112986 REV

Ethiopia

Health Sustainable Development Goals (MDGs) Program for Results

Additional Financing

Environmental and Social System Assessment (ESSA) Update

ACRONYMS AND ABBREVIATIONS

CASH	Clean and Safe Health Facilities
CCC	Community Care Coalition
CPD	Continuing Professional Development
CSOs	Civil Society Organizations
EPE	Environmental Policy of Ethiopia
ESSA	Environmental and Social System Assessment
FMHACA	Food, Medicine and Healthcare Administration and Control Authority
HCWM	Health Center Waste Management
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immuno-Deficiency Virus
HRH	Health Resources for Health Strategy
HRIS	Human Resource Information System
HSTP	Health Sector Transformation Plan
IPPS	Infection Prevention and Patient Safety Committees
JCF	Joint Consultative Forum
MEFCC	Ministry of Environment, Forest and Climate Change
RHBs	Regional Health Bureaus

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I. BACKGROUND

1. The Ethiopia Health MDGs Program for Results (PforR) was the first Bank operation using the PforR instrument in Ethiopia's country program. The Program is financed through an IDA Credit (Cr. #5209) in the amount of SDR65.1 million (US$100 million equivalent) and Grant (TF#14107) in the amount of US$20 million from the Health Results Innovation Trust Fund (HRITF). The Program was approved on February 28, 2013 and became effective on June 17, 2013 with an original closing date of June 30, 2018. Technical Assistance support is provided through an additional Grant from HRITF (TF#14815) in the amount of US$400K that was approved and became effective on December 23, 2013, with an original closing date of June 30, 2015 which was extended to February 28, 2018.

2. The PDO is to improve the delivery and use of a comprehensive package of maternal and child health (MCH) services. The PDO is aligned with sector priorities of the Government's Health Sector Strategy under the HSTP 2015-2020 that was launched in October 2015 and continues to be supported under the Sustainable Development Goals Performance Fund (SDG PF), a pooled fund supported by 11 development partners[1]and managed by the Federal Ministry of Health (FMOH).

3. The PforR focuses on results from Maternal and Child Health (MCH) services and strengthening of select areas of the health system, including procurement, financial management, safeguards, monitoring and evaluation. Upon achievement identified DLIs, disbursement is made into the SDGPF. In addition to the DLIs, there is an agreed Program Action Plan (PAP) with 17 actions designed to address key system gaps and support program implementation towards the achievement of agreed results.

4. Currently, progress towards achievement of the PDO is rated Satisfactory. There has been consistent and verified progress on all DLIs and steady progress in the implementation of most actions in the agreed PAP. The program has seen mixed progress Actions on Environmental and Social Safeguards in the Program Action Plan. There is relatively good progress on the following agreed actions, namely: (i) All health facilities establishing and operating infection prevention and patient services committees, and (ii) Availing appropriate temporary storage facilities for collection of hazardous wastes until final disposal is completed. The mid-term review (MTR) in January 2016 noted that more progress is required under these actions because the implementation of the actions is not consistent across all health facilities, and achievements vary across regions. There are other areas where progress has been slower such as documentation of land acquisition for health facilities construction, and documentation of outreach and specific actions focused on providing services to vulnerable persons. The most critical is the lack of an effective institutional mechanism for coordination and reporting on environmental and social safeguards.

5. An Additional Financing (AF) for the Ethiopia Health Millennium Development Goals (MDGs) Program for Results (PforR) in the amount of US$230 million has been proposed. It aims to scale up development impact through: (i) increased focus on Reproductive Maternal Newborn Child Adolescent Health (RMNCAH) to reduce maternal and child deaths; (ii) support to select areas of the Government of Ethiopia's Health Sector Strategy; and (iii) expansion of Technical Assistance and Capacity Building efforts in order to enhance implementation support.

6. The AF responds to the Government's request to continue support to the SDG PF that supports its Health Sector Strategy through non earmarked and harmonized support to the sector. It will ensure the Government is able to meet its commitment to reduce preventable maternal and child deaths by building on the progress made and to more comprehensively address maternal and child health issues with a focus on adolescents and other areas of the health system. The PDO will remain the same. In order to enhance

[1]UK DFID, UNICEF, EU, GAVI, Netherlands Government, Spanish Development Cooperation, UNFPA, Irish Aid, WHO, Italian Cooperation and the World Bank.

development impact, the AF will continue to reflect the Government's focus on quality and equity of health services.

7. The AF will: (i) allow current priority areas to continue receiving support; and (ii) scale up activities that have proven to be effective (e.g. expansion of access to skilled birth attendance). The AF will support the Government's Sustainable Development Goals Performance Fund, which defines the program boundary in support of the Health Sector Transformation Plan (HSTP) 2015-2020 through the MDGPF platform which focuses on provision of primary health care services. The Sector Strategy establishes goals to improve equity, coverage and utilization of essential health services, improve quality of health care, and enhance implementation capacity of the health sector at all levels of the system. The AF is deemed more appropriate compared to a new operation because program identified under the original operation remains highly relevant, the PforR instrument has been effective, and that AF is an effective way to provide continued and scaled up support to the program, building on well-performing implementation arrangements. The AF to the Program will contribute towards addressing the financing gap identified as part of the Government's strategy and it uses well-performing implementation and institutional arrangements to maximize outcomes, while at the same time bringing additional resources and build stronger partnerships.

8. The request is also consistent with the Bank's guidelines for AF, namely that the program is well performing: (i) overall implementation progress (IP) has been consistently rated satisfactory or moderately satisfactory over the most recent 12 months; and (ii) progress towards the Program's Development Objective (PDO) has been rated satisfactory throughout the period of implementation.

9. The AF will use existing institutional and implementation arrangements under the original program. Implementation will continue to follow Ethiopia's decentralized federal structure of administration, which provides for shared responsibility for health policy, regulation and service delivery between the FMOH, Regional Health Bureaus (RHBs) and Woreda Health Offices. The Joint Consultative Forum (JCF) chaired by the FMOH and co-chaired by one of the development partners in the sector will continue to be the highest body for dialogue on sector policy and reform issues between the Government of Ethiopia, its partners and wider stakeholders. Disbursement arrangements will also remain the same, disbursing directly to the SDG PF that supports priority needs of the health sector, while verification protocols will be adjusted according to the identified list of added and restructured DLIs.

10. Environmental and Social System Assessment (ESSA) was conducted for the original program in 2012. Stakeholders' consultation on the ESSA was held on 19 December 2012, and it was disclosed on the World Bank Infoshop and in-country on December 12, 2012. The original ESSA has to be updated to reflect the changes in the institutional arrangement in the MOH, and the progress made over the Program period. The update takes into account the ESSA conducted for the Enhancing Shared Prosperity through equitable Services (ESPES) and other efforts exerted to build capacity in environmental and social safeguards at local level. The update of the ESSA is informed by the findings from relevant document reviews, key informant interviews of the FMOH staff, field level assessment in Benishangul-Gumuz region, and the consultation held with the Program stakeholders on 22 December 2016 in Addis Ababa. In general, the update gives special emphasis to (i) the institutional arrangement and linkages for the implementation of agreed safeguards actions, (ii) potential impacts of any new activities to be considered in the proposed AF, and (iii) the challenges and opportunities for improved environmental and social risk management in the health sector. The ESSA will inform the design of the AF with regard to any possible DLI(s) on safeguards and/or additional actions in the PAP.

II. METHODS

11. This ESSA Update examines existing environmental and social management systems relevant to the health sector, based on the review of the original ESSA, and recommends actions to address any risks

or challenges identified. The exercise considered the assessment of performance of the existing country systems in relation to the needs of the proposed AF, in relation to (a) the environmental and social management systems defined in the country's policies and legal and strategic frameworks; and (b) the capacity and experience of the health sector in applying the environmental and social management systems associated with the program's environmental and social effects.

12. The ESSA considers the strengths and gaps in the system with respect to the five of the six core principles outlined in the OP/BP 9.00. These principles establish the policy and planning elements that are generally necessary to achieve outcomes consistent with PforR objectives. They are intended to guide the assessment of the borrower's systems and of its capacity to plan and implement effective measures for environmental and social risk management. They also serve as a basis for the provision of World Bank implementation support.

13. ***Core Principle 1: General Principle of Environmental and Social Management***. This core principle aims at promoting environmental and social sustainability in the program design; avoiding, minimizing, or mitigating adverse impacts; and promoting informed decision-making related to the program's environmental and social impacts.

14. **Core Principle 2*: Natural Habitats and Physical Cultural Resources***. This core principle aims at avoiding, minimizing, or mitigating adverse impacts on natural habitats and physical cultural resources resulting from the implementation of the program.

15. ***Core Principle 3: Public and Worker Safety***. This core principle promotes public and worker safety with respect to the potential risks associated with: (a) construction and/or operation of facilities or other operational practices; (b) exposure to toxic chemicals, hazardous wastes, and other dangerous materials; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

16. ***Core Principle 4: Land Acquisition***. This core principle aims at managing land acquisition and loss of access to natural resources in a manner that avoids or minimizes displacement and assists affected people in improving, or at the minimum restoring, their livelihoods and living standards.

17. ***Core Principle 5: Indigenous Peoples and Vulnerable Groups***. This core principle aims at giving due consideration to the cultural appropriateness of, and equitable access to, program benefits, giving due attention to the rights and interests of indigenous peoples and to the needs or concerns of vulnerable groups.

18. ***Core Principle 6: Social Conflict***. This core principle aims to avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

19. This Update of the original ESSA is intended to ensure that the AF to the PforR will be implemented in a manner that maximizes potential environmental and social benefits and avoids, minimizes, or mitigates adverse environmental and social effects and risks.

20. This Update includes the following: (a) a review of relevant policy, legal, and institutional frameworks to identify the strengths and weakness of the system as related to the six core principles; (b) a description of the potential environmental and social effects associated with the Program activities; (c) an assessment of institutional roles and responsibilities; and (d) a description of current capacity and performance to carry out those roles and responsibilities. More specifically, the ESSA reviewed the Government of Ethiopia's regulatory and administrative framework and the capacity and experience of the health sector in managing environmental and social effects that are likely to be associated with the AF.

21. On the basis of the findings of the analysis, the ESSA Update proposes for inclusion in the Program Action Plan a set of actions to strengthen the existing system. These actions are expected to contribute to achieving the program's results and to enhance institutional performance.

22. An institutional analysis was carried out to identify the roles, responsibilities, and structures of the responsible bodies, within the health sector, for implementing environmental and social management and assessment activities, including coordination between different entities at the federal, regional, and woreda levels.

