

**Ethiopia: Health
Millennium Development Goals Program for Results**

Environmental and Social System Assessment

Draft for Consultation

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ACRONYMS AND ABBREVIATIONS

ACGs	Anti-Corruption Guidelines	OP	Operational Policy (of the World Bank)
AIDS	Acquired Immune Deficiency Syndrome	ORS	Oral Rehydration Solution
ANC	Antenatal Care	P for R	Program for Results
ARAP	Abbreviated Resettlement Action Plan	PBS	Protection of Basic Services
ART	Antiretroviral Therapy	PCDP	Pastoral Community Development Project
ASC	Audit Service Corporation	PDO	Project Development Objective
BPR	Business Process Reengineering	PEPFAR	President's Emergency Plan for AIDS Relief
BSC	Balanced Score Card	PFSA	Pharmaceutical Fund and Supply Agency
CAS	Country Assistance Strategy	PHC	Primary Health Care
CBHI	Community Based Health Insurance	PHCU	Primary Health Care Unity
CC	Community Conversations	PHEM	Public Health Emergency Management Agency
CEmONC	Comprehensive Emergency Obstetric Care	PMTCT	Preventing Mother-to-Child Transmission
CEOC	Comprehensive Emergency Obstetric Care	PMU	Project Management Unit
CIF	Community Investment Fund	PNC	Postnatal Care
CIFA	Country Integrated Fiduciary Assessment	PPA	Public Procurement and Property Administration Agency
CLTS	Community Led Total Sanitation	PSNP	Productive Safety Net Programme
CLTSH	Community Led Total Sanitation and Hygiene	RAP	Resettlement Action Plan
CPAR	Country Procurement Assessment Report	RHB	Regional Health Bureau
CPD	Continuing Professional Development	SANA	Situation Analysis and Needs Assessment
CPIA	Country Policy and Institutional Assessment	SAP	Strategic Action Plan
CPR	Contraceptive Prevalence Rate	SEA	Strategic Environmental Assessment
CPS	Country Partnership Strategy	SHI	Social Health Insurance
CSA	Central Statistical Agency	SNNPRS	Southern Nations, Nationalities, and People's Regional State
CSRP	Civil Service Reform Program	SWOT	Strengths, Weaknesses, Opportunities and Threats
DDT	DichloroDiphenylTrichloroethane (insecticide)	TA	Technical Assistance
DFID	UK Department for International Development	TB	Tuberculosis
DHS	Demographic and Health Survey	TBA	Traditional Birth Attendants
DLI	Disbursement Linked Indicators	TC	Technical Committee
EDHS	Ethiopia Demographic Health Survey	ToT	Training of Trainers
EIA	Environmental Impact Assessment	ULGDP	Urban Local Government Development Project
EPI	Epidemiology	UNFPA	United Nations Population Fund
EPLAU	Environmental Protection, Land administration and Use Authority	UNICEF	United Nations International Children's Emergency Fund
ESMM	Environmental and Social Management Manual	VAT	Value Added Tax
ESSA	Environmental and Social Systems Assessment	VCT	Voluntary Counseling and Testing
FAO	Food and Agriculture Organization	US	United States
FEACC	Federal Ethics and Anti-corruption Commission	WASH	Water, Sanitation and Hygiene
FEPA	Federal Environmental Protection Authority	WHO	World Health Organization
FGM	Female Genital Mutilation	WorHO	Woreda Health Officers
FMHACA	Food, Medicine and Healthcare Administration and Control Authority	ZHD	Zonal Health Department

FMOH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunization
GOE	Government of Ethiopia
GTP	Growth and Transformation Plan
HC	Health Center
HCWM	Health Care Waste Management
HEP	Health Extension Program
HEW	Health Extension Worker
HID	Health Infrastructure Directorate
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HNP	Health Nutrition and Population
HoF	House of Federation
HP	Health Post
HRD	Human Resource Development
HRH	Human Resource for Health
HRITF	Health Results Innovation Trust Fund
HSDP	Health Sector Development Plan
IDA	International Development Association
IBEX	Integrated Budget and Expenditure
NMA	National Meteorology Agency
OFAG	Office of Federal Auditor General

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SECTION 1 INTRODUCTION

1.1 Background

The World Bank is currently working with the Government of Ethiopia to provide support for the health sector to improve delivery and use of a comprehensive package of maternal and health services. It is agreed to use the Bank's new Program for Results (PforR) financial instrument for this operation. PforR is a new form of World Bank financing that supports countries to design and deliver their own development programs. To do this, PforR links disbursement to verified achievement of results.

The Health Sector Development Program (HSDP) reflects the Government of Ethiopia's (GoE) commitment to achieve the Health Millennium Development Goals (MDGs) and provides the overarching framework for the health sector. The fourth phase of the Program, HSDP IV 2010-2015, is also the main vehicle for achieving Ethiopia's Growth and Transformation Plan (GTP, 2010-2015) goals related to health.

The proposed PforR operation will disburse against a subset of HSDP IV results which are known to contribute to the achievement of the maternal and child health Millennium Development Goals. The funds disbursed will support activities financed through the Millennium Development Goals Performance Fund (MDGPF) window of HSDP IV.. The activities supported by the MDGPF focus on priorities identified by the Health Sector Development Program (excluding wage costs). All activities are agreed annually at the Joint Consultative Forum that provides the platform for discussion between the Government and partners. .

To inform preparation of the PforR operation, the World Bank conducted a comprehensive Environmental and Social System Assessment (ESSA) of the existing country environmental and social management systems used to address the environmental and social effects (defined as benefits, impacts and risks) of the activities financed through the MDGPF window.

This report presents the findings and recommendations of the ESSA exercise. The report is organized in seven sections, as follows:

Section 1 presents the general background to the Program and the ESSA exercise as well as a brief introduction to the key elements of the health sector in Ethiopia and the Health Sector Development Program. **Section 2** provides a description of the proposed Program for Results Operation. **Section 3** describes the scope and methodology of the Environmental and Social Systems Assessment process conducted to inform design and preparation of the Program for Results Operation. **Section 4** examines the potential environmental and social effects of the proposed Program. **Section 5** describes existing environmental and social systems currently in use in the health sector to address the environmental and social effects of the Millennium Development Goals Performance Fund financed activities. **Section 6** presents a set of summary matrices of the detailed ESSA analysis with respect to the six Core Principles of OP/BP 9.00 that is presented in full in Annex 3. **Section 7** presents the ESSA actions proposed for inclusion in the overall Program Action Plan.

1.2 The Health Sector in Ethiopia

For the last two years, Ethiopia has been implementing a five-year national poverty reduction strategy known as the Growth and Transformation Plan (2010-2015). The health sector goals envisaged by the GTP are closely aligned with the Millennium Development Goals (MDGs). The GTP places particular emphasis on human development and its contribution to economic growth. The national Health Sector Development Program (HSDP IV) is an important vehicle for achieving the GTP health targets.

The National Health Policy, issued in 1993, established the basis for the design and formulation of the country's comprehensive twenty-year Health Sector Development Program. The most important priority in the Policy is fulfilling the health needs of less privileged citizens; those who live in the rural areas and constitute 83% of the population. Prominent issues at the core of the Policy are democratization and decentralization of the healthcare

system; developing preventive, promotive and curative components of healthcare services; ensuring healthcare accessibility to all; and, encouraging private and NGO participation in the sector.

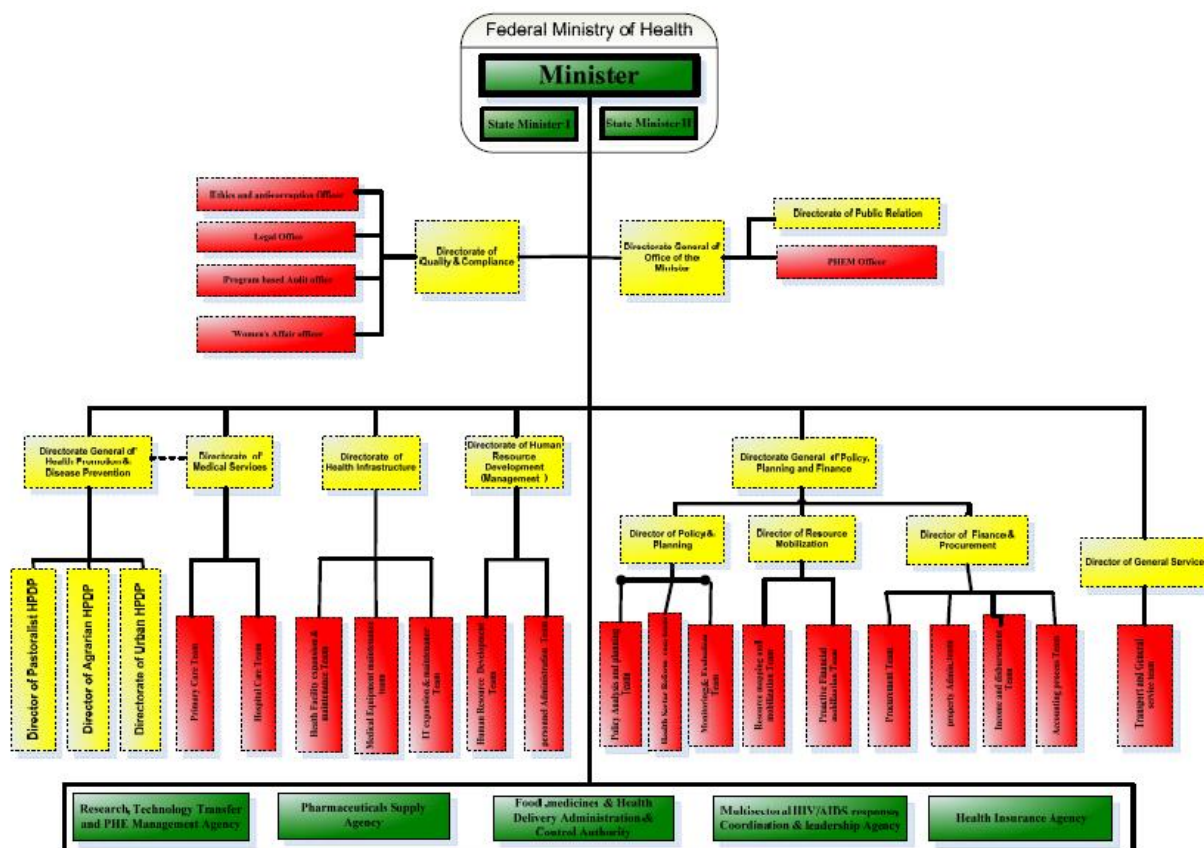
HSDP has been under implementation since 1997. Three phases of the program have been completed, with the fourth phase being implemented at present (2010-2015). HSDP IV was developed following a series of consultative and participatory processes involving discussions with stakeholders and two rounds of the Joint Assessment of National Strategies (JANS). The design of the program was also based on a thorough analysis of major bottlenecks in the healthcare system, identification of high impact interventions, anticipated scenarios and the estimated cost of achieving the health MDGs by 2015.

1.2.1 Organization of the Health Sector

Figure 1 presents the organizational structure of the Federal Ministry of Health. Several Directorates and Authorities are involved in delivery of the HSDP IV and the MDG Performance Fund. Details pertaining to the specific roles of the Directorates and Authorities involved in Program delivery and responsibilities in addressing the environmental and social effects of HSDP IV and the MDG Performance Fund financed activities are described in subsequent sections of this report.

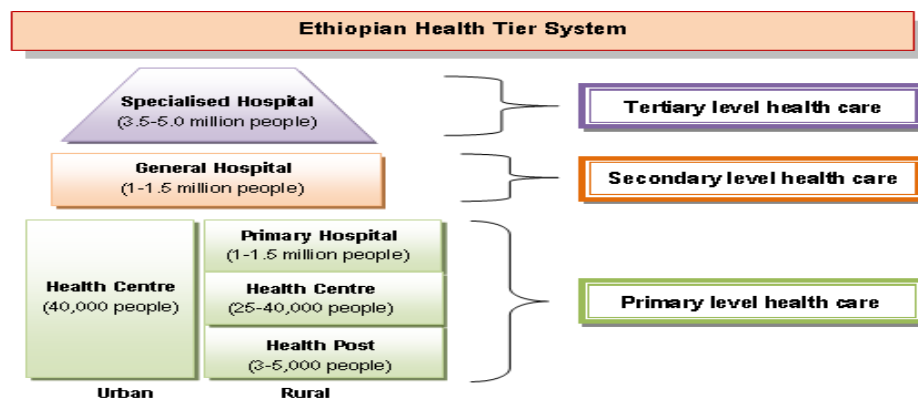
Ethiopia has a devolved federal structure of governance and the Constitution provides for shared responsibility for health policy, regulation and service delivery between the Federal Ministry of Health (FMOH), Regional Health Bureaus (RHBs) and Woreda Health Offices (WorHOs). In line with government’s decentralization policy, decision making power in the sector has been devolved from the Federal Ministry of Health to regional health bureaus and woreda health offices. Accordingly, the MoH and Regional Health Bureaus (RHBs) focus on policy formulation and provision of technical support. And, woreda health offices retain primary responsibility for managing health system operations in their jurisdictions.

Figure 1: The Organizational Structure of the Federal Ministry of Health



The recently introduced reform and restructuring program of the health sector, known as Business Process Reengineering (BPR), has led to establishment of a three-tier health care delivery system in Ethiopia (Figure 2) to deliver essential health services and ensure referral linkages. Rapidly expanding private service providers (including for-profit and not-for-profit) are augmenting the public sector service delivery outlets, especially in the urban areas. Providers of services in public facilities remain the major recipients of health sector financing, while private providers (both for-profit and not-for-profit) received less than one-fifth (about 16 percent) of the total national health expenditure¹.

Figure 2: Ethiopian Health Tier System



The first tier comprises the woreda health system that consists of satellite health posts (HP), health centers (HC) and a primary hospital, which together form a Primary Health Care Unit (PHCU).

- Staffed with two HEWs, each health post serves 3-5,000 persons. The HEWs are expected to spend less than 20% of their time in their respective health posts. More than 80% of their time is meant to be spent on community outreach program visits to households, with a primary focus on mothers and children. The HEWs conduct 96 hours of training for the households in their catchment area on selected Health Extension Program (HEP) packages. The HEWs also follow-up on progress households make in practicing the knowledge and skills acquired through training before they graduate as model families. In addition, the HEWs provide selected health care services, including: family planning, epidemiology (EPI), clean delivery and essential newborn care services, diagnosis and treatment of malaria and pneumonia, and management of diarrhea and dehydration using Oral Rehydration Solution (ORS).
- On average, a health center has 20 staff and provides preventive and curative services. HCs serve as a referral center and practical training site for HEWs. A HC in rural areas serves a population of 25 – 40,000, in urban areas the population covered by one HC may also reach up to 40,000.
- A primary hospital is staffed with 53 health personnel and provides inpatient and ambulatory services to a population of 1-1.5 million. A primary hospital provides all the services of a HC as well as emergency surgical services, including caesarean section, and access to blood transfusion services. It also acts as a referral point for HCs in its catchment area, in addition to being a practical training centre for nurses and other paramedical health professionals.

The second tier in the Ethiopian healthcare system is comprised of a general hospital with population coverage of 1-1.5 million. This type of hospital provides inpatient and ambulatory services. With a staff of 234 professionals, a

¹ Ethiopia's Fourth National Health Accounts, 2007/2008

general hospital serves as a referral center for primary hospitals and a training center for health officers, nurses, emergency surgeons and other health workers.

The third tier of the system consists of a specialized hospital with population coverage of 3.5 - 5 million and a professional staff of 440.

1.3 Health Sector Development Program IV, 2010-2015

HSDP IV reflects the Government of Ethiopia’s commitment to achieve the Health MDGs. HSDP IV supports human capital development and remains the main vehicle for achieving Ethiopia’s GTP goals related to health. HSDP IV envisions a strong client centered approach to improve access to health services; in particular, ensuring timeliness, quality, safety and responsiveness.

1.3.1 Core Themes and Program Areas of HSDP IV

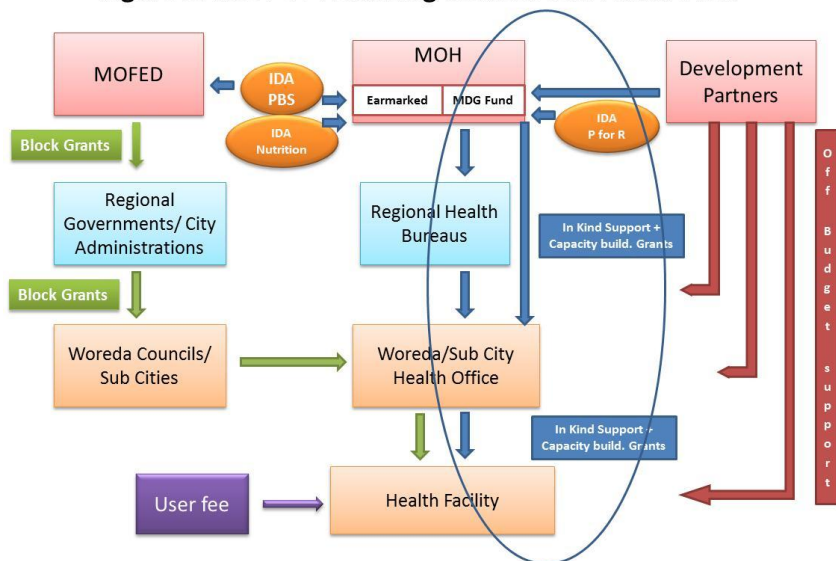
HSDP IV is nation-wide in scope and covers the entire health sector. The Program focuses on three core themes: (a) *effective and timely* delivery of quality health care covering preventive, curative and rehabilitative services and improving healthy behaviors; (b) strong leadership in developing evidence-based policies setting priorities to reduce inequities and establish governance structures to ensure accountability, transparency and active participation of communities in decisions related to health; and (c) improving access to health facilities that are staffed, equipped, responsive to users and able to generate timely information on service provision.

HSDP IV is organized in three functional program areas: 1. Leadership and Governance; 2. Strengthening Service Delivery; and 3. Expansion and strengthening health infrastructure and resources.

Each area has sub-programs and earmarked budgets. The Leadership and Governance area has three sub-programs covering Community Empowerment, Monitoring and Evaluation, Operational Research, and Health Systems Strengthening and Capacity Development. The Strengthening Service Delivery is the largest area comprised of 11 sub-programs covering maternal and newborn, child, reproductive and adolescent health, nutrition, hygiene and environmental health, prevention and control of communicable and non-communicable diseases, public health emergency management and public health and nutrition research and quality assurance. The Expansion and Strengthening of health infrastructure and resources area is comprised of five sub-programs covering expansion of Primary Health Care (PHC) facilities and hospital infrastructure, salaries, training, supply of pharmaceuticals and medical equipment and health care financing.

HSDP IV has a well-defined results chain linking inputs to outcomes and how these outcomes contribute to achieving the MDGs and GTP goals in the health sector.

Figure 3. HSDP IV Financing Sources and Funds Flow



HSDP IV is financed through multiple channels, including: block grants transferred by the Federal Ministry of Finance and Economic Development to regional states which in turn release them to Woreda Councils which allocate resources across all sectors (Channel 1); non-earmarked resources provided by donors through the Millennium Development Goals Performance Fund (MDGPF) as well as earmarked external funds provided to the Federal Ministry of Health (Channel 2); and, technical assistance provided by partners to the sector (Channel 3). HSDP IV also receives off-budget support from some

partners and contributions through user fees.

PforR support through the MDGPF (Channel 2) will be linked to achievement of results under the direct control of government. However, these results will require inputs from activities financed by other sources such as block grants. The results focus on improved coverage of evidence-based interventions that will help Ethiopia accelerate progress towards achievement of the maternal and child health MDGs and strengthen oversight functions of the health system.

Previously, through the Provision of Basic Services (PBS) Project and the Nutrition Project, the Bank has supported investments in the health sector. PBS investments have been channeled through block grants to finance about a third of the salary costs of the Health Extension Workers (HEWs). Specifically, PBS II provided funding to the Federal Ministry of Health for supply of essential medical products. The Bank-funded Nutrition Project also provided support for targeted interventions in the health sector. While support from PBS will continue under PBS III, the scope of the Program for Results operation will support activities financed through the MDGPF, with the exception of the high value procurement. HSDP IV financing sources and funds flow are shown in Figure 3 above.

SECTION 2 PROGRAM FOR RESULTS DESCRIPTION

2.1 Development Objective

The Program for Results Development Objective (PDO) is to improve delivery and use of a comprehensive package of health services. The proposed PDO is a subset of the HSDP IV mission statement which aims to reduce morbidity, mortality and disability and improve the health status of Ethiopian citizens through provision of a comprehensive package of promotive, preventive, curative and rehabilitative services via a decentralized and democratized health system.

The PforR operation will be supported by an IDA Credit of US\$100 million and a grant of US\$20 million from the Health Results Innovation Trust Fund (HRITF). These funds represent approximately 16 percent of the projected MDGPF commitments during the next five years (Table 3). Technical Support for strengthening the monitoring and evaluation system, especially for the annual rapid facility assessment and impact evaluation, will be provided through the HRITF grant.

2.2 Scope

The PforR operation contributes to the HSDP IV objectives by disbursing against achievement of a subset of key results. Thus the PforR operation changes the focus of health sector assistance from inputs to tangible results for communities with emphasis on using robust and credible data from diverse sources. It relies on existing institutional arrangements to ensure close harmonization with other development partners and builds on an existing and successful Government program supporting important innovations included in HSDP IV.

Specifically, disbursements from the PforR operation will support activities under the MDGPF with the exception of the high-value procurement. To date, MDGPF-supported financing gaps have been in maternal health (equipment and commodities for providing emergency obstetric care, ambulances and contraceptives), child health (cold chain strengthening, supply of vaccine, immunization campaigns), capacity building of health extension workers and health systems strengthening (procurement of medical equipment for hospitals and health centers, and construction of health centers). Consistent with the mandate of the MoH², the majority of expenditures under the MDGPF will be made at the federal level, with goods and services transferred in-kind to sub-national levels according to assessed need and disease burden. Government wage costs are not covered by the MDGPF. Table 1 presents the specific activities and results supported by the MDGPF.

The Joint Financing Arrangement (JFA) sets out the governance and reporting requirements for the MDGPF. As of 2012, partners supporting the MDGPF include Australian AID, UK Department for International Development, Spanish Corporation, Italian Corporation, Irish Aid, UNFPA, UNICEF and WHO. In addition, the Netherlands Government has recently joined the JFA. Such support will allow government to apply donor-partner resources in priority areas to improve health outcomes.

² Proclamation 471/2005

Table 1. Scope and Results supported by MDGPF

Priority area	Activities	Intermediate results	Outcomes ³
<i>Accelerating progress towards maternal health MDG</i>	<ul style="list-style-type: none"> • Supplying equipment and commodities for providing emergency obstetric care • Supplying contraceptives • Providing ambulances to all Woredas • In-service training of midwives and training of Health Officers in Emergency Surgical and Obstetric skills • Capacity building of health extension workers in clean and safe delivery 	<ul style="list-style-type: none"> • Health centers offer basic emergency obstetric care • Woredas have functional ambulance services • Midwives receive in-service training • Health officers trained in emergency surgical and obstetric care 	Increase in <ul style="list-style-type: none"> • Skilled care at child birth, • Antenatal care • Contraceptive prevalence
<i>Sustain the gains made in child health MDG</i>	<ul style="list-style-type: none"> • Strengthening of cold chain systems • Supplying vaccines • Holding Immunization campaigns • Supplying bed nets 	<ul style="list-style-type: none"> • Health centers have functional cold chain equipment • Outreach campaigns held • Long lasting insecticidal nets distributed 	<ul style="list-style-type: none"> • Increased immunization coverage
<i>Strengthen health systems</i>	<ul style="list-style-type: none"> • Constructing Health Centers • Supplying essential medical products and equipment • Validating HMIS semi-annually • Undertaking Surveys and studies 	<ul style="list-style-type: none"> • Health centers built • Health facilities report HMIS information in time • Annual Facility Readiness Assessment undertaken 	<ul style="list-style-type: none"> • Improved HMIS • Roll out of balanced score card and institutional performance incentives • Improvement in Facility readiness score

The scope of activities to be financed will be determined annually through a consultative process involving stakeholders of the Joint Consultative Forum⁴. The Forum is chaired by the Minister of Health and co-chaired by the partner chairing the Health Nutrition and Population (HNP) partner group.

With IDA joining the existing MDGPF financing arrangement through the new Program for Results operation the principles of effective donor harmonization are upheld to support the GoE's priority investments in the sector. The harmonization arrangements for the PforR operation with respect to investing in results achieved through the MDGPF are detailed in Table 2. Table 3 presents the full complement of funding sources of HSDP IV and the MDGPF.

Table 2: Harmonization of PforR with MDGPF

Area	Harmonization	MDF Fund	P for R
Scope	Support priority areas under the HSDP framework except Salaries	Yes	Yes (with exception of high value procurement)
One Plan	Develop and agree on "one comprehensive plan" including procurement and technical assistance plans which are evidence based with realistic targets	Yes	Yes
One Budget	Implement MDG Fund Budget in a manner consistent with overall federal budget consulting in advance with partners on any major changes	Yes	Yes
One Program following country systems	Procure and transfer goods and services in kind to sub-national levels as per proclamation 471/2005 based on the need and disease burden	Yes	Yes
	Follow procedures of Public Procurement and use the standard bidding documents issued by the Public Procurement Authority	Yes	Yes
	Maintain financial records of MDG fund operations in-line with GOE budgetary laws and procedures	Yes	Yes
One reporting	Prepare quarterly MDG Fund Financial and Activity Report within 45 days of end of each quarter indicating up to date advances, expenditures and remaining balances	Yes	Yes
	Share all internal audit reports with the Minister of Health within 30 days of completion which will be reviewed as part of annual external audit	Yes	Yes
	Share annual external audit along with financial statements and management letter with signatories within nine months of the end of the Ethiopian Financial year	Yes	Yes
	Ensure effective implementation of new information management system for financial and technical reporting	Yes	Yes
	Use Joint Review Mission as independent Monitoring Mechanism	Yes	Yes (with additional validation)
Handling of Corruption	Inform each other promptly of any instances of corruption and take legal action to stop, investigate and prosecute in accordance with applicable law	Yes	Yes

³ Outcomes are limited to the Disbursement Linked Indicators

⁴ The Joint Consultative Forum includes the Government of Ethiopia, donors supporting the health sector and other key stakeholders

Table 3. Estimated Program Financing (US\$ Million)

Source	HSDP IV Financing		MDGPF Financing	
	Amount	% of Total	Amount	% of Total
Government	1,447.0	31.4		
IDA/HRITF (P for R operation)	120.0	2.6	120.0	17.1
Other Financing Sources	1,998.3	43.3		
UK DFID	413.0	9.0	413.0	58.8
PEPFAR	400.0	8.7		
UNICEF	55.0	1.2	2.5	0.4
Netherlands Government	43.6	0.9	43.6	6.2
Australian AID	43.0	0.9	43.0	6.1
Spanish Development Corporation	34.1	0.7	34.1	4.9
UNFPA	25.0	0.5	15.0	2.1
Irish AID	13.0	0.3	13.0	1.9
WHO	10.0	0.2	10.0	1.4
Italian Corporation	8.0	0.2	8.0	1.1
Total Program Financing	4,610.0	100	702.20	100.0

2.3 Key Results and Disbursement Linked Indicators

The proposed key program results are: (i) Antenatal coverage (%); (ii) Deliveries attended by Skilled Health Providers (%); (iii) Pentavalent vaccine 3 coverage for children aged 12-23 months (%); and (iv) Contraceptive Prevalence Rate (%).

The disbursement linked indicators (DLIs) are proposed based on the following criteria: (a) evidence of their contribution to MDGs; (b) under the span of control of government; (c) achievable in the time-frame of the Program; and (d) objectively measurable and verifiable. An indicative list of the DLIs is presented in Table 4 which includes a combination of outcome and process indicators. These indicators will be finalized during appraisal.

Table 4. Disbursement Linked Indicators and Targets

No.	Disbursement Linked Indicator ⁵	Targets					
		Baseline	Yr. I	Yr. II	Yr. III	Yr. IV	Yr. V
1.	Deliveries attended by skilled birth providers (%)	10	-	14	-	18	-
2.	Children 12-23 months immunized with Pentavalent 3 vaccine (%)	TBD			5% increase		10% increase
3.	Pregnant women receiving antenatal care (%)	43		48		56	
4.	Contraceptive Prevalence Rate (%)	27.3		31		35	
5.	Health Facilities reporting HMIS data in time (Average number for 4 quarters)	50	55	50	70	75	80
6.	Development and implementation of Balanced Score card approach to assess facility performance and related institutional incentives		Protocol	Pilot	Pilot	Decision to scale-up	Scale-up
7.	Development and implementation of Annual Rapid Facility Assessment to assess readiness to provide quality MNCH services	Agency selected	Baseline	Survey	Survey	Survey	Survey
8.	Improved transparency of the PFSA	NA	Website launched	Website updated and first open call issued	Web site updated	Web site updated	Website updated

⁵ The criteria used are: The DLIs are (i) important of themselves with process indicators linked to outcomes contributing to MDGs; (ii) measurable and verifiable, (iii) targets realistic and achievable, and within the government's span of control.

