ENVIRONMENT AND SOCIAL SYSTEMS ASSESSMENT (ESSA) – ADDENDUM

Additional Financing and Restructuring of the

Primary Health Care Quality Improvement Program (PHCQIP)

(P167598) (P178856)

April 2023

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A. Introduction

BACKGROUND

1. The World Bank is 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 Primary Health Care Quality Improvement Program (the Program), which has been effective since June 2020. The Program aims to support the first five years of implementation of the 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 Program 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 sustainable, system-wide quality improvement. The PforR promotes PHC quality improvements in three key areas: Results Area 1 – integrating 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 Program 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 (DLI) and Disbursement-Linked Results (DLR) with the current state of implementation and to remove bottlenecks to implementation. Although the nine original DLIs will be retained, DLRs will be modified to provide more flexibility in the timeframe for their achievement. Some new DLRs will be added. An Investment Project Financing (IPF) component will also be added to the Program to channel the available additional financing for technical assistance and goods critical to improving Program results. The IPF component is outside the purview of this systems assessment.

4. In April 2019, before the initiation of the operation, the World Bank team prepared an ESSA according to the World Bank's Policy for PforR financing requirements[1]. The parent ESSA reviewed the capacity and adequacy of existing country systems to plan and implement effective measures to manage environmental and social (E&S) risks under the Program and identified necessary additional measures to strengthen the country systems. The Program Action Plan (PAP) of the PHCQIP includes the recommended actions to address the identified gaps.

5. This ESSA Addendum covers any additional E&S aspects that may arise from the restructuring of the Program and recommends related mitigation actions. The overall objective of the exercise is to ensure that E&S risks continue to be avoided, reduced, or mitigated adequately through the country's systems. **This Addendum does not constitute a new ESSA and should be considered together with the ESSA of the parent PforR on 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.

OBJECTIVES OF THE ESSA ADDENDUM

6. The ESSA addendum aims to address the environmental and social risks specific to the proposed restructuring 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 Program restructuring, including the new DLRs added as part of the restructuring; and
- recommend any additional actions to further strengthen the environmental and social systems, if not already covered under the ESSA original PAPs.

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), the 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 national policy and legal requirements related to environment and social management in the health sector that were adopted/amended after the Program approval in June 2019. The review also included (i) World Bank implementation supervision reports, aide memoires, ESSA, and mid-term review for the parent Program, and (ii) select documents concerning the Kyrgyz Republic Emergency COVID-19 Project (173766), also 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 Program activities, including coordination between different entities at the national, regional, and local levels. Sources included recently adopted regulations, various reports, and news coverage on the medical waste management system's capacity and performance during the COVID-19 emergency.
- Questionnaires: The World Bank distributed a questionnaire on system functionality and efficiency with the MoH, MHIF, and patient association representatives.
- Consultations: The World Bank carried out consultations with representatives from stakeholders during the preparation of the Addendum. The draft addendum was then translated into Russian to conduct the National ESSA Disclosure Workshop with key stakeholders, complying with the World Bank's information access and disclosure policy.

B. Program Achievements

8. The Program plays a critical 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 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. The restructuring will align the DLIs with a realistic timeline to 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.

9. The Program's E&S arrangements have helped the MoH develop key legislation and implementation arrangements for the Government's program. For example, the Government approved Decree No. 719 of 30 December 2019 "On the issues of medical waste management and handling of mercury-containing products in health care organizations of the Kyrgyz Republic," the "Procedure for Handling Medical Waste," and the "Procedure for Work and Handling of Mercury-containing Products." In addition, the Decree requires healthcare staff to undergo mandatory training on the safe handling of medical waste. Since the Decree's approval, training has been provided regularly to health organizations.

10. The Program's E&S systems have been rated MU since January 2022 due to the need for more documentation on the implementation progress of the Program's environmental and social action plan. However, the Mid-Term Review (MTR) revealed significant progress on the PAP actions, and, therefore, the ratings were upgraded in December 2022 to Moderately Satisfactory (MS).

C. Description of the Restructuring and Additional Financing

11. The PDO is to contribute to improving the quality of primary health care services in the Kyrgyz Republic remains unchanged. At the same time, the PDO indicators will be updated to reflect difficulties in measuring the original indicators.