Desk Review

23. A desk review of literature related to: (a) federal and regional policies, strategy documents and, legal requirements related to environmental and social management; (b) ESSAs undertaken for the original Health MDGs and ESPES PforR; (c) technical project documents, including reviews and evaluations from previous and ongoing World Bank projects. Relevant regional reports from Benishangul-Gumuz were also reviewed.

Fieldwork

24. Field visit to Benishangul-Gumuz was undertaken in October 2016. Two senior local consultants were involved in the field data collection. In order to observe the operational level performance, the consultants visited two health facilities in Homosha woreda: Ashura health post and the Homosha health center. This was organized to get an insight on what is happening at field level with regards to the environmental and social management.

Key Informant Interviews

25. Semi-structured interviews with Government of Ethiopia officials and technical experts involved in environmental and social management of the health sector, at all levels. The team interviewed staff of FMOH, FMHACA and staff of the BOH, and woreda health office in Benishangul-Gumuz region. At facility level, the team also interviewed frontline health workers in a health center and health post.

Consultations

26. Consultation on the ESSA Update was held, with the Program stakeholders, on December 22, 2016 in Addis Ababa, Ethiopia. Representatives from the FMOH, WHO, and Civil Society Organizations (CSOs) participated in the Consultation, and provided valuable comments. Their comments and inputs are included in this final version of the Update. The ESSA Update, including any agreed actions to strengthen or improve environmental and social management capacity, will be publicly available on the World Bank Infoshop and the FMOH website.

III. DESCRIPTION OF APPLICABLE ENVIRONMENTAL AND SOCIAL MANAGEMENT SYSTEMS

27. In order to assess the applicable legal and regulatory frameworks of Ethiopia, the ESSA Update looked at the relevant policies and laws in the health sector for environmental and social impact assessment and management.

Applicable Policies, Laws and Guidelines

28. In Ethiopia, the basic principles of environmental law are derived from various documents. These include; the Federal Democratic Republic of Ethiopia Constitution, the Environmental Policy of Ethiopia, the Conservation Strategy of Ethiopia and different proclamations, regulations and guidelines.

29. The major principle which is reflected nearly in all of these documents is the concept of sustainable development in the context of holistic and integrated development approach as the guiding principle that helps to improve the living conditions of the society at large. This principle is based on social development, economic growth and environmental protection as its main pillars. The principle is devised to perceive development activities in a holistic manner than in a piecemeal approach. That is, according these documents, development is not a compartmentalized activity that stands on its own but achieved through efforts that integrate environmental protection activities.

30. According to Ethiopia's environmental legal instruments, the ESSA is devised with the view to safeguarding environmental and social impacts when development activities are being conducted. It can be stated that Ethiopia has a number of policies, laws, regulations, strategies, etc., that can adequately address core principles and key planning elements incorporated into OP/BP 9.00, if implemented properly.

The Federal Democratic Republic of Ethiopia Constitution

31. The FDRE Constitution in its Article 43 provides that the Ethiopians have the right to improved living standards and to sustainable development and the right to participate in national development and, in particular, to be consulted with respect to policies and projects affecting their community. Regarding environmental rights, the Constitution provides that that all citizens have the right to a clean and healthy environment; and those who have been displaced or whose livelihoods have been adversely affected as a result of state programs have a right to commensurate monetary or alternative means of compensation, including relocation with adequate state assistance.[2] One of the broad objectives of Ethiopia's environmental and health policies and laws is protection of human health via clean environment. Protection of public health means providing the means to ensure absence of adverse effects to human health, including effects that are not immediately apparent. That is why the Constitution imposes duties on the State in this regard. The Constitution states that:

> "The state has the obligation to allocate ever increasing resources to be provided to the public health, education and other social services."[3]

32. In Article 92, the FDRE Constitution provides for the environmental objectives in which the government shall endeavor to ensure that all Ethiopians live in a clean and healthy environment. For this purpose, the government shall take all the responsibilities to ensure that development projects, such as investment activities and other activities like construction of health facilities, health related waste management systems shall not damage or destroy the environment and affect human health.

Environmental Policy of Ethiopia (EPE), 1997

33. One of the key guiding principles emphasizes on the right of every person to live in a healthy environment. This right, as discussed above, is guaranteed by the FDRE Constitution as one of the fundamental rights. A healthy environment can be taken as an environment that supports the existence of all forms of life including the human species. From the view point of rights of people, a degraded environment has an impact on human dignity and health. It has also an adverse impact on the health of other species. Hence a healthy environment is the one that is not harmful to the health and well-being of human beings (and also other species).

[2] See Article 44 of the Constitution.

[3] FDRE Constitution, Article 41 (4).

34. The EPE provides 11 policy statements, and those related to EIA include:

- Ensuring environmental impact assessments to consider not only physical and biological impacts but also address social, socioeconomic, political and cultural conditions.
- Recognizing public consultation is an integral part of EIA and ensuring that EIA procedures make provision for both an independent review and public comment before consideration by decision makers.
- Ensuring that preliminary and full EIAs are undertaken by the relevant sectoral ministries or departments, if in the public sector, and by the developer, if in the private sector.
- Establishing the necessary institutional framework and determine the linkages of its parts for undertaking, coordinating and approving EIAs.
- Developing EIA and environmental audit capacity and capability in the Environmental Protection Authority, sectoral ministries and agencies as well as in the regions.

Health Policy of the Transitional Government of Ethiopia, 1993

35. Areas which are given priority and higher emphasis by the Health Policy include:

- Control of communicable diseases, epidemics and diseases related to malnutrition and poor living conditions.
- Promotion of occupational health and safety.
- Development of environmental health.
- Rehabilitation of the health infrastructure, and
- Development of an appropriate health service management system.

36. One of the strategies devised by the 1993 Health Policy is health education. The health education strategy has components that include:

- Inculcating attitudes of responsibility for self-care in health and assurance of safe environment.
- Encouraging the awareness and development of health promotion life-styles and attention to personal hygiene and healthy environment.

Health Sector Transformation Plan (The Sector Strategy) 2015/16–2019/20

37. The Health Sector Transformation Plan (HSTP) dwells on environmental issues in its discussion on hygiene and environmental sanitation. Specific HSTP goals for 2020 include:

- Increase proportion of households with access to improved latrines to 82 percent.
- Increase proportion of Open Defecation Free (ODF) kebeles to 82 percent.
- Meet and sustain international health regulation core capacities, by end of 2016.
- Increase the number of healthcare facilities that implement the national healthcare facility standards to 100 percent.
- Scale up Community-led and School-led total sanitation and hygiene and sanitation marketing; and
- Build adaptation and resilience to climate change in the health sector.

Integrated Urban Sanitation and Hygiene Strategy and Strategic Action Plan

38. This strategic document has vision clean and green cities with a healthy environment and improved quality of life for the urban population having adequate sanitation services with a high level of hygiene by 2025. Its mission statement declares that:

> "To provide, with minimal impact on the environment, acceptable, affordable and sustainable sanitation services for urban households, informal settlements,

institutions and visitors through enhanced urban health extension program, committed leadership, accountability, inter-sectoral Coordination integrated development, effective performance monitoring and private sector and Community involvement with a Sector-Wide Approach in financial resource allocation."

39. From the vision and mission statements of this strategic action plan, it can be seen that environmental and social issues are given prominence. The document also states some current concerns regarding sanitation and hygiene in urban centers, such as: (i) serious problems in urban sanitation and hygiene, from basic latrines to final waste disposal; (ii) low level of awareness on sanitation by both policy makers and primary consumers of services.

40. The Action Plan lists down activities which are consistent with Core Principle 1, General Principle of Environmental and Social Management of the OP/BP 9.00.

Healthcare Waste Management Directive No. 16/2013

41. This Directive was issued by Ethiopian Food, Medicine and Healthcare Administration and Control Authority (FMHACA)[4] with the mandate given to it by Article 55 (3) of the Food, Medicine and Healthcare Administration and Control Proclamation No. 661/2009. The objective of the directive is to protect the public from health risks and hazards associated with healthcare wastes and it is applicable on all healthcare facilities regulated by the Authority or appropriate organ that manage healthcare wastes. This Directive puts environmental impact assessment as a requirement, particularly in the waste disposal activities.

Medicines Waste Management and Disposal Directive, 2011

42. This directive was issued by the FMHACA as per Article 55 (3), and the objective is to protect the public and the environment from health risks and hazards of medicines waste by ensuring safe management and disposal practice. The directive provides specific rules on handling of medicines waste, healthcare facilities and retail medicine outlets, medicine manufacturers and suppliers, working procedures of disposal firms.

43. The directive also considers EIA as a core activity for the purpose of mitigating environmental and social impacts from medical waste management and disposal. It puts special emphasis on making the disposal sites environment and society friendly; ensuring the existence of secured disposal site and all the facilities in disposal firms; controlled non-engineered landfills and site selection, design and management of operations of highly engineered sanitary landfills to be in compliance with EIA requirements and should not affect the aquifer, other watercourses or air; and disposing by sewer should be monitored to avoid impact on the environment and public health.

Small Scale Medicine Establishment Directive No. 26/2014

44. One of the objectives of the directive is to ensure products manufactured in small scale medicine establishments are up to the required safety, quality, and as appropriate, efficacy requirements. When seen generally, this directive is issued for the purpose of maintaining the safety of the products to be manufactured by small-scale medicine establishments.

Changes in Institutional Arrangements

[4] This is a semi-autonomous entity which is accountable to the FMOH.

45. According to the Environmental Organs Establishment Proclamation No. 295/2002, establishment of environmental units in sectoral organs (such as the FMOH), is a requirement for effective follow up of environmental performance of the activities of these sectoral organs. The law also rules that environmental units in various sectoral organs have to work in coordination with environmental protection institutions. The FMOH, has an environmental case team with in the Health Extension and Primary Health Services Directorate.

46. Although there is a separate unit, environmental and social issues related activities are being carried out by other directorates as well. For instance, the Infrastructure Directorate has rules and standards to follow while constructing health facilities. At the regional level, the visited Benishangul-Gumuz Regional State Health Bureau recently established the Regulatory Core Process.

IV. COUNTRY SYSTEM CAPACITY AND PERFORMANCE ASSESSMENT

Access, equity and infrastructure of health facilities

47. In 2015/16, there were a cumulative number of 16,480 health posts, 3,562 health centers and 241 hospitals). In terms of infrastructure in the health facilities, about half of the facilities have regular electricity or generators. About 88-100 percent of hospitals (public & private), 84 percent higher clinics, 61 percent lower clinics, 57 percent health centers and 29 percent of health posts have regular power sources. Over three-quarters of all health facilities (public and private) have an improved water source in their facility, including 71 percent of health centers and 49 percent of health posts. Furthermore, nationwide, 55.1 percent of the health facilities have access to water supply. In addition, over two-thirds of health facilities, including 70 percent of health posts, have access to emergency transport. Table 1 lists the regional distribution of health facilities and population ratio to health facilities.