2.4 Implementation Arrangements

The Program for Results' implementation arrangements are as follows:

Technical: Implementation of HSDP IV follows Ethiopia's decentralized federal system of governance which provides for shared responsibilities between the MoH, Regional Health Bureaus and Woreda Health Offices. The MoH is responsible for planning, budgeting and reporting funds released through MDGPF through which the PforR funding will be disbursed. The JCF chaired by the Minister of Health will be the highest body responsible for overall policy dialogue and reform issues between the GoE, partners and stakeholders in the health sector. The JCF will determine the scope of support proposed under the MDGPF annually. The JCCC chaired by the Director General of Policy, Plan and Finance General Directorate will be the technical arm for the implementation of MDGPF under oversight of the JCF.

Fiduciary, Environment and Social Aspects: The Directorate for Policy, Plan and Finance General Directorate will be responsible for the fiduciary and performance reporting coordination with other departments in the MoH and the Regions. The PFSA under the MoH is responsible for procurement of health sector goods while the PMU procures the civil works (i.e., rehabilitation and construction of health centers only) under the MDGPF. The MoH sets policies, strategies and guidelines for improving services for underserved populations and health care waste management. The Regions are responsible for applying these guidelines accordingly. The Directorate for Pastoral Health Promotion and Disease Control coordinates health initiatives in the four regions that need special attention (i.e., Afar, Somali, Benishangul-Gumuz and Gambella) and is responsible for environmental health, hygiene and sanitation activities at the national level including joint initiatives with the Federal Environment Protection Agency.

Program Monitoring Arrangements: HSDP II introduced a new Health Monitoring Information System (HMIS) which is currently being scaled-up. At the Federal level, information is received on 108 indicators disaggregated by facility type and management every quarter. The MoH has introduced semi-annual HMIS validation to improve quality and timeliness of the data collected using the HMIS. Under the Ethiopia Hospital Reform Initiative, data on Key Performance Indicators (KPIs) is also being collected and information on a core set of 36 KPIs is shared with the MoH by the Regional Health Bureaus each quarter. The PforR operation will build on these resources and support robust validation of data collected to provide credible information on the Disbursement Linked Indicators (DLIs). Standardized surveys such as Demographic and Health Surveys will be used to report on population level DLIs while annual rapid facility assessments using standard tools⁶ will provide information on facility readiness to deliver DLIs.

⁶ WHO Service Availability and Readiness Assessment tested in Africa

SECTION 3 ENVIRONMENTAL AND SOCIAL SYSTEM ASSESSMENT PROCESS

3.1 Scope

The Program for Results financing instrument is a new form of World Bank financing that aims to help countries design and deliver their own development programs. To do this, PforR links disbursement to verified achievement of results.

Associated with the PforR financing modality is a different approach to assessing and addressing environmental and social effects related to the Program. With standard Bank investment lending operations, the Borrower is required to comply with the set of World Bank Safeguard Policies applicable to the project or program and prepare the relevant safeguard instruments to avoid, mitigate and manage the environmental and social impacts of a project or program.

For PforR operations, rather than having the Borrower apply the standard set of Bank environmental and social safeguard policies, early in Program preparation, the Bank task team is responsible for conducting a comprehensive assessment of the country systems in place for managing environmental and social effects (defined as benefits, impacts and risks) associated with the proposed set of Program related investments. This assessment, called the Environmental and Social System Assessment (ESSA), also assesses government's institutional capacity to plan, monitor and report on environmental and social management measures. The findings of the ESSA inform preparation of the Program Action Plan that government will use to bridge any significant gaps in the existing environmental and social management system with respect to the sustainability principles of the PforR Operational Policy (OP/BP 9.00). The Bank provides implementation support as warranted for implementation of the agreed Program Action Plan.

Specifically, the ESSA exercise is designed to consider the consistency of the existing country systems with the proposed PforR operation along two dimensions: (1) systems as defined in the legal and regulatory framework of the country; and, (2) capacity of the Program institutions to effectively apply the environmental and social management systems associated with the Program's environmental and social effects as well as the proposed set of actions in the Program Action Plan that address the major gaps in the system as identified in the ESSA with respect to the six core principles of OP/BP 9.00.

The six core principles that guide the ESSA analysis are presented in the Program-for-Results financing guidelines are as follows: **Core Principle 1: General Principle of Environmental and Social Management.** This core principle aims to promote environmental and social sustainability in Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making related to the Program's environmental and social impacts. **Core Principle 2: Natural Habitats and Physical Cultural Resources.** This core principle aims to avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program. **Core Principle 3: Public and Worker Safety.** This core principles aims to promote public and worker safety with respect to the potential risks associated with: (i) construction and/or operation of facilities or other operational practices under the Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards. **Core Principle 4: Land Acquisition.** This core principle aims to manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assists affected people in improving, or at the minimum restoring, their livelihoods and living standards. **Core Principle 5: Indigenous Peoples and Vulnerable Groups.** This core principle aims to give due consideration to the cultural appropriateness of, and equitable access to, Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups. **Core Principle 6: Social Conflict.** This core principle aims to avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

In analyzing a program for consistency with the sustainability principles of OP/BP 9.00, the ESSA is intended to ensure that programs supported by PforR financing are implemented in a manner that maximizes potential environmental and social benefits and avoids, minimizes or mitigates any and all adverse environmental and social impacts and risks. For this PforR operation, the ESSA examines Ethiopia's existing environmental and social management systems as applicable to the health sector and, in particular, to the set of activities supported by the MDG Performance Fund.

For each MDGPF supported activity, the ESSA reviews the relevant legal and regulatory framework and guidelines, and identifies strengths in the system as well as inconsistencies with the six core principles of OP/BP 9.00. The ESSA describes the potential environmental and social effects associated with the MDGPF supported activities. The ESSA assesses institutional roles and responsibilities related to MDGPF implementation and describes current capacity and performance to carry out those roles and responsibilities. The ESSA also considers public participation, social inclusion, and grievance redress mechanisms in place and as applied in MDGPF activities.

This ESSA presents the baseline data used to inform the analysis of the existing systems vis-à-vis the six Core Principles for environmental and social management in OP/BP 9.00. Based on the findings of the analysis, the ESSA report presents a set of actions to strengthen the existing system proposed for inclusion in the Program Action Plan. These actions are intended to contribute to the Program's anticipated results to enhance institutional performance.

It is important to note that the ESSA will get updated based on the feedback received from stakeholders and implementation experience of the Program for Results operation going forward. The following section presents the steps undertaken in the ESSA preparation process to date and what the next steps include (e.g., stakeholder consultations).

3.2 Methodology

In order to assess the existing systems as well as analyze how these systems are applied in practice, the process of preparing the ESSA has drawn on a wide range of data.

Inputs analyzed for this ESSA include the following:

Desk Review of policies, legal framework and program documents: The review examined the set of national policy and legal requirements related to environment and social management in the health sector. The review also examined technical and supervision documents from previous and ongoing World Bank project and programs in the health sector, namely the Protection of Basis Services Program and Nutrition Project.

Institutional Analysis: An in-depth institutional analysis was carried out to identify the roles, responsibilities and structure of the relevant institutions responsible for implementing the MDGPF funded activities, including coordination between different entities at the national, woreda and kebele levels. Sources included: existing assessments of key institutions that are implementing HSDP IV and MDGPF activities focusing on environmental and social assessment and management processes. The Federal Environmental Protection Authority which has the overall mandate in enforcing environmental and social impact assessment at the national level was assessed. Available literature and documents were also consulted to assess the health care waste management system's capacity and performance.

Interviews: Interviews were held with various GoE ministries and authorities, including those at the national, regional, woreda and kebele level as well as technical experts involved with environmental and social impact assessment and management in the health sector. Specifically, formal interviews were conducted with relevant personnel in the MoH, Afar and Benishangul-Gumuz RHBs, Addis Ababa Health Bureau, woreda health offices in Addis Ababa, Afar and Benishangul-Gumuz and key staff in the Equitable Development Directorate General of the Ministry of Federal Affairs, experts in the Ministry of Urban Development and Construction and experts in the Addis Ababa Bureau of Labor and Social Affairs. In addition, interviews were held in a sample of health care

facilities to assess strengths and gaps in effectively managing environmental and social effects in the sector at the regional and local level.

Field visits: Assessment of the performance and capacity of the existing system used data gathered during a series of targeted field visits. Field visits to various health facilities⁷ were carried out in urban, agrarian and pastoralist regions (Addis Ababa, Butajira woreda of the Southern Nationalities, Nationalities and Peoples Region (SNNPR), and Assosa zone of Benshangul Gumuz). The aim of the field visits was to assess baseline conditions and how environmental and social management issues are managed by MDGPF implementing agencies. A total of 11 health care facilities were visited in Afar, Benishangul-Gumuz, Assosa, Abrahamo, Afambo, Hinale and Borchele to inform preparation of the ESSA, including⁸: 2 hospitals, 7 health centers and 2 health posts. Consultations with regional, zonal and woreda officials provided additional data to inform the ESSA on institutional capacity for applying the system at the national, regional, woreda and kebele levels.

Stakeholder Consultation Process

The ESSA process includes comprehensive stakeholder consultations and disclosure of the ESSA Report following the World Bank's Access to Information Policy. At present, the ESSA consultation process has just begun and is embedded in the Program consultation process. To date, it has included an initial consultation on an early draft of this report held with the Federal Ministry of Health in July 2012 and a set of technical reviews of the revised ESSA report held with the Federal Ministry of Health in October and November 2012.

Going forward, the Program team will develop a comprehensive consultation process for the ESSA report to be held in November and December 2012. Likely aspects of such a process will include a stakeholder workshop which participants drawn from the four regions that need special attention, civil society, development partners supporting the health sector and program implementers at different levels.

⁷As per the recommendations of MoH, site visits were conducted in three locations, namely Addis Ababa, Butajira *woreda* in SNNPRS and Assosa Zone in Benshangul Gumuz which respectively were representative of Urban, Agrarian and Pastoral Regions. The visit aimed at getting an overview of the environmental management practices at the visited health facilities. However, this was not considered a comprehensive assessment and review of the environmental management practice in health facilities in the visited regions.

⁸ The emphasis of the visit to Health Centres was due to their greater environmental relevance as facilities that provide broader health care services (in comparison to health posts) and consequently their higher generation of health care wastes. While hospitals can also be considered an important source of health care waste, they were given less attention in this assessment as they will not be supported under the proposed PforR operation

SECTION 4 ENVIRONMENTAL AND SOCIAL EFFECTS OF THE PROGRAM

The activities supported by MDG Performance Fund are described in Section 2, Table 1. The key activities involve the supply of health products including equipment; construction and rehabilitation of health centers; and, the provision of health services by health facilities nationwide.

It is important to note that the current menu of investments under the MDGPF does not include hospitals and any activities that could significantly convert natural habitats or significantly alter important biodiversity and/or physical cultural resource areas. The Joint Coordinating Forum, which includes the Ministry of Health and MDG pooling partners will discuss potential environmental and social implications of proposed new investments under MDGPF on annual basis.

As such, based on the scope and scale of the agreed MDGPF menu of investments, this Section describes the potential environmental and social effects associated with or generated by activities financed through the MDGPF window of HSDP IV.

The Section is organized in two sub-sections: (i) environmental benefits, impacts and risks that may be generated by MDGPF investments; (ii) social benefits, impacts and risks that may be generated by MDGPF investments.

4.1 Environmental Benefits, Impacts and Risks

4.1.1 Environmental Benefits

Overall, the HSDP IV program is delivering substantive gains, particularly with respect to environmental health and sanitation. For instance, the HSDP IV Annual Performance Report (2010/11) highlights that the number of households served with improved latrines increased from 12,673,106 in 2009/2010 (EFY 2002) to 14,993,248 in 2010/2011 (EFY 2004).

Moreover, under HSDP IV, several institutional development measures were undertaken which include:

- Mainstreaming linkages between health and environment in line with the 2008 Libreville Declaration⁹. In this context, a Situation Analysis and Needs Assessment report and the National Joint Action Plan (NJAP) were designed by the Ministry of Health.
- Developing the National Hygiene and Sanitation Strategic Action Plan, 2011-2015.
- Developing a five-year strategic plan on climate change, in collaboration with the Federal Environmental Protection Authority.
- Training Health Extension Workers and other public health professionals on implementation and certification of Community-Led Total Sanitation and Hygiene (CLTSH).
- Training health workers on water quality and safety, particularly in the use of analytical water quality test kits. And, analytical test kits were distributed to the regions.
- Developing a five-year National Health Care Waste Management Plan of Action, 2011-2015
- Developing a National Water Quality Monitoring and Surveillance and Acute Watery Diarrhea Prevention and Control Strategy
- Developing a Community-led Total Sanitation and Hygiene Implementation and Verification Guideline and Training Program

⁹The Libreville Declaration on Health and Environment was signed by 52 governments of Africa on 29 August, 2008. As signatory of the Declaration, Ethiopia conducted a Situation Analysis and Needs Assessment (SANA) exercise on health and environment inter-linkages. This Country report was used for the preparation of a joint action plan which has now been finalized. While the SANA report provided the country baseline in terms of risk factors, strategic frameworks, alliance between health and environment, the National Joint Plan of Action provided costed intervention areas for addressing pertinent environmental and health issue of the country.

Similar environmental benefits are expected going forward during the life of the PforR operation in reducing environmental health pollution.

Overall, the environmental benefits expected of the PforR operation include a less polluted environment due to improved medical waste management practices and improved health for all Ethiopian Citizens due to the improvements envisioned in the extent and quality of the provision of health services at the woreda and kebele levels.

4.1.2 Adverse Environmental Impacts and Risks

Potential adverse impacts and risks that may be generated by MDGPF financed activities were identified and verified during the ESSA field visits. The relative risk rating of each is indicated in this section and further described in the detailed systems analysis in Annex 3.

1. Medical Waste Management

The main adverse impact identified pertains to generation of medicinal and health care waste and use and disposal of insecticides used for vector-borne disease control. This is considered a significant risk if not properly mitigated either directly through the HSDP IV Program Design and PforR Program Action Plan. Previous assessments commissioned by the World Bank identified these aspects as having important environmental and social implications during previous phases of the Health Sector Development Program (World Bank, 2010). Expansion in health care service delivery envisioned under the MDDPF will increase generation of health care waste including expired medicines and insecticides used to control vector-borne disease.

A study by USAID (2009) on the general status of injection safety and health care waste management in 72 health facilities in three regions and one city administration (Amhara, Harari, Tigray and Dire Dawa) identified the non-functionality of incinerators and shortage of personal protective equipment as a common challenge in the handling of health care waste. A report by Deneke et al (2010) noted that only one facility out of the total of nine visited used a complete color coding waste segregation system.

Consistent with the observations of Deneke et al (2010), the ESSA field visits confirmed that segregation of waste at the Health Care Facility (HCF) level is low, with only one of eleven HCFs visited demonstrating a well-established waste segregation practice. However, the field visits also confirmed that almost all facilities constructed under the HSDP have low-temperature incinerators, which at the time of visit were functional. However, incinerators at two facilities were already showing signs of deterioration¹⁰, despite having only been constructed in the past two years.

From an environmental perspective, it is to be noted that the incinerators used for health care waste disposal and management can be sources of air pollution, releasing into the atmosphere carcinogenic pollutants such as dioxins and furans. Almost all health facilities in Ethiopia use low temperature incinerators which release such pollutants. At this time, there are no data to ascertain the extent of air pollution and the degree of risk that this pollution source represents both to the environment and to the citizens of Ethiopia. The ESSA analysis could not access data on this important consideration and, as such, the Bank team will continue to seek robust data on this issue in the near term in order to ensure that the risk is quantified and mitigated appropriately in line with the CPs of OP/BP 9.00. At this time, it is not possible to determine if this impact and risk is acceptable. This will be determined in the near term when robust data are made available to the Bank ESSA team to further this analysis.

Regarding pharmaceutical and medicinal waste, there is a need for improvement of the existing practice at the health care facility level. In most facilities visited, pharmaceutical and medicinal waste; including containers and expired medicines are buried in shallow pits (which are easily accessible to the public) or disposed of with non-

¹⁰ It was reported that this was a result of the limited waste minimization and waste segregation practice, which has increased the load on the incinerators. In line with this, the ESSA field visits showed that paper, plastic and other types of waste were being incinerated in these facilities.

hazardous waste. Since some pharmaceutical waste is hazardous, there is a need to implement appropriate remediation actions. However, in most facilities the amount of medicinal waste generated was minimal.

Picture sets 1 and 2 illustrate the different health care and pharmaceutical waste management practices at HCFs visited to inform the ESSA process.

Picture Set 1- Good healthcare waste management practice at the Butajira Health Centre in SNNPRS



Picture set 2 – Sub-optimal health care waste management practice at a health care facility visited. Note that the incinerator is only two years old and is already showing signs of deterioration due to the load of waste incinerated. There is no waste minimization and segregation practices at the facility.



2. Use and Disposal of Insecticides for Vector- Borne Disease Control

In Ethiopia, all three major malaria vector control measures are used, including: environmental management, Indoor Residual Spraying (IRS) and Long-Lasting Insecticidal Nets (LLINs).

With regards to IRS and LLINs, HSDP IV has set the following targets:

- 100% of villages with development projects in malaria-endemic areas will incorporate malaria preventive and control measures during the planning, implementation and post implementation phases
- Scale up IRS coverage to 90% of the targeted areas by 2013 and maintain coverage until 2015
- 100% of households in malaria-endemic areas own one LLIN per sleeping space
- At least 80% of people at risk for malaria use LLINs properly and consistently

The most commonly used insecticides for malaria control in Ethiopia are organophosphate insecticides and carbamates. Although DDT is not used at the present for malaria control, there is accumulation of obsolete DDT found in storage facilities throughout the country. Recently, the MoH, in collaboration with the Ministry of Agriculture, is in the process of transporting both national and regional obsolete chemicals through the Greek enterprise Polyeco S.A. Waste Management and Valorization Industry to the final disposal site in France.

The 2012 National Malaria Guidelines highlight that there is a need to strengthen environmental management practices of IRS activities. The same guidelines emphasize that much remains to be done to meet World Health

Organization (WHO) and Food and Agriculture Organization (FAO) standards of environmental compliance and human safety measures when using insecticides for IRS operations. Moreover, owing to the shortage of operational budgets allocated for IRS operations at the local level, as well as limited understanding of the risks of exposure to insecticides, personal protective materials for spray personnel are not widely available at the local level.

Regarding insecticides and associated wastes (empty sachets, cartons, broken gloves, used masks, and other insecticide-contaminated materials), the Ministry of Agriculture is developing a pesticide containers management strategy. The Ministry of Health can benefit from this strategy in effectively handling pesticide containers.

Overall, the risk rating for this set of impacts is rated as moderate to high. And, in order to adequately address these adverse impacts so as to minimize the risks to an acceptable level for the PforR operation to proceed, the MoH has developed and endorsed insecticide storage standards to ensure that WHO and FAO requirements are met. Moreover, in collaboration with the Ministry of Agriculture, efforts are underway for the transport of obsolete pesticides to facilities outside the country for proper disposal. It was also reported that in malaria-prone areas, incinerators and other facilities are put in place for the proper disposal of insecticide waste¹¹.

3. *Physical Infrastructure Construction and Rehabilitation*

Through the MDGPF the only physical infrastructure that will be financed during HSDP IV is rehabilitation and construction of health centers. At this time, the MDFPF expects to finance rehabilitation and construction of 106 health centers. The environmental risks due to rehabilitation and construction of these facilities is considered minimal, site specific and time bound given the size, distribution and number of facilities to be constructed over the life of the PforR operation.

The MoH uses a standard design and set of engineering principles for construction of all health centers in Ethiopia. The health centers occupy a physical footprint of up to 1 hectare including the location for the placenta pit and incinerator. Picture set 3 displays a typical health center and incinerator.

Picture set 3: Health Center and health center incinerator



The sites selected for construction of the 106 new health centers will be selected with direct involvement of community leaders and members. The proposed facilities are relatively small in size and physical footprint, thus lowering the risk of large scale adverse environmental impact. Indeed, land erosion and destruction of natural habitats during construction are expected to be minimal with proper early screening practices and compliance with good practice general civil works construction guidelines. As such, the risk rating for these impacts is considered to be low. However, potential adverse impacts include those that may arise during the time bound construction phase for the 106 health clinics would increase the risk rating to “moderate”. Some of likely adverse impacts during construction include:

- **Soil and water pollution** may occur during the construction phase of the health centers, particularly where latrines for workers are not well managed. Construction waste, particularly used oil, tools, equipment and temporary infrastructure may also result in additional sources of soil and water pollution. **This is considered to**

¹¹Comments received from MoH on a draft report of this assessment.

be a minor to moderate risk if general good practice environmental management guidelines are not followed during construction.

- **Pressures on existing water sources:** construction of the health centers will require water which may place pressure on existing water sources. **This is deemed to be a minor risk as the early screening and siting practices, if applied properly, can ensure sufficient supply of water for construction and operation of the individual health center without detracting from other users of the same water source.**
- **Noise pollution:** construction of the health centers may create excessive noise pollution if construction guidelines and regulations are not followed. **This risk is rated as low to moderate since it can be easily mitigated by following well established guidelines.**
- **Water-Borne Disease:** construction work may also create stagnant pools of water, which may provide a breeding ground for vectors of water-borne disease. **This risk is deemed to be low as through diligent application of good practice civil works construction guidelines, this risk can be eliminated.**
- **Natural Habitats and Physical Cultural Resources:** construction activities may also adversely impact natural habitats and unknown physical cultural resources if early screening and appropriate siting for the health centers is not undertaken or carried out properly (i.e., no chance finds procedures established). **This risk is considered to be low to moderate as the capacity of local staff to conduct the proper early site screening for each health center may be limited and require technical support to ensure that the screening adequately addresses this risk.**

4.2 Social Benefits, Impacts and Risks

4.2.1 Social Benefits

In addition to the environmental health benefits presented under the previous section, i.e, **Environmental** Benefits, this sub-section includes additional social benefits expected to be generated by interventions that will be supported by the MDGPF.

Equity Driven Measures in the Health Sector

Over the last five years, a number of equity driven policies have been promoted through the HSDP. Foremost among these is the Health Extension Program that aims to empower local communities through the provision of preventive and promotive services. Other policies recently formulated and embedded in the program include accelerated expansion of health centers and training and deployment of health officers to address the shortage and high turnover of physicians in health care facilities across the country.

Additional steps taken to improve the set of social benefits generated by the program include: a policy shift in the treatment of pneumonia by HEWs, upgrading 30% of existing health centers, training and deployment of emergency surgeons to provide Comprehensive Emergency Obstetric Care (CEOC) services, and scaling up health insurance schemes. These efforts are designed to ensure equity, demonstrate government commitment to expanding access to health services to all and inclusion of the poor in health service delivery and coverage.

Owing to their marginalization and comparatively limited access to socioeconomic development over the last few decades, the GoE has designated four of the country's regions, namely: Afar, Somali, Benishangul-Gumuz, and Gambella, as regions that need special attention. In this respect, Article 89 (2) of the Constitution stipulates that government has the obligation to ensure that all Ethiopians are afforded equal opportunity to improve their economic situation and to promote equitable distribution of wealth. Article 89 (4) states that 'Nations, Nationalities and Peoples least advantaged in economic and social development shall receive special assistance'.

To ensure equity between regions, government has established the Ministry of Federal Affairs (MoFA) to promote equitable development, emphasizing delivery of special support to the four regions that need special attention. The purpose of the special support is to address the inequalities that have traditionally existed between the regions, thereby hastening equitable growth and development.

The Federal Special Support Board, which consists of relevant sector ministries including the MoH, was reorganized in March 2011. The MoFA acts as Vice Chair and Secretariat of the Board. A Technical Committee (TC) comprised of sector ministries constitute the Board was also established under the MoFA to monitor and report on implementation of the special support plans. The Board coordinates the affirmative support provided to the four regions by different entities of the federal government to ensure effectiveness of the implementation process.

In addition, the Equitable Development Directorate General established within the MoFA, with Directorates created to operate for each region. The Directorate General coordinates and directs case teams to collect, organize and analyze data on the gaps in capacity building, social and economic development, good governance, gender and environmental development in the four regions.

Within the MoH, the Pastoralist Health Promotion and Disease Prevention Directorate coordinates and provides technical support on implementation of HSDP IV to these regions. Under this Directorate, case teams are tasked with attending to the Program's activities in the four regions. As well as rendering technical assistance, the case teams support supervision of Program implementation. In addition, resident professionals are assigned to the four regions to render technical back-up to sector activities.

Thus, at the policy and institutional levels, the structure and operation of these entities represent an important step forward in the ongoing effort to realize equitable development and growth in the four regions that need special attention.

Health Infrastructure Development

Another area in which equitable development is being promoted is in the construction of new healthcare facilities and the provision of medical equipment to existing and new healthcare facilities. In this respect, the MoH is adopting steps to promote equity across regions by focusing investment efforts in the four regions that require special attention.

As part of its special support policy, the MoH constructs and equips health centers in these regions. The MoH also constructs 75% of the health centers in the four regions that need special attention, while in other regions the MoH supports only 50% of health centers constructed. The Regional Health Bureaus will construct the remaining health centers. The MoH also provides medical equipment for all health centers constructed.

In other regions, the Regional Health Bureaus construct the health posts, whereas the MoH provides the medical equipment. The RHBs also match the HCs that MoH constructs through construction of the same number or 50% of health centers built.

Health Care Financing

In Ethiopia, health services are financed by federal and regional governments, grants and loans from bilateral and multilateral donors, non-governmental organizations, and private contributions. Despite improvements over the past few years, healthcare financing remains a challenge. Since adoption of HSDP III, the MoH introduced a healthcare financing strategy designed to improve efficiency in the allocation and utilization of public sector health resources. Specifically, the healthcare financing component of HSDP IV aims to create a sustainable healthcare financing system, mobilizing resources for the health sector, promoting efficient allocation, improving utilization of available health resources and enhancing equity through effective expenditure management. Relevant components of healthcare financing reform under the Program include: revenue retention and utilization, fee waiver administration, exempted health services, and health insurance schemes. Each is described below.

Revenue Retention and Utilization: The MoH prepared an operational manual for use by regional governments and city councils. The manual outlines the procedures for user fee collection, financial administration, accounting, auditing and procurement of goods and services. The revenue retention and utilization process is steered by health facility governance boards established in each health center and hospital. The boards are comprised of representatives drawn from the community, the health sector, finance and other sectors. These boards decide on utilization of the user fee revenues collected. As noted in the Annual Performance Report of HSDP IV for FY10/11,

90 hospitals and 2,151 health centers retained revenue collected from user fees and 87 hospitals and 1,738 health centers used the revenue for health service quality improvements.

Fee Waiver Administration: The fee waiver system is designed to provide access to free medical services for households certified as the poorest of the poor in urban and rural areas. To participate in the system, households are required to meet the eligibility criteria and obtain beneficiary cards issued by the local government administration. The local government, in turn, covers the costs incurred by the health facilities as a result of the free waiver arrangement. According to the 2010/11 HSDP IV Annual Performance Report, some 2.2 million indigent households were certified in eight regions by the end of FY10/11, with preparatory work commencing in the Gambella, Afar and Somali regions. Implementation of the fee waiver system is marked by the challenge associated with identification and certification of eligible indigent households. This obstacle is being addressed in a systematic manner, but it is likely to take time to ensure full coverage of all eligible households while preventing leakage in the system.

Exempted Health Services: Healthcare financing reform has also made essential health services free of charge to the public through an exemption component. Health services included under this component are EPI, HIV/AIDS-related services (VCT, ART), TB diagnosis and treatment, maternal health (ANC, delivery, PNC), family planning, and malaria prevention, diagnosis and treatment. Even though the exemption arrangement does not target a particular group, vulnerable and disadvantaged segments of the population, who are not eligible for the fee waiver arrangement, are benefiting from the component because it affords them access to certain medical services free of charge.

Health Insurance Schemes: Another element of the Program emphasizing equity for all is a special health insurance scheme. Out-of-pocket payments by households represent a significant contribution to healthcare financing in Ethiopia; accounting for 37% of total healthcare expenditure (HSDP IV, 2010). Such financing arrangements adversely affect the poor impeding their access to health services, while favoring the more privileged segment of the population. In order to create a more equitable health insurance financing mechanism, the government has introduced an insurance scheme designed to achieve universal access. The health insurance scheme encompasses two components: Community Based Health Insurance (CBHI) for the rural population and urban informal sector, and Social Health Insurance (SHI) for the formal sector.

Important steps have been taken to pilot CBHI in select regions (e.g., Tigray, Amhara, Oromiya and SNNPR). CBHI is currently being piloted in 13 woredas in these regions, which together target a total population of 1.7 million or 335,000 households. Of the total number of households in the pilot woredas, 107,803 have become members of CBHI. With an aim to promote equity, further steps have been taken to ensure that 25,577 of CBHI member households are included as beneficiaries without payment of the associated insurance premium because they are identified as indigents or the poorest of the poor. The number of indigent households included in the program is expected to grow as the scheme is scaled-up.

