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HEALTH POLICY ANALYSIS CENTER

Integration of the Sustainable Development Goals 2030 in the strategic programs of Kyrgyzstan's healthcare sector and the country's Development Strategy 2030

Bishkek – 2017

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
DHS	Demographic Health Survey
HIV	Human Immunodeficiency Virus
IHHS	Integrated Household Survey
KR	Kyrgyz Republic
MDGs	Millennium Development Goals
MoH	Ministry of Health
MICS	Multi-Indicator Cluster Survey
NCDs	Non-Communicable Diseases
NSC	National Statistics Committee
NSDS	National Sustainable Development Strategy of the Kyrgyz Republic in 2013-2017
OOPs	Out-of-pocket payments
RH	Reproductive Health
SBP	State Benefit Program on the provision of healthcare services to the citizens of the Kyrgyz Republic
SDGs	Sustainable Development Goals
SDTP	Sustainable Development Transition Program for the Kyrgyz Republic 2013-2017
SGDs	Strategic Government Documents
UN	United Nations
WHO	World Health Organization

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I. Sustainable development agenda 2030

At the UN Summit in September 2015 member countries of the United Nations adopted the ***Sustainable Development Agenda 2030*** based on the foundation laid by the Millennium Development Goals (MDGs). The Agenda aims at achieving an equitable, rights-based, equal and inclusive world. It obliges the stakeholders to work together promoting sustainable and inclusive economic growth, social development and environmental protection towards universal good including children, women, youth and future generations. To implement this common agenda one will need a comprehensive approach to sustainable development and collective action at all levels to address current tasks whereas the common task is not to leave anyone behind and solve the problem of inequality and discrimination as the main distinctive feature.

Sustainable development goals take into account various national circumstances, capacity and the level of development, as well as national strategies and priorities. The targets are of global nature, whereas every country independently sets its own national targets being guided by global objectives while taking into account its national circumstances at the same time. Aims and objectives include economic, social and environmental components, and incorporate their interrelations in the process of achievement of sustainable development goals in all their aspects.

Table 1. Sustainable Development Goals

No. of the Goal	Name
Goal 1	End poverty in all its forms everywhere
Goal 2	End hunger, achieve food security and improved nutrition and promote sustainable agriculture
Goal 3	Ensure healthy lives and promote well-being for all at all ages
Goal 4	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Goal 5	Achieve gender equality and empower all women and girls
Goal 6	Ensure availability and sustainable management of water and sanitation for all
Goal 7	Ensure access to affordable, reliable, sustainable and modern energy for all
Goal 8	Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
Goal 9	Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation[
Goal 10	Reduce income inequality within and among countries
Goal 11	Make cities and human settlements inclusive, safe, resilient and sustainable
Goal 12	Ensure sustainable consumption and production patterns
Goal 13	Take urgent action to combat climate change and its impacts

No. of the Goal	Name
Goal 14	Conserve and sustainably use the oceans, seas and marine resources for sustainable development
Goal 15	Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
Goal 16	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
Goal 17	Strengthen the means of implementation and revitalize the global partnership for sustainable development

Each Goal includes between 5 and 19 objectives that consist of targets and means of their accomplishment supported by the global community. All in all there are 169 of such targets and means, including 126 targets and 43 means. The targets are formulated in such a way as to present both the task and the quantitative indicators of its accomplishment by 2030. All in all about 229 quantitative indicators have been defined to monitor the progress towards achieving sustainable development goals.

Part of the Sustainable development goals were previously included in the Millennium development goals, such as goals on poverty, healthcare, education, environment and gender equality. However despite SDGs maintained certain continuity with the MDGs, they cover a much broader set of development issues both on a global and national levels. They shifted away from the social sector goals and covered such sectors as economic development, rights of vulnerable groups, public governance improvements and many other issues. SDGs have the following features different from the MDGs[1]:

i. “unprecedented in scale”, covers all sectors of stewardship and development as well as economic, environmental and social determinants of health;
ii. “comprehensive and indivisible”, which means that aims and objectives are interrelated and autonomous and require policy alignment vertically and horizontally and imply commitment to overall multisectoral government and social approaches;
iii. “global in nature and universally applicable” and thus important for all counties (both developed and developing) “taking into account various national realities, capabilities and levels of development”;
iv. pay special attention to social justice and the coverage of hard-to-reach population groups, which is reflected in the promise that “no one will be left behind”; there is acknowledgment of the important role of taking into account gender peculiarities, equality and human rights, and that they represent an integrated organization structure connecting many tasks facing the society; there

[1] Towards the development of the roadmap for implementation of the Sustainable development agenda until 2030 in WHO Europe. European regional committee, 66th session. Copenhagen, Denmark, September 12-15 2016.

is also acknowledgment of the importance of peace and security as preconditions for sustainable development;

v. “Inclusive”, which means that executing tasks and reaching goals is only possible in partnership.

Ensuring healthy lives and promoting well-being for all at all ages are important components of sustainable development. However, despite significant success in improving health and well-being of people in recent years, inequality in access to healthcare still persists. Access to health and well-being is one of the basic human rights which makes it even more important to provide all people without exceptions with opportunities to obtain quality health and medical services. At the same time one must take into account that improving population’s health will depend to a large degree on the successful implementation of tasks that are not only part of SDG 3, but also other SDGs.

Figure 1. Health in the era of Sustainable development goals

Prerequisites for the formulation of tasks within the framework of SDG 3 “Ensure healthy lives and promote well-being for all at all ages” included the guiding principles set forth in the twelfth general WHO program “Not merely the absence of disease”:

I. ***Ensuring universal health coverage:*** providing the countries with an opportunity to support or expand access to main health services and financial protection and promoting universal health coverage as a uniting concept in global healthcare.

II. ***Millennium goals in health-related development, addressing incomplete and future objectives:*** accelerating the accomplishment of existing healthcare goals by 2015 and thereafter. This priority includes the completion of elimination of polio and some forgotten tropical diseases.

III. ***Addressing the problem of non-communicable diseases, psychological health, violence, injuries and disability.***

IV. ***Implementation of the provisions of International healthcare rules***: ensuring that all countries can fulfill the requirements relating to the availability of the capacity stated in the Rules.

V. ***Expanding access to vital high quality, effective and affordable healthcare products*** (drugs, vaccines, diagnostic equipment and other medical technologies.

VI. ***Addressing the problems related to social, economic and environmental determinants of health*** as the means to improve the performance of healthcare system functioning and reduce inequality in health in countries and among them.

SDG 3 "Ensure healthy lives and promote well-being for all at all ages" envisages 13 universally applicable objectives the implementation of which will be monitored through 26 indicators adopted at the global level (Table 2).

Table 2. Objectives and indicators of SDG 3 "Ensure healthy lives and promote well-being for all at all ages".

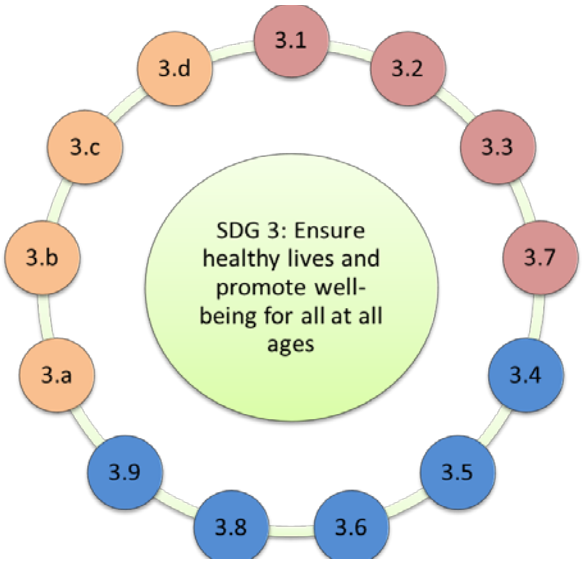
Objectives	Indicators
3.1. By 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1. Maternal mortality ratio
	3.1.2. Proportion of births attended by skilled health personnel
3.2. By 2030 end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	3.2.1. Under-five mortality rate
	3.2.2. Neonatal mortality rate
3.3. By 2030 end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	3.3.1. Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations
	3.3.2. Tuberculosis incidence per 1,000 population
	3.3.3. Tuberculosis incidence per 1,000 population
	3.3.4. Malaria incidence per 1,000 population
	3.3.5. Number of people requiring interventions against neglected tropical diseases
3.4. By 2030 reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.1. Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease
	3.4.2. Suicide mortality rate
3.5. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1. Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders

Objectives	Indicators
	3.5.2. Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol
3.6. By 2020 halve the number of global deaths and injuries from road traffic accidents	3.6.1. Death rate due to road traffic injuries
3.7. By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	3.7.1. Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods
	3.7.2. Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group
3.8. Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	3.8.1. Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)
	3.8.2 Share of the population with high household health expenditure as a share of total costs or income of the household
3.9. By 2030 substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.9.1. Mortality rate attributed to household and ambient air pollution
	3.9.2. Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)
	3.9.3 Mortality rate attributed to unintentional poisoning
3.a. Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	3.a.1. Age-standardized prevalence of current tobacco use among persons aged 15 years and older
3.B Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding	3.b.1. Proportion of the population with access to affordable medicines and vaccines on a sustainable basis
	3.b.2. Total net official development assistance to medical research and basic health sectors

Objectives	Indicators
flexibilities to protect public health, and, in particular, provide access to medicines for all	
3.c. Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	3.c.1. Health worker density and distribution
3.d. Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	3.d.1. International Health Regulations (IHR) capacity and health emergency preparedness

Objectives 3.1, 3.2, 3.3 и 3.7, related to mother and child health and communicable diseases, are based on the accomplishments and experience in MDG implementation. At the same time the remaining tasks are new and despite being important health objectives for many years, they were not included in the MDGs. Objectives 3.4, 3.5, 3.6, 3.8 and 3.9 are related to the non-communicable diseases, psychological health and abuse of psychoactive substances, road accidents, universal health coverage and access to quality healthcare services, dangerous chemical substances and environmental pollution. Objectives 3.a, 3.b, 3.c and 3.d are called “means” and cover such areas as global security in relation to health, health human resources, access to medical products and research and development[2].

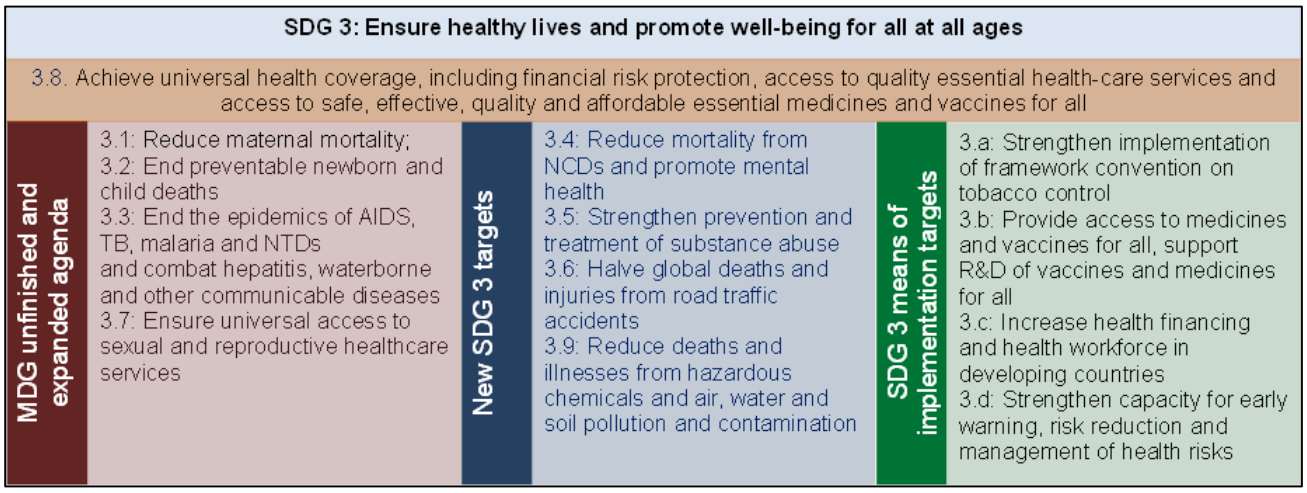
Figure 2. Objectives within SDG 3



Of the existing 13 tasks included in SDG 3, the key one is objective 3.8 “Ensure universal health coverage including the protection from financial risks, access to quality vital health services and access to safe, effective, quality and affordable vital drugs and vaccines for all”.

[2] Towards the development of the roadmap for implementation of the Sustainable development agenda until 2030 in WHO Europe. European regional committee, 66th session. Copenhagen, Denmark, September 12-15 2016.

Figure 3. Interrelation between the objectives of SDG 3



This approach defines universal health coverage as the key objective whose implementation will enable to reach tasks in other objectives as well. As shown on Figure 3, all objectives in SDG 3 may be split into (a) those that are aimed to build on the measures set forth in MDGs, (b) new tasks; and (c) means to achieve SDG 3 objectives. Implementation of all these tasks will on the one hand have an impact on improving universal health coverage, and on the other hand implementation of task 3.8 will enable achieving greater alignment and reducing fragmentation of the health sector and promote healthcare systems strengthening for the countries.

II. Adaptation of the Sustainable Development Goals (SDGs) 2030 in the health sector.

2.1 Relevance of population health protection in the context of the country's development.

Health is one of the most important factors of social development in all economic systems. Health of the population is not only an objective in itself, but rather one of the prerequisites of economic growth of the country. Health relates to the key element of production force - the producer as such with his/her ability to work and exercise work skills, and only full health makes it possible to achieve high labor productivity. While being an integral feature of labor resources, health, among other qualitative features of the workforce (education, qualifications), has an important impact on the rates of socio-economic development of the society.

The population's health status depends directly on the socio-economic conditions, or, in other words, the population's health status is the most precise and adequate reflection of the quality of life. Many negative health problems of the population are related predominantly to social, common and production-related factors (low income, poor nutrition and water, insufficient housing, poor working conditions, unsatisfactory

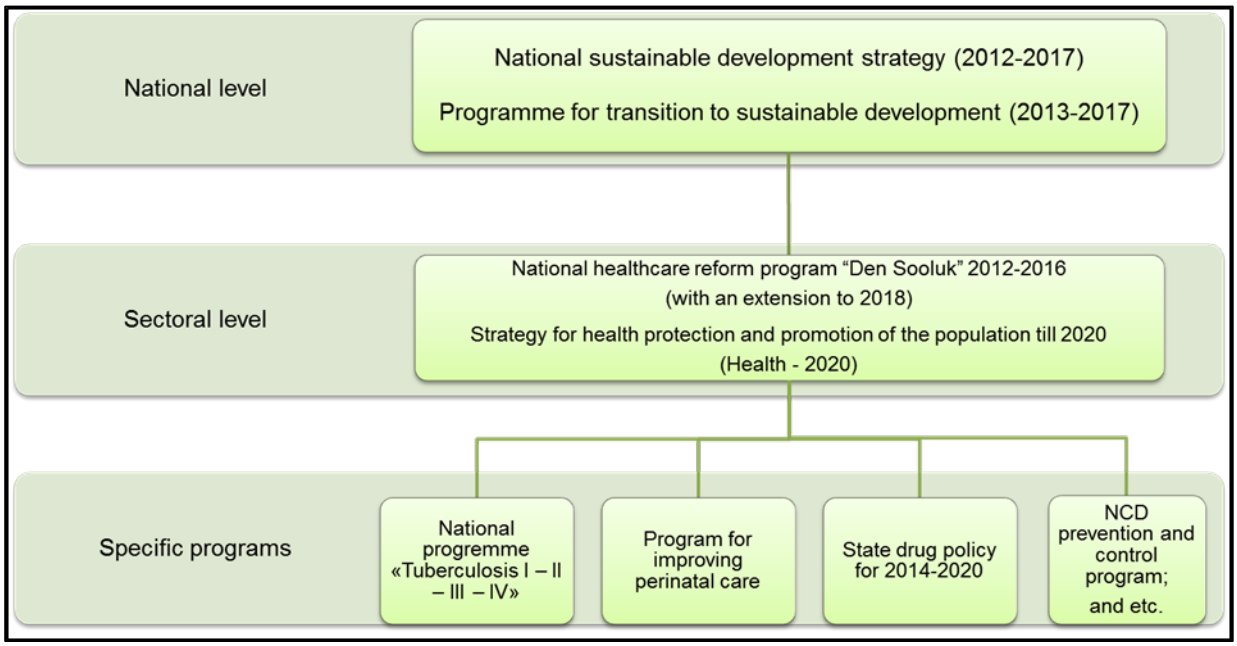
services and recreation, alcoholism, drug addiction, constant psychological and emotional stress etc.). This is why one of the key elements of the society's social and economic development is healthcare for the population, which leads us to conclude that healthcare is the main activity of the state in ensuring the citizens' rights to life and health. In the current state of societal development healthcare is of enormous social importance and is one of the key components of the social sphere.

