



REQUEST FOR CEO ENDORSEMENT

PROJECT TYPE: Full-sized Project

TYPE OF TRUST FUND: GEF Trust Fund

For more information about GEF, visit TheGEF.org

PART I: PROJECT INFORMATION

Project Title: Reducing UPOPs and Mercury Releases from the Health Sector in Africa			
Country(ies):	Ghana, Madagascar, Tanzania and Zambia	GEF Project ID: ¹	4611
GEF Agency(ies):	UNDP (select) (select)	GEF Agency Project ID:	4865
Other Executing Partner(s):	WHO, Health Care Without Harm	Submission Date:	2014-05-19
GEF Focal Area (s):	Persistent Organic Pollutants	Project Duration(Months)	48
Name of Parent Program (if applicable):		Project Agency Fee (\$):	645,320
<ul style="list-style-type: none"> ➤ For SFM/REDD+ <input type="checkbox"/> ➤ For SGP <input type="checkbox"/> ➤ For PPP <input type="checkbox"/> 			

A. FOCAL AREA STRATEGY FRAMEWORK²

Focal Area Objectives	Expected FA Outcomes	Expected FA Outputs	Trust Fund	Grant Amount (\$)	Cofinancing (\$)
(select) CHEM-1	Outcome 1.3: POPs releases to the environment reduced	Indicator 1.3: UPOPs releases avoided or reduced from the health-care sector	GEF TF	2,919,510	12,000,000
(select) CHEM-1	Outcome 1.5: Country capacity built to effectively phase out and reduce releases of POPs	Indicator 1.5.2. Legal and regulatory frameworks enhanced; national plans developed and implemented	GEF TF	3,015,783	14,000,000
(select) CHEM-3	Outcome 3.1: Country capacity built to effectively manage mercury in priority sectors	Indicator 3.1.1: Countries implement pilot mercury management and reduction activities	GEF TF	517,902	2,936,164
(select) (select)			(select)		
(select) (select)			(select)		
(select) (select)			(select)		
(select) (select)			(select)		
(select) (select)			(select)		
Total project costs				6,453,195	28,936,164

B. PROJECT FRAMEWORK

¹ Project ID number will be assigned by GEFSEC.

² Refer to the [Focal Area Results Framework and LDCF/SCCF Framework](#) when completing Table A.

Project Objective: The proposed Africa Regional Healthcare Waste Project seeks to:
1. Implement best environmental practices and non-incineration and mercury-free technologies to help African countries meet their Stockholm Convention obligations and to reduce mercury use in healthcare;
2. Ensure the availability and affordability of non-incineration waste treatment technologies in the region, building on the outcomes of the GEF supported UNDP/WHO/HCWH Global Medical Waste project.

Project Component	Grant Type	Expected Outcomes	Expected Outputs	Trust Fund	Grant Amount (\$)	Confirmed Cofinancing (\$)
1. [Regional component] Disseminate technical guidelines, establish mid-term evaluation criteria and technology allocation formula, and build teams of national experts on BAT/BEP at the regional level	TA	1.1 Technical guidelines, evaluation criteria and allocation formula adopted 1.2 Country capacity to assess, plan, and implement healthcare waste management (HCWM) and the phase-out of mercury in healthcare built	1.1.1 Mid-term evaluation criteria and formula for the allocation of technologies among countries 1.2.1 Teams of national experts trained (at the regional level).	GEF TF	401,172	1,800,000
2. [National component] Health Care Waste National plans, implementation strategies, and national policies in each recipient country	TA	2.1 Institutional capacities to strengthen policies and regulatory framework, and to develop a national action plan for HCWM and mercury phase-out enhanced. 2.2. National Plan with Implementation Arrangement adopted	2.1.1 National policy and regulatory framework for HCWM and mercury phase-out 2.1.2 National action plan including the selection of up to 1 central or cluster treatment facility, 2 hospitals, and 3 small rural health posts as models.	GEF TF	423,235	3,000,000
3a. [Regional component] Make available in the region affordable non-incineration HCWM systems and mercury-free devices that conform to BAT and international standards	TA	3a.1 Favorable market conditions created for the growth in the African region of affordable technologies that meet BAT guidelines and international standards	3a.1.1 HCWM systems and mercury-free devices for at least 12 health posts, 8 hospitals and 4 central or cluster facilities procured 3a.1.2 Initial set of HCWM systems and mercury-free devices given to 3 health posts, up to 2 hospitals, and 1 central or cluster treatment facility per country	GEF TF	3,768,496	16,196,164

