Federal Democratic Republic of Ethiopia
Ministry of Health

Ethiopia Program for Results (Hybrid) for Strengthening Primary Health Care Services (P175167)

Final Environmental and Social Management Framework (ESMF)

with Labor Management Plan (Annexed)

AUGUST 2023

ADDIS ABABA

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ACRONYMS

ANRS	Amhara National Regional State
BGRS BoFED	Benshangul Gumuz Regional State Bureau of Finance and Economic Development
CoC	Codes of Conduct
CRVS	Civil Registration and Vital Statistics
EDHS	Ethiopia Demographic and Health Survey
EFM	Ecological Framework Model
EmONC	Emergency Obstetric and Newborn Care
EPSA	Ethiopian Pharmaceutical Supply Agency
EHS	Essential Health Services
EHS	Environment Health and Safety
ESIA	Environmental and Social Impact Assessment
ESMP	Environmental and Social Management Plan
ESRS	Environmental and Social Review Summary
ESS	Environmental and Social Standards
ESS	Ethiopia Socioeconomic Survey
FEPA	Federal Environment Protection Authority
FGM/C	Female genital mutilation/cutting
FMHACA	Ethiopian Food, Medicine and Healthcare Administration and Control Authority
GBV	Gender Based Violence
GER	Gross Enrolment Ratio
GIIP	Good International Industry Practice
GMU	Grant Management Unit
GoE	Government of Ethiopia
GPI	Gender Parity Index
HC	Health Centers
HCF	Health Care Facility
HP	Health Posts
HSDP	Health Sector Development Program
HSTP	Health Sector Transformation Plan
HUC	Historically Underserved Communities
HUCP	Historically Underserved Community Plan
HWMS	Health Care Waste Management System
ICWMP	Infection Control and Waste Management Plan
IDA	International Development Association
IDP	Internally Displaced People
INVEA	Immigration Nationality and Vital Events Agency

IPF	Investment Project Financing
ITCZ	Inter-Tropical Convergence Zone
JCF	Joint Consultative Forum
LMP	Labour Management Procedures
NER	Net Enrolment Ratio
NGO	Non-Governmental Organization
OHS	Occupational Health and Safety
PHC	Public Health Care
POM	Project Operation Manual
RF	Resettlement Framework
RHB	Regional Health Bureaus
RMNCAH+N	Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition
SDG PF	Sustainable Development Goals Performance Fund
SEA	Sexual Exploitation and Abuse
SH	Sexual Harassment
SOPs	Standard Operating Procedures
SPHCS	Strengthening Primary Health Care Services
SRA	Security Risk Assessment
TNRS	Tigray National Regional State
WHO	World Health Organization
WWSAO	Woreda Women and Social Affairs Office
UNICEF	United Nations Children Fund

Executive Summary

I. Introduction

The GoE through MoH requested the Bank for finance to address the priority needs of the HSTP II through the Sustainable Development Goals Performance Fund (SDG PF). The goals of the SDG PF are to augment financial gaps of HSTP II in priority areas. In response to it, the Ethiopia PforR Strengthening Primary Health Care Services (SPHCS) project was developed which consists of both PforR and IPF components. The main focus of the IPF component is on emergency health and nutrition response in conflict-affected areas, having a total allocated fund of US 124 million to be financed by the IDA. Both the Health PforR and IPF components will be implemented from 2021-2025 through the MoH, the Immigration and Citizenship Services (ICS) and their regional counterparts. This ESMF is designed to address the environmental and social risks management aspects of the IPF component project. Its main objective is to establish an environmental and social management process that meets the National environmental and social requirements and World Bank ESF standards applicable for addressing environmental and social risks of the Investment Project Financin (IPF) Component of the Program for Result (PforR) SPHCS subprojects.

Methodology: The methodology applied for preparing the ESMF includes conventional methods involving review of relevant legislations, policies and other documents, secondary data collection and analysis, conducting field visits on selected sample regions and Woredas, as well as carrying consultation with project implementers and stakeholders

II. Description of the Project

Project Development Objectives (PDO): The IPF Component project shares the PDO of the parent PforR project which is "*to improve access to and equitable provision of high-quality Primary Health Care (PHC) services, with a focus on* Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition *(RMNCAH+N), while strengthening health systems*".

The IPF component will support the government emergency health and recovery plan for conflict-affected areas. The Program activities under the IPF component mainly targets communities in conflict-affected areas of Tigray, Afar, Amhara, Oromia and Benshangul Gumuz regions focusing on emergency health and nutrition response. The interventions are intended to strengthen PHC services and address the needs of conflict affected communities, vulnerable people including women, children, and people with disabilities, Internally Displaced Poples (IDPs), and underserved traditional local communities. The IPF will support the provision of health and nutrition services as well as medicines, medical consumables, equipment, restoration of health service infrastructure, ambulance services, deployment of mobile health teams, and human resources as per MOH's conflict-related health emergency response plans to ensure access in conflict-affected areas and IDP settings. The IPF will also support the improvement of the CRVS system for the Immigration and Citizenship Service (ICS) (formerly the Immigration, Nationality and Vital Events Agency (INVEA)) but also for the MOH, Ethiopian Statistics Service (ESS), and National Security Service, as well as religious bodies that officiate marriages and burials. Periodic updates of the health sector rapid response assessment will be conducted at least once a year. The updates

would include assessing the disruption of access to regular health services, the level of damage and loss in health facilities, and the adequacy of services provided in meeting the needs of affected communities.

a) Description of the IPF Subcomponents

The IPF Component will have the following four main subcomponents.

- IPF Sub-component I: Provision of EHS Focusing on RMNCAH+N to Conflict-Affected population and IDPs
- IPF Sub-component II: Civil Registration and Vital Statistics (CRVS)
- IPF Sub-component III: Technical Assistance and Capacity Building
- IPF Sub-component IV: Contingent Emergency Response:

b) Institutional and Implementation Arrangements

MOH will be responsible for planning, budgeting, and reporting funds released from the pooled fund, through which International Development Association (IDA) and GFF funding will be disbursed under the IPF operation. The implementation in Tigray will be conducted by UNICEF, as per the agreement with MoH and MoF, while MoH will be responsible for implementation of services in all other regions covered by the IPF sub-component I.

The implementation of CRVS activities (IPF sub-component II) will be conducted by Immigration and Citizenship Service (ICS). The ICS management will provide overall strategic guidance for the implementation of the project. A technical committee will be established to provide support on technical issues during implementation of the project. ICS will develop a budgeted annual work plan to be submitted to the World Bank for its no objection.

III. Environmental and Social baseline conditions of the five conflict affected regions

A detailed biophysical and socioeconomic baseline description for each of the five conflict affected regions covered by the IPF Component project—namely Tigray, Afar, Amhara, Oromia and Benshangul Gumuz Regions—is provided in chapter 3 of the main report.

IV. Relevant Policy, Legal and Institutional Framework of Environmental and Social Management

The GoE has enacted the necessary legal frameworks for E&S management and institutions to support its implementation and enforcement. The primary legislations that support E&S management in Ethiopia are the Federal Democratic Republic of Ethiopia (FDRE) Constitution, Environmental Policy of Ethiopia, EIA Proclamation No. 299/2002, Solid Waste Management Proclamation No. 513/2007; Research and Conservation of Cultural Heritage Proclamation No. 209/2000; the Labor Proclamation No. 1156/2019, Proclamation no.1161/2019 on Expropriation of Land for Public Purposes, EIA Procedural Guideline (2003); ESMP Preparation Guideline (2004); National Social Protection Policy; National Policy on Ethiopian Women; and other Laws, Strategies, and Guidelines Enforcing Special Support for Developing Regions and Vulnerable Groups. These and other relevant policies, legislations, and guidelines have been reviewed.

Moreover, review of the World Bank ESF (i.e., ESSs) as well as relevant Environment Health and Safety (EHS) guidelines was also carried out. Accordingly, it was noted that all except ESS 9 are potentially applicable to the IPF Component. In addition, relevant EHS guideline which appeared to be most relevant to the IPF Component subprojects were reviewed and applied as necessary.

V. Procedures to Address Environmental and Social Issues

Overview of Subproject categorization and the Environmental and Social Standards (ESS) requirements: The IPF Component Project is generally categorized as "Substantial Risk" project (i.e. Environmental and Social) and hence Ministry of Health (MoH) and its partner institutions will be required to undertake the appropriate environmental and social assessment of subprojects in accordance with the *national law and any requirements of the ESSs* that deemed relevant to the sub-projects. It is anticipated that the activities related to procurement and distribution of medical supplies and equipment of the IPF Component project will likely fall into Schedule I of the EIA procedural guideline (2003). Depending on the type and scale of damage and restoration works needed to rehabilitate the health care facilities (HCFs), the specific HCF restoration subprojects could fall either under Schedule II or III. On the other side, most of the TA activities are related to capacity building, training, provision of technical support to digitize CRVS systems, and mainstreaming of legal frameworks and preparation of SOPs. As a result, most of the IPF Component Technical Assistance (TA) activities will fall under Type 3 TA activities which will only require designing the Capacity building ToRs to address ESF related issues. There is only one TA activity (i.e. on mainstreaming a legal framework) that falls under Type 2 TA which requires agreeing on TORs to ensure that the planning process includes adequate assessment of environmental and social implications consistent with the ESF. The IPF Component project will not have Type 1 TA activities."

Sub-project Screening and Approval Process: The key steps which need to be followed in fulfilling the procedural requirements of the IPF Component Project ESMF involve seven steps. Each of these steps and the activities to be undertaken under each step are elaborated in the main report.

VI. Environmental and Social Impacts and Mitigation Measures

The main activities that would cause for the occurrence of adverse risks during project implementation are anticipated to be sub-component 1 subprojects and to some extent subcomponent 2. The activities of Subcomponent-3 are almost entirely type-3 technical assistance subprojects and are anticipated to have minimum direct adverse impacts on the physical and social environment. The potential adverse social and environmental risks of subcomponent-1 and 2 activities that are likely to arise during the various phases of the IPF component project implementation can be classified into the following:

a. Adverse environmental and social impacts that will arise from the procurement, distribution, storage and use of medical supplies and equipment (Subcomponent 1)
b. Adverse environmental and social risks that will arise from the civil works to be conducted during restoration of damaged HCFs and establishment of temporary satellite clinics (Subcomponent 1). Examples of potential risk include child labour, SEA/SH and involuntary resettlement. Measures have

been included in the labour management procedure, GBV action plan and the Resettlment framework for the IPF.

c. Adverse environmental and social risks that will arise from the provision of essential health services in conflict affected areas and IDP settings including by the mobile health teams to be deployed (Subcomponent 1). There could be risk of security to the project and community due to the context the acivtiey is operating in. Security risk Management plan has been prepared for the project to prevent and mitigate related risks during the implementation.
d. Adverse environmental and social risks that will arise from restoration of ambulance services and provision of vehicles and motorcycles to strengthen CRVS services in conflict affected areas (Subcomponent 1 & 2).
e. Adverse environmental and social risks that will arise from the increased distribution and use of IT equipment such as Personal Computers (PCs), laptops, tablets, servers, printers e.t.c. to ensure continuous provision of civil registration services in conflict affected areas(Subcomponent 1 & 2) .

Overall, the environmental and social risk assessment carried as part of the present IPF Component ESMF has also concurred with the Environment and Social Review Summary (ESRS) conclusion that the overall risk rating for both environmental and social is "Substantial". This is in consideration of the aforementioned group of activities which are the risk drivers and the overall adverse impacts they can cause in the project areas under consideration. The main generic environmental and social risks that are anticipated to occur by the IPF Component project activities together with its proposed mitigation measures and responsible institutions for implementation and monitoring are summarized in the indicative Environmental and Social Management Plan (ESMP) tables (Refer Table 15 in the main report).

VII. Grievance Redress Mechanism

A grievance mechanism for the IPF project is designed based on an understanding of the issues that are likely to be the subject of concerns and grievances. Grievance about the IPF project may arise for different reasons. The project information may not be disclosed in relevant local languages and in a manner that is accessible and culturally appropriate, the process may not encourage stakeholders' feedback, particularly those vulnerable individuals and groups as a way of informing project design and implementation, or the project-affected communities and vulnerable groups may raise concerns about equitable access and quality PHC services. More importantly, grievances and disputes may arise involving involuntary resettlement. How the IPF project responds (or is perceived to be responding) when such grievances surface is important and can have significant implications for the overall implementation of the project. The key consideration for the IPF project-specific grievance redress mechanism that will be established/strengthened to allow PAPs to complain about any decision or activities regarding the project are outlined in table 16 of the main report.

According to World Bank Grievance Redress, communities and individuals who believe they are adversely affected by a Bank-supported project may submit complaints to existing project-level grievance redress mechanisms or the Bank's Grievance Redress Service (GRS). For information on how to submit

complaints to the Bank's corporate GRS, see http://www.worldbank.org/GRS, and for the Bank's Inspection Panel, see www.inspectionpanel.org.

Central point of contact for project-level Grievance Mechanism (GRM): (1) Dr Ruth Nigatu, Chief of Staff, email: Ruth.nigatu@moh.gov.et; (2) Dr Feven Girma, Director, PCD, email: Feven.girma@moh.gov.et; and (3) Worku Gizaw, Strategic Affairs Coordinator, email: worku.gizaw@moh.gov.et, Phone: +251 0912016866.

VIII. Stakeholder Engagement

During project preparation, consultations were conducted with MoH and implementing entities. Moreover, consultations were conducted with the Bank and other development partners. Another round of stakeholder and community consultations were conducted recently as part of the preparation process of the present safeguard instruments for the IPF Component. The Stakeholder and community consultations were conducted at Federal level with the MoH and its relevant Agencies, Directorates and third party implementer, i.e., UNICEF. At the regional level, the consultations were carried out in a sample of three conflict affected regions, namely Oromia, Amhara and Afar regions and two woredas found within them. The consultations at the Federal level including the Oromia region were conducted from 31/01/23 to 14/02/23 and the remaining regional and Woreda level consultations between 19/02/23 and 25/02/23. Both the officials/experts and community members in the consultation raised their concerns on how the project shall be promptly and effectively implemented. The consulted members of local community also consistently raised concern regards what measures will be put in place by the project to address the risks and adverse impacts associating with involuntary resettlement. Participants were explained that MoH will prepare a resettlement plan (RP) for any IPF project activity those results in economic or physical displacement. A comprehensive Stakeholder Engagement Plan (SEP) was prepared for the parent PforR SPHCS project in April 2022 and was disclosed. The SEP will apply for the IPF Component Project and will continue to be used along with the present ESMF and other E&S risk management instruments prepared for the IPF component project.

IX. Capacity Building and Training Requirements

The existing capacities and practical experiences in the area E&S risk management of the main IPF Subcomponent-I Project implementing institution, which is the MoH, is evolving and needs to be further strengthened. The MoH has deployed one environment officer under the Design and Construction Directorate and a Social Development specialist is reported to be under recruitment. The Environment Officer is supposed to follow up the E&S issues of all development projects conducted by the Ministry. Moreover, the MoH assert that it also has Environmental Health professionals under its Environmental Hygiene and Public Health Directorate who are also often deployed for managing E&S risks. In practice, this Directorate is focused on addressing the key environmental and social risks that are known to occur while operating a health care facility. The roles played by this department in the RHB are similar to the

one at federal level. Given the SEA/SH risks, the GBV Specialists shall also be contracted for the project.

During the consultation carried out with staff of the Agency, it appeared that EPSA does not have environment risk management staff. There exists a capacity gap in EPSA in the area of E&S risk management. A consultation with the third party project implementing partner UNICEF also revealed that E&S risk management of projects is carried as part of the wider program planning, monitoring and evaluation systems. In a similar trend, the E&S risk management capacities of the ICS appears to be weak. The institution has no E&S risk management staff at any level, at the head office or regional branches.

In summary, the consultation discussions and assessments held with the institutions have shown that there are capacity gaps in E&S management which needs to be filled through deploying adequate human resource and training. As a result, it is recommended that the capacity gap in E&S risk management manpower should be filled in prior to commencement of IPF project operations as follows.

- Deploy environment, social, and gender specialists at MoH dedicated for the IPF Component.
- Deploy environment, social, and gender specialists at Ethiopia Pharmaceuticals Supply Agency (EPSA) dedicated for the IPF Component
- Deploy qualified environment and social focal persons at ICS and EPSA,
- Deploy qualified environmental and social risk management specialists at UNICEF and focal persons at each Regional Health Bureau.

Training requirements: One of the capacity building areas for the lead implementing institution (MOH and ICS) and the Partner Institutions (EPSA and Regional Health Bureau) involved in the implementation of the IPF Component subprojects is the provision of training. The training to be offered will also need to address target groups from different beneficiary and stakeholder institutions, as well as high level project coordination and management groups. Detailed topics that would need to be covered by the training are listed in the main report. The breakdown of estimated costs for putting the ESMF into operation is provided in Table 20. The total estimated costs for mainstreaming environment into the IPF Component Project for the next four years of implementation period are USD 963,000.

X. MONITORING OF ESMF IMPLEMENTATION

Quarterly, Biannual and Annual Internal E&S performance monitoring report on ESMF implementation will be prepared by the MoH and ICS Environmental and Social Specialists and delivered to the State Minister of MoH, Federal and Regional EPAs and the World Bank. In addition, any "Higher Risk" subproject financed by the IPF Component Project that has been subject to an ESIA study will also be required to produce an annual performance audit report, for delivery to the Federal and Regional EPAs and the World Bank. An external independently commissioned annual environmental and social risk management and performance audit will be carried out covering all IPF Component subprojects. This will be conducted as part of the annual performance audit of the IPF Component.

1. Introduction

Ethiopia has made remarkable progress in achieving significant health outcomes over the past two decades including attaining the fourth Millennium Development Goal (MDG), reducing child mortality, three years ahead of target, and it made good progress towards achieving MDG 5, improving maternal health. However, it is lagging behind in some of the health targets. The rate of neonatal and under-five children mortality remains high, the prevalence of stunting remains stagnant, and the Reproductive, Maternal, Newborn, Child, Adolescent and Youth Health (RMNCAYH) outcome is still lingering. Besides, the health and nutrition outcomes show the overwhelming gaps between income groups and geographic areas or regions. Given this situation, the Government of Ethiopia (GoE) has adopted a second Health Sector Transformation Plan (HSTP II) aiming to accelerate achievements in strategic priorities including maternal and child health performance.

The GoE, through MoH, requested Bank finance to address the priority needs of the HSTPII through the Sustainable Development Goals Performance Fund (SDG PF). The goals of the SDG PF are to augment financial gaps of HSTP II in priority areas. In response to it, the Ethiopia PforR Strengthening Primary Health Care Services (SPHCS) project was developed which consists of both PforR and IPF components. The PDO of the SPHCS project is to improve access to and equitable provision of high-quality PHC services, with a focus on RMNCAH+N, while strengthening health systems. The main focus of the IPF component is on emergency health and nutrition response in conflict-affected areas, having a total allocated fund of US 124 million to be financed by the International Development Association (IDA). Both the Health PforR and IPF components will be implemented from 2022-2026 through the Ministry of Health (MoH), the Immigration Nationality and Vital Events Agency (INVEA) and their regional counterparts. This ESMF is designed to address the environmental and social risks management aspects of the IPF component project. It provides an Environmental and Social Management Framework (ESMF) for the IPF Component project. The main objective of the ESMF is to establish an environmental and social management process that meets the National environmental and social requirements and World Bank ESF standards applicable for addressing environmental and social risks of the

IPF Component of the PforR SPHCS subprojects. The ESMF includes GBV Action Plan as an annex and is complemented by a Stakeholder Engagement Plan (SEP), a Security Risk Assessment (SRA), a Social Assessment (SA), and a Resettlement Policy Framework (RPF).

Chapter one outlines of the purpose, objectives and methodologies of the IPF Component Project ESMF. Description of the IPF Component Project and its components are outlined in Chapter two. The next chapter (Chapter.3) broadly sets the environmental and social baseline descriptions, which is followed by review of applicable policies, legislations and World Bank ESS in Chapter four. Whereas the essential procedures and process of the ESMF implementation are presented in chapter five, the environmental and social benefits and adverse risks of the IPF Component Project are presented in chapter six. The subsequent Chapters outline the GRM on Chapter 7, Stakeholder Consultation on Chapter 8, and capacity building and training including budget for ESMF implementation on Chapter 9.

1.1 Purpose and objectives of the ESMF

The main objective of the Environmental and Social Management Framework (ESMF) is to provide an environmental and social management process for the IPF Component of the SPHCS Project. Since the specific sites for some of the subproject activities found under the IPF component project cannot be identified prior to appraisal, an ESMF was chosen as the appropriate tool. This ESMF outlines an environmental and social screening process which will enable qualified project personnel to screen sub-projects for site specific potential negative environmental and social impacts. The ESMF also provides guidance towards identification and mitigation of potential environmental and social risks and impacts of the IPF component project and enhances positive outcomes including benefits for project beneficiaries and the environment. It also provides measures to project implementing institutions and key regulatory stakeholders to ensure project activities are implemented in an environmentally friendly and sustainable manner as required by the World Bank Environmental and Social Standards (ESSs) and the National Environmental Policies and relevant legislation pertaining to sustainable environmental and social management of sub project activities. To this end, this ESMF has been prepared in compliance with the Bank's ESF and relevant national policies and laws on environmental and social assessment.

The objectives and purposes of the IPF Component Project ESMF can be summarized as follows:

- identifying the main environmental and social risks and impacts of the IPF component of the program and proposed associated mitigation measures.
- To review Government of Ethiopia's (GoE) environmental policies, legislation, regulatory and institutional frameworks in conjunction with the World Bank's ESS.
- To establish clear procedures and methodologies for integrating environmental and social issues in planning, review, approval and implementation of subprojects to be financed under the IPF component project;
- To carry out stakeholder consultations which ensure that all key stakeholders, including potentially affected persons, are aware of the objectives and potential environmental and social risks and impacts of the proposed IPF component project, and that their views are incorporated into the project design as appropriate as possible.
- Assess the current capacity at the relevant National and regional level health sector institutions to implement the ESMF, and make appropriate recommendations;
- Specify appropriate roles and responsibilities, and outline the necessary reporting procedures, for managing and monitoring environmental and social risk management related to the IPF component subprojects;
- Provide an indicative Environmental and Social Management Plan (ESMP) and monitoring mechanisms to ensure that environmental and social risks and impacts of subprojects requiring ESMP will be managed effectively;

The total estimated costs for implementing the ESMF of the IPF Component Project for the four years of implementation period is USD 963,000.

1.2 Justification for the ESMF

The World Bank ESS requires that all Bank-financed operations are screened for potential adverse environmental and social impacts, and that the required environmental and social assessments be carried out based on the screening results. This ESMF was prepared to ensure that investments under the IPF component project are implemented in accordance with World

Bank's Environmental and Social Standards and GoE's National Environmental legislation. The ESMF is an instrument that examines the risks and impacts when a project consists of a series of subprojects, and the risks and impacts cannot be determined until subproject details have been identified. The IPF component project have sub-components that deal with procurement and distribution of medical supplies and equipment for conflict-damaged and -affected health facilities, restoration of health service infrastructures, and strengthening physical rehabilitation services. However, the specific locations where the restoration of health service infrastructure and strengthening of physical rehabilitation services will takeplace are yet to be determined by conducting assessments on a semi-annually basis. According to the World Bank ESF, projects supported by the Bank through IPF are required to meet the ten ESSs outlined in the ESF depending on their relevance/applicability to the specific project. The importance of this ESMF, therefore, emanates from the need to fulfill both the World Bank ESSs and national environmental requirements throughout the process of the IPF project implementation. Hence, as part of the project preparation, the FDRE Ministry of Health have prepared this ESMF, which will serve as a basis for management of any potential environmental and social risks and impacts originating from the subproject activities.

1.3 Potential Users of the ESMF

This ESMF has been prepared for use by the project implementing agencies, which are mainly Ministry of Health (MoH), participating Regional Health Bureaus, Ethiopian Pharmaceutical Supply Agency (EPSA), UNICEF, Immigration and Citizenship Services (ICS), as well as other entities to be involved in the planning, implementation and management of the proposed subprojects of the IPF component project. As such, the ESMF will also be useful to the following stakeholders:

- Project financier (IDA)
- National Ministry of Environment and Forest and state level branch offices
- Federal Environment Protection Authority and relevant Regional States Environment Protection Offices
- Stakeholders and beneficiary local communities

1.4 Methodology

The methodology adopted for preparing the ESMF includes conventional methods which are briefly discussed below.

a. Review of relevant legislation, policies and other documents

Relevant literature was reviewed for the ESMF preparation:

- IPF program-related documents were reviewed with the aim to provide program background information, development objective and components. Project-related documents reviewed include draft Program Appraisal Document (PAD), draft Environmental and Social System Assessment (ESSA), draft Environmental and Social Review Summary (ESRS) appraisal state, Environmental and Social Commitment Plan (ESCP), and Stakeholder Engagement Plan (SEP).
- Existing national policies and legal documents, regulations and guidelines on environmental management;
- Existing ESMFs for similar World Bank projects such as Ethiopia COVID-19 Emergency Response Project, Additional Finance for Ethiopia COVID 19 Emergency Response Project,
- World Bank /IFC EHS guidelines
- World Bank Environmental and Social Standards for IPF projects as outlined in the Environmental and Social Framework.

b. Data Collection and Analysis

Secondary data was collected, analyzed and applied to compile the environmental and social baseline of the ESMF. Secondary data mainly from the socioeconomic profiles and atlas of the project regions, UNICEF publications and other published and draft level documents were used to compile the environmental and social baseline as well as legal and institutional frameworks of the present ESMF. In addition, qualitative approaches were also used to collect additional data from relevant bodies.

c. Field Visits

The ESMF team conducted field observations in selected three sample regions, namely Oromia, Amhara and Afar Regional states. The purpose of the field visits were to conduct observations on conflict affected areas and to carry community as well as stakeholder consultations. The team specifically conducted site visits and community consultations at Chifra Woreda in the Afar Region and Jari IDP Camp in Oromia Region between 19/02/23 to 25/02/23. The site observations were instrumental towards comprehending the scale of environmental and social impacts inflicted by the conflict. Fig-1 below shows some of the damages inflicted by the conflict.

Figure 1 Showing schools and health facilities damaged by the conflict

d. Consultation with project implementers and stakeholders

As part of the ESMF preparation process stakeholder and community consultations were conducted at Federal level with the MoH and its relevant Agencies as well as Directorates, the Immigration and Citizenship Services, and the third-party implementer i.e. UNICEF, as well as project beneficiaries and conflict affected communities. At regional level the consultation was carried in a sample of three conflict affected regions namely Oromia, Amhara and Afar regions and two woredas found in them. The consultations at Federal level including the Oromia region were conducted between 31/01/23 to 14/02/23 and the remaining regional and Woreda level consultations between 19/02/23 to 25/02/23. The consultations were focused on providing information and receiving the concerns and opinions of the participants regarding the overall IPF Component Project objectives, its main components for which the ESMF was prepared. The consultations were also carried out to obtain their input in the identification of environmental and social impacts of the IPF Component project and design of mitigation measures.

Key stakeholders consulted included representatives from:

- Ministry of Health
- Immigration and Citizenship Service (ICS)
- Ethiopian Pharmaceutical Supply Agency (EPSA)
- Regional Civil Registration and Vital Statistics
- Relevant Departments at Federal MoH
- Regional Health Bureaus (Amhara, Afar, and Oromia)

2. Description of the Project

Project Development Objectives (PDO): The IPF Component project shares the PDO of the parent PforR project which is "*to improve access to and equitable provision of high-quality PHC services, with a focus on RMNCAH+N, while strengthening health systems*"**.** The PDO is designed to be met through a chain of interventions, outputs, and outcomes, using resources from the PforR instrument focusing on RMNCAH+N and the health system exclusively in non-conflict areas, and from the IPF instrument focusing on emergency health and nutrition response in conflict-affected areas.

2.1 Project Target Beneficiaries

The Program activities under the IPF component mainly targets communities in conflict-affected areas of Tigray, Afar, Amhara, Oromia and Benshangul-Gumuz regions focusing on emergency health and nutrition response. It is expected to benefit the communities in the conflict affected areas, including vulnerable groups by strengthening the system and services to provide accessible PHC service. The interventions are intended to strengthen PHC services and address the needs of conflict affected communities, vulnerable people including women, children, people with disabilities, IDPs, and underserved traditional local communities.

2.2 The IPF Component Project

The IPF component will support the government emergency health and recovery plan for conflict-affected areas. It will support and enhance the development of a resilient health service delivery system in the conflict-affected parts of the country, requiring huge investments. The IPF will support the provision of health and nutrition services as well as medicines, medical consumables, equipment, and human resources as per MOH's conflict-related health emergency response plans to ensure access in conflict-affected areas and IDP settings. Assessments will be

conducted on a semi-annually basis to determine the number of people affected by conflict; evaluate the completeness and effectiveness of the package of health and nutrition services being provided; identify any changes or inclusion of interventions based on the needs of the community and includes other interventions as the situation develops from area to area. The outcome of the assessment will also help to revise the annual work plan and review the set of interventions being undertaken. It is estimated that 20 percent of the total financing of the program will be required for providing essential health services (EHS) in the conflict affected areas.

Periodic updates of the health sector rapid response assessment will be conducted at least once a year. These updates would also take into consideration inputs from other potentially relevant assessments conducted by development partners or government agencies. The updates would include assessing the disruption of access to regular health services, the level of damage and loss in health facilities, and the adequacy of services provided in meeting the needs of affected communities.

The IPF will also support the strengthening of the Civil Registration and Vital Statistics (CRVS) system. The IPF will support the improvement of the CRVS system for the Immigration and Citizenship Service (ICS) (formerly the Immigration, Nationality and Vital Events Agency (INVEA)) but also for the MOH, Ethiopian Statistics Service (ESS), and National Security Service, as well as religious bodies that officiate marriages and burials.

2.2.1 Description of the IPF Subcomponents

IPF Sub-component I: Provision of EHS Focusing on RMNCAH+N to Conflict-Affected Population and IDPs: The key activities to be financed under this sub-component include**:** (i) procurement and distribution of medical supplies and equipment for conflict-damaged and -affected health facilities; (ii) restoration of health service infrastructure, ambulance services, and mentorship program; (iii) deployment of mobile health teams and establishment of district emergency management team to continue delivery of IDP essential health and nutrition services and provide training to health workers on survivor-centered care; (iv) provide psychosocial

support; (v) strengthen facility disaster preparedness, response, and regional emergency coordination cells; (vi) strengthening physical rehabilitation services; and (vii) project monitoring and evaluation.

IPF Sub-component II: Civil Registration and Vital Statistics (CRVS): This sub-component is a continuation of support provided for strengthening the CRVS system in the IPF sub-component of the Ethiopia Health SDGs PforR that closed on June 30, 2022. The COVID-19 pandemic and the conflict have severely affected the performance of the civil registration system. This has disrupted registration services due to the closure of civil registration offices during conflict, with some offices destroyed and registration materials looted; reduction in operating hours of civil registration offices due to COVID restriction. The Program will contribute to addressing the existing challenges, ensuring operational continuity, and enhancing the system for continued production of comprehensive vital statistics.

A weak CRVS system is a constraint to sound maternal and child health information and hinders the registration of vital events. To institutionalize the CRVS system, ICS and the health sector need to collaborate on respective civil registration activities in an integrated and harmonized manner. To ensure continuous provision of civil registration services in conflict-affected areas and for IDPs and pastoralist population, mobile registration tools such as laptops and tablets will be used by civil status officers in the communities; civil registration services will be linked to mobile services in the health sector; and innovative ways of conducting training remotely will be established. An assessment will be undertaken to establish the needs in conflict-affected areas and best approaches to offer the services on a continuous basis.

This TA supports the digitization of the CRVS system, capacity building, social and behavior change communication, coordination, monitoring and evaluation (M&E), and project management. The government is required to finalize and approve the draft Data Protection Protocol prior to deploying the digitized CRVS. The activities to be supported include: (i) digitization of the CRVS system, converting the manual paper-based registration system to a digital, interoperable CRVS system in consultation with key stakeholders, including the MOH, Regional Vital Events Registration Agencies, and the ESS; (ii) amendment of the legal framework, consultants will review and align the legal framework with the new digital systems,

review processes and procedures, and develop SOPs; (iii) capacity building, continuing the training of civil registrars at different levels, including kebeles and refugee camps; (iv) social and behavior change communication; (v) strengthening CRVS activities in conflict-affected areas, (vi) coordination, monitoring, and evaluation activities; and (vii) project management.

IPF Sub-component III: Technical Assistance and Capacity Building: This sub-component aims to strengthen the implementation capacity of MOH, Regional Health Bureaus (RHBs), and other implementing agencies in the health sector including Ethiopian Pharmaceutical Supply Agency (EPSA). The support will include areas of financial management (FM) and procurement capacity at EPSA and MOH; data and management information systems including MOH vital events notification function, M&E, health care financing, and strengthening public-private partnerships. Additionally, this component will support technical assistance for the planned scale-up of emergency obstetric and newborn care (EmONC), the expansion of comprehensive services in PHC facilities, and the rollout of a new self-care package envisioned in HSTP II as well as monitoring the implementation of the fraud and anticorruption system. This TA support will be measured by number of technical assistants deployed in the sector, such as FM and procurement experts deployed at the federal and regional levels; technical experts such as RMNCAH+N, health financing, gender and GBV, data and management information systems; Environmental and Social (E&S) standards; Public Private Partnership. The provision of a technical assistance sub-component will also support assessments of fraud and anticorruption and other emerging issues on RMNCAH+N and related health systems.

IPF Sub-component IV: Contingent Emergency Response: There is a high probability that Ethiopia may experience an epidemic or other health emergency with the potential to cause major adverse social and economic impacts. This sub-component will improve the country response capacity in the event of an eligible emergency, following the procedures described in World Bank Policy on Investment Project Financing, paragraph 12 (Rapid Response to Crisis and Emergencies). This CERC will enable the country to request and access rapid World Bank support for mitigation, response, and recovery in the affected areas. The CERC will serve as a first-line financing option for emergency response. Unused IDA funding will be allocated to this sub-component in the event of an eligible emergency.

2.3 Institutional and Implementation Arrangements

MOH has functional Directorates following the nationwide health sector reform. The Directorates were established based on their functions, under the Office of the Minister and the State Ministers. MOH has seven agencies that are responsible for guiding and implementing health and health-related activities. MOH also supports regions in systems development and developing health sector programs aligned with national plans and goals. It mobilizes additional resources to improve service delivery and creates platforms for mutual accountability, information flow, and efficient use of resources.

MOH- Regional Health Bureaus (RHBs) Joint Steering Committee: The Minister of Health chairs this forum that meets every two months to facilitate smooth, effective implementation of HSTP priority activities. The meetings focus on the implementation and progress of the plan and challenges faced during its implementation.

MOH will be responsible for planning, budgeting, and reporting funds released from the pooled fund, through which IDA and GFF funding will be disbursed under the IPF operation. The Joint Consultative Forum (JCF), which is the highest governance body for dialogue, oversees the implementation of HSTP II.

The implementation of the EHS to conflict-affected areas (IPF sub-component I) will be conducted through a third-party implementing agency with proven access into these hot spots. The implementation in Tigray will be conducted by UNICEF, as per the agreement with MOH and MOF, while MOH will be responsible for implementation of services in all other regions covered by the IPF sub-component I. Furthermore, a well-defined transition plan will be developed to make sure that a handover process is clearly defined up front that helps the government take over the implementation responsibility when the situation improves. The details will be included in the contract agreement.

The implementation of CRVS activities (IPF sub-component II) will be conducted by Immigration and Citizenship Service (ICS). The ICS management will provide overall strategic

guidance for the implementation of the project. A technical committee will be established to provide support on technical issues during implementation of the project. Among other responsibilities, the committee will monitor and evaluate the implementation of the project; facilitate exchange of information on best practices; provide technical advice on activities of the project; and make recommendations for consideration by the CRVS federal steering committee. A Project Operation Manual (POM) that details project implementation arrangements will be adopted before the Program becomes effective. ICS will develop a budgeted annual work plan to be submitted to the World Bank for its no objection. It will produce quarterly financial reports and annual audit reports.

2.3.1 Institutional arrangement for ESMF Implementation

As stated in the preceding sections, the main implementing agency of Subcomponent-I and III of the IPF Project is the Ministry of Health (MoH) in collaboration with the five conflict-affected Regional Health Bureaus. The Ethiopian Pharmaceutical Supply Agency (EPSA) will be a partner implementing institution under the MoH in the areas of procurement and distribution of medical supplies and equipment. UNICEF will also act as third party implementing entity for subcomponent-1 of the IPF project in Tigray region. The main implementing agency for Subcomponent II of the IPF project will be the Immigration and Citizenship Services (ICS). The institutional arrangement for ESMF implementation is also going to follow the same lines. The ESMF implementation will be spearheaded by the GMU environment and social staff and are expected to work in close collaboration with the E&S staff of partner institutions (i.e., RHBs, ICS and EPSA) as well as third party implementing institution (i.e. the UNICEF).

Identification of subprojects will be carried through consultative process by the lead implementing agency (MoH), the partner institutions such as, Immigration and Citizenship Service (ICS), Ethiopian Pharmaceuticals Supply Agency (EPSA), and Regional States Health and CRVS sector offices as well as by third party implementers such as UNICEF. The identified subprojects will be reviewed and compiled into an annual action plan by the relevant technical working group and will be forwarded to GMU/MoH (Office of the state minister) and the ICS for endorsement and approval. Subprojects included in the approved annual action plan of the IPF Component Project will be eligible for applying the ESMF procedures.

2.3.2 The IPF Component Subproject Typology

The IPF Component project appears to consist of two subproject types under subcomponent 1 and 2. The first type of subprojects involves technical assistance and capacity building related activities. The second type is subproject activities whose implementation will involve the undertaking of physical installations, construction, and operational works. Table 1 below shows the typology of IPF Component subproject activities.

Table 1: Showing subproject typology of the IPF Component

Subproject class	Subprojects involving physical installations, construction & operational works	Technical Assistance related Subproject Activities/
Component – 1	- support the provision of health and nutrition services as well as medicines, medical consumables, equipment, and human resources - procurement and distribution of medical supplies and equipment - restoration of health service infrastructure (535HFs) - restoration of ambulance services; -deployment of mobile health teams and temporary health posts/clinics - providing essential health services (EHS) in the conflict affected areas - strengthening physical rehabilitation services - restoration of mentorship programs	-establishment of district emergency management team to continue delivery of IDP essential health and nutrition services and provide training to health workers on survivor-centered care; -provide psychosocial support
IPF Sub Component 2: Civil Registration and Vital Statistics (CRVS):	- provision of mobile registration tools such as laptops and tablets to officers to ensure continuous provision of civil registration services in conflict-affected areas and for IDPs; - linking civil registration services to mobile services in the health sector; - digitization of the CRVS system, converting the manual	- TA support for capacity building, social and behavior change communication, coordination, monitoring and evaluation (M&E), and project management. --digitization of the CRVS system, converting the manual paper-based registration system to a digital, interoperable CRVS system - amendment of the legal framework, consultants will review and align the legal framework with the new digital

	paper-based registration system to a digital	systems, review processes and procedures, and develop SOPs; - capacity building, continuing the training of civil registrars at different levels, including kebeles and refugee camps - social and behavior change communication; - strengthening CRVS activities in conflict-affected areas - review processes and procedures, and develop SOPs - Capacity building, continuing the training of civil registrars at different levels, including kebeles and refugee camps; - The expansion of comprehensive services in PHC facilities, - Rollout of a new self-care package envisioned in HSTP II
IPF Sub-component III: Technical Assistance and Capacity Building:	- data and management information systems including MOH vital events notification function	-strengthen the implementation capacity of MOH, Regional Health Bureaus (RHBs), and other implementing agencies in the health sector including Ethiopian Pharmaceutical Supply Agency (EPSA). -support will include areas of financial management (FM) and procurement capacity at EPSA and MOH - support technical assistance for the planned scale-up of emergency obstetric and newborn care (EmONC), - the expansion of comprehensive services in PHC facilities

2.3.3 Project exclusion criteria

In light of achieving the objectives of the IPF Component project, the following criteria would be applied to exclude subprojects from financing. These are:

- Activities that may cause long term, permanent and/or irreversible impacts (e.g. loss of major natural habitat and biodiversity)
- Construction in environmentally sensitive areas such as National Parks, fragile ecosystems, and wildlife reserve.
- Activities that have high probability of causing serious adverse effects to human health and/or the environment
- Activities that may have significant adverse social impacts and may give rise to significant social conflict
- Activities that cause or lead to child abuse, child labor exploitation, forced labor or human trafficking.

- Activities that have significant risks and/or adverse impacts on sensitive cultural receptors, tangible or intangible, or that could damage non-replicable cultural property.
- Activities that impact land owned or claimed by Historically Underserved Communities (HUCs) without complete and documented Free, Prior, and Informed Consent (FPIC) of such communities.

3.Environmental and Social context and baseline conditions of the conflict affected regions

3.1 Afar Regional State

Afar regional state is situated in the northeastern part of Ethiopia with an area of around 150,000 km^2 that stretches into the lowlands covering the Awash Valley and the Danakil Depression. Geographically, the region is situated longitudinally between 39°34' and 42°28' East and latitudinally between 8°49' and 14°30' North. The region is bordered to the northwest by Tigray region, to the southwest by Amhara region, to the south by Oromia region and to the southeast by the Somali region of Ethiopia. It is also bordered to the east by Djibouti and to the northeast by Eritrea.

The conflict affected woredas of the Afar region are found distributed in four zones of the region situated along the northwestern and southwestern borderlines that interface with both Amhara and Tigray regions. As these zones constitute a larger proportion of the region, the environment and social baseline is provided for the whole region to provide a broader context for the ESMF.

3.1.1 Climate and Weather

Three of the most important factors determining an area's climate are altitude, air temperature and precipitation. The climate of the region is highly associated to altitude and vegetation cover of the area. This factor determines the regional local climate, ranging from dry hot to wet hot.

Temperature: The temperature of the region is highly associated to altitude of the area, i.e., as altitude rise, temperature of the region decreases and vice versa. The region altitude is most dominantly low. This factor determines the local temperature ranging from 12.5^0c to > 27.5^0c. In general, large part of the region has >27.5^0c annual average temperature which covers 38.7 % of

the region, where as north west part of the region has 15-17.5^{0}c, this cover only 0.13% of the region area. The rest more than 60% of the region has 20^{0}c-27.5^{0}c.

Rainfall: The amount of annual rainfall of the region varies, in different seasons. This seasonal amount of rainfall basically depends on a strong air flow from the south west to the north east that is caused by a deep low pressure zone over the Arabian Sea and the northern Indian Ocean. The region is highly characterized by low rainfall zone and associated with altitude and vegetation cover of the area. Relatively high altitude area such as western highland periphery of the region receives >900 mm of rain. These areas cover only 0.88% of the region area. Whereas most of the region (51.33% of the region) receives < 300 mm.

3.1.2 Morphology, Relief and Ecology

The present landscape of Afar Region is very much a product of the tectonic processes, continuing episodes of rifting and volcanism. The region is an area of low land, with an irregular drainage system and depression including Dalol area which is 114 m below sea level. 35.47% of the region has an elevation less than 400 m above sea level whereas 51.44% has an elevation between 400 to 900 m and 13.09% has an elevation above 900 m above sea level.

There are only three agro-ecological zones in which the population in Afar Region lives. A majority of the population live in arid (48%) and semi-arid (49%) followed by a much smaller number in semiarid zones (3.3%). These agro-ecological zones are not suitable for rain-fed crop production and pastoralism is pursued as the only livelihood option. However, the region is endowed with irrigation water from the Awash River. Many areas in the region are irrigable and crop production can be boosted to ensure food supplies in the region, and in the country at large.

3.1.3 Surface and Groundwater Resources

The region is endowed with large amount of surface and groundwater resource. Awash River is one of the main and the largest perennial river in the region which passes across many districts in the region. Based on hydrological classification, the region is divided into two main basins, namely the Awash and Denakil drainage basins. The south and central parts of the region fall within the drainage basin of the Awash River. Some of the major tributaries of Awash Basin are

Mille, Kebena and Kesem River. Whereas Awura, Telalak and Gulina rivers flow into Denakil basin.

In the region there are also a number of lakes, such as Lake Asahle, Lake Dalol, Lake Afdera, Lake Abe, and Lake Gemeri which are all salty lakes.

Afar Regional State is also endowed with groundwater resource recharged by subsurface flow from the southern, western and eastern highlands, surface water percolation through weaker geologic planes from precipitation within the valley, and recharge from the Awash River and its tributaries. The two major aquifers of the region, i.e., the recent volcanic sediment which is the local aquifer in the area is less faulted, less permeable and high content of minerals. But the regional aquifer which is tertiary volcanic is highly faulted, highly permeable and less mineral contents.

3.1.4 Land use and Land cover

According to Regional Atlas of Afar Region, 8 major distinct type of land cover classification are identified. These are:

Table 2: Land use types of Afar Region

No	Land use type	Coverage (%)	Remarks
1	***Cultivated Land***	3.20%	Mostly found in Dubti, Asayita and Afambo woreda of Zone 1
2	Wood lands	0.19%	Mostly found in Mile, Dubti, Gewane, Buremudaytu and Dalifage woreda.
3	Grass Land	6.05%	It is defined where the area is dominated by grass with very few shrub or bushes. This land covers uses as the major source for grazing. It predominantly found in Ewa and Chifra Woreda.
4	Bush land and shrub land	17.07%	Found in western and south central part of the region.
5	Wetlands/Swamp land	0.79%	It is found in north part of Afambo, Assayita, Elidar and Dubti Woreda. It shows the seasonal or perennial marshland of the region.
6	Water body	0.75%	Lakes are categorized in this land cover
7	Exposed rock surface	21.13%	This unit refers to steep and degraded landscape of the region with shallow and stony soils.
8	Exposed and Flat Sand surface	46.16%	It predominantly found in central and north eastern part of the region.
9	Salt Flat surface	1.74%	It predominantly found in east and north eastern part of the region specially, Dalol, Berahle, Afdera, Dubti and Afambo Woreda.

3.1.5 Biological Baseline Environment Condition

Flora: A large part of Afar Regional State falls under the category of desert and semi-desert scrubland vegetation types dominated by invasive species and grazing lands. Acacia woodlands, thorned bush lands, grazing savannas, diverse riverine wetlands and riverine forests covers small part of the region mainly concentrated in parks and along Awash River.

Intrusions and expanding of invasive tree species (like *Prosopis Juliflora*) at an alarming rate which displaces so many pastorals from their productive lands. However, the invasive exotic species become a 'blessing in disguise', a lot of development actors and donors prove that the tree has multi-purpose value and are working on changing the tree into economic value. The major plant species of the region are listed in table 3 below.

Table 3: Major Plant Species found in Afar Region

No	*Afar Vernacular Name/ Local name*	*Scientific Name*
1	*Tikblyita*	*Acacia senegal*
2	*Eebto*	*Acacia seyal*
3	*Keselto*	*Acacia nilotica*
4	*Germayto*	*Acacia oerfota nubia Benth*
5	*Sukhto*	*Tamarix aphylla*
6	*Hidayito*	*Suaeda monoica*
7	*Alayto*	*Balanites aegyptiaca*
8	*Gersa*	*Dobera glabra*
9	Dergihara	Prosopis juliflora
10	*Geleato*	*Calotropis procera*
11	*Gerento*	*Acacia nubicaa*
12	*Adayto'*	*Salvadora persica*

Source: Afar Bureau of Agriculture, 2023.

Fauna: The region is also known for its large number of mammal, reptile and bird species concentrated in the two National Parks (i.e., Yangudi Rassa and Awash National Parks) and the Awash River. The main wildlife species present in the region are described in table 4.

Table 4: Major wildlife species in Afar

S/n	Major Wild Animal Species

1	Baboon Occasional
2	Beisa oryx
3	little dik-dik
4	Jackals
5	Warthogs
6	Leopards
7	Lesser kudu
8	Bushbuck
9	Soemmerrings
10	Hyena

Source: Afar Bureau of Agriculture, 2023

3.1.6 Overview of Afar Regional State Socio-Economic Baseline

***Demographic, Ethnic and Religious Features*:** The population in the Afar regional state is estimated to be 1.8 million consisting of 991,000 (54.69%) men and 821,002 (45.31%) women, approximately two percent of the total population of the country.[1] The rural population of the regional state accounts for 81% of the total. More than 19% of the population of the region lives in urban areas. As elsewhere in Ethiopia, the population of Afar is young: 12% is under-five years of age and 39.5% is under 18 years of age.[2] The total fertility rate in Afar region is high; 5.5 in 2016.[3] Most people are pastoralist or agro-pastoralist and are very dependent on their livestock.

Afar is home for more than 90.03% of the ethnic Afar with the remaining 9.97% belongs to different ethnic groups (Somali, Argobba, Tigrayan, Amhara, Welayta and Hadiya). According to the 2007[4] census, of the total residents of the Afar Regional State, 9695.27% were Muslim/Islam, 3.93% Orthodox, 0.67 % Protestant and 0.071% Catholic.

Socio-economic: The primary occupation is livestock rearing or pastorialism (92%). Crop production, trade and mixed agriculture are the other occupations. Regarding secondary employment of pastorialists, it is almost non-existent. Therefore about 91% are without secondary occupation except for a very small proportion of pastoral community. The low level of secondary occupation has reduced the capacity of generating additional income for the pastoral

[1] 2019 projection based on the 2007 Census; CSA
[2] Data comes from 2017 projection based on the 2007 Census; CSA.
[3] EDHS 2016, p.84.
[4] This is the latest data with breakdowns on the religious composition of the population of Oromia.

community economy and, thereby, has not improved the food security status of the household economy.[5]

Among the population aged ten years and over 626,041 or 80.6% were reported to be economically active and 149,663 or 19.3% economically inactive. Among the male population 92.4% were economically active and 65.2% of female population. In urban areas women are almost equally active as men and in rural areas men are significantly more active which reflects the fact that women's work as housewives is not considered as being economically active.[6]

Land Ownership and customs[7]: The Constitution of the Federal Democratic Republic of Ethiopia, Article 40 (3) provides that the right to ownership of rural and urban land, as well as of all natural resources, is exclusively vested in the State and the peoples of Ethiopia. Land is a common property of the Nations, Nationalities, and Peoples of Ethiopia and shall not be subject to sale or to other means of exchange. The Constitution of the Afar National Regional State, Article 38 (3) also provides that the right to ownership of rural and urban land as well as all natural resources is exclusively vested in the state and the people. Land is the common property of the peoples of the region and shall not be subject to sale or other means of exchange. However, since in most parts of the region, land is divided by clans and administered by clan leaders; the state and public co-ownership of land is hardly recognizable.

Food Security and Livelihoods: Afar region is among the ten national regional states of Ethiopia. It is grouped under food insecure regional states with high levels of vulnerability caused by repeated shocks. Most of the people of this region are pastoralists and have experienced severe food insecurity for many years. According to the Afar Bureau of Food Security, there were about 562,080 individuals with food security difficulties. This is due to varied climatic conditions, traditional production system, poor regional development policy and lack of sound research in the study area.[8]

Afar has some of the highest malnutrition rates in the country. There is little food production and what grows often is destroyed by cyclic drought, floods or locust invasions. Many children

[5] Ethiopian Roads Authority (2016). Environmental and social Impact Assessment for Yalo Dalol Road. P, 48.
[6] Ibid, p.49
[7] FAO (2008). Afar National Regional State: Rural Land Use and Administration Policy.
[8] ABoFS. 2016. Annual Food Security Report. Afar: Afar Bureau of Food Security.

consume just a mono diet of camel or goat milk and bread. Women and girls are also malnourished, particularly during and after pregnancy. The number of children who are wasted (low weight for age) has been increasing since 2005 due to recurrent emergencies, poor feeding practices and diseases, particularly malaria and diarrhea. Stunting prevalence is 41% amongst children whose mothers have no education or just primary education compared to 14% of children whose mothers have higher education.[9]

Most Vulnerable and Underserved Groups in Afar: The large proportion of households in Afar region characterized as a distinct social and cultural group possessing the following characteristics in varying degrees: (a) self-identification as members of a distinct social and cultural group and recognition of this identity by others; (b) collective attachment to geographically distinct habitats, ancestral territories, or areas of seasonal use or occupation, as well as to the natural resources in these areas; (c) customary cultural, economic, social, or political institutions that are distinct or separate from those of the mainstream society or culture; and (d) a distinct language or dialect, often different from the official language or languages of the country in which they reside.

Sexual and Gender Based Violence: In Afar, the percentages of women (ages 15-49) who have ever experienced psychological violence, physical violence or sexual violence committed by their current or most recent husband/partner are 13 percent, 12 percent and three percent, respectively; this lower than in any other region except Somali.[10] However, the percentage of women who believe that a husband is justified in hitting or beating his wife in various circumstances is 69 percent and 16 percent of men believe that wife beating is justified in some circumstances,[11] so there may be underreporting of violence against women.

3.1.7 Access and Provision of Social Services in Afar

Health: While Ethiopia experienced a significant decline in the fertility rate from 5.9 children per woman in 2000 to 4.3 children in 2016, in Afar, that number has increased from 4.9 to 5.5 during the same period. Similarly, while nationally early childhood mortality rates are

[9] UNICEF (2022). Afar Regional Brief.
[10] EDHS 2016, p.306
[11] Ibid, p.283 and 284

decreasing, in Afar these rates are increasing, particularly the infant mortality rate which increased from 64 deaths per live 1,000 births in 2011 to 81 deaths per 1,000 live births in 2016. Moreover, vaccination coverage at only 20% is the second lowest coverage of children in the country as the community move from place to place. Large numbers of pregnant women who do not have any antenatal care and do not deliver in a health facility contribute to the many infants who die during the first 28 days of life.[12]

In terms of health facilities, Afar region has 7 government hospitals, 2 private hospitals (specialty Hospitals), 97 health centers and 344 health posts. There are also two private higher clinics and 32 primary clinics.

WASH: Afar's regular droughts put a huge strain on the water supply schemes which even in the best of times are insufficient to meet the demands of the population and their livestock. The percentage of households using improved drinking water sources is the second lowest in Ethiopia after Somali region. In Afar, 57 percent[13] of households use improved drinking water sources, but if the Sustainable Development Goal (SDG) indicator is used as the measure, the use of safely managed drinking water services is less than 11% of the population. In some areas, women and children walk for more than four hours in search of water. Moreover, most institutions, including health facilities and schools, lack water. Poor sanitation is another major challenge with only 4.1% of people in Afar region having access to improved sanitation facilities, 1% in rural and 11% in urban areas[2] . Afar region also suffers frequent outbreaks of cholera and other forms of acute watery diarrhoea, causing the deaths of many children.[14]

Education: The school enrolment rates in Afar are among the lowest in the country. The Net Enrolment Ratio (NER) for pre-primary education in Afar was the second lowest in the country at 5.8%; the NER for primary schools was 46%, and the NER for Grades 9 and 10 at 6%, and Grades 11 and 12 at 2% in secondary school are the lowest in the country. The Gender Parity Index (GPI) for Afar primary schools is 0.87 meaning more boys is enrolled. However, those

[12] UNICEF (2022). Afar Regional Brief.
[13] EDHS, 2016
[14] UNICEF (2022). Afar Regional Brief.

children who attend school often fail to acquire basic skills, such as literacy and numeracy due to unskilled teachers, irrelevant curriculum, and inadequate learning materials.[15]

3.1.8 Social Protection Services in Afar

Child Protection: Progress related to gender equality and women empowerment in Afar has been particularly slow. Over the 25 years, between 1991 and 2016, there was no significant change in the prevalence of child marriage in the Afar region (from 69% to 67%). Female genital mutilation/cutting (FGM/C) among girls and women aged 15 to 19 years also remains prevalent, the second highest in the country, and is often the most extreme form, infibulations. FGM/C has decreased only marginally in the past two decades, from 98.6% in 2000 to 91.2% in 2016.[16]

Social Policy: Multidimensional child deprivation is high with 91% of children deprived in three to six dimensions. Deprivation in housing (92%) and sanitation (88%) are the largest contributors to multidimensional poverty for children under 18 years of age in Afar region. In addition, Afar has the highest deprivation rate in health (80%) and nutrition (85 percent). 66% of rural households in the region are enrolled in the Productive Safety Net Programme (PSNP) compared with 11% of rural households at national level.[17]

3.2 Amhara Regional State

The Amhara Region is located in the Northwestern part of Ethiopia. The region covers a total area of approximately 154,000 km^2. It borders Tigray Region in the North, Afar Region in the East, Oromia Region in the South, Benishangul-Gumuz Region in the Southwest and the country of Sudan in the West. Amhara region is divided into eleven Administrative Zones and one Special Woreda with a total of 139 woredas.

3.2.1 Climate and Weather

The annual mean temperature of the region ranges from 15^0C to 21^0C. But in the valleys and marginal areas the temperature exceeds 27°C. Seasonal rainfall in the region is driven mainly by

[15] UNICEF (2022). Afar Regional Brief.
[16] UNICEF (2022). Afar Regional Brief.
[17] Ibid

the migration of the Inter-Tropical Convergence Zone (ITCZ) and there is strong inter-annual variability of rainfall across the region. The eastern and northeastern parts of the region experiences very little rainfall (CCKP, 2021). The region has three main rainfall seasons: the primary rain season (Kiremt) starts from mid-June to mid-September, Winter/Bega occurring from October to January which has drier and colder conditions and Autumn/Belg which is a secondary wet-season occurring from February to May (CCKP, 2021). The long term mean annual rainfall of the region is 1165.2 mm and the spatial distribution ranges from 850 mm to more than 1485 mm (Ayalew et al., 2012a).

3.2.2 Topography and Ecology

Amhara Region is divided into three major topographic areas: highland (above 2,300 meters), semi-highland (1,500 to 2,300 meters) and lowland (below 1,500 meters) accounting for 20%, 44% and 28% of the land area respectively (Adenew and Abdi, 2005). The elevation ranges from 500 masl in the northwestern lowlands to the highest peak of the country 4,533 masl at Ras Dashen (Alemu and Bawoke, 2019). Within these ranges exist extraordinary geo-diversity (deep and wide valleys, undulating plains, flat plains, depressions, terraces, mountain chains, plateaus). In the case of Simien Mountains National Park, for example, this contributed to the site's Outstanding Universal Values / OUVs to qualify as a Natural World Heritage Site.

As a result of the contrasting physiographic and climatic features, the region has diverse ecosystems. About 8 broadly categorized ecosystems based on vegetation characteristics (montane grassland, moist montane forest, dry evergreen montane forest and evergreen scrub, *combretum-terminalia* woodland, *acacia-commiphora* woodland, wetland and aquatic) exist in the region.

3.2.3 Water Resources

Amhara Region has enormous potential with particular reference to both surface and ground water resources. The surface water includes rivers, lakes, streams, ponds and wetlands. Most of the surface water resources appear in the form of runoff in the four major river basin systems which are Abay, Tekeze, Awash, and Danakil Basins.

Table 5: Major river basins of Amhara Region

No	River Basin	Catchment Area (KM^2)	Water resource (BM*3)	Area coverage (%)
1	Abbay	95,041.86	47.1	60.46
2	Tekeze	43,323.75	3.8	27.56
3	Awash	16,065.63	15.2	10.22
4	Golina/Danakil	2,766.68	0.6	1.76

Source: Amhara Bureau of Water Resource Development (2015)

The region has 9 lakes including Lake Tana, Ethiopia's largest lake, 497 perennial rivers and 2860 streams. As a result, the region has one of the most abundant surface water resources in the country.

3.2.4 Land use and Land cover

Out of the total area of the region, 2%, 27% and 6% is covered by high forest, shrub land and woodland, respectively. More than 60% of the total land area in ANRS is covered by Afromontane vegetation, of which dry Afromontane forests covers the largest proportion approximately 18%.

Table 6: Land use/land cover of Amhara Region

Class Name	2022	
	Area(ha)	Area Cover (%) of the Region
Agriculture	8,963,856.54	57.02
Bare Land	681,245.19	4.33
Built Up	923,454.36	5.87
Grass Land	165,543.66	1.05
Natural Forest	2,757,941.82	17.54
Plantation Forest	1,829,607.57	11.64
Water Body	299,599.65	1.91
Wet Land	98,542.71	0.63
Total	**15,719,792**	**100**

Source: Regional Environment and Forest Protection Authority

3.2.5 Biological Baseline Environment Condition

3.2.5.1 Flora and Fauna of the Region

With wide altitude variations ranging from 500 meters in the northwestern lowlands to the highest peak of the country 4,533 masl at Mount Ras Dejen, the region has become home to large number of flora, fauna and microbial species. There are two national parks and five protected areas. The national parks are Simien Mountains National Park/SMNP and Borena Sayint Worehimenu National Park/BSWNP.

As indicated in the State of Environment of the Region revised in 2022, the region shares the highest proportion of Ethiopian highland endemic bird areas, i.e., over 75% of globally identified Endemic Bird Areas are found in the region. About 11 Important Bird Areas/IBAs are identified in the region. About 50% of endemic bird species, 62.5% of large endemic mammals, 34.8% of small mammals, 66.6% of birds, 40.5% fish of Ethiopia are found in the region.

The flora and fauna of the region is summarized in Table 7 below.