Kyrgyzstan already has the experience of integrating global initiatives in the national development policy documents. According to the *National voluntary report* prepared by Kyrgyzstan in 2015 for the annual ministerial review in the UN Economic and Social Council, the First document in the country where the MDGs were incorporated was the first MDG progress report published in 2003. This report set the system of national goals, objectives and targets, that later became the main basis for their inclusion in the national development documents. At the same time the first national strategic document directly incorporating MDGs as part of the government policy under development was the the Healthcare development policy 2006-2010 "Manas Taalimi". It is this program where one could follow the dynamics of MDGs 4, 5 and 6, and not as the healthcare indicators but rather as "Millennium development goals indicators". One of the priority streams in the healthcare sphere was proclaimed as its orientation towards the accomplishment of the MDGs. Later on MDG elements started being incorporated in the national strategic documents, however until the development of the National sustainable development strategy (NSDS) most of the indicators monitoring the progress in the implementation of the MDGs were missing.

Beginning from 2012 the issues of sustainable development were put to the forefront in Kyrgyzstan. In fact the MDG system already laid the foundation of sustainable development viewing development as a comprehensive issue. This was all reflected in the development and adoption of two strategic documents at the national level: National sustainable development strategy 2013-2017 and Sustainable development transition strategy 2013-2017. Despite all of them being adopted before 2015, both of these documents prioritize sustainable development.

As for the government policy in the health sector, it is described in the national and sectoral strategic documents, such as the National sustainable development strategy (2012-2017), Kyrgyz Republic's Sustainable development transition strategy 2013-2017, Strategy for health protection and promotion of the population of the KR 2020 (Health - 2020), National healthcare reform program "Den Sooluk" 2012-2016. The Den Sooluk program is being implemented on the basis of a sector-wide approach whereas an agreement was reached with the development partners regarding its extension until 2018. Furthermore there are various specific programs aimed at the implementation of policy measures in concrete areas of the healthcare sector.

Figure 4. Defining the policy in the healthcare sector



Attachment 1 presents various government documents currently reflecting certain elements of tasks included in the SDGs and health-related objectives. At the same time it also provides strategic documents of different levels, both national and sectoral, as well as those defining policy measures in relation to certain objectives and streams.

This approach makes it possible to further integrate all objectives within the framework of SDGs based on national priorities. In other words, some of the objectives may be integrated in the national strategic documents such as the long-term Sustainable development strategy or NSDS-II. The remaining objectives may form a part of the health sector reform program which will be developed to replace the current Den Sooluk program. More detailed policy measures to achieve the targets in relation to these objectives will be reflected in the specific programs within the healthcare sector.

2.2 Suggestions on SDG implementation in the long-term Sustainable development strategy

To implement the assignments issued by Vice Prime-Minister of the Kyrgyz Republic O. Pankratov of July 7 2016 No16-2530 and No16-2531, the Ministry of health created a working group to adapt SDGs in the health sector which included representatives of the Ministry of Health, MHIF, National Statistics Committee, republican health institutions etc. The activities of the working group were carried out with active support of the World Health Organization. The working group developed suggestions on the integration of SDG-3 in the draft Sustainable development concept of the KR 2030.

Based on the analysis of the current situation it is suggested to formulate the ***goal*** of health sector development 2030 as the creation of prerequisites for effective prevention and treatment of various diseases, increase of accessibility and quality of healthcare services, especially for the poor, aimed at the reduction of population morbidity taking

into account SDG 3 “Ensure healthy lives and promote well-being for all at all ages” and other health-related goals.

Implementation of the health sector policy will concentrate on the following priorities:

1) Reducing the population’s burden of disease;
2) Public health capacity building;
3) Healthcare system strengthening and development.

The table below provides information on how the objectives stipulated in the draft Sustainable development concept of the Kyrgyz Republic 2030 may be connected to the SDG-3 tasks and other health-related Goals.

Table 2: Interrelation of the health sector policy within the framework of the Sustainable development concept of the KR 2030 with the Sustainable Development Goals.

KR’s draft Sustainable Development Concept 2030	SDGs
Priority 1: Reducing the population’s burden of disease	
Improve access and quality of healthcare services for the population and reduce financial burden of disease	*SDG3:* 3.8 Ensure universal health coverage
	SDG3: 3.B Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
	SDG-3: 3.C Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries
	SDG–1: 1.5 Build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters
Continue activities aimed at improving mother and child health	*SDG-3:* 3.1 Reduce the global maternal mortality ratio to less than 70 per 100,000 live births
	SDG-3: 3.2 End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

KR's draft Sustainable Development Concept 2030	SDGs
	SDG-3: 3.7 Ensure universal access to sexual and reproductive health-care services
	SDG-2: 2.1. End hunger and ensure access by all people to safe, nutritious and sufficient food all year round
	SDG-2: 2.2 End all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons
	SDG-5: 5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences
Stabilize the spread of HIV.	*SDG-3:* 3.3 End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
Improve the quality of healthcare services at different levels of the healthcare system to fight TB, hepatitis and other infectious diseases including water-borne ones	*SDG-3:* 3.3 End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
	SDG-3: 3.9 Substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
	SDG-6: 6.1 Achieve universal and equitable access to safe and affordable drinking water for all
	SDG-6: 6.2 Achieve access to adequate and equitable sanitation and hygiene for all and end open defecation
Improve effectiveness of prevention and control of non-communicable diseases	*SDG-3:* 3.4 Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
	SDG-3: 3.6 Halve the number of global deaths and injuries from road traffic accidents
	SDG-3: 3a "Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate"
Ensure affordable psychosocial assistance to reduce mortality, morbidity and disability of persons with psychological disorders	*SDG-3:* 3.4 Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

KR's draft Sustainable Development Concept 2030	SDGs
Priority 2: Public health capacity building	
Improve the effectiveness of population needs-driven public health service	*SDG-3:* 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
	SDG-3: 3.9 Substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
Strengthen government oversight of water supply facilities	*SDG-3:* 3.9 Substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
	SDG-6: 6.1. Achieve universal and equitable access to safe and affordable drinking water for all
	SDG-6: 6.2. Achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations
Reduce diseases related to food safety and balanced nutrition	*SDG-3:* 3.9 Substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
	SDG-2: 2.1 End hunger and ensure access by all people to safe, nutritious and sufficient food all year round
Priority 3: Healthcare system strengthening and development	
Ensure universal health coverage by improving government programs aimed at the provision of health services and increased rational use of financial resources	*SDG-3:* 3.8 Ensure universal health coverage
	SDG-3: 3.C Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries
	SDG–1: 1.5 Build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters
Ensure more efficient use of financial resources aimed at preferential provision of drugs to socially vulnerable population groups	*SDG-3:* 3.B Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

KR's draft Sustainable Development Concept 2030	SDGs
Prevent brain drain and improve quality of medical and pharmaceutical education	*SDG-3:* 3.C Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries
Introduce unified and standardized medical information systems in practical healthcare	*SDG-17:* 17.18 By 2020 enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, health status, geographic location and other characteristics relevant in national contexts.

These proposals will require further consultations for further prioritizing. However while prioritizing one must keep in mind that the government has undertaken certain commitments to protect the health of the population and some of them are stipulated in various regulatory documents. In particular, Article 47 of the **Constitution** of the Kyrgyz Republic says that «*Each person is entitled to health protection*», whereas «*Free healthcare services and preferential healthcare services are provided within the limits of the state benefit package envisaged by law*». For these purposes the Government approves the **State benefit package program designed to provide citizens with healthcare services** that defines the guaranteed volume, types and conditions for healthcare provision to the citizens of the Kyrgyz Republic, ensures the exercising of the rights of the Republic's citizens to healthcare services in healthcare organizations regardless of their ownership and participating in this program.

The law "On the protection of health of citizens in the Kyrgyz Republic" is the main regulatory act that regulates the issues of health protection of citizens in the Kyrgyz Republic. This Law regulates the issues of the citizens' rights to the protection of their health, defines the authority of state and local self-governance bodies on the issues of health protection, regulates the activities of healthcare organizations and defines professional rights, responsibilities and liabilities of medical and healthcare personnel etc.

The Law "On public health" aimed at (a) protecting the health of the population; (b) forming healthy lifestyles; (c) preventing communicable and non-communicable diseases. In this document the state undertakes the commitment to perform oversight in such areas as the safety of drinking water, food, air etc.

There is a number of other legislative documents that define the responsibility of the government for ensuring protection of health of the citizens of the Republic.

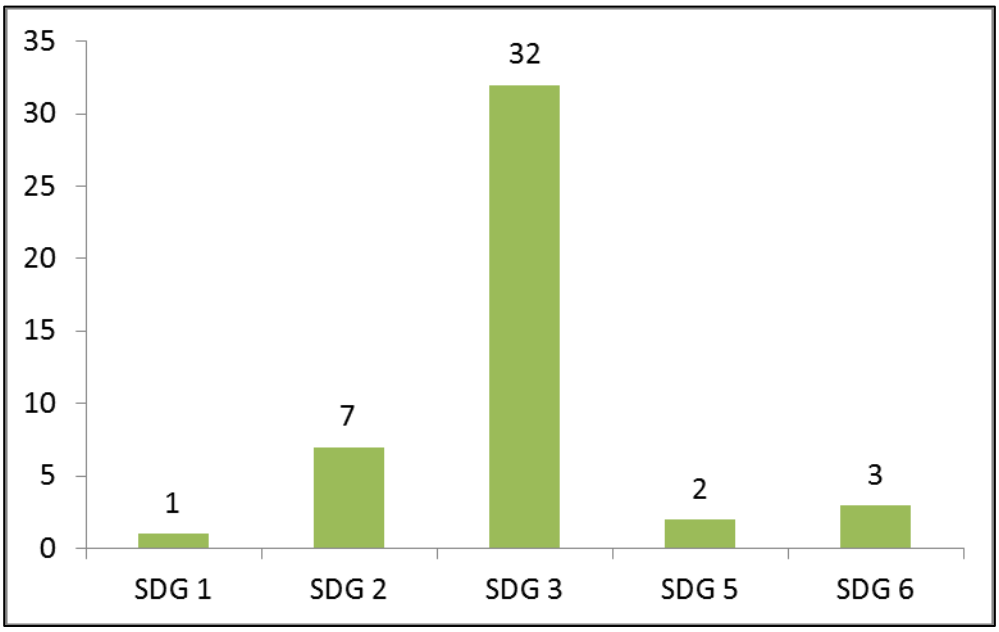
However, besides national commitments, Kyrgyzstan, being a member of international organizations, has undertaken a number of commitments defined at the global level and included in the SDGs. For instance:

- The political declaration adopted at the high-level meeting of the UN General Assembly on prevention and control of non-communicable diseases.
- Political declaration on HIV and AIDS: on the fast-track to accelerate the fight against HIV and AIDS.
- Resolution 67/81 of the UN General Assembly on Universal health coverage of the population.
- Resolution 66/115 of the UN General Assembly on health and environment, health and disasters etc.
- Resolution 69 of the World Health Assembly on the issues of health in the Sustainable development agenda 2030.
- Resolution “Towards the development of the roadmap for implementation of the Sustainable development agenda until 2030 in WHO Europe”.

2.3 Suggestions on indicators to monitor SDG implementation progress in healthcare.

Simultaneously with the development of proposals on the integration of SDG3 and health-related objectives in the Sustainable development concept, the working group on adaptation of SDGs in the health sector developed proposals on monitoring the progress of their implementation. This work included discussion and alignment of a set of indicators with various stakeholders. As a starting point in development of the set of indicators was an assignment commissioned by Vice-Prime-Minister of the Kyrgyz Republic, O.Pankratov, as of July 7, 2016. In this assignment all ministries and agencies were instructed to draw up an inventory of the Sustainable Development Goals and Objectives and their Monitoring indicators. The assignment already included preliminary distribution of the SDGs and their objectives to the responsible agencies. According to the assignment, Ministry of Health needed to submit its proposals regarding to SDG3 as well as to other health –related objectives. This effort resulted in the development of national indicators for the monitoring of SDG implementation in the health sector that include 45 indicators, of which 32 indicators are for SDG3 and 13 - for other SDGs. For each of the indicators sources of data were identified as well as baselines for 2015 and targets for 2030 (Attachment 2).

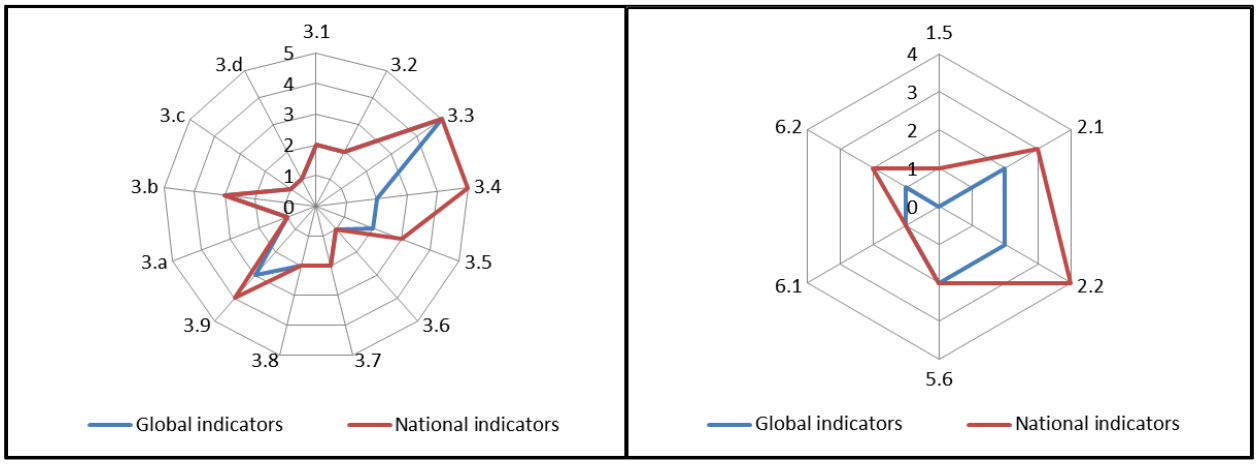
Figure 5. Distribution of national health-related indicators by SDGs.



When working on the list of indicators, the working group was guided by a number of criteria for the selection of indicators:

1. One of the key principles in defining the set of indicators was to achieve the greatest compatibility as possible of national indicators with the global ones, which should ease the process of preparing country reports on SDG implementation progress in the future. However achieving full convergence of global and national indicators does not appear to be possible, because some of the global indicators are general and **require localization taking the national context into account.**
2. When considering the indicators, preference was given to quantitative indicators.
3. Indicators should be simple and easy to understand.
4. Data collection methodology and sources should be developed and defined for the indicators. Preference was given to the indicators for which data collection experience already exists and those which were used to analyze the situation in health sector or to track the implementation of various programs in health sector.

Figure 6. Compatibility of national and global health indicators.



As one can see in Figure 6, almost all global indicators in SDG3 were coupled with similar national indicators. Only two indicators were exceptions:

(1) 3.3.5 “Number of people requiring interventions against neglected tropical diseases” - excluded because it is not relevant for Kyrgyzstan.
(2) 3.b.3 “Total net official assistance for development purposes targeted at health research and at main healthcare sectors” - at present there is no official data which could provide full information about the volume of external assistance.

At the same time when developing indicators to monitor the progress in implementing health-related tasks in other SDGs, the working group suggested 13 national indicators whereas only 8 had been defined at the global level.

