Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS
Country Report

Reporting Period: 2003-2004

KYRGYZ REPUBLIC
ACRONYMS

AIDS   Acquired Immunodeficiency Syndrome
CA    Civil Association
CMCC  Country Multisectoral Coordination Committee
GFATM Global Fund to Fight AIDS, Tuberculosis and Malaria
HCF   Health Care Facilities
HIV   Human Immunodeficiency Virus
IDU(s) Injecting Drug User(s)
IEC   Information, education and communication
IEM   Information and educational materials
IEP   Information and educational programs
KR    Kyrgyz Republic
MoH KR Ministry of Health of Kyrgyz Republic
MIA KR Ministry of Internal Affairs of Kyrgyz Republic
MSM   Men, who have sex with men
NAC(s) National AIDS Committee(s)
NAP   National AIDS Programme
NGO(s) Nongovernmental Organization(s)
PLHIV People Living with HIV
PAHA  People, affected by HIV/AIDS
RA    Republican Association
RMCC  Republican Multisectoral Coordination Committee
RNC   Republican Narcological Center
SDCC  State Drug Control Commission
SES   Sentinel Epidemiological Surveillance
SDMK  Spiritual Directorate of Muslims of Kyrgyzstan
STD(s) Sexually Transmitted Disease(s)
STI(s) Sexually Transmitted Infection(s)
SW    Sex-workers
TV    Television
UN    United Nations
UNAIDS Joint United Nations Programme on HIV/AIDS
UNDAF United Nations Development Assistance Framework
UNDP   United National Development Programme
UNFPA United Nations Population Fund
UNHCR Office of the United Nations High Commissioner for Refugees
UNICEF United Nations Children’s Fund
USAID Unites States Agency for International Development
VCT   Voluntary Counseling and Testing
VHC   Viral Hepatitis C
WHO   World Health Organization
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<th>NATIONAL COMMITMENT AND ACTION</th>
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<tbody>
<tr>
<td>1. National Composite Policy Index on HIV/AIDS - 0.6;</td>
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<tr>
<td>2. Amount of national funds spent by the Government on HIV/AIDS response - $217,440(^1);</td>
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<tr>
<th>NATIONAL PROGRAMME AND BEHAVIOR LEVEL</th>
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<tbody>
<tr>
<td>Prevention</td>
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<tr>
<td>3. 0% of IDUs, who both correctly identify ways of preventing HIV and who reject major misconceptions about HIV transmission</td>
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<tr>
<td>4. 6.9% of MSM, who both correctly identify ways of preventing HIV and who reject major misconceptions about HIV transmission</td>
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<tr>
<td>5. 1.1% of SW who both correctly identify ways of preventing HIV and who reject major misconceptions about HIV transmission</td>
</tr>
<tr>
<td>6. 0% prisoners who both correctly identify ways of preventing HIV and who reject major misconceptions about HIV transmission</td>
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<tr>
<td>7. 69.3% of IDUs reached with prevention programs from among respondents(^2)</td>
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<td>8. 75.3% of SW reached with prevention programs from among respondents</td>
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<tr>
<td>9. 79.2% of MSM reached with prevention programs from among respondents.</td>
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<tr>
<th>Treatment/Care</th>
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<tr>
<td>10. 31.1% of representatives of highly vulnerably sentinel groups with STI turned to state-owned health care facilities and received appropriate diagnostics, treatment and counseling services;</td>
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<table>
<thead>
<tr>
<th>Behavior/Knowledge</th>
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</thead>
<tbody>
<tr>
<td>11. 16.1% of injecting drug users adopted behavior that reduced transmission of HIV;</td>
</tr>
<tr>
<td>12. 80.9% of SW reporting condom use with the most recent client in the last 12 months;</td>
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<tr>
<td>13. 68.3% MSM reporting condom use with the most recent partner in the last 6 months;</td>
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<table>
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<th>IMPACT</th>
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<tbody>
<tr>
<td>12. 6.2% HIV prevalence among injecting drug users;</td>
</tr>
<tr>
<td>13. 1.7% HIV prevalence among sex-workers;</td>
</tr>
<tr>
<td>14. 2.7% HIV prevalence among prisoners;</td>
</tr>
<tr>
<td>15. 0.5% HIV prevalence among STI patients.</td>
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</table>

\(^1\) This amount does not include expenses on maintenance of buildings, travel and other expenses; taking all these funds into account, the total amount of government funds disbursed on HIV/AIDS is $221,345.  
\(^2\) It reflects the coverage by prevention programs of IDUs, SW and MSM questioned within SES in 2004 (in Bishkek and Osh cities).
II. OVERVIEW OF HIV/AIDS EPIDEMIC

1. Despite the fact that Kyrgyz Republic still has a low prevalence of HIV-infection, the situation is rapidly changing every year.

By 01.01.05 a cumulative number of officially registered PLHA was 655 people, including 31 AIDS patients. 40 HIV infected people have died in the country, including 23 people who died of AIDS\(^3\). Of special concern is the fact that life expectancy of many of them was less than a year since the moment of disease registration.

HIV incidence rate in Kyrgyz Republic is 13.5 per 100,000 people\(^4\), but it is estimated that today around 7,000 people are living with HIV/AIDS in the country. HIV infection cases have been registered practically in all regions of the republic.

Young people prevail among HIV infected, and 54.6% of all identified HIV/AIDS cases are in the age group 15-29 years.

In order to study the prevalence of sexually transmitted and blood borne infections (HIV infection, viral hepatitis C (VHC), syphilis), to learn about high risk behaviors, level of awareness of HIV transmission routes and prevention means, as well as about the coverage by prevention programs of the most socially vulnerable population groups, in 2004 the country implemented sentinel epidemiological surveillance (SES)\(^5\) in 6 sentinel groups including injecting drug users (IDUs) – 514 people; sex workers (SW) – 352 people; men, who have sex with men (MSM) – 101 people; STI patients – 647 people; prisoners in penitentiary system – 450 people and pregnant women – 899 people. This helped to study the prevalence of HIV infection, VHC and syphilis among these groups to further develop and introduce prevention programs and consequently evaluate them.

