

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

Environmental and Social System Assessment

February 2013

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome	IDA	International Development Association
CBHI	Community Based Health Insurance	IPPS	Infection Prevention and Patient Safety
DDT	Dichloro Diphenyl Trichloroethane (insecticide)	JANS	Joint Assessment of National Strategies
DLI	Disbursement-linked indicators	MDG	Millennium Development Goal
EIA	Environmental Impact Assessment	MDGPF	Millennium Development Goal Performance Fund
EPLAUA	Environmental Protection, Land Administration and Use Authority	OP	Operational Policy (of the World Bank)
ESMF	Environmental and Social Management Framework	PforR	Program for Results
ESSA	Environmental and Social Systems Assessment	PBS	Protection of Basic Services
FAO	Food and Agriculture Organization	PCDP	Pastoral Community Development Project
FEACC	Federal Ethics and Anti-corruption Commission	PFSA	Pharmaceutical Fund and Supply Agency
FEPA	Federal Environmental Protection Authority	PHEMA	Public Health Emergency Management Agency
FMHACA	Food, Medicine and Healthcare Administration and Control Authority	PMU	Project Management Unit
FMOH	Federal Ministry of Health	PSNP	Productive Safety Net Program
GOE	Government of Ethiopia	SANA	Situation Analysis and Needs Assessment
GTP	Growth and Transformation Plan	SNNPRS	Southern Nations, Nationalities, and People's Regional State
HCWM	Health Care Waste Management (Plan)	SWOT	Strengths, Weaknesses, Opportunities and Threats
HIA	Health Impact Assessment	TB	Tuberculosis
HIV	Human Immunodeficiency Virus	ULGDP	Urban Local Government Development Project
HMIS	Health Management Information System	UNFPA	United Nations Population Fund
HNP	Health Nutrition and Population	UNICEF	United Nations International Children's Fund
HRH	Human Resource for Health	WASH	Water, Sanitation and Hygiene
HRITF	Health Results Innovation Trust Fund	WHO	World Health Organization
HSDP	Health Sector Development Plan		

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SECTION 1 INTRODUCTION

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. The PforR financing allows countries to design and deliver their own development programs. To do this, PforR operations link disbursement to verified achievement of results.

The Health Sector Development Program (HSDP) reflects the Government of Ethiopia's (GoE) commitment to achieve the health-related 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) goals related to health.

The proposed PforR operation will disburse against a subset of HSDP IV results that are known to contribute to the achievement of the maternal and child health-related MDGs. The funds disbursed will support activities financed through the Millennium Development Goals Performance Fund (MDGPF) of HSDP IV. The activities supported by the MDG Performance Fund focus on priorities identified by the HSDP (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:

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 HSDP.

Section 2 provides a description of the proposed PforR operation.

Section 3 describes the scope and methodology of the ESSA process conducted to inform design and preparation of the PforR 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 MDG 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 Program Action Plan with the Government.

1.1 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. The GTP places particular emphasis on human development and its contribution to economic growth. The national 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 20-year HSDP. 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 percent of the population. Prominent issues at the core of the policy are democratization and decentralization of the healthcare system: developing preventive,

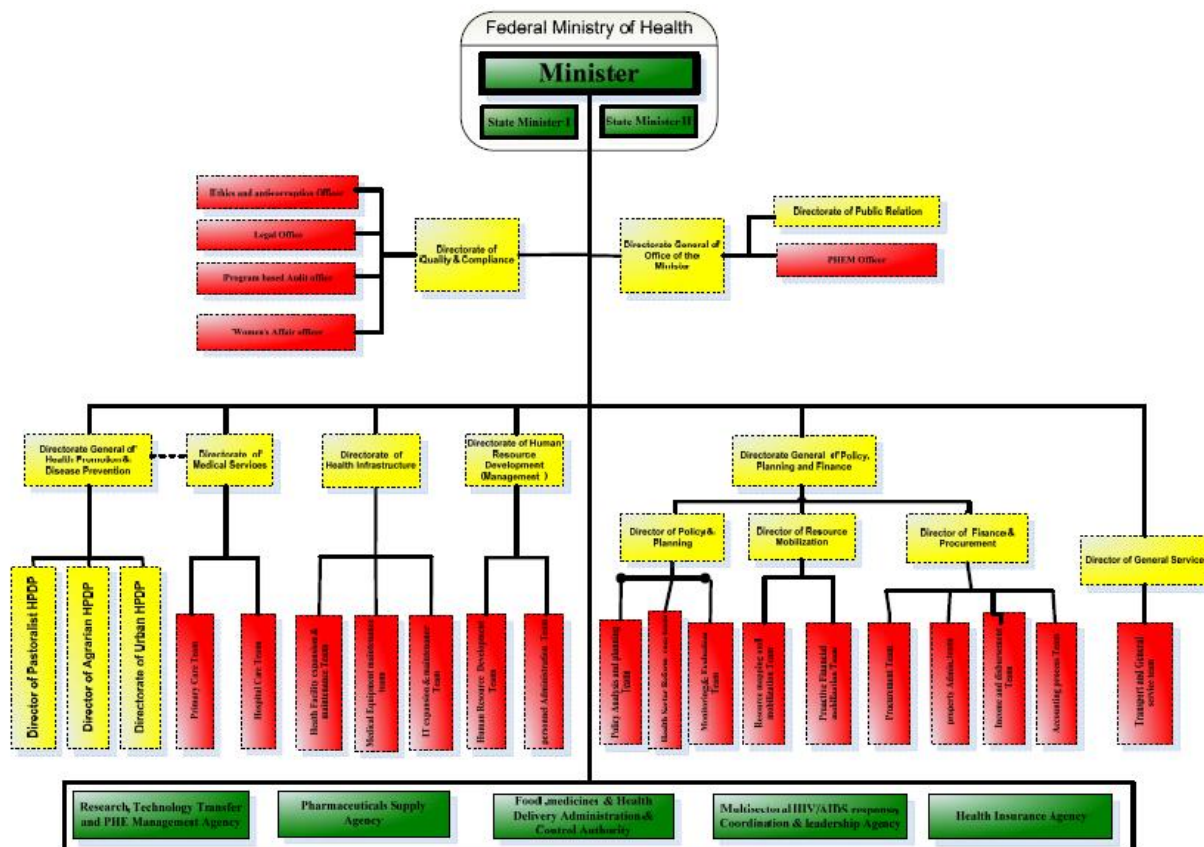
promotive and curative components of healthcare services; ensuring healthcare accessibility to all; and encouraging private and NGO participation in the sector.

HSDP has been under implementation since 1997. Three phases of the Program have been completed. 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-related MDGs by 2015.

Figure 1 presents the organizational structure of the Federal Ministry of Health (FMOH). 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 FMOH, regional health bureaus, and woreda health offices. In line with Government’s decentralization policy, decisionmaking power in the sector has been devolved from FMHO to regional health bureaus and woreda health offices. Accordingly, FMOH and regional health bureaus 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 reform and restructuring program of the health sector, known as *business process re-engineering*, 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 expenditure.¹

Figure 2. ETHIOPIA'S THREE TIER PUBLIC HEALTH SYSTEM



The first tier comprises the woreda health system that consists of satellite health posts, health centers, and a primary hospital, which together form a primary health care unit.

- Staffed with two health extension workers, each health post serves 3,000 to 5,000 persons. The health extension workers are expected to spend less than 20 percent of their time in their respective health posts. More than 80 percent of their time is meant to be spent on community outreach program visits to households, with a primary focus on mothers and children. The health extension workers conduct 96 hours of training for households in their catchment area on selected health extension programs. The health extension workers also follow-up on progress that households make in practicing the knowledge and skills acquired through training before they graduate as model families. In addition, the health extension workers provide selected health care services, including family planning, epidemiology, clean delivery and essential newborn care services, diagnosis and treatment of malaria and pneumonia, and management of diarrhea and dehydration using oral rehydration solution.
- On average, a health center has 20 staff and provides preventive and curative services. Health centers serve as a referral center and practical training site for health extension workers. A health center in rural areas serves a population of up to 25,000; in urban areas the population covered by one health center may reach up to 40,000.
- A primary hospital is staffed with 53 health personnel and provides inpatient and ambulatory services to a population of 60,000 to 100,000. A primary hospital provides all the services of a health center as well as emergency surgical services, including Caesarean section, and access to blood transfusion services. It also acts as a referral point for health centers in its catchment area, in addition to being a practical training center for nurses and other paramedical health professionals.