As already mentioned, one of the important criteria to select indicators was availability of the confirmed data sources. During work on indicators the working group defined three basic data sources:

1. Administrative data: most of the information comes from routine reports of various government agencies such as Ministry of Health, Mandatory Health Insurance Fund, Republican Health Information Center, National Statistics Committee etc.
2. Large-scale surveys: regular specialized large-scale surveys are needed to collect information, for example Multi-Indicator Cluster Survey, Demographic Health Survey, Health Module of the Integrated Household Survey, Discharged Patient Survey etc.
3. Specialized studies and reports: the information sources for indicators may be various reports and findings of studies carried out by international organizations, NGOs etc.

Also, to ensure better monitoring of SDG progress and integration into the national SDG monitoring system, a passport has been developed for each national indicator containing the following information:

Table 3. Passport structure for the proposed SGD3 indicators and health-related objectives

No.	Category	Description
1.	Indicator title	Indicator title and officially recognized interpretation/definition of the indicator
2.	Indicator definition	Brief description of the current indicator
3.	Unit of measurement	Precise information about the units this indicator should be measured in
4.	Type of the indicator	Whether the indicator is quantitative or qualitative
5.	Purpose	Description of the goal - why this indicator needs to be collected and analyzed
6.	Data collection and processing and calculation methods	Description of the methodology/standards for data collection to define the indicator, indicator calculation methods including formulas and components (if it is a calculated indicator). Also a description is provided of the relevant official national and international methodologies and standards related to the collection, calculation and presentation of the indicator.
7.	Sources of data	Description of the official sources of data for the indicator and/or data for the components needed to calculate the indicator.
8.	Additional sources of data	Description of additional sources of data, if available
9.	Frequency of collection and reporting	Description of the current frequency of data collection for the current indicator
10.	The need for special tools (funding) for data collection or reporting on the data	The need for additional costs besides public financing to monitor this indicator
11.	Additional information and references	Description of additional reference information including the description of the definition, methods of collection and processing of data as well as external sources of additional information related to this indicator.

III. Conclusion

The healthcare sector is currently the leader in adapting SDGs in the Kyrgyz Republic. Despite the fact that clear criteria and procedures for prioritizing SDGs and objectives incorporated in them have not been developed at the national level yet, just as criteria and procedures for their consequent integration in the national strategic documents, the Ministry of Health with support of the World Health Organization and other development partners is prepared to make its suggestions. At present, Kyrgyzstan has started development of the long-term sustainable development concept by 2040. It is planned to develop mid-term strategy of the NSDS-II. In addition, Den Sooluk Program is about to finish and it is required to develop the next National Health Sector Development Program. Based on the current situation it is important to achieve the alignment of the

sectoral program with national long-term and mid-term sustainable development programs as well as with global Sustainable Development Goals. On the assumption of the objectives formulated at the global level health policy should be aimed at provision of the universal coverage with health services through solving the issues of human resources, drug provision, health financing, ensuring access to services etc. Also, efforts in the health sector will be aimed at reducing disease burden, particularly NCD burden.

At the same time it is necessary to complete aligning the current proposals in relation to SDG integration in the health sector and their monitoring indicators in line with the national context. One should also keep in mind that there is a number of challenges and risks in SDG implementation in the health sector, such as:

- Insufficient political commitment which may lead to delays in the implementation of tasks or their non-execution.
- Child and maternal mortality rates are sensitive to the social and economic situation in the country.
- Brain drain of qualified staff both the administration of the Ministry of Health and from the health sector due to low salaries.
- Failure to conduct planned activities should the funding be insufficient.
- Absence of effective intersectoral cooperation mechanisms in the country.
- Monitoring of SDG implementation will require additional financial resources to conduct specialized surveys (for instance, DHS, MICS, IHHS health module etc.).
- Taking into account the large number of SDGs and their integral objectives and progress indicators, SDG monitoring may turn out to be a large burden for the country which will make it necessary to prioritize both the SDGs and their objectives and indicators.

Attachment 1: Interrelation between health-related Sustainable Development Goals (SDGs) and Strategic Government Documents (SGDs).

SDGs	SGDs	Relevant sections
Goal 1. End poverty in all its forms everywhere		
1.3 Implement nationally appropriate social protection systems and measures for all	Sustainable Development Transition Program for the Kyrgyz Republic 2013-2017 (SDTP)	Subsection 4.3 Healthcare. Objectives: (i) Increase access of vulnerable groups to specialized healthcare services; (ii) Ensure rational and efficient use of financial resources aimed at preferential provision of drugs to socially vulnerable population groups; (iii) Guarantee the provision of free basic healthcare services to the socially vulnerable groups.
	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Subchapters: 3.1. Solidarity; 3.2. Reducing inequality; 3.3. Promoting the concept of life-long health.
	State Benefit Program to provide healthcare services to the citizens of the Kyrgyz Republic	Approved by the Resolution of the Government of the Kyrgyz Republic in accordance with the Law of the Kyrgyz Republic "On the protection of health of citizens in the Kyrgyz Republic" to increase effectiveness of social protection of vulnerable groups. The list of categories of citizens entitled to free and preferential healthcare services under the SBP, section I "Categories of citizens entitled to free outpatient and inpatient healthcare services in accordance with their social status".
1.3 Implement nationally appropriate social protection systems and measures for all	Non-communicable disease prevention and control program in the Kyrgyz Republic 2013-2020.	Chapter 6. Main priority streams of the Program, § 5. Reducing inequality in access to healthcare services regardless of geographical issues, transportation and income

SDGs	SGDs	Relevant sections
		level.
1.5 Build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters	The Program of adaptation of the healthcare sector of the Kyrgyz Republic to climate change 2011-2015.	The objectives of the Program are aimed at prevention and reduction of communicable and non-communicable morbidity, reduction of population mortality due to adverse climatic factors, prevention of accidents resulting from natural disasters, development of activities to supply safe drinking water and food products and improvements of the public health system infrastructure to provide qualified healthcare services to the population in the conditions of a changing climate. Chapters: Impact of climate change and health risk factors, Impact of climate change on food security, Impact of climate change on food safety, Safe drinking water and climate change.
	Food security and nutrition program in the Kyrgyz Republic 2015-2017.	Goal: Ensuring availability of staple foods in the Kyrgyz Republic in accordance with the established norms, and improving the stability of food supplies to the country's population.
Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture		
2.1 End hunger and ensure access by all people to safe, nutritious and sufficient food all year round	Food security and nutrition program in the Kyrgyz Republic 2015-2017.	Subchapters: 2.2. Food availability Goal. Ensure stable access to food for vulnerable population groups and protect them from the impact of high food prices. 2.3. Food use and balanced nutrition. 2.4. Food safety
	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Subchapter 10.4 Strengthening population health
2.2. End all forms of malnutrition	Food security and nutrition program in the Kyrgyz Republic 2015-2017.	Subchapters: 2.2. Food availability Goal. Ensure stable access to food for vulnerable population groups and protect them from

SDGs	SGDs	Relevant sections
		the impact of high food prices. 2.3. Food use and balanced nutrition.
Goal 3. Ensure healthy lives and promote well-being for all at all ages		
3.1 Reduce the global maternal mortality ratio to less than 70 per 100,000 live births	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Subchapter 5.2. Mother and child health; 13. Intersectoral interaction on the issues of mother and child health protection, prevention and treatment of HIV, TB, non-communicable diseases.
	National healthcare reform program of the KR "Den Sooluk" 2012-2016.	Chapter 8. Mother and newborn health
	"Perinatal service improvement program in the Kyrgyz Republic 2008-2017"	Goal of the program - to reduce maternal, perinatal, neonatal and infant mortality, improve the quality of healthcare services for mothers and newborns with equal opportunities in all regions of the country.
	Communication strategy on the issues of safe maternity within the framework of the "Community action for health" program (order of the MH KR of 05.06.2015 No 305).	Goal of the communication strategy - to improve the target groups' awareness and understanding of the main aspects of safe maternity, and thus increase their interest, engagement and responsibility for women's health during pregnancy, childbirth and postpartum period.
	Sustainable Development Transition Program for the Kyrgyz Republic 2013-2017 (SDTP)	Subsection 4.3 Healthcare.
3.2 End preventable deaths of newborns and children under 5 years of age.	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Subchapter 5.2. Mother and child health; 13. Intersectoral interaction on the issues of mother and child health protection, prevention and treatment of HIV, TB, non-communicable diseases.
	National healthcare reform program of the KR "Den Sooluk" 2012-2016.	Chapter 9. Child health

SDGs	SGDs	Relevant sections
	Sustainable Development Transition Program for the Kyrgyz Republic 2013-2017 (SDTP)	Subsection 4.3 Healthcare.
	"Perinatal service improvement program in the Kyrgyz Republic 2008-2017"	Goal of the program - to reduce maternal, perinatal, neonatal and infant mortality, improve the quality of healthcare services for mothers and newborns with equal opportunities in all regions of the country.
3.3 End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Subchapters: 5.3. HIV infection; 5.4. Tuberculosis. Chapters: 10. Public health capacity building; 12 Creating an environment for the population's health 13. Intersectoral interaction on the issues of mother and child health protection, prevention and treatment of HIV, TB, non-communicable diseases.
	National healthcare reform program of the KR "Den Sooluk" 2012-2016.	Chapters: 10. Tuberculosis; 11. HIV infection
	State program on HIV epidemics stabilization in the Kyrgyz Republic 2012-2016.	Goal of the Program - stabilize and eventually reduce the rate of HIV-infection spread in the KR.
	"Tuberculosis-IV" program 2013-2016.	Goal of "Tuberculosis-IV" program - further reduction of TB incidence and mortality rates in the Kyrgyz Republic
	Local malaria transmission resurgence prevention program in the Kyrgyz Republic 2014-2018.	The goals of the Program include maintaining resilient epidemiological well-being, prevention of resurgence of local malaria transmission and international certification of the country as a country free from malaria.
	Sustainable Development Transition Program for the Kyrgyz Republic 2013-2017 (SDTP)	Subsection 4.3 Healthcare.

SDGs	SGDs	Relevant sections
3.4 Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Chapter 5. Reducing the burden of disease Subchapter 5.1. Non-communicable diseases.
	NCD prevention and control program in the Kyrgyz Republic 2013-2020.	The goal of the Program is create a national system for NCD prevention and control in the Kyrgyz Republic.
	National healthcare reform program of the KR “Den Sooluk” 2012-2016.	Chapter 12. Public health, § 1. Strengthening the intersectoral approach to public health.
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	Anti-drug program of the Government of the Kyrgyz Republic	Chapter 2.3. Reducing the demand for illicit drugs 2.3.1. Primary prevention of substance abuse 2.3.2. Secondary prevention of substance abuse 2.3.3. Tertiary prevention of substance abuse
3.6 Halve the number of global deaths and injuries from road traffic accidents	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Chapter 13. Intersectoral interaction on the issues of mother and child health protection, prevention and treatment of HIV, TB, non-communicable diseases.
3.7 Ensure universal access to sexual and reproductive health-care services	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Chapter 13. Intersectoral interaction on the issues of mother and child health protection, prevention and treatment of HIV, TB, non-communicable diseases.
	State Benefit Program to provide healthcare services to the citizens of the Kyrgyz Republic	The list of categories of citizens entitled to free and preferential healthcare services under the SBP, section II “Categories of citizens entitled to free healthcare services in accordance with their clinical indications at outpatient and inpatient levels”.
3.8 Ensure universal health coverage.	National healthcare reform program of the KR “Den Sooluk” 2012-2016.	Chapter III. Expected outcomes and key services in the priority areas of the “Den Sooluk” program.
3.9 Substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Chapter 12. Creating an environment for the population’s health

SDGs	SGDs	Relevant sections
and soil pollution and contamination		
3.a. Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Chapter 11. Prevention: health determinants and risk factors
	Non-communicable disease prevention and control program in the Kyrgyz Republic 2013-2020.	Chapter 6. Main priority streams of the Program, §1 Formulating the national policy for NCD prevention and control on the basis of an intersectoral approach and partnership
	National healthcare reform program of the KR "Den Sooluk" 2012-2016.	Chapter 7. Cardio-vascular diseases 12. Public health, § 1. Strengthening the intersectoral approach to public health.
3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide	The Program of the Government of the Kyrgyz Republic on the development of the area of drugs circulation in the Kyrgyz Republic in 2014-2020.	The Goal of the Program is to ensure availability of vital, safe, effective and quality drugs for the citizens of the Kyrgyz Republic, and their rational use.
	"Immunoprophylaxis" program in 2013-2017.	The Program aims at reducing incidence and mortality rates of vaccine-preventable infectious diseases by ensuring sustainable coverage of the population with immunization, increasing access to vaccines with guaranteed quality and actively promoting evidence-based immunization, as well as the achievement of the MDGs by 2015.

SDGs	SGDs	Relevant sections
access to medicines for all		
3.C Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Chapters: 8. Human resources; 6. Healthcare system strengthening and development; 7. Health insurance funding and development
	National healthcare reform program of the KR "Den Sooluk" 2012-2016.	Chapters: 14. Healthcare financing; 15. Forming the resources for the healthcare system. § 1. Investing into human resources
Goal 5. Achieve gender equality and empower all women and girls		
5.6 Ensure universal access to sexual and reproductive health-care services	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Intersectoral interaction on the issues of mother and child health protection, prevention and treatment of HIV, TB, non-communicable diseases.
	State Benefit Program to provide healthcare services to the citizens of the Kyrgyz Republic	The list of categories of citizens entitled to free and preferential healthcare services under the SBP, section II "Categories of citizens entitled to free healthcare services in accordance with their clinical indications at outpatient and inpatient levels".
Goal 6. Ensure availability and rational use of water and sanitation for all		
6.1 Achieve universal and equitable access to safe and affordable drinking water for all	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Chapter 10. Public health capacity building; subchapters: 10.1. Epidemiological oversight of diseases; 10.2. Health protection measures; 12. Creating an environment for the population's health
	The Program of adaptation of the healthcare sector of the Kyrgyz Republic to climate change in 2011-2015.	Chapter on "Safe drinking water and climate change".

SDGs	SGDs	Relevant sections
6.2 Achieve access to adequate and equitable sanitation and hygiene for all and end open defecation	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Subchapters: 10.1. Epidemiological oversight of diseases; 10.2. Health protection measures; 12. Creating an environment for the population's health
Goal 7. Ensure access to affordable, reliable, sustainable and modern energy for all		
7.1 Ensure universal access to affordable, reliable and modern energy services.	The Program of adaptation of the healthcare sector of the Kyrgyz Republic to climate change in 2011-2015 8.5. The program for the development of social protection of the population of the Kyrgyz Republic in 2015-2017.	Chapter on "Pilot project on the use of solar panels in hospitals".
Goal 17. Strengthen the means of achieving sustainable development and facilitate global partnership mechanisms in the interests of sustainable development		
17.18 By 2020 enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, health status, geographic location and other characteristics relevant in national contexts.	Health protection and promotion strategy of the Kyrgyz Republic 2020 (Health 2020).	Chapter 9. Introduction of unified and standardized medical information systems.
	The program of e-health of the Kyrgyz Republic in 2016-2020.	Developed for the purposes of effective execution of the KR Government Program on e-governance (electronic government) in executive state bodies and KR LSG bodies in 2014-2017. The main purpose of e-health is to improve quality and accessibility of healthcare services for the population and implement personalized records of the provision of healthcare services to citizens on the basis of wide-scale application of information and communication technologies.

Attachment 2: Suggested indicators for health-related Sustainable development goals

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
Goal 1. End poverty in all its forms everywhere							
1.5 Build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters		1.5.1 Number of hospitals offering healthcare services during emergencies that have the "Hospital safety index"	of the MH on the basis of specialized studies		4 hospitals	All national and province level hospitals	*Indicator suggested by the WHO.* The data may only be received in the course of an assessment based on the WHO methodology "Hospital Safety Index". In 2016 safety assessment was conducted with WHO's support. It is planned to conduct the assessment in 2017.