I. Prevalence of HIV, VHC and Syphilis among Pregnant Women in General Population

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<table>
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<tbody>
<tr>
<td>HIV</td>
<td>0% (0/899)</td>
</tr>
<tr>
<td>VHC</td>
<td>1.4% (13/899)</td>
</tr>
<tr>
<td>Syphilis</td>
<td>1.4% (13/899)</td>
</tr>
</tbody>
</table>

SES (II) 2004 (Bishkek and Osh cities)

According to SES data, there were no HIV infection cases in the sentinel group of pregnant women, but the syphilis cases revealed in this group indicate that there is a real threat of heterosexual HIV infection transmission from vulnerable groups to the general population. At the same time, revealed VHC cases indicate that surveyed pregnant women either concealed the facts of injecting drug use, or, perhaps, they were infected during medical manipulations at health care facilities. So, the prerequisites for parenteral spread of HIV infection in general population also exist.

II. Prevalence of HIV, VHC and Syphilis among Injecting Drug Users (IDUs), Sex Workers (SW), Men Who Have Sex with Men (MSM), Prisoners and STI Patients


\(^5\) SES data in Kyrgyz Republic Country Report for 2004 are used for the first time, that is why they cannot be considered as baseline data. Consequent reports will include new data that will help to track changes in the situation.
**IDUs**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>6.2% (32/514)</td>
</tr>
<tr>
<td>VHC</td>
<td>53.1% (273/514)</td>
</tr>
<tr>
<td>Syphilis</td>
<td>12.3% (63/514)</td>
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</tbody>
</table>

**Sex Workers**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>1.7% (6/352)</td>
</tr>
<tr>
<td>VHC</td>
<td>4% (14/352)</td>
</tr>
<tr>
<td>Syphilis</td>
<td>22.0% (77/352)</td>
</tr>
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**MSM**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
</tr>
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<tbody>
<tr>
<td>HIV</td>
<td>0% (0/101)</td>
</tr>
<tr>
<td>VHC</td>
<td>1% (1/101)</td>
</tr>
<tr>
<td>Syphilis</td>
<td>4% (4/101)</td>
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</table>

**Prisoners**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>2.7% (12/450)</td>
</tr>
<tr>
<td>VHC</td>
<td>32.4% (144/450)</td>
</tr>
<tr>
<td>Syphilis</td>
<td>20.1% (89/450)</td>
</tr>
</tbody>
</table>

**STI Patients**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>0.5% (3/647)</td>
</tr>
<tr>
<td>VHC</td>
<td>2.6% (17/647)</td>
</tr>
<tr>
<td>Syphilis</td>
<td>20.9% (135/647)</td>
</tr>
</tbody>
</table>

The following conclusions were made on the basis of analysis of the obtained data:

HIV/AIDS epidemic in Kyrgyzstan is still on the initial stage. However, according to SES performed in 2004 in the city of Osh with the population of 246 people, there are indications of concentrated epidemic (HIV infection prevalence among IDUs is 11.6%).

The highest HIV prevalence in the country is registered among IDUs (6.2%) and prisoners (2.7%) due to the fact that these groups more frequently practice high risk injecting behaviors. Due to the same reason VHC prevalence is also high in these groups (53.1% and 32.4% respectively). 5% of sex workers have had the experience of injecting drug use, which could also result in HIV infection. It is in line with official statistics that reflects HIV epidemiological situation in Kyrgyz Republic and demonstrates that parenteral transmission is a leading cause of HIV infection and accounts for 83.0% cases.

Prevalence of antibodies to syphilis in blood of practically all sentinel groups remains at a relatively high level (SW – 22.0%; STI patients – 20.9%; prisoners – 20.1%, IDUs – 12.3%), and this is a factor that increases the risk of sexual HIV transmission, which is confirmed by the registered HIV cases, in particular, among SW (HIV prevalence is 1.7%), among whom prevalence of antibodies to syphilis is the highest. In practice, according to official statistics, there is a clear growing trend of heterosexual transmission of HIV (from

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6 SES (II) 2004 (Bishkek and Osh cities)
7 SES (II) 2004 (Bishkek and Osh cities)
3.3% in 2001 to 17.0% in 2004"). It is an indirect evidence of a rather long latent stage of epidemic development among injecting drug users and of the beginning of penetration of HIV infection from the IDU groups to the general population.

Penitentiary facilities of Kyrgyz Republic also face a real threat of quick spread of HIV infection through both parenteral and sexual transmission routes. By 31.01.05 over 17,000 prisoners were kept at penitentiary facilities of the country, of whom 0.7% were HIV infected.

Despite the fact that the lowest prevalence of VHC (1.0%) and syphilis (4.0%) has been observed among MSM, the risk of parenteral and sexual HIV transmission in this environment is very real.

III. NATIONAL RESPONSE TO HIV/AIDS EPIDEMIC

1. National Commitment and Action

Government of Kyrgyz Republic realizes the importance of problem of HIV infection spread and undertakes measures to overcome it.

The national policy on HIV/AIDS is based on a multisectoral approach with the participation of government bodies. Support provided by the top national officials creates favorable conditions for the development of prevention programs. Country Multisectoral Coordination Committee (CMCC) to Fight HIV/AIDS, Tuberculosis and Malaria, chaired by the vice-prime-minister of Kyrgyz Republic, was established at the Government of Kyrgyz Republic by the Government of KR Resolution № 204 as of June 2, 2005 and is functioning now. This single coordination bodies meets the Three Ones requirements, includes all stakeholders and ensures strengthening of the Government leadership in response to HIV/AIDS, and also helps to expand partnership between government structures, civil society sector and international organizations. Six consultative sectors were established to support CMCC activities, including sectors on national policy and legislation; health care and social protection; information, education and communications; on implementation of Global Fund grants; for defense and law enforcement bodies; and on monitoring and evaluation.

Thanks to the increased funding and growing number of donors the country faced the need to organize national coordination and implement monitoring and evaluation of the functioning HIV/AIDS programs. With this purpose, in December 2004 a special body – Sector for Coordination and Monitoring of HIV/AIDS Programs – was established at the Department for Social and Cultural Development within the Administration of the Prime Minister of Kyrgyz Republic. This body has been functioning as the CMCC secretariat. Establishment of this Sector demonstrates the government approach to HIV/AIDS as a problem for country development as a whole, and not just as a purely medical problem.

