Mozambique Primary Health Care Strengthening Program-for-Results (P163541)

Addendum to the Environmental and Social Systems Assessment (ESSA)

Contents

I. Introduction

1. The World Bank is supporting the Government of Mozambique's health sector through the Primary Health Care Strengthening Program (PHCSP-P163541). Using the Program-for-Results (PforR) financing mechanism, the Program's Development Objective is to improve the utilization and quality of reproductive, maternal, child, and adolescent health and nutrition services, particularly in underserved areas. Program co-financing from IDA and the Global Financing Facility in the amount of US$105 million was approved by the Board on December 20, 2017. The DLI matrix in the approved Program Appraisal Document also reflects co-financing from the Netherlands (US$35.5 million) and USAID (US$22.5 million), as letters of their indicative commitments were provided to the Bank during Program preparation.

2. The Program focuses on three thematic areas of the Investment Case (IC) for Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH-N): (i) enhancing coverage, access, and quality of primary health care services, including high-impact

supply and demand-side interventions, with a focus on underserved areas; (ii) strengthening the health system for improved stewardship, financial sustainability, expenditure efficiency and equity, and gender responsiveness of service delivery, together with improved Civil Registration and Vital Statistics systems; and (iii) enabling Ministry of Health to effectively manage the implementation of the IC, through technical assistance, capacity development, monitoring and evaluation (M&E), and Health Partners coordination activities.

3. Prior to the launch of the program, in 2017, the Bank team prepared an Environmental and Social Systems Assessment (ESSA) according to the requirements of the Bank's Policy for PforR financing. The ESSA reviewed the capacity of existing country systems to plan and implement effective measures to manage environmental and social risks of the program and to determine if any measures would be required to strengthen the country system. Thus, the ESSA recommended number of actions under the Safeguards Action Plan (SAP) that addressed the identified gaps, and these were fully integrated in the Program Action Plan (PAP).

4. Since the Board Approval of PHCSP, the Governments of Canada and the United Kingdom committed additional financing to the Program with approximately US$57 million and US$33 million, respectively. These funds will allow the scaling up of disbursement-linked results (DLRs) and the inclusion of a new disbursement-linked indicator (DLI) on availability of essential medicines in primary health care facilities. Moreover, the Additional Financing will require the extension of the Program closing date by 12 months to December 2023. Overall, there are no significant changes to the original government program as such the Environmental and Social Risk Rating remain unchanged, Substantial.

5. Despite this, to ensure that new environment and social risk continue to be avoided, reduced and mitigated adequately, the Bank team prepared this Addendum for the ESSA already prepared for the parent Program to cover environmental and social aspects of this child Program (PHCSP Additional Financing - P168314).

A. Objectives of the ESSA addendum

6. This document is an Addendum for the Environmental and Social Systems Assessment of the Primary Health Care Strengthening Program (PHCSP P163541) and is aiming at addressing the environmental and social risks related to the Additional Financing of the Program (AF PHCSP P168314).

7. The addendum has the following specific objectives:

- To assess the implementation progress of the recommendations and actions in the PAP for PHCSP.
- To identify relevant legislative and procedural changes since the preparation of the ESSA for the PHCSP.
- To identify new potential environmental and social risks and impacts from the AF PHCSP.

- To recommend measures to further strengthen the environmental and social system.

B. Methodology of the ESSA addendum

8. The preparation of the Addendum involved a series of interviews and consultation with stakeholders related to the Health, Environment and Medicines sectors, namely Department of Environmental Health (DSA) and the Centre of Medicines and Medical Supplies (CMAM). The DSA belong to the National Directorate of Public Health at central level Ministry of Health (MISAU) and CMAM is an autonomous entity mapped to MISAU but with large administrative and budgetary autonomy. Moreover, we undertook documental analysis (e.g. Aide Memoire, Implementation Status Reports, Program Action Plan) from the current and past World Bank funded projects and programs at MISAU, particularly: Public Financial Management for Results Program (P124615) and Primary Health Care Strengthening Program (P163541). We have also translated the draft Addendum into Portuguese to conduct meaningful discussions with the Client, which resulted in the current consensual addendum.