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture							
2.1 End hunger and ensure access by all people to safe, nutritious and sufficient food all year round	2.1.1 Prevalence of undernourishment	2.1.1 Number of women of child-bearing age with anemia	NSC (DHS, a large-scale study)	MH, USAID	35%	21%	*Indicators suggested by the MHCP group.* In accordance with the Scaling Up for Nutrition (SUN) strategy in the KR, adopted on the basis of KR's accession to the Global SUN movement, which is directly linked to SDG aims 2, 14 in 2016-2020, a number of indicators were defined which are related to undernourishment: reduction of the number of women with anemia by 40% by 2025 and underweight children at birth by 25%.
		2.1.1.a. Number of underweight children at birth	NSC (MICS, a large-scale study)	MH, UNICEF	5,9% (2014)	4,40%	

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
	2.1.2 Level of moderate or acute absence of food security of the population (on the basis of the food security absence evaluation scale)	2.1.2. Level of moderate or acute absence of food security of the population (on the basis of the food security absence evaluation scale)	NSC, administrative data/ Food security newsletter		NSC, baselines and targets will be clarified		Coincides with the SDG indicator (level 1). Discuss the indicator with the NSC.
2.2 End all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons	2.2.1 Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age	2.2.1. 2.2.1 Prevalence of stunting amount children under five	NSC (MICS, a large-scale study)	MH, UNICEF	12,9% (2014)	7%	Coincides with the SDG indicator (level 1). In accordance with the Scaling Up for Nutrition (SUN) Strategy in the KR in 2016-2020 “Reducing stunting among children by 30%” calculations have been preformed until 2025.
	2.2.2. Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards)	2.2.2. Number of children with malnutrition.	NSC (MICS, a large-scale study)	MH, UNICEF	2,8% (2014)	not more than 2.8%	Coincide with SDG indicator (level 1) and the indicators for Scaling Up for Nutrition strategy (SUN) in the KR

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
	among children under 5 years of age, by type (wasting or overweight)	2.2.3. Share of children with excessive body mass and obesity under 5	NSC (MICS, a large-scale study)	MH, UNICEF	7,0% (2014)	not more than 7%	Coincide with SDG indicator (level 1) and the indicators for Scaling Up for Nutrition strategy (SUN) in the KR
		2.2.4. Share of children exclusively breast-fed in the first 6 months	NSC (MICS, a large-scale study)	MH, UNICEF	41,1% (2014)	61%	The indicator was suggested by UNFPA and UNICEF, included in the Scaling Up for Nutrition strategy (SUN) in the KR
Goal 3. Ensure healthy lives and promote well-being for all at all ages							
3.1 Reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1 Maternal mortality ratio	3.1.1 Maternal mortality ratio per 100,000 livebirths	NSC, administrative data	MH	38.5	34.2	Coincides with the SDG indicator (level 1). The target was defined as the reduction of the maternal mortality rate (MMR) at least by 1/3 by 2030 compared to the calculated baseline of 2010 (51.3).
	Proportion of births attended by skilled health personnel	3.1.2. Share of childbirths attended by any qualified personnel	NSC (MICS, a large-scale study)	MH, UNICEF	98,4% (2014)	no less than 99%	Coincides with the SDG indicator.

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
3.2 By 2030 end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	3.2.1 End under-five mortality rate per 1000 livebirths	3.2.1 Children mortality rate per 1000 livebirths	NSC, administrative data	MH	21.5	no more than 25.0	Coincides with the SDG indicator (level 1).
	3.2.2 Neonatal mortality rate per 1000 livebirths	3.2.2 Neonatal mortality rate per 1000 livebirths	NSC, administrative data	MH	14.0	no more than 12	Coincides with the SDG indicator (level 1).
3.3 By 2030 end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations	3.3.1 Number of new HIV infections (estimate) per 1,000 annual average population, including:	RC “AIDS” / Spectrum Program		0.16	0.05	Coincides with the SDG indicator (level 1). The work of the Spectrum program is supported by donors only until 2020
		men			0.23	0.06	The calculations were done based on the estimated number of new cases of HIV among men and women based on the projections of the “Spectrum” program in 2015 (new cases among men - 698, population 2 948 932, women - 250, population - 3 008 339).
		women			0.08	0.03	

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
		3.3.1 Number of new infections (estimate) per 1,000 annual average population by age, including:	RC “AIDS” / Spectrum Program				The calculations were based on the estimated number of new cases of HIV infection, by age, based on the Spectrum program projections, 2015 (new cases among the 0-14 age group - 4, population 2,948,932; 15 and above - 944 new cases, population - 4,078,402).
		0-14 years			0.002	0	
		15 years old and above			0.23	0.06	
	3.3.2 TB incidence rate per 1000 persons per year	3.3.2. TB incidence year per 1000 persons per year	RMIC	NCF	0.98	0.64	Coincides with the SDG indicator (level 1). The targets have been calculated on the basis of the actual data on the annual (%) reduction of the incidence rate according to the National TB program for the last 10 years.

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
	3.3.3 Malaria incidence rate per 1000 persons per year	3.3.3. Number of local cases of malaria	RMIC		0	0	According to the Document on preliminary levels of indicators of accomplishment of aims in the area of SDGs for countries that have no local cases of malaria, this indicator is now shown. As of now no cases of malaria were registered in the country, and the country is heading towards elimination of this infection.
	3.3.4 Number of new hepatitis B cases per 100,000 population annually	3.3.4 Number of new hepatitis B cases per 100,000 population annually	RMIC		5.9	no more than 5	Coincides with the SDG indicator (level 2).
	3.3.5 Number of people requiring interventions against neglected tropical diseases						Exclude this indicator, it is not relevant for KR

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
By 2030 reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	3.4.1.a Mortality from the cardiovascular diseases per 100,000 thousand population	NSC, administrative data	MH	297	252,6 (annual reduction by 1%)	Coincides with the SDG indicator, split into 4 indicators (level 2).
		3.4.1.b Mortality due to new growth per 100,000 population	NSC, administrative data	MH	64.5	60.0	
		3.4.1.c Mortality from diabetes per 100,000 thousand population	NSC, administrative data	MH	6.0	4.0	
		3.4.1.d Mortality from chronic respiratory diseases	NSC, administrative data	MH	21.0	16.0	
	3.4.2 Suicide mortality rate	3.4.2. Suicide mortality rate per 100,000 population	NSC, administrative data	MH	7.0	5.0	Coincides with the SDG indicator (level 2).
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for	3.5.1. Drug dependency per 100,000 persons per year	RMIC, administrative data		6.5	6,2 (annual reduction by 5%)	The indicator was suggested by the MH; since there is no data on the treatment coverage, 2 indicators were proposed on drug and alcohol

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
	substance use disorders	3.5.1.a. Alcohol dependence per 100,000 persons per year	RMIC, administrative data		23.5	22,3 (annual reduction by 5%)	dependence
	3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol	3.5.2. Alcohol consumption per capita in liters of pure alcohol per calendar year	NSC, administrative data	MH	4,29 liters	3,86 liters (annual reduction by 10%)	Coincides with the SDG indicator (level 1), however the country conducts calculations per average annual population size. (SDGs - population above 15).
3.6 By 2020 halve the number of global deaths and injuries from road traffic accidents	3.6.1 Death rate due to road traffic injuries	3.6.1. Death rate due to road traffic injuries per 100,000 population	NSC		15.6	15.0	Coincides with the SDG indicator (level 1).
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and	3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	NSC (DHS, a large-scale study)	MH, USAID	36,3% (2012)	40.0%	Coincides with the SDG indicator (level 1).

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
programmes	3.7.2. Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	3.7.2. Adolescent birth rate (number of births per 1000 women of this age group)	NSC, administrative data	MH	0.01	no more than 0.01	Coincides with the SDG indicator (level 1). The indicator is split in 2 indicators According to the Document on preliminary suggested levels for the indicators of accomplishment of the SDG objectives an opinion was voiced that there is no need to collect data on girls 10-11 of age due to the rarity of cases. NSC conducts data on the childbirths among adolescents in the age of 12-14 and 15-19.
		under 15 years (12-14 years)			0.01	no more than 0.01	
		15-19 years			42.3%	35.0%	

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)	3.8.1. Post-partum observation of newborns after discharge from a healthcare institution for 2 days after the discharge from the maternity hospital (broken down by quintiles by the well-being status)	NSC (MICS, a large-scale study)	MH, UNICEF	24,7% (2014)	70%	According to the Document on preliminary suggested levels for the indicators of accomplishment of SDG objectives this indicator was designated as a Level 3 indicator. Universal health coverage in this definition is a comprehensive indicator including a multitude of indicators pertaining to health coverage, for the majority of which data is available. At present there is no international standard to measure health coverage. A collection of sets by disaggregated data requires more work. This is why UNICEF in the KR has suggested an indicator that reflects the coverage of services on oversight of newborns.

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
	3.8.2 Share of the population with high household health expenditure as a share of total costs or income of the household	3.8.2. Share of households with OOPs over 40% of their capacity-to-pay	NSC (IHHS, Health module)	WHO	15% (2014)	11%	
3.9 By 2030 substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.9.1 Mortality rate attributed to household and ambient air pollution	3.9.1. Mortality from toxic impact of carbon oxide per 100,000 population	NSC, administrative data		0.7	no more than 0.5	According to the Document on suggested levels for the accomplishment of the SDG goals the indicator has been associated with level 1 and as a measure of commitment one could take the levels of air pollution in the household use of solid fuels.
	3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of	3.9.2.a Mortality from acute intestinal infections per 100,000 population	NSC, administrative data		1.9	no more than 1.5	SDG indicator associated with level 2 There is no administrative data

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
	hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)	3.9.2.b Mortality from typhoid fever per 100,000 population	NSC, administrative data		0.02	not more than 0,02 (singular cases)	monitoring the quality of water in the country, this is why the MH suggested 2 indicators related to mortality from the use of water of poor quality
	3.9.3 Mortality rate attributed to unintentional poisoning	3.9.3. Mortality from unintentional poisoning and the impact of poisonous substances	NSC, administrative data		7	no more than 5.0	SDG indicator associated with level 2
3.a. Facilitate when needed the implementation of the Framework convention of the World Health Organization on the fight against tobacco in all countries	3.a.1 Standardized by age spread of tobacco use by persons below 15 years of age	3.a.1 Spread of tobacco use	MH (STEPS, GYTS, specialized surveys)	WHO	25,7% (2014 25-64 years) 8,2% (GYTS, 2014г. 13-15 years)	Reduction by 15%.	The data may only be provided on the basis of studies - STEPS planned for 2017 and GYTS (unknown).
3.B. Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential	3.B.1 Proportion of the population with access to affordable medicines and vaccines on a sustainable basis	3.b.1.1 The share of state financing allocated to purchase vaccines	MH, operational data		75.20%	90%	*The indicator has been proposed by the MH. The share of funds allocated for purchasing vaccines and the capitation norm may demonstrate access*

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all							*of the of the population to affordable drugs.*
		3.b.1.2 Capitation norm allocated to preferential provision of drugs under APMHI at the primary level.	MHIF, operational data		50 soms	no less than 60 soms	
	3.b.2. Share of the target population covered with all immunizations included in the national vaccination calendar	3.b.2. Full coverage with vaccines of children between 24 and 35 months.	NSC (MICS, a large-scale study)	MH, UNICEF	80.4% (2014)	no less than 96%	

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
	3.b.3 Total net volume of development financial assistance aimed at health research and main healthcare sectors						*According to the data provided by the NSC "Preliminary levels for indicators of accomplishment of sustainable development goals as of March 24 2016" the provided data refers to sponsor countries that the information is coming from, so maybe exclude this indicator????*

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	3.c.1 Health worker density and distribution	Number of doctors and mid-level health workers per 10,000 population	RMIC, administrative data		Number of doctors - 21.9, mid-level health workers - 55.9	Number of doctors - 35.0, mid-level health workers - 65	SDG indicator associated with level 2
3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness	3.D.1 Number of SQPs organized in accordance with IHR	MH, operational data		7 (2015)	11	SDG indicator associated with level 2 *Indicator suggested by the MH.*

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
Goal 5. Ensuring gender equality and empowerment of all women and girls							
Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences	5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	5.6.1. Share of married women and sexually active unmarried women in the age of 15-49, which were informed of some method of contraception	NSC (DHS, a large-scale study)	MH, USAID	94.4% (2012)	no less than 95%	SDG indicator associated with level 2
		Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education	MH		3	5	SDG indicator associated with level 3 It is planned to adopt two documents: Comprehensive state program on family and child care support in 2017-2027 National reproductive health promotion program in 2017-2030
Goal 6. Ensure availability and rational use of water and sanitation for all							
6.1 By 2030, achieve universal and equitable access to safe and affordable drinking water for all	6.1.1 Proportion of population using safely managed drinking water services	Access of the population to improved sources of drinking water	NSC (DHS, MICS)	MH, USAID, UNICEF	85.9% (2012)	no less than 95%	SDG indicator associated with level 1

SDGs	Global indicators	National indicators	Source of data		Baseline, 2015	Target, 2030	Comments
			Responsible organization	Co-implementing parties			
6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations	6.2.1 Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water	Access of the population to improved sanitary facilities (non-public improved toilet)	NSC (DHS, MICS)	MH, USAID, UNICEF	95.1% (2012)	98%	SDG indicator associated with level 1
		6.2.1a. Share of households with a hand-washing facility with soap and water	NSC (DHS, MICS)	MH, USAID, UNICEF	86.8% (2012)	95%	

Attachment 3:

Passports for the sustainable development indicators of the healthcare sector

GOAL 1. END POVERTY IN ALL ITS FORMS EVERYWHERE

1.5 By 2030, build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters

General description	
Indicator title	1.5.1 Number of hospitals offering healthcare services during emergencies that have the “Hospital safety index”
Justification/Definition of the indicator	Safety index estimate - is the ability of the hospital to withstand the impact of factors causing an emergency, whilst maintaining operations with maximum throughput capacity.
Unit of measurement	Number of hospitals
Type of indicator	Quantitative
Purpose	Outcomes of the hospital safety assessment provide an opportunity to assess the hospitals’ preparedness for emergencies and to recommend improvements to this preparedness thus planning activities to prepare and respond to emergencies.
Methodology	
Data collection and processing and calculation methods	Data collection is based on WHO methodology “Hospital safety index”. The parameters are brought together in four modules, each of them representing one of the main components of hospital safety. 1. The threats influencing hospital safety and the hospital’s role in preparing and responding to emergencies and disasters. 2. Structural safety 3. Non-structural safety 4. Preparing and responding to emergencies and disasters In the process of assessment each parameter is assigned one of the three levels of safety: Low, Medium or High. The assessment data is entered into a special checklist form which is thereafter processed by the Safety Index Calculator software which automatically calculates the Hospital Safety Index which is a numerical expression of the safety of the assessed hospital, i.e. its ability to withstand the influence of factors causing the emergency whilst maintaining operations with maximum possible throughput capacity. Along with the calculation of the overall safety index, the software also computes the index for each module separately. The value of the Hospital safety index may vary from 0,00 to 1,00.
Sources of data	MoH
Additional sources of data:	Survey data on the assessment of the Hospital Safety Index.
Frequency of collection and reporting	Depends on the assessments
The need for special tools (funding) for data collection or reporting of the data	Additional funds are required to conduct hospital safety assessments. In 2016-2017 hospital safety assessment at the national and oblast levels was conducted with WHO’s support.
Additional information and references	
The safety group to which a hospital belongs, is denoted in the following manner: A (aba), B (bbc), C (ccb) etc., where the capital letter denotes the group that the hospital has been associated with according to the value of the overall hospital safety index, whereas lower case letters denote the groups that the hospital has been associated with depending on the value of the index for each model separately.	

Depending on the value of the safety index the hospital under assessment is associated with one of the three safety groups:

1. If the safety index is between 0,66 and 1,00, the hospital belongs to group A, which points at its high level of safety. It is probable that the hospital will be capable of operating in the circumstances of an emergency and disasters. Nevertheless it is recommended to continue mid-term and long-term activities aimed at strengthening of the hospital's capacity to respond to emergencies and disasters and at increasing its safety level.
2. If the safety index is between 0,36 and 0,65, the hospital belongs to group B, which points at its medium level of safety. Short-term interventions are necessary. The hospital's current safety and emergency&disaster preparedness levels are such that the safety of patients and personnel as well as the hospital's ability to work during and after emergencies and disasters are potentially at risk.
3. If the safety index is between 0,00 and 0,35, the hospital belongs to group A, which points at its low level of safety. Urgent interventions are necessary. It is unlikely that the hospital will be able to operate during emergencies or disasters or thereafter, and the current levels of safety and response to emergencies and disasters are insufficient to protect the lives of patients and hospital personnel during emergencies and disasters and thereafter.