Federal Budget Grant Distribution

In response to concerns expressed by the four regions that need special attention, the Ethiopian Federal Democratic Republic (EFDR) House of Federation (HoF) has revised and adopted a block grant allocation formula. The revised distribution formula is designed to address shortcomings identified in the previous version. Effective in 2009, the revised block grant allocation formula was developed on the basis of the estimation of the relative fiscal gap in each region, which takes into account revenue raising potential and expenditure needs.

The revenue potential comprises tax and non-tax sources (personal income tax, business profit tax, value added tax (VAT), agricultural income tax, rural land use fee, sales tax (ToT), and fees from medical supplies and treatment). In the assessment of expenditure needs, the public sectors considered include: general administration (public order, security, and justice), education, health, agriculture and natural resources, clean water supply, rural road construction and maintenance, micro and small scale enterprise development, and urban development.

The fiscal gap in the respective regions refers to expenditure needs minus revenue raising potential. In addition, a special grant component has been incorporated into the budget formula aimed at reducing inequalities between

developing and other regions (The Federal Budget Grant Distribution Formula, HoF, 2009). Table 5 depicts the grant percentage allocation for each region based on fiscal gaps in line with the budget formula.

Table 5: Block grant percentage allocation by region¹²

Regions	Percentage Share of Block Grants	Revised Percentage share of Block Grants
Tigray	7.11	7.04
Afar	3.18	3.34
Amhara	23.57	23.33
Oromia	32.86	32.53
Somali	8.09	8.43
Benishangul-Gumuz	1.68	1.96
SNNPR	20.10	19.90
Gambella	1.47	1.57
Harari	0.90	0.89
Dire Dawa	1.02	1.01
Total	100	100

Compared to other regions, the four regions that need special attention have lower fiscal capacity and higher expenditure needs. These inequalities are a result of systematic failure in the past to invest in human capital and institutions in these regions. Ensuring equity in the provision of basic services including health requires correcting inequalities which necessitates implementing special assistance arrangements.

Accordingly, the revised block grant allocation formula is designed to address the special circumstances faced in these regions, thereby mitigating the inequalities in the provision of basic services.

The formula provides for redistribution of one percent of the block grant each year to the four regions that need special attention in line with the following indicators: (1) land cultivated, (2) population, (3) tropical livestock unit, (4) number of unemployed people in urban areas, (5) number of poor people, (6) spatial price index and (7) tax raising efforts.

On this basis, the budget shares allocated for the regions that need special attention according to the indicators set out in the special fund program are: Afar (18.61%), Somali (42.48%), Benishagul-Gumuz (28.87%), and Gambella (10.03%) (The Federal Budget Grant Distribution Formula, Hof, 2009).

In turn, this budget reallocation alters the original block grant percentage shares computed for all regions. As illustrated in Table 5, the percentage shares of each region for three years as of 2009/2010 was recalculated by combining the block grant with a specific grant for each of the four regions that need special attention.

In sum, the GoE has made significant strides to promote equity and inclusion in the provision of public health services by adopting a number of measures, through HSDP, including MDGPF, to reach the most underprivileged citizens in the country. All such measures generate important social benefits. Such benefits will continue to be generated under HSDP IV and MDGPF investments supported by the PforR operation.

4.2.2 Adverse Social Impacts and Risks

Based on the menu of investments approved for MDGPF support, the set of adverse social impacts and risks are limited to the following:

¹² Source: The Federal Budget Grant Distribution Formula (HoF, 2001)

1. Construction of health centers could require land acquisition that might result in displacement of citizens and or loss of access to resources. **However, this risk is considered highly unlikely and is rated as a very low risk for due to the physical footprint of each health center is limited to 1 hectare.** As such, land acquisition and resettlement can be avoided completely in rural areas by selecting an alternate site for each health center that would not require land acquisition or resettlement; in urban areas selection of alternate sites that avoid land acquisition may be a bit more challenging, but possible with robust early screening and appropriate siting practices that ensure that displacement or loss of access to resources does not occur at all with respect to siting the 106 health centers. **To eliminate this risk, it is strongly recommended that the screening and siting practices for all 106 health centers avoid any and all land acquisition and resettlement.**
2. **Environmental pollution from improper medical waste disposal including hazardous waste, insecticides and expired medicines.** If the health facilities fail to follow established guidelines for proper disposal of all types of medical waste, environmental pollution may cause near term direct and long term indirect and direct adverse health impacts on local citizens. **This risk is rated as high to significant based on the detailed analysis presented in Annex 3. The specific mitigation measures include proactive implementation of HSDP IV program design elements and specific actions included in the Program Action Plan.**
3. **Public and worker safety considerations are also important when considering potential adverse social impacts and risks that may be generated by MDGPF investments.** Specific impacts and risks may include construction phase accidents (if personal protective equipment is not issued) and exposure to improperly disposed of construction waste. During the operation phase of health facilities, both patients and other members of the public as well as health care workers may experience accidents due to improper use of medical equipment or lack of protective gear as well as adverse health impacts due to exposure to improperly disposed of medical waste as well as expired medicines. **Such risks are deemed moderate to high and the appropriate measures include proactive and immediate implementation of Program design elements already embedded in the HSDP IV design as well as select actions included in the Program Action Plan.**

4.3 Cumulative Effects

As a national program, HSDP IV and all of the activities financed through the MDGPF window will generate a number of positive cumulative impacts, covering the whole spectrum of nation-wide health improvements, including: improved overall health status of the vast majority of citizens given earlier and free access to essential health services, better sanitary conditions with improvements in medical waste management, including hazardous and pesticide waste and better skilled health professionals administering care at regional, woreda and kebele health facilities.

Given the geographic dispersion of participating kebeles and the scale of proposed civil works investments (health centers only), adverse cumulative impacts related to construction impacts are considered unlikely and would present a very low risk, since the proposed 106 health centers will be widely dispersed and each occupy a small physical footprint and follow highly standardized design and engineering principles that include avoiding, minimizing and mitigating environmental and social impacts on the individual project scale.

However, in terms of medical waste disposal in urban areas (e.g. Addis Ababa), given the number of health care facilities located in the city, improper handling of health care waste may result in moderate adverse cumulative impacts on the local environment and represent a moderate to high risk. Furthermore, in the context of malaria control measures such as IRS and LLINs, **the scale of interventions in malaria prone areas together with improper disposal of insecticide waste may generate adverse cumulative impacts that may be considered to be of moderate risk in urban areas if not addressed properly and swiftly.**

In addition, **improper disposal of expired pharmaceuticals and obsolete pesticides at regional centers may also generate adverse cumulative impacts in the area of the regional centers that would be rated as a high risk, if processing at these facilities is not carried out according to protocol and in a timely fashion representing a high risk to local citizens in the vicinity of the regional processing facilities.**

SECTION 5 ETHIOPIA'S ENVIRONMENTAL AND SOCIAL MANAGEMENT SYSTEMS

OP/BP 9.00 requires that all PforR operations function within an adequate legal and regulatory framework to guide environmental and social impact assessment and management. In this context, management of the environmental and social effects of MDGPF-financed activities is assessed based on the existing environmental and social management systems of Ethiopia.

In order to assess the adequacy of Ethiopia's legal and regulatory framework, relevant laws and institutions for environmental and social impact assessment and management are described in this section, along with the roles and responsibilities of institutions involved in the assessment and management processes. The assessment of how these systems function in practice is presented in Section 6 along with a structured gap analysis that identifies inconsistencies between the framework and the requirements of OP/BP 9.00.

This section is organized in two subsections: (i) environmental impact assessment and management system; and, (ii) social impact assessment and management system.

5.1 Environmental Impact Assessment and Management System

5.1.1 Applicable Policies, Laws and Guidelines

This section describes the legal and regulatory requirements for environmental impact assessment and management in Ethiopia. The relevance of these requirements to MDGPF investments is assessed with due consideration of the requirements and guidelines of OP/BP 9.00.

The **Ethiopian Constitution** adopted in 1995 provides the framework for environmental protection and management in Ethiopia. The concept of sustainable development and environmental rights are presented in Articles 43, 44 and 92 of the Constitution.

- Article 43: The Right to Development identifies citizens' right to: improved living standards and sustainable development and participate in national development and to be consulted with respect to policies and projects affecting their community.
- Article 44: Environmental Rights stipulations that all citizens have the right to a clean and healthy environment; and those who have been displaced or whose livelihoods have been adversely affected as a result of state programs have a right to commensurate monetary or alternative means of compensation, including relocation with adequate state assistance.
- Article 92: Environmental objectives are identified as: government shall endeavor to ensure that all Ethiopians live in a clean and healthy environment. The design and implementation of programs shall not damage nor destroy the environment. Citizens also have a right to full consultation and to expression of views in the planning and implementation of environmental policies and projects that directly affect them. Government and citizens shall have the duty to protect the environment.

The **Environmental Policy** of Ethiopia was approved by the Council of Ministers in 1997. It is comprised of 10 sector and 10 cross-sector components, one of which addresses 'Human Settlements, Urban Environment and Environmental Health'. The Policy is based on the findings and recommendations of the National Conservation Strategy of Ethiopia. The Policy contains elements that emphasize the importance of mainstreaming socio-ecological dimensions in development programs and projects.

The **National Conservation Strategy** (1995) takes a holistic view of natural and cultural resources and seeks to present a coherent framework of plans, policies and investments related to environmental

sustainability. The Strategy consists of five volumes including: the Natural Resource Base, Policy and Strategy, Institutional Framework, the Action Plan and Compilation of Investment Program.

A number of proclamations and supporting regulations contain provisions for the protection and management of the environment and put into effect the principles of the Constitution and the Environmental Policy. Specifically, the Environmental Impact Assessment Proclamation No. 299/2000 contains provisions designed to ensure sustainable development while Proclamation 299/2000 makes Environmental Impact Assessment mandatory not only for development projects but also for policies, plans and programs.

Relevant policies, proclamations, regulations, guidelines and plans are detailed below.

The goal of the **Environmental Policy** of Ethiopia is to improve and enhance the health and quality of life of all Ethiopians and to promote sustainable social and economic development through sound management of the environment and use of resources so as to meet the needs of the present generation without compromising the ability of future generations to meet their own needs.

The Environmental Policy provides a number of guiding principles that require adherence to the general principles of sustainable development. In particular, the need to ensure that Environmental Impact Assessment:

- Considers impacts on human and natural environments
- Provides for early consideration of environmental impacts in project and program design
- Recognizes public consultation processes as essential to effective management
- Includes mitigation and contingency plans
- Provides for auditing and monitoring
- Is a legally binding requirement

Proclamation 513/2007, Solid Waste Management aims to promote community participation to prevent adverse impacts and enhance benefits resulting from solid waste management. It provides for preparation of solid waste management action plans by urban local governments.

Proclamation 299/2002, Environmental Impact Assessment makes EIAs mandatory for implementation of major development projects, programs and plans. The Proclamation is a tool for harmonizing and integrating environmental, economic, cultural, and social considerations into decision making processes in a manner that promotes sustainable development. The law clearly defines:

- Why there is a need to prepare EIAs
- What procedure is to be followed in order to implement EIA
- The depth of environmental impact studies
- Which projects require full EIA reports
- Which projects need partial or no EIA report
- To whom the report must be submitted

Proclamation 300/2002, Environmental Pollution Control requires developmental activities to consider environmental impacts before their establishment. The Proclamation requires ongoing activities to implement measures that reduce the degree of pollution to a set limit or quality standard. Thus, one of the dictates of the legislation is to ensure, through inspection, the compliance of ongoing activities with the standards and regulations of the country through an environmental audit.

Proclamation 295/2002, Establishment of Environmental Protection Organs establishes the organizational requirements and identifies the need to establish a system that enables coordinated but differentiated responsibilities of environmental protection agencies at federal and regional levels. The Proclamation indicates duties of different administrative levels responsible for applying federal law.

EIA Directive 1/ 2008, Directive to Determine Projects Subject to Environmental Impact Assessment was issued to determine the categories of projects subject to the Environmental Impact Assessment Proclamation 299/ 2002. To this end, the Environmental Impact Assessment Proclamation is to be applied to the types of projects listed under these directives. The types of projects subject to EIA in the health sector are the construction of hospitals which are part of the HSDP IV investment menu, but are not included in the menu of activities supported by the MDGPF.

Proclamation 159/2008, Prevention of Industrial Pollution Regulation: As a follow up to Proclamation 300/2002, a regulation to prevent industrial pollution was developed by the Federal Environmental Protection Authority to ensure compatibility of industrial development with environmental conservation. This Proclamation includes comprehensive industrial pollution standards for a range of industrial and mining activities.

Guideline for Environmental Management Plan (draft), May 2004 outlines measures for preparation of an Environmental Management Plans (EMP) for proposed developments in Ethiopia and institutional arrangements for implementation of EMPs.

EIA Procedural Guideline (draft), November 2003: This guideline outlines the screening, review and approval process for development projects in Ethiopia and defines the criteria for undertaking an EIA.

EIA Guideline, July 2000: The EIA Guideline Document provides essential information covering the following elements:

- Environmental Assessment and Management in Ethiopia
- Environmental Impact Assessment Process
- Standards and Guidelines
- Issues for sector environmental impact assessment in Ethiopia covering agriculture, industry, transport, mining, dams and reservoirs, tanneries, textiles, hydropower generation, irrigation projects and resettlement
- The guideline contains annexes that:
 - Identify activities requiring a full EIA, partial measure or no action
 - Contain sample forms for application
 - Provide standards and guidelines for water and air

Waste Handling and Disposal Guideline, 1997: The Waste Handling and Disposal Guidelines have been in use by health facilities since 1997. The Guidelines are meant to help industry and local authorities handle medical waste situation at the local level.

Health Sector-Specific Policies, Laws and Guidelines

The Ethiopian Health Sector Policy emphasizes promotion of occupational health and safety and environmental health.

Proclamation 189/2010, Ethiopian Food, Medicine and Health Care Administration and Control Authority Establishment Council of Ministers gives FMHACA the mandate to protect consumer health by ensuring the standard of health institutions and the hygiene and environmental health protection requirements for communities.

Proclamation 661/2009, Food, Medicine and Health Care Administration and Control provides provisions to:

- Ensure proper disposal of expired medicine and foods and raw materials
- Ensure handling and disposal of trans-regional solid and liquid wastes from different institutions are not harmful to public health
- Ensure the quality of trans-regional water supply for the public is up to the standard
- Ensure availability of necessary hygienic requirements in public health institutions

- Ensure any waste generated from health or research institutions is handled with special care and disposed of according to procedures that meet national standards
- Ensure that untreated waste generated from septic tanks, seepage pits, and industries is not discharged into the environment, water bodies or water convergences

The National Health Care Waste Management Strategic Action Plan 2012-2015 (2012) focuses on four thematic areas:

- Legal and regulatory framework to provide guidance to health care managers on minimum operation requirements and the need to standardize Health Care Waste Management practices in all health care facilities in the country
- Resource mobilization of 3,428,892,763 Birr to finance implementation of the HCWM Action Plan for four years
- Process of operational research in pollution reduction and adoption of environmentally-friendly technologies
- Conduct behavioral-changes targeting patients, care givers, visitors and the community in the vicinity of health facilities

National Malaria Guidelines, 2012 provide guidance on diagnosis and management of malaria to healthcare workers, including measures for managing environmental impacts of insecticide use and disposal.

National Hygiene and Sanitation Strategic Action Plan for Rural, Peri-Urban and Informal Settlements in Ethiopia 2010-2015 (2011). This Plan focuses on rural and urban, domestic and institutional on-site sanitation, hand-washing and safe drinking water handling in the home. Urban aspects of the Plan address peri-urban, small towns and informal settlement sanitation where on-site solutions can be applied. A separate national strategy is under development to address large-scale and communal off-site sanitation needs in urban areas in Ethiopia.

Medicinal Waste Management and Disposal Directive, 2011 is applicable to: a) disposal of medicinal waste, but not to medical equipment or management of other health care waste generated by health institutions; and (b) all government, non-governmental and private organizations involved in medicinal waste handling and disposal. The Directive requires disposal firms to have secured an appropriate disposal site depending on the Environmental Impact Assessment conducted with support of the Federal Environmental Protection Authority. In addition, a disposal firm is required to have all the facility and practice standards prescribed under this Directive.

The Guideline for waste handling and disposal in health facilities (2006) was developed to:

- Enable health professionals to protect themselves against health hazards which might be encountered as result of their occupation
- Create awareness among healthcare workers about the importance of safe disposal of waste generated at health facilities
- Prevent and control environmental pollution by waste carelessly disposed of from health facilities
- Provide technical support to health professionals and environmental health workers engaged in day-to-day health inspection and control activities

Proclamation 197/2000, Ethiopian Water Resources Management Proclamation ensures that the water resources of the country are protected and utilized for the highest social and economic benefits of all citizens, to supervise that they are duly observed, and to ensure that harmful effects of water are prevented and that management of water resources is carried out properly. This Proclamation protects water bodies from improper disposal of medical waste.

The detailed legal framework for the management of medical waste in Ethiopia is presented in Annex 1

5.1.2 Institutional Roles and Responsibilities for Environmental Impact Assessment and Management

Table 6 summarizes the roles and responsibilities of institutions involved in environment and social management in Ethiopia. Identification of institutional roles and responsibilities takes into account potential environmental implications of MDGPF supported activities and the requirements of OP/BP 9.00.

Table 6: Institutional Roles and Responsibilities for Environmental and Social Management

Entity	Roles and Responsibilities for Environmental and Social Management
Federal Environmental Protection Authority/Regional Environmental Agencies	As the national entity for environmental management, EPA is responsible for: Enforcing and ensuring compliance to the EIA proclamation which currently is being implemented through delegated authority provided to sector ministries Reviewing EIAs and monitoring the implementation of EIA recommendations which is also in part being implemented through delegated authority provided to sector ministries Regulating environmental compliance and developing legal instruments that ensure the protection of the environment Ensuring that environmental concerns are mainstreamed into sector activities, Coordinating, advising, assessing, monitoring and reporting on environment-related aspects and activities
Ministry of Health/Regional Health Bureaus	Organize environment health, hygiene, sanitation and public health services Supervise food safety, drinking water supply and the management of solid and liquid waste
Ministry of Water and Energy/Regional Water Bureaus	Prevent and control pollution of water resources
Ministry of Labour and Social Affairs/Regional Labour Bureaus	Implement environmental and social management activities in their respective regions, in line with the mandates and roles and responsibilities of their respective Ministry.

The current system of government in Ethiopia is organized into a federal structure, comprised of the federal government and nine regional states. Government administration of EIA in Ethiopia is shared between the federal government and regional states. The Environmental Protection Organs Establishment Proclamation (295/2002) established the institutions responsible for the regulation of EIA; these include the Federal Environmental Protection Authority, Regional Environmental Agencies and the Sector Environmental Units. Currently, a new structure is in effect, the *delegated* sector authorities which, through Federal EPA's delegation, have been assigned the dual role of ensuring timely and effective implementation of sector specific EIAs as well as of reviewing EIA reports.

Federal Environmental Protection Authority is the lead agency responsible for formulating policies, strategies, laws and standards to ensure social and economic development activities sustainably enhance human welfare and safety of the environment (Article 6, Proclamation 295/2002). The regulation of EIA is one of the key responsibilities entrusted to EPA. In this respect, the EPA is responsible for establishing a system for undertaking EIA in public and private sector projects. The Federal EPA is responsible for developing a directive that identifies categories of projects likely to generate adverse impacts and require a full EIA, and for issuing guidelines that direct preparation and evaluation of EIA reports (Proclamation 299/2002, Articles 5 and 8).

In addition, the Federal EPA is responsible for evaluating EIA reports of projects that need to be licensed and executed by the federal government and projects that are likely to generate inter-regional impacts. The Federal EPA is also responsible for monitoring, auditing and regulating implementation and performance of such projects. The Federal EPA holds primary responsibility for providing technical support on environmental protection and management to regional states and sector institutions.

Regional environment bodies: Proclamation 295/2002 requires regional states to establish or designate their own regional environmental agencies. The regional environmental agencies are responsible for

coordination formulation, implementation, review and revision of regional conservation strategies as well as environmental monitoring, protection and regulation (Article 15). Relating to EIA specifically, Proclamation 299/2002 gives regional environmental agencies the responsibility to evaluate EIA reports of projects that are licensed, executed or supervised by regional states and that are not likely to generate inter-regional impacts. Regional environmental agencies are also responsible for monitoring, auditing and regulating implementation of such projects. The institutional standing of regional environmental agencies varies among regions. In some regions, they are established as separate institutions, while in others they are within Regional Sector Bureaus (e.g., Bureau of Agriculture).

Sector environment units: The other environmental organs stipulated in the Environmental Protection Organs Establishment Proclamation (295/2002) are ‘Sector Environmental Units’ which are to be established in every competent sector institution (i.e. the line ministry and regional sector agencies). These Sector Environment Units have the responsibility of coordinating and implementing activities in line with environmental protection laws and requirements (Article 14, Proclamation 295/2002). Article 13 of the EIA Proclamation 299/2002 requires that public instruments undertake EIA. To this end, Sector Environmental Units play an important role in ensuring that EIA is carried out on projects initiated by their respective sector institution.

Delegated authority: The Federal Environment Protection Agency has delegated authority to sector institutions to ensure implementation of EIAs in their sector and to undertake EIA reviews. For instance, the Federal Ministry of Water and Energy is responsible for ensuring that an EIA is undertaken on water and energy projects and to review the EIA. This delegation has been communicated to sector ministries through an official letter sent by the Federal EPA.

The organization of additional environmental and social management roles and responsibilities within the health sector are described below.

The **Food Medicine Health Care Administration and Control Authority (FMHACA)** is an autonomous entity under the Ministry of Health. The Authority has the mandate, as per Proclamation 661/2009 to regulate:

- Health care practice
- Health care premises which includes healthcare facilities, food establishments, medicine facilities, health related facilities and port inspection sites
- All health professionals
- Health care products from production to consumption of medicines, medical equipment and devices, food and food supplements, herbal products, cosmetics, complimentary and traditional medicines.

These regulatory activities are decentralized and function throughout all regions and woredas of Ethiopia. At the regional, zone and woreda levels, these regulatory activities are implemented through the **Health and Health-Related Services and Product Regulation Core Process**.

The **Pastoral Health Promotion and Disease Control Directorate** coordinates health initiatives in the four regions that need special attention (Afar, Somali, Gambela and Beneshangul-Gumuz). The Directorate provides targeted support to these regions and works as a liaison between the Ministry of Health and the Ministry of Federal Affairs. The Directorate offers short and long-term technical support to these regions by assigning experts to support districts in these regions. The Directorate is responsible for coordinating environmental health, hygiene and sanitation activities of the Ministry at the national level. The Directorate serves as the sector unit for environmental management within the Ministry, fulfilling the requirements of Proclamation 295/2002 that stipulates the establishment of Environmental Units within sector organs. Moreover, the Directorate leads the Ministry’s participation in joint initiatives with the Federal EPA including strengthening environmental health interventions in line with the Libreville Declaration and mainstreaming the climate change agenda in the health sector.

The health care delivery process is one of the eight core processes being implemented by the MoH. This core process has two components: health promotion and disease prevention, and curative and rehabilitation services. The **Medical Services Directorate** is responsible for the latter and is mandated to ensure quality, affordable and accessible medical services nationwide. This Directorate, in line with its role in infection prevention and health safety, coordinates the National Infection Prevention and Patient Safety (IPPS) Advisory Working Group. This Advisory Group was responsible for development of the National Health Care Waste Management Strategic Action Plan 2012-2015.

This Plan focuses on achieving four objectives:

1. Implement and support revision of the legal and regulatory frameworks for HCWM
2. Standardize HCWM practices and equip HCFs
3. Improve institutional and management capacities of HCFs as well as Woreda, Zonal, Regional and Central Health Authorities
4. Establish a proper HCW Monitoring Plan at HCF, Woreda, Zonal, Regional and Federal levels

This Directorate, with support from the Pastoralist Directorate, has been given the responsibility of monitoring and supervising implementation of the Plan. The IPPS Committees have been formed at the Regional Health Bureau, Zonal Health Department and Woreda Health Office level under the Curative and Rehabilitative or Health Promotion and Disease Prevention Core Processes to lead implementation of the Plan and ensure that there is input from the Environmental Health Officer is a member of the committee and who coordinates HCWM activities.

The **Health Infrastructure Directorate** ensures efficient and effective use of essential public health services, human resources, health information technology and infrastructure necessary for accessible and quality health service delivery at the national level. With respect to its work pertaining on health facility expansion and rehabilitation, the Directorate:

- Manages health facility construction contracts and supervises building sights
- Designs health facilities and allocation of medical equipment
- Sets construction standards and provides information and consultancy services regarding construction of health facilities
- Coordinates and oversees safe, secure and environmentally sound operation and maintenance of appliances, including air conditioners, boilers, stoves, water supply and sewerage systems and medical equipment
- Develops facility standards for essential civil works

This Directorate is responsible for ensuring that the design of all facilities incorporates provisions for addressing environmental impacts, including facilities for infectious and hazardous healthcare waste management. The Directorate is responsible for developing environment, health and safety standards for contractors, incorporating such requirements in healthcare facility construction contracts and monitoring compliance of contractors to these requirements. The Directorate's facility design for health centers is stringent when considering the environmental aspects of incinerators included in the design developed by the Directorate.

The **Agrarian Health Promotion and Disease Control Directorate** is responsible for coordination of health promotion and disease prevention package implementation in four regions (i.e., Tigray, Amhara, Oromia and SNNPR). It is also tasked with coordination of nationally identified tasks in the Agrarian Health Sector Development Program to reach both national and MDG targets. This Directorate is responsible for coordinating vector-transmitted disease control at the national level. In this context, management of hazardous materials associated with disease control lies with this Directorate. The Directorate was involved in development of the National Malaria Guideline (2012). The Directorate ensures that facilities establish methods for proper management of insecticide use and disposal of waste.

The **Health Extension Program (HEP)** is an innovative community-based initiative introduced in 2003 during the Third Health Sector Development Program (HSDP III). The HEP helps create a healthy environment by making available essential health services at the local level. The objective of HEP is to improve equitable access to essential preventive health services through community based health services with a focus on sustained preventive health actions and increased health awareness.

The HEP is the central mechanism of health service provision in Ethiopia. The HEP consists of a package of basic and essential promotive, preventive and selected high impact curative health services. The HEP has been under implementation in agrarian, urban and pastoral areas of the country since 2002. The program is aimed at enabling households to produce and maintain their health (HSDP IV, 2010; Report by MoH, WHO, and UNICEF, 2011). Implemented at household level, the HEP is comprised of four major health categories: disease prevention, family health, environmental hygiene and sanitation and health education and communication. The HEP is delivered through a network of five household's organized under one model family to influence one another in practicing a healthy life style. Health extension workers provide training and technical support to the networks of families to implement HEP packages.

In connection with HEP, HSDP IV focuses on scaling up urban and pastoralist HEP, improving the quality of HEP in rural areas and maintaining program coverage. In the case of nomadic and semi-nomadic populations and shifting cultivators, who comprise the majority of citizens in the regions that need special attention, and who have special health needs that are not met by static facility-based health systems, the Federal MoH established an appropriate health service delivery for this population. Accordingly, 16 HEP packages were adapted to pastoralist needs and translated into local languages. To ensure achievement of the program objectives, the Pastoralist Health Promotion and Disease Prevention Directorate was also established in the MoH.

In the context of the 2008 Libreville Declaration on health and environment inter-linkages, the joint MoH-EPA Situation Analysis and Needs Assessment (SANA) report identified the health and environment priorities of the country. As follow-up to the SANA report, a **National Plan for Joint Action (NPJA)** was prepared to implement interventions aimed at:

- Developing and updating the national frameworks to address environmental impacts
- Strengthening health and environment institutions capacity to mainstream EIA and HIA
- Strengthening environmental monitoring and surveillance in line with environmental risk factors to human health
- Establishing a joint system for the assessment of health and environment risks

In the context of the National Plan of Joint Action, the organizational structure that creates clear linkages between the health and environment sectors has been proposed (Figure 4). This Plan of Action should be implemented in the near term.

5.2 Social Impact Assessment and Management System

5.2.1 Land Acquisition, Resettlement and Compensation

OP/BP 9.00 requires that land acquisition and loss of access to resources are managed in a manner that avoids or minimizes displacement and that affected people are compensated and assisted in improving or at least restoring their livelihoods and living standards. This section assesses the legal and regulatory framework for land acquisition and compensation in Ethiopia as it applies to the health sector and, more specifically, as it applies to the menu of investments supported by the MDGPF.

In order to assess the adequacy of the social management system, relevant policies, laws, and regulations are summarized below as well as the roles and responsibilities of institutions involved in the resettlement and compensation processes in Ethiopia. The assessment of how these systems function in practice is included. And, a detailed gap analysis is presented in Section 6 summarizing inconsistencies between the system and the requirements of OP/BP 9.00.

Under the PforR operation, the MoH will handle land acquisition, resettlement and compensation based on the Ethiopian legal and regulatory framework. MDGPF activities that may require land acquisition include the construction of 300 health centers.