Having recognized that HIV/AIDS spread has an impact on the social and economic development and national security of the country, key Kyrgyzstan ministries and institutions take an active part in the implementation of the Government Program to Prevent HIV/AIDS, Sexually and Parenterally Transmitted Infections in Kyrgyz Republic for 2001-2005, and developed on its basis their sectoral HIV/AIDS/STI/Drug Use prevention programs. Such programs exist at the Ministry of Health, Ministry of Defense, Ministry of Education, Ministry of Internal Affairs, National Guard, Ministry of Labor and Social Protection, Ministry of Ecology and Emergency Situations, Internal Security Troops at the MIA, Border Service, Ministry of Transport and Communication, State Committee on Tourism, Sports and Youth Policy, Spiritual Directorate of Muslims of Kyrgyz Republic. Similar programs have been developed on the oblast (province) and district levels in all regions of the country. In 2005 the term of implementation of these Programs is expiring, that is why it is planned to organize monitoring and evaluation of their implementation, and a new five-year program for 2006-2010 will be developed on the basis of the obtained data.

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10 Statistical data of the Ministry of Justice of KR.
A new law № 149 “On HIV/AIDS in Kyrgyz Republic” was adopted on August 13, 2005. Amendments made to the Law had brought the national legislation much closer to international standards that guarantee protection to people, living with, and affected by HIV/AIDS from stigmatization and discrimination, and create additional conditions for the protection of their rights to a voluntary and confidential testing and to comprehensive treatment and social care.

In 2004 the Ministry of Labor and Social Protection of Kyrgyz Republic developed and approved the Guidelines on the Procedures of Social Protection for People, Living with HIV/AIDS and Members of Their Families, that guarantees welfare payments, provision of social services, pensions and social insurance to these people.

The country has established sustainable partnership relations between governmental, non-governmental and international organization. UNAIDS, UNDP, WHO, UNFPA, UNICEF, USAID/CDC, Fund Soros-Kyrgyzstan and others have been providing technical and financial support to the activities of government-based CMCC on HIV/AIDS/STI and drug use prevention; on harm reduction programs; on development and introduction of clinical protocols on antiretroviral therapy; on sentinel epidemiological surveillance (SES) programs; on programs of cooperation with uniformed services on HIV/AIDS prevention, monitoring and evaluation of AIDS programs; on protection of reproductive health; on family planning and prevention of vertical transmission; and on information and educational programs (IEP) for young people.

Since 2004 Kyrgyzstan has been receiving grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria. These funds are allocated to the strengthening of political and legal support to AIDS prevention programs; to the development of prevention programs to reduce vulnerability of youth, to decrease HIV infection spread in vulnerable groups (in particular, IDUs, SW, prisoners and MSM), to ensure donor blood and medical manipulations safety, and to provide health and social support to PLHA and people affected by HIV/AIDS.

Government provides funding to HIV/AIDS prevention programs through key ministries and institutions. According to 2004 data, USD 201,345 were allocated to AIDS service¹¹. These funds cover the staff salaries and HIV testing expenses. Funds to provide clinical care and treatment to people with HIV and AIDS, and on HIV/AIDS impact mitigation were not disbursed. USD 16,095 were allocated for the treatment of STI patients¹². Today it is not possible to track the expenses of other ministries and institutions on HIV/AIDS programs in the cash flow of their other expenses.

2. National Programs and Behavior

PREVENTION

1. None of IDU respondents could both correctly identify ways of preventing HIV and reject major misconceptions about HIV transmission (0/514*100%=0%)

As soon as the composite index is negative, we should review the indicators of respondents’ knowledge level separately:

Knowledge about actual transmission routes (297/514*100%=57.8%)
Knowledge of misconceptions about transmission routes (120/514*100%=23.3%)

2. 6.9% of MSM, who both correctly identify ways of preventing HIV and who reject major misconceptions about HIV transmission (7/101*100%=6.9%)

As in the previous case, let us review the respondents’ knowledge level indicators separately:

Knowledge about actual transmission routes (44/101*100%=43.6%)
Knowledge of misconceptions about transmission routes (46/101*100%=45.5%)

3. 1.1% of SW who both correctly identify ways of preventing HIV and who reject major misconceptions about HIV transmission (4/352*100%=1.1%)

As in the previous cases, let us review the respondents’ knowledge level indicators separately:

Knowledge about actual transmission routes (282/352*100%=80.1%)
Knowledge of misconceptions about transmission routes (32/352*100%=9.1%)

4. None of prisoners who both correctly identify ways of preventing HIV and who reject major misconceptions about HIV transmission (0/450*100%=0%)

As in the previous cases, let us review the respondents’ knowledge level indicators separately:

Knowledge about actual transmission routes (211/450*100%=46.9%)
Knowledge of misconceptions about transmission routes (201/450*100%=44.7%)

Analysis of respondents’ knowledge levels in the sentinel groups “injecting drug users”, “men who have sex with men”, “sex workers” and “prisoners” indicates that they have some idea about HIV transmission routes, but it is not systematized, most probably, due to the fact that the respondents are not permanent participants of prevention programs, or are not covered by them at all. More focus should be put to the information and educational activities on HIV/AIDS in all vulnerable groups. More targeted information and educational materials should be published, more people should be covered by them, etc.

5. 69.3% of IDUs are reached with prevention programs from among respondents (356/514*100%=69.3%)

Sociological survey in the sentinel group was performed with the use of CDC questionnaires that suggested that respondents should indicate whether they received at least one of six listed services: HIV/AIDS prevention IEM; disposable syringes at needle exchange outlets; disinfecting solutions; condoms; health care; or psychosocial counseling. Analysis of the questionnaires showed that the coverage of IDUs with prevention programs is rather high. Value of this indicator differs cardinally differs from the value of indicator of coverage of IDUs with HIV/AIDS prevention services, computed on the basis of the data provided by Kyrgyz Republic Drug Control Agency and Republican Narcological Center at the Ministry of Health of Kyrgyz Republic. The computation was made with the use of following formula: total 4,543 IDUs participate in the prevention programs, which is 8.4% of the total estimated number of IDUs (54,000 people)\(^\text{13}\) (4543/54 000*100%=8.4%). This indicator (8.4%) can be considered more reliable because it reflects the real picture of coverage of IDUs with prevention programs. Compared to the indicator of coverage of IDUs with prevention programs in 2002, when it amounted to 3.8% (2050/54000*100%=3.8%), a 2.2 increase dynamics is observed, which is an evidence of successful introduction of prevention programs for IDUs during 2002-2004 period.

