

ANNEX 4: ASSESSMENT OF ENVIRONMENTAL AND SOCIAL SYSTEMS – Addendum

I. Introduction

1. The World Bank supports the Moroccan government's health sector through the Improvement of Primary Health in Rural Areas PforR, through a US\$100 million loan that has been in effect since 2015. The original PDO is "to increase access to primary health care in targeted rural areas" in seven regions with the lowest health outcomes. To achieve the PDO, the Program included seven Disbursement-Linked Indicators (DLIs) focusing on improving antenatal care visits, skilled birth attendance, number of sick child visits, diagnosis and treatment of diabetes, overall visits to rural primary health centers, participation of health facilities in quality competitions and the establishment of a health management information system. The main expected results of PforR are to increase the use of primary health care services in targeted rural areas, improve the accountability of the health system and establish a health information system in public health institutions. These results are achieved through two areas: firstly, improving primary health care in rural areas, and secondly, improving health care governance. The Program has been restructured and is rated moderately satisfactory. The last restructuring took place in December 2019 and extended the loan closing date to December 31, 2020.

2. Prior to the launch of the Program in 2015, the World Bank prepared an Environmental and Social Systems Assessment (ESSA) in accordance with the requirements of the World Bank's policy on PforR financing. The ESSA examined the capacity of existing national systems to plan and implement effective measures to manage environmental and social risks under the Program and identified measures needed to strengthen the national system. As a result, the ESSA recommended several actions under the ESSA Action Plan (AP) that addressed the identified gaps, and these have been fully integrated into the Program Action Plan (PAP).

3. With the advent of the COVID-19 pandemic, the government requested additional financing (AF) of US\$35 million from the World Bank's COVID-19 FTF and the reallocation of US\$13.01 million of undisbursed funds under the ongoing PforR. The Program would be extended until September 30, 2021. Overall, there are no significant changes to the original government program, so the environmental and social risk rating remains unchanged: Substantial.

4. To ensure that environmental and social risk continues to be adequately managed, reduced and mitigated, the World Bank has prepared this addendum to the ESSA to cover possible additional environmental and social aspects that may result from this scale-up and restructuring. This addendum does not constitute a new ESSA and should be considered in conjunction with the ESSA of the parent Program.

A. Objectives of the ESSA addendum

5. The ESSA addendum is intended to address specific environmental and social risks to the proposed AF and has the following objectives:

- To identify potential legislative and procedural changes since the preparation of the ESSA for the parent Program.
- To identify potential new environmental and social risks and impacts of the proposed AF.
- Recommend measures to further strengthen the environmental and social system.

B. Methodology of the addendum to the ESSA

6. The preparation of the addendum involved a series of interviews and consultations with health sector stakeholders, including the Directorate of Hospitals and Ambulatory Care (DHSA), the Directorate of Epidemiology and Disease Control (DELM) and the Directorate of Planning and Financial Resources (DPRF) of the Ministry of Health, as well as an extensive review of documents (Aide-Mémoire, Implementation Status and Results Reports, PAPs) of the parent Program.

II. Background

7. Morocco has increased its level of preparedness and response to prevent the risk of more loss of life. On April 1, 2020, the Ministry of Health announced the acquisition of 100,000 tests, and COVID-19 testing capacity was strengthened in 15 public and private laboratories. The government has also invested in the production of masks and hydroalcoholic solutions. Standard operating procedures and protocols have been developed for quarantine, isolation, case management and infection prevention and control. In this regard, several military facilities (including temporary hospitals - Field Hospitals) have been mobilized at the regional level, while 72 public hospitals have been reinforced to care for and treat coronavirus patients. In addition, the government has increased the capacity of hospital beds and intensive care units, bringing the total capacity of ICU beds to 1,640 and the total number of beds to 13,456.¹ 138 ambulances have been assigned to the COVID-19 intervention, and efforts are underway to strengthen the capacity of health workers. Three emergency telephone numbers have been established and information, education and communication materials and messages have been developed. A fully electronic health information system has been set up and is regularly updated with laboratory test results, enabling real-time epidemiological reporting and informing evidence-based decision-making.

8. Morocco has also mobilized additional short-term resources to combat COVID-19. The government has announced a US\$3.2 billion COVID-19 Pandemic Fund to address immediate needs in the health sector and provide economic stimulus. Although significant funding has been secured at the national level, rapid mobilization of additional funds remains essential to increase fiscal space and ensure sustained support to respond to the pandemic.