GOAL 2. END HUNGER, ACHIEVE FOOD SECURITY AND IMPROVED NUTRITION AND PROMOTE SUSTAINABLE AGRICULTURE

2.1 End hunger and ensure access by all people to safe, nutritious and sufficient food all year round

2.1.1 SDG indicator: Prevalence of undernourishment

General description	
Indicator title	2.1.1 Number of women of child-bearing age with anemia
Justification/Definition of the indicator	Percentage of women of reproductive age (15-49) with anemia
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	DHS results are intended to provide information necessary to assess the existing social programs and develop new strategies to improve health status and healthcare services for women and children in the Kyrgyz Republic. This study also promotes the expansion of the database of health and demographic indicators at the international level.
Methodology	
Data collection and processing and calculation methods	The study was conducted by the National statistics committee of the KR together with the Ministry of health of the KR. DHS data is based on a survey of women that had spent the night in the household prior to the survey. Prevalence of anemia based on hemoglobin levels is adjusted for altitude (for children and women) and smoking (for women) with the use of CDC formulas (CDC, 1998). "Women with anemia" included women with the hemoglobin levels from 11,9 g/dl and less (for non-pregnant women) and 10,9 g/dl and less (for pregnant women). Household questionnaires and Individual questionnaires were drafted on the basis of standard questionnaires developed by the MEASURE DHS program. Generic DHS questionnaires were adapted to the Kyrgyz Republic's circumstances by the experts of the National statistics committee (NSC) and the Ministry of Health of the KR (MoH). A number of suggestions were taken into account including those from USAID, a number of UN agencies including United Nations Development Program (UNDP), UN Children's Fund (UNICEF) and United Nations Populations Fund (UNFPA) as well as other international and non-governmental organizations. Initially the questionnaires were developed in English with consequent translation into Kyrgyz and Russian.
Sources of data	DHS
Additional sources of data:	none
Frequency of collection and reporting	DHS were conducted in 1997 and 2012.
The need for special tools (funding) for data collection or reporting oF the data	During the surveys financial and technical assistance was provided by the United States Agency for International Development (USAID). Additional funds for the execution of the study were provided by the United Nations Populations Fund (UNFPA) in the KR.

Additional information and references
Anemia is a condition characterized by the low hemoglobin level in erythrocytes which is necessary to transport oxygen to tissues and organs. Approximately half of the anemia burden around the world is the result of iron deficiency. Iron deficiency occurs mostly due to inadequate consumption of biologically digestible iron, especially in the periods of increased need for iron (such as during pregnancy, for instance) and increased blood loss due to parasites or infections such as malaria. Anemia is an especially serious problem for pregnant women leading to premature birth and low weight at birth.

General description	
Indicator title	2.1.1.a. Number of underweight children at birth
Justification/Definition of the indicator	Share of children weighing less than 2500 grams at birth as a percentage of the total number of livebirths weighed at birth.
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	This indicator enables assessing health status of mothers and newborns. It makes it possible to assess the effectiveness of programs under implementation in the republic and to plan preventive activities and treatment on the issues of mother and child health.
Methodology	
Data collection and processing and calculation methods	Multi-Indicator Cluster Survey (MICS) to assess the status of women and children is conducted by the National Statistics Committee of the Kyrgyz Republic in cooperation with the statistics departments of provinces and the cities of Bishkek and Osh as part of the global MICS program. Three types of questionnaires were used in this survey. The question about the child's weight at birth is included in questionnaire No 3 about children under 5, whereas for each child under five residing in a household its mother or the caregiver is questioned. Calculation: Number of children born last in the two years preceding the survey whose weight at birth was estimated at less that 2500 grams X 100 / number of livebirths weighed at birth.
Sources of data	MICS
Additional sources of data:	RMIC, routine statistical data
Frequency of collection and reporting	MICS in the KR was conducted in 2006 and 2014.
The need for special tools (funding) for data collection or reporting of the data	The survey was conducted with financial and technical assistance from the UN Children's Fund (UNICEF) and with co-financing of the UN Populations Fund (UNFPA).
Additional information and references	
The weight at birth is an illustrative indicator of not only the mother's health status and nutrition, but also of the newborn's chances of survival, growth, long-term health and psychological and social development. Low weight at birth (below 2500 grams) is associated with a number of serious risks for children's health. Children that had not received sufficient amounts of nutrients in their mother's womb are more susceptible to the risk of death in the first few days, months and years of their lives. Surviving children with low weight at birth frequently suffer from immune system disorders and are at a higher risk of developing such conditions as diabetes, cardio-vascular diseases, certain types of cancer and anemia. Low weight at birth is also connected with a lower IQ and cognitive disorders influencing their school achievements and employment opportunities in their adult life.	

General description	
Indicator title	2.1.2. Level of moderate or acute absence of food security of the population (on the basis of the food security absence evaluation scale) *The methodology is under discussion with the NSC*
Justification/Definition of the indicator	
Unit of measurement	
Type of indicator	
Purpose	
Methodology	
Data collection and processing and calculation methods	
Sources of data	
Additional sources of data:	
Frequency of collection and reporting	
The need for special tools (funding) for data collection or reporting of the data	
Additional information and references	

2.1 By 2030 end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons

SDG indicator: 2.2.1 Prevalence of stunting among children under 5 years of age (height for age <-2 average quadratic deviation from the median of the World Health Organization (WHO) Child Growth Standards)

General description	
Indicator title	2.2.1. 2.2.1 Prevalence of stunting amount children under five
Justification/Definition of the indicator	Percentage distribution of stunting children under 5 among children under 5 subjected to a nutrition status assessment on the basis of height vs. age.
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	This indicator enables assessing children's nutrition status, evaluating the effectiveness of programs under implementation in the republic and planning of preventive activities and treatment on the issues of children's health and nutrition.
Methodology	
Data collection and processing and calculation methods	MICS in the KR is conducted by the National Statistics Committee of the Kyrgyz Republic in cooperation with the statistics departments in oblasts and the cities of Bishkek and Osh as part of the global MICS program. During MICS the weight and height of all children under 5 were measured with the use of anthropometric equipment recommended by UNICEF. Calculation: Number of children under 5 with insufficient height for their age (percentage below 2SD) X 100 / number of children under 5 whose anthropometric data was taken (height vs. age)
Sources of data	MICS
Additional sources of data:	none
Frequency of collection and reporting	MICS in the KR was conducted in 2006 and 2014.
The need for special tools (funding) for data collection or reporting of the data	The survey was conducted with the financial and technical support from the UN Children's Fund (UNICEF) and co-financing from the UN Populations Fund (UNFPA).
Additional information and references	
Height vs. age – is the measure of linear height. Children whose height-to-age ratio is more than 2 standard deviations less that the median for this indicator for standard population (2SD) are considered stunting. Growth delays are caused by chronic undernourishment for prolonged periods of time and relapses and chronic diseases.	

SDG indicator: 2.2.2. Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting or overweight)

General description	
Indicator title	2.2.2. Number of children with wasting
Justification/Definition of the indicator	Percentage distribution of children with wasting under 5 among children under 5 subjected to a nutrition status assessment on the basis of weight vs. height.
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	This indicator enables assessing children's nutrition status, evaluating the effectiveness of programs under implementation in the republic and planning of preventive activities and treatment on the issues of children's health and nutrition.
Methodology	
Data collection and processing and calculation methods	MICS in the KR is conducted by the National Statistics Committee of the Kyrgyz Republic in cooperation with the statistics departments in oblasts and the cities of Bishkek and Osh as part of the global MICS program. During MICS the weight and height of all children under 5 were measured with the use of anthropometric equipment recommended by UNICEF. Calculation: Number of children under 5 with insufficient weight for their height (percentage below 2SD) X 100 / number of children under 5 whose anthropometric data was taken (weight vs. height)
Sources of data	MICS
Additional sources of data:	none
Frequency of collection and reporting	MICS in the KR was conducted in 2006 and 2014.
The need for special tools (funding) for data collection or reporting of the data	The survey was conducted with the financial and technical support from the UN Children's Fund (UNICEF) and co-financing from the UN Populations Fund (UNFPA).
Additional information and references	
The children whose "weight for a particular height" is below median weight of children in the control population by more than 2SD, are classified as wasting. Wasting or exility is usually the result of a recent disease or acute nutrition deficit.	

General description	
Indicator title	2.2.3. Share of children with excessive body mass and obesity under 5
Justification/Definition of the indicator	Percentage distribution of children with excessive weight and obesity under 5 among children under 5 subjected to a nutrition status assessment on the basis of weight vs. height.
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	This indicator enables assessing children's nutrition status, evaluating the effectiveness of programs under implementation in the republic and planning of preventive activities and treatment on the issues of children's health and nutrition.
Methodology	
Data collection and processing and calculation methods	MICS in the KR is conducted by the National Statistics Committee of the Kyrgyz Republic in cooperation with the statistics departments in oblasts and the cities of Bishkek and Osh as part of the global MICS program. During MICS the weight and height of all children under 5 were measured with the use of anthropometric equipment recommended by UNICEF. Calculation: Number of children under 5 with excessive weight for their height (percentage above 2SD) X 100 / number of children under 5 whose anthropometric data was taken (weight vs. height)
Sources of data	MICS
Additional sources of data:	none
Frequency of collection and reporting	MICS in the KR was conducted in 2006 and 2014.
The need for special tools (funding) for data collection or reporting of the data	The survey was conducted with the financial and technical support from the UN Children's Fund (UNICEF) and co-financing from the UN Populations Fund (UNFPA).
Additional information and references	
The children whose weight is more than several units above the average weight of children in the standard population are considered obese (excessive weight and obesity). The children whose weight-to-height ratio is more than 2SD above the median value of the standard population are classified as having moderate or articulated excessive weight (obesity).	

General description	
Indicator title	2.2.4. Share of children exclusively breast-fed in the first 6 months
Justification/Definition of the indicator	Percentage of children in the age of 0-5 months exclusively breastfed.
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	This indicator enables assessing children's nutrition status, evaluating the effectiveness of programs under implementation in the republic and planning of preventive activities and treatment on the issues of children's health and nutrition.
Methodology	
Data collection and processing and calculation methods	MICS in the KR is conducted by the National Statistics Committee of the Kyrgyz Republic in cooperation with the statistics departments in oblasts and the cities of Bishkek and Osh as part of the global MICS program. The data on feeding practices of infants and young children are based on mothers' responses pertaining to the intake of food and liquids during the day or night before the survey. As for infants under 6 months exclusive breastfeeding pertains to children that have been receiving only breast milk (as well as vitamins, mineral supplements or medicines). Calculation: Number of children in the age between 0 and 5 months, exclusively breastfed X 100 / total number of children 0-5 months of age in the interviewed households
Sources of data	MICS
Additional sources of data:	none
Frequency of collection and reporting	MICS in the KR was conducted in 2006 and 2014.
The need for special tools (funding) for data collection or reporting of the data	The survey was conducted with financial and technical assistance from the UN Children's Fund (UNICEF) and with co-financing of the UN Populations Fund (UNFPA).
Additional information and references	

Correct breastfeeding of infants and young children may increase their chances of survival; it also promotes improved health and development of the child especially in the critical period between birth and two years of age. Breastfeeding in the first few years of life protects children from infections, provides an ideal source of nutrients while also being cost-effective and safe. Early migration to baby food may promote growth delays and the lack of nutrients; it can also be unsafe if sanitary and hygienic conditions including drinking water are not easily available. Research has shown that prolonged breastfeeding, consumption of age-adequate safe solid, semi-solid and soft products in sufficient amounts in the age above 6 months improves overall health and development and provides opportunities to reduce growth delays in the first two years of life. UNICEF and WHO recommend to start breastfeeding of infants within one hour from birth and breastfeed them exclusively in the first six months of life and continue breastfeeding until the age of 2 or more.

The data of the feeding practice survey has certain limitations, some of which pertain to the ability of the respondent to provide full account of the intake of food and liquid by the child, since there could be recall errors and the lack of knowledge of cases when other people would feed the child.

GOAL 3. ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES

3.1 Reduce the global maternal mortality ratio to less than 70 per 100,000 live births

General description	
Indicator title	3.1.1. Maternal mortality ratio per 100,000 livebirths
Justification/Definition of the indicator	According to the WHO definition, maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	This indicator enables assessing all losses of pregnant women (due to abortions, ectopia, obstetric of extragenital pathology throughout the entire gestation period) and birthing mothers and new mothers during 42 days after the termination of pregnancy. It enables assessing the effectiveness of maternal and child health programs.
Methodology	
Data collection and processing and calculation methods	Maternal mortality rate is calculated as follows: number of the deceased pregnant women (from the beginning of pregnancy), birthing mothers and new mothers during 42 days from the termination of pregnancy x 100,000 / number of livebirths.
Sources of data	NSC
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per month, incrementally - one year
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
Maternal mortality does not include deaths resulting from homicide, suicide, poisoning, trauma and other violent reasons.	

General description	
Indicator title	3.1.2. Share of childbirths attended by any qualified personnel
Justification/Definition of the indicator	Share of childbirths attended by any qualified personnel
Unit of measurement	per cent
Type of indicator	quantitative
Purpose	The analysis of this indicator in combination with other indicators makes it possible to assess the effectiveness of preventive activities and the work of local health authorities in the area of mother and child health, and to develop a number of specific measures to improve the health of pregnant women and children.
Methodology	
Data collection and processing and calculation methods	MICS in the KR is conducted by the National statistics committee of the Kyrgyz Republic in cooperation with the statistics departments of oblasts and the cities of Bishkek and Osh as part of the global MICS program. MICS includes a number of questions that make it possible to identify the share of deliveries attended by qualified healthcare professionals. Qualified healthcare professionals include physicians, nurses and midwives. Calculation: number of deliveries attended by any qualified personnel among women aged 15-49 years that gave birth within two years before the survey x 100 / total number of deliveries among women aged 15-49 years that gave birth within two years before the survey
Sources of data	MICS
Additional sources of data:	none
Frequency of collection and reporting	MICS in the KR was conducted in 2006 and 2014.
The need for special tools (funding) for data collection or reporting of the data	The survey was conducted with the financial and technical support from the UN Children's Fund (UNICEF) and co-financing from the UN Populations Fund (UNFPA).
Additional information and references	
In three quarters of maternal mortality cases the death of the mother occurs during delivery and during the postpartum period immediately after childbirth. The single most important measure to ensure safe maternity is to secure the presence of a competent healthcare professional with midwife's skills for each delivery and the availability of transportation to a healthcare institution for obstetric assistance in emergency cases.	

3.2 By 2030 end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

General description	
Indicator title	3.2.1 Children mortality rate per 1000 livebirths
Justification/Definition of the indicator	The indicator defining children's mortality rate under 5 which shows the probability of death of a child born in a given year before reaching the age of five.
Unit of measurement	promille
Type of indicator	quantitative
Purpose	The analysis of this indicator makes it possible to assess the effectiveness of preventive activities and the work of local health authorities in the area of mother and child health and to develop a number of specific measures to improve the health of pregnant women and children. The level of this indicator is also used to assess overall population health status, social well-being and the quality of prevention and treatment among women and children.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical and perinatal death certificates registered in the civil registries. Primary processing and collection of data about the deceased children is performed at the level of oblast state statistics authorities. Collection of data across the country is performed by the National statistics committee of the Kyrgyz Republic. Calculation: number of deceased children under 5 x 1000 / number of live births
Sources of data	NSC
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per year
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
Children's mortality rate under 5 was selected by UNICEF as the specific and most important indicator of the children's status in various countries, as a principal indicator of the children's population. According to the WHO definition, live birth refers to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.	