Ecosystem	Altitude range	Areas	Major plant species	Major wild mammals
1. Afroalpine and Sub-Afroalpine	3200m to 4620m	Simien Mountains, AbuneYosef, Zigit, Aboy Gara, Guna, Ambafarit, Menz Gussa, Chokie, Adama Mountains	*Acanthus sennii, Echinopsellenbeckii, Knipho fiafoliosa, Lobelia rhynchopetalum,* *Helichrysumhochstetteri, Erythrinabrucei,* *Euryopspinifolius, Erica arboreaare*	Walia Ibex, Starck's Hare, Ethiopian Wolf, Gelada Baboon, endemic birds of Spot-breasted Plover, Blue-winged Goose, Black-headed Siskin and Ankober Serin.
2.Montane Grassland	1500-3200m	Gojjam, Wollo, Gondar, and North Showa.	*Pennisetum, Hyparrhenia, Cynodon, Eragrostis, Panicum, Cymbopogon, Chloris, Andropogon, legumes, Trifolium, sedges , rushes and woody plant species of Acacia abyssinica, Acacianegrii Acacia pilispina, Juniperus procera, Oleae uropaea, Allophylus abyssinica, Celtisafricana, Crotonmacrostachyus, Milletiaferruginea, Maesalanceolata, Buddeljapolystachya, Erythrinabrucei, Myrsineafricana, Calpurnia aurea, Dovyalisabyssinica, Draceanaafromontanumas well as Shrubby species such as Acokantheraschimperi, Carissa edulis, Eucleaschimperi, Rosa abyssinica and Maytenusarbutifolia*	
3.Moist Montane Forest	1500-3000m	Wofwasha and Borena Sayint Worehimeno	*Podocarpus falcatus, Juniperous procera, Croton macrostachyus, Euphorbia sp., Olea sp., Schefflera abyssinica, Prunus africana, Syzygium guineense*	Meneliks Bushbuck Leopard, Serval Cat, Bushbuck, commonDuicker.
4. Dry Evergreen Montane Forest and Evergreen	1500-3200m	Simian Mountains National Park, Guna Community Protected Area	*Juniperus procera, Podocarpus falcatus,Celtiskraussiana,Mimusops kummel, Oleaeuropaeasubsp, Rosa abyssinca, Prunus Africana, Euphorbia ampliphylla, Smilax aspera, Ficussp , Ekebergiacapensis, ,and others*	Menelik'sBushbuck, Common bushbuck, Klipspringer, Hamadryas Baboon, Anubis Baboon, ColobusGuereza, Serval Cat, Crested Porcupine, Warthog, Bohor Reedbuck, Grey Duiker, and Spotted Hyaena. Common bird species of the area include Great spottedeagle, Harwood's Francolin, Blue-winged Goose,Yellow- fronted Parrot, Prince Ruspoli'sTuraco, White

Shrub		and Wof Washa.Some		collared pigeon, Abyssinian Catbird, Abyssinian Long Claw, Black-headed Siskin, Yellow throated Seed eater, and Ankober Serin.
5.Combretum-Terminalia woodland	500-1900m	Jawi, Alefa, Quara, Metema and Armacho	*Combretummolle, Combretumaculeatum, Combretumadenogonium, Combretumcollinum) and Terminalia species (Terminalialaxiflora and Terminalia brownii), Adansonia digitata,Oxytenanthera abyssinica,Dalbergia melanoxylon, Diospyros mespiliformis, Pterocarpus lucens, Boswellia papyrifera, Anogeissus leiocarpa,Lannea spp (Lannea welwitschii,Lannea fruticosa)andStereospermum kunthianum*	Greaterkudu,Leopard,Common/Golden Jackal,Commonbushbuck,Common duiker,SpottedHyena,Anubisbaboon,Patas monkey, Ardvark ,Vervet Monkey,Honey badger,Caracal,African civet cat,African wild cat, Serval cat ,squirrel,Porcupine, Oribi,Leopard, warthog,Rockhyrax,common duiker and others. Important birds in the ecosystem include Red- throated bee-eater,African white backed Vulture, Red-footed Falcon, White headed vulture,Ostrichand Red-billed Hornbill.Characteristic reptiles include African rock python, Monitorlizard, Egyptian cobra and different lizards
6. Acacia-commiphora woodland	900-1900m		*Acacia prasinata, Acacia bussei, Acacia Senegal, Acacia seyal and Acacia tortilis) and Commiphora species (Commiphora alaticaulis, Commiphora boranensis, Commiphora africana, Commiphora boranensis, Commiphora cilliata, Commiphora monoica, Commiphora serrulata and Commiphora obovata).Balanites aegyptiaca*	lesser kudu, greater kudu, waterbuck, serval cat, gazelles and others. Characteristic birds include Ostrich, Hunter‘s Sunbird, Shining Sunbird, Golden- breasted Bunting, Salvadori's Seedeater, Yellow-throated Seedeater, Ruppell's Weaver, White- headed Buffalo Weaver, Golden-breasted Starling, White-tailed Swallow and Stresemann‟s Bush Crow
7. Wetland		Lake Tana area, Chefa wet lands, Zimbiri.	*Mimusops kummel, Terminaliabrownii, Syzygiumguineense, Ficussycomorus, Acacia polyacantha, Celtis Africana, Phoenix reclinata and others*	Important bird sites for both endemics and visitors from Africa, Europe and other parts of the world. This includes Egerts, Glossey ibis, Sacard ibis, Black Crowned crane, Spur Winged geese, Saddle billed strok, Egyptian goose,African jacana,Pied crow,Hadad ibis,Pied kingfisher,African fish eagle,African darter,White winged black terns,Goliath heron,Senegal wattled plover,Spur winged plover,Wattled ibis,Hammerkop,Rougets rail, Oriole, Starling, White winged cliff chat, Weavers, Doves, Wattled crane, Grey heron, Black headed heron, Affrican open bill

Table 7: Flora and Fauna of Amhara Regional State

Source: State of Environment, Amhara-2022

3.2.6 Wetlands

Wetland ecosystem vegetation include different wetland grasses species, herbaceous plants like papyrus beds, woody plants of *Mimusops kummel, Terminaliabrownii, Syzygiumguineense, Ficussycomorus,* Acacia *polyacantha, Celtis Africana*, *Phoenix reclinata* and others. Most wetlands of the region are also important bird sites for both endemics and visitors from Africa, Europe and other parts of the world.

Table 8: Wetlands in Amhara Region

No.	Name /Register wetlands/	Area Coverage (ha)	Location /woreda/
1	Yigonda wetland	412.53	Bahir Dar Zuria (Zegie)
2	Chimba wetland	1224.78	North Achefer & Bahir Dar Zuria
3	Legediya wetland	1192.50	North Achefer
4	Geldha wetland	588.39	Dera
5	Wolela and Shersher		Fogera

According to the State of Environment of the Region published by Amhara Region Environment and Forest Protection Authority, wetlands of the region coverage declined from 1,136,020.32 to 174,436.74 hectares in seven years between 2015 and 2022. Drainage or water losses by underground pumping, diversion for recession agriculture, free overgrazing, illegal settlement, flooding and siltation and introduction of invasive weeds are among the most factors which are negatively impacting ecosystem of the wetlands.

3.2.7 Overview of Amhara Regional State Socio-Economic Baseline

***Demographic, Ethnic and Religious Features*:** Currently, the demographic situation of the Amhara region shows an annual growth of 2.3 percent which leads the total population size to 22.1 million (male 11.0 million and female 11.1million) as of the year 2019/20. The population of the region accounts roughly 22 percent of the total population of the country while in terms of area the region contributes around only 15 percent. Regarding the settlement pattern, the

overwhelming majority, i.e., nearly 79.92% of the population, resides in rural areas and is engaged mainly in agriculture.

The highest ethnic share is occupied by Amhara ethnic group which covers about 92.12% of all ethnic groups residing in ANRS. Other ethnic groups include the Agaw/Awi (3.46%), Oromo (2.62%), Kamant (1.39%), and Argoba (0.41%). Of the total population of the Region, 82.5% are Orthodox Christians, 17.2% Muslims, 0.2% Protestants and 0.1% others.[18]

Socio-economic: Apart from a small percentage of the population engaged in the services and industry sectors, nearly 79.92% of the population resides in rural areas and is engaged in agriculture.

Socio-cultural and historical heritage: The Amhara Region is rich in cultural and historical heritage. Very old monasteries, rock-hewn churches, palaces and castles are found in the region. The Lalibella Rock-hewn Churches and the Gondar Castle that are registered as International Cultural Heritage sites are found in this Region. There are several monasteries on Lake Tana Islands, which is also the origin of Blue Nile (Abay) River. The Blue Nile Falls is found just few kilometers downstream of the Regional Capital, Bahir Dar, which is a tourist attraction site.[19]

Land Ownership and custom: in the Amhara region, the formal land administration system is designed and implemented on basis of the federal and regional laws, namely the federal land proclamation (456/2005) and the regional land law (133/2006). There is no land in the Amhara region without any designated holder. The holder of the land can be a natural person, a legal person, a group of people, or the state.

Food Security and Livelihoods: In Ethiopia, most food shortages have been geographically concentrated along with two broad belts. The first belt consists of the mixed farming production system area of the central and northern highlands. The second belt covers the low-lying agro-pastoral lands ranging from Wollo in the North, through Hararghe and Bale, to Sidama and

[18] MoALR (2018). Updated Social Assessment: Sustainable Land Management Program Resilient Landscape and Livelihood Project (RLLP). Addis Ababa.
[19] Development Bank of Ethiopia (2017). Environmental and Social Management Framework (ESMF) For Ethiopia Off-grid Renewable Energy Program and Ethiopia Clean Cooking Energy Program. Addis Ababa.

Gamo Gofa in the South.[20] The ANRS belongs to the first drought-prone belt, which is characterized by rugged terrain, highly degraded soil, climate variability, population pressure, deforestation, and overgrazing.[21]

Most Vulnerable and Underserved Groups in Amhara: Basic principles regarding vulnerable peoples are stated in the Constitution of the Federal Democratic Republic of Ethiopia and various proclamations, where the most comprehensive is the Social Protection Policy, approved by the Council of Ministers in December 2014. As per the different social assessments conducted by the Government of Ethiopia (GoE) as part of the World Bank's Environemntal and Social Management (ESM) requirement in Amhara region, the underserved and vulnerable groups comprise, among others, *people living in the conflict affected areas, people living with disability, women minority group representatives, unemployed and land less youths, people living with HIV and/or marginalized minority groups who work as potters, tanners, smiths, weavers, woodworkers etc. or other groups highly vulnerable due to deprivation and other factors.*

Sexual and Gender Based Violence: Rates of GBV are high in Amhara region.[22] The proportion of women (aged 15-49) who have ever experienced psychological, physical or sexual violence committed by their current or most recent husband/partner is 26%, 22%, and 10%, respectively.[23] The percentage of women who believe that a husband is justified in hitting or beating his wife in various circumstances is 65%. In contrast, 46% of men agree that wife beating is justified in some circumstances.[24] These figures are high, but a declining trend has occurred since 2011.

3.2.8 Access and Provision of Social Services in Amhara Region

[20] Tolossa, D. Causes of Seasonal Food Insecurity in Oromiya Zone of Amhara Region: Farmers' View. In Proceedings of the Contemporary Development Issues in Ethiopia, Kalamazoo, MI, USA, 16–18 August 2001.
[21] Ramakrishna, G.; Demeke, A. An Empirical Analysis of Food Security in Ethiopia: The Case of North Wello. Afr. Dev. 2005, 27.
[22] FDRE, Ministry of Women, Children and Youth Affairs, Assessment of Conditions of Violence Against Women (VAW) in Ethiopia, draft report, 2013.
[23] EDHS 2016, p. 306
[24] Ibid., pp. 283 and 284.

Health: Health is one of the fundamental social developments indicators of the region as well as a country. Getting health service is a human right and without it economic development of a regional state and the country becomes impossible. Taking this idea into consideration, both the regional and national government have conducted preventive based health strategy. As a result, to increase health services the sector development program is mainly focus in the establishment of primary healthcare services and capacity building. The prevention of contagious diseases has been given great attention nowadays. In the region, the first categorized diseases are all types of malaria, intestinal parasitic worms, diarrhea and other related diseases. Hence, the strategy focuses on preventing and treating such diseases. In order to reduce the effect of the above health problems and challenges currently, in the region, there are about 82 hospitals, 864 health centers and 3,564 health posts, 931 private pharmacy, 4 referral hospitals and 7 general hospital which are providing health services in the regional sate. Concerning the health professionals of the region, on the average one medical specialist serves 117,407, one medical doctor serves 15,136 one nurse serves 1,979 people, and from these we understand that there is an improvement in health services. However, it is limited as compared to the number of the people.

WASH: According to the 2016 EDHS, 64% of households used improved drinking water sources in Amhara. This is almost the same as the national average of 65%.[25] About 17% of water sources in Amhara are piped compared to, for example, 27% in Tigray region.[26] The Ethiopia Socioeconomic Survey (ESS) 2017 presents the time needed to collect water. In Amhara, 37% of households spend 30 minutes or more reaching the nearest water source, fetching water and returning to their dwelling. Even though access to water sources in the regions has improved significantly compared to 2011 – when the incidence in this indicator was 67% – it is above the national average of 32%, and signifies that more than one third of the population in the region is deprived of water sources. Like elsewhere in the country, women and girls are mainly responsible for fetching water.[27] The availability and sufficiency of drinking water is 82% and

[25] EDHS 2016.
[26] CSA, Drinking Water Quality in Ethiopia. Results from the 2016 Ethiopia Socioeconomic Survey, 2017, p. 11. Note that the ESS found 62% of households with improved water sources.
[27] UNICEF, Integrated WASH/MUS/CBN Programme Baseline and Midline Survey Report, 2017, p. 37

75%, respectively.[28] While there are efforts to construct water points and schemes, water point functionality is a challenge.[29] There are large inequities within the region, and particular zones have very low coverage rates due to complex hydrogeology and the need for high tech, solid investments. This is true for Waghimra zone, north and west Gonder and Oromo zone, and the Blue Nile gorge.

Education: Though several efforts have been made to improve the education coverage of the region, its quality is still in its infant stage by any standard. In fact, progress has been shown in terms of number of teachers and working in 2019/20. Accordingly, the total number of teachers in primary schools includes TTI Certificate1584, Diploma 131935, Degree 5533 and Master's degree 86. In secondary schools the following data has been shown in terms of number of teachers and working in 2019/20. Accordingly, the total number of teachers in secondary schools TTI Certificate 122, Diploma 278, Degree 32,593 and Master's degree 2,676.

Progress has been shown in terms of number of educational institutions both in government and private working in the year 2019/20. Accordingly, the total number of kindergarten 448, primary schools 9080 , Secondary Schools (9-12) 593 and preparatory schools (11-12) 376, thus there are a total of 10,497 educational institutions in the region from kindergarten up to preparatory schools.[30]

Education is a means to sustain and accelerate the overall development in a country and it has a direct effect on individuals' productivity and earnings as well. Hence, the challenge of development is the challenge of education. As a result of this, in recent years strengthening the links between economic growth and human development is given due attention as a means to escape from poverty.[31]

Based on the above principle the regional state is providing education for its citizens. As a result the Gross and Net enrolment rate (Grade 1-8) in rural and urban in 2019/20 in the region is

[28] CSA, Drinking Water Quality in Ethiopia. Results from the 2016 Ethiopia Socioeconomic Survey, 2017, p. 18.
[29] World Bank, Maintaining the Momentum while Addressing Service Quality and Equity: A diagnostic of water supply, sanitation, hygiene and poverty in Ethiopia. WASH Poverty Diagnostic, 2018, p. 30.
[30] Ibid, P 36.
[31] Ibid, P 39.

80.9% and 72.4% respectively. With respect to Gross enrolment rate of secondary school (9-10) and Gross enrolment total (Grade 11-12) are 49.1% and 285,217 respectively.[32]

3.2.9 Social Protection Services in Amhara

Child Protection: The EDHS 2016 shows an increase in the average median age of marriage between 2000 and 2016 in Amhara region. Nonetheless, the median age of 16.2 years among women aged 20-49 years is still very low, and is the lowest in the country. There has been a significant decline in child marriage rates reported by women in the age group 20-24 years, from 75% in 1991 to 43% in 2016.[33] This puts Amhara in the fifth position (shared with Tigray) of 11 regions. In the 10 years before the EDHS 2016, there was an annual reduction rate of 5%.[34] Progress in Amhara needs to be five times faster to eliminate child marriage by 2030 and achieve SDG 5.3.[35] The rationale of child marriage in Amhara region relates to a local strategy to form family alliances. It is believed that marriage reduces the risk that daughters engage in pre-marital sex, exposing them to sexually transmitted diseases and pregnancy while unmarried, which would lead to family disgrace and social stigmatization.[36]

3.3 Benishangul-Gumuz Regional State

The Benishangul-Gumuz regional state is located in the western frontier of Ethiopia. The region has a total surface of 50,380 km.^{2} It shares borders with Sudan in the north-west, South Sudan in the west, Amhara regional state in the east, and Oromia region in the south. The region is organized into three administrative zones (Metekel Zone, Assosa Zone, and Kemashi Zone) and 20 Woredas.

3.3.1 Climate and Weather

[32] Ibid, P 39.
[33] The EDHS 2016 does not include data on child and early marriage across regions in Ethiopia. This data is provided by UNICEF, Ending Child Marriage: A profile of progress in Ethiopia, 2018, p. 8.
[34] Ibid., p. 10.
[35] Ibid.
[36] Save the Children a.o., Child Marriage and Female Circumcision: Evidence from Ethiopia, Young Lives Policy Brief, 2014, p. 2 and Coffey, Every Last Girl Strategy, 2013. pp. V and X.

The state has diverse topography and climate. The later includes the familiar traditional zones - "kola", "dega", and "woyna dega". "About 75% of the State is classified as "kola" (low lands) which is below 1500 meters above sea level. The altitude ranges from 550 in areas bordering the Sudan to 2,500 m.a.s.l. The average annual temperature reaches from 20-25^{0}C. During the hottest months (January - May) it reaches 28 - 34^{0}C. The annual minimum and maximum mean temperature registered at Asosa for the last 26 years is 12.4^{0}C and 27.8^{0}C respectively. The annual rainfall amount ranges from 500-1800 mm. The rainy season spreads through May to October."

3.3.2 Topography and Ecology

Benishangul-Gumuz Region State has three major physiographic divisions. The first one is the cool temperate agro-climatic zone that includes the mountain ranges and high plateaus of the region (above 2,500 m) lie in the Wombera and Dangur woreda. It covers about 0.19% of the total area of the region. The second is the warm temperate agro-climatic zone (1,500-2,500m), which comprises low plateaus of the region and covers about 7.96% of regional land surface. The third is lowlands of the state (less than 1,500 m) constitute about 91.86% of the total land area of the region (BoFED, 2017).

The Benshangul Gumuz region is traversed by the Blue Nile River and it divides the region into two. The Northern half of the region constitutes the Metekel zone and the Southern half consists of the Assossa and Kamashi zones plus the Mao-Komo special woreda. With the vast variation in elevation, however, the region is principally a lowland region. Reports indicate that whereas 63% of the areas in the region have a plain and undulating topography, the remaining 25% and 12 % of the area has steep rolling and mountainous topography respectively.

According to the Strategic Plan for conservation and management of woody biomass, two main types of ecological systems for the woodland/shrub land of the region are identified based largely on the dominant species composition and agro-climatic zone. These are the Boswellia-Comiphora-Acacia (Xerophillous) Woodlands and Terminalia-Combretum (Deciduous) Woodland ecological systems.

3.3.3 Water Resources

Benishangul Gumuz National Regional State is endowed with large inland water resources. The region has four main rivers: Abay (Blue Nile), Gilgel Beles, Dabus, Didessa, Angar and Dinder rivers. The Benishangul gumuz region is the last region crossed by the Abay River before it leaves Ethiopia and enters into the Sudan. The river divides the region into two almost equal halves. The Dabus and Beles rivers are two of the major tributaries of the Abay River which joins it in the region. These main rivers originate from the highlands of Amhara and Oromia Regional State and have tributaries from within the region. Being home to the great renaissance dam which is under construction, the region is being endowed with a large man-made lake in the near future.

3.3.4 Biological Baseline Environment Condition

Flora and Fauna of the Region: Benishangul Gumuz region is covered by natural terrestrial vegetation that consists of dense forest, Riverine forest, broad-leaved deciduous wood lands, acacia woodland, bush land, shrub lands, boswellia wood land and bamboo thickets. Reports indicate that there are more than 55 indigenous tree species in the region. The Oxytenanthera Abyssinia, the lowland bamboo, is found in most of the Benishangul Gumuz regional state, though disappearing recently. According to the strategic plan for woody biomass conservation and development, out of the total land area of the region about 5% is cultivated land, 49% is woodland, 28% is bush land, 9% is bamboo land, 3% grass land, 0.15% marsh land, and about 2% open rocky.

Owing to its vast terrestrial vegetation, the region is home to a number of wildlife animals. These include lions, tiger, bush buck, Anubis baboon, vervet monkey, warthog, bush duiker, bush pig, Colobus monkey, etc.

Protected Areas: Game Reserve and main bird Sanctuary of Dabus is found in the Region. Also, the Didessa national park is located in the Kamashi zone of the region. According to the Mao-Komo Woreda (Tongo) office of Agriculture and rural development, there are two protected areas. These are the Gore Shishime forest found around Gore Kebelle and Gara Mimi forest.

The Region has varied wild life species including Elephant, Giraffe, Rhinoceros, Hippopotamus, Buffalo, Roan antelope and Hartebeest, Lion, Tiger, Patas monkey and Anubis baboon are found in the region. Estimates indicate the availability of about 40 species of larger mammals and estimated bird species of 500-550.

Land use and land cover: Benshangul Gumuz region is endowed with vast marginal land which is suitable for agriculture and other economic activities. According to the strategic plan for woody biomass conservation and development, out of the total land area of the region about 5% is cultivated land, 49% is woodland, 28% is bush land, 9% is bamboo land, 3% grassland, 0.15% marsh land, and about 2% open rocky land. In recent years, large amounts of land have been leased to (mainly international) investors in agriculture, who have brought in modern farming techniques and created employment.

The existing land cover types of the region are categorized as open grassland, open shrub land, dense forest, riverine forest, broad-leaved deciduous wood lands, acacia woodland, bush land, boswellia wood land and bamboo thickets. Wooded grassland and open woodland are common in the Mao-Komo Woreda.

3.3.5 Overview of Benishangul-Gumuz Regional State Socio-Economic Baseline

According to the CSA Population Projection of Ethiopia for All Regions at Wereda Level in 2017 the total population of the region is 1,066,001 (541,002 male and 524,999 female). Out of the total population 230,000 (117,000 male and 113,000 female) are urban resident and the remaining 836,000 (424,000 male and 412,000 female) are living in rural area.

***Demographic, Ethnic and Religious Features*:** Interestingly, the Constitution of the Benishangul-Gumuz regional state explicitly differentiates between endogenous and other peoples. Article 2 of the Regional Constitution classifies the following five ethnic groups as endogenous: the Berta, Gumuz, Shinasha, Mao and Komo. However, none of those five ethnic groups has a numerical majority: the three most numerous endogenous groups are the Berta (25.9%), the Gumuz (23.3%) and the Shinasha (7.6%). The Mao constitutes 1.9% and Komo (0.96) count for less than 1% of the total population. Striking is the large number of Amhara

(22.1%) and Oromo (8.93%), an illustration of the impact of migration (Census 2007). Benishangul-Gumuz is a sparsely populated region. This, together with its fertile soil, makes the region attractive to many Ethiopian farmers from other regions who wish to leave their own small and exhausted plots behind. This interregional migration is clearly reflected in the ethnic composition of the region's population. According to recent study, the number of Oromo ethnic groups in the region increase from 8.93% in 2007 to 20.9% in 2021. Thus, the current number of Amhara and Oromo constitute 43% of the total population in the region. Muslim and Orthodox Christianity are the major religious groups in the region comprising for 45% and 33%, respectively.

Socio-economy: Its economy is largely dependent on agriculture, including crops, livestock and forestry. There is potential for agricultural productivity gains. Many farmers still rely on ploughing by hand or oxen. In recent years, large amounts of land have been leased to (mainly international) investors in agriculture, who have brought in modern farming techniques and created employment.

In major towns of the region like Assosa trading activities and employment opportunities are the basic livelihood strategies of the community. However, in rural areas crop production is the main economic activities. The region has huge agricultural potentials and hence, several investors are practicing commercial farms in the region. These commercial farms suck large youth labor from both rural and urban areas. The construction of the ongoing Grand Ethiopian Renaissance Dam (GERD) has also created job opportunity for hundreds of youth living in the region.

Socio-cultural and historical heritage: Some of the historical sites found in the region include a site known as BELKURKUMU (a pre-Asosa town), the Cave of Gundul (Place of Good Luck), as well as the Court and Palace of Sheik Hojele (BGRS BoFED, 2022). The BYa'amesira historical mosque which is located near Gore town at approximately 6 km from the town at a special kebelle of ya'abeldgis is also another historical site. The mosque is celebrated by Muslim community once every year.

Land Ownership and custom: The Constitution of the Federal Democratic Republic of Ethiopia (FDRE) states that the right to ownership of rural and urban land, as well as all natural resources, is exclusively vested in the State and People of Ethiopia. Article 40 of the Constitution indicates that land is a common property of the Nations, Nationalities and the People of Ethiopia, and shall not be subjected to sale or to other means of transfer.

The Land Policy of Ethiopia strongly support that project plans must include attractive and sustainable resettlement strategies to the people who are going to be displaced as a result of the development plan, and they have to be fully convinced, compensated and have to participate in all phases of the project implementation. It is the right for existing land owner to be compensated fully and satisfactorily if land is expropriated by the state.

Based on the principles of the Constitution, the Benshangul Gumuz Region Land Use and Land Administration Policy issued policies on rural land use and administration. The regional policy guiding principles include:

- Land ownership is exclusively vested in the state and people of the region and shall not be subjected to sale or to other means of exchange
- Where the holding right changes, payment of due compensation is to be made by new holder to a previous and lawful holder.
- Any land user is obligated to properly manage the land given to him or her

Food Security and Livelihoods: In the region food security embraces a wide range of crops such as cereals, pulses, oilseeds etc. The fact that most of the land within the private peasant holding is under these food crops comes as no surprise when the struggle for self-sufficiency in food is being intensified. Bamboo is a fast growing plant, representing a valuable source of energy (e.g. firewood and charcoal) for households, food (bamboo shoots and feed for cattle and wild animals), construction and other uses (furniture, flooring, and household tools etc). It has been part of the livelihoods of rural communities in the region (BGRS BoFED, 2022). The artisan mining also significantly contributes to the employment of at least 1.26 million people and supports the livelihood of over 7.5 million populations (Beyene, 2015).

Sexual and Gender Based Violence: As in other regions of Ethiopia, Benishangul-Gumuz region has a deeply rooted patriarchal society in which men hold primary power in private and public life. The EDHS 2016 asked women ages 15 to 49 if they had ever experienced different types of violence by their current or most recent husband/partner. The responses in Benshangul-Gumuz were: psychological (26%); physical (20%); sexual seven%). The% of women who believe that a husband is justified in hitting or beating his wife in various circumstances was 55%. And, 28% of men agree that wife beating is justified in some circumstances.

3.3.6 Access and Provision of Social Services in Benshangul Gumuz

Health: Heath services are essential elements in ensuring a full and meaningful life for the people. The climate and topography of the region create a favorable environment for the presence of carriers of tropical diseases such as mosquitoes and flies. Low educational status of the population, unsafe drinking water, poor hygiene and inadequate nutrition exacerbate the situation. Malaria, intestinal parasites, respiratory tract infections, diarrhea, skin and eye infections are endemic causing morbidity and mortality (BGRS BoFED, 2022).

According to the BGRS Physical and Socio Economic Profile, 2022, a number of factors hamper amelioration of the situation. Health services are limited, health manpower, medical equipment and supply are in short supply, and the widely dispersed settlement pattern of the population causes difficulty for the health facilities to reach and serve the population. Currently there are 519 health facilities in the region. These consist of 6 hospitals, 61 health centers, 449 health posts, 2 Regional Blood banks and 1 Regional Laboratory (BGRS BoFED, 2022).

Hence, there is 1 hospital for 203,167 persons, one health center for 19,94 persons and one health post for 2,715 persons. They are higher than the standard. Total of 3,389 medical and technical personnel serve in all the facilities in the region. Out of these, only 72 are Medical doctors. This indicates the ratio of one doctor to 16,931 persons, one health officer to 5,975 persons and one nurse to 937 persons.

WASH: Hand washing with soap has significant effects on a reduced incidence of diarrhea and other transmissible diseases. According to the EDHS 2016, 63% of households in Benishangul-

Gumuz have a place for washing hands (nine% have a fixed site and 54% have a movable site), which is slightly above the national average of 60%. Almost one out of five of these households have water and soap, which is quite low, but relatively high compared to other regions. The EDHS data shows that only two% of households use improved (not shared) sanitation facilities in Benishangul-Gumuz, which is a huge challenge. This is 1.5% of rural households and 3.4% of urban households. Another 2.6% of households have an improved but shared toilet facility.

Education: According to the Education Statistics Annual Abstract (ESAA) 2018/19, the Gross Enrolment Ratio (GER) of 37 per cent and the Net Enrolment Ratio (NER) of 24.5 per cent for pre-primary education (ages 4-6) in Benishangul-Gumuz are still quite low. In comparison, the national average of the pre-primary GER is 41 per cent and NER is 25 per cent. Similar to most regions, the rates in Benishangul-Gumuz are far from the national GER target of 80 per cent by 2020 and Sustainable Development Goal (SDG) 4.2. The Gender Parity Index (GPI) for Benishangul-Gumuz primary education is 0.86 ─ compared to a national average of 0.90 ─ meaning there are more boys enrolled in primary education than girls.

In 2018/19, the GER in secondary education in Benishangul-Gumuz was 59% for grades 9 and 10 and 13% for grades 11 and 12. The NER was 19% for grades 9 and 10 and seven% for grades 11 and 12, which is not very high. The gender parity in Benishangul-Gumuz secondary education stood at 0.75 in 2018/19, which is far from the ESDP V target of 0.94 for that year (UNICEF: Situation analysis of children and women: Benishangul-Gumuz Region).

3.4 Oromia Regional State

Extending from west to east and to the southern borders of the country, Oromia is the largest regional state in Ethiopia with a total area of approximately 353,000km^2. Accordingly, Oromia is bordered by all regional states of the country with the exception of Tigray: to the east, it borders on the Somali and Afar regional states; to the north, it borders on the Amhara and Benishangul-Gumuz regions; to the west, it borders on the Gambella region. Oromia region has also international boundaries, Sudan on the west; Kenya on the south; and Somalia on the south-east.

Administratively, Oromia region is divided into 20 Zones, 30 town administrations, 287 rural and 46 town Woredas.

3.4.1 Climate and weather

Temperature: Oromiya is located between latitude $3^0$40'N and 10^0 35'N. So it experiences tropical climate because of the relatively high angular position of the sun. It experiences overhead sun twice a year. However, due to modification by altitude, highland temperature varies from as low as 10 ^{0}C to over 22 ^{0}C, while in lowlands it varies from 22^0 C to over 30^0 C. The annual range of temperature is about 4^0C on the highlands, while it varies from 40°C to 10°C in the lowlands. In general since all places in the Region experiences an overhead sun twice a year, there is no significant difference in seasonal distribution of temperature.

Rainfall: The duration, amount and spatial distribution of the rainfall of Oromiya depend upon location of a place relative to Atlantic and Indian Ocean as well as Red sea air pressure and air circulation systems and variation in elevations. The highlands of Illubabor face the humid equatorial westerly (south-west winds) and receive high amount of rainfall in summer. So this area is the wettest part of Oromiya. The amount of rainfall decreases in all directions from the highlands of Illubabor. The rest of the highlands of Illubabor, the plateau of Wellega and the Bale massif get mean annual rainfall of 2000-2400 mm. The Shewan plateau, the Arba-Gugu-Chercher Ranges, the Bale and Jemjem highlands get rainfall of 1400-1800 mm. The adjoining plateaus of lesser elevation get a precipitation varying from 1000-1400 mm. The Rift Valley, Borena and Bale low plateaus get 600 to 1000 mm, and the middle Awash valley and south eastern Borena receive less than 400mm.

3.4.2 Morphology, Relief and Ecology

Oromiya Region has of great physiographic diversity. Its landscape includes high and rugged mountain ranges, undulating to rolling plateaus, panoramic gorges and deep incised river valleys, and rolling plains. Rising from less than 500 m.a.s.l to high ranges that culminate into Mt. Tullu

Dimtu (4377m) the highest peak of the region. The region can be divided into three physiographic units;

a) The Eastern Highlands and Associated Lowlands

This sub-region is bound on the east by the edge of the eastern escarpment of the rift system. It makes up about three - fifth of Oromiya. It ranges in elevation from less than 500 to over 4000m, which reaches 4377m in mountain Tullu Dimtu. The sub-region includes the Bale-Arsi Massif, which forms the roof of Oromiya. In general, the land surface of this sub-region gradually decreases in elevation south and south-east and north wards from the central massif in the west.

b) The Rift System

The Rift System makes up about a tenth of the region's land surface. It is bound by the rift valley edges on west and east. On north, it funnels out to the Afar Depression with obscure natural feature to delimit it from the Afar Depression. The portion of the rift system of the region varies in elevation from less than 1000, in its northern and southern extremes to over 2000m along eastern and western edges of its escarpments.

c) The Western Highlands and Associated Lowlands

The Western Sub-Region is located to the west of the rift system extending to the border of Sudan. It makes up about a quarter of the region's land surface. From its highest section in east (the central Shewan plateau and to a lesser extent the Jimma-Ilubabor highlands) it gradually decreases in elevation west ward to the Sudan border where it drops to less than 1500m and northward to the Blue Nile gorge that drops to elevation of less than 1000m. The Associated lowlands of the Western Sub-Region have limited spatial coverage. Major lowlands include the Blue Nile Gorge, the Baro and Ghibe lowlands.

Table 9: Agro-ecology of Oromiya Region

Traditional Agro Climatic Zones	Area_km^2	%
Unsuitable Wurch	851	0.23
Wurch	1,309	0.36
Dega	21,446	5.90
Woyina Dega	123,586	34.01
Upper Kola	182,891	50.33

Lower Kola	33,292	9.16
Total	**363,376**	**100.00**

3.4.3 Surface and Groundwater Resources

Surface water drainage system of Oromiya Region can be classified into three major drainage systems depending on the physiographic setting of the region;

The Western Drainage System: The Abay River Basin (17.2% of the regional land surface) with its left-flank tributaries which include Dabus, Didesa, Guder, Muger, Jama, etc. Small portion of south-western and south-eastern extremes is drained by the tributaries of Baro (the Nile River System) and the upper Gibe (Omo river system of inland drainage of the Lake Rudolf system).

The Eastern Drainage System: The river basins include the Genale (Genale, Weyib, Dawo) and the Wabi Shebele.

The Rift Valley Drainage System: River Awash, which rises in the western flank flows across the rift valley within Oromiya and beyond to the Afar depression. Other minor and numerous streams drain into lakes of the Rift Valley.

The major lakes found in the region includes Ziway, Abijata, Shala and Langano. The region is also endowed with numerous crater lakes (such as Hora, Babogaya, Kuriftu, Bishoftu, Zukala and Cheleleka in East Shewa, Wenchi and Dendi in West Shewa) and man-made lakes such as Koka, Fincha'a, Malka Wakena, Gibe etc.

The region is also endowed with groundwater potential which is highly dependent on its geological structure and the characteristic distribution of its rock formations.

3.4.4 Land use and Land cover

The land use pattern of Oromiya Region correlates with its population distribution, warm to cool highland and hot lowlands. As a result, in highland, there is intensive land utilization as compared to lowlands. This analysis is based on the Regional Atlas revised in 2020.

Table 10: Land use/Land cover of Oromiya Region

Land use/Land cover		Coverage (in %)	Areas fall under this category
Cultivated Land	Intensively Cultivated Lands	13.7	Larger portions of Arsi highland and North Shewa and smaller portion of East & West Shewa, West Wellega, East Welegga, Kellem Wellega, Jimma, East & West Hararge highland, West Arsi, Bale and Finfine,
	Moderately Cultivated Land:	11.6	Larger portions of West Shewa and Horo Guduru zones, smaller portions of East Wellega, North Shewa, Southwest Shewa, Jimma, Arsi, Bale, Borena, West Guji, Finfinne Special Zone, Guji, East Shewa, West and East Harerge zones.
	Perennial Crop Cultivation:	3.14	West Wellega, Ilubabor, and in smaller portions of Jimma and East Wellega zones
Vegetation	Afro-Alpine Heath Vegetation:	0.34	Limited to central Arsi - Bale massifs,
	High Forest:	8.11	Larger part of Ilubabor, in some districts of Jimma zone, highlands of Bale zone, West Arsi and West Guji
	Woodland	40	West Wellega, Horo Guduru, East Wellega, West Shewa, North Shewa, Bale, Arsi, West Arsi, Borena and Guji zones.
	Riparian Woodland and Bushland	0.5	Along the river banks and flood plains in the semi-arid and arid parts of the region
	Bushland and Shrubland:	23.2	In some parts of Borena, Guji, Bale and West & East Harerge, Arsi, West Arsi, East Shewa, Horo Guduru, Jimma, Ilubabor, East Shewa East Wellega.
	Grassland	33.7	Larger portions of Borena, parts of Guji, Bale, East & West Harerge zones, the Rift Lakes Region and the middle Awash valley, upper Gibe, Dideessa, Dabus, Baro and Abay valleys.
Swamps and Marshes:		0.31	Occur along river valleys, edges of lakes and in seasonally flooded areas
Salt Flats, Exposed rock or sand surface:		1.88	
Water Body		0.73	All natural and manmade lakes in the region
Urban or Built-Up Land		0.002	All towns, institutions, industries and etc

3.4.5 Terrestrial Vegetation Cover

The following types of vegetation attempts to express vegetation distribution in Oromiya.

Afro and Sub-Afro-Alpine Vegetation: It prevails in areas of above 3100 m.a.s.l. They occur in spatially limited areas of mountain tops and massif (Arsi-Bale) with low temperature (less than 10^0C) and precipitation of about 600mm, which often falls in the form of sleets and hailstones.

The Coniferous Forests: Predominantly occur on plateaus, mountains and massifs of Shewa, Arsi, Bale, Borena, West Guji, Guji and East and West Harerge zones. These forests are dominated by *Juniperus Procera* (Tid), *Podocarpus Gracilior* (Zigiba, birbirsa) , *Olea Africana* (wayira, ejersa) , *Hagenia Abyssinica* (koso, Feto), *Olean Acacia* (girar, lafto), and Crotons (bisana, bakanisa).

Broad-Leafed Forest: It covers western highlands and in some parts of central-eastern highlands of Oromiya dominantly they are Syzygium guineense (dokma, baddessa), *Aningeria adolfifriderci* (Qararo), *Crotons, Ekebergia* (loel, sombo) and *Arundinaria alpina* (kerkaha, leman).

Woodland and Savannah Region: It makes up part of Borena, West Guji, Guji, central and southern Bale, southern, eastern and northern West of Harerge zones and the Lakes Region. It consists of mixed deciduous woodland and Savannah, juniperus woodland and savannah and acacia woodland and savanna.

The Grasslands: It occupies extensive portion of Borena, West Guji, parts of Bale, smaller portion of Kelem Wellega, and parts of West and East Hararghe zones, and northern Rift and Awash Valley.The grassland region consists *Aristida, Cenchrus ancheri_Dactyloctenium Scindicum* and *Hyparrhenia Filipendula* grasslands.

The Steppe Region: It is characterized by scattered thorny deciduous shrubs and short acacia, which are commonly gum-bearing and aromatic tufts of grass cover ground. It is mainly limited to south-eastern Borena, Guji and Bale zones.

3.4.6 Wildlife (Fauna)

Diverse climate and topography have provided wide range of natural environments which form favorable habitats for quite a wide variety of fauna and flora in Oromiya. The conservation areas

of high wildlife concentrations include parks, sanctuaries, reserves and controlled hunting areas as described below.

There are about four National Parks in the region. These consist of the Awash National Park, the Bale Mountain National Park, the Abijata-Shala National Parks and, the Nech Sar National Park. The national parks in Oromiya have a wide variety of mammals and birds some of them are *Oryx*, and *Soemmering's Gazelle*, *But-eared fox*, *Caracal*, *Aardvark*, *Columbus monkeys*, *Hamadros baboons*, *Klipspringer*, *Leopard*, *Bush Buck*, *Hippopotamus*, *Cheetah*, *Kudu*, Mountain Nyala (*Tragelaphus buxtoni*), Simen Fox (*Canis Semensis*), Menelik's Bush Buck, *Burchell's Zebra* , *Grant's gazelle* and more than 600 species of birds. There are also three wildlife sanctuaries in the region. Erer-Fafan Sanctuary has a sizable herd of elephants, Abyssinian Genet and Minelik's Bush Buck. Yabello is a sanctuary formerly known for brown Swayne's Harte beest before transfer of the animal to Nech Sar bordering lake Abaya.

3.4.7 Overview of Oromia Regional State Socio-Economic Baseline

***Demographic, Ethnic and Religious Features*:** Oromia region is the largest in Ethiopia not only in terms of geographic area but also in terms of population size. According to the CSA Population Projection of Ethiopia for All Regions at Wereda Level in 2017, the total population in Oromia is 35,467,001 of which 17,788,003 are male and 17,678,998 female. The same data source shows that the overwhelming number of population in Oromia region live in rural area: 30,113,000 (15,103,000 male and 15,010,000 female) *vis-à-vis* only 5,354,000 (2,685,000 male and 2,669,000 female) urban resident. As reported in the 2007 Population and Housing Census, making 87.8% of the total population in the region the Oromo ethnic group overwhelmingly dominate followed by Amhara (7.2%), Guragie (0.93%), Gedeo (0.9%), and Somalie (0.33%). Altogether, the number of other Ethiopian national groups comprised 2.84% of the total population. Muslim, Orthodox and Protestant Christianity were the major religious groups in Oromia region making 47%, 30.5%, and 18%, respectively.

Socio-economic: Agriculture is the dominant sector of the economy in the Oromia region. The sector provides foodstuffs, industrial raw materials, generates employment for about 89 percent of the economically active population, accounts for the largest share (more than 90%) of the

export items and constitutes the largest proportion of the Regional Gross Domestic Products. For instance, in 2002 Ethiopian Fiscal Year, the Regional Gross Domestic Product growth (GDP at constant basic price) was estimated to be 9.5%. The agriculture sector contributed the lion share accounting for about 66.4% of the total Regional GDP. Service and industry sectors took 23.3 and 10.3% respectively (OBF, 2013). Though sedentary agriculture is the main source of livelihood for the majority of the rural population in the Oromia region, pastoralism and agro-pastoralism livelihood system is common in low land areas. There are 33 pastoral and agro-pastoral woredas in the region, distributed in 6 zones (Borana, Guji, Bale, East Hararghe, East Shewa and West Hararghe). The pastoral and agro-pastoral areas of the region cover about 152,170 km^2.

Land Ownership and custom: as per the laws, the de jure scheme of access to rural land is limited only to government grant, inheritance, gift (donation) and lease (rent). Meanwhile, Oromia regional state (ORS), had issued rural land regulation No. 151/2012to give effect for federal framework rural land proclamation and ORS rural land proclamation No. 130/2007. This regulation, unlike proclamation, by introducing the concept of prescriptive limitation makes those who bought rural land and squatter a lawful holder of rural land if they have used to it for twelve or more consecutive years. In effect, it provides another scheme of access to rural land holding rights that has not recognized in primary laws, viz. Federal as well as ORS constitution and rural land proclamations.

Food Security and Livelihoods: Oromia is also home for the most productive rural landscapes in Ethiopia. Apart from the forest, agriculture, livestock and settlement mosaics are the dominant characteristic feature of these landscapes. The Oromia region is also home for the largest livestock population in Ethiopia (24.4million) CSA, 2018.[37] Over 84% of the population in the Oromia region live in rural areas, where agriculture is the main source of livelihood for the majority of the people. The main agricultural crops include maize, teff, wheat, barley, peas, bean and various types of oil seeds. Coffee is the main cash crop in the region. The communities of some Woreda are pastoralists. Based on assessment made, the top economic and livelihood bases

[37] CSA (2018) Agricultural sample survey 2017/18, Volume II report on livestock & livestock Characteristics (Private peasant holding)

of the urban population are petty trade and crop production or farming while for rural populations' pastoral and agro pastoralist mode of life. The supplementary economic activities of the communities are mining like Gold, sand and stone and also selling of milk and honey production.

Most Vulnerable and Underserved Groups in Oromia: Basic principles regarding vulnerable peoples are stated in the Constitution of the FDRE and various proclamations, where the most comprehensive is the Social Protection Policy, approved by the Council of Ministers in December 2014. As per the different social assessments conducted by the Government of Ethiopia (GoE) as part of the World Bank's ESM requirement in Oromia region, the underserved and vulnerable groups comprise, among others, w*omen in male-headed and female-headed households, Polygamous households, pastoral and agro-pastoral groups, unemployed rural youth, most vulnerable community members (such as* orphans, pregnant and lactating mothers, elderly households, people living with HIV and AIDS), and o*ccupational minorities* (such as craft worker, potters, smiths, wood workers, tanners, weavers and basket weaving).

Sexual and Gender Based Violence: Due to East Shewa and Arsi being close to Addis Ababa, survivors can access one of the three (3) One-Stop-Centres in Addis Ababa that provide a comprehensive response to SGBV. In Oromia, there are One-Stop-Centres in Adama, Jimma and Shashemene towns. One-Stop-Centres are usually located in government hospitals; these centres are public structures, where a survivor can report a SGBV incident and receive an adequate response, including medical, legal, psychosocial and safe space services. In locations, where there are no One-Stop-Centres, survivors can approach the Bureau of Women, Children's and Youth Affairs at the zone level as the main point of entry for reporting SGBV and child protection incidents. The One-Stop-Centre is a public service and is free of charge.

3.4.8 Access and Provision of Social Services in Oromia

Health: According to the 2012 (EFY) Health and Health Related Indicators published by MoH, Oromiyaa has 104 Hospitals, 1405 Health Centers and 7,090 Health Posts. These health

infrastructures constitute the three levels of health facilities that ordinary individuals can consider for accessing:

- In every kebele, health posts exist that provide outreach services, including preventative and referral services. The health posts serve as a link between the community and the higher-level health facilities. Minor diseases are also treated at the health posts by health extension workers.
- At the woreda level, health centres exist that provide comprehensive primary health services both preventative and curative, in-patient and out-patient services. The health centres also provide vaccination and psychosocial support. However, not all health centres have psychiatric nurses. Services are provided by general practitioners and public health officers.
- At the zone level, one can access the General Hospital to which patients needing surgery or obstetrical care, including other specialized care, are referred.

WASH: More than 24 woredas in the Oromia region benefit from the Government's efforts with the support of UNICEF's WASH programme to improve access to water in Oromia. This is part of the overall progress in WASH in Ethiopia, where 57% of the population now relies on improved water supply sources such as water taps or hand pumps rather than unprotected and risky sources such as rivers and streams. The increased access to clean and safe water has benefitted children in Ethiopia significantly, contributing to the reduction of under-five child mortality by two-thirds and a significant reduction in child stunting.[38]

Education: Among the program target areas, Oromia region is where the highest proportion of illiterate household heads (women and men age 15-49). According to the 2016 EDHS, 83.8% of women and 79% of men age 15-49 had no education or illiterate. As education is the key social determinant of health, the existence of higher percentage of household heads with no education in the region would negatively impact on the implementation of PHC services proposed in the IPF program. Thus, measures to mitigate the differential impact of education need to be designed

[38] https://unicefethiopia.org/category/ethiopia-2/oromia/page/2/

in the program implementation. Whereas the NER for primary education (age 7-14) in Oromia is 99.8 %, the NER for secondary education (age 15 -18) stands at 25.4%.

3.5 Tigray Regional State

Tigray region is located in the northern tip of the country. According to the CSA (2013)[39], the region has a total area of 53,000 km^2. Tigray region shares a longer border with Amhara regional in the south, west and north-west, with Afar region in the east and north-east, with Eritrea in the north and with Sudan in the west. Administratively, Tigray region is divided into seven zones and 52 woredas (34 rural and 18 urban woredas) and 814 tabias subdistricts which is the smallest administrative unit. The seven zones constitute Central Zone, Eastern Zone, South Eastern Zone, Southern Zone, North Western, Western Zone and Mekele Special zone .

Between 2018 and 2020, as part of a reform aimed to deepen and strengthen decentralization, woredas were reorganised. Tigray was re-organised into 88 woredas in January 2020 (A. Sofie et.al, 2021).

3.5.1 Climate and Weather

Temperature: Average temperature in the region is estimated to be 18^0C, but varies greatly with altitude. In the highlands of the region, during the months of November, December and January, the temperature drops to 5^0C. In the lowlands of western Tigray, especially areas around Humera, the average temperature increases from 28^0C to 40^0C during the summer. (H. Fitsum, J. Pender, et.al, 1999).

Rainfall: Tigray is a semi-arid area characterized by a long dry season, with a main rainy season between June and September. Some parts of the southern and eastern zones of the region have a bimodal type of rainfall with short rains between February and April. Rainfall distribution in the region is characterized by high temporal and spatial variability, with annual precipitation ranging from 450 to 980 mm (Gebremedhin et al., 2004). According to Belay (1996) the coefficient of

[39] Federal Demographic Republic of Ethiopia Central Statistical Agency Population Projection of Ethiopia for All Regions at Wereda Level from 2014 – 2017

variation in annual rainfall in Tigray is about 28%, which is much higher than the 8% national average in Ethiopia (cited in Hagos et al., 1999).

The amount of rainfall increases with altitude and from east to west, and decreases from south to north. Average rainfall varies from about 200 mm in the northeast lowlands to over 1000 mm in the southwestern highlands. In the highlands close to the eastern escarpment the average rainfall is 450 mm. In the central part of the region near Axum and in southwestern Tigray average rainfall approaches 1000 mm. Rainfall declines again with altitude as we move further to the west. Most of the rainfall falls during the "Meher" season from June to September (it is most intense during July and August). In some parts of Tigray, there is short rainy season called "Belg" which falls during the months of March, April and May(H. Fitsum, J. Pender, et.al, 1999).

3.5.2 Morphology, Relief and Ecology

The region has a diverse topography, with peak highlands (8%), midlands (39%) and lowlands (53%), which together create diversified agroecological conditions and many niches for biodiversity (Hagos et al., 1999) in G.Tesfay.

The Tigray highlands have been uplifted by some 2500 meters in ca. 25 million years, since the Miocene. This has led to the creation of a steep escarpment on the eastern side of the region, towards the Rift Valley. The plateau itself, generally drops towards the west. Yet, as uplift has been rapid (in geological terms), deep valleys and gorges have incised, the most notable of which are occupied by Tekeze, Weri'i and Giba rivers, with spectacular roads winding across them (Sofie A. et.al, 2021).

Altitude varies from about 500 m.a.s.l in the northeast to almost 4000 m.a.s.l. in the southwest. In the east of Tigray, there is an escarpment that drops from 2000 m.a.s.l steeply to 500 m.a.s.l. As we move west of the escarpment the area is largely made of mountainous plateaus. The altitude of this area ranges from 1500–3000 m.a.s.l, which again drops in elevation, as we move further west, to about 500 m.a.s.l. About 53% of the land is lowland (kolla—less than 1500 m.a.s.l.), 39% is medium highland (weinadega—1500 to 2300 m.a.s.l.), and 8% is upper

highland (Dega—2300 to 3000 m.a.s.l.) (BoA, 1995). Due to the marked variations in topography and altitude, there are different agro-ecological niches or microclimates within short distances (Amare, 1996). Tigray belongs to the African drylands, which is often called the Sudano-Sahelian region (Warren and Khogali, 1992) in (H. Fitsum, J. Pender, et.al, 1999).

3.5.3 Land use and Land cover

G. Tesfay (2006), in his Book titled: "Agriculture, Resource Management and Institutions" discussed land use and land cover of Tigray region. Though the data presented by the author would have slightly changed by developments taken place over the last decade and half, the lack of access to updated data from Tigray region due to the conflict situation has left no option except to rely on this complete set of data presented as follows. The distribution of land use/land cover type in Tigray is given in Table 11. The major types of land use are bush and shrub land (36.20%), cultivated land (28.21%), and grass lands (22.78%). Other forms of land use account for 10.81% of the land mass. Cultivable land is the dominant land use in the highlands of Tigray, where there is high population density (Pender *et al*., 2002b). The natural forest resource of the region is over exploited and covers only about 0.2% of the total land area. The decline in forest cover has a long history and is closely linked with human economic activities and population pressure (Nyssen *et al*., 2004). Rehabilitation activities are under way through area closures, afforestation and plantation programmes and community mobilization (Pender *et al.*, 2002b; Gebremedhin *et al.*, 2003).

Table 11: Land use/Land cover type of Tigray

	Land use-land cover type	Area (hectares)	Proportion (%)
1	Cultivated land	1,434,792	28.21
2	Grassland	1,158,681	22.78
3	Bush and shrub land	1,840,918	36.20
4	Woodland and plantations	295,082	5.80
5	Natural forest	9,407	0.18
6	Afro alpine	670	0.02
7	Exposed rocks and soil	335,569	6.60
8	Water body and wetlands	8,053	0.16
9	Urban	2,610	0.05
	Total*	**5,085,782**	**100.00**

* The total area for the land use/land cover study does not include about 2,142 square kilometres land which was excluded for security seasons during the time of survey. (Source: Ministry of Agriculture (2003))

3.5.4 Flora and Fauna

The highland plateau of Tigray is said to have been once covered by Junipers, Olea, and Cordia, alternating with montane Acacia - Andropogon Savannah, and by edaphic grasslands and swamps in the flat valley bottoms. As a result of centuries of continuous use, these lush conditions have been converted into the almost barren plateau which exist today (Hunting, 1974). The remnants of climax vegetation that are still existent in some localities also indicate that the region was once covered with lush vegetation, in the not so distant past. In the Eastern, Southern and Western zones of the region there are still some areas with good stands of forests and woodlands. Dessea and Boholeusot in Eastern zone, Hirmi, and Tekezze valley in Western Tigray, Hugumburda and Grat Kahsu in Southern Tigray are the main localities with substantial vegetative cover, accounting for 1.6 percent of the total land area of Tigray (Land Use Planning Team, 1996). The commonly occurring tree species in these areas are *Juniperus procera, Olea europea, Cordia africana, Podo carpus gracilior* and *Acacia spp.*. In addition to the above mentioned tree species, large areas of the Tigray region are covered by incense trees (*Boswellia papyfifera*) and gum Arabic trees (*Acacia senegal*). In the Western Zone an area of 500,000 hectares is estimated to have a stand of 30,000,000 trees. In Dansha area there is a good stand of solid stemmed bamboo (Oxytenanthera abyssinica) of potential economic significance (Fitsum H., Pender J., et.al, 1999). Open woodland of small shrub and tree species has regenerated during the past decades in exclosures, and semi-natural forest vegetation remains largely restricted to small, isolated patches holding different afromontane forest types (Sofie A. et.al, 2021).

Fauna: Tigray hosts several wildlife species including elephants in the Qafta Sheraro National Park. The Qafta Sheraro National Park is found in Western Tigray and it is the only Nationally Gazatted Parks found in Tigray Region.

A total of 167 mammal species, 95 bird species, and 9 reptile species have been recorded at the Qafta Sheraro National Park site. The park is home to a transboundary African elephant population of about 500 individuals, which it shares with Eritrea's Gash-Setit, and

which constitutes the northernmost elephant population in Eastern Africa. The Elephant population in Qafta migrates seasonally between Ethiopia and Eritrea. Kafta-Sheraro is also an important wintering site for demoiselle cranes. During a certain expedition to Kafta-Sheraro National Park from 26 March to 16 April 2009, more than 21,500 Demoiselle Cranes Anthropoides Virgo were recorded, or 9% of the world population of the species. This constitutes the first evidence of a large concentration of Demoiselle Cranes in East Africa. It appears to confirm that the Kafta-Sheraro area serves as a wintering site for the species, and identifies this part of the Tekeze Valley as a wetland of International significance (Wikipedia, Retrieved on 20 March 2023).

Other notable wildlife species include lion, leopard, caracal, aardvark, greater kudu, roan antelope, red-fronted gazelle, hyena, crocodile, cheetah and red-necked ostrich(Wikipedia, Retrieved on 20 March 2023).

3.5.5 Overview of Tigray Regional State Socio-Economic Baseline

Demographic, Ethnic and Religious Features*:** As per the CSA Population Projection of Ethiopia for All Regions at Woreda Level in 2021, Tigray region has a total population of 5,247,005 out of which 2,587,003 are male and 2,660,002 female. Out of the total population of the region, the ***urban resident comprise 1,400,000 (690,000 male and 710,000 female) vis-à-vis 3,847,000 (1,400,000 male and 1,950,000 female) ***rural residents.*** As to the CSA forecast, Tigray is among the regions in Ethiopia with high rate of urbanization: the proportion of urban resident was 13.69% in 1994. 16.18% in 2007, 28.68% in 2017 and estimated to be 38.3% in 2032 and 42.7% in 2037. Tigray's population density strongly follows the "classic" distribution in the country, as presented already by Mesfin Woldemariam in 1972. High population densities are found in the highlands, in relation to several factors including more suitable climate (moisture and less evaporation), lower incidence of diseases, and often fertile soils on volcanic materials.

According to the 2007 Population and Housing Census, in ethnic composition, the overwhelming majority (96.6%) of the total population is ethnic Tigray, followed by Amhara 1.6% and Irob

0.71%. Other ethnic groups comprised only 1.09% of the total population. In terms of religious composition, 95.6% of the total population were Orthodox Christian and the proportion of other religious groups was meager: Muslim 3.9%, Catholics 0.7%, and Protestant 0.08%.

Socio-economic: In Tigray, agriculture contributes around 57% to the regional GDP, of which 36% is from crop production and about 17 and 4% is from livestock and forestry respectively (TRS BOPED, 2004). Rain fed crop production is the main economic activity for over 85 percent of the population, supplemented by livestock rearing under mixed-subsistence systems (G.Tesfay, 2006). According to PEFA Assessment 2018 by the World Bank, the gross domestic product (GDP) of Tigray National Regional State (TNRS) in 2016/2017 was ETB 102 billion at the then basic price, where the largest contribution was from the agriculture sector at 36.7 percent. The share of the agriculture sector is declining slightly over the years from 42 percent in 2012/2013 to 36.7 percent in 2016/2017. About 53.5 percent of the households in TNRS were generally engaged in the farming activity. Households' average landholding is about 0.6 ha with 78 percent of them holding in the range of 0.01 ha to 1.0 ha. TNRS has a number of popular tourist attraction sites contributing to its service sector (PEFA Assessment 2018 by the World Bank).

Land Ownership and custom: According to the 1994 Constitution of the Federal Government, land is publicly owned, hence not freely tradable. In the Tigray region, the regional government improved the rural land policy in 1997. The current policy allows unlimited periods of use-rights for title holders as long as they maintain their residency in the village, and different temporary land transfer rights in a form of contract arrangement with restrictions on the duration of contract (*Negarit Gazeta* Number 23/1989 Eth. calendar, issued in March 1997). Farmers can sharecrop, lease and lend their individual parcels for a limited period, but can neither mortgage nor sell them. Farmers have the right for claiming compensation in the event of state taking land for their investment, and inheritance right is also recognized (G.Tesfay, 2006).

Food Security and Livelihoods: In Tigray, poverty has declined in the past 20 years mainly due to impressive agricultural growth and pro-poor spending on basic services and social protection.

The region saw a 34-percentage-point decline in monetary poverty between 2000 and 2016.[40] The food poverty rate in Tigray was also the highest of all regions, at 32.9%. Women are more likely to live in poverty than men. According to the Tigray Socio-Economic Baseline Survey, 43% of women lived in monetary poverty compared to 22% of men. Likewise, 24% of women lived in food poverty compared to 11% of men[41]. Despite improvements in poverty reduction many Tigrayans remain vulnerable to chronic food insecurity. This is reflected in the high rates of malnutrition in children under 5 years. UNOCHA assessed that Tigray region is in third place among all regions when it comes to most repeated beneficiaries of relief food, meaning there were relief food needs at least nine times between 2013 and 2018, reaching 173,576 beneficiaries. Most vulnerable people in Tigray have crop farming as their main livelihood (UNICEF Regional Profile; Tigray).

Sexual and Gender Based Violence: In Tigray, the proportion of women (aged 15-49) who have ever experienced psychological, physical or sexual violence by their current or most recent husband/partner is 27%, 19% and 12%, respectively.41 The percentage of women who believe that a husband is justified in hitting or beating his wife in various circumstances is 65%, while 31% of men share the same belief/opinion.[42]

3.5.6 Access and Provision of Social Services in Afar

Health: Tigray has a three-tiered primary health system. The primary healthcare unit includes health posts, health centres and primary hospitals; secondary care provided by general hospitals; and tertiary care provided by specialized referral hospitals. Fig 1 depicts the healthcare system in 2015 and 2020. The latest data on the health facilities were reported on Tigray Region Health Bureau (TRHB)'s bulletin. In 2015, there were 39 hospitals (2 referral, 15 general, 22 primary), 204 health centres and 712 health posts. As of November 2020, 40 hospitals (2 referral, 14 general, 24 primary), 226 health centres and 741 health posts (Gebregziabher M, Amdeselassie F, Esayas R, et al, 2022).

