Kyrgyzstan

❶ GENERAL INFORMATION

Portfolio categorization:	Focused
Window for application:	23 March 2020
GF Investment to date	US$ 147,381,178
Income classification:	Lower lower-middle
Application modality:	Tailored for focused
Allocation amount:	Total: US$ 26,436,393 HIV: US$ 11,491,690 TB: US$ 14,944,703
Disease burden:	HIV-High; TB-High
Income level:	USD 1,220[1]
Population:	6.3 million (2018)
Eligibility:	TB and HIV

❷ KEY MESSAGES – Improvements and Opportunities

(see section 5. for details)

HIV/AIDS

Concentrate on reaching 90-90-90 targets, especially the second one – ART scale up.

Expand HIV testing in Key Populations.

Conduct new assessment and provide reliable data on the population size and HIV prevalence in the KP, primarily PWID, CSW and MSM.

Other target groups (e.g. labour migrants) could be considered in funding request only on the presentation of solid epidemiological data and proposition of evidence-based interventions likely to produce a measurable impact on HIV morbidity and mortality in the country.

Focus Matching Funds request on clear results, sustainable approaches, actionable interventions to remove human rights-related barriers and provide measurable contributions to the continuum of care.

TB

Strengthen sputum transportation system

Address regional difference in TB laboratory capacity

Strengthen external quality control (EQC) of the TB laboratory service

Address existing procurement and supply chain management issues

Address RR/MDR TB treatment retention issues with measures that will be institutionalized and supported from domestic funding after the grant

RSSH

RHSS programming should shift from health systems support more appropriate for early stages of development (e.g. salary support and short-term training) to a more strategic and cross cutting health and community systems strengthening (e.g. capacity building of primary health care, governance, procurement and supply management, health financing, data management, etc.).

RHSS programming needs to be coordinated and aligned with other partners, such as GAVI, CDC and USAID, World Bank, other multi- and bilateral partners.

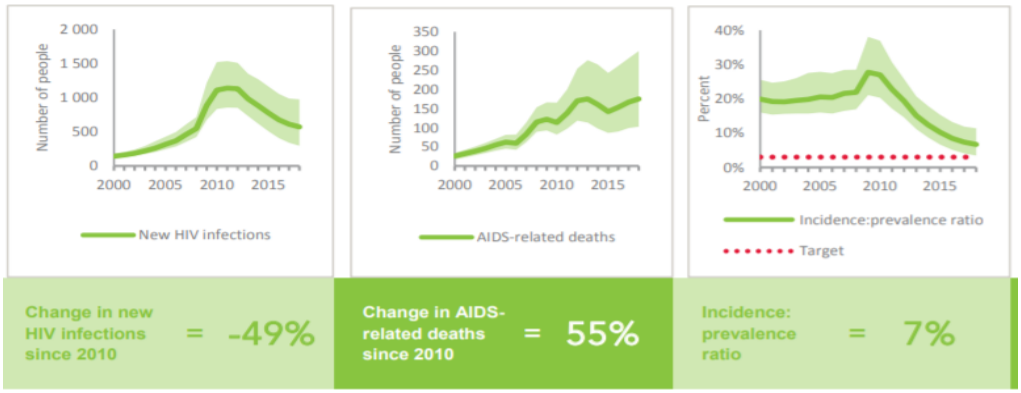
RHSS interventions should have a clear focus on transition planning with an eventual goal of the country to sustain such investments.

[1] World Bank, Country profile. Accessible at: https://data.worldbank.org/

❸ Key epidemiological data and analysis

HIV/AIDS

HIV incidence in Kyrgyzstan has decreased significantly (by 49%) since 2010, however AIDS related deaths continue to rise (55% increase since 2010). The incidence-prevalence ratio is 7 (while the target is below 3).



According to 2018 Spectrum estimates the number of PLHIV in the country is 8,500. Out of this number 68% were diagnosed, 64% of diagnosed were put on ARV treatment and 76% of PLHIV who are on treatment had viral suppression (that translates just in 30% of virally suppressed among all PLHIV).

