrgyzstanis<br>• Ensure equal access of youth to state and municipal services<br>• Widen youth's active participation in the process of preparing and making decisions<br>• Increase effectiveness of the system of youth field management | 3–5, 8, 10, 16 |

contd.

| Document title | Details of normative legal acts | Priority focal areas | Related SDGs |
|---|---|---|---|
| Programme on food and nutrition security in the Kyrgyz Republic for 2019–2023 | Decree of the Government of the Kyrgyz Republic of 27 June 2019, No. 320 | • Improve food availability for consumption by the population<br>• Ensure that food is accessible to the population<br>• Improve the population's nutrition status<br>• Increase safety of food products | 2, 3, 6, 12 |
| National Strategy of the Kyrgyz Republic for achieving gender equality by 2020 and national plan of action for achieving gender equality in the Kyrgyz Republic for 2012–2014 | Decree of the Government of the Kyrgyz Republic of 27 June 2012, No. 443 | • Economic empowerment of women<br>• Create a system of functional education<br>• Eliminate gender discrimination and widening women's access to justice<br>• Advance gender parity in decision-making and promote women's political participation | 4, 5, 10, 16 |
| Procedure for handling industrial and consumer waste in the Kyrgyz Republic | Decree of the Government of the Kyrgyz Republic of 5 August 2015, No. 559 | • Create a waste management system | 6, 12, 15 |
| State guarantees programme on the provision of medical aid and health care to citizens | Decree of the Government of the Kyrgyz Republic of 20 November 2015, No. 790 | • Provision of guaranteed volume, types of and conditions for medical care to citizens that ensure the realization of their rights to receive medical care in health-care organizations that participate in the State Guarantees Programme in accordance with the legislation of the Kyrgyz Republic, regardless of their form of ownership | 3, 10 |

## The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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