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ANNEX 4: ENVIRONMENT AND SOCIAL SYSTEMS ASSESSMENT (ESSA) – ADDENDUM

Additional Financing (P178856) to Primary Health Care Quality Improvement (PHCQIP) Program for Results (PforR) (or Program) (P167598).

I. Introduction

1. The World Bank is partially supporting the program of the Kyrgyz Government on Public Health Protection and Health Care System Development for 2019-2030 "Healthy Person – Prosperous Country" (State Program of Health Development 2030 (SPHD2030)) through the Improving Primary Health Quality Program-for-Results, PforR, or the Program, which has been effective since June 2020. The PforR aims to support the first five years of the implementation of SPHD 2030 in area #2 related to the 'Development of Primary Health Care' (PHC). Some cross-cutting areas of SPHD 2030 also form part of this PforR, to the extent that they relate directly to PHC improvement. The Program promotes establishing and strengthening PHC quality-of-care monitoring, purchasing, and governance systems to build and strengthen the foundations for a stainable system-wide quality improvement. The PforR promotes the quality improvements of PHC by supporting results in three key areas: Results Area 1 – integrate sustainable quality improvement mechanism into service delivery, Results Area 2 – strengthening strategic purchasing for quality care, and Result Area 3 – Strengthening Health Sector Stewardship and governance for quality improvement.

2. The PforR has been rated as moderately unsatisfactory (MU) since February 2021 due to substantial delays in implementation. The core reasons for the delays are the changes in the implementing Ministry structure in 2020 and 2021 (merging and then unmerging the Ministry of Health (MoH) with the Ministry of Social Development), significant management and staff turnover at the MoH and MHIF since the start of implementation, an unfavorable procurement environment, limited capacity to design and implement complex policy changes, and the COVID-19 pandemic.

3. This is the first restructuring of the Program to align the Program's (Disbursement Linked Indicators) DLIs and (Disbursement Linked Results) DLRs with the current state of implementation and to remove bottlenecks to implementation. This is to be achieved by retaining the nine original DLIs but modifying and including new DLRs and providing more flexibility in the timeframe for their achievement. An Investment Project Financing (IPF) Component has also been added to the Program through which the additional co-financing available for the Program will be channeled to finance technical assistance and goods critical to improving Program results. The IPF Component is outside the purview of this systems assessment.

4. The World Bank team had prepared an ESSA according to the requirements of the World Bank's Policy for PforR financing in April 2019 before the initiation of the operation[1]. The parent ESSA reviewed the capacity and adequacy of existing country systems to plan and implement effective measures to manage environmental and social risks under the PforR and determined necessary additional measures to strengthen the country system. These recommended actions that addressed the identified gaps were fully integrated into the Program Action Plan (PAP) of PHCQIP.

[1] https://documents1.worldbank.org/curated/en/284691557236998151/pdf/Final-Environmental-and-Social-Systems-Assessment-ESSA-Primary-Health-Care-Quality-Improvement-Program-P167598.pdf

5. To ensure that E&S risks continue to be avoided, reduced or mitigated adequately through the country systems, the World Bank team has prepared this ESSA Addendum to cover potential additional E&S aspects that may arise from the PforR additional financing and recommend related mitigation actions. **This addendum does not constitute a new ESSA and should be considered together with the ESSA of the parent PforR on PHCQIP.**

A. Objectives of the ESSA addendum

6. The ESSA addendum aims to address the environmental and social risks specific to the proposed AF of the PHCQIP and has the following objectives:

- identify and scope potential legislative and procedural changes that may have taken place since the preparation of the ESSA for PHCQIP;
- identify any new potential environmental and social risks and impacts that may emerge from the restructured components, including the new DLRs added to the AF; and
- recommend any additional measures to further strengthen the environmental and social system, if not already covered under the ESSA program.

B. Methodology of the ESSA addendum

7. The preparation of the addendum involved a desk review, institutional analysis, interviews, and consultations with stakeholders related to the health sector and environmental protection, namely, personnel from various departments of the Ministry of Health (MoH) and Mandatory Health Insurance Fund (MHIF), Republican Endocrinology Center as well as Patient Associations like the Kyrgyz Family Planning Alliance and the Chui Diabetes Community:

- Desk Review of policies, legal framework, and program documents: The review examined the set of national policy and legal requirements and concerned institutions related to environment and social management in the health sector that were adopted/amended after the PforR was approved in April 2019. The review also included World Bank implementation supervision reports, Aide Memoire from the parent PforR, parent ESSA, Mid-Term Review report, Program Restructuring Paper, and the Kyrgyz Republic Emergency COVID-19 Project (173766) currently under implementation.
- Institutional Analysis: An institutional analysis was carried out to revisit the roles, responsibilities, and structure of the relevant institutions responsible for implementing the PforR activities, including coordination between different entities at the national, regional, and local levels. Sources included recently adopted regulations and reports, and news on the medical waste management system's capacity and performance due to COVID-19 emergency.
- Questionnaires: Checklists of questions seeking information and data related to system functionality and efficiency were also shared with MoH, MHIF, and patient association representatives.
- Consultations: Consultations with representatives from the concerned stakeholders were carried out during the preparation of the Addendum. The draft addendum was then translated into Russian to conduct meaningful discussions with key stakeholders, complying with the Bank’s information access and disclosure policy.