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

The second tier in the Ethiopian healthcare system is comprised of a general hospital with population coverage of 1 million to 1.5 million. This type of hospital provides in-patient and ambulatory services. With a staff of 234 professionals, a 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 million to 5 million and a professional staff of 440.

1.2 HSDP IV (2010-2015): Core Themes and Program Areas

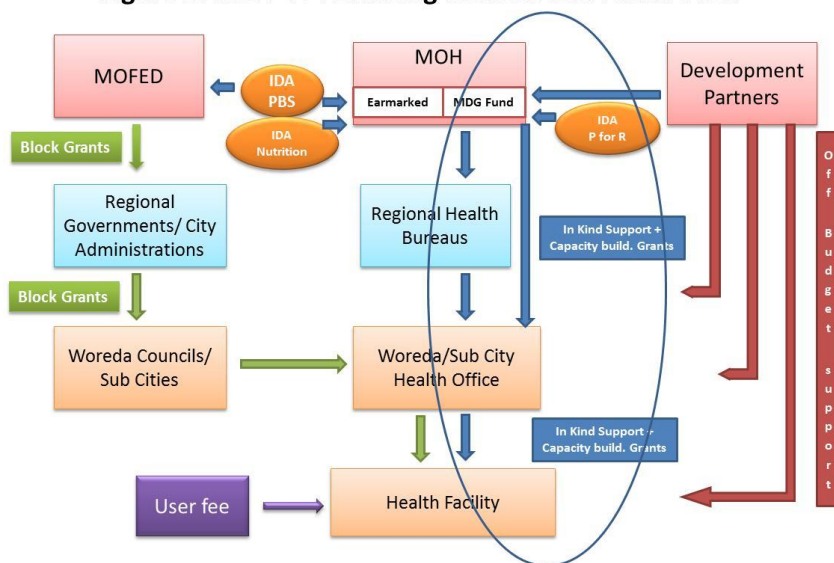
HSDP IV reflects the Government of Ethiopia’s commitment to achieve the health-related MDGs. HSDP IV supports human capital development and remains the main vehicle for achieving Ethiopia’s GTP goals related to health. HSDP IV envisions a strong client-centered approach to improve access to health services,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

HSDP IV is nationwide 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 to set priorities that reduce inequities and establish governance structures to ensure accountability, transparency, and active participation of communities in health-related decisions; 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: Leadership and Governance, Strengthening Service Delivery, and Expansion and Strengthening Health Infrastructure and Resources. Each area has sub-programs and earmarked budgets. The *Leadership and Governance* area has 3 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 with 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 5 sub-programs covering expansion of primary health care facilities and hospital infrastructure, salaries, training, supply of pharmaceuticals and medical equipment, and health care financing.

Figure 3. HSDP IV Financing Sources and Funds Flow



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.

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 MDG Performance Fund as well as earmarked external funds provided to FMOH (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 MDG Performance Fund (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 toward achievement of the maternal and child health-related MDGs and strengthen oversight functions of the health system.

Previously, through the Provision of Basic Services (PBS) Project and the Nutrition Project, the World Bank has supported investments in the health sector. PBS investments have been channeled through block grants to finance about one-third of the salary costs of the health extension workers. Specifically, PBS II provided funding to FMOH for supply of essential medical products. The Bank-funded Nutrition Project also provided support for targeted interventions in the health sector. While support will continue under PBS III, the scope of the PforR operation will support MDGPF-financed activities, 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 of PforR Program

The proposed program development objective for the PforR Program is to improve delivery and use of a comprehensive package of health services. The proposed development objective is a subset of the HSDP IV mission statement that 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 5 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 of PforR Program

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 MDGPF activities 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 FMOH,² the majority of expenditures under the MDG Performance Fund will be made at the federal level, with goods and services transferred in-kind to subnational levels according to assessed need and disease burden. Government wage costs are not covered by the MDG Performance Fund. Table 1 presents the specific MDGPF-supported activities and results.

The Joint Financing Arrangement sets out the governance and reporting requirements for the MDG Performance Fund. As of 2012, partners supporting the MDGPF include Australian AID, Department for International Development (UK), Italian Cooperation, Irish Aid, Spanish Cooperation, UNFPA, UNICEF, and WHO. In addition, the Netherlands Government has recently joined the Joint Financing Arrangement. 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 scorecard 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 Forum.⁴ 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 PforR operation, the principles of effective donor harmonization are upheld to support the Government's priority investments in the sector. The harmonization arrangements for the PforR operation with respect to investing in results achieved through the MDG Performance Fund are detailed in Table 2. Table 3 presents the full complement of funding sources of HSDP IV and the MDG Performance Fund.

Table 2. Harmonization of PforR with MDG Performance Fund

Area	Harmonization	MDF Fund	PforR
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 MDGPF 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 9 months of the end of the Ethiopian FY	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 (a) antenatal coverage (% increase); (b) deliveries attended by skilled health providers (% increase); (c) Pentavalent-3 vaccine coverage for children ages 12-23 months (% increase); and (d) contraceptive prevalence rate (% increase).

The proposed disbursement linked indicators are based on the following criteria: (a) evidence of their contribution to MDGs; (b) under the span of control of Government; (c) achievable in the timeframe 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

Disbursement-linked indicator ^{/a}	Targets					
	Baseline	Yr. I	Yr. II	Yr. III	Yr. IV	Yr. V
DLI 1, Deliveries attended by skilled birth providers (%)	10	-	14	-	18	-
DLI 2, Children 12-23 months immunized with Pentavalent 3 vaccine (%)	TBD			5% increase		10% increase
DLI 3, Pregnant women receiving antenatal care (%)	43		48		56	
DLI 4, Contraceptive Prevalence Rate (%)	27.3		31		35	
DLI 5, Health facilities reporting HMIS data in time (Average number for 4 quarters)	50	55	50	70	75	80
DLI 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
DLI 7, Development and implementation of Annual Rapid Facility Assessment to assess readiness to provide quality MNCH services	Agency selected	Baseline	Survey	Survey	Survey	Survey
DLI 8, Improved transparency of the PFSA	NA	Website launched	Website updated and first open call issued	Website updated	Website updated	Website updated

^{/a} The criteria for DLIs: (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 PforR Program implementation arrangements are as follows:

Technical. Implementation of HSDP IV follows Ethiopia’s decentralized federal system of governance, which provides for shared responsibilities among the FMOH, regional health bureaus, and woreda health offices. The FMOH is responsible for planning, budgeting, and reporting funds released through the MDG Performance Fund through which the PforR funding will be disbursed. The Joint Coordinating Forum chaired by the Minister of Health will be the highest body responsible for overall policy dialogue and reform issues between the Government, partners, and stakeholders in the health sector. The Joint Coordinating Forum will determine the scope of support proposed under the MDG Performance Fund 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 Joint Coordinating Forum.

Fiduciary, environment and social aspects. The Policy, Plan and Finance General Directorate will be responsible for the fiduciary and performance reporting coordination with other departments in the FMOH and the regions. The PFSA under the FMOH 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 MDG Performance Fund. The FMOH 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, Benishangul-Gumuz, Gambella, and Somali) 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. 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 FMOH 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 is also being collected and information on a core set of 36 key performance indicators is shared with the FMOH 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. Standardized surveys such as Demographic Health Surveys will be used to report on population-level disbursement-linked indicators while annual rapid facility assessments using standard tools⁵ will provide information on facility readiness to deliver disbursement-linked indicators.

⁵ WHO Service Availability and Readiness Assessment tested in Africa

SECTION 3 ENVIRONMENTAL AND SOCIAL SYSTEM ASSESSMENT PROCESS

3.1 Scope of ESSA

Associated with the PforR financing modality is a different approach to assessing and addressing environmental and social effects related to the Program. With standard World 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 environmental and social safeguard policies, early in Program preparation, the World Bank task team is responsible for conducting a comprehensive environmental and social system assessment (ESSA) 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. The 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 Operational Policy/Bank Procedure (OP/BP) 9.00, *Program for Results Financing*. 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: (a) systems as defined in the legal and regulatory framework of the country; and (b) 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.