II. Description of the Additional Financing

9. The Program's PDO and PDO results indicators will remain unchanged. The DLIs of the program will be scaled up to reflect the increase in financing. The end targets of the existing indicators in the results framework will also be adjusted to reflect the additional financing and the additional 12 months in Program duration. The geographical coverage of DLI 4 on "Percentage of children between 0-24 months of age receiving the Nutrition Intervention Package" will increase from 6 to 8 provinces by adding the provinces of Sofala and Inhambane. Moreover, a new DLI (12) on "Average availability of a set of tracer drugs of essential maternal and reproductive health medicines at health facility level" will be introduced (Table 1). The changes remain within the original Program boundary vis-à-vis the Government's broader program, the IC.

Table 1. DLIs for parent Program and AF.

Current DLIs	Nature of/ Rationale for Modification
DLI 1: Percentage of Institutional Deliveries in 42 lagging districts as defined in the IC	The targets will be increased to reflect projections against a more recent baseline (2017 versus 2016), and the additional financing allocated.
DLI 2: Percentage of secondary schools offering sexual and reproductive health services (information and contraceptive methods), based on visits by health professionals, at least monthly.	The targets will remain the same in percentages but will encompass a larger number of secondary schools, considering the previously unaccounted increase in the number of existing secondary school and adding technical schools. The number of minimum visits will be reduced to at least quarterly, consistent with technical and logistical/administrative recommendations.

DLI 3: Couple Years of Protection (CYPs)	The CYP targets will be increased, according to projections being formulated in consultation with MISAU and health partners. Additional financing will supplement financing available from other partners and create more confidence in the ability of Mozambique to meet its contraceptive supply chain costs (which will require multiple funding streams) during the period of implementation.
DLI 4: Percentage of children between 0-24 months of age receiving the Nutrition Intervention Package (NIP) in the 8 Provinces with the prevalence of stunting above 35% (Cabo Delgado, Inhambane, Manica, Nampula, Niassa, Sofala, Tete, and Zambézia)	The proposed modification will expand the coverage to all provinces with stunting prevalence above 35% (high prevalence according to WHO standards). The targets remain unchanged in percentage, but will expand the coverage of the targeted population in numeric terms by around 20%.
DLI 7: Number of technical health personnel assigned to the primary health	The targets will increase, and a sub-indicator will be added on the expansion of the number of primary health care facilities with at least two Maternal and Child Health Nurses, consistent with the priorities of MISAU's Human Resource Development Plan, and required reinforcements to address critical staffing gaps for RMNCAH.
DLI 8: Percentage of district/rural hospitals that received performance-based allocations (PBA) in accordance with a minimum of two scorecard assessments in the previous fiscal year	The inclusion of an equity grant will ensure necessary flow of funds for procurement of critical basic inputs for hospital operations, defined as prerequisites to compete for performance-based grants. The addition of a year 5 target will help ensure continuity and sustainability.
DLI 9: Percentage of rural health centers in priority districts that received PBA in accordance with a minimum of two scorecard assessments with community consultations in the previous fiscal year	The inclusion of an equity grant will ensure necessary flow of funds for procurement of critical basic inputs for rural health center operations, defined as prerequisites to compete for performance-based grants.
DLI 10 Number of APEs that are trained and active	Targets will increase the pace of APE training and deployment. The incorporation of sub-targets on the utilization of UpSCALE, an application that provides real time data collection, e-learning, user tracking, supply requisitions, and other relevant features, can also critically contribute to strengthen the quality of APE service delivery and data management.
DLI 11 Percentage of deaths certified in health facilities with data on cause of death, coded per ICD 10, reported in SISMA and sent to the civil registry	The revision of existing Civil Registration and Vital Statistics (CRVS) targets will focus on enhancing collaboration with the Ministry of Justice and Constitutional and Religious Affairs to ensure that certified deaths sent to the civil registry are indeed effectively registered.
Proposed DLIs	**Nature of/ Rationale for Modification**
DLI 12 Average availability of a set of tracer drugs of essential maternal and reproductive health medicines at health facility level.	The indicator would be similar to DLI 1 of the Public Financial Management for Results Program (P124615, closing March 2019). The measurement methodology would differ, reducing the number of products to track from the current 15 to just 5 key medicines that would be representative enough on the effectiveness of the supply chain for critical medicines. This would be intended to reduce the "noise" accompanying the long and varied supply chain for each product. Key process sub indicators are also being discussed to reinforce planned reforms on the centralized structure of CMAM and the possible outsourcing pilot for last mile drugs delivery.