II. Context

8. The PforR plays a vital role in the overall health reform agenda of the Government. The Program is the only PHC sector-wide support currently available and takes a comprehensive approach towards improving the quality of PHC. Through the DLI approach, the Program has fostered collaboration between different units of the MoH, MHIF, training, and research institutions and, most notably, between the e-health and health service delivery initiatives. Since December 2021, progress has been made in the Program's DLI areas. Key technical staff and consultants have been hired, technical working groups have been formed, and activities are ongoing. Donor-funded TA is helping the Government implement critical activities. The Implementation Plan has been updated to include activities originally envisaged for Years 2 and 3 of implementation. Although the Program is showing some progress in each of the 9 DLI areas, it is currently not on track to achieve many DLR within the Program's timeline. restructuring will align the DLIs with a realistic timeline to better ensure their realization. At the same time, additional financing will provide resources for the MoH to procure the necessary TA and goods to improve Program results. The PforR has been rated Moderately Unsatisfactory (MU) since February 2021. However, given the current rate of progress, and the completion of the verification of 2021 results and audits, the ratings of implementation progress towards the achievement of the PDO will be upgraded from MU to Moderately Satisfactory (MS).

9. The Program's environmental and social (E&S) arrangements have helped the MoH develop key legislation and implementation arrangements for the Government's program. For example, the Government issued the Decree No. 719 dated of 2019 "On issues of handling medical waste and work with mercury-containing products in healthcare organizations of the Kyrgyz Republic" including Procedure on Medical Waste Management and Procedure on Working and Handling Mercury-containing Devices. The Decree also requires healthcare staff to undergo mandatory training and instruction on the rules for the safe handling of medical waste. Since the Decree approval, training was provided regularly to health organizations.

10. The Program's E&S systems have been rated MU since January 2022 due to the lack of documentation on the implementation progress of the Program's environmental and social action plan. However, the review carried out during the Mid-Term Review (MTR) revealed significant progress on the Program Action Plan (PAP) actions. Given this progress, the ratings was upgraded in December 2022 to Moderately Satisfactory (MS).

III. Description of the Additional Financing

11. The PforR PDO to contribute to improving the quality of primary health care services in the Kyrgyz Republic and PDO indicators remain largely unchanged in their focus:

a. PDO level indicators:

PDO 1: Number of pregnant women who received a hemoglobin test and urine analysis for bacteriuria during the first trimester in a public PHC facility or SESS lab.
PDO 2: Number of patients with suspected or confirmed diabetes (type I or II) who receive an HbA1c test in a public PHC facility.
PDO 3: Increase in drug coverage for priority conditions under the Additional Drug Program, as measured by the number of prescriptions reimbursed for:

(a) Test strips
(b) Iron supplement
(c) Hypertension drugs; and

PDO 4: A unit fully designated to quality improvement is established within the Ministry of Health and

functioning.

12. The PHCQIP will be split into two components. Component 1 will take over the DLIs and result areas/activities that currently constitute the PHCQIP. A new IPF component will be added to accommodate two subcomponents that will contribute to the PDO while complementing and supporting Component 1 through goods, non-consulting services, and TA.

b. *Changes to the DLIs and DLRs under Component 1: The PforR Component:*

13. The restructuring maintains the existing nine DLIs and assigns them to Component 1. The AF would support the achievement of the DLIs by providing the necessary TA and goods, hence improving the ability of the Program to improve its performance. The proposed changes to the DLIs and DLRs are presented in the table below. New DLRs have been added to the current operation and are within the scope of this ESSA addendum. Some results like DLR 2.2 and DLR 5.1 have already been achieved and have been excluded from the current assessment.

Disbursement Linked Indicators	New Disbursement Linked Results
DLI 1: A national e-platform for collecting and reporting quality of care indicators from PHC facilities is established and functioning	*(1.4) A module for collecting medical waste information is online, and at least 50 percent of health organizations (excluding FAP[2]) upload information thereon.*
DLI 2: A national in-service training e-platform is established and functioning	*(2.2) A revised regulation on accumulation and requirements of credit hours or points for physicians and nurses, including online learning and CPV[3], is approved.* *(2.5) At least 30 percent of public-sector PHC physicians and nurses have passed the online course on medical waste management.*
DLI 3: Number of pregnant women who received hemoglobin test and urine analysis for bacteriuria during the first trimester in a public PHC facility	*(3.5) 64,000 women above the highest previously verified and paid (in 2025)*
DLI 5: The SGBP[4] is revised to improve effective coverage for priority conditions at the primary care level	*(5.1) The SGBP is updated to include HbA1c tests for all diabetic patients and antihypertensive drugs for uninsured patients at the same level of benefits as the insured.* *(5.3) PHC services and out-patient drug packages in the SGBP are revised based on SGBP revision methodology.*
DLI 6: The provider payment mechanism for PHC is revised to improve quality and effective coverage for priority services	*(6.2) Procedure classification is integrated into online CIF (or e- health card)* *(6.3) Fully functional API for MHIF to use the online CIF data.* *(6.5) A revised provider capitation payment mechanism implemented* *(6.6) At least one pay-for-quality mechanism complements capitation payment for PHC*