III. Description of additional financing

9. The original Program Development Objective has been revised to take into account the specificities of COVID-19 emergency response as follows: "to expand access to primary health care in targeted rural areas and strengthen case detection and management to respond to the COVID-19 pandemic in the Program area". The revised PDO will ensure that PforR can contribute to responding to the threat posed by the COVID-19 pandemic while continuing to strengthen the health system and responding to this emergency by supporting the government's pandemic preparedness plan. Achievements towards the revised PDO will be measured by a revised results framework to include the following new indicators:

a. PDO Indicators:

- PDO Indicator 5 (new DLI 8): "Number of polymerase chain reaction (PCR) tests performed to diagnose COVID-19"; and

¹ Source: Ministry of Health

- PDO Indicator 6 (new DLI 9): "Number of health facilities that are designated as COVID-19 facilities and equipped in accordance with Ministry of Health guidelines".

b. Intermediate Outcome Indicators:

- "Number of designated laboratories with COVID-19 diagnostic capabilities established per MoH guidelines"; and
- "Number of resuscitation units established as per MoH guidelines".

10. While the parent Program focuses on the rural areas of seven Moroccan regions, the AF will extend the Program areas to the urban areas of the seven regions and will cover the urban and rural areas of two additional regions (Casablanca-Settat and Rabat-Sale-Kenitra) and three provinces and one municipality in the south (provinces of Guelmim, Tan-Tan and Sidi Ifni; and (c) Assa municipality). The two additional regions have the main national hospitals (26 in Casa-Settat and 19 in Rabat-Sale-Kenitra) and concentrate 34 per cent of the national population.

11. In line with government priorities, a new results area will be added to the Program to focus on the COVID-19 emergency response. It would support capacity building for disease detection through the provision of technical expertise, laboratory equipment and systems to ensure rapid case and contact tracing, in line with WHO guidelines in the strategic response plan. It would also enable Morocco to mobilize a rapid response capacity with trained and well-equipped front-line health workers. Activities supported 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 would 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 will be achieved through the preparation of financing plans for establishing and equipping specialized units in selected hospitals, the preparation of treatment guidelines, clinical training of health workers and hospital infection control guidelines, and the provision of medical supplies, diagnostic reagents, including kits and other operating costs. This would include support for intensive care facilities within hospitals with medical equipment and training of health teams.

IV. Status of implementation of the PAP

12. The evaluation of the PAP revealed a significant delay in the designation of E&S focal points at the national and regional levels. In the meantime, medical waste management has improved in urban and semi-urban hospitals, but not in rural Primary Health Care Facilities (PHCFs) despite the creation of a

budget line (dedicated to medical waste transport and disposal) in the annual budget of the Ministry of Health's Regional Directorate and Delegations to outsource medical and pharmaceutical waste management at the hospital and PHCF levels. This situation is largely explained by the lack of interest of private providers with regard to the dispersion of ESSPs and the small quantities of medical and pharmaceutical waste (MPW) they produce.

13. The PforR includes a DLI on quality assessments and an indicator on the establishment of a grievance redress mechanism (GRM), both of which are operational. These activities have catalyzed a wider interest in quality of care, and during the period of implementation of PforR, the Moroccan health system has made great strides towards becoming an evolving health system through learning.

V. Legislative and procedural changes

14. The environmental and social system described in the ESSA of the parent Program is still applicable both in terms of laws, regulations and standards and in terms of procedures and effective implementation of these laws and standards.

15. Article 4 of Decree No. 2-09-139 stipulates that producers of MPW are required to set up an internal management system. Article 5 specifies that, regardless of the producer of 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 order signed in 2018 between the Ministry of Health and the Department of Environment on the management of medical and pharmaceutical waste describes the technical and organizational tools for effective management of medical waste in health care institutions. This draft joined order, which is currently being validated by the SGG, regulates

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

17. The Ministry of Health has gained a great deal of experience in the application of Law 12-03 and its implementing decrees through hospital construction projects financed by international donors. The experience of the Ministry of Health in this field has also benefited from its participation in Environmental Impact Assessment (EIA) committees at the central and regional levels.

18. The Ministry of Health (DHSA and DELM) produced a guide for the management of medical sharps waste in health care facilities in 2002, and with the support of WHO (CEHA), a practical guide for the management of medical waste in health care facilities was developed in 2004. In 2013, the terms of reference for the environmental audit of hospitals for medical and pharmaceutical waste management were established. This audit reference framework serves as a didactic and operational tool to support the

various healthcare institutions in their efforts to improve the management of medical and pharmaceutical waste, regardless of their level of performance in this area.

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

20. Since 2004, public hospitals have started to outsource the management of MPW , from internal collection to transport and waste disposal.