III. Implementation Progress of the PAP

10. The original operation PHCSP was approved on December 20, 2017 and became effective on April 18, 2018 and to date the program has disbursed a 25% advance of the grant. So comparatively to the timeframe of the program, little time elapsed and few activities were implemented. For instance, all the environmental and social actions foreseen under the PAP are still within the time limit. Despite this, when analyzing the progress towards its completion it is likely that the initiated processes will be successfully concluded within the timeframe. In Annex 1 we provide a summary of the status of the environmental and social actions of the PAP and recommendations for next steps.

IV. Legislative and Procedural Changes

11. The environmental and social system described in the parent ESSA is still applicable both in terms of laws, regulations, standards, and in terms of procedures and actual implementation of those laws and standards. There have been no changes in terms of legislation or procedures. However, with the inclusion of new DLI 12 - Average availability of a set of tracer drugs of essential maternal and reproductive health medicines at health facility level – it is important to reinforce the existence of two norms that should be observed:

12. Regulation for the Management of Hazardous Waste ("Decree no. 83/2014, of 31st December, Regulation") – The regulation establishes the rules for the production and management of the hazardous waste within the territory of Mozambique and applies to every individual as well as to public and private companies that are involved in the management of hazardous waste. This applies to (i) biomedical waste, (ii) radioactive waste, (iii) emissions and discharges of effluents, and (iv) wastewater containing the hazardous characteristics.

13. Regulation for Disposal of Pharmaceutical Products (Ministerial Diploma no. 74/2016 of 28th October) - This diploma applies to public and private health units, manufacturers of pharmaceuticals, importers and distributors of medicines, pharmacies, medicine posts, general stores, non-governmental organizations and individuals. The diploma addresses subjects such as disposal methods and forms of treatment of pharmaceutical products prior to disposal, classification by category of pharmaceutical products and procedures for the disposal of pharmaceutical products.

14. The Ministry of Health recognizes that there is room to improve implementation and compliance track record of the above regulations, particularly the disposal of the pharmaceutical waste generated through the National Health Service (NHS). CMAM is responsible for ensuring that proper disposal of pharmaceuticals is undertaken by warehouses at Central, Provincial (responsible for Provincial and General Hospitals pharmaceutical waste) and District levels (responsible for health centers and district and or rural hospitals waste). On the contrary, the waste generated by pharmaceutical companies and private care facilities is not managed by CMAM since the procurement, distribution and storage of medicines and medical supplies is not supported by Government. For this reason, it falls outside the scope of this PHCSP Additional

Financing addendum. None the less, the Government, regulates how these companies and private providers should handle medical and pharmaceutical waste. The Health General Inspectorate enforces the adherence to those rules.

15. Until recently (2016), there were no specific legislation detailing the procedures and methods required for the disposal of pharmaceutical waste. Until then, CMAM has been relying mostly on open-pit burning which is not recommended due to health and environment risks associated with this method. Seldomly CMAM had used safer but costly methods such as the incineration in high-temperature industrial furnaces of kilns of ceramics and cement factories, because there are not widely available and lack of coordination with Provincial Directorates for Health and respective warehouses. However, as CMAM becomes more familiar with the legal requirements and existing systems for disposal, and increasingly improves the coordination with the Provincial entities and the central Department of Environmental Health, the management of pharmaceutical waste in an environmentally acceptable manner is steadily improving. This results also from an improved registry and return of expired and or damaged pharmaceutical products by health facilities to CMAM warehouses. As such, in 2018 CMAM successfully prepared and implemented a National Pharmaceutical Disposal Plan to incinerate waste generated in 4 Central and Regional Medical Warehouses during 2017 and 2018 using the existing procedures emanating from the legislation (Decree no. 83/2014 and 74/2016) by following the recommendations of the Manual of Procedures for Pharmaceutical Waste Disposal.[1] The full report on this activity is yet to be elaborated.