[2] Feldsher-Midwife Point (FAP)
[3] Clinical Practice Vignettes (CPV)
[4] State-Guaranteed Benefits Package (SGBP)

DLI 7: The Additional Drug Package (ADP) for insured population is revised and its budget is increased to improve effective coverage for priority conditions at the primary care level	*(7.6) Regulation updating ADP basic pricing methodology is adopted.* *(7.7) Regulation on reimbursement of drugs under ADP is adopted* *(7.11) Regulation for prescription of drugs under the ADP is adopted.*
DLI 8: Price regulation mechanisms for the Additional Drug Package for insured population are developed and implemented	*(8.1) Permanent regulation on the pricing of medicines is adopted.* *(8.3) MoH collects information on price compliance for at least 10 percent of drug dispensing points* *(8.4) A public information campaign on medicine prices is conducted* *(8.5) MoH collects information on price compliance for at least 10 percent of drug dispensing points*
DLI 9: A unit fully designated to quality improvement (QI unit) is established within the MoH and functioning	*(9.4) Reports on the quality of care developed and distributed to key decision makers and PHC providers at least twice in CY 2025.* *(9.5) New DLR on quality-of-care strategy (flow sheets) to be determined*

c. ***Adding an IPF Component to the Program- Component 2:***

14. A new IPF component (Component 2) will be added to accommodate two subcomponents that will contribute to the PDO while complementing and supporting Component 1. Component 2.1 will finance goods and services to strengthen the diagnostic and clinical capacity of PHC and provide PHC organizations with basic diagnostic and clinical equipment and goods to improve the quality of care across a wide range of health services, including Maternal and Child Health (MCH) and Non-communicable Diseases (NCDs). Sub-component 2.1 support the achievement of the DLIs under component 1. Sub-component 2.2 will finance the consulting services and training necessary to develop systems and tools (such as IT system for MWM, training modules for the LMS, standards and procedures for MWM, health financing arrangements, etc.), the DLI2s in component 1 will support the implementation of these systems and tools. The IPF component will be implemented in line with the Environmental and Social Framework (ESF) policy and standards, for which the required instruments and documents were prepared separately. The IPF Component is outside the purview of this ESSA Addendum.

IV. Implementation Progress of the PAP

15. The assessment of the Program's PAP revealed that implementation of the action items was slow. The Program's Environmental and Social Systems have been rated Moderately Unsatisfactory (MU) since January 2022 due to the lack of documentation on the implementation progress of the Program's environmental actions. However, the review during the Mid-Term Review (MTR) revealed significant progress on the Program Action Plan (PAP) actions. Given this progress, the ratings were upgraded in December 2022 to Moderately Satisfactory (MS).

16. Operationalization of interventions that were expected to make health services more inclusive and accessible to economically vulnerable groups, like DLIs 5, 7 and 8 related to State-Guaranteed Benefits Package (SGBP) and Additional Drug Package (ADP), have been much delayed and patient grievances at the PHC level are also not getting adequately captured and addressed by the existing feedback mechanisms.

17. The Program has four recommended environmental actions to mitigate the environmental risks associated with the Program. These are (i) Update sector policies and standards to enable integrated infection and pollution control at the PHC level as well as processing, utilization, and final disposal of HCW generated by PHC organizations; (ii) Strengthen the information management framework for preventing infectious diseases and environmental pollution at PHC level, including indicators of infection prevention and control, health care waste management, and water quality; Develop systems for capacity building on infection prevention and control and health care waste management for PHC-level personnel. (iii) Developing and implementing training; and (iv) Implement selected healthcare waste management models in selected districts and PHC facilities, with adequate budget allocated and a committee designated to provide adequate oversight of the full HCWM cycle. The implementation status of the PAPs is summarized below.

18. The Program action item on updating sector policies and standards on HCW management has been completed. Related legislation developed included: i) Government Decree No. 719 of December 30, 2019 regarding medical waste processing5; ii) Order No. 61 of the Ministry of Health of the Kyrgyz Republic dated February 5, 2020, on the implementation of the Decree of the Government of the Kyrgyz Republic No. 719 of December 30, 2019; and iii) Order No. 1025 of the Ministry of Health dated 23 August 2022 on the integration of the immunization program into the medical waste management system, and the management of medical waste disposal in the vaccination rooms of healthcare organizations of the Kyrgyz Republic. The updating of some other legislations was also undertaken and included: i) procedure № 719 (12.30.2019) on the issues of medical waste management and handling of mercury-containing products in health care organizations of the Kyrgyz Republic, ii) amendments of government resolution № 32 (12.01.2012) on approval of the instructions on infection control in health facilities; and iii) government resolution № 85 (10.02.2012) on approval of the single register (list) of public services provided by executive authorities, their structural units and subordinated institutions.