VI. Environmental and social risks and impacts of additional funding

21. Additional financing keeps the risk profile of the original Program at “substantial”. The COVID-19 pandemic crisis involves a highly contagious disease that is rapidly spreading and resulting in a potentially fatal course of disease in affected patients. The disease therefore has the potential to infect not only other patients, but also hospital staff, and could result in a high patient load in ill-prepared hospitals and health centers.

22. While the national health and environmental legislation (national system) described above includes the measures necessary to mitigate potential risks, the AF also includes the measures necessary to ensure the protection of hospital staff, to communicate risk reduction to the general population and to provide documentation for diagnosis and monitoring of the disease. The AF is therefore structured to manage and reduce the risks associated with the COVID-19 crisis. The parent Program has contributed to the establishment of systems in rural areas, including E&S risk management systems such as waste management, GRMs, which have strengthened health service delivery and reduced the risk of contagion and reproduction of the disease. Health services in urban areas are considered sufficiently robust to manage the current crisis. The extension of the AF to two additional regions will help the government to improve crisis management.

23. Overall, the implementation of the Program is likely to have more benefits and positive impacts in the targeted communities. It is important to stress that the different risks and impacts identified in the HSSE for the interventions of the parent Program remain relevant for this AF. The ESSA of the parent Program identified the increase in sanitary waste at the ESSP level as the main environmental risk, and this remains the case for AF. Indeed, the volumes of infectious wastes generated by COVID-19 activities specific to AF will increase due to the increased production of personal protective equipment (PPE) such as gloves, face and nasal masks, waterproof protective gowns, rubber boots, rubber aprons, tissues and other contaminated materials.

24. The production of medical waste resulting from the management of COVID-19 patients will be limited to hospitals and support structures (field hospitals). These hospital waste management systems are based on a clear procedure developed by the DHSA to manage the medical waste generated at the COVID-19 isolation units. This procedure is currently being validated and will be widely applied (see section IX). The environmental managers of the regional representations of the Ministry of Health will ensure the strict application of this procedure. Indeed, the Ministry of Health (DHSA and DELM) organized on 13 March 2020 a training day for trainers on "the use of personal protective equipment and infection prevention and control measures". During this training, the participants were introduced to and explained the management methods for the MPWs generated during the treatment of COVID-19 patients. Similarly, a series of procedures developed by the DHSA in the area of hospital hygiene was made available to them, including the procedure for managing MPWs in general. In these hospitals, wastewater management is

not as critical as in the rural areas covered by the parent Program. Indeed, all hospitals and associated structures (field hospitals) are connected to the sanitation network of the urban centers where they are located.

25. The environmental officers of the regional representations of the Ministry of Health will help monitor the strict application of these procedures.

26. The transport, treatment and disposal of sanitary waste will be carried out by private companies authorized by the Ministry of Health for the transport part and by the Department of Environment for the treatment and disposal part.

27. Laboratory testing for COVID-19 most often involves nucleic acid amplification tests (NAATs). Polymerase Chain Reaction (PCR) tests use reagents such as guanidine thiocyanate which is considered hazardous especially to the skin (corrosion) and eyes (damage/irritation). Acute toxicity (oral, dermal and inhalation) is Category 4 according to the OSHA Hazard Communication Standard 2012 (29 CFR 1910.1200²) which is the lowest risk category.

28. Based on the above, the expected adverse effects with the increased scope of the Program remain negligible as long as the regulatory aspects and recommendations of the ESSA action plan are implemented in all regions targeted by the Program. In addition to the appointment of E&S focal points in the two additional regions, the extension will require the integration of the existing structures into the existing E&S supervision system.

29. The proposed AF does not include activities requiring the acquisition of land, as the activities are mainly focused on upgrading and equipping existing infrastructure and increasing the number of COVID-19 tests. As with the parent Program, activities requiring such acquisition will be excluded from the Program.

30. The proposed AF will have positive social impacts as it is expected to improve surveillance, case management, monitoring and containment of COVID-19 outbreak. However, there are potential social risks associated with the proposed AF: (i) community health and safety and in particular the exposure of high-risk individuals to the virus when using the materials, equipment and drugs acquired; (ii) the limited capacity of vulnerable groups to access facilities and services designed to combat the disease and the growing social discontent due to the lack of necessary tests, drugs and equipment; (iii) the limited capacity of health services to respond to the epidemic; and (iv) insufficient communication regarding the disease prevention and control effort. These risks are addressed by the Program, which aims to ensure equity of access to health care, strengthen social responsibility and participatory governance, and develop grievance redress mechanisms (GRMs) that are easily accessible, culturally appropriate and understandable to affected individuals and communities. The Program will include mechanisms to ensure the inclusion of vulnerable populations (elderly, youth, female-headed/widow-headed households, orphans, homeless, etc.), including communication and access for all. Protocols will need to ensure that infected people in remote areas will have access to the benefits of the Program and that guidelines such as the WHO guidelines on risk communication and community engagement during the pandemic will be

² <https://www.osha.gov/dsg/hazcom/ghoshacomparison.html>

followed³.