V. AF PHCSP Environmental and Social Risks and Impacts

16. The design of the AF does not introduce significant changes in the nature and areas of intervention of the Parent Program. However, the introduction of a new DLI concerning availability of medicines in service delivery points requires few modifications on the ESSA to take into account the potential need to dispose pharmaceuticals that may expire. Therefore, the different risks and impacts identified in the ESSA for the parent Program interventions are also relevant to the AF. Generally, the implementation of the Program will likely result in more benefits and positive impacts in targeted communities. However, there are noteworthy activities that, even though will not introduce new environmental and social risks may require more attention because of the potential direct, indirect and cumulative risks and impacts stemming from:

17. Increase of End Targets - The increase of end targets to reflect the additional financing will also imply an additional 12 months of the Program duration. Therefore, the impacts are expected to continue being of low magnitude since they are spread across a longer period so will tend to be similar as described in the PHCSP ESSA. Although will be cumulatively slightly more,

[1] MISAU. 2016. Manual de Procedimentos de Eliminação de Resíduos Farmacêuticos. CMAM/UNFPA. 1ª Edição.

particularly for the expansion of access to the primary care network through additional health centers and supplies.

18. Increase of Geographical Areas – Only the DLI 4 on Percentage of children between 0-24 months of age receiving the Nutrition Intervention Package will be extended to Sofala and Inhambane provinces. The expected negatives impacts with this expansion are negligible since these provinces are already being covered by the Safeguards Actions Plan and ESSA recommendations.

19. Addition of the Scope of Intervention - A new DLI 12 on Average availability of a set of tracer drugs of essential maternal and reproductive health medicines at health facility level will be added to the Program. This could bring about an increment of specific pharmaceutical waste at district and provincial levels. Thus, there is a possibility that some medicines will expire and or be damaged. This likelihood of production of pharmaceutical waste, while small, can pose environmental and social risks during the storage, handling and disposal phases.

20. From the above, the Environmental and Social Risk Rating remain unchanged, Substantial, as none of the new activities are likely to have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected people.

VI. Recommendations to Strengthen the Environmental and Social System

21. Infrastructure Expansion - We recommend that provincial focal points and chief medical officers are further and regularly trained until the end of the program on Environmental and Social Impact Assessment (ESIA) national legislations and management best practices. This training should be extended to the new focal points where the expansion of access to the primary care network due to additional financing will occur. Moreover, we recommend adequate and dedicated staffing to ensure that ESIA approvals are obtained prior to construction and contractors commitments according to ESMPs are included in construction documents.

22. Exclusion of High Risk Interventions - We further stress that the large contracts and expenditures on construction of new Level Three and Four health facilities and hospitals, or health centers that would be classified as category A or category A+ under Decree 54/2015, of December 31, will remain ineligible, as outlined under section II of the Financing Agreement.

23. Pharmaceutical Waste Disposal - The existing Environmental and Social Management System of the Government of Mozambique includes a Handbook for Procedures of Pharmaceutical Waste Disposal. However, since most of the Pharmaceutical Waste is stored at Central level it is recommended that a roll over capacity building on Procedures of Pharmaceutical Waste Disposal is undertaken to the Hospitals and Medical Stores at Provincial and Districts level. Although the Rural Health Centers at local level are not allowed to dispose themselves the pharmaceutical waste, they should be also targeted for capacity building but

focusing on areas such as the handling, storing and returning of expired or damaged medicines and medical supplies.

24. Moreover, we recommend that a Pharmaceutical Waste Inventory and Disposal Plan is developed on a roll over bases, from central to provincial and district medical stores and hospitals. The plans for pharmaceutical waste disposal should be prior discussed with relevant stakeholders. In addition, they should be followed by a stakeholder engagement plan to help guide the implementation strategy and monitoring activities during the waste disposal by the different interested and affected parties. These plans should also include a map of the appropriate locations of sites and/or incinerators for pharmaceutical waste disposal.

25. MISAU should also undertake an inventory of the existing equipment for disposal of pharmaceutical products, including the operational status and develop a plan for repair and/or replacement where appropriate to ensure more integrated and efficient management of pharmaceutical waste including selection of strategic locations where disposal of waste from one or more warehouse and hospitals can jointly be done to reduce costs and or risks to the environment.