Table 1. Regional Public Health Facility to population ratio, 2015/16

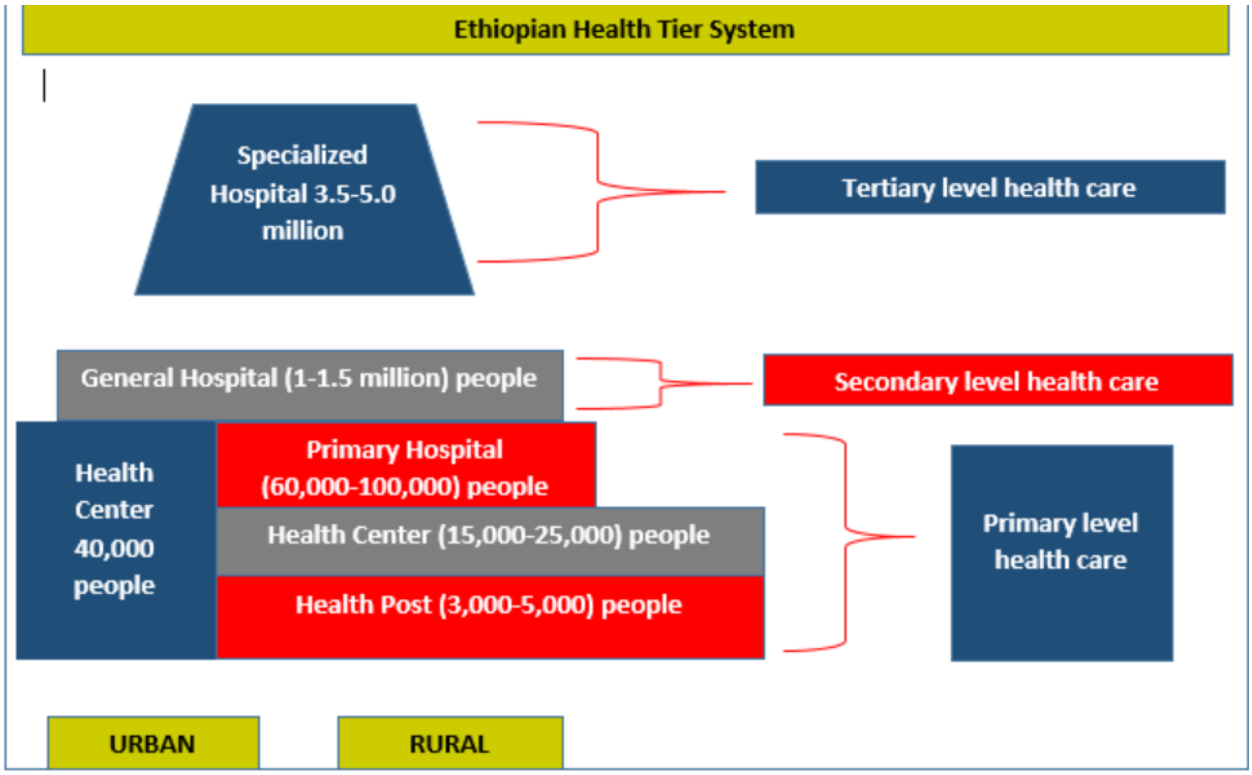
Region	Population	Functional health center		Functional hospital		Health post	
		Number	Ratio	Number	Ratio	Number	Ratio
Tigary	5055999	202	25030	15	337067	712	7101
Afar	1723007	84	20512	6	287168	396	4351
Amahra	20399004	834	24459	42	485691	3336	6115
Oromia	33691991	1320	25524	53	635698	6519	5168
Somali	5452994	204	26730	9	605888	1062	5135
Benishangul Gumuz	1005001	37	27162	2	502501	399	2519
SNNPR	18276012	726	25174	41	445756	3842	4757
Gambella	409002	29	14104	1	409002	118	3466
Harari	232000	8	29000	7	33143	31	7484
Addis Ababa	3273001	88	218200	11	297546	-	-
National	**90076012**	**3547**	**25395**	**189**	**476593**	**16447**	**5477**

Source: FMOH. (2014/15). Health and health related indicators 2007 (E.C.)

48. In terms of human resources, the Health Extension Workers (HEWs) and medium level professional (Nurses, Environmental Health, Laboratory and pharmacy) has reached the WHO standard for east Developed Countries. Similarly, the physician to population ratio has reached 1: 58,290 by the end of 2014/15.

The health sector is organized in a three tier system and the target for each facility is indicated in figure 1.

Figure 1. Ethiopia's Health Tier System



Source: HSTP 2015

Directorates responsible for environmental and social management

Federal

Human Resource Management Directorate

49. In this Directorate, activities related to preparing strategies and following up healthcare worker retention, incentive packages, training and capacity building are dealt with. In addition, the directorate has responsibility to look after workers' safety.

50. In the area of workers' safety, the Directorate has recruited one staff. The staff member is assigned to handle the occupational health and safety of the Ministry staff in line with the Labor and Social Affairs requirements pertaining to personal protective equipment and occupational health and safety practices.

51. The Directorate faces challenges related to urban/rural and regional disparities, poor motivation, retention and performance of the human resource. In addition, the Human Resources Information System (HRIS) is not fully functional to support Human Resource planning and development, supervision, performance monitoring and improvement.

Health System Strengthening Special Support Directorate

52. The Directorate performs different tasks to improve the equitable and quality health service access and utilization in the four emerging regions, namely: Somali, Afar, Benishangul-Gumuz and Gambela. The FMOH defines vulnerable persons as those who are mobile (communities who move from place to place due to the nature of their livelihood); HIV positive persons, disabled persons, and people working in development corridors. The issue of addressing the health needs of vulnerable persons is integrated in different programs across the FMOH and this directorate also focuses on addressing health needs of vulnerable person in these four emerging regions as one of the priority to improve the health status of communities living in these regions.

53. However, lack of transport facilities, inadequacy of some of the old facilities and those (some built for other purposes but converted to health facilities for disabled persons) and lack of community awareness about the needs of vulnerable people are some of the challenges that limit the effectiveness of the service to this group of people.

Health Infrastructure Directorate

54. With regards to environmental and social management, the Directorate's role is site screening/selection of health facilities. In addition, the directorate also works to ensure public and worker occupational safety guidelines are incorporated in the civil works contracts for construction of health facilities.

55. In terms of performance, the actual site screening is done by regions and woredas. However, the Directorate prepares relevant site selection criteria, coordination and inspection of the work. The site selection criteria developed in 1998 does not have environmental impact and risk criteria in the site selection screening forms for all health facilities. In addition, it does not ensure that the screening is explicit in addressing natural habitats and physical cultural resources considerations in order to avoid siting health centers in areas that would impact either or both.

56. However, with regard to public and worker safety, the directorate complies with the guidelines prepared by the Ethiopian Government Public Procurement Agency related to components and specification of bid documents for construction of government buildings and civil works.

Medical Service Directorate

57. This directorate is responsible for the coordination and supervision work of Infection Prevention and Patient Safety Committees (IPPS) to facilitate implementation of facility level health center waste management (HCWM). In addition, the Directorate is also involved in issues related to hazardous waste disposal. With regard to the implementation of the HCWM, the Directorate has made effort to operationalize IPPSCs. This include setting standards for IPPSCs, organizing training for IPPSCs, ensuring the allocation of budget for supplies and equipment, developing recognition mechanism for best performers and institutionalizing regular review mechanism.

58. However, there are challenges related to fulfilling the required HCWM supplies and ensure continuous workers' commitment in implementing waste segregation practices at the facility level. Furthermore, old facilities and those built before the standard health facilities design was operationalized find it difficult to properly implement waste management procedures and also fulfill public and workers' safety requirements.

Health Extension and Primary Health Service Directorate

59. Under this Directorate hygiene and environmental health, health extension and health education and communication case teams are organized and they are responsible for environmental and social management issues. Their environmental and social management related activities are embodied in the 16 Health extension packages implemented across the country and these include: excreta disposal, solid and liquid waste disposal; water supply; food hygiene and safety measures; and healthy home environment.

The Ethiopian Food, Medicines and Health Care Administration and Control Authority (FMHACA)

60. In accordance with Food, Medicine and Health Care Administration and Control Proclamation No. 661/2009, the Authority is provided with a mandate to regulate the 4Ps (Practice, Premises, Professionals and Products). In addition, food, health and medicine related issues that need to be regulated are also given as mandate to the authority. Similar to the other tasks and responsibilities of the Ministry, these activities are decentralized and are being carried out by regions and *woredas*. The four Ps comprise the following: i) *Practice*: Health care practices; ii) *Premises***:** Which includes, Healthcare facilities, Food establishments, Medicine Facilities, Health related Facilities, Port inspection sites and Health related facilities; iii) *Professional***:** all Health professionals; and iv) *Product***:** From production up-to consumption of Medicines, Medical equipment and devices, Food and Food supplements, Herbal products, Cosmetics, Complimentary and traditional Medicines.

61. The tasks and responsibilities of the authority that are related to the update of the 2013 action plan and which focus on environmental and social management are the following: i) Ensure proper disposal of expired and unfit for use food, medicines and their raw materials; ii) Ensure handling and disposal of trans-regional solid and liquid wastes from different institutions are not harmful to public health; and iii) Monitor and control illegal food, medicines and health services and take appropriate measures.

V. ASSESSMENT OF BORROWER SYSTEMS RELATIVE TO SIX CORE PRINCIPLES

62. Following the Strengths, Weakness, Opportunity and Threat **(**SWOT) analysis framework, the Update reviews the changes that have been made since the ESSA 2013 as follows:

- Strengths of the system, or where it functions effectively and efficiently and is consistent with OP/BP9.00.
- Weaknesses (or gaps) between the principles espoused in OP/BP 9.00 and capacity constraints, examined at two levels: (i) the system as written in applicable laws and regulations; and (ii) how the system functions in practice.
- Opportunities to strengthen the existing system. The ESSA identified actions that lie within the mandate and scope of the Program implementing agency. These are used to inform development of performance enhancing measures.
- Threats (or risks) to the proposed actions designed to strengthen the system.

63. The following Table summarize the strengths, gaps, opportunities, and risks associated with the System with respect to each Core Principle.

Core Principle 1: General Principle of Environmental and Social Management
Applicability: Overarching

- The national standard set for health facilities in the HSTP on average, targets a *woreda* to have 20 health posts, 4 health centers and a primary hospital by year 2020. These new health facilities are planned to be constructed, each with a physical foot print of a minimum of one hectare, which includes placenta pits and incinerators.
- Facilities that receive health products and equipment under the Additional Funding need effective

health care waste management, including hazardous materials such as expired pharmaceuticals.
o Pesticides used in the vector control programs (bed nets) require appropriate storage, distribution, use and disposal mechanisms.

