

Kyrgyzstan



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Kyrgyzstan is a landlocked, mountainous country of 198 500 km² bordering Kazakhstan, Uzbekistan, Tajikistan and China. It gained independence in 1991. In March 2005, following a contentious parliamentary election, the government was overthrown and a new President and Prime Minister installed. The new leadership has promised to continue market reforms and increase anti-corruption measures. The capital city is Bishkek, and political-administrative divisions include seven *oblasts* and 64 *rayons*. The population is mainly Muslim (75%). Agriculture is the main source of income for the predominantly rural population. Kyrgyzstan remains heavily indebted and one of the poorest countries in the WHO European Region.

HEALTH & DEVELOPMENT

Comprehensive long-term reform of the health system is in progress. The Government of Kyrgyzstan aims to improve population health, reduce the financial burden of seeking care, and improve the quality of health care services. The reforms were initiated in 1996 with the “Manas National Health Care Reform Program” which outlined the vision of change for 10 years. In 2005, evaluations of the reforms identified substantial progress as well as continuing challenges and remaining tasks. The activities of the original Manas reforms are now being carried forward under the “Manas Taalimi National Health Reform Program” for 2006-2010. The new Program has been approved at the highest government level, and supported by the international community through a Sector-Wide Approach (SWAp). Both the first Manas reform plan and its successor focus on a set of comprehensive changes in the organization, financing and content of the health system.

Health financing reforms eliminated fragmentation which was inherent in the previously decentralized financing system. This was accomplished through the creation of regional purchasing pools (and from 2006, a single national pool) under the Mandatory Health Insurance Fund for allocation of resources using output-based *strategic purchasing* methods, a radical change from the previous input-based budgeting process based on allocations decided centrally. Simultaneously, and in part due to the change of incentives and the Law on Health Care which gave greater autonomy to providers, hospital downsizing occurred and led to savings on utilities and other fixed costs.

Primary care services have been reorganized in Family Group Practices (FGPs), which by 2004 had enrolled approximately 98.5% of the population. An outpatient drug benefit has been introduced to improve access to medicines for primary care management of conditions such as hypertension and to reduce unnecessary hospitalizations. Despite continuous increases in funding for primary health care, salaries for healthcare staff remain low and there is a shortage of personnel in remote areas.

Maternal mortality rate has increased soon after independence and remains at high level. Poverty is an important health determinant; infant mortality rates are 1.8 times higher in the 20% poorest households than in the wealthiest 20%. A long tradition of childhood immunization with good coverage of the Expanded Programme on Immunizations (EPI) vaccines has been maintained.

Leading morbidity causes^a are respiratory (23.8% in 2007) and urogenital system diseases (12.8% in 2007).

Main causes of mortality^a are cardiovascular diseases (48.3% in 2007), injuries and poisoning (9.8% in 2007) respiratory diseases (9.4% in 2007), and cancers (7.9% in 2007).

Tuberculosis remains an important disease, particularly in prisons (incidence rate over 40 times greater than in general population) where multidrug-resistant tuberculosis is a major problem. Syphilis and gonorrhoea increased until 1997 and decreased since 2000. HIV/AIDS incidence has increased, particularly in the southern part of the country along the opium/heroin trade routes. According to the United Nations Office for Drug Control and Crime Prevention 2001 survey, drug addicts totaled 2% of the total population, mainly males. Waterborne diseases are common due to widespread contamination of water sources.

^a Health of population and activities of health facilities in the Kyrgyz Republic, Republican Medical Information Center, 2008

Total population (2007) ¹	5 224 300
% under 15 (2005) ²	33.2
Population distribution % rural (2007) ²	65.2
Life expectancy at birth (2007) ¹	67.8
Under-5 mortality rate per 1000 (2007) ²	35.3
Maternal mortality ratio per 100 000 live births (2007) ¹	62.5
Total expenditure on health % GDP (2006) ³	6.3
General government expenditure on health as % of general government expenditure (2006) ³	12.7
Human Development Index Rank, out of 177 countries (2005) ⁴	116
GNI per capita US\$ (2007) ⁵	590
Adult (15+) literacy rate (2005) ⁴	98.7
Population living below national poverty line % (1990-2004) ⁴	41.0
% population with sustainable access to an improved water source (2004) ⁴	77
% population with sustainable access to improved sanitation (2004) ⁴	59

Sources:

¹ Health of population and activities of health facilities in the Kyrgyz Republic, Republican Medical Information Center, 2008

² Women and Men of the Kyrgyz Republic 2008

³ Report on National Health Accounts in Kyrgyzstan, CHSD MoH, 2008

⁴ Human Development Report, 2007/2008 accessed at http://hdrstats.undp.org/countries/data_sheets/cst_ks_KGZ.html