[40] Federal Democratic Republic of Ethiopia, National Planning Commission, Ethiopia's Progress Towards Eradicating poverty: An interim report on 2015/16 poverty analysis study, 2017, p. 21.
[41] Regional State of Tigray, Socio-Economic Baseline Survey Report of Tigray Regional State, Nov. 2018
[42] EDHS 2016,

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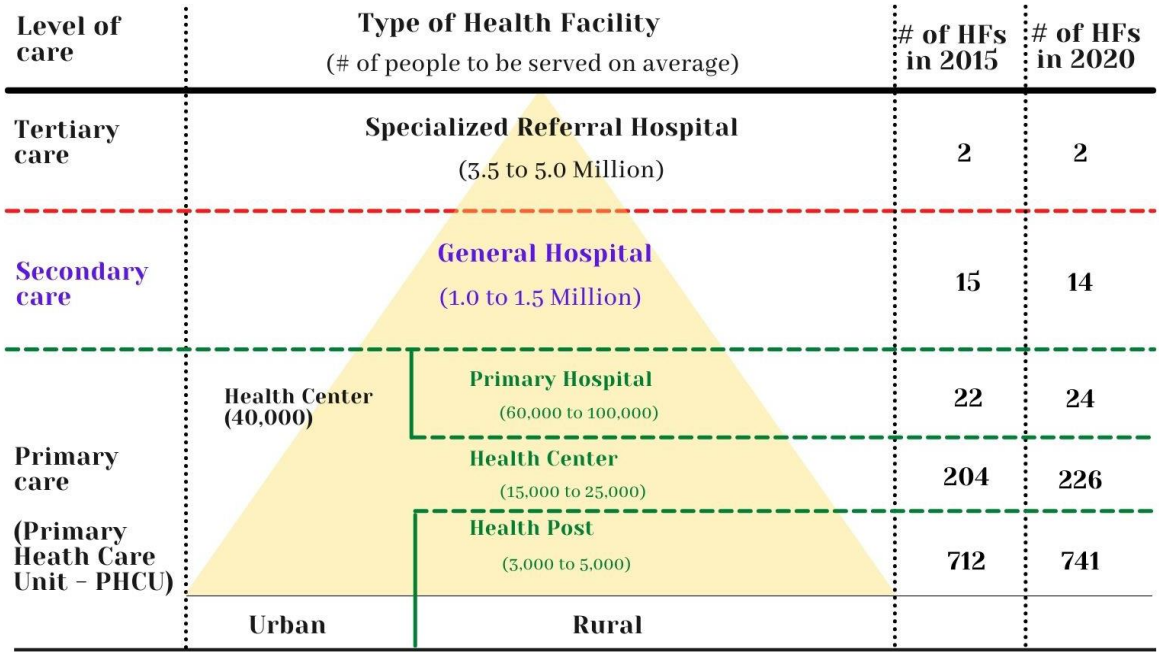

Figure 2: Structure of the Tigray Health Care System

(Source: Gebregziabher M, Amdeselassie F, Esayas R, et al. Geographical distribution of the health crisis of war in the Tigray region of Ethiopia. BMJ Global Health 2022;7:e008475. doi:10.1136/bmjgh-2022-008475)

WASH: The Ethiopia Socio-economic Survey (ESS) 2017 found that 72.1% of households used improved drinking water sources in Tigray. This stands above the national average of 66%. About 26% of water sources in Tigray are piped. The ESS 2017 also presents the time needed to collect water. According to the EDHS 2016, one third of households in Tigray are located more than 30 minutes away from a water source (necessary to reach it, fetch water and return to the dwelling). This rate is nearly equal to the national average of 32%. Like elsewhere in the country, women and girls are mostly responsible for fetching water in Tigray. The availability and sufficiency of drinking water is 77.8% and 72.2%, respectively (UNICEF, Regional Profile: Tigray).

Despite efforts by the regional government and partners to carry out water supply projects, the sustainability of water services is a concern. There is a lack of spare parts, poor design and

maintenance, and insufficient post-construction support. Interventions in most of the lowland and dry mountainous areas have been undermined by droughts that deteriorated ground and river water (e.g., in the Tsaeda-emba, Gulomekada (Hayelom) and Seharti Samre woredas). Creating water supply in drought-affected environments is expensive and requires high-tech equipment and human resources. The community sense of ownership over water supply systems is very low, which leads to premature non-functionality of systems (UNICEF, Regional Profile: Tigray).

Education: It is a key social factor influencing an individual's awareness and attitudes for accessing essential health service. According to the Education Statistics Annual Abstract (ESAA) 2017/18, the gross enrolment ratio (GER) and net enrolment ratio (NER) for pre-primary education in Tigray were among the highest rates in Ethiopia, at 87% and 86%, respectively. This is far higher than the national average of 44% (GER) and 43% (NER). The GER and NER for Tigray primary schools continue to increase and exceeded 100% in 2017/18.20 The Gender Parity Index for Tigray primary schools was 0.94, compared to the national average of 0.9. These ratios show that the region is performing better than the national average. Despite progress in enrolment ratios, there are challenges to be met in Tigray regarding the quality of education, student achievement and dropouts. The illiteracy rate among children aged 15 to 17 years, which is one of the indicators for measuring the quality of education, is 30% in Tigray, significantly lower than the national average (UNICEF, Regional Profile: Tigray).

As per the 2016 EDHS, respondents who completed secondary or more than secondary school were assumed to be literate. All other respondents were given a sentence to read, and they were considered literate if they could read all or part of the sentence. To know the household heads' level of education, the EDHS sampled women and men aged 15-49. The data reveals the proportion of the household heads with no education (illiterate) compose the majority: 72.2% for women and 68.7% for men age 15-49. Given the national average 48% of women and 28% of men age 15-49 with no education, the proportion of illiterate household heads is significantly higher for the Tigray region.

4 Relevant Policy, Legal and Institutional Framework of Environmental and Social Management

4.1 Applicable policies and strategies forming the national environmental and social management system

4.1.1 The Constitution

The constitution of the Federal Democratic Republic of Ethiopia was issued in August 1995 with several provisions which provide basic and comprehensive principles and guidelines for environmental protection and management in the country. 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

- The Peoples of Ethiopia as a whole, and each Nation, Nationality and People in Ethiopia in particular have the right to improved living standards and to sustainable development.
- Nationals have the right to participate in national development and, in particular, to be consulted with respect to policies and projects affecting their community.

Article 44- Environmental Rights

- All persons have the right to a clean and healthy environment.
- All persons who have been displaced or whose livelihoods have been adversely affected as a result of State programs have the right to commensurate monetary or alternative means of compensation, including relocation with adequate State assistance.

Article 92- Environmental Objectives

- Government shall endeavor to ensure that all Ethiopians live in a clean and healthy environment.
- The design and implementation of programs and projects of development shall not damage or destroy the environment.
- People have the right to full consultation and to the expression of views in the planning and implementations of environmental policies and projects that affect them directly.

- Government and citizens shall have the duty to protect the environment.

Article 40: Land and Natural Resource

In relation to land and natural resources, the Constitution under Article 40 proclaims that land and natural resources are commonly owned by the people of Ethiopia and shall not be subject to sale or other means of exchange. It stipulates the rights of Ethiopian farmers and pastoralists to obtain land for cultivation and for free grazing without payment and the protection against eviction from their possession.

Article 42: Rights of Labor: Article 42(2) stipulates that 'workers have the right to a healthy and safe work environment', obliging an employer (be it government or private) to take all necessary measures to ensure that workplace is safe, healthy and free of any danger to the wellbeing of workers.

Article 41: Economic, Social and Cultural Rights

Article 41 of the Constitution states that every Ethiopian has the right to access publicly funded social services. Sub Article 5 of the same article stipulates, the state, within available means, should allocate resource to provide rehabilitation and assistance to physically and mentally disabled, the aged and to children who are left without parents or guardians.

Regional states constitutions: Regional states have their own constitutions upholding the federal constitution in its entirety and constituting their regional particulars. All the regional state constitutions have addressed land and natural resources management and environmental protection. The regional states constitutions state that:

- The regional governments are entrusted to administer land and natural resources in the name of the people and deploy for the common benefit of the same;
- The regional governments and all citizens of the regions are responsible for the conservation of natural resources and the environment;
- Concerned communities shall be given opportunity to express their opinions in the formulation and implementation of policies in relation to the environment.

4.1.2 Environment Policy of Ethiopia

The first comprehensive statement of Environmental Policy of Ethiopia was approved by the Council of Ministers in April 1997 that was based on the policy and strategic findings and recommendations of the Conservation Strategy of Ethiopia. The policy is aimed at guiding sustainable social and economic development of the country through the conservation and sustainable utilization of the natural, man-made and cultural resources and the environment at large. The overall policy goal is to improve and enhance the health and quality of life of all Ethiopians and to promote sustainable social and economic development through the sound management and use of natural, human-made and cultural resources and the environment as a whole so as to meet the needs of the present generation without compromising the ability of future generations to meet their own needs. The Environmental Policy provides a number of guiding principles that require adherence to the general principles of sustainable development. In particular, the need to ensure that Environmental Impact Assessment:

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

4.1.3 Public Health policy

The government assigned a very high priority to significantly improving health care and, in 1998, issued a health policy based on the following main principles:

- Democratization and decentralization of the health care system;
- Promotion of disease preventive components;
- Ensuring accessibility to health care for the whole population;
- Promotion of private sector and NGO participation in the provision of health care;
- Development of appropriate capacity based on needs assessment; and

- Promotion and strengthening of inter-sectoral activities through a national self-reliance program.

The priority areas of the policy are in the field of Information Education and Communication (IEC) of health to create awareness and behavioral change of the society towards health issues, emphasis on the control of communicable disease, epidemics, and on diseases that are related to malnutrition and poor living condition, promotion of occupational health and safety, the development of environmental health, rehabilitation of health infrastructures, appropriate health service management system, attention to traditional medicines, carrying out applied health research, provision of essential medicines, and expansion of frontline and middle level health professionals.

4.1.4 Health Sector Development Programs (1997-2015)

The Ethiopian Health Sector Development Program (HSDP) is a comprehensive policy framework that has been implemented in four phases (HSDP I, II, III and IV) from 1997 – 2015. These HSDPs set the national policy context for the IPF program, especially Sub-component I which supports provision of Essential Health Service (EHS) focusing on RMNCAH+N to conflict-affected areas and IDPs. This can be evident from the aims of the HSDPs which were to develop a health system that provides comprehensive and integrated Primary Health Care (PHC) services, targeting at community health level facilities. It focuses on communicable diseases, common nutritional disorders, environmental health and hygiene, reproductive health care, immunization, the treatment and control of basic infectious diseases like upper respiratory tract infections, the control of epidemic diseases like malaria, and the control of sexually transmitted diseases especially HIV/AIDS. Through implementing these PHC measures, the Ethiopian HSDP envisioned Universal Health Coverage (UHC) which guaranteeing access to EHS for everyone while providing protection against financial risk. In line with this, the designs and contents of the subsequent HSDP I-IV specifically takes stock of the health MDGs by giving utmost attention to the prevention and control of poverty related diseases.

While the HSDP has been severing as the umbrella for the development of Ethiopian health sector, several specific programs and strategies have been introduced to augment the national policy framework on PHC and institutional system to reach out to the needs of the most disadvantaged and vulnerable groups. Having considered the gains and challenges in implementing HSDP I, and realizing that essential health services have not reached people at the grassroots level, HSDP II introduced the Health Extension Program (HEP) in 2003 as an innovative community based approach. HSDP III commenced Accelerated Expansion of Primary Health Care Coverage (2005-2009) as part of PHC expansion through investment in additional health facilities (Health Centers (HCs) and Health Posts (HPs)). These health policy measures innovate both the equity and system of PHC organization. In terms of equity measures, both policy frameworks focus on providing quality promotive, preventive and selected curative health care services in an accessible and equitable manner to reach out to the needs of all segments of the population, with special attention to the most vulnerable such as Pregnant and Lactating Women (PLW), newborns, children under five, people with disabilities and pastoral communities. With regards to PHC delivery system, Beside Primary Hospitals, the HPs and HCs are organized into PHCUs. The investment in health facility construction and expansion during the HSDP III promote universal PHC coverage and institutionalization of the community health services at health post level or decentralized state system of governance. Yet, the National Nutrition Strategy was introduced in 2008 with due attention to malnutrition vulnerable groups of society, particularly infants and under five children, PLW, IDPs, food insecure households, and other groups such the elderly and people living with HIV/AIDS.

4.1.5 Health Sector Transformation Plan I and II (2015-2025)

The MoH assessed that remarkable progress has been achieved in the coverage of PHC as the result of the implementation of the successive HSDPs highlighted just before almost for two decades, from 1997 to 2015. Then, the implementation of Ethiopian Health Sector Transformation Plans (HSTP I and HSTP II) followed not as the new health policy framework but as continuation of the HSDP I, II, III, and IV. The HSTP I (2015/16 - 2019/20 FY) in line with Ethiopia's second Growth and Transformation Plan (GTP II) has set three key areas of

focus for PHC: quality and equity; universal health coverage, and transformation. To this end, the HSTP sets out four pillars of excellence. These are excellence in: health service delivery; quality improvement and assurance; leadership and governance; and health system capacity. In each of these pillars, reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAH+N) continued to be top priority for the HSTP.

4.1.6 Climate Resilient Green Economy

The Climate Resilient Green Economy (CRGE, 2011) is Ethiopia's overarching framework and a national strategy towards a green economy. The Green Economy Strategy is believed to provide an opportunity to promote sustainable development in Ethiopia. Currently, it builds on an investment plan of over 60 initiatives that are, or can be, turned into financed projects. The CRGE has three complementary objectives: i) fostering economic development and growth, ii) ensuring abatement and avoidance of future GHG emissions; and iii) improving resilience to climate change. To achieve these objectives, CRGE sets out to tap into international climate finance, seize opportunities for innovation and new technologies, and create competitive advantages via sustainable resource use and improving productivity.

Having the same pillars of PHC just stated, the implementation of HSTP II (2020/2021-2024/2025 FY) pays due attention to enhance: health equity; public health emergency management system; management and use of health information systems; evidence informed decision making and innovation; and strengthen enabling health regulatory system. Thus, as part of the HSTP II, the government of Ethiopia has put in place the National Health Equity Strategic Plan (2020/21-2024/25) with the goal to narrow the existing inequities in essential health care services in terms of access, uptake, and quality including contributing towards addressing the social determinants of health by the end of 2025. Likewise, the implementation of Health Information System Strategic Plan (2020/21-2024/25) is commenced to ensure evidence-based decision making through improving and promoting access to and use of quality data at all levels of the health system by nurturing digital health information technologies, mobilizing adequate resources and improving management of the health information system. In sum, as for the earlier

health policies, the national policy framework in the HSTP I and II directly align with the four IPF Sub-components.

4.1.7 Water Resource Policy

The Ethiopian Water Resource Management Policy was formulated in 1998 for comprehensive and integrated water resources management towards efficient, equitable, and optimal utilization of the available water resources for socio-economic development on sustainable basis. The specific objectives of the policy include:

- To promote development of the water resources of the country for economic and social benefits of the people, on equitable and sustainable basis;
- To allocate and apportion the water, based on comprehensive and integrated plans and optimum allocation principles that incorporate efficiency of use, equity of access, and sustainability of resources:
- To manage and combat drought as well as other drought associated impacts, and disasters through efficient allocation, redistribution, transfer, storage and efficient use of water resources; and
- To conserve, protect and enhance water resources and the overall aquatic environment on sustainable bases.

The document includes policies to establish and institutionalize environment conservation and protection requirements as integral parts of water resources planning and project development.

4.1.8 National Biodiversity Policy

The National Biodiversity Policy (NBP) was established in 1998 based on a holistic ecosystem approach to conserve, develop and utilize the country's biodiversity resources. Integration of biodiversity conservation and development in federal and regional sectoral development initiatives, and mobilization of international cooperation and assistance, have been identified as the principal strategies for implementation of the policy.

The policy provides for guidance towards effective conservation, rational development and sustainable utilization of the country's biodiversity, and contains comprehensive policy provisions for the conservation and sustainable utilization of biodiversity. Protection of biodiversity-related traditional indigenous knowledge and communities' benefit sharing arrangements are not yet effective. Similarly, the potential of biodiversity-related opportunities has not yet been exploited to enhance sustainable livelihood to the desired level. However, there is a general understanding with respect to changing the management approach in order to bring about the desired benefits.

Wetlands are considered among the most productive type of ecosystem in the world, providing benefits far in excess of those obtained from alternative uses to which they are subjected. Ethiopia is endowed with vast wetlands, however, efforts towards their conservation and sustainable utilization are very limited, and no clear policy and legislative framework have been designed.

4.1.9 FDRE National Occupational Safety and Health Policy and Strategy

The National Policy and strategy on Occupational Safety and Health (OSH) was endorsed by the FDRE Council of Ministers in July 2014. The OSH policy and strategy was prepared to implement the rights of Labour as stipulated in article 42(2) of the Constitution and also implement the requirements of International Conventions on Occupational Health and Safety (No.155) to which Ethiopia is a signatory. The overall objective of the national OSH Policy and strategy is to avoid, prevent or minimize occupational and health hazards by providing effective OSH services in all working places and thereby contribute to the socioeconomic development of the Country.

The guiding principles of the National OSH policy and strategy are stated as the following:

a. Occupational Safety and Health Services are basic rights of workers
b. Occupational Safety and Health Services are necessary in all working places
c. Occupational accidents and health hazards can be prevented
d. Tripartite and bipartite cooperation and coordination are key instruments for the national OSH policy and strategy implementation.

The national OSH policy and strategy is applicable to all types of work places and economic activities in Ethiopia.

4.1.10 The National Policy on Ethiopian Women (1993)

It underlines the need to establish equitable and gender sensitive public policies that empower woman, especially in education and property rights, and engaging them in decision making. Improving healthy working conditions, ensuring access to basic services, protecting woman from harmful traditional practices are among the emphasized key issues.

4.1.11 Gender Mainstreaming Strategy and Guideline (2010)

This strategy was adopted at policy, program and project level by government and development parteners to ensure the outcomes of development to be shared equally between men and women; both men and women enjoy equal opportunities, status and recognition.

The ratification of the Family Law and amendements made to the criminal code significantly support to fight abuses committted against woman and children. Proclamation No.1156/2019 gives special attention to woman and young workers. The proclamation provides protection for woman in general and pregenant woman in particular from hard work and long hours. The law clearly states that women should not be discriminated against as regards to employment and payment on bases of her sex. Gender norms in Ethiopia vary widely depending on geographic location, ethnicity, and religion, especially related to property ownership, inheritance, and the division of assets after divorce. However, the new Family Code has changed all that. Passed in 2000, it gives equal rights to women in marriage and it requires all assets be divided equally among both partners in the case of a divorce. Ethiopia is one of many developing countries implementing gender policy reforms, especially regarding women's equal access to assets and resources.

4.1.12 Ethiopian Women Development Package (2007)

It envisions to build democratic society where women are equal participants and beneficiaries of economic, social and political life of the country. Widespread awareness creation of women to actively participate in the development process; organizing and associate women to address challenges they face; capacitate women to solve problems and fight demeaning perceptions & fight for their rights; facilitate linkages and support among created associations and organization; and enable women to benefit economically and socially.

4.2 Applicable Proclamations, Regulations and Procedural Guidelines forming the National Environmental Management System

4.2.1 Environnemental Impact Assessment Proclamation (Proclamation No. 299/2002)

The ESIA Proclamation is used to predict and manage the environmental effects of a proposed development activity as a result of its design, sitting, construction, operation, or an ongoing one as a result of its modification or termination, entails and thus helps to bring about intended development.

The proclamation is an effective means of harmonizing and integrating environmental, economic, cultural and social considerations into the planning and decision-making processes thereby promoting sustainable development. Moreover, it serves as a basic instrument in bringing about administrative transparency and accountability, to involve the public and the communities in particular, in the planning and execution of development programs that may affect them and their environment. The objective of undertaking the assessment study is to ensure the impacts of a development project and the incorporation of mitigating measures for the adverse significant impacts. The ESIA law and associated guidelines clearly defines:

- Why there is a need to prepare ESIAs
- What procedure is to be followed in order to implement ESIA
- The depth of environmental impact studies
- Which projects require full ESIA studies

- Which projects need partial or no ESIA studies
- To whom the report must be submitted

There are ongoing efforts carried by the Federal EPA to review the ESIA Proclamation in order to update and improve it.

a. Environmental Impact Assessment Procedural Guidelines Series (Series 1 and 2)

In order to facilitate the implementation of Environmental Impact Assessment Proclamation (Proclamation 299/2002), the Federal EPA had formulated four procedural guidelines, namely, Review Guideline Series 1: Guidelines for Review Approach; Review Guideline, Series 2-Guidelines for Contents and Scopes of Report; Review Guideline, Series 3-Checklist of Environmental Characteristics and Review Guideline, Series 4- Review Criteria. These widely applied draft environmental impact assessment guidelines were under review to enhance the documents in light of the experiences gained so far and to publish it for official use after endorsement by the Authority. The review process is still ongoing and yet to be completed. Review Guideline Series 1 and 2 will be elaborated to a certain extent here and any further updates made to the documents will apply after official publication of the reviewed guidelines.

b. Procedural Guideline Series 1 -Guidelines for Review Approach

This guideline pointed out roles and responsibilities of the Federal EPA and Regional Environmental Agencies, the proponent, consulting firm, interested and affected parties, and the licensing agency. In the guideline, the ESIA processes and requirements, and comprehensive description of the EA process has been stated. It also outlined projects which may have adverse and significant environmental impacts, and may, therefore, require full ESIA (Schedule 1), projects whose type, scale or other relevant characteristics have the potential to cause some significant environmental impacts but not likely to warrant an environmental impact study (Schedule 2) and projects which would have no impact and does not require environmental impact assessment (Schedule 3).

c. Procedural Guideline Series 2 - Guidelines for Contents and Scopes of Report

This guideline among others indicates structure and content of the Environmental Impact Study Report and describes the contents including the administrative, legal and policy requirements, assessment and mitigation measures. The guideline indicates the following main types of mitigating measures, which need due considerations:

- Preventing, reducing or minimizing impacts before they occur;
- Eliminating an actual impact over time by incorporating appropriate maintenance measures during the life of the project;
- Rectifying an impact by repairing, rehabilitating or restoring the affected environment;
- Compensating for an impact by replacing or providing substitute resources or environments as well as contingency plans in case of emergencies;
- Maximizing beneficial impacts through specific additional actions

d. Directive No.3/2018 (2010 EC)

Directive on issuing "professional competence certificate to consultants and firms providing service in Environmental Impact Assessment, Environmental Audit and Climate Change fields"

The Directive has been issued by the MoEFCC (now called Federal EPA) and has been in force for the last ten years. It has become an important milestone in the development of the ESIA system in Ethiopia. The directive stipulates that ESIA and Environment Audits should be conducted by professional consultants and firms that are registered and certified for their competence by the Federal EPA. ESIAs and Environment Audits prepared by unregistered and uncertified firms will not be eligible for review and approval. The Regional EPFCCs also apply the stated directive of Federal EPA and some even have re-published as their regional directive after customizing it to the context of their respective regions. The previous Directive no.2/2014 was put under review by the former MOEFCC and is re-published as Directive no.3/2018 after updating it.

e. ***Environmental guideline and management plan***

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

- ESIA 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 ESIA.

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

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

4.2.2 Environnemental Pollution Control Proclamation (Proclamation No. 300/2002)

This proclamation is aimed at eliminating or, when not possible, to mitigate pollution as an undesirable consequence of social and economic development activities. It has also an objective of protecting the environment and safeguarding of human health, as well as maintaining of the biota and the aesthetic value of the environment. The Proclamation, among others has considered control of pollution; management of hazardous waste, chemical and radioactive substances; management of municipal wastes; the importance and need to respect environmental standards; and punitive and incentive measures.

4.2.3 Solid Waste Proclamation (Proclamation 513/2007)

Solid Waste Management proclamation 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.

4.2.4 Hazardous waste management and disposal control (Proclamation No.1090/2018)

This is one of the recently introduced environmental legislations that specifically deal with hazardous wastes, the proclamation in its preamble elucidated hazardous waste as one of the most crucial environmental problems in Ethiopia. It stated the importance of prevention and control of these type of wastes and emphasized the need for creation of a system to control the generation, storage treatment, recycling and reuse as well as transportation and disposal of hazardous wastes to prevent harm to human and animal health as well as the environmental.

The proclamation defined "hazard" as the inherent characteristics of a substance, agent, or situation having the potential to cause adverse effects or damage to human or animal health, the environment, biodiversity and property and has determined the categories and characteristics of hazardous waste in annex I and annex II respectively. The objectives of this proclamation are stated as;

- Create a system for the environmentally sound management and disposal of hazardous Waste
- Prevent the damage to the human or animal health, the environment, biodiversity and property due to the mismanagement of hazardous waste.

Further its scope of application is also stated as:

- Waste that belong to any category contained in Annex One of this Proclamation, and waste possesses any of the characteristic contained in Annex Two; as well as on those wastes that might be categorized as hazardous waste by the directive to be issued by the Ministry;
- Person, who generates, reuses, recycles, stores, transports, or disposes hazardous waste at large in nation.

The proclamation within its 24 articles has dealt with all character and management of hazardous wastes.

4.2.5 Food and Medicine Proclamation No.1112/2019

The proclamation provides for a national legal framework that enables to establish a coordinated food, medicine, medical device, cosmetics, and tobacco products regulatory system and seeks to prevent and control the public's health from unsafe, inefficacious and poor quality medicine, and unsafe and ineffective medical devices. The proclamation sets the following regulatory requirements with regard to manufacturing, import, trade and distribution of medicine and medical equipment

- Any medicine and medical device shall not be manufactured, imported, exported, stored, distributed, transported, sold, hold, used, or transfer to any other person without registration and marketing authorization.
- The medicine or medical device institution or another appropriate person shall ensure that every product under its possession is stored, transported, and sold in accordance with good storage and distribution practices and in such a way that its quality, safety, and efficacy or effectiveness is maintained.
- Any medical device shall meet quality, safety and effectiveness requirements issued or adopted by the appropriate organ.
- Where national standard is not issued or adopted, the executive organ may regulate medicine and medical device in accordance with requirements prescribed by international organizations, other countries, and requirements or guidelines issued by manufacturing companies acceptable to the executive organ.
- Every part of a transportation equipment having direct contact with the medicine or medical device shall be clean and shall not render the product to cause any chemical, physical, or microbiological contamination.
- No one may manufacture, import, export, wholesale or store any radiopharmaceutical or radiation emitting medical device unless he gets a certificate of competence from the executive organ and appropriate body.
- The handling of any regulated product under this proclamation and that is expired, unusable, or unfit for use for any reason shall not be in a manner that could contaminate other products.

- Any product that is segregated in accordance with sub-article (1) of this article shall be disposed with due care to the health of human, animal and the environment, and the cost shall be covered by its owner or another appropriate person.
- The executive organ or regional health regulator, upon request by the appropriate person, shall give the necessary information regarding products disposed of in accordance with this provision.

4.2.6 Medicinal Waste Management and Disposal Directive, 2011

The directive 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 governmental, 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.

4.2.7 The Guideline for Waste Handling and Disposal in Health Facilities (2006)

The guideline was developed to:

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

4.2.8 Water Resources Management Proclamation (197/2000)

The purpose of the Proclamation is to ensure that the water resources of the country are protected and utilized for the highest social and economic benefits of the people of Ethiopia, to follow up

and supervise that they are duly conserved, ensure that harmful effects of water are prevented, and that the management of water resources is carried out properly.

4.2.9 Expropriation of landholding for Public Purposes, Payment of compensation and Resettlement of Displaced People (Proclamation No 1161/2019):

The previous proclamation no. 455/2005 has been repealed and replaced by a new Proclamation no. 1161/2019. The new proclamation has introduced extensive improvements to the principles and provisions governing the process of expropriation of landholdings for public purposes and payment of compensation. The new legislation bases itself on the following four principles:

***Principle 1*:** Expropriation of land for public purposes shall be made only on the basis of approved land use plan, urban structural plan; or development master plan.

Principle 2: Compensation and Resettlement Assistance Compensation for the expropriated land shall sustainably restore and improve the livelihood of displaced people.

Principle 3: The amount of compensation to be paid at Federal, or Regional or Addis Ababa or DireDawa level for simillar properties and economic losses in the same areas shall be simillar.

Principle 4: Where land is expropriated for public purpose, the procedure shall be transparent, participatory, fair and accountable.

The new proclamation has made improvemnts to the amount and kind of compensation entitlements to displaced people. Landholders whose land is expropriated for public purposes are entitled for property compensation, displacement compensation, displacement assistance, economic loss compensation and social ties discontinuance and moral damage compensations as deemed appropriate. The determination of the amount of property compensation for the property on the land is improved from “replacement cost” to “replacing the property anew”. Simillarly the determination of compensation for permanent improvement to land is clarified to be based on “current value of capital and labor expended on the land”. Determination of displacement compensation for expropriated Land holding where equivalnet substitute land is not available is

improved from the previous "ten times" to "fifteen times" the highest annual income generated during the last three years preceding the expropriation of land.

The new legislation has also introduced new provisions on resettlement (i.e. livelihood restoration) and compensation for economic loss aspects. Article 16(1) of the proclamation states that "Regional states…..shall establish fund for compensation payment and rehabilitation" Moreover the the next subarticle 16(2) puts a responsibility to regional states to develop a resettlment packages that enable displaced people to sustainably resettle. Subarticle 16(3) places the duty to resettle the people displaced on Urban or Woreda administrations based on the resettlement package and allocated budget.

4.2.10 Council of Ministers Regulation No. 472/2020

The new regulation No. 472/2020 repealed Council of Ministers Regulation on Payment of Compensation for Property Situated on Landholdings Expropriated for Public Purposes (Regulation No. 135/2007). This Regulation contains property valuation and compensation methods and formulae that should be used in calculating compensation for various properties. It also contains lump sum compensation to be paid for severed social relationship and moral damages.

The regulation also sets the provision of land expropriation procedure, propriety right to develop the land to be expropriated, and provision of substitute of land, housing and resettlement and shareholder rights of the displaced.

4.2.11 Proclamation 1156/2019 - The Labor Law

The Proclamation repealed and substituted the former Labor Proclamation No.377/2003. But much of the provisions of the previous labor law were retained with some improvements and additions. . One of the important improvements made is on protecting child labor by increasing the minimum age for young workers to be 15 years old (versus the previous 14 years) and have introduced a new sub-article (14h) prohibiting Sexual Harassment or Sexual Assault at workplace to prevent GBV.

Proclamation 1156/2019 covers health and safety at work, harmonious industrial relation and minimum workplace standard and addresses workplace vulnerability. Article 92-93 of the proclamation defines obligation of employers and employees in work-place including assignment of safety officers and committee. The Labor Proclamation mandates employers to protect occupational safety, health and create better working environment for their workers. Article 92 states that "An employer shall take the necessary measure to safeguard adequately the health and safety of the workers…" The law requires employers to i) take appropriate steps to ensure that workers are properly instructed and notified concerning the hazards of their respective occupations and the precautions necessary to avoid accident and injury to health; ii) ensure that directives are given and also assign safety officer; establish an occupational, safety and health committee of which the committee's establishment, shall be determined by a directive issued by the Minister; and iii) provide workers with protective equipment, clothing and other materials and instruct them of its use.

In addition to enacting its labor codes, Ethiopia is also a signatory to the international UN conventions and has ratified the major international human rights instruments. Ethiopia has also ratified the following ILO conventions:

- Forced Labor Convention No.29 /1930;
- Freedom of Association and Protection of the Right to Organize Convention, No.87/1948;
- employment Service Convention, No.88/1948;
- Right to Organize and Collective Bargaining Convention, No.98/1949;
- Abolition of Forced Labour Convention, No.105/1957;
- Minimum Age Convention No. 138 /1973;
- Occupational Safety and Health Convention, No.156/1981;
- Termination of employment Convention, No.158/1982;
- The Rights of the Child Convention (1989); and
- The Worst Forms of Child Labor Convention No.182/1999.

The 2005 Occupational Health and Safety Directive*:* developed as a follow-up to the labor Proclamation provides guidance on the establishment of occupational health and safety committees in public and private organizations.

4.2.12 Proclamations on Persons with Disability and Vulnerable Groups

Proclamation No. 568/2008 Rights to employment for Persons with Disabilities: makes null and void any law, practice, custom, attitude and other discriminatory situations that limit equal opportunities for persons with disabilities. It also requires employers to provide appropriate environment for work, training and take affirmative measures particularly when employing women with disabilities.

4.3 World Bank Environmental and Social Standards

According to the World Bank Environmental and Social standards, projects supported by the Bank through Investment Project Financing are required to meet the Environmental and Social Standards (ESS). The ESS is designed to help Clients to manage the risks and impacts of a project, and improve their environmental and social performance, through a risk and outcomes-based approach. Clients are required to manage environmental and social risks and impacts of the project throughout the project life cycle in a systematic manner, ***proportionate to the nature and scale of the project*** and ***the potential risks and impacts***.

The Environmental and Social Commitment Plan (ESCP) have outlined actions that need to be completed. These include preparation of environmental and social management framework (ESMF), and Resettlement Plan Framework, Social Assessment, GVB Action Plan, LMP, ICWMP and OHS plan. In the context of the present Ethiopia PforR SPHCS project the ESMF and RPF instruments has been proposed as a management tool for the IPF component of the project as the specific sites for the implementation of the subproject activities has not been fully identified at this stage. However, during implementation stage, the site-specific risk management instruments (ESMP, ESIA) will be prepared to mitigate risks associated with the sub project activities.

This IPF Component PforR SPHCS project ESMF will serve as an instrument to satisfy the Bank's ESS1 on Assessment and Management of Environmental and Social Risks and Impacts. In the present context of the IPF Component PforR SPHCS project, the Environmental Assessment takes into account the natural environment (air, water, and land); human health and safety; as well as social aspects (involuntary resettlement and physical cultural resources) in an integrated way.

Table 12: World Bank applicable Environmental and Social Standards

World Bank Environmental and Social Standards (ESS)	Applicable	Explanation
ESS1: Assessment and Management of Environmental and Social Risks and Impacts	Yes	The IPF Component project activities involve procurement and distribution of medical supplies and equipment, restoration of health service infrastructures, and providing technical assistance and capacity building activities to populations and IDPs in conflicted affected areas. Reports indicate that many health facilities found in the five conflict affected regions are either partially or fully damaged in which case both necessitate the undertaking of re-construction works. Besides medical supplies, the restoration of health facilities may also require the procurement and installation of medical equipment such as X-Rays and etc. Establishment of district emergency management team and deployment of mobile health teams may also result in waste management issues during implementation. These types of subproject activities can pose potential environmental and social risks during the construction and installation activities, triggering ESS 1. ESS1 is therefore relevant for activities under the IPF Component. The ESMF is designed to identify these potential risks and direct the project implementing team to practical ways of avoiding or mitigating them. **Note**: For projects involving multiple small subprojects, the client will carry out appropriate environmental and social assessment of subprojects, and prepare and implement such subprojects, as follows: (a) Substantial Risk, Moderate Risk and Low Risk subprojects, in accordance with national law and any requirements of the ESSs that the Bank deems relevant to such subprojects. Note also that the overall Environmental and social risk rating of the IPF Component is "Substantial". The environmental risk rating is also "Substantial". Annex-III of the Federal EPA ESIA Procedural Guideline, (November 2003) has outlined the schedule of activities (subprojects) for which a full ESIA, Preliminary ESIA or no action is required. The schedule of activities listed in Annex-III of the guideline is widely applied by the Federal and Regional competent authorities to classify sub-projects into one of the three Categories.

ESS2: Labor and Working Conditions	Yes	The IPF Component project will engage public workers that will provide essential health services, primary health care & CRVS services for conflict affected population and IDPs, workers hired by the project (direct workers such as consultants, technical experts for TAs and project management staff and third party implementer workers), and workers hired by contractors to undertake civil works for restoration of health facilities under the project. These involve MoH, and EPSA staff engaged in project implementation, as well as staff working in outsourced activities to third party project implementers. The project will develop LMP to mitigate risks. The potential risks identified include occupational health and safety (OHS) risks specifically to hazards from exposure to COVID 19, security risks, SEA/SH, child labor during construction as well as workplace accidents/injuries; community health and safety issues (e.g., exposure to medical Thus, ESS2 remains relevant and is triggered by the IPF component project. The IPF component project will develop Labor Management Procedures and will be annexed as part of the ESMF.
ESS3: Resource Efficiency and Pollution Prevention and Management	Yes	The IPF Component will provide essential health services, medical consumables, equipment and medicines for conflict affected areas and IDP settings. It will also deploy mobile health teams and establish management teams to continue delivering essential health and nutrition services. These and similar other IPF project activities have potential impacts from use of natural resources such as Water and Energy as well as disposal of hazardous chemicals, and production of health care waste and wastewater. The generation of significant amounts of solid and liquid waste in the health centers to be supported under this project will require well-prepared disposal facilities. Moreover, the construction activities to be carried to restore the damaged health facilities will likely generate pollutants that will be released to air, water and soil. As a result, ESS 3 will be triggered by the IPF Component subproject activities.
ESS4 Community Health and Safety	Yes	Construction activities for restoration of health facilities, deployment of additional human resource and mobile teams to provide essential health services including by third party implementer, and establishment of district emergency response teams would likely require mobilization of workers to the conflict affected areas and IDP settings. community health and safety issues (e.g., exposure to medical wastes & other hazardous materials); communicable disease (e.g., COVID-19) which may arise from the interaction of project workers with local communities, between project workers; GBV in relation to contacts between project workers, and members of the project affected local communities and members of local communities. SEA/SH and GVB risks could affect both the health workers and community health and safety. The procurement and distribution of medical supplies and provision of vehicles under IPF Sub-components I & II will also increase the mobility of health and CVRS workers which may induce traffic accident risks both to the workers and the community. Improperly managed medical waste stream generated by subproject supported activities may also pose public health risks. Thus, ESS4 is relevant and is triggered by the IPF Sub-components I & II in line with Traffic and Road Safety risks, security risks, and risks from the use of security personnel. .
ESS5 Land	Yes	The requirements of the ESS5 are applicable in relation to the civil works of the IPF

Acquisition, Restrictions on Land Use and Involuntary Resettlement		Sub-component I. That is, the social assessment reveals the reconstruction of conflict-damaged health facilities and establishment of temporary or satellite clinics in IDP Camps require land acquisition with potential involuntary resettlement risks, physical or economic displacement or both. ESS 5 will be triggered. The IPF Component has prepared a separate RPF to help manage these risks and will be applied in conjunction with this ESMF on relevant subprojects.
ESS6 Biodiversity Conservation and Sustainable Management of Living Natural Resources	Yes	There are about 2643 health facilities in the five conflict affected regions reported to have been partially or wholly damaged. These health facilities are found distributed both in urban and rural areas where critical or sensitive natural habitats may also be present. The construction activities to restore these facilities and to establish sattelite clinics may affect biodiversity and critical habitats. Hence, ESS6 is relevant for this project.
ESS7 Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Yes	The applicability of the ESS7 concerns the project-affected pastoral and agro-pastoral communities in Afar, Benishangul-Gmuz, and parts (Borena and Guji) of Oromia. Because these are recognized as a distinct social and cultural group as per the defining features given in paragraph 8 of the ESS7. The provisions of the ESS7, therefore, establish the requirements for the MoH to assess, manage, and monitor and evaluate the disproportionate resettlement risks and impacts due to land acquisition for the reconstruction of health facilities or establishment of temporary or satellite clinics to address the need of essential health service in the IDP Camps. It is expected that the project activities will benefit the local population with an improved child, maternal health and civic registration services. Hence, ESS7 applies for this project.
ESS8 Cultural Heritage	Yes	ESS8 applicable in association with the civil works of the IPF Sub-component I that may involve excavations, demolitions, or other physical changes with potential risks to the cultural heritages in the project target areas. In particular, previously unknown cultural heritage may be discovered while excavation for the project civil works or tangible cultural heritage may be located under the surface. A chance finds may include the discovery of a single artifact, an artifact indicating the presence of a buried archaeological site, human remains, fossilized plant or animal remains or animal tracks, or a natural object or soil feature that appears to indicate the presence of archaeological material. Owing to this, preparation of a Chance Find Procedure (CFP) is needed. The Chance Finds Procedure (CFP) is available in Annex VI.
ESS9 Financial Intermediaries	No	Financial Intermediaries (FIs) are not involved in this project.
ESS10 Stakeholder Engagement and Information Disclosure	Yes	ESS10 set out the provision for open and transparent engagement with the IPF project stakeholders from federal to local community level as an essential element to enhance project acceptance, and make a significant contribution to successful project design and implementation. As per this requirement, the MoH develop and implement a Stakeholder Engagement Plan (SEP) proportionate to the nature and scale of the IPF project and its potential risks and impacts. During the project preparation, consultations were conducted with MoH and implementing entities. The higher management body of the MoH, the different directorates and regional Health bureaus meet on monthly bases to assess the overall performances of the health system and the preparation of the project. Moreover, consultations were conducted with the Bank and other development partners on the same. Stakeholder and community consultations were also carried as part of the preparation of the

		ESMF, RPF, SA and SRA instruments in two of the five target regions (Amhara and Afar). The methodology for the social Assessment employed different sampling procedures that allow representativeness both in terms of project target areas and stakeholder groups. First, as to the coverage of the IPF target areas, all the conflict-affected regions (Tigray, Amhara, Afar, Benishangul-Gumuz and Oromia) were included. Consultation with the heads and health expertise in the respective Regional Health Bureaus (except Tigray) were conducted. For Tigray region, information was obtained through interview with the PHC program head and expertise of UNICEF, a third party implementing agency in the region. The IPF Component project have also draft GVB action that consist of provision on gender equality and the mitigation of gender-based violence to avoid potential adverse impacts are included. The establishment of project level Grievance Redress Mechanism (GRM) will be undertaken, targeting integration with existing GRM structures in MoH and Regional Health Bureaus, and maintained and strengthened throughout the project lifecycle. Application of the ESS 10 will be closely monitored and reported on through the project life-cycle. Thus ESS 10 remains applicable to the IPF Component project.

4.4 Relevant EHS Guidelines (World Bank Group) for IPF Component subprojects

4.4.1 EHS General Guidelines

The EHS general guidelines section 1 to 4 provides guidance on prevention and control of environmental, occupational health and safety, community health and safety, as well as on construction and decommissioning impacts that may occur during new, restoration or modification of existing health care facilities. As the IPF Component subprojects consist of civil works, which will involve manual labor work activities, section 2.0 of the EHS general guidance provides some appropriate strategies and recommendations useful to minimize occupational health and safety hazards. It describes the sources of hazards and recommended strategies for the prevention of risks associated with over-exertion, slips and falls, work in heights, struck by objects, and working in confined spaces and excavations in construction and decommissioning sites.

4.4.2 EHS Guidelines for Health Care Facilities

The EHS Guidelines for Health Care Facilities provide information relevant to the management of EHS issues associated with health care facilities (HCF) which includes a diverse range of facilities and activities involving general hospitals and small inpatient primary care hospitals.

Ancillary activities may include medical laboratories and research facilities and blood banks and collection services. The guideline addresses waste management. Air emissions, and wastewater discharges from HCFs as well as Occupational Health and Safety aspects for health workers. These are reviewed and applied in this ESMF as appropriate.

4.4.3 EHS Guidelines for Water and Sanitation

The EHS Guidelines for Water and Sanitation include information relevant to the operation and maintenance of (i) potable water treatment and distribution systems, and (ii) collection of sewage in centralized systems (such as piped sewer collection networks) or decentralized systems (such as septic tanks subsequently serviced by pump trucks) and treatment of collected sewage at centralized facilities

Table 13: Comparison of World Bank ESF (EE 1-10) with Ethiopian Legal and Policy framework

ESF Environmental and Social Standards (ESS)	Status of application to the project	Available national policy and legislation to fulfill the performance standard	Gaps	Measures to bridge the gap
ESS-1: Assessment and Management of Environmental and Social Risks and Impacts	ESS-1 is applicable to the IPF Component	The Federal EIA Proclamation No. 299/2002 and related regional EIA regulations mandatorily requires a project proponent to undertake EIA. The Federal EIA procedural guideline (2003) classifies projects into Schedule I, II and III to facilitate the undertaking of EIA proportionate to the risks and impacts of each project. The EIA proclamation and regulations seek all direct, indirect and cumulative impacts likely to occur during project life cycle are considered in the assessment. The stated legislation and regulation also require stakeholder and community consultations to be carried as part of the EIA process. The preparation of ESMP based on mitigation hierarchy and monitoring plan is also required by the EIA proclamation and associated guidelines.	-Requirement of the EIA proclamation and regional regulations do not cover "associated facilities" as defined by the ESF. -Requirements of the EIA proclamation and regional regulations do not explicitly seek for consideration of risks and impacts associated with primary suppliers as defined by the ESF during EA.	-EA requirements for "primary suppliers" shall be addressed as part of the present ESMF process when and if it occurs -The application and use of EHS guidelines as appropriate to subproject EA is required by the present ESMF. - The ESS 1 requirements for E&S risk management of

			-Apart from the presence of effluent standards for specified industrial sectors, the EIA proclamation is not complemented by a guideline similar to EHS and do not require its use	"Associated facilities" should apply as appropriate to bridge the gap.
ESS-2:Labour and Working Conditions	ESS-2 is applicable to the IPF Component.	The former Labor Proclamation No.377/2003 is repealed and substituted by the new Proclamation 1156/2019. The new legislation remains to be the labor legislation applied invariably all over the Country without customization to regional contexts. The labor law is applied to govern all aspects of employment relations based on a contract of employment that exists between a worker and an employer. The legislation covers formation of contract of employment defining the rules and conditions of employment, non-discrimination, equal opportunity for women workers, the right to form trade unions (workers organizations), working conditions of young labor setting the minimum age for child labour to be 15 and working conditions, and arbitration/conciliation mechanism to handle grievances and disputes of workers in relation to employment. The labour law also covers occupational safety, health and work environment aspects. The labor law largely fulfils the requirements of ESS 2. Proclamation No. 568/2008 Rights to employment for Persons with Disabilities makes null and void any law, practice, custom, attitude and other discriminatory situations that limit equal opportunities for persons with disabilities.	All the rules of the labor law are applicable to employment relations based on a contract of employment that exists between a worker and an employer. The labor law is not applicable to community workers as it is not based on employment relations between worker and employer. As most workers of subprojects are likely to be contracted through formal employment process, there are no major gaps between ESS 2 and the labor law.	- The ESMF should adopt the provisions of both the labor law and ESS 2 for undertaking complete Labor Management Practices.
ESS-3 Resource Efficiency and Pollution	ESS-3 is applicable to the IPF	The requirements of ESS-3 are largely fulfilled by the following national legislations and International Conventions which Ethiopia is a	Detailed guidelines to support the	The application of relevant sections of the General

Prevention	Component	Party, which are widely referred during ESIA studies. These include: -The Pollution Control Proclamation no. 300/2002 which set the binding provisions for prevention and control of pollution addresses management of hazardous waste; chemicals and radioactive materials, management of non-hazardous municipal waste, and set the provisions for issuing environmental standards including for air, water and various effluents. The proclamation is complemented by effluent standards for certain industrial sectors. - Ethiopia has ratified and is party to the following three International Conventions that help in managing/avoiding the use of restricted and banned pesticides, chemicals trade and trans-boundary movement of Hazardous wastes. These are: -The Stockholm Convention on POPs - The Rotterdam Convention on PIC procedures -The Basel Convention on trans-boundary movement of Hazardous Wastes. Besides the Proclamation for the Registration and Control of Pesticides (Proclamation No. 674/2010) provides for the procedures of approval and registration of pesticides to be imported or manufactured in Ethiopia.	avoidance, minimization or reduction of environmental and health impacts of pesticides during application are not sufficiently available.	EHS and sector specific EHS guideline is required when appropriate.
ESS-4: Community Health, Safety and Security	ESS-4 is applicable to the IPF Component	Building Proclamation No. 624/2009 contain certain provisions that partly address the issues of community safety in the areas of building designs and community exposure to health risks. Other regulations such as prevention of industrial pollution require industrial facilities to prepare emergency response systems. In general, some aspects of the ESS 4 are either fully or partially addressed across the existing sector legislations and regulations.	There are gaps in fully addressing the community Health, Safety and Security aspects as defined in the ESF.	The application of relevant sections of the General EHS and sector specific EHS guideline is required when appropriate.
ESS-5: Land acquisition and	ESS-5 is applicable to	The new Proclamation no 1161/2019 for expropriation of land for public purposes has	The entitlements for compensation	The application of ESS 5 to bridge

Involuntary Resettlement	the IPF Component	provisions that address resettlement and compensation of involuntary resettlements caused by land acquisition for public purposes. The new proclamation provides for various types of compensation for resettlers such as property, displacement and economic loss compensations. Resettlers are also entitled for replacement land substitution and compensation for disruption of social ties. Entitlement for compensation is based on legal land holding. Valuation of compensation will be based on current costs and values to replace the properties anew. The proclamation also consists of a provision for establishing resettlement fund, resettlement package to restore livelihood of resettlers and complaint hearing and appeal provision to address complaints in relation to resettlement and compensation.	of resettlers is based on legal land holding and do not include informal settlers without any legal landholding.	the gap and cover the informal resettlers during resettlement is required. -reliance on the more elaborate provisions of proclamation 1161/2019 and regulation 472/2020 is required to bridge the gap of non-clarity.
ESS-6: Biodiversity Conservation and Sustainable Management of Living Natural resources.	ESS-6 is applicable to the IPF Component	The Federal EIA Proclamation no.299/2002 has defined the terms “Environment” and “Impact” broadly to include all forms of habitats, biodiversity, heritage and ecosystems. "Environment" means the totality of all materials whether in their natural state or modified or changed by human; their external spaces and the interactions which affect their quality or quantity and the welfare of human or other living beings, including but not restricted to, land atmosphere, whether and climate, water, living things, sound, odor, taste, social factors and aesthetics. "Impact" means any change to the environment or to its component that may affect human health or safety, flora, fauna, soil, air, water, climate, natural or cultural heritage, other physical structure, or in general, subsequently alter environmental, social, economic or cultural conditions. The impact of a project shall be assessed on the basis of the size, location, nature, cumulative effect with other concurrent impacts or phenomena, trans regional effect, duration, reversibility or irreversibility or other related effects of the project. The EIA report is required to contain information on the characteristics and duration of all the estimated direct or indirect, positive or negative impacts,	None.	None

		as well as measures proposed to eliminate, minimize, or mitigate negative impacts. Thus, the requirements of ESS 6 are broadly addressed through the EIA process. There are also more specific sectoral laws and regulations which complement the EIA proclamation in conserving habitats and biodiversity such as: -Forest Development, Conservation and Utilization Proclamation no. 1065/2018 -Development Conservation and Utilization of Wildlife Proclamation No. 541/2007 -Wildlife Development, Conservation & Utilization Council of Ministers Regulations No.163/2008. -National Biodiversity Strategy and Action Plan (NBSAP).		
ESS-7: Indigenous People	ESS-7 is applicable to the IPF Component	The Constitution of FDRE recognizes all the Nations, Nationalities and Peoples of Ethiopia and provides for equal rights to them through its various articles. The frequently applied name for the Indigenous people as defined in ESS 7 in Ethiopia are "Nationalities". Thus, all nationalities are equally treated in accordance with the mainstream laws in project EIA studies which involve carrying a series of consultations with community and stakeholders to include their opinions and views during project design and implementation. As the IPF subprojects will be implemented in Afar, Benshangul Gumuz and Oromia-regions where pastoralist and semi-pastoral communities reside, the potential risks of the project may disproportionately impact these groups who are historically underserved or mostly vulnerable due to their distinct livelihood strategies, ways of living and other socio-economic dynamics. The Bank will apply ESS7 for this project in the same spirit as previously agreed with the GoE.	The application of an Indigenous People's policy was controversial in Ethiopia, until a GoE-WB agreement has been reached that it would be applied in four regions (Afar, Benishangul-Gumuz, Gambella, and Somali) as well as pastoralist areas in other regions; in line with the Ethiopian constitution which notes that "Government shall provide special assistance to Nations,	The gaps in the definition of Indigenous people between the national system and ESS 7 is already bridged through discussions and agreement between the World Bank and the GoE. The requirements of the ESS7 will be put in place when applicable.

			Nationalities, and Peoples least advantaged in economic and social development."	
ESS-8: Cultural Heritage	ESS-8 is applicable to the IPF Component	As described above in ESS 6 the term "Impact" is defined broadly by the EIA proclamation. The definition reflects the kind of adverse impacts a project proponent is required to assess which includes any change to the environment or to its component that may affect flora, fauna, **natural or cultural heritage**, or in general, subsequently alter environmental, social, economic or **cultural conditions**. Thus, the Federal proclamation on EIA has provisions by which it considers the issues of cultural resources. Article 41 of Proclamation No. 209/2000 on research and conservation of cultural heritage also contains the measures that should be taken during chance finding of heritages.	Though natural and cultural heritages are required to be included during EIA process, the preparation of a Cultural Heritage Management Plan (CHMP) as indicated in the ESF is not required by the national EIA law.	The application of ESS 8 requirement for CHMP is required when appropriate.
ESS 10: Stakeholder Engagement and Information Disclosure	ESS-10 is applicable to the IPF Component	Article 15 of the EIA Proclamation requires public participation/consultation during EIA study process and public disclosure of EIA reports. Current practice also shows public consultations are carried during EIA studies and minutes of consultation produced. Incorporation of the views and concerns of stakeholders into the EIA report usually carried.	The stakeholder and public consultations requirement is focused on initial EIA study phase and do not continue through the project lifecycle as required by ESS-10. Thus, preparation of Stakeholder Engagement Plan not required by the EIA proclamation. Establishing	The application of ESS 10 requirement for SEP is required to continue engagement of stakeholders during project implementation and beyond when appropriate.

			GRM to address public concerns is also not required by the EIA proclamation.	

4.4.4 Institutional Roles and Responsibilities for Environmental and Social Impact Assessment and Management

4.4.3.1 The Federal Environment Protection Authority (FEPA)

As per Proclamation No. 1263/2021, the former Environment, Forest and Climate Change Commission (EFCCC) has been reinstated with its first status as "Environment Protection Authority (EPA)" and is made accountable to the Ministry of Planning and Development. Though Proclamation no.1263/2021 has stated that the powers and duties of the new EPA shall be determined by a regulation to be issued by the Council of Ministers in the future, a transitional provision under article (107) stated that "*the provision of Article 104 which repeals the establishment laws shall be effective on the date the law, that provides for the organizational structure as well as the powers and duties of each institution, publicized in the Federal Negarit Gazette*". Accordingly, the powers and duties of the EPA remains the same until the new mandates are published and it includes the following:

- Coordinate activities to ensure that the environmental objectives provided under the Constitution and the basic principles set out in the Environmental Policy of the Country are realized;
- Establish a system for evaluating and decision making, in accordance with the Environmental Impact Assessment Proclamation, the impacts of implementation of investment programs and projects on environment prior to approvals of their implementation by the concerned sectoral licensing organ or the concerned regional organ;
- Coordinate actions on soliciting the resources required for building a climate resilient green economy in all sectors and at all Regional levels; as well as provide capacity building support and advisory services;

- Establish an environmental information system that promotes efficiency in environmental data collection, management and use;
- Enforcing and ensuring compliance to the ESIA proclamation which currently is being implemented through delegated authority provided to sector ministries;
- Reviewing ESIAs and monitoring the implementation of ESIA 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; and
- Coordinating, advising, assessing, monitoring and reporting on environment-related aspects and activities

Sector environment units: The other environmental organs stipulated in the Environmental Protection Organs Establishment Proclamation (295/2002) are 'Sector Environmental Units' which have been established in some of the line Ministries. These Sector Environment Units have the responsibility of coordinating and implementing activities in line with environmental protection laws and requirements (Article 14, Proclamation 295/2002). Article 13 of the ESIA Proclamation 299/2002 requires that public instruments undertake ESIA. To this end, Sector Environmental Units play an important role in ensuring that ESIA is carried out on projects initiated by their respective sector institutions. However, capacity of these units is limited.

4.3.3.2 Regional Environment Agencies

At regional level, there are environmental bureaus to implement environment management systems within their respective jurisdictions. 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 protection, regulation and monitoring. Relating to ESIA specifically, Proclamation 299/2002 gives regional environmental agencies the responsibility to evaluate ESIA 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 of the regions, they are established as separate institutions in the form of Environment, Forest, and Climate Change Authorities, while in others they are joined with Land use administration and utilization agencies as EPLAUA. Table14 shows the institutional standing of the Environment Authorities in the IPF project regions.

Table 14: Summary of Existing Institutions and Critical Legislations for Environmental and Social Management at the five project target regions

Region	Responsible Regional Environment Bureau/ Agency	ESIA Regulations enacted at regional level	Other Key Environmental Management Legislations/guidelines			Remarks
			Pollution Control	Solid Waste Manage-ment	Regional guideline for ESIA	
Oromia	Oromia EPA	Yes	Yes	No	Yes	-It has zonal and woreda level Environment Offices
Tigray	Tigray EPLAUA	Yes	Yes	Yes	Draft	-Apply Federal ESIA procedural guideline - Has woreda level Environment Offices
Amhara	Amhara EFWPPDA	Yes	Yes	No	Yes	-ESIA guideline Directive 01/2010 - It has zonal and woreda level Environment Offices
Benshangul Gumuz	Benshangul Gumuz EPLAIB	No (Draft level)	No	No	No	-Apply Federal ESIA law & guideline -It has zonal and woreda level Environment Offices
Afar	Afar EPRLUA	Yes	Yes	No	No	Apply Federal ESIA procedural guideline

Source: Zereu G., Compiled from field assessment data and consultations, updated for EDFP ESMF, 2020.

4.3.3. 3 Zonal and Woreda level Environment, Forest, Land Utilization, and Climate Change Offices

It is identified that institutional structures exist for environmental management in the five regions (namely Amhara, Oromia, Tigray, Benshangul and Afar regions) at zonal and woreda levels. It should be noted that all the regional, zonal and woreda level environment offices are located in the capital cities of the respective zone and woreda cities/towns. However, there are some cities and towns which have their own city level environmental protection offices. For example, in Oromia regional state, eighteen selected Cities with potential growing economic activities are made to have their own Environment Protection Forest and Climate Change (EPFCC) Offices with a Zonal office status.

The roles and responsibilities of the woreda level environmental organs in Oromia and Afar regions are almost identical. Their main areas of responsibility fall in carrying environmental performance monitoring and follow up of development projects for which ESMPs and screening reports are approved and the review and approval of Schedule III (category C) environmental and social screening reports.

4.3.3.4 Ministry of Labor and Skills/Regional Labor and Social Affairs Bureaus

The Ministry of Labor and Skills (MoLS) is responsible to ensure industrial peace, maintain employee's health and safety at workplace, improve working condition and environment, promote efficient and equitable employment services. Implementing Occupational Safety & Health, and prevention of child labor are also among the mandates, roles and responsibilities of their Ministry. Overall, the Ministry shall have the following powers and duties:

- With a view to ensuring the maintenance of industrial peace (a) encourage and support workers and employers to exercise their rights to organize and collective bargaining; (b) encourage the practice of participating in bilateral forums between workers and employers and tri-partite forums including the government; and (c) establish efficient labor dispute settlement mechanisms;
- Issue and follow up the implementation of occupational health and safety standards;

- Create conducive conditions for the provision of efficient and equitable employment services; determine conditions for the issuance of work permit to foreigners, issue such permits and incorporation with the relevance bodies, supervise compliance there with; regulate the provision of foreign employment service to Ethiopians;
- Establish a system for technical and vocational training that are in line with the country's general development policy, labor, employment and skill development; follow up the implementation of the same;
- Create, in collaboration with the concerned economic and social sectors, conducive conditions for facilitating linkages which promote labor market and employment activity;
- Establish, manage and follow up implementation of training centers that enable to accelerate human resource development and utilization and effectiveness of technology;
- Register workers' and employers' unions established at national level;
- Register workers' unions and collective agreement relating to federal public enterprise situated in cities accountable to the federal government, and carry out labor inspection services in such enterprise; provide conciliation services to amicably settle labor disputes arising between employers and employees.

Regional governments have established bureau/agency responsible to implement the national vision and set mission of the Ministry. Woreda and town administrations have offices whose responsibility is investigation and supervision of establishment (manufacturing plants) to ensure that all stakeholders are adhering to Proclamation No. 1156/2019.

In addition to the Ministry of Labour and Skills, the Ministry of Urban and Infrastructure is responsible to ensure public and workers safety at construction sites. Regional governments have adopted different approaches to establish a body responsible for the construction sector, as a department within the bureau of urban development, housing and construction (Amhara region) or an independent bureau of construction (Oromia region).

4.3.3.5 Ministry of Women and Social Affairs (MoWSA) /Regional Women, Children and Youth Bureaus

MoWSA has the responsibility to ensure that women and children are benefiting from development activities and are protected from harm. Its main area of responsibilities focus on

awareness creation and compilation and dissemination of data and information on woman and children; ensuring opportunities are created for woman to participate in political, economic and social affairs; ensure woman and children are not discriminated against and devise strategies for the proper application of affirmative actions; encourage and support women to organize and ensure their agenda (including children) are mainstreamed into national and regional policies, legislations and programs.

The Ministry is responsible for follow-up of the implementation of national and international laws; conducting research and formulating policies and guidelines; collaborating with organizations working on women, child and youth affairs; and providing capacity building support to ensure the equal participation and benefit of women, children and youth in the protection of their rights and security.

In order to address the wide-ranging problems of women, children and youth, the Ministry has carried out several activities that included gender mainstreaming, reducing Harmful Traditional Practices (Female Genital Mutilation and Early Marriage), children Care and Support, establishing children parliament, reducing youth unemployment rate and increasing Youth Representation in the legislative and judiciary. Even though the tasks of the Ministry require working in coordination with other basic sectors and oversight bodies, the coordination is yet to be developed.