While the level of HIV testing in general population is high (16%), it provides low yield.

HIV prevalence in adult population is 0.2%. HIV is concentrated among KPs with prevalence of 14.3% among PWID, 11.3% among prisoners, 6.6% among MSM and 2% among CSW. HIV prevalence has increased among MSM and PWID compared to 2013. HIV testing coverage in last 12 month based on IBBS was 20.2% for MSM, 43.7% in PWID, 49% among FSW and prisoners 26.1%. Based on the programmatic data the coverage with prevention programs among KPs is following: 72.7% - MSM, 66,1% PWID, 61.4% FSW. However, the data should be treated with extreme caution as the last population size assessment for KPs was conducted in 2013 and the latest IBBS in 2016.

There are anecdotal reports about increased HIV prevalence among labour migrants, primarily working in Russia, but so far there are little solid data to support such a claim.

There are high levels of stigma and discrimination. Over 70% of people say they would not buy vegetables from a shopkeeper who was living with HIV. Over 31% of people living with HIV reported a health worker disclosed their status without consent, and over 9% - denial of health services. Legal environment is not fully enabling; there is overly broad criminalization of HIV, criminalization of possession of drugs for personal use, police harassment of sex workers, etc.

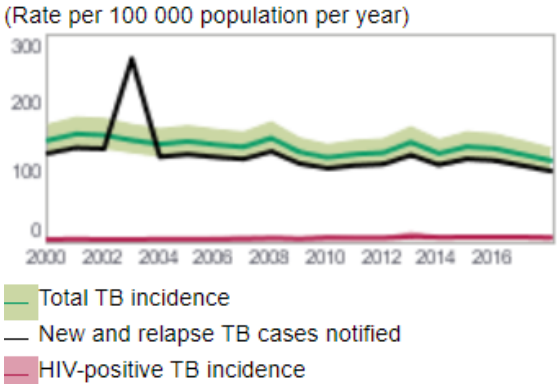
Tuberculosis

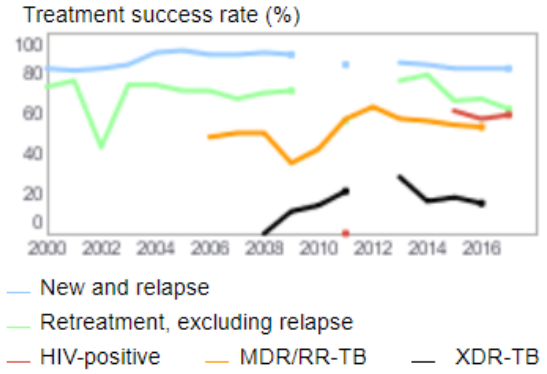
Estimated tuberculosis incidence rate is 116/100.000 population, it has declining trend, but still is higher than in 1990 and is the highest among all Central Asia countries. TB mortality rate is 6.2/100.000 and has significantly decreased since 2000 (23/100.000).

Multi drug resistant tuberculosis remains an acute and growing challenge with Kyrgyzstan being on WHO list of high MDR-TB burden country. RR/MDR TB prevalence among new cases – 29%, among previously treated cases – 68%. The estimated number of RR/MDR TB incident cases was 3,000, however only 1,685 RR/MDR TB cases were diagnosed (56% case detection) and only 1,282 of them were enrolled on second-line treatment (76%). Treatment success rate for RR/MDR TB cases was very low too (53% for 2016 cohort and only 15% for XDR TB cases).

In 2018 6,338 new and relapse TB cases were notified; male-to-female ratio was 1.5; treatment coverage was 87%. 61% of pulmonary TB cases were bacteriologically confirmed. Treatment success rate for new and relapse TB cases was 82% (2017 cohort).

100% of new and relapse TB cases were tested for HIV. 71% of HIV-positive TB cases were enrolled on ART. However, the interaction and cooperation between HIV and TB services is limited and generally confined just to referrals and patient consulting.