<p>3b. [National component] Demonstrate HCWM systems, recycling, mercury waste management and mercury reduction at the model facilities, and establish national training infrastructures</p>		<p>Outcome 3.b.1: HCWM systems, recycling, Mercury waste management and Mercury reduction at the model facilities demonstrated and national training infrastructures established [National component]</p>	<p>3b.1.1 BAT/BEP implemented at the model facilities</p> <p>3b.2.1 Recycling programs in the model facilities</p> <p>3b.3.1. Safe storage sites for mercury and mercury-free devices used in model facilities</p> <p>3b.4.1 National training program</p>			
<p>4a. [Regional component] Evaluate the capacities of each recipient country to absorb additional non-incineration HCWM systems and mercury-free devices and distribute technologies based on the evaluation results and allocation formula</p> <p>4b. [National and regional component] Expand HCWM systems and the phase-out of mercury in the recipient countries and disseminate results in the Africa region</p>	<p>TA</p>	<p>4a.1 Capacities of recipient countries to absorb additional technologies evaluated</p> <p>4a.2 Additional technologies distributed depending on evaluated capacities for absorption</p> <p>4b.1 HCWM systems expanded to other facilities in the country</p> <p>4b.2 Country capacity to manage mercury and to phase in mercury-free devices improved</p> <p>4b.3 National training expanded</p> <p>4b.4 Information disseminated at environment and health conferces in</p>	<p>4a.1.1 Evaluation report for each recipient country including recommendations for improvement</p> <p>4a.2.1 Additional technologies distributed to countries based on the evaluation and allocation formula</p> <p>4b.1.1 BAT/BEP and related infrastructures improved and expanded in the recipient countries</p> <p>4b.2.1 More mercury devices phased out and stored and more mercury-free devices deployed</p> <p>4b.3.1 More people trained in HCWM and mercury</p> <p>4b.4.1 Replication tools disseminated</p>	<p>GEF TF</p>	<p>1,396,634</p>	<p>6,500,000</p>

		the region				
5. Monitoring, learning, adaptive feedback, outreach, and evaluation.	TA	5.1 Project's results sustained and replicated	5.1.1 M&E and adaptive management applied to project in response to needs, mid-term evaluation findings with lessons learned extracted 5.1.2. Lessons learned and best practices are disseminated at national, regional and global level	(select)	141,000	800,000
	(select)			(select)		
	(select)			(select)		
	(select)			(select)		
Subtotal					6,130,537	28,296,164
Project management Cost (PMC) ³				GEF TF	322,658	640,000
Total project costs					6,453,195	28,936,164

C. SOURCES OF CONFIRMED COFINANCING FOR THE PROJECT BY SOURCE AND BY NAME (\$)

Please include letters confirming cofinancing for the project with this form

Sources of Co-financing	Name of Co-financier (source)	Type of Cofinancing	Cofinancing Amount (\$)
-------------------------	-------------------------------	---------------------	-------------------------

³ PMC should be charged proportionately to focal areas based on focal area project grant amount in Table D below.