It should be noted that programs aimed at reduction of HIV/AIDS spread among IDUs have been implemented only in big cities and cover a limited number of drug users in need of prevention interventions. Ten non-governmental organizations perform these interventions that include information and educational campaigns, syringe exchange, legal protection, free distribution of condoms, outreach work, rehabilitation activities, etc. Currently 15 syringe exchange outlets are

\(^{13}\) Statistical data of the Republican Narcological Center at MoH of KR for 2004.

\(^{14}\) Survey was performed by the KR Drug Control Agency in cooperation with national experts of SDCC, RNC and CBO Socium among IDUs in Bishkek in 2002.
functioning in the country, and 9 of them were opened during 2004 alone. They receive funding and technical support from GFATM. To methadone substitution therapy programs are operating in Bishkek and Osh cities. The programs cover 272 participants. The country has 5 rehabilitation programs for individuals with alcohol and drug dependence; these programs function at the narcological clinics and NGO that provide services to IDUs. Since 2004 STI related services to IDUs are provided by one vulnerable-groups-friendly clinic in Bishkek.

75.3% of SW are reached with prevention programs from among respondents (265/352*100%=75.3%)

Today 10 non-governmental organizations located in big cities of the country implement various interventions, which include outreach work, information and educational campaigns, free distribution and social marketing of condoms, pre- and post-testing counseling, advocacy, syringe exchange among drug injecting SW, STI related services, etc.

According to CDC-developed questionnaire, a respondent is supposed to indicate whether he/she received at least one of the listed services: HIV/AIDS prevention IEM; disposable syringes at needle exchange outlets; disinfecting solutions; condoms; STI related health care; or psychosocial counseling. Analysis of the questionnaires demonstrated that the share of SW, who received IEM was 57.1%, and this rather high indicator confirms the success of information campaign; 59.4% of respondents were receiving condoms. However, despite the existence of free condom distribution programs and the development of programs for social marketing of condoms (PSI) in Osh and Bishkek in 2003-2004, they did not manage to fully meet the estimated SW’s need in condoms.

STI related services to SW are provided by 3 friendly clinics/rooms (please, see more detailed description in Treatment and Care section). However, it should be noted that 1,412 SW (1412/3700*100%=38.2% of estimated number of SW in the country) turned for STI related services in 2004, of whom 727 turned for care for the first time and 685 were regular clients of the clinics. Syphilis was diagnosed in 24.6% of new-comers (179/727*100%= 24.6%), while this indicator among the regular clients was 10.1% (69/685*100%=10.1%).

A Six-Step counseling program recommended by UNAIDS was initiated only in Bishkek, and this may explain the low coverage of SW by psychosocial counseling that was 30.9%.

It should also be noted that by the beginning of the year all prevention programs for SW were not functioning due to the lack of funds, and they were restarted only after the receipt of GFATM grants.

6. 79.2% of MSM are reached with prevention programs from among respondents (80/101*100%=79.2%)

Intervention in this area is performed by only one non-governmental organization, which operations mostly include information and educational campaigns, condoms distribution, advocacy and human rights protection, as well as promotion of tolerant public attitude towards MSM.

The intervention activities are implemented only in three of seven country regions and in Bishkek city. SES involved only MSM representatives in Bishkek. As well as in other sentinel groups, the survey was based on CDC questionnaires. Percentage of MSM coverage with prevention programs is rather high, particularly, by some services: condoms distribution 68.3%; IEM coverage – 62.0%; psychosocial support – 29.8%.

TREATMENT AND CARE

Data were provided by RSD GFATM in 2005.
Data were received at the friendly clinic NGO “Nauchmedlait” in 2005.
8. 31.1% of representatives of highly vulnerably sentinel groups with STI turned to state-owned health care facilities and received appropriate diagnostics, treatment and counseling services (187/598*100%=31.1%)\textsuperscript{17}

14.1% of IDUs with STI symptoms who turned to health care facilities for STI diagnostics and treatment and received a full treatment in the last 12 months:
\begin{itemize}
  \item 11/78*100%= 14.1%
  \item under 25 years of age – 0;
  \item over 25 years – 11/78*100%=14.1%;
  \item men: 8/43*100%=18.6%
  \item women: 3/35*100%=8.5%
\end{itemize}

30.1%\textsuperscript{18} of SW with STI symptoms who turned to health care facilities for STI diagnostics and treatment and received a full treatment in the last 6 months:
\begin{itemize}
  \item 80/266*100%=30.1%
  \item under 25 years of age – 53/172*100%=30.8%
  \item over 25 years – 27/94*100%=27.8%
\end{itemize}

75% of MSM with STI symptoms who turned to health care facilities for STI diagnostics and treatment and received a full treatment in the last 12 months:
\begin{itemize}
  \item 6/8*100%=75%
  \item under 25 years of age - 5/7*100%=71.4%
  \item over 25 years - 1/1*100%= 100%
\end{itemize}

36.6% of pregnant women with STI symptoms who turned to health care facilities for STI diagnostics and treatment and received a full treatment in the last 6 months:
\begin{itemize}
  \item 90/246*100%=36.6%
  \item under 25 years of age – 40/142*100%=28.2%
  \item over 25 years – 50/104*100%=48.1%
\end{itemize}

Total in sentinel groups: 187/598*100%=31.1%

By 01.01.05 there were 2 STI clinics, 84 STI rooms at health care facilities\textsuperscript{19}, 11 private STI centers\textsuperscript{20}, 3 friendly clinics\textsuperscript{21}, that provide STI related services in the country. In 2004 total 2,049 people who turned to these facilities were diagnosed with syphilis (1,084 men and 965 women); 1,844 of them were appropriately diagnosed, treated and counselled, which amounted to 89.9% (1844/2049*100%=89.9%)\textsuperscript{22}.