PDO INDICATORS

12. The PDO indicators are:

- **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 (i) test strips, (ii) iron supplements, and (iii) anti-hypertension drugs.
- **PDO 4**: A unit fully designated to quality improvement is established within the MoH and functioning.

13. The PHCQIP will be split into two components. Component 1 will take over the DLIs and result areas/activities that currently constitute the PHCQIP. In addition, a new IPF component (with two sub-components) will be added to strengthen the operation's contribution to the PDO while complementing and supporting Component 1 through goods, non-consulting services, and TA.

CHANGES TO THE DLIS AND DLRS UNDER COMPONENT 1: THE PFORR COMPONENT

14. The restructuring maintains the existing nine DLIs and assigns them to Component 1. The AF (under an investment project modality) would support the achievement of the DLIs by providing the TA and goods that cannot easily be procured through the results-based component, hence improving the ability of the Program to improve its performance. The proposed changes to the DLIs and DLRs are presented in Table 1 below. New DLRs have been added to the current operation and are within the scope of this ESSA addendum. Some results, such as DLR 2.2 and DLR 5.1, have already been achieved and are excluded from the current assessment.

Table 1: New Disbursement-Linked Results

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 healthcare 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 the accumulation and requirements of credit hours for physicians and nurses, including online learning and CPV[3], is approved.* *(2.5) 30 percent of public-sector PHC health workers complete the online course on healthcare waste management with credit hours.*
DLI 5: The SGBP[4] is revised to improve effective coverage for priority conditions at the primary care level	*(5.2) A revised SGBP is adopted to include HbA1c tests for all diabetic patients and bisoprolol for uninsured patients at the same level of benefits as the insured.* *(5.3) The PHC services under the SGBP are revised based on the adopted SGBP revision methodology.*
DLI 6: The provider payment mechanism for PHC is revised to improve quality and effective coverage for priority services	*(6.2) The PHC procedure classification is integrated with e-CIF and outpatient card.* *(6.3) The MHIF has full-fledged online (read) access to the data on medical services provided at PHC.* *(6.5) Contracts between the MHIF and PHC organizations are based on the revised capitation payment mechanism.*
DLI 7: The Additional Drug Package (ADP) for the insured population is revised, and its budget is increased to improve effective coverage for priority conditions at the primary care level	*(7.4) A regulation on the methodology for setting the internal reference pricing and drug reimbursement under the preferential drug packages (ADP and SGBP) is adopted.* *(7.10) A regulation on the rules for prescribing drugs under the preferential drug packages is adopted.*

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

DLI 8: Price regulation mechanisms medicines are developed and implemented	*(8.1) Government decree on permanent rules for regulating the pricing of medicines is adopted.* *(8.2) Regulation on the methodology for monitoring the implementation of the price regulation mechanism, including patient feedback mechanism, is adopted.* *(8.3) A public information campaign on medicine prices is conducted.* *(8.4) The module on price regulation in the National Medicines Database is developed and fully functional, including patient feedback function.* *(8.5) The implementation of price regulation is monitored in at least 10 percent of drug dispensing points during the year (based on 8.2).*
DLI 9: A unit fully designated to quality improvement (QI unit) is established within the MoH and functioning	*(9.3) Reports on the quality of care are developed and distributed to key decision makers and PHC providers at least twice in CY 2024.* *(9.4) Reports on the quality of care are developed and distributed to key decision makers and PHC providers at least twice in CY 2025.*

NEW COMPONENT 2: IPF COMPONENT TO THE PROGRAM- COMPONENT 2:

15. The new IPF component (Component 2) will accommodate two subcomponents that will contribute to the PDO while complementing 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 will complement 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, standards and procedures for medical waste management, Learning Management System (LMS) modules, 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, and the required instruments and documents are separate. Therefore, the IPF Component is outside the purview of this ESSA Addendum.

D. Implementation Progress of the PAP

16. 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.

17. 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).

18. 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.

19. 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 processing[5]; (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 August 23, 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. Additional updated legislation includes: (i) procedure No. 719 of December 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 No. 32 of January 12, 2012 on approval of the instructions on infection control in health facilities; and (iii) government resolution No. 85 of February 10, 2012 on approval of the single register (list) of public services provided by executive authorities, their structural units, and subordinated institutions.