Core Principle 1: *General Principle of Environmental and Social Management.* This 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 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 principles aims to promote public and worker safety with respect to the potential risks associated with: (a) construction and/or operation of facilities or other operational practices under the Program; (b) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the Program; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

Core Principle 4: *Land Acquisition.* This 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 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 principle aims to avoid exacerbating social conflict, especially in fragile situations, 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. 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. Based on the findings of the analysis, the ESSA 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 be updated based on the feedback received from stakeholders and implementation experience of the PforR 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 of ESSA Analysis

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. 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 levels 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 FMOH; Afar and Benishangul-Gumuz Regional Health Bureaus; Addis Ababa Health Bureau; woreda health offices in Addis Ababa, Afar, and Benishangul-Gumuz; 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 facilities were carried out in urban, agrarian, and pastoralist regions.⁶ 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, including 2 hospitals, 7 health centers, and 2 health posts.⁷ 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.

3.3 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. The ESSA 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 FMOH in July 2012. A set of technical reviews of the revised ESSA report was held with the FMOH in October and November 2012. The Government of Ethiopia and the World Bank conducted an open technical consultation on December 19, 2012, on the draft ESSA (formally disclosed in the Bank's InfoShop on December 12, 2012) with federal ministries and agencies, civil society organizations, donor/partner groups and regional representatives from the four Ethiopian regions that require special attention. The agenda, consultation report, and list of participants for this consultation are attached in Annex 4.

Going forward, the Program team will develop a comprehensive consultation process for the ESSA report to be held between February and June 2013. Likely aspects of such a process will include a day-long stakeholder workshop with participants drawn from the four regions that need special attention, civil society, development partners supporting the health sector, and program implementers at different levels. Once these consultations are completed, the relevant reports and list of participants will be included in the updated ESSA and redisclosed.

The consultation reports highlight key points discussed at each session and the Bank's response to specific questions. All interested parties are invited to access the publically disclosed ESSA and send in comments to the World Bank for review.

⁶As per the recommendations of FMOH, site visits were conducted in three locations, namely Addis Ababa, Butajira woreda in Southern Nationalities, Nationalities and Peoples Region (SNNPR) 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.

⁷ The emphasis of the visit to health centers 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 key MDGPF-supported activities involve the supply of health products, including equipment, construction and rehabilitation of health centers, and provision of health services by health facilities nationwide. The key activities are summarized in Table 1, Section 2.

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 FMOH and MDG pooling partners, will discuss potential environmental and social implications of proposed new investments under MDGPF on an 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: (a) environmental benefits, impacts, and risks that may be generated by MDGPF investments; and (b) 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, HSDP IV 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 Declaration.⁸ In this context, a Situation Analysis and Needs Assessment (SANA) 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.
- 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

⁸ The Libreville Declaration on Health and Environment was signed by 52 governments of Africa on August 29, 2008. As signatory of the Declaration, Ethiopia conducted a 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.

Medical waste management

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

A study by USAID (2009) on the general status of injection safety and healthcare 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 healthcare waste. A report by Haylamichael and Desalegne (2012) notes that only one facility out of the total of nine visited used a complete color-coding waste segregation system.

Consistent with the observations of Haylamichael and Desalegne, the ESSA field visits confirmed that segregation of waste at the health care facility (HCF) level is low, with only one of eleven health care facilities visited demonstrating a well-established waste segregation practice. However, the field visits also confirmed that almost all facilities constructed under HSDP have low-temperature incinerators, which at the time of visit were functional. However, incinerators at two facilities were already showing signs of deterioration,⁹ despite being only 2 years old.

From an environmental perspective, **it is to be noted that the incinerators used for healthcare 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.** The ESSA analysis found no available data to provide 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. Without the data, it is not possible to determine if the measures of impact and risk are acceptable. This will be determined in the near term when robust data are made available to the Bank ESSA team in order to ensure that any impact and risk is quantified and mitigated appropriately in line with the core principles of OP/BP 9.00.

Regarding pharmaceutical and medicinal waste, there is a need for improvement of the existing practice at the healthcare 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-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 healthcare facilities visited to inform the ESSA process.

⁹ It was reported that this was a result 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.

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



Picture Set 2. Sub-optimal healthcare waste management practice. 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 this health care facility visited.



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, and long-lasting insecticidal nets.

With regards to indoor residual spraying and long-lasting insecticidal nets, HSDP IV has set the following targets:

- 100 percent 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 indoor residual spraying coverage to 90 percent of the targeted areas by 2013 and maintain coverage until 2015.
- 100 percent of households in malaria-endemic areas own one long-lasting insecticidal net per sleeping space.
- At least 80 percent of people at risk for malaria use long-lasting insecticidal nets properly and consistently.

The 2012 National Malaria Guidelines highlight that there is a need to strengthen environmental management practices of indoor residual spraying activities. The same guidelines emphasize that much remains to be done to meet WHO and FAO standards of environmental compliance and human safety measures when using insecticides for indoor residual spraying operations. Moreover, owing to the shortage of operational budgets allocated for indoor residual spraying 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 FMOH can benefit from this strategy in effectively handling pesticide containers. The most commonly

used insecticides for malaria control in Ethiopia are organophosphate insecticides and carbamates. Although DDT is not used at present for malaria control, there is accumulation of obsolete DDT found in storage facilities throughout the country. The FMOH, 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.

Overall, the risk rating for this set of impacts is rated as “moderate” to “high”. 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 FMOH has developed and endorsed insecticide storage standards to ensure that WHO and FAO requirements are met. As mentioned, 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 waste.¹⁰

Physical infrastructure construction and rehabilitation

Through the MDG Performance Fund the only physical infrastructure that will be financed during HSDP IV is rehabilitation and construction of health centers. At this time, the MDG Performance Fund 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 FMOH 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 one 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 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. Land erosion and destruction of natural habitats during construction are expected to be minimal with proper early screening practices and compliance with good practice and 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, which would increase the risk rating to “moderate”. Some of likely adverse impacts during construction include the following:

- ***Soil and water pollution*** may occur 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 be a minor to moderate risk if general good practice environmental management guidelines are not followed during construction.

¹⁰ Comments received from FMOH on a draft report of this assessment.

- **Pressures on existing water sources** 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** may result 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 vectors** could have a breeding ground in stagnant pools of water at construction sites. This risk is deemed to be “low. Through diligent application of good practice civil works construction guidelines, this risk can be eliminated.
- **Natural habitats and physical cultural resources** are at risk 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”. The capacity of local staff to conduct 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

This sub-section includes the social benefits, impacts, and risks expected to be generated by interventions that will be supported by the MDG Performance Fund.

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 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 to improve the HSDP-generated social benefits include a policy shift in the treatment of pneumonia by health extension workers, upgrading 30 percent of existing health centers, training and deployment of emergency surgeons to provide comprehensive emergency obstetric care, 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 Government of Ethiopia has designated four of the country’s regions — Afar, Somali, Benishangul-Gumuz, and Gambella — in need of special attention. In this respect, Article 89 (2) of the Constitution stipulates that the 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, the Government has established the Ministry of Federal Affairs to promote equitable development, emphasizing delivery of special support to the designated four regions. 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, comprising relevant sector ministries, including FMOH, was reorganized in March 2011. The Ministry of Federal Affairs acts as Vice Chair and Secretariat of the Board. A Technical Committee, comprised of sector ministries on the Board, was also established under the Ministry of Federal Affairs 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 Ministry of Federal Affairs, has directorates 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 FMOH, 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 backup 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 FMOH 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, FMOH constructs and equips health centers in these regions. The FMOH also constructs 75 percent of the health centers in the four regions that need special attention, while in other regions the FMOH supports only 50 percent of health centers constructed. The regional health bureaus will construct the remaining health centers. The FMOH also provides medical equipment for all health centers constructed.

In other regions, the regional health bureaus construct the health posts, whereas FMOH provides the medical equipment. The regional health bureaus also construct 50 percent of health centers, matching the same number of health centers that FMOH constructs.

Healthcare financing

In Ethiopia, health services are financed by federal and regional governments, grants, and loans from bilateral and multilateral donors, nongovernmental organizations, and private contributions. Despite improvements over the past few years, healthcare financing remains a challenge. Since adoption of HSDP III, FMOH 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 component is described below.