Due to the restructuring of STI service the number of clinics was reduced, while the network of STI rooms at health care facilities was expanded, which, seemingly, made STI services more accessible for the population. However, staffing with STI doctors at the state owned health care facilities at the district level is insufficient. The number of STI rooms has grown in recent years, but they are mostly located in the capital and big oblast cities, while high cost of STI treatment is restricting for socially disadvantaged population groups. That is why in 2004 the number of friendly clinics was increased thanks to the opening of 2 new clinics in the Northern and Southern regions of the country. Now 3 friendly clinics are providing STI related services to vulnerable groups (IDUs, SW, MSM), their clients and socially unprotected populations. They perform their activities with the financial support of international organizations (since 2004 they receive funds from GFATM). A positive aspect here is that they now have an opportunity to provide free, confidential health

\textsuperscript{17} The computation of this indicator was reviewed and these data already include corrections.
\textsuperscript{18} The computation of this indicator was reviewed and these data already include corrections.
\textsuperscript{19} Statistical data from the Republican STI Clinic at MoH of KR for 2004.
\textsuperscript{20} Statistical data from the National Statistics Committee for 2004.
\textsuperscript{21} Statistical data from the friendly clinic NGO “Nauchmedlait” in 2004.
\textsuperscript{22} Statistical data from the Republican STI Clinic at MoH of KR for 2004.
services to the representatives of vulnerable groups. However, these clinics cannot cover the needs of all vulnerable groups, such as injecting drug users, prisoners, refugees and others; there is no system of confidential and friendly services for adolescents and socially unprotected groups of young people. Private STI rooms are affordable only for the solvent people and the opportunity to receive confidential treatment significantly increases the medical aid appealability of these rooms. So, in 2004 private STI rooms were attended by 749 patients with syphilis, and 399 of them turned there for the first time.

BEHAVIOR AT NATIONAL LEVEL

9. 80.9% of SW reporting condom use with the most recent client in the last 12 months; 
\[
(283/350*100\% = 80.9\%)
\]
under 25 years of age 197/231*100%=85.3% 
over 25 years 76/119*100%=63.9%

Despite the fact that percentage of condom use by SW with the last client is rather high, however, the analysis of SES questionnaires showed that 75.6% (266/352x100%=75.6%) of them had STI symptoms during last 6 months. At the same time, only 25.9% of SW turned for medical assistance with STI, while others tried to treat it themselves or did not take any measures at all, while 61.2% of SW indicated in the questionnaires that “regular medical examination and treatment of STI are one of the means to prevent HIV infection”. During the survey 55.5% of SW showed condoms that they had with them. They mentioned the following reasons why they had not used condoms: unwilling partner – 38.6%; do not think it necessary – 10.8% - and these are rather high values. Other reasons of non-use of condoms, possibly, include drug or alcohol intoxication during sexual contacts, because 5% of respondents had the experience of drug use, and in 69.1%23 of cases commercial sex is accompanied with the use of alcoholic beverages. Taking into account all the abovementioned, as well as high prevalence of antibodies to syphilis in the blood of respondents (22.0%), high percentage of condom use at sexual contacts in this sentinel group is rather dubious.

10. 68.3% of MSM reporting condom use with the most recent client in the last 6 months 
\[
(41/60*100\% = 68.3\%)
\]
Percentage of condom use in this sentinel group is rather high and this explains a low STI prevalence (8/101x100%=7.9%) within 6 months. 95% of respondents reported that sexual contact without condom is one of the possible routes of HIV transmission, while answering about the reasons of non-use of condom with an irregular sexual partner during the last sexual contact 12% of respondents said that they did not consider it necessary; 8% underscored that they did not like sex with condoms. Only 23.4% of MSM used lubricants at anal sexual contacts. The fact of frequent change of partners is of special concern: 70% of respondents had 2 and more partners, and 56% of MSM had non-regular sexual partners (at an average, 2.6 such partners a month). Taking into account the prevalence of VHC (1.0%) and syphilis (4.0%) among MSM, the risk of parenteral and sexual transmission of HIV in this environment is very real.

Share of MSM who turned for STI related services at health care facilities was 75% - it is the highest percentage of appealability with STI in all sentinel groups.

It should be taken into account that MSM were surveyed only in Bishkek (currently this group is hard to access), and in other regions the questioning can bring different data.

11. 16.1% of injecting drug users adopted behaviors that reduce transmission of HIV. 
\[
(62/386*100\% = 16.1\%)
\]
under 25 years of age  18/62*100%=29.0% 
over 25 years  44/324*100%=13.6%

23 SES (II) 2004  (Bishkek and Osh cities)
Men: 41/291*100% = 14.1%
under 25 years: 9/43*100% = 20.9%
over 25 years: 32/248*100% = 12.9%

Women: 21/95*100% = 22.1%
under 25 years: 9/19*100% = 47.4%
over 25 years: 12/76*100% = 15.8%

Summary indicator is rather low. It can be explained by the lack of systematized knowledge on HIV/AIDS problem (0%), due to which the respondents were not permanent participants of the prevention programs, or were not reached with them at all. It should be noted that all respondents were not ‘newcomers’ and had a significant record of drug use (5 years)24 with already established behavioral patterns conducive to the risk of HIV infection at injecting drug use.

Despite the fact that percentage of disposable syringes availability is rather high (72-87%), at the same time 42.3% of respondents drew the drug solution from shared vessels; 25.5% used the shared water to rinse syringes and needles; 18.8% - used drugs that were filled up in the syringe by somebody else; 15.9% - poured drug from one syringe to another; 11.5% - added blood to drug solution, etc. There is high percentage of use of shared injecting equipment at the last shot of drug (45.5%)25. So, the reservoir of HIV infection is sustained and there is a real threat of a rapid spread of HIV infection in this environment.

61.7% of IDUs practiced condom use with commercial sexual partner and 53.6% - with non-regular sexual partner at the last sexual contact. This indicator in this sentinel group is rather high, but syphilis prevalence (12.3%) among IDUs shows, as it was mentioned earlier, that heterosexual penetration of HIV infection from IDUs into general population poses a real threat.

While analyzing this summary indicator it should be noted that there is a number of reasons that determine a low coverage of this group by prevention programs. First of all, there is a lack of professionally trained staff capable of working with this population, and hence the opportunities to reach IDUs with prevention programs are limited due to the lack of staff. Secondly, an ‘increment’ of new drug users occurs quicker than these people get into the focus of activities of projects designed for IDUs. Thirdly, this target group, especially its ‘younger’ portion, is still hard to reach.