20. The action item to **strengthen the information management framework for preventing infectious diseases and environmental pollution at the 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 at health organizations using a paper-based system and subsequently 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 into DLI 1.

21. Progress has been made 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. Training on ICMWM is provided by both the Kyrgyz State Medical Institute for Retraining and Continuous Education (KSMIRCE) and the Republican Center for Infection Control (RCIC). The KSMIRCE 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 on 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

[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

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.

22. The action **to pilot and implement healthcare 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. Accordingly, the dropped action was replaced by a new action on procuring medical waste shredders.

E. Legislative and Procedural Changes

23. The country E&S system as described in the parent ESSA remains applicable for the Operation (both existing Program and new Project), in terms of laws, regulations, standards, and procedures spelled out for those laws and standards.

24. 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" has resulted in some improvement in PHC facilities' medical waste management, particularly in Bishkek. The Decree applies to public and private institutions and includes standard procedures for managing medical waste in the health sector.

25. The MoH and PHC facilities have gained experience applying Decree 719 and its procedures, particularly during the COVID-19 pandemic. However, some limitations encountered during the application of this Decree for managing COVID-19 medical waste, among others, necessitated the amendment of the Decree related procedures. To overcome these limitations, the MoH issued Order on August 22, 2022, which created an interdepartmental working group to identify issues and propose changes to the Decree. The proposed changes include: automation of medical waste handling at PHC, adding beauty salons to the list of medical institutions that must comply with the Decree No. 719, and the transportation of medical waste in accordance with the Rules for The Transportation of Hazardous Goods by Road.[6] Transportation of medical waste is carried out by private and municipal utility organizations. It is guided by the Decree of the Government of the Kyrgyz Republic on transporting dangerous goods. However, it is still being determined when and to what extent the proposed changes will be adopted.

26. MoH Order No. 1025 of August 23, 2022, established a working group to revise Government Resolution № 85 of February 10, 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.

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

[6] Decree of the Government of Kyrgyz Republic No. 198 of April 11, 2012.

28. After the approval of Government Decree No. 719 of 2019, training was provided to health organizations. The Decree requires healthcare staff to undergo mandatory training on 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.

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

30. In 2020, a few other health-related laws and decrees were adopted related to the import of medicines in the cases of pandemic emergencies: (i) Law No. 144 of August 25, 2020, "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")" ; (ii) The Law of June 2022 on "Legal aid Guaranteed by the State" provides for the protection of rights, freedoms, and interests of people through access to justice and protection of fundamental human rights. The Law is inclusive and extends legal aid to foreign citizens, stateless persons, and refugees. It could also constitute a legal recourse for negligence or discrimination in the delivery of public health services.

31. 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.

F. Institutional and Stakeholder Assessment

32. The stakeholder institutions identified for the PHCQIP were assessed in the parent ESSA and remain relevant at the time of restructuring. The March 2021 merger of the MoH with the Ministry of Social Development in 2020 was rolled back in November of the same year and does not need to be assessed for system adequacy. No new stakeholders are expected to participate in the operation, although the role of some stakeholders may be enhanced, like: (i) the patient associations may have further stake due to the SGBP and ADP revisions (ii) private medical waste disposal service providers may have an important role and may be affected by changes in medical waste management and information requirements. The patient associations and health officials were consulted on the scope of the restructuring as part of the preparation of the ESSA addendum.

33. **Ministry of Natural Resources, Ecology and Technical Supervision (MNRETS)**. The MNRETS and MoH coordinate efforts on implementing and enforcing the Law 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 the implementation of all environmental protection legislation, including the safe disposal of waste generated in healthcare organizations. However, the coordination between the healthcare institutions and the Ministry of Environment's local subordinates needs strengthening to ensure adequate monitoring of healthcare waste disposal at the designated sites.