Proclamation no. 1263/2021 has expanded the roles and responsibilities of MoWSA by incorporating mandates in the areas of social protection, rights of persons with disability, and trafficking of persons which were previously handled by the former MoLSA. Article 36(2) of the proclamation states that "The powers and duties entrusted to the Ministry of Labor and Social Affairs other than those concerning labor affairs and the powers and duties entrusted to the Ministry of Women, Children and Youth under other laws that are currently in force are hereby vested in the Ministry of Women and Social Affairs ". Accordingly, MoWSA is responsible to establish a system to strength social protection system by expanding social security system, and follow up the implementation of the same. It will also be responsible for implementing

Proclamation no. 676/2010 and 1178/2019 which deal with the rights of persons with disability and suppression of trafficking of persons.

Regional governments have also established Woman, Children and Youth Affairs Bureau responsible to implement national visions and objectives at region level. All urban administrations have offices responsible to promote women, children and youth agenda. All staff members of the bureau are engaged in the issue of women, children, and youth. Therefore, the task of all technical staff members is focused on providing supports such as awareness creation, training, community mobilization, empowerment, legal support, preparing guidelines, strategies and directives.

Woman, Child and Social Affairs offices also provide legal support to children and women victim of physical and sexual abuse by offering free legal counsel. The offices work in close collaboration with Labor and Social Affairs, Justice Department, the Police and the court to ensure perpetrators get appropriate punishment. Efforts to rehabilitate victims are, however, hindered due to capacity limitations.

5. Procedures to Address Environmental and Social Issues

This ESMF is designed to support the application of World Bank Environmental and Social Standards in combination with the Ethiopian legislation on environmental impact assessment to the IPF Component of the Ethiopia PforR SPHCS Project. ESS1 on Assessment and Management of Environmental and Social Risks and Impacts is among the standards triggered by the IPF Component Project and thus the relevant principles of ESS 1 in relation to subproject categorization are briefly outlined as follows.

The IPF Component Project being a project which consists of a series of sub-project activities for which list of tentative locations of damaged HCFs is present and yet more sites would be identified through the proposed semi-annual assessment to update the level of damage and loss in health facilities as well as where more sites would also be identified for the temporary/satellite clinics establishment, the risks and impacts cannot be fully determined until the subproject locations have been fully identified and assessed. The IPF component also intends to provide essential health services, procure and distribute medicine and equipment as well as provide mobile registration tools such as laptops and tablets for civil registration officers in conflict affected and IDP settings during which health care and other types of wastes that need proper management would be generated. For such subprojects involving multiple small subprojects, that are fully identified, prepared and implemented during the course of the project, MoH and its partner institutions will carry out appropriate environmental and social assessment of the subprojects, and prepare and implement such subprojects, as follows:

i. (a) Substantial Risk, Moderate Risk and Low Risk subprojects, in accordance with National law and any requirements of the ESSs that the Bank deems relevant to such subprojects as determined during its review for “no objection” clearance of the sub-project. Where subprojects are likely to have minimal or no adverse environmental or social risks and impacts (i.e., low risk), such subprojects do not require further environmental and social assessment following the initial scoping. However, the environmental guideline for construction contractors will be applicable.

The IPF Component Project is generally categorized as "Substantial Risk" project (i.e., Environmental and Social) and hence MoH and its partner institutions will be required to undertake the appropriate environmental and social assessment of subprojects in accordance with the ***national law and any requirements of the ESSs*** that deemed relevant to the sub-projects. Accordingly, the most important National guideline that defines the categorization of subprojects into various schedules is the EIA Procedural Guideline issued by the Federal Environment Protection Authority in November 2003. The ESIA Procedural Guideline Categorizes all development projects into three Schedules of activities or projects. The full list of Schedule I, II and III subprojects of the EIA procedural guideline (2003) is provided in Annex -III. It should also be noted that the relevant ESSs that are likely to be triggered by the IPF Component Project are broadly assessed and outlined in Table 12 of this ESMF and will need to be customized and applied for each sub-project.

It is anticipated that the activities related to procurement and distribution of medical supplies and equipment of the IPF Component project will likely fall into Schedule I which require full ESIAs as the Trade, Importation and Exportation of Pharmaceuticals is generally categorized under Schedule I Activities (refer section 26, bullet no.7 of the EIA Procedural guideline) in the EIA procedural guideline (2003). On the other hand, whereas subprojects related to development of new hospitals and dispensaries are categorized as schedule II activities, projects to develop ***small scale*** medical centres and provision of medical supplies and equipment are categorized under Schedule III activities which do not require any EIA. Therefore, depending on the type and scale of damage and restoration works needed to rehabilitate the health care facilities, the specific HCF restoration subprojects could fall either under Schedule II or III. This will have to be determined through the subproject E & S screening, review and approval process in close consultation with the relevant regional EPAs. In the event the relevant regional EPAs lack to provide clarity on the appropriate national categorization for a screened subproject, it will be advisable to proceed in accordance with the ESF categorization which recommends an ESMP (Preliminary ESIA) for substantial and moderate risk subprojects.

5.1 Risk Categorization of Technical Assistance (TA) Subprojects

As with any project to which the ESF applies, IPF-Component project TA activities need to be evaluated for purposes of project risk classification. The relevant risks that need to be assessed are *not* simply the impacts resulting from the TA activities themselves (which would in most cases be minimal) but *also* the potential downstream environmental and social implications that may arise when and if the TA leads to future investments. Hence, for example, if a TA project supports aspects of the design of a future major infrastructure investment, the risk classification of the TA should reflect the expected risks associated with the infrastructure the TA is helping to design.

The IPF Component project also consist of Technical Assistance (TAs) related activities under its subcomponent 1, 2 & 3. These are shown in Table 1 under section 2.3.1 where effort is made to identify and show the Technical Assistance related subproject/activities present under subcomponent 1, 2 and 3 of the IPF Component project. It is evident from Table 1 that none of the TA will have activities that seek to prepare feasibility studies, detailed technical designs or bid documents that facilitate for future investments in infrastructure. Instead, most of the TA activities are related to capacity building, training, provision of technical support to digitize CRVS systems, and mainstreaming of legal frameworks and preparation of SOPs. As a result, based on the OESRC Advisory note, most of the IPF Component subproject TA activities will fall under Type 3 TAs with only one TA activity on mainstreaming a legal framework falling under Type 2 TA. The IPF Component project will not have Type 1 TA activities.

Following the identification of the TA typology and subsequent risk classification exercise, the following actions are advised to be taken to ensure that the TA subproject are carried with due consideration to the ESF requirements'. The recommended actions includes;

- For capacity building in Type 3 TA, the Bank team should review the activities towards which the capacity building is being directed, to determine the extent to which these relate – if at all – to matters covered by the ESF. If there is such a relationship, the TORs for the capacity building should be designed accordingly.

- Where Type 2 TA provides advice on the development of policies or strategies with potentially significant downstream E&S impacts, it will again be important to agree on TORs that will ensure that the planning process includes adequate assessment of environmental and social implications and that the advice provided through the TA for addressing those implications is consistent with the ESF. In addition,
- For TA projects (as for any other project to which the ESF applies), stakeholder engagement in accordance with ESS 10 is key.

5.2 Sub-project Screening and Approval Process

Step 1: Sub-project Identification

Sub project refers to the set of activities derived from the IPF Component project and sub-component activities including technical assistance studies and consultancies for which support through investment project financing is sought by the client. Identification of subprojects is carried through consultative process by the lead implementing agency (MoH), the partner institutions such as, Immigration and Citizenship Service (ICS), Ethiopian Pharmaceuticals Supply Agency (EPSA), and Regional States Health and CRVS sector offices as well as by third party implementers such as UNICEF. The identified subprojects will be reviewed and compiled into an annual action plan by the relevant technical working group and will be forwarded to GMU/MoH (Office of the state minister) and the ICS for endorsement and approval. Subprojects included in the approved annual action plan of the IPF Component Project will be eligible for E&S screening.

Step 2: Checking Eligibility of subprojects

The ESCP stipulates exclusion of potential project activities as ineligible for the IPF Component financing based on the following criteria:

- Activities that may cause long term, permanent and/or irreversible impacts (e.g., loss of major natural habitat and biodiversity)
- Construction in environmentally sensitive areas such as National Parks, fragile ecosystems, and wildlife reserve

- Activities that have high probability of causing serious adverse effects to human health and/or the environment
- Activities that may have significant adverse social impacts and may give rise to significant social conflict
- Activities that cause or lead to child abuse, child labor exploitation, forced labor or human trafficking.
- Activities that have significant risks and/or adverse impacts on sensitive cultural receptors, tangible or intangible, or that could damage non-replicable cultural property.
- Activities that impact land owned or claimed by Historically Underserved Communities (HUCs) without complete and documented Free, Prior, and Informed Consent (FPIC) of such communities.

The sub-project will be subjected to screening process by the MoH GMU E&S staff in collaboration with its counterpart E&S staff in the RHBs & EPSA, and the focal persons deployed by partner institution (i.e., ICS) as well as by the E&S staffs of third party implementing institution (i.e., UNICEF) against environmental and social checklist indicated in the first section of Annex I. check their eligibility for the project financing. In checking the eligibility of the sub projects the questions in Annex I would be answered as "Yes" or "No". If the answer to any one of the questions in the annex is 'Yes', then the subproject will be redesigned to be acceptable or stopped if redesigning is not possible. If on the contrary the answer is 'No' for all the questions, then one must proceed to the next step.

Step 3: Screening

The screening aims at categorizing the sub-projects into one of the environmental and social categories consistent with National EIA Guidelines and WB ESF. It is a key environmental and social management process aiming at determining appropriate studies and follow up that might be required for sub-project activities. Screening will be carried out on each subproject activities once they have been identified during planning phase of the IPF Component Project.

This ESMF requires that all relevant IPF Component subprojects having specified site location, as well as relevant technical assistance subprojects, be screened for social and environmental impacts. Screening will be required where investments will be made on restoration of damaged HCFs, or on development of temporary satellite clinics, on provision of Essential Health Care Services and medical supplies/equipment distribution, storage and handling etc. which are included in the endorsed action plan of the IPF Component Project.

In order to fulfill the requirements of ESS-1 and National EIA guidelines, the environmental and social screening will follow two stages. Initially, a screening of subprojects will be carried to categorize it into one of high, substantial, moderate or low risk. During this first stage, the subproject will be screened using the screening form attached in Annex-I. Under the IPF Component, it is anticipated that the majority of subproject activities will fall under substantial risk (in line with the overall categorization of the IPF Component as "Substantial" risk rating) and no "High Risk" sub-projects are expected. Once the subprojects are screened and confirmed to fall on or below substantial risk category, then further categorization will be carried by applying the national screening system to identify the schedule of activities into which the subproject will fall (Schedule I, II &III). Based on the nature and scale of the IPF Component subprojects it is expected that except for the procurement and distribution of medical supplies, most will fall under schedule II or III which may require Preliminary ESIA (i.e. ESMP)or no ESIAs.

The GMU environment and social staff in collaboration with the E&S staff of partner institutions (i.e., RHBs, ICS and EPSA) as well as third party implementing institution (i.e., UNICEF) will initiate the screening process by completing the form contained in Error! Reference source not found.. The aim of the screening form is to assist in identifying potential environmental and social impacts based on field investigations in the area of the subproject site. While completing the screening/scoping form the assessor should undertake the assignment after:

- ✓ Gaining adequate knowledge of baseline information of the area.
- ✓ Gaining knowledge of proposed sub project activities for the area.
- ✓ Having been briefed / trained in environmental and social screening.

The outcome of environmental scoping/screening will be classifying the proposed IPF Component subproject into one of Substantial, Moderate, or low Categories and Schedule I, II or III activities, and the subproject will be managed in compliance with both categories.

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The completed screening report will be submitted first to the MoH and/or Regional state GMU coordinator for internal checking and approval. It will then be submitted as appropriate to the Federal, or nearest Regional, Zonal, Woreda or City level EPA with an official application letter for review and approval. The relevant EPA office to which it is submitted will review the Screening Report and will:

(b) Accept the document - with conditions relating to implementation;

(c) Accept the documents with required and/or recommended amendments; or

(d) Reject the document with comments as to what is required to submit an acceptable Screening Report.

Following the approval of the subproject environmental screening report by the relevant EPA office, the subproject will be fed into one of the following processes based on its approved Categorization.

ii. Schedule 1 projects are fed into the standard ESIA process

iii. Schedule II subprojects will require a partial or preliminary ESIA (ESMP) and will necessitate the inclusion of environmental and social mitigation and enhancement measures in the design and implementation of subprojects.

iv. Schedule III projects are not subject to environmental assessment as no potential impacts are anticipated. Thus, no further action is required. However, all subprojects financing civil works and management of health care waste require at least a simple ESMP incorporating good E&S construction and waste management practices. The environmental guideline for construction contractors will be applicable.

The next step in the ESMF process is to proceed to the next actions to fulfill the requirements based on the screening categorization, which is outlined in step 4 below.

Step 4: E&S Instrument Preparation for Screened Subprojects

If the outcome of the E&S screening finally results in categorizing the subproject as schedule-I activities, the following actions need to be pursued. Schedule I projects will be subject to a full Environmental and Social Impact Assessment that could be carried out with the help of registered and licensed team of environment and social consultants. In a similar way, if the outcome of the E&S screening finally results in categorizing the subproject as schedule-II activities, it will be required to undertake a Preliminary ESIA which also needs to be .carried out with the help of registered and licensed team of environment and social consultants The depth of information requirement (i.e. content) to be consisted in the preliminary ESIA is defined in consultation with the relevant Federal or Regional, EPA. Generally, the scope of ESIA for schedule II project may vary, but it is narrower than that of Schedule-I ESIA. Like Schedule I ESIA, it examines the project's potential negative and positive environmental impacts and recommends any measures needed to prevent, minimize, mitigate, or compensate for adverse impacts and improve environmental performance which will be summarized in the ESMP. MoH, EPSA, ICS, UNICEF (i.e. third party implementer) and the Regional health bureaus would ensure that all the necessary mitigation measures are incorporated in the ESMP including the Infection Control and Waste Management Plan (ICWMP).

Following that, the ESIA, either full or preliminary, will be send to the World Bank Country office for review and clearance /no-objection. Finally the preliminary or full ESIA will be submitted by the EPSA. RHB. ICS or GMU of MoH to the relevant Regional or Federal EPA with an official letter of application for review and approval.

Note: If, on the other hand, the outcome of the E&S screening finally results in categorizing the subproject as schedule-III activities, no further actions to carry Environmental Assessment will be needed. However, all subprojects financing civil works and management of health care waste require at least a simple ESMP incorporating good E&S construction and waste management practices. Based on the nature of the schedule-III subproject, a distinct ESMP (which will be based on the generic E&S management and monitoring plan included in this ESMF) including Infection Control and Waste Management Plan (ICWMP) will be prepared to address and

mitigate the expectedly few and minor environmental and social impacts of the subproject and attach it with the E&S screening report for further implementation.

Step 5A: Review and Decision

The Federal and relevant Regional, Zonal, Woreda or City level EPA will review the Full or Preliminary ESIAs submitted to it by the MOH/GMU, EPSA, ICS or UNICEF. The purpose of review is to examine and determine whether the Full or Preliminary ESIA is an adequate assessment of the environmental effects of the IPF Component under consideration and of sufficient relevance and quality for decision-making. The outcome of the review of the Full or Preliminary ESIA by the Regional, Zonal, Woreda or City level EPA will result in either one of the following:

(a) Accept the document - with conditions relating to implementation;

(b) Accept the documents with required and/or recommended amendments; or

(c) Reject the document with comments as to what is required to submit an acceptable ESIA and ESMP.

Step 5B: Disclosure

While in the review and approval process, as required by the World Bank guidelines and the National ESIA proclamation, the Full or Preliminary ESIA documents must be disclosed for public review at a place accessible to local people (e.g., at a local government office, i.e., kebele council, City/town and regional bureaus, at the Regional/Federal EPA, MoH website, etc.), and made available in a form, manner, and language they can understand. Disclosure of the Full or Preliminary ESIA in the World Bank's info shop is also a requirement for the IPF Component subprojects. The approved Full or Preliminary ESIA will be send finally to the World Bank Country office for further disclosures in the info shop.

Step 6: Implementation & Supervision

When approval has been given to the Full or Preliminary ESIA, implementation of mitigation measures and systemic follow-up is needed for the sub-project. The MoH/ GMU E&S risk management staff and EPSA, ICS and UNICEF environmental and social staff will be required to enforce implementation of mitigation measures as proposed in the ESMP by all responsible institutions and stakeholders. Environmental and social clauses will need to be added in contractual agreements to be signed with contractors for them to implement the ESMP during construction phases. They should be required to prepare C-Site Rehabilitation Plan, C-ESMP for site rehabilitation/restoration works, C-OHS management plan, and C- GVB prevention and response plan, C-Greivance Management Procedure, Traffic Management Plan along with Code of conduct, and C-Waste management plans. In addition, there will be a need to ensure that the specifications, ToRs and final procurement agreements to be made with contractors for medical supplies should consist of articles that express the need to comply with the E&S requirements of the ESCP.

Internal monitoring to ensure the compliance of IPF component subproject implementation activities against the mitigation measures set out in its ESMP, will be carried out by the environment and social risk management staff of the MoH/GMU, EPSA, ICS and UNICEF who are responsible for environmental and social management as well as the supervisory engineer at the HCFs restoration/rehabilitation construction site. The MoH/GMU, EPSA, ICS, RHB and UNICEF environment and social risk management staff will have the primary responsibility for carrying out this monitoring by regularly visiting the subprojects, and pursuing the corrective measures as required. Periodic reports of internal monitoring should be prepared quarterly by the environment and social risk management staff and submitted to the MoH/GMU and then to office of the state minister (MoH) as part of the regular IPF Component Project M&E process.

The implementation of the recommended mitigating measures will also be monitored by the Regional, Zonal, Woreda or City level EPA offices. The MoH/GMU risk management staff and those in the partner institutions will have to collaborate in the planning for external compliance monitoring and inspections that will be conducted by the relevant Regional, Zonal, Woreda or

City level EPA offices. The planning for external compliance monitoring/inspection could be initiated by the Regional, Zonal, Woreda or City level EPA itself or (if that is not coming forward from EPA side) by the GMU and partner institution environment focal persons in line with the M&E system.

Step 7: Environmental and Social Risk Management Monitoring Reports

Quarterly, biannual and annual environmental and social risk management monitoring reports must be prepared by the GMU in collaboration with the environment staff in the partner and third party implementing institutions. The environmental and social risk management monitoring reports should be submitted to office of the state Minister (MoH), to the Regional EPA and the World Bank for review. The purpose of these reports is to provide:

- measure the success rate of the project;
- verify the accuracy of the environmental and social impact predictions;
- determine the effectiveness of measures to mitigate adverse effects of projects on the environment;
- determine whether interventions have resulted in dealing with negative impacts; determine whether further interventions are needed, or monitoring is to be extended in some areas;

5.3 Subprojects Involving Cultural Heritage Management

The civil works proposed in the IPF Sub-component I may involve excavations, demolitions, or other physical changes with potential risks to the cultural heritages in the project target areas. Analysis of national legislation, Proclamation No. 839/2014 on Classification of Cultural Heritages into National and Regional Cultural Heritages, review of available studies in the project area, and key informant interview with regional and local stakeholders were used to identify the known tangible and intangible cultural heritages in the project target areas that may be affected due to the undertaking of the civil works of the IPF project. However, the assessment finding reveal no known cultural heritages or none of those cultural heritages recognized in Article 2 of the Ethiopian Proclamation No. 839/2014 can be at risk.

Besides, even if the cultural heritage is not legally recognized, impacts on cultural heritage that are recognized by local communities was assessed. This consideration is important because the cultural heritage may be designated, protected, or managed by religious, tribal, ethnic, or other community authorities, and therefore recognized in accordance with tradition and customs. In some communities, the character, location, and use of heritage sites and objects may be kept secret or known only to authorized persons. Yet again, the key informants identified no cultural heritage and no concerns were expressed either. Thus, no risks to known cultural heritages are expected from the undertaking the civil works under the IPF Sub-component I.

However, previously unknown cultural heritage may be discovered while excavation for the project civil works or tangible cultural heritage may be located under the surface. A chance finds may include the discovery of a single artifact, an artifact indicating the presence of a buried archaeological site, human remains, fossilized plant or animal remains or animal tracks, or a natural object or soil feature that appears to indicate the presence of archaeological material.

Therefore, a chance finds procedure which will be followed if previously unknown cultural heritage is encountered during the undertaking of the civil works associated with the IPF Sub-component I is prepared. According to the ESCP, chance find procedure should be included in the ESMF. MoH shall ensure the contractor and subcontractor implement the chance finds procedure described in the ESMF and included in all site-specific C-ESMPs involving subprojects with earthmoving activities. Among other things, a chance finds procedure for the project covers the identification, notification, documentation, and management of chance finds in accordance with national laws, ESS8, and where applicable, internationally accepted practice and local customs. Accordingly, a complete chance find procedure incorporating the above procedure of the proclamation enriched with other necessary good practice procedures is presented in ***Annex IV***.

5.4 Projects involving land acquisition or restriction on access to land use

It is known that the IPF Component Project consists of a series of civil works for restoration/rehabilitation of HCFs damaged by the conflict in the project target regions. Though

the location of parts of the damaged HCFs in four of the five conflict affected regions are identified and a tentative list of damaged HCFs is presented, more sites would be identified through the proposed semi-annual assessment to update the level of damage and loss in health facilities. In addition, it is anticipated that additional sites will be identified for the temporary/satellite clinics establishment.

Given the nature and characteristics of the civil works that would take place for HCFs restoration/rehabilitation and establishment of temporary satellite clinics subprojects, in which case many HCFs are fully or heavily damaged, the scale of construction activities is generally predicted to apply ESS 5 on land acquisition, restriction of access to land use as well as involuntary resettlement. In the event that such land acquisition impacts occur, a separate and standalone Resettlement Policy Framework (RPF) document that outlines the procedures to be followed for RAP preparation is prepared for the IPF component and it will be applied in concurrence with the present ESMF.

6. Environmental and Social Impacts and Mitigation Measures

6.1. Environmental and social risks and benefits

This chapter describes the potential environmental and social benefits and risks of the IPF Component subproject activities of the SPHCS PforR project. The main activities that would cause for the occurrence of adverse risks during project implementation are anticipated to be sub-component 1 subprojects and to some extent subcomponent-2. As stated in section 5.1, the activities of Subcomponent 3 are almost entirely type-3 technical assistance subprojects and are anticipated to have minimum direct adverse impacts on the physical and social environment. The potential adverse social and environmental risks of subcomponents 1 and 2 activities that are likely to arise during the various phases of the IPF component project implementation can be classified into the following:

a. Adverse environmental and social impacts that will arise from the procurement, distribution, storage and use of medical supplies and equipment (Subcomponent 1)

b. Adverse environmental and social risks that will arise from the civil works to be conducted during restoration of damaged HCFs and establishment of temporary satellite clinics
c. Adverse environmental and social risks that will arise from the provision of essential health services in conflict affected areas and IDP settings including by the mobile health teams to be deployed.
d. Adverse environmental and social risks that will arise from restoration of ambulance services and provision of vehicles and motorcycles to strengthen CRVS services in conflict affected areas.
e. Adverse environmental and social risks that will arise from the increased distribution and use of IT equipment such as PCs, laptops, tablets, servers, printers, etc., to ensure continuous provision of civil registration services in conflict affected areas.

The environmental and social risk assessment carried as part of the present IPF Component ESMF has concluded that the overall risk rating for both environmental and social is "Substantial". This is in consideration of the aforementioned group of activities which are risk drivers and the overall adverse impacts they can cause in the project areas under consideration. The main generic environmental and social risks that are anticipated to occur with the IPF Component project activities are described as follows.

6.2 PROJECT BENEFICIAL IMPACTS

As the analyses of the findings of the social assessment reveal, access to PHC service in the project target regions has been low in comparison with the national level even in pre-conflict period. The impacts of the conflict further complicated the matter: The already poor PHC services are getting worsened. In line with each IPF sub-components, the implementation of the IPF program would have several positive outcomes that cumulatively improve the provision of PHC services in conflict-affected areas of the country.

6.3 PROJECT ADVERSE ENVIRONMENTAL IMPACTS AND MITIGATION MEASURES

6.3.1 Environmental risks during planning phase

6.3.1.1 E&S risks during procurement of medical supplies and equipment

The main environmental and social risk anticipated to occur in relation to the procurement and distribution of medical supplies and equipment is associated with substandard products. Procurement, distribution and use of substandard medicines, medical consumables and equipment will primarily affect community health due to ineffectiveness of the essential health services to be provided to the target communities. Moreover, in the medium term, the disposal of the substandard and perhaps ineffective medicines, medical consumables and equipment will affect the environment if not appropriately carried. Uncontrolled disposal of substandard medical consumables can spread out infection and contamination to people trying to reuse it and may also create pollution to nearby water bodies. The disposal of substandard and ineffective radiation emitting medical equipment can further pose hazard to the environment and health of people. Such environmental and social risks can be fully avoided by careful planning and management of the procurement process to deliver high quality and proven medical supply and equipment. The following are among the measures required:

- Prepare, review and endorse a procurement plan for acquisition of all medical supplies and equipment from certified suppliers only and adhere to it.
- The GMU/EPSA/PMU will be responsible for ensuring that the required technical specifications are met as per WHO guidelines and Good International Industry Practice (GIIP).
- Preparation of technical specifications on the PPE for healthcare workers and service staff (e.g., cleaners) according to WHO interim guidance on rational use of PPE for COVID-19.
- Carry out due diligence for all potential suppliers to guarantee quality equipment and medical products.
- Carry out due diligence for all potential suppliers to guarantee quality supply of personal protective equipment and products.

- Procurement of medical products should adhere to national regulation and/or to GIIP and to any vaccine manufacturers requirements. The WHO Technical specifications document for procurement of PPE equipment is available at: https://www.who.int/publications/i/item/WHO-2019-nCoV-PPE_specifications-2020
- Distribution of goods or services on basis of need, while ensuring that the distribution systems is not compromised due to elite capture.

6.3.1.2 Risk of environment unfriendly purchasing

Waste can be minimized in a HCF through proper procurement planning. Environmentally friendly/preferable purchasing refers to the purchase of the least damaging products and services, in terms of environmental impact. Choosing products during purchasing by their safety and environmental friendliness can help health-care centers to reduce their overall impact on the environment, provide healthier conditions for patients and staff by switching to less hazardous materials (e.g., solvents, cleaning fluids), and lower the costs related subsequently to waste disposal. A widely cited example is the purchase of mercury versus a mercury-free thermometer. When mercury thermometers break, there are costs associated with cleaning up a hazardous material and then preventing mercury from entering the environment at the final disposal stage. Required factors for consideration in environmental friendly or green procurement includes:

- Less toxic
- Minimally polluting
- Energy efficient
- Safer and healthier for patients, workers, and the environment
- Higher recyclability and recycled content
- Prevention and minimization of the production of waste by integrating systems and practices to avoid the creation of waste into equipment and consumables purchasing.
- Good management practices rigorously applied to purchase and control of chemicals and pharmaceuticals; and
- Source reduction measures such as purchasing restrictions to ensure the selection of methods or supplies that are less wasteful or generate less health care waste;

6.3.2 Environmental risks during construction phase

The construction phase of the IPF Component project will mainly focus on the restoration and rehabilitation of the HCFs damaged in the conflict affected areas. The construction phase can take place simultaneously with the other phases of the IPF project (i.e., planning and operation phases). There are damaged health care facilities in all the five conflict affected regions reported and construction activities will take place in all the five regions. The degree of construction and rehabilitation required in each HCF is expected to vary based on the level of damage as the infrastructures are either fully or partially destroyed. The main environmental, social, and occupational safety risks anticipated to occur during implementation of construction activities along with required mitigation measures are presented as follows.

6.3.2.1 Impacts on Soil

Construction activities to restore fully damaged HCFs conduct site clearing and excavation activities to prepare the grounds for foundations. The excavation work will result in the displacement of the fertile topsoil affecting the structure and fertility of the soil. Impact on soil also happens due to soil compaction which affects the soil structure and its permeability. Soil compaction occurs due to movement of construction machines and vehicles around the construction site and may affect agricultural and grazing lands in the rural and peri-urban areas. On the other hand, soil contamination impacts could occur due to oil spills and other hazardous substances released from construction equipment and related machine servicing/washing activities during construction operations. Loss of topsoil and impairment of natural soils caused by earthworks, operation of heavy machinery, quarries and borrow pits will be among the main soil erosion issue of concern. Required measures to minimize impacts on soil include the following.

- Demarcate the area to be stripped clearly, so that the contractor does not strip beyond the demarcated boundary.
- Top soil stripped should be stockpiled for rehabilitation of quarry and borrow sites.
- The topsoil should be uniformly spread onto other areas to be rehabilitated

- Access and haul roads should have gradients or surface treatment to limit erosion, and road drainage systems should be provided.
- Pre-defined, essential road routes should be clearly demarcated and adhered-to in order to restrict soil compaction to certain areas.
- Vehicles should not drive on soil when it is wet to avoid further soil compaction.

6.3.2.2 Land degradation and erosion risks

The restoration and rehabilitation of fully and partially damaged HCFs will require construction materials input for masonry, concrete works and backfill. Quarrying to extract construction materials will cause land degradation and erosion adverse effects. Excavation activities at construction materials extraction sites often involve topographical and land-cover changes often including clearing of preexisting vegetation. The quarrying operations can expose the soil structure to erosion unless necessary precautions are taken. Erosion might result in adverse cumulative effects far beyond the HCF restoration sites and the project area of influence, affecting slopes, streams, rivers, and dams by siltation. Required measures to minimize impacts on soil include advising the following actions to quarry operators from which primary materials are sourced for restoration of HCFs to:

- Where appropriate, construction material extraction sites should be selected in consultation with relevant local/woreda authorities including Mining office and woreda EPA office.
- Select appropriate low-impact extraction methods (e.g., excavation and quarrying) that result in final site contours supportive of habitat restoration principles and final land use.
- Topsoil and overburden should be removed separately and segregated for later use during site reinstatement.
- Smaller, short-lived extraction sites (e.g., borrow pits) should be reclaimed immediately.
- Affected land should be rehabilitated to acceptable uses consistent with local or regional land use plans. Land that is not restored for a specific community use should be seeded and revegetated with native species.

6.3.2.3 Impact on water resources

Construction activities to restore HCFs taking place in close proximities to surface and ground water bodies can cause adverse effects by releasing solid and liquid wastes to the water bodies. There can be deterioration in water quality of both surface and groundwater due to release of used oil and grease from maintenance works of vehicles and machineries operating in the project sites. Depending on the number of workers involved, domestic solid waste and wastewater generated by construction workers at sites would create risk to the environment including nearby surface water bodies unless properly managed. Adequate portable or permanent sanitation facilities serving all workers should be provided at all construction sites. Other sources of water pollution include sedimentation, changes in biological activity in streams and on their banks, chemicals spillage, and contaminated run off from petroleum product drippage, exhaust emissions and corrosion of metals, among others. Required measures to minimize impacts on water resources include the following:

- Provide segregated waste receptacles within the construction site to encourage reuse and recycling of some useful waste materials.
- Provide sufficient temporary ablution facilities for construction workers and staff so they do not relieve themselves in the fields.
- Provide dedicated bins for hazardous waste, located on hard standing within the construction camp.
- All staff must be responsible to keeping all food and packaging waste on them to be disposed of at the waste bins within the construction site camp.
- Placement of drip trays under vehicles and relevant equipment when stationary;
- Fuel, lubricant and waste oil storage, dispensing and operating facilities must be designed and operated in a way to prevent contamination of water.
- Sewage wastewater from construction sites should be emptied regularly with vacuum trucks and disposed of in approved disposal facilities/sites by the local municipal authorities.
- Consider disposing collected used oils and lubricants through recyclers or reusers as furnace oil\

- Prepare a Contractor Waste Management Plan (C-Waste Management Plan) for the subproject site and ensure compliance with it.

6.3.2.4 Noise and Vibration Impacts

The likely potential impacts that are anticipated to arise during construction phase of the IPF Component is the release of noise and vibration during operation of heavy-duty vehicles and other equipment. Heavy duty machinery and vehicular movement, driver behavior, vehicles' horns, construction and maintenance activities would generate ambient noise levels and vibration that creates nuisance to the communities around. The potential impact of noise depends not only on its level but also on the proximity of residential and sensitive areas to the site. As the partially damaged HCFs may still provide health care services to patients, the noise and vibration impacts could adversely affect the patients and medical workers nearby the construction sites. Communities residing around the project sites will also be affected by vibration and noise impacts. Required measures to minimize impacts on water resources include the following:

- Avoid use of old or damaged machinery with high level of noise emissions that would have a negative impact on the environment and the people, including construction workers and nearby communities.
- Installation of proper sound barriers and / or noise containments, with enclosures and curtains at or near the source equipment (e.g., grinders)
- Installation of natural barriers at facility boundaries, such as vegetation curtains
- locate noise generating sources away from residential or other noise-sensitive receptors (e.g.: patient treatment areas, wards, etc.)
- Avoid using heavy construction machinery during night-time
- Carry out regular maintenance on the construction machineries
- Select transport routes to minimize noise pollution in sensitive areas
- Install noise silencer on the construction machineries

6.3.2.5 Impact on Air Quality

The construction activities to restore and rehabilitate the HCFs will also generate dust and gaseous emissions from combustion of fossil fuels by the construction vehicles and equipment.

The construction operations will apply diesel engine construction machinery, concrete mixing equipment, generators and vehicles transporting and offloading construction materials to the site. Air pollutants including SOx. NOx and CO will be released from the diesel engines of the machineries and equipment operating in and out of the subproject site which will have an incremental adverse impact on the local air quality.

Local air quality is also anticipated to be adversely affected due to dust re-suspension that will be caused during construction vehicle movements and wind gust at construction site. As the construction activities are scheduled to be carried in five different regions/places having varying weather and climate, the degree of occurrence of dust re-suspension and impacts caused by movement of construction vehicles may also vary from place to place. Generally, dust re-suspension impacts are anticipated to be sever in dry and hot weather areas. Vehicles transporting construction materials in and out of the project site are expected to be the main causes of dust re-suspension and gaseous emissions in the project areas.

Dust re-suspension and gaseous emission releases in the project area will affect not only members of the communities found along the access road leading to the project site, but also the patients and medical workers in the HCFs under restoration, The dust re-suspension releases can create unbearable disturbances to medical workers and patients who may be present close to the HCF under re-construction. Required mitigation measures for minimizing impacts of dust re-suspension and gaseous emissions includes the following:

- Vehicles and machinery must be kept in good condition to prevent excessive smoke from exhausts.
- A routine maintenance program for all equipment, vehicles, trucks and power generating engines should be in place.
- Regularly spray water to suppress the resuspension of dust during construction, particularly during use of gravel roads and dirt tracks.
- Wetting exposed soil and site areas with water to control dust emissions.

- Minimize unnecessary idling of running diesel engines of machineries, vehicles and equipment.
- Limit the speed of vehicle movements to minimize dust.

6.3.2.6 Impact of construction wastes

Waste categories that are expected to be generated during the restoration and rehabilitation construction activities of the HCFs include the following:

- Site clearance and excavation waste: will include substantial amount of debris, waste soils, stones, rocks and biomass waste resulting from site clearance and foundation excavation activities.
- General construction waste: include broken chips of hollow block/brick, scrape materials waste consisting of cardboard panels, wood, metals, glasses, material packaging wastes, waste concrete, waste roofing materials, broken construction tools and vehicle parts, equipment cleaning waste, etc.
- Domestic solid and liquid waste: wastes generated and released from daily consumptions of construction workers at site.

The impact of soil waste on the environment and community usually arises when it is improperly disposed at unauthorized places blocking drainage channels and pass ways, destroying community open green spaces etc., affecting the movement and wellbeing of communities. Unless properly managed, the construction wastes would affect the environment by causing contamination of soil and ground water and community health. Unattended accumulation of both the general construction waste and domestic solid and liquid waste streams within or outside the HCFs premises could also become a concern for community health. Required mitigation measures for minimizing impacts of dust re-suspension and gaseous emissions include the following:

- The contractor shall work to facilitate proper waste handling and disposal from the site. All solid wastes must be taken to the approved disposal site or landfill.
- Construction wastes should be recycled or reused as much as possible to ensure that materials that would otherwise be disposed of as waste are diverted for productive uses.

- Dispose the construction waste materials ("spoil") only at designated sites approved by the responsible local authority.
- Consider reusing the soil spoil for land restoration purpose.
- Vehicles hauling dirt or other construction debris from the site shall cover any open load with a tarpaulin or other secure covering to minimize dust emissions and dropping of debris.

6.3.2.7 Impacts on terrestrial flora and fauna

The restoration and rehabilitation of HCFs targeted under the IPF component project were already existing facilities that were in service prior to the conflict situation. The damaged HCFs are found in rural, urban and peri-urban settings in all the five project target regions. As a result, the impact of construction activities to be carried in the damaged HCFs is not generally anticipated to affect terrestrial habitats of wildlife for there will be no land clearing on such sensitive natural habitats. However, certain sites in deep rural areas could be situated close proximity to natural habitats of wildlife. Under such circumstances, noise and vibration releases due to the construction activities such as transportation of materials in and out of site can affect the wildlife. Wildlife may be forced to migrate from their habitat. Therefore, in addition to being a nuisance to the wildlife, excess noise and vibration could affect communications, mating behaviors, hunting and survival instincts. Required mitigation measures for minimizing impacts of noise and vibration on wildlife are similar to the list of recommended actions under 6.3.2.4 section above.In addition the construction contractor should include terms in the Code of Conduct (CoC) to be signed by each worker that prohibit wild life hunting, cutting of trees and any other activity that may result on a negative impact to flora and Fauna.

6.3.2.8 Occupational Health and Safety Hazards during Construction phase

The construction activities to restore the damaged HCFs will have a potential to expose the construction workers, staff of the HCFs working in the compound, patients and visitors to a number of common hazards. Ensuring the well-being of the aforementioned workers and visitors requires consideration of the occupational health and safety aspects of the construction activities

as well as workplace conditions. The generic type of potential hazards to which they can be exposed includes:

- ***Physical hazards*** (over-exertion, slips and falls, work at heights, hot works (welding) and electrocution, being struck by objects, injury by moving machinery, and due to walking and working surfaces, powered hand-tool operation, excavations, ladders, noise and dust).
- ***Electrical and Explosive hazards*** (electrocution and electrical shocks)
- ***Fire and explosion hazards*** (welding gas cylinders, portable gasoline containers for generators and other gasoline powered equipment, fuel transfers for onsite heavy equipment operation);

Construction workers would be actively involved in potentially hazardous activities such as heavy equipment operations, soil excavations, and the handling and assembly of various building materials. In addition, during construction phase it is expected that there will be many unattended cables and wires, wastes such as metal cut offs, material packaging wastes, and construction debris all along the construction site. Improper handling and storage of these waste materials may cause hazards to workers and people accessing the site.

a) Physical Hazards

Physical hazards have a potential to pose occupational risks some of which could be life-threatening, for example, fatal falls from high scaffolds and improper work platforms if workers do not use safety latches when working at heights. Working with high voltage and hot works (welding) pose a risk of electrocution and burn. In addition, falling debris could injure workers if personal protective equipment (PPE) are not provided or properly used. Back injury could occur if workers lift heavy objects using inappropriate body posture. Other potential hazards might be: inadequate lighting during working hours or limited level of visibility during rainstorms creating difficulty for staff driving heavy equipment, driving equipment with improper brake system, and lack of concentration while working and exposure to hazardous wastes such as paints, adhesives and cleaning solvents. The following mitigation measures must be carried out to reduce/avoid adverse impacts related to Occupational Health and Safety that may arise during the construction phase;

- All construction workers must be oriented on safe work practices and guidelines and ensure that they adhere to safe work practices. New workers must be provided with

introduction training/awareness on health and safety features and procedures of the site, as well as general safety breifing on the use of equipments at site. In addition, workers must also receive toolbox & briefings when they move to new activities.

- Conduct training on how to prevent and manage incidences, proper handling of electricity, water, machinery etc. and on various modes of escape, conduct and responsibility during such incidences. All workers must fully be aware and mentally prepared for potential emergency.
- Use signage to warn staff and/or visitors in the construction activities of dangerous places and activities.
- Clear marking of work site hazards and training in recognition of hazard symbols,
- Strict instructions on safety must be given for drivers of heavy equipment.
- Supervision of works must be done regularly (daily) to ensure that safety conditions are met while any deviation from safety regulations is immediately reclaimed following the best practices of safety at work procedures.
- Develop evacuation procedures to handle emergency situations.
- Provide adequate OHS protective gear to construction workers, such as hearing protection for workers doing in places over 80dB for 8 hours; Safety Glasses/Face Shield for those working with any chemical or using any mechanical equipment to protect their eyes and face; Use correct gloves for the job; use body overall to protect against dust, vapors, splashes; use safety shoe such as water/chemical/ electrical hazard resistant boots for foot protection, and hard helmets to prevent injuries from falls and overhead material drop. In addition the construction contractor should include terms in the Code of Conduct (CoC) to be signed by each worker to appropriately wear and use safety gears while at work site.

For work at height risk:

- Provide guardrails with mid-rails and toe boards at the edge of any fall hazard area.
- Proper use of ladders and scaffolds by trained employees.
- Use of fall prevention devices, including safety belts.
- Oil drums, material piles, and wooden planks should not be used to work at height.

- Where appropriate, the contractor should consider implementing safe systems of work and permit to work at heights.

For risk due to work environment temperature:

- Work and rest periods should be adjusted depending on temperature and workloads.
- Providing temporary shelters to protect against the elements during working activities or for use as rest areas.
- Use appropriate protective clothing.
- Provide easy access to adequate hydration such as drinking water

b) Electrical and Explosive Hazards

Electrical and Explosive Hazards could happen from exposed electric lines and portable gasoline containers for generators and construction equipment and other gasoline powered equipment, fuel transfers for onsite heavy equipment operations and gas cylinders applied for welding. Most of the construction equipment uses diesel petrol so that there would be diesel containers risk of explosion. The contractor will employ lightning protection designed to meet the requirements. All equipment that needs electric power and without provisions for electrical safety have risks of electric hazard. Exposed or faulty electrical devices, such as circuit breakers, panels, cables, cords and hand tools, can pose a serious risk to workers and staff moving close to the construction site. The contractor should have technician that oversee and provide maintenance for any malfunctioning electric device.

Mitigation Measures:

Electrical and explosive hazards must be controlled by the adoption of safe equipment and machinery use methods, training programs and occupational health and safety management systems. These include:

- All electrical installations and equipment must be inspected and tested regularly, including earthling/grounding systems.
- Electrical devices that can generate sparks must not be used near flammable or volatile gases or liquids.

- Disconnect equipment attached to high-voltage or high-amperage power sources from the source or provide a lockout device on the breaker box to prevent circuit activation before maintenance performed.
- Where appropriate, the contractor should consider implementing safe systems of work and permit to work electrical system installations..
- Place away gasoline from fire.
- Provide, train and ensure of all personnel in the use of Personal Protective Equipment (PPEs)
- Clear marking of work site hazards and training in recognition of hazard symbols,
- Train all personnel in fire prevention and protection,
- Avail or provide a full first aid kit at the construction yard,
- Fencing of the construction site to restrict entry of unauthorized persons and curb electrical accidents.
- Provide fire arrest equipment such as fire extinguishers, with type and volume commensurate with the volume and type of flammable materials available at the public works area.

C. Increased Traffic and Road Safety Risks during construction pahse

Project traffic and road safety risks during construction phase are associated with civil works of IPF Sub-component I that can use construction vehicles such as trucks and machineries. The use of these motorized transportations can cause traffic and road safety risks to project workers, affected- communities, and road users. The level of risks may vary depend on specific circumstance. Higher risk of traffic accidents is expected at construction sites or on the roads serving these sites, particularly in areas where the road network is already limited, and which are usually occupied by pedestrians. Similarly, some groups within the affected-communities may be particularly vulnerable to project-related traffic accidents, for example, children, the early, people with disability, and pregnant women.

Required measures include:

- Placing appropriate road signs and signals on the roads to project construction sites, junction layout, and alignments.
- Provision of pedestrian footways and crossings.
- Placing barriers for pedestrians and vehicles.

6.3.3 Environmental risks during Operation phase

The main drivers of environmental risks of the IPF Component project during operation phase are anticipated to involve the following activities:

a. Adverse environmental risks that will arise from the provision of essential health services in conflict affected areas and IDP settings including by the mobile health teams to be deployed.
b. Adverse environmental and social risks that will arise from restoration of ambulance services and provision of vehicles and motorcycles to strengthen CRVS services in conflict affected areas (Subcomponent 1 & 2).
c. Adverse environmental and social risks that will arise from the increased distribution and use of IT equipment such as PCs, laptops, tablets, servers, printers etc. to ensure continuous provision of civil registration services in conflict affected areas (subcomponent 2).

The adverse environmental risks related to provision of essential health services will involve not only operations carried in the existing and functional HCFs and temporary clinics, but also in those restored and rehabilitated HCFs when they become operational. Besides the routine generation of health care waste from the provision of essential health services, the operations of the HCFs will also involve receiving, storing and usage of medical supplies and equipment procured under subcomponent-1 and this activity may ultimately lead to occurrence of expired medicines and other medical supplies at certain time downstream, which need to be addressed for its safe and sound disposal. These and other operational phase risks of the IPF component are outlined below.

6.3.3.1 Impacts of Health Care Waste Releases

The operational activities of existing HCFs, the restored and rehabilitated as well as the temporary/satellite clinics in conflict affected and IDP areas to provide essential health services to the communities will ultimately generate a stream of hazardous solid and liquid medical

wastes. The hazardous medical wastes to be generated by the HCFs may consist of infectious wastes; sharps; needles; and other used medical consumables, pathological wastes as well as laboratory wastes including chemicals used for testing samples. Other medical wastes expected to be generated during operation of the HCFs also involves blood transfusion wastes, patient diagnosis sample wastes, etc. As these medical wastes are going to be generated on a daily basis its collection, transport, treatment and disposal will be of high importance to avoid adverse risks to the environment and public health. Moreover, the HCFs would also generate general wastes such as medical consumables packaging wastes, cleaning wastes, office wastes etc. which also seek for proper handling and disposal.

According to the national health-care waste management manual (2021), about 75% and 90% of waste by volume of the waste produced by health care providers is non-hazardous or general health care waste. The remaining 10–25% of health-care waste is regarded as "hazardous" or "infectious" which may result in a variety of human and animal health risks, and environmental problems. Improper and inadequate medical waste management practiced by HCFs and satellite clinics in the conflict affected and IDP areas can cause pollution to the environment (i.e., surface water pollution if disposed to water bodies & local air pollution caused by foul odor if disposed on open dumps) affecting health workers and the public health through infection and contamination.

As the Impact of Improper Healthcare Waste Management is high, appropriate technologies and methods should be used to treat and dispose environmental and social risks. The National Health Care Waste Management Manual (2021) has outlined in detail the basic principles and recommendations necessary to manage health care waste at health-care service providers level. The manual in its Annex-9 also consists of a template for preparing Facility Health Care Waste Management Plan which is essential to prepare and implement by essential health service providers under the IPF component project in conflicted affected areas. The following are among the required mitigation measures for minimizing environmental and social risks of improper Healthcare Waste Management (WBG/IFC EHS Guidelines for Healthcare Facilities and the National health-care waste management manual (2021).

Need for HWMS and ICWMP

- Health care facilities should establish, operate and maintain a health care waste management system (HWMS) adequate for the scale and type of activities and identified hazards.
- Each health care facility and satellite clinic providing essential health services should prepare (prior to the start of operations under the IPF component project) an Infection Control and Waste Management Plan (ICWMP) based on the template provided in Annex II and in accordance with the National Health-Care Waste Management Manual (2021).

Waste Identification, Segregation

- Waste should be identified and segregated at the point of generation. Non-hazardous waste, such as paper and cardboard, glass, aluminum and plastic, should be collected separately and recycled. Food waste should be segregated and composted. Infectious and / or hazardous wastes should be identified and segregated according to its category using a color-coded system.
- All waste bags or containers would be labeled with basic information in the local language of the area where the HCF is located and/or in English.
- Waste should be labeled appropriately, noting the substance class, packaging symbol (e.g. infectious waste, radioactive waste), waste category, mass / volume, place of origin within hospital, and final destination.
- All healthcare waste generated during care of COVID-19 patients should be treated as infectious waste and managed in accordance to WHO guidelines on Water Sanitation, Hygiene and Waste Management for COVID-19.

Waste collection and storage

- Collection bins should be placed at specific points or at strategic locations for dumping the medical wastes and other waste types, hence segregating the medical waste from other wastes. The bins should be emptied regularly to licensed collection centers or disposal sites to avoid soil and groundwater contamination.

- Seal and replace waste bags and containers when they are approximately three quarters full. Full bags and containers should be replaced immediately.
- Identify and label waste bags and containers properly prior to removal.
- Ensure safety and health of the health care waste handlers through provision of appropriate PPEs, vaccination against Hepatitis B and tetanus as well as provision of post-exposure prophylaxis (PEP).
- Waste storage areas should be located within the facility and sized to the quantities of waste generated, with the following design considerations:
    - ✓ Hard, impermeable floor with drainage, and designed for cleaning / disinfection with available water supply;
    - ✓ Secured by locks with restricted access;
    - ✓ Designed for access and regular cleaning by authorized cleaning staff and vehicles;
    - ✓ Protected from sun, and inaccessible to animals / rodents;
    - ✓ Equipped with appropriate lighting and ventilation;
    - ✓ Segregated from food supplies and preparation areas; and
    - ✓ Equipped with supplies of protective clothing, and spare bags / containers.
- Unless refrigerated storage is possible, storage times between generation and treatment of waste should not exceed 48 hours during cool season, 24 hours during hot season.
- Store mercury separately in sealed and impermeable containers in a secure location.
- Store cytotoxic waste separately from other waste in a secure location.
- Store radioactive waste in containers to limit dispersion, and secure behind lead shields.
- Packaging containers for sharps should be puncture-proof.

Waste transportation

- Transport waste destined for off-site facilities according to the guidelines for transport of hazardous wastes / dangerous goods in the General EHS Guidelines and the National health-care waste management manual (2021) as appropriate.
- Hazardous and general waste must not be mixed during collection, transport, and storage.

- Transport waste to storage areas on designated trolleys/carts, which should be cleaned and disinfected regularly.
- Transport packaging for infectious waste should include an inner, watertight layer of metal or plastic with a leak-proof seal. Outer packaging should be of adequate strength and capacity for the specific type and volume of waste.
- Transport vehicles should be dedicated to waste and the vehicle compartments carrying waste sealed.
- Infectious waste would be contained from its point of origin to the point at which it is treated and rendered no longer infectious.

Treatment and disposal

- Healthcare Waste should be treated according to the National Healthcare Waste Management Manual (2021) which categorizes HCW in Ethiopia into eight classes (i.e. Sharps, Infectious, Pathological, Pharmaceutical, Cytotoxic, Chemical, Radioactive, Non-hazardous or general health-care wastes). The treatments are described at section 5.3 to 5.5 of the manual for waste treatment and disposal.
- Facilities receiving hazardous health care waste should have all applicable permits and capacity to handle specific types of health care waste.
- Healthcare waste should be disposed after treatment. The recommended types of final disposal methods are outlined in section 5.4, 6.6 and 6.7 of the National Health-care waste management manual, 2021).
- Health care waste generated in the management of COVID-19 patient is considered infectious wastes and should be treated in the following methods and technologies sequentially: chemical disinfection, wet thermal treatment, inertization, microwave irradiation, incineration and landfill disposal.
- Burial sites would be fenced to prevent access by community members or animals. Burial would not be used in areas with high water tables. The bottom of the pit would be at least 1.5 meters higher than the groundwater level.

- Facilities would secure the services of reputable waste handlers to ensure, to the extent possible, that final disposal of health care waste is performed according to applicable federal and local regulations.
- The Regional, Zonal and Woreda environment protection and health offices would ensure that only treated infectious wastes are buried in landfills.

The above recommendations highlight some useful actions which HCFs providing essential health services as part of the IPF component project implementation activities would need to implement. However, for a full range of alternative recommendations they can adapt and apply, the IPF component project implementing HCFs are advised to refer both the National health care waste management manual (2021) and EHS Guidelines for Healthcare Facilities.

The HCFs will comply with the national policy on injection safety policy and the CDC COVID-19 Vaccination Program (2020) on minimization of potential waste of vaccine, constituent products, or ancillary supplies. The HCFs will further adhere to the Infection Control and Waste Management Plan (ICWMP) they shall prepare based on the template in Annex II of this ESMF regarding safe handling and disposal of injection and ancillary waste.

6.3.3.2 Impact of Health Care Facility Waste Water Releases

The operational activities of HCFs will inevitabley generate wastewater the volume of which depends on its size nd scale of operations. The HCFs to be restored, rehabilitated and become operational with support of the IPF component project in the conflict affected areas involves hospitals, health centres and health posts. As a consequence wastewater to be generated from the operational activities of the HCF may consist of sewage, graywater from washing, bathing, laundry, labortaory amd other technical processes. As the uncontrolled release of such wastewater will affect the environment and community health, there will be a need to manage the wastewater releases by the HCFs to prevent and avoid risks to the environment and community health. Required actions to mitigate the impacts of wastewater releases involve the following:

- Rehabilitate, restore and operationalize existing wastewater treatment facilities in the damaged HCFs in the conflict affected areas

- Where existing wastewater facilities of the HCFs are damaged beyond repair or have no treatment facilities at all, develop appropriate type of wastewater treatment facility based on the national guideline/manual for Health care waste management (2021). Chapter 6 of the National Health Care Waste Management Manual (2021) provides a range of wastewater treatment options for the different types and locations (i.e Urban or Rural) of HCFs. According to the guideline/manual larger HCFs, particularly those that are not connected to any municipal treatment plant, should operate their own wastewater treatment plant. The treated effluent of the on-site wastewater treatment plant must comply with the general effluent standards before discharge. The treated effluent should be disinfected with an appropriate disinfectant prior to discharge to the environment. For HCFs, especially primary care facilities and HCFs located in the rural areas, that do not have an on-site wastewater treatment plant or a sewerage system in their area may opt to provide a basic wastewater treatment system. The basic wastewater management systems, which can be used by the HCFs include septic tank system; centralized basic system; and lagoon system.
- Connect and treat the wastewater generated by each HCF during its operations before releasing to the environment

6.3.3.4 Risks of Increased Traffic Accidents

The IPF component project will procure and distribute vehicles and motorcycles to restore ambulance services and to strengthen CRVS services in the conflict affected areas. Apparently, the restoration of ambulance and CRVS services will represent a huge positive beneficial impact for the local communities who gain from these social services. However, if proper precautions are not exercised, the movement of the vehicles and motorcycles could also increase the occurrence of traffic accidents that negatively affect community members, health care workers, properties, as well as the drivers themselves. These could occur due to several reasons including from poorly trained or inexperienced driving, poor traffic management on the roads, and poor maintenance of the vehicles/motorcycles itself.

The IPF component project will also procure and distribute medical supplies and equipment to the HCFs in the conflict affected areas, an activity that involves road transportation of drugs,

medicines and radiation equipment. Potential traffic accidents during road transportation of drugs and medicine can cause the release of hazardous substances that will adversely affect the environment and community health. EPSA, which is the responsible agency to undertake these project activities, currently applies both its own fleet of vehicles dedicated for transport of medical supplies and equipment throughout the country. Customers of EPSA are also entitled to use their own means to transport their medical supply purchases. There will be a need to further strengthen the safe transport of medical supplies and equipment exercised by EPSA and its customers to ensure that community health and the environment is not affected by the accidental release of hazardous drug and medicine substances to the environment.

Required mitigation measures for minimizing traffic accidents include the following:

- Adoption of best transport safety practices across all aspects of project operations with the goal of preventing traffic accidents including:
  - ✓ Emphasizing safety aspects among drivers
  - ✓ Improving driving skills and requiring licensing of drivers
  - ✓ Adopting limits for trip duration and arranging driver rosters to avoid overtiredness
  - ✓ Avoiding dangerous routes and times of day to reduce the risk of accidents
  - ✓ Use of speed control devices (governors) on trucks, and remote monitoring of driver actions
- Regular maintenance of vehicles and use of manufacturer approved parts to minimize potentially serious accidents caused by equipment malfunction or premature failure.

Where project activities such as restoring ambulance services may contribute to an increase in traffic along existing roads, recommended measures include

- Collaboration with local communities and responsible authorities to improve signage, visibility and overall safety of roads, particularly along stretches located near schools or other locations where children may be present. Collaborating with local communities on education about traffic and pedestrian safety (e.g. school education campaigns.
- Ambulance drivers should follow guidance on safe emergency driving,

The procedures for transportation of hazardous materials (in this case for example: drugs and medicines) should include:

- Proper labeling of containers, including the identity and quantity of the contents, hazards, and shipper contact information.
- Providing a shipping document (e.g. shipping manifest) that describes the contents of the load and its associated hazards in addition to the labeling of the containers.
- Ensuring that the volume, nature, integrity and protection of packaging and containers used for transport are appropriate for the type and quantity of hazardous material and modes of transport involved.
- Ensuring adequate transport vehicle specifications
- Training employees involved in the transportation of hazardous materials regarding proper shipping procedures and emergency procedures

6.3.3.4 Risk of medicinal waste and disposal

Under certain circumstances, not all medicines and medical supplies procured and distributed to the HCFs are wholly utilized before its expiry dates. Accumulation of unused medical supplies and equipment that has expired or become unfit for use due to various reasons may occur through the value chain starting at the central stores of EPSA, its regional branches, to the stores of downstream health care facilities that are engaged in providing essential health services. Uncontrolled disposal of expired drugs and medicines will affect human health and the environment. In order to prevent uncontrolled disposal of medicine waste, the Ethiopian Food, Medicine and Healthcare Administration and Control Authority (FMHACA) (now called Ethiopian Food and Drug Authority) has issued Directive No.2 /2011 titled: Medicines Waste Management and Disposal Directive. The objective of the directive is to protect the public and the environment from health risks and hazards of medicines waste by ensuring safe management and disposal practice. According to the Medicines Waste Management and disposal Directive, a Health care facility which does not have a disposal facility approved by the appropriate organ is prohibited to carry out medicines waste disposal (Article 8). Instead, any health institution which

does not have an approved disposal facility shall use disposal referral system of licensed disposal firms, respective medicines suppliers or central disposal sites (Article 9). In doing so, the health care facility has to submit an application to the appropriate organ requesting for approval of disposal of medicines waste (Article 7(2)). The Directive provides guidance on the procedures to be followed for disposing medicinal wastes. It also provides guidance on the type of medicinal wastes and recommended disposal methods. During the consultations made with EPSA representatives it was stated that EPSA applies the procedures of the directive to dispose expired and unfit for use medicinal wastes in its store. Health care facilities in the conflict affected areas and IDP settings are also recommended to apply the directive while disposing their medicinal wastes. A summary of medicinal wastes and recommended disposal methods by the Directive is presented in Annex-v of this report.

6.3.3.5 Risk of radioactive wastes and disposal

The health sector is one of the main users of radiation equipment for medical purposes. The procurement and distribution of medical supplies and equipment for conflict-damaged and affected health facilities is likely to involve radiation medical equipment to replace or substitute the damaged once. As the radiation medical equipment are expected to contain radioactive materials the import, distribution, operation and final disposal of such equipment will have to comply with the requirements and procedures of Proclamation No. 1025/2017 on Radiation and Nuclear Protection. The Ethiopian Radiation Protection Authority (ERPA) is responsible to regulate the safety and security of radiation and nuclear technologies. It is also responsible to protect individuals, the society, and the environment from radiation hazards. As a consequence, the procurement, import and distribution of medical radiation equipment to be carried by EPSA and the operation and end of life disposal of such radiation equipment by the beneficiary HCFs will have to comply with the requirements and procedures of ERPA as stipulated in Proclamation no. 1025/2017 on Radiation and Nuclear Protection and the EHS General Guidelines on OHS Risks from Radiation Hazards.

6.3.3.6 Occupational Health Risks during operation phase

Health care facilities are a potential source of infectious waste and these could pose unsafe conditions for healthcare staff. Of particular concern are health workers handling infectious

waste (including sharps) without adequate protective gear, storage of sharps in containers that are not puncture-proof and health workers becoming incontact with patients with infectious waste. While some OHS risks will be new borne by equipment or services introduced after renovation or upgrade of facilities, most other effects are existing (hence cumulative) and would only be exacerbated by increased use of healthcare services. Below is a list of OHS risk sources for healthcare staff:

- Biological hazards (blood or other body fluids with potential to cause diseases);
- Lack of adequate lighting in workplaces;
- Lack of safe access particularly for disabled employees;
- Inadequate ventilation in rooms;
- Lack of adequate PPE and training (or neglect of safety precautions/ guidelines) in use of medical equipment;
- Misuse of equipment and materials for functions they are not designed;
- Lack of safety signage in specific areas (e.g. X-ray rooms) from radioactive hazards;
- Electrical hazard;
- Eye hazards such as splashes in laboratories and operating rooms; and
- Chemical hazards (acids, alkalis, expired drugs, oxidizing and reactive chemicals);
- Likelihood of the impact occurring is high unless control measures are instituted. Although it is a cumulative impact, the risk to human health is significant.