Policies, Laws, and Regulations for Resettlement and Compensation

All land in Ethiopia is considered public property. The 1975 Proclamations of Public Ownership of Rural Land 31/1975 and Urban Land 47/1975 abolished the 1960 Constitutional decree that recognized private ownership of land. Ownership of land is now vested in the State and Ethiopian citizens have only a usufruct right over the land.

The abolishment of private ownership was enshrined in the Constitution of Ethiopia (1/1987 Ethiopian Calendar), Article 13(2) and No 1/1995, Article 40(3)). According to these decrees, land is public property and cannot be subject to sale or other means of transfer or exchange. Article 40 recognizes the right of farmers to land and right of pastoralists to free land for grazing and cultivation. The Constitution states that the state has the power to expropriate land in the interest of the public by paying compensation in advance commensurate to the value of the expropriated property. Article 44 of the Constitution states the right of displaced persons to financial or alternative means of compensation including relocation with adequate state assistance.

The 1995 Constitution, Article 40(2), 40(4), 40(5) and 40(8), includes legal frameworks that protect citizen's rights to private property and sets conditions for expropriation of such property for state or public interests. Regarding immovable property built on land, the Constitution states that every citizen shall retain full right to immovable property built on the land and to improvements s/he brings about on the land by her or his labor or capital. Hence, the State owns all land, but citizens have a usage right and full ownership of developments and improvements built on state land. This includes the right to alienate developments, to remove them or claim compensation for expropriation of property.

Based on the framework provided by the Constitution, two Proclamations were issued: 1) Expropriation of Land Holdings for Public Purposes and Payment of Compensation Proclamation and 2) Rural Land Use and Land Administration.

Proclamation 455/2005 Expropriation of Land for Public Purposes and Payment of Compensation

The general condition for which land and property can be expropriated is for public purpose defined as use of land by the appropriate body with urban structure plan or development plan to ensure the interest of

citizens to acquire direct or indirect benefits from the use of the land and to consolidate sustainable socio-economic development.

Priority to land- to- land compensation

The Proclamation provides for expropriation of and compensation for land in both rural and urban areas. According to the Proclamation, land-to-land compensation is considered where possible and provides for compensation of displaced persons for lost assets, as well as some assistance.

Eligibility

Compensation should be paid to any land holder that includes individual, government or private organization. According to the Proclamation, landholder means an individual, government or private organization or any other organ that has legal personality and lawful possession over the land to be expropriated and owns property situated thereon.

According to Article 7(1) and (2), a landholder whose holding has been expropriated shall be entitled to compensation for her or his property situated on the land and for permanent improvements s/he has made to the land. The amount of compensation for property shall be determined on the basis of the replacement cost of the property. Thus, Proclamation 455/2005 determines that only legal landowners with crops, perennial crops or other property are eligible for compensation.

Land Asset Classification, Valuation and Compensation

Land assets are classified as movable and immovable. For movable assets, compensation will be paid for inconvenience and other transition costs. Immovable properties could be classified as urban and rural. In urban areas, this category of properties includes residential houses, business installations, institutional structures, stores, fences and public service providing installations. In rural areas, this category of properties may include seasonal crops, perennial fruit trees, timber trees and other cash crops.

A rural landholder whose landholding has been permanently expropriated shall be paid displacement compensation, in addition to compensation payable for property situated on the land and for permanent improvements made to such land, which shall be equivalent to ten times the average annual income s/he secured during the five years preceding expropriation of the land.

Where substitute land, that can be easily ploughed and generate comparable income, is available, compensation shall be equivalent to the average annual income secured during the five years preceding expropriation of the land.

Urban land holders whose land holding has been expropriated will be provided with a plot of urban land the size of which is determined by the urban administration to construct a house. Such persons are also entitled to displacement compensation equivalent to the annual rent of the demolished dwelling house or be allowed to reside free of charge for one year in a comparable dwelling house owned by the urban administration.

On the basis of Proclamation 455/2005 Article 7(2) for expropriation of land holdings for public purposes, compensation will be made at replacement cost. With this method of valuation, depreciation of structures and assets will not be taken into consideration. Compensation rates and valuation of properties will be based on a nationally set formula based on data collected from local market assessments. Compensation is commensurate with loss of assets however replacement cost does not consider location value.

In urban areas, minimum compensation should not be less than the current cost of constructing a single room low cost house in accordance with the standard set by the concerned region. Compensation for permanent improvements to land shall be equal to the value of capital and labor expended on the land.

The cost of removal, transportation and erection shall be paid as compensation for a property that can be relocated and continue its service as before.

Valuation of property will be done by certified institutions or individual consultants on basis of a valuation formula determined at the national level or, where such capacity does not exist, by a committee composed of five persons (rural) designated by the Woreda or city administration. Procedures for valuation are to be determined by specific Directives.

Detailed directives on compensation are provided in Council of Ministers Regulation 135/2007 “Payment of compensation for property situated on landholding expropriated for public purposes”.

Public Utilities

According to Proclamation 455/2005, valuation of fair compensation required to replace utility lines owned by government or parastatal organizations is determined by the utility provider. Valuation must be done within 30 days upon receipt of the expropriation order and the land must be vacated within 60 days after compensation is paid.

Procedures for Expropriation

The law requires that the expropriation order has to be given prior to relocation. Such order shall not be less than 90 days before relocation; however, if there is no crop or perennial plant, farm land could be expropriated within 30 days of receipt of the expropriation order. The law regulates that compensation has to be paid before relocation.

Grievance Redress

Complaints are addressed by a grievance committee established by the Woreda or city administration. The second level of grievance is the Woreda or municipal appellate court and the decision of the court will be final. According to the law, execution of an expropriation order will not be delayed due to complaint regarding compensation payments.

Proclamation 456/2005 Rural Land Administration and Land Use regulates use and administration of rural land and recognizes farm, pastoral, semi-pastoral and communal land holdings. It outlines a grievance mechanism and dispute resolution system. The law requires that all land holdings be issued a certificate in the name of both wife and husband or the name of all joint holders and should be registered in a database.

The law provides for the obligation to pay compensation to landholders if the holder is displaced or to provide replacement land with compensation for lost assets. The Proclamation requires that rural landholders expropriated for federal projects must be compensated based on federal compensation laws or, if displaced for regional projects, they must be compensated according to regional regulations. The Proclamation also states that the holder of rural land who is evicted for purposes of public use shall be given compensation or shall be given substitute land.

Disputes arising from land holding rights are resolved amicably through agreement (an arbitration body to be elected by the parties to the dispute) or in accordance with rural land administration laws of the regional state. The Ministry of Agriculture and Rural Development will be responsible for implementation of this law while regional states are expected to pass region-specific laws with detailed provisions for implementation and appropriate institutional arrangements for application of the regional provisions.

Labor and Social Affairs

Proclamation 377/2003 Labor requires employers to provide a good working environment to workers in order to safeguard their health. Employers must ensure that the equipment used by employees is safe and provide proper working gear.

The **Occupational Health and Safety Guideline (2003)** was developed as a follow-up to the labor Proclamation and provides guidance on occupational health and safety requirements.

Regional Proclamations on Land Acquisition and Compensation

The Amhara, Oromia, SNNPR and Tigray Regional States have passed laws on land acquisition and compensation. In these four regions the process of land registration and certification has been taking place. All regional laws and directives are consistent with national laws with slight variations relevant to their respective contexts.

5.2.2 Institutional Arrangements

The **Ministry of Agriculture and Rural Development** is responsible for implementation of the Rural Land Administration and Land Use Proclamation (456/2005). The Ministry is also responsible for developing new policies and amendments to existing ones as well as establishing information exchange on rural land use and administration issues.

The **Ministry of Urban Development and Construction** is responsible for resettlement planning in Ethiopia. This responsibility was transferred from the Ministry of Federal Affairs (MFA) according to the Proclamation on Revitalization of Federal Bodies of 2006.

Regional states have the responsibility to enact rural land administration and land use laws with detailed provisions on implementation and to establish institutions to support implementation of these laws. Following establishment of the Federal EPA, regional governments established the Environmental Protection, Land administration and Use Authority (EPLAU) vested with responsibility of the administering rural land. EPLAU is embedded in the Bureau of Agriculture and is responsible for providing technical and administrative support as well as carrying out a review and monitoring function for implementation of regulations related to land acquisition.

Kebele, Woreda and City administrations are key players in implementation of the land acquisition regulation and related guidelines. The woreda administration in rural areas and the city administrations in urban areas have the power to expropriate rural or urban holdings for public purposes. They are responsible for setting up a resettlement committee, valuation committee and effecting compensation payments. The woreda administration is also responsible for establishing Kebele level implementation committees; clarifying policies and operational guidelines of Kebele compensation committees; establishing standards for unit rates, coordinating and supervising implementation by Kebele compensation committees and ensuring that appropriate compensation procedures are followed.

The **Ministry of Health as Implementing Agency**, according to Proclamation 455/2005, the implementing agency is any government agency or public enterprise that undertakes or causes to be undertaken development works with its own force or through contractors. As such, the Ministry of Health is the government agency initiating construction of the MDGPF financed Health Centers and is therefore responsible for paying compensation related to land acquisition as long as the Ministry directly finances construction of the Health Centers. Regional government will be responsible for Health Centers financed from regional budgets. The law requires that the implementing agency prepare detailed information on the

land required for the work at least a year before commencement of the work and pay compensation in accordance with the Proclamation.

Federal government financed Health Centers, the Ministry of Health will ensure proper consultation is conducted and grievance mechanisms established in accordance with the law. The Ministry will also ensure that assets are valued properly and compensation calculated according to legal requirements and paid in full and on time. The Ministry must also ensure that construction of the Health Centers takes place only after due process for land acquisition is completed. The woreda administration has the responsibilities to pay or cause payment of compensation and provide rehabilitation support to the extent possible.

5.2.3 Grievance Mechanisms

Quality health service delivery is central to improving the health status of the population. In this respect, HSDP IV focuses on ensuring comprehensive and continuous quality monitoring to enable health system management and service delivery staff to guarantee quality performance in health service provision.

A three-pronged approach is applied in the process of quality monitoring and improvement: (i) supply side interventions, (ii) demand side interventions, and (iii) regulatory framework.

The supply side interventions include providing adequate numbers of skilled and motivated professionals and strengthening the supply chain management system to ensure adequate and uninterrupted supply of pharmaceuticals at points of service delivery.

The demand side interventions promote active and inclusive participation of the community in improving service quality. To facilitate this, mechanisms and procedures are designed whereby patient and client feedback is received and the quality of services optimized. The main mechanism for community participation in monitoring is through the health facility governance boards in which community members are actively involved. The governance boards' acts as the forum where grievances regarding health service delivery are considered and recommendations are proposed for corrective action and quality improvement. Additional quality monitoring mechanisms are the patients' rights charter and regular surveys on client satisfaction.

The regulatory framework is designed to monitor adherence to quality standards by health service providers. The framework focuses on the quality and standards of professional practice, medical supplies, and the physical environment of health facilities. The regulatory framework encompasses an independent inspection system to enhance regulation and monitoring of adherence to service quality standards.

As far as the four regions that need special attention are concerned, the grievance handling process is facilitated through the Joint Steering Committee of MoH and RHBs, which form part of the HSDP governance structure. The Joint Steering Committee holds quarterly meetings, attended by high level officials from MoH and regional states. The meetings are held at the national level to review the performance of the regions with respect to implementation of HSDP IV, including activities financed through the MDGPF. During the review meetings, the four regions that need special attention use the forum to bring their concerns and demands to attention, so that action is taken.

In addition, the Federal Special Support Board holds quarterly review meetings with representatives of the four regions. In these meetings, performance with respect to provision of special support to these regions is reviewed. Regions that need special attention have an opportunity to use these meetings as grievance mechanisms whereby they may voice complaints concerning the special support provided by the relevant sector ministries and neighboring regional states.

After a final decision is reached on each case, written feedback is provided to the complainant and referrals are made for follow-up action including prosecution. It is important to point out that the complainant has the right to report to FEACC seeking their intervention at any point during the process especially if the issue relates to allegations of fraud and corruption

Citizen Involvement to Ensure Accountability and Effective Service Delivery

HSDP IV recognizes the importance of citizen engagement and ownership in ensuring accountable and responsive health services. As such, the Program encourages active participation of citizens through networks of five households guided by a model household to improve healthy lifestyles and use of preventive and promotive health services. These networks are supported by the Health Extension Workers who deliver the package of essential health services at the community level and facilitate community dialogue on health issues. In addition, women's groups and traditional leaders are being actively engaged to help address the cultural barriers that limit the access to safe motherhood services.

To enhance community voice in decisions related to health service delivery, HSDP IV introduced representation of community members on the governance boards of all public health facilities. By the end of the HSDP IV, it is expected that the boards of all facilities will have community representatives. These boards make decisions on use of user fees collected at the facility level to improve service delivery. And, under the Community Based Health Insurance Scheme, the boards have been authorized to contract staff to enhance local accountability.

Key performance indicators used in Ethiopia's flagship hospital reform program include demand side governance measures used to assess facility performance. These indicators include also sharing information on user rights and receiving user feedback. Performance indicators being applied to enhance users' role in this respect, include:

- Posting a statement of patient rights and responsibilities in public places in the hospital
- Monitoring patient experience with care through patient satisfaction surveys conducted on a biannual basis
- Implementing a strategy for involvement of patients and the public in service design and delivery including procedures to be followed such as suggestion boxes, complaints procedures, public meetings, establishment of patient groups and activities to engage vulnerable and marginalized groups

The Public Relationship Department of the MoH scans the media daily to monitor issues related to deficiency of services in the sector. Such issues are immediately brought to the attention of the concerned officer. At present, four Regions have established Regional Health and Health Related Services Quality Assurance Authorities and others are in the process of establishing similar authorities. These authorities are mandated to monitor the quality of care in both public and private sector health facilities as well as pharmacies.

A strong civic education component on the quality of care is being introduced through these new structures using call-in programs on local radio stations. While these are all positive efforts, there is no systematic documentation on the effectiveness of these measures except for key performance indicators used for hospitals.

With respect to PforR support for the MDGPF, these key performance indicators can provide important monitoring information to ensure the desired environmental and social effects of the Program as per OP/BP 9.00 are realized. Section 6 provides details as to how such indicators may be used to attend to some of the gaps in the system as written or as observed in practice.

SECTION 6 SUMMARY OF THE ENVIRONMENTAL AND SOCIAL SYSTEMS ANALYSIS

The ESSA analyzes the system for environmental and social management as relevant to the PforR operation vis-à-vis the six Core Principles of OP/BP 9.00. The gaps identified through the ESSA process and actions to address those gaps contribute to the Program’s aim to enhance institutional performance and governance in the health sector in Ethiopia.

The ESSA analyzed Ethiopia’s environmental and social management system for consistency with the sustainability standards of OP/BP 9.00. The analysis identified where there are procedural and policy gaps with respect to OP/BP 9.00 as well as performance constraints in carrying out environmental and social management processes. The ESSA identified a set of viable actions to strengthen the system and improve performance which are presented in Section 7.

Assessing the environmental and social management system that will be applied to MDGPF investments draws on the contextual and background information presented in Sections 1 to 5 of this report. Drawing on the baseline data presented in the earlier sections of this report, the analysis is organized by the six Core Principles of OP/BP 9.00 and synthesizes the ESSA findings using a SWOT approach.

The SWOT approach is applied to the PforR context in the following manner:

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

The following six matrices summarize the strengths, gaps, opportunities and risks with respect to each core principle. The detailed analysis from which the summary matrices are based on is presented in Annex 3.

Core Principle 1: General Principle of Environmental and Social Management

<p>Applicability: Overarching</p> <ul style="list-style-type: none"> • During the remaining period of HSDP IV, 106 new health centers are planned to be constructed, each with a physical foot print of one hectare which includes placenta pits and incinerators. • Facilities that receive health products and equipment under MDGPF need effective health care waste management, including hazardous materials such as expired pharmaceuticals • Pesticides used in the vector control programs (bed nets) require appropriate storage, distribution, use and disposal mechanisms 	
<p>Strengths:</p> <ul style="list-style-type: none"> • EIA system provides a comprehensive framework for environmental and social impact assessment • Existence of comprehensive health center construction standards and guidelines • National legislation on medical waste management and health care waste management strategic action plan exist • Ongoing efforts to improve availability of health services to underserved populations • Establishment of health and health related services and products regulation units by the regions • National provision to establish Infection Prevention and Patient Safety committees (IPPS) at regional and woreda levels as well as in health facilities • Awareness by local health operators of regulatory requirements 	<p>Gaps:</p> <ul style="list-style-type: none"> • Health center construction guidelines provide limited guidance on screening for potential environmental impacts and risks – this is deemed a minor risk as it is possible to mitigate through the Program Action Plan • Delayed implementation of the national Joint Plan of Action prepared by MOH and EPA for capacity building to undertake and monitor/audit EIA – this is deemed a moderate risk and should be immediately addressed by the MoH through the Program Action Plan as one of the first actions to be completed post effectiveness • Only a limited number of health centers currently have IPPS Committees – this represents a moderate to significant risk as without such committees in place it is highly unlikely that the health facilities will properly manage medical waste generated at their facilities or decrease stress on the health center incinerators • Poor compliance with health care waste management practices especially segregation and pre-treatment – this represents a significant risk and should be addressed immediately through the Program Action Plan post effectiveness • Health facilities and suppliers are allowed to dispose expired medicines without adequate oversight of FMHACA – this represents a significant risk as expired pharmaceuticals may be used by the local population leading to health problems and such medicines may lead to environmental pollution in the immediate vicinity of the disposal area • Pesticides used for vector control are not collected and disposed properly – this represents a minor to moderate risk to the local population, but it can be easily mitigated through application of the existing medical waste and hazardous waste management guidelines as well as through support of the IPPS committees at each health facility • Shortage of health professionals, especially highly skilled and women health providers, in the four regions requiring special attention
<p>Opportunities:</p> <ul style="list-style-type: none"> • Ongoing performance appraisal and institutional rewards under the Hospital Reform Program. Proposed use of Balanced Score Card approach covering health centers and woreda health offices linking performance to instructional rewards • Annual health facility readiness assessment to regularly inform the program managers and policy makers regarding the status of the environmental and social management processes • Innovations by regions and facilities to retain health care workers • Existence of a clearly defined and costed joint MOH- EPA Joint plan of action for capacity building, including training • Implementation of the national Joint Plan of Action to strengthen capacity to assess and manage environmental and health impacts • Development of technical guidelines for environmental screening • Identification of appropriate temporary storage facilities near health facilities for hazardous waste and transportation to appropriate final disposal sites. 	<p>Risks:</p> <ul style="list-style-type: none"> • Not capitalizing the opportunities to address the gaps in a timely fashion will lead to localized and regional environmental health problems among the population and environmental pollution in areas. Both risks are deemed moderate to significant and should be mitigated through a combination of dedicated enforcement of health facility compliance with national legislation and existing guidelines, application of all provisions of the HSDP IV program that address the key gaps identified through the ESSA analysis (e.g. Hospital Reform Program, Balanced Score Card, Facility Readiness Assessments, MoH-EPA Joint Plan of Action, among others), specific actions included in the PforR Program Action Plan (e.g., technical guidelines for environmental screening for proper siting and construction of the new health centers and identification of appropriate storage facilities for hazardous waste and transport to appropriate final disposal sites) as well as dedicated Bank implementation support.

Core Principle 2: Natural Habitats and Physical Cultural Resources	
<p>Applicability: Limited</p> <ul style="list-style-type: none"> Activities funded through the MDGPF will likely generate limited impact on natural habitats and physical and cultural resources since civil works are limited in number and have a small physical footprint that facilitates appropriate siting, thus avoiding adverse impacts on natural habitats and any chance finds. Construction of facilities such as health centers and disposal of medical wastes may pose some risk to natural habitats and physical cultural resources if not sited appropriately and if chance finds procedures are not embedded in general construction contracts and supervised appropriately 	
<p>Strengths:</p> <ul style="list-style-type: none"> National proclamation and EIA procedure guidelines are consistent with the principle of environmental protection Screening criteria for projects in national parks and areas containing endangered flora and fauna are established. 	<p>Gaps:</p> <ul style="list-style-type: none"> Limited capacity to review EIAs (EPA) and manage natural habitats due to resource constraints, enforcement issues, inadequate public consultations/ participation, lack of equipment, training and incentives No documented national system strengths regarding treatment of physical cultural resources. No documented guidelines or standards for chance finds procedures in the health sector.
<p>Opportunities:</p> <ul style="list-style-type: none"> Availability of simplified physical cultural resources screening procedures under the Bank-financed Productive Safety Nets Program (PSNP) wherein each subproject is screened for whether it is located within a recognized cultural heritage or a world heritage site. Screening procedures include a check list to assess whether a subproject has the potential for disturbing a known cultural or religious site. 	<p>Risks:</p> <ul style="list-style-type: none"> Inability to apply practical and operationally feasible early screening practices for known physical cultural resources and chance finds in the health sector may lead to adverse environmental impacts natural habitats and physical and cultural resources. The risk is deemed to be minor to moderate if the MoH adopts the PSNP simplified screening procedures for known physical cultural resources and develops and applies internationally recognized chance finds procedures in the early screening practices for site selection of the 106 health centers to be financed through the MDGPF as well as to ensure that disposed medical and hazardous waste, including bed nets are not disposed of in natural habitats or affecting physical cultural resources.

Core Principle 3: Public and Worker Safety	
<p>Applicability: Overarching</p> <ul style="list-style-type: none"> Rehabilitation, construction and operation of health centers are prone to expose the general public as well as health service providers and construction workers to risks such as exposure to infectious waste, toxic or hazardous materials including pesticides and expired medicines, operational risks (needle pricks) at health facilities and civil works construction phase associated adverse environmental and social impacts 	
<p>Strengths:</p> <ul style="list-style-type: none"> Availability of national proclamations and guidelines addressing public and worker safety. These cover a range of important aspects including environmental pollution control; labor laws; occupational health safety regulations; food, medicine and health care administration and control; management of public health emergencies and national hazards (e.g., droughts) 	<p>Gaps:</p> <ul style="list-style-type: none"> The national EIA system does not comprehensively encompass aspects of public and worker safety Site selection criteria issued by the MOH for health centers may not incorporate government guidance on avoiding hazard prone areas Public and worker safety issues are not adequately addressed during construction of health facilities Health workers are prone to occupational hazards such as needle pricks As stated under CP2: (i) Poor compliance with health care waste management practices, especially segregation and pre-treatment and (ii) FMHACA does not have adequate oversight over health facilities and suppliers who dispose expired medicines improperly. Pesticides and other hazardous material used for vector control are not collected and disposed properly – also impact public and worker safety considerations under CP3. The waste management issues are treated under CP2 and crossed referenced to CP3.
<p>Opportunities:</p> <ul style="list-style-type: none"> Incorporate the identified gaps on public and worker safety measures in all civil works contracts for construction of the 106 new health centers. This opportunity is reflected in the Program Action Plan The HSDP IV Program’s annual facility readiness assessments allow the MoH to monitor compliance with all recommended public and worker safety measures already embedded in the Program’s design 	<p>Risks:</p> <ul style="list-style-type: none"> Inability to ensure public and worker safety can result in spread of communicable diseases and may cause physical injuries to the public seeking health services and to health care workers at public health facilities. These risks are deemed to be moderate to significant. The waste management issues can be treated as described under CP2, the construction phase risks can be mitigated through inclusion of appropriate safety measures in all health center civil works contracts, operation phase risks can be mitigated through existing measures in place in the HSDP IV Program. All such measures need to be adopted by the MoH immediately post effectiveness and monitored closely to ensure compliance and completion of the listed actions.

Core Principle 4: Land Acquisition

Applicability: Limited

- The MDGPF proposes construction of 106 new health centers. Given the size of each health center and scale of land required (1 ha), such construction poses a relatively limited risk of land acquisition and displacement or potential loss of access to natural resources since appropriate early screening and siting practices can be applied to avoid the need for land acquisition, displacement and loss of access to resources.
- However, it is important to note that the risk of land acquisition and displacement is likely to be slightly higher, rated moderate, in urban areas where population density is high and in agrarian areas where land resources are scarce. It will be lower in pastoral and agro-pastoral areas, where land is relatively abundant and population density is low. Therefore a risk rating of minor to moderate is appropriate in this instance for land acquisition.

Strengths:

- The federal government and most regional states, with the exception of Afar, Somali and Benishangul-Gamuz, have established laws and guidelines that clearly stipulate the process of land acquisition, resettlement and compensation processes
- Land is owned by the State and citizens are given usufruct rights over the land
- A legal landholder whose holding has been expropriated is entitled to compensation at replacement cost for assets on and any permanent improvements to the land. The amount of compensation for property shall be determined on the basis of replacement cost
- Rural landholders who lose land permanently shall be paid displacement compensation, in addition to compensation payable for property situated on the land and for permanent improvements made to such land
- Urban land holders whose land holding has been expropriated will be provided with a plot of urban land the size of which is determined by the urban administration to construct a house. Such persons are also entitled to displacement compensation
- Availability of dispute resolution and grievance mechanisms through compensation review committees, arbitration tribunal as well through the court system
- Most cities have established guidelines and systems for valuation and compensation.

Gaps:

- Lack of standardized procedures for land acquisition across regions
- Lack of an explicit statement in the land laws on avoiding or minimizing land acquisition
- Land registration and certification are not carried out in pastoral and agro pastoral regions. Land for health centers must be sought from communal land which is not documented
- The legal framework only recognizes legal titles and quasi-legal titles (such as customary rights over land and communal land), and does not cater to citizens with no legal rights. Citizens without legal rights to land receive “special assistance”, but not formal compensation for loss of land
- Independent valuation is not the norm
- Replacement costs do not consider location
- Compensation is focused on replacement of land and assets, not restoration of livelihoods. The legal framework does not explicitly state that livelihoods should be restored to previous levels or improved.
- There are no specific provisions for transitional assistance
- Land can be expropriated before relocation sites are ready. Forced eviction is possible after expiry of the notice period
- Excessive work load and capacity limitations of committees of experts assigned by local authorities (kebeles) for valuation of assets lead to delays
- Inability of city administrators to use the services of independent valuers due to budget constraints lead to weak application of existing acquisition and compensation systems
- Consultations with PAPs are not conducted systematically and grievance handling mechanisms can be slow to resolve disputes
- Lack of proper documentation of the consultation procedures

Opportunities:

- Appropriate early screening and siting procedures used for siting each of the 106 health centers can eliminate the risk of land acquisition and resettlement. This action is included in the Program Action Plan.
- Establishment of appropriate and transparent mechanisms for consultation and documentation in regions that operate under a communal land system will mitigate the risk of faulty land acquisition and resettlement practices in those regions that operate under a communal land system. This action is included in the Program Action Plan.
- In the few instances where land acquisition, resettlement or loss of access to resources is necessary, the MoH should ensure that PAPs receive compensation and are properly resettled before the land is expropriated and ensure that people without legal rights to land are compensated for lost assets and provided with resettlement assistance. This action is included in the Program Action Plan

Risks:

- Inability to rehabilitate and adequately compensate affected people while acquiring land for the construction of health centers will adversely affect livelihoods and living standards of displaced people.

Core Principle 5: Indigenous Peoples and Vulnerable Groups	
<p>Applicability: Overarching</p> <ul style="list-style-type: none"> • There is an ongoing dialogue between the Government of Ethiopia and the Bank on formal designation of Indigenous Peoples given the country context. • The Government has identified four regions (Somali, Afar, Beneshangul-Gumuz and Gambella) that require special attention. HSDP IV aims to provide regionally tailored approaches that ensure distributional, gender balanced and culturally appropriate access to health services, as well as technical support to these regions to ensure coverage and provision of health services is on par with the rest of the country. 	
<p>Strengths:</p> <ul style="list-style-type: none"> • Devolution of decision making powers to regional health bureaus and woreda health offices for managing and coordinating the health systems in their catchment areas • Establishment of a federal special support board consisting of sector ministries under the Prime Minister’s office to ensure better coordinated cross-sector affirmative support to the four regions that need special attention • Creation of an Equitable Development Directorate under the MFA focusing on gathering data on existing gaps in capacity, social and economic development, governance, gender and environment • Establishment of pastoralist Health Promotion and Disease prevention directorate within the MoH to provide dedicated technical support complemented by semi-annual supervision visits to assess implementation • Twinning each of the four regions requiring special attention with better performing regions • Improved physical access to services through health extension workers and mobile clinics; additional matching support from MoH for health center construction. • Improving financial access of the poor to health services, such as: (a) exemption of user fee for health services from; (b) introduction of the fee waiver program for the indigent population; and, (c) piloting of the Community-Based Health Insurance scheme (CBHI) in 13 woredas • Quarterly review meetings with representatives of the four regions that require special attention to discuss the quality of support and address grievances • Biannual supervision missions by MoH to the four regions to assess implementation and address emerging issues 	<p>Gaps:</p> <ul style="list-style-type: none"> • Challenge in implementing the fee waiver scheme for street dwellers and poor residents who do not have a permanent address • On the supply side, limited capacity to plan and effectively implement programs. Lack of availability of human resources for health service provision (both specialists and female health extension workers) and additional focus required by health extension workers on community case management still remain a challenge in the four regions requiring special attention • On the demand side, pervasive and deep-rooted socio-cultural beliefs and attitudes and gender inequalities result in underutilization of health services and continuation of harmful traditional practices such as female genital mutilation. Preference for female providers during child birth also limits access to skilled care • HRH Strategic Plan has not yet been approved
<p>Opportunities:</p> <ul style="list-style-type: none"> • Effective use of women’s groups, panel discussions and community conversations targeting special groups such as pregnant women, traditional leaders (both religious and community elders), and other vulnerable groups to address demand side barriers • Availability of mobile vans that offer public education programs in ethnic languages specifically targeting culturally sensitive good health practices • Commitment to scale up the CBHI scheme targeting indigent populations and provision of a social health insurance scheme for the formal sector to help address financial barriers in accessing health care services • Enhancing health extension worker skills in community case management of childhood illnesses and safe delivery services and training of health officers in emergency surgical and obstetric procedures • Recruit women health workers • Avail ambulances at each Woreda health office to improve access to referral care 	<p>Risks:</p> <ul style="list-style-type: none"> • Inability to improve delivery of essential health services and addressing demand side barriers for such services building on existing opportunities will adversely affect vulnerable populations especially women and children.