General description	
Indicator title	3.2.2 Neonatal mortality rate per 1000 livebirths
Justification/Definition of the indicator	According to the current WHO definition, neonatal death is the death of children within the first 0-27 days from birth per 1000 live births.
Unit of measurement	promille
Type of indicator	quantitative
Purpose	The analysis of this indicator makes it possible to assess the effectiveness of preventive activities and treatment, as well the effectiveness of mother and child health programs, and to develop a number of specific measures to improve the health of pregnant women and children.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical and perinatal death certificates registered in the civil registries. Primary processing and collection of data about the deceased children is performed at the level of oblast state statistics authorities. Collection of data across the country is performed by the National statistics committee of the Kyrgyz Republic. Calculation: number of children that died before reaching one month of age (0-27 full days) *X* 1000 / number of live births
Sources of data	NSC
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per year
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
Neonatal period begins with birth and ends after 27 full days after birth. Neonatal death (deaths among live born newborns within the first 27 full days of life) may be split in early neonatal death, which occurs within the first 6 days of life, and late neonatal death, which occurs between full days 7 and 27 of life.	

3.3 By 2030 end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

SDG indicator: 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations

General description	
Indicator title	3.3.1 Number of new HIV infections (estimate) per 1,000 annual average population.
Justification/Definition of the indicator	Upon UNAIDS recommendation (Joint UN program for HIV/AIDS) the true number of people living with HIV in the country is computed by the SPECTRUM forecasting software. The actual number of registered people with HIV does not fully reflect incidence of the HIV infection.
Unit of measurement	promille
Type of indicator	quantitative, intensive
Purpose	Studies of HIV incidence rate among the population, indicator of impact of preventive activities
Methodology	
Data collection and processing and calculation methods	SPECTRUM forecasting software projects incidence rates on the basis of annual data updates in the software performed by RC AIDS specialists - the number of registered PLHIV, number of PLHIV undergoing ART, number of pregnant women taking ART drugs etc. The UNAIDS team (Joint UN program for HIV/AIDS) improves the software version every year and evaluates preliminary projections. Calculation: the number of new cases of HIV (according to the SPECTRUM projections) X 1000 / (average annual population of the country - number of HIV-infected people)
Sources of data	RC AIDS
Additional sources of data:	none
Frequency of collection and reporting	Once per year or once every two years
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
Estimates of people living with HIV in Kyrgyzstan based on the 2016 projections are published on UNAIDS website http://www.unaids.org/ru/regionscountries/countries/kyrgyzstan/	

General description	
Indicator title	3.3.1. Number of new infections (estimate) per 1,000 annual average population by gender (male/female)
Justification/Definition of the indicator	Upon UNAIDS recommendation (Joint UN program for HIV/AIDS) the true number of people living with HIV in the country is computed by the SPECTRUM forecasting software. The actual number of registered people with HIV does not fully reflect incidence of the HIV infection.
Unit of measurement	promille
Type of indicator	quantitative, intensive
Purpose	Studies of HIV incidence rates among the population taking gender approach into account; it also reflects the effectiveness of preventive programs among men and women.
Methodology	
Data collection and processing and calculation methods	SPECTRUM forecasting software projects incidence rates on the basis of annual data updates in the software performed by RC AIDS specialists - the number of registered PLHIV, number of PLHIV undergoing ART, number of pregnant women taking ART drugs etc. The UNAIDS team (Joint UN program for HIV/AIDS) improves the software version every year and evaluates preliminary projections. Calculation: Estimated number of new cases of HIV among men (according to the SPECTRUM projections) X 1000 / (average annual male population of the country - number of HIV-infected men) Calculation: Estimated number of new cases of HIV among women (according to the SPECTRUM projections) X 1000 / (average annual female population of the country - number of HIV-infected women)
Sources of data	RC AIDS
Additional sources of data:	none
Frequency of collection and reporting	Once per year or once every two years by June of the next reporting year
The need for special tools (funding) for data collection or reporting of the data	
Additional information and references	
Estimates of people living with HIV in Kyrgyzstan based on the 2016 projections are published on UNAIDS website: http://www.unaids.org/ru/regionscountries/countries/kyrgyzstan/	

General description	
Indicator title	3.3.1.a Number of new infections (estimate) per 1,000 annual average population by age (0-14 years old, 15 and above)
Justification/Definition of the indicator	Upon UNAIDS recommendation (Joint UN program for HIV/AIDS) the true number of people living with HIV in the country is computed by the SPECTRUM forecasting software. The actual number of registered people with HIV does not fully reflect incidence of the HIV infection.
Unit of measurement	promille
Type of indicator	quantitative, intensive
Purpose	Studies of age-related HIV incidence rates among the population; it also reflects the effectiveness of preventive programs among children and adults.
Methodology	
Data collection and processing and calculation methods	SPECTRUM forecasting software projects incidence rates on the basis of annual data updates in the software performed by RC AIDS specialists - the number of registered PLHIV, number of PLHIV undergoing ART, number of pregnant women taking ART drugs etc. The UNAIDS team (Joint UN program for HIV/AIDS) improves the software version every year and evaluates preliminary projections. Calculation 1: Estimated number of new HIV cases among children under 15 (according to the SPECTRUM projections) X 1000 / (average annual population of the country between 0 and 14 years of age - number of HIV-infected persons in the age 0-14 years) Calculation 2: Estimated number of new HIV cases among people 15 years of age and above (according to the SPECTRUM projections) X 1000 / (average annual population of the country 15 years of age and above - number of HIV-infected persons 15 years of age and above)
Sources of data	RC AIDS
Additional sources of data:	none
Frequency of collection and reporting	Once per year or once every two years by **June of the next reporting year**
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
Estimates of people living with HIV in Kyrgyzstan based on the 2016 projections are published on UNAIDS website: http://www.unaids.org/ru/regionscountries/countries/kyrgyzstan/	

General description	
Indicator title	3.3.2 TB incidence rate per 1000 persons per year
Justification/Definition of the indicator	Indicator of new TB cases diagnosed per 1000 population per year
Unit of measurement	promille
Type of indicator	quantitative, intensive
Purpose	The analysis of TB incidence rates enables assessing the epidemiological situation among the population of the republic overall and by administrative territories, and makes it possible to assess the effectiveness of current TB treatment and prevention programs in the republic. This incidence rate is also used to assess overall population health status, social well-being and the quality of prevention and treatment of the population.
Methodology	
Data collection and processing and calculation methods	Collection of data is performed on the basis of urgent notifications about newly discovered cases of the infectious disease that are sent to the Disease prevention and state sanitary and epidemiological surveillance centers (DP&SSESC) online using the Automated information system "Surveillance of incidences of infectious and parasitic diseases among the population and food product safety" (AIS SIIPDPFPS). Aggregate data is reflected in the state statistical reporting forms (monthly form No 1 "Report on infectious, parasitic and non-communicable diseases" and annual form No 8 "Report on active tuberculosis incidence rates"). Data on TB incidence is also contained in the reporting form No 33. Calculation: absolute number of newly discovered TB cases X 1000 / average annual permanent population.
Sources of data	RMIC
Additional sources of data:	NCF
Frequency of collection and reporting	Once per year
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
When calculating the indicator on a monthly basis, one needs to use a conversion factor to ensure comparability of the obtained data with the annual data.	

General description	
Indicator title	3.3.3 Number of local cases of malaria
Justification/Definition of the indicator	The level of newly discovered cases of malaria discovered in the reporting year per 1000 population
Unit of measurement	promille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of malaria prevention activities.
Methodology	
Data collection and processing and calculation methods	Data collection is performed on the basis of urgent notifications about the newly discovered infectious disease that are sent to the SSES organizations. Aggregate data is reflected in the monthly state statistical reporting form No 1 “Report on individual infectious and parasitic diseases”. Calculation: absolute number of newly discovered malaria cases X 1000 / average annual permanent population.
Sources of data	RMIC
Additional sources of data:	SSESC
Frequency of collection and reporting	Once per month
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
As of now no cases of malaria were registered in the country, and the country is heading towards elimination of this infection. When calculating the indicator on a monthly basis, one needs to use a conversion factor to ensure comparability of the obtained data with the annual data.	

General description	
Indicator title	3.3.4 Number of new hepatitis B cases per 100,000 population annually
Justification/Definition of the indicator	The level of newly discovered cases of hepatitis B discovered in the reporting year per 100,000 population
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of hepatitis B prevention activities. The level of this indicator is also used to assess overall population health status and the quality of prevention and treatment of the population.
Methodology	
Data collection and processing and calculation methods	Data collection is performed on the basis of urgent notifications about the newly discovered infectious disease that are sent to the SSES organizations. Aggregate data is reflected in the monthly state statistical reporting form No 1 “Report on individual infectious and parasitic diseases”. Calculation: absolute number of newly discovered hepatitis B cases X 100,000 / average annual permanent population.
Sources of data	RMIC
Additional sources of data:	SSESC
Frequency of collection and reporting	Once per month, incrementally - one year
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
When calculating the indicator on a monthly basis, one needs to use a conversion factor to ensure comparability of the obtained data with the annual data.	

By 2030 reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

SDG indicator: 3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease

General description	
Indicator title	3.4.1. Mortality from the circulatory system diseases per 100,000 thousand population
Justification/Definition of the indicator	Mortality from circulatory system diseases in the reporting year per 100,000 population
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of preventive activities and programs for non-communicable diseases. The level of this indicator is also used to assess overall population health status and the quality of prevention and treatment of the population.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical death certificates registered in the civil registries. Aggregated data is collected and processed by oblast statistics departments and the National statistics committee of the KR. Calculation: the absolute number of people that died from circulatory system diseases registered in the civil registries in the reporting year x 100,000 / average annual permanent population
Sources of data	NSC
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per month, incrementally - one year
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
According to an agreement with the National statistics committee of the KR the mortality database is handed over to the Republican medical information center of the Ministry of Health of the KR (Form 2 “Data on the number of births, marriages, divorces and deaths by causes of death” - on a monthly basis with a 1,5 month lag from the reporting month, and Form C52 “Population mortality by causes of death” - annually, in June of the year following the reporting year). When calculating the indicator on a monthly basis, one needs to use a conversion factor to ensure comparability of the obtained data with the annual data.	

General description	
Indicator title	3.4.1.a Mortality due to new growth per 100,000 population
Justification/Definition of the indicator	Mortality from new growth in the reporting year per 100,000 population
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of preventive activities for non-communicable diseases. The level of this indicator is also used to assess overall population health status and the quality of prevention and treatment of the population.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical death certificates registered in the civil registries. Aggregated data is collected and processed by oblast statistics departments and the National statistics committee of the KR. Calculation: the absolute number of people that died from new growth registered in the civil registries in the reporting year X 100,000 / average annual permanent population
Sources of data	NSC
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per month, incrementally - one year
The need for special tools (funding) for data collection or reporting on the data	none
Additional information and references	
According to an agreement with the National statistics committee of the KR the mortality database is handed over to the Republican medical information center of the Ministry of Health of the KR (Form 2 “Data on the number of births, marriages, divorces and deaths by causes of death” - on a monthly basis with a 1,5 month lag from the reporting month, and Form C52 “Population mortality by causes of death” - annually, in June of the year following the reporting year). When calculating the indicator on a monthly basis, one needs to use a conversion factor to ensure comparability of the obtained data with the annual data.	

General description	
Indicator title	3.4.1.b Mortality from diabetes per 100,000 population
Justification/Definition of the indicator	Mortality from diabetes in the reporting year per 100,000 population
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of preventive activities and programs for non-communicable diseases. The level of this indicator is also used to assess overall population health status and the quality of prevention and treatment of the population.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical death certificates registered in the civil registries. Aggregated data is collected and processed by oblast statistics departments and the National statistics committee of the KR. Calculation: the absolute number of people that died from diabetes registered in the civil registries in the reporting year X 100,000 / average annual permanent population
Sources of data	NSC
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per year
The need for special tools (funding) for data collection or reporting on the data	none
Additional information and references	
According to an agreement with the National statistics committee of the KR the mortality database is handed over to the Republican medical information center of the Ministry of Health of the KR (Form C52 “Population mortality by causes of death” - annually, in June of the year following the reporting year).	

General description	
Indicator title	3.4.1.c Mortality from chronic respiratory diseases per 100,000 population
Justification/Definition of the indicator	Mortality from chronic respiratory diseases in the reporting year per 100,000 population
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of preventive activities and programs for non-communicable diseases. The level of this indicator is also used to assess overall population health status and the quality of prevention and treatment of the population.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical death certificates registered in the civil registries. Aggregated data is collected and processed by oblast statistics departments and the National statistics committee of the KR. Calculation: the absolute number of people that died from chronic respiratory diseases registered in the civil registries in the reporting year x 100,000 / average annual permanent population
Sources of data	NSC
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per year
The need for special tools (funding) for data collection or reporting on the data	none
Additional information and references	
According to an agreement with the National statistics committee of the KR the mortality database is handed over to the Republican medical information center of the Ministry of Health of the KR (Form C52 “Population mortality by causes of death” - annually, in June of the year following the reporting year).	

General description	
Indicator title	3.4.2. Suicide mortality rate per 100,000 population
Justification/Definition of the indicator	Mortality from suicide (intentional self-inflicted harm) in the reporting year per 100,000 population
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of suicide prevention activities. The level of this indicator is also used to assess overall population health status and the quality of prevention and treatment of the population.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical death certificates registered in the civil registries. Aggregated data is collected and processed by oblast statistics departments and the National statistics committee of the KR. Calculation: the absolute number of people that died from suicide (intentional self-inflicted harm) registered in the civil registries in the reporting year x 100,000 / average annual permanent population
Sources of data	NSC
Additional sources of data:	RMIC, MoI
Frequency of collection and reporting	Once per month, incrementally - one year
The need for special tools (funding) for data collection or reporting on the data	none
Additional information and references	
According to an agreement with the National statistics committee of the KR the mortality database is handed over to the Republican medical information center of the Ministry of Health of the KR (Form 2 “Data on the number of births, marriages, divorces and deaths by causes of death” - on a monthly basis with a 1,5 month lag from the reporting month, and Form C52 “Population mortality by causes of death” - annually, in June of the year following the reporting year). When calculating the indicator on a monthly basis, one needs to use a conversion factor to ensure comparability of the obtained data with the annual data.	

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

General description	
Indicator title	3.5.1 Drug dependence incidence per 100,000 population
Justification/Definition of the indicator	The level of newly discovered cases of diseases with drug dependence discovered in the reporting year per 100,000 population
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of preventive activities for drug dependence. The level of this indicator is also used to assess overall population health status and the quality of prevention and treatment of the population.
Methodology	
Data collection and processing and calculation methods	Data collection is performed on the basis of form No030-1/v which is filled out for each newly hospitalized patient. Aggregate data is reflected in the annual form approved by the MoH KR and NSC. Calculation: the absolute number of newly discovered cases of drug dependence X 100,000 / average annual permanent population.
Sources of data	RMIC
Additional sources of data:	RNC
Frequency of collection and reporting	Once per year
The need for special tools (funding) for data collection or reporting on the data	none
Additional information and references	

General description	
Indicator title	3.5.1.a. Alcohol dependence incidence per 100,000 population
Justification/Definition of the indicator	The level of newly discovered cases of alcohol dependence discovered in the reporting year per 100,000 population in the age of 15 and above
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of preventive activities for alcohol dependence. The level of this indicator is also used to assess overall population health status and the quality of prevention and treatment of the population.
Methodology	
Data collection and processing and calculation methods	Data collection is performed on the basis of form No030-1/v which is filled out for each newly hospitalized patient. Calculation: the absolute number of newly discovered cases of alcohol dependence in the age of 15 and above X 100,000 / average annual permanent population.
Sources of data	RMIC
Additional sources of data:	RNC
Frequency of collection and reporting	Once per month, incrementally - one year
The need for special tools (funding) for data collection or reporting on the data	none
Additional information and references	

General description	
Indicator title	3.5.2. Alcohol consumption per capita in liters of pure alcohol per calendar year
Justification/Definition of the indicator	Consumption of various alcoholic beverages by the population purchased in retails networks and public food outlets in natural terms converted to pure alcohol
Unit of measurement	Liters per capita
Type of indicator	quantitative
Purpose	The level of alcohol consumption is considered to be one of the three priority public health issues around the world. Despite the fact that overall only half of the planet's population consumes alcohol, it is the third leading global risk factor for morbidity and premature death after tobacco smoking and high blood pressure.
Methodology	
Data collection and processing and calculation methods	*The methodology will be discussed with the NSC* Calculation of the consumption of alcoholic beverages in natural terms is performed by the state statistics authorities at the republican level on the basis of data on the production, import and export taking into account changes in stock in wholesale and retail trade and the industry. Overall volume of consumption of alcoholic beverages converted to pure alcohol is defined as the total consumption of individual types of alcoholic beverages converted to pure alcohol. Consumption of alcoholic beverages per capita converted to pure alcohol is determined by dividing the total volume of consumption of all types of alcoholic beverages converted to pure alcohol by the average annual population.
Sources of data	NSC
Additional sources of data:	Research data (KAR) Global reports of the World Health Organization on the situation with alcohol and health http://www.who.int/substance_abuse/publications/global_alcohol_report/en/#
Frequency of collection and reporting	Annually
The need for special tools (funding) for data collection or reporting on the data	none
Additional information and references	
To obtain more complete data on the consumption of alcoholic beverages in natural terms, a balanced consumption calculation method is applied. The balance is expressed by the following formula: Stb + Pr + I = Con + E = Ste, Where STb, Ste - stock of the goods at the beginning and at the end of the reporting period; Pr - production of the goods over the reporting period; I - import of the goods; Con - domestic consumption of the goods; E - export of the goods. According to the above formula the balanced alcoholic products consumption calculation method on the domestic market is calculated using the following formula: Con = Stb +Pr + I - E - Ste. To convert certain types of alcoholic beverages in natural terms to pure alcohol one should use ratios that reflect the 100% spirit content in one liter of an alcoholic beverage. For certain types of alcoholic beverages these ratios are as follows:	

ıdka - 0,4
Liquor - 0,3
Grape wines - 0,14
Grape wine drinks - 0,18
Fruit and berry wines - 0,18
Fruit and berry beverages - 0,18
Cognac including cognac drinks - 0,4
Champagne and sparkling wines - 0,11
Beer - 0,04
Low alcohol drinks - 0,06
To convert the volume of consumption of certain types of alcoholic beverages obtained using the balanced method from natural terms to pure alcohol multiply the volume of consumption in natural terms by the relevant conversion factor.