34. **Patient Associations.** Two patient associations, the *Kyrgyz Family Planning Alliance* and the *Chui Diabetes Community/ Childhood Without Diabetes* explained that community awareness about diabetes, pregnancy-related risks and precautions, and other priority conditions is moderate to low. In addition, this awareness varies significantly by location (urban, rural, and remote). The stakeholders identified various barriers to access and quality of services at the PHC level, including insufficient monitoring of the quality of services at the PHC level, shortage of medical specialists considering the number of patients, lack of medication and equipment, and inadequate staff technical and patient handling skills. Although the MoH and MHIF have taken steps to enhance public health awareness and knowledge about the SGBP through their website, videos, information boards at PHC organizations, and leaflets and brochures, community awareness remains limited. Simple, concise messaging in the native language in oftentimes missing. Even within patient associations, awareness is higher among office bearers than ordinary members.[7]

G. Additional Financing Environmental and Social Risks and Impacts

35. The overall Environmental and Social risk is Moderate due to a Moderate environmental risk and Low social risk.

ENVIRONMENTAL RISKS

36. 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 will be all still relevant after the Program is restructured, and no additional risks are anticipated after the restructuring. The risks and impacts include:

- Risks of infection or injury for medical and sanitary personnel when providing medical care to patients or handling medical waste.
- Risks of patient infection at healthcare facilities with inadequate infectious and epidemiological control (infections transmitted through air, water, or the use of poorly sterilized medical instruments).
- Risks of air, soil, and water contamination due to inadequate management and handling of healthcare waste.
- 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;

37. 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, the proposed 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, the proposed e-learning modules on medical waste (under DLI 2) are expected to facilitate capacity building and training of healthcare workers on proper Health Care Waste Management (HCWM), especially in remote areas. It is expected to improve the skills and knowledge of concerned medical staff to handle and manage medical waste safely, enhance the proper

[7] 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

management of the generated medical waste, and minimize the safety and health risks for the involved healthcare staff.

38. Furthermore, the procurement of the IT and medical waste management equipment (waste shredders, vehicles for waste transportation) through the Component 2 will lead to more effective and safer medical waste management in PHC facilities by reducing the bulk volume of waste and associated transportation and disposal costs and preventing reuse of waste.

SOCIAL RISKS

39. The Social risk is Low. The main social risks are:

- Adverse community-level impacts of unsafe transportation and disposal of medical waste generated by PHC organizations.
- Occupational health risks for staff providing PHC due to lack of adequate awareness and training on safe handling of medical waste.
- Risks of harm to patients due to inadequate medical staff skills, service breakdown, or deficient equipment or supplies.
- Low levels of awareness among pregnant women and patients with priority conditions from remote, rural areas about the recommended tests and procedures, their costs, and where to obtain them.
- The SGBP budget allocation may be insufficient to cover the recommended tests for uninsured patients and vulnerable groups, including pregnant women and elderly persons.
- The 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 elderly patients.
- Poor last-mile implementation and low awareness about the revised care protocols and coverage through the SGBP may exclude the most vulnerable population (including internal migrants) from accessing state-financed benefits.
- In the absence of effective compliance monitoring with drug pricing and low public awareness in remote and rural areas, the most vulnerable may not benefit from this price regulation.
- Absence of effective systems to capture patient feedback and redress grievances at the PHC level.

ASSESSMENT OF BORROWER SYSTEMS AGAINST THE CORE PRINCIPLES

40. 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.

41. **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. The Kyrgyz Republic also has recognized Civil Society Organizations (CSOs) representing patient interests who are engaged occasionally and undertake policy advocacy. While the implementing agencies have a clear mandate related to the program's scope, there are some gaps associated with enforcing these legal provisions. For example, while systems are in place to ensure patients' rights, investigate and address complaints, and provide quality services at PHC institutions, patient awareness about their rights and the quality of PHC services continue to be low.[8]

42. 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. 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.[9] To further revamp this system, in February 2022 MoH initiated the "Electronic Document Management System" to help track individual complaints and requests of citizens and to respond to them.[10]

43. Still, GRM operation is the weakest for PHC. 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'.[11] Given the scale of the PHC network, the absence of a systematic feedback mechanism at the PHC level poses a challenge to assessing patient satisfaction and ensuring effective service delivery.[12]

44. **Core Principle 3.** The Kyrgyz Republic has a National Strategy for handling medical waste produced by PHC organizations that could pose a risk for PHC staff and the general public. There are also critical regulations on medical waste management in the country, e.g., MoH Order No. 214 of 2018, which details the entire medical waste management system, including the organization of waste management in units, the decontamination of medical waste in autoclaves, and the actions to be undertaken in emergency situations. Also, Decree No. 719 of 2019 and its procedures on handling medical waste require mandatory training of PHC workers in this respect.