National Government	Ghana: Ministry of Health ; Ministry of Local Government and Rural Development; EPA; Madagascar: Direction Générale de l'Environnement; Ministère de la Santé Publique (MSP) - Direction de la Promotion de la Santé - Service de Santé et Environnement; MSP - Centre Hospitalier Universitaire (CHU) Tambohobe FIANARANTSOA ; Hôpital Universitaire Mères Enfants TSARALALANA; MSP - Hospital Universitaire Joseph Raseta BEFELATANANA; MSP - Centre Hospitalier de Référence de District MANJAKANDRIANA; MSP - Service de la Vaccination (GAVI); Tanzania: MoHSW; Zambia: Zambia Environmental Management Agency (ZEMA); Ministry of Health	In-kind	10,015,067
National Government	Ghana: Ministry of Health ; Ministry of Local Government and Rural Development; EPA; Madagascar: Direction Générale de l'Environnement; Ministère de la Santé Publique (MSP) - Direction de la Promotion de la Santé - Service de Santé et Environnement; MSP - Centre Hospitalier Universitaire (CHU) Tambohobe FIANARANTSOA ; Hôpital Universitaire Mères Enfants TSARALALANA; MSP - Hospital Universitaire Joseph Raseta BEFELATANANA; MSP - Centre Hospitalier de Référence de District MANJAKANDRIANA; MSP - Service de la Vaccination (GAVI); Tanzania: MoHSW; Zambia: Zambia Environmental Management Agency (ZEMA); Ministry of Health	Cash	4,435,835
GEF Agency	Regional: UNDP	In-kind	2,300,000
Other Multilateral Agency (ies)	Madagascar: UNHABITAT, WHO; Fonds d'Appui pour L'Assainissement (FAA) Tanzania: Department of Health & Human Services - Centers for Disease Control and Prevention (CDC) Regional: WHO	In-kind	4,996,637
Other Multilateral Agency (ies)	Madagascar: UNHABITAT, WHO, World Bank. Regional: WHO	Cash	1,323,000

CSO	Madagascar: Voahary Salama; Tanzania: Jhpiego; Agenda; PASADA Regional: Health Care Without Harm (HCWH)	In-kind	2,078,450
CSO	Madagascar: Voahary Salama; Tanzania: Jhpiego; Agenda; PASADA Regional: Health Care Without Harm (HCWH)	Cash	2,100,000
Private Sector	Ghana: Zoomlion Ghana Limited Madagascar: Groupe Adonis Environnement S.A.	In-kind	890,000
Private Sector	Ghana: Zoomlion Ghana Limited Madagascar: Groupe Adonis Environnement S.A.	Cash	797,175
Total Co-financing			28,936,164

D. TRUST FUND RESOURCES REQUESTED BY AGENCY, FOCAL AREA AND COUNTRY¹

GEF Agency	Type of Trust Fund	Focal Area	Country Name/ Global	(in \$)		
				Grant Amount (a)	Agency Fee (b) ²	Total c=a+b
UNDP	GEF TF	Persistent Organic Pollutants	Ghana	1,613,298	161,330	1,774,628
UNDP	GEF TF	Persistent Organic Pollutants	Madagascar	1,613,299	161,330	1,774,629
UNDP	GEF TF	Persistent Organic Pollutants	Tanzania	1,613,299	161,330	1,774,629
UNDP	GEF TF	Persistent Organic Pollutants	Zambia	1,613,299	161,330	1,774,629
(select)	(select)	(select)				0
(select)	(select)	(select)				0
(select)	(select)	(select)				0
(select)	(select)	(select)				0
(select)	(select)	(select)				0
(select)	(select)	(select)				0
Total Grant Resources				6,453,195	645,320	7,098,515

¹ In case of a single focal area, single country, single GEF Agency project, and single trust fund project, no need to provide information for this table. PMC amount from Table B should be included proportionately to the focal area amount in this table.

² Indicate fees related to this project.