26. The Verification Protocol of DLI 12 should include a requirement that an Annual Report on Pharmaceutical Waste Disposal is prepared which should include information on safely disposed quantities, planned quantities to dispose following year and expected cost, number of health units achieving minimum and acceptable compliance with national policy and legislation on pharmaceutical waste disposal, and challenges faced in the process.

27. We encourage MISAU to seek ways to integrate into SMAM and SIGLUS, the electronic platform for the management of medicine and medical commodities supply chain, information about produced quantities of pharmaceutical waste by registering expired and returned pharmaceutical products (particularly from Rural Health Centers to District Medical Stores) into the system. This would improve substantially the planning of pharmaceutical waste disposal and increase its accountability.

28. Improving Intra and Inter Sector Strategic Level Coordination - We recommend that CMAM and MISAU's Environmental Health Department (DSA) conduct joint planning missions regarding Biomedical and Pharmaceutical Waste Management, this should also include the design and implementation of a comprehensive capacity development and awareness raising work plan. Moreover, other institutions such as the DPTADER or Municipalities should be invited to take part given the role on this institutions in the management of the general waste to increase the impact of awareness.

VII. Consultations of the ESSA Addendum

For the preparation of the Addendum various consultation meetings were held, always in Portuguese, to ensure effective communication. Upon completion of the first draft of the Addendum to the ESSA, a copy was translated into Portuguese and circulated among stakeholders for comments and suggestions. Finally, face-to-face meetings were conducted to ensure all comments have been taken into consideration. Next, we summarized the main issues and concerns raised during the consultations.

Table 2. Summary of the raised questions and issue during consultation meetings.

Date	Participants	Main Issues/Concerns
07.08.18 19.10.18*	Ana Paula Thuzine* – DSA[2]. Bruno Nhancale – BM[3]. Alfredo Zunguze – BM. Courtney Ivins – BM.	- Ensure the responsibilities set in the PAP are assigned accordingly to each institution. - Ensure involvement of key stakeholders during implementation of the PAP. - When requested DSA participates and provides health and environmental best practices guidance during the pharmaceutical disposal process. - There is a need to train and raise awareness to local staff responsible for the medical and pharmaceutical waste handling and disposal.
20.08.18	CMAM and BM (see participants signed sheet in **Error! Not a valid result for table.**).	- Both, paper and electronic (SMAM and SIGLUS) register methods for management of medicine and medical commodities supply chain are working are being used in parallel until the electronic methods is validated but currently it does not include information on disposal or returning of expired products. - CMAM is only responsible for managing the pharmaceutical waste generated through the National Health Service, whereas the private clinics and pharmacies are responsible to manages their own following the national legislation. - The Health Facilities does not manage the pharmaceutical waste but instead return to higher hierarchical level (District Stores). - Is key to involve the DSA and other key stakeholders (e.g. MITADER4) during the disposal of pharmaceutical waste. - For adequate management of pharmaceutical waste CMAM considers important to (i) undertake inventories of existing pharmaceutical waste quantities, (ii) assess the available means to dispose the waste, (iii) produce a disposal plan, including construction or renovation of incinerator mainly at provincial levels. - There have not been procedures for Pharmaceutical Waste Disposal till recently, and CMAM is planning to implement this in phases from central/regional to provincial and district medical stores and hospitals (general and central). - CMAM recognizes that the legal covenants on pharmaceutical waste management under PFM4R - P124615 (i. maintain norms for disposal of pharmaceuticals products and ii. develop pharmaceutical disposal plans) are not yet fully implemented and is unlikely to be by the end of project. However, CMAM sees the importance of addressing this issue and agrees that on pharmaceutical waste management should be included in the PHCSP ESSA Addendum taking in consideration the new comments and current discussions.
06.09.18 19.10.18*	António Santos* – CMAM Edson Massango – CMAM Clayton Lençol – DAS Sérgio Gomes* - CMAM	- Capacity building should also be extended to the central level of CMAM, specifically to personnel at Central and Regional medical stores who work with management of waste products. - Clarify, the Year 1 is it considered counting for the effective date of the Parent Program or the Additional Finance? - We suggest that the responsibilities of Pharmaceutical Waste Disposal are primary assigned to CMAM, but obviously with the DSA's specialized support in specific areas. - The Completion Measurement of the Safeguards Action #1 (Capacity Building) is too high we suggest that reducing to 50% is a more realistic target. - Can CMAM contract technical assistance for Safeguards Actions #1,2,3 and 4? - Considering the cascade training approach adopted by CMAM, we suggest that training at district level, for both stores and rural centers, should target for Year 3.

