

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

I. Introduction

1. The World Bank is supporting the Government of Morocco's health sector through the Improving Primary Health in Rural Areas Program-for-Results (PforR) program, which has been effective since 2015. The PDO of the US\$100 million Program is "to expand access to primary health care in targeted rural areas" in seven regions which had the poorest health outcomes. To attain the PDO, the program included seven DLIs focusing on improvements in antenatal care visits, skilled deliveries, number of sick child visits, diabetes diagnosis and treatment, overall visits to rural primary health centers, participation of health facilities to quality competitions, and establishment of health management information system (HMIS). The expected key results of the PforR are to increase the use of primary healthcare services in targeted rural areas, improve accountability of the health system and establish a health information system in public health facilities. These are accomplished through two Program areas: first, improving health care at the primary level in rural areas, and second, improving governance in healthcare. The Program has been restructured twice, and it has been rated as **moderately satisfactory** since December 2017. The last restructuring took place in December 2019 and extended the Program closing date to December 31, 2020.

2. Prior to the launch of the Program in 2015, the World Bank team prepared an ESSA according to the requirements of the World Bank's Policy for PforR financing. The ESSA reviewed the capacity of existing country systems to plan and implement effective measures to manage environmental and social risks under the Program and determined necessary measures to strengthen the country system. Thus, the ESSA recommended several actions under the ESSA Action Plan (AP) that addressed the identified gaps, and these were fully integrated into the Program Action Plan (PAP).

3. With the advent of the COVID-19 pandemic, the government has requested a third program restructuring with the objectives to include US\$35 million additional financing (AF) from the World Bank Fast Track COVID-19 Facility and the reallocation of undisbursed funds of US\$12.98 million. The Program would be extended to close in June 30, 2021.

4. To ensure that E&S risks continue to be avoided, reduced or mitigated adequately, the World Bank team prepared this ESSA addendum to cover potential additional E&S aspects that may raise from this structuration. **This addendum does not constitute a new ESSA and should be considered together with the ESSA of the parent Program.**

A. Objectives of the ESSA addendum

5. The ESSA addendum aims to address the environmental and social risks specific to the proposed AF of the Improving primary health program (P173944) and has the following objectives:

- identify potential legislative and procedural changes since the preparation of the ESSA for the "Improving Primary Health in Rural Areas" Program;
- identify new potential environmental and social risks and impacts from the Improving primary health program AF; and
- recommend measures to further strengthen the environmental and social system.

B. Methodology of the ESSA addendum

6. The preparation of the addendum involved a series of interviews and consultations with stakeholders related to the health sector, namely the Directorate of Hospitals and outpatient care (*Direction des hôpitaux et des soins ambulatoires - DHSA*) and the Directorate of Epidemiology and Diseases Control (*Direction de l'épidémiologie et lutte contre les maladies-DELM*) and Planning and Financial Resources Department of MoH (*Département de la planification et des ressources financières – DPRF*), and a thorough document review (e.g. Aide Memoire, Implementation Status Reports, PAP) for the parent World Bank funded Program at the Ministry of Health (MoH). The draft addendum will be translated into French to conduct meaningful discussions with key stakeholders, complying with the Bank's Information access and disclosure policy.

II. CONTEXT

7. Morocco has been augmenting its level of preparedness and response to prevent the potential for greater loss of life. On April 1, 2020, the MoH announced the acquisition of 100,000 tests, and COVID-19 testing capacity has been reinforced in 13 public and private laboratories. The government has also invested in the production of masks and hydroalcoholic solutions and regulated their prices. Standard operating procedures and protocols for quarantine, isolation, case management, and infection prevention and control (IPC) have been developed. In terms of actual isolation/quarantine and case management, several military facilities (including temporary hospitals - *Hôpitaux de campagne*) have been mobilized at the regional level, while 46 public hospitals were strengthened to handle and treat coronavirus patients. For COVID-19 cases, the government has been scaling up hospital beds and intensive care units (ICU) capacity, bringing the total capacity of ICU beds to 1,640 and the total number of beds to over 20,000. Private clinics will be called upon if the number of cases cannot be accommodated in public facilities. 138 ambulances were dedicated to COVID-19 response, and efforts are ongoing to reinforce health workers capacity. Three hotline numbers were put in place and Information, Education and Communication (IEC) materials and messages have been developed. A fully electronic health information system has been put in place which will regularly be updated with laboratory testing results, enabling real-time epidemiologic reporting and informing evidence-based decision-making.