Core Principle 6: Social Conflict	
<p>Applicability: Not Applicable</p> <ul style="list-style-type: none"> • The proposed program will not exacerbate social conflict nor will it operate in a fragile state context, a post-conflict area or in areas subject territorial disputes. • The program is designed to yield significant social benefits to all citizens and to improve distributional equity of health services, particularly in the four regions that require special attention. 	
<p>Strengths:</p> <ul style="list-style-type: none"> • Strengths listed with respect distributional equity under Core Principle 5 will apply. 	<p>Gaps:</p> <ul style="list-style-type: none"> • Gaps listed with respect to distributional equity under Core Principle 5 will apply.
<p>Opportunities:</p> <ul style="list-style-type: none"> • Opportunities listed with respect to distributional equity under Core Principle 5 will apply 	<p>Risks:</p> <ul style="list-style-type: none"> • Inability to improve the delivery of essential health services and addressing demand side barriers in regions requiring special attention will affect distributional equity of health services.

SECTION 7 ESSA INPUTS TO THE PROGRAM ACTION PLAN

7.1 Measures to Enhance Performance

The Program for Results operation aims to strengthen government performance in the health sector to support achievement of the health MDGs by 2015. This includes support for investments that will also result in strengthening application of the environmental and social management systems in the sector.

The ESSA exercise highlights a number of important opportunities available to the Government of Ethiopia to strengthen these systems through the PforR operation. The opportunities presented in this section are tangible actions to enhance application of the environmental and social management system in the health sector. These actions are proposed for inclusion in the Program Action Plan.

To complement efforts expended to implement the proposed actions, additional measures to enhance application of the systems to MDGPF investments, as highlighted in the opportunities sub-sections of each Core Principle in Section 6, have been embedded in the Program design and in planned Bank implementation support for the Program.

The relationship between these three types of systems enhancing measures is as follows:

1. **Program Design** includes measures undertaken during Program preparation, agreements and areas for further study, development of technical tools and use and design of key performance indicators, scorecard, HSDP IV capacity building program and Disbursement Linked Indicators (e.g. facility readiness assessments). These measures are discussed throughout Section 6 and presented in the overall HSDP IV MDGPF Program for Results operation design.
2. **Program Action Plan** is comprised of a set of actions agreed with government that will be carried out either prior to or after the Program is effective. Based on the ESSA findings, specific actions have been proposed for inclusion in the overall Program Action Plan in order for the GoE to bridge the most significant gaps in the system as written and as assessed through the track record. As mentioned in Sections 1 - 6, many of the minor gaps identified are already being addressed through the HSDP IV design and through the PforR operation DLIs. The set of actions listed in the matrix below focus on the most significant gaps that require attention in order for the Program to achieve the expectations of OP/BP 9.00.
3. **Program Implementation Support Plan** is the structure of Bank implementation support to be provided to the MoH throughout implementation. This includes: Reviewing implementation progress and achievement of program results; helping to resolve implementation issues and to carry out institutional capacity building efforts; monitoring performance of Program systems, including implementation of the agreed Program Action Plan; and monitoring and evaluation of changes in Program risks as well as compliance with legal covenants.

The matrix below presents the proposed set of environmental and social management systems related actions to be embedded in the Program Action Plan. The Bank and the Government of Ethiopia will discuss the proposed actions and reach mutual agreement on the content and set of actions to be implemented as part of the Program Action Plan designed to bridge the most significant gaps in the systems as analyzed through the ESSA process.

The ESSA and the Program Action Plan are living documents that may be updated as deemed necessary.

7.2 Proposed Actions to Improve System Performance

Proposed ESSA Actions for Inclusion in the Program Action Plan

#	Risk	Action	Responsibility	Timeframe	Indicator
1	Construction of new health centers does not adequately identify and mitigate adverse environmental impacts of the works leading to environmental damage, including loss of natural habitats and known or unknown physical cultural resources. Risk of increased environmental pollution and environmental health impacts.	<p>Site Screening for new Health Centers (Core Principle 1 and 2):</p> <ul style="list-style-type: none"> Incorporate environmental impact and risk criteria in the site selection screening forms for all health centers constructed through the MDGPF window. Ensure that the screening is explicit in addressing natural habitats and physical cultural resources considerations in order to avoid siting HCs in areas that would impact either or both. Appropriate mitigation measures to address induced impacts should also be identified during the site screening process for all new health centers financed through the MDGPF window. 	MoH, RHBs and WHOs tasked with carrying out the site screening exercise for site selection of all new health centers financed by the MDGPF	Prior to final selection of a site for construction of a new health center.	Early site screening forms reflect good practice in terms of appropriate health center siting, avoiding adverse impacts on natural habitats and known physical cultural resources and make explicit induced impacts.
2	Capacity gaps lead to a weak system of robust environmental management in the health sector leading to adverse environmental and social impacts such as environmental pollution and loss of environmental resources as well as environmental health problems.	Regulatory Equipment and Resources (Core Principle 1): Avail necessary equipment and resources to the Health and Health Related Services and Products Core Process unit staff required for fulfilling their regulatory tasks; including vehicles and equipment, such as water quality analytical kits.	MoH	Ongoing	Facility Readiness Assessment documents track and reflect provision and use of appropriate regulatory equipment and resources at health facilities nationwide.
3	Capacity gaps lead to weak system of robust environmental management in the health sector leading to adverse environmental and social impacts such as environmental pollution and loss of environmental resources as well as environmental health problems.	Healthcare Worker Retention, Incentive Packages, Training and Capacity Building (Core Principle 1, 3, 5 and 6): To improve service delivery, the MoH should implement the Human Resources for Health Strategic Plan (2009-2020). The Plan sets out details on planning, management, education, training, skills development and financing mechanisms for Human Resources for Health. Implementing the HRH Strategic Plan will support the overarching goals of HSDP IV and MDGPF investments by promoting faster human resources development and deployment in the health sector.	MoH	Begin implementation prior to effectiveness as outlined in the HRH Strategic Plan	Health Management Information System, Balanced Scorecard and Facility Readiness Assessments reflect ongoing investments and interventions recommended in the HRH Strategic Plan across health facilities nationwide.
4.	Poor segregation and final disposal of health care waste (Core Principles 1 and 2) leading to environmental	Support all health facilities to establish and operate Infection Prevention and Patient Services Committees to facilitate implementation of facility	Pastoralist health promotion and disease prevention Directorate working with Regional Health Bureaus	Begin implementation prior to effectiveness since both actions are already defined and	Number of health centers having IPPS Committees Number of health centers complying with guidelines

	pollution and health problems.	level HCWM Plans following the HRH Strategic Action Plan for 2012-2015.		mandated in the national environmental and social management system	(Rapid Facility Assessment)
5.	Improper disposal of hazardous waste including expired pharmaceuticals (Core Principles 1 and 2) leading to environmental pollution and health problems.	Avail appropriate temporary storage facilities for collection of hazardous wastes until final and appropriate disposal is completed. Undertake community mobilization activities and provide incentives for systematic collection of hazardous materials and waste at the community level.	Pastoralist health promotion and disease prevention Directorate working with Regional Health Bureaus and Woreda Health offices		Number of Regions having satisfactory procedures and arrangements for final disposal of hazardous wastes FMHACA establishes protocol and institutional arrangements for disposal of expired medicines
6.	Public and worker safety (Core principle 3)	Construction phase of HCs: Incorporate public and worker occupational safety guidelines in the civil works contracts for construction of health centers. Operation phase of HFs: Ensure adoption of Occupational Health and Safety Guidelines and compliance with Labor and Social Affairs requirements pertaining to personal protective equipment and occupational health and safety practices in health facilities.	Infrastructure Directorate	Ongoing as part of the government's overall waste management plan for the health sector	% of contracts awarded that include occupational safety guidelines
7.	Land acquisition, resettlement and compensation (Core Principle 4)	Document consultations and participatory nature of discussions held where communal land is used for construction of health centers; document, where applicable, compensation for land, assets, and/or livelihoods.	Infrastructure Directorate	Prior to validating civil works contracts for health centers	% of new health centers constructed in communal land having documentation of consultation and, where applicable, compensation for assets, land and/or livelihoods.
8.	Indigenous Peoples and Vulnerable Groups	Document outreach and specific actions focused on providing services to all vulnerable persons.	MOH		Documentation on outreach and actions to assist/serve all vulnerable groups

ANNEXES

Annex 1: Legal Framework for Medical Waste Management in Ethiopia

Proclamation/Policy	Scope and Application	Responsible Entity
Environmental Policy of Ethiopia	It indicates priority to be given to waste collection services and safe disposal; development of guidelines for waste disposal and on techniques to enable the cost-effective implementation of defined standards of control; establishment of system for monitoring compliance with environmental pollution control standards and regulations and for the handling and storage of hazardous waste disposal; and promotion of waste minimization strategies. It also affirms that employers who deploy workers without training and personal protection equipment should be held legally liable. Moreover, it ensures the need to keep an up-to-date register of toxic, hazardous and radioactive	Federal EPA
Food, Medicine and Health care Administration and Control Proclamation no.661/2009	It stipulates that the handling and disposal of solid and liquid wastes derived from different institutions must not be harmful to public health; emphasis is on ensuring the availability of necessary hygiene requirements in controllable health-related institutions; and stresses the proper disposal of medicines when they expire or when they are deemed to be unfit for use in accordance with the proclamation. In addition, it indicates that any waste generated from HCFs must be handled with special care and their disposal procedures must meet the standards set by the relevant executive organ. It also prohibits discharging untreated wastewater generated from septic tanks and seepage pits into the environment and clearly states that no legal/natural person collects or disposes of solid, liquid or other waste in a manner that contaminates the environment and is harmful to health. Moreover, it stresses the need for protection of employees from any occupational hazard that affects their health and well being.	FMHACA
Radiation Protection Proclamation no. 571/2008	It states that no radioactive material including radioactive waste shall be acquired, distributed, used, transported, stored or disposed of without meeting the requirements of the issuing authority including the requirements of notification and authorization.	FRPA
Solid Waste Management Proclamation no. 513/2007	It is applicable mainly to non-hazardous solid waste derived from HCFs such as glass containers and tin cans, plastic bags, food related solid waste and other general waste. It stipulates that any legal and/or natural person should get a permit from concerned bodies of an urban administration to engage in the collection, transport, use or disposal of solid waste.	FEPA
The Bamako Convention Ratification Proclamation no. 355/2003	Parties to the Convention are obligated to take appropriate legal, administrative and other measures within the area under their jurisdiction to prohibit the import of all hazardous waste into Africa from non-contracting parties and provide detailed procedures for the control of trans-boundary movements and management of hazardous waste within Africa.	FEPA
Environmental Pollution Control Proclamation no. 300/2002	It is applicable to non-hazardous waste and all forms of hazardous waste streams generated from HCFs. It requires that the generation, keeping, storage, transportation, treatment or disposal of any hazardous waste must be with a permit from the FEPA or the relevant Regional State Environmental Agencies. Moreover, it emphasizes that any natural and/or legal person who is involved in the collection, recycling, transportation, treatment or disposal of any hazardous waste should take appropriate precautions to prevent any damage to the environment or to human health or well-being.	FEPA
Environmental Protection Organs Establishment Proclamation no. 295/2002	The proclamation requires sector agencies to establish their environmental units so that their activities are in harmony with pertinent environmental protection requirements.	FEPA
Environmental Impact Assessment Proclamation no. 299/2002	It declares that no project shall commence without an environmental impact assessment if it is required, as stated in directives. This therefore, includes the construction of HCFs. It also states that any natural/legal person who violates the provisions of this proclamation shall be regarded as having committed an offence and shall be liable in accordance with the FDRE Criminal Code.	FEPA
Stockholm Convention on Persistent Organic Pollutants Ratification Proclamation No. 279/2002	It defines the control of the release of persistent organic pollutants (e.g. dioxins/furans) from unintentional sources such as medical waste incinerators. The convention encourages parties to promote the application of available, feasible and practical measures to achieve a realistic and meaningful level of release reductions including dioxins/furans from medical waste incinerators through the adoption of best available options and environmental practices including the use of low-waste technology; the use of less hazardous substances; the promotion of recovery and recycling of waste; good housekeeping and preventive maintenance programs; improvements in waste management with the aim of stopping open and other uncontrolled burning of waste including the burning of landfill sites. Moreover, when sites for construction of new waste disposal facilities are sought, considerations are to be given to alternatives such as activities to minimize the generation of medical waste, including resource recovery, reuse, recycling, and waste separation and promoting the use of products that generate less waste	FEPA
Basel Convention on the Control of Trans-Boundary Movements of Hazardous Waste and their Disposal Ratification Proclamation	The Convention obliges parties to ensure that the generation of hazardous waste and other waste be reduced to a minimum, taking into account social, technological and economic factors and to ensure the availability of adequate disposal facilities, for the environmentally sound management of hazardous waste and other waste materials that shall be located, to the extent possible, within it. In addition, it emphasizes that any natural/legal persons involved in	FEPA

Proclamation/Policy	Scope and Application	Responsible Entity
no. 192/2000	the management of hazardous waste or other waste to take all the necessary steps to prevent pollution due to hazardous waste and other waste. It also contains provisions for co-operation among parties in the development and implementation of environmentally sound low-waste technologies and the improvement of existing technologies with a view of eliminating the generation of hazardous and other waste materials.	
Labor Proclamation no. 377/2003 and International Labor Convention Ratification no. 152/1999	Both specify that employers have the responsibility to take the necessary measures to safeguard adequately the health and safety of their workers by complying with occupational safety and health standards; by providing the necessary on job instructions; notifying the associated hazards on the task; and informing their workers of the necessary precautions to be taken to avoid accident or injury to health. In addition, both require employers to provide workers with appropriate personal protective equipment.	MOLSA
The Technical Guideline on the Environmentally Sound Management of Biomedical and Healthcare Wastes	Defines HCW, explains risks arising from HCW and recommends applicable waste treatment and disposal technologies, reuse and recycling of waste, labeling and packaging of waste for off-site transport and training for staff. It also defines responsibilities for HCF managers.	FEPA
Blueprint Standards for Hospital Management in Ethiopia	Guides hospitals to have clearly defined policies, procedures, and financial mechanisms to ensure supply of all necessary materials for proper infection prevention and waste management including proper treatment and disposal mechanisms for all kinds of waste.	MoH
Infection Prevention Guidelines for Healthcare Facilities in Ethiopia	Specifies that waste generated in HCFs should be managed properly with emphasis on the process of waste segregation, collection, transport, treatment and disposal. It stipulates that proper waste management is one principle of infection prevention and contains recommendations on how to treat and dispose of sharps and hazardous waste and, solid and liquid waste materials from HCFs.	MoH
Healthcare Waste Management National Guideline	Contains key points on the need for managing HCW, and HCWM principles including waste categories, segregation, reuse and recycling, storage, handling, transport, treatment and disposal, accident and spillage, occupational safety and workers training needs. It recommends the use in hospitals, health centres, clinics and health posts of a three color-coded waste bin system. That is, non-risk/non-hazardous waste (black bag), infectious clinical waste (yellow bag) and sharps (yellow safety box) for medical waste segregation. In specialty areas an additional red bag for waste with high heavy metals content and effluents is recommended. It states that HCWM is to be both an administrative and technical issue and stresses HCFs to develop an infectious waste management plan as part of HCWM. In this regard, it recommends awareness and training programs for medical and ancillary staff to be strengthened; appropriate, environmentally friendly and affordable technologies to be selected for the treatment and disposal of HCW by taking into account the resources of HCFs; definite specific administrative procedures; and allocate resources at all levels to ensure proper HCWM.	
Standards for the Establishment and Practice of Pharmaceutical Compounding Laboratory	Specifies that materials which are unfit for distribution whether starting material, packaging and/or finished products to be disposed as per the relevant disposal guideline. Additionally, it recommends that all the rejected materials should be clearly identified, recorded and stored separately before disposal.	
Code of Practice for the Handling and Disposal of Waste Materials within HCFs	It is a voluntary instrument. It defines types of HCW, the need for waste segregation and container requirements, color coding system, the necessary precautions during waste transport, requirements for intermediate and final storage area, waste disposal techniques.	
The Criminal Code of the Federal Democratic Republic of Ethiopia Proclamation no. 414/2004	The new Criminal Code of Ethiopia contains a list of penalties for offences against laws promulgated to protect public health and control of pollution including the spreading of human diseases by negligence; unintentional contamination of water; discharge of pollutants into the environment by breaching relevant laws; failure to manage hazardous waste in accordance with relevant laws; and implementation of a project without conducting a full EIA as required by the law.	MoJ

Annex 2: Environmental Impact Assessment Process in Ethiopia

Environmental Impact Assessment Process

Proclamation 299/2002 states that an EIA is a mandatory requirement for implementation of any project likely to generate adverse environmental impacts. Project developers seeking a permit follow the EIA process as outlined in the Proclamation, the steps for which are outlined below. These steps, which are stipulated in the EIA Procedural Guideline (2003), largely follow the standards for environmental management procedures and processes under OP/BP 9.00.

Screening: As per the EIA Procedural Guideline (2003), the screening process enables the Competent Authority to decide on the:

- Need for and level of assessment required
- Level of government responsible for the project (Federal or Regional)
- Necessary permits or approval processes required (e.g. rezoning)
- Merit-based acceptability of the consultant to assist the proponent
- Public participation process
- Total life-cycle of the project

The proponent is required to submit a screening report to the Authority, based on which a decision will be made as to whether an EIA is required and the type of EIA required (full, partial/preliminary).

In order to assist in the Screening Process, the Federal EPA has enacted a Directive to determine projects subject to Environmental Impact Assessment (EIA Directive 1/ 2008). As per this directive, the only project typology in the health sector that requires an EIA is the construction of hospitals¹³. It is important to note that since the MDGPF will not finance construction of hospitals, only health centers, the EIA Directive is not applicable, at this time, to this Program for Results Operation.

Scope of an EIA

The EIA Procedural Guideline (2003) indicates that a detailed plan of study for the scoping exercise should be prepared. This plan of study is important in ensuring that where public consultation is required, the relevant parties are identified.

The plan of study for EIA should contain the following:

- Description of the environmental issues identified during scoping that may require further assessment
- Description of feasible alternatives identified during scoping that may be further investigated
- Indication of additional information required to determine the potential impacts of the proposed activity on the environment
- Description of the proposed method of identifying these impacts
- Description of the proposed method of assessing the significance of these impacts

After the approval of the Competent Authority, an EIA is then conducted in accordance with the findings of the scoping exercise. Taking into account the baseline study which includes the social, economic, physical, ecological, socio-cultural, and institutional environment in the project area, an EIA is undertaken which identifies and predicts impacts and evaluates their significance.

¹³ It is important to note that although HSDP IV will include construction of health centres and health posts and hospitals, MDGPF only includes rehabilitation and construction of health centers that do not require that an EIA be prepared.

Consideration of Strategic, Technical and Site Alternatives

The EIA must include the contents listed in Part III of the EIA proclamation and the EIA Procedural Guideline (2003), including the following elements of OP/BP 9.00:

- Consideration of **Project alternatives** including the project site, design and technologies and reasons for preferring the proposed site. Note that the ‘without project’ alternative is also explicitly stated in this guideline.
- Consideration of **Cumulative Impacts** which should be assessed along with overall environmental and social impacts in the EIA.
- Consideration of **Trans-regional impacts**

Impact Mitigation Measures

Part III of the EIA proclamation explicitly states that ‘an environmental impact study report shall contain a description of measures proposed to eliminate, minimize, or mitigate negative impacts.

Monitoring and Reporting

Part IV of the EIA Proclamation states that:

- The Authority or the relevant regional environmental agency shall monitor implementation of an authorized project in order to evaluate compliance with all commitments made by and obligations imposed on the proponent during authorization
- When the proponent fails to implement the authorized project in compliance with commitments entered into or obligations imposed upon him/her, the Authority or the relevant regional environmental agency may order him/her to undertake specified rectification measures
- Any other authorizing or licensing agency shall, in tandem with the Authority's decision to suspend or cancel any authorization to implement a project, suspend or cancel the license it may have issued in favor of the project

Consultation and Disclosure

Part V of the EIA proclamation stipulates that the Authority or the relevant regional environmental agency shall:

- Make any environmental impact study report accessible to the public
- Ensure that comments made by the public and communities likely to be affected by implementation of a project are incorporated into the environmental impact study report as well as in its evaluation

Grievances

There is a procedure for grievance in the EIA proclamation, which states:

- Any person dissatisfied with the authorization or monitoring or any decision of the Authority or the relevant regional environmental agency regarding the project may submit a grievance notice to the head of the Authority or the relevant regional environmental agency
- The decision of the head of the Authority or relevant regional environmental agency shall be issued within 30 days following the receipt of the grievance

Annex 3: Detailed Environment and Social Systems Analysis

Core Principle 1: General Principle of Environmental and Social Management

OP 9.00: Environmental and social management procedures and processes are designed to (a) promote environmental and social sustainability in Program design; (b) avoid, minimize or mitigate against adverse impacts; and (c) promote informed decision-making relating to a program's environmental and social effects.

BP 9.00: Program procedures will:

- Operate within an adequate legal and regulatory framework to guide environmental and social impact assessments at the program level.
- Incorporate recognized elements of environmental and social assessment good practice, including (a) early screening of potential effects; (b) consideration of strategic, technical, and site alternatives (including the "no action" alternative); (c) explicit assessment of potential induced, cumulative, and trans-boundary impacts; (d) identification of measures to mitigate adverse environmental or social impacts that cannot be otherwise avoided or minimized; (e) clear articulation of institutional responsibilities and resources to support implementation of plans; and (f) responsiveness and accountability through stakeholder consultation, timely dissemination of program information, and responsive grievance redress measures.

Applicability

Core Principle 1 is considered within the scope of the MDGPF investments in three areas to deliver a comprehensive package maternal and child health services as envisaged in the program in order to mitigate environmental and social impacts: (i) civil works rehabilitation and construction of health centers, (ii) medical waste management and (iii) pesticide management.

Civil works: During the remaining three years of HSDP IV, the MDGPF window is expected to fund rehabilitation and construction of 106 health centers. As described earlier, each health center has a physical footprint of 1 hectare including the location for the placenta pit and incinerator. At this time, the MDGPF will not finance any other type of civil works. As such, of the three types of health facilities financed by HSDP IV, only the environmental and social effects of rehabilitating, constructing and operating health centers is assessed against Core Principle 1.

Medical waste management: the MDGPF will finance procurement and provision of medical supplies, equipment, pharmaceuticals and other inputs to health posts, health centers and hospitals across the Ethiopian Health System. Hazardous waste is also considered. The main considerations related to medical waste management are storage, distribution, use and disposal of medical waste in the health sector.

Pesticide management: entails storage, distribution, use and disposal of ISRs and LLINs distributed to health facilities across the Ethiopian Health System.

Strengths

With respect to the three areas considered against Core Principle 1, the ESSA confirms that the environmental and social management systems in place to address these areas exhibit a number of strengths and equivalence with the guiding principles of OP/BP 9.00.

Of relevance to Core Principle 1 are the following system strengths:

1. **EIA System:** The EIA system described in Annex 2 provides a comprehensive framework for environmental impact assessment that is well aligned with the main considerations of Core Principle 1. The

EIA directive of 2008 clearly stipulates the types of health care facilities required to prepare full EIAs.¹⁴ And, the EIA procedural guidelines include a number of aspects that correspond well with Core Principle 1, including: early screening, specifying site alternatives including a ‘no action’ alternative for health care facility construction, cumulative and trans-boundary impacts, and identification of mitigation measures as well as a robust grievance mechanism. The ESSA review noted evidence of collaborative efforts between the lead national institutions for environmental management, namely the Federal EPA and MoH on a number of issues of relevant to environmental health, including efforts made towards mainstreaming national EIA requirements in the sector; indeed, EIA mainstreaming work is already jointly planned and budgeted. The details on relevant polices and proclamations are provided in Annex 2.

2. Health Center Construction Standards and Guidelines: The MoH has developed a comprehensive set of standards and engineering designs streamlined for construction of all health centers in Ethiopia. The Physical Facility Standards Manual includes site selection and construction requirements, adherence to the Building Proclamation 624/2009, the Ethiopian Standard Building Code, the Life Safety Code (National Fire Protection Code), the National Electrical Design Code and the Ethiopian Disability Code. The Standards Manual also includes due consideration of building space and elements (windows, doors, toilets, stairwells, room size) and building systems (water supply and plumbing, water quality, waste management systems, electrical systems and the fire protection system). The Standards Manual requires provision at each health center of a safe environment for patients, personnel and the public (ref. Public and Worker Safety Core Principle 3). It presents specific standards of cleanliness and safety to be maintained at all health centers in the toilets, delivery, examination, treatment and procedure rooms and ancillary areas (laundry, administration, storage and janitorial spaces). Due consideration is also given in the Standards Manual to environmental and social requirements related to the health center morgue and green areas. In addition, the Federal MoH, through its Planning and Project Department, prepared and published in 1998 a Civil Works Implementation Checklist (minimum requirements); a Site Selection Criteria (minimum requirements) report; and, a set of Briefs on Rehabilitation, Upgrading, Expansion, Refurbishment and Preventive Maintenance of Health Facilities. These documents are to be used in tandem for all rehabilitation and construction works of health centers alongside the Standards Manual and health center engineering design and standards protocol issued by the Federal MoH.

3. Medical Waste Management: National legislation on medical waste management, including hazardous medical waste, is comprehensive and aligned with the requirements of OP/BP 9.00 and the main considerations of Core Principle 1. The legal framework is complemented by a number of design and construction guidelines for health facilities that incorporate sound medical waste management practices. In some cases, health centers visited as part of the ESSA preparation process were observed to have well-constructed incinerators, placenta pits, boxes for sharp waste disposal and adequate water supply and sanitation facilities. In addition, some facilities had already begun implementation of the **Health Care Waste Management Strategic Action Plan**, establishing a facility level Infection Prevention and Patient Committee (IPPC) to systematically address health care waste management issues.

4. Human Resource Development forms a key component of the successive phases of HSDP. Under HSDP III, for example, the main human resource development objective was to improve staffing and implementation of a transparent and accountable human resource management practice at all levels of the health system. It was envisaged that this would be done by increasing the number and capacity of training institutions, including use of health institutions as training centers, establishing a platform for implementation of the Civil Service Reform Program (CSRP) and introducing incentive packages to retain and motivate healthcare staff (HSDP IV, 2010). Staffing requirements to achieve universal Primary Health Care by the end of HSDP III were also a part of this effort. As part of this approach, the MoH focused attention on training community and mid-level health professionals. In addition, 31,831 HEWs were trained and deployed to implement the HEP at the community

¹⁴ According to this directive, only hospitals are required to undertake full EIAs. As discussed in the previous section, HSDP IV MDGPF will only finance construction of health centers.

level. And, in 2005, an Accelerated Health Officer Training Program was launched, to address the clinical service and public health sector management needs at the woreda level. With respect to the Human Resources for Health (HRH) needs for Comprehensive Emergency Obstetric Care and other emergency surgical services at PHC level, a master's level curriculum on Emergency Surgery was developed and training commenced at five universities. Indeed, by the end of HSDP III, a comparison of planned and achieved professional training targets shows that targets were reached in the case of community level training and training of most mid-level health professionals.

5. Awareness of Regulatory Requirements. FMHACA has the mandate, as per Proclamation 661/2009, to regulate health care facilities. The ESSA confirmed that this work had begun and that the Health and Health-related Services and Products Regulation Core Process has been established in health bureaus, departments and woredas visited during the ESSA preparation process. Field visits also confirmed that one hospital and three health centers reported that regional, zonal or woreda level experts under this Core Process had visited their facilities and briefed them on regulatory requirements, including requirements in relation to healthcare waste management. Moreover, with the intention of improving their performance, experts of the Core Process provided them with checklists and guidelines on how to assess the facility and register improvements. In addition, inspection checklists and guidelines developed by FMHACA had been provided to the regions. The ESSA confirmed that FMHACA is providing regular support to health facilities throughout the country on the requirements of this Core Process, mainly through branch offices.