Required Mitigation measures include:

- Ensure the implementation of standard precautions and transmission based precautions in line with national guidelines for IPC in healthcare facilities taking into account guidance from WHO and/or CDC on COVID19 infection control,
- Update and implement HCF OHS plan and/or emergency response plan,
- Ensure identification of risks (Job Risk Assessment) and instituting proactive measures,
- Train the healthcare workers on the potential OSH risks in relation to COVID-19,

- Provision of adequate and required personal protective equipment (PPE) to health workers and enforce on use. This includes: single use medical mask, gown, Apron, eye protection, boots or closed shoes.
- Provision of a system for disinfection of the multi-use PPE if not available.
- Implementation of systemic risk management plan comprising risk prevention, evacuation of accident victims, evaluation and improvement measures.
- Ensure availing of Material Safety Data Sheet for all chemical use in the lab to the lab technicians.
- The beneficiary facilities (labs and HCF) will prepare sub-project specific ICWMP and this will include update of the health facility OSH plan.

6.3.3.7 Risk of electronic waste releases

In order to ensure continuous provision of civil registration services in conflict-affected areas and for IDPs and pastoralist population, the IPF Component subproject will provide mobile registration tools such as laptops and tablets for the civil status officers. As such the increased distribution and use of IT equipment such as PCs, laptops, tablets, servers, printers etc. is anticipated to increase the release of e-waste in the medium term due to the fact that these electronic gadgets will end up in the e-waste stream at the end of their life cycle. As the capacity building initiative to digitize and link the CRVS system with the health and other sectors is continuing to be supported by various Bank financed projects, the adverse impacts of the e-waste stream on the environment can also be anticipated to build up in this process. Therefore, there is a need to consistently apply a well-organized e-waste management system throughout the Immigration and Citizenship Service (ICS).

Required mitigation actions to minimize impacts of e-waste stream include:

- Develop guideline for e-waste management consisting of recovery, re-use, recycling as well as its collection and disposal mechanisms to be used by all project beneficiaries. The e-waste guideline would need to be consistent and compliant with the relevant provisions and procedures set out in the Electronic and Electrical Waste Regulation No. 425/2018.

- Publish the e-waste management guideline and disseminate to project beneficiaries
- Provide training and awareness on use of the e-waste management guideline to project beneficiaries

6.4 PROJECT ADVERSE SOCIAL IMPACTS

Despite the potential social benefits stated above, the IPF Component Project has also potential social risks related to vulnerable individuals or groups, workers, and surrounding community. The following section describes expected social risks:

6.4.1 Project Social Risks during Construction Phase

The project social risks during the construction phase are categorized into the following

6.4.1.1 Risks related to labour and working conditions

Risks related to Labour and Working Conditions are expected from IPF Sub-component I and Sub-component II. The undertaking of the activities of these IPF Sub-components require the project hiring of direct and contracted workers involving with the following risks:

Child labor: *IPF Sub-component I* has civil works for renovation of the health facilities (conflict-damaged Hospitals, Health Centers, and Health Posts) and establishment of temporary Health Post to reach out to the basic health needs for vulnerable groups (such as IDPs in Camps) in the conflict-affected areas. As the MoH outsource these civil works to third-party, the contracted organization may employ children for construction works. The findings of the ESMF and Social Assessment explored obvious push factors for child labour on the side of the contracted organization: It may employ children seeking to make advantage of hiring cheap child labour or due to lack/shortage of labour workers, particularly for the civil works in remote rural and pastoral areas. Also, there are inherent push factors to child labour within the communities in the project areas. The project target regions have low Net Enrolment Rate (NER) in primary school. The entire school system in Tigray has been stopped following the war in the north and did not open yet. Afar, Amhara and Benishangul-Gumuz regional states rank the first three lowest NER in primary school in Ethiopia**.** This means that a proportion of children are out of

school and easily available for child labour needed for the project civil works. Yet, the extreme poverty level in most of the project target regions coupled with the loss of household livelihood due to conflicts can add to push factor or exacerbate risk of child labour.

Required mitigation actions to minimize child labor include:

- The project's LMP specify the minimum age for employment or engagement in connection with the project, which will be the age of 14 as per ESS2 (paragraph 17) unless national law specifies a higher age.
- Verification of age prior to employment of the project workers by requesting the applicant to provide a legal confirmation such as birth certificate, Kebele ID Card, school certificate, or other official documents demonstrating age.
- Document the personal records of the project workers for official inspection.
- Sudden inspection by the project by Social Safeguard Specialist or local implementing partner (Woreda Women and Children Affairs). If a child under the minimum age is discovered working on the project, terminate the employment of the child. The project LMP incorporate the requirement to terminate the engagement with the Contractors violating the rule.

Minimum age: For the same push factors stated both on the side of contracted organization and local communities, a child over the minimum age and under the age of 18 may be employed or engaged in connection with the project civil works in a manner that is likely to be hazardous or interfere with the child's education or be harmful to the child's health or physical, mental, spiritual, or social development. In line with this, proposed mitigation measures include:

- A child over the minimum age and under the age of 18 will not be employed or engaged in connection with the project in a manner that is likely to be hazardous, interfere with the child's education, or be harmful to the child's health or physical, mental, spiritual, moral, or social development. The project LMP specify the type of project activities considered hazards in this regard.
- To support monitoring, the Contractors outsource for the project civil works create and maintain a separate record of all project workers over the minimum age and under 18.

Accordingly, inspection of the working conditions by the project Social Safeguard Specialist or local implementing partner (Woreda Women and Children Affairs).

6.4.1.2 Involuntary resettlement risks

Involuntary resettlement risks in general: Potential involuntary resettlement risks and adverse impacts arise in association with the undertaking of the civil works of the IPF Sub-component I. The restoration/construction of the damaged health facilities (Hospitals, Health Centers, Health Posts, and infrastructure (such as blood banks, drug stores, and Zonal and Woreda Health Offices) will be carried within the same compound. Thus, issues of project-related land acquisition or restrictions on land use are unlikely. Consequently, no significant involuntary resettlement risks are expected by way of physical displacement (relocation, loss of residential land, or loss of shelter) or economic displacement (loss of land, assets, or access to assets leading to loss of income sources or other means of livelihood). Likewise, no substantial risks of restrictions on land use or prohibitions on the use of agricultural, residential, commercial, or other land can be directly introduced and put into effect as part of the restoration/construction of conflict damaged health facilities and infrastructure.

However, the establishment of temporary satellite clinics to provide essential health services in IDP camps will envisage the issues of project-related land acquisition and restriction on land use and access to communal resources. The associated involuntary resettlement risks (physical and economic displacement) would be significant as well. This is because, as to the finding of the social assessment, the current number of IDPs in the conflict-affected areas is by far more than what has been assessed by the MoH in CIARP covering the period from November 2020 to December 2021 and used in the preparation of the IPF project. The case of Oromia region provides a typical example here. According to the desk review from Oromia Health Bureau, currently, there are 1,187,341 IDPs in the region with a critical need of PHC compared to 600,000 planned in the PAD. More importantly, the number of the IDPs is expected to continuously increasing as the impact of the conflict has been expanded to five more Zones (Bunno Bedele, Illubabor, West Shawa, South-west Shawa, and East Shawa) than what is

considered during the project design. The increment of the number of the IDPs in the conflict-affected areas implies the need for establishing more temporary satellite clinics which in turn require more project-related land acquisition. Therefore, the risks of the physical and economic displacement can be significant. Recommended mitigation actions to minimize Involuntary Resettlement Risks:

As a general principle, the project applies a mitigation hierarchy. To avoid involuntary resettlement or, when unavoidable, minimize involuntary resettlement by exploring project design alternatives. After the avoidance and minimization steps, mitigate adverse social and economic impacts from land acquisition or restrictions associating with IPF Sub-component I by: (a) providing timely compensation for loss of assets at replacement cost; and (b) assisting displaced persons in their efforts to improve, or at least restore their livelihoods and living standards in real terms, to pre-displacement levels or to levels prevailing prior to the beginning of project implementation, whichever is higher. In order to guide the implementation of these and more other mitigation measure, a separate and stand-alone Resettlement Policy Framework (RPF) document that outlines the procedures to be followed for RAP preparation is prepared for the IPF component and it will be applied in concurrence with the present ESMF.

Disproportionate involuntary resettlement risks to Historically Underserved Communities (HUCs): Land acquisition related to the establishment of temporary satellite clinics may have disproportionate impacts for the pastoral and agro-pastoral communities in Afar, Benishangul-Gumuz and parts (Borena and Guji Zones) of Oromia. The differential impacts of the project-related land acquisition are expected from the collective attachment that inextricably link the lives of the pastoral communities to the land on which they live and the natural resources on which they depend. The concept of collective attachment justifies that the economies, modes of production, social organization, and cultural and spiritual lives of the project-affected pastoral and agro-pastoral communities are generally linked to the particular territories and natural resources they occupy. For pastoral and agro-pastoral communities, therefore, involuntary

resettlement risk from project-related land acquisition goes beyond the physical and economic displacement.

To mitigate the risks, a targeted social assessment for the purposes of ESS7 is conducted when HUCs are present in, or have collective attachment to, the land required for the project purposes. A key aspect of the targeted social assessment is understanding the relative vulnerabilities of the affected HUCs and how the project may affect them. Accordingly, the determination, delivery, and distribution of compensation and shared benefits to affected HUCs will take account of the institutions, rules, and customs of these HUCs, as well as their level of collective attachment to the land required for the purposes of the project. Guided by the findings of the targeted social assessment, eligibility for compensation can either be individually or collectively based, or be a combination of both. Where compensation occurs on a collective basis, as far as practicable mechanism that promote the effective distribution of compensation to all eligible members, or collective use of compensation in a manner that benefits all members of the group, will be defined and implemented.

6.4.1.3 Risks to cultural heritage

The risks to cultural heritage are expected in association with the civil works of the IPF Sub-component I. The social assessment is conducted in the recognition that cultural heritage provides continuity in tangible and intangible forms between the past, present, and future lives of the project-affected communities. People identify with cultural heritage as a reflection and expression of their constantly evolving values, beliefs, knowledge, and traditions. Cultural heritage, in its many manifestations, is important as a source of valuable scientific and historical information, as an economic and social asset for development, and as an integral part of people's cultural identity and practice.

The civil works proposed in the IPF Sub-component I may involve excavations, demolitions, or other physical changes with potential risks to the cultural heritages in the project target areas. Analysis of national legislation, Proclamation No. 839/2014 on Classification of Cultural

Heritage into National and Regional Cultural Heritage, review of available studies in the area, and key informant interview with regional and local stakeholders were used to identify the tangible and intangible cultural heritages in the project target areas that may be affected due to the undertaking of the civil works of the IPF project. Tangible cultural heritage assessed includes movable or immovable objects, sites, structures, groups of structures, and natural features and landscapes that have archaeological, paleontological, historical, architectural, religious, aesthetic, or other cultural significance. Intangible cultural heritage encompasses practices, representations, expressions, knowledge, and skills—as well as the instruments, objects, artifacts, and cultural spaces associated therewith—that the project-affected communities and groups recognize as part of their cultural heritage, as transmitted from generation to generation and constantly recreated by them in response to their environment, their interaction with nature, and their history.

As the reconstruction or renovation activities of the damaged health facilities and infrastructure will be carried within the prior sites, none of those cultural heritages recognized in Article 2 of the Ethiopian Proclamation No. 839/2014 can be at risk. Impacts on cultural heritage that are recognized by local communities as important need to be considered even if the cultural heritage is not legally recognized or protected. This consideration is important because the cultural heritage may be designated, protected, or managed by religious, tribal, ethnic, or other community authorities, and therefore recognized in accordance with tradition and customs. In some communities, the character, location, and use of heritage sites and objects may be kept secret or known only to authorized persons. Yet again, the key informants identified no cultural heritage and no concerns were expressed either. Thus, no risks of the project to known cultural heritages are expected. However, previously unknown cultural heritage may be discovered while excavation for the project civil works or tangible cultural heritage may be located under the surface. A chance finds may include the discovery of a single artifact, an artifact indicating the presence of a buried archaeological site, human remains, fossilized plant or animal remains or animal tracks, or a natural object or soil feature that appears to indicate the presence of archaeological material.

As a mitigation measure, a Chance Finds Procedure is developed as part of the Environmental and Social Commitment Plan (ESCP). Project-specific procedure to be followed if previously unknown cultural heritage is encountered during the excavations involving the project civil works include:

- ✓ Notify Woreda Culture and Tourism Office of found objects or sites on the same day.
- ✓ Fence-off the area of finds or sites to avoid further disturbance.
- ✓ Cooperate with cultural heritage experts (at woreda, regional or national organization as appropriate) in assessment of found objects or sites, identifying and implement actions consistent with the requirements of the ESS8 and national law.
- ✓ Train project personnel and project workers on chance find procedures
- ✓ The Chance Finds Procedure (CFP) is available in Annex VI.

6.4.2 Project Social Risks during the Operation Phase

As the findings of the ESMF exposed, the following are potential social risks that may occur during the project operation phase.

6.4.2.1 Risks from working conditions and management of worker relationships

Risks related to working conditions and management of worker relationships concerns those project workers involving formal contractual arrangements as direct workers or contracted workers. Both IPF Sub-component I and Sub-component II engage ***direct workers***, worker with whom the MoH and ICS has a directly contracted employment relationship and specific control over the work, working conditions, and treatment of the project workers. Accordingly, *IPF Sub-component I* will engage: (a) health work force as RMNCAH+N experts, mobile health teams and district emergency management team to continue delivery of IDP essential health and nutrition services and provide training to health workers on survivor-centered care and provide psychosocial support; (b) PIU (E&S Safeguard Specialists, Gender and GBV specialist); and (c) technical assistants in the health sector such as Financial Management (FM) and procurement

experts (at the federal and regional levels). *IPF Sub-component II* will employ data and management information systems experts to ensure operational continuity and institut9ionalize the CRVS system. In addition, Mobile CRVS Officers will be employed to ensure continuous provision of civil registration services in conflict-affected areas and for IDPs and mobile pastoralist population. Besides the aforesaid direct workers, *IPF Sub-component I* involve contracted workers for the civil works. ***Contracted workers*** are workers employed by a third party (i.e., contracted organization) to perform the civil works, where contracted third party exercises control over the work, working conditions, and treatment of the project workers. Owing to such contractual arrangements involving multiple parties, disagreements and conflict of interest can occur over the terms and conditions of employment resulting in strained project worker-management relationships. The project Labour Management Procedures (LMP) set out details of mitigation measures in this respect

6.4.2.2 Community Health and Safety risks

Risks related to Community Health and Safety are associated with the project activities under IPF Sub-component I and II. The findings of the ESMF examined that Community Health and Safety (CHS) risks from these project activities can differ within affected-communities depending on various factors that can contribute to vulnerability, including age, gender, or physical disability.

A. Increased Traffic and Road Safety (TRS) risks

The provision of PHC include ambulance services procured for the project, and the transportation for mobile health team services to IDPs and remote/mobile pastoral communities depend on procured vehicles. Whereas, the support of IPF Sub-component II include procurement of motorcycles and field vehicles to facilitate mobile CRVS (continuous provision of civil registration services in conflict-affected areas and for IDPs and pastoralist population), supervision and monitoring of registration activities as well as transfer of registration document between kebeles, woredas, zones, and regional and federal offices. The use of these motorized transportations can cause traffic and road safety risks to project workers, affected communities,

and road users. The level of risks may vary depend on specific circumstance. Higher risk of traffic accidents is expected, particularly in areas where the road network is already limited, and which are usually occupied by pedestrians. Similarly, some groups within the affected-communities may be particularly vulnerable to project-related traffic accidents, for example, children, the early, people with disability, and pregnant women.

Beyond the TRS mitigation measures proposed as part of health and safety or traffic management in ESMF (***Annex IX***), the preparation of project TRS risk management plan that set out specific safety measures, for example, measures necessary to manage traffic speeds. But, the need for specific TRS risk management plan will be decided based on further project-related TRS risks assessment considering the following key aspects:

- ✓ Information on traffic incidents and accidents from heavy vehicles (such as construction vehicles and trucks carrying heavy construction materials) used by the Contractors for the project civil works, ambulance services, and motorcycles and field vehicles used to facilitate mobile PHC services and mobile CRVS inaccessible project areas such as remote and transhumance pastoral communities; and
- ✓ Vehicle mix, volume, speed, and condition (including vehicle weight, height, length, and any hazardous materials likely to be carried), and TRS status of the existing roads (including availability of road signs and signals, lane widths, slopes, speed management, roadside uses, pedestrian usage and facilities, air pollution, and any risks that these may pose).
- ✓ Putting speed limits, training of construction and ambulance drivers, regular checking and maintenance of vehicles, etc

B. Security risks to project workers and communities

Project's Contextual Security Risks (PCSRs): The ESMF findings explored that there are external social and political factors (at the country, regional, zonal or woreda/local level) that the IPF project does not control but which can significantly impede on the implementation of the project. The PCSRs are rooted in the Fragile, Conflict and Volatile situations in the project target regions and/or specific zones/woredas:

- Despite peace agreement is signed between the federal government and TPLF, the health facilities in Tigray region are still not under the reach of the administrative control of the MoH.
- The current security situation in Amhara region depicts either the state of socio-political tensions and instabilities or recurring active conflict. Several project target Woredas in North Wollo, North Gonder, and South Gonder Zones represent the former case arising from the territorial clam with the Tigray region and active armed informal groups. Whereas, quite many woredas in North Showa Zone (e.g., Efratana Gidim, Antsokiya, Showa Robit Town) and Oromia Special Zone (e.g., Senbete and Ataye Towns) face security threats from the recurring armed attack by armed group.
- The health facilities in many Woredas of all the Wollega Zones (Kelem, Horo Guduru, East and West) are not under the reach of the Regional Health Bureau owing to the security risks and threats to the health workers and local political administration from the armed groups. The PHC delivery in several Woredas of North Shawa Zone has been halted due the physical violence and kidnapping against the health workers by the armed groups.

Project service-induced conflict: Informants have been explained that the IPF program interventions make distinction among the conflict-affected Zones or Woredas. For example, informants from Oromia Regional Health Bureau explained that several neighboring conflict-affected areas in Oromia region face the same impacts of conflict. For example, the four Wollega-Zones and the neighboring Buno Bedele and Illubabor Zones face critical health problem due to damages to health facilities. But, the IPF program interventions target the former while exclude the latter. The same is true in other conflict-affected Zones, North Shawa is included while the neighboring Zones (West-Shawa and South-West Shaw) are excluded from the proposed IPF program interventions and benefits. It is likely that the excluded communities feel the sense of unfair treatment leading them to tension and conflict with the government and neighboring communities included in the project benefits. Also, project service-induced conflict may exacerbate existing tensions and inequality between the project beneficiary and non-beneficiary communities escalate to have a negative effect on the stability and human security.

Analyzed this way, security risks from project service-induced conflict can significantly affect the project implementation. In line with this, details of mitigation mefasures are included in the draft SRA and SMP.

Risks from the use of security personnel: The social assessment reconnoitered obvious security risks that require the government (federal, regional, or local government) to engage security personnel to safeguard the project workers, assets and activities. The project will operate under known high Contextual Security Risks. These are: (a) continuing security risks and threats from the war in the northern Ethiopia; (b) as shown earlier, quit many project target areas are in active conflict and volatile situation involving organized and armed groups; (c) the nature of some project activities engage mobile teams requiring them travel to remote areas where the movement of armed groups exist; and (d) the IPF has the civil works. Given these security scenarios, the government will seek to retain public security force or private security personnel. Depending on the level of security risk, the use of public security force for the project safeguarding purpose may include Local Militias, Regional Police/Special Force, Federal Police or Defense Army. Public security may also be assigned to provide regular—or extra—support to a local community where the operation of the IPF project exists, but not be involved in protecting the specific project on a regular basis. Whereas, the project may use private security personnel (e.g. in-house employees or contracted security providers) for minor security risks such as for example guarding building materials at the project construction site located in a safe town. Therefore, the presence of security person can pose risks to, and have unintended impacts on, both the project workers and local communities from different perspective. The social assessment expects the risks of the use of security personnel for the purpose of the project from different dimensions:

- In undertaking the daily duties, the way in which the project security personnel interact with communities and project workers may appear threatening to them or may lead to conflict.

- In particular, interaction with public security forces can be the most challenging aspect for the project implementing agency the MoH as it does not control the decisions or behavior of public security personnel and may have limited influence in this regard.
- For the high Contextual Security Risks just mentioned, it is likely to make the decision to arm the project security personnel that may lead to inappropriate security response.
- Project security personnel can be engaged both by the government and project contractor, a third party to which the MoH outsource the project civil works. This may create gaps in the management of project security personnel giving ways to security risks.
- Interactions between communities and project security personnel can lead to tensions if the security personnel are involved in enforcing land acquisition and resettlement or preventing access to cultural heritage sites. Therefore, if not properly managed, risks from the use of security personnel may have a repercussion on the project implementation.

Considering the above mentioned sources of security risks to project workers and communities, a stand-along project Security Management Plan is prepared.

C. Risks of social exclusion

HUCs may not receive equitable access to the project PHC services as that is significantly constrained by exceptionally poor health facilities and infrastructure in their areas. Also, the project PHC services and benefits such as child nutrition may not devised or delivered in a form that is culturally appropriate to HUCs. Required mitigation measures in this regard include:

- The physical investment in IPF Sub-component I pays a due attention and address the constraints of PHC services inherent to the poor health facilities in HUCs areas. This includes establishment of temporary or satellite clinics beyond rehabilitating conflict damaged heath facilities.
- Apply innovative PHC delivery approaches such as deployment of mobile health team to reach out to the project areas with transhumance pastoral communities or where health facilities are basically inaccessible and establishment of temporary or satellite clinics is infeasible.

- Behavioral change communications on RMNCAH+N in a form that is culturally appropriate and meaningful consultation (e.g. using local languages, consider the local literacy level, food habits, lifestyles, and gender sensitive) tailored to HUCs.

Likewise, HUCs such as pastoral and agro-pastoral communities may not receive equitable access to the project CRVS services due to the exceptional poor infrastructure and basic social services supporting the system. Recommended mitigation measure in this regard include:

- Strengthen basic facilities such as ICTs that in the project areas with pastoral and agro-pastoral communities that support the automation of CRVs.
- Apply innovative CRVS approaches such as deployment of mobile CRVS team to reach out to the project areas with transhumance pastoral communities or where basic facilities such as ICTs are basically lacking to support digitized CRVS.
- Behavioral change communications on the vital relevance of the CRVS for health, social, legal and social policy planning in a way that is culturally appropriate and meaningful consultation (e.g. using local languages, consider the local literacy level, socio-cultural attitudes, and gender sensitive) tailored to HUCs.

6.4.2.3 GBV-SEA/SH Risks

The IPF project can increase the risk of SEA/SH both in public and private spaces, by a range of perpetrators and in a number of ways. A preliminary GBV risk assessment for the IPF project was conducted using the Ecological Framework Model (EFM). Applying this model entails two critical issues in the assessment of the IPF project-related SEA/SH risks and devising mitigation measures for those risks:

First, when considering SEA/SH risks, there are different “areas of impact” that influence both the nature of the risk and the appropriate prevention and mitigation measures that the project can implement. These are: (a) the project site, it is the location where the IPF project’s activities are being undertaken. This includes both the actual locations where civil works are conducted, and also the associated areas such as the locations of workers’ camps, quarries, etc; (b) communities adjoining the project, that is, the area of impact beyond the project site. This extends beyond the specific location where civil works are being carried out and the adjoining communities are at

risk of SEA/SH, particularly when the IPF project workers are highly mobile; and (c) there are also regional and national areas of impact that will not be affected by the specific interventions of the IPF project but may benefit through institutional strengthening and other efforts to address SEA/SH risks. An assessment at the regional and/or national level can give the MoH an understanding of those experiencing GBV in the region or country, as well as the type and scale of violence, and its acceptability, in the IPF project-affected communities.

Second, there are a number of SEA/SH risk factors for the IPF project that cut across several spheres including communities and institutions and, depending on their scope, they can exacerbate existing risks or can create new ones.

Taking the aforesaid broader and multifaceted context, the assessment identified the following as the major GBV risks for SEA/SH prevention and response action plan of the IPF project:

- Women and girls are at particularly high risk of GBV because of societal norms that perpetuate power differentials between males and females and support or condone males' violence against women and girls. An important additional risk factor is the IPF project-related labor influx. Labor influx and the extent to which the affected community has capacity to absorb labor influx, as well as the inflow of income to workers, can exacerbate already existing inequities between workers and community members for SEA/SH risks. Thus, the risks from the project labor influx can be expected in many ways: (a) large influx of workers may increase the demand for sex work; (b) increased risk of early marriage in project-affected communities where marriage to an employed man is seen as the best livelihood strategy for an adolescent girl; (c) relative higher wages for project workers can lead to an increase in transactional sex; and (d) the risk of incidents of sexual activity between laborers and minors, even when it is not transactional, can also increase.
- Several additional risk factors that aggravate the vulnerability of women and girls to SEA committed by project workers include: high levels of poverty in the project area; large population of young women; low levels of education among women and girls; low rates of employment among women; and high crime levels/violence in the larger community.

- Some of the forms of SEA that may be committed by the project workers against women and girls in the community include: rape and sexual assault; sexual harassment; unwanted sexual advances including touching; physical violence/assault; use of abusive, demeaning or culturally inappropriate language; transaction sex; and other forms of humiliating, degrading or exploitative behavior.
- SH is a risk for any work environment, particularly environments that are stringently hierarchal, give significant and/or undue power to management, and do no promote and reflect female leadership. Additional risk factors for SH include female laborers working alongside male laborers in the project construction site without adequate supervision; without separate latrine and other sanitation facilities for males and females; and without specific mechanisms, for females to share concerns about their working environments, including concerns about sexual harassment.
- Laws on domestic violence - legislation does not extend to unmarried intimate partners and protection orders for domestic violence do not exist.
- Prevention and response to project-related risks of GBV require multipronged efforts and sectors, including the government who are critical to ensuring that SEA and SH prevention and accountability mechanisms are in place. However, the assessment of the local capacity to prevent and respond to GBV, including SEA/SH, and the availability of safe and ethical service provision for survivors are found to be low across all the IPF project implementing areas.
- ***Security posed GBV risks:*** Given the fragile and conflict affected situation of in the IPF project areas, it is likely that the government (federal, regional, or local government) to engage security personnel to safeguard the project workers, assets and activities. Thus, both project physical security measures and security guards can have particularly significant impacts on women, who are likely to be traversing distances for domestic tasks. They may be disproportionately affected by the presence of (typically male and potentially armed) security guards, whom they may encounter daily in following their routine.

The IPF project requires to devise appropriate SEA/SH risk mitigation and ongoing monitoring measures. As a requirement to integrate SEA/SH Prevention and Response measures to IPF project, key elements of the plan include:

- *Emphasize prevention*: Adopt risk-based approaches that aim to identify project-related key risks of SEA/SH and to undertake measures to prevent or minimize harm.
- *Behavioral Standards, Codes of Conduct, and Disciplinary Measures:* Behavioral Standards or a CoC that explicitly prohibits SEA/SH are recommended. Explicit provisions that prohibit and define SEA/SH in line with international standards, including a prohibition on sexual activity with anyone under the age of 18, and define mandatory consequences elevate awareness of SEA/SH risks and provide a clear path of accountability for violations. Through such means, the MoH will introduce explicit SEA/SH prohibitions in contractually binding instruments before project actors begin activities in connection with the project.
- *Sensitization and Training:* Incorporate sensitization and/or training on SEA/SH that aims for: (i) health staff; (i) workers, both from the contractor and sub-contractors; (ii) consultants, such as the supervising Engineers or others working in the project area; (iii) IA staff involved with the project; (iv) the GM operator on how to handle GBV complaints in a survivor-centered manner and in line with the best interests of the child approach; and (v) Managers are particularly important to train as they have the responsibility for ensuring compliance of staff with the CoCs as well as implementing sanctions for non-compliance. Training on SEA/SH will also be done within the project's adjoining communities and will be designed in an age-appropriate manner and format when children are included in outreach activities. Sensitization or training is not a one-time requirement; rather, it is a continuing process throughout project implementation that is informed by the project activities and context.
- ***Ensure accountability and response framework:*** An Accountability and Response Framework documents, in a single place, how allegations of SEA/SH will be handled, along with the disciplinary action for violations by project actors. It include, at a minimum:

- ✓ Steps for handling and reviewing allegations, including timeframe, and responsibilities for each stage of the process.
- ✓ Procedures for review of complaints or incident reports, including information on the investigation and verification process.
- ✓ Confidentiality requirements for dealing with cases (e.g. consent and information sharing protocols).
- ✓ Internal reporting of allegations, for case accountability including the GM process for capturing disclosure of SEA/SH.
- ✓ Protocols for responding to survivors, using the survivor-centered approach (as describe below), and including a pathway to refer survivors to appropriate support services where they exist.
- ✓ Specific protocols to address allegations involving children, incorporating consideration of the best interests of the child, specialist support services, and the role of parents/guardians in the response process.
- ✓ Disciplinary measures against project actors who commit SEA/SH as per the CoC annexed here with.
- ✓ Protocols for protection of whistleblowers and prohibition on retaliation against both complainants and whistleblowers, consistent with the World Bank's Commitments on Reprisals

- ***GBV Service Provider Identification and Mapping:*** It is important that the MoH identifies in advance the available, quality GBV service providers to refer survivors for support. It is necessary for the PIU to identify more than one GBV service provider or to conduct a more in-depth mapping of different service providers prior to project activities commencing.
- ***Retain GBV Specialist:*** Since the overall GBV risk for the project is rated as substantial, as per the requirement in the World Bank GPN on Addressing Sexual Exploitation and Abuse and Sexual Harassment (SEA/SH) in Human Development (HD) Operations (paragraph 43 and 47), the MoH need to retain a GBV Specialist in the project implementing staff as early as possible before the commence of the project.

- ***Ensure gender equity in the staff recruitment:*** It is recommend that the project HD Operations encourage gender-sensitive staffing or equitable recruitment in the project at all levels, including women in management/leadership positions. In addition to ensuring that individuals with required expertise are engaged, it is recommend that the IPF project may consider how gender-sensitive staffing of the PIU or health staff can support SEA/SH mitigation measures.
- ***Creating Safe Spaces at the Facility-level:*** The MoH or Contractors for the civil works should consider how the physical facilities they use or develop can help to reduce the risk of SEA/SH for example through: having separate, safe and easily accessible facilities (e.g., toilets, sleeping areas) for male and female users, which can be locked from the inside; having safe, accessible, well-lit waiting areas and other public spaces (such as construction sites); and visibly displaying signs around the project site (if applicable) that signal to workers and the community that the project site is an area where SEA/SH is prohibited; or is a safe, SEA/SH free zone.
- ***Build on existing local knowledge:*** Engage community partners—local leaders, civil society organizations, and gender and child advocates—as resources for knowledge on local-level risks, effective protective factors and mechanisms for support throughout the project cycle.
- ***Enable continuous monitoring and learning:*** Ensure operations integrate mechanisms for regular monitoring and feedback to track effectiveness and to build internal knowledge of what works to prevent, mitigate and respond to SEA/SH.
- Clearly define the GBV requirements and expectations in the bid documents and the necessary actions in the CoCs.
- The project site will ensure that separate toilet and hygiene facilities are available and functional for men and women working on the site, including inside-locking doors and appropriate lighting.
- Coordinate with school communities and organize activities/disseminate information on SEA targeting adolescent girls.

6.4.2.4 Differential risks to HUCs

The differential risks and impacts of the project may take the form of undesired contact and conflict of cultural norms. There are communities in remote pastoral project target woredas such as Adar and Barahle in Zone 1 Afar region, and Jardaga Jarte in Borena Zone Oromia region with limited external contact or people in voluntary isolation. Undesired contact with these people due to labour influx from the project civil works and mobile health team (IPF Sub-component I) and mobile CRVS team (IPF Sub-component II) may lead to adverse socio-cultural impacts on them. For example, the coming of the project workers having different socio-cultural backgrounds with largely isolated pastoral communities may undermine the local language, cultural practices, institutional arrangements, and religious or spiritual beliefs which the people in voluntary isolation view as essential to their identity or well-being. As these groups of people are likely to defend undesired contact with the project workers, that may lead to conflicts and instability with adverse impacts on the project implementation. Undesired contact could pose significant health risks to such communities as many may not have developed immunity to viruses and diseases common among mainstream populations. Required mitigation actions to minimize Risks to HUCs include:

- Include in the project LMP appropriate protocols to avoid undesired contact, and disciplinary measures to workers violating the Code of Conduct.
- Training for project workers on distinct socio-cultural norms, lifestyles, and traditional institution of the project-affected communities, particularly remote pastoral communities or people of voluntary isolation.

6.4.2.5 Risks of weak coordination for E&S management

As shown in the findings of the ESMF, the existence of poor institutional communication and coordination is analyzed from different dimensions: (a) poor horizontal communication and coordination of activities within the respective IPF project implementing agencies; (b) poor hierarchical communication and coordination of activities among the implementing agencies from the MoH down to woreda level; and (c) poor inter-agency or inter-sectoral communication and coordination of activities among the relevant partner implementing organizations. It is worth

to take the case of MoH to exemplify poor horizontal communication and coordination of activities. The existing implementing arrangement is based on expert pool system than the usual approach of establishing a dedicated Project Implementing Unit (PIU). That is, the system brings together environmental, social, and GBV expertise in different Directorate for the joint responsibilities. But, in practice, the institutional mechanism for effective communication and coordination of project activities among these work units is not established. To mitigate the problem, it is recommended that the MoH establish a dedicate project Social Safeguard Team.

6.4.3 Environmental and Social Management Plan

This section presents an overall statement of intent with regard to environmental and social management plans (ESMP) for the IPF Component Project. ESMP is a delivery mechanism for environmental and social mitigation measures. The overall purpose of the ESMP is to ensure that requirements provided in the ESMF are translated into practical management actions which can be adequately resourced and integrated into the Project phases. Table 15 presents a generic ESMP for the IPF Component Project based on existing information on subprojects. The ESMP provides a logical framework within which identified negative impacts shall be mitigated and positive impacts enhanced. It indicates the expected impact, actions to mitigate it, time frame, responsible body and the estimated cost. It translates the generic mitigation and management measures into actions to be undertaken during the various phases of the project. It also establishes roles and responsibilities for effective implementation of the mitigation measures.

The present generic ESMP also provides guidance and information to prepare and implement site specific ESMP during the course of the IPF Component Project implementation. Accordingly, based on the screening/scoping outcomes, for each IPF Component subproject an ESIA and/or ESMP shall be developed based upon the specific subproject design and a final set of construction and operation phase mitigation and monitoring measures will be determined by taking the generic ESMP of this ESMF into consideration.

For mitigation measures related to design change, in collaboration with MoH and its partner implementing agencies, the design and supervision consultancy organization assigned to design the restoration subproject will be responsible for incorporating the recommended mitigation measures into the design and into the technical specifications of the main project report.

In addition, for subprojects under construction, the construction contractor will be required to prepare and implement a C-ESMP, OHS Plan and Traffic Management Plan as found appropriate by taking the subproject specific ESIA/ESMP and the ESMP of the ESMF into consideration. For subproject operation phase, the relevant implementing entity will be required to prepare and implement the operation phase measures. For the IPF Sub-Components I and II with substaintial security risks, the project is required to conduct security risk assessment and subsequently prepare security risk management plan.

Table 15: Environmental and Social Management Plan

No.	Potential Environmental & Social Impacts	Recommended Mitigation Measures	Responsible Institution for implementing the measures	Responsible for monitoring the implementation of mitigation measures	Implementation Period	Budget Estimate
Adverse Environnemental Impacts (Planning phase)						
1	E&S risks during procurement of medical supplies and equipment	-Prepare, review and endorse a procurement plan for acquisition of all medical supplies and equipment from certified suppliers only and adhere to it. -The GMU/EPSA/PMU will be responsible for ensuring that the required technical specifications are met as per WHO guidelines and Good International Industry Practice (GIIP) -Procurement of medical products should adhere to national regulation and/or to GIIP and to any vaccine manufacturers requirements. The WHO Technical specifications document for procurement of PPE equipment is available at: https://www.who.int/publications/i/item/WHO-2019-nCoV-PPE_specifications-2020 -Distribution of goods or services on basis of need, while ensuring that the distribution systems is not compromised due to elite capture. -Carry out due diligence for all potential suppliers to guarantee quality equipment and medical products. Carry out due diligence for all potential suppliers to guarantee quality supply of personal protective equipment and products.	- EPSA -MoH/ GMU	- MoH Management	During implementation phase	Part of project cost

2	Risk of environment unfriendly purchasing	Recommended factors for consideration in environmental friendly or green procurement include: -Less toxic -Minimally polluting -Energy efficient -Safer and healthier for patients, workers, and the environment -Higher recyclability and recycled content -Prevention and minimization of the production of waste by integrating systems and practices to avoid the creation of waste into equipment and consumables purchasing. -Good management practices rigorously applied to purchase and control of chemicals and pharmaceuticals -Source reduction measures such as purchasing restrictions to ensure the selection of methods or supplies that are less wasteful or generate less health care waste;	- EPSA -MoH/ GMU	- MoH Management	During implementation phase	Part of project cost

No.	Potential Environmental & Social Impacts	Recommended Enhancement /Mitigation Measures	Responsible Institution for implementing the measures	Responsible for monitoring the implementation of mitigation measures	Implementation Period	Budget Estimate
Adverse Environnemental Impacts (Construction phase)						
3	**Impacts on Soil**	-Demarcate the area to be stripped clearly, so that the contractor does not strip beyond the demarcated boundary. -Top soil stripped should be stockpiled for rehabilitation of quarry and borrow sites. -The topsoil should be uniformly spread onto areas to be rehabilitated -Access and haul roads should have gradients or surface treatment to limit erosion, and road drainage systems should be provided. -Pre-defined, essential road routes should be clearly demarcated and adhered-to in order to restrict soil compaction to certain areas. -Vehicles should not drive on soil when it is wet to avoid further soil compaction.	-Construction contractor - Construction Supervisor	- RHB E&S Focal Persons - MoH/ GMU E&S staff	During Construction period	Part of project construction cost
4	**Land degradation and erosion risks:** Quarrying to extract construction materials will cause land degradation and erosion.	- Where appropriate, construction material extraction sites should be selected in consultation with relevant local/woreda authorities including Mining and EPA office. -Select appropriate low-impact extraction methods (e.g. excavation and quarrying) that result in final site contours supportive of habitat restoration principles and final land use; -Topsoil and overburden should be removed separately and segregated for later use during site reinstatement,	-Construction contractor - Construction Supervisor	- RHB E&S Focal Persons - MoH/ GMU E&S staff - Regional/Zonal or Woreda Level EPA Offices	During Construction period	Part of project construction cost

		-Smaller, short-lived extraction sites (e.g. borrow pits) should be reclaimed immediately -Affected land should be rehabilitated to acceptable uses consistent with local or regional land use plans. Land that is not restored for a specific community use should be seeded and revegetated with native species.				
5	**Impact on water resources:** Construction activities taking place in close proximities to surface water bodies can cause adverse effects by releasing solid and liquid wastes	-Provide segregated waste receptacles within the construction site to encourage reuse and recycling. -Provide dedicated bins for hazardous waste, located on hard standing within the construction camp. -All staff must be responsible to keeping all food and packaging waste on them to be disposed of at the waste bins. -Placement of drip trays under vehicles and relevant equipment when stationary; -Fuel, lubricant and waste oil storage, dispensing and operating facilities must be designed and operated in a way to prevent contamination of water. -Empty sewage wastewater regularly with vacuum trucks and disposed of in approved disposal facilities/sites by the local municipal authorities. -Consider disposing collected used oils and lubricants through recyclers or reuses as furnace oil. -Prepare a C-Waste Management Plan for the subproject site and ensure compliance with it.	-Construction contractor - Construction Supervisor	- RHB E&S Focal Persons - MoH/ GMU E&S staff - Regional/Zonal or Woreda Level EPA Offices	During Construction period	Part of project construction cost
6	**Noise and Vibration Impacts:** As the partially damaged HCFs may still provide health care services to patients, the noise and vibration impacts could	-Avoid use of old or damaged machinery with high level of noise emissions -Installation of proper sound barriers and / or noise containments, with enclosures and curtains at or near the source equipment (e.g. grinders) -Installation of natural barriers at facility boundaries, such as vegetation curtains	-Construction contractor - Construction Supervisor	- RHB E&S Focal Persons - MoH/ GMU E&S staff - Regional/Zonal or Woreda Level EPA Offices	During Construction period	Part of project construction cost

	adversely affect the patients and medical workers as well as communities nearby the construction sites.	-locate noise generating sources away from residential or other noise-sensitive receptors (e.g.: patient treatment areas, wards, etc.) -Avoid using heavy construction machinery during night-time -Carry out regular maintenance on the construction machineries -Select transport routes to minimize noise pollution in sensitive areas -Install noise silencer on the construction machineries				
7	**Impact on Air Quality** due to dust resuspension and diesel fuel combustion:	-Vehicles and machinery must be kept in good condition to prevent excessive smoke from exhausts. -A routine maintenance program for all equipment, vehicles, trucks and power generating engines should be in place. -Regularly spray water to suppress the resuspension of dust during construction, particularly during use of gravel roads and dirt tracks. -Wetting exposed soil and site areas with water to control dust emissions. -Minimize unnecessary idling of running diesel engines of machineries, vehicles and equipment. -Limit the speed of vehicle movements to minimize dust.	-Construction contractor - Construction Supervisor	- RHB E&S Focal Persons - MoH/ GMU E&S staff - Regional/Zonal or Woreda Level EPA Offices	During Construction period	Part of project construction cost
8	**Impact of construction wastes**: Uncontrolled disposal of site clearance and excavation waste, general construction waste, as well as	-The contractor shall work to facilitate proper waste handling and disposal from the site. All solid wastes must be taken to the approved disposal site or landfill. -Construction wastes should be recycled or reused as much as possible. -Dispose the construction waste materials (“spoil”)	-Construction contractor - Construction Supervisor	- RHB E&S Focal Persons - MoH/ GMU E&S staff - Regional/Zonal or Woreda Level EPA Offices	During Construction period	Part of project construction cost

	domestic solid and liquid waste adversely affect the environment	only at designated sites approved by the responsible local authority. -Consider reusing the soil spoil for land restoration purpose. -Vehicles hauling dirt or other construction debris from the site shall cover any open load with a tarpaulin or other secure covering to minimize dust emissions and dropping of debris.				
9	Occupational Health Hazards during Construction phase: Construction workers would be actively involved in potentially hazardous activities that exposing them to physical, electrical and fire hazards.	*Recommended mitigation measures to reduce/avoid physical hazards:* -All construction workers must be oriented on safe work practices and guidelines and ensure that they adhere to safe work practices. -New workers must be provided with introduction training/awareness on health and safety features and procedures as well as general safety breifing on the use of equipments at site. -Use signage to warn staff and/or visitors in the construction activities of dangerous places and activities. -Strict instructions on safety must be given for drivers of heavy equipment. -Supervision of works must be done regularly (daily) to ensure that safety conditions are met. - Develop evacuation procedures to handle emergency situations. - Provide adequate OHS protective gear to construction workers, and include terms in the CoC signing to appropriately wear and use safety gears while at work site. - Where appropriate, the contractor should consider implementing safe systems of work and permit to work at heights.	-Construction contractor - Construction Supervisor	- RHB E&S Focal Persons - MoH/ GMU E&S staff - Regional/Zonal or Woreda Level Labor and Social Affairs Offices	During Construction period	Part of project construction cost

		Recommended mitigation measures to reduce/avoid electrical and explosive hazards: -All electrical installations and equipment must be inspected and tested regularly -Electrical devices that can generate sparks must not be used near flammable or volatile gases or liquids. -Disconnect equipment attached to high-voltage or high-amperage power sources from the source or provide a lockout device on the breaker box to prevent circuit activation before maintenance performed. -Place away gasoline from fire. -Provide, train and ensure of all personnel in the use of PPEs -Clear marking of work site hazards and training in recognition of hazard symbols, -Avail or provide a full first aid kit at the construction yard, -Fencing of the construction site to restrict entry of unauthorized persons and curb electrical accidents.	-Construction contractor - Construction Supervisor	- RHB E&S Focal Persons - MoH/ GMU E&S staff - Regional/Zonal or Woreda Level Labor and Social Affairs Offices	During Construction period	Part of project construction cost

No.	Potential Environmental & Social Impacts	Recommended Enhancement /Mitigation Measures	Responsible Institution for implementing the measures	Responsible for monitoring the implementation of mitigation measures	Implementation Period	Budget Estimate
Adverse Environnemental Impacts (Opération phase)						
10	**Impacts of Health Care Waste Releases:** The operational activities of existing, restored/rehabilitated, and the temporary/satellite HCFs will generate a stream of hazardous solid and liquid medical wastes that adversely affect the environment and human health.	- HCFs should establish, operate and maintain a health care waste management system (HWMS) adequate for the scale and type of activities and identified hazards. -Each health care facility and satellite clinic providing essential health services should prepare an Infection Control and Waste Management Plan (ICWMP) based on the template provided in Annex II and in accordance with the National Health-Care Waste Management Manual (2021). -Waste should be identified and segregated at the point of generation. Infectious and / or hazardous wastes should be identified and segregated according to its category using a color-coded system. -All waste bags or containers would be labeled with basic information in the local language of the area where the HCF is located and/or in English. -All healthcare waste generated during care of COVID-19 patients should be treated as infectious waste and managed in accordance to WHO guidelines on Water Sanitation, Hygiene and Waste Management for COVID-19. - As it is un-handy to fit the long list of recommended mitigation measures in this table, please refer section 6.3.5.1 in the main body of the ESMF for the long list	- RHBs Environmental Hygiene & sanitation Directorate - HCF Environmental Hygiene & sanitation staff - UNICEF (as 3rd Party implementer) Environmental Hygiene & Sanitation staff	-RHB E&S focal persons. -MoH E&S staff and GMU	During Operation Phase	Part of project operational costs

		of actions.				
11	**Impact of Health Care Facility Waste Water Releases** Uncontrolled release of wastewater from operational activities of HCFs will affect the environment and community health,	-Rehabilitate, restore and operationalize existing wastewater treatment facilities in the damaged HCFs in the conflict affected areas -Where existing wastewater facilities of the HCFs are damaged beyond repair or have no treatment facilities at all, develop appropriate type of wastewater treatment facility based on the national guideline/manual for Health care waste management (2021). -Connect and treat the wastewater generated by each HCF during its operations before releasing to the environment	- RHBs Environmental Hygiene & sanitation Directorate - HCF Environmental Hygiene & sanitation staff - UNICEF (as 3rd Party implementer) Environmental Hygiene & Sanitation staff - Construction Contractor	-Woreda Health office -RHB E&S focal persons. -MoH E&S staff and GMU	During Construction and Operation	Part of project cost
12	**Risks of Increased Traffic Accident:** The procurement, distribution, and movement of ambulances, vehicles and motorcycles could increase the occurrence of traffic accidents affecting the community,	*Recommended mitigation measures for minimizing traffic accidents include the following:* -Adoption of best transport safety practices across all aspects of project operations with the goal of preventing traffic accidents including: -Emphasizing safety aspects among drivers -Improving driving skills and requiring licensing of drivers -Adopting limits for trip duration and arranging driver rosters to avoid overtiredness. -Avoiding dangerous routes and times of day to reduce the risk of accidents	- RHBs -Woreda Health Offices -Regional CRVS offices -Woreda CRVS offices -	- MoH GMU - ICS -EPSA Management	During Operation Phase	Part of project operational costs

	properties and the drivers. Traffic accidents during road transportation of drugs and medicine can cause the release of hazardous substances.	-Use of speed control devices (governors) on trucks, and remote monitoring of driver actions -Regular maintenance of vehicles and use of manufacturer approved parts to minimize potentially serious accidents caused by equipment malfunction or premature failure.	Regional/Woreda /City Traffic Police Offices - Regional/Woreda /City Authorities			
		To prevent traffic accidents from ambulance services: - Collaboration with local communities and responsible authorities to improve signage, visibility and overall safety of roads, particularly along stretches located near schools or other locations where children may be present - Collaborating with local communities on education about traffic and pedestrian safety -Ambulance drivers should follow guidance on safe emergency driving,				
		The procedures for transportation of hazardous materials (in this case for example: drugs and medicines) should include: -Proper labeling of containers, including the identity and quantity of the contents, hazards -Providing a shipping document (e.g. shipping manifest) that describes the contents of the load and its associated hazards in addition to the labeling of the containers. -Ensuring that the volume, nature, integrity and protection of packaging and containers used for transport are appropriate for the type and quantity of hazardous material and modes of transport involved. -Ensuring adequate transport vehicle specifications				

		-Training employees involved in the transportation of hazardous materials regarding proper shipping procedures and emergency procedures				
13	**Risk of medicinal waste and disposal**: Uncontrolled disposal of expired, unfit for use drugs and medicines will affect human health and the environment.	-Apply Directive No.2 /2011 titled: Medicines Waste Management and Disposal Directive -The Directive provides guidance on the procedures to be followed for disposing medicinal wastes. -Health care facilities in the conflict affected areas and IDP settings are also recommended to apply the directive while disposing their medicinal wastes. -A summary of medicinal wastes and recommended disposal methods by the Directive is presented in Annex III of this report.	- EPSA E&S staff -RHB E&S focal persons - HCFs Environmental hygiene and Sanitation staff - UNICEF (as 3rd Party implementer) Environmental Hygiene & Sanitation staff	- Regional/Zonal /City EPA offices -	-During Operation Phase	Part of project operational costs
14	**Risk of radioactive wastes and disposal:** The procurement and distribution of medical supplies and equipment for conflict-damaged and affected health facilities is likely to involve radiation medical equipment to replace or substitute the damaged once. Radiation medical equipment are expected to contain radioactive materials.	The procurement, import and distribution of medical radiation equipment to be carried by EPSA and the operation and end of life disposal of such radiation equipment by the beneficiary HCFs will have to comply with the requirements and procedures of ERPA as stipulated in Proclamation no. 1025/2017 on Radiation and Nuclear Protection.	- EPSA - MoH GMU - RHBs - Beneficiary HCFs	- Ethiopian Radiation Protection Authority (ERPA)	During Operation Phase	Part of project operational costs

15	**Occupational Health Risks during operation phase:** Health care facilities are a potential source of infectious waste and these could pose unsafe conditions for healthcare staff.	-Ensure the implementation of standard precautions and transmission based precautions in line with national guidelines for IPC in healthcare facilities taking into account guidance from WHO and/or CDC on COVID19 infection control, -Update and implement HCF OHS plan and/or emergency response plan, -Ensure identification of risks (Job Risk Assessment) and instituting proactive measures, -Train the healthcare workers on the potential OSH risks in relation to COVID-19, -Provision of adequate and required PPE to health workers and enforce on use. This includes: single use medical mask, gown, Apron, eye protection, boots or closed shoes. -Provision of a system for disinfection of the multi-use PPE if not available. -Implementation of systemic risk management plan comprising risk prevention, evacuation of accident victims, evaluation and improvement measures. -Ensure availing of Material Safety Data Sheet for all chemical use in the lab to the lab technicians.	- RHBs -HCFs Management - UNICEF (as 3rd Party implementer)	- Regional/Zonal / Woreda Labor and Social affair office.	During Operation Phase	Part of project operational costs
16	Risk of electronic waste releases: Increased distribution and use of IT equipment such as PCs, laptops, tablets, servers, printers, etc., is anticipated to increase the release of e-waste in the medium term affecting the environment.	- Develop guideline for e-waste management consisting of recovery, re-use, recycling as well as its collection and disposal mechanisms to be used by all project beneficiaries. The e-waste guideline would need to be consistent and compliant with the relevant provisions and procedures set out in the Electronic and Electrical Waste Regulation No. 425/2018. - Publish the e-waste management guideline and disseminate to project beneficiaries - Provide training and awareness on use of the e-waste management guideline to project beneficiaries	- ICS - Regional/Woreda CRVS offices	- Federal/Regional EPA offices	During Operation Phase	Part of project operational costs

No.	Potential Environmental & Social Impacts	Recommended Enhancement /Mitigation Measures	Responsible Institution for implementing the measures	Responsible for monitoring the implementation of mitigation measures	Implementation Period	Budget Estimate
Project Adverse Social Risks						
17	**Risks related to Labor and Working Conditions:** As the MoH outsource these civil works to third-party, the contracted organization may employ children for construction works.	-The project's LMP specify the minimum age for employment or engagement in connection with the project as the age specified in national law or in ESS2 (the age of 14), whichever is higher. -Verification of age prior to employment of the project workers by requesting the applicant to provide a legal confirmation such as birth certificate, Kebele ID Card, school certificate, or other official documents - Document the personal records of the project workers for official inspection. - Sudden inspection by the project Social Safeguard Specialist or local implementing partner (Woreda Women and Children Affairs). - If a child under the minimum age is discovered working on the project, terminate the employment of the child.	-Construction contractor - UNICEF (as 3rd Party implementer)	-Construction Supervisor - Regional/Zonal/ Woreda Labor and Social affair office. -Regional/Zonal /Woreda Women Youth and Children office	During construction & operation phase	Part of project Cost
18	**Community Health and Safety risks:** The use of motorized	Beyond the Traffic and Road Safety (TRS) mitigation measures proposed under Section 6.3.3.2 above, the need for specific TRS risk management plan will be decided based on	- RHBs -Woreda Health	- MoH GMU - ICS	During Operation Phase	Part of project operational

	transportations can cause traffic and road safety risks to project workers, affected-communities, and road users.	further project-related TRS risks assessment considering the following key aspects -Information on traffic incidents and accidents from heavy vehicles used by the Contractors for the project civil works, ambulance services, and motorcycles and field vehicles used to facilitate mobile PHC services and mobile CRVS inaccessible project areas -Vehicle mix, volume, speed, and condition and TRS status of the existing roads (including availability of road signs and signals, lane widths, slopes, speed management, roadside uses, pedestrian usage.	Offices -Regional CRVS offices -Woreda CRVS offices Regional/Woreda/City Traffic Police Offices Regional/Woreda/City Authorities	-EPSA Management		costs
19	GBV-SEA/SH Risks: The IPF project can increase the risk of SEA/SH both in public and private spaces.	The IPF project requires devising appropriate SEA /SH risking mitigation and ongoing monitoring measures. As a requirement to integrate SEA/SH Prevention and Response measures to IPF project, key element of the plan include: -Emphasize prevention: Adopt risk-based approaches that aim to identify project-related key risks of SEA/SH and to undertake measures to prevent or minimize harm. -Updating ESMPs and C-ESMPs to include the SEA/SH prevention and response Action Plan. -Create awareness on SEA/SH mitigation and response mechanisms within the implementing agency (IA) and contractors. -Stakeholder consultations including the participation of the community that will take place throughout the life of the project,	-MoH GMU Gender specialist -ICS PIU gender specialist	- MoH Gender Directorate	During construction and Operation Phase	Part of project operational costs

		every six months, which will help to inform GBV risks mitigation in the project. -Publicly post or otherwise disseminate messages clearly prohibiting SEA/SH in all project implementation sites during the construction and operation period of the project, whether the project workers are perpetrators or survivors. -Build on existing local knowledge: Engage community partners—local leaders, civil society organizations, and gender and child advocates—as resources for knowledge on local-level risks, effective protective factors and mechanisms for support throughout the project cycle.				
20	**Involuntary resettlement risks:** The establishment of temporary satellite clinics in IDP camps may likely cause land acquisition and restriction on land use and access to communal resources.	-Follow mitigation hierarchy to avoid, minimize or mitigate resettlement impacts -Apply the procedures of the Resettlement Policy Framework (RPF) document prepared for the IPF component project.	-RHBs E&S staff -Local Urban or Rural Land Administration Authorities	-MoH GMU E&S staff	During construction phase	Part of project cost
21	**Anticipated risks to Historically Underserved Communities:** Disproportionate risks and impacts for the pastoral and agro-pastoral communities (i.e.	- Include in the project LMP appropriate protocols to avoid undesired contact, and disciplinary measures to workers violating the Code of Conduct. - Training for project workers on distinct socio-cultural norms, lifestyles, and traditional institution of the project-affected communities, particularly remote pastoral communities or people of voluntary	- RHB E&S Focal persons -Construction contractor _Third party implementer	-MoH GMU E&S staff	During Operation phase	Part of project cost

	HUC) may arise due to unequal opportunity of access to the PHC and CRVS services.	isolation.				

No.	Potential Social Impacts	Recommended Mitigation Measures	Responsible Institution for implementing the measures	Responsible for monitoring the implementation of mitigation measures	Implementation Period	Budget Estimate
Social Risks During Planning Phase						
22	The establishment of temporary or satellite clinics to provide essential health services in IDP camps and reconstruction health facilities may requires land acquisition with potential risks and impacts of involuntary resettlement.	• Resettlement Framework (RF) is prepared for project-related land acquisition with potential resettlement impacts whose exact nature and locations are not yet known and the scope and scale of resettlement aspects cannot be determined as a result. The RF establish general principles, procedures, and organization arrangement compatible with relevant national law and the World Bank ESS2. • Once the number of temporary satellite clinics required for the IPF program is decided and the exact locations are known, the RF will be expanded into a specific Resettlement Plan. The scope and level of detail of the resettlement plan varies with the magnitude of displacement and complexity of the measures required to mitigate adverse impacts. Project activities that will cause physical and/or economic displacement will not commence until such specific plans have been finalized and approved by the Bank. • The consultation process ensure that women's	-The Social Safeguard Specialist in the MoH -Respective target Regions -Respective target Woreda or -Urban Land Administration Office	-The Social Safeguard Specialist in the MoH -Respective target Regions	During planning phase and continue throughout the project lifecycle	Potential costs are estimated early in the project design phase and integrated into the design IPF Sub-component I

		perspectives are obtained and their interests factored into all aspects of resettlement planning and implementation.				
23	Involuntary resettlement from the project land acquisition for the establishment of temporary or satellite clinics and reconstruction of health facilities may have disproportionate risks and impacts for the affected HUCs.	• As the IPF project is under preparation, the design or exact location of the project civil works require land acquisition cannot be known during project preparation and that will only be designed during the project implementation. For this reason, the finding of the social assessment proposes the preparation of the Historically Underserved Community Planning Framework (HUCPF). The framework specifies resettlement principles, design criteria applied to the civil work activities of the IPF Sub-component I to be prepared during project implementation, the timing for completion of any specific plans and includes a clear statement of roles and responsibilities, budget, and commitment for funding. • However, a stand-alone Historically Underserved Community Plan (HUCP) is prepared once the exact location of the civil work activities of the IPF Sub-component require land acquisition is known and the presence of the HUCs in or around the specified project site is confirmed.	-The Social Safeguard Specialist in the MoH -Respective target Regions -Respective target Woreda or -Urban Land Administration Office	-The Social Safeguard Specialist in the MoH -Respective target Regions	During planning phase and continue throughout the project lifecycle	Potential costs are estimated early in the project design phase and integrated into the design IPF Sub-component I
Social Risks During Construction Phase						
24	Child labour or employing children under the minimum age in the civil works of the project.	• The project's LMP specify the minimum age for young worker employment or engagement in connection with the project as the age specified in national law (i.e the age of 15) as it is higher than the one in ESS2 (the age of 14), • Verification of age prior to employment of the project workers by requesting the applicant to provide a legal confirmation such as birth certificate, Kebele ID Car, school certificate, or other official documents demonstrating age. • Document the personal records of the project workers	-Project Social Safeguard Specialist in the MoH -Contractors -Respective Regional & Woreda Women	-Project Social Safeguard Specialist in the MoH -Respective Regional & Woreda	During construction phase	Core activity of IPF Sub-component I

		for official inspection.	and Social Affairs Bureau/Office	Women and Social Affairs Bureau/Office		
25	Children over the minimum age (i.e., age of 14) and under the age of 18 may be employed or engaged in connection with the project civil works.	A child over the minimum age (i.e. the age of 15) and under the age of 18 will not be employed or engaged in connection with the project in a manner that is likely to be hazardous, interfere with the child's education, or be harmful to the child's health or physical, mental, spiritual, moral, or social development. The project LMP specify the type of project activities considered hazards in this regard.				
26	The excavations or other physical changes involving the civil works may cause risks to unanticipated discovery or recognition of cultural heritage.	A Chance Finds Procedure is developed as part of the Environmental and Social Commitment Plan (ESCP). Project-specific procedures include: ✓ Notify Woreda Culture and Tourism Office of found objects or sites on the same day. ✓ Fence-off the area of finds or sites to avoid further disturbance. ✓ Cooperate with cultural heritage experts (at woreda, regional or national organization as appropriate) in assessment of found objects or sites, identifying and implement actions consistent with the requirements of the ESS8 and national law. ✓ Train project personnel and project workers on chance find procedures	-The Social Safeguard Specialist in the MoH -Respective Regional/Woreda Culture and Tourism Bureau/Office	-The Social Safeguard Specialist in the MoH -Respective Regional/Woreda Culture and Tourism Bureau/Office	During construction phase	Core activity of IPF Sub-component I
Social Risks During Operation Phase						
27	HUCs may not receive equitable access to the project PHC services as that is significantly constrained by exceptionally poor health facilities and	• The physical investment in IPF Sub-component I pays a due attention and address the constraints of PHC services inherent to the poor health facilities in HUCs areas. This includes establishment of temporary or satellite clinics beyond rehabilitating conflict damaged heath facilities. • Apply innovative PHC delivery approaches such as deployment of mobile health team to reach out to the	-The Social Safeguard and GBV Specialists in the MoH -Respective RHBs	-The Social Safeguard and GBV Specialists in the MoH -Respective	Throughout operation phase	Part of project cost

	infrastructure in their areas.	project areas with transhumance pastoral communities or where health facilities are basically inaccessible and establishment of temporary or satellite clinics is infeasible.	-Respective WHOs -Respective WWSAOs	RHBs		
28	The project PHC services and benefits such as child nutrition may not devised or delivered in a form that is culturally appropriate to HUCs	Behavioral change communications on RMNCAH+N in a form that is culturally appropriate and meaningful consultation (e.g., using local languages, consider the local literacy level, food habits, lifestyles, and gender sensitive) tailored to HUCs.	-The Social Safeguard and GBV Specialists in the MoH -Respective RHBs -Respective WHOs -Respective WWSAOs	-The Social Safeguard and GBV Specialists in the MoH -Respective RHBs	Throughout operation phase	Part of project cost
29	HUCs such as pastoral and agro-pastoral communities may not receive equitable access to the project CRVS services due to the exceptional poor infrastructure and basic social services supporting the system.	• Strengthen basic facilities such as ICTs that in the project areas with pastoral and agro-pastoral communities that support the automation of CRVs. • Apply innovative CRVS approaches such as deployment of mobile CRVS team to reach out to the project areas with transhumance pastoral communities or where basic facilities such as ICTs are basically lacking to support digitized CRVS. • Behavioral change communications on the vital relevance of the CRVS for health, social, legal and social policy planning in a way that is culturally appropriate and meaningful consultation (e.g. using local languages, consider the local literacy level, socio-cultural attitudes, and gender sensitive) tailored to HUCs.	-The Social Safeguard and GBV Specialists in the MoH -Respective RHBs -Respective WHOs -Respective WWSAOs	-The Social Safeguard and GBV Specialists in the MoH -Respective RHBs	Throughout operation phase	Part of project cost
30	Risks from working conditions and management of worker relationships involving multiple	Prepare the labor management procedures set out a systematic approach to the management of labour issues in the project. More specifically, the LMP identify the different categories of project workers that are likely to be involved in the project. Accordingly, set out the ways to	-Social Safeguard Specialist in the MoH	MoH	Throughout the project operation phase	Part of the project cost

	parties and categories of project workers.	manage the sources (e.g. Terms and Conditions of Employment) of disagreement and conflict of interest at work place.	-Contractors			
31	Occupational Health and Safety (OHS) risks involving project civil works and PHC delivery	The project LMP incorporates specific/appropriate OHS measures to prevent and protect workers from occupational injuries and illness.	-Social Safeguard Specialist in the MoH -Contractors -Workers' Representative/OHS Committees	-Social Safeguard Specialist in the MoH	Throughout the project operation phase	Part of the project cost
32	Increased TRS risks from motorized transportation in project civil works, PHC services, and mobile CRVS	The need for specific TRS risk management plan will be decided based on further project-related TRS risks assessment considering the following key aspects: (a) Information on traffic incidents and accidents from heavy vehicles (such as construction vehicles and trucks carrying heavy construction materials), ambulance services, and motorcycles and field vehicles used to facilitate mobile PHC services and mobile CRVS for inaccessible project areas; and (b) vehicle mix, volume, speed, and condition.	-Social Safeguard Specialist in the MoH -Contractors outsourced for the project civil works -Drivers hired by the MoH and Contractors	Social Safeguard Specialist in the MoH	Throughout the project operation phase	Part of the project cost
33	Potential threats to the project workers, sites, assets and activities as well as to project-affected communities	Project Security Risk Assessment (SRA) is conducted and security risk management is prepared accordingly.	-The MoH -Contractors outsourced for project civil works	-MoH management -Social Safeguard Specialist in the MoH	Throughout the project operation phase	Part of the project cost

34	The implementation of the IPF project can exacerbate or add to a new GBV risks through labour influx.	Assessment of the project-related risk of exacerbating SEA/SH. Based on the assessment of the GBV risks, prepare a stand-alone project GBV-SEA/SH Preventive and Response Action Plan.	-GBV Specialist in the MoH	-GBV Specialist in the MoH	Throughout the project operation phase	Part of the project cost
35	The risk of undesired contact and social conflict that may arise due to the socio-cultural differences between project workers and remote pastoral communities with limited external contacts.	• Include in the project LMP appropriate protocols to avoid undesired contact, and disciplinary measures to workers violating the Code of Conduct. • Training for project workers on distinct socio-cultural norms, lifestyles, and traditional institution of the project-affected communities, particularly remote pastoral communities or people of voluntary isolation.	-The Social Safeguard and GBV Specialists in the MoH	-The Social Safeguard and GBV Specialists in the MoH	Throughout the project operation phase	Part of the project cost

7. Grievance Redress Mechanism

A grievance mechanism for the IPF project is designed based on an understanding of the issues that are likely to be the subject of concerns and grievances. Grievances about the IPF project may arise for different reasons. The project information may not be disclosed in relevant local languages and in a manner that is accessible and culturally appropriate, taking into account any specific needs of groups that may be differentially or disproportionately affected by the project or groups of the population with specific information needs. The process may not encourage stakeholders' feedback, particularly those vulnerable individuals and groups as a way of informing project design and implementation. The project-affected communities and vulnerable groups may raise concerns about equitable access and quality PHC services. More importantly, grievances and disputes may arise in the course of the implementation of IPF Sub-component I involving involuntary resettlement. The reasons, among others, may be related to the issues of valuation of assets and compensation and successions, divorces, and other family issues resulting in disputed ownership or disputed shares between inheritors or family members.