Strengths	**Gaps**
2013 ESSA findings which are also relevant now: o EIA system provides a comprehensive framework for environmental and social impact assessment. o Existence of comprehensive health center construction standards and guidelines. o National legislation on medical waste management and health care waste management strategic action plan exist. o Ongoing efforts to improve availability of health services to underserved populations. o Establishment of health and health related services and products regulation units by the regions. o National provision to establish IPPS committees at regional and woreda levels as well as in health facilities. o There is awareness by local health operators of regulatory requirements. ***Findings of the current study*** o The MOH has prepared the Health Sector Transformation Plan in August 2015. This guides the work in the health sector for 2015/16 - 2019/20. o In 2014 a Small Scale Medicine Establishment Directive No. 26/2014 was issued by FMHACA. The directive covers the issue of site screening adequately. It specifies that small scale medicine producing firms need to be located in places where they do not cause negative impacts to the environment and the society. o Status of IPPS functions is included as one activity in the health care facility quarterly report. This has increased follow up and commitment. o Most public facilities (mainly health centers not health posts) are supported with IPPS committees having members from environmental and occupational health, including IPPS trained nurses/health officers. o Most facilities in the regions have started implementation of the Health Care Waste Management Strategic Action Plan. o Regions have started to carry out status assessment of private and public health facilities. This has become routine and is being carried out annually. The assessment focuses on areas of	***2013 ESSA findings which are also relevant now:*** o Health center construction guidelines provide limited guidance on screening for potential environmental impacts and risks – this is deemed a minor risk as it is possible to mitigate through the Program Action Plan. o Delayed implementation of the national Joint Plan of Action prepared by FMOH and FEPA for capacity building to undertake and monitor/audit EIA – this is deemed a moderate risk and should be immediately addressed by the FMOH through the Program Action Plan as one of the first actions to be completed post effectiveness. o Health facilities and suppliers dispose expired medicines without adequate oversight of FMHACA – this represents a significant risk as expired pharmaceuticals may be used by the local population leading to health problems and such medicines may lead to environmental pollution in the immediate vicinity of the disposal area. o Pesticides used for vector control are not collected and disposed properly – this represents a minor to moderate risk to the local population, but it can be mitigated through application of the existing medical waste and hazardous waste management guidelines as well as through support of the IPPS committees at each health facility. o Shortage of health professionals, especially highly skilled and women health providers, in the four regions requiring special attention. o Most health facilities in kebeles lack appropriate fencing. As a result, the chances that children pick some of the hazardous materials is high. ***Findings of the current study:*** o Core regulatory team are constrained with transport for the necessary supervision and inspection. This is a serious concern in the visited area. o Most of the regulatory staff joins the work force with only health related technical knowledge having limited regulatory capacity.

hygiene, sanitation, solid and liquid waste disposal. o The seven hygiene and environmental health packages which include, solid and liquid waste management as one component, is being implemented by the Health extension program in all regions. o The Human Resource Information System (HRIS) has become operational and is used to track data related to human resource. o New in-service training centers have become operational in different regions including the emerging regions. o New effort to retain highly skilled professions through provision of better remuneration including of salary. o All newly built health facilities are obliged to have certificate of competency (they are required to fulfill the four Ps- professionals, product, premises and practices) before they start providing service. o Since 2015 health services facilities quality and safety is given high attention. In line with this, Clean and Safe Health Facility (CASH) initiative is launched. The initiative also includes tasks for IPPS committees. o Since 2015 FMHACA is made to be accountable to all the regulatory works it is performing including what it is doing and also not doing. o More than 38,000 Health Extension Workers (HEWs) were trained and deployed all over the country, availing two HEWs in every Kebele (a cluster of villages).	This has affected the inspection work. o Most facilities report the list of expired medicine to the regulatory body (federal or regional). However, there is still challenges related to disposal of expired medicine or medical devices due to unavailability of disposal site within the country. o Some directives prepared by federal offices are in English. In some cases, these are transferred to woredas without being translated into the local languages or Amharic. As a result, they may not be properly understood and implemented. o Safety training was given to most health practitioners by the regulatory body. However, the challenge of health workers related occupational hazards such as needle pricks still exists, especially with private health facilities. o The Health Sector Transformation Plan (HSTP), 2015 document has highlighted the following gaps: o Enforcement has not begun to make sure that the guidelines and directives for continuing professional development (CPD) are implemented; o The CPDs are not yet well linked to re-licensure and career progression; o There is room to strengthen in-service training so that it is need-based, well-planned, coordinated, quality assured, monitored and evaluated for their effectiveness; and to ensure that when IST (In Service Training) is mostly face-to-face and group based then innovative and efficient in-service training modalities like on-the-job training, and blended learning approaches are used. o The problem of staff turnover is not yet abated.
Opportunities ***2013 ESSA findings which are also relevant now;*** o Ongoing performance appraisal and institutional rewards under the. o Annual health facility readiness assessment to regularly inform the program managers and policy makers regarding the status of the environmental and social management processes. o Innovations by regions and facilities to retain health care workers. o Existence of a clearly defined and costed joint FMOH- FEPA Joint plan of action for capacity building, including training. o Implementation of the national Joint Plan of Action to strengthen capacity to assess and	**Risks** ***2013 ESSA findings which are also relevant now:*** o Not capitalizing the opportunities to address the gaps in a timely fashion will lead to localized and regional environmental health problems among the population and environmental pollution in areas. Both risks are deemed moderate to significant and should be mitigated through a combination of dedicated enforcement of health facility compliance with national legislation and existing guidelines, application of all provisions of the HSDP IV program that address the key gaps identified through the ESSA analysis (e.g. Hospital) o Reform Program, Facility Readiness

manage environmental and health impacts. o Development of technical guidelines for environmental screening. o Identification of appropriate temporary storage facilities near health facilities for hazardous waste and transportation to appropriate final disposal sites. ***Findings of the current study:*** All newly built health facilities are required to have certificate of competency (they are required to fulfill the four Ps- professionals, product, premises and practices) before they start providing service.	Assessments, FMOH-FEPA Joint Plan of Action, among others), specific actions included in the PforR Program Action Plan (e.g., technical guidelines for environmental screening for proper siting and construction of new health centers and identification of appropriate storage facilities for hazardous waste and transport to appropriate final disposal sites) as well as dedicated Bank implementation support. ***Findings of the current study:*** Staff working in the regulatory unit, especially at woreda level feel that the job involves personal risk, such as communicable diseases and physical injuries on people carrying out the inspection and assessment. As a result, the unit is facing continuous challenge to maintain its human resource capacity and perform its duties. This is a challenge in the area *visited*. The risk is deemed moderate and requires consorted effort from regional and woreda administration to give relevant protection for the officers.
Core Principle 2: Natural Habitats and Physical Cultural Resources **Applicability: Limited** o Activities funded through the AF will likely generate limited impact on natural habitats and physical and cultural resources since civil works are limited in number and have a small physical footprint that facilitates appropriate siting, thus avoiding adverse impacts on natural habitats and any chance finds. o Construction of facilities such as health centers and disposal of medical wastes may pose some risk to natural habitats and physical cultural resources if not sited appropriately and if chance-finds procedures are not embedded in general construction contracts and supervised appropriately.	
Strengths ***2013 ESSA findings which are also relevant now:*** o National proclamation and EIA procedure guidelines are consistent with the principle of environmental protection. o Screening criteria for projects in national parks and areas containing endangered flora and fauna are established.	**Gaps** ***2013 ESSA findings which are also relevant now:*** o Limited capacity to review EIAs and manage natural habitats due to resource constraints, enforcement issues, inadequate public consultations/ participation, lack of equipment, training and incentives. o No documented national system strengths regarding treatment of physical cultural resources. o No documented guidelines or standards for chance-finds procedures in the health sector. ***Findings of the current study:*** o In the emerging regions there is limited skilled human resource to screen and follow up the construction of health facilities. For

	example, in Benishangul-Gumuz regional state, there is only one engineer assigned for the purpose. o The site screening is mainly done by the committee (constituting of the community and woreda officials) established to select construction sites.
Opportunities ***2013 ESSA findings which are also relevant now:*** o Availability of simplified physical cultural resources screening procedures under the Bank-financed PSNP wherein each Sub-project is screened for whether it is located within a recognized cultural heritage or a world heritage site, in addition to a chance-finds procedure. o Screening procedures include a checklist to assess whether a subproject has the potential for affecting a known cultural or religious site.	**Risks** ***2013 ESSA findings which are also relevant now:*** o Inability to apply practical and operationally feasible early screening practices for known physical cultural resources and chance-finds in the health sector may lead to adverse environmental impacts on natural habitats and physical and cultural resources. The risk is deemed to be minor to moderate if the FMOH adopts the PSNP simplified screening procedures for known physical cultural resources and develops and applies internationally recognized chance-finds procedures in the early screening practices for site selection of new health facilities to be financed through the additional funding as well as to ensure that medical and hazardous waste, including bed nets are not disposed of in natural habitats or affecting physical cultural resources.
Core Principle 3: Public and Worker Safety **Applicability: Overarching** Rehabilitation, construction and operation of health centers are prone to expose the general public as well as health service providers and construction workers to risks such as exposure to infectious waste, toxic or hazardous materials including pesticides and expired medicines, operational risks (needle pricks) at health facilities and civil works construction phase associated adverse environmental and social impacts.	
Strengths ***2013 ESSA findings which are also relevant now*** o Availability of national proclamations and guidelines addressing public and worker safety. These cover a range of important aspects including environmental pollution control; labor laws; occupational health safety regulations; food, medicine and healthcare administration and control; management of public health emergencies and national hazards (e.g., droughts). ***Findings of the current study*** o Basic equipment and buildings exists in health centers and health posts, especially with those constructed with the support of development	**Gaps** ***2013 ESSA findings which are also relevant now*** o The national EIA system does not comprehensively encompass aspects of public and worker safety. o Health workers are prone to occupational hazards such as needle pricks. o As stated under Core Principle 2: (i) Poor compliance with healthcare waste management practices, especially segregation and pretreatment, and (ii) FMHACA does not have adequate oversight over health facilities and suppliers that dispose expired medicines improperly.