19. The action item to strengthen the information management framework for preventing infectious diseases and environmental pollution at PHC level has been largely completed. However, while a system for collecting HCW data is in place, there are remaining challenges. Data on medical waste generation and processing are collected using a paper-based system, which is aggregated at the rayon, oblast, and national levels, in the form of national statistics. However, these statistics are not sufficiently granular and cannot be analyzed to improve medical waste management. As part of the Program restructuring, the development of an online module to streamline the collection of HCW data has been incorporated as a DLR in DLI 1.

20. Progress on the Program action item on developing systems for capacity building on infection prevention and control and health care waste management for PHC-level personnel has been made. Training on ICMWM is provided by both the Postgraduation education institute (PGI) and the Republican Center for Infection Control (RCIC). The PGI provides training as part of the 5-yearly training cycle for doctors, while the RCIC provides more in-depth training and monitoring through a simulation room. After the approval of Government Decree 719 of 2019, training and instruction on the rules for the safe handling of medical waste became mandatory and was provided to health organizations. As part of the Program restructuring, a new DLR aims to enhance the knowledge of healthcare workers on proper Health Care Waste Management (HCWM) by ensuring that at least 30 percent of public-sector PHC physicians and nurses have passed the online course on medical waste management.

[5] Decree of the Government of the Kyrgyz Republic dated December 30, 2019, No. 719 “On issues of handling medical waste and work with mercury-containing products in health care organizations of the Kyrgyz Republic

21. The action to pilot and implement health care waste management models in selected districts and PHC facilities is dropped as there is no longer a need to pilot different models of HCWM. The MoH has decided to procure medical waste shredders for a limited number of PHC facilities based on selected criteria. Analysis of the situation with medical waste showed that the bulk of medical waste is accumulated in oblast centers, and therefore there are plans to install purchased equipment for shredding and disposal of medical waste in these oblast centers. The action has been revised accordingly and included in the recommended PAP in the ESSA addendum.

V. Legislative and Procedural Changes

22. The E&S system described in the parent ESSA remains applicable for the whole Program including the AF in terms of laws, regulations, standards, and in terms of procedures spelt out for those laws and standards.

23. The adoption of Decree No. 719 dated December 30, 2019, No. 719 "On issues of handling medical waste and work with mercury-containing products in healthcare organizations of the Kyrgyz Republic" its procedure on medical waste management demonstrated some improvement in handling medical wastes in PHC facilities, particularly in Bishkek. Decree 719 is applicable to both public and private institutions and includes standard procedures for the overall management of medical waste in the health sector.

24. The MOH and PHC facilities have gained experience applying Decree 719 and the procedures, particularly during the COVID-19 pandemic. Some limitations associated with the application of Decree 719 for managing COVID-19 medical waste, among others, necessitated the amendment of related procedures. To overcome these limitations, the MoH issued Order on August 22, 2022, by which an interdepartmental working group was created to address issues and propose changes to the Decree. The proposed changes mostly concern requirements to automate medical waste handling at PHC, to add beauty salons to the list of medical institutions that must comply with the Decree No. 719, and to transport medical waste in accordance with the Rules for The Transportation of the Hazardous Goods by Road adopted the Decree of the Government of Kyrgyz Republic #198 adopted on April 11, 2012. Transportation of medical waste is carried out by private and municipal utility organizations and is guided by the Decree of the Government of the Kyrgyz Republic on the transportation of dangerous goods. However, it is unclear when and to what extent the proposed changes will be adopted.

25. The Ministry of Health of the Kyrgyz Republic Order № 1025 of 23.08.2022 established a working group to revise the Government of Kyrgyz Republic's Resolution № 85 of 10.02.2012 "On approval of the single register (list) of public services provided by executive authorities, their structural units and subordinated institutions". This revision aims to include the transportation of medical waste by the republic's healthcare organizations into the public services register.

26. The MoH Order No. 61 of February 5, 2020, provides detailed instructions on the requirements for collection of information on medical waste. The information is collected at the health facilities and then transferred to the rayon, oblast, and national levels (Center for epidemiological surveillance). The information is collected twice per year.

27. After the approval of Government Decree 719 of 2019, training was provided to health organizations. The Decree requires healthcare staff to undergo mandatory training and instruction on the rules for the safe handling of medical waste. The KSMIRCE's Department of Public Health annually holds professional development courses for medical workers on infection control and medical waste

management according to an approved program with further certification and assignment of qualification categories. After revising all infection control and medical waste management regulations, bylaws will be developed to improve systems for monitoring medical waste. Training materials and manuals on infection control and medical waste management will be updated, and training seminars will be held for PHC specialists on the new regulations.