8. Morocco also needs to mobilize additional resources in the short term to combat COVID-19. The government announced a COVID-19 Fund of US\$3 billion to respond to immediate needs in the health sector and provide an economic stimulus. While significant funding has been sourced domestically, raising additional funds quickly remains critical to expanding fiscal space and ensuring sustained support to respond to the pandemic.

III. Description of the Additional Financing

9. The program PDO has been extended to consider the COVID-19 specificities as follow: “to expand access to primary health care in targeted rural areas and to strengthen detection and case management to respond to the COVID-19 pandemic in the Program Area.” The expanded PDO would ensure that the PforR can help to respond to the threat posed by the COVID-19 pandemic while continuing to strengthen the health system and enabling responsiveness to this emergency by supporting the government's pandemic preparedness plan. Achievements towards the revised PDO and expanded objective will be measured through a revised results framework to include three new indicators:

a. PDO level indicators:

- **PDO indicator 5** (new DLI 8): “Number of Polymerase Chain Reaction (PCR) tests

conducted to diagnose COVID-19”; and

- **PDO indicator 6** (new DLI 9): “Number of health facilities that are designated as COVID-19 facilities and equipped as per MoH guidelines”.

b. Intermediate results indicator:

- “Number of designated laboratories with COVID-19 diagnostic capacities established per MoH guidelines”.

10. While the parent Program focuses on seven Moroccan regions, the AF will extend the program areas by 2 additional regions (Casablanca-Settat and Rabat-Sale-Kenitra) which include the key national hospitals (26 in Casa-Settat and 19 in Rabat-Sale-Kenitra) and concentrate 34% of national population.

11. In line with the government priorities, area new activity would be added to the Program to focus on the emergency COVID-19 response. This activity would provide immediate support to respond to the COVID-19 pandemic. It would support enhancement of disease detection capacities through provision of technical expertise, laboratory equipment and systems to ensure prompt case finding and contact tracing consistent with WHO guidelines in the Strategic Response Plan. It would also enable Morocco to mobilize surge response capacity through trained and well-equipped frontline health workers. Supported activities would include:

- **Case Detection, Case Confirmation, Contact Tracing, Case Recording and Case Reporting.** This would help: (i) strengthen disease surveillance systems, public health laboratories, and epidemiological capacity for early detection and confirmation of cases; (ii) combine detection of new cases with active contact tracing; (iii) support epidemiological investigation; (iv) strengthen risk assessment, and (v) provide on-time data and information for guiding decision-making and response and mitigation activities. Additional support could be provided to strengthen health management information systems to facilitate recording and on-time virtual sharing of information.
- **Health System Strengthening.** The Program would support the health care system for preparedness planning to provide optimal medical care, maintain essential community services and minimize risks for patients and health personnel, including training health facilities staff and front-line workers on risk mitigation measures and providing them with the appropriate personal protective equipment (PPE) and hygiene materials. Strengthened clinical care capacity could be achieved through financing plans for establishing specialized units in selected hospitals, treatment guidelines, clinical training of health workers and hospital infection control guidelines. This would include support for intensive care facilities within hospitals with medical equipment and training of health teams.

IV. Implementation Progress of the PAP

12. The assessment of the Program’s PAP revealed an important delay in the designation of the E&S focal points at national and regional levels. Meanwhile, medical waste management has improved in hospitals in urban and semi-urban areas, but not in rural Primary health care centers (Etablissements de Soins de Santé Primaires - ESSP). The creation of a budgetary line (dedicated to health waste transport and elimination) in the annual budget of MoH regional directorate and of MoH delegations helped externalize the medical and pharmaceutical waste management at the hospitals and ESSP levels.

13. The PforR includes a DLI on quality assessments as well as an indicator on the establishment of a grievance redress mechanism (GRM), both of which are operational and have been highly effective. These activities have catalyzed a broader focus on quality of care, and during the PforR implementation period,

the Moroccan health system has made great strides in becoming an evolving health system through learning.