31. The GRM is fully operational through the "Centre d'écoute et de gestion des réclamations" (CEGR), and the strengthening of GRM management capacity at the regional level was completed by the end of December 2019, including the establishment of regional telephone numbers. The MGP is fully decentralized to the level of health facilities at the national level. The PGM portal is now part of the national chikaya.ma portal. As a result of these efforts, the CEGR has recently changed its name to the "Central Claims Management Unit" (CCMU). Through this mechanism, patients can report their complaints by telephone or via the Internet and provide feedback on staff and health centers so that they can be directed to the appropriate service. The CCMU continues to receive and process complaints from patients using health services provided by the Ministry of Health. During the period 2016-2018, more than 4,700 claims were submitted. 73 percent of them were related to health services and were processed through feedback to the institutions concerned by the higher levels of decision-making in the health system.

32. Moroccan Law No. 09-08 of February 18, 2009 relating to the protection of individuals with respect to the processing of personal data and its implementing decree No. 2-09-165 of May 21, 2009, constitute the framework governing the protection of data and privacy⁴. The law establishes the National Commission for the Protection of Personal Data⁵ as the supervisory authority for 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. The data protection requirements are intended to be aligned with those of the EU in order to allow data processing in Morocco. Personal data is defined as any information, regardless of its nature and format, relating to an identified or identifiable person, including genetic data, and therefore covers patients and other data created in hospitals and laboratories. Thus, Morocco has a solid framework for data protection and the management of data processing grievances that may arise from testing regimes. Regional and central E&S focal points, through the MRM, will monitor the implementation of the regulations.

33. The activities financed under the proposed additional funding will make it possible to maintain and strengthen the protection of workers in the health system through the financing of appropriate personal protective equipment (PPE) and hygiene materials.

34. Of the above, the environmental and social risk rating remains unchanged, namely "substantial", as none of the new activities is likely to have significant, sensitive, diverse or unprecedented adverse effects on the environment and/or the people affected.

VII. Recommendations for strengthening the environmental and social system

35. The recommendations of the parent Program's ESSA and the proposed plan of action (as presented in the "Plan of Action" table below) will be used for the entire Program. Two key actions have been added to manage the increased geographical scope and to better target the risks due to the COVID-19 crisis, to be carried out immediately after the entry into force of the AF. The first proposed additional recommendation concerns the management of COVID-19 related medical waste and suggests the

³ <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/risk-communication-and-community-engagement>

⁴ <https://www.cndp.ma/images/lois/Loi-09-08-Fr.pdf>,
<https://www.cndp.ma/images/lois/Decret-2-09-165-Fr.pdf>

⁵ <https://www.cndp.ma/fr/>

adoption of the guidelines of the United Nations Environment Program (UNEP) and the Secretariat of the Basel Convention which are as follows⁶:

In this case the best course can be to 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 is 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.

36. The application of the COVID-19 medical waste management procedure is included in the budget of the hospitals concerned by this additional funding. The regional focal points are to monitor the implementation of this procedure and report periodically to the central focal point.

37. The institutional organization is put in place to implement the initial recommendations of the ESSA and will be maintained for AF implementation. In this regard, the DELM designated E&S Focal Point at the central level and the Regional E&S Focal Points designated for each region under the parent Program will continue to monitor the implementation of the ESSA recommendations and proposed procedures and report periodically to the Program Implementation Unit. The same institutional procedures will apply to the two new regions to which the Program has been expanded, and the designation of the corresponding E&S Focal Points will be completed no later than 30 days after the entry into force of the proposed AF.

38. As a first step, through its communication unit, the Division of Communication, Protocols and Awareness Mechanisms is putting in place to ensure effective communication to ensure that the population understands the risks of the pandemic around prevention and control of the disease. Through targeted efforts, the Division will ensure that vulnerable populations are able to benefit from the Program, particularly with regard to communication by accessible means and the provision of physical access for all, including persons with disabilities. Protocols will need to ensure that infected people in remote areas will have access to the benefits of the Program. International best practices and guidelines such as the WHO guidance on risk communication and community engagement - Pillar 2 of the Operational Planning Guidelines to Support Country Preparedness - are followed⁷.