28. In June 2021, a practical guide on "Water supply, sanitation and hygiene in health care organizations of the Kyrgyz Republic within the framework of infection control" was issued by the MoH.

29. A few other health-related laws and decrees were adopted in 2020 that related to the import of medicines into the republic in the cases of pandemic emergency situations. These laws include the Law dated August 25, 2020, No. 144 "On Amendments to Certain Legislative Acts of the Kyrgyz Republic (to the Laws of the Kyrgyz Republic "On International Emergency Assistance", "On the Circulation of Medicines", "On the Circulation of Medical Devices")". However, in addition, the law related to "Legal aid Guaranteed by the State", passed in June 2022, provides for protection of rights, freedoms and interests of people through access to justice and protection of fundamental human rights. It is inclusive and also extends legal aid to foreign citizens, stateless persons and refugees and could be used as a legal recourse for any negligence or discrimination in delivery of public health services.

30. Overall, the legal and policy architecture available in the country is found to be adequate to handle the Environment and Social risks that may arise due to Program implementation.

VI. Institutional Assessment

31. The stakeholder institutions identified for PHCQIP remain relevant for the additional finance and have already been assessed by the parent ESSA. The merger of Ministry of Social Development with the Ministry of Health in 2020 has been rolled back in 2021 and hence does not need to be assessed for system adequacy. No new stakeholders are expected to participate in the operation, although the role of some like - a) the patient associations and b) private medical waste disposal service providers- may get enhanced given the greater emphasis on SGBP-ADP revision and bio-medical waste information and management. The patient associations and health officials were consulted on the scope of the AF as part of the preparation of the ESSA addendum.

32. **Ministry of Natural Resources, Ecology and Technical Supervision (MNRETS)**. The MNRETS and MoH coordinate efforts on implementing and enforcing the Law of KR on "Production and Consumption waste", which covers infections and hazardous waste, and the Decree of the Government of the country No. 719 "On the issues of handling medical waste and mercury-containing products in healthcare organizations of the Kyrgyz Republic". The State Service on Environmental and Technical Safety under the Ministry of Environment is in charge of enforcing implementation of all environmental protection legislation, including safe disposal of waste generated in healthcare organizations. However, the coordination by healthcare institutions and Ministry of Environment's local subordinates in monitoring MWs proper disposal at the dedicated sites needs strengthening.

33. **Patient Associations-** Consultations with members of two patient associations, the Kyrgyz Family Planning Alliance and the Chui Diabetes Community/ Childhood without diabetes revealed that the extent of awareness about diabetes, other priority conditions and pregnancy related health precautions among the community is moderate to low and varies significantly with location- urban, rural and remote. A

number of barriers to accessing services at the PHC level were identified - low level of monitoring of the quality of services at PHC level, shortage of medical specialists considering the large patients inflow, insufficient medication and equipment, low technical and patient handling skills/capacities of the staff at PHC level- all of which impact the quality of services. Although MoH and MHIF have taken steps to enhance public health awareness and about SGBP through its website, videos, information boards at PHC organizations, apart from leaflets and brochures, the awareness remains limited, in the absence of use of simple, concise messaging in the native language. Even within patient associations, awareness is found to be higher among office bearers than among ordinary members.[6]

VII. Additional Financing Environmental and Social Risks and Impacts

Environmental risks.

34. The environmental risks under the proposed additional financing remain 'Moderate' as rated in the original program since it supports similar activities. The risks, impacts, activities, and benefits of the parent Program outlined in the original ESSA are all still relevant to the Program AF and no additional risks are anticipated by the AF activities. The risks and impacts are mainly related to the primary healthcare waste management system to manage infectious and medical waste associated with the Program activities. This includes:

A. Risks of infection for medical and sanitary personnel when providing medical care to patients.
B. Risks of patient's infection at healthcare facilities with poor/inadequate infectious and epidemiological control (infection transmitted through air, water and/or the use of poorly sterilized medical instruments.
C. Risks of air, soil and water contamination due to inadequate management and handling of healthcare waste.
D. The risks of infectious and parasitic diseases in PHC facilities are associated with inadequate provision of clean drinking water and disinfectants, especially in rural areas;

35. The addition of two new DLRs and channeling the AF through the IPF Component will positively affect the primary healthcare facilities' medical waste management system. First, developing an e-system for recording, registering, reporting, and monitoring medical waste generated (under DLI1) will improve reliable data collection on the quantity and classes of all medical waste generated and help better allocate the resources to manage the waste. Second, enhancing capacity building and training of healthcare workers on proper Health Care Waste Management (HCWM) will also enhance the proper management of the generated medical waste and minimize the safety and health risks of the involved healthcare staff. Furthermore, the procurement of the IT and medical waste management equipment (waste shredders, vehicles for waste transportation) through the investment component will lead to more effective and safer medical waste management in the PHC facilities (reduce the bulk volume of waste and associated transportation and disposal costs, preventing reuse and eliminate associated human infection and disease spreading). It will also support the development of e-learning platforms (under DLI2), improving the skills and knowledge of concerned medical staff to handle and manage medical waste safely.