Revenue retention, and utilization. The FMOH 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, and from health, 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 8 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 epidemiology, HIV/AIDS-related services (i.e., voluntary counseling and testing, and antiretroviral therapy); TB diagnosis and treatment; maternal health (antenatal and postnatal care, and delivery), 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. Out-of-pocket payments by households represent a significant contribution to healthcare financing in Ethiopia; accounting for 37 percent 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 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 House of Federation 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, agricultural income tax, rural land use fee, sales tax, 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. 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 region

<i>Regions</i>	<i>Percentage (%) share of block grants</i>	<i>Revised percentage (%) share of block grants</i>
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

Source: The Federal Budget Grant Distribution Formula (House of Federation, 2009).

Comparatively, 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 that necessitate 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: (a) land cultivated, (b) population, (c) tropical livestock unit, (d) number of unemployed people in urban areas, (e) number of poor people, (f) spatial price index, and (g) 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 18.61% (Afar), 42.48% (Somali), 28.87% (Benishangul-Gumuz), and 10.03% (Gambella).¹¹

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 Government of Ethiopia 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 the MDG Performance Fund, 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:

- (a) ***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

¹¹ The Federal Budget Grant Distribution Formula (House of Federation, 2009).

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.

- (b) ***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.

- (c) ***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 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 nationwide health improvements. These impacts include improved overall health status of the vast majority of citizens who are 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 healthcare 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 indoor residual spraying and long-lasting insecticidal nets, 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, *Program-for-Results Financing*, 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, the ESSA looks at the relevant laws and institutions for environmental and social impact assessment and management, 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: (a) the environmental impact assessment and management system and (b) the 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.

Adopted in 1995, the **Ethiopian Constitution** 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 **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: Natural Resource Base, Policy and Strategy, Institutional Framework, Action Plan, and Compilation of Investment Program.

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 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 (EIA) completes the following:

- 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 decisionmaking processes in a manner that promotes sustainable development. The proclamation 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 proclamation 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 EIA Proclamation 299/2002. To this end, the EIA 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 MDGPF-supported activities.

Proclamation 159/2008, Prevention of Industrial Pollution Regulation. As a follow up to Proclamation 300/2002, this 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 for proposed developments in Ethiopia and institutional arrangements for implementation of Environmental Management Plans.

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 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;
- Annexes that (i) identify activities requiring a full EIA, partial measure or no action; (ii) contain sample forms for application; and (iii) 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 (FMHACA) 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.

National Health Care Waste Management (HCWM) 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 HCWM practices in all healthcare 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, handwashing, 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 healthcare waste generated by health institutions; and (b) all government, and nongovernmental 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 occupationl
- Create awareness among healthcare workers about the importance of safe disposal of waste generated at health facilitiesl
- 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

<i>Entity</i>	<i>Roles and responsibilities for environmental and social management</i>
Federal Environmental Protection Authority Regional Environmental Agencies	As the national entity for environmental management, FEPA is responsible for: <ul style="list-style-type: none"> • 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.
Federal 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 FEPA 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 (FEPA) 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 FEPA. In this respect, the FEPA is responsible for establishing a system for undertaking EIA in public and private sector projects. The FEPA 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 FEPA 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 FEPA is also responsible for monitoring, auditing, and regulating implementation and performance of such projects. The FEPA holds primary responsibility for providing technical support on environmental protection and management to regional states and sector institutions.

Regional environmental 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 sector environmental units, stipulated in the Environmental Protection Organs Establishment Proclamation (295/2002), are to be established in every competent sector institution (i.e., the line ministry and regional sector agencies). These 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 FEPA 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 FEPA.

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** is an autonomous entity under the Ministry of Health. The FMHACA has the mandate, as per Proclamation 661/2009, to regulate:

- Healthcare practice;
- Healthcare premises, which includes healthcare facilities, food establishments, medicine facilities, health-related facilities and port inspection sites;
- All health professionals;
- Healthcare products from production to consumption of medicines, medical equipment and devices, food and food supplements, herbal products, cosmetics, AND 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 FMOH 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 FEPA, including strengthening environmental health interventions in line with the Libreville Declaration and mainstreaming the climate change agenda in the health sector.

The healthcare delivery process is one of the eight core processes being implemented by FMOH. 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 HCWM Strategic Action Plan 2012-2015.

This National HCWM Strategic Action 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 health care facilities;
3. Improve institutional and management capacities of health care facilities as well as woreda, zonal, regional and central health authorities;
4. Establish a proper HCWM Monitoring Plan for health care facilities at woreda, zonal, regional and federal levels.

The Medical Services Directorate, with support from the Pastoralist Directorate, has been given the responsibility of monitoring and supervising implementation of the National HCWM Strategic Action 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. The IPPS committees lead implementation of the Plan and ensure that there is input from the environmental health officer who is a member of the committee and who coordinates healthcare waste management 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** is an innovative community-based initiative introduced in 2003 during HSDP III. The Health Extension Program helps create a healthy environment by making available essential local-level health services. The objective of the Health Extension Program 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 Health Extension Program is the central mechanism of health service provision in Ethiopia. The Health Extension Program consists of a package of basic and essential promotive, preventive, and selected high impact curative health services. The Health Extension Program 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 FMOH, WHO, and UNICEF, 2011). Implemented at household level, the Health Extension Program is comprised of four major health categories: disease prevention, family health, environmental hygiene and sanitation, and health education and communication. The Program is delivered through a network of five household's organized under one model family to influence one another in practicing a healthy lifestyle. Health extension workers provide training and technical support to the networks of families to implement Health Extension Program packages.

In connection with Health Extension Program, HSDP IV focuses on scaling up urban and pastoralist Health Extension Program, improving the its quality in rural areas and maintaining program coverage. The FMOH established appropriate health service delivery for 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. Accordingly, 16 Health Extension Program packages were adapted to pastoralist needs and translated into local languages. To ensure achievement of program objectives, the Pastoralist Health Promotion and Disease Prevention Directorate was also established in the FMOH.

In the context of the 2008 Libreville Declaration on health and environment inter-linkages, the joint FMOH-FEPA 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** 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. 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 be 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 MDG Performance Fund.

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 FMOH 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.

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: (a) *Expropriation of Land Holdings for Public Purposes and Payment of Compensation Proclamation* and (b) *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 landholder. 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 their property situated on the land and for permanent improvements they have 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 landholders 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 landholdings 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, farmland 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

The Proclamation regulates use and administration of rural land and recognizes farm, pastoral, semi-pastoral, and communal landholdings. It outlines a grievance mechanism and dispute resolution system. The law requires that all landholdings 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 landholding 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 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 FEPA, regional governments established the Environmental Protection, Land Administration and Use Authority (EPLAUA) vested with responsibility of the administering rural land. EPLAUA 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 **Federal 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 FMOH 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.

For federally financed health centers, FMOH 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: (a) supply side interventions, (b) demand-side interventions, and (c) 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 FMOH and regional health bureaus, which form part of the HSDP governance structure. The Joint Steering Committee holds quarterly meetings, attended by high-level officials from FMOH 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 MDGPF-financed activities. 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 FMOH 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 MDG Performance Fund, 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:

- **Strengths** of the system, or where it functions effectively and efficiently and is consistent with OP/BP 9.00.
- **Weaknesses (or gaps)** between the principles espoused in OP/BP 9.00 and capacity constraints, examined at two levels: (i) the system as written in applicable laws and regulations, and (ii) how the system functions in practice.
- **Opportunities** to strengthen the existing system. The ESSA identified actions that lie within the mandate and scope of the Program implementing agencies. These are used to inform development of performance-enhancing measures.
- **Threats (or risks)** 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 IPPS committees 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 FMOH and FEPA for capacity building to undertake and monitor/audit EIA – this is deemed a moderate risk and should be immediately addressed by the FMOH through the Program Action Plan as one of the first actions to be completed post effectiveness. • 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 scorecard 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 FMOH- FEPA 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 Scorecard, Facility Readiness Assessments, FMOH-FEPA Joint Plan of Action, among others), specific actions included in the PforR Program Action Plan (e.g., technical guidelines for environmental screening for proper siting and construction of 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 (FEPA) 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 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 checklist 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 FMOH adopts the PSNP simplified screening procedures for known physical cultural resources and develops and applies internationally recognized chance-finds procedures in the early screening practices for site selection of 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 Core Principle 2: (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 Core Principle 3. The waste management issues are treated under Core Principle 2 and crossed referenced to Core Principle 3.
<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 annual facility readiness assessments allow the FMOH 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 Core Principle 2, the construction phase risks can be mitigated through inclusion of appropriate safety measures in all health center civil works contracts, operation phase risks can be mitigated through existing measures in place in the HSDP IV Program. All such measures need to be adopted by the FMOH immediately post effectiveness and monitored closely to ensure compliance and completion of the listed actions.