V. Legislative and Procedural Changes

14. The E&S system described in the parent ESSA remain applicable for the whole program including the AF both in terms of laws, regulations, standards and in terms of procedures and actual implementation of those laws and standards.

15. Article 4 of the Decree No. 2-09-139 stipulates that generators of Medical and Pharmaceutical Waste (MPW) are required to set up an internal management system. Article 5 specifies that, regardless of the generator of the MPWs, the management of such waste includes source separation, packaging, storage and, where appropriate, collection and transport, treatment and disposal of such waste.

16. The joint decree (2018) between the Ministry of Health and the Environment Department on the management of medical and pharmaceutical wastes describe the technical and organizational tools for an efficient management of medical waste in health care institutions. The decree regulates:

- the organization and operation of the internal waste management system (as mentioned in the Article 4 of the Decree No. 2-09-139);
- the rules for the storage of medical and pharmaceutical wastes, particularly those relating to the duration, characteristics and maintenance conditions of the premises intended for them;
- appropriate techniques and different processes of treatment and disposal of medical and pharmaceutical categories 1 and 2 wastes ;
- the procedures for the approval, implementation and control of equipment for the treatment of medical and pharmaceutical categories 1 and 2wastes.

17. The Ministry of Health developed deep experience in the application of this law and its implementing decrees through hospital construction projects with funding from international donors. The experience of the Ministry of Health in this field benefited also from its participation in the EIA Committees at central and regional levels.

18. The Ministry of Health (DHS and DHM) produced in 2002 a guide for the management of medical waste in health-care settings, and with WHO (CEHA) support, a practical guide for the management of medical waste in health care institutions has been developed in 2004. In 2013, the environmental audit reference framework for hospitals for the management of medical and pharmaceutical waste has been established. This audit standard serves as both a didactic and operational tool to support the various health establishments in their efforts to improve the management of MPWs, whatever their performance levels in this area.

19. The Ministry of Health has developed and implemented health program aimed at controlling environmental factors that have been identified as important determinants of health, such as drinking water, bathing water, ambient air and disease vectors.

20. It's worth noting also that since 2004, all public hospitals have outsourced the management of MPWs from internal collection to transport and disposal by shredding and sterilization.

VI. AF PHCSP Environmental and Social Risks and Impacts

21. The additional financing increases the risk profile of the original program. The current crisis of the COVID pandemic involves a highly contagious disease that is spreading fast and leads to potentially deadly course of illness in the affected patients. The disease has thus the potential to infect not only other patients, but also hospital personnel, and lead to high load of patients in underprepared hospitals and health centers.

22. While the national health and environmental legislation (national system) described above, includes necessary measures to mitigate potential risks, the AF includes also necessary measures to ensure the protection of hospital workers, communicate about the reduction of risks to the general population, and provide material to ensure diagnosis and tracking of the disease. The AF therefore is structured to manage and reduce the risks related to the COVID crisis. The parent program has helped build systems in rural areas, including systems to manage E&S risk such as waste management, GRMs, that strengthened the provision of health services and reduce the risks of contagion and reproduction of the disease. The health services in urban areas are considered robust enough to manage the current crisis. The extension of the AF to two additional regions will help the Government to improve the crisis management.

23. Generally, the implementation of the Program will likely result in more benefits and positive impacts in targeted communities. It is important to underline, that the different risks and impacts identified in the ESSA for the parent Program interventions remain relevant to this AF. The ESSA for the parent Program identified the increase of health waste at the ESSP level as the main environmental risk, and this remain the case for the AF. Meanwhile, infectious waste volumes generated by the specific COVID-19 activities of the AF, will increase because of higher generation of personal protective equipment (PPEs) such as gloves, face and nose masks, waterproof protective gowns, rubber boots, rubber apron, paper tissues and other contaminated materials.

24. Through the AF, the increase in the production of medical and pharmaceutical waste will be limited to hospitals in targeted urban areas and not in the rural medical facilities. The hospital waste management systems are based on a clear and widely applied procedures (see section IX) developed by DHSA to manage health waste produced at the level of COVID-19 isolation units. In these hospitals, wastewater management is also not as critical as in rural areas targeted by the parent Program. Indeed, all the hospitals and associated structures are connected to the sanitation network of the urban centers where they are located.