3.6 By 2020 halve the number of global deaths and injuries from road traffic accidents

General description	
Indicator title	3.6.1. Death rate due to road traffic accidents per 100,000 population
Justification/Definition of the indicator	Mortality from road traffic accidents in the reporting year per 100,000 population
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of road traffic accident prevention activities. The level of this indicator is also used to assess overall population health status and the quality of prevention and treatment of the population.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical death certificates registered in the civil registries. Aggregated data is collected and processed by oblast statistics departments and the National statistics committee of the KR. Calculation: the absolute number of people that died as a result of road traffic accidents registered in the civil registries in the reporting year x 100,000 / average annual permanent population
Sources of data	NSC, MoI
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per month, incrementally - one year
The need for special tools (funding) for data collection or reporting on the data	none
Additional information and references	
According to an agreement with the National statistics committee of the KR the mortality database is handed over to the Republican medical information center of the Ministry of Health of the KR (Form 2 “Data on the number of births, marriages, divorces and deaths by causes of death” - on a monthly basis with a 1,5 month lag from the reporting month, and Form C52 “Population mortality by causes of death” - annually, in June of the year following the reporting year). When calculating the indicator on a monthly basis, one needs to use a conversion factor to ensure comparability of the obtained data with the annual data.	

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

General description	
Indicator title	3.7.1. Proportion of married women aged 15-49 years who have their need for family planning satisfied with modern methods
Justification/Definition of the indicator	The percentage of married women aged 15-49 years using modern contraception methods, among married women aged 15-49 years
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	The analysis of this indicator will enable access of women of reproductive age to modern contraception methods and allow to develop plans for sustainable provision of contraceptives to women from risk groups to reduce the risk of infant and maternal mortality. The findings of the study are necessary to assess the existing social programs and develop new strategies to improve health status and healthcare services for women and children in the Kyrgyz Republic.
Methodology	
Data collection and processing and calculation methods	The study was conducted by the NSC KR jointly with the MoH KR. DHS data is based on a survey of women that had spent the night in the household prior to the survey. Household questionnaires and Individual questionnaires were drafted on the basis of standard questionnaires developed by the MEASURE DHS program. Generic DHS questionnaires were adapted to the Kyrgyz Republic's circumstances by the experts of the National statistics committee (NSC) and the Ministry of Health of the KR (MoH). Calculation: The share of married women aged 15-49 that use any modern method of contraception at the time of the study to postpone or limit childbirth from the total number of married women aged 15-49 questioned during the survey x 100 / the share of married women aged 15-49 with the overall need for family planning services (the sum of the share of married women aged 15-49 that have an unsatisfied need for family planning services + the share of married women aged 15-49 that use any modern contraception method at the time of the study)
Sources of data	DHS
Additional sources of data:	MICS
Frequency of collection and reporting	DHS in the KR was conducted in 1997 and 2012.
The need for special tools (funding) for data collection or reporting on the data	During the surveys financial and technical assistance was provided by the United States Agency for International Development (USAID). Additional funds for the execution of the study were provided by the United Nations Populations Fund (UNFPA) in the KR.
Additional information and references	
Modern methods include female sterilization, male sterilization, birth control pills, intra uterine devices (IUDs), injection methods, implants, male condoms, foam/jelly and the lactation amenorrhea method.	

General description	
Indicator title	3.7.2. Under 15 birth rate (aged 12-14 years) (number of births per 1000 women of this age group)
Justification/Definition of the indicator	Birth rate among adolescent girls aged below 15 per 1000 adolescent girls of this age group
Unit of measurement	promille
Type of indicator	quantitative
Purpose	The analysis of this indicator will enable assessing the effectiveness of programs underway in the republic as well as existing strategies to improve the reproductive health of women. Assess the effectiveness of awareness campaigns on this matter. Plan activities to improve mother and child health in the KR.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical birth certificates registered in the civil registries, and registry entries on birth. Aggregated data is collected and processed by oblast statistics departments and the National statistics committee of the KR. Calculation: Number of adolescent girls aged below 15 that gave birth X 1000 / average annual number of adolescent girls in this age group
Sources of data	NSC
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per year
The need for special tools (funding) for data collection or reporting on the data	-
Additional information and references	

General description	
Indicator title	3.7.3. Birth rate in the 15-19 age group (number of births per 1000 women of this age group)
Justification/Definition of the indicator	Birth rate among adolescent girls aged between 15 and 19 per 1000 adolescent girls of this age group
Unit of measurement	promille
Type of indicator	quantitative
Purpose	The analysis of this indicator will enable assessing the effectiveness of programs underway in the republic as well as existing strategies to improve the reproductive health of women. Assess the effectiveness of awareness campaigns on this matter. Plan activities to improve mother and child health in the KR.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical birth certificates registered in the civil registries, and registry entries on birth. Aggregated data is collected and processed by oblast statistics departments and the National statistics committee of the KR. Calculation: Number of adolescent girls aged 15 -19 that gave birth X 1000 / average annual number of adolescent girls in this age group
Sources of data	NSC
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per year
The need for special tools (funding) for data collection or reporting on the data	none
Additional information and references	

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

SDG indicator: 3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)

General description	
Indicator title	3.8.1. Post-partum observation of newborns after discharge from a healthcare institution for 2 days after the discharge from the maternity hospital (broken down by quintiles by the well-being status).
Justification/Definition of the indicator	Percentage of women aged 15-49 that gave birth to a live child over the last 2 years whose child received postnatal oversight by any healthcare professional for a period of 2 days after the discharge from the healthcare institution (broken down by quintiles by the well-being status).
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	This indicator enables assessing the scale of provision of the necessary modern services to children and assessing the effectiveness of programs under implementation in the republic.
Methodology	
Data collection and processing and calculation methods	MICS in the KR is conducted by the National Statistics Committee of the Kyrgyz Republic in cooperation with the statistics departments in oblasts and the cities of Bishkek and Osh as part of the global MICS program. The Postnatal Oversight module was developed to be used during the MICS surveys intended to collect information about the contacts of newborns and mothers with the source of healthcare services, and not about the content of medical oversight. The need for such an approach is explained by the fact that as the PNO programs' coverage grows, there is a need to measure their scale and provide a reliable platform for the provision of the necessary services. Calculation: the percentage of women aged 15-49 that gave birth to a live child over the last 2 years whose child received postnatal oversight by any healthcare professional for a period of 2 days after the discharge from the healthcare institution (broken down by quintiles by the well-being status) X 100 / number of women aged 15-49 that gave birth to a live child over the last two years.
Sources of data	MICS
Additional sources of data:	none
Frequency of collection and reporting	MICS in the KR were conducted in 2006 and 2014.
The need for special tools (funding) for data collection or reporting on the data	The survey was conducted with the financial and technical support from the UN Children's Fund (UNICEF) and co-financing from the UN Populations Fund (UNFPA).
Additional information and references	
The time of delivery and the period immediately thereafter are the critical window of opportunity when it is possible to make an intervention to save the lives of both the mother and the newborn. A **postnatal visit** is a separate visit to monitor the newborns status and provide him/her with treatment and prevention services	

General description	
Indicator title	3.8.2. Share of households with OOPs over 40% of their capacity-to-pay
Justification/Definition of the indicator	The share of households with high healthcare expenditures relative to total household income or expenditures (more than 40%)
Unit of measurement	per cent
Type of indicator	quantitative
Purpose	This indicator enables assessing the level of healthcare expenditures that may account for a significant share of the household's total expenditures. The main question is how the healthcare expenditures (including medicines and other health-related expenditures) influence the household's living standards.
Methodology	
Data collection and processing and calculation methods	The threshold of catastrophic out-of-pocket payments is the share of the household's budget or the household's capacity to pay. Out-of-pocket payments may be considered catastrophic if they exceed, for instance, 25% of the household's budget, whereas the budget is defined as the total income or total consumption (i.e. actual expenditures). $\sum_i w_i 1\left(\frac{\text{расходы на здравоохранения домохозяйств}}{\text{общие расходы или доходы домохозяйств}} > \tau\right)$, where i is the household, 1 () indicator function, w_i corresponds to the survey sample, represents the threshold of non-proportionate healthcare expenditures.
Sources of data	NSC (Integrated household survey, Healthcare module)
Additional sources of data:	
Frequency of collection and reporting	Data of the IHHS Health module was collected in 2001, 2004, 2007, 2010 and 2015.
The need for special tools (funding) for data collection or reporting of the data	During the survey technical and financial assistance was offered by the World Health Organization (WHO), the UK's Department for International Development (DFID) and Swiss Development and Cooperation Agency (SDC).
Additional information and references	

3.9 By 2030 substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

General description	
Indicator title	3.9.1. Mortality from toxic impact of carbon oxide per 100,000 population
Justification/Definition of the indicator	Mortality from toxic impact of carbon oxide in the reporting year per 100,000 population
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of activities to prevent fires and other instances when carbon oxide poisoning may occur. The level of this indicator is also used to assess the level of population's social well-being.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical death certificates registered in the civil registries. Aggregated data is collected and processed by oblast statistics departments and the National statistics committee of the KR. Calculation: the absolute number of people that died from toxic impact of carbon oxide registered in the civil registries in the reporting year x 100,000 / average annual permanent population
Sources of data	NSC
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per year
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
According to an agreement with the National statistics committee of the KR the mortality database is handed over to the Republican medical information center of the Ministry of Health of the KR (Form C52 "Population mortality by causes of death" - annually, in June of the year following the reporting year).	

General description	
Indicator title	3.9.2.a Mortality from intestinal infections per 100,000 population
Justification/Definition of the indicator	Mortality from intestinal infections in the reporting year per 100,000 population
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of sanitary and hygienic preventive activities and the population's sanitary awareness. The level of this indicator is also used to assess the population's social and economic well-being and the quality of prevention and treatment of the population.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical death certificates registered in the civil registries. Aggregated data is collected and processed by oblast statistics departments and the National statistics committee of the KR. Calculation: the absolute number of people that died from intestinal infections registered in the civil registries in the reporting year X 100,000 / average annual permanent population
Sources of data	NSC
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per month, incrementally - one year
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
According to an agreement with the National statistics committee of the KR the mortality database is handed over to the Republican medical information center of the Ministry of Health of the KR (Form 2 "Data on the number of births, marriages, divorces and deaths by causes of death" - on a monthly basis with a 1,5 month lag from the reporting month, and Form C52 "Population mortality by causes of death" - annually, in June of the year following the reporting year). When calculating the indicator on a monthly basis, one needs to use a conversion factor to ensure comparability of the obtained data with the annual data.	

General description	
Indicator title	3.9.2.b Mortality from typhoid fever per 100,000 population
Justification/Definition of the indicator	Mortality from typhoid fever in the reporting year per 100,000 population
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of sanitary and hygienic preventive activities as well as anti-epidemic activities and the population's sanitary awareness. The level of this indicator is also used to assess the population's social and economic well-being and the quality of prevention and treatment of the population.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical death certificates registered in the civil registries. Aggregated data is collected and processed by oblast statistics departments and the National statistics committee of the KR. Calculation: the absolute number of people that died from typhoid fever registered in the civil registries in the reporting year X 100,000 / average annual permanent population
Sources of data	NSC
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per year
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
According to an agreement with the National statistics committee of the KR the mortality database is handed over to the Republican medical information center of the Ministry of Health of the KR (Form C52 "Population mortality by causes of death" - annually, in June of the year following the reporting year).	

General description	
Indicator title	3.9.3. Mortality from unintentional poisoning and the impact of poisonous substances
Justification/Definition of the indicator	Mortality from unintentional poisoning and the impact of poisonous substances in the reporting year per 100,000 population
Unit of measurement	kilomille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the effectiveness of activities to prevent mortality from unintentional poisoning and the impact of poisonous substances.
Methodology	
Data collection and processing and calculation methods	The data is collected on the basis of medical death certificates registered in the civil registries. Aggregated data is collected and processed by oblast statistics departments and the National statistics committee of the KR. Calculation: the absolute number of people that died from unintentional poisoning and the impact of poisonous substances registered in the civil registries in the reporting year x 100,000 / average annual permanent population.
Sources of data	NSC
Additional sources of data:	RMIC
Frequency of collection and reporting	Once per year
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
According to an agreement with the National statistics committee of the KR the mortality database is handed over to the Republican medical information center of the Ministry of Health of the KR (Form C52 “Population mortality by causes of death” - annually, in June of the year following the reporting year).	

3.a. Facilitate when needed the implementation of the Framework convention of the World Health Organization on the fight against tobacco in all countries

General description	
Indicator title	3.A.1 Prevalence of tobacco use
Justification/Definition of the indicator	Estimate of tobacco use among the population of various age groups
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	The data on tobacco prevalence makes it possible to plan activities aimed at the reduction of tobacco use and demand and helps the country to fulfill its obligations under the WHO Framework convention on tobacco control (WHO FCTC).
Methodology	
Data collection and processing and calculation methods	Prevalence of tobacco use in the KR is assessed with the help of international donors; two studies were conducted in 2014: - GYTS - a global tobacco use survey of adolescents aged 13-15, and STEPS - a WHO instrument implying a survey of persons aged 25-64 on the epidemiological surveillance of the risk factors of non-communicable diseases in the KR. GYTS uses a global standardized methodology including a two-stage sampling of schools that are selected with a probability proportionate to their number. The study uses a standard questionnaire with a number of main questions; it is also permitted to include additional questions satisfying the needs of the country for key indicators of tobacco use and the fight against tobacco. STEPS is a WHO instrument on epidemiological surveillance of risk factors of non-communicable diseases in the KR implying a representative sampling study at the country level. A WHO questionnaire is used, adapted to the KR (Main module. Tobacco use)
Sources of data	Data of STEPS, GYTS and other studies
Additional sources of data:	Other representative surveys aimed at assessing tobacco use at the national level
Frequency of collection and reporting	As the surveys are conducted
The need for special tools (funding) for data collection or reporting of the data	STEPS and GYTS were conducted with the financial support from WHO and CDC
Additional information and references	
GYTS n the KR was conducted in 2014 by the MoH in collaboration with the MES&C; STEPS was also conducted in 2014 by the MoH in collaboration with the NCC&T and KSMIR&QU. http://www.who.int/tobacco/surveillance/gyts/en/ http://www.who.int/chp/steps/instrument/en/	

3.b. Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

General description	
Indicator title	3.B.1.1 The share of state financing allocated to purchase vaccines
Justification/Definition of the indicator	Percentage of public spending on vaccine purchases relative to the overall spending on vaccine purchases from all sources.
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	According to the European Vaccine Action Plan 2015-2020 of the "Immunoprophylaxis" program 2013-2017 a task was set to "ensure financial stability of the national immunization programs" and strengthen political commitment to the immunization program and ensure its financial sustainability using public resources. This is why monitoring of this indicator will strengthen the support of the immunization agenda in ensuring stable and long-term access to domestic financing (EVAP goals 1 and 5) taking into account national and global EIP goals.
Methodology	
Data collection and processing and calculation methods	Calculation: public spending on vaccine purchases X 100 / overall spending on vaccine purchases from all sources.
Sources of data	MoH
Additional sources of data:	RCI, UNICEF procurement department, GAVI secretariat
Frequency of collection and reporting	2 times per year
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
Joint WHO/UNICEF report *http://www.who.int/immunization/monitoring_surveillance/data/en/) (1) WHO (http://www.data.unicef.org/child-health/immunization) (2) UNICEF* European Vaccine Action Plan www.euro.who.int/ data/assets/pdf_file/ Kyrgyzstan's report to the GAVI secretariat https://appsportal.gavialliance.org "Immunoprophylaxis" program 2013 - 2017.	