45. The HCW generated at the PHC organizations is collected, segregated, deactivated/disinfected, and then transported to the disposal fields or collection points at the secondary hospital level. The PHC organizations uses plastic bags and containers to transport medical waste to secondary institutions. The hospitals collect, segregate, and disinfect/deactivate the HCW of different origins, including those gathered from PHC organizations and private healthcare organizations. Out of a total of 500 healthcare organizations (HCI), 120 hospitals have autoclaving 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

[8] Program Paper on Proposed Restructuring for the PHCQIP- Additional Finance, 2023, World Bank
[9] Environment and Social Systems Assessment- PHCQIP.
[10] Mid- Term Review Report, PHCQIP, September 2022
[11] Aide-Memoire: Mid-term Review and Restructuring Mission, 26-30 September 2022
[12] Environment and Social Systems Assessment- PHCQIP.

transport disinfected waste to disposal sites or a pyrolysis plant. 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 waste (e.g., placenta). 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, the Osh plant is not operational. The 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 the pyrolysis plant.

46. The KSMIRCE is the main agency providing in-service training to health specialists and nursing staff and offers training modules on occupational health and safety. However, there are knowledge and attitude-related gaps that pose safety-related risks. The proposed addition of online training of PHC-level staff on handling and disposal of medical waste is expected to help bridge this gap and enhance safety for the staff and the community.

47. **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 benefits packages are in place that offer free or subsidized medical aid to citizens, including the SGBP, ADP, Single payer system for the 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.

48. **While systems and provisions are in place, their operationalization and targeting of the vulnerable have been challenging.** For example, to access SGBP benefits, enrolment with an FGP is required to benefit from the package; 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 the identification of the poor. Their eligibility is subjectively decided by a committee constituted at the health facility. In the absence of clarity about eligibility and benefits/ exemptions, the poor cannot avail of optimal benefits. This lack of clarity and low community-level stakeholder awareness and participation in the design and selection of services and medicines under the SGBP also means that the uptake of these benefits is lower than expected and exposes 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[13], it is unclear how this information is used to improve quality.

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

H. Recommendations to Strengthen the E&S System

49. 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 are:

- Develop an electronic module for collecting medical waste information; ensure that health organizations upload information thereon.
- Develop an e-learning module on medical waste management targeted to physicians, nurses, and other healthcare staff. The e-learning module should include an evaluation and certification.
- Procure and install equipment for medical waste management and report on the medical waste managed semi-annually.

50. The institutional organization put in place to implement the original ESSA recommendations will be maintained after the restructuring. 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.

51. The current grievance redress mechanisms (GRM) is aimed at higher-level health organizations (i.e., hospitals). At the PHC level, however, there is no formal and systematic mechanism for accountable and timebound grievance redressal. A dedicated and systematic GRM that covers institutions offering PHC is important, considering that many 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 its benefits and how stakeholders can access it. The GRM will need offline and online modalities that both urban and rural citizens can access. Periodic analysis of the number and nature of complaints will need to be undertaken and publicly disclosed by the 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.

52. Additional social recommendations for the operation are:

- **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 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.
- **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.
- **Simplified and Extensive Public Awareness.** Most communications and public awareness initiatives of the MoH 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 the Kyrgyz language. In the past, Village Health Committees have effectively raised public awareness about health issues. They 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.