25. The environmental officers at the regional representations of the MoH will help control the strict application of these procedures.

26. Transport, treatment and elimination of health waste are provided by private companies that are accredited by the MoH for the transport and by the Environmental Department (ED) for the treatment and elimination activities. The only technology agreed by the ED for the treatment is the steaming.

27. Laboratory testing for COVID-19 most commonly involves nucleic acid amplification tests (NAAT). Polymerase Chain Reaction (PCR) testing uses reagents such as guanidine thiocyanate which is considered hazardous particularly to skin (corrosion) and eyes (damage/irritation). The acute toxicity (oral, dermal and inhalation) is Category 4 under the 2012 Occupational Safety and Health Administration (OSHA) Hazard Communication Standard (29 CFR 1910.1200¹) which is the lowest risk category.

¹ <https://www.osha.gov/dsg/hazcom/ghoshacomparison.html>

28. Based on the above, the expected negative impacts with the increase of scope of the Program remain negligible, as far as legislations expects and the Safeguards Actions Plan and ESSA recommendations are implemented in the whole Program targeted regions. Beyond the nomination of E&S focal points in the two additional regions, the extension will require the integration of existing structures into the existing E&S supervision system.

29. The proposed AF does not include activities requiring the acquisition of land, since the activities focus mainly on upgrading and equipping existing infrastructure and strengthening the number of COVID-19 tests. As for the parent program, activities requiring such acquisition will be excluded from the Program.

30. The proposed AF will have positive social impacts as it should improve COVID-19 surveillance, case management, monitoring and containment. However, it will have potential social risks which are mainly relate to: (i) community health and safety and particularly the exposure of high-risk individuals to the virus while using the acquired material, equipment and medicine; (ii) limited capacity of vulnerable groups to access facilities and services designed to combat the disease and increasing social discontent due to the lack of tests, medicine and needed equipment; (iii) limited capacity of the health services to respond to the outbreak; and (iv) inadequate communication around the prevention and control effort of the disease. These risks are managed through the Program activities, as the program aims to ensure equity of access to health care, strengthen social accountability and participatory governance and develop grievance management mechanisms that are easily accessible, culturally appropriate and understandable for the people and communities affected. The Program will contain mechanisms to ensure the inclusion of vulnerable populations (elderly people, youth, female-headed households/widows, orphans, the homeless, etc.), including regarding communication and access for all. Protocols will have to ensure infected persons in remote areas will have access to the program benefits, and that guidelines such as WHO guidance on Risk communication and community engagement during the pandemic are followed.²

31. The GRM is fully operational through the center for receives and manages complaints “*Centre d’écoute et de gestion des réclamations- CEGR*”, and capacity building for managing the GRM at the regional level were completed by the end of December 2019, including the establishment of regional hotline numbers. The GRM is fully decentralized at the health facility level nationwide. The GRM portal is now part of the national portal *chikaya.ma*. Considering these efforts, the CEGR recently changed its name to central unit in charge of complaints handling “*Unité centrale de gestion des réclamations - UCGR*”. Patients are able to report complaints by phone or through the internet using the mechanism and provide feedback on the personnel and health centers so that they can be directed to the appropriate department. The UCGR continues to receive and address claims from patients who use the health services offered by MOH. During 2016-2018, more than 4,700 claims were submitted. 73 percent were related to health services and handled through feedback to concerned facilities handling by higher levels of decision making in the health system.

32. Morocco’s law No 09-08, dated February 18, 2009 relating to protection of individuals regarding the processing of personal data and its implementation Decree n° 2-09-165 of May 21, 2009 (together the Data Protection Law), are the framework governing data protection and privacy.³ The law establishes the

² <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/risk-communication-and-community-engagement>

³ <https://www.cndp.ma/images/lois/Loi-09-08-Fr.pdf>,
<https://www.cndp.ma/images/lois/Decret-2-09-165-Fr.pdf>,
<https://www.cndp.ma/fr/>

Data Protection National Commission (*Commission Nationale de Protection des Données Personnelles*) as authority overseeing its application. This law aims to ensure effective protection of individuals against the misuse of data likely to infringe on their privacy and to harmonize the Moroccan system of personal data protection with those of its partners. Data protection requirements are intended to be aligned with EU requirements to allow for data processing in Morocco. Personal data is defined as any information regardless of their nature, and format, relating to an identified or identifiable person, including genetic data, and does thus cover patients and other data created in the hospitals and laboratories. Thus, Morocco has a strong framework for data protection and the management of grievances related to data processing that could arise from testing regimes. E&S regional and central focal points through the GRM will monitor the application of the regulations.