General description	
Indicator title	3.b.1.2 Capitation norm allocated to preferential provision of drugs under APMHI at the primary level.
Justification/Definition of the indicator	Financial resources allocated exclusively to preferential drug provision per person.
Unit of measurement	Soms/person
Type of indicator	Quantitative
Purpose	The budget of preferential drug provision under the AMHIP for the current year is formed taking this indicator into account.
Methodology	
Data collection and processing and calculation methods	Capitation norm is formed on the basis of the volume of MHI funds received. Approved by the Oversight council on health and mandatory health insurance.
Sources of data	MHIF
Additional sources of data:	none
Frequency of collection and reporting	annually
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	
Preferential provision of drugs provides opportunities for a certain population category to obtain a number of drugs in pharmacies using FGP family physician prescriptions at preferential prices.	

General description	
Indicator title	3.b.2. Full coverage with vaccines of children between 24 and 35 months
Justification/Definition of the indicator	Percentage of children aged 24-35 months who received all vaccines recommended according to the national vaccination calendar before their first birthday (measles - before their second birthday).
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	Children's vaccination level makes it possible to assess the effectiveness of activities to prevent manageable infections in the republic as well as current national programs and mother and child health strategies. The vaccination level is included in the Health 2020 indicators, MDGs and other international programs.
Methodology	
Data collection and processing and calculation methods	MICS findings provided an assessment of the coverage of children aged 12-23 months and 24-35 months with immunization in the Kyrgyz Republic. Information on the coverage with immunization was collected on all children under the age of 3. All mothers and caregivers were asked to provide an immunization record. However in Kyrgyzstan children's medical cards (MoH form 112) and immunization records (MoH form 063) are kept in the local healthcare institutions and can very rarely be found at home. This is why during this study vaccination data was copied from these forms in the healthcare institutions and in rare cases was based on the recall of mothers or caregivers. The resulting vaccination coverage is based on the information obtained from the medical cards and from interviews with mothers or caregivers. Calculation: number of children aged 24-35 months, that received all vaccines according to the national vaccination calendar before their first birthday (measles - before their second birthday) X 100/ number of children aged 24-35 months in the surveyed households
Sources of data	MICS
Additional sources of data:	DHS
Frequency of collection and reporting	MICS in the KR were conducted in 2006 and 2014, DHS - in 1997 and 2012.
The need for special tools (funding) for data collection or reporting of the data	During MICS financial and technical assistance was provided by the UN Children's Fund (UNICEF), during DHS assistance was provided by the United States Agency for International Development (USAID). Additional funds for the execution of these studies were provided by the United Nations Populations Fund (UNFPA) in the KR.
Additional information and references	
According to the WHO guiding principles the child must receive vaccines to prevent TB, pertussis, diphtheria, tetanus, polio, measles, hepatitis B, Haemophilus influenza B, mumps and rubella. All doses of the main vaccines are recommended to be administered during the first year of life. At the same time depending on the epidemiological situation in the country the first doses of vaccines against measles and rubella may be recommended at the age of 12 months or later. The recommended number and time frames of the other doses may vary slightly depending on the epidemiological situation and may include supplementary injections at an older age.	

Ministry of Health of the KR adopted WHO recommendations on children's immunization. Since 2001 vaccination plans include all of the above mentioned vaccines according to the National vaccination program. The pentavalent vaccine introduced in 2009 (Penta) replaced the DPT vaccine and the hepatitis B vaccine except for the first dose of hepatitis B vaccine at birth. Besides DPT the pentavalent vaccine contains vaccine against hepatitis B and Haemophilus influenza B which follows the same administering scheme as the DPT. Since 2002 vaccination against measles, mumps and rubella (MMR) is administered at the age of 12 months.

Vaccination makes it possible to reduce infant and child mortality from manageable infections and consequently increase life expectancy which is an indicator of the country's social and economic development along with the maternal and child mortality.

3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

General description	
Indicator title	3.c.1. Number of doctors and mid-level health workers per 10,000 population
Justification/Definition of the indicator	Number of doctors and mid-level health workers per 10,000 population at the end of the reporting period
Unit of measurement	decimille
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the availability of healthcare professionals in any given region. It makes it possible to plan the redistribution of new healthcare professionals (graduates of HEIs and SEIs), the doctor's deposit, qualification upgrading and specialization of the medical cadre.
Methodology	
Data collection and processing and calculation methods	Data collection is performed on the basis of the "Medical personnel" electronic database installed in every healthcare institution. The information is captured in the reporting form No 17 "Medical personnel report". Aggregated data is collected in OMIC, RMIC.
Sources of data	RMIC
Additional sources of data:	none
Frequency of collection and reporting	Once per quarter
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	

3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

General description	
Indicator title	3.D.1 Number of SQPs organized in accordance with IHR
Justification/Definition of the indicator	Number of SQPs organized in accordance with IHR
Unit of measurement	Number of SQPs
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the equipped sanitary and quarantine points (SQPs) at international road border crossing points of the Kyrgyz Republic intended to prevent the international spread of diseases and ensure their prevention and control and public health response.
Methodology	
Data collection and processing and calculation methods	Data collection is performed on the basis of annual reporting from territorial DP&SSESC. Aggregate data is collected and processed by the Republican center of quarantine and especially dangerous infections.
Sources of data	RCQEDI, DSSES,
Additional sources of data:	none
Frequency of collection and reporting	Once per quarter and based on annual results
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	

GOAL 5. ENSURING GENDER EQUALITY AND EMPOWERMENT OF ALL WOMEN AND GIRLS

Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

General description	
Indicator title	5.6.1. Share of married women and sexually active unmarried women aged 15-49, which were informed of some method of contraception
Justification/Definition of the indicator	Percentage distribution of married women and sexually active unmarried women aged 15-40 who were informed of a modern contraception method among all married and sexually active women aged 15-49 interviewed at the time of the survey
Unit of measurement	Per cent
Type of indicator	Quantitative
Purpose	The analysis of this indicator can be applied in practice in reproductive health programs. Women's awareness about family planning methods provides an insight into one of the main conditions for the use of methods of contraception. It makes it possible to assess the effectiveness of family planning programs. The findings are necessary to assess the existing social programs and develop new strategies to improve health status and healthcare services for women and children in the Kyrgyz Republic.
Methodology	
Data collection and processing and calculation methods	The study was conducted by the National statistics committee of the KR together with the Ministry of health of the KR. DHS data is based on a survey of women that had spent the night in the household prior to the survey. Household questionnaires and Individual questionnaires were drafted on the basis of standard questionnaires developed by the MEASURE DHS program. To obtain information on the awareness of women about the methods of contraception, titles and/or descriptions of the 12 methods of contraception were read out loud, and the respondents were asked whether they had heard of each of these methods. Furthermore, the respondents were asked about other methods that could prevent pregnancy that they might have heard of. Calculation: number of married women and sexually active unmarried women aged 15-49, who were informed of some modern method of contraception X 100 / number of married women and sexually active unmarried women aged 15-49, who were interviewed during the survey.
Sources of data	DHS
Additional sources of data:	MICS
Frequency of collection and reporting	DHS in the KR were conducted in 1997 and 2012.

The need for special tools (funding) for data collection or reporting of the data	During the surveys financial and technical assistance was provided by the United States Agency for International Development (USAID). Additional funds for the execution of the study were provided by the United Nations Populations Fund (UNFPA) in the KR.

Additional information and references

Modern methods include female sterilization, male sterilization, birth control pills, intra uterine devices (IUDs), injections, implants, male and female condoms, lactation amenorrhea method (LAM) and urgent contraception.
Sexually active unmarried women aged 15-49 were those that had their last intercourse within 30 days before the survey.

General description	
Indicator title	5.6.2. Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education
Justification/Definition of the indicator	Number of adopted and approved laws and regulations that guarantee women's access to sexual and reproductive health care, information and education
Unit of measurement	Number of approved documents
Type of indicator	Quantitative
Purpose	This indicator makes it possible to identify countries with laws and regulations in force that guarantee women's access to reproductive and sexual health protection services
Methodology	
Data collection and processing and calculation methods	This indicator will only monitor the adoption of legislation at the level of the Government of the KR It is planned to adopt two state programs up until 2030: 1. Comprehensive state program on family and child care support in 2017-2027 2. National reproductive health protection program in 2017-2030
Sources of data	MH
Additional sources of data:	none
Frequency of collection and reporting	as the documents are approved
The need for special tools (funding) for data collection or reporting of the data	none
Additional information and references	

GOAL 6. ENSURE AVAILABILITY AND RATIONAL USE OF WATER AND SANITATION FOR ALL

6.1 By 2030, achieve universal and equitable access to safe and affordable drinking water for all

General description	
Indicator title	6.1.1. Access of the population to improved sources of drinking water
Justification/Definition of the indicator	Percentage distribution of permanent population in households that have access to improved sources of drinking water
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	The analysis of this indicator enables assessing the level of social and economic well-being and the effectiveness of sanitary and hygienic preventive activities.
Methodology	
Data collection and processing and calculation methods	In DHS 2012 data was collected on a whole series of household characteristics that had an impact on the health of its members and reflected the household's social and economic status. Characteristics of the dwellings included such indicators as the sources of drinking water, type of lavatories, construction materials (roof, walls and the floor), access to electricity and food cooking equipment. These findings are captured in the DHS by households and de jure (permanent) population by cities and towns and rural areas. Calculation: Number of permanent household population that have access to improved sources of drinking water X 100 / number of permanent population in households interviewed during the survey.
Sources of data	DHS
Additional sources of data:	MICS
Frequency of collection and reporting	DHS in the KR were conducted in 1997 and 2012.
The need for special tools (funding) for data collection or reporting on the data	During the surveys financial and technical assistance was provided by the United States Agency for International Development (USAID). Additional funds for the execution of the study were provided by the United Nations Populations Fund (UNFPA) in the KR.
Additional information and references	
The source of drinking water is an indicator of the water's suitability for drinking. DHS 2012 used a classification of improved and non-improved sources of water, recommended by the WHO/UNICEF Joint monitoring program for water supply and sanitation. Improved water supply sources included: running water in the house, running water in the yard/garden, public drinking water pump, pipe well or well, protected water well, protected spring. DHS 2012 also assessed the time spent on delivering water and water purification methods that Kyrgyzstan's population employ to treat the water used for drinking. Population de jure includes all permanent household dwellers regardless of whether they were present at the time of the DHS survey or not. Access of the population to drinking water and its further development are reflected in the Drinking water supply development strategy for the settlements in the Kyrgyz Republic 2026, approved by Resolution No 155 of the Government of the Kyrgyz Republic dated March 28 2016.	

General description	
Indicator title	6.2.1. Access of the population to improved sanitation
Justification/Definition of the indicator	Percentage of the population with access to improved sanitary facilities (non-public improved toilet)
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	The analysis of this indicator will enable assessing the population's access to water disposal and sanitation services through the development of centralized sewerage systems, and the effectiveness of sanitary and hygienic prevention activities as well as the sanitary culture of the population. The level of this indicator is also used to assess the level of population's social well-being.
Methodology	
Data collection and processing and calculation methods	In DHS 2012 data was collected on a whole series of household characteristics that had an impact on the health of its members and reflected the household's social and economic status. Characteristics of the dwellings included such indicators as the sources of drinking water, type of lavatories, construction materials (roof, walls and the floor), access to electricity and food cooking equipment. These findings are captured in the DHS by households and de jure (permanent) population by cities and towns and rural areas. Calculation: Number of permanent household population that have access to improved non-public toilet X 100 / number of permanent population in households interviewed during the survey.
Sources of data	DHS
Additional sources of data:	MICS
Frequency of collection and reporting	DHS in the KR was conducted in 1997 and 2012.
The need for special tools (funding) for data collection or reporting of the data	During the surveys financial and technical assistance was provided by the United States Agency for International Development (USAID). Additional funds for the execution of the study were provided by the United Nations Populations Fund (UNFPA) in the KR.
Additional information and references	
Availability of sanitary and hygienic facilities in the household is an important factor reducing the risk of the spread of diarrhea and other diseases inside the household. According to the standards established by the WHO/UNICEF Joint monitoring program for water supply and sanitation the hygienic status of lavatories is defined on the basis of the type of facility in use and whether it is a commonly used place or not (UNICEF and WHO 2012). The household's toilet/lavatory is classified as hygienic if it is only used by household members (i.e. is not a place commonly used with other households) and if the type of the facility effectively separates human waste from contact with humans. Such types of facilities include toilets with flushing or manual flushing and a discharge into a tubed sewerage system/septic tank/waste pit, ventilated and improved waste pits, waste pits with liner and composting toilets. The issues of waste water disposal and further solutions to these problems are also reflected in the Drinking water supply development strategy for the settlements in the Kyrgyz Republic 2026, approved by Resolution No 155 of the Government of the Kyrgyz Republic dated March 28 2016. Taking into account the relevance of this problem, it is necessary to envisage in draft SDGs of the KR 2030 a section on the development of centralized household and drinking water supply and waste water disposal in the settlements in the Kyrgyz Republic. This work is conducted jointly with the Ministry of Health of the KR, Department for the development of drinking water supply under Gosstroy, State inspection on environmental and technical safety under the PKR.	

General description	
Indicator title	6.2.1A Share of households with a hand-washing facility with soap and water
Justification/Definition of the indicator	Share of households with a hand-washing facility with soap and water
Unit of measurement	Per cent
Type of indicator	quantitative
Purpose	The analysis of this indicator will enable assessing the population's access to water disposal and sanitation services through the development of centralized sewerage systems, and the effectiveness of sanitary and hygienic prevention activities as well as the sanitary culture of the population. The level of this indicator is also used to assess the population's social and economic well-being and the quality of prevention and treatment of the population.
Methodology	
Data collection and processing and calculation methods	In DHS 2012 data was collected on a whole series of household characteristics that had an impact on the health of its members and reflected the household's social and economic status. To obtain information about hand washing, the DHS interviewer asks to show him/her the place where household members wash their hands most frequently, and based on the observations, he/she records information on the availability of water, soap or other cleaning agents. Calculation: number of households that have a place for hand washing with soap and water X 100/ number of households interviewed during the survey.
Sources of data	DHS
Additional sources of data:	MICS
Frequency of collection and reporting	DHS in the KR was conducted in 1997 and 2012.
The need for special tools (funding) for data collection or reporting of the data	During the surveys financial and technical assistance was provided by the United States Agency for International Development (USAID). Additional funds for the execution of the study were provided by the United Nations Populations Fund (UNFPA) in the KR.
Additional information and references	
Hand washing with soap is an ideal hygienic practice. Research shows that hand washing with soap and water (or cleaning agents for hands such as ashes or sand) significantly reduces the risk of transmission of diarrhea, respiratory infections and other diseases (Ensink 2008, Luby 2005).	