39. The Program's grievance redress mechanisms are placed under the Central Claims Management Unit - CCMU in the Ministry of Health. It has been put in place and will be further strengthened to manage the expanded regional scope and new tasks under the FA, such as grievances that will arise during the COVID-19 crisis, e.g. regarding lack of access to health care, testing or other benefits of the Program. The

⁶ UNEP (2003) Technical Guidelines on the Environmentally Sound Management of Biomedical and Healthcare Wastes, at <http://archive.basel.int/pub/techguid/tech-biomedical.pdf>

⁷ <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>

GRM is managed centrally in the Ministry of Health and is deployed to the regions as part of the Parent Program. It will need to integrate the two additional regions and increase the capacity to manage grievances related to access to health care for COVID-19 pandemic. The E&S focal points at the central and regional level will establish a monitoring and reporting mechanism to include grievances in the regular Program reports.

40. The ESSA of the parent Program was consulted with civil society representatives on February 4, 2015. The ESSA addendum was published on the Bank's and the Ministry of Health website since May 11, 2020 and the translated version shared with stakeholders ahead of consultations. Consultations on the ESSA addendum were held on 28 May and 1 June, 2020 with stakeholders via audio/video connection, without physical workshop due to social distancing measures. The document was also distributed to stakeholders through electronic means such as emails. Comments received during the consultation sessions have been taken into consideration and a summary of principal questions and concerns brought up during consultations is included in the ESSA addendum published on the website of the World Bank and the Ministry of Health. Consultations will continue to be carried out during the implementation of the Program in order to engage in dialogue with populations and patients, vulnerable persons and stakeholders. The consultations will use the WHO guidelines mentioned 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 |
| 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 point to be designated in the two additional regions | 30 days after entry into force | Ministry of Health | Monitoring by the PIU | |
| The target regions are preparing regional plans for the management of medical and pharmaceutical waste, based on the national plan. | 2016 2017-2018 | Ministry of Health | Regional plans Annual progress reports | No, but couldn't be achieved during Covid crises |

| | | | | |
|---|---|---|---|--|
| The nine targeted regions produce annual progress reports on the implementation of regional plans. | | | | |
| Realization of the diagnostic study of the waste treatment system | December 2015 | Ministry of Health | Study | No, but could not be achieved due to COVID-19 outbreak |
| The diagnosis of current grievance management systems, the strategy and the draft manual for the implementation of grievance management mechanisms are finalized. | December 2015 | | Grievance management procedure | Yes |
| 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 | | Reports | |
| Expansion of the revised grievance management mechanism | December 2018 | | | |
| Ensure regular monitoring and detail in the annual Program progress report the environmental and social aspects, that cover inter alia handling of grievances related to the Program, including those related to COVID-19, and how personal data management | June 2021 | Ministry of Health – DPRF | Reports | |
| Development of protocols and awareness-raising mechanisms to ensure the inclusion of vulnerable populations among the beneficiaries of the Program | Continuous - 30 days after entry into force | Ministry of Health – Division de la communication | Protocols developed and communication campaigns carried out | |

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 +ⵍⵎⴰⵔⴷⵉⵏ ⵎⵏⵉⵙⵜⵉⵏ وزارة الصحة +ⵍⵎⴰⵔⴷⵉⵏ +ⵏⵓⵔⵓⵙ</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.

REPORT OF THE STAKEHOLDER CONSULTATION WORKSHOP
ON THE ASSESSMENT OF ENVIRONMENTAL AND SOCIAL SYSTEMS
OF THE PROGRAMME FOR IMPROVING PRIMARY HEALTH CARE IN RURAL AREAS AND RESPONDING
TO THE COVID-19 PANDEMIC EMERGENCY

(Rabat, 28 May and 01 June 2020)

INTRODUCTION

1. Jointly organized by the Ministry of Health and the World Bank, a public information and consultation on the draft addendum to the Environmental and Social Systems Assessment (ESSA) of the Results-Based Program (RBP) to improve primary health in rural areas and respond to the emergency of the covid-19 pandemic, was held by WebEx in Rabat, on 28 May and 01 June 2020.

2. About ten people participated in this virtual public consultation, representing the Department of Health and NGOs. Executives from the World Bank also took part in the consultation (cf. List of participants in annex).

3. The consultation consisted of two sessions, namely: (i) a presentation of the Program, the features of the Program Loan for Results (PPR) instrument, and the results and recommendations of the addendum to the ESSA; and (ii) a question and answer session.

PART ONE: OPENING / PRESENTATION

4. Ms. Ibtissam Alaoui, External Communication Officer at the Bank's office in Rabat, opened the session by welcoming the participants and presenting the general objectives of the session. All participants were invited to introduce themselves.