33. The activities financed under the proposed AF will help maintain and strengthen the protection of health system workers through the funding of appropriate PPE and hygiene materials.

34. Based on the above, the E&S risk rating remains unchanged, i.e., substantial, as none of the new activities are likely to have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected people.

VII. Recommendations to Strengthen the E&S System

35. The parent ESSA recommendations and proposed action plan will be used for the whole program. Several actions have been added (see table below) to manage the increased geographical scope, and to better target risks due to the COVID-19 crisis. Proposed additional recommendation concern the COVID-19 medical waste management and suggest the adoption of the United Nations Environment Program (UNEP) and the Secretariat of the Basel Convention⁴ guidelines:

take advantage of the fact that the virus is not very long lived outside the body. The precise time it lasts is not known yet, but the best evidence is that it can last up to 3 days on hard surfaces like plastic, but less so on porous surfaces.

Outside the hospital environment, masks, PPE, tissues, and other non-biodegradable corona-virus related waste are collected separately, double bagged and labelled with the date. There is no need to treat these materials with disinfectant first. If there is a possibility that masks or PPE are being targeted for illegal reuse, they can be cut or mutilated before disposal. Public Health England advises that it should then be left for 72 hours before sending for disposal as usual municipal waste. By this time, it poses minimal risk to waste handlers.

The application of the COVID-19 medical waste management procedure is integrated into the budget of the hospitals concerned by this FA. The regional focal points should monitor the implementation of this procedure and report periodically to the central focal point.

36. The institutional organization put in place to implement the original ESSA recommendations and those related to the AF is going to be maintained. The E&S focal point designated at the DELM at the central level and the E&S regional focal points designated for each region under the parent program continue to monitor the implementation of ESSA recommendations and proposed procedures and report periodically to the project implementing unit. The same institutional procedures will be used for the

⁴ UNEP (2003) Technical Guidelines on the Environmentally Sound Management of Biomedical and Healthcare Wastes, at <http://archive.basel.int/pub/techguid/tech-biomedical.pdf>

additional regions. The nomination of related E&S focal points will be completed before effectiveness of the proposed AF.

37. Initially, through its communications unit *Division de la communication* integrated in the MoH, outreach protocols and mechanisms are being developed to ensure an efficient communication to have the population understand the risks of the pandemic around the prevention and control of the disease. Through targeted efforts, it will ensure that vulnerable populations can access the program benefits, including regarding communication in means accessible to everyone, and the provision of physical access for all, including people living with disabilities. Protocols will have to ensure infected persons in remote areas will have access to the program benefits International best practices and guidelines such as WHO guidance on Risk communication and community engagement – Pillar 2 of the Operational Planning Guidelines to Support Country Preparedness – are followed.⁵

38. The grievance redress mechanisms (GRM) of the program is placed under the *Unité centrale de gestion des réclamations - UCGR* at the MOH. It has been rolled out and will be further be strengthened to be able to manage the enlarged regional scope and new tasks under the AF, such as grievances that will arise during the COVID-19 crisis, e.g. about the lack of access to health care, testing or other program benefits. The GRM is run centrally at the MoH and being rolled out to the regions in the parent program. It will need to integrate structures to cover the two additional regions and increase the capacity to manage grievances related to COVID health access. The E&S focal point at central and regional level will establish a monitoring and reporting mechanism to include grievances into the regular program reporting.