F. CONSULTANTS WORKING FOR TECHNICAL ASSISTANCE COMPONENTS:

Component	Grant Amount (\$)	Cofinancing (\$)	Project Total (\$)
International Consultants	569,571	4,721,364	5,290,935
National/Local Consultants	2,077,904	8,279,616	10,357,520

G. DOES THE PROJECT INCLUDE A "NON-GRANT" INSTRUMENT? No

(If non-grant instruments are used, provide in Annex D an indicative calendar of expected reflows to your Agency and to the GEF/LDCF/SCCF/NPIF Trust Fund).

PART II: PROJECT JUSTIFICATION

A. DESCRIBE ANY CHANGES IN ALIGNMENT WITH THE PROJECT DESIGN OF THE ORIGINAL PIF⁴

- A.1 National strategies and plans or reports and assessments under relevant conventions, if applicable, i.e. NAPAS, NAPs, NBSAPs, national communications, TNAs, NCSA, NIPs, PRSPs, NPFE, Biennial Update Reports, etc. N/A: no change since PIF submission.
- A.2. GEF focal area and/or fund(s) strategies, eligibility criteria and priorities. Since PIF approval, the Minamata Convention was agreed to on 19 January 2013. The Minamata Convention was adopted and opened for signature on 10 October 2013, at a Conference of Plenipotentiaries in Kumamoto, Japan. The European Union and 86 countries signed the Convention on the first day it was open. A further 5 countries signed the Convention on the final day of the Diplomatic Conference, 11 October 2013. The U.S. became the first to accept the Convention on 6 November 2013.
- The Convention will enter into force 90 days after it has been ratified by 50 nations. It is expected that the treaty will come into force with the next three to five years.
- In October 2013, the Governments of the Republic of Madagascar, the United Republic of Tanzania and the Republic of Zambia signed the Minamata Convention on Mercury. The Government of the Republic of Ghana has not (yet) signed the Minamata Convention. It is expected though that the Republic of Ghana will become a party to the Minamata Convention.
- Once the Minamata Convention has been ratified by the four project countries and the Convention has been domesticated, Mercury-added products, such as thermometers and sphygmomanometers, will have to be phased out by 2020 in accordance with Article 4 – paragraph 1. From that date onwards, the manufacture, import and export of Mercury-added products will no longer be allowed. The Convention also expects countries to introduce a minimum of 2 measures with the objective to phase-down the use of dental amalgam, in accordance with article 4 – paragraph 3.
- The proposed project is entirely in line with the objectives of the Minamata Convention as it will support countries in preparing to meet their future commitments under the Convention.
- A.3 The GEF Agency's comparative advantage: Addressed in PIF (see section C of the PIF)
- A.4. The baseline project and the problem that it seeks to address: No changes as compared to the situation and baseline described in the PIF.
- A. 5. Incremental /Additional cost reasoning: describe the incremental (GEF Trust Fund/NPIF) or additional (LDCF/SCCF) activities requested for GEF/LDCF/SCCF/NPIF financing and the associated global environmental benefits (GEF Trust Fund) or associated adaptation benefits (LDCF/SCCF) to be delivered by the project: Please refer to the attached draft project document, in particular Section II. Strategy, Section "Incremental reasoning and expected global, national and local benefits" (page 40).
- A.6 Risks, including climate change, potential social and environmental risks that might prevent the project objectives from being achieved, and measures that address these risks: Please refer to the attached draft project document, in particular Section III. Project Results Framework (last column "Risks and Assumptions") - page 47 - and Annex VI: Risk Analysis and Risk Mitigation Measures (page 106).
- A.7. Coordination with other relevant GEF financed initiatives Already addressed in PIF (see section B.6). Please also refer to the attached draft project document, Annex V: Coordination Activities (page 100).

B. ADDITIONAL INFORMATION NOT ADDRESSED AT PIF STAGE:

B.1 Describe how the stakeholders will be engaged in project implementation.