5. Mrs. Fatima El Kadiri - Project Manager presented the background and main features of the Additional Financing (AF) to the Support Program for Improving Primary Health in Rural Areas. In line with government priorities, a new results area would be added to the Program to focus on the COVID-19 emergency response. This outcome area would provide immediate support to respond to the COVID-19 pandemic. It would support capacity building for disease detection through the provision of technical expertise, laboratory equipment and systems to ensure rapid case and contact tracing, in line with WHO guidelines in the strategic response plan. It would also enable Morocco to mobilize a rapid response capacity with trained and well-equipped front-line health workers.

The AF, planned to be implemented over a 2-year period (2020 - 2022), includes funds from the COVID-19 Fast Track Facility (FTCF) in the amount of US\$ 35 million and also proposes to reallocate US\$ 12.98 million of undisbursed funds from the parent PforR. Activities supported include :

- Case detection, case confirmation, contact tracing, case registration and case reporting. This will enable : (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 investigations; (iv) strengthen

risk assessment; and (v) provide timely data and information to guide decision-making and response and mitigation activities. Additional support could be provided to strengthen health management information systems to facilitate the recording and virtual sharing of information in a timely manner.

- Health system strengthening. The Program would support the health-care system in preparedness planning to provide optimal medical care, maintain essential community services and minimize risks to patients and health personnel, including training of health facility staff and front-line workers on risk mitigation measures and the provision of appropriate personal protective equipment (PPE) and hygiene materials. Strengthening clinical care capacity could be achieved through funding plans for the establishment of specialized units in selected hospitals, treatment guidelines, clinical training of health staff and hospital infection control guidelines. This would include supporting intensive care facilities within hospitals by providing medical equipment and training health teams.

The institutional set-up of the parent project is continued for the AF and remains unchanged.

6. Mr. Khalid Anouar (Environmental Specialist) presented the framework, objectives, methodology and main results of the addendum to the Environmental and Social Systems Assessment (ESSA) applicable to the Program. It was recalled that in accordance with the World Bank's operational policies on RPPs, the preparation of the Program includes three evaluations: (i) a technical assessment, (ii) a fiduciary systems assessment, and (iii) an environmental and social systems assessment (ESSA) which is the subject of the consultation session. The objective of these assessments is to identify, prevent and mitigate all risks to the Program both during the preparation phase and during implementation. As the World Bank's support is at the programmatic level, the objective is to strengthen and improve the systems applicable to the Program. The main objectives of the World Bank's operational policies on environmental and social management were presented. They are articulated around the objectives of: promoting environmental and social sustainability; reducing environmental and social risks related to the implementation of the Program's activities; and taking into account environmental and social issues and risks in decision-making processes. The ESSA assesses the Program's systems in relation to these general objectives, to evaluate both the formal systems, as defined by the applicable laws, regulations and procedures, and the actual practices and capacity of the institutions involved in the Program in terms of environmental and social management.

7. Overall, the implementation of the Program is likely to have more benefits and positive impacts in the targeted communities. The proposed additional funding does not include activities requiring land acquisition as the activities are primarily focused on upgrading and equipping existing infrastructure and increasing the number of Covid-19 tests. The AF will support and accompany the implementation of sustainable medical and pharmaceutical waste management practices and will also strengthen the protection of health system workers through the financing of personal protective equipment (PPE) and appropriate hygiene materials.

8. As with the Parent Program, activities requiring such acquisition will be excluded from the Program. The proposed additional funding will have positive social impacts as it is expected to improve surveillance, case management, monitoring and containment of COVID-19. The Program aims to ensure equity of access to health care, strengthen social responsibility and participatory governance, and develop complaint management mechanisms (CMPs) that are easily accessible, culturally appropriate and understandable to affected individuals and communities. The Program contains mechanisms to ensure

the inclusion of vulnerable populations (elderly, youth, female-headed/widow-headed households, orphans, homeless, etc.), including communication and access for all. Protocols will need to ensure that those infected in remote areas will have access to the benefits of the Program and that guidelines such as the WHO guidelines on risk communication and community engagement during the pandemic will be followed.

9. Overall, the environmental and social risks associated with the Program's activities are considered to be low to moderate, with the Program not financing any investments with significant or substantial social and environmental risks, in accordance with the requirements of the World Bank's RPP Policy. The ESSP of the parent Program identified the increase in sanitary waste at the ESSP level as the main environmental risk, and this remains the case for the AF. Indeed, the volumes of infectious wastes generated by VIDOC-19 activities specific to AF will increase due to the increased production of personal protective equipment (PPE) such as gloves, face and nasal masks, waterproof protective gowns, rubber boots, rubber aprons, tissues and other contaminated materials. The generation of sanitary waste will be limited to hospitals and support structures (field hospitals). These hospital waste management systems are based on a clear and widely applied procedure (see section IX), developed by DHSA to manage the health-care waste generated at the Covid-19 isolation units. The environmental officers of the regional representations of the Ministry of Health will ensure the strict application of these procedures.