Social Risks.

A. Adverse community level impacts of unsafe transportation and disposal of bio-medical waste generated by organizations providing primary healthcare.

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[6] Stakeholder Consultations with representatives of MoH, MHIF and Republican Endocrinology Center; members of public associations- Kyrgyz Family Planning Alliance, Chui Diabetes Community/ Childhood without diabetes

B. Occupational health risks for functionaries providing PHC, due to lack of adequate awareness and training on safe handling of bio-medical waste.

C. Low levels of awareness among pregnant women, and patients with priority conditions from remote, rural areas about the tests and procedures required to be conducted.

D. Package of services under the revised SGBP may exclude tests or drugs that are most critical and relevant for uninsured patients and vulnerable groups including women and old age patients.

E. Poor last-mile implementation and low awareness about revised SGBP may exclude the most vulnerable (including internal migrants) from accessing state-sponsored benefits.

F. Package of preferential drugs identified for being part of ADP may exclude drugs and medicines that are required for patients from vulnerable and uninsured households.

G. In the absence of effective monitoring of compliance with drug pricing and low public awareness in remote and rural areas, the most vulnerable may not benefit from this price regulation.

H. Absence of effective systems to capture patient feedback and redress grievances at the PHC level.

Assessment of Borrower Systems Against the Core Principles

36. Based on the environment and social risk screening, the Core Principles found to be relevant to the operation are- Core Principle #1: Program E&S management systems are designed to promote E&S sustainability: Core Principle #3: Program E&S management systems are designed to protect public and worker safety: Core Principle #5:Program E&S systems give due consideration to cultural appropriateness of, and equitable access to, Program benefits, giving special attention to the rights of Indigenous Peoples and vulnerable groups. Core Princple#4 is not relevant as no private land acquisition or resettlement related adverse impacts are anticipated.

Core Principle 1- As analyzed in the parent ESSA, country systems and, sector specific laws and policies are adequate and in place to address the adverse E&S risks and impacts of program activities particularly those associated with the management of medical waste. KR also has recognized Civil Society Organizations (CSOs) representing patient interests who are engaged from time to time and who undertake policy advocacy. While the implementing agencies have a clear mandate related to the scope of the program, there are some gaps related to enforcing these legal provisions. For example, while there are systems in place to ensure that patient's rights are enforced and all complaints investigated and addressed, and also systems to ensure that quality services are provided by PHC institutions, patient awareness about their rights and the quality of PHC level services continue to be low.[7] The health sector has a robust grievance redressal mechanism (GRM) to address grievances related to negligence, denial, or discrimination in the delivery of health services, but its operation is the weakest for PHC. The sector-wide GRMs includes: a) a well-publicized telephone hotline and a call-center managed by MHIF to address complaints of patients and quality councils about unfair payments or discrimination based on patient's inability to pay, b) a MoH managed GRM where patients grievances are registered in Grievance Logs maintained at the health facility, Rayon, Oblast and the Ministry levels, c) grievances regarding violation of patient's rights raised with professional associations or the Commission established for the purpose, c) monitoring visits by officials from regional units to review quality of services and the status of grievance redress, and d) patient satisfaction surveys conducted by MHIF.[8] To further revamp this system in

[7] Program Paper on Proposed Restructuring for the PHCQIP- Additional Finance, 2023, World Bank

[8] Environment and Social Systems Assessment- PHCQIP.

February 2022 MoH initiated the "Electronic Document Management System" to help track individual complaints and requests of citizens and to respond to them.[9]

However, no PHC level grievance related data is available- the Mid-term Review and Restructuring Mission of September 2022 noted that 'no requests or grievances related to the Program were received during the reporting period'.[10] Given the scale of the PHCI network, the absence of a systematic feedback mechanism at the PHC level poses a challenge to assessing patient satisfaction and ensuring effective service delivery. [11]

Core Principle 3- KR has a National Strategy in place for handling bio-medical waste expected to emerge from PHC institutions (PHCI) and poses a risk for PHC-level staff and the general public. There are also key regulations pertaining to medical waste management in the country, e.g. MoH Order No. 214 2018, which details the entire medical waste management system: organization of waste management in units, decontamination of medical waste in autoclaves, and actions in emergency situations. Also, Decree No. 719 of 2019 and its procedures on the handling of medical waste.