39. The ESSA of the parent Program was consulted with representatives of civil society on February 4, 2015. Consultations for the proposed AF will be conducted remotely without physical workshops because of the containment. The addendum of the ESSA will be translated into French and shared with stakeholders. It will be disclosed on the MoH website and the Bank’s website for remote consultations and distributed to stakeholders through electronic means such as e-mails and social media. Comments will be collected and taken into consideration, and main issues and concerns raised during the consultations will be summarized and insert into the final version of the addendum. Consultations will be conducted during the implementation of the program to engage with populations and patients, those with vulnerabilities, and those living remotely. The consultations will use WHO’s guidelines as referenced above.

VIII. Action Plan


Action	Deadline	Responsibility	Measure of achievement	Action finalized Yes/No
Manual of Procedures				
Finalization of the manual of procedures, incorporating, inter alia, the provisions of the National Plan for the Management of Medical and Pharmaceutical Waste.	30 June 2015	Ministry of Health	Procedures manual submitted to and acceptable to the Bank.	Yes

⁵ <https://www.who.int/docs/default-source/coronaviruse/covid-19-sprp-unct-guidelines.pdf>
<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/risk-communication-and-community-engagement>

Dissemination/training on the environmental aspects of the Procedures Manual to staff in the target regions.	2016	Ministry of Health	Dissemination plan; Training plan	Yes
Environmental and Social Management System (ESMS)				
Officials in the 9 regions will monitor environmental aspects on the basis of indicators agreed with the Ministry of Health.	April 2016	Ministry of Health	Monitoring Indicator	Extended to the AF
E&S focal points will be nominated for the two additional regions	Prior to effectiveness of program AF	Ministry of health – Regions	Monitoring by PIU	
The target regions are preparing regional plans for the management of medical and pharmaceutical waste, based on the national plan. The nine targeted regions produce annual progress reports on the implementation of regional plans.	2016 2017-2018	Ministry of Health	Regional plans Annual progress reports	No, but couldn't be achieved during COVID crises
Realization of the diagnostic study of the waste treatment system	December 2015	Ministry of Health	Study	No, but couldn't be achieved during COVID crises
The diagnosis of current grievance management systems, the strategy and the draft manual for the implementation of grievance management mechanisms are finalized.	December 201		Grievance management procedure	Ongoing
A pilot is set up to test the grievance management system.	December 2016	Ministry of Health	SIS	
The pilot is evaluated, and the implementation manual is reviewed.	December 2017		Rapports	
Expansion of the revised grievance management mechanism	December 2018			
Enlarging GRM to (i) cover COVID complaints and manage responses, and (ii) cover the two additional regions Establishment of a monitoring and reporting system collecting grievance and resolution data from project areas and consolidate to integrate into regular reporting E&S regional and central focal points through the GRM will monitor the application of the regulations regarding data protection	Immediately after program AF effectiveness	Ministry of Health - <i>Unité centrale de gestion des réclamations - UCGR</i>	Monitoring reports	

Development of outreach protocols and mechanisms to ensure the inclusion of vulnerable populations among program beneficiaries	Ongoing/ Immediately after program AF effectiveness	Ministry of Health - <i>Division de la communication</i>	Protocols developed and communications undertaken	

IX. Procédure de gestion des déchets médicaux et pharmaceutiques au niveau des unités d'isolement COVID-19

<p>ROYAUME DU MAROC Ministère de la Santé</p>		<p>المملكة المغربية +ⵍⵎⵖⵔⵉⵏ ⵎⵓⵔⵓⵙⵉⵏ وزارة الصحة +ⵎⵓⵔⵓⵙⵉⵏ +ⵏⵓⵔⵓⵙⵉⵏ</p>
<p>REDACTEUR Direction des Hôpitaux et des Soins Ambulatoires (DHSA)</p>	<p>PROCEDURE DE GESTION DES DMP DECHETS DES SALLES D'ISOLEMENT (COVID-19)</p>	
<p>Procédures 001 version mars 2020</p>		
<p>Gestion des déchets médicaux et pharmaceutiques générés au niveau d'une unité d'isolement : Covid-19</p>		

**GESTION DES DÉCHETS MÉDICAUX ET PHARMACEUTIQUES
(DMP) GÉNÉRÉS AU NIVEAU DES UNITÉS D'ISOLEMENT
Cas du CORONA VIRUS**

1. OBJET :

Cette procédure décrit les modalités de gestion des déchets médicaux et pharmaceutiques (DMP) au niveau des unités d'isolement, notamment les modalités du tri, d'emballage de ces déchets ainsi que le circuit de collecte interne et leur transport vers l'unité de traitement.