10. The AF will entail potential social risks that are mainly related to : i) the health and safety of the community and in particular the exposure of high-risk people to the virus when using acquired materials, equipment and drugs; ii) the limited capacity of vulnerable groups to access facilities and services designed to combat the disease and the growing social discontent due to the lack of necessary tests, drugs and equipment; iii) the limited capacity of health services to respond to the epidemic; and iv) insufficient communication about the effort to prevent and control the disease. These risks are being addressed by the Program.

11. With regard to the social and environmental management systems applicable to the Program, the legal and regulatory frameworks and the procedures developed are generally in line with the provisions of the Bank's PPR Policy. Nevertheless, the capacities of the E&S Focal Points at the regional level in terms of environmental and social management are insufficient and require sustained strengthening. To mitigate these risks, which are considered substantial, the Program will strengthen environmental and social capacities at the regional level through continuous training on the implementation of mechanisms and tools (environmental and social monitoring sheets) that will be regularly monitored and evaluated.

12. All these measures are set out in the ESSA Action Plan, which will be an integral part of the Program's action plan and which provides for specific measures to strengthen the quality and performance of the environmental and social management system of the Ministry of Health's regional representations, through :

- Designation of E&S Focal Points in the 2 new regions integrated into the Program (in addition to the E&S Focal Points already designated under the parent Program);
- Training/awareness raising to strengthen the capacity of the E&S focal points in the implementation and monitoring of the procedure for the management of medical and pharmaceutical waste;
- The establishment of mechanisms and tools: E&S focal points trained, monitoring sheets,

- The development of protocols and awareness-raising mechanisms to ensure the inclusion of vulnerable populations among the beneficiaries of the Program and regular monitoring and evaluation.

13. At the end of the presentation, it was recalled that the draft version of the addendum to the ESSA is published on the portal of the Ministry of Health; the synthesis of the comments resulting from the consultation and received by email will be integrated into the final version of the addendum to the ESSA which will also be published on the portal of the Ministry of Health and on the World Bank website.

PART TWO: DISCUSSIONS WITH PARTICIPANTS

14. During the discussion that followed these presentations, participants had both the opportunity to ask questions for clarification on the Program in general or on the ESSA Addendum in particular, and to provide their own thoughts and comments on a range of relevant topics.

(A) QUESTIONS AND CLARIFICATIONS

1. Items relating to the ESSA addendum

Questions and proposals :

(i) The draft joint order signed in 2018 between the Ministry of Health and the Department of Environment on the management of medical and pharmaceutical waste describes the technical and organizational tools for effective management of medical waste in health-care institutions. This order is currently being validated by the SGG ;

(ii) The E&S focal points of the parent project are not designated;

(iii) The National Medical and Pharmaceutical Waste Management Plan has not yet been validated, therefore the regional MPW management plans cannot be developed;

(iv) The COVID-19 waste management procedure developed by DHSA has not yet been validated;

(v) The addendum to the ESSA presents only the problems related to MPW, QUID of masks and protections in household waste;

(vi) The Ministry of Health has carried out several communication activities for the general public and civil society;

(vii) With regard to the inclusion of people with special needs in the programme, NGOs have developed communication and awareness-raising approaches and tools for this category of people. It would be advisable for the Ministry to approach these NGOs in order to strengthen its efforts and avoid the exclusion and worsening of the conditions of these persons during the period of confinement and beyond.

Responses :

(i) The World Bank team will incorporate in the final version of the addendum to the ESSA the modifications necessary to take into account the fact that the joint order on the management of MPWs is currently being validated by the SGG;

(ii) The MOH team recalled that the focal points have been designated and that they held a meeting in November 2019 on the status of implementation of the ESSA action plan of the parent project;

(iii) The World Bank team recalled that during the development of the parent project's ESSA in 2015, it was agreed with the teams of the Ministry of Health to produce during the implementation of the Program, regional plans for the management of MPWs at the level of the participating regions in order to integrate health facilities in rural areas;

(iv) With regard to communication activities, the Bank team recalled that these activities must be directed towards the people benefiting from and affected by the Program, including vulnerable people or those with special needs;

(vii) With regard to the management of MPWs, the evaluation analyzed the systems that apply to the Program's activities. The Program only funds protective equipment for Covid hospitals¹⁹.

(vi) The final version of the addendum to the ESSA will take account of the fact that the procedure for the management of MPWs linked to Covid19 is currently being validated;

(vii) The World Bank team also recalled that the grievance management system will be strengthened to include all the activities financed by the Program, with the support of the ES focal points;

2. Program Issues :

Questions and comments :

(i) The Bank and the Ministry of Health do not take into account the comments of NGOs participating in the public consultations.