The HCW generated at the PHCI is collected, segregated, deactivated/disinfected, and then transported to the disposal fields or collection points at the secondary hospital level. The PHCI uses plastic bags and containers to transport medical waste to secondary institutions. The hospitals collect, segregate, and disinfect/deactivate the HCWs of different origins, including those gathered from PHCI and private healthcare organizations. Out of a total of 500 healthcare institutions (HCI), 120 hospitals have autoclave systems (22 hospitals in Bishkek). In 2021, microwave treatment was introduced in some HCI in parallel with autoclaving. There are no incinerations in the country, and their use is banned. Hospitals either have their own sanitary fields, Beccari pits, etc., or transport disinfected waste to disposal sites or pyrolysis plants. Sanitary fields are about 5mx5m fenced areas within the territory of hospitals and are used to store medical waste temporarily. Beccari pits are secure cement pits that chemically decompose anatomical and placenta types of wastes. Every hospital has a 2 m x 6 m x 2 m deep pit divided into three compartments located on the territory of the hospital. These pits were built with support from the Swiss Cooperation. One privately owned pyrolysis plant operates near Bishkek with a capacity of 10 tons/day. This plant has five vehicles for collecting autoclaved waste from the hospitals. An additional pyrolysis plant in the southern region between Osh and Jalal-Abad cities is privately owned but not functioning. Both Bishkek and Osh pyrolysis plants have all necessary licenses and permits; however, Osh plant is not operational. Bishkek plant currently collects medical waste from state hospitals in Bishkek, as well as private hospitals in Bishkek and hospitals in the northern region of the country. This plant processes medical waste, plastic, rubber, and other types of solid waste in an environmentally sound manner as an alternative to dumpsites that are more harmful to the environment. There is a total of 406 dumpsites in the country, 299 of which are illegal. Health organizations use either legal dumpsites after disinfecting medical waste or transport the waste to a pyrolysis plant.

The Kyrgyz State Medical Institute of Retraining and Continuous Education (KSMIRCE), which is the nodal agency providing professional training to health specialists and nursing staff, has modules in place on measures related to occupational health and safety. However, there are knowledge and attitude related gaps that pose safety-related risks. The emphasis on mandatory online training of PHC level staff on handling and disposal of bio-medical waste under the AF is expected to help bridge this gap and ensure

[9] Mid- Term Review Report, PHCQIP, September 2022
[10] Aide-Memoire: Mid-term Review and Restructuring Mission, 26-30 September 2022
[11] Environment and Social Systems Assessment- PHCQIP.

safety for the functionaries and the community.

Core Principle 5- The country systems are aligned to ensure equitable access to program benefits for all, including those belonging to vulnerable groups, through Constitutional provisions and laws of the land on health protection and access to health services. Several government programs and benefit packages are in place that offer free or subsidized medical aid to citizens, including the SGBP, ADP, Single payer system for health sector, universal medical coverage for citizens, special provisions for automatic exemption of the most vulnerable citizens from making co-payments, and additional financial incentives for PHC institutions treating uninsured patients to prevent discrimination in services and ensure equity. While systems and provisions are in place, their operationalization and targeting of the vulnerable has been challenging. For example, to access SGBP benefits enrolment for the package is mandatory; but there is low public awareness about this requirement, including the eligibility and process for getting enrolled. Similarly, although as per policy patients from poor households are exempt from making co-payment, there are no clear SoPs for identification of the poor. Their eligibility is subjectively decided by a committee constituted at that health facility. In the absence of clarity about eligibility and benefits/ exemptions, the poor are unable to avail optimal benefits. This lack of clarity and low community level stakeholder participation in the design and selection of services and medicines under the SGBP and ADP also means that the off take of these benefits is lower than expected and exposes the vulnerable households to high levels of personal health expenditure. Similarly, although MHIF has a defined system to investigate complaints and a mandate to undertake periodic satisfaction surveys on a 5 percent sample of inpatients and PHC users[12], it is unclear how this information is used to improve quality.

VII. Recommendations to Strengthen the E&S System

37. The parent ESSA recommendations and recommended PAP remain relevant, although, some updates are needed. The recommended environmental actions update to strengthen the E&S systems for the Program and its AF are:

a. Develop an electronic module for collecting medical waste information; At least 50 percent of health organizations (excluding FAP) upload information thereon.

b. Develop e-module on medical waste management targeted to physicians, nurses, and other healthcare staff. The e-module should include a certification on attending and passing the module requirement.

c. Procure and install equipment for medical waste management and report on the medical waste managed semi-annually.

38. The institutional organization put in place to implement the original ESSA recommendations and those related to the AF is going to be maintained. The E&S focal point designated at the MOH under the parent program will continue to monitor the implementation of ESSA recommendations and proposed procedures and report periodically to the project implementing unit.

39. The current grievance redress mechanism (GRM) is aimed at higher health institutions and there is absence of a formal and systematic mechanism for accountable and timebound grievance redressal at

[12] Toward Universal Coverage in Health: The Case of State Guaranteed Benefit Package of Kyrgyz Republic. 2013. World Bank

the PHC level. A dedicated and systematic GRM that covers institutions offering PHC is important, considering that a large proportion of patients access basic health services at these facilities. This PHC level GRM will need to be simple and accessible, and parallel efforts will be required to ensure public awareness about a) its availability and benefits, and b) the modes by which stakeholders can access it. The GRM will need to have multiple offline and online modes of access so that it can be used by both urban as well as rural citizens. Periodic analysis of the number and nature of complaints will need to be undertaken and publicly disclosed by MoH. It will need to be used for course- correction, strengthening the quality of services and ensuring better targeting. MoH will also need to share this periodic analysis as part of its regular progress reporting with the World Bank.