2. OBJECTIF

Mettre en place une gestion sécurisée des déchets générés au niveau des unités d'isolement afin de réduire notamment leur risque infectieux tout au long de la filière (au sein de l'établissement et à l'extérieur).

3. DOMAINE D'APPLICATION :

- Unité d'isolement ;
- Lieu d'entreposage final ;
- Le véhicule du transport ;
- L'unité de traitement.

4. REFERENCES

- La loi 28-00 relative à la gestion des déchets et à leur élimination ;
- Décret n°2.09.139 du 25 jourmada I 1430 (21 mai 2009) relatif à la gestion des déchets médicaux et pharmaceutiques ;
- Décret 2-14-85 du 20 janvier 2015 relatif à la gestion des déchets des déchets dangereux ;
- Guide de gestion des déchets médicaux et pharmaceutique du Ministère de la Santé.

5. ACTEURS CONCERNES :

- Professionnels de santé ;
- Agents chargés de la manutention, de la pré-collecte, du transport vers le site de traitement, ainsi que du traitement et de l'élimination des déchets au niveau des installations de traitement.

6. CONDITIONS PARTICULIÈRES DE GESTION DES DÉCHETS

6.1. Tri

Au niveau des unités d'isolement, les déchets assimilés aux déchets ménagers sont considérés comme des déchets à risque infectieux.

Ainsi, tous les déchets ménagers et ceux à risque infectieux doivent être conditionnés dans le même container menu de son sac rouge : Restes des nourritures, ustensiles en plastique (jetables), gobelet, champs d'examen, équipements de protection individuelle (à l'exception des lunettes), papier absorbant, sacs, bouteilles en plastique vides, mouchoirs ...etc

6.2. Emballage des DMP

- Les conteneurs de couleur jaune pour les objets piquants coupants et tranchants ;
- Les sacs rouges pour tous les autres déchets ;
- Des containers (de préférence d'une couleur différente des autres DMP : rouge /ou bleu) ; afin de différencier les conteneurs des déchets infectieux émanant des salles d'isolement de ceux émanant des autres services ;
- Le remplissage des sacs et des containers ne doit pas dépasser les trois quarts de leurs capacités ;
- Les sacs rouges une fois remplis au ¾ doivent être scellés ;
- Les conteneurs jaunes des DPT une fois remplis aux trois quarts, peuvent être mis dans les containers avec sacs rouges ;

- Les containers doivent être fermés hermétiquement.

NB :

- Les conteneurs pour les objets piquants et tranchants sont à usage unique ;
- Les containers doivent être étiquetés.

6.3. Pré-collecte / Transport interne :

- **Quand la pré-collecte se ferait –elle ?**

L'évacuation doit se faire au moins une fois par jour (à une heure bien déterminée et régulière) et selon un circuit prédéfini par l'hôpital : (CLIN/ Responsable d'hygiène/Direction).

- **Qui ferait la pré-collecte ?**

Le collecteur habituel des déchets (soit d'une société sous-traitante, soit une autre personne désignée par la Direction) ; doté d'un habillement convenable sécurisé et sécurisant : veste, pantalon, charlotte, bavette(masque), gants, lunettes, bottes et d'une sur- blouse jetable.

- **Comment se fait la pré-collecte ?**

Le collecteur bien protégé, procède à la récupération des containers, après les avoir désinfectés entièrement de l'extérieur à l'aide d'un détergent /désinfectant (l'eau de javel dilué à 12°) selon les recommandations de L'OMS, et au transfert directement des containers vers le lieu de stockage final en attente de leur évacuation pour traitement.

La pré-collecte doit avoir lieu moyennant des chariots réservés exclusivement à cette action en respectant les instructions de la direction de l'hôpital concernant notamment la fréquence et le circuit de l'opération de pré-collecte.

NB : l'agent chargé de la pré-collecte doit veiller à ce que les containers remplis n'entrent pas en contact avec les containers vides (propres).