partners. o The Federal Government's Public Procurement Agency has developed guidelines related to components and specification of bid documents for construction of government buildings and civil works. This describes public and worker occupational safety measures to be considered in the civil works. o The MOH has assigned a staff to look after issues related to occupational health and safety of the ministry staff in line with the Labor and Social Affairs requirements pertaining to personal protective equipment and occupational health and safety practices.	Pesticides and other hazardous material used for vector control are sometimes not collected and disposed properly. ***Findings of the current study*** o The study team observed than an autoclave provided to Ashura health post in Benishangul-Gumuz Regional state requires appropriate training to ensure proper utilization of the equipment. There is therefore need to ensure due attention is paid for proper training before medical equipment are dispatched. o Availability of tap water and electricity remains a challenge in some health posts. Lack of key utilities affects the quality of services and necessitates the use of alternatives such as use of wells and transported in water. o Budget constraint for operational costs is a constraint to timely maintenance of facilities even for minor repairs.
Opportunities ***2013 ESSA findings which are also relevant now*** Incorporate the identified gaps on public and worker safety measures in all civil works contracts planned to be constructed in the HSTP. ***Findings of the current study*** o The Annual Facility Readiness Assessments developed by FMHACA guidelines allow the FMOH to monitor compliance with all recommended public and worker safety measures already embedded in the Program's design.	**Risks** ***2013 ESSA findings which are also relevant now*** Inability to ensure public and worker safety can result in spread of communicable diseases and may cause physical injuries to the public seeking health services and to health care workers at public health facilities. These risks are deemed to be moderate to significant. The waste management issues can be treated as described under Core Principle 2, the construction phase risks can be mitigated through inclusion of appropriate safety measures in all health center civil works contracts, operation phase risks can be mitigated through existing measures in place. All such measures need to be adopted by the FMOH immediately post effectiveness and monitored closely to ensure compliance and completion of the listed actions.
Core Principle 4: Land Acquisition **Applicability: Limited** The national standard set for health facilities in the HSTP, on average, targets a *woreda* to have 20 health posts, 4 health centers and a primary hospital by year 2020. Given the size of each health facility and scale of land required such construction poses a relatively limited risk of displacement or potential loss of access to natural resources, and could be mitigated with early screening, good siting practices, and appropriate compensation, as per Ethiopia's Laws and procedures.	

It is important to note that the need for the Government to acquire land and relocate people as per existing Laws and procedures is likely to be lower in pastoral and agro-pastoral areas, where land is relatively abundant and population density is low. It could be moderate, but slightly higher, in urban areas where population density is high and in agrarian areas where land resources are scarce. Therefore, a risk rating of minor to moderate is appropriate in this instance for land acquisition given the mitigation measures, Laws and regulation in place.

Strengths	**Gaps**
2013 ESSA findings which are also relevant now o A legal landholder whose holding has been expropriated is entitled to compensation at replacement cost for assets on and any o permanent improvements to the land. The amount of compensation for property shall be determined on the basis of replacement cost. o Rural landholders who lose land permanently shall be paid displacement compensation, in addition to compensation payable for property situated on the land and for permanent improvements made to such land. o Urban land holders whose land holding has been expropriated will be provided with a plot of urban land the size of which is determined by the urban administration to construct a house. Replacement land is provided in rural area as well, including for dwelling. Compensation for the property on the land will also be provided. o Such persons are also entitled to displacement compensation. o Availability of dispute resolution and grievance redress mechanisms through compensation review committees, arbitration tribunal as well through the court system. o Most cities have established guidelines and systems for valuation and compensation.	***2013 ESSA findings which are also relevant now*** o Lack of standardized procedures for land acquisition across regions. o Lack of an explicit statement in the land laws on avoiding or minimizing land acquisition. o Land registration and certification are not carried out in pastoral and agro pastoral areas. Land for health centers must be sought from communal land which is not documented. o The legal framework only recognizes legal titles and quasi-legal titles (such as customary rights over land and communal land), and does not cater to citizens with no legal rights. Citizens without legal rights to land receive "special assistance", but not formal compensation for loss of land. o Independent valuation is not the norm. Rather, asset evaluation committee comprised of various experts' will do the asset evaluation. o Replacement costs do not consider location. o Compensation is focused on replacement of land and assets, not restoration of livelihoods. The legal framework does not explicitly state that livelihoods should be restored to previous levels or improved. o There are no specific provisions for transitional assistance. o Land can be expropriated before relocation sites are ready. Forced eviction is possible after expiry of the notice period. o Excessive work load and capacity limitations of committees or experts assigned by local authorities (kebeles) for valuation of assets lead to delays. o Inability of city administrations to use the services of independent valuators due to budget constraints lead to weak application of existing acquisition and compensation systems. o Consultations with project-affected people are not conducted systematically and grievance-handling mechanisms can be slow

	to resolve disputes. ***Findings of the current study*** Proper documentation of the land acquisition consultation process, which was included as an Action in the 2013 ESSA program action plan, has seen slow implementation and has been strengthened through DLIs and PAP in this AF.
Opportunities ***2013 ESSA findings which are also relevant now*** o Appropriate early screening and siting procedures used for siting the HSTP planned health facilities may reduce the risk of land acquisition and resettlement. o Establishment of appropriate and transparent mechanisms for consultation and documentation of land acquisition consultations in regions that operate under a communal land system will mitigate the risk of faulty land acquisition and resettlement practices in those regions that operate under a communal land system. o In the few instances where land acquisition, resettlement or loss of access to resources is necessary, the FMOH should ensure that project-affected people receive compensation and are properly resettled before the land is expropriated and ensure that people without legal rights to land are compensated for lost assets and provided with resettlement assistance.	**Risks** ***2013 ESSA findings which are also relevant now*** Inability to rehabilitate and adequately compensate affected people while acquiring land for the construction of health facilities will adversely affect livelihoods and living standards of displaced people. ***Findings of the current study*** Though the Government has Laws and Regulations that need to be followed before it can acquire land for development purposes, the lack of proper documentation of the consultation process for land acquisition presents a weakness of the social safeguards system. Mitigation measures on documentation of the voluntary process for land acquisition has been recommended as part of the proposed AF.
Areas for strengthening and mitigation measures*:* o Since communities are eager to have a health facility in their neighborhood coming into amicable settlement with them will not be a problem, and the program will strengthen the following institutions and systems related to land acquisition: o Strengthen/develop standard procedures that could be followed for land acquisition across program participating regions. o Strengthen/develop procedures to assist people with no legal rights and use entitlement framework of existing World Bank's funded operation within the regions to compensate and assist program affected people. o Strengthen the existing procedure to include restoration of livelihoods of program affected people and coordinate with other schemes of the government within the region to provide income restoration.	**Recommendation:** Land obtained for construction of facilities will follow Ethiopia's Laws and Regulations which govern processes and procedures when land is acquired for development purposes. Land acquired for construction of facilities or for other development purposes for the sector, shall follow Government Laws and procedures and shall be obtained through: i) well documented voluntary process involving the community; or ii) public vacant land.

○ Strengthen the capacity of implementing agencies to plan, undertake and document the process of land acquisition, particularly to improve consultation; independent valuation of assets; and grievance redress mechanism. ○ Establishment of appropriate and transparent mechanisms for consultation and documentation of land acquisition consultations in regions that operate under a communal land system will mitigate the risk of faulty land acquisition and resettlement practices. ○ Assignment of a focal person at the FMOH responsible and accountable for the documentation, reporting and monitoring of all land acquisition matters.	
Core Principle 5: Indigenous Peoples and Vulnerable Groups **Applicability: Overarching** The Government has identified four regions (Afar, Benishangul-Gumuz, Gambella, and Somali) that require special attention. HSTP aims to have regionally tailored approaches that ensure distributional, gender balanced and culturally appropriate access to health services, as well as technical support to these regions to ensure coverage and provision of health services is on par with the rest of the country.	
Strengths ***2013 ESSA findings which are also relevant now:*** ○ Devolution of decision making powers to regional health bureaus and woreda health offices for managing and coordinating the health systems in their catchment areas. ○ Establishment of a federal special support board consisting of sector ministries under the Prime Minister's office to ensure better coordinated cross-sector affirmative support to the four regions that need special attention. ○ Creation of an Equitable Development Directorate under the Ministry of Federal Affairs and Pastoralist Area Development focusing on gathering data on existing gaps in capacity, social and economic development, governance, gender and environment. ○ Twinning each of the four regions requiring special attention with better performing regions. ○ Improved physical access to services through health extension workers and mobile clinics; additional matching support from FMOH for health center construction. ○ Improving financial access of the poor to health services, such as: (a) exemption of user fee for health services; (b) and introduction of fee waiver program for the vulnerable population; ○ Quarterly review meetings with representatives of the four regions that require special attention to discuss the quality of support and address	**Gaps** ***2013 ESSA findings which are also relevant now:*** ○ Challenge in implementing the fee waiver scheme for street dwellers and poor residents who do not have permanent addresses. ○ Pervasive and deep-rooted socio-cultural beliefs and attitudes and gender inequalities result in underutilization of health services and continuation of harmful traditional practices such as female genital mutilation. Preference for female health workers during child birth also limits access to skilled birth attendants. ***Findings of the current study*** ○ Though different services (as measured by SPA+ SARA, DHS) are being provided to the different vulnerable persons the process of service provision for vulnerable populations including refugees is not well understood. Various mitigation measures have been included in the Program. ○ There is an influx of migrant workers to the development corridors. These migrant workers (considered as vulnerable people in most regions) compete for the health services with the local population residing in these areas. Budget is not adequate to enable the

grievances. o Bi-annual supervision missions by FMOH to the four regions to assess implementation and address emerging issues. ***Findings of the current study:*** o Establishment of pastoralist Health System Strengthening Special Support Directorate within the FMOH to provide dedicated technical support complemented by semi-annual supervision visits to assess implementation. o The provision of ART is expanded to development corridors which are increasingly being visited by migrant workers of government mega projects and private sector agricultural investments. o Special support health professionals are deployed for regions and woredas. o In the visited Benshangul-Gumuz Region, a Community Care Coalition (CCC) is in the process of establishment and it has the potential to mobilize the community to make financial contribution for health services. This goes hand in hand with what is intended about engaging the health development army. In addition, this is already being institutionalized and operationalized in Tigray and Amhara.	health services accommodate this challenge.
Opportunities ***2013 ESSA findings which are also relevant now:*** o Effective use of women's groups, panel discussions and community conversations targeting special groups such as pregnant women, traditional leaders (both religious and community elders), and other vulnerable groups to address demand side barriers. o Availability of mobile vans that offer public education programs in local languages specifically targeting culturally sensitive health practices. o Commitment to scale up the CBHI scheme targeting vulnerable populations and provision of a social health insurance scheme for the formal sector to help address financial barriers in accessing health care services. o Enhancing health extension worker skills in community case management of childhood illnesses and safe and clean delivery services and training of health officers in emergency surgical and obstetric procedures. This is mainly in the emerging regions. In the other regions, recently, the strategy is to provide skilled delivery service by health centers and above not health posts. o Recruit women health workers. o Availing ambulances at each woreda health office	**Risks** ***2013 ESSA findings which are also relevant now:*** Inability to improve delivery of essential health services and addressing demand side barriers for such services building on existing opportunities will adversely affect vulnerable populations especially women and children.

to improve access to referral care. ***Findings of the current study:*** There is a need to fill the positions of health workers in the health posts and health centers with workers who speak the local languages.	