Section V "Management Arrangements" (page 60) of the attached project document describes the management

⁴ For questions A.1 –A.7 in Part II, if there are no changes since PIF and if not specifically requested in the review sheet at PIF stage, then no need to respond, please enter "NA" after the respective question.

roles these partners will assume during project implementation, while in Section I (Situation Analysis) and its subsection on "Stakeholder Analysis" (page 20) the various project stakeholders have been described.

B.2 Describe the socioeconomic benefits to be delivered by the Project at the national and local levels, including consideration of gender dimensions, and how these will support the achievement of global environment benefits (GEF Trust Fund/NPIF) or adaptation benefits (LDCF/SCCF): Please refer to Section B.3. of the project proposal's PIF and Section II: Strategy and its subsection "Socio-economic benefits including gender dimensions" of the project document (page 41).

B.3. Explain how cost-effectiveness is reflected in the project design: Please refer to the attached project document Section II: Strategy and Cost-effectiveness and its subsection "Cost-effectiveness" (page 43).

C. DESCRIBE THE BUDGETED M & E PLAN:

The budgeted M&E plan is described in detail in the attached draft project document (Section VII. Monitoring Framework and Evaluation - page 66, and in table 8: M & E Work Plan and Budget). The elements of the section "M&E work plan and budget" are as follows:

- Inception Workshop and Report. Responsible parties: Project Manager, UNDP CO and UNDP GEF. Indicative costs: 139,400 US\$. Timeframe: Within first two months of project start up.

- Measurement of Means of Verification of project results. Responsible parties: UNDP GEF RTA/Project Manager will oversee the hiring of specific studies and institutions, and delegate responsibilities to relevant team members. Indicative costs: To be finalized in Inception Phase and Workshop. Timeframe: Start, mid and end of project (during evaluation cycle) and annually when required.

- Measurement of Means of Verification for Project Progress on output and implementation. Responsible parties: Oversight by Project Manager, Project team. Indicative costs: To be determined as part of the Annual Work Plan's preparation. Timeframe: Annually prior to ARR/PIR and to the definition of annual work plans.

- ARR/PIR. Responsible parties: Project manager and team, UNDP CO, UNDP RTA and UNDP EEG. Indicative costs: None. Timeframe: Annually

- Periodic status/ progress reports. Responsible parties: Project manager and team and UNDP CO. Indicative costs: None. Timeframe: Quarterly

- Mid-Term Evaluation. Responsible parties: Project manager and team, UNDP CO, UNDP RCU, External Consultants (i.e. evaluation team). Indicative costs: US\$ 32,000 US\$. Timeframe: At the mid-point of project implementation.

- Final Evaluation. Responsible parties: Project manager and team, UNDP CO, UNDP RCU and external Consultants (i.e. evaluation team). Indicative costs: US\$ 32,000 US\$. Timeframe: At least three months before the end of project implementation.

- Project Terminal Report. Responsible parties: Project manager and team, UNDP CO and local consultant. Indicative costs: none. Timeframe: At least three months before the end of the project.

- Audit. Responsible parties: UNDP CO, Project manager and team. Indicative costs: 20,000 US\$. Timeframe: Once in four years.

- Visits to field sites. Responsible parties: UNDP CO, UNDP RCU (as appropriate) and Government representatives. Indicative costs: For GEF supported projects, paid from IA fees and operational budget. Timeframe: Yearly.

TOTAL indicative COST (Excluding project team staff time and UNDP staff and travel expenses): US\$ 223,400 US\$

PART III: APPROVAL/ENDORSEMENT BY GEF OPERATIONAL FOCAL POINT(S) AND GEF AGENCY(IES)

A. RECORD OF ENDORSEMENT OF GEF OPERATIONAL FOCAL POINT(S) ON BEHALF OF THE GOVERNMENT(S): (Please attach the [Operational Focal Point endorsement letter\(s\)](#) with this form. For SGP, use this [OFP endorsement letter](#)).