(ii) Avoid confusing COVID-19 centers with other health centers so that people with chronic diseases continue to seek care, especially in rural areas.

(iii) Strengthening community participation in the monitoring-evaluation of projects and activities financed in the health sector.

Responses :

(i) The Bank team recalled that the principle of public consultation requires that all comments from participants be taken into account and recorded in the consultation minutes. The latter is integrated in the final version of the evaluation report which is published on the websites of the Ministry of Health and the World Bank;

(ii) The Bank team recalled that the additional funding only includes health care facilities designated COVID-19 in accordance with the MOH guidelines, which are mostly hospitals, and which participate in the national strategy to combat COVID-19.

(iii) The World Bank team took note of the participants' comment on community participation during the evaluation of the Program. The World Bank will ensure that the relevant stakeholders are involved during the Program Completion Report which will be conducted within six months after the closure of the Program.

(B) COMMENTS OF A GENERAL NATURE

At the end of the discussions, it became clear that both the results and the recommendations of the ESSA addendum were shared and adopted by the participants.

CONCLUSION

The representatives of the World Bank thanked those present for their participation in the consultation. They assured that all their remarks and suggestions would be taken into account during the next stages of the preparation of the Program and in the finalization of the addendum to the ESSA. The final version of the addendum to the ESSA, which will include the minutes of the consultation, will be published on the portal of the Ministry of Health and on the World Bank website.

List of those invited and those who participated in the virtual public consultation

| Nom | Titre | Organisation- Direction | Emails | Présence |
|----------------------------|--|----------------------------|--|----------|
| Sanae Cherqaoui | Chef de Division de la Coopération | Division de la Coopération | scherqaoui@hotmail.fr | Oui |
| Dahani Iman | Chargée de programmes de coopération Service des Organisations Internationales et Intergouvernementales | Division de la Coopération | dahani.iman@gmail.com | Oui |
| Chaimae Elbakkali | Chef de Service des Organisations Internationales et Intergouvernementales | Division de la Coopération | chaimae.elbakkali@gmail.com | Oui |
| Bouchrif Brahim | Chef de département santé environnement | IPM | brahim.bouchrif@pasteur.ma | Oui |
| Abdellatif asmama | Chef du service d'hygiène | CHUIS-Rabat | asmamaabdellatif@gmail.com | Oui |
| Khallaf Mohammed | Chef du service de salubrité de l'environnement | DELM- MS | mkhallaf@sante.gov.ma ou khallafm@yahoo.fr | Oui |
| Echkale Abdessalam | | DHSA | aechkale@gmail.com | Oui |
| Fatima El Kadiri El Yamani | Cheffe du projet | Banque Mondiale | felkadirielyama1@worldbank.org | Oui |
| Franco Russo | Senior Operations Officer | BM | frusso@worldbank.org | Oui |
| Taoufiq | Senior Natural Resources | BM | tbennouna@worldbank.org | Oui |

| | | | | |
|---------------------|---|--|--|-----|
| Bennouna | Specialist | | | |
| Markus Vorphal | Senior Social development specialist | BM | mvorpahl@worldbank.org | Oui |
| Houcine Gabi | Social development specialist | BM | hgabi@worldbank.org | Oui |
| Fatiha Bouamoud | Program assistant | BM | fbouamoud@worldbank.org | Oui |
| Ibtissam Alaoui | External Communications | BM | ialaoui@worldbank.org | Oui |
| Khalid Anouar | Environmental specialist | BM | kanouar@worldbank.org | Oui |
| Céline Abric | Country Manager | Handicap International - Morocco | c.abric@hi.org | Oui |
| Aziz Rhali | Président | Association marocaine des droits humains (AMDH) | aziz_rhali@yahoo.fr | Oui |
| Ilegh | | | ailegh7@gmail.com | |
| Hassan El Bari | Président | Association Marocaine des déchets solides (AMADES) | amades_morocco@yahoo.fr | |
| ELHAMRI Hicham | Chef du Département de Toxicologie et Hydrologie | INH | elhamrih@yahoo.fr | |
| ELOUARDI Abdelmoula | Chef du Département de Microbiologie et Hygiène Alimentaire | INH | abdoelouardi@yahoo.fr | |
| Abdelghani Drhimer | | DHSA- MS | drhimer2@gmail.com | |
| Mustapha Elhousni | | DHSA- MS | mhousni70@hotmail.fr | |
| ILHAM BACISS | | DHSA- MS | ilhame76b@hotmail.fr | |