7.1 Principles for the Project GRM

How the IPF project responds (or is perceived to be responding) when such grievances surface is important and can have significant implications for the overall implementation of the project. ***Table 16*** outlines key consideration for the IPF project-specific grievance redress mechanism that will be established/strengthened to allow PAPs to complain about any decision or activities regarding the project.

Table 16: Key consideration for the IPF project-specific GRM

No.	Key considerations	Detail about the GRM procedure
1	**Disclosure of the GRM**	A grievance mechanism is established as early as possible in project develop ment. GRM uptake locations need to be established at Regional and Woreda levels and Kebele Appeals Committee (KAC). The existence and condition of access to register (how, where, and when) shall be widely disseminated within the IPF implementation areas. To make IPF project grievance mechanisms accessible to all stakeholders, it is helpful to advertise them publicly and broadly via newspapers, radio broadcasts, or

No.	Key considerations	Detail about the GRM procedure
		other accessible and appropriate channels.
2	**Expectation When Grievances Arise**	Affected or concerned persons expect to be heard and taken seriously. Thus, the MoH (Social Safeguard and GBV Specialists) and other respective regional, *Woreda*, and Kebele Appeals Committee levels implementing agencies and stakeholders need to provide adequate information to people that they can voice grievances and work to resolve without fear of retaliation.
3	**Grievance Submission Method**	It is helpful to make the procedures to submit project-related grievances simple and easy to understand. Thus, IPF project-related complaints can be submitted formally and informally through telephone (hotline), e-mail, MoH websites, program staff, text message (SMS), suggestion/complaint boxes, grievance form or in person. However, once the complaint is received, it will have to be documented in writing using a standard format containing detailed timeline for resolving conflict/complaint. Grievance mechanisms take into account the cultural attributes of HUCs and their traditional mechanisms for raising and resolving issues. Devise for multiple channels through which complaints can be registered in a safe and confidential manner, including through anonymous complaint reporting mechanisms.
4	**Registration of Grievances**	Complaints will be recorded in a log using standard format, examined, investigated and remedial actions will be taken.
5	**Management of Reported Grievances**	The procedure for managing grievances is expected to be as follows: • The affected or concerned person files his/her grievance, relating to any issue associated with the IPF project in writing or phone to the KAC. Where it is written, the grievance note should be signed and dated by the aggrieved person. In addition, where it is phone, the receiver should document every detail. • Where the affected or concerned person is unable to write, the KAC will write the note on the aggrieved person's behalf. • Assigned/focal staffs at Regional and Woredas level will collaborate with *Kebele* administrators/KACs by giving them awareness training on how to document and report grievance.
6	**Integrating IPF project's GRM with traditional grievance resolution system**	The project-affected communities have a long established traditional mechanism of conflict resolution. In all project areas, the traditional forms of managing grievances can even be recognized and used by the government structures. Thus, existing informal conflict resolution mechanisms identified as part of the social assessment under the Sub-section 4.4.3.2 can be used, provided they are deemed suitable for the project's purposes and, as needed, can be supplemented with project-specific arrangements. In some instances, it may be cost effective and sustainable to build on and improve the formal-informal mechanisms for the project grievance redress.

No.	Key considerations	Detail about the GRM procedure
7	**Gender-sensitive**	The project will ensure that the Grievance Mechanism is gender-sensitive during committee formation and implementation. It will ensure that women are represented in the GRM committee and the GRM equally address grievances received from men and women as well as vulnerable groups.
8	**Response time and transparency matter**	The response time for a submit grievance shall not take more than one month at latest. It is good practice for the project GRM to publicly commit to a certain time frame in which all recorded complaints will be responded to and to ensure this response time is enforced. This helps allay frustration by letting people know when they can expect to be contacted by the project area focal personnel and/or receive a response to their complaint. Combining this with a transparent process by which stakeholders can understand how decisions are reached inspires confidence in the project's GRM system
9	**Grievances Reporting Mechanism**	The grievance reporting mechanism is as follows: • The KAC report the complaints registered, addressed and review unresolved appeals and forward them to the Woreda Appeal Committee (WAC) every two weeks. • The WAC forward the list of grievances, their resolution and any unresolved cases to the Regional Appeal Committee (RAC) every month. • The RAC will be responsible for compiling submitted and processed complaints/grievances on regular basis and report to the environmental and social safeguard specialists in the MoH every two months. • The environmental and social safeguard specialists in the MoH compile grievance reports from the respective IPF target regions and submit to the World Bank on a quarterly basis.
10	***Don't impede access to legal remedies***	If the project is unable to resolve a complaint, it may be appropriate to enable complainants to have recourse to external experts. These may include public defenders, legal advisors, legal NGOs, or university staff. The Environmental and Social Safeguard specialists in the MoH are required to work in collaboration with these third parties and affected communities to find successful resolution of the issues. However, this is not always possible, and situations may arise where complainants will choose to pursue further legal system. In such a case, MoH will inform the person with complaints his right to resort to the formal Court System.

7.2 Steps in the GRM Process

Grievance procedures are required to ensure that PAPs can present complaints or concerns, without cost, and with the assurance of a timely and satisfactory resolution of the issue. Grievances will be actively managed and tracked to ensure that appropriate resolutions and actions are taken. A well-organized and well-functioning grievance redressing system is an essential and necessary mechanism to provide remedies to grievances presented by project-affected people early enough to avoid unnecessary project implementation delays and

obstructions. Accessibility for disadvantaged or vulnerable individuals or groups is important, as is documenting grievances received and responses provided.

The project will have complaint and feedback collection mechanisms for all project related communications for stakeholders of the project. The compliant and feedback of project related issues will be collected at all level of project implementation sites namely at the national level of MoH, and respective line agencies and ICS as well as at sub-national level at RHBs, Woreda health offices and health facilities.

Grievance can be of various types, civil service work related grievance will be handled by the civil service office at woreda, region and national level, whose salaries are financed through government funds and for whom the Ethiopian regulations for civil servants apply. As such, only the provisions on Occupational Health and Safety as well as protection in the work force (child and forced labour prohibition) applies which both requirements will be adequately provided in the project ESMF. Whereas service provision related grievances by the service beneficiaries will be handled at health facilities.

The GRM will include the following steps:

a) Step 1: Receipt of complaint- A verbal or written complaint from any individual or group will be received by the focal person in the health facility, and complaint will be recorded and kept. The means of receiving complaints may be: (a) *in person*, this may be verbal or written complaints directly submitted to the focal person in the health facility; (b) g*rievance box*, it is placed in strategic places of project implementation sites or communities where project affected parties would drop in their grievances at any time; (c) p*hone Call or SMS*, this will be at project affected parties own discretion and capability. Where possible, details of relevant immediate contact persons in the project area shall be made available; (d) Central point of contact for project-level GRM at this stage: (1) Dr Ruth Nigatu, Chief of Staff, email: Ruth.nigatu@moh.gov.et; (2) Dr Feven Girma, Director, PCD, email: Feven.girma@moh.gov.et; and (3) Worku Gizaw, Strategic

Affairs Coordinator, email: worku.gizaw@moh.gov.et, Phone: +251 0912016866; and (e) there shall also be an option for anonymous feedback/grievance submission method

b) Step 2: The submitted grievance discussed with the respective health facility
c) Step 3: Determination of corrective action proposed and communicated
d) Step 4: Unaddressed Grievance raised to Woreda Grievance Office
e) Step 5: Appeal to the Regional (or, where available, Zonal) Grievance Office
f) Step 6: The project-specific GRM will not prevent the rights of the project-affected party with complaints for formal court option. If cases cannot be resolved at any of these levels, the complainant will go to the court. This would also assist in creating an alternative space for project-affected parties who would otherwise not be able to voice out their concerns through the established project GRM structure for fear of reprisals despite repeated assurances of protection.

7.3 Grievance Log

The project grievance mechanism should have a log where grievances are properly registered in writing and maintained as a database. Different ways in which users can submit their grievances, which may include submissions in person, by phone, text message, mail, e-mail or via a web site. But, that needs to be properly recorded and documented. The record should contain the name of the individual or organization; the date and nature of the complaint; any follow-up actions taken; the final result; and how and when this decision was communicated to the complainant. Where applicable, there is a chance of providing anonymous feedback/grievances.Overly personal data (such as copy of ID, house number and the like) should therefore be optional and kept confidential unless required to disclose to authorities. In addition to informing the complainant of the outcome (in writing where appropriate), it is also good practice as part of the broader community engagement process to report back periodically to communities and other stakeholder groups as to how the project has been responding to the grievances it has received..

7.4 Handling of GBV/SEA/SH Complaints

Grievances related to SEA/SH will be recorded confidentiality and the survivor will be given the options to seek legal redress, health care or psycho-social support as per their preference. Special attention will be given to SEA/SH grievances (marked as confidential) to ensure confidentiality and to avoid intimidation of complainants or victims.

Grievance related with gender-based violence is being handled at health facilities label with various approaches. Ministry of Women and Social affair together with Ministry of Health and Ministry of Justice have initiated one stop shopping for GBV victims at 57 hospitals and this initiative will be scaled up to other hospitals progressively. The Community level GBV grievance handling is being managed by Ministry of Women and Social affair at their structure up to the grass root level.

The grievance handling time varies based on the complexity of the problem. GBV grievances appeared at the one stop shopping centers will be handled at the center of those hospitals with multidisciplinary team, followed by management of all aspects of violence by each team members which vary from one day to an extended periods of months to resolve and ensure justice.

Those GBVs happened at other health facilities as well as at community level will be managed by the health facilities management followed by the woreda justice/regional/federal level justices to ensure its timely handing. The time frame might vary based on the case from weeks to months.

The project GMs should follow good practice in receiving, recording, and referring all SEA/SH omplaints. The following considerations are important for designing a SEA/SH responsive GM:

- The GM should adopt a survivor centered approach in which the safety and well-being of the SEA/SH survivor is the first priority, the survivor will be treated with dignity and respect, and the survivor's choice and the agency will be respected in all decisions

- In order to act in the best interests of children, GMs will need to have specific protocols for children who are survivors of SEA/SH. GM operators should be trained on how to respond to cases involving children,
- Devise for multiple channels through which complaints can be registered in a safe and confidential manner, including through anonymous complaint reporting mechanisms.
- Information on how to report complaints be disseminated among beneficiaries and communities.
- The personal information of a survivor be protected.
- The GM serve primarily to refer complainants to GBV service providers (whether related to the project or not) immediately after receiving a complaint.
- The GM operates without prejudice to any other complaint mechanisms or legal recourse to which an individual or community may otherwise have access under formal law.

7.5 Monitoring and Evaluation

The Stakeholder Engagement Plan will be periodically revised and updated as necessary in the course of the project implementations in order to ensure that the information presented herein is consistent and is the most recent, and that the identified methods of engagement remain appropriate and effective in relation to the project context and specific phases of the development. Any major changes to the project related activities and to its schedule will be duly reflected in the SEP. Adequate institutional arrangements, systems and resources will be put in place to monitor the application of stakeholder engagement plan across the whole project. Also, The performance of the project GRM shall be subject to continuous M&E and that forms a part of the SEP.

Monthly summaries and internal reports on public grievances, enquiries and related incidents, together with the status of implementation of associated corrective/preventative actions will be collated by responsible staff and referred to the senior management of the project(s). The periodic summaries will provide a mechanism for assessing both the number and the nature of

complaints and requests for information, along with the Project's ability to address those in a timely and effective manner.

Table 17: Indicators and their monitoring mechanisms

SN	*Indicator*	*Frequency of reporting*	*Means of verification*
1	Number of GO-NGO Forum conducted	Biannually	Meeting minute
2	Number of Joint Steering Committee meetings	Every other month	Meeting minute
3	Number of Biannual Performance review meetings	Biannually	Meeting minutes
4	Number of annual review meeting conducted	Annually	Meeting minutes
5	Number of grievances handled	Biannually	Grievance report

7.6 The World Bank Group Grievance Service

According to World Bank Grievance Redress, communities and individuals who believe they are adversely affected by a Bank-supported project may submit complaints to existing project-level grievance redress mechanisms or the Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed to address project-related concerns and impacts. Project affected communities and individuals may submit their complaint to the Bank's Independent Inspection Panel, which determines whether harm occurred, or could occur, because of the Bank's noncompliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the Bank's attention and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the Bank's corporate GRS, see http://www.worldbank.org/GRS, and Bank's Inspection Panel, see www.inspectionpanel.org. The Bank's GRS will be shared with the project affected community as part of project information disclosure. Considering the very low literacy level of the project affected communities to access the Bank's GRS through website, the GRM provide alternative means including but not limited to posting the phone number of the Bank's GRS and Inspection Panel at the Country Office on community notice board.

8. Stakeholder Engagement

8.1 Stakeholders Engagement Activities during the Project Design

As per the provisions set out in the ESS10, engagement begins as early as possible in project preparation because early identification of, and consultation with, affected and interested parties allows stakeholders' views and concerns to be considered in the project design, implementation, and operation.

During the project preparation, consultations were conducted with MoH and implementing entities. The higher management body of the Ministry of Health, the different directorates and regional health bureaus have been meeting on a monthly basis to assess the overall performance of the health system and the preparation of the project. Moreover, consultations were conducted with the Bank and other development partners on the same. The project being a hybrid PforR with IPF component, during the preparation, Environment and Social System Assessment (ESSA) consultations and related stakeholder consultation workshops were also conducted. Further information is provided below regarding virtual consultations conducted during the design period of the project.

a) Meeting with SDG Performance Fund Contributors and Signatories

There were two round of discussions with SDGPF partners (11 contributors of the SDGPF) on the preparation of the project, held on June 23, 2021, 4:30 PM-5:30 PM and February 15, 2022 4:00 PM-5:00 PM. The discussions were on the design and scope of the program, proposed implementation arrangement, proposed DLIs and Program actions. There were clarification

questions from the participants including: Whether the new operation will support the sector through the SDGPF or not? How much of the resources will flow through the SDGPF? Explanation on the IPF vs PforR instrument was detailed.

b) Meeting with MOH Directorate Directors and delegates on Environmental and Social System Assessment findings.

Consultations were conducted with different directorates and regional representatives as part of the preparation of the Environment and Social System Assessment (ESSA). Furthermore, discussions were held on February 22, 2022 with MoH directors and their delegates on environmental and social assessment findings. Inputs and comments were collected from the participants for project preparation.

A comprehensive Stakeholder Engagement Plan (SEP) was prepared for the parent PforR SPHCS project in April, 2022 and was disclosed. The SEP will apply for the IPF Component Project and will continue to be used along with the present ESMF and other E&S risk management instruments prepared for the IPF component project.

8.2 Stakeholder and Community Consultations for IPF Component Project

In addition to the stakeholder consultations carried during the parent PforR project design and preparation process described above, another round of stakeholder and community consultations were conducted recently as part of the preparation process of the ESMF, Social Assessment, Resettlement Framework and LMP for the IPF Components. The stakeholder and community consultations were conducted at Federal level with the MoH and its relevant Agencies, Directorates and third party implementer, i.e., UNICEF. At the regional level the consultations were carried out in a sample of three conflict affected regions, Oromia, Amhara and Afar regions and two woredas found in them. The consultations at the Federal level including the Oromia region were conducted between 31/01/23 to 14/02/23 and the remaining regional and Woreda level consultations between 19/02/23 to 25/02/23. The objectives of the stakeholder consultation were to:

- develop a list of project-affected and other interested parties for stakeholder consultation and engagement.
- disclose project information to allow stakeholders to understand the risks and impacts of the project, and potential opportunities, and make available project-related information as early as possible in the project cycle and in a manner, format, and language appropriate for each stakeholder group.
- undertake a process of meaningful consultation in a manner that provides stakeholders with opportunities to express their views on potential project risks and impacts and allows MoH to consider and respond to them through designing appropriate mitigation measures.
- accommodate the views and circumstances of different stakeholders, paying special attention to the concerns and special needs of the disadvantaged or vulnerable individuals or groups. It takes into account the different access and communication needs of various groups and individuals, especially those more disadvantaged or vulnerable, including consideration of both communication and physical accessibility challenges.
- provide the social baselines and inputs for the preparation of the ESMF, RF, SMP, SEP and GBV Risk Assessment, Prevention and Response Action Plan.

Participants of the community consultation composed of community representatives (clan leaders, community elders, religious leaders) and members of vulnerable groups including Pregnant and Lactating Women (PLW), returnee IDPs, and the elderly with special needs. The first community consultation was held in Chifra woreda on February 23, 2023 and about 15 participants were took part in. The participants were selected from five different kebeles (Chifra town, Ander Kello, Weama, Teabay, and semsem). Participants' gathering at Chifra primary hospital seeking for health service was used as a good opportunity to allow the selection of community consultation participants from different kebeles. The selection was done with the support of the Head of Chifra Woreda Health Office and the CEO of Chifra Primary Hospital. The second community consultation was conducted in Tehuledere woreda on February 20, 2023. About 20 participants were took part in this community consultation selected from six different kebeles, namely: Jari, Wahelo, Gobeya 012, Kete, Godguadit 05, and Amumo. The same

selection approach as Chifra was used: Participants were met at Hayq Health Center waiting for health service and selected for community consultation by the help of the health workers.

As required in ESS10, meaningful stakeholder engagement depends on timely, accurate, accessible, and comprehensible information. Therefore, making available project-related information as early as possible in the project cycle and in a manner, format, and language appropriate for each stakeholder group is important. As part of this early project information disclosure, before directly jumping to consultation, stakeholders were provided with relevant IPF project-related information: (a) the purpose, scale, and duration of the project; (b) IPF Sub-components and the nature of the proposed activities under each Sub-component; (c) potential IPF project benefits and opportunities; (d) potential risks and impacts of the project on local communities, and the proposals for mitigating these; (f) the proposed stakeholder engagement process highlighting the ways in which stakeholders can participate; and (g) the process and means by which grievances can be raised and will be addressed.

8.3 Summary of stakeholder's consultation on IPF project: Views, concerns and responses given

For the purpose of IPF project consultations, the selection of relevant stakeholders and participants of community consultation was done as per the requirements of ESSs 1, 4, 5, 7 and 10. With this key note, summary views and concerns raised by the participants and responses given are presented below.

Interviewed officials/expertise and community consultation participants alike expressed their feeling of appreciation and thankful about the proposed IPF project interventions focusing on the special needs of conflicted affected areas and vulnerable individuals and groups. Given the critical health problems owing to huge damage to health facilities in the conflict, all the participants in the consultation invariably felt anxious even the delay of the proposed IPF project interventions. However, both the officials/expertise and community members in the consultation raised their concerns on how the project shall be promptly and effectively implemented. Responses were given on these concerns that the World Bank is highly committed in providing

technical assistance in conducting the environmental and social assessment and preparation of the required E&S management plans for speedily project disbursement. Besides, the proposed institutional and implementation arrangements for the effective execution of the E&S safeguard instruments were discussed with the participants. Particularly, the health management members and workers consulted at the Woreda and health facility level raised additional concerns on how to overcome the constraining factors of institutional gaps for the successful execution of the proposed IPF project interventions. Responding to this concern, the innovative approaches to reach out to the inaccessible conflict-affected areas/communities and technical assistance and capacity building activities proposed in the IPF project to strengthen the institutional capacity were shared with the participants. At the end, mutual understanding was made on the point and the officials/expertise and local community members agreed to play their roles and responsibilities for strengthening the project grassroots implementing arrangements.

One of the key issues emphasized by the participants of community consultation and interviewed community representatives raised in relation to project land acquisition for the civil works under the IPF Sub-component I. The participants expressed that the proposed PHC interventions, through the reconstruction of conflict-damaged health facilities and establishment of temporary or satellite clinics at IDP Camps, are of top priority for the local communities and the project land acquisition for these purposes are welcomed in this respect. But, the consulted members of local community consistently raised the major concern regards what measures will be put in place by the project to address the risks and adverse impacts associated with involuntary resettlement. Responding to this concern, response was given that the IPF project will apply the mitigation hierarchy: avoid, minimize, and compensate the resettlement risks and impacts. Participants were explained that following mitigation hierarchy approach, MoH will prepare a resettlement plan (RP) for any IPF project activity that results in economic or physical displacement; project affected persons (PAPs) will be actively engaged in the planning and implementation of the RP; no physical and/or economic displacement will occur without proper compensation measures; and accessible and inclusive IPF project specific grievance redress mechanism will be established. After clarifying with these responses, the participants

acknowledge they are awareness of the project mitigation measures and their concerns addressed.

Justifying the special circumstances and needs they have, members of vulnerable groups and historically underserved communities approached through a separate interview expressed their serious concerns on how the IPF project implementation will overcome the social, cultural, and economic constraints with disproportionate impacts on them. Response was given highlighting the potential risks and impacts that might disproportionately affect vulnerable and disadvantaged groups, and describing the differentiated measures taken to avoid or minimize these including deployment of mobile health and CRVS teams, preparation of Underserved Community Plan, and establishment of temporary or satellite clinics to reach out to the special needs of vulnerable groups and HUCs. Participants' expression of acknowledgement for the differential mitigation measures proposed in the IPF project concludes on the concerns of the members of vulnerable groups and HUCs.

8.4 Stakeholder Engagement Program

A stakeholder engagement intends to build and maintain constructive relationships with the project-affected and other interested parties. Because the project circumstances and stakeholder concerns can change or new ones may emerge, stakeholder engagement is conducted throughout the IPF project cycle. Accordingly, the SEP may need to be updated during project implementation. This allows improvement to the project implementation based on stakeholder feedback, and proactive management of concerns.

8.4.1 Strategies for effective and inclusive engagement

Iterative process: The project stakeholder engagement will apply an iterative process. Iterative means maintaining a continuous and two-way process of consultation between the project implementing agencies and stakeholders. Iterative consultation process is an opportunity to get information, as well as to educate project implementing staffs about the local context in which

the project take place, to raise issues and concerns, ask questions, and potentially help shape the project by making suggestions for the project implementing agencies (MoH, ICS, IPSA and UNICEF) to consider and respond to.

Meaningful consultation: The project applies meaningful consultation tailored to the special needs and concerns of vulnerable and disadvantaged individuals and groups. The strategy of meaningful consultation emphasized: (a) it is particularly important to understand the project impacts and whether they may disproportionately fall on the disadvantaged or vulnerable individuals or groups, who often do not have a voice to express their concerns or understand the impacts of the project. In such cases, the SEP devise an array of strategies tailored to the need of the specific group in question; (b) approaches to meaningful consultation are most effective when they build on existing customary institutions and decision-making processes; and (c) eeaningful consultation recognizes that the roles of men and women in HUCs' cultures are often different from those in the mainstream groups, and that women have frequently been marginalized both within their own communities and as a result of external developments, and may have specific needs. A meaningful consultation takes this special concerns of women into account.

Strategy for inclusive consultation: Various types of barriers may influence the capacity of disadvantaged or vulnerable individuals and groups (such as PLW, women and girls in general, children, people with disability, the elderly, and HUCs) to articulate their concerns and priorities about the project impacts. These barriers can be linked to socio-political, societal conflict, educational, or practical factors. To address such barriers, therefore, the project engagement devise differentiated strategies tailored to the special needs and concerns of vulnerable and disadvantaged individuals and groups including but not limited to:

- Identify vulnerable or disadvantaged individuals or groups and the limitations they have in participating and/or in understanding the project information or participating in the consultation process.

- What might prevent these individuals and groups from participating in the planned consultation process? (For example, language differences, lack of transportation to events, inaccessibility of venues, mobility impairment. . . etc).
- Understand how the vulnerable or disadvantaged individuals and groups normally get information about the community and projects activities.
- Do they have limitations about time of day or location for public consultation?

Accordingly, as stated below, the project engagement applies additional support or resources that might be needed to enable vulnerable or disadvantaged individuals and groups to participate in the consultation process.

Obtaining Free, Prior, and Informed Consent (FPIC): As described under the social risks of the project, HUCs may be particularly vulnerable to the loss of, alienation from, or exploitation of their land and access to natural and cultural resources resulting from land acquisition for the civil works of IPF Sub-component 1. In recognition of this vulnerability, in addition to the General Requirements set out in ESSs 1 and 10, the MoH will obtain the FPIC of the affected HUCs in circumstances in which the project will:

(a) Have adverse impacts on land and natural resources subject to traditional ownership or under customary use or occupation;

(b) Relocation of HUCs from land and natural resources subject to traditional ownership or under customary use or occupation; or

Have significant impacts on HUCs' cultural heritage that is material to their identity and/or cultural, ceremonial, or spiritual lives.

8.4.2 Methods of engagement

Various methods of engagement will be used as part of the project's continuous interaction with the stakeholders, to ensure that different stakeholder groups are successfully reached and are involved in the process of consultation, decision-making and the development of impact management solutions. These include but not limited to the following.

Public/community meetings/hearings: As a good procedure, information that is communicated in advance of public consultations primarily includes an announcement thereof in the public media – local, regional and national, as well as the distribution of invitations and full details of the forthcoming meeting well in advance, including the agenda. It is crucial that this information is widely available, readily accessible, clearly outlined, and reaches all areas and segments of the target community. Invitation to and participation in public/community meetings/hearings should be free from manipulation or coercion. Public/community meetings may be ongoing as required during the life of the project. These parameters can be achieved by implementing the following approach:

- Planned early enough to scope key issues in the meeting. Drafting an agenda for the consultation meeting is an opportunity to provide a clear and itemized outline of the meeting's structure, sequence, chairpersons, a range of issues that will be discussed and a format of the discussion (e.g. presentation/ demonstration followed by a Questions & Answers – Q&A session, facilitated work in small groups, feature story and experience sharing, thematic sessions with a free speaking format enabling the exchange of ideas). A clearly defined scope of issues that will be covered at the meeting gives the prospective participants an opportunity to prepare their questions and comments in advance.
- Advance public notification of an upcoming consultation meeting. Distribution of targeted invitations to the consultation meeting or a hearing is an important element of the preparation process and is based on the list of participants that is compiled and agreed in advance of the consultation. Invitations may be sent both to certain individuals that have been specifically identified as relevant stakeholders (e.g. representatives of authorities, leaders of local NGOs and initiative groups, village chairpersons) and as public invites (e.g. addressed to initiative and professional bodies, local organizations, and other public entities). Text of individual invitations can be tailored to reflect the specifics of an invitee and their role in the process, whereas the text of public invitations normally indicates general details. Means of distributing the invitations should be appropriate to the customary methods of communication that prevail locally in the Project Area of Influence (PAI). Depending on the availability and technical feasibility, the following means of distribution

can be used: direct mail (post); as an inclusion with other existing public mailings, utility bills, or circulates from a local authority. The invitation should typically contain a clear request for confirmation of the participation, also specifying a date by which the confirmation is expected. All invitations that were sent out are tracked in order to determine and manage the response rate. If no response has been received, the invitation can be followed up by a telephone call or e-mail where possible.

- An attendance list is made available at the commencement of the consultation/hearing /meetings in order to record all participants who are present at the meeting and their affiliation. Wherever possible, attendees' signatures should be obtained as a proof of their participation. Details of the attendees who were not initially on the list (e.g. those participating in place of somebody else, or general public) should be included in addition to those who have registered for the meeting in advance.
- In most cases and as a general practice, the introductory part of the meeting or hearing should be delivered in a format that is readily understandable to the audience of laypersons and should be free of excessive technical jargon in particular meetings at the community level and out of the health system structure. If necessary, preference should be given, whenever possible, to the oral and visual methods of communication (including presentations, pictorials, illustrations, graphics and animation) accompanied by hand-out materials imparting the relevant information in understandable terms rather than as text laden with technical intricacies. Where technical specifics of the project's particular activities or solutions are required to be delivered in a greater level of detail, it will be ensured that the information conveyed remains comprehensible to all members of the audience and that the description of complex technicalities is adapted to their level of understanding, thereby enabling productive feedback and effective discussion.
- If a large audience is expected to attend a public meeting or a hearing, necessary arrangements will be made to ensure audibility and visibility of the presentation and any demonstrations involved. This includes provision of a microphone, proper illumination, projector, places allocated for the wheelchair users, etc. Taking records of the meeting (Meeting minutes or proceedings) is essential both for the purposes of transparency and the

accuracy of capturing public comments. At least three ways of recording may be used, including:

- ✓ Taking written minutes of the meeting by a specially assigned person or a secretary;
- ✓ Audio recording (e.g. by means of voice recorders);
- ✓ Photographing;
- ✓ Where feasible, the video recording may also be undertaken; and
- ✓ Combination of the above methods assures that the course of the meeting is fully documented and that there are no significant gaps in the records which may result in some of the important comments received from the stakeholder audience being overlooked.

- It is essential to allocate a sufficient amount of time for a concluding Q&A session at the end of any public meeting or a hearing. This allows the audience to convey their comments and suggestions that can subsequently be incorporated into the design of the project.
- As a possible option in addition to the Q&A session nearer the close of the public meeting/hearing, evaluation (feedback) forms may be distributed to participants in order to give them an opportunity to express their opinion and suggestions on the project. This is particularly helpful for capturing individual feedback from persons who may have refrained from expressing their views or concerns in public. Questions provided in the evaluation form may cover the following aspects at the community level:
  - ✓ Participant's name and affiliation (these items are not mandatory if the participant prefers to keep the form confidential)
  - ✓ How did they learn about the Project and the consultation meeting?
  - ✓ Are they generally in favour of the Project or what are the advantages/expectations of the project?
  - ✓ What are their main concerns or expectations/hopes associated with the Project or the particular activity discussed at the meeting?
  - ✓ Do they think the Project will bring some advantages to their community as a whole? Is there anything in the Project and its design solutions that they would like to change or improve?

- ✓ Do they think that the consultation meeting has been useful in understanding the specific activities of the Project, as well as associated impacts and mitigation measures? What aspects of the meeting they particularly appreciated or would recommend for improvement?

- Includes the promise that the public's contribution will influence the decision. Public participation promotes sustainable decisions by recognizing and communicating the needs and interests of all participants, including decision makers.
- Gender-inclusive through awareness that men and women often have differing views and needs.
- Keeping a record of all public comments received during the consultation meetings enables the project's responsible staff to initiate necessary actions, thereby enhancing the project's overall approach taking onto consideration the stakeholders' priorities. The recorded comments and how they have been addressed by the project becomes an appropriate material for inclusion in the project's regular reporting to the stakeholders. Besides, if comments cannot be addressed, it is also important to explain why when reporting back to stakeholders.
- Reported back in a timely way to those consulted, with clarification of next steps.

The use of notice boards: Existing notice boards in the communities may be particularly useful for distributing the announcements, such as boards adjacent to the widely visited public premises – post offices, chain stores, transport links, and offices of the local NGOs. When the notifications are placed on public boards in open air, it should be remembered that the posters are exposed to weather, may be removed by passers or covered by other advertisements. The project's staff will therefore maintain regular checks in order to ensure that the notifications provided on the public boards remain in place and legible.

Targeted workshops: The workshops with experts will be held to consult on the revision and development of new policies and normative documents**.** Also, several workshops with stakeholders will be carried out. The main topics of these workshops will include raising stakeholder awareness on project benefits, establishing project implementation procedure, timing

for project implementation, GRM and GBV. Other topics relevant for these workshops will be identified during project implementation as necessary.

Placement of project materials: Placement of the project materials in the public domain is also accompanied by making available a register of comments and suggestions that can be used by any member of the affected community and general public to provide their written feedback on the contents of the presented materials. As a rule, the register is made available for the entire duration of the requisite disclosure period. Where necessary, a project representative or an appointed consultant should be made available to receive and record any verbal feedback in case some stakeholders experience a difficulty with providing comments in the written form.

Webpage/platform: For those with knowhow and have access to use, a dedicated webpage/platform will be created for the project to enable users to find all the information about the project. The goal of the platform is to provide core information about the project and to ensure accessible online feedback to project stakeholders and to support several stakeholder engagement activities. The platform will also be used to publish all the ESMPs.

Letters: Letters will be an instrument used in order to facilitate the project implementation process through good collaboration between the implementing entities and other stakeholders.

Differential methods for vulnerable or disadvantaged individuals and groups: The stakeholder engagement process is inclusive and undertaken to accommodate the needs and circumstances of different stakeholders, paying special attention to identified disadvantaged or vulnerable individuals or groups.

- If necessary, logistical assistance should be provided to enable participants from the remote areas, persons with limited physical abilities and those with insufficient financial or transportation means to attend public meetings scheduled by the project.
- Ensuring the participation of vulnerable individuals and groups in project consultations may require the implementation of tailored techniques. Since their vulnerable status may lead to people's diffidence and reluctance or physical incapacity to participate in large-

scale community meetings, visiting such individuals/families at their homes or holding separate small group discussions with them at an easily accessible venue is a way for the project to reach out to the groups who, under standard circumstances, are likely to be insufficiently represented at community gatherings. The project will depend on the health extension workers and women development armies in this regard.

- The project will engage with vulnerable or disadvantaged individuals and groups at the grass root level through health extension workers regular community conversation meetings and pregnant women conferences which will be organized at the community level in close communication with the health centers and health posts.
- Relevant project information should also be accessible for stakeholders with sensory disabilities, for instance, through providing documents in Braille or engaging a sign language interpreter at a consultation meeting, as appropriate.
- In cases where literacy levels are low such as pastoral areas, additional formats like oral communication, location sketches, physical models, and presentation of video records are used to communicate relevant project information.

Table 18: Summary of planned stakeholder engagement activities

Target stakeholders	***Topic(s) of engagement***	***Method(s) used***	***Location/frequency***	***Responsibilities***
Project affected people: Women of reproductive age group, Pregnant women, Lactating women, post-natal women, Malnourished pregnant women, People with disability, Communities living in developing regional states, people affected and/or displaced people by internal conflict, survivors of GBV	Project related information, availing all the necessary detailed information about the project components benefits and other related issues to get the service, to investigate any side effects occurrences to manage	Meetings, conference, face to face meetings with affected communities through the home-to-home visit by health extension workers, health women development armies and other structures	Health facilities, Villages, RHBs and Nationally through mass media, local media on regular bases	MOH/ICS/RHB
Project Affected institutions and workers: Public health facilities, health care workers training institutions, health facilities residing in	Project related information, availing all the necessary detailed information about the project components benefits and other	Distribution of documents, trainings and meetings/ workshops	National, Regional and district level on regular bases	MOH/RHB/District health offices

internal conflict areas, and health care workers	related issues to provide the services availing grievance handling system			
Other interested parties (Internal):	Project related assessments and document provision for all concerned parties of the internal stakeholders of MOH	Circulation of relevant project documents, findings and publications	National and regional level	MOH/RHBs
Other interested parties (External):	Project related assessments and document provision for all concerned parties of the external stakeholders of MOH	Circulation of relevant project documents, findings and publications	National and regional level	MOH/RHBs

8.5 Description of the Planned Information Disclosure Methods

As a standard practice, the Project materials including the project proposal, educational materials on RMNCYH, and nutrition, ESMF, ESMP, SEP, RPF or Resettlement Action Plans (RAP) will be released for disclosure. Those tasks will be accompanied by making available the registers of comments and suggestions from the public at the health posts, health centers, hospitals and vital event registration areas by respective management of the project. Those documented feedback and comments will be regularly evaluated by the quality improvement committees of the health facilities and those which need attention of the higher management of the health system will be reported to higher structure of the health system.

Health sector managers and the project implementing team will continue applying a similar approach to disclosure of any additional E&S appraisal materials that will be prepared as part of the project development on top of any project implementation related information's. The ESMF report together with the associated ESMPs in English will be made available for public review for the period of 60 days in accordance with the international requirements. These documents will be available at venues and locations frequented by the community and places to which public have unhindered access such as health posts, health centers, hospitals and health offices of

the health system. Free printed copies of the ESMF/ESMPs and the SEP in English/Amharic and other local languages as appropriate will be made accessible for the general public at the following locations:

- Ministry of Health Ethiopia and Regional Health Bureaus
- Immigration and Citizenship Service
- Health Facilities at all levels if deemed necessary
- Other designated public locations to ensure wide dissemination of the materials.

Electronic copies of the ESMF, ESMPs, RPF, RAP (as required) and SEP will be placed on the MOH and RHBs dedicated website. This will allow stakeholders with access to internet to view information about the planned development and to initiate their involvement in the public consultation process. The mechanisms which will be used for facilitating input from stakeholders will include press releases and announcements in the media, notifications of the aforementioned disclosed materials to local, regional and national NGOs as well as other interested parties.

Table 19: Stakeholder engagement and disclosure methods

Stakeholder Group	***Project Information Shared***	***Means of communication/ disclosure***
Community group	ESMF, ESMPs, and stakeholder engagement plan; Public Grievance Procedure; Regular updates on Project development.	Through health extension workers, women development army and meetings and other community gathering events
Governmental sectors	ESMF, ESMP, Executive Summary, and Stakeholder Engagement Plan; Regular updates on Project development; Additional types of project's information if required for the purposes of regulation and permitting.	Dissemination of hard copies of the ESMF, ESMP, RPF package, and SEP at all sectoral offices and Project status reports if necessary as well as meetings and round tables.
Development partners	ESMF, ESMP, RFP, RAP (if triggered), and Stakeholder Engagement Plan; Public Grievance Procedure; Regular updates on Project development.	ARM, SDG-PF triggering factors, SDG performance progress report, and other relevant data, public notices. Electronic publications and press releases on the MOH website. Dissemination of hard copies at designated public locations. Press releases in the local media. SDG-PF quarter meetings and other Consultation meetings.

Implementing partners	ESMF, ESMP, RFP, RAP (if triggered), and Stakeholder Engagement Plan; Public Grievance Procedure; Regular updates on Project development	ARM, Public notices. Electronic publications and press releases on the MOH website; Dissemination of hard copies at designated public locations; Press releases in the local media. GO-NGO meetings and other Consultation meetings
Health institutions and Health care workers	ESMF, ESMP and Stakeholder Engagement Plan; Regular updates on Project development; Additional types of Project's information if required for the purposes of regulation and permitting.	ARM, Dissemination of hard copies of the ESMF, ESMP, RFP package, and SEP at all sectoral offices and Project status reports if necessary as well as meetings and round tables.
Employees under the project	Employee/Workers Grievance Redresses Procedure; Updates on Project development.	Staff handbook. Email updates covering the Project staff and personnel; Regular meetings with the staff. Posts on information boards in the offices and on site. Reports, leaflets.

9. Capacity Building and Training Requirements

9.1 Institutional Capacity Assessment

Effective implementation of the ESMF, RPF and all the other safeguard instruments prepared for the IPF Component Project will require technical capacity within the lead project implementing institution and partner institutions. There will be need for in-depth understanding of the

operationalization mechanism of the ESMF to be provided to the various lead and partner institutions and key stakeholders involved in the implementation of the IPF Component project activities. Capacity building will be necessary to support the teams in appreciating their roles in providing supervision, monitoring, evaluation and environmental reporting on the subprojects activities. Therefore, there is a need to develop the capacity of the project implementing units, staff from partner and beneficiary institutions to support implementation of the IPF Component with regard to social and environmental aspects. The following sections outline the capacity building needs of the implementing agencies and partner institutions.

9.2 Assessment of capacities and practical experiences of implementing Agencies on Environmental and social management.

The main implementing agency of Subcomponent-I and III of the IPF Project is the Ministry of Health (MoH) in collaboration with the five conflict-affected Regional Health Bureaus. The Ethiopian Pharmaceutical Supply Agency (EPSA) will be a partner implementing institution under the MoH in the areas of procurement and distribution of medical supplies and equipment. UNICEF will also act as third party implementing entity for subcomponent-1 of the IPF project in Tigray region. The main implementing agency for Subcomponent II of the IPF project will be the Immigration and Citizenship Services (ICS). The institutional arrangement for ESMF implementation is also going to follow the same lines.The ESMF implementation will be spearheaded by the GMU environment and social staff and are expected to work in close collaboration with the E&S staff of partner institutions (i.e., RHBs, ICS and EPSA) as well as third party implementing institution (i.e. the UNICEF).

The existing capacities and practical experiences in the area of environmental and social management of the main IPF Subcomponent-I Project implementing institution; which is the MoH, is evolving and needs to be further strengthened. The MoH has deployed one environment officer under the Design and Construction Directorate and a second Social Development specialist is reported to be under recruitment. The Environment Officer is supposed to follow up the E&S issues of all development projects conducted by the Ministry, whether it is construction

or other project conducted by the Strategic Partnership and Grant Management Directorate. All donor financed projects and programs including active World Bank projects under implementation by the MoH are coordinated from one pool: The Strategic Partnership and Grant Management Directorate. As observed during the consultation meeting with MoH, this directorate is supposed to depend on the environment officer present under the design and construction directorate for all its E&S risk management issues.

Moreover, the MoH assert that it also has Environmental Health professionals under its Environmental Hygiene and Public Health Directorate who are also often deployed for managing E&S risks. In practice, this Directorate is focused on addressing the key environmental and social risks that are known to occur while operating a health care facility. Such E&S issues addressed include health care hazardous waste management, building/installation of incinerators, health facility sanitation, and the Directorate has developed several useful guidelines for these and related purposes. The Directorate also runs the national WASH program which makes it conversant to World Bank E&S risk management procedures.

The Regional Health Bureaus also appear to have a department on environmental hygiene and public health. The roles played by this department in the regional health bureaus are similar to the one at federal level. They focus on addressing the key E&S issues encountered at health care facilities which are focused on health care waste management. Expired and unfit for use medicines and supplies are also disposed under the supervision of this department based on the Medicine Waste Management and Disposal Directive issued by FMHDA. Structurally, the environmental hygiene departments also extend down to Zone, Woreda and kebele levels, but availability of man-power differs from place to place and often public health/environmental hygiene positions are covered by other health professionals.

On the other hand, EPSA which will spearhead the procurement and distribution of medical supplies and equipment activities is engaged on its operational activities without due focus on environmental and social risk management aspects. During the consultation carried with staff of

the Agency, it appeared that EPSA do not have an environment risk management staff. The Agency is certified for Quality Management System (ISO9001) but its practices in relation to management of environmental aspects as component activity is invisible. The medicines, medical supplies, and equipment handled by EPSA are very wide in variety and it consists of radiological equipment such as X-Rays, CT Scans, etc., which involve radioactive substances. Apart from applying the FMHDA Directive on Medicines Waste Management and Disposal Directive applied to dispose its wastes of expired/out of use drugs, the Agency appears to be less conversant to other aspects of E&S risks that could arise from its operational activities. Thus, there appears to exist a capacity gap in EPSA in the area of E&S risk management.

A consultation with the third party project implementing partner UNICEF revealed that environmental and social risk management of projects is carried as part of the wider program planning, monitoring and evaluation systems. As such there is no unit or section for E&S risk management in the UNICEF Country Office, but there are focal persons to follow issues such as gender, mental health, climate change and environmental issues separately. The Donor relation and report writing unit together with Program Monitoring Unit of UNICEF continuously checks whether the planning indicators that would include environmental and social performance of projects are met in accordance with the PforR. A results framework report is prepared by the Program Monitoring Unit which is verified by regular field visits made by health and construction units of UNICEF.

In a similar trend, the environmental and social risk management capacities of the Immigration and Citizenship Services appears to be weak. The institution has no E&S risk management staff at any level, at the head office or regional branches. During consultation with the ICS staff, it was explained that the ICS and its branch offices apply a manual prepared by the Ministry of Finance to dispose IT equipment.

The practical experience of the IPF component implementing institutions in the area of E&S risk management practices vary widely. Whereas the MoH at the head office level has started

practicing E&S risk management procedures with its currently ongoing Bank financed projects, such practices are almost inexistent in the ICS and EPSA. In MoH there are practices of preparing ESIA documents for some projects financed by donors and it is becoming well versed with the National and World Bank E&S risk management requirements. However, there is a wide gap in following up implementation of ESMF procedures, ESMPs and conducting E&S monitoring across all the projects under implementation. Thus, the existing capacities in MoH will need to be further strengthened. The existing E&S risk management practices at Regional Health Bureaus are limited to the Key but traditional issues of health care waste management at facility level. The existing practices by the environmental hygiene/public health experts are short of addressing other aspects of E&S risks that would arise during construction and operation phases of a subproject.

In summary, the consultation discussions and assessments held with the institutions have shown that there are capacity gaps in environmental and social management which needs to be filled through deploying adequate human resource and training. As a result, it is recommended that the capacity gap in E&S risk management manpower should be filled in as follows.

- Deploy one environment, one social, and one gender specialist at MoH dedicated for the IPF Component.
- Deploy one environment, one social, and one gender specialist at EPSA dedicated to the IPF Component
- Deploy qualified environment and social focal persons at Immigration and Citizenship Services and EPSA,
- Deploy qualified Environmental and Social risk management specialists at UNICEF and focal persons at Regional Health Bureaus.

In addition to achieving the ESMF procedures and requirements, the E&S risk management specialists of MoH, EPSA, ICS and those focal persons to be assigned in the regional health bureaus and UNICEF will collaboratively work on the following,

- The preparation of annual work programs and budgets to fulfill ESMF requirements of subprojects;

- Monitoring project progress as it relates to compliance with the ESMF guidelines, resolving implementation bottlenecks, and ensuring overall that project implementation proceeds smoothly;
- Collecting and managing information relevant to the subproject environmental management works (i.e. environmental monitoring and audit reports of ESMPs),
- Ensuring that the implementing partner and beneficiary bodies are supported adequately and that they adhere to the principles of the project, specific to compliance with ESMF guidelines.

9.3 Training requirements

One of the capacity building areas for Lead implementing institution (MOH and ICS) and the Partner Institutions (EPSA, Regional Health Bureau) involved in the implementation of the IPF Component subprojects is the provision of training. The training to be offered will also need to address target groups from different beneficiary (e.g., focal persons from HCFs) and stakeholder institutions (e.g., Regional EPAs) which will have a role in implementing the ESMF at various levels. The training is also necessary for high level project coordination and management groups, (such as members of Strategic Partnership and Grant Management Directorate) as well as to relevant members of the broader stakeholders to create awareness on environment management aspects of the IPF Component Project. As a result, the type of trainings necessary to these various target groups will vary and is briefly outlined as the followings:

a. Technical training on the ESMF

MoH will organize several capacity building trainings for Environmental, Social and gender experts at various level . This detailed training will mainly focus on the technical staffs that will be involved in directly applying the ESMF procedures. It includes the Environmental &Social experts in the lead implementing agency (MOH and ICS) and, Environmental & Social staff in partner institutions (EPSA & Regional Health bureaus) as well as other relevant stakeholder institutions, member of technical working groups in ICS will have to participate in the training to facilitate for smooth implementation of IPF component project ESMF. The training will focus in explaining the details of the National and World Bank environmental requirements and the

procedures that need to be fulfilled to comply with it. Implementation of the ESMF including all aspects of the World Bank ESSs, environmental management, EIA, public consultation, and integration of environmental management into development planning will be the center topics for the training. The training would also cover skills upgrading refreshment topics such as, environmental and social screening and categorization processes, EIA review and quality assurance, environmental audits, environmental guidelines and others as necessary. The trainings will be delivered both by internal capacity and external bodies i.e. EPA and individual and firm level consultants. Detailed topics that would need to be covered by the training include the following:

- ✓ Overview of enabling policy, legal and institutional framework for ESMF
- ✓ Basic principles of the ESF, ESMF, RPF and relevant EHSGs
- ✓ Environmental and social screening process
- ✓ Assignment of environmental and social categories
- ✓ Scoping and the preparation of preliminary and full ESIAs
- ✓ Preparation of terms of reference for carrying out ESIA/ESMPs
- ✓ Specific aspects of environmental and social assessments and risks management
- ✓ Review and clearance of the screening results and separate ESIA/ESMP reports
- ✓ Supervision, monitoring, evaluation and environmental and social reporting
- ✓ Infection Control and Waste Management Plan (ICWMP) Preparation
- ✓ Community Health and Safety as well as OHS measures including application of PPE

✓ Stakeholder engagement plan and all other instruments necessary for compliance with environmental and social standards.

- ✓ Participatory public consultation and engagement
- ✓ Cultural adaptation and outreach to address the needs of underserved traditional local communities
- ✓ Gender Based Violence (GBV) prevention and Control
- ✓ Grievance Redress Mechanisms (GRM) of the IPF Project, Stakeholders Engagement
- ✓ Public consultation process in view of the ESMF requirements
- ✓ Discussion of, and amendments to, the environmental and social screening form.

9.4 Proposed ESMF implementation budget

The breakdown of estimated costs for putting the ESMF into operation is provided in Table -20. This includes the costs of providing the capacity building and training set out in Chapter 9. The total estimated costs for mainstreaming environment into the IPF Component Project for the next four years of implementation period are USD **963,000.** This consists of the following:

a) USD 80,000 which will be included in the consultants procured to provide full/partial ESIA/ESMP for IPF Component subprojects. These consultants will be responsible for the work on preparation of ESIA, ESMP, and CHMP documents.

b) USD 20,000 for the preparation and printing of ESMF training materials;

c) USD 260,000 for delivery of ESMF training including participants subsistence & logistical expenses

d) USD 160,000 to undertake annual external Environmental and Social Performance Audit

e) USD 105,000 for Implementation and monitoring of GBV/SEAH action plan.

f) USD 288,000 for provision of an Environmental and Social expert in MoH and EPSA for the four years duration of the project;

g) USD 50,000 for end of project E&S performance evaluation

The above costs will be funded from IPF Component Project. The MoH, EPSA and ICS Environmental and Social Specialists will report on IPF Project ESMF expenditure. This will provide for another way of monitoring on the extent that environmental and social issues are being addressed by the project beneficiaries and stakeholders.

Costs related to the required mitigation measures for IPF Component subprojects are not set out in the budgets presented here. These will be assessed and internalized by beneficiary institutions as part of the overall IPF Component subproject cost. Each subproject will count with the necessary resources to implement recommended mitigations measures in its E&S management

instruments. It is extremely difficult to estimate the proportion of project costs that can be expected to be devoted to mitigation measures. However, a rough rule of thumb is that they should be expected to cost between 2% and 5% of the total project cost. Compensation and resettlement costs will be borne by project beneficiary regional and local authorities.

Table 20: Proposed Budget for Implementation of the IPF Component Project ESMF

Activity	YR1	YR2	YR3	YR4	YR5	TOTAL	Notes
Technical Assistance support for preparation of ESMF & RPF Screening Reports, partial ESIAs, ESMPs, CHMPs,		20,000	20,000	20,000	20,000	80,000	Assume lump sum USD 20,000 for preparation of 2 full/partial ESIA, per year (assuming that one document prepared by 10,000USD).
Training supplier develops ESMF & RPF training modules		20,000				20,000	Assume lump sum USD 20,000 for development and printing of training materials/ modules
Training supplier delivers Technical ESMF training		130,000		130,000		260000	Assume 100 participants x USD 200 pd x 5days + 10,000 USD stationary+ 20,000USD trainers cost
Envi & Social risk management experts		72,000	72,000	72,000	72,000	288,000	Assume maximum USD 1500 per month for E&S experts at MoH & EPSA total 4.
Budget for external Annual Environmental and Social Performance Audit		40,000	40,000	40,000	40,000	160,000	External Environmental and social performance Audit to be carried once per year.
Implementation of GBV action Plan		30,000	30,000	30,000	15,000	105,000	Part time GBV consultant to support action plan
End of project E&S performance evaluation					50,000	50,000	
Total ESMF costs		312,000	162, 000	292,000	197,000	**963,000**	

10. MONITORING OF ESMF IMPLEMENTATION

Quarterly, Biannual and Annual Internal E&S performance monitoring report on ESMF implementation will be prepared by the MoH and ICS Environmental and Social Specialists and delivered to the State Minister of MoH, Federal and Regional EPAs and the World Bank. In addition, any "SubstentialRisk" subproject financed by the IPF Component Project that has been subject to an ESIA study will also be required to produce an annual performance audit report, for delivery to the Federal and Regional EPAs and the World Bank.

An external independently-commissioned annual environmental and social risk management and performance audit will be carried out covering all IPF Component subprojects. This will be conducted as part of the annual performance audit of the IPF Component. The external independent risk management and performance audit team will report to the MoH, ICS and the World Bank. The annual E&S performance audit is necessary to indicate:

a) To what extent environmental and social considerations are being incorporated into the planning process;
b) That mitigation measures are being identified and implemented by partner, beneficiary, and stakeholder institutions, and
c) To check that IPF Component subprojects are being correctly screened. The audit will be able to identify any amendments in the ESMF approach that are required to improve its effectiveness.

Indicators for ESMF Performance Monitoring can include, but not limited to, the following:

(i) number of safeguard staff maintained (PIU, focal persons, contractors, consultants),
(ii) number of subprojects identified/prepared,
(iii) number of subprojects screened,
(iv) number of subproject field appraisals completed,
(v) number of screening reports reviewed and approved by regulatory bodies,
(vi) number of E&S instruments (ESIAs/ESMPs/others) prepared based on the screening reports recommendations,

(vii) number of trainings conducted and number of trainees,

(viii) number of community/public consultations conducted,

(ix) number of project workers with employment contracts, signed CoC, and minimum age verified,

(x) number of grievances received and resolved,

(xi) number of E&S violations notified by the regulatory bodies,

(xii) number of E&S accidents/incidents/near misses,

(xiii) number of GBV/SEA incidents,

(xiv) number of traffic accidents,

(xiv) number of security incidents,

(xvi) number of cases of occupational and community diseases,

(xvii) chance finds procedures initiated, and

(xviii) E&S costs expended, etc.

The E&S annual performance audit report will include:

- A summary of the environmental and social performance of the IPF Component, based on a sample of subprojects;
- A presentation of compliance and progress in the implementation of the project ESMPs, RAP, and CHMPs;
- A review of implementation of Gender/GBV action plan implementation, assessment of robustness and functionality of GRM, assessment of effectiveness of stakeholder's engagement.
- A synopsis of the environmental and social performance audit results from individual project monitoring measures (as set out in the project ESMPs, and CHMPs).

11. Annexes

Annex I: ES Screening form

I. Screening Template for Potential Environmental and Social Issues

This form is to be used by the E&S risk management specialists of the MoH, EPSA, ICS, Regional Health Bureaus (RHB) and other partners (i.e. UNICEF) to screen for the potential environmental and social risks and impacts of a proposed subproject. Sub project refers to the set of activities derived from the IPF Component and sub-component activities including technical assistance studies and consultancies for which support through investment project financing is sought by the client. Subproject E&S measures therefore apply to restoration and EHS provision of HCFs, Satellite Clinics, procurement and distribution of medical supplies and CRVS activities. It will help the lead project implementing and partner institutions E&S specialists in identifying the relevant Environmental and Social Standards (ESS), establishing an appropriate E&S risk rating for these subprojects and specifying the type of environmental and social assessment required, including specific instruments/plans. Use of this form will allow the MoH EPSA, RHB, ICS and UNICEF to form an initial view of the potential risks and impacts of a subproject***. It is not a substitute for project-specific E&S assessments or specific mitigation plans.***

A note on *Considerations and Tools for ES Screening and Risk Rating* is included in this Annex to assist the process.

Subproject Name	
Subproject Location	
Subproject Proponent	
Estimated Investment	
Start/Completion Date	

Subproject eligibility check:

Subproject eligibility/ exclusion criteria question	**Yes**	**No**
1. Will the subproject involve activities that may cause long term, permanent and/or irreversible impacts (e.g. loss of major natural habitat)?		
2. Will the subproject involve construction in environmentally sensitive areas such as National Parks, fragile ecosystems, and wildlife reserve?		
3. Will the subproject involve activities that may have significant adverse social impacts and may give rise to significant social conflict?		
4. Will the subproject conduct activities that have high probability of causing serious adverse effects to human health and/or the environment?		

Subproject eligibility/ exclusion criteria question	Yes	No
5. Will the subproject activities cause or lead to child abuse, child labor exploitation, forced labor or human trafficking?		
6. Will the subproject activities lead to significant risks and/or adverse impacts on sensitive cultural receptors, tangible or intangible, or that could damage non-replicable cultural property?		
7. Will the subproject activities impact land owned or claimed by Historically Underserved Communities (HUCs) without complete and documented Free, Prior, and Informed Consent (FPIC) of such communities?		
If any of the above questions are answered as "Yes", the proposed subproject is not eligible for financing under this ERP.		

The next part of the screening form is to be used if the subproject is eligible. Its objective is to define the ES risk categorization of the subproject.