IV. MAJOR CHALLENGES AND ACTIONS NEEDED TO ACHIEVE GOALS AND OBJECTIVES

HIV/AIDS prevention activities are implemented in the country on the basis of Strategic Plan and Government Program to Prevent HIV/AIDS and Sexually Transmitted Infections in Kyrgyz Republic for 2001-2005, approved by the Government of Kyrgyz Republic. The program budget is USD 50 million, but at the current stage the Government of Kyrgyz Republic, even with the contributions of international organizations, can provide only small portion of the needed funds. Besides, these funds are allocated to support the existing facilities included in the program (premises, salaries to the staff), to ensure safety of medical manipulations with donor blood, and to perform epidemiological monitoring of HIV/AIDS/STI. No funds are planned for the publication of information and educational materials and organization of monitoring of the programs being implemented.

In 2004 activities of all coordination committees on HIV/AIDS at both national and oblast levels was often rather formal, the progress reports from the regional governments were mostly limited to the description of facts, while really existing problems have never been discussed at RMCC and, respectively, there were no attempts to find their solution. Heads of the regions have never planned to fund information and prevention programs on HIV/AIDS. There has never been a meeting of the Sector on Information, Education and Communications that is responsible for coordination of all information and educational work in the country. Teaching of the “Healthy Life Styles” course with the sections on HIV/AIDS/STI and safer sexual behavior was not renewed at the secondary schools of the country, - it was canceled in 2002 by the order of the Ministry of Education of KR. A rather tense situation in 2002-2004 around a teacher’s manual “Healthy Life

24 SES (II) 2004 (Bishkek and Osh cities)
25 SES (II) 2004 (Bishkek and Osh cities)
Styles”, around its authors and people who participated in its development and introduction at secondary schools, as well as a passive attitude of the Ministry of Health of KR, which did not take part in the development of National Core Indicators and system of monitoring and evaluation of national activities to implement AIDS response programs in KR, to a certain extent became the reason for a temporary refusal from a sociological questioning of youth aged 15-24 years.

It should be noted that private sector, non-governmental universities, independent mass media have been rather poorly mobilized to respond to HIV infection spread. Besides, the insufficient mass media awareness of the existing governmental policy on HIV/AIDS, of its goals, objectives and implementation, is the result of a low media cooperation with the RMCC. Mass media works without a system and is often biased, the issues of competence and observance of ethics in the published materials are sometimes rather acute, and there is an inadequate access to information and training. Until now the issue of preferential terms for the information placement (PSA, video spots on HIV/AIDS on TV and radio channels) has not been solved; there is no government funding of social programs.

Reliability of information published in the media and observance of ethical norms in its presentation have a primary importance for the development of public opinion. It is confirmed by a real life example of clamor around the teacher’s manual “Healthy Life Styles” when the newspaper editorial board used a deliberately distorted information, which contributed to the outburst of negative attitude of certain part of population towards the issues of youth sexual education, sexuality and safer sex that were covered in several sections of this manual. As a result, the issues of HIV/AIDS/STI, drug use and safer sex were removed from the secondary school curriculum, which in its turn virtually undermined the implementation of the Government Program to Prevent HIV/AIDS and Sexually and Parenterally Transmitted Infections in one of the priority areas, i.e., ‘reduction of vulnerability of young people’.

Legislation of Kyrgyz Republic on HIV/AIDS generally meets the requirements of international law, or is being changed to establish such conformity. However, by-laws and real legal practice are often in contradiction with the basic principles of prevention programs. There is no system of accessible legal support to vulnerable groups.

Treatment of sexually transmitted infections in vulnerable groups is not sufficient. Programs to reduce vulnerability of sex workers are implemented only in two cities of the country and even they are not provided with the needed supply of condoms.

Due to the poor funding of prevention programs, the interventions implemented in the country do not achieve the ultimate goal to limit further spread of HIV infection in the country. For instance, prevention programs for IDUs manage to reach only 8.4% of the estimated number of injecting drug users, which is not sufficient to ensure an efficient prevention of HIV transmission among drug users.

In the first six months of 2004 all basic programs for sex workers in the country were not working due to the lack of funds for their development.

A prevention program for MSM is operating only in Bishkek, but already in the end of 2004 similar interventions were initiated in three other regions, including the south of the country.

Antiretroviral therapy is not available for people living with HIV/AIDS, who need it. Not everywhere people, including representatives of vulnerable groups, have access to anonymous, voluntary testing and psychosocial counseling. The situation is especially complicated at penitentiary facilities, where HIV and STI prevalence is generally higher than among general adult population of the country.

In order to achieve the goals set for 2010, i.e., to increase awareness of young people aged 15-24 years on the methods of prevention of sexual transmission of HIV and of major misconceptions about HIV transmission; and to curb the HIV spread in this population group, the following activities should be implemented:

- To perform comparative studies of sexual behavior and injecting drug use in different age, social, ethnic and regional groups of young people with the use of qualitative methods;

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• To include programs for the development of healthy life styles in all curricula of secondary schools, colleges and higher educational institutions;
• To organize social marketing of condoms in different youth groups;
• To run advertising campaign in the media on HIV/AIDS/STI prevention targeted at general youth audience;
• To organize peer-education sessions on HIV/AIDS/STI and drug use prevention;
• To organize training and postgraduate training for teachers to teach the “healthy life styles” subject at all educational institutions of the country;
• To publish a textbook for schoolchildren on the development of healthy life styles;
• To publish and distribute targeted information and advertising materials specifically targeted at the most vulnerable youth groups characterized with high sexual activity and use of psychoactive substances;
• To create the network of trusted state physicians for the most vulnerable youth groups;
• To create specialized service structures for adolescents on the basis of state-owned clinics;
• To provide information support to service structures for adolescents.

In order to achieve the goals set for 2010 in the area of reduction of infection of children born to HIV infected mothers, the following steps should be undertaken:
• To organize functioning of information and educational programs on HIV/AIDS/STI prevention among women in fertile age in all regions;
• To cover at least 80% of pregnant women with psychosocial counseling, and, if necessary – an informed testing for HIV/AIDS/STI;
• To develop programs for pregnant women, who are not registered at ANC at the place of residence, in cooperation with non-governmental organizations representing the interests of individual communities;
• To establish system to support a timely identification and preventive treatment of women, living with HIV.