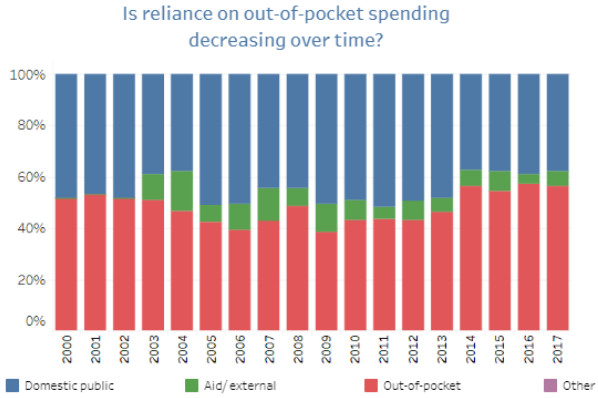


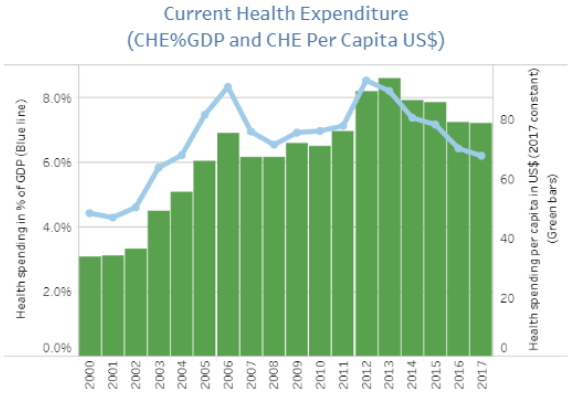
Human rights baseline assessment carried out in 2017 identified high level of TB stigma and discrimination in healthcare and community settings, punitive polices, regulations and practices as barriers in accessing TB services.

❹ Health Financing

Financing of the Kyrgyz health system comes from three principal sources: the public sector (general taxation and mandatory health insurance), private households (mainly in the form of out-of-pocket payments) and external funds from international development agencies.

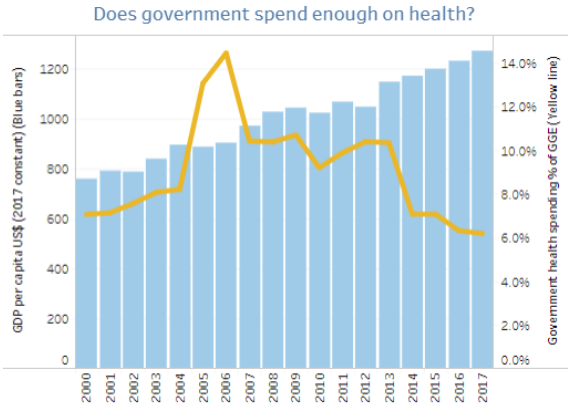
In 2017, private expenditure accounted for the bulk (56%) of total health expenditure, followed by funding from the state budget (38%) and external funding (6%) and reliance on the out-of-pocket spending is increasing since 2009.