6. Infection Prevention and Patient Safety (IPPS) Committee. The HCWM Strategic Action Plan stipulates that an IPPS Committee be established at the Regional Health Bureau, Zone Health Department and Woreda Health Office either under the Curative and Rehabilitative or Health Promotion and Disease Prevention Core Processes; with an Environmental Health Officer who will be a member of the committee and coordinate HCWM activities. The existence of an IPPS Committee at different levels of government was confirmed during the ESSA field visit to the Benshangul-Gumuz Region and the Butajira Woreda. Regarding activities implemented, the ESSA confirmed that these Committees actively support health care facilities to implement the HCWM Strategic Action Plan.

7. Performance and Capacity of the Health Extension Program. Health Extension Workers support the community in improving environmental health standards. The performance of the HEP was assessed in relation to reported use of used LLINs and containers of hazardous compounds. In this respect, HEWs interviewed in Benshangul-Gumuz indicated that they are advising communities on the implications of using hazardous materials for domestic purposes and the need to dispose of them at designated facilities. HEWs also confirmed that their supervisors are supporting the process of retrieving hazardous materials.

Gaps in the system as written

As noted in subsection 6.1.2, the current environmental and social management system in place and applied to the health sector in Ethiopia is fairly strong and well aligned with the requirements of OP/BP 9.00 and the main considerations of Core Principle 1. However, the assessment did note that although the MoH has established a standard design and comprehensive set of construction guidelines for health care facilities that address environmental impacts, *the specific guidelines on site selection provide limited guidance on screening sites for healthcare facilities based on the potential environmental impacts and risks*. In addition, *the national system does not address induced impacts* which are part of the main considerations of Core Principle 1.

These two gaps are considered to be minor as they can be easily mitigated through diligent application of an early site screening form. This action is included in the set of proposed actions to be included in the Program Action Plan.

Gaps in the system as applied in practice

Beyond the gaps in the system as written, the ESSA found a number of performance gaps in how the system is applied in practice. In this sub-section, **the critical performance gaps are described to inform design of the PforR operation including preparation of the Program Action Plan that will function to bridge these gaps, and the Program implementation support offered by the Bank.**

Each gap is described in detail in this sub-section.

However, it is important to note upfront that HSDP IV is specifically designed to address many of these gaps through the following actions, some of which are financed through the MDGPF:

- Scale-up urban and pastoralist HEPs and improving the quality of the HEP in rural areas.
- Enhance the quality of healthcare provision.
- Raise commitment of leadership across the healthcare system.
- Focus special attention on offering skilled attendance at delivery, PMTCT and TB case detection rates.
- Improve motivation and retention of health personnel.
- Expand and convert selected health centers into primary hospitals to enable them to provide emergency surgical services with a focus on Comprehensive Emergency Obstetric Care (**note this will not be financed through the MDGPF and as such was not assessed in this exercise**).
- Provide special support to the four regions that need special attention.
- Address gender mainstreaming considerations in the health sector.

Such measures are ongoing as part of HSDIP IV and, as such, no additional actions through the Program Action Plan are deemed necessary in order to fill the associated gaps identified in the ESSA.

With this in mind, the performance gaps observed during the ESSA preparation process are as follows:

1. EIA System: The ESSA identified a number of gaps with respect to how the national EIA system is applied in practice. **Although a full EIA is only required for construction of hospitals, which will not be financed through the MDGPF window, these gaps are listed since they are relevant to considering the institutional capacity gaps pertinent to the PforR operation as a whole.** The gaps listed are considered to be higher order gaps that the Government of Ethiopia might consider taking action to address. However, they most lie beyond the scope of the Program and need to be addressed at a national level as they affect all sectors, including the health sector. **For those gaps that are within the MoH's mandate, appropriate actions are included in the ESSA so as to address the gaps within the scope of the Program.**

- a. The **National Joint Plan of Action** has prioritized and budgeted for both EIA and HIA mainstreaming activities in the sector. However, these activities have not been implemented. This action is listed in the proposed set of actions to be included in the Program Action Plan.
- b. **EIA Delegation to Sectors:** In the context of the Federal EPA's delegation of EIA responsibility to sector institutions (i.e., to ensure implementation and review of EIAs in their sector), the ESSA observed that this delegation exercise has not been successful, for the following reasons: (i) in principle, EIAs should be reviewed by an independent entity and not by the sector responsible for implementing a project, (ii) sector institutions have their own priorities and are not accountable for failures associated with preparation and review of EIAs, given this delegated responsibility, (iii) select ministries do not officially recognize the delegation letter issued by the Federal EPA nor accept the associated responsibilities to prepare

and review EIAs in their sector, (iv) there has been limited guidance provided by the Federal EPA to sector ministries with respect to their delegated responsibilities.

- c. **MoH Capacity to Implement the EIA System:** With respect to application of the EIA system in the health sector, the MoH, as a Federal EPA delegated authority, has the dual role of preparing EIAs in the health sector (for hospitals only, not health centers) as well as reviewing EIA reports. The MoH has given the Pastoralist Health Promotion and Disease Prevention Directorate responsibility to implement the EIA directive in line with Proclamation 295/2002.¹⁵ The Directorate must coordinate the Ministry's efforts in environmental management related to the EIA system as they pertain to the health sector at the national level. In this respect, efforts have been made, through joint initiatives,¹⁶ to strengthen application of the EIA system in the sector. However, this Directorate lacks the required human resource capacity to effectively carry out this task and, as a result, the EIA system is not yet widely applied in the health sector. The ESSA review noted that there is a need to strengthen the capacity of the Directorate to ensure systematic application of the system in the sector, particularly at the woreda and kebele level. **Again, since an EIA is only required for hospitals, this gap is considered a higher order gap for government to address and it is not addressed in the Program Action Plan that focuses on those actions required to fill the gaps related to program performance and systems directly applicable to the PforR operation.**
- d. **EPA Capacity to Review EIAs:** The capacity of the competent authority responsible for EIA review is often weak since the EPA has delegated such responsibilities to sector authorities. The EPA is the regulatory organ accountable to the Prime Minister (according to Article 3(2) of Proclamation 295/2002). The EPA is expected to regulate activities carried out not only by private sector project stakeholders, but also by government. However, the capacity of EPA to regulate the activities of public sector development projects has been limited due to insufficient number of experts. The Federal EPA and the regional environmental authorities are overburdened and cannot review EIA Reports in a manner that is expected of them. The ESSA process noted that the Federal EPA did not have any records of EIAs completed for hospitals financed by the Health Sector Development Program in the last five years. In addition, the ESSA team also consulted the Addis Ababa EPA's EIA Department and their staff confirmed that in the past three years, they had received three EIAs from private clinics for review, but that they had no record of receiving EIAs from the public sector related to health facilities.

Constraints that influence the EPA's ability to carry out this function include:

Resource Allocation: The Federal EPA's budget allocation is limited. For instance, during FY08/09, while the overall budget of the country was 49 billion Birr, only 4 million Birr was allocated to EPA (0.008% of the total budget). As a comparison, during the same fiscal year, the health sector was allocated 2 billion (4% of the total budget) of which 52.8 million was allocated for the prevention and mitigation of environmental risk factors (MoH and EPA, 2010). The EPA has budget constraints to effectively coordinate implementation of the EIA system. This includes environmental audits in the health sector.

Effectiveness of Mechanism: At present, the EPA enforcement mechanism is weak in terms of ensuring that project proponents submit their EIA Reports to the Federal EPA or relevant regional organs. There is also no means of compelling developers to complete the EIA process. Regarding instruments, it is only EIA Proclamation 299/2002 which has been officially

¹⁵ The Environmental Organs Establishment Proclamation (Proclamation No. 295/2002) requires the establishment of Sector Environmental Units.

¹⁶ This specifically refers to the joint EPA-MoH National Joint Plan of Action which among others specifically focuses on the mainstreaming of EIA and HIA within the health sector.

enacted. And, since 2002, only the EIA Directive of 2008 has been issued, but the Directive's status is unclear, particularly with respect to the dictates of the Environmental Protection Organs Establishment Proclamation 295/2002 that requires approval of the Council of Ministers for such documents to be declared official.

Public Participation: According to the EIA Proclamation, the public must participate at two stages: during preparation of the EIA report and during its review process. In general, public consultations, both during preparation and review need to be strengthened. As there are no specific guidelines for public participation, it remains a challenge to determine whether the consultation undertaken has been at the required level.

Incentives: Article 16 of the EIA Proclamation stipulates that incentives should be available to project proponents. However, the provision is unclear as to how these incentives are to be implemented, as there are no directives or guidelines in this regard.

2. Medical Waste Management: The **ESSA identified a number of significant gaps in how the system to manage medical waste, including hazardous waste, is applied in practice**, as follows:

- a. The **Health Care Waste Management Strategic Action Plan 2012-2015** requires establishment of a facility level Infection Prevention and Patient Safety (IPPS) Committee, which is given administrative responsibility for implementation of a HCWM Plan in health care facilities across the country. The IPPS Committee is required to have an environmental health officer as a member. This officer is responsible for implementing HCWM plans at each facility. The ESSA field visits observed that environmental health officers were found on duty in two hospitals and four health center. And, at one hospital and four health centers, IPPS Committees had been established and were led by environmental health officers. It was reported to the ESSA team that the established Committees met regularly¹⁷ to discuss IPPS concerns. **However, since only a limited number of HCFs had IPPS Committees established, additional work needs to be done to implement the HCWM Plan and to systematically track establishment of the IPPS Committees in all health care facilities and to monitor progress with respect to how well the HCWM Plans are applied at the facility level. This significant gap is included as an action to be included in the Program Action Plan.**
- b. **Health Care Waste Segregation and Management.** Point (a) above is important because, while the HCWM plan aims to implement several HCWM practices including HCF level waste segregation, the ESSA team observed that the **existing segregation practice at the facility level was limited**¹⁸. **The established system for health care waste minimization and segregation is not implemented effectively at the local level.** Segregation of waste and pre-treatment of infectious waste are not properly practiced at health centers. Only four out of ten health centers surveyed used incinerators, while others used open burning for final handling of healthcare waste. Biological waste such as placentas were generally disposed and buried in non-watertight disposal pits. Operational guidelines were not found in any of the assessed health centers. Equipment and resources required for environmental regulatory tasks (e.g., vehicles and water quality analytical kits) were not available. And, of the seven health centers visited, only one, the Butajira Health Center, had a well-established waste segregation practice in place¹⁹. This practice has helped to reduce the load on the health center's incinerator, which at the present is only operating a few days a week. In three health facilities, where such

¹⁷ The consultant was provided with samples of minutes of meeting of the IPPS committee at 1 hospital and 3 health centres.

¹⁸ Of the total of 10 health care facilities visited, an established and well functioning waste segregation practice was observed in one.

¹⁹ It was reported to the consultant that the segregation system at Butajira health centre was started with support from USAID. Although this support has now stopped the Health Centre has continued the segregation practice which has brought about multifaceted benefits to the HCF.

segregation practices were not in place, it was observed that the incinerators were overloaded and showing signs of deterioration. In these facilities, it was observed that there was limited knowledge among healthcare workers on waste categorization. Plastic water bottles, paper, and medicine vials were observed in the incinerators during these field visits. **This significant gap is to be addressed through concerted actions already embedded in the design of the HSDP IV program as well as additional immediate actions proposed for inclusion in the Program Action Plan.**

- c. **Disposal of Expired Medicine: ESSA field visits noted that the methods used for disposal of expired medicine was weak.** Prior to 2011, there were no official guidelines, directives or standards focused on disposal of medicine waste. Prior to its re-establishment as FMHACA, the Drug Administration and Control Agency (DACA) provided support for the disposal of expired medicine. This was done through a moderately-high temperature incinerator that the Agency had at its facility. Upon request from suppliers and health care facilities, the Agency availed its incinerator for the disposal of expired medicine. This incinerator was dismantled after 2009 as the role of FMHACA evolved to that of a regulator, rather than that of an agency that assisted in the disposal of such products.

Apart from this, there were also three sites where expired medicine from various sources were disposed of, namely sites around Akaki-Kality and Koshe (the solid waste disposal site for the city of Addis Ababa) and an incinerator at Paulos Hospital. Currently, the Paulos Hospital incinerator and Koshe site are not serving this purpose. In other cities and rural areas, similar disposal sites were used for disposing of expired medicines. **The ESSA team noted that there are expired medicine storage units in healthcare facilities constructed under the first year of HSDP IV for storing and disposing of expired pharmaceuticals.** At the present, health care facilities and suppliers are permitted to dispose of expired medicines directly. The Medicine Waste Directive of 2011 has clear requirements for disposal of such products, including establishment of a committee consisting of a representative of FMHACA, the police, health and pharmacy professionals, environmental experts, Kebele administrator, among others, who are required to be at the site during disposal of expired medicines to ensure that the disposal process is as per the Directive requirements. **However, there is no way of ensuring that disposal of expired medicine is done as per the Directive due to human resource capacity constraints.**

- d. **Management of Pesticides and Associated Waste for Vector Transmitted Disease Control:** The ESSA review noted that **hazardous materials used for vector transmitted disease control were not collected and disposed of properly.** Health Extension Workers interviewed during the ESSA process indicated that they do not have the capacity for collection of hazardous materials and waste. **The HEWs interviewed confirmed that they are not able to support the logistics for transport of these products to the proper facilities which are often situated at a distant location from the HCF.**

3. In relation to the regulatory function of the **Health and Health Related Products and Services Core Process**, the ESSA noted the following gaps:

- a. **Limited availability of equipment and resources required for undertaking tasks.** Resources required to carry out regulatory tasks associated with this Core Process are not readily available. Experts of the core process explained to the ESSA team that they require means of transportation to go to HCFs and other sites for inspection. However, vehicles are not

available²⁰. Similarly some experts pointed out that office furniture and equipment are only partly available²¹. Other essential equipment such as water quality analytical kits are not readily available.

b. *Human resources.* Experts interviewed by the ESSA team across all levels of government indicated that there are human resource capacity limitations for undertaking required regulatory tasks efficiently, particularly in the four regions that need special attention like Benshangul Gumuz, where less than ten experts²² were reported to be available to undertake such tasks. Regulatory requirements under the Food, Medicines, Health Care Administration and Control Proclamation may not be fulfilled according to official guidelines due to these capacity constraints and limited staffing at the local level. In the areas visited by the ESSA team, it was noted that the number of environmental health professionals varied widely across regions. For instance, in the Butajira Woreda, six experts and one support staff were available to undertake activities associated with this Core Process. Conversely, in Benshangul Gumuz, six experts were available at the regional level and only one in the Assosa Zone Health Department.

c. *Training.* Staff training on equipment use and environmental and health inspection and audit techniques are needed as the staff tasked with carrying out these functions lack appropriate skills to carry out the tasks effectively and efficiently.

d. Furthermore, given the identified capacity limitations and mandate for regulating facilities beyond the health care sector²³, at present, the Core Process has focused its activities on private sector health facility rather than public ones²⁴.

4. Shortage of Health Specialists. According to a recent assessment conducted by the MoH in collaboration with WHO and UNICEF (2011) there is an acute shortage of physicians and specialists in the regions. Specifically, there was only one gynecologist in the Afar region, one surgeon and one gynecologist in the Gambella region, and two surgeons, two pediatricians, two gynecologists, one internist, and one ophthalmologist in the Somali region. In connection with human resource development, the ESSA review identified the lack of a human resource motivation and retention strategy, an absence of standardized professional development programs, and a shortage as well as attrition of highly skilled professionals as the main limitations of the health system (HSDP IV, 2010). The ESSA also noted that the Human Resources for Health Strategic Plan and the MoH recognize that health professionals are generally unmotivated to serve in the public sector. They are also not keen to move to underserved rural areas and operate in public health institutions in such areas.

5. Performance and Capacity at the Health Care Facility Level. The ESSA team observed that in line with the standard design requirements of the Health Infrastructure Directorate (HID), all hospitals and most health centers visited had incinerators, placenta pits, burial pits and boxes for collecting sharp wastes in place at the time of the field visit. An exception observed was the Assosa Health Center²⁵ which did not have an incinerator

²⁰ In Butajira *woreda* for instance, a motorcycle used for inspection purposes was not working at the time of visit. Similarly at the Benshangul Gumuz Regional Health Bureau, experts use the vehicles of other departments (which are not readily available) for inspection purposes.

²¹ This was reported both by the Assosa Zone Health Department and the Butajira *woreda* Health Office, which was also in line with observations of the consultant.

²² This information was provided to the consultant by experts of the Health and Health Related Core Process within the Benshangul Regional Bureau who indicated that six experts are available for this task at the regional level and three at each of the three zones in Benshangul Gumuz, bringing the total number to nine experts.

²³ Please note that the health and health related services and products Core Process has also the mandate of regulating food and beverage establishments and other health related facilities such as drug stores and pharmacies.

²⁴ This information was provided by both the Butajira health office and Benshangul-Gumuz Regional Health Bureau.

²⁵ According to the Acting Head of the Assosa Health Centre, the facility was constructed around 50 years ago and hence did not incorporate the design standards of the Public Health Infrastructure Directorate

as per the standard design set by HID²⁶. All hospitals and health centers visited also had water supply systems and septic tanks in place. However, at some health centers in rural settings²⁷, this system was not in use as water was supplied from shallow wells in the vicinity. In the HCFs visited during the ESSA preparation process, potable water supply was provided after construction of the facilities. In two health facilities visited, shallow groundwater wells that serve the facilities were constructed in close proximity to the Health Centers' waste disposal sites where hazardous waste is disposed. At these facilities, given the proximity and landscape, it was observed that there may be risks of contamination of the shallow groundwater wells. In this regard, although the mandate of availing HCFs with potable water supply lies with the water sector, the aforementioned cases are good indications that it is often the case that such water supply is not provided to HCFs as required.

Opportunities

This sub-section describes the opportunities available to the GoE to improve the performance capacity of the institutions involved in implementing activities financed through the MDGPF window. **The set of proposed opportunities are based on both the strengths of the existing system and the gaps identified through the ESSA SWOT process.** The opportunities are presented as they pertain to actions proposed for inclusion in the Program Action Plan and actions that the Bank can provide through its implementation support to the GoE.

1. Health Facility Readiness Monitoring HSDP IV will receive technical support from the Bank through the PforR operation to refine the **Balanced Score Cards** to objectively assess performance of health facilities and design a system that provides institutional incentives linked to performance. In addition, technical support will also be provided to design and implement **Annual Rapid Facility Assessments** to determine facility readiness to offer key maternal and child health services. The Health Results Innovation Trust Fund will be used to finance such support. Such support will be complemented by capacity building inputs from PBS III which focuses on enhancing fiduciary systems and governance at the sub-national level. Further, the PBS III will also be supporting comprehensive facility surveys which will provide benchmarking for the rapid annual facility assessments. **Such actions are embedded in the Program design and, as such, do not require additional actions through the Program Action Plan.**

2. Health Extension Worker Training and Capacity Building: With the aim of improving service delivery, the government introduced the **Business Process Reengineering** (BPR) process that thoroughly analyzed the HRH situation in the country. Based on the results, the Human Resources for Health Strategic Plan (2009-2020) was developed. The HRH Strategic Plan sets out details on the HRH planning, management, education, training and skill development, legal framework and financing mechanisms. In regards to human resources, the Strategic Plan identifies two main challenges: uneven distribution of health staff in the country with significant deficits in rural areas and underserved regions; and high attrition of physicians from public health institutions. **The Program Action Plan includes a specific action to implement the Strategic Plan immediately post effectiveness to address the associated gaps as detailed in the ESSA.**

3. Healthcare Worker Retention and Incentive Packages: As a result of the HRH scoping exercise, and in consultation with Regional Health Bureaus, the MoH has been conducting a review of the merits and barriers of introducing different incentive packages aimed at motivating health professionals to be deployed in rural and disadvantaged areas of the country. MoH is also considering various financial and non-financial incentive schemes that some regional states have put in place. For example, the incentive scheme implemented by the Health Bureau of Southern Nationalities, Nationalities and Peoples Region (SNNPR), observed during the ESSA field visit, may serve as an example worthy of replication. The hospitals in the Region are classified as category A, B and C. The hospitals classified under Category A are those serving most remote rural and pastoral groups. Hospitals under Category B are the ones serving the rural populations. And the hospitals that come

²⁶ Note that Health Infrastructure Directorate has a stringent design requirement for health centres which in general provide basic health care services, but are required to have well constructed brick incinerators which were similar to those observed in hospitals

²⁷ Namely at the Abrahamo Health Centre in Benshangul Gumuz and the Hamus Gebeya Health Centre in Butajira *Woreda*.

under category C are those operating in the urban areas.

In order to encourage and motivate health professionals to serve the most underserved population groups, the Regional Government pays salary top-ups to medical practitioners working in health facilities classified under categories A and B. By way of incentive, the Regional Health Bureau pays physicians and specialists up to 5,000 Birr per month as salary top-ups. Similarly, physicians and specialists working in category B health facilities are paid up to 3,000 Birr per month. No such top-ups are paid to those working in category C facilities. In addition, doctors working in the A category are offered better privileges in the form of early release and sponsorship for further studies, as compared to those in the B category. By contrast, those working in category C health facilities are required to serve for a period of full four years before they can obtain release or sponsorship. Similarly, the Regional Health Bureaus have adopted certain incentive measures as a means of motivating health professionals. These include payment of salary top-ups to medical doctors up to Birr 2,000, and releasing physicians after two years of service to pursue further education. In order to address the issue and as indicated in the HRH Strategic Plan, MoH is expected to develop a strategic financial and non-financial incentive package. **However, the twelve-year HRH Strategic Plan, produced in 2009, has yet to be approved or launched. Hence, issues related to professional staff motivation and retention remain unaddressed requiring due attention with a view to promoting fast human resource development and deployment in the health sector. Again, one of the proposed ESSA related actions in the Program Action Plan speak to ensuring implementation of the HRH Strategic Plan to also fill this significant gap.**

4. Medical Waste Management: One area where such support could be immediately beneficial is through the joint MoH-EPA initiative on health and environment linkages. The **National Joint Plan of Action has clearly identified the mainstreaming of EIA and HIA as one of its core areas of intervention.** To this end, Table 9 highlights the activities to be undertaken, the budget earmarked for these activities and the institutional responsibility for its implementation. Since this Action Plan has already been approved and the specific actions budgeted, it would be fairly straightforward to implement it in an effort to strengthen the capacity of the Pastoralist Health Promotion and Disease Prevention Directorate to carry out its functions with respect to medical waste management at the local health facility level. **This action is included in the Program Action Plan.**

Table 9: Proposed Activities of the MoH-EPA National Joint Plan of Action

Specific objective	Joint Action	Budget (USD)	Responsible Body
Improve capacity of EPA to review and approve EIA and strategic environmental assessment (SEA)	Gap identification and supporting accordingly Strengthen and enhance the unit with multidisciplinary professionals dedicated to review EIA and monitor the environmental management plans	74,610	MoH, FEPA
Strengthen and incorporate HIA within the EIA	<ul style="list-style-type: none"> Establish technical committee to review the EIA process in order to streamline HIA Develop protocol for joint environmental and health impact assessment Organize consultative workshops with the Regional EPA and Health Bureaus with regards to the joint environmental & health impact assessment protocol 	71,580	MoH, FEPA
Promote HIA and EIA mainstreaming and enforcement of regulatory laws	<ul style="list-style-type: none"> Asses and amend EIA proclamation accordingly Draft and propose regulation and directives on mainstreaming of HIA in EIA and enforcement mechanism. Convene familiarizing workshop of the new regulations and directives with the stake holders 	189,455	MoH, FEPA

Specific objective	Joint Action	Budget (USD)	Responsible Body
Build capacity of lead institutions to conduct regular post EIA monitoring & auditing	<ul style="list-style-type: none"> Review the functional state of post EIA monitoring & auditing and identify the gaps Assess the capacity needs of lead agencies to undertake comprehensive post-EIA monitoring Build human capacity of the lead institutions to undertake post EIA monitoring & auditing. 	35,000	MoH, FEPA

5. Hazardous Waste Disposal: Availing temporary storage facilities in locations near health facilities is an important measure government can implement immediately for collection of hazardous waste. This measure along with concerted efforts to mobilize communities and provide incentives for systematic collection and disposal of hazardous materials will help address the gaps identified by the ESSA. **Both actions are detailed in the Program Action Plan as they pertain to proper storage and disposal of expired pharmaceuticals and materials used to prevent vector-borne diseases**

6. EIA Screening and Induced Impacts: Although the mandates for availing land for HCF construction are under the Ministry of Urban Development and Construction²⁸, there is still a need for the health sector to develop a technical guideline for environmental screening during the selection of sites which provides for consideration of different alternatives taking the environmental impacts into account²⁹. Such a guideline will support development of mitigation measures including induced impacts identified during the screening process. **This action is included in the Program Action Plan.**

Risks

The risk of not addressing the written and applied gaps and capitalizing on the opportunities in a timely fashion would be that the approach taken towards addressing these impacts will not be consistent with the guidance under OP/BP 9.00. The risks are rated as minor to moderate with a few deemed to represent significant environmental and social risk in terms of increasing environmental pollution and health related problems. Gaps that lie within the scope of the MDGPF window are addressed either through elements already embedded in the HSDP IV Program design or the proposed actions derived from the ESSA analysis for inclusion in the Program Action Plan. Of particular note are the EIA system related gaps that are considered to be higher order gaps and beyond the scope of the Program. These should be brought to the attention of government for action.

Core Principle 2: Natural Habitats and Physical Cultural Resources

<p><i>OP 9.00:</i> Environmental and social management procedures and processes are designed to avoid, minimize and mitigate against adverse effects on natural habitats and physical cultural resources resulting from program.</p>
<p><i>BP 9.00:</i> As relevant, the program to be supported: Includes appropriate measures for early identification and screening of potentially important biodiversity and cultural resource areas. Supports and promotes the conservation, maintenance, and rehabilitation of natural habitats; avoids the significant conversion or degradation of critical natural habitats, and if avoiding the significant conversion of natural habitats is not technically feasible, includes measures to mitigate or offset impacts or program activities. Takes into account potential adverse effects on physical cultural property and, as warranted, provides adequate measures to avoid, minimize, or mitigate such effects.</p>

²⁸Specifically under the *woreda* or *kebele* administration for rural sites and the City Administration for urban sites.

²⁹ It is the observation of the consultant that the health sector participates and provides inputs during the selection of sites for HCF construction. However, this is not based on specific screening criteria as stipulated in the EIA Procedural Guideline (2003) which requires this to be undertaken taking into account environmental considerations.

Applicability

The provisions in Core Principle 2 are considered in relation to the how the existing environmental and social impact and risk mitigation and management systems function in the health sector. **The analysis confirmed that the set of MDGPF investments may generate limited adverse impacts and risks on natural habitats**, as it is not expected that construction of the health centers will convert critical natural habitats due to the screening procedures in place to mitigate this type of risk. **With respect to impact on physical cultural resources, MDGPF investments are unlikely to adversely affect physical cultural resources.** However, since construction of health centers and medical waste disposal may pose a limited risk to natural habitats and physical cultural resources, this Core Principle has limited applicability to the Program. **As such, both risks are deemed to be minor to moderate and straightforward to mitigate as described herein.**

Strengths

With respect to system strengths applicable to the main considerations of Core Principle 2, the ESSA process identified that the EIA Proclamation and the EIA procedural guideline are consistent with Core Principle 2. Specific areas where the national environmental management system addresses this Core Principle are: (i) EIA proclamation is clear in the objectives of an EIA to protect the environment (natural systems); and, (ii) Project screening criteria accounts for the sensitivity of the area in screening for projects in national parks and areas containing endangered flora and fauna.

At this time, the ESSA analysis could not access complete information on the system's overall approach to handling physical cultural resources in Ethiopia. As such, both strengths and gaps with respect to the systems application to handling known physical cultural resources and chance finds procedures cannot be fully analyzed in the context of Core Principle 2.

Gaps in the system as written

Although the ESSA review was able to glean some data with respect to the main considerations of Core Principle 2, at this time, the data made available are extremely limited. In order to fully assess the national systems with respect to the environmental and social management systems in place to address the effects of public civil works on natural habitats and physical cultural resources, additional research, including field site visits, is required to fully inform the ESSA analysis with respect to Core Principle 2.

Gaps in the system as applied in practice

As a proxy for how the system has been applied in practice with respect to addressing considerations related to Physical Cultural Resources, the ESSA reviewed the track record of the Bank-financed Productive Safety Net Program (PSNP). Use of the Program's Environmental and Social Management Framework (ESMF) was used to document performance related to Physical Cultural Resources. Recent findings from an August 2012 assessment include the following:

The PSNP's Environmental and Social Management Framework is used to screen community level sub-projects. The ESMF incorporates: (i) a checklist as to whether or not a subproject has the potential for disturbing a cultural or religious site. If the rating is marked 'high' and there are no other 'high' ratings, suitable mitigating measures are adopted, which must include reaching agreement with concerned stakeholders. If this is not possible, or if there are other 'high' assessments for the same sub-project, it is marked as "of Environmental Concern". If, the sub-project is marked as "of Environmental Concern", the woreda specialists decide whether an EIA is required; and, (ii) each subproject is screened as to whether it is located within a recognized Cultural Heritage or World Heritage site.

Table 10 presents the screening rates for PSNP public works (PW) subprojects between 2006 and 2012.