In order to develop the Country Report on the Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS in 2007 the data should be gathered in accordance with the following plan:

| Data Collection Plan |
|----------------------|---|---|---|
|                      | 2005 | 2006 | 2007 |
| Households survey    |     | x    |     |
| Health care facilities survey | x | x | x |
| Schools survey       | x    | x    |     |
| Workplace survey     |     |     | x    |
| Study of existing information | x |     |     |

SUPPORT REQUIRED FROM COUNTRY’S DEVELOPMENT PARTNERS

The following support from country’s development partners is needed to the country to achieve the established goals and objectives:
• To create monitoring and evaluation system that would meet UNAIDS guidelines;
• To train specialists in this area;
• To provide methodological support;
• To support training programs;
• To purchase computers;
• To develop behavioral and serological surveillance;
• To mobilize funds for the implementation of monitoring and evaluation.
VI. MONITORING AND EVALUATION ENVIRONMENT

3. Data of sentinel epidemiological surveillance (II) for 2004 (Bishkek and Osh cities).
CONSULTATION PROCESS/DEVELOPMENT OF THE NATIONAL REPORT ON MONITORING OF THE FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV/AIDS

1) Which institutions/structures were responsible for filling out the forms for different indicators?

   a) National Coordination Council or its equivalent  Yes
   b) National AIDS Programme  Yes

2) Contribution made by:

   Ministries of:
   - Education  No
   - Health  Yes
   - Labor and Social Security  Yes
   - Foreign Affairs  Yes
   - Others:  Yes
   - Defense  Yes
   - Internal Affairs  Yes
   - National Guards  Yes
   - Transport and Communication  Yes
   - State Committee on Tourism, Sports and Youth Policy  Yes
   - State Committee on Drug Control  Yes
   - State Committee on Religions  Yes
   - Spiritual Directorate of Muslims of Kyrgyzstan  Yes

   Civil society organizations  Yes
   People living with HIV/AIDS  Yes
   Private sector  No
   UN system  Yes
   Bilateral organizations  Yes
   International NGO  Yes
   Others

3) Was the Report discussed at a broad forum?  Yes

4) Does central organization keep the research results?  Yes

5) Are data available for open consultations?  Yes

Name and Position: L.V. Steinke, Chief Sanitary Physician of Kyrgyz Republic, Deputy Minister of Health

Date: 27.05.2005

Signature: ____________________________
Strategic Plan

1. Has your country developed a national multi-sectoral/action framework to combat HIV/AIDS? (Multisectoral strategies should include, but not be limited to, the health, education, labor and agriculture sectors.)


The Government Programs includes the following activity areas:
- To improve the national policy on HIV/AIDS/STI;
- To ensure safety of medical manipulations;
- To reduce vulnerability of youth;
- To reduce vulnerability of injecting drug users;
- To reduce vulnerability of commercial sex workers;
- To develop information and educational programs on HIV prevention;
- To ensure health care provision to patients with STI;
- To prevent intrauterine mother-to-child transmission of HIV;
- To provide health and social support to HIV infected people, AIDS patients and members of their families.

Multisectoral approach to HIV/AIDS problems is ensured through the involvement of government sectors, civil society and private organizations in the implementation of the above strategies.

2. Has your country integrated HIV/AIDS into its general development plans (such as its National Development Plans, United Nations Development Assistance Framework, Poverty Reduction Strategy Papers and Common Country Assessments)?

Issues of HIV/AIDS prevention and response are included in the program Comprehensive Development Basis, in particular, in the national strategy component on poverty reduction; included in the national human development reports and in the government program for the realization of Kyrgyzstan children’s rights “New Generation”, and in national youth development program “Zhashtyk”, and in others.

3. Does your country have a functional national multisectoral HIV and AIDS management/coordination body? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Since 1997 the Republican Multisectoral Coordination Committee on HIV/AIDS/STI and Drug Use (RMCC) was operating at the Government of Kyrgyz Republic. In 2005 a new coordination body and Country Multisectoral Coordination Committee were established; it included representatives of government structures, civil society and international organizations. The new body consists of six technical sectors:
- on national policy and legislation;
• on health care and social protection;
• on information, education and communications;
• on implementation of the Global Fund grants;
• on defense and law enforcement bodies;
• on monitoring and evaluation.

Each technical sector includes representatives of all stakeholders and is targeted to implement strategies defined by the Government Program for 2001-2005.

4. Does your country have a national HIV and AIDS body that promotes interaction between government, people living with HIV, the private sector and civil society for implementing HIV and AIDS strategies/programmes? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

In December 2004, the Sector for HIV/AIDS Coordination and Monitoring was created at the Department of Social and Cultural Development at the Administration of Prime-Minister of Kyrgyz Republic. This body, *inter alia*, shall coordinate interaction between the government structures, international organizations, civil society and private sector in HIV/AIDS epidemic response. The Sector for HIV/AIDS Coordination and Monitoring is a standing body that performs the functions of CMCC secretariat. The Sector functions and terms of reference are regulated by the provisions on Department of Social and Cultural Development at the Administration of Prime-Minister of Kyrgyz Republic. The Sector has quarterly and annual action plans.

5. Does your country have a national HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil society organizations? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Since 2002 the Association of AIDS-servicing NGO has been functioning in the country. In 2004 the NGOs involved in harm reduction program united in Harm Reduction Association “Partners’ Network”. Both associations have their statutes with the defined terms of reference, membership and staffing structure.

6. Has your country evaluated the impact of HIV and AIDS on its social and economic development for planning purposes?

No, it has not.

7. Does your country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services including armed forces and civil defense forces?

Strategy of the Kyrgyz Republic Government Program on Reduction of Vulnerability of Youth envisages implementation of prevention activities among active duty military servicemen, soldiers of the MIA system, National Guard and other uniformed services.

**Prevention**

1. Does your country have a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population?

The Government Program to Prevent HIV/AIDS/STI for 2001-2005 includes development of information and educational programs on HIV prevention as one of priority strategies. Activities of
this strategy are implemented within the technical sector of Republican Multisectoral Coordination Committee of Kyrgyz Republic on Information, Education and Communication. Assistance for the implementation of this strategy is provided by civil society and international organizations.

2. Does your country have a policy or strategy promoting reproductive and sexual health education for young people?

Education of young people on reproductive and sexual health issues is planned within the strategies of the Government Program to Reduce Vulnerability of Youth and to Develop Information and Educational Programs on HIV Prevention. Activities in this area are performed with an active participation of international organizations (UNDP, UNFPA and UNIFEM) and non-governmental organizations (Alliance for Reproductive Health, Kyrgyz Family Planning Alliance, Association of Family Doctors’ Groups).