I. Environmental and Social Program Action Plan

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

No	Program Action Plan (Parent PforR)	Timing	New/ Revised Action	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 Completed	Develop an electronic module for collecting medical waste information; At least 50 percent of health organizations (excluding FAP) upload information thereon.	December 2024	A module for collecting medical waste information is online, and at least 50 percent of health organizations (excluding FAP) upload information thereon. *(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 Completed	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.	December 2025	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

No	Program Action Plan (Parent PforR)	Timing	New/ Revised Action	Timing	Completion Measurement	Responsibility
3	Pilot and implement 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.	Pilot is to start at 6 months after Program Effectiveness Dropped	Procure and install equipment for medical waste management and report on the medical waste managed semi-annually.	No later than 12 months after Program Effectiveness	Number of tenders completed, equipment installed, and training on the operation of the equipment are provided; Report on the MWM developed and distributed to key decision-makers and PHCs semi-annually.	MoH
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 12 months of the effectiveness of restructuring /AF	Half-yearly progress reporting to the World Bank on complaints received, redressed, pending, and analysis on the nature of grievances.	MoH
5	-	-	Strengthen the information management system to track the program's effectiveness in	Within 12 months of effectiveness	HMIS data providing details of the number of pregnant women, members of poor and	MoH

No	Program Action Plan (Parent PforR)	Timing	New/ Revised Action	Timing	Completion Measurement	Responsibility
			providing health services and access to benefits under the SGBP package in an inclusive manner.	of the restructuring	vulnerable households availing PHC services and receiving benefits under SGBP.	

J. Disclosure

53. The parent ESSA was consulted upon with representatives of civil society as follows: (i) disseminating the draft ESSA among key stakeholders on January 21, 2019, and February 11, 2019; (ii) publication on the website of the MoH; and (iii) public consultation organized in Bishkek.

54. Stakeholder consultations to inform the ESSA addendum were held on March 2-3, 2023. Inputs from the stakeholders were incorporated into this ESSA addendum. The draft addendum was then translated into Russian and Kyrgyz and shared with relevant stakeholders. It was also disclosed on the MoH website (March 14, 2023) and the WB's website (March 15, 2023) with the intent of seeking feedback. The ESSA addendum findings and recommendations were shared at a disclosure workshop on March 17, 2023 by the World Bank team, attended by representatives of the MoH, MIHF, CSOs, MWM service providers, and members of patient associations (Annex 1). The comments and suggestions received from the participants have been incorporated in the ESSA Addendum's final version to be disclosed on the MoH and World Bank websites.

ANNEX 1. Minutes of the Public Consultations

Date: March 17, 2023

Venue: Bishkek, Ministry of Health of the KR, Conference-Hall

Objective: Present the content of ESSA Addendum and collect feedback (comments and suggestions) from the stakeholders on the main findings and the proposed Program Action Plans (PAPs).

Participants: Representatives of the World Bank, Ministry of Health, Mandatory Health Insurance Fund, State Agency for Environmental Protection and Forestry under the GoKR, Non-Government Organizations, private medical waste management processors (the list is enclosed).

Presentation and Discussions: Representative of the World Bank delivered a presentation on the draft ESSA Addendum. The presentation covered the proposed restructuring of the PHCQIP. The presenter informed that the objective of the ESSA Addendum was to ensure that E&S risks under PHCQIP additional financing continue to be avoided, reduced, or mitigated adequately through the country systems. Also, the participants were informed that this Addendum does not constitute a new ESSA. Still, it addresses any additional E&S aspects that may arise from the restructuring of the Program and recommends related mitigation actions.

The Bank representatives also briefly described the findings of the Environmental and Social Assessment, stating that – current environmental risks, as it pertains to the healthcare system are 1) risks of infection or injury for medical and sanitary personnel when providing medical care to patients or handling medical waste; 2) Risks of patient infection at healthcare facilities with inadequate infectious and epidemiological control (infections transmitted through air, water, or the use of poorly sterilized medical instruments); 3) Risks of air, soil and water contamination due to inadequate management and handling of healthcare waste; 4) 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. Low levels of awareness among pregnant women and patients with priority conditions from remote, rural areas about the recommended tests and procedures, their costs, and where to obtain them. In regards to social risks, these include 1) SGBP budget allocation may be insufficient to cover the recommended tests for uninsured patients and vulnerable groups, including pregnant women and elderly persons; 2) 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; 3) Poor last-mile implementation and low awareness about the revised care protocols and coverage through the SGBP may exclude the most vulnerable population (including internal migrants) from accessing state-financed benefits; 4) In the absence of effective compliance monitoring with drug pricing and low public awareness in remote and rural areas, the most vulnerable may not benefit from this price regulation; 5) Absence of effective systems to capture patient feedback and redress grievances at the PHC level.