Core Principle 6: Social Conflict

Applicability: Not Applicable

The proposed program will not exacerbate social conflict nor will it operate in a fragile state context, a post-conflict area or in areas subject to territorial disputes.
The program is designed to yield significant social benefits to all citizens and to improve distributional equity of health services, particularly in the four regions that require special attention.

Strengths	**Gaps**
2013 ESSA findings which are also relevant now: Strengths listed with respect distributional equity under Core Principle 5 will apply.	***2013 ESSA findings which are also relevant now:*** Gaps listed with respect to distributional equity under Core Principle 5 will apply.
Opportunities	**Risks:**
2013 ESSA findings which are also relevant now: Opportunities listed with respect to distributional equity under Core Principle 5 will apply.	***2013 ESSA findings which are also relevant now:*** Risks listed with respect to distributional equity under Core Principle 5 will apply. o Over burdening the health services with influx of migrant workers could limit the health service provided to local people as well as migrant workers. Though the government is trying its best to avoid this, there could be a possibility that this will trigger negative feeling between host communities and migrant workers.

VI. RECOMMENDATIONS

64. These recommendations are additional and organized based on the status of the implementation of the 2013 ESSA Action Plan.

Site Screening for new Health Centers

- The relevant documents should be updated to incorporate environmental and social impacts and risk criteria in the site selection screening forms for all health facilities.
- Engaging people in the process of site selection should be as per the Laws and Regulations as indicated in environmental laws of the country,[5]

[5] For instance, see Environmental Protection Organs Establishment Proclamation No.295/2002. In its Article 15 (1), this Proclamation states that: "Each national regional state shall establish an independent regional environmental agency or designate an existing agency that shall, based on the Ethiopian Environmental Policy and Conservation Strategy and ensuring public participation in the decision making process." (Emphasis added).

Equipment and Resources for Regulatory Purposes of Health Facilities

- Almost all the standards and guidelines are prepared in English, and when these are sent to the woredas without being translated to the local languages or Amharic, some workers find it difficult to fully understand the contents. It is recommendation that for some standards and guidelines, translated versions are also shared in order to ensure language accessibility.
- Adequate transport support, especially for zone and woreda offices, for inspection work is an area that needs attention.
- Capacity building of the regulatory body on areas of health care facilities regulatory work.

Healthcare Worker Retention, Incentive Packages, Training and Capacity Building

- Review the health worker retention and incentive package and identify areas of improvement.

Establishment and operationalization of Infection Prevention and Patient Safety Committees (IPPS) to facilitate implementation of facility level health center waste management (HCWM)

- A continuous supply and ensuring availability of IPPS supplies and commodities should be given attention;
- Transfer best practices observed in the public health facilities to private health facilities.

Temporary storage facilities for collection of hazardous wastes until final disposal

- Efforts have to be made to encourage health facilities constructed before the Medicines Waste Management and Disposal Directive was adopted to comply with the Directive;
- Refresher training in standard hazardous waste disposal including disposal of expired medicines;
- In most places the basic hazardous waste disposal facilities exist but when they are damaged due to various reasons, proper maintenance is not done because of budget constraints. As this is the last thing that will be done when there is budget constraint, earmarking a budget for this kind of activity may help.

Consultations with affected people when communal/private land is used for construction of health centers

- Staff members who carry out consultation should be made aware of the importance of documenting the process;
- Forms that guide the consultation process should be prepared by the responsible Government Agency and provided to the regions.

Outreach and specific actions focused on providing services to vulnerable people

- Staff involved in the service provision should be made aware about the importance of the documentation process;
- Prepare forms that guide the documentation process (disaggregation by vulnerable persons) and provide to regions; this can be part of the M&E process

Institutional Arrangement

- It is recommended to have a focal person in the Environment Case Team of the ministry to coordinate the activities and commitments including documentation of environmental and social management and assessment reports. The focal person could work with the Ministry of Environment, Forest and Climate Change (MEFCC) and the Ministry of Labor and Social affairs to ensure that regulatory bodies are involved in the implementation of agreed actions.

VII. ACTION PLAN

Table 2. Proposed actions to be included in the Program Action Plan (PAP)

	Action	Responsibility	Timeframe
1	Strengthen the coordination and reporting on environmental and social safeguards in FMOH	FMOH	Year 1-3
2	Update relevant documents to incorporate environmental impact and risk criteria in the site selection screening for all health facilities.	FMOH	Year 1
3	Capacity building of staff of the regulatory body on areas of health care facilities regulatory and inspection work	FMHACA	Year 1-3
4	Enforce compliance with the Medicines Waste Management and Disposal Directive on health facilities constructed before the issuance of the directive	FMOH/ FMHACA	Year 1-3
5	Document consultations with communities on land acquisition for construction of health facilities	FMOH	Year 1-3

ANNEX I: DETAILS ON THE IMPLEMENTATION OF THE 2013 ESSA ACTION PLAN AND RECOMMENDATIONS

a. Site Screening for new Health Centers

65. The 2013 ESSA mentions that the FMOH has developed comprehensive set of standards and engineering designs streamlined for construction of all health centers in Ethiopia. In addition, the FMOH, through its Planning and Project Department, has prepared and published in 1998 a Civil Works Implementation Checklist (minimum requirements); a Site Selection Criteria (minimum requirements) report. These documents are being used in rehabilitation and construction works of health centers.

66. In addition to what was mentioned in the 2013 ESSA, the following developments are observed.

Positive Developments

- In 2014 a Small Scale Medicine Establishment Directive No. 26/2014 was issued. The directive covers the issue of site screening adequately. It specifies that small scale medicine producing firms need to be located in places where they don't cause negative impacts to the environment and the society.
- In addition, it requires that such establishments need to be constructed in sites that does not impair the required safety, quality and efficacy requirements of medicine products.

Challenges or gaps

However, these documents are not updated to incorporate the gaps identified by the ESSA team related to:

- Incorporating environmental and social impact and risk criteria in the site selection screening forms for all health centers;
- Ensuring that the screening is explicit in addressing natural habitats and physical cultural resources considerations in order to avoid siting health centers in areas that would impact either or both; and
- Appropriate mitigation measures to address induced impacts.

Suggestions for improvement

- The relevant documents should be updated by considering the challenges/gaps identified.

b. Equipment and Resources for Regulatory Purposes of Health Facilities

The following suggestions were made in the 2013 ESSA:

- Availing necessary equipment and resources to the Health and Health-Related Services and Products.
- Core Process unit staff need resources, including vehicles and equipment, such as water quality analytical kits for fulfilling their regulatory tasks.

Positive developments

- Since 2015 health services facilities quality and safety is given high attention. In line with this, Clean and Safe Health Facility (CASH) initiative was launched;
- Since 2015 FMHACA is accountable to all the regulatory works;

- All newly built health facilities are required to have certificate of competency (they are required to fulfill the four Ps- professionals, product, premises and practices) before they start providing service.
- Regulatory frameworks have been developed that made such facilities mandatory. Two of these frameworks are:
  - Small Scale Medicine Establishment Directive No. 26/2014, which adequately incorporates the need for equipment installation and use of the necessary health related equipment in the small scale medicine manufacturing firms. For instance, it provides in its Article 12 that the location, design, materials and equipment, their layout, etc. shall aim to minimize risks on humans, the medicines and the surrounding.
  - Healthcare Waste Management Directive No. 16/2013. In its various articles, this Directive provides that, Healthcare professionals or waste handlers, waste transport or transfer employees, incinerator operators, etc. shall wear proper personal protective equipment whose materials from which they are made of should fulfill internationally accepted standards.

Challenges or gaps

- Since most of the health facilities were constructed before the standards were set, the knowledge of the health providers towards safety is limited. In addition, the inspection is done on areas that were not thought or planned previously, and these have made supervision difficult;
- Most of the regulatory staff join the work force with health related technical knowledge, having limited regulatory knowledge, and this affects the inspection work;
- Specialized health professionals are in short supply, particularly in rural areas, affecting the quality of services;
- Core regulatory team from FMHACA is constrained with transport to make the necessary supervision and inspection.

Suggestion for improvement

- Currently the FMHACA is handling food, medicine and health related regulation activities. This mandate is extensive and must be well managed to ensure quality regulatory functioning of the agency. Clear definition of tasks, capacity building and if needed separation of tasks needs to be considered.
- Adequate transport support for the inspection work is an area that needs attention; and
- Capacity building of the regulatory body on areas of health care facility supervision and inspection.

c. Healthcare Worker Retention, Incentive Packages, Training and Capacity Building

The 2013 ESSA states the following action: "…To improve service delivery, the FMOH will facilitate the implementation of the Human Resources for Health Strategic Plan (2009-2020)".

Positive developments

- Continuing Professional Development (CPD) Guideline for Health Professionals and in-service training in the health sector was developed in 2013 by FMOH. CPD refers to all activities health professionals undertake formally so as to develop their knowledge, skills and attitudes in response to the health service needs of the public.
- In addition, FMOH has developed and operationalized the Human Resource Information System (HRIS). The system has administrative, personnel, leave, license, performance, and training modules. These modules help to track and report on these components of human resource management.

Challenges or gaps

The Health Sector Transformation Plan (HSTP) highlighted the following bottlenecks:

- Enforcement has not begun to make sure that the guidelines and directives for continuing professional development (CPD) are implemented;
- Some in-service trainings are not always need-based, well-planned, coordinated, quality assured, monitored and evaluated for their effectiveness;
- IST (In Service Training) is mostly face-to-face and group based with limited use of innovative and efficient in-service training modalities like on-the-job training, and blended learning approaches; and
- The problem of staff turnover is not yet abated as indicated in the annual reports of most of the directorates.

Suggestions for improvement

- Strengthening the monitoring and evaluation of the implementation of the guidelines and directives for continuing professional development (CPD). This should be backed by continuous commitment of management to address the feedback collected from the monitoring and evaluation.
- Review the health worker retention and incentive package and identify areas for improvement.

d. Establishment and operationalization of Infection Prevention and Patient Safety Committees (IPPS) to facilitate implementation of facility level health center waste management (HCWM).

Positive developments

- The IPPS guideline was developed in 2012 and the standards were set. In addition, trainings were organized to familiarize the committee with the standards.
- Status of IPPS functions is included as one activity in the health care facility quarterly report. This has increased follow up and commitment.
- Most public facilities are supported with such committees having members from environmental and occupational health, including IPPS trained nurses/health officers.