NAME	POSITION	MINISTRY	DATE (MM/dd/yyyy)
(GHANA) - Dr Raymond BABANAWO MINISTRY OF ENVIRONMENT, SCIENCE AND TECHNOLOGY	OFP, Technical Director	MINISTRY OF ENVIRONMENT, SCIENCE AND TECHNOLOGY	GHANA: 12/29/2011
(MADAGASCAR) Mrs. Christine Edmee RALALAHARISOA	OFP, Director General for Environment	MINISTRY OF THE ENVIRONMENT AND FORESTS	MADAGASCAR: 02/23/2011
(TANZANIA) Dr. Julius NINGU	OFP, for Permanent Secretary, Director of Environment	VICE PRESIDENT'S OFFICE	TANZANIA: 05/04/2011
(ZAMBIA) Mr. Kenneth NKOWANI	OFP, Director, Environment and Natural Resources Management Department	MINISTRY OF LOCAL GOVERNMENT, HOUSING, EARLY EDUCATION, AND ENVIRONMENTAL PROTECTION	ZAMBIA: 12/29/2011

B. GEF AGENCY(IES) CERTIFICATION

This request has been prepared in accordance with GEF/LDCF/SCCF/NPIF policies and procedures and meets the GEF/LDCF/SCCF/NPIF criteria for CEO endorsement/approval of project.

Agency Coordinator, Agency Name	Signature	Date (Month, day, year)	Project Contact Person	Telephone	Email Address
Adriana Dinu, UNDP – GEF Executive Coordinator and Director a.i		05/19/2014	Mr. Jacques Van Engel Officer-in-Charge UNDP MPU/Chemicals	212-906-6687	jacques.van.engel@undp.org

ANNEX A: PROJECT RESULTS FRAMEWORK (either copy and paste here the framework from the Agency document, or provide reference to the page in the project document where the framework could be found). Please refer to the UNDP project document Section III – page 47

ANNEX B: RESPONSES TO PROJECT REVIEWS (from GEF Secretariat and GEF Agencies, and Responses to Comments from Council at work program inclusion and the Convention Secretariat and STAP at PIF).

STAP Comments:

a) Though perhaps implied, there is no discussion of handling of destruction residues (e.g. ash) in the PIF. The project should be developed recognising the need to address potentially toxic residues from health care waste destruction.

UNDP Response: As you know, the project specifically aims to reduce/minimize UPOPs releases by replacing UPOPs-generating disposal technologies (including co-combustion in coal-fired plants, etc.) with treatment technologies that do not generate POPs (non-incineration). The project is thus promoting treatment technologies (for example autoclave systems) that will not generate any toxic residues. The project looks at the waste once it has been treated by the autoclaves since autoclaving lends itself to recycling of sterilized materials such as plastic and glass. Throughout the Project Document and in the country-specific components in the Annexes, information on possible recycling options is explored in order to minimize the disposal of waste in traditional landfills once it has been treated by autoclave.

In any case, by replacing incinerators with non-incineration technologies, the quantity of ash can only be dramatically decreased by the project.

b) In building on the previous UNDP Health care waste project, the STAP hopes that the lessons of the older project will be clearly elaborated in the new project document, along with specific improvements and alterations in approach being made to improve deliverables and benefits.

UNDP Response: The project reflects lessons of the previous, global project and will use many of the outcomes of that project (such as the training modules, technical specifications, assessment tools, guidance documents, etc. developed by that previous project).

Specifically, the approach of a regional meeting at the start of the new project (Component 1) addresses the problems in the global project of inconsistent understanding and uneven capacities by national project teams and a lack of synergy among countries due to each country starting at different times and implementing activities with no direct interaction with each other. The intensive regional training at the start of the project will foster more communication, collaboration and synergy among national projects and is a more efficient use of technical resources compared to the old project.