The presenter highlighted that while the country has some rather good clinical practice guidelines/clinical protocols, the government needs to exercise better control over the implementation thereof.

The presenters shared the main recommendations to address major environmental and social issues. These are 1) Develop an electronic module for collecting medical waste information; 2) Develop an e-learning module on medical waste management targeted to physicians, nurses, and other healthcare staff; 3) Procure and install equipment for medical waste management; 4) Consultative process to finalize Benefit Packages, to ensure that the package of drugs and benefits included in the SGBP and ADP are

inclusive and relevant for patients; 5) Clarity on Eligibility and Entitlements of the patient who can benefit from the package and 6) Conduct simplified and extensive awareness among the general public.

The discussion following the presentation covered many aspects of the healthcare sector; cross-sectoral cooperation between private and healthcare sectors; public health; ecology, and the environment.

Ms. Eshkhodjaeva, Consultant, MOH KR, thanked the WB team for sharing the findings and the assessment recommendations. Ms. Eshkhodjaeva shared her concerns about current issues with medical waste management at the PHC level, especially in rural areas. She indicated that additional funding is required to organize a proper medical waste management and disposal system before introducing an electronic module for collecting medical waste information from PHC organizations. Responding to this concern, Mr. Tilek Buteshov informed that actions to address these concerns are considered under the parent PforR and the restructuring and aiming to support the MWM management capacity at the Primary Healthcare level.

Mr. Abilov B.A., PforR coordinator, MOH KR, suggested having a separate component in the Program that focuses on improving medical waste management at the Primary Healthcare level. This would include developing an electronic module for collecting information on generated medical waste and its handling and disposal.

Ms. Beyshebaeva Zinat, Head, Department of Public Health, Licensing of Medical and Pharmaceutical Services, MoH KR, noted that in coming development assistance in the healthcare sector of KR, it is recommended to combine all socio-environmental related activities into one comprehensive project, rather than having them dispersed under different projects funded by other donor organizations. Ms. Eshkhodjaeva, Consultant, MOH KR, agreed with the points made by Ms. Beyshebaeva and added that different DLIs of current PforR cover socio-environmental measures and to strengthen control on their implementation it would be good to combine them into one DLI.

Mr. Kant, tire processing plant, noted that in recent years municipal landfill sites resisting to accept medical wastes, even after disinfection. In this regard, his plant started receiving medical wastes from the territorial hospitals, as well as from primary health care centers (Zhany-Zher village municipality) for final destruction in the pyrolysis unit. Currently, his plant processes 2000-3000 tons annually and is ready to accept even more waste from other Chui oblast Healthcare organizations.

The discussion also touched on monitoring the general population's access, particularly in rural areas, to diabetes tests and medicines due to their low-level social status. More attention to these issues is needed.

Conclusion: Wrapping up the consulting meeting with the stakeholders, Mr. Abilov thanked the presenters for the informative presentation and the participants for their active discussions.

LIST OF PARTICIPANTS

Ministry of Health of the Kyrgyz Republic		
1	B. A. Abilov	Coordinator of PforR, Dept of Strategic Planning and Programs Implementation, Ministry of Health
2	Z. B. Beyshebaeva	Head of the Department for Public Health, Licensing of Medical and Pharmaceutical Services, MoH KR
3	Boobekova A.A.	Department of Organization of Medical Care and Drug Policy,

		Ministry of Health
4	Kanymetova A.K.	Republican Center for Infection Control (RCIC)
5	Eshkhodjaeva	Consultant, Ministry of Health
6	Dobrynina N.P.	Republican Endocrinology Center
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7	Ablesova Ch. S.	Chair of the Chui oblast association of diabetes patients
8	Dzholchieva G. A.	Member of the Chui oblast association of diabetes patients
MHIF		
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10	Duysheeva E.A.	
11	Salamatova G.D.	
Kant Tyres Processing Plant		
12	Egemberdiev D.D.	Director
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13	Lulwa Ali	Senior Environment Specialist
14	Harjot Kaur	Senior Social Specialist
15	Almaz Asipjanov	Environment Consultant
16	Amit Anand	Social Consultant