Core Principle 4: Land Acquisition

Applicability: Limited

- The 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 project-affected people 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 FMOH should ensure that project-affected people receive compensation and are properly resettled before the land is expropriated and ensure that people without legal rights to land are compensated for lost assets and provided with resettlement assistance. 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 Ministry of Federal Affairs 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 FMOH 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 FMOH 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 FMOH 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 PforR operation aims to strengthen government performance in the health sector to support achievement of the health-related 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 FMOH 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 following matrix 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 ESSA Actions for Inclusion in the Program Action Plan

#	<i>Risk</i>	<i>Action</i>	<i>Responsibility</i>	<i>Timeframe</i>	<i>Indicator</i>
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 health centers 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. 	FMOH, regional health bureaus and WHO's 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.	<p>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.</p>	FMOH	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.	<p>Healthcare Worker Retention, Incentive Packages, Training and Capacity Building (Core Principle 1, 3, 5 and 6): To improve service delivery, the FMOH will facilitate the implementation of 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</p>	FMOH	Ongoing	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.

#	<i>Risk</i>	<i>Action</i>	<i>Responsibility</i>	<i>Timeframe</i>	<i>Indicator</i>
		HSDP IV and MDGPF investments by promoting faster human resources development and deployment in the health sector.			
4.	Poor segregation and final disposal of health care waste (Core Principles 1 and 2) leading to environmental pollution and health problems.	Support all health facilities to establish and operate Infection Prevention and Patient Safety Committees to facilitate implementation of facility level HCWM Plans following the HRH Strategic Action Plan for 2012-2015.	Pastoralist health promotion and disease prevention Directorate working with regional health bureaus	Ongoing as defined and mandated in the national environmental and social management system	Number of health centers having IPPS Committees Number of health centers complying with guidelines (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 waste.s FMHACA establishes protocol and institutional arrangements for disposal of expired medicines.
6.	Public and worker safety (Core principle 3).	Construction phase of health centers: Incorporate public and worker occupational safety guidelines in the civil works contracts for construction of health centers. Operation phase of health facilities: 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.	FMOH.		Documentation on outreach and actions to assist/serve all vulnerable groups.

ANNEXES

Annex 1: Legal Framework for Medical Waste Management in Ethiopia

<i>Proclamation/Policy</i>	<i>Scope and Application</i>	<i>Responsible Entity</i>
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 health care facilities 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 health care facilities 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 health care facilities. 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 health care facilities. 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

<i>Proclamation/Policy</i>	<i>Scope and Application</i>	<i>Responsible Entity</i>
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.	FMOH
Infection Prevention Guidelines for Healthcare Facilities in Ethiopia	Specifies that waste generated in health care facilities 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 health care facilities.	FMOH
Healthcare Waste Management National Guideline	Contains key points on the need for managing healthcare waste, 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 centers, 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 healthcare waste management is to be both an administrative and technical issue and stresses health care facilities to develop an infectious waste management plan as part of HCWM Guidelines. 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 health care facilities; definite specific administrative procedures; and allocate resources at all levels to ensure proper healthcare waste management.	
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 Healthcare Facilities	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, *Program-for-Results Financing*.

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 lifecycle 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 FEPA has enacted EIA Directive 1/2008 to determine projects subject to EIA. As per this directive, the only project typology in the health sector that requires an EIA is the construction of hospitals.¹² It is important to note that since the MDG Performance Fund will not finance construction of hospitals, but only health centers, the EIA Directive is not applicable, at this time, to this PforR 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 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.

¹² It is important to note that although HSDP IV will include construction of health centers and health posts and hospitals, the MDG Performance Fund only includes rehabilitation and construction of health centers that do not require an EIA.

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 that 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.

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 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*** that 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

As envisaged in the Program to mitigate environmental and social impacts, Core Principle 1 is within the scope of the MDGPF investments in three areas to deliver a comprehensive package of maternal and child health services: (a) civil works rehabilitation and construction of health centers, (b) medical waste management, and (c) 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. Each health center has a physical footprint of 1 hectare, including the location for the placenta pit and incinerator. At this time, the MDG Performance Fund 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 MDG Performance Fund 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. This area entails storage, distribution, use, and disposal of Insecticides used for indoor residual spraying (ISR) and long-lasting insecticidal nets 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.¹ 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 healthcare 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 FEPA and FMOH on a number of issues of relevance to environmental health, including efforts made toward mainstreaming national EIA requirements in the sector. The EIA mainstreaming work is already jointly planned and budgeted. The details on relevant policies and proclamations are provided in Annex 2.
2. **Health center construction standards and guidelines.** The FMOH 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 (refer to 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 FMOH, 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 FMOH.
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

¹ 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.

Infection Prevention and Patient Committee to systematically address healthcare 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, 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, FMOH focused attention on training community and mid-level health professionals. In addition, 31,831 health extension workers were trained and deployed to implement the Health Extension Program at the community 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 needs for comprehensive emergency obstetric care and other emergency surgical services at primary healthcare-level, a masters-level curriculum on emergency surgery was developed and training commenced at five universities. 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 healthcare 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, core process experts 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 core process requirements, 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. Also, an Environmental Health Officer, a committee member, will coordinate healthcare waste management 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 healthcare 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 Health Extension Program was assessed in relation to reported use of used long-lasting

insecticidal nets and containers of hazardous compounds. In this respect, health extension workers 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. Health extension workers 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 FMOH has established a standard design and comprehensive set of construction guidelines for healthcare 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 since they can be easily mitigated through diligent application of an early site screening form. This action is included in the proposed 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 World Bank.

It is important to note that HSDP IV is specifically designed to address many of these gaps through the following actions, some of which are financed through the MDG Performance Fund:

- Scale up urban and pastoralist Health Extension Program and improve the quality of the Health Extension Program 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, preventing mother-to-child transmission, 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 MDG Performance Fund 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 in HSDP IV; 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 mostly lie beyond the scope of the Program and need to be addressed at a national level since they affect all sectors, including the health sector. For those gaps that are within the FMOH 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 Program Action Plan.
- (b) *EIA delegation to sectors.* In the context of the FEPA 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 FEPA nor accept the associated responsibilities to prepare and review EIAs in their sector; and (iv) there has been limited guidance provided by the FEPA to sector ministries with respect to their delegated responsibilities.
- (c) *FMOH capacity to implement the EIA system.* With respect to application of the EIA system in the health sector, FMOH, as a FEPA-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 FMOH has given the Pastoralist Health Promotion and Disease Prevention Directorate responsibility to implement the EIA directive in line with Proclamation 295/2002.² The Directorate must coordinate the FMOH 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,³ 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 is considered a higher-order gap for government to address and 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.

² The Environmental Organs Establishment Proclamation (Proclamation No. 295/2002) requires the establishment of Sector Environmental Units.

³ This specifically refers to the joint EPA-FMOH National Joint Plan of Action which among others specifically focuses on the mainstreaming of EIA and HIA within the health sector.

- (d) ***EPA capacity to review EIAs.*** The capacity of the Competent Authority responsible for EIA review is often weak since the FEPA has delegated such responsibilities to sector authorities. The FEPA is the regulatory organ accountable to the Prime Minister (according to Article 3(2) of Proclamation 295/2002). The FEPA is expected to regulate activities carried out not only by private sector project stakeholders, but also by Government. However, the capacity of FEPA to regulate the activities of public sector development projects has been limited due to insufficient number of experts. The FEPA 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 FEPA 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. The EIA 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 FEPA 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 percent of the total budget). As a comparison, during the same fiscal year, the health sector was allocated 2 billion Birr (4 percent of the total budget) of which 52.8 million Birr was allocated for the prevention and mitigation of environmental risk factors (FMOH and FEPA, 2010). The FEPA 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 FEPA 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 that has been officially 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 healthcare 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 regularly to discuss IPPS concerns.⁴ However, since only a limited number of healthcare facilities 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 healthcare facilities and to monitor progress with respect to how well the HCWM Plans are applied at the facility level. This significant gap is included in the Program Action Plan.
- (b) *Healthcare Waste Segregation and Management.* Point 2(a) above is important because, while the HCWM plan aims to implement several HCWM practices, including waste segregation in healthcare facilities, the ESSA team observed that the existing segregation practice at the facility level was limited.⁵ The established system for healthcare 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 use 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 place.⁶ This practice has helped to reduce the load on the health center's incinerator, which at present is only operating a few days per week. In three health facilities, where such 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 as well as additional immediate actions proposed for inclusion in the Program Action Plan.