40. Some additional social recommendations for strengthening the E&S systems for the operation include the following:

d. **Consultative process to finalize Benefit Packages-** In order to ensure that the package of drugs and benefits included in the SGBP and ADP are inclusive and relevant for patients belonging to the vulnerable groups, patient associations, patients with priority conditions and pregnant women, uninsured patients and members of vulnerable households should be consulted before finalizing the SGBP and ADP packages. Past experience of packages not being backed with adequate resource deployment or provisioning of medicines and services at the health facilities could be avoided by ensuring that enough resources and medicines/ tests that are included in the package are available at PHC institutions in all urban as well as rural locations.
e. **Clarity on Eligibility and Entitlements-** Standard protocols need to be developed to ensure that there is clarity about who among the poor are eligible for exemption from co-payments and the process to be adopted for establishing eligibility and availing benefits under the packages.
f. **Simplified and Extensive Public Awareness-** Most IEC and public awareness initiatives of the Ministry use complex, official language to raise general awareness about preventive health, priority conditions and access to PHC services. Considering the low levels of awareness among those living in remote and rural areas, simple, easy to understand messaging needs to be adopted and prepared in Kyrgyz language. In the past, Village Health Committees have been effectively used to raise public awareness about health issues and could be involved in raising awareness about priority conditions, early pregnancy related precautions/ measures and the benefits offered by the state under SBGP and ADP.

VIII. Environmental and Social Program Action Plan

Recommended Items for the Program Action Plan to Strengthen Environmental and Social Management Systems of the Program and its AF

No	Program Action Plan (Parent PforR)	Timing	New/ Revised Action (AF)	Timing	Completion Measurement	Responsibility
ENVIRONMENT						
1	Strengthen the information management framework for preventing infectious diseases and environmental pollution at PHC level, including indicators of infection prevention and control, health care waste management, and water quality.	No later than 12 months after the Program effectiveness	Develop an electronic module for collecting medical waste information; At least 50 percent of health organizations (excluding FAP) upload information thereon.	No later than 12 months after Program Effectiveness	A module for collecting medical waste information is online, and at least 50 percent of health organizations (excluding FAP) upload information there on. *(DLR 1.4 and related verification procedure)*	MoH
2	Develop systems for capacity building on infection prevention and control and healthcare waste management for PHC-level personnel.	No later than 6 months after Program effectiveness	Develop an e-module on medical waste management targeted to physicians, nurses, and other healthcare staff. The e-module should include a certification on attending and passing the module requirement.	No later than 12 months after Program Effectiveness	At least 30 percent of public-sector PHC physicians and nurses have passed the online course on medical waste management. (DLR 2.5 and related verification procedure)	MoH
3	Pilot and implement healthcare	Pilot is to start 6 months after	Procure and install equipment for medical waste management and	No later than 12 months	Number of tenders completed, equipment installed, and training on	MoH

No	Program Action Plan (Parent PforR)	Timing	New/ Revised Action (AF)	Timing	Completion Measurement	Responsibility
	waste management models in selected districts and PHC facilities, with adequate budget allocated, and a committee designated to provide adequate oversight of the full HCWM cycle.	Program effectiveness	report on the medical waste managed semi-annually.	after Program Effectiveness	the operation of the equipment are provided; Report on the MWM developed and distributed to key decision-makers and PHCs semi-annually.	
SOCIAL						
4	-	-	Strengthen the Grievance Redressal Mechanism to improve its effectiveness and accountability in receiving and addressing complaints at the PHC level in a timebound manner.	Within 6 months of effectiveness of AF	Half-yearly progress reporting to the World Bank on complaints received, redressed, and pending and analysis on the nature of grievances.	MoH
5	-	-	Strengthen the information management system to track the program's effectiveness in providing health services and access to benefits under SGBP / ADP package in an inclusive manner.	Within 12 months of effectiveness of AF	HMIS data providing details of the number of pregnant women, members of poor and vulnerable households availing PHC services and receiving benefits under SGBP/ ADP.	MoH

IX. DISCLOSURE

41. The ESSA of the parent PforR was consulted with representatives of civil society by disseminating the draft ESSA among key stakeholders on January 21, 2019, and on February 11, 2019, and by publishing it on the web-site of the Ministry of Health of the KR and by following with the public consultation organized in Bishkek.

42. Stakeholder consultations to inform the assessment for the AF were held on 2-3 March 2023 and their inputs are incorporated in this ESSA addendum. The draft addendum was translated into Russian and Kyrgyz language and shared with relevant stakeholders. It was also disclosed on the MoH website and the Bank's website for seeking feedback and its findings and recommendations were shared at a disclosure workshop organized at --- on 17th March 2023, where representatives of MoH, MHIF, CSOs and members of patient associations participated. The comments and suggestions received from the participants were incorporated in the Final ESSA Addendum and disclosed on the MoH and World Bank website on ---- .