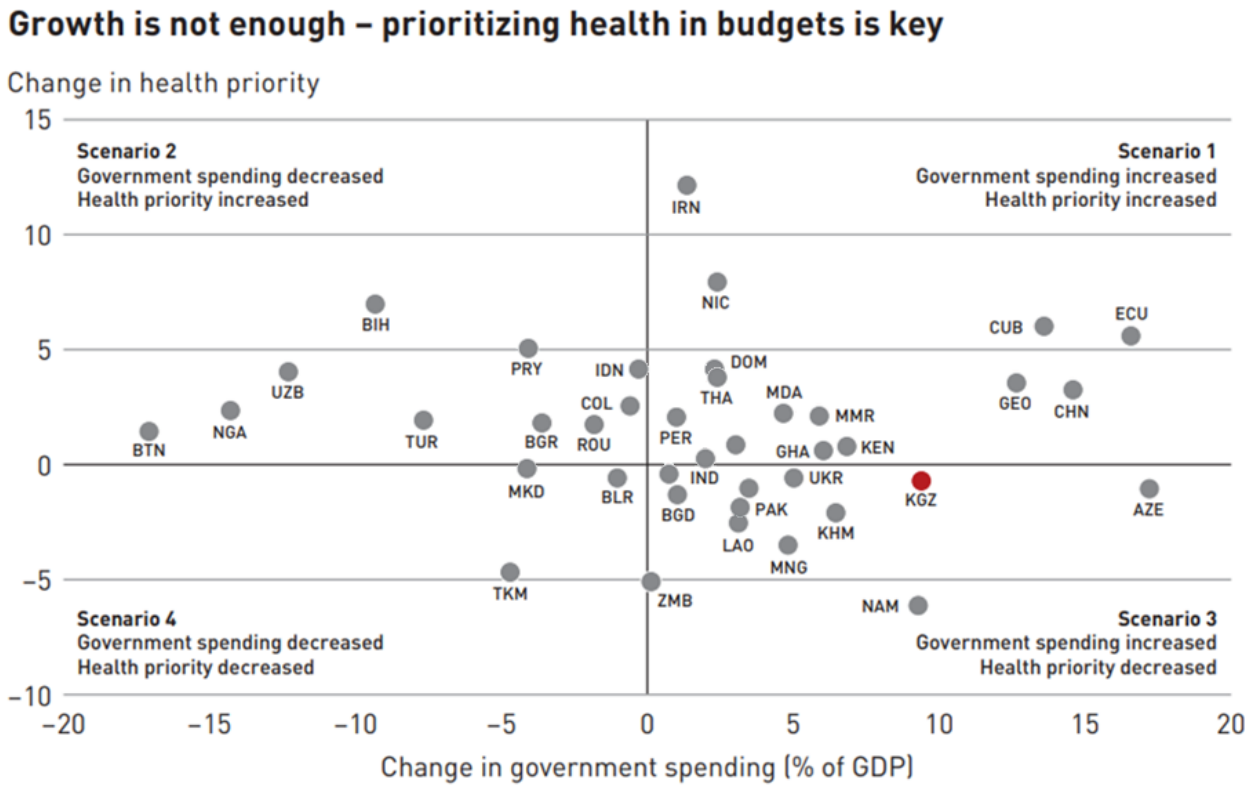
From 2005 to 2017 current health expenditures as a percentage of gross domestic product (GDP) decreased from 7.5% to 6.2%.

Current health expenditures per capita increased between 2005 and 2017 from US$66 to US$79 (US$ constant 2017).



Despite the 2008–2010 global financial crisis, Kyrgyzstan sustained rapid economic growth between 2000 and 2017 and the cumulative growth of health spending was more than twice the income growth over the same period. The fast economic growth is generally associated with higher government revenues and health spending.

However, Kyrgyzstan is among the countries that reduced priority to health: despite overall government expenditure increased (by 9.4 times), the health share in the budget fell (-0.7). Setting priorities for health in budget allocations is a choice by governments and society.



Note: Changes in health priority correspond to the difference between the 3-year average of government spending on health as a share of government spending in 2000 and in 2017. Changes in government spending correspond to the difference between the 3-year average of government spending as a share of GDP in 2000 and in 2017.