[2] DSA – Department of Health and Environment.
[3] BM – World Bank.
[4] Ministry Land, Environmental and Rural Development.

REPÚBLICA DE MOÇAMBIQUE

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CENTRAL DE MEDICAMENTOS E ARTIGOS MÉDICOS

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Figure 1. List of participants of the consultation meeting for the ESSA Addendum preparation.

VIII. Safeguards Actions for the PAP

	Action Description	DLI	Due Date	Responsible Party	Completion Measurement	Means of Verification
1	**Capacity Building** Conduct refreshment courses to key staff that are responsible for Pharmaceutical Waste Management (handle, store and dispose) at the Provincial and Regional and Central Hospitals and Medical Stores based on existing material.[5] Conduct refreshment courses to key staff that are responsible for Pharmaceutical Management (receiving, store, returning of expired/damaged medicines) at the District Medical Stores and Rural Health Centers based on existing material.[6]	☐	**Year 2** **Year 3**	CMAM	At least 50% of people with key role in Pharmaceutical Waste Management successfully trained.	Signed attendance spreadsheets for the entire course.
2	**Pharmaceutical Waste Management (I)** Improve the registry of compliance obligations during pharmaceutical waste handling at Rural Centers and disposal at District, Provincial, and Central Hospitals and Medical Stores to include: disposal methods, site of disposal, list of participants and witnesses, community monitoring actions, etc., and disseminate.	☐	**Year 2**	CMAM	Registry Form for compliance obligations on Pharmaceutical Waste Management improved and disseminated.	Registry Forms available at Rural Centers, District, Provincial, and Central Hospitals and Medical Stores.
3	**Pharmaceutical Waste Management (III)** Conduct pharmaceutical waste and equipment for disposal inventory for District, Provincial and Central Hospitals and Medical Stores and prioritize the waste disposal according to a timeline based on waste	☐	**Year 2**	CMAM	Elaboration of the inventory and 100% execution of the pharmaceutical waste disposal	Inventory Reports and Register Forms for pharmaceutical waste disposal.

[5] MISAU. 2008. Gestão, Controlo e Dispensa de Medicamentos: Manual de Procedimentos dos Hospitais. USAID Deliver Project, 3ª Edição; MISAU. 2008. Gestão, Controlo e Dispensa de Medicamentos: Manual de Procedimentos dos Depósitos Provinciais de Medicamentos. USAID Deliver Project, 3ª Edição; MISAU. 2016. Manual de Procedimentos de Eliminação de Resíduos Farmacêuticos. UNFPA, 1ª Edição.

[6] MISAU. 2008. Gestão, Controlo e Dispensa de Medicamentos: Manual de Procedimentos dos Centros de Saúde. USAID Deliver Project, 3ª Edição; MISAU. 2016. Manual de Procedimentos de Eliminação de Resíduos Farmacêuticos. UNFPA, 1ª Edição.

	Action Description	DLI	Due Date	Responsible Party	Completion Measurement	Means of Verification
	quantities, environmental risks and opportunities costs (e.g. synergies in transporting or incinerating waste from 2 or more different locations in one facility).				according to the timeline.	
4	**Pharmaceutical Waste Management (IV)** Elaborate annually national reports on pharmaceutical waste management based on terms of reference agreed with the World Bank.		**Year 2**	CMAM	Elaboration of Pharmaceutical Waste Management Report	Report
5	**Intra and Inter Sectorial Coordination** Develop and implement a generic Stakeholder Engagement Plan on Pharmaceutical Waste Disposal at District, Provincial, and Central Hospitals and Medical Stores for key players: CMAM, DSA, Local Communities, Municipalities, Protection Police, Environmental Licensing authorities, etc., attending their roles from the identification phase (e.g. site selection), preparation phase (e.g. environmental education and awareness) throughout the last phase of monitoring (community monitoring).	☐	**Year 2**	CMAM	At least two joint missions taken annually	Mission reports