Development of national plans and implementation strategies in Component 2 minimizes difficulties faced by the old project when decisions by some national project teams were not strategic and did not advance a national roadmap. The regional procurement approach in the new project (Component 3) eliminates the problems encountered by the previous project when some national project teams did not use technical specifications developed by the global project team and/or faced difficulties with specific bidding rules.

The mid-term evaluation of capacities to absorb additional technologies (Component 4) is seen as an incentive for countries in the first phase of the project, since countries that do better will receive more technologies during Component 4. This is in contrast with the global project wherein countries received a pre-determined number of technologies regardless of the level of development of their healthcare waste management system nationwide.

In sum, the new project was developed with all the lessons of the previous, global project in mind. The project's chief technical advisor under the global project was closely associated with the development of this project as International technical advisor – so that continuity in the teams was also facilitated between the two projects.

c) The project could consider a definition of Health Care Waste (HCW) that is more refined than Hazardous Chemical Waste (HCW) to be adopted for this project, to ensure consistency across Nations involved in the project.

UNDP Response: We would like to point out that each country's Ministries of Health define the components of healthcare waste differently. Using an overly broad definition will be too vague, while using narrow definitions will go against regulations that are specific to each country. For example, materials with dried blood are not considered infectious waste in some developed countries because of the advanced system of segregation, collection, transport and disposal in place, but in developing countries where personal protection is not common, ad hoc containers are used, transportation is often poorly monitored, and disposal is in open dumpsites, materials with dried blood should be included in the definition of infectious waste. In many developed countries, only certain types of isolation waste is considered infectious depending on the transmission-based precautions in place in the isolation room or ward, but in developing countries, it is better from an infection prevention perspective to just consider all isolation waste as infectious.

The 2013 WHO international guidelines on healthcare waste (the so-called Blue Book) identifies components of healthcare waste that are generally accepted by many albeit not all countries – the 2013 WHO description of HCW is what is used as a reference in this project. Since any differences between countries and with the WHO Blue Book are generally small in actual practice, focus instead is given to rigorous segregation of those components that require treatment under a country's regulations versus those that do not need treatment.

Additionally, most countries deal with chemical hazardous waste under a different set of regulations (generally hazardous chemical waste regulations under the MOE) which are separate from infectious waste regulations under the MOH. The project will primarily deal with infectious healthcare waste and, except for mercury, will not focus on chemical waste (which comprises a very small portion, usually between 1 to 5%, of the waste stream of an urban tertiary hospital, and generally 0% for small primary health posts).

Reference in the UNDP ProDoc: See list of Definitions on Page 9 of the ProDoc, including HCW and infectious waste.

d) The project developers are advised to examine projects from other focal areas that deal with market transformation and technology transfer (as is frequent under the Climate Focal Area) to strengthen the replication mechanism of the project.

UNDP Response: We would like to mention one technology-related project in particular, the Solar Chill project – which was mentioned in the review, since it has been a major topic in Expanded Programmes on Immunization and WHO. Some strategies/approaches of the SolarChill project were followed in the previous global medical waste project during the non-incineration technology development in Tanzania, developing prototypes based on modifications of existing technologies in industrialized countries.

The final activity of the global project, working with an existing autoclave manufacturer in Africa to develop a prototype for healthcare waste, also follows the SolarChill approach. Similar to the SolarChill project, the global project worked with WHO and national governments to develop technical specifications and regulations which will facilitate market transformation. A good example in the global project is Vietnam's recent promulgation of autoclave standards developed by the global project and regulations that will likely result in widespread adoption of cleaner treatment technologies for healthcare waste that do not generate any UPOPs.

Lessons in market transformation related to non-mercury devices, such as the importance of minimum standards, regulations phasing out mercury devices, and hospital staff participation in the selection of alternatives, were also used in the global project. Importantly, encouraging local manufacturers and manufacturers of low-cost technologies to expand their markets to Africa is an explicit approach in Component 3a of the regional project. Obviously, and as underlined in response to Comment b), this project will build upon the lessons and outcomes of the global HCWM project.