6.4. Stockage :

- Les containers doivent être stockés dans le local dédié à cet effet et répondant aux normes de sécurité et d'hygiène requises ;
- Le collecteur doit désinfecter les surfaces des containers à l'aide d'un produit désinfectant agréé ;
- Le chariot de pré-collecte doit être impérativement nettoyé et désinfecté après chaque opération de pré-collecte.

NB :

- Le local de stockage doit être obligatoirement verrouillé et non accessible aux personnes non autorisées ;
- Le local de stockage doit être nettoyé et désinfecté après chaque opération de transport des déchets ;
- Le personnel chargé du stockage doit respecter les règles de précaution standard notamment le port des moyens de protection individuelle et le lavage des mains ;
- Le local de stockage des DMP doit être réservé exclusivement à cet effet, il ne doit en aucun cas servir pour le stockage des containers vides (propres).

6.5. Collecte et Transport

- **Qui fait le transport ?**

Le transport des déchets d'isolement se fait dans les mêmes conditions que les DMP de catégorie 1 et 2 par des véhicules autorisés par le Ministère de la santé pour le transport desdits déchets sous la responsabilité de la société sous-traitante.

- **Quand se fait le transport ?**

L'enlèvement se fait selon le planning habituel préétabli et contractuel entre l'hôpital et son prestataire de la gestion des DMP.

- **Comment se fait le transport ?**

Avant le chargement des containers dûment étiquetés, différenciés des autres containers des DMP (couleur différente), les agents responsables de l'enlèvement doivent procéder à la pulvérisation par un désinfectant sur l'ensemble des containers. Ensuite les agents responsables de la collecte et transport procèdent au chargement en sécurité dans le véhicule préalablement désinfecté, afin de les transporter vers le site de traitement et d'élimination des déchets.

Cette opération est sanctionnée par l'établissement du bordereau de suivi habituel.

NB : Le transporteur-collecteur doit prendre toutes les dispositions nécessaires pour éviter tout contact entre les containers remplis et les containers vides propres.

6.6. Traitement et élimination

- **Acheminement des déchets à risque infectieux vers l'usine de traitement.**

- Juste après le déchargement, il faut nettoyer et désinfecter le véhicule de transport des DMP au niveau des locaux de l'installation de traitement des DMP ;
- Nettoyage et désinfection immédiate des containers vidés (eau chaude+ eau de javel à 12°...);
- Procéder au traitement desdits déchets dès leur réception (les traiter en priorité) et le remplissage et signature du bordereau de suivi et faire retourner une copie à l'hôpital ;
- Après le traitement, les déchets traités doivent rejoindre la décharge publique.

NB :

Au niveau du site de traitement des DMP ; les mesures d'hygiène et de sécurité renforcées doivent être prises notamment :

- Le port des tenues répondants aux règles d'hygiène : (gants, masques, bottes, lunettes, bonnet, veste et pantalon, imperméables et sur-blouse jetable) ;
- Interdiction de manipulation directe des déchets par le personnel ;
- Observance du lavage et désinfection des mains convenablement, et à l'aide d'une solution ou gel hydro alcoolisée ;
- Nettoyage et désinfection adéquats des surfaces et des locaux du site de traitement.

Logigramme du circuit des déchets médicaux et pharmaceutiques (DMP) générés au niveau des unités d'isolement

Documents / outils	Circuit sale	Fonction / Responsabilité
<p>Précautions Standard</p> <p>Planning de pré-collecte des DMP</p> <p>Bordereau de suivi des DMP remplis et signés</p>		<ul style="list-style-type: none"> - Agent chargé de la pré-collecte / stockage. - Responsable de la gestion des DMP au niveau de l'hôpital - Responsable de la gestion des DMP au niveau de l'hôpital - Collecteur transporteur - Agent chargé de la pré-collecte / stockage.
Documents / outils	Circuit propre	Fonction / Responsabilité
<p>Précautions Standard</p>		<ul style="list-style-type: none"> - Agent chargé de la pré-collecte / stockage - Responsable de la gestion des DMP au niveau de l'hôpital

NB : Toutes les mesures et précaution doivent être prise pour éviter le contact des conteneurs vides et ceux remplis des DMP.