Table 10: PSNP Subproject PCR Screening Rates, 2006-2012

Year	Data Collection Method	Subproject Screening Rate
2006	Review sample	
2007	Review sample	
2008	Review sample	
2009	Review sample	34%-70% (34% for subprojects screened individually; If subprojects screened in groups (within village) are included, rate is approx. 70%)
2011	Review sample	98% (with some quality concerns) and no screening in pastoral regions
January 2012	Actual total figures provided by regional PWFUs in workshop	96% (46,001 subprojects planned for 2012 reportedly screened, out of a total of 47,902, excl. pastoral regions)

Frequency of Encountering Physical Cultural Resources: During standard public works operations, if archaeological physical cultural resources are encountered during excavations, construction is halted and relevant authorities notified. In January 2012, the PSNP Public Works Focal Units in four highland regions (Amhara, Oromiya, Southern nations and Tigray) reported that there had been no instances of PCR chance-finds encountered. This is not surprising, since Program activities do not typically involve excavation; rather they are mainly soil and water conservation activities and rehabilitation of health posts. In addition, Program activities are not permitted to involve land-use changes.

As such, the data available for the ESSA review with respect to PCRs is extremely limited at this time. The track record reviewed through the PSNP Public Works component is one experience that the ESSA draws on to inform this analysis. Since available data are limited at this juncture in the ESSA process, it is recommended that the ongoing stakeholder consultations make explicit this aspect of Core Principle 2 so as to gather additional data on the track record with regards to how well consideration of physical cultural resources have been applied in practice in the health sector and, in particular, with respect to construction of health centers.

Furthermore, no data were available for the ESSA review as to whether natural habitats had been adversely affected due to construction of HCFs or improper medical waste management practices in HCFs over the course of the first three phases of HSDP.

The track record could not be examined due to lack of data. As such, as is the case of completing the assessment of the systems in place and performance to date with respect to managing health sector impacts on physical cultural resources, the same holds true in terms of completing the analysis with respect to managing impacts on natural habitats. Only with additional data and field work will the ESSA analysis be completed.

Opportunities

At this time, the opportunities identified under Core Principle 1 may be considered, in general, applicable to addressing the overarching concerns with respect to potential adverse impacts on natural habitats.

With respect to the main considerations of Core Principle 2 with respect to Physical Cultural Resources, the data made available for the ESSA analysis are incomplete. Only with additional data on the system established to address PCRs in Ethiopia and with respect to civil works similar to those carried out in the health sector can the system strengths and gaps be properly assessed. Furthermore, only through additional field visits and through the Program consultation process can information on how well that system has been applied in practice

can a determination be made as to what gaps in the system as applied may need to be addressed in the Program design, Program Action Plan or Bank implementation support.

However, in the interim, in light of these data gaps, the ESSA analysis has considered the relative likelihood of adverse impacts on natural habitats and chance finds in terms of the planned construction of the 106 health centers. Based on the assessment presented under CP1, and given the small physical footprint of each health center, it is expected that through diligent application of the early site screening form, that the MoH and regional and local teams siting each health center can incorporate elements into the screening exercise that attend to the central consideration to avoid any and all adverse impact on natural habitats as well as to identify sites where known physical cultural resources exist. In addition, chance finds procedures can be included in all general civil works contracts for each of the health centers. With these two straightforward actions, any potential risks associated with the construction of the planned health centers can be mitigated.

The additional risk of environmental pollution due to improper waste management can be mitigated through the actions described under CP1. The actions proposed should incorporate measures to ensure medical and hazardous waste (including expired pharmaceuticals and vector-borne disease prevention materials) are disposed of properly and do not affect natural habitats or known physical cultural resources.

Risks

The risks are as described above. The known risks are rated as minor to moderate as diligent site screening and civil works siting will function to eliminate most of the risks associated with CP2. Further risks, in particular those related to chance finds procedures will be assessed and presented once the ESSA team has access to additional data and has subsequently completed a more thorough analysis with respect to Core Principle 2.

Core Principle 3: Public and Worker Safety

OP 9.00: Environmental and social management procedures and processes are designed to protect public and worker safety against the potential risks associated with (a) construction and/or operations of facilities or other operational practices developed or promoted under the program; (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

BP 9.00:

- Promotes community, individual, and worker safety through the safe design, construction, operation, and maintenance of physical infrastructure, or in carrying out activities that may be dependent on such infrastructure with safety measures, inspections, or remedial works incorporated as needed.
- Promotes use of recognized good practice in the production, management, storage, transport, and disposal of hazardous materials generated through program construction or operations; and promotes use of integrated pest management practices to manage or reduce pests or disease vectors; and provides training for workers involved in the production, procurement, storage, transport, use, and disposal of hazardous chemicals in accordance with international guidelines and conventions.
- Includes measures to avoid, minimize, or mitigate community, individual, and worker risks when program activities are located within areas prone to natural hazards such as floods, hurricanes, earthquakes, or other severe weather or climate events.

Applicability

The applicability of Core Principle 3 to the set of MDGPF financed activities is assessed with a particular focus on how the existing systems protect citizens from risks associated with construction and operation of health centers, exposure to toxic, hazardous or dangerous materials and waste as well as pesticide management and rehabilitation and construction of health centers and construction in locations prone to natural hazards. In all

such respects, the Core Principle can be considered applicable to the proposed PforR operation in an overarching manner.

Strengths

Preliminary review of the limited data available for the ESSA analysis identified the existence of the following set of Proclamations and guidelines as system strengths:

- Environmental Pollution Control Proclamation 300/2002
- Labour Proclamation 377/2003
- Occupational Health and Safety Guideline (2003)
- Food, Medicine and Health Care Administration and Control Proclamation 661/2009
- Labour and Social Affairs requirements that employers maintain an accident register, ensure that employees are not at risk and provide all workers with the required protective equipment. Such measures were confirmed during the ESSA field visits when Confirmed Health and Health-Related Products and Services Core Process experts presented inspection checklists which contained clear assessment points on personal protective equipment and occupational health and safety.
- Establishment and operation of the Public Health Emergency Management Agency (PHEM) under MoH which is responsible for addressing public health issues during emergencies – including natural hazards such as droughts.

Gaps in the system as written

The ESSA identified the following gaps in the system as written when considered against the main elements of Core Principle 3:

1. The EIA system does not comprehensively encompass aspects of public and worker safety.
2. It is not evident that the site selection criteria and guidelines issued by the MoH for HCF incorporates PHEM guidance with respect to avoiding siting HCFs near or in hazard prone areas.

Gaps in the system as applied in practice

The data available for the ESSA review with respect to the main considerations of Core Principle 3 were limited. At this time, additional information is needed to fully ascertain the nature of the gaps in the system as applied in practice, specifically with respect to the extent to which the Labor and Social Affairs sector is monitoring fulfillment of its **occupational health and safety requirements in HCFs** across the country.

The preliminary ESSA analysis with respect to this Core Principle identified the need for robust data on the activities of PHEM in addressing public health issues during natural hazards beyond siting and construction of HCFs. The PHEM guidebook is comprehensive, but how it's applied in practice has not been ascertained at this time. As such the ESSA analysis on this aspect remains preliminary.

Preliminary information available for the ESSA indicates that **public and worker safety** is not adequately addressed during the construction of HCFs. In addition, post construction and during operation of health centers, public and health worker safety is not adequately addressed. In one study, nine out seventy healthcare workers had needle injuries during a 12 month period. Additional data are required to quantify and qualify such findings as well as fully assess the extent to which construction and operational phase of HCFs throughout the country follow published guidelines and formal legislation on occupational health and safety. **The ESSA analysis will continue to gather data in this area and the gaps in the system as applied in practice will be updated accordingly along with any required refinements to the Program Action Plan.**

The ESSA analysis confirmed that at present there is no **inventory on the amount of pharmaceutical waste** in Ethiopia. To date, data have not been collected on the volume of expired medicines from facilities and suppliers retained or shipped to a specific storage facility. Hence, **expired medicine is, in general, found on the premises of health care facilities and suppliers of pharmaceutical products. This poses a moderate to high risk to the public should expired medicine be distributed to patients at public healthcare facilities. Though, again, due to lack of data, the ESSA analysis on this aspect of how well the system is applied in practice could not be completed. As these data are acquired, the ESSA analysis will be completed and documented here.**

Opportunities

At this time, one important opportunity available to the MoH to address the gaps identified is to ensure public and worker safety measures are incorporated as part of civil works contracts for construction of health centers. This aspect lies within the mandate of the Health Infrastructure Directorate of MoH and can be easily implemented. This opportunity is listed as an action in the Program Action Plan.

Risks

The risks associated with Core Principle 3 will be fully assessed and documented once the ESSA analysis on this Core Principle has been completed.

Core Principle 4: Land Acquisition

<i>OP 9.00:</i> Land acquisition and loss of access to natural resources are managed in a way that avoids or minimizes displacement, and affected people are assisted in improving, or at least restoring, their livelihoods and living standards.
<i>BP 9.00:</i> As relevant, the program to be supported: <ul style="list-style-type: none">▪ Avoids or minimizes land acquisition and related adverse impacts;▪ Identifies and addresses economic and social impacts caused by land acquisition or loss of access to natural resources, including those affecting people who may lack full legal rights to assets or resources they use or occupy;▪ Provides compensation sufficient to purchase replacement assets of equivalent value and to meet any necessary transitional expenses, paid prior to taking of land or restricting access;▪ Provides supplemental livelihood improvement or restoration measures if taking of land causes loss of income-generating opportunity (e.g., loss of crop production or employment); and▪ Restores or replaces public infrastructure and community services that may be adversely affected.

Applicability

Core Principle 4 is considered in light of the fact that the MDGPF will finance rehabilitation and construction of 106 health centers. Given the scale of each health center and the size of land required for each center, such construction poses a relatively minor risk of land acquisition and displacement and/or potential for loss of access to natural resources.

Rehabilitation works at existing health centers, medical waste management on site and disposal offsite and pesticide management are unlikely to require land acquisition or loss of access to natural resources and any environmental pollution that results from these activities are adequately addressed under Core Principle 1. As such, the main considerations related to Core Principle 4 are with respect to land acquisition and loss of access to resources caused by construction of health centers in urban, rural, pastoral and agro-pastoral areas of the country.

The risk for land acquisition and loss of access to resources is likely to be higher in urban areas where population density is high and in agrarian areas where land scarcity is an issue. The relative risk of land acquisition and loss of access to resources is likely to be low in pastoral and agro pastoral areas where land is relatively abundant and population density is also low.

It is important to note that the vast majority of the civil works construction (health posts, health centers, and hospitals) was carried out during earlier phases of HSDP. And, the focus of the fourth phase of the Health Service Delivery Program is on improving service delivery, institutional capacity building and performance management measures rather than civil works construction.

In fact, HSDP IV introduces a shift from health infrastructure construction, as follows:

- Expansion and conversion of selected health centers to become primary hospitals, enabling them to provide emergency surgical services including Comprehensive Emergency Obstetric Care (note this expansion will not be financed through the MDGPF window)
- Preventive maintenance and rehabilitation of existing health facilities including health posts, health centers and hospitals (note MDGPF will only support rehabilitation of health centers);
- Completing construction of 16 blood banks, thereby meeting facility needs and contributing to achieving MDG 5 for availability of adequate and safe blood supply (this activity will not be financed by MDGPF);
- Prioritizing construction of logistic hubs to ensure effective storage and distribution of pharmaceuticals (this activity will not be financed by MDGPF).

Strengths

As presented in Section 5, pertinent legal frameworks have been enacted including laws for land acquisition, resettlement and compensation. The federal government and most regional states, with the exception of Afar, Somali and Beneshangul, have established laws and guidelines that clearly stipulate the process of land acquisition and compensation. These laws identify the roles and responsibilities of the implementing agencies, the regional authorities and the local administrative bodies with respect to land acquisition, resettlement and compensation processes and requirements.

Land laws in Ethiopia do not give direct land ownership rights to citizens. With the issuance of Proclamations 31/1975 and 47/1975, ownership of land is vested in the State and Ethiopian citizens have usufruct rights over land.

Article 40 (3) of the Constitution recognizes land as a common property of the Nations, Nationalities and Peoples of Ethiopia, and prohibits sale or any other form of exchange of land. Article 40 (5) stipulates ‘Ethiopian pastoralist have a right to free land for grazing and cultivation as well as a right not to be displaced from their own lands’. Articles 40(4) and 40(5) of the Constitution provide for free land without payment for farmers and pastoralists. Furthermore, Proclamation 89/1997 confirms the constitutional principle that holding rights on land can be assigned to peasants and nomads, and that these are to be secured from eviction and displacement. In connection with land acquisition and property rights, Constitution Article 40(8) empowers government to expropriate private property for public purposes subject to payment in advance of compensation commensurate to the value of the property.

As presented in Section 5, the power to expropriate landholdings belongs to a woreda (rural local government) or urban administration for a development project (Proclamation 455/2005, Article 3). The implementing agency is required to provide written notification, with details of timing and compensation, which cannot be less than 90 days from expropriation (Proclamation 455/2004, Article 4). Land valuations are done at the woreda and urban administration levels. These local government units establish valuation committees to value private property (Proclamation 455/2005). The landholder is entitled compensation for property on the basis of

replacement value. Permanent improvements to the land, equal to the value of capital and labor expended (Proclamation 455/2005, Article 7) are specified as a valid basis for determining replacement value. It is also required that the cost of removal, transportation and construction be paid as compensation for a relocated property. Compensation will also be based on current cost, cost of demolishing, lifting, and reinstalling. The valuation formula is provided by Proclamation 455/2005, Article 7.

In addition to compensation, according to Proclamation 455/2005, Article 7, displacement compensation shall be paid equivalent to ten times the average annual income s/he secured during the five years preceding expropriation of the land (Proclamation 455/2005, Article 8(3)). Compensation will be in an amount sufficient to reinstate displaced citizens to their economic position prior to displacement. The relevant regional administration is required to give another piece of land to any citizen who has lost her or his land in favor of a public project (Proclamation 455/2005). Those with informal or undocumented rights, and those without titles or use right (e.g. squatters, encroachers) are eligible for specific assistance. Such assistance recognizes “typical claim to use rights or even ownership” after occupation of unused or unprotected lands has been established. Informal usufruct rights are likely to have structures or land improvements eligible for compensation, as stated in Proclamation 455/2005. Such principles are well aligned with the guidelines of OP/BP 9.00 and Core Principle 4, in terms of ensuring compensation is sufficient to replace assets and meet transitional expenses.

In connection with dispute resolution and grievance mechanisms, if misunderstandings and disputes arise between the principal parties involved in the resettlement and compensation processes, the preferred means of settling disputes is through arbitration (Proclamation 455/2005). The number and composition of the arbitration tribunal may be determined by the concerned parties. A complaint related to the amount of compensation shall be submitted to the regular court having jurisdiction (Proclamation 455/2005 Article 11(1)) if the administrative body for handling disputes has not yet been established. Appeals for dispute resolution may be referred to the High Court (Regulation 51/2007). Similarly, if the land holder is not satisfied with the decision of the compensation grievance review committee, the case may be referred to the High Court (Regulation 51/2007).

As such, a robust system has been established to address the land acquisition, resettlement and compensation issues associated with the health sector, including the relatively limited subset of interventions to be financed by the HSDP IV through the MDGPF window. **The system as written is aligned with the main elements of Core Principle 4, although certain specific gaps in the system as written remain. These gaps are presented below.**

Gaps in the system as written

Core Principle 4 of OP/BP 9.00 requires that land acquisition and loss of access to resources are managed in a way that avoids or minimizes resettlement and that affected citizens are assisted in improving or at least restoring their livelihood and living standards. In this regard, gaps important to consider in light of the types of investments financed by the MDGPF, in particular, construction of 106 new health centers, are as detailed here:

Region-specific laws and guidelines are lacking in pastoral and agro pastoral regions: One of the gaps in the system as written is the absence of region-specific land use and administration laws in the pastoral and agro pastoral regions that account for the specific conditions regarding land use in these regions. In the absence of such region-specific laws and directives, the national framework guides land acquisition in these regions. This is important, because when it comes to the four regions that need special attention, the majority of the citizens are pastoralists, agro-pastoralists and shifting cultivators. And, unlike in agrarian communities, the livelihood strategies of these citizens are such that they are based on a communal land use system rather than individual ownership. **As practiced in agricultural societies around the country, land registration and certification has not been carried out in these regions. As a result, the land required for the construction of health facilities is obtained from commonly held land. When land is sought for the construction of health centers, it is acquired with involvement of the community through identification of a suitable plot in**

consultation with the concerned local government administration. However, this process is not well documented. This gap is considered to represent a moderate risk, but one that can be easily mitigated through diligent documentation of the open and transparent community consultation process carried out with respect to selecting a site on communal land for construction of one of the new health centers. This action is included in the Program Action Plan.

Avoiding or minimizing land acquisition: Land acquisition, according to the aforementioned proclamations listed in Section 5, occurs when it is necessary for public purposes and ensures improvement in the use of the land for the benefit of the population. However, **there is no explicit statement in the law to indicate government intentions to minimize land acquisition.** Some regional proclamations and directives specify conditions whereby land is to be acquired with the aim of minimizing the need or practice of land acquisition overall. The conditions include the need to prove that there are no alternative and better sites for the intended purpose. And, the land holder has the right to appeal against the land acquisition. **Such conditions are lacking from the national system that frames the overarching land acquisition process in Ethiopia and are a significant gap with respect to the main considerations of Core Principle 4. But, in this instance, can be mitigated in a fairly straightforward manner by siting the 106 health centers on plots that would not require land acquisition or resettlement.**

Eligibility: The legal framework recognizes only legal titles and some quasi-legal titles (such as customary right over land and communal land) as well tenants in government housing in urban areas. The law does not cater for citizens with no legal rights to use of the land. These citizens are therefore ineligible for formal compensation by law. Rather, they receive “special assistance” as described above in subsection 6.4.2. The law presumes there is no tenant in rural areas as absentee landlordism was abolished in 1975. Tenancy for residence has no link with ownership; hence is not provided for in the Proclamation whose main thrust is expropriation of land and compensation for property. **This gap is particularly important to consider in light of the fact that construction of health centers may result in such citizens being resettled and/or losing access to resources due to reallocation of a specific land plot for construction of a new health center.**

Valuation and Compensation: Valuation of assets is done by a committee of experts assigned by the Woreda and Kebele Administrations. It is only in cases where there are capacity limitations that independent valuation is required. Eligibility is limited to legal land holders. Regional directives assign responsibility of valuation to the Environmental Protection, Land Administration and Use Authority (EPLAU) and do not have provisions for independent valuation. **Compensation is commensurate with loss of assets however replacement cost does not consider location value.**

Restoration of Livelihood: The legal framework allows for some form of support to displaced citizens but it does not explicitly state that livelihoods should be restored to previous levels or improved. In addition to compensation for loss of moveable and immovable property and permanent development on land, displacement compensation is provided for permanent or temporary loss of land to compensate for loss of income from land. Similarly, displacement compensation is paid to urban dwellers equivalent to annual rent or is provided through a housing assignment for one year. **There are no specific provisions in the Proclamation for transitional assistance except for a general statement in the Proclamation 455/2005 for woreda and city administration to provide rehabilitation support to the extent possible.** The proclamations on land acquisition are limited to providing adequate compensation for property lost and have no provision for livelihood restoration.

Timing of Expropriation: Proclamation 455/2005 allows land to be expropriated and does not state the need for adequate preparation of relocation sites before expropriation. Forceful eviction is possible after the expiry of the notice period which is 90 days after payment or offer to payment of compensation. **This gap is significant and contrary to the guidance under Core Principle 4 and needs to be addressed.**

Gaps in the system as applied in practice

World Bank supported projects, including the Urban Local Government Development Project (ULGDP, urban), Provision of Basic Services (PBS, rural mainly agrarian) and the Pastoral Community Development Project (PCDP, pastoral) were assessed as part of the ESSA preparation process to ascertain how well the system addresses land acquisition issues in practice.

The ULGDP Community Investment Projects include works in the areas of roads, drainage, solid waste management, market development, slaughter house construction and construction of public toilets. The screening of subprojects takes place at identification and categorization of subprojects is approved by the regional environmental authority. All projects that require land acquisition are screened and an Abbreviated Resettlement Action Plan (ARAP) or Resettlement Action Plan (RAP) is prepared.

From the data reviewed, it is noted that cities tend to have established guidelines and systems for valuation and compensation. Cities also conduct initial screening to determine the extent of land acquisition and its impact on citizens. However, **the quality of the screening varies across cities mainly due to capacity constraints. Specifically, due to budget constraints, and the fact that valuations are not done by independent valuers, the impact of projects on land and private assets tends to be underestimated in terms of valuation and compensation payments delayed.** Compensation for lost assets is based on replacement cost. However, such replacement costs are based on costs that are not independently assessed or determined and these may not reflect current market prices. **The ESSA review found that, partly as a result of this, grievances over compensation amounts are common.**

With respect to land registration and certification processes, the data reviewed confirm that this is an ongoing process in most regions but has not begun in others. This fact makes verification of property challenging. **Consultation with Project Affected Peoples (PAPs) is not conducted systematically and grievance handling mechanisms are often inadequate and delayed.**

The Local Investment Grant (LIG) component of PBS was used for infrastructure development in the health sector. Typical projects implemented through LIG were water and sanitation, primary health, primary and secondary education, rural roads, rural infrastructure and municipal services (construction of city roads, sewage and drainage, parks and recreations areas, waste disposal facilities, prevention and control of pollution). LIG was implemented in cities and in rural areas. **The ESSA review found that in many cases, construction of health posts occurred within the legal boundary of compounds of existing facilities and did not involve land acquisition.**³⁰

Identification of sites for construction in the PCDP operation was based on community consultation. Communities donate communal land as their contribution to the establishment of basic services in their community. In pastoral and agro pastoral regions where PCDP operates, community leaders, in consultation with their communities and local administration officers, allocate land for provision of basic services as part of their contribution to the establishment of such services; as such no compensation is paid. This is the practice in pastoral and agro pastoral regions where the MDGPF may be constructing health centers. **Lack of guidelines for ensuring a systematic process is followed for acquiring communal land for construction of is deemed a significant gap identified in Core Principle 4. The ESSA review found that there is lack of proper documentation of the community consultation process and how the decision for allocation of communal land for construction of the service (based on an assessment of alternative sites) is also lacking. However, this gap can be easily addressed through systematic and dedicated documentation of all instances where communal land was allocated for construction of one of the 106 new health centers to be financed through the MDGPF window. This action is included in the Program Action Plan.**

³⁰ MoFED PBS II Environmental and Social Sustainability Study. June 2011.

The decentralized form of government in Ethiopia means that decisions are made at the woreda or kebele level. The regulatory framework for land acquisition is executed mainly by woreda and city administrators. As such, it is difficult to ensure standardized procedures for application of the law across regions. In addition, implementation capacity varies across regions and there is limited capacity in the four regions that need special attention to apply legal requirements that pertain to land acquisition. High staff turnover at the local level has also undermined capacity building efforts in the past. In addition, lack of adequate resources at the woreda and kebele level have hampered monitoring and supervision of resettlement and compensation procedures associated with land acquisition. Such gaps represent additional risks with respect to ensure land acquisition processes are aligned with the expectations of CP4.

Opportunities

Of the gaps identified in the system as written and as observed in how the system has been applied in practice, important opportunities exist to strengthen system performance. Of the gaps identified in subsections 6.4.4 and 6.4.5, the most significant in terms of alignment with the guiding principles of OP/BP 9.00 and Core Principle 4 are:

1. **Eligibility:** The legal framework recognizes only legal titles and some quasi-legal titles (such as customary right over land and communal land) as well tenants in government housing in urban areas. The law does not cater for citizens without legal rights to use the land. These citizens are therefore ineligible for compensation by law.
2. **The opportunity arises for the Government of Ethiopia** to consider how best to address resettlement and compensation of citizens who lack legal right to use land that is expropriated for public purposes. This is considered a higher order opportunity that is beyond the scope of the PforR operation. What the MoH can do under the Program is select sites for new health centers that avoid the need for land acquisition and resettlement. This can be done easily using the site screening forms applied when selecting a site for such a facility.

Another important **opportunity available to the MoH that lies within the scope of the Program** is the ability to request communities that operate under a communal land process to document the consultations and participatory nature of discussions held when allocating a specific plot of communal land for construction of an MDGPF financed health center. This action is included in the Program Action Plan presented in Section 7 and is easily implemented by the MoH through the screening exercise carried out prior to site identification for each new health center that will be financed through the MDGPF window in these regions.

3. **Restoration of Livelihood:** The legal framework allows for some form of support to the displaced citizens but it does not explicitly state that livelihoods should be restored to previous levels or improved. The proclamations on land acquisition are generally limited to providing adequate compensation for property lost and have no provision for livelihood restoration. Again this is a higher order opportunity beyond the scope of this Program, but an important opportunity for the GoE to consider addressing. What the MoH can do under the Program is select sites for new health centers that avoid the need for land acquisition and resettlement. This can be done easily using the site screening forms applied when selecting a site for such a facility.

4. **Valuation of Assets:** On the basis of Proclamation 455/2005 Article 7(2) for expropriation of land holdings for public purposes, compensation will be made at replacement cost. With this method of valuation, depreciation of structures and assets will not be taken into consideration. Compensation rates and valuation of properties will be based on a nationally set formula based on data collected from local market assessments. Compensation is commensurate with loss of assets however replacement cost does not consider location value. As with 1 and 2 above, addressing this gap entails a higher order opportunity for the GoE beyond the scope of this Program, but an important opportunity for the GoE to consider addressing. What the MoH can do under the Program is select sites for new health centers that avoid the need for land acquisition and resettlement as well as

impacts on assets that would need to undergo such valuation and compensation. This can be done easily using the site screening forms applied when selecting a site for such a facility.

5. **Timing of Expropriation:** The requirements for Proclamation 455/2005 allow land to be expropriated and do not state the need for adequate preparation of relocation site before expropriation. Forceful eviction is possible after the expiry of the notice period which is 90 days after payment or offer to payment of compensation. The higher order and Program specific opportunity is as identified above for both the GoE and the MoH.

Risks

The risk of not addressing the written and applied gaps and capitalizing on the opportunities in a timely fashion would be that the approach taken towards addressing these impacts will not be consistent with the guidance under OP/BP 9.00.

Core Principle 5: Indigenous Peoples and Vulnerable Groups

<p><i>OP 9.00:</i> Due consideration is given to cultural appropriateness of, and equitable access to, program benefits giving special attention to rights and interests of Indigenous Peoples and to the needs or concerns of vulnerable groups.</p>
<p><i>BP 9.00:</i></p> <ul style="list-style-type: none"> ▪ Undertakes free, prior, and informed consultations if Indigenous Peoples are potentially affected (positively or negatively) to determine whether there is broad community support for the program. ▪ Ensures that Indigenous Peoples can participate in devising opportunities to benefit from exploitation of customary resources or indigenous knowledge, the latter (indigenous knowledge) to include the consent of the Indigenous Peoples. ▪ Gives attention to groups vulnerable to hardship or disadvantage, including as relevant the poor, the disabled, women and children, the elderly, or marginalized ethnic groups. If necessary, special measures are taken to promote equitable access to program benefits.

Applicability

With respect to the Indigenous Peoples considerations of Core Principle 5, formal discussions between the Bank and government on whether (given the country context) and how to consider identification and designation of Indigenous Peoples have been ongoing since 2009. Government remains uncomfortable with formal designation of Indigenous Peoples in Ethiopia and progress has been slow in reaching an understanding of which groups might be considered Indigenous in the Ethiopian context.

Since February 2012, a note appearing in the MOP of each Board package for Ethiopia has summarized the situation as follows: (a) dialogue between the Government of Ethiopia and the Bank on Indigenous Peoples is ongoing, (b) starting with operations considered by the Board after December 2012, the rights and access to project and program benefits for Indigenous Peoples will be considered to the extent that it is found to be relevant to the areas of operation of the proposed projects and programs; and (c) relevant operations presented to the Board up to December 2012 will endeavor to contain features that approach functional equivalence with due consideration to Indigenous Peoples.

In lieu of an explicit agreement with the GoE on formal identification and designation of Indigenous Peoples, thus far, task teams have been able to achieve much of the intent of formally considering the rights and access to project or program benefits of Indigenous Peoples through Environmental Assessment or Involuntary Resettlement procedures. In the case of this PforR operation, a similar approach has been adopted and the focus, in this case, is placed on examining those elements of the overall HSDP IV program design and scope that ensure distributional, gender balanced and culturally appropriate access to public health services; with special emphasis on the four regions that require dedicated support.

Given this background, Core Principle 5 is applicable to this PforR operation on the basis of the following considerations:

1. The Ethiopian Government has identified four of the country's nine regions as deserving of affirmative support given their marginalization to date. Accordingly, Somali, Afar, Benishangul-Gumuz and Gambella have been designated as the regions that need special attention to redress the inequalities and disadvantages that they have experienced in socioeconomic development over the past several decades. In line with this commitment, the Ministry of Federal Affairs (MoFA) has adopted a five year strategy (2009-2014) to ensure fast and sustainable development in these four regions. And, **the Federal Ministry of Health has designed HSDP IV to ensure that one of the areas of strategic focus is the provision of special support to these regions.**

2. In the context of these four regions, social mobilization has been identified as a strategic direction in the implementation of the aforementioned strategy. As clearly set out in the strategy, emphasis is placed on ensuring involvement of local government and communities for implementation of the strategy and HSDP IV program activities, including those financed through the MDGPF.