⁴ The consultant was provided with samples of minutes of meeting of the IPPS committee at 1 hospital and 3 health centers.

⁵ Of the total of 10 health care facilities visited, an established and well functioning waste segregation practice was observed in one.

⁶ It was reported to the consultant that the segregation system at Butajira Health Center was started with support from USAID. Although this support has now stopped the Health Center has continued the segregation practice, which has brought about multifaceted benefits to the facility.

- (c) ***Disposal of expired medicine.*** From ESSA field visits it was 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 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 healthcare facilities, the Agency availed its incinerator for the disposal of expired medicine. This incinerator was dismantled after 2009 when the role of FMHACA evolved to regulator and no longer provider of assistance in disposal of such products.

Apart from this, there were also three sites where expired medicine from various sources were disposed of: 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 providing this disposal service. 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 present, healthcare 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, and 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 indicted that they do not have the capacity for collection of hazardous materials and waste. The health extension workers 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 healthcare facility.

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 health care facilities and other sites for inspection. However, vehicles are not available.⁷ Similarly some experts

⁷ 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.

pointed out that office furniture and equipment are only partly available.⁸ 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 experts were reported to be available to undertake such tasks.⁹ 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. Comparatively, 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 healthcare sector,¹⁰ at present, the core process has focused its activities on private sector health facility rather than public ones.¹¹

4. **Shortage of Health Specialists.** According to a recent assessment conducted by the FMOH 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 HRH Strategic Plan and the FMOH 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 Healthcare Facility Level.** The ESSA team observed that in line with the standard design requirements of the Health Infrastructure Directorate, 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 was observed at the Assosa Health Center which did not have an incinerator as per the standard design set by

⁸ 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.

⁹ 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.

¹⁰ Note that the health and health-related services and products core process also has the mandate of regulating food and beverage establishments and other health-related facilities such as drugstores and pharmacies.

¹¹ This information was provided by both the Butajira health office and Benshangul-Gumuz Regional Health Bureau.

Health Infrastructure Directorate.¹² All hospitals and health centers visited also had water supply systems and septic tanks in place. However, at some health centers in rural settings,¹³ this system was not in use as water was supplied from shallow wells in the vicinity. In the healthcare facilities visited, 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 healthcare 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 healthcare facilities 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 healthcare facilities as required.

Opportunities

This sub-section describes the opportunities available to the Government of Ethiopia to improve the performance capacity of the institutions involved in implementing activities financed through the MDGPF window. The 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 World Bank can provide through its implementation support to the Government of Ethiopia.

1. Health Facility Readiness Monitoring. HSDP IV will receive technical support from the World Bank through the PforR operation to refine the *balanced scorecard approach* 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 subnational level. Further, the PBS III will also be supporting comprehensive facility surveys that 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 process* that thoroughly analyzed the human resources for health situation in the country. Based on the results, the HRH Strategic Plan (2009-2020) was developed and sets out details on the planning, management, education, training and skill development, legal framework, and financing mechanisms. In regards to human resources, the HRH 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 HRH

¹² According to the Acting Head of the Assosa Health Center, the facility was constructed around 50 years ago and hence did not incorporate the design standards of the Public Health Infrastructure Directorate. [Note that Health Infrastructure Directorate has a stringent design requirement for health centers, which in general provide basic health care services but are required to have well-constructed brick incinerators that were similar to those observed in hospitals.]

¹³Namely at the Abrahamo Health Centre in Benshangul Gumuz and the Hamus Gebeya Health Centre in Butajira *Woreda*.

Strategic Plan immediately post-effectiveness to address the associated gaps as detailed in the ESSA.

3. **Healthcare Worker Retention.** As a result of the human resources for health scoping exercise, and in consultation with regional health bureaus, the FMOH 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. FMOH is also considering various financial and non-financial incentive schemes that some regional states have put in place. For example, the incentive scheme, which was implemented by the SNNPR Health Bureau observed during the ESSA field visit, may serve as an example worthy of replication. The hospitals in the SNNPR 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 under category C are those operating in the urban areas.

4. **Healthcare Worker Incentive Packages.** 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 category A are offered better privileges in the form of early release and sponsorship for further studies, as compared to those in the category B. By contrast, those working in category C health facilities are required to serve for a period of 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, FMOH 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 speaks to ensuring implementation of the HRH Strategic Plan to also fill this significant gap.

5. **Medical Waste Management.** One area where such support could be immediately beneficial is through the joint FMOH/FEPA 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 Joint Plan of Action 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 FMOH-EPA National Joint Plan of Action

<i>Specific objective</i>	<i>Joint action</i>	<i>Budget (US\$)</i>	<i>Responsible entity</i>
Improve capacity of EPA to review and approve EIA and strategic environmental assessment	<ul style="list-style-type: none"> • Gap identification and supporting accordingly; • Strengthen and enhance the unit with multi-disciplinary professionals dedicated to review EIA and monitor the environmental management plans. 	74,610	FMOH, 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 and health impact assessment protocol. 	71,580	FMOH, FEPA
Promote HIA and EIA mainstreaming and enforcement of regulatory laws	<ul style="list-style-type: none"> • Assess 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 stakeholders. 	189,455	FMOH, FEPA
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 and 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 and auditing. 	35,000	FMOH, FEPA

6. **Hazardous Waste Disposal.** Availing temporary storage facilities in locations near health facilities is an important measure that 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 proposed Program Action Plan as they pertain to proper storage and disposal of expired pharmaceuticals and materials used to prevent vector-borne diseases.

7. **EIA Screening and Induced Impacts.** Although the mandates for availing land for healthcare facility construction are under the Ministry of Urban Development and Construction,¹⁴ 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 into account the environmental impacts.¹⁵ Such a guideline will support development of mitigation measures, including induced impacts identified during the screening process. This action is included in the proposed 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 toward 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 design or the proposed actions derived from the ESSA analysis for inclusion in the Program

¹⁴ Specifically under the woreda or kebele administration for rural sites and the city administration for urban sites.

¹⁵ It is the observation of the consultant that the health sector participates and provides inputs during the selection of sites for healthcare facility 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.

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

OP 9.00: 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.

BP 9.00: 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.

Applicability

The provisions in Core Principle 2 are considered in relation to 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 since 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, Core Principle 2 has limited applicability to the Program. As such, both risks are deemed to be minor to moderate, and mitigation would be straightforward.

Strengths

With respect to system strengths, the ESSA process identified that the EIA Proclamation and the EIA Procedural Guidelines are consistent with Core Principle 2. EIA Proclamation is clear in the objectives of an EIA to protect the environment (natural systems). And 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 present 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 PSNP 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 ESMF is used to screen community-level sub-projects. The ESMF incorporates: (a) 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, (b) 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 Physical Cultural Resources Screening Rates, 2006-2012

<i>Year</i>	<i>Data collection method</i>	<i>Subproject screening rate</i>
2006	Public works review sample	
2007	Public works review sample	
2008	Public works review sample	
2009	Public works review sample	34-70% (34% for subprojects screened individually); Approximately 70% if subprojects screened in groups (within village) are include.,.
2011	Public works review sample	98% (with some quality concerns) and no screening in pastoral regions.
January 2012	Actual total figures provided by regional Public Works Focal Units in workshop	96% (46,001 subprojects planned for 2012 reportedly screened, out of a total of 47,902, excluding 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 physical cultural resources 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 physical cultural resources is extremely limited. 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 this aspect of Core Principle 2 explicit so as to gather additional data on the track record with regards to how 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 health care facilities or improper medical waste management practices in health care facilities 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 fieldwork will the ESSA analysis be completed.