3. Does your country have a policy or strategy to promote information, education and communication and other preventive health interventions for groups with high or increasing rates of HIV infection?

Reduction of vulnerability of injecting drug users, sex workers, men who have sex with men, prisoners and youth is a priority strategy of the Government Program. Work with the representatives of these groups, interventions to protect their health, and information and educational activities to prevent HIV/STI infection are implemented by the respective government bodies and civil society organizations in many regions of the country.

4. Does your country have a policy or strategy that promotes IEC and other health interventions for cross-border migrants?

The strategy to reduce vulnerability of youth includes migrants (both internal migrants and refugees) as one of subgroups for interventions. Such interventions are implemented by the office of United Nations High Commissioner for Refugees (UNHCR), International Organization on Migration and National Red Crescent Society of KR. Prevention work among migrants is also implemented by the Spiritual Directorate of Muslims of Kyrgyzstan (SDMK).

5. Does your country have a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities?

Activities to ensure access of vulnerable groups to preventative commodities are defined in the key strategies of the Government Program. In Kyrgyz Republic, they provide condoms and implement their social monitoring. Harm reduction programs for injecting drug users are also being introduced. These programs have syringe exchange outlets and implement substitution therapy (with methadone).

6. Does your country have a policy or strategy to reduce mother-to-child HIV transmission?

The Government Program has a separate item that defines the strategy to reduce mother-to-child HIV transmission. This strategy was being implemented within technical sectors on health care and education, information and communication at the Republican Multisectoral Coordination Committee.

**Human Rights**

1. Does your country have laws and regulations that protect against discrimination people living with HIV/AIDS?

2. Does your country have laws and regulations that protect against discrimination groups of people identified as being especially vulnerable to HIV/AIDS?

   No, it does not

3. Does your country have a policy to ensure equal access for men and women to prevention and care, with emphasis on vulnerable populations?

   Yes. Women and men in Kyrgyz Republic have equal opportunities to turn to state-owned health care facilities. Commercial clinics and health rooms are more affordable for men, because women are more economically dependent.

4. Does your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee?

   No, it does not

Care and Support

1. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups? (Comprehensive care includes, but is not limited to, VCT, psychosocial care, access to medicines, and home and community-based care.)

   No, it does not.

2. Does your country have a policy or strategy to ensure or improve access to HIV/AIDS-related medicines, with emphasis on vulnerable groups? (HIV/AIDS-related medicines include antiretrovirals and drugs for the prevention and treatment of opportunistic infections and palliative care.)

   No, it does not

3. Does your country have a policy or strategy to address the additional needs of orphans and other vulnerable children?

   No, it does not
1. **Government funding for HIV/AIDS**

*Amount of national funds disbursed by governments in low- and middle-income countries*

According to 2004 data, USD 217,440 were disbursed to AIDS service. These funds were allocated to reimburse personnel and HIV tests. Funds for HIV/AIDS related clinical care and treatment and for mitigation of HIV/AIDS impact were not allocated. USD 16,095 were allocated to treat STI. These data have been obtained from the Republican AIDS Association at the MoH of KR and from Republican STI Clinic at MoH of KR for 2004.

**GOVERNMENT HIV/AIDS POLICIES**

*National Composite Policy Index*

**A. Strategic Plan**

1. Country has developed national multi-sectoral strategies to combat HIV/AIDS – 1;
2. Country has integrated HIV/AIDS into its general development plans – 1;
3. Country has a national multisectoral HIV and AIDS management/coordination body – 1;
4. Country has a national HIV and AIDS body that promotes interaction between government, people living with HIV, the private sector and civil society – 1;
5. Country has a national and active HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil society organizations – 1;
6. Country has evaluated the social and economic impact of HIV and AIDS for planning purposes – 0;
7. Country has a strategic framework for addressing HIV and AIDS issues among its national uniformed services (including military and civil defense forces) – 1.
**B. Prevention**

1. Country has a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS – 1;
2. Country has a policy or strategy promoting HIV and AIDS-related reproductive and sexual health education for young people – 1;
3. Country has a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk populations – 1;
4. Country has a policy or strategy to promote information, education and communication and other preventive health interventions for cross-border migrants – 1;
5. Country has a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities – 1;
6. Country has a policy or strategy to prevent mother-to-child transmission of HIV – 1.

**C. Human Rights**

1. Country has laws and regulations that protect people living with HIV and AIDS against discrimination – 1;
2. Country has non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination – 0;
3. Country has a policy to ensure equal access, between men and women, to prevention and care with a special focus to vulnerable groups – 1;
4. Country has a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee – 0.

**D. Care and Support**

1. Country has a policy or strategy to promote comprehensive HIV and AIDS care and support, especially for vulnerable groups – 0;
2. Country has a policy or strategy to ensure or expand the access to medicines for HIV and AIDS treatment, especially for vulnerable groups – 0;
3. Country has a policy or strategy to address the additional needs of orphans and other vulnerable children – 0.

**Calculation of the Composite Index:**

\[
A = \frac{6}{7} = 0.9; \quad B = \frac{6}{6} = 1.0; \quad C = \frac{2}{4} = 0.5; \quad D = 0.
\]

Total Composite Index = \( \frac{A+B+C+D}{4} = \frac{2.4}{4} = 0.6. \)
Current Monitoring and Evaluation system in Kyrgyz Republic includes:

- Organization of HIV surveillance and behavioral studies:
  - sentinel epidemiological surveillance;
  - routine statistics;
  - various surveys performed from time to time;
- Reporting system – a centripetal information flow, starting from data collection, and feedback.
- Data analysis is performed by the Department of Epidemiology and AIDS Prevention on the basis of an established statistical format (Form 4).
- Application of M&E data for the development of IEC materials and information and educational programs.

In order to obtain reliable statistical data that would meet the requirements of the UNAIDS Monitoring the Declaration of Commitment on HIV/AIDS Guidelines on Construction of Core Indicators, the Kyrgyz Republic should establish the following:

- General structure of HIV/AIDS related monitoring and evaluation;
- General management action framework for monitoring and evaluation;
- General database;
- Tools to collect data and systems for monitoring and evaluation;
- A detailed work plan for monitoring and evaluation;
- Attract additional funds;
- Train specialists in monitoring and evaluation.