3. In practical terms, social mobilization requires consultative discussions and common understanding with regional governments to ensure their full commitment, ownership and support for the national strategy and health sector program. With the same goal in mind, consultations will be carried out with communities so that they are informed about the special programs and devote local knowledge toward implementation of both.

4. With respect to vulnerable groups, several **health sector financing reforms** have been carried out as part of the Health Sector Development Program. Relevant components of these reforms include the fee waiver arrangement, exempted service and the Community-Based Health Insurance scheme (CBHI).

a. The **fee waiver arrangement** provides access to free medical service for vulnerable people identified as the poorest of the poor in urban or rural areas. For eligibility, community members are required to produce a beneficiary card issued by the relevant local government administration. This entitles them to free medication at public health facilities.

b. Through the **exemption component**, the reform has made accessible services of public health importance, such as HIV/AIDS-related services, tuberculosis diagnosis and treatment, maternal health, family planning and malaria prevention, diagnosis and treatment, to all citizens. Even though the exemption arrangement does not target a particular group, vulnerable and disadvantaged members of the community benefit from the services provided because it affords them access to public health services free of charge.

c. The **CBHI** provides health insurance benefits to citizens in the informal sector in rural and urban areas. The scheme is currently being piloted in 13 woredas in 107,803 households across the country. The scheme will be scaled up at the zone level where these woredas are located. To date, 25,577 of the 107,803 households have been included in the scheme, after being identified as the poorest of the poor. Thus, poor households, which represent some of the most vulnerable citizens' have access to health insurance benefits without payment of premiums through the CBHI.

Strengths

In line with government's decentralization policy, decision making power in the health sector has been devolved to Regional Health Bureaus and Woreda Health Offices. Accordingly, the focus at the Federal MoH and Regional Health Bureaus remains on formulation of policies and guidelines and the provision of technical

support. Woreda Health Offices are responsible for managing and coordinating operation of the health system in their jurisdictions.

The Federal Special Support Board, which consists of sector ministries including the MoH, has been established under the Prime Minister's office. The objective of this Board is to coordinate the affirmative support provided to the four regions that need special attention by the federal government and to ensure overall effectiveness of targeted activities sponsored in these regions.

Within the MoFA, the Equitable Development Directorate General was established with specific directorates for each of the four regions. The Directorate General coordinates and directs case teams to collect, organize and analyze data in relation to existing gaps in capacity building, social and economic development, good governance, gender and environmental development in the target regions.

Within the MoH, the Pastoralist Health Promotion and Disease Prevention Directorate was established to coordinate and provide technical support to the four regions for effective implementation of HSDP IV. In particular, the Directorate provides technical support in planning and report preparation. The case teams provide support in supervision of implementing the Program. In addition, three to four high level resident professionals are assigned to the regions to render technical back-up to activities implemented in the health care system.

As a strategic approach, each of the four regions has been twinned with another better performing region to enable it to build local institutional capacity in health service planning, delivery and management. Within each of the four regions, arrangements are made whereby best practice is shared between ethnic groups and woredas to facilitate exchange of experience in program implementation and service delivery.

With regards to ensuring equitable access to program benefits, special attention is given to regions that require special attention in terms of construction of health facilities. The MoH constructs and equips all health centers in these regions, whereas in other regions, the contribution of the Ministry is limited to the supply of equipment. With respect to health centers, the MoH covers construction costs of 75% of health centers built in the four regions. When it comes to developed regions, the MoH shares 50% of the construction cost of health centers.

Based on a recent needs assessment exercise, the HSDP IV allows for special support by the MoH to address capacity gaps in these four regions. In line with this support, aid is given to enhance leadership implementation capacity and upgrade Health Extension Worker skills through refresher training sessions. During 2011/2012, a total of 24,000,000 Birr was granted to the four regions for such training.

Pastoralists and agro-pastoralists account for more than 60% of the population in the four regions that need special attention. In view of this, mobile healthcare services are incorporated in the design of the public health system delivered in Somali and Afar. The mobile healthcare service is appropriate and suitable as a mechanism of health service delivery given the nomadic and semi-nomadic livelihood strategies of these communities.

The Federal Special Support Board holds joint quarterly review meetings with representatives of the developing regions, during which the quality and status of the special support is assessed. The meetings are also used as a forum whereby the four regions may voice grievances that they may have concerning the assistance given to them by the relevant sector ministries and neighboring regions.

The MoH conducts biannual supervision in these four regions to assess implementation effectiveness of HSDP IV MDGPF financed activities and to adopt necessary measures to rectify any shortcomings. In addition, the respective regions conduct supervision twice a year for similar reasons. Joint quarterly steering committee meetings, attended by high level officials from MoH and regional states, are held at the national level to review the performance of the regions in the implementation of HSDP IV MDGPF financed activities. These review

meetings serve as an additional opportunity for the four regions to bring their concerns and demands to attention.

Social mobilization plans have been drawn up at federal level and adapted to the situation of each region as an implementation modality for HSDP IV. This modality is tailored to the special circumstances of these four regions. The modality was designed taking into account the capacity limitations of the leadership in the health care system and cultural barriers that hinder community members, particularly women, from utilizing available health services. The main purpose of the social mobilization modality is to expand the Health Extension Program and exert a determined effort to improve maternal and child health service provision and utilization. Through participation of community and religious leaders, the social mobilization modality is aimed at demystifying cultural norms and beliefs that act as obstacles to the utilization of maternal and child health services offered at HSDP IV (including MDGPF) financed health facilities.

Health Service Accessibility to the Urban Poor: Fee waivers constitute one of the major components in the healthcare financing reforms currently being implemented by the Federal MoH as part of HSDP IV. The objective of the fee waiver system is to ensure accessibility of health services to indigents in urban and rural communities. According to the HSDP IV Annual Performance Report (2010/11), some 2.2 million indigents were screened and certified as eligible beneficiaries of the fee waiver program in six of the nine regions and the two city administrations by the end of FY10/11. Preparatory work is currently underway to avail these services in three regions that need special attention (i.e., Afar, Somali, and Gambella). A total of 25.6 million Birr was allocated at the woreda level in eight regions to provide the service during this past fiscal year. On average, the budget allocated is 41,006 Birr per woreda. According to Regulation 26/2008 of the Addis Ababa City Administration, screening and selection of households eligible for the fee waiver service is the responsibility of woreda administrations. Beneficiary quotas are determined for the woredas by sub-city administrations on the basis of land area, population size and number of destitute families. Woreda screening committees are composed of representatives from the local administration, religious leaders, community elders, civil society and iddirs. Indigent households identified as the poorest of the poor are selected as eligible beneficiaries. Woreda administrations forward lists with beneficiary names to the city offices for certification. The certificates are issued to beneficiaries bearing the names, address and photographs of the spouses and the names of all household members.

The free medical service certificates entitle beneficiary households to medical treatment free of charge at health centers, and upon referral, at hospitals. Woreda and sub-city administrations enter into service agreements with health centers and hospitals operating within their territories or neighboring cities, to cover the costs of medication for fee waiver beneficiaries.

Mobile Healthcare Services Program: The Mobile Healthcare Services Program, presently implemented in the Somali and Afar regions, constitutes another modality of health service provision in these areas. In the Somali Region, for example, the mobile health teams were piloted in 2004 in eight areas affected by severe drought and a measles epidemic. During this period, the mobile health teams operated without formal training, service implementation guidelines or activity monitoring. In 2006, when the Somali region was hit by another severe drought, the mobile health teams were reintroduced in sixteen woredas. During this time, training was organized for the mobile teams with the focus on preventing child morbidity and mortality.

Additional services rendered were emergency nutrition and ITNs distribution. The service was expanded in 2009 to twenty woredas, introducing immunization and maternal health services. Based on lessons learned, the Regional Health Bureau and partners have improved service delivery. Likewise, the service package has been expanded from a measles epidemic response to full treatment of major child diseases and conditions (e.g., malaria, pneumonia, diarrhea, and malnutrition) and, more recently, to including WASH activities and capacity building for the local health system (Mobile Health and Nutrition Service Implementation Guideline, Somali RHB, 2011).

The mobile health teams aim to improve access to and utilization of child and maternal health, nutrition, and WASH services. The service is aimed at prevention of morbidity and prevention and control of outbreaks. An operational manual was developed to standardize and harmonize the mobile health and nutrition services operated in the Regions by the Regional Health Bureau. This manual is currently in use across Regions.

Essentially, the mobile health program consists of two service packages: Health service provision (child health, maternal health, and health education and BCC) and support to the woreda health office (integration of HEW with mobile health and nutrition team (MHNT) through on-the-job training, logistics, referral and reporting). Each MHNT is staffed with two health workers (clinical and/or midwife nurses), two health extension workers (HEW), one site-based social mobilizer and one driver. The responsibilities of the health workers in the team include medical consultation and nutritional screening, health education and WASH. The mobile teams conduct regular outreach service in line with their work schedule outlined in the implementation manual. They carry out their work in coordination on the basis of planning, monitoring, supervision, reporting and review meetings, which are coordinated by a regional health and nutrition task force (Mobile Health and Nutrition Service Implementation Guideline, 2011).

In the Afar Region, mobile health teams began operating in 2008/2009. Currently, they operate in four woredas (Korri, Biddu, Bure Medaytu, and Dubti). The service will be introduced in two more woredas (Terru and Erpitti) in 2012. The service package encompasses maternal, newborn and child health, family planning, health education, personal hygiene and environmental sanitation, malaria examination and treatment.

A mobile health team comprises four health workers (two males and two females). By qualification, the health workers are one midwife nurse, one clinical nurse, one environmental health officer, and one health officer. All health workers are female and native to the Afar region. Female health workers are preferred and more appropriate since, in the local cultural context, Afar women show willingness to access maternal health services when rendered by female service providers. The health personnel in the mobile health service teams are of Afar origin in order to overcome language barriers and facilitate ease of communication with patients in remote areas.

As an incentive, health workers are remunerated a daily allowance of Birr 150 to top-up their salaries. Mobile health teams are supervised by a health professional that operates at the regional level and who is remunerated an allowance for ten to fifteen days as a salary top-up. The ESSA preparation process found that the mobile health services are effective and successful in reaching out to mothers and children particularly in inaccessible communities of the Afar Region. Hence, expansion of the program will help toward achievement of better health outcomes. As far as the effectiveness and practicality of the program is concerned, all the relevant stakeholders - health officials, health workers as well as service recipients – indicated general agreement that it offers the best means of reaching the most inaccessible communities. The program is particularly suited to pastoralists who relocate their settlements on a regular basis due to the migratory nature of their livelihoods system.

Health officials, practitioners as well as service recipients consider the mobile health service to be an appropriate and practical mode of health service delivery in pastoral areas. The suitability of the approach to reach inaccessible and remote pastoral villages and respond to maternal, newborn and child health needs make the mobile health service highly desirable, despite important cost implications. Yet, implementation of the mobile health program is still at a pilot stage and remains limited and small-scale.

Gaps in the system as written

The ESSA analysis found that the system as written with respect to providing access to public health services to vulnerable groups is robust and well aligned with the guidelines of OP/BP 9.00 and Core

Principle 5. Specifically, MoFA has adopted a 5 year strategy to ensure sustainable development in the special regions. The MoH designed HSDP IV in such a way that one area of strategic focus is the provision of support to the four regions. These regions have been designated for targeted support to redress inequalities and disadvantages in socioeconomic development. And, vulnerable groups benefit in many ways from health sector financing reform carried out as part of HSDP IV. Relevant interventions include fee waiver, exempted service, community-based health insurance schemes and programs.

However, one gap in the system as written remains launching and implementing the HRH Strategic Plan. Although prepared in 2009, the twelve-year HRH Strategic Plan has yet to be formally approved. An important element of this Plan is the MoH's financial and non-financial incentive package which is lacking. **Hence, issues related to professional staff motivation and retention remain and require attention to promote human resource development and deployment in the sector. This risk is deemed moderate to significant if the HRH Strategic Plan is not approved and implemented immediately post effectiveness. Such action is included in the Program Action Plan.**

Gaps in the system as applied in practice

To date, a significant number of important advances have been achieved as a result of government's commitment to attaining the health MDGs, in particular with respect to advances made through the health sector reforms and decentralization of health service planning and management. However, disparities in coverage and health outcomes between geographic and socioeconomic groups remain and need to be addressed in order for MDGs 4 and 5 to be achieved by 2015.

At the Program implementation level, **certain gaps in culturally and gender appropriate staffing at remote health care facilities remain.**

In addition, in principle, the fee waiver system is meant to be inclusive of the urban poor as a whole. Regulation 26/2008 (Section 4, Number 11), identifies different disadvantaged groups to be eligible beneficiaries of the fee waiver system. Included are low income families, street dwellers, persons with disabilities, the elderly and the mentally ill without income and means of support. This indicates that the fee waiver system and the legal framework accommodate the urban poor regardless of their background and circumstances. Yet, in practice, **the analysis shows that especially street dwellers and poor residents without a permanent address experience difficulty in accessing fee waiver service.** In the selection and screening process, these groups are disqualified from the service for lack of identity cards and permanent physical address. **This shortcoming is acknowledged in HSDP IV annual performance report of the MoH. The report identifies the process of selecting eligible indigent households as a challenge. Realizing this to be a difficult aspect of the healthcare financing reform, the Ministry has organized fee waiver orientation workshops for relevant parties involved in the screening and selection processes.**

Underutilization of service delivery facilities: According to health officials and practitioners in the four regions that require special attention, the ESSA noted there is a high degree of reluctance on the part of the local population to use public healthcare services. In part, under-utilization is explained in terms of community expectations of these health facilities. For example, when health centers are constructed, citizens in the Afar Region expect these facilities to deliver curative rather than preventive services. In the case of pastoral communities, citizens expect the health facilities and Health Extension Workers to also provide veterinary services. When they find out that this is not the case, there is a tendency not to use the facilities (Report by MoH, WHO, and UNICEF, 2011).

Social mobilization

In September 2011, the Pastoralist Health Promotion and Disease Prevention Directorate prepared a report entitled ‘Social Mobilization for Health Extension Program’. The document assesses and identifies a range of socio-cultural, operational and practical barriers to implementing the HEP in the Regions that need special attention. Based on the assessment, the Directorate adopted an implementation modality to address the observed challenges.

The report presents a comprehensive list of barriers that have limited program implementation in the regions that need special attention. The document defines the barriers as gaps in attitudes, skills and inputs. These include inadequate commitment on the part of the leadership, favoritism on ethnic grounds, mismanagement of allocated resources, favoring curative medicine over preventive health, limited knowledge and awareness regarding the Health Extension Program, inadequate skills to plan, carry out and delegate work and responsibilities associated with the program, abuse of medical supplies and problems of professional integrity.

The report also indicates that these gaps are evident among health care management as well as healthcare professionals. In particular, pervasive and deep-rooted socio-cultural beliefs and attitudes, long-held by the community, are noted to hinder progress in program implementation. In this respect, factors associated with gender inequalities, traditional practices and socio-religious pressures result in underutilization of health services. As a consequence, maternal, newborn and child health are adversely affected.

The ESSA review noted that in the Afar Region, women are disinclined to seek antenatal, delivery and postnatal care services at health facilities. This is mainly due to cultural factors. It was observed that in Afar, visiting health facilities is considered taboo for women. Because of this, by the time a woman gets to a health facility, she is typically in critical condition and often too late for the treatment of otherwise curable illnesses.

In connection with delivery, women are often discouraged from seeking health services by the likelihood of being assisted by male health workers. In fact, the majority of the 29 midwives in the Afar Region are men. Owing to socio-cultural barriers, it is reported that close to 90% of deliveries take place at home largely with the assistance of traditional birth attendants (TBAs). The available postnatal care (PNC) services at health facilities in these regions are also underutilized for similar reasons.

Local women in Afar are also reluctant to accept and make use of family planning services, mostly on cultural and religious grounds. Traditionally, the Afar raise large families, which makes it a challenge to promote family planning and encourage acceptance and uptake of the service in local communities.

The disparities in maternal health coverage, largely attributable to underutilization, become more evident by comparing the service coverage figures for the regions that need special attention against the national average during 2009/10. Table 11 depicts the national average service coverage on ANC, PNC, clean and safe delivery by HEW, delivery attended by skilled attendant, and CPR against the corresponding rates for the Regions that need special attention.

Table 11: Comparison of selected MDG maternal health indicators between the national average and corresponding rates for regions that need special attention (MOH, 2009/10)³¹

Indicator	National	Afar	Somali	Ben-Gumuz	Gambella
Antenatal care coverage (%)	71.4	25.3	56.5	53.5	31.3
Deliveries attended by skilled personnel (%)	16.8	12.9	213.0	5.7	10.7
Clean and safe delivery service coverage (%)	17.0	0.5	0.9	8.1	0.4
Postnatal care coverage (%) ⁰	36.2	9.5	5.2	21.1	3.0
Contraceptive acceptance rate (%)	61.9	13.5	8.6	38.6	13.2

In addition, misconceptions are widely prevalent surrounding female circumcision. It is believed that uncircumcised women tend to be promiscuous, and are unlikely to find husbands and bear children. Such misconceptions have resulted in the widespread practice of genital mutilation in the Afar Region. Likewise, there is a strong tendency among local women to favor traditional healing over modern medicine. Hence, they tend to decline immunization, associating vaccines administered with contraceptive injections.

As part of the social mobilization program, concerted efforts have been underway in the Afar Region since 2011 aimed at demystifying misconceptions and promoting utilization of health services. To expedite the process, a region-wide structure has been established at the community level up to regional institutions. The structure consists of representatives of community groups such as women's associations, youth associations, clan leaders, community elders, religious leaders, health extension workers and others. With budget support allocated by Regional Health Bureaus, the social mobilization program is implemented through forums used to build public awareness and enable local communities to gain ownership of the Health Extension Program.

As part of this effort, the stories of individuals cured of their illnesses through modern medicine, after unsuccessful attempts with traditional means, are being used to increase public awareness and demystify misconceptions. To that effect, the traditional information dissemination system known as *dagu* is used to spread the news by word of mouth.

There is also an effort, carried out through social mobilization, to demystify female genital mutilation (FGM) in the Afar Region. The educational and awareness-raising campaign against the practice dates back to 1996. However, because of the limitations in the approach and strategy followed, the impacts were limited. Hence, to ensure long-lasting changes in attitudes and behavior, the social mobilization structure was embraced as a pragmatic approach. Accordingly, an all-inclusive structure composed of religious leaders, clan elders, relevant government sector officials, civil society representatives, and TBAs was established. Sub-committees were formed at woreda and kebele levels to extend the operations of the structure across the Region. Important steps taken in the process of demystifying FGM were to organize study tours and send delegations to the Muslim African countries of Egypt, Tunisia, and Senegal. The tours were arranged and conducted in collaboration with the Regional Council of Islamic Affairs and local religious leaders.

The main purpose of the visits was to draw lessons and experience regarding the implications and connections of the FGM practice vis-à-vis Islamic beliefs. Based on the lessons learned, mutual understanding was reached with the religious leaders that there was no connection between the FGM practice and Islamic beliefs. Subsequently, the religious leaders represented in the committees took the initiative to play a leading role in educating community members against practicing FGM, as well as prohibiting or discouraging the practice. In cooperation with kebele and woreda administrations, a system was introduced to register pregnant women and

³¹ Source: Health and Health Related Indicators: MoH, 2009/10

new born babies. In this way, the committees made sure that new born baby girls were not subjected to the practice of circumcision.

Recognizing the relevance and power of the media, radio groups were formed in each kebele and sub-kebele, with the supply of radio sets. It was arranged for the groups to follow the weekly twenty-minute radio show on harmful traditional practices (HTP) broadcast in cooperation with Afar FM radio. In addition, in the effort to enhance local capacity, a training of trainers (ToT) program was conducted on HTP for 111 youths. After the program, the youths organized and facilitated a series of community conversations (CCs) on HTP issues in 11 kebeles and 111 sub-kebeles.

With an aim to use schools as entry points, teachers were given similar training so that they would teach students for five minutes of the regular periods concerning HTP issues. Educational and awareness training were also given to individuals involved in the practice of circumcision regarding the fact that FGM had no religious basis and, indeed, the action resulted in serious health and other consequences to young girls. As a means to encourage them to relinquish the practice, steps were taken to facilitate their engagement in alternative sources of income.

In Benishangul-Gumuz, similar socio-cultural barriers affect maternal, newborn and child health and limit implementation of the Health Extension Program. As a result, pregnant women and mothers are reluctant or find it difficult to access antenatal, delivery, and postnatal care services.

A report prepared by the Regional Health Bureau in 2012 attributes underutilization of health services by women in Metekel Zone of the Region to a set of specific beliefs. In the first case, husbands are noted to discourage or prevent their wives from accessing antenatal and delivery services at health facilities.

This view is shared by women in the zone who decline the service for fear of male health workers. Lack of awareness regarding safe delivery at health facilities and the value of antenatal and postnatal care is a hindering factor in this respect. Second, due to misconceptions, pregnant women are not allowed to give birth at home or at health facilities, rather they give birth in the bush. This is due to the belief that contact between household objects and a drop of blood during delivery will cause misfortunes to family members such as serious illnesses or the death of husbands and children. As a result, women are pressured into giving birth in the bush regardless of the health risks. In addition, unsanitary materials such as sharp stones and pieces of wood are used to cut the umbilical cord of newborns. People practicing witchcraft (*gaffiya*) also places pressure on pregnant women not to seek antenatal and delivery services at health institutions.

To recapitulate, according to the ‘Assessment of Healthcare Provision among Pastoral Communities’, conducted by MoH in collaboration with WHO and UNICEF (2011:22-23), a number of challenges impede effective implementation of the HEP in pastoral areas in the four regions that need special attention, specifically:

- **Community perception:** Communities perceive Health Extension Workers as providers of curative services, particularly to mothers and children in the regions that need special attention. This is mainly due to being under resourced in terms of technical personnel and medical equipment and supplies. When these expectations are not met, communities find it difficult to accept the health workers and use their services.
- **Capacity limitations of HEWs:** Health extension workers are overburdened with additional tasks assigned to them by woreda or kebele administrations, on top of their regular duties and responsibilities, making it difficult for them to properly carry out their work.

- **Lack of transport facilities:** Owing to the non-availability of transport service and widely scattered settlement pattern, health extension workers are not able to travel between communities and households at the required pace to provide health services.
- **Low community participation:** The success of HEP is said to have been constrained by inadequate participation of communities.
- **Health posts are not sufficiently equipped:** Many health posts in these regions are insufficiently equipped. As a result, HEWs are forced to operate under conditions where essential drugs and commodities such as vaccines, ORS, palliative drugs and delivery beds, as per the HEP, requirements are in short supply.
- **Referral system not properly organized:** Not practicing curative medicine, HEWs seldom issue referrals. For this reason, community members visit nearby health centers to access such services on their own. This has undermined the capacity of HEWs to assume full responsibility for addressing the community health needs as well as their acceptance by the local population.
- **Number of female HEWs remains inadequate:** Female health workers are preferred for the HEP since their services mainly involve maternal, newborn and child healthcare. However, in the case of the Afar region, the number of female HEWs remains low because of the difficulty in identifying the desired number of women who meet the educational qualification required for the position. In Afar, the number of HEWs in 2012, as confirmed by field data, is 776. Of these, only 215 are women or 28% of the total number of HEWs in the Region.

Opportunities

In order to overcome these barriers and bring about positive attitude and behavioral changes, panel discussions and community conversations are being used in all woredas and zones in the Region as the vehicles of social mobilization. Participants at panel discussions include pregnant women, religious leaders, community elders, health professionals and women, children, youth affairs office staff. While pregnant women are the main participants in the community conversation sessions, issues for discussion tend to focus on challenges involving underutilization of antenatal, delivery, and postnatal services and the measures that should be introduced to deal with the constraints and enhance the rate of utilization.

The social mobilization work is strengthened by the use of a mobile video van, which moves around towns and villages playing to the public educational programs recorded in different ethnic languages. The prerecorded educational messages focus on HIV/AIDS, reproductive health, family planning and harmful traditional practices.

The CBHI, currently in a pilot phase in a limited number of woredas, will be expanded across the country under HSDP IV. Once scaled-up, the program is likely to ensure social equity for the poor including those in the regions that need special attention.

What is important to note here is that the gaps in the system as written and the gaps in the system as applied in practice are deemed to represent a moderate to significant risk to the success of the overall Program. However, it is essential to note that all are being or will be addressed through HSDP IV and its MDGPF window of financing. This is because both are specifically designed to address the remaining gaps identified here towards achieving these MDGs and ensuring equity in access to public health services by vulnerable groups of citizens. All such efforts are embedded in HSDP IV and will become evident over the life of the Program. As such, additional efforts through the Program Action Plan are not

necessary, though Bank implementation support may support continued efforts to ensure equitable access to this system by this subset of the urban poor.

Risks

The risk of not addressing the written and applied gaps and capitalizing on the opportunities in a timely fashion would be that the approach taken towards addressing these impacts will not be consistent with the guidance under OP/BP 9.00. **The set of gaps identified under this CP are deemed range from moderate to significant if appropriate actions are not taken in the near term to address them. However, as stated above, the Program Design includes measures to address all gaps identified and, thus, further actions through the Program Action Plan are not necessary. The Bank team will need to ensure that during regular supervision missions and through ongoing Bank implementation support, the HSDP IV actions and interventions listed to address the gaps are indeed applied and monitored nationwide.**

Core Principle 6: Social Conflict

<i>OP 9.00:</i> Avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.
<i>BP 9.00:</i> Considers conflict risks, including distributional equity and cultural sensitivities.

Applicability

The proposed Program will not exacerbate social conflict, nor will it operate in a fragile state context, a post-conflict area or in areas subject to territorial disputes. As such, this core principle is considered only in so far as the Program would affect distributional equity and cultural sensitivities.

From this perspective, as discussed with respect to the main considerations of Core Principle 5, the Program is designed to yield significant social benefits to all citizens in terms of improving distributional equity of health services, particularly in the four regions that necessitate special attention, as well as in terms of improving access to decentralized health services delivered in a gender balanced and culturally sensitive manner to all citizens.

Strengths

System strengths with respect to distributional equity and cultural sensitivities are well covered under Core Principle 5 and apply equally here with respect to Core Principle 6.

Gaps in the system as written

Gaps in the system as written with respect to distributional equity and cultural sensitivities are as described under Core Principle 5 and again apply equally here in terms of Core Principle 6.

Gaps in the system as applied in practice

Gaps in the system as applied in practice with respect to distributional equity and cultural sensitivities are as presented under Core Principle 5 and apply equally under Core Principle 6.

Opportunities

Opportunities to strengthen the environmental and social management system with respect to distributional equity and cultural sensitivities are as indicated under Core Principle 5 and apply here under Core Principle 6 in the sense of supporting MDGPF interventions in the four regions that require special attention.

Risks

The risk of not addressing the written and applied gaps and capitalizing on the opportunities presented above with regards to Core Principle 6 will be that the Program will not be consistent with the guidance provided by OP/BP 9.00

ANNEX 4: SOURCES

In addition to the laws, policies, and regulations cited in this report, the ESSA has drawn from a range of sources including academic journals, GoE documents, technical reports, and project documents. This annex lists sources that were consulted in the preparation of the ESSA.

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13. Emebet Dagnachew, Nurse, Megele 33 Health Post
14. Fantaye Zinabe, Health Extension Worker, Megele 33, Benshangul Gumuz
15. Fatu Yusuf, Health Extension Worker, Megele 33, Benshangul Gumuz
16. Fetlework Weretaw, Sanitarian, Butajira Zonal Hospital
17. Habtamu Taye, Deputy Head of the Benshangul Gumuz Region Health Bureau,
18. Habtamu Tesfaye, Assistant Director/M&E Coordinator, Policy and Planning Directorate, Federal MoH
19. Hussein Ali, Sanitarian, Assosa Hospital
20. Mahmud Hussein, Pharmacist, Hamus Gebeya Health Centre, SNNPRS
21. Manaye Seyoum, Officer at the Pastoralist Health Promotion and Disease Control Directorate, FMOH (and focal person for the environment at FMOH)

22. Medhin Demeke, Deputy Head of Office and Disease Control Coordinator, Butajira Woreda Health Office
23. Samson Assefa, Representative (Acting Head) of the Ambramo Health Centre
24. Shemsu Aman Abdela, General Manager, Butajia Zonal Hospital
25. Sileshi Taye, WASH Consultant, FMOH (Previously with the Ministry's Hygiene and Environmental Health Department, MoH)
26. Solomon Kebede, Director of the Environmental Standards Directorate, FEPA (previously Head of Impact Assessment Services at FEPA)
27. Tigist Tekle, Head of Butajira Health Centre
28. W/o Fantu, EIA Expert, Addis Ababa Environmental Protection Authority
29. W/t Meseret, Environment Audit Expert, Addis Ababa Environmental Protection Authority
30. Yassin Desse, Officer, Health and Health Related Services and Products Quality Control, Butajira Woreda Health Office