Questions	Answer		ESS relevance	Due diligence / Actions
	Yes	No		
Does the subproject involve civil works including new construction, expansion, upgrading or rehabilitation/restoration of healthcare facilities and/or waste management facilities? Could climate change or extreme weather adversely impact the project?			ESS1	ESIA/ESMP, SEP
Does the subproject involve land acquisition and/or restrictions on land use?			ESS5	RAP/ARAP, SEP
Does the subproject involve acquisition of land for establishing temporary/satellite medical treatment purposes?			ESS5	
Is the subproject associated with any external waste management facilities such as a sanitary landfill, incinerator, or wastewater treatment plant for healthcare waste disposal?			ESS3	ESIA/ESMP, SEP
Is there a sound regulatory framework and institutional capacity in place for healthcare facility infection control and healthcare waste management?			ESS1	ESIA/ESMP, SEP/ ICWMP

Questions	Answer		ESS relevance	Due diligence / Actions
	Yes	No		
Does the subproject have an adequate system in place (capacity, processes, and management) to store and transport medical supplies and equipment, to address medicine waste and safely handle radiological equipment for disposal?				ICWMP
Does the subproject involve recruitment of workers including direct, contracted, primary supply, and/or community workers?			ESS2	LMP, SEP
Does the subproject have appropriate OHS procedures in place, and an adequate supply of PPE (where necessary)?				OHS Plan
Does the subproject have a GRM in place, to which all workers have access, designed to respond quickly and effectively?				
Does the subproject involve trans boundary transportation (including Potentially infected specimens may be transported from healthcare facilities to testing laboratories, and transboundary) of specimen, samples, infectious and hazardous materials?			ESS3	ESIA/ESMP, SEP
Does the subproject involve use of security or military personnel during construction and/or operation of healthcare facilities and related activities?			ESS4	ESIA/ESMP, SEP
Is the subproject located within or in the vicinity of any ecologically sensitive areas?			ESS6	ESIA/ESMP, SEP
Are there any indigenous groups (meeting specified ESS7 criteria) present in the subproject area and are they likely to be affected by the proposed subproject negatively or positively?			ESS7	
Is the subproject located within or in the vicinity of any known cultural heritage sites?			ESS8	ESIA/ESMP, SEP
Does the project area present considerable Gender-Based Violence (GBV) and Sexual Exploitation and Abuse (SEA) risk?			ESS4	ESIA/ESMP, SEP
Does the subproject carry risk that disadvantaged and vulnerable groups may have inequitable access to project benefits?			ESS1	ESIA/ESMP, SEP
Is there any territorial dispute between two or more countries in the subproject and its ancillary aspects and related activities?			*OP7.60 Projects in Disputed Areas*	Governments concerned agree

Categorization & Recommendations:

After compiling the above, determine which risk category the subproject falls under based on the environmental categories High, Substantial, Moderate and Low risk. If the subproject falls under "High Risk" either it will be redesigned to lower its risk level or excluded from financing. If the subproject falls under "Substantial, Moderate or low" risk categories, proceed to identify the category of the subproject (i.e. Schedule I, II or III) based on the National EIA procedural guideline issued by the Federal Environment, Forest and Climate Change Commission.

a. World Bank ESF Categorization

	High Risk	IPF Component subproject highly unlikely to fall under "High Risk" rating. High risk subprojects will have either to be redesigned to lower its risk category or excluded from financing by the IPF Component Project.
	Substantial Risk	IPF Component subproject may likely fall under "Substantial Risk" rating. In the event that subproject falls under "Substantial Risk" the Environmental and social Assessment of the subproject should be conducted in accordance with National law and any requirements of the ESSs that the Bank deems relevant to such subprojects.
	Moderate Risk	Environmental and social Assessment of the subproject should be conducted in accordance with National law and any requirements of the ESSs that the Bank deems relevant to such subprojects.
	Low Risk	Sub project is not subject to environmental assessment as no potential impacts are anticipated. However, all subprojects financing civil works and management of health care waste require at least a simple ESMP incorporating good E&S construction and waste management practices. The environmental guideline for construction contractors will be applicable.

***Place tick in applicable box**

b. National EIA Procedural Guideline (2003) Categorization

	Schedule 1	Some IPF Component subproject likely to fall under "Schedule-I" Category. In the event that subproject falls under "Schedule-I" the subproject is to be fed into the standard ESIA process determined by the Federal or Regional EPAs
	Schedule 2	Subproject will require a partial/preliminary ESIA and will necessitate the preparation of preliminary ESIA / ESMP.
	Schedule III	Subproject is not subject to environmental assessment as no potential impacts are anticipated.

***Place tick in applicable box**

Reviewer:

Name:

Signature:

ANNEX II: GUIDANCE FOR SUBPROJECT RISK CATEGORIZATION

Pursuant to the ES Policy, subprojects are classified as *High Risk*, *Substantial Risk*, *Moderate Risk* or *Low Risk* taking into account relevant potential risks and impacts.

1. A Project is classified as **High Risk** after considering, in an integrated manner, the risks and impacts of the Project, taking into account the following, as applicable.

    a. The Project is likely to generate a wide range of significant adverse risks and impacts on human populations or the environment. This could be because of the complex nature of the Project, the scale (large to very large) or the sensitivity of the location(s) of the Project. This would take into account whether the potential risks and impacts associated with the Project have the majority or all of the following characteristics:

(i) Long term, permanent and/or irreversible (e.g., loss of major natural habitat or conversion of wetland), and impossible to avoid entirely due to the nature of the Project;

(ii) High in magnitude and/or in spatial extent (the geographical area or size of the population likely to be affected is large to very large);

(iii) Significant adverse cumulative impacts;

(iv) Significant adverse transboundary impacts; and

(v) a high probability of serious adverse effects to human health and/or the environment (e.g., due to accidents, toxic waste disposal, etc.);

b. The area likely to be affected is of high value and sensitivity, for example sensitive and valuable ecosystems and habitats (legally protected and internationally recognized areas of high biodiversity value), lands or rights of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities and other vulnerable minorities, intensive or complex involuntary resettlement or land acquisition, impacts on cultural heritage or densely populated urban areas.

c. Some of the significant adverse ES risk and impacts of the Project cannot be mitigated or specific mitigation measures require complex and/or unproven mitigation, compensatory measures or technology, or sophisticated social analysis and implementation.

d. There are significant concerns that the adverse social impacts of the Project, and the associated mitigation measures, may give rise to significant social conflict or harm or significant risks to human security.

e. There is a history of unrest in the area of the Project or the sector, and there may be significant concerns regarding the activities of security forces.

f. The Project is being developed in a legal or regulatory environment where there is significant uncertainty or conflict as to jurisdiction of competing agencies, or where the legislation or regulations do not adequately address the risks and impacts of complex projects, or changes to applicable legislation are being made, or enforcement is weak.

g. The past experience of the implementing agencies in developing complex Projects is limited; their track record regarding ES issues would present significant challenges or concerns given the nature of the Project's potential risks and impacts.

h. There are significant concerns related to the capacity and commitment for, and track record of relevant Project parties, in relation to stakeholder engagement.

i. There are a number of factors outside the control of the Project that could have a significant impact on the ES performance and outcomes of the Project.

2. A Project is classified as **Substantial Risk** after considering, in an integrated manner, the risks and impacts of the Project, taking into account the following, as applicable.

a. the Project may not be as complex as High Risk Projects, its ES scale and impact may be smaller (large to medium) and the location may not be in such a highly sensitive area, and some risks and impacts may be significant. This would take into account whether the potential risks and impacts have the majority or all of the following characteristics:

(i) They are mostly temporary, predictable and/or reversible, and the nature of the Project does not preclude the possibility of avoiding or reversing them (although substantial investment and time may be required);

(ii) there are concerns that the adverse social impacts of the Project, and the associated mitigation measures, may give rise to a limited degree of social conflict, harm or risks to human security;

(iii) they are medium in magnitude and/or in spatial extent (the geographical area and size of the population likely to be affected are medium to large);

(iv) the potential for cumulative and/or transboundary impacts may exist, but they are less severe and more readily avoided or mitigated than for *High Risk* Projects; and

(v) there is medium to low probability of serious adverse effects to human health and/or the environment (e.g., due to accidents, toxic waste disposal, etc.), and there are known and reliable mechanisms available to prevent or minimize such incidents;

b. The effects of the Project on areas of high value or sensitivity are expected to be lower than High Risk Projects.

c. Mitigatory and/or compensatory measures may be designed more readily and be more reliable than those of High Risk Projects.

d. The Project is being developed in a legal or regulatory environment where there is uncertainty or conflict as to jurisdiction of competing agencies, or where the legislation or regulations do not adequately address the risks and impacts of complex Projects, or changes to applicable legislation are being made, or enforcement is weak.

e. The past experience of the implementing agencies in developing complex Projects is limited in some respects, and their track record regarding ES issues suggests some concerns which can be readily addressed through implementation support.

f. There are some concerns over capacity and experience in managing stakeholder engagement but these could be readily addressed through implementation support.

3. A project is classified as **Moderate Risk** after considering, in an integrated manner, the risks and impacts of the Project, taking into account the following, as applicable:

a. the potential adverse risks and impacts on human populations and/or the environment are not likely to be significant. This is because the Project is not complex and/or large, does not involve activities that have a high potential for harming people or the environment, and is located away from environmentally or socially sensitive areas. As such, the potential risks and impacts and issues are likely to have the following characteristics:

(i) Predictable and expected to be temporary and/or reversible;
(ii) Low in magnitude;
(iii) Site-specific, without likelihood of impacts beyond the actual footprint of the Project; and

(iv) Low probability of serious adverse effects to human health and/or the environment (e.g., do not involve use or disposal of toxic materials, routine safety precautions are expected to be sufficient to prevent accidents, etc.).

b. The Project's risks and impacts can be easily mitigated in a predictable manner.

4. A project is classified as ***Low Risk*** if it's potential adverse risks to and impacts on human populations and/or the environment are likely to be minimal or negligible. These Projects, with few or no adverse risks and impacts and issues, do not require further ES assessment following the initial screening.

ANNEX III: NATIONAL EIA PROCEDURAL GUIDELINE FOR SCHEDULE OF ACTIVITIES

Schedule I. List of projects that require FULL EIA.

1. Agriculture

- water management projects for agriculture (drainage, irrigation)
- large scale mono- culture (cash and food crops)
- Pest control projects
- Fertilizer and nutrient management
- Land development schemes covering an area of 500 hectares or more to bring forest land into agricultural production
- Agricultural programmers necessitating the resettlement of 100 families or more.
- Development of agricultural estates covering an area of 500 hectares or more
- Construction of dams, man-made lakes, and artificial enlargement of lakes with surface areas of 200 hectares or more.
- Drainage of wetlands wildlife habitat or of virgin forest covering an area of 100 meters or more.
- Introduction of new breed, species of crops, seeds or animals
- Surface water fed irrigation projects covering more than 100 hectares
- Ground water fed irrigation projects more than 100 hectares
- River diversions and water transfers between catchments

2. Livestock and Range management

- Large Scale livestock movement
- Introduction of new breeds of livestock
- Introduction of improved forage species
- Large scale open range rearing of cattle, horses, sheep etc
- Large scale livestock production in Urban area

- Large scale slaughter house construction
- Ectoparasite management (cattle dips, area treatment)
- Intensive livestock rearing units

3. Forestry activities

- Timber logging and processing
- Forest plantation and afforestation and introduction of new species
- selective removal of single commercial tree species
- pest management
- Conversion of hill forest land to other land use
- Logging or conversion of forest land to other land use within the catchments area of reservoirs used for municipal water supply, irrigation or hydropower generation or in areas adjacent to parks
- Logging with special emphasis for endangered tree species
- Large scale afforestation/reforestation, mono-culture forest plantation projects which use exotic free species
- Conversion of forest areas which have a paramount importance of biodiversity conservation to other land use
- Resettlement programs in natural forest and woodland areas.

4. Fisheries activities

- Medium to large scale fisheries
- Artificial fisheries (Aqua-culture for fish, algae, crustaceans shrimps, lobster or crabs).
- Introduction of new species in water bodies commercial fisheries

5. Wildlife

- introduction of new species
- wildlife catching and trading
- hunting
- wildlife ranching and farming
- zoo and sanctuaries

6. Tourism and Recreational Development

- Construction of resort facilities or hotels along the shorelines of lakes, river, islands and oceans
- Hill top resort or hotel development
- Development of tourism or recreational facilities in protected and adjacent areas (national parks, marine parks, forestry reserves etc) on islands and in surrounding waters
- Hunting and capturing
- Camping activities walk ways and trails etc.
- sporting and race tracts/sites
- Tour operations

7. Energy Industry

- Production and distribution of electricity, gas, steam and hot water
- Storage of natural gas
- Construction of off shore pipelines in excess of 50 km in length
- High power transmission line
- Construction of combined cycle power station
- Thermal power development (i.e. coal, nuclear)
- Hydro-electric power
- Bio-mass power development
- Wind -mills power development
- Solar (i.e. Impact due to pollution during manufacture of solar devices, acid battery spillage and improper disposal of batteries)
- Nuclear energy

8. Petroleum Industry

- Oil and gas fields exploration and development, including Construction of offshore and onshore pipelines
- Construction of oil and gas separation, processing, handling and storage facilities.
- Construction of oil refineries
- Construction of product deposits for the storage of petrol, gas, diesel, tar and other products within commercial, industrial or residential areas.
- Transportation of petroleum products

9. Food and beverage industries

- manufacture of vegetable and animal oils and fats
- oil refinery and ginneries
- processing and conserving of meat
- manufacture of dairy products
- brewing distilling and malting
- fish meal factories
- slaughter - houses
- soft drinks
- tobacco processing
- canned fruits, and sources
- sugar factories
- other agro-processing industries

10. Textile in industry

- cotton and synthetic fibres
- dye for cloth
- ginneries

11. Leather Industry

- tanning
- tanneries
- dressing factories
- other cloth factories

12. Wood, Pulp and Paper Industries

- manufacturing of veneer and plywood
- manufacturing of fiber board and of particle - board
- manufacturing of pulp, paper, sand-board cellulose – mills

13. Building and Civil Engineering Industries.

- industrial and housing Estate
- major urban projects (multi-storey building, motor terminals, markets etc)
- tourist installation
- construction and expansion/upgrading of roads, harbours, ship yards, fishing harbours, air fields (having an air strips of 2,500 feet or longer) and ports, railways and pipelines
- River drainage and flood control works.
- hydro - electric and irrigation dams
- reservoir
- Storage of scrap metal.
- military installations
- construction and expansion of fishing harbours
- developments on beach fronts

14. Chemical industries

- manufacture, transportation, use and storage of pesticide or other hazardous and or toxic chemicals
- production of pharmaceutical products
- storage facilities for petroleum, petrochemical and other chemical products (i.e. filling stations)
- Production of paints vanishes, etc.

15. Extractive industry

- extraction of petroleum
- extraction and purification of natural gas
- other deep drilling - bore-holes and wells
- mining
- quarrying
- coal mining

- Sand dredging.

16. Minerals extraction and processing

- Metallic minerals such as Iron, Lead, Copper, Nickel
- Industrial minerals such as kaolin, diatomite
- Construction Minerals
- Mineral Water
- Thermal Water
- Extraction of salts from brines.

17. Non-metallic industries (Products)

- manufacture of cement, asbestos, glass, glass-fibre, glass-wool
- processing of rubber
- plastic industry
- lime manufacturing, tiles, ceramics

18. Metal and Engineering industries.

- manufacture and assembly of motor - vehicles
- manufacture of other means of transport (trailers, motor-cycles, motor-vehicle bicycles-cycles)
- body - building
- boiler - making and manufacture of reservoirs, tanks and other sheet containers
- foundry and Forging
- manufacture of non - ferrous products
- iron and steel
- electroplating

19. Waste treatment and disposal

(a) Toxic and Hazardous waste

- construction of Incineration plants
- construction of recovery plant (off-site)
- construction of waste water treatment plant (off-site)
- construction of secure landfills facility
- construction of storage facility (off - site)
- Collection and transportation of waste.
- installation for the disposal of industrial waste

(b) Municipal Solid Waste

- construction of incineration plant
- construction of composting plant
- construction of recovery/re-cycling plant

- construction of Municipal Solid Waste landfill facility
- construction of waste depots.
- collection and transportation

(c) Municipal Sewage

- construction of wastewater treatment plant
- construction of marine out fall
- Night soil collection transport and treatment.
- construction of sewage system

20. Water Supply

- canalization of water courses
- diversion of normal flow of water
- water transfers scheme
- abstraction or utilization of ground and surface water for bulk supply
- water treatment plants
- Construction of dams, impounding reservoirs with a surface area of 100 hectars
- Ground water development for industrial, agricultural or urban water supply of greater than 4000 m^3 /day
- Drainage Plans in towns close to water bodies

21. Transport

- Major urban roads
- Rural road programmes
- Rail infrastructure and railways
- Trans-regional and International high way
- Upgrading or rehabilitation of major rural roads
- Airports with basic runway

22. Health projects

- vector control projects (malaria, bilharzias, trypanosomes etc)

23. Land Reclamation and land development

- rehabilitation of degraded lands
- dredging of bars, greyone, dykes, estuaries etc.
- spoil disposal.

24. Resettlement/relocation of people and animals

- resettlement plan
- establishment of refugee camps

25. Multi-sectoral Projects

- Agro-forestry
  - ♦dispersed field - tree inter-cropping
  - ♦alley cropping
  - ♦living fences and other linear planting
  - ♦windbreak/shelterbelts
  - ♦taungya system
- Integrated conservation and development programs, e.g.. protected areas.
- Integrated Pest Management (e.g. IPM)
- Diverse construction - public health facilities, schools, storage building, tree
- Nurseries, facilities for ecotourism and field research in protected areas, enclosed latrines, small enterprises, logging mills, manufacturing furniture carpentry shop, access road, well digging, camps, dams, reservoirs.
- River basin development and watershed management projects
- Food aid, humanitarian relief

26. Trade: Importation and Exportation of the following

- hazardous Chemicals/Waste
- plastics
- petroleum products
- vehicles
- used materials
- wildlife and wildlife products
- pharmaceuticals
- food
- beverages
- GMOs and GMOs based products

27. Public instruments

- decisions to change designated status
- family planning
- technical assistance
- development strategies
- urban and rural land use development plans e.g. master plans,
- structural adjustment,
- national budget
- Policies and Programmes formulations, etc.

28. All projects in environmentally sensitive areas should be treated as equivalent to Schedule 1 activity irrespective of the nature of the project.

Schedule. 2. List of Projects That Require A PRELIMINARY ENVIRONMENTAL IMPACT Study.

A List of Small - Scale Activities and Enterprises

- Fish culture
- Bee-keeping
- Small animal husbandry and urban livestock keeping
- Horticulture and floriculture
- Wildlife catching and trading
- Production of tourist handicrafts
- Charcoal production
- Fuel wood harvesting
- Wooden furniture and implement making
- Basket and other weaving
- Nuts and seeds for oil processing
- Bark for tanning processing
- Brewing and distilleries
- Bio-gas plants
- Bird catching and trading
- Hunting
- Wildlife ranching
- Zoo, and sanctuaries
- Tie and dye making
- Brick making
- Beach sailing
- Sea weed Farming
- Salt pans
- graves and cemeteries
- Urban Livestock Keeping
- Urban agriculture.
- Fish landing stations.
- Wood carving and sculpture
- Hospitals and dispensaries, Schools, Community centre and Social halls, play grounds
- Wood works e.g. boat building
- Market places (livestock and commodities).
- Technical assistance
- Rain water harvesting
- Garages
- Carpentry
- Black smith.
- Tile manufacturing

- Kaolin manufacturing
- Vector control projects e.g. Malaria, Bilharzia, trypanosomes
- Livestock stock routes
- Fire belts.
- Tobacco curing kilns
- Sugar refineries
- Tanneries
- Pulp plant
- Oil refineries and ginneries
- artisanal and small scale mining
- Rural road
- Research having the potential to affect ecosystems functions, use, or the health and welfare of the society.
- Rural water supply and sanitation
- Land drainage (small scale)
- Sewerage system

Schedule 3. Lists of Projects That May Not Require Environmental Impact Assessment

1. Social infrastructure and services

    - Educational facilities (small scale)
    - Audio visual production
    - Teaching facilities and equipment
    - Training
    - Medical centre (small scale)
    - Medical supplies and equipment
    - Nutrition
    - Family planning

2. Economic infrastructure and services
    - Telecommunication
    - Research, small scale

3. Production Sector

- Irrigation
    - Surface water fed irrigation projects covering less than 50 hectares
    - Ground water fed irrigation projects covering less than 50 hectares
- Agriculture
    All small scale agricultural activities

- Forestry
    - Protected forest reserves (small scale)
    - Productive forest reserves (small scale)

- Livestock
- Rearing of cattle (<50 heads); pigs (<100 heads), or poultry (<500 heads)
  - Livestock fattening projects (small scale)
  - Bees keeping projects (small scale)
- Fisheries
  - Artesian fisheries (small scale)
- Industry
  - Agro industrial (small scale)
  - Other small scale industries having no impact to the environment
- Trade
  - All small scale trades except trade in endangered species and hazardous materials
- Financial assistance
  - Programme assistance
  - Non-project or special country support
  - Food aid not involving GMOs based food
- Emergency Operations
  - Assistance to refugee returned and displaced person

4. All projects involved in environmental enhancement programs

Annex IV: Infection Control and Waste Management Plan (ICWMP) Template

1. Introduction

1.1 Describe the project context and components

1.2 Describe the targeted healthcare facility (HCF):

- Type: E.g. general hospital, clinics, inpatient/outpatient facility, medical laboratory, quarantine or isolation centers; satellite/temporary clinic..
- Functions and requirement for the level infection control, e.g. biosafety levels;
- Location and associated facilities, including access, water supply, power supply;
- Capacity: beds

1.3 Describe the design requirements of the HCF, which may include specifications for general design and safety, separation of wards, heating, ventilation and air conditioning (HVAC), autoclave, and waste management facilities.

2. Infection Control and Waste Management

2.1 Overview of infection control and waste management in the HCF

- Type, source and volume of healthcare waste (HCW) generated in the HCF, including solid, liquid and air emissions (if significant)
- Classify and quantify the HCW (infectious waste, pathological waste, sharps, liquid and non-hazardous) following WBG EHS Guidelines for Healthcare Facilities and pertaining GIIP.

- *Given the infectious nature of the novel coronavirus, some wastes that are traditionally classified as non-hazardous may be considered hazardous. It's likely the volume of waste will increase considerably given the number of admitted patients during COVID-19 outbreak. Special attention should be given to the identification, classification and quantification of the healthcare wastes.*
- Describe the healthcare waste management system in the HCF, including material delivery, waste generation, handling, disinfection and sterilization, collection, storage, transport, and disposal and treatment works.
- Provide a flow chart of waste streams in the HCF if available
- Describe applicable performance levels and/or standards
- Describe institutional arrangement, roles and responsibilities in the HCF for infection control and waste management

2.2 Management Measures

- Waste minimization, reuse and recycling: HCF should consider practices and procedures to minimize waste generation, without sacrificing patient hygiene and safety considerations.
- Delivery and storage of specimen, samples, reagents, pharmaceuticals and medical supplies: HCF should adopt practices and procedures to minimize risks associated with delivering, receiving and storage of hazardous medical goods.
- Waste segregation, packaging, color coding and labeling: HCF should strictly conduct waste segregation at the point of generation. Internationally adopted method for packaging, color coding and labeling the wastes should be followed.
- Onsite collection and transport: HCF should adopt practices and procedures to timely remove properly packaged and labelled wastes using designated trolleys/carts and routes. Disinfection of pertaining tools and spaces should be routinely conducted. Hygiene and safety of involved supporting medical workers such as cleaners should be ensured.
- Waste storage: A HCF should have multiple waste storage areas designed for different types of wastes. Their functions and sizes are determined at design stage. Proper maintenance and disinfection of the storage areas should be carried out. Existing reports suggest that during the COVID-19 outbreak, infectious wastes should be removed from HCF's storage area for disposal within 24 hours.
- Onsite waste treatment and disposal (e.g., an incinerator): Many HCFs have their own waste incineration facilities installed onsite. Due diligence of an existing incinerator should be conducted to examine its technical adequacy, process capacity, performance record, and operator's capacity. In case any gaps are discovered, corrective measures should be recommended.
- Transportation and disposal at offsite waste management facilities: Not all HCF has adequate or well-performed incinerator onsite. Not all healthcare wastes are suitable for incineration. An onsite incinerator produces residuals after incineration. Hence offsite waste disposal

facilities provided by local government or the private sector are probably needed. These offsite waste management facilities may include incinerators, hazardous wastes landfill. In the same vein, due diligence of such external waste management facilities should be conducted to examine its technical adequacy, process capacity, performance record, and operator's capacity. In case any gaps are discovered, corrective measures should be recommended and agreed with the government or the private sector operators.

- Wastewater treatment: HCF wastewater is related to hazardous waste management practices. Proper waste segregation and handling as discussed above should be conducted to minimize entry of solid waste into the wastewater stream. In case wastewater is discharged into municipal sewer sewerage system, the HCF should ensure that wastewater effluent comply with all applicable permits and standards, and the municipal wastewater treatment plant (WWTP) is capable of handling the type of effluent discharged. In cases where municipal sewage system is not in place, HCF should build and properly operate onsite primary and secondary wastewater treatment works, including disinfection. Residuals of the onsite wastewater treatment works, such as sludge, should be properly disposed of as well. There're also cases where HCF wastewater is transported by trucks to a municipal wastewater treatment plant for treatment. Requirements on safe transportation, due diligence of WWTP in terms of its capacity and performance should be conducted.

3. Emergency Preparedness and Response

Emergency incidents occurring in a HCF may include spillage, occupational exposure to infectious materials or radiation, accidental releases of infectious or hazardous substances to the environment, medical equipment failure, failure of solid waste and wastewater treatment facilities, and fire. These emergency events are likely to seriously affect medical workers, communities, the HCF's operation and the environment.

Thus, an Emergency Response Plan (ERP) that is commensurate with the risk levels is recommended to be developed. The key elements of an ERP are defined in ESS 4 Community Health and Safety (para. 21).

4. Institutional Arrangement and Capacity Building

A clearly defined institutional arrangement, roles and responsibilities should be included. A training plan with recurring training programs should be developed. The following aspects are recommended:

- Define roles and responsibilities along each link of the chain along the cradle-to-crave infection control and waste management process;
- Ensure adequate and qualified staff are in place, including those in charge of infection control and biosafety and waste management facility operation.
- Stress the chief of a HCF takes overall responsibility for infection control and waste management;
- Involve all relevant departments in a HCF, and build an intra-departmental team to manage, coordinate and regularly review issues and performance;

- Establish an information management system to track and record the waste streams in HCF; and
- Capacity building and training should involve medical workers, waste management workers and cleaners. Third-party waste management service providers should be provided with relevant training as well.

5. Monitoring and Reporting

Many HCFs in developing countries face the challenge of inadequate monitoring and records of healthcare waste streams. HCF should establish an information management system to track and record the waste streams from the point of generation, segregation, packaging, temporary storage, transport carts/vehicles, to treatment facilities. The HCF is encouraged to develop an IT based information management system should their technical and financial capacity allow.

As discussed above, the HCF chief takes overall responsibility, leads an intra-departmental team and regularly reviews issues and performance of the infection control and waste management practices in the HCF. Internal reporting and filing systems should be in place.

Externally, reporting should be conducted per government and World Bank requirements.

Annex V: Summary of Medicines Waste and Their Disposal Methods

No	Category	Disposal methods	Comments
1	Solids Semi-solids, Powders	Landfill Waste encapsulation Waste inertization Medium and high temperature incineration (cement kiln incinerator)	
2	Liquids	Sewer High temperature incineration (cement kiln incinerator)	Antineoplastics shall not be disposed in sewer.
3	Ampoules	Crush ampoules and flush diluted fluid to sewer	Antineoplastics shall not be disposed in sewer.
4	Anti-infective medicines	Waste encapsulation Waste inertization Medium and high temperature incineration (cement kiln incinerator)	Liquid antibiotics may be diluted with water, left to stand for several weeks and discharged to sewer.
5	Antineoplastics	Return to supplier, manufacturer or donor, Waste encapsulation, Waste inertization, High temperature incineration (cement kiln incinerator)	Antineoplastics shall not be disposed into landfill unless encapsulated, and shall not be disposed by sewer or by medium temperature incineration.
6	Controlled	Waste inertization	Shall not be disposed into

	substances	Medium and high temperature incineration (cement kiln incinerator)	landfill unless immobilized.
7	Aerosol canisters	Landfill, waste encapsulation	Not to be burnt: may explode.
8	Disinfectants	To sewer: small quantities of diluted disinfectants (max. of 50 liters per day under supervision)	No undiluted disinfectants shall be disposed to sewer.
9	PVC plastic, Glass	Landfill	Shall not be disposed by burning.
10	Paper, cardboard	Recycle, burn or landfill	

Annex VI: IPF PROJECT CHANCE FINDS PROCEDURE

1. Introduction

The social assessment revealed that the IPF project civil works, establishment of temporary or satellite clinics for PHC at IDP Camps and renovation of health facilities, proposed under Sub-component I will involve excavations, demolitions, or other physical changes with potential risks to the cultural heritages in the project target areas. Analysis of national legislation, Proclamation No. 839/2014 on Classification of Cultural Heritages into National and Regional Cultural Heritages, review of available studies in the area, and key informant interview with regional and local stakeholders identified no known cultural heritage to be affected due to the project civil works. However, the analysis of the social assessment reveals while some cultural heritage in a country may have already been identified, and in some cases legally protected, many areas may not have been subject to cultural heritage surveys, and therefore documentation regarding possible cultural heritage may be relatively limited. Consequently, the IPF project expects previously unknown cultural heritage may be discovered while excavation for the project civil works or tangible cultural heritage may be located under the surface. A chance finds may include the discovery of a single artifact, an artifact indicating the presence of a buried archaeological site, human remains, fossilized plant or animal remains or animal tracks, or a natural object or soil feature that appears to indicate the presence of archaeological material. Therefore, in accordance with the requirements of the ESS8, the project-specific procedure is prepared that outlines actions required if previously unknown heritage resources are encountered during project construction or operation.

2. Objectives

The IPF project recognizes that cultural heritage provides continuity in tangible and intangible forms between the past, present, and future lives of the project-affected communities. People identify with cultural heritage as a reflection and expression of their constantly evolving values, beliefs, knowledge, and traditions. Cultural heritage, in its many manifestations, is important as a source of valuable scientific and historical information, as an economic and social asset for development, and as an integral part of people's cultural identity and practice. Backdrop to this, project-specific CFP is prepared with the objectives:

- To promote meaningful consultation with relevant stakeholders, including project-affected communities in identifying risks to cultural heritage resulting from the IPF project activities.
- To design mitigation measures to protect cultural heritage from the adverse impacts of the project activities and support its preservation.
- To address cultural heritage as an integral aspect of sustainable development.

3. Scope of Cultural Heritage

The scope of cultural heritage to be considered in the CFP for the IPF project is in line with the ESS8, paragraph 4. Accordingly, the term *'cultural heritage'* encompasses tangible and intangible heritage, which may be recognized and valued at a local, regional, national or global level, as follows:

- *Tangible cultural heritage*, which includes movable or immovable objects, sites, structures, groups of structures, and natural features and landscapes that have archaeological, paleontological, historical, architectural, religious, aesthetic, or other cultural significance. Tangible cultural heritage may be located in urban or rural settings, and may be above or below land.
- *Intangible cultural heritage,* which includes practices, representations, expressions, knowledge, skills—as well as the instruments, objects, artifacts and cultural spaces associated therewith— that communities and groups recognize as part of their cultural heritage, as transmitted from generation

to generation and constantly recreated by them in response to their environment, their interaction with nature and their history.

- Cultural heritage may have different values for different individuals or groups, regardless of whether it has been legally protected or previously identified or disturbed.
- Impacts on cultural heritage that are recognized by local communities as important need to be considered even if the cultural heritage is not legally recognized or protected. This consideration is important because the cultural heritage may be designated, protected, or managed by religious, clan, ethnic, or other community authorities, and therefore recognized in accordance with tradition and customs. In some societies, the character, location, and use of heritage sites and objects may be kept secret or known only to authorized persons.

Given the above stated broader scope of cultural heritage, the requirements of ESS8, ESS7 (as it sets out additional requirements for cultural heritage in the context of HUCs) and ESS6 (as it recognizes the social and cultural values of biodiversity) will apply to the need for managing the potential risks and adverse impacts from the undertaking of the project civil works proposed in IPF Sub-component I.

4. Chance Finds Procedure for the IPF Project

It is important to consider the risks and impacts to cultural heritage at all stages of the project cycle as part of the environmental and social assessment. Early attention to cultural heritage is particularly important as its presence may need to be considered in the design of, and during, the implementation of the IPF project. A project-specific chance finds procedure covers the identification, notification, documentation, and management of chance finds in accordance with national laws and, where applicable, internationally accepted practice and local customs.

4.1 Identification

Cultural heritage may have different values for different individuals or groups, regardless of whether it has been legally protected or previously identified or disturbed. For example, a local shrine may be important for traditional religious worship, but may be unknown or not considered significant by national cultural heritage authorities. In some cases, archaeological evidence, both on and beneath the surface, may be of limited interest to a local community, but significant to specialists for an understanding of past human habitation. Thus, the first procedure to be followed to avoid damage to cultural heritage during the project implementation is stakeholder consultation. Stakeholders will include, as relevant: (I) project affected parties, including individuals and communities within the country who use or have used the cultural heritage within living memory; and (b) other interested parties, which may include national or local regulatory authorities that are entrusted with the protection of cultural heritage and none governmental organizations and cultural heritage experts, including national and international cultural heritage organizations.

The project will carry out meaningful consultations with stakeholders in accordance with ESS10 in order to identify cultural heritage that may be affected by the project; consider the significance of the cultural heritage affected by the project. Relevant stakeholders are identified and consulted early in project preparation, as this can help to identify cultural heritage, document its presence and significance, assess potential project impacts, and determine appropriate mitigation measures in a timely manner. The variety in types of cultural heritage may call for consultation with different stakeholders, including local and indigenous tradition bearers where appropriate, who may have different interests in, or attach different significance to, the cultural heritage.

Documentation of consultations on cultural heritage usually includes the following: (a) the way in which stakeholders recognize and understand the cultural heritage and the values they attribute to it; (b) any issues relating to the need for confidentiality regarding the cultural heritage, for example, location or details of traditional use of the cultural heritage and individuals involved, as appropriate; (c) any existing or potential conflicts arising from different views regarding the cultural heritage; and (d) any views of affected communities and other interested parties regarding ways to address project-related risks to, and impacts on, the cultural heritage, including on proposed mitigation measures.

4.2 Notification

When artefacts or sites of cultural heritage are encountered by chance while undertaking excavation for the civil works under IPF Sub-components, the following steps will be applied:

a) Notification to the project manageer
b) Stop all the activities of the project civil works in the chance finds construction site;
c) The identifier must immediately inform his/her site supervisor of the discovery;
d) The site supervisor needs to cordon off the site in the chance finds and do not allow anybody access to the area;
e) The site supervisor will report to the case to the relevant authorities, particularly the Woreda Culture and Tourism Office in the chance finds; and
f) If appropriate, Woreda Culture and Tourism Office will report to the Regional Culture and Tourism Bureau for further analysis.

4.3 Documentation

Methods for documenting cultural heritage typically include field surveys to identify cultural heritage likely to be affected by the project. Over small areas, manual survey techniques may be appropriate, while for larger areas, various cultural heritage survey techniques and technologies (for example photogrammetry, remote sensing for cross-referencing, and comparing survey data) may be more appropriate. For intangible cultural heritage, identification typically involves consultations with tradition bearers and practitioners of certain cultural practices and documented by recording the intangible forms and collecting documents that relate to it. The application of such methods is proportionate to the risks and impacts of the project on cultural heritage.

4.4 Assessment of risks and impacts

- Assessment of risks and impacts to a chance finds will carry out a meaningful consultation with the relevant stakeholders, as appropriate, in accordance with ESS10. The assessment, as set out in ESS1, will consider direct, indirect, and cumulative project-specific risks and impacts on cultural heritage.

- The assessment of direct risks and impacts, such as those caused by the project construction activities of IPF Sub-component I, are often the most readily apparent. These impacts generally result from excavation, dredging, demolition, or the vibration caused by construction machineries used in the project civil works. Indirect and cumulative impacts assess risks to cultural heritage that may occur during project implementation resulting from changing conditions of the physical environment such as pollution (air, land, soil, water) and inappropriate waste generation from the health facilities.

- Where necessary due to the potential risks and impacts of the project, the assessment will involve the participation of cultural heritage experts. If the social assessment determines that the project may, at any time during the project life cycle, have significant potential risks and impacts on cultural heritage,

the MoH will engage cultural heritage experts to assist in the identification, valuation assessment, and protection of cultural heritage.

- Impacts on cultural heritage that are recognized by local communities as important need to be considered even if the cultural heritage is not legally recognized or protected. This consideration is important because the cultural heritage may be designated, protected, or managed by religious, clan leaders, or other community authorities, and therefore recognized in accordance with tradition and customs. In some communities, the character, location, and use of heritage sites and objects may be kept secret or known only to authorized persons.

- The assessment of risks and impacts also takes into consideration the significance of intangible cultural heritage that may be materially affected or put at risk as a result of the project. For example, project activities may require cutting of trees or the movement of boulders that are used for cultural or religious practices and are considered sacred.

- Assessment of risks and impacts to a chance finds will carry out a meaningful consultation with the relevant stakeholders, as appropriate, in accordance with ESS10.

4.5 Design appropriate mitigation measures

- The implementation of the IPF project will avoid impacts on cultural heritage exploring for design alternative of the project civil works. When avoidance of impacts is not possible, the MoH will identify and implement measures to address impacts on cultural heritage in accordance with the mitigation hierarchy.

- Overall, mitigation measures may include relocating or modifying the physical footprint of the project; documentation; strengthening the capacity of national and sub-national institutions responsible for managing cultural heritage affected by the project; establishment of a monitoring system to track the progress and efficacy of these activities; establishment of an implementation schedule and required budget for the identified mitigation measures; and cataloging of finds.

- Based on the nature and scale of environmental and social risks to, and impacts on, cultural heritage, a Cultural Heritage Management Plan (CHMP) may be prepared as a stand-alone document or as part of the project ESMF.

5. Indicative outlines of Cultural Heritage Management Plan

If the findings of the social assessment classified the project risks to cultural heritage as substantial or high necessitating preparation of stand-alone management plan, an indicative outline of the elements of the Cultural Heritage Management Plan (CHMP) include the following:

a) A review of the legal and institutional framework applicable to cultural heritage;
b) Roles and responsibilities of the different project and other interested parties, for example, the MoH, project civil work contractors, project-affected people, and cultural heritage authorities;
c) The steps to identify and manage cultural heritage throughout the project life cycle;
d) Proposed mitigation measures to be undertaken;
e) Steps for incorporating relevant requirements relating to cultural heritage into project procurement documents, including chance find procedures;
f) Implementation schedule and budget; and

Annex VII: Gender-Based Violence (SEA/SH) Risk Assessment and Prevention and Response Action Plan

ACRONYMS AND ABBREVIATION

C-ESMPs	Project Civil Contractor's Environmental and Social Management Plans
CoC	Code of Conduct
EDHS	Ethiopian Demographic and Health Survey
ESF	Environmental and Social Framework
ESMF	Environmental and Social Management Framework
ESMPs	Environmental and Social Management Plans
GBV	Gender-Based Violence
GPN	Good Practice Note
IA	Implementing Agency
MoH	Ministry of Health
IPF	Investment Project Financing
PforR	Program for Results
RF	Resettlement Framework
SA	Social Assessment
SEA/SH	Sexual Exploitation and Abuse/Sexual Harassment
SMP	Security Management Plan
WB	World Bank
WHO	Woreda Health Office

1. Introduction

1.1 Project Background

2. In Ethiopia there is an urgent need to support the health system that resulted from the devastation of the conflicts in different parts of the country. This has led to a significant disruptions in the delivery of essential health services (EHS) including key reproductive, maternal, neonatal, child, and adolescent health plus nutrition (RMNCAH+N) services. As justified in the IPF program design, conflicts have had devastating impacts on people's lives, both from direct physical harm and the collapse of the health system[43].

3. The proposed IPF interventions are built on the recently closed Ethiopia Health Sustainable Development Goals Program-for-Results (PforR) that performed well and built strong institutional arrangements while bringing consistency to the health sector. While complementing the PforR, the proposed IPF program will support the government emergency health and recovery plan for the conflict-affected areas. It will support and enhance the development of a resilient health service delivery system in the conflict-affected parts of the country which require huge investments.

4. In the context of the IPF project, the requirements to undertake GBV Risk Assessment, Prevention and Response Action plan is set out in line with: (a) Sub-component I that involves civil works with the risks of Sexual Exploitation and Abuse or Sexual Harassment (SH)—here after termed as SEA/SH—against project beneficiaries or members of project-affected communities (both adults and children) the project beneficiaries or members of project-affected communities (both adults and children) due to labour influx; and (b) Sub-component II that produce PHC and CRVS related services to the project-affected communities; project workers may use access to these project services to extract gain or favor from those who seek them. For these risks, the World Bank (WB) Environmental and Social Standard (ESS4) and Good Practice Note (GPN) set out the requirements for the MoH to: first, identify and assess the risks of SEA/SH, including social and capacity assessments; second, address the risks by identifying and implementing appropriate SEA/SH risk mitigation and monitoring measures; and third, respond and refer any reported IPF project-related GBV allegations to GBV service providers. The project should include effective monitoring and evaluation (M&E) mechanisms, which meet the World Bank's requirements on SEA/SH and allow for reporting on allegations that are project-related and for monitoring case follow-up.

1.2 Objectives of the Assessment

5. The preparation of this document aims to assess the risks of GBV based on an in-depth understanding of the country context. This includes an outline of the relevant risks, stakeholders related to it (including referral services) and develop a system for the project to handle respective risks (and incidents, if occurred). The specific objectives are to:
   - Identify and assess the risks of SEA/SH in IPF project, particularly Sub-components I and II including: undertaking social risk assessment at the community-level risks, assess capacity and availability of quality, safe and ethical services for survivors; review the capacity of the MoH to respond to SEA/SH risks, and rate the project for overall risk using the World Bank's standard GBV risk assessment tool.
   - Address the risks of SEA/SH of the IPF by identifying and implementing appropriate mitigation

[43] Program Appraisal Document for Ethiopia Program for Results (Hybrid) for Strengthening Primary Health Care Services, November 15, 2022.

and monitoring measures. Based on the risks identified, devise the corresponding mitigation measures and implement actions suggested to mitigate project-related risks of SEA/SH. Monitor the effectiveness of the mitigation measures for corrective actions as appropriate.

- Respond by preparing project response actions for GBV cases. Provide essential services for survivors and report case through the GM as appropriate keeping survivor information confidential and anonymous.

1.3 Definition of GBV/SEA/SH

6. At the project-level, provisions on gender in the WB Environmental and Social Framework (ESF) are focused on gender equality and inclusion, particularly in the context of addressing disadvantaged or vulnerable groups, including the risks of GBV. However, defining GBV for scoping is not an easy task. Thus, as opposed to all forms of GBV, the World Bank GPN (2022)[44] identify SEA and SH as the most common forms of GBV involving IPF project risks for action plan. To avoid the bewilderment that may arise in the usage of terms in this document, we define GBV first, then prove the operational definitions of SEA and SH bed on the World Bank GPN for the scope of the IPF project.

7. ***GBV:*** It is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially-ascribed (i.e., gender) differences between males and females. GBV includes acts that inflict physical, mental, sexual harm or suffering; threats of such acts; and coercion and other deprivations of liberty, whether occurring in public or in private life. GBV disproportionately affects women and girls across their lifespan and takes many forms, including sexual, physical, and psychological abuse. It occurs at home, on the streets, in schools, workplaces, farm fields, and refugee camps; during times of peace as well as in conflicts and crises. The term GBV is most commonly used to underscore systemic inequality between males and females—which exists in every society in the world—and acts as a unifying and foundational term for most forms of violence perpetrated against women and girls.

8. ***SEA:*** It composes two key terms, namely: sexual exploitation (SE) and sexual abuse (SA). The operation definitions of these terms in the context of Bank-financed operations/projects are given as follow. ***SE*** occurs when access to or benefit from Bank-financed goods, works, non-consulting services or consulting services is used to extract sexual gain. Example, a community member may be promised employment on the IPF project site in exchange for sex. Whereas, ***SA*** occurs when a project worker (contractor staff, sub-contractor staff, project personnel) uses force or unequal power *vis-à-vis* a community member or colleague to perpetrate or threaten to perpetrate an unwanted sexual act. Example, the project worker may have a sexual relationship with an underage child.

9. ***SH:*** In Bank-financed operations/projects, sexual harassment occurs between the project personnel/staff or within the context of the company of a subcontractor or contractor and relates to employees of the company experiencing unwelcome sexual advances or requests for sexual favors or acts of a sexual nature that are offensive and humiliating among the same company's employees. Example, the project worker may send sexually explicit text messages to a coworker or may leave an offensive picture that is sexually explicit on a co-worker's desk.

[44] *The World Bank (2022). Good Practice Note: Addressing Sexual Exploitation and Abuse and Sexual Harassment (SEA/SH) in Investment Project Financing involving Major Civil Works, Third Edition.*

10. Therefore, there may be different categories of GBV that may be exacerbated by World Bank-financed IPF involving major civil works. However, since SEA and workplace SH are the types of GBV most likely to occur in or be exacerbated by the project, the risk identification and mitigation of these forms of GBV are the primary focus of the SEA/HA Prevention and Response Action Plan for the IPF project.

1.4 Methodology

11. This GBV (SEA/SH) Risk Assessment, Prevention and Response Action Plan is prepared based on both primary and secondary data sources. The primary data was obtained through the following methods. First, consultation with relevant stakeholders from federal to woreda levels was conducted to obtain expertise information on contributing factors to project-related SEA/SH risks and assessment of the local capacity of formal systems to prevent and respond to GBV and the availability of safe and ethical service provision for survivors. ***Annex 3*** provides signed form with the full contact address of the stakeholders consulted from federal to woreda levels and sample photos. Second, key informant interview was conducted with community representatives such as elders and clan leaders with the aim to obtain information on the socio-cultural features that differentiate based on gender. Third, a separate interview was arranged for the project-affected women to ensure that their views are obtained and their special needs factored into the planning and implementation of the IPF project. ***Annex 1*** provides the guiding questions for gender-based violence (SEA/SH) risk assessment. Finally, two community consultation was held: one in Afar region Zone 1 Chifra woreda on February 23, 2023 and about 15 participants were took part in; and the other in Amhara region South Wollo Zone Tehuledere woreda on February 20, 2023 and 20 participants were took part in. Community consultation was a method for gathering information on the social norms and values of the project-affected communities contributing to SEA/SH. ***Annex 4*** provides community consultation participants' attendance and sample photos. Whereas, the secondary data was obtained through the review of relevant sources including the World Bank's ESF and Good Practice Note on Addressing Sexual Exploitation and Abuse and Sexual Harassment (SEA/SH) in Investment Project Financing involving Major Civil Works; Ethiopian Demographic and Health Survey (2016), and previous empirical studies. The sources of secondary data were used to situate Ethiopian context GBV risks extrapolate to IPF project. ***Annex 5*** provides sample photos from stakeholders and community consultation.

2. Review of Legal and Policy Framework

2.1 Relevant national legal instruments

12. By ratifying the international conventions such the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1979 and UN Resolution 52/86 on Crime Prevention and Criminal Justice Measures to Eliminate Violence Against Women in 1998, the Ethiopian Constitution (Article 9) has made these treaties to be an integral part of the law of the land. In addition, the Ethiopian Constitution under its chapter of fundamental freedoms and rights proclaimed several rights including the equality of men and women in the social, legal, economic, and political realms and to protect them from gender-based violence.

13. In addition to the constitutions, some other more specific gender-based laws have been enacted to protect the rights of women in general and to end gender-based violations:

- The Ethiopian Federal Revised Family Law which is one of such laws enacted in 2000 and is used to protect and safeguard equality between sexes in their relation concerning marriages (Proc. No. 213/2000). The Ethiopian Criminal Code has been revised in line with the constitutional provisions and essences in a way to confirm that those articles deal with women's rights and their

protection against any form of violence. Unlike the 1957 Penal Code, the revised Code incorporated explicit provisions tackling violence against women. The Code has elaborated the ambiguous conceptions and provisions of gender-based violence, incorporating new offenses, redefining the elements of these offenses, and revising the penalties applicable in cases of violation. Yet, the Ethiopian government has recently amended its legislation by excluding rape crimes from pardon and amnesty laws as it lengthened jail terms for sex offenders.

2.2 Applicable World Bank's legal provisions

14. The World Bank's ESF set out the requirements for the MoH relating to the identification and assessment of environmental and social risks and impacts associated with the IPF project. While the ESF itself does not explicitly mention about SEA/SH, various ESSs are in alignment with the recommendations for addressing the risks of SEA/SH related to the IPF project, including:
    - As per the provision in ESS1, the Environmental and Social Assessment (ESA) identifies potential environmental and social impacts early on in project preparation and is usually the primary vehicle for assessing SEA/SH risks on an IPF involving major civil works. In line with this requirement, the project implementing agency MoH carries out an ESA of the project to assess its environmental and social risks throughout the project life cycle.
    - ESS2, paragraph 13, has the requirement for non-discrimination and equal opportunity. As set out in this provision, the employment of the project workers will be based on the principle of equal opportunity and fair treatment, and there will be no discrimination with respect to any aspects of the employment relationship, such as recruitment and hiring, compensation (including wages and benefits), working conditions and terms of employment, access to training, termination of employment, or disciplinary practices on the basis of personal characteristics such as gender. The same paragraph further stipulates that the project labor management procedures will set out measures to prevent and address gender based harassment, intimidation, and/or exploitation.
    - ESS4 states the general provision that when the MoH retains direct or contracted workers to provide security to safeguard its personnel and property, it will assess the risks posed by these security arrangements to those within and outside the project site including GBV. Likewise, ESS5 has the requirement for the MoH to ensure in the consultation process that women's perspectives are obtained and their interests factored into all aspects of resettlement planning and implementation. Yet, as required in the ESS10, the process of preparing the Stakeholder Engagement Plan (SEP) should be inclusive, to accommodate the needs and circumstances of different stakeholders, paying special attention to identified disadvantaged or vulnerable individuals or groups including women.
15. To supplement the provisions in the aforesaid ESSs, the World Bank provides a Good Practice Note (GPN) on Addressing Sexual Exploitation and Abuse and Sexual Harassment (SEA/SH) in Investment Project first published in 2018 and revised twice in 2020 and 2022. The GPN recommends that the MoH consult with local organizations, women's groups, and nongovernmental organizations (NGOs) to: (a) understand the types of GBV that are present in the project-affected community and that may be exacerbated due to the undertaking of the project; (b) map services and safe spaces available to survivors of GBV; (c) define the specific ways that SEA/SH risks are to be addressed in the project by identifying

prevention and mitigation measures, including the development of a SEA/SH Action Plan; and (d) consider other ongoing efforts to prevent and respond to GBV more broadly, including ongoing efforts to prevent sexual and physical violence against children, how the project will complement/use them, and how the project SEA/SH prevention interventions linked wherever possible with existing activities in the health sector and other GBV service providers, such as justice/security, psychosocial support and economic empowerment programming.

3. Findings of the GBV Risk Assessment

3.1 Ethiopian Context GBV Risks: Findings of the Desk Review

16. As reported in the 2016 EDHS[45], in Ethiopia, violence against women and girls continues to be a major challenge and a threat to women's empowerment. Women and girls face physical, emotional, and sexual abuses that undermine their health and ability to earn a living; disrupt their social systems and relationships; and rob them of their childhood and education. In line with this, the findings of the EDHS on Ethiopian context GBV risks assessed as follow.

17. As to the ***prevalence of GBV***: (a) 23% of women age 15-49 have experienced physical violence since age 15, and 15% have experienced physical violence in the past 12 months before the survey; (b) 10% of women age 15-49 reported that they have experienced sexual violence at some point in their lives, and 7% reported that they had experienced sexual violence in the past 12 months before the survey. Five percent of women had experienced sexual violence by age 18, including 2% who had experienced sexual violence by age 15; and (c) women may experience a combination of different forms of violence. Sixteen percent of women experienced physical violence only, 3% experienced sexual violence only, and 7% experienced both physical and sexual violence. Overall, 26% of women age 15-49 have experienced either physical or sexual violence, or both.

18. The findings of the 2016 EDHS on the ***patterns of GBV*** by background characteristics showed: (a) the youngest women (age 15-19), women with no children, and never married women are less likely to have experienced physical violence since age 15 than most other women; (b) rural women are only somewhat more likely (24%) than urban women (21%) to have experienced physical violence since age 15; (c) women's experience of sexual violence has a linear relationship with age. The percentage of women who have experienced sexual violence increases from 4% for women age 15-19 to 14% for women age 40-49; (d) urban women (7%) are less likely than rural women (11%) to experience sexual violence; (e) women with no education are four times as likely to have experienced violence during pregnancy as women with more than secondary education; and (e) women with more than secondary education (5%) are half as likely to have ever experienced sexual violence as women with no education (13%).

19. As to the ***perpetrators of GBV,*** the findings of 2016 EDHS showed enormous percentage of close partners. Accordingly, in line with perpetrators of physical violence, among all ever-married women age 15-49 who have experienced physical violence since age 15, 68% report their current husbands/partners as perpetrators of physical violence, and 25% report former husbands/partners as perpetrators. For perpetrators of sexual violence, among ever-married women age 15-49 who had ever experienced sexual violence, 69% reported their current husband/partner and 30% reported former husbands/partners as perpetrators. Perpetrators of different forms of GBV are exclusive to marital control by current husband/partner (if currently married) or most recent husband/partner (if formerly married): about 39% of

[45] *Central Statistics Agency (2016). The Ethiopian Demographic and Health Survey. CSA: Addis Ababa.*

ever-married women reported that their husbands/partners are jealous or angry if they talk with other men, 33% reported that their husbands/partners insist on knowing where they are at all times, 16% reported that their husbands/partners try to limit their contact with their families, 15% reported that their husbands/partners do not permit them to meet their female friends, and 13% reported that their husbands/partners frequently accuse them of being unfaithful. Overall, 16% of ever-married women reported that their husbands/partners display three or more of the specified behaviours.

20. Studies (Deribe et al. 2012[46]; EDHS 2016[47]; Marisa et al. 2018[48]) on the GBV risks in Ethiopian context, emphasized that there is no single driver of GBV, including SEA/SH but multiple risk factors for GBV at the individual, relationship, community, institutional and policy levels. As to the studies, these multiple factors are rooted in two major causes. The first driver of GBV is root in the patriarchy system that prevails across societies in Ethiopia. It is a form of mental, social, spiritual, economic and political organization/structuring of society produced by the gradual institutionalization of unequal gender relation, maintained and reinforced by different institutions linked closely together to achieve consensus on the lesser value of women and their roles. The institutions of patriarchal system are interconnect not only with each other to strengthen the structures of domination of men over women, but also with other systems of exclusion, oppression and/or domination based on the social construction of gender. The second driving force of GBV in Ethiopia is rooted in the weak policy enforcement. In this regard, the 2016 EDHS justified that Ethiopia has many laws in place at all levels of the legal system that guarantee equal rights and prohibit most forms of GBV, including women's equal property rights, female genital mutilation (FGM), child marriage, most forms of rape, and some intimate partner violence. However, for many reasons, including the often-discordant levels of the formal and informal legal system, the general culture of acceptance of GBV, the poor training of law enforcement and judges, and the lack of institutional support behind the enforcement of the bans, the policies are widely ineffective at preventing GBV, including SEA and SH.

21. Therefore, assessing the IPF project-related SEA/SA risks involves two essential issues. First, the Ethiopian and/or regional context in which the project will operate, and second, the potential risks that the implementation of the IPF project may bring. As set out in the WB's requirement for the MoH, these SEA/SH risks need to be assessed throughout the project's life by monitoring the situation, assessing the effectiveness of risk mitigation measures, and adapting them accordingly.

3.2 Assessment of GBV in the project areas: Findings of Stakeholder Consultation

22. To know the impacts of the conflict, key informants were asked to discuss on the incidents and types of GBV in the IPF target regions/woredas. However, informants underscore that GBV cases are underreported to reveal the accurate extent of the problem. As an illustration, the key informant from Afar regional state expressed the incidents of GBV cases in the region during the war in the northern part of the country as follows:

> *Nine women with rape cases from Ewa and Gulina Woredas in Zone 4, six rape cases in Abala, Berhale and Megale woredas from Zone 2, and one rape case in Chifra woreda Zone 1 have been*

[46]Deribe et al. (2012). Magnitude and correlates of intimate partner violence against women and its outcome in Southwest Ethiopia. *PLoS, 7 (4): 20-37.*

[47]*Central Statistics Agency (2016). The Ethiopian Demographic and Health Survey. CSA: Addis Ababa.*

[48]Marisa et al. (2018). Systematic Literature Review of Gender Based Violence in Ethiopia: Magnitude, policies and interventions https://safeguardingsupporthub.org/documents

officially reported to Afar Regional Bureau of Women and Children Affairs. The number of the reported GBV cases is misleading to depict the whole picture. Based on the Bureau's own assessment, conflict-related GBV incidents including sexual rape occurred in all the 23 woredas affected by the war. But, the GBV cases are by far underreported and various constraining factors contributed for this including: fear of social stigma and discrimination to the victim as well as family, lack of awareness about where and how to report the case, and inaccessibility to the health facilities and police for the immediate reporting as these organizations were not functioning in the course of the war, to mention but only the major reasons.

23. Informant from Oromia region have witnessed even a more severe cases of conflict-related GBV. From the discussion during interview, it was learnt that there are women and young girls who have been kidnapped by the armed groups in different parts of the region, particularly in all the four Wollega Zones, for their sexual service. The informant further stated that:

    Various acts of GBV including physical violence and assault; attempted rape; rape including gang rape, oral and anal rape; insertion of foreign objects into the vagina; intentional transmission of HIV; verbal abuse including ethnical slurs; abduction; and other violations have been committed in the conflict-affected areas in the Oromia region.

24. In Tigray region, nearly half of the survivors that the JIT interviewed were survivors of gang rape. The JIT reported, the ENDF, EDF, and TSF are implicated in multiple reports of gang rape, although the gravity and brutality of the reported cases vary. As the illustrative case, the JIT report presented: "One woman survivor informed the JIT that she was taken from a minibus by 4 EDF soldiers and kept for 11 days, and gang raped by 23 EDF soldiers who also inserted foreign objects into her vagina. The soldiers left her for dead when she fell unconscious and she was found and taken to a Hospital in Mekelle where she was treated for 4 months" (JIT 2021, p. 42).[49]

25. Likewise, the JIT reported that the Tigrayan fighters deliberately committed gang rape and sexually assaulted women and girls in Kobo, a town in the northeast of Amhara region, seemingly in revenge for the losses among their ranks at the hands of Amhara militias and armed farmers. Substantiating this, the assessment by Amnesty International (2022)[50] exposed that:

    In and around Chenna, a village north of the Amhara regional capital Bahir Dar, Tigrayan forces raped and sexually assaulted at least 30 women and girls as young as 14, often in their own homes after having forced them to provide food for them. Fourteen of the 30 survivors interviewed by Amnesty International said that they were gang raped by multiple Tigrayan fighters, who often threatened them and used ethnic slurs (p. 4).

[49]Report of the Ethiopian Human Rights Commission (EHRC)/Office of the United Nations High Commissioner for Human Rights (OHCHR) Joint Investigation into Alleged Violations of International Human Rights, Humanitarian and Refugee Law Committed by all Parties to the Conflict in the Tigray Region of the Federal Democratic Republic of Ethiopia

[50]Amnesty International (2022). Ethiopia: Summary Killings, Rape and Looting by Tigrayan Forces in Amhara. https://www.amnesty.org/en/documents/afr25/5218/2022/en/, accessed March 22, 2023.

26. Informants were asked to discuss on the consequences in line with the above incidents and types of conflict-caused GBV. According to the finding, GBV has caused multifaceted health, psychosocial and economic impacts on the live of the victim. The explanation by a psychosocial expertise interviewed in Hayik Health Center, Tehuledere Woreda, South Wollo Zone, Amhara region can depict the whole ideas:

> *We have seen diverse health impacts to the conflict-caused GBV victims. Some of the health consequences such as intentional transmission of HIV, uterine prolapse and fistula from group rape, and fissure due to rape in anal intercourse have lifelong health threatening. Unwanted pregnancy, psychosocial stress, and sexually transmitted diseases other than HIV are common health impacts to the GBV victims we have seen in the course of medical examination.*

27. Given the differential risks and threats of conflict in the IPF target areas, the interview with the key informants has assessed the local capacity and availability of quality, safe and ethnical services for the GBV survivors. The finding has shown that there are encouraging efforts to improve a GBV service provision. The inauguration of GBV survivor rehabilitation center in Semera, Afar region is a good example in this respect. However, the overall local capacity of formal systems to prevent and respond to GBV and the availability of safe and ethical service provision for survivors was assessed as weak. Below are some of the quotes from the informants as reason:

- *Access to medical and institutional care for the GBV survivors is very much limited in Amhara region in general. If I witness you this based on my experience in Tehuledere woreda, none government partner support such as UNICEF mobile health team is the only efforts for the psychosocial support to the GBV victims. So, I am extremely worried that the psychosocial supports for the GBV survivors may be discontinued after the phase out of the supports by none government mobile health team* (informant from Hayik Health Center).

- A One-stop service centers in Afar regions are limited in number, established only in referral hospitals: There are only four One-stop service centers in the region—one each in Dubti, Asayita, Kalwan and Dalifage Hospitals. Whereas, the GBV victims exist too far from these centers, usually in remote pastoral kebeles (informant from Afar Regional Health Bureau).

- Besides limited number of One-stop centers in conflict-affected areas of the region, only a few of these that provide with a relative service. Most of them lacked the basic requirements for safe and ethical service provision for the GBV survivors (informant from Oromia Regional Health Bureau).