⁵ World Development Indicators database, World Bank, revised 17 October, 2008, accessed at <http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf>

OPPORTUNITIES	CHALLENGES
<ul style="list-style-type: none"> • Strong Government ownership of the health reform agenda and formal commitment to gradually increasing the funding of the sector over the next five years • Institutionalization of health policy analysis and training in the new Ministry of Health (MOH) Centre for Health Systems Development • Pooling of funds at the national level provides new opportunities for improving equality of resource allocation and reducing the financial burden of care for the poor • Establishment of professional associations for professional development and increasing quality of care • Development of Community Action for Health, to empower communities to control social determinants of health • Good childhood immunization programmes. 	<ul style="list-style-type: none"> • Low income and high indebtedness of the country lead to low levels of resource mobilization for health care • High out-of-pocket share in health spending undermines financial protection objectives and places a disproportionate burden on poor households • Quality of care is uneven, and outdated practice patterns of medicine remain, particularly in the area of drug prescription and use • Limited human resource (HR) capacity at different levels; low healthcare staff salaries, no HR development plan, high medical education costs and inflexible training programmes for nurses • Difficulty in attracting qualified health care personnel to remote rural areas • Rapidly increasing drug prices limit access to medicines • Outdated physical infrastructure for health care.

PARTNERS

Among multilateral agencies other than WHO, the World Bank has been the main partner, supporting the health system reforms since 1995. Global initiatives such as the Global Alliance for Vaccines and Immunizations (GAVI) and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) have mobilized a large amount of funds, but integration of these with health system reform is yet to be accomplished.

Among bilateral agencies, the United States Agency for International Development (USAID), through its *ZdravReform* and later *ZdravPlus* programmes was the first to provide support to both Manas reforms (beginning in 1994) and their ongoing implementation. Important assistance has also been provided through the United States Centers for Disease Control and Prevention (CDC). Support from the Swiss Development Corporation (SDC) and the United Kingdom Department for International Development (DFID) has also been long-term and vital for the support of the reforms. Financial support for the health system more generally has also been provided by the Governments of Germany and Japan.

Coordination of the activities of international agencies has been formalized through the SWAp. Several donors are providing direct budget support for Manas Taalimi, including, DFID, the German Development Bank (KfW), SDC, the Swedish International Development Agency (SIDA) and the World Bank. Others, most notably USAID, and other UN Agencies continue to support Manas Taalimi through parallel financing arrangements.

OPPORTUNITIES	CHALLENGES
<ul style="list-style-type: none"> • Excellent coordination among international partners with strong support for health reform • A shared recognition of WHO's role in guiding the formulation of both Manas reform programs, including the organization of the sectoral performance assessment framework • The SWAp is leading to further improvement in the alignment of donor assistance with the government's reform programme and to greater harmonization of activities. 	<ul style="list-style-type: none"> • Strong leadership demonstrated in the health sector is absent in the other parts of the public administration, jeopardizing the success of health reforms • Some areas such as harm reduction and sexually transmitted infections are poorly addressed • Encouraging agencies providing financial and technical support to the vertically organized disease control programs (mostly HIV/AIDS and tuberculosis) to support their integration into the overall health reform strategy.

WHO STRATEGIC AGENDA

WHO's mission in Kyrgyzstan is to support the Government's efforts to improve the health status of the population and reduce health inequalities, increase access to basic health services, and improve the quality of care. The strategic agenda focuses on:

- **Health care delivery.** Continuing support of primary health care development for delivering personal care and improving hospital quality with particular focus on hospital-acquired infections; developing public health and infectious disease surveillance systems, strengthening disease control by supporting the development of a coherent coordinated national prison health system to stop the spread of HIV and tuberculosis; ensuring effective and sustainable immunization of target populations; ensuring a unified approach to health promotion and inter-sectoral action to address major risk factors.
- **Resource generation.** Influencing policy to stop the proliferation of medical schools and promote a system to generate the appropriate skill-mix of high quality graduates, continuing support for local capacity building, and strengthening pharmaceutical regulations and policy.
- **Health financing.** Maintaining support for health financing policy development, including its monitoring.
- **Stewardship.** Ongoing support to national health policy development and policy analysis; supporting the health system policy makers to take a comprehensive, multi-sectoral approach to interrupt emerging epidemics of tuberculosis and HIV; supporting development of national policies in key neglected areas such as mental health and malaria control; supporting health system preparedness to respond to emergency situations; supporting the MOH shift of approach from hierarchical control to "modern stewardship", ensuring a focus on improving public health.

ADDITIONAL INFORMATION

EURO country page
WHO country page

<http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=KGZ&CtryInputSubmit>
<http://www.who.int/countries/kgz>

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