❺ Progress to date

HIV Program

Key area / priority	Successes	Challenges	Opportunities
Testing and prevention	• PMTCT • A range of projects targeting PWID, CSW and MSM with basic prevention package and relatively high HIV testing coverage • Active involvement of NGOs	• The bulk of HIV testing is focused on wrong populations with low yield • KP size assessment and IBBS data are outdated • OST coverage is low and retention rate is suboptimal. • Prevention projects largely serve the same clients and have limited access to new populations • Prevention among KP and support to NGOs are highly dependent on external financial support • High levels of violence and other human rights violations of sex workers documented, alongside decrease in coverage of sex workers	• Significant financial and technical support from multiple partners, incl. US CDC, USAID, GIZ, etc. • Possibility to conduct in 2020 a new IBBS based on a solid methodology that will allow data based strategic planning • Prioritization of key populations in country disease response • Emphasis on index testing and exploring other HIV testing approaches with a potential of higher yield in the new grant • Possibility to address social contracting and sustainability strengthening in the RHSS component of the new grant
Treatment	• Scale up of ART and substantial increase in domestic funding for ARV procurement • Accelerated TLD transition	• Slowing ART enrolment and suboptimal adherence promotion while the potential of NGOs and prevention projects for that is underused • ART provision to migrant workers, who represent a substantial part of the population and patients	• Significant financial and technical support from multiple partners, incl. US CDC, USAID, GIZ, etc. • Strengthening the role of NGOs and prevention projects in linkages to care, ART enrolment and patient adherence promotion, reduction of human rights barriers in the new grant • Focus on Test-and-Start and MMS
Zero discrimination and reducing barriers	• Vibrant and vocal civil society • Efforts to develop a strategic plan for a comprehensive response to human rights-related barriers to HIV and TB services	• High level of stigma and discrimination associated with HIV and KP • Despite increased human rights investment and commitment, so far there is little evidence of progress in addressing barriers • Strategic plan yet to be finalized and approved through interministerial order	• Focus on clear results, sustainable approaches, actionable and quality interventions to remove human rights-related barriers, and provision of measurable contributions to the HIV and TB care continuum in the new grant
RSSH and Sustainability of Programs	• Strengthened health system • Increased domestic funding earmarked for HIV	• Outreach workers and NGO subcontracting are not sufficiently institutionalized	• Significant health systems related support from multiple partners, incl. GAVI, US CDC, USAID, GIZ, etc.

	• Improved HIV laboratory capacity and treatment quality	• Decentralization of HIV care and ART to primary health care that is not yet ready or motivated • Access to quality drugs and medical goods at affordable prices through international platforms • Gradual decrease in external funding as donors are preparing to leave and expect the country to sustain the investments	• Strengthen cross-cutting RSSH programming in the new grant, with a special emphasis on capacity building of primary health care, governance, procurement and supply management, health financing, data, etc.

TB Program

Key area / priority	Successes	Challenges	Opportunities
Detection	• Rolling out rapid molecular diagnostics	• Weak sputum transportation system and inefficient referral leading to long delays in diagnostic • The level of laboratory capacity at the regional level varies significantly, e.g. Osh having none of it • External quality control (EQC) of the laboratory service is insufficient	• Significant financial and technical support from USAID and other development partners • Piloting a new sputum transportation system within a framework of the current grant with a potential for institutionalization • Further lab strengthening with a special focus on regional capacity development in the new grant
Treatment	• Steady decline in TB incidence and mortality since 2001 • Expanded access to MDR-TB treatment	• Population mobility, geographical, transportation and poverty barriers limiting access to care • Suboptimal RR/MDR TB treatment retention • Low RR/MDR TB treatment success rate and very low TSR for XDR TB • Limited interaction and cooperation between HIV and TB services • Limited community-based care and support, including aimed at human rights and treatment literacy	• Massive transition to newly recommended less toxic and more effective MDR-TB treatment regimens • Addressing the needs of the most vulnerable patients, including prisoners, released from penitentiary institutions, etc. in the new grant • Piloting a range of treatment adherence promotion measures in the new grant with their institutionalization programming (i.e. transition to domestic funding by the end of the grant) • Strengthening TB/HIV cooperation in the new grant
RSSH and Sustainability of Programs	• Strengthened reference lab and overall laboratory capacity	• TB information system is a delayed problematic issue with a long history. At the moment it looks like it will be solved with USAID support, but the timeline and outcome are not yet clear. • Poor infection prevention and control (IPC) in health facilities, directly contributing to MDR-TB spread	• Exploiting available cost saving alternatives, including predominantly out-patient treatment (addressing existing IPC issues as well), involvement of primary health care, procurement of quality medical products at affordable prices through international platforms • Advocacy and planning for increased domestic financing of

		• Weak drug and medical product planning and supply chain management, especially at the regional level • Heavy dependence on external funding for the MDR-TB drug procurement	TB control interventions, especially for medications

❻ Annexes & References

- UNAIDS data 2019, UNAIDS
- WHO Global TB report 2019, WHO
- WHO Health Expenditure Database;
- Global Spending on Health 2019, WHO
- World Bank, Country profile.