Opportunities

The opportunities identified under Core Principle 1 may be generally considered 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 physical cultural resources 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 Core Principle 1 and given the small physical footprint of each health center, it is expected — through diligent application of the early site screening form — that the FMOH and regional and local teams can incorporate elements into each health center site-screening exercise that would 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 Core Principle 1. 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

Core Principle 2. Any further risks, particularly 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.
- Labor Proclamation 377/2003.
- Occupational Health and Safety Guideline (2003).
- Food, Medicine and Health Care Administration and Control Proclamation 661/2009.
- Labor and Social Affairs requirements, which state employers must maintain an accident register, ensure that employees are not at risk and provide all workers with the required protective equipment. Such requirements were confirmed during the ESSA field visits when confirmed health and health-related products and services core process experts presented inspection checklists that contained clear assessment points on personal protective equipment and occupational health and safety.
- Establishment and operation of the Public Health Emergency Management Agency (PHEMA) under FMOH, 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:

- (a) The EIA system does not comprehensively encompass aspects of public and worker safety.
- (b) It is not evident that the site selection criteria and guidelines issued by the FMOH incorporate PHEMA guidance with respect to avoiding siting health care facilities 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 present, 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 healthcare facilities across the country.

The preliminary ESSA analysis with respect to Core Principle 3 identified the need for robust data on the activities of PHEMA in addressing public health issues during natural hazards beyond siting and construction of healthcare facilities. The PHEMA guidebook is comprehensive, but how it is 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 healthcare facilities. In addition, post-construction and during operation of health centers, public and health worker safety is not adequately addressed. In one study, 9 out of 70 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 healthcare facilities 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 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 healthcare facilities and suppliers of pharmaceutical products. This poses a moderate to high risk to the public if expired medicine are distributed to patients at public healthcare facilities. Though, 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.

Opportunities

At this time, one important opportunity available to the FMOH 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 FMOH 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

<p><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.</p>
<p><i>BP 9.00:</i> As relevant, the program to be supported:</p> <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 MDG Performance Fund 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 at existing health centers, onsite medical waste management and offsite disposal, and pesticide management are unlikely to require land acquisition or loss of access to natural resources. 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 HSDP IV 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 healthcare 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 to 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 10 times the average annual income the landholder 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 their 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 landholder 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.

Gaps in the system as written

Core Principle 4 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 MDGPF-financed investments, in particular, construction of 106 new health centers, are detailed as follows.

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 landholder 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, these gaps 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”. The law presumes there is no tenant in rural areas since absentee landlordism was abolished in 1975. Tenancy for residence has no link with ownership, and 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 landholders. Regional directives assign responsibility of valuation to the Environmental Protection, Land Administration and Use Authority (EPLAUA) 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, mainly 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, slaughterhouse 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 or Resettlement Action Plan 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 screenings 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. Consultations with project-affected people are not conducted systematically, and grievance-handling mechanisms are often inadequate and delayed.

The local investment grant component of PBS was used for infrastructure development in the health sector. Typical projects implemented through local investment grants 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 recreational areas, waste disposal facilities, prevention and control of pollution). Local investment grants were 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.¹⁶

Identification of construction sites 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,

¹⁶ MoFED PBS II Environmental and Social Sustainability Study (June 2011).

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 MDG Performance Fund may be constructing health centers. Lack of guidelines for ensuring a systematic acquisition of communal land for construction 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 MDGPF-financed health centers. This action is included in the Program Action Plan.

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 turnover of local-level staff 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 Core Principle 4.

Opportunities

Out of the the gaps identified, important opportunities exist to strengthen system performance. Of the gaps identified, the most significant in terms of alignment with the guiding principles of OP/BP 9.00 and Core Principle 4 are as follows:

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 to citizens without legal rights to use the land. These citizens are therefore ineligible for compensation by law.

Resettlement and compensation of citizens without legal right to use expropriated land. 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 FMOH 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.

Communal land for construction of health center. Another important opportunity available to the FMOH, which 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 FMOH 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.

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. This is a higher-order opportunity beyond the scope of this Program but an important opportunity for the Government of Ethiopia to consider addressing. What the FMOH can do under the Program is to 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.

Valuation of assets. On the basis of Proclamation 455/2005 Article 7(2) for expropriation of landholdings 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 comprising data collected from local market assessments. Compensation is commensurate with loss of assets, however replacement cost does not consider location value. Addressing this gap entails a higher-order opportunity beyond the scope of this Program, but an important opportunity for the Government of Ethiopia to consider addressing. What the FMOH 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.

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 Government of Ethiopia and the FMOH.

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 toward addressing these impacts will not be consistent with the guidance under OP/BP 9.00.

Core Principle 5: Indigenous Peoples and Vulnerable Groups

OP 9.00: 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.

BP 9.00:

- 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 World 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. 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 Memorandum of the President 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.
- (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 Government of Ethiopia thus far on formal identification and designation of Indigenous Peoples 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; the focus, in this case, is placed on examining those elements of the overall HSDP IV program design and scope that ensures distributional, gender balanced, and culturally appropriate access to public health services, with special emphasis on the four regions that require special support.

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

- (a) The Ethiopian Government has identified 4 of the country's 9 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 has adopted a 5-year strategy (2009-2014) to ensure fast and sustainable development in these 4 regions. And FMOH has designed HSDP IV to ensure that one of the areas of strategic focus is the provision of special support to these regions.

- (b) In the context of these 4 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 MDG Performance Fund.
- (c) 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.
- (d) 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 component, and the Community-Based Health Insurance (CBHI) scheme:
 - (i) 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.
 - (ii) 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.
 - (iii) 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 GOE decentralization policy, decisionmaking power in the health sector has been devolved to regional health bureaus and woreda health offices. Accordingly, the focus at the FMOH 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 FMOH, 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 Ministry of Federal Affairs, 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 FMOH, 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 healthcare 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 FMOH constructs and equips all health centers in these regions; whereas in other regions, the contribution of the FMOH is limited to the supply of equipment. With respect to health centers, the FMOH covers construction costs of 75 percent of health centers built in the four regions. When it comes to developed regions, the FMOH shares 50 percent of the construction cost of health centers.

Based on a recent needs assessment exercise, the HSDP IV allows for special support by the FMOH 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 percent 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 FMOH conducts biannual supervision in these four regions to assess implementation effectiveness of MDGPF-financed activities in HSDP IV 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 FMOH and regional states, are held at the national level to review the performance of the regions in the implementation of MDGPF-financed activities in HSDP IV. 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 healthcare 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 FMOH 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 6 of the 9 regions and the 2 city administrations by the end of FY10/11. Preparatory work is currently underway to avail these services in 3 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 8 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 8 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 16 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 Insecticide-treated bednets distribution. The service was expanded in 2009 to 20 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 water, sanitation, and hygiene activities and capacity building for the local health system (Mobile Health and Nutrition Service Implementation Guideline, Somali Regional Health Bureau, 2011).

The mobile health teams aim to improve access to and utilization of child and maternal health, nutrition, and water, sanitation, and hygiene 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 by the regional health bureau. This manual is currently in use across regions.

Essentially, the Mobile Healthcare Services Program consists of two service packages: health service provision (child health, maternal health, and health education and Behavior Change Communication) and support to the woreda health office (integration of health extension workers) with mobile health and nutrition team through on-the-job training, logistics, referral, and reporting). Each mobile health and nutrition team is staffed with two health workers (clinical and/or midwife nurses), two health extension workers, 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 water, sanitation, and hygiene instruction. 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, and 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 10 to 15 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 Healthcare Service Program 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 Healthcare Service 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, Ministry of Federal Affairs has adopted a 5-year strategy to ensure sustainable development in the special regions. The FMOH 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, and 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 12-year HRH Strategic Plan has yet to be formally approved. An important element lacking in this Plan is the FMOH financial and non-financial incentive package. 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-related 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 healthcare facilities remain. Also, 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 FMOH. 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, FMOH has organized fee waiver orientation workshops for relevant parties involved in the screening and selection processes.