Challenges or gaps

- The newly constructed health facilities have IPPS. However, some of the old facilities which were constructed for other purposes but converted to health facilities, lack adequate IPPS commodities.
- The program lacks continuity as there are limited incentives for the committee members to serve for a long time.
- IPPS supplies and commodities are not adequately available.

Suggestions for improvement

- A continuous supply and availability of IPPS supplies and commodities should be given attention;
- The best practices observed in the public health facilities should also be transferred to the private health facilities;

e. Extent to which appropriate temporary storage facilities for collection of hazardous wastes until final and appropriate disposal is completed.

The 2013 ESSA mentions that national legislation on medical waste management, including hazardous medical waste, is comprehensive and aligned with the requirements of OP/BP 9.00.

Positive developments

- Most facilities in the regions have started implementation of the Health Care Waste Management Strategic Action Plan.
- The seven hygiene and environmental health packages which includes, solid and liquid waste management as one component, is being implemented by the Health extension program in all regions.

- The Integrated Urban Sanitation and Hygiene Strategy and strategic action plan was developed in 2016 by FMOH; and
- The Healthcare Waste Management Directive sufficiently covers the importance of storage for hazardous wastes and considers it as one of the major requirements in the process of waste management before treatment and/or disposal.

Challenges or gaps

- Newly constructed health facilities have IPPS facilities as they are constructed for the purpose. However, some of the old facilities which were constructed for other purposes but changed to health facilities lack adequate IPPS facilities and proper hazardous waste disposal structures.
- The steps in identification, segregation and disposal of hazardous waste are not adhered to in all health facilities.

Suggestions for improvement

- Health facilities constructed before the Medicines Waste Management and Disposal Directive was issued should be assessed and encouraged to comply with the directive.
- Mechanism that oblige the relevant person to undertake hazardous waste management tasks complemented with continuous appropriate awareness creation interventions should be given attention; and

f. Public and Worker Safety

Positive developments

During construction phase of health facilities:

- The Public Procurement Agency has developed guidelines related to components and specification of bid documents for construction of government buildings and civil works. This describes public and worker occupational safety measures to be considered in civil works.
- The FMOH Infrastructure Directorate complies with these guidelines when preparing bid documents. A review of some of the recent bid documents prepared by the directorate confirms compliance.

During operation phase of health facilities:

- The FMOH has assigned one staff to handle the occupational health and safety of the Ministry staff in line with the Labor and Social Affairs requirements pertaining to personal protective equipment and occupational health and safety practices.

Challenges or gaps

- Most of the time, budget for construction finishes before the whole building is completed. In this kind of situations, priority is given to make the buildings habitable, with reduced attention to public and worker safety.

g. Extent to which consultations and participatory nature of discussions held where communal land is used for construction of health centers is documented.

Positive development

- In general, there is a well rooted understanding and appreciation regarding the precautions and steps that should be followed in handling compensation for land, assets, and/or livelihoods.

Challenge or gaps

- Though the process of consultation and participation of the concerned stakeholders is undertaken, attention is not given to the documentation of the consultation process.

Suggestions for improvement

- The staff members who carry out the consultation process should be made aware about the importance of the documentation process.
- Forms that will guide the consultation process should be prepared by the responsible Government Agency and provided to the regions. The documentation that needs to be made is related to the process carried out with community in identifying health facility construction sites including agreed actions. This will help to follow up decisions made and also resolve conflicts if they arise.
- Periodic reports prepared by regions should include the number of consultations held.

h. Extent to which outreach and specific actions focused on providing services to all vulnerable persons is documented.

Positive developments

- Quarterly integrated supportive supervision and annual review meeting are carried out;
- The provision of ART is expanded to development corridors.
- Special support health professionals are deployed for regions and *woredas.*
- Functional health extension program is provided at all levels; and
- Mobile health clinics are implemented in Afar and Somali regions.

Challenges or gaps

- Though different services (as measured by SPA+ SARA, DHS) are being provided to the different vulnerable persons the process of service provision for vulnerable populations including refugees is not well understood. Various mitigation measures have been included in the Program.

Suggestions for improvement

- The staff involved in the service provision should be made aware about the importance of the documentation process; and
- Forms that will guide the documentation process (disaggregation by the vulnerable persons) should be prepared by the FMOH and provided to the regions; this can be part of the M&E process.

i. Issues on Institutional Arrangement

The Environmental Organs Establishment Proclamation No. 295/2002 requires establishment of environmental units in sectoral organs (such as the FMOH) for effective follow up of environmental performance of the activities of these sectoral organs. The law also rules that environmental units in various sectoral organs to work in coordination with environmental protection institutions.

ANNEX II: FIELD VISIT REPORT TO HOMOSHA AND ASHURA

BENISHANGUL-GUMUZ REGIONAL STATE HEALTH BUREAU AND HOMOSHA WOREDA HEALTH OFFICE AND HEALTH FACILITIES

Status of the action plan implementation

a. Site Screening for New Health Facilities

Site screening for construction of new health facilities should make sure that construction will not negatively impact natural habitats and physical cultural resources, as indicated in the Bank's Core Principle 2 of BP 9:00.

Positive Developments

There are efforts to comply with the Bank's Core Principle 2, with the view to reducing the negative impacts on the environment and people in the construction of new health facilities. For instance, screening of sites is mainly done by a committee (constituting community representatives and woreda officials) established to select construction sites.

Challenges or gaps

The KII and focused group discussions during the field visit have revealed a number of challenges associated with site screening for construction of new health facilities. These include:

- There is limited skilled human resource that can follow up the construction of health facilities. There is only one engineer in Benishangul-Gumuz Regional State for this purpose, who covers all the woredas.
- Even though site selections are made by committees, which constitute members from the community and woreda officials, and standards of health facility construction are also available, environment and social risk issues could be encountered at a later stage. For instance, at the visited Homosha health center, the waste disposal pit was encroached by recently settled residents due to the absence of a fence which is a must for all health centers to protect residents and animals against potential health hazards and medical waste.

Suggestions for improvement

- The guideline prepared for site screening and construction of health facilities by FMOH is relatively old and also gives less emphasis to avoiding environmental and social risks. It requires to be updated considering all environmental and social issues relevant for screening site selection for construction of new health facilities.
- Engaging the community in the process of site selection should always be a mandatory process as per the Law of the country.

b. Regulatory Equipment and Resources

Regulating the proper functioning of health facilities is bestowed in the FMHACA at federal level and the Regulatory Department of Health Bureaus of regional states. One of the objectives of these federal as well as regional regulatory organs is averting health problems due to substandard health institutions, incompetent and unethical health professionals, poor environmental health and communicable

diseases.[6]Poor environmental health is defined as: "all factors in human physical environment which may cause a deleterious effect on the physical development, health and survival of human beings."[7]

Positive developments

- The Regulatory Department of the Benishangul-Gumuz Health Bureau was able to carry out annual status assessment of private and public health facilities in 2016. The assessment focus areas are hygiene, sanitation, solid and liquid waste disposal. Sanitation is the major problem in the health service institutions regarding disposal of solid, liquid and hazardous wastes. The Regulatory Department advises health facility institutions (hospitals, health centers and health posts) to correct things in a certain time framework, if they do not act as per the standards set. They are given oral admonishment, written admonishment and finally banning the institution progressively. The CASH initiative calls for this measure to be equally applied in private health service providers as well as public.
- The standards used for private and public health facilities are similar. The outcome of the assessment is disclosed to the facilities and agreement was reached between the Regulatory Department and the health facility institutions. Accordingly, due dates have been set for improving the gaps identified. In addition to the overall annual assessment, routine inspections are carried out on quarterly basis.
- In 2015 a regulation entitled "Food, Medicine and Health Care Administration and Control Regulation No. 91/2007 E.C." was issued by the Regional State based on federal proclamation entitled "Food, Medicine and Health Care Administration and Control Proclamation No. 661/2009." The Regional State's Regulation has similar objectives with the Federal Proclamation.
- One vehicle and four computers were donated FMHACA in 2016. This has improved the performance of the Regulatory Department.
- Electronic management information system is being installed to improve the information sharing process.
- The regulatory unit had no separate budget allocated to it until 2016. However, in 2016 about 500,000 ETB was allocated. Even though this might not be sufficient, it is a good beginning. However, there is no budget still for zones and woredas.

Challenges or gaps

- Awareness problem in the justice administration organs (police, prosecution and courts) on the significance of the regulatory activities.
- Availability of personal protection tools needs to be strengthened in order to ensure personal safety standards as defined by Government Regulations so as to build the capacity of Zone and woreda staffs in the regulatory department to undertake the regulatory tasks.
- Zone and woreda staffs in the regulatory department have less capacity to undertake the regulatory tasks due to lack of sufficient operational budgets. In addition, there are instances where their capacity to fulfil their duties are hindered due to lack of budgets, the lack of attention to quality by decision makers rather than simply assigning staff to tasks remains a major challenge.
- Relatively less costly but useful equipment such as weighing scale, measuring tape, camera, thermometer, sound pollution measuring meter, GPS, iodine salt testing and food poison testing kits are still lacking in some facilities. In some instances, samples are sent to Addis Ababa due to lack of such services.
- Operational costs also remain a challenge in the areas visited. Transport is limited and this is worse in the woredas and zones as they do not have any vehicle at all.
- FMHACA needs to further strengthen the capacity of inspectors to ensure that professional independence in safety standards and processes are adhered to.
- Staff turnover is a major challenge in the regulatory unit, even more aggravated than the other departments due to skills shortage as well as lack of sufficient incentives. The reasons for this include:

[6]Food, Medicine and Health Care Administration and Control Proclamation No. 661/2009, preamble.

[7]Proclamation No. 661/2009, Article 2 (29).

lack of sufficient incentives, the personal injury and safety risky nature of the jobs and many of the incentive packages do not cover the staff in the regulatory department.

Suggestion for improvement

- There needs to be awareness creation to other administration organs to help them understand occupational health and safety issues so that they give attention.
- Improve availability of operational budget in order to ensure full completion of tasks assigned as per regulations set by the Government.
-

Changes since 2013

- Vehicles and computers are bought.
- Database center established with the purpose of availing data online.
- At the bureau level, the number of staff in the regulatory department now increased to six. Of these, one has an MSc degree and five are degree holders. Three are specialized in Environmental Health and the rest three are specialized as health officers.
- The intensity of trainings has increased at the Federal and Regional levels and there is training at least on a monthly basis, though zone and woreda staffs may not get trainings with the same intensity.

c. Healthcare Worker Retention, Incentive Packages, Training and Capacity Building:

At present, retaining experienced workers in the Ethiopian governmental offices is a big challenge and the health sector is no different in this regard. However, efforts are being made to retain these experts at federal as well as regional levels. The major reason for this problem is repeatedly indicated as the small incomes for these workers as compared to other private or NGO workers.