Reference in the UNDP ProDoc: Page 66 describes the Procurement approach, which builds on the experience of the procurement under Global Fund projects.

e) The Stockholm Convention Toolkit on dioxin emissions may be used by the project to track reductions in emissions.

UNDP Response: We have indeed used the Stockholm Convention's dioxin emissions toolkit as a basis, and went beyond it by also utilizing more refined tools developed as part of the global HCWM toolkit. For dioxin emission calculations, the Stockholm Convention Toolkit classified medical waste incinerators into four types whereas the global HCWM toolkit describes 22 different types of medical waste incinerators and provides emission factors for each based on peer-reviewed data from the scientific literature. Both this and the Stockholm Convention tools will continue to be used for further estimates during the implementation of the project. Both toolkits are referenced in various parts of the Project Document.

Reference in the UNDP ProDoc: See reference on page 75, as well as several references to the UNEP mercury toolkit.

f) It is strongly recommended that a stringent ongoing monitoring mechanism be made a part of this project, so that trouble-shooting is ongoing, and countries have a better chance at implementing the appropriate preparatory steps for implementation of technologies.

UNDP Response: The National Project Coordinator will take on this role at the country level. Additionally, based on lessons learned from the Global HCWM project, we decided that having continuous on the ground support, consisting of a national project coordinator and 2 national technical experts, would improve continuous support to Health care facilities and greatly improve project monitoring. Additionally the project will be using a combination of regionally-trained local consultants and international consultants prepared to provide support at all levels throughout the project.

During the initial regional intensive training and planning, the national project teams will develop a detailed project management tool that will detail the main activities, the recommended timelines and milestones of each activity, and indicators for each activity. This exercise will ensure that there is a clear and consistent understanding of what needs to be done and at the same time will provide a mechanism for monitoring.

Reference in the UNDP ProDoc: The monitoring mechanisms are parts of Outcomes 1.2, 1.5 and 2.2 and incorporated in Components 1, 2, 3b, 4b and 5. Details are provided in Chapters V and VII.

g) STAP kindly requests feedback on the usefulness of the STAP guidance document on POPs disposal.

UNDP Response: The project does not deal with POPs stockpiles, POPs disposal technologies and post-destruction residuals, as such the STAP guidance document on POPs disposal was not the main reference document during project development. We do however, of course, agree with the necessity to look at HCWM as a management process/system, involving both technology and practice. We thus believe that we followed the holistic, systemic approach encouraged in the STAP comments.

ANNEX C: STATUS OF IMPLEMENTATION OF PROJECT PREPARATION ACTIVITIES AND THE USE OF FUNDS⁵

A. PROVIDE DETAILED FUNDING AMOUNT OF THE PPG ACTIVITIES FINANCING STATUS IN THE TABLE BELOW:

PPG Grant Approved at PIF: US \$200,000			
<i>Project Preparation Activities Implemented</i>	<i>GEF/LDCF/SCCF/NPIF Amount (\$)</i>		
	<i>Budgeted Amount</i>	<i>Amount Spent To date</i>	<i>Amount Committed</i>
Travel	39,000	6,066	32,934
International Consultants	91,000	30,257	60,743
Local Consultants	60,000	31,392	28,608
Workshops and stakeholder consultations	10,000	9,275	725
Total	200,000	76,990	123,010

⁵ If at CEO Endorsement, the PPG activities have not been completed and there is a balance of unspent fund, Agencies can continue undertake the activities up to one year of project start. No later than one year from start of project implementation, Agencies should report this table to the GEF Secretariat on the completion of PPG activities and the amount spent for the activities.

ANNEX D: CALENDAR OF EXPECTED REFLOWS (if non-grant instrument is used)

Provide a calendar of expected reflows to the GEF/LDCF/SCCF/NPIF Trust Fund or to your Agency (and/or revolving fund that will be set up)

N/A