Under-utilization 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 FMOH, 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 Health Extension Program 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 child delivery, women are often discouraged from seeking health services with 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 percent of deliveries take place at home, largely with the assistance of traditional birth attendants. The available postnatal care services at health facilities in these regions are also under-utilized 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 people 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 antenatal and postnatal care, clean and safe delivery by health extension workers, delivery attended by skilled attendant, and contraceptive prevalence rates against the corresponding rates for the four 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

<i>Indicator</i>	<i>%</i>				
	<i>National</i>	<i>Afar</i>	<i>Somali</i>	<i>Ben-Gumuz</i>	<i>Gambella</i>
Ante-natal 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
Post-natal care coverage	36.2	9.5	5.2	21.1	3.0
Contraceptive acceptance rate	61.9	13.5	8.6	38.6	13.2

Source: Health and Health Related Indicators: FMOH, 2009/10.

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 regionwide 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 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 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 traditional birth attendants 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 female genital mutilation 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 female genital mutilation 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 female genital mutilation 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 female genital mutilation, as well as prohibiting or discouraging the practice. In cooperation with kebele and woreda administrations, a system was introduced to register pregnant women and newborn babies. In this way, the committees made sure that newborn 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 20-minute radio show on harmful traditional practices broadcast in cooperation with Afar FM radio. In addition, in the effort to enhance local capacity, a training-of-trainers program was conducted on harmful traditional practices for 111 youths. After the program, the youths organized and facilitated a series of community conversations on harmful traditional practices in 11 kebeles and 111 sub-kebeles.

With an aim to use schools as entry points, teachers were given similar training so that they can teach students (for five minutes out of the regular periods) about harmful traditional practices. Educational and awareness training were also given to individuals involved in the practice of circumcision regarding the fact that female genital mutilation had no religious basis and 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 under-utilization 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, but 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 FMOH in collaboration with WHO and UNICEF (2011), a number of challenges impede effective implementation of the Health Extension Program 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 health extension workers.*** 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 provided health services.
- ***Low community participation.*** Constraint to the success of the Health Extension Program is said to be attributed to inadequate participation of communities.
- ***Health posts are not sufficiently equipped.*** Many health posts in these regions are insufficiently equipped. As a result, health extension workers are forced to operate

under conditions where essential drugs and commodities such as vaccines, oral rehydration solution, palliative drugs and delivery beds, as per the Health Extension Program requirement are in short supply.

- ***Referral system not properly organized.*** Not practicing curative medicine, health extension workers 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 health extension workers to assume full responsibility for addressing the community health needs as well as their acceptance by the local population.
- ***Number of female health extension workers remains inadequate.*** Female health workers are preferred for the Health Extension Program since their services mainly involve maternal, newborn, and child healthcare. However, in the case of the Afar region, the number of female health extension workers 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 health extension workers in 2012, as confirmed by field data, is 776. Of these, only 215 are woman or 28 percent of the total number of health extension workers 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 under-utilization 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 prerecorded educational messages focusing on HIV/AIDS, reproductive health, family planning, and harmful traditional practices. The public educational programs are recorded in different ethnic languages.

The CBHI Program, 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.

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 toward 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 further continued efforts to ensure equitable access to this system by this subset of the urban poor.

Risks

By not addressing the written and applied gaps and capitalizing on the opportunities in a timely fashion, the risk 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 Core Principle 5 would 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; 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

OP 9.00: Avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

BP 9.00: Considers conflict risks, including distributional equity and cultural sensitivities.

Applicability

The proposed PforR Program will not exacerbate social conflict, nor will it operate in a fragile situation context, a post-conflict area, or in areas subject to territorial disputes. As such, Core Principle 6 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 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 PforR Program will not be consistent with the guidance provided by OP/BP 9.00.

ANNEX 4: PUBLIC CONSULTATION REPORTS

Ethiopia Health Millennium Development Goals PforR Disclosure and Consultations on Environmental Social Systems Assessment

Activity (Date): Disclosure (December 12, 2012)
Consultation (December 19 2012)

Core team: Desta Solomon, Asferachew Abebe, and Ian Campbell
supported by Cary Anne Cadman and Yasmin Tayyab from Washington, D.C.

Duration: Half-day sessions

Draft Agenda:

Time	Activity	Focal Point
9:30-10:00	Registration	Eleni Albeji
10:00- 10: 30	Welcome and outline of the PforR operation	Ramana
10:30-11:00	Presentation of ESSA	Desta Solomon & Asferachew
11:00 -11:30	Tea	
11:30-13:00	Participant feedback	Asferachew
13:00-13:30	Summarizing the conclusions	Ian Campbell
13:30-14:00	Lunch	

List of invitees:

Regional level:

1. Bureau Head and focal person for pastoral health services from 4 Regions requiring special attention
2. Bureau Head and focal person for pastoral health from Oromiya
3. Bureau Head and focal person for urban health services from Addis Ababa City Administration.
4. Afar People's Development Association
5. Somali CSO

National:

CSOs

1. Consortium of Christian Relief and Development Association (CRDA)
2. National Environmental forum
3. Consortium of Reproductive Health Association (CORHA)
4. Save the Children Consortium

Federal Ministries/Agencies:

1. Ministry of Health
2. Ministry of Federal Affairs
3. Ministry of Labor and Social Affairs
4. Environmental Protection Agency

Partners:

1. All partners supporting the health sector

Summary of consultation held on the draft Environmental and Social Systems Assessment Report

Background:

The draft ESSA was disclosed by the Bank on December 12, 2012. A stakeholder consultation of the draft ESSA was held on December 19, 2012. Consultation participants included representatives from the Ministries of Health, Water and Energy; regional health bureaus; NGOs that are working in the regions requiring special attention, as well as umbrella NGOs; and development partners supporting the health sector.

Summary:

The consultation started with a brief introduction of the proposed PforR operation to clarify the key guiding principles, context and processing steps. This was followed by a presentation of the draft ESSA highlighting the key findings and proposed actions to mitigate the weaknesses identified. Clarifications were also given to the participants on how the ESSA of a PforR differs from the safeguard assessments of Bank's investment lending operations. The stakeholders actively participated in the consultation.

Key themes emerged in the discussions with issues raised and clarifications provided:

- (a) *Was the scope of the assessment limited to regions requiring special attention?* The scope included agrarian as well as urban regions in addition to regions requiring special attention.
- (b) *How will the proposed action plan integrate with existing action plan agreed by the partners supporting the MDGPF and what happens if the action plan is not implemented?* The proposed action plan will be fully integrated with the ongoing action plan agreed with all pooling partners and duplication will be avoided. The action plan will be referenced in the Program legal document and its satisfactory implementation will be a requirement for the program.
- (c) *How adequate is the assessment and whether a wider stakeholder engagement especially non-state actors is envisaged?* The stakeholders can access the ESSA from the Bank's website and provide comments. In addition, the Bank through existing joint implementation support mechanisms will be monitoring the performance of the government system in this regard, including the implementation of the action plan.
- (d) *Why is Core Principle 6 not being applied because some regions may have social conflict?* This core principle is applied from a broader national perspective and the support from the program will actually benefit regions that require special attention.
- (e) *Suggestion made for a need to address cultural diversity and sensitivities while planning service delivery.* The team acknowledged this suggestion. The FMOH has developed special strategies responding to such needs, and the implementation of these strategies will be documented to learn and improve services for special groups.
- (f) *There are clearly defined existing processes to acquire land that involve local governments to undertake adequate consultations to minimize the risk of displacements.* The ESSA appreciates the existence of such processes and proposes to document consultations held.
- (g) *What roles can the other ministries and NGOs play in the implementation of ESSA action plan and whether there will be any grants for such involvement?* It was clarified that the PforR supports the government program, and ongoing strategies for cross-ministerial collaboration and partnerships with NGOs will be applicable. Supporting environmental and social systems strengthening activities envisaged at all levels and providing feedback on the implementation of ESSA action plan would be immensely helpful.
- (h) *What about the disposal of large quantities of medical wastes..* It was raised that disposal of medical wastes is a big problem in Ethiopia and whether there is a plan to involve private sectors in the management and disposal of medical wastes. The representative from the FMOH responded that there is a strategy for managing healthcare wastes, and it is envisaged that the implementation of the strategy will help to deal with the problem.
- (i) *What about the application of the guidelines for managing medical wastes.* It was clarified that from the limited site visits made, it was noted that the guidelines are not being systematically implemented. However, the implementation appeared to be better in facilities where there are infection control and

patient safety committees and hence the recommendation on establishment of such committees in all facilities.

This summary of the consultation is included in Annex 6 of the Project Appraisal Document.

Annex 5: RESOURCES

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 documents listed in this annex were consulted in the preparation of the ESSA.

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