ANNEX 1 – Status of the Environmental and Social Actions of the PAP

ENVIRONMENTAL SAFEGUARDS

	Action	DLI*	Due date	Responsible Party	Completion Measurement **	Next steps and deadlines (Abril, 2018)	Point of situation and deadlines (October , 2018)
10	**Environmental Health Department Training** Satisfactory completion of at least one training of Environmental Health Department technicians at central level and provincial focal points and chief medical officers on the EIA process, focusing on roles and responsibilities of sector personnel at each stage, especially for activities/projects involving construction works, and on project screening.	☐	Within 12 months of Program effectiveness	MISAU (DNSP and Environmental Health Department)	Program Action Plan Implementation Report (PAP IR). Number of persons trained in general and by province. Screening forms completed by DSA for (a) Project subprojects; (b) MISAU projects.	Share the implementation plan with the Bank before the end of the mission. Conducting training in AIA (July to December 2018).	Training proposals already submitted to the Planning and Cooperation Department (CPD) for authorization and ToRs shared with the Bank It is suggested that this training be carried out along with training in biomedical waste management, since the participants are the same (DAS technicians, focal points and chief medical officers).
11	**Health Waste Management (I)** Provide MISAU's Environmental Specialist with training on health facility waste management	☐	Within 12 months of Program effectiveness	MISAU (DNSP and DNAM)	Completion of training by Environmental Specialist	Share ToR and CV of the Environmental Specialist (April 6, 2018).	Completed The specialist's CV is not clear in relation to his expertise on hospital waste management. MISAU should develop ToR for the training of DAS technicians, including the environmental specialist, in hospital waste management. Share the ToRs with the Bank.

						Share HSDP evaluation report (April 30, 2018).	Training may be performed by an MISAU (in-house) specialist or by an outside consultant (to MISAU), preferably nationally. The ToRs should be finalized and the training take place until December 28. The reports has been shared with the WB.
12	**Health Waste Management (II)** Preparation and distribution of informational materials on health waste management and delivery of at least one training on health waste management at provincial levels for chief medical officers and for managers of health facilities with in-patient care	☐	Within 12 months of Program effectiveness	MISAU (DNSP and DNAM)	Informational materials available at health facilities with in-patient care (80%). Number of people trained in general and per facility.	Share training plan (April 30, 2018).	Contacted WHO to provide material that will be adapted by MISAU. The material will be finalized by September 15, 2018. Training in hospital waste management is dependent on the training of DSA technicians including the environmental specialist, who will then replicate at the provincial and district levels.
13	**Health Waste Management (III)** Inclusion of waste management in health facility scorecard.	☒	Within 12 months of Program effectiveness	MISAU (DNSP and DNAM)	Year 1 DLI validation Scorecard	Draft Performance Indicator Scorecard (6 de Abril)	There is already a draft scorecard under review for the District Hospitals and Rural Health Center, the DSA will become more involved in the thematic discussions

							and provide comments particularly on the "HEALTH - ENVIRONMENTAL PCI" .
14	**Health Waste Management (IV)** Ensure that health waste management protocols are included in training curricula for health professionals	☐	Within 12 months of Program effectiveness	MISAU (DNSP, DRH, DNAM)	PAP IR Training *curricula.* Number of undertaken courses.	Share Curricula that reflect contents on hospital waste management (May 31, 2018)	To share the curricula and / or Thematic Plans of the Disciplines that address the hospital waste management until October , 2018.
15	**Disaster Contingency** Conduct at least one training on new disaster contingency protocols for APEs and SDSGCAS managers in vulnerable districts as defined by the National Institute of Calamities Management (INGC)	☐	Within 24 months of Program effectiveness	MISAU (DNSP/Department of Environmental Health) in coordination with INGC	PAP IR Curriculum Number of people trained	Finalize training coordination with INGC (April 30, 2018)	Identified the INGC technician to carry out the training. Identify APEs and SDSGCAS managers to be trained Plan the training • Terms of Reference (10/30/18) • Training Calendar • (10/30/18) • List of Participants (10/30/18) • Training Program and Material (12/14/18) • Start Training (01/21/19)