Positive developments

- The Government of the Benishangul-Gumuz Regional State has decided to raise the remunerations of specialized experts such as gynecologists and pediatricians from 40,000 – 50,000 ETB, although it has not yet prepared procedures and guidelines. It is reported that this has helped to retain these specialized doctors.
- In addition to the already existing two training centers (Pawe Hospital and Asosa Health Training Center) the region has established two short in-service health training centers at Kamashi and Asosa health centers. It is indicated that this helps to retain workers as they always seek to enhance personal development and also they sign a bond agreement to serve for some time as per the agreement.
- Professional and hardship allowances for health workers assigned in hot and marginal areas is being paid and this is strictly followed.
- Residential quarters are being provided to health workers providing service at hospitals and health college level and for all those who are outside woreda towns.
- Training assessment is carried out and this is being used when organizing training.
- The Human Resource Information System has become operational and is used to track the data related to human resource.

Challenges or gaps

- There is frequent staff turnover, particularly those who are with high education levels such as gynecologists and pediatricians do not stay in the regional state. It is clear that regional state investment in training is not fully recovered from those who obtained education with the assistance of the regional state.

Suggestions for improvement

- Implement the Health Resources for Health Strategy (HRH) that includes development of appropriate continuous education, career structure and incentive mechanism for all categories of HRH, including those working in environmental and social safeguards.

d. Establishment and operationalization of Infection Prevention and Patient Safety Committees (IPPS) to facilitate implementation of facility level health center waste management (HCWM)

Positive developments

- At the health post level, the 1 to 5 networks are used as 'health service army'. The leaders of these networks are used to disseminate health related information and there is a good level of awareness on wastes and their management. Nearly all respondents at grassroots level are well aware of the importance of correctly disposing wastes (hazardous, liquid and solid). For instance, they know that some wastes (e.g. expired medicines are not disposed at a health post level but should be sent to health centers for disposal as there are no facilities for their disposal).
- Some of the health institutions have strong committees and full time focal person on infection prevention, especially as part of the Clean and Safe Health Facilities (CASH) initiative. Committees for disposal of expired medicines are also established. Currently, the CASH initiative is operational in BSGRS in the hospitals and in a number of health centers. There is good progress in terms of fulfilling personal protective equipment such as sanitary utensils, goggles, rubber aprons, knee-high boots, etc.
- Infection Prevention and Patient Safety Guideline for Health Care Facilities in Ethiopia, a guideline prepared by the FMOH in 2012 and it is being applied in health facilities in the regional state.
- Training are conducted on infection prevention and patient safety, especially for hospital staff as well as for health centers and health posts. The hospitals use their own staff for training the rest of the staff members. TOT method is widely applied for training purposes.
- For CASH initiative, TOR has been prepared by the FMOH and the Benishangul-Gumuz RS adopted it based on the local context. Even the hospitals prepared their own TOR to effectively implement the CASH initiative.
- Many health institutions now have installed incinerators and placenta pits through the WASH program; and in the health center and health post visited, placenta pits are built though in some instances other wastes meant to be burnt during the dry seasons are included.[8] Solid wastes (not including hazard waste) is put in the pits to be burnt during dry seasons, instead, since 2015 hazardous waste is incinerated and liquid waste is disposed on its own procedure.
- Expired medicines are disposed by committees. DDT is considered as hazardous. There is minimal utilization of DDT now but people get it from agricultural sector and use it as domestic pest control (for killing bed bugs). Except DDT, there are no other hazardous wastes which are used by the community. Health extension workers give lessons for members of communities on the impacts of hazardous chemicals in churches, mosques and market places. The educational programs also include on waste disposal aspects.
- A software, known as Human Resource Information System is developed by FMOH and Tulane International Ethiopia in October 2014. A job description of health workers is also prepared with the assistance of ICAP in 2008 E.C.

Challenges or gaps

- Knowledge on use of incinerators needs further strengthening to address turnover of staff, and to avoid improper use of incinerators Although IPPS committees are established at the health center level, they operate intermittently.

[8] The team saw this at Ashura Health Post in Homosha Woreda.

- Some health institutions do not have running water, and alternative water sources are used including use of wells dug in their compounds facing the challenge of drying up or being nonfunctional due to lack of maintenance for the water pumps.
- In BSGRS, there are 2 hospitals and 37 health centers. It is expected that in all of these health institutions IPPS Committees should have been well functioning. But these committees are established only in 20 of these institutions (including the two hospitals); and even then some of the existing ones are not well functional, might not include all key stakeholders.
- The two hospitals in the RS use low temperature incinerators. It would be good if the incinerators are high temperature ones. Encapsulation of hazardous wastes is necessary but this is completely out of the reach of the RS.
- There are no color coded bins for waste segregation. Color coded waste collection could not be realized at health center level due to budget constraints.
- The field trip to Homosha Health Center found urgent need of ensuring safe location of disposal pits and proper handling and disposal of expired medicines so that residences (some of whom have moved closer to the facility after it had been constructed) are not impacted by improper open pit disposal. Long term planning, and a functional grievance redress mechanism must be strengthened to safeguard the health of populations.

Suggestions for improvement

- The Health Bureau and/or the health facilities may seek cooperation with partners with more capacity in the area of environmental and social safeguards, partially to address operational budget challenges but also to gain the technical expertise in specific areas.

e. Extent to which appropriate temporary storage facilities for collection of hazardous wastes until final and appropriate disposal is completed

Positive developments

- Awareness about the disposal of hazardous waste is growing over time.
- As reported by the health workers at the Ashura Health Post, expired medicines are not disposed at health post. They are stored in separate boxes until they are sent to health centers for their final disposal.
- Health centers have segregated waste disposal mechanisms for ordinary wastes and hazardous wastes. They have also a separate safety box as a temporary storage for sharp and pointed objects, like used syringes.

Challenges or gaps

- Color coded collection of wastes is not fully adhered even in hospitals. This situation made the temporary storage facilities of hazardous wastes substandard.

Suggestions for improvement

- In most places the basic hazardous waste disposal facilities exist but when they are damaged due to various reasons; proper maintenance is not done because of budget constraints. As this is the last thing that will be done when there is budget constraint, if there is no possibility of increasing the budget, earmarking the budget for this kind of activity may help.

f. Public and worker safety

Positive developments

- Personal protective equipment is more or less fulfilled at hospital level, but must be improved at health center level.
- Hospitals can fulfill these from their internal revenue based on the Health Care Financing Implementation Strategy of 1998. According to this Strategy, health facilities can utilize a certain portion of their internal revenue for purchasing certain items.

Challenges or gaps

- Improvement in the quality of construction of health facilities has been observed, however, some older facilities standards are still in need of improvement to ensure adequate space for the variety of uses at facilities.
- Some of the equipment are not properly utilized as appropriate training was not given to operate them and water or electricity is not available. For example, the Ashura health post in Homosha woreda, has autoclaves which are not operational as appropriate training was not given to the staff working there. Operation of medical equipment without sufficient training could pose a hazard to personnel.
- Closer cooperation between The Health Bureau and MOLSA/BOLSA is required to ensure that workers' safety standards are adhered to.

Suggestion for improvement

The Health Bureau needs to establish closer collaboration with MOLSA/ BOLSA.

g. Extent to which consultations and participatory nature of discussions held where communal land is used for construction of health centers is documented

Positive developments

Existence of site selection committee.

Challenges or gaps

- While there might not be critical land shortage in the regional state at this moment, this situation might in the future and the extent to which people are consulted where land acquisitions are made from communal lands will have to be strengthened. It is indicated that this condition cannot continue indefinitely as the population size is increasing and also there are big interests for investment projects, such as large-scale commercial farming.

h. Extent to which outreach and specific actions focused on providing services to all vulnerable persons is documented.

Positive developments

- Clear meaning is given to vulnerable groups. According to the understanding of the Health Bureau, the major vulnerable groups are people who are living with HIV/AIDS or the ones who are highly exposed to the virus.
- Use of the manuals prepared by the concerned organs, especially by Federal HIV AIDS Prevention and Control Office. For instance, the manual entitled "HIV Behavior Change Communication Framework" which was prepared in 2011 with financial aid from the Global Fund is under use. It is indicated that the manual was found effective for easy communication among people who live with the virus. In addition, goals which are commonly referred as the three 90s: getting 90 percent of people living with the virus; of these 90 percent should use the antiretroviral drug; and from these 90 percent of the viral load should be suppressed.

- There are also other manuals and guidelines which are used to assist vulnerable groups, to address the gaps in assistance when donor resources become unavailable and community engagement becomes important to organize fundraising locally. It is based on this idea that "Community Care Coalition" is established with the view to establishing self-help associations. The fundraising can be made in kind or in liquid cash. (E.g. labor, hides and skins from slaughters on Christian/Muslim holidays, eucalypt tree donations from communal lands, etc.). There is community contribution to health facilities in kind and/or in cash. For example, civil servants sometimes contribute 0.5 – 1.0 percent of their salaries.
- Multi-sectoral Response HIV/AIDS Prevention and Control Core Process has been established.
- The Federal HIV AIDS Prevention and Control Office prepared a manual entitled "HIV Behavior Change Communication Framework" in 2011 with finance obtained from Global Fund. The manual is found effective in easy communication among people who live with the virus. There are also goals which are commonly known as three 90s. They mean that: getting 90 percent of people living with the virus; of these 90% should use the antiretroviral drug; and from these people, in 90 percent of them the viral load should be suppressed.

i. Issues on Institutional Arrangement

No change in institutional arrangement has been introduced at the regional state level since 2013.

10) Additional Points

- The Community Care Coalition (CCC) which is in the process of establishment in the region has the potential to mobilize the community to make financial contribution for health services. This is already being institutionalized and operationalized in Tigray and Amhara.
- Engaging communities in all health packages was seen as a positive development.
- Communities are organized in 1 to 5 groups which made communication easier for health extension workers. However, the major communication is made with selected group leaders, especially for training purposes (TOT). This may have its own negative impact as information can be diluted on its way to the members of the group.
- Nearly in all aspects of the health activities, there are budget problems. The following are the major areas identified as having finance problems.
- Fieldworks are highly limited by finance problems and this in turn limits the assistance that should have offered for communities and health extension workers.
- There are many instances where overtime works are not paid due finance problem. This is one of the reasons for high staff turnover.

Issues that need improvement: i) Burning of expired medicines; ii) When expired medicines are burned in open pits, they release fumes which has pungent odor. Earlier, the open pits used to be far from residential quarters, increasing population size must be taken on board in enforcement of environmental standards.

end