3.3 Assessing Gender-Based Violence-SEA/SH in the IPF Components of the Project

3.3.1 *GBV risk factors for the project civil works*

28. As justified earlier, IPF Sub-component 1 involves major civil works that can increase the risk of SEA/SH both in public and private spaces, by a range of perpetrators and in a number of ways. Thus, the WB's ESF and GPN have provisions that set out the requirement for the IPF project to assess the GBV risk factors that the IPF component of the project may have related to SEA/SH and identify and implement prevention and response mitigation measures to address those risk factors. Accordingly, a preliminary was conducted using the Ecological Framework Model (EFM). Applying this model entails

two critical issues in the assessment of the GBV risks related to the IPF component of the project and devising mitigation measures for the identified risk factors.

29. First, when considering SEA/SH risks, there are different "areas of impact" that influence both the nature of the risk and the appropriate prevention and mitigation measures that the project can implement. These are: (a) the project site, it is the location where the IPF project's activities are being undertaken. This includes both the actual locations where civil works are conducted, and also the associated areas such as the locations of workers' camps, quarries, etc; (b) communities adjoining the project, that is, the area of impact beyond the project site. This extends beyond the specific location where civil works are being carried out and the adjoining communities are at risk of SEA/SH, particularly when the IPF project workers are highly mobile; and (c) there are also regional and national areas of impact that will not be affected by the specific interventions of the IPF project but may benefit through institutional strengthening and other efforts to address SEA/SH risks. An assessment at the regional and/or national level can give the MoH an understanding of those experiencing GBV in the region or country, as well as the type and scale of violence, and its acceptability, in the IPF project-affected communities. Second, there are a number of SEA/SH risk factors for the IPF project that cut across several spheres including communities and institutions and, depending on their scope, they can exacerbate existing risks or can create new ones. Taking the aforesaid broader and multifaceted context, the assessment identified the following GBV risk factors for the prevention and response action plan of the IPF component of the project.

- *Local context GBV risk factors*: The project area context GBV risks factors manifest in many ways: (a) women and girls are at particularly high risk of GBV because of societal norms that perpetuate power differentials between males and females and support or condone males' violence against women and girls; (b) several other local context GBV risk factors that aggravate the vulnerability of women and girls to SEA committed by project workers include: high levels of poverty in the project area; large population of young women; low levels of education among women and girls; low rates of employment among women; and high crime levels/violence in the larger community; and (c) due to unequal treatment of the existing patriarchal system of property ownership, women have limited capacity to defend their interest in and benefits from the project resettlement packages.

- *Labour influx*: Labour influx is an important GBV risk factor in the IPF component of the project.Labor influx and the extent to which the affected community has capacity to absorb labor influx, as well as the inflow of income to workers, can exacerbate already existing inequities between workers and community members for SEA/SH risks. Thus, the risks from the project labor influx can be expected in many ways: (a) large influx of workers may increase the demand for sex work; (b) increased risk of early marriage in project-affected communities where marriage to an employed man is seen as the best livelihood strategy for an adolescent girl; (c) relative higher wages for project workers can lead to an increase in transactional sex; and (d) the risk of incidents of sexual activity between laborers and minors, even when it is not transactional, can also increase.

- *Weak local capacity for GBV prevention and response mechanism*: Prevention and response to project-related risks of GBV require multipronged efforts and sectors, including the government who are critical to ensuring that SEA and SH prevention and accountability mechanisms are in place. However, the assessment of the local capacity to prevent and respond to GBV, including SEA/SH, and the availability of safe and ethical service provision for survivors are found to be low across all the IPF project implementing areas.

30. The Fragility, Conflict and Violence (FCV) situations in the IPF project would increase GBV/SEA/SH risk factors:
    - The IPF project will entirely implementing in areas undergoing a humanitarian or emergency crisis such as a natural disaster, conflict, epidemic, or famine. In such fragile or conflict-affected environments, communities may have undergone traumatic experiences, social norms may have shifted, the social fabric may have broken down, the rule of law may be difficult to enforce, and program supervision may be difficult.
    - Women and children are often unaccompanied during forced displacement thus increasing their vulnerability, and there is often limited security in camps for internally displaced persons and refugees.
    - Dependence on emergency assistance to meet basic needs increases risks of SEA in exchange for receiving aid.

3.3.2 GBV risk factors for the project HD Operations

31. The project HD operations are associated with IPF Sub-component I and II. Sub-component I supports the provision of EHS focusing on RMNCAH+N while Sub-component II finance Civil Registration and Vital Statistics (CRVS). Hence, Sub-component I includes activities that qualify all the three programs (Health, Nutrition, and Population (HNP)) identified by the Bank definition for the HD Operation projects. Whereas, Sub-component II include activities relation to Population program:
    - ***Health:*** Project Health program supports those activities associated with PHC services aimed to strengthen people-centered, integrated, and multidisciplinary primary health care services to ensure equitable access to, and quality of, care (including services targeting health promotion and disease prevention), and disease preparedness and response at the community level for universal coverage and financial protection.
    - ***Nutrition:*** The Nutrition program supports activities associated with nutrition that aim to scale up cross-sectoral strategies to reduce the stunting of children under-5.
    - ***Population:*** It will undertake activities associated with Population: Scale up evidence-based packages of interventions to address key population issues related to demographic transition, including support for reproductive health and related high-fertility issues, improving adult survival, managing the burden of non-communicable diseases, and managing and enhancing aging care.

32. The project HNP programs of the project may increase risks of SEA/SH**.** These risks can arise from beneficiary interactions with program actors and from their participation in program activities. Female project actors may also be exposed to SEA/SH risks in the performance of their responsibilities. Therefore, it is important to understand how these interactions may create conditions that trigger or exacerbate SEA/SH, for women and girls, and to set in place mitigation measures that seek to prevent SEA/SH.

3.3.3 GBV risks for project civil works

33. The findings of the assessment based on the desk review and stakeholder consultation show the following GBV risks in the IPF components of the project:

    - *SEA risks:* Some of the forms of SEA that may be committed by the project workers against women and girls in the project-affected community include: rape and sexual assault; sexual harassment; unwanted sexual advances including touching; physical violence/assault; use of abusive, demeaning

or culturally inappropriate language; transaction sex; and other forms of humiliating, degrading or exploitative behavior.

- *SH risks related to the project working environment:* Risk factors for SH for the IPF project include female laborers working alongside male laborers without adequate supervision of work sites; without separate latrine and other sanitation facilities for males and females; and without specific mechanisms, for females to share concerns about their working environments, including concerns about sexual harassment. Given the nature of the IIPF activities, additional SH may be environments that are stringently hierarchal, give significant and/or undue power to management, and do no promote and reflect female leadership.

- *Security posed GBV risks*: Given the fragile and conflict affected situation of in the IPF project areas, it is likely that the government (federal, regional, or local government) to engage security personnel to safeguard the project workers, assets and activities. Thus, both project physical security measures and security guards can have particularly significant impacts on women, who are likely to be traversing distances for domestic tasks. They may be disproportionately affected by the presence of (typically male and potentially armed) security guards, whom they may encounter daily in following their routine.

3.3.4 SEA/SH risks for HD Operations

34. The findings of the GBV risk assessment depend on the consultation as well as review of relevant secondary sources identified the SEA/SH risks from the project HD Operation as follows.
    - Lack of Behavioral Standards or a written CoC in the health system (at hospital, health center and health post level) that explicitly sets out standards of behavior for health staff and conveys that breaches will be investigated and penalized may encourage for abusive behavior.
    - The finding of the GBV assessment reveal that trainings have not been undertaken for health service providers on the health response to GBV, including testing, post-exposure treatment, and counseling on HIV/AIDS/sexually transmitted infections and pregnancy, including emergency contraception. This may impede on the capacity of the health staff to respond to the GBV victims.
    - As the project will deploy mobile health team for the provision of PHC services for people in remote areas such as pastoral communities, this will involve women health staff working alongside men with no or insufficient supervision increasing their SEA/SH risks.
    - The health system have no written protocols about the management of GBV as a health response. Protocols should include providing information on referral to other relevant services (legal, psychosocial, shelter, livelihood, and community services) available to the survivor.
    - The diversity of the project HD Operations, with a high level of person-to-person activity, multiple layers of organizational hierarchy, and a focus on the delivery of essential services that need to be made available to every person.
    - The project HNP programs dealing with maternal and child health or female genital mutilation (FGM) specifically target women and girls put them at higher risk for SEA/SH.
    - The health sector is the most used entry point into services for women who have experienced any form of violence and who are seeking help
    - The provision of Essential Health Services to people may increase the level of person-to-person contact, including with vulnerable groups, such as children or people with disabilities accessing health care that make increase their risk for SEA/SH.

3.3.5 ***Project GBV risk screening and rating***

35. The World Bank GPN on Addressing Sexual Exploitation and Abuse and Sexual Harassment (SEA/SH) in Human Development (HD) Operations (paragraph 8) sets out the provision for the MoH identifying, rating the project GBV risks and applying mitigation measures to address these risks. Also, where the HD Operations finance major civil works such as the IPF Sub-component I, the guidance in the GPN on Addressing SEA/SH in IPF Involving Major Civil Works (Civil Works GPN) is applicable for the SEA/SH to such project component. Thus, the SEA/SH risk screening questions used in the risk rating for the IPF project are adapted (both from the infrastructure and human development) to fit to the specific context and components of the IPF project. Accordingly, the screening questions are set based on: (a) risk screening questions for country-level GBV prevalence; (b) risk screening questions common to project HD operations and civil works; (c) risk screening questions for the project HD operations; and (d) risk screening questions for the project civil works. This was substantiated with the assessment findings from the desk review (Sub-section 3.1) and stakeholder consultation (Sub-section 3.2) to determine the final GBV risk rating for the Project. Finally, a composite SEA/SH risk rating is calculated for the IPF project based on aggregation of risk ratings for the questions and corresponds to either a:
    - Low colored as
    - Moderate colored as
    - Substantial colored as or
    - High risk rating colored as

GBV Risk Screening and Rating for the IPF Components

Risk Screening Questions for Country-Level GBV Prevalence	*Response Answer*	*Risk Rating*	*Comment Risk Response Mechanism*
1. How prevalent is intimate partner violence (IPV)?	Common	**Substantial Risk**	As assessed in EDHS (2016), IPV is the most common form of violence against women in Ethiopia that takes different forms. Among all ever-married women age 15-49 who have experienced physical violence since age 15, 68% report their current husbands/partners as perpetrators of physical violence. Likewise, the proportion of women whose current husband/partner (if currently married) or most recent husband/partner (if formerly married) demonstrates at least one of the following controlling behaviours make 39%: is jealous or angry if she talks to other men; frequently accuses her of being unfaithful; does not permit her to meet her female friends; tries to limit her contact with her family; and insists on knowing where she is at all times. This statistics can help to estimate the prevalence of IPV in the project target areas as substantial.
2. How prevalent is any form of sexual violence?	Relatively High	**Substantial**	The 2016 EDHS assessed that 10% of women age 15-49 reported that they have experienced sexual violence of any form at some point in their lives, and 7% reported that they had experienced sexual violence in the past 12 months preceding the survey. Five percent of women had experienced sexual violence

		Risk	by age 18, including 2% who had experienced sexual violence by age 15. Based on the country context data, the prevalence of any form of sexual violence in the IPF project target areas can be assessed as substantial.
3. How prevalent is child marriage (defined as marriage before exact age of 18 as reported by women)?	Relatively High	Substantial Risk	According to EDHS (2016), in Ethiopia, women tend to marry considerably earlier than men. The median age at first marriage is 17.1 years. The median age at first marriage has increased slightly since 2011, from 16.5 years to 17.1 years. During the same period, the percentage of women marrying before age 18 has declined from 63% to 58%. Eight percent of women married before their 15th birthday in 2011, as compared with 6% in 2016.
4. Does the country have laws banning sexual harassment, marital rape and domestic violence?	Yes, but weak enforcement	Substantial Risk	Ethiopia has put in place appropriate legal and policy provisions to promote the rights of women and girls. These rights are enshrined in the Constitution. Ethiopia has also ratified many of the international and continental agreements that promote and protect women's rights, including the Convention on the Elimination of Discrimination against Women (CEDAW), and the Protocol to the African Charter on the Rights of Women in Africa. In addition, Ethiopia has established specific legal measures and actions to address violence, including the Revised Family Law in 2000 and the Revised Criminal Code in 2005 (UN Women 2016). However, as assessed in EDHS (2016) the enforcement of this legal instrument is weak.
5. Does the country have a national action plan on addressing violence against women and girls?	Yes	**Lower Risk**	The new national Women's Development and Change Strategy (2013) and the revised package on how to realize the strategy has put in place a clear direction on protection, prevention, and provision of services for women survivors of violence. Further, the country has put in place the regulation for gender mainstreaming in all public sectors.
6. Does the country have a national GBV working group?	Yes	Low Risk	For the aforesaid national action place, the government of Ethiopia has put in place the requisite institutional mechanisms at federal, regional and organizational levels, including the establishment of: (1) The Ministry of Women and Social Affairs, (2) Regional Women and Social Affairs Bureau in the respective regions, (3) Women and Social Affairs in the respective Woredas, (4) Child and Women Protection Units within the various police units, (5) a Special Bench for violence against women cases within the federal criminal court, and (6) each public organization from federal to woreda level has Gender Directorate or Gender Department dedicated for prevention of

			GBV.
7. Is there a national referral protocol for GBV Service Provision	Yes	Moderate Risk	In line with the establishment of One-Stop service centers, the referral system is intended to connect survivors to appropriate multi-sector GBV prevention & response service in timely and safe manner. GBV partners established referral systems to connect the survivors and at-risk groups to appropriate multi sector GBV prevention and response services. However, the system is not effective enough for various constraining factors.
Risk Screening Questions Common to Project HD Operations and Civil Works	***Response Answer***	***Risk Rating***	***Comment Risk Response Mechanism***
8. Is your project in an area of the country with a humanitarian crisis or emergency situation?	Yes	Higher Risk	• The IPF project will entirely implementing in areas undergoing a humanitarian or emergency crisis such as a natural disaster, conflict, epidemic, or famine. In such fragile or conflict-affected environments, communities may have undergone traumatic experiences, social norms may have shifted, the social fabric may have broken down, the rule of law may be difficult to enforce, and program supervision may be difficult. • Women and children are often unaccompanied during forced displacement thus increasing their vulnerability, and there is often limited security in camps for internally displaced persons and refugees. • Dependence on emergency assistance to meet basic needs increases risks of SEA in exchange for receiving aid.
9. Is the project region or province in the lowest poverty quartile of the country?	Yes	**Higher Risk**	As the 2016 Ethiopian Demographic and Health Survey found out, the IPF project will be implemented in regions in the lowest poverty quartile of a country, underserved and the most vulnerable to neglect. Such high poverty scores may mean residents of these areas are particularly vulnerable to many forms of exploitation, including sexual exploitation and may lack the resources and agency to avoid and report abuse.
10. Is the project in hard-to-supervise areas (for instance, very remote or geographically diffuse projects)?	Yes	**Higher Risk**	The implementation of the IPF project is spread across a wider area, and/or whose activities are in remote, very diffuse or hard-to-access areas, or are in areas to which project implementing staff of the MoH or Bank staff are unable to travel present greater challenges for supervision and therefore a higher risk of potential abuse and under-reporting of problems.
11. During project preparation, consultation was undertaken with women's groups, groups that advocate for children and adolescent rights, and other stakeholders.	No	**Higher Risk**	During the project preparation phase, consultations have not undertaken with women and women's groups in a safe environment to allow free participation, or having had concerned raised. However, consultation with vulnerable and disadvantaged groups in the local community including women has been conducted in all the IPF project target regions except Tigray in in the preparation of the project ESMPs GBV risk assessment and response action plan, including ESMF, SA, SMP, RF, and LMP.

			Likewise, key informant interview with leaders of the women Organizations (Ministry of Women and Social Affairs, Women and Social Affairs Bureau in the respective targeting regions, Women and Social Affairs Office in the sampled woredas) has been conducted.
12. During stakeholder consultations in the preparation of the project ESMPs including GBV Risk Assessment and Response Action Plan, did groups advocating for women, children and adolescent girls raise concerns about the project's potential additional SEA/SH risks?	Yes	**Higher Risk**	The consulted women have discussed various incidents of conflict-related GBV in all the IPF target regions including rape and group rape. However, all the interviewees invariably underscore the underreported of the GBV cases for various constraints. Accordingly, women's views are obtained and their special needs factored into the preparation of the ESMF, SA, RF, SMP and SEA/SH Preventive and Response Action Plan for the IPF project
13. Is the project rural, pre-urban or urban??	Includes All	**Higer Risk**	The IPF project areas include urban area but mostly rural and peri-urban areas. In urban settings, transactional sex and forced sex may be common, while rural settings may have higher risk of forced marriage or early marriage. None of these contexts are free from GBV, however, services may be harder to access in general and harder to access anonymously in rural areas. Because of the scarcity in services and social taboos governing access to services when available, rural areas are given higher risk ratings.
Risk screening Questions for the Project HD Operations	***Response Answer***	***Risk Rating***	***Comment Risk Response Mechanism***
14. Do end-users of health services know the true cost of health services and medicines?	Yes	**Lower Risk**	The end-users know that medical service in Ethiopia is largely subsidized by government. Circumstances that may put pressure on women to make up for the cost via sexual favors or other transactional sex is rare.
15. Does the health system include protocols on how to respond to survivors of GBV seeking care?	No	**Higher Risk**	In the project area, the health system have no written protocols about the management of GBV as a health response. So, the IPF project needs to put in place protocols that include providing information on referral to other relevant services (legal, psychosocial, shelter, livelihood, and community services) available to the survivor. These protocols can either be national or site-specific.
16. Are health service providers trained to manage GBV as a health response?	No	Substantial Risk	As the GBV risk assessment finding reveals, trainings have not been undertaken for health service providers on the health response to GBV, including testing, post-exposure treatment, and counseling on HIV/AIDS/sexually transmitted infections and pregnancy, including emergency contraception.

17. Are there a site-specific CoC or Behavioral Standards for health service providers that includes prohibitions against (a) sexual harassment; (b) sexual exploitation; and (c) sexual abuse?	No	**Higher Risk**	As per the result of the GBV risk assessment, there are no site-specific CoC or Behavioral Standards for the project actors that may increase the risks of GBV associating with the implementation of IPF project. It is recommended that the existence of Behavioral Standards or a CoC that explicitly sets out standards of behavior for staff and conveys that breaches will be investigated and penalized may serve as a deterrent for abusive behavior. Behavioral Standards or CoC also ensure that all staff understand the expectations of behavior and have been informed of these standards.
18. Will the project be able to monitor implementation across the full span (both in terms of geographic spread and duration) of the work?	No	**Higher Risk**	Effective monitoring of the IPF project by the Social Safeguard or GBV specialist in the MoH is challenging for three major reasons. First, the project areas are areas with high security risks from recurring conflicts. Second, the project areas (Afar, Beninshangul-Gumuz and parts of Oromia regions) are mostly remote. Third, the geographic scope of IPF project areas in Amhara and Tigray regions are vast for periodic monitoring. As a result, identification of project related GBV risks and its occurrence as well as obtaining feedback from the affected community to assess whether the project activities are aggravating SEA/SH in its area of influence is difficult. These may be situations that increase the project related GBV risks.
19. Are female workers in close proximity to male workers with limited supervision?	Yes	Higher Risk	The IPF Sub-component I will deploy Mobile Health Team to reaching out to remote areas such as pastoral communities to provide PHC services. Under such circumstance, it is likely that women staff work in close proximity to male workers with no or insufficient supervision. This may be one factor for higher risk of project-related GBV risks.
Screening Questions for the Project Civil Works	***Response Answer***	***Risk Rating***	***Comment Risk Response Mechanism***
20. How much infrastructure construction, upgrading or rehabilitation does the project entail?	Major	Substantial Risk	A total of 48 hospitals, 598 health centers, and 2643 health posts were damaged completely or partially from the conflicts in the five project target regions. In addition, numerous health infrastructure including Zonal/Woreda Health Offices, drug stores, and blood banks were damaged as well. Yet, the project intend to construct temporary or satellite clinics at IDP Camps. The civil works of the IPF Sub-component I involve the renovation or reconstruction of all these health facilities and infrastructure.
21. What is the extent of the influx of labor associated with project activities?	High	High Risk	The project is expected to cause huge labor influx because the civil works under *IPF Sub-component I* necessitate large number of contracted workers including laborers. Besides, both IPF Sub-component I and Sub-component II engage direct workers. Increasing GBV risk is expected when project labour influx is coupled with project areas with small remote pastoral

			communities (in Afar, Benishangul-Gumuz and parts (Borena and Guji areas) of Oromia regions), context with pre-existing social conflicts, high prevalence of GBV, and weak law enforcement.
22. Are women working near men without supervision?	Yes	High Risk	In association with the project civil works of the IPF Sub-component I, female laborers can work alongside male workers in the project construction site without adequate supervision; without separate latrine and other sanitation facilities for males and females; and without specific mechanisms, for females to share concerns about their working environments, including concerns about sexual harassment. Also, under the activities (e.g. mobile health team and mobile CRVS team for remote/inaccessible areas such as pastoral communities) of IPF Sub-component II women may work with or near men without supervision.
23. Are project activities on a school route or other routes that women and girls use to carry out their daily activities	Yes	Substantial Risk	Most project activities (project civil works, mobile health team, mobile CRVS team) are on a school or routes where girls and women are likely to be traversing distances for schooling and daily domestic tasks.
24. Will military forces or private security agents be recruited under this project?	Yes	High Risk	The IPF project will operate under high Contextual Security Risks that are rooted in the Fragile, Conflict and Volatile situations in all the project areas. For this reason, the assessment reconnoitered obvious security risks that require the government (federal, regional, or local government) to engage security personnel to safeguard the project workers, assets and activities.
Overall Evaluation of Risk for the IPF components of the project	**High Risk**		

4. GBV – SEA/SH Risk Mitigation, Prevention and Response for IPF Project

36. As shown in the above table, the overall evaluation of the SEA/SH Screening for the IPF project is rated as High Risk. The higher the project-related GBV risks, the more the Action Plan it will need to address the problem. The IPF project requires to devise appropriate SEA/SH risk mitigation and ongoing monitoring measures. As a requirement to integrate SEA/SH Prevention and Response measures to IPF project, key element of the plan include:
    - **Emphasize prevention:** Adopt risk-based approaches that aim to identify project-related key risks of SEA/SH and to undertake measures to prevent or minimize harm.
    - ***Behavioral Standards, Codes of Conduct, and Disciplinary Measures:*** Behavioral Standards or a CoC that explicitly prohibits SEA/SH are recommended. Explicit provisions that prohibit and define SEA/SH in line with international standards, including a prohibition on sexual

activity with anyone under the age of 18, and define mandatory consequences elevate awareness of SEA/SH risks and provide a clear path of accountability for violations. Through such means, the MoH will introduce explicit SEA/SH prohibitions in contractually binding instruments before project actors begin activities in connection with the project.

- ***Sensitization and Training:*** Incorporate sensitization and/or training on SEA/SH that aims for: (i) health staff; (i) workers, both from the contractor and sub-contractors; (ii) consultants, such as the supervising Engineers or others working in the project area; (iii) IA staff involved with the project; (iv) the GM operator on how to handle GBV complaints in a survivor-centered manner and in line with the best interests of the child approach; and (v) Managers are particularly important to train as they have the responsibility for ensuring compliance of staff with the CoCs as well as implementing sanctions for non-compliance. Training on SEA/SH will also be done within the project's adjoining communities and will be designed in an age-appropriate manner and format when children are included in outreach activities. Sensitization or training is not a one-time requirement; rather, it is a continuing process throughout project implementation that is informed by the project activities and context.
- ***Grievance Mechanisms and Referrals for Survivors:*** In all cases, project GMs should follow good practice in receiving, recording, and referring all SEA/SH complaints. The following considerations are important for designing a SEA/SH responsive GM:
  - ✓ The GM should adopt a survivor centered approach in which the safety and well-being of the SEA/SH survivor is the first priority, the survivor will be treated with dignity and respect, and the survivor's choice and the agency will be respected in all decisions
  - ✓ In order to act in the best interests of children, GMs will need to have specific protocols for children who are survivors of SEA/SH. GM operators should be trained on how to respond to cases involving children,
  - ✓ Devise for multiple channels through which complaints can be registered in a safe and confidential manner, including through anonymous complaint reporting mechanisms.
  - ✓ Information on how to report complaints be disseminated among beneficiaries and communities.
  - ✓ The personal information of a survivor be protected.
  - ✓ The GM serve primarily to refer complainants to GBV service providers (whether related to the project or not) immediately after receiving a complaint.
  - ✓ The GM operates without prejudice to any other complaint mechanisms or legal recourse to which an individual or community may otherwise have access under formal law.
- ***Ensure accountability and response framework:*** An Accountability and Response Framework documents, in a single place, how allegations of SEA/SH will be handled, along with the disciplinary action for violations by project actors. It include, at a minimum:
  - ✓ Steps for handling and reviewing allegations, including timeframe, and responsibilities for each stage of the process.
  - ✓ Procedures for review of complaints or incident reports, including information on the investigation and verification process.
  - ✓ Confidentiality requirements for dealing with cases (e.g. consent and information sharing protocols).
  - ✓ Internal reporting of allegations, for case accountability including the GM process for capturing disclosure of SEA/SH.

- ✓ Protocols for responding to survivors, using the survivor-centered approach (as describe below), and including a pathway to refer survivors to appropriate support services where they exist.
- ✓ Specific protocols to address allegations involving children, incorporating consideration of the best interests of the child, specialist support services, and the role of parents/guardians in the response process.
- ✓ Disciplinary measures against project actors who commit SEA/SH as per the CoC annexed here with.
- ✓ Protocols for protection of whistleblowers and prohibition on retaliation against both complainants and whistleblowers, consistent with the World Bank's Commitments on Reprisals

- ***GBV Service Provider Identification and Mapping:*** It is important that the MoH identifies in advance the available, quality GBV service providers to refer survivors for support. It is necessary for the PIU to identify more than one GBV service provider or to conduct a more in-depth mapping of different service providers prior to project activities commencing.
- ***Retain GBV Specialist:*** Since the overall GBV risk for the project is rated as substantial, as per the requirement in the World Bank GPN on Addressing Sexual Exploitation and Abuse and Sexual Harassment (SEA/SH) in Human Development (HD) Operations (paragraph 43 and 47), the MoH need to retain a GBV Specialist in the project implementing staff as early as possible before the commence of the project.
- ***Ensure gender equity in the staff recruitment:*** It is recommend that the project HD Operations encourage gender-sensitive staffing or equitable recruitment in the project at all levels, including women in management/leadership positions. In addition to ensuring that individuals with required expertise are engaged, it is recommend that the IPF project may consider how gender-sensitive staffing of the PIU or health staff can support SEA/SH mitigation measures.
- ***Creating Safe Spaces at the Facility-level:*** The MoH or Contractors for the civil works should consider how the physical facilities they use or develop can help to reduce the risk of SEA/SH for example through: having separate, safe and easily accessible facilities (e.g., toilets, sleeping areas) for male and female users, which can be locked from the inside; having safe, accessible, well-lit waiting areas and other public spaces (such as construction sites); and visibly displaying signs around the project site (if applicable) that signal to workers and the community that the project site is an area where SEA/SH is prohibited; or is a safe, SEA/SH free zone.
- ***Build on existing local knowledge:*** Engage community partners—local leaders, civil society organizations, and gender and child advocates—as resources for knowledge on local-level risks, effective protective factors and mechanisms for support throughout the project cycle.
- ***Enable continuous monitoring and learning:*** Ensure operations integrate mechanisms for regular monitoring and feedback to track effectiveness and to build internal knowledge of what works to prevent, mitigate and respond to SEA/SH.
- Project-level measures to address SEA/SH risks consider other ongoing efforts to prevent and respond to GBV more broadly, including ongoing efforts to prevent sexual and physical violence against children, and how the project will complement/use them. For instance, project SEA/SH prevention interventions be linked wherever possible with existing activities in the health sector, and other GBV service providers, such as justice/security, psychosocial support and economic empowerment programing.

- Coordinate with school communities and organize activities/disseminate information on SEA targeting adolescent girls.

5. Operationalization of this SEA/SH Prevention and Response Plan: Project Annual Work Plan and Budget

37. The MoH will ensure the commitments and planned activities in this SEA/SH Prevention and Response Plan are operationalized through the project annual work plan and budget. MoH must include environmental and social activities in this SEA/SH Prevention and Response Plan with estimated budget in the annual work plan and budget. The project annual work plan and budget passes through a review by task team leaders and environmental and social specialists prior to issuance of no objection. The below table presents details of SEA/SH Prevention and Response Action Plan for the IPF project.

Detailed SEA/SH Prevention and Response Action Plan for the IPF Project

	Activity to Address SEA/SH risk	*Steps to be taken*	*Timelines*	*Responsible*	*Monitoring (Who will monitor)*	*Output indicators*	*Estimated Budget*
1	***Capacity building of the PIU on SEA / SH Responsibilities and Key Actions***						
1.a	Capacity building sessions for the staffs and management/leadership members of project implementing entities from MoH and ICS to woreda level on GBV, SEA/SH. Each training will be a Three -Days training on: -Gender based violence (GBV), SEA and SH - Developing a comprehensive approach to Prevention of and Response to project related GBV, SEA and SH in the implementation of the IPF Sub-components I and II -Build Scenarios, case studies and field experience relevant to the subject -Review of the Code of Conduct /disciplinary action for violation of CoC, -Roles and responsibilities of actors involved in the project, including coordination mechanisms internal to the project to ensure adequate attention to and monitoring of GBV, SEA and SH risks -Internal GBV, SEA and SH case-reporting mechanism, accountability structures, and referral procedures within agencies -Community-based reporting of GBV, SEA cases related to project staff by community members Services available/referral pathway.	-To prepare for the training using the developed module and materials -The Contractors and consultants contracts to be reviewed -Human resource manuals and staff capacity to be assessed -Project code of conduct to be prepared -Conduct training for targeted audience -Develop a work plan on enhancing prevention and protection -To appoint an internal focal point in charge of reporting (who might include one in HR department)	The first Quarter of the implementation period	GBV Directorate in the MoH	GBV Specialist in the Directorate	- Number of trainings conducted -Number of strained staff and management/leadership members -Focal point identified	20,000 USD

1.b	Ongoing Oversight Measures in the Project, and under that activity include ensuring that SEA and SH are regular agenda items on the meeting of the implementing team in the MoH.	-Ensure the Organized regular Implementing Team meetings include: -SEA & SH agenda -Reports and updates -Follow up actions	Start in quarter one and continuous	GBV Directorate in the MoH	GBV Specialist in the Directorate	-Number of monitoring of project meetings held with SEA/SH as an agenda item -Percentage of cases/issues/concerns followed up	
2	**Mapping out GBV/SEA prevention and response service providers**						
2.a	Mapping of GBV Service providers will be undertaken in the project implementation woredas. The mapping exercise will include government social services, CBOs, NGOs, and other civil society organizations. Map woredas where the project is implemented for referral services for survivors of GBV, SEA and SH	-Conduct field visits and or remote/desk review to identify and map the existing services, gap analysis, entry points for survivor assistance, and local actors working on the prevention of and/or response to GBV -Towards achieving this, the following will be undertaken: Conduct a desk review of GBV service providers in hosting woredas and communities. Including the prevention and response mechanism Field visits. Stakeholder consultations - Analyze the services for	Within the first quarter from effectiveness	GBV Directorate in the MoH	GBV Directorate in the MoH	The Mapping Report	10,000 USD

		survivors available in all project locations and assess their quality as per standards, including health care, psychosocial support, police and legal/justice services					
2.b	Develop/Review and update a multi-sectoral GBV referral pathway(s) in line with the National systems and global standards The survivors will have a place to go and report. Where confidentiality can be done.	a. Considering the mapped out GBV prevention and response service providers, a referral pathway for service providers will be developed/updated b. Disseminate the referral pathway/list to stakeholders including service providers c. Information dissemination on existing GBV response services and the importance of timely reporting will be conducted	a. Within the first quarter of the kick-off of the work plan b. To be frequently updated and maintained throughout project implementation. c. Throughout the project period	GBV Directorate in the MoH	GBV Directorate in the MoH	-The referral pathway developed/ updated -The level of dissemination undertaken -Information dissemination conducted	
2.c	Capacity building of multi-sectoral GBV service providers on relevant GBV response topics.	The capacity building plan will be developed based on service mapping findings and appropriate budget will be allocated.	Within the first quarter	GBV Directorate in the MoH	GBV Directorate in the MoH	- Capacity building plan developed (for service providers)	
3	Capacity Building of Workers						

3.a	Conduct GBV/SEA orientation training for project staff specifically in touch with the communities in implementation of the IPF Sub-components I and II. In line with the Good Practice Note recommendations, the training will cover the following topics: 1. Defining Gender-Based Violence، its Forms, manifestations and Consequence 2. Highlights of the frameworks addressing GBV 3. Principles of Reporting Gender-Based Violence 4. Scenarios and field experience relevant to the subject 5. The CoC and the laid down guidelines and possible disciplinary action for violation of CoC 6. Roles and responsibilities of the key actors involved in the project, 7. Case-reporting mechanism, accountability structures, and referral procedures within agencies 8. Community members reporting processes on issues related to project staff 9. Services available/referral pathway. 10. GRM	- Conduct training for project staff - Retrain where appropriate during the implementation	Within the first quarter from effectiveness	GBV Directorate in the MoH	GBV Directorate in the MoH	- Number of training conducted for project staff - Percentage of workers that have attended training.	10,000 USD
4	**Undertake Community Awareness Raising to Support Prevention of and Response to SEA & GBV Related to the Project**						
4.a	Community-awareness on the risks of sexual exploitation and abuse (SEA) & GBV. This focus will include: - GBV - SEA - Reporting mechanisms and channels	- Develop a community engagement plan (including strategies to engage those in isolated locations) - Engage the administrative leadership, chiefs, elders, and women groups and focus on their level of knowledge on	Ongoing	GBV Directorate in the MoH	GBV Directorate in the MoH	-No. of engagements with the local government administrators -No of partnerships formed with	

	- Available services at the project implementation woredas, at regional and national levels - Explain rights and entitlements ensuring that people do not fail to report on GBV and SEA out of fear of losing much-needed material assistance. - The awareness will primarily highlight as communities, they are entitled to receive and that their rights will not be affected by their potential complaints.	GBV, SEA, conduct awareness and sensitize the leaders - Identify and establish partnerships with existing CSO's - Collaborate with CSOs undertaking similar community forums and awareness raising with bid to concur on content and delivery of the messaging - Develop a Community GBV/SEA sensitization program, material and messages - Conduct community sensitization	throughout Project implementation period.			CSOs -No. of forums conducted -No. of forums conducted with communities in isolated locations -No. of woredas reached -The kind of multiplier awareness sessions that would follow	20,000 USD
4.b	In collaboration with Woreda Women and Social Affairs offices, provide targeted training for volunteer champions (women leaders, girls).Involve at least 5 champions per woreda; cluster them into groups of 5 woredas to have population of approx. 20-25 participants per training. To thus have 5 pieces of training for all the targeted woredas. The training to be for a two day period and focus on: - Awareness – TOTs who can create awareness back at the community - To have community owner processes that can easily deal with the issue of potential gatekeepers and opinion shapers - Making use of existing community-relevant	- Identifying and contacting the champions per woreda - Prepare for the training using the already developed module and materials - Conduct training Share information, education and communication (IEC) materials for further dissemination - Develop champions / Stakeholder Engagement Plan for SEA related issues	Within the first quarter from effectiveness	GBV Directorate in the MoH	Local woman led CBO (or as will be agreed during the champion's training)	- Number of champions trained - Stakeholder Implementation plan developed and implemented - Number of activities conducted by champions - Number of	

	informal structures - The benefits for the champions is that: They will likely use the same language for ease of awareness Champions will remain as a community resource ensuring sustainability They provide a data base of those that can be reached to provide awareness, e.g., on radio program					women, men, boys and girls reached by champions led activities	
B	Develop audience specific IEC/BCC materials and disseminate awareness materials for community engagements, awareness and information	- Collect and select relevant and applicable existing materials on prevention & response to SEA. - The material will enhance awareness on PSEA for staff as well as for communities - Dissemination be undertaken the target woredas	-Within the first quarter of the kickoff of the work plan -Dissemination will be conducted throughout the project period	GBV Directorate in the MoH	GBV Directorate in the MoH	- Number and type of GBV/SEA IEC material gathered - Number of avenues that the dissemination has been effected	
C	Organize orientations campaigns in schools to mitigate risks of GBV against school girls. The focus will be -GBV -Reporting mechanisms and channels -Available services at the project implementation woredas, at regional and national levels **-Explain importance of timely reporting to access lifesaving GBV services in case of Rape/Sexual assault.** The training will be conducted by the champions (women & girls) who will participate in the ToT	- Identifying and contacting the schools in the targeted woredas - Prepare for the training using the already developed module and materials - Conduct training - Share information, education and communication (IEC) materials for further dissemination	Throughout the project period on regular basis	ToT trained Woreda level champions	Gender/GBV Specialist	- Number of schools targeted by campaigns	

	trainings.						
	-Review and input into the existing GRM. -The intention is to have the project utilise common GRM that is purposed and responsive to GBV issues. This will include training GRM committee members on GBV guiding principles. This will ensure more effectiveness and without risk of a survivor moving through different systems. -Relevant measures/procedures will be included in the GRM to address the special needs of people living in isolated locations -The input will be into the GRM by the Social Impact Team, for specific GBV/SEA/SH procedures -GBV reporting mechanism will multi-pronged: to enable survivor-centred, appropriate, adequate, sensitive, consensual and confidential service	- Undertake internal review of the existing GRM for GBV/SEA mitigation responsiveness and where need be, input Train GRM committee members on GBV guiding principles - Ensure GBV complaints are handled in safe and confidential manner - Inform employees and the community on how to report cases of GBV related to the project. - Inform on what constitutes of CoC breaches to the GRM, and how such cases are handled - Develop enhance where they already exist (and where feasible) mechanisms to hold accountable alleged perpetrators including possible disciplinary action for violation of the CoC	Ongoing throughout Project implementation period.	GBV Directorate in the MoH	GBV Directorate in the MoH	A GBV/SEA responsive and integrated GRM No. of referrals of GBV incidents made	implementation budget for these SEA/SH activities
5	**Monitoring of SEA/ SH & GBV Incidences and or Reports: The monitoring will be towards assessing the status and performance in terms of compliance, emerging issues and proposing recommendations for improvement as the situation will present. The monitoring process will be objective, with no bias.**						

	Purposed and continuous monitoring of the cases reported or occurring in the respective communities. Comprehensive monitoring will be undertaken. This will enable supervision and verification that the project implementation meets the standards. This approach will strengthen monitoring and evaluation systems. The monitoring will be towards: - Ensuring prompt, confidential response to SEA, SH & GBV matters - Securing requisite support to SEA, SH & GBV survivors - Supporting the GRM teams to adhere to rules around consent and confidentiality of the survivor - Ensuring vulnerable groups' safe access to services (livelihoods)	- Develop a monitoring tools - Undertake time to time assessment of the Referral pathway for effectiveness and vigilance to survivor centered approach - Paying attention to - Community/beneficiaries response and feedback - The monitoring will be on a continuous basis and the days can be applied on a need basis which will be from time to time be referenced from the guidance note	Ongoing throughout Project implementation period.	GBV Directorate in the MoH	GBV Directorate in the MoH	The swiftness in response to feedback received The level and quality of services accorded to the survivors	No need for budget. It is part of the PIU duties
6	**Reporting**						
	Periodic Reports will be done Recommendations will be made, and proposals given towards enhancing the relevance, effectiveness and appropriateness of the response to SEA and SH	- Periodic reports will be developed and shared with the Bank. Documented and recorded reports will be buttressed with the evidence of the findings and results of the activities. - The reports will focus on the prevention, protection and response mechanism, the appropriateness of handling the survivors.	Ongoing throughout Project implementation period but at a minimum every 6 months	GBV Directorate in the MoH	GBV Directorate in the MoH	Periodic Reports	No need for budget. It is part of the PIU duties
7	**Define and reinforce GBV/SEA/SH requirements in procurement processes and contracts**						

7a.	Incorporate GBV/SEA/Requirements and expectations in the contractor and consultants' contracts.	Ensure that GBV/SEA issues are incorporated in all contracts signed by contractors and consultants	During project implementation.	GBV Directorate in the MoH	MoH World Bank Team	GBV/SEA standards in procurement/contract document	No need for budget. It is part of the PIU duties
7b.	Allocation of funds for GBV/SEA/SH related costs in procurement documents.	Clearly define SEA/SH requirements and expectations in the bid documents	During preparation of bid and Contract documents	GBV Directorate in the MoH	World Bank Team	Bid documents with clearly defined SEA/SH requirements Contract documents with clearly defined SEA/SH clauses/requirements	
7c.	Workers (Contractor/consultant) sensitization on GBV/SEA.	Develop a training plan for workers, contractors and consultants Conduct training on GBV/SEA risks, responsibilities and legal/policy requirements	Quarter 2 after commencement of the project During project implementation.	Gender Specialist and Project Area Focal Person,	GBV Directorate in the MoH	Number of contractors' and consultants staff trained,	
8	**Separate toilet and shower facilities for men and women and GBV/SEA-free signage**						

	Provide separate facilities for men and women and display signs, posters and pamphlets around the project site that signal to workers and the community that the project site is an area where GBV/SEA is prohibited	Provide separate facilities Design and print pamphlets and posters. Distribute the pamphlets and posters to the project site Install signage on the facilities Visit Project gangs/camps to check on the availability and usability of separate sanitary facilities.	Before the commencement of the civil works	Project civil works contractors	GBV Directorate in the MoH and Project Area Focal Person,	Number of separate toilet and shower facilities for men and women Display signs/IEC materials	The cost will be covered by Project contractors

Annex 1: Guiding Questions for Gender-Based Violence (SEA/SH) Risk Assessment

Part I: Assessment of the Project Context

1. What kind of Sexual Exploitation and Abuse (SEA) and Sexual Harassment (SH) commonly prevail in the local community? ***Probe:*** Assess the prevalence of early marriage, rape, physical abuse (e.g. wife beating culture), psychological abuse (e.g. verbal insult, humiliation), actual or threatened physical intrusion of a sexual nature, and request for sexual favor for employment opportunity or in work place.
2. What are the social, cultural and economic factors of the local community that undermine the participation and active role of women in all spheres of life? ***Probe:*** assess who make decision in the household, who take part in community meetings, does proper ownership system give equal right to women, and compare boys and girls in terms of school enrollment.
3. Assess how those discrimination justified in *question 2* adversely affect women's active participation in the planning and implementation of the IPF components of the project.
4. Also, assess how those discrimination justified in *question 2* adversely affect women's equal development benefits from the IPF project?
5. Assess the awareness of the members of the local community on GBV. ***Probe:*** Do the local community know that those perceptions and acts justified in *questions 1-4* are gender based violence? Do victim women know where to report in case of GBV? Does proper GBV responding systems exist??
6. Given the discussions in *questions 1-5*, ask what the community consultation participants propose as the mitigation measures in the implementation of the IPF project.

Part II: Assessment of Conflict-Caused GBV Risks and Threats

7. Describe the extent of conflict-caused GBV cases reported in your Region/Woreda/Kebele. *Probe*: discuss the types and consequences of the reported GBV cases on the health, psychosocial, and economic life of the victim.
8. Assess the local capacity and availability of quality, safe and ethnical services for the GBV survivors.
9. Discuss the capacity of the Region/Woreda to respond to the SEA/SH risks. Explain the ongoing GBV interventions/program by the Region/Woreda.

Annex 2: Codes of Conduct for Contractors and the SEA/SH Prevention and Response Action Plan

1. To build a system for SEA/SH risk prevention and mitigation, the IPF project must:
   - Have all employees of contractors (including sub-contractors), supervising Engineers and other consultants with a footprint on the ground in the project area sign codes of conduct (CoCs);
   - Have an effective SEA/SH Action Plan so that workers understand behavior expectations and policies, as well as an effective Grievance Mechanism (GM). This Action Plan should include training and communication. It should also include plans to make the project-affected community aware of the CoC the project staff have just signed; and
   - As part of the SEA/SH Action Plan, define accountability and response protocols, which set out the procedures followed for holding individuals accountable and penalizing staff that have violated SEA/SH policies.

Codes of Conduct from Standard Procurement Document

Code of Conduct for Contractor's Personnel (ES) Form

***Note to the Employer**:*

***The following minimum requirements shall not be modified**. The Employer may add additional requirements to address identified issues, informed by relevant environmental and social assessment.*

The types of issues identified could include risks associated with: labor influx, spread of communicable diseases, Sexual Exploitation and Sexual Abuse (SEA) *etc.*

Delete this Box prior to issuance of the bidding documents.

Note to the Bidder:

The minimum content of the Code of Conduct form as set out by the Employer shall not be substantially modified. However, the Bidder may add requirements as appropriate, including to take into account Contract-specific issues/risks.

The Bidder shall initial and submit the Code of Conduct form as part of its bid.

Code of Conduct for Contractor's Personnel

We are the Contractor, [enter name of Contractor]. We have signed a contract with [enter name of Employer] for [enter description of the Works]. These Works will be carried out at [enter the Site and other locations where the Works will be carried out]. Our contract requires us to implement measures to address environmental and social risks related to the Works, including the risks of sexual exploitation, sexual abuse and sexual harassment.

This Code of Conduct is part of our measures to deal with environmental and social risks related to the Works. It applies to all our staff, labourers and other employees at the Works Site or other places where the Works are being carried out. It also applies to the personnel of each subcontractor and any other personnel assisting us in the execution of the Works. All such persons are referred to as "Contractor's Personnel" and are subject to this Code of Conduct.

This Code of Conduct identifies the behavior that we require from all Contractor's Personnel.

Our workplace is an environment where unsafe, offensive, abusive or violent behavior will not be tolerated and where all persons should feel comfortable raising issues or concerns without fear of retaliation

REQUIRED CONDUCT

Contractor's Personnel shall:

1. carry out his/her duties competently and diligently;
2. comply with this Code of Conduct and all applicable laws, regulations and other requirements, including requirements to protect the health, safety and well-being of other Contractor's Personnel and any other person;
3. maintain a safe working environment including by:
    a. ensuring that workplaces, machinery, equipment and processes under each person's control are safe and without risk to health;
    b. wearing required personal protective equipment;
    c. using appropriate measures relating to chemical, physical and biological substances and agents; and
    d. following applicable emergency operating procedures.
4. report work situations that he/she believes are not safe or healthy and remove himself/herself from a work situation which he/she reasonably believes presents an imminent and serious danger to his/her life or health;
5. treat other people with respect, and not discriminate against specific groups such as women, people with disabilities, migrant workers or children;
6. not engage in Sexual Harassment, which means unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature with other Contractor's or Employer's Personnel;
7. not engage in Sexual Exploitation, which means any actual or attempted abuse of position of vulnerability, differential power or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another;
8. not engage in Sexual Abuse, which means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions;
9. not engage in any form of sexual activity with individuals under the age of 18, except in case of pre-existing marriage;
10. complete relevant training courses that will be provided related to the environmental and social aspects of the Contract, including on health and safety matters, Sexual Exploitation and Abuse (SEA), and Sexual Harassment (SH);

11. report violations of this Code of Conduct; and
12. not retaliate against any person who reports violations of this Code of Conduct, whether to us or the Employer, or who makes use of the grievance mechanism for Contractor's Personnel or the project's Grievance Redress Mechanism.

RAISING CONCERNS

If any person observes behavior that he/she believes may represent a violation of this Code of Conduct, or that otherwise concerns him/her, he/she should raise the issue promptly. This can be done in either of the following ways:

1. Contact [enter name of the Contractor's Social Expert with relevant experience in handling sexual exploitation, sexual abuse and sexual harassment cases, or if such person is not required under the Contract, another individual designated by the Contractor to handle these matters] in writing at this address [ ] or by telephone at [ ] or in person at [ ]; or 2.
2. Call [ ] to reach the Contractor's hotline (if any) and leave a message.

The person's identity will be kept confidential, unless reporting of allegations is mandated by the country law. Anonymous complaints or allegations may also be submitted and will be given all due and appropriate consideration. We take seriously all reports of possible misconduct and will investigate and take appropriate action. We will provide warm referrals to service providers that may help support the person who experienced the alleged incident, as appropriate.

There will be no retaliation against any person who raises a concern in good faith about any behavior prohibited by this Code of Conduct. Such retaliation would be a violation of this Code of Conduct.

CONSEQUENCES OF VIOLATING THE CODE OF CONDUCT

Any violation of this Code of Conduct by Contractor's Personnel may result in serious consequences, up to and including termination and possible referral to legal authorities.

FOR CONTRACTOR'S PERSONNEL:

I have received a copy of this Code of Conduct written in a language that I comprehend. I understand that if I have any questions about this Code of Conduct, I can contact [enter name of Contractor's contact person(s) with relevant experience] requesting an explanation. Name of Contractor's Personnel: [insert name]

Signature: _____
Date: (day month year): _____

Countersignature of authorized representative of the Contractor:
Signature: _____
Date: (day month year): _____

Annex 4: Community Consultations Attendance Sheets

Attendance Form for Community Consultation

I. Composition of the Community Consultation Participants

The composition of the community consultation participants will include community representatives (clan leaders, community elders, and religious leaders), members of project-affected communities, women, IDPs, and People with Disabilities, and pastoral communities. The total number of participants per community consultation session is expected to be 15-20.

II. Basic Information

- Name of selected region: Amhara
- Name of selected zone: South Wolo
- Name of selected woreda: Haik
- Name of selected kebele: _____
- Date of consultation conducted: 28/02/2023
- Consultation start time: 02:30 AM
- Consultation end time: 05:45 AM
- Venue: Haik Health Center
- Name of consultation moderator: Dr. Deribe & Tsion.

III. List of Participants

S/No	Name	Sex	Social Status	Phone Number	Signature
1	Zehabu Ali	F	OPD		
2	Ibrahim Ahmed	M	OPD		
3	Belay Yimam	M	OPD		
4	Ahmed Ali	M			
5	Getachew Tehon	M	Com'y Rep		
6	Fufi Ereey	F	Pregnant		
7	Yeruta Nuri	F	Pregnant & Lactating		
8	Tajudin Endris	M	Elderly		
9	Abdu Ahmed	M	Elderly		
10	Shemsheddin Mohammed	M	Religious leader		
11	Sebsebe Lemo	M	Youth		
12	Tesfaye Mehiletu	M	Youth		
13	Ahmed Yimer	M	Youth		
14	Sheh Hussen Mohammed	M	Religious leader		
15	Demeke Yimam	F	OPD		
16	Enderas Mamo	M	Patient		
17	Hawa Mohamed	F	Youth		
18	Aregu Seid	F	Patient		
19	Hussen Ibrahim	M	Patient		
20	Seid Anwol	M	Community Representative		

Attendance Form for Community Consultation

I. Composition of the Community Consultation Participants

The composition of the community consultation participants will include community representatives (clan leaders, community elders, and religious leaders), members of project-affected communities, women, IDPs, and People with Disabilities, and pastoral communities. The total number of participants per community consultation session is expected to be 15-20.

II. Basic Information

- Name of selected region: Afar
- Name of selected zone: _____
- Name of selected woreda: Chifra
- Name of selected kebele: _____
- Date of consultation conducted: 23/02/2023
- Consultation start time: 10:15 AM
- Consultation end time: 12:30
- Venue: Chifra Primary Hospital
- Name of consultation moderator: Dr. Deribe & Tsion

III. List of Participants

S/No	Name	Sex	Social Status	Signature
1	Fatuma Ahmed	F	Lactating Woman	
2	Hawa Warie	F		
3	Hasena Wetika	F	Pregnant & Lactating woman	
4	Hasena Hamado	F	"	
5	Amina Hames	F	"	
6	Hawa Ahmed	F	Person w/ disability	
7	Hassen Ahmed	M	Patient	
8	Musa Mohamed	M	Youth	
9	Amina Ali	F	Patient	
10.	Asuris Wopris	M	Community Elder	
11	Acerebe Sultan	F	Elder Person	
12	Ahmed Agli	M	Community Elder	
13	Hassen Tadees	M	Person with disability	
14	Momin Wetika	M	Elder	
15	Mesele Metema	M	Youth	
16				
17				
18				
19				
20				

Annex 5: Sample Photos taken from Stakeholders and Community Consultation

A. Consultation at Woreda Level

Consultation with Chifra Woreda Officials

Consultation at South Wolo Zone Health Department

B. Consultation at Community Level

Community Consultation (Chifra Woreda)

Community Consultation at Haik Woreda

Consultation with IDP at Jari Camp

ANNEX VIII: CODES OF CONDUCT FOR CONTRACTORS AND THE SEA/SH PREVENTION AND RESPONSE ACTION PLAN

2. To build a system for SEA/SH risk prevention and mitigation, the IPF project must:
   - Have all employees of contractors (including sub-contractors), supervising Engineers and other consultants with a footprint on the ground in the project area sign codes of conduct (CoCs);
   - Have an effective SEA/SH Action Plan so that workers understand behavior expectations and policies, as well as an effective Grievance Mechanism (GM). This Action Plan should include training and communication. It should also include plans to make the project-affected community aware of the CoC the project staff have just signed; and
   - As part of the SEA/SH Action Plan, define accountability and response protocols, which set out the procedures followed for holding individuals accountable and penalizing staff that have violated SEA/SH policies.

Codes of Conduct from Standard Procurement Document

Code of Conduct for Contractor's Personnel (ES) Form

Note to the Employer:

Note to the Bidder:

The following minimum requirements shall not be modified*. The Employer may add additional requirements as appropriate, including to take into account Contract-specific issues/risks.*

The minimum content of the Code of Conduct form, as set out by the Employer shall not be substantially modified. However, the Bidder may add requirements as appropriate, including to take into account Contract-specific issues/risks.

The types of issues identified could include risks associated with: labor influx, spread of communicable diseases, Sexual Exploitation and Sexual Abuse (SEA) etc.

The Bidder shall initial and submit the Code of Conduct form as part of its bid.

Code of Conduct for Contractor's Personnel

We are the Contractor, [enter name of Contractor]. We have signed a contract with [enter name of Employer] for [enter description of the Works]. These Works will be carried out at [enter the Site and other locations where the Works will be carried out]. Our contract requires us to implement measures to

address environmental and social risks related to the Works, including the risks of sexual exploitation, sexual abuse and sexual harassment.

This Code of Conduct is part of our measures to deal with environmental and social risks related to the Works. It applies to all our staff, labourers and other employees at the Works Site or other places where the Works are being carried out. It also applies to the personnel of each subcontractor and any other personnel assisting us in the execution of the Works. All such persons are referred to as "Contractor's Personnel" and are subject to this Code of Conduct.

This Code of Conduct identifies the behavior that we require from all Contractor's Personnel.

Our workplace is an environment where unsafe, offensive, abusive or violent behavior will not be tolerated and where all persons should feel comfortable raising issues or concerns without fear of retaliation

REQUIRED CONDUCT

Contractor's Personnel shall:

13. carry out his/her duties competently and diligently;
14. comply with this Code of Conduct and all applicable laws, regulations and other requirements, including requirements to protect the health, safety and well-being of other Contractor's Personnel and any other person;
15. maintain a safe working environment including by:
    e. ensuring that workplaces, machinery, equipment and processes under each person's control are safe and without risk to health;
    f. wearing required personal protective equipment;
    g. using appropriate measures relating to chemical, physical and biological substances and agents; and
    h. following applicable emergency operating procedures.
16. report work situations that he/she believes are not safe or healthy and remove himself/herself from a work situation which he/she reasonably believes presents an imminent and serious danger to his/her life or health;
17. treat other people with respect, and not discriminate against specific groups such as women, people with disabilities, migrant workers or children;
18. not engage in Sexual Harassment, which means unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature with other Contractor's or Employer's Personnel;
19. not engage in Sexual Exploitation, which means any actual or attempted abuse of position of vulnerability, differential power or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another;
20. not engage in Sexual Abuse, which means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions;
21. not engage in any form of sexual activity with individuals under the age of 18, except in case of pre-existing marriage;

22. complete relevant training courses that will be provided related to the environmental and social aspects of the Contract, including on health and safety matters, Sexual Exploitation and Abuse (SEA), and Sexual Harassment (SH);
23. report violations of this Code of Conduct; and
24. not retaliate against any person who reports violations of this Code of Conduct, whether to us or the Employer, or who makes use of the grievance mechanism for Contractor's Personnel or the project's Grievance Redress Mechanism.

RAISING CONCERNS

If any person observes behavior that he/she believes may represent a violation of this Code of Conduct, or that otherwise concerns him/her, he/she should raise the issue promptly. This can be done in either of the following ways:

3. Contact [enter name of the Contractor's Social Expert with relevant experience in handling sexual exploitation, sexual abuse and sexual harassment cases, or if such person is not required under the Contract, another individual designated by the Contractor to handle these matters] in writing at this address [ ] or by telephone at [ ] or in person at [ ]; or 2.
4. Call [ ] to reach the Contractor's hotline (if any) and leave a message.

The person's identity will be kept confidential, unless reporting of allegations is mandated by the country law. Anonymous complaints or allegations may also be submitted and will be given all due and appropriate consideration. We take seriously all reports of possible misconduct and will investigate and take appropriate action. We will provide warm referrals to service providers that may help support the person who experienced the alleged incident, as appropriate.

There will be no retaliation against any person who raises a concern in good faith about any behavior prohibited by this Code of Conduct. Such retaliation would be a violation of this Code of Conduct.

CONSEQUENCES OF VIOLATING THE CODE OF CONDUCT

Any violation of this Code of Conduct by Contractor's Personnel may result in serious consequences, up to and including termination and possible referral to legal authorities.

FOR CONTRACTOR'S PERSONNEL:

I have received a copy of this Code of Conduct written in a language that I comprehend. I understand that if I have any questions about this Code of Conduct, I can contact [enter name of Contractor's contact person(s) with relevant experience] requesting an explanation. Name of Contractor's Personnel: [insert name]

Signature: _____
Date: (day month year): _____
Countersignature of authorized representative of the Contractor:
Signature: _____
Date: (day month year): _____

ANNEX IX : GUIDELINE FOR TRAFFIC MANAGEMENT PLAN

In addition to the recommended mitigation actions to prevent risk of traffic accident from increased traffic movement activity caused by vehicles and motorcycles distributed by the IPF project to restore ambulance services and to strengthen CRVS services as well as during transport of medical supplies and equipment under Section 6.3.3.2 , if any of the construction activities to be carried for restoration of damaged HCFs in the conflict affected areas should cause disruption of traffic movement including temporary loss of roadways, blockages due to deliveries and site related activities, a Traffic Management Plan will need to be prepared by the contractor that include a description of the anticipated service disruptions, community information plan, and traffic control strategy to be implemented so as to minimize the impact to the surrounding community. The plan shall consider time of day for planned disruptions, and shall include consideration for alternative access routes, access to essential services such as medical, disaster evacuation, and other critical services. The plan shall be approved by the construction supervisor officer. Elements of the traffic management plan to be developed and implemented by contractor shall include:

- Alternative routes will be identified in the instance of extended road works or road blockages;
- Public notification of all disturbance to their normal routes;
- Signage, barriers and traffic diversions must be clearly visible, and the public warned of all potential hazards;
- Provision for safe passages and crossings for all pedestrians where construction traffic interferes with their normal route;
- Active traffic management by trained and visible staff at the site or along roadways as required to ensure safe and convenient passage for the vehicular and pedestrian public; and
- Adjustment of working hours to local traffic patterns, e.g. avoiding major transport activities during rush hours or times of livestock movement.

ANNEX X: CONFLICT AFFECTED AREAS AND DAMAGES TO HEALTH FACILITIES MASTER LIST

Region	*Zone*	*Woreda*	*Number of Health Institution Affected*		
			Health Centers	*Hospitals*	*Health Posts*
Afar	Zone 1	Adar	1	-	59
		Chifra	4		
	Zone 2	Barahle	1	1	
		Abeala	2		
	Zone 4	Yallo	3	1	
		Golina	2		
		Awra	3		
		Ewa	2		
	Zone 5	Telalk	2	-	
		Hadalela	1		
		Samurobi	2		
		Dawe	1		
Region Total	***4***	***12***	***24***	***2***	***59***
Amhara	Oromo Special Zone	Jile Timuga	4	2	1,728
		Artuma Fursi	6		
		Bati Town	1		
		Bati Rural	7		
		Kemisie Town	1		
		Dewa Chefa	7		
		Dewie Harwa	2		
	North Shewa	Antsokia Gemza	4	4	
		Efrata Gidem	7		
		Gishi	4		
		Qewet	3		
		Menz Gera	4		
		Menz Qeya	4		
		Menz Lalo	3		
		Menz Mama	4		
		Mida Weremo	5		
		Mojana Wedera	3		
		Shewarobit	1		
		Tarmaber	4		
	Dessie	Dessie Town	8	1	
	North Wollo	Rata Kobo	9	4	
		Kobo Town	1		
		Lalibela Town	1		
		Angot	4		
		Woldia	2		
		Gazo	3		
		Meket	7		

. . . . . Continued

Region	*Zone*	*Woreda*	*Number of Health Institution Affected*		
			Health Centers	*Hospitals*	*Health Posts*
		Lasta	8		
		Habru	8		
		Gubalafto	7		
		Gidan	6		
		Wadla	6		
		Bugina	3		
		Dawunt	4		
		Raya Alamata	4		
		Raya Chercher	2		
	Wagehemera	Abergelie	5	5	
		Tagbji	3		
		Sekota Town	1		
		Sekota Zuriya	6		
		Gazgibila	5		
		Ziquala	5		
		Dehana	6		
		Sehala	3		
		Korem Town	1		
		Oflla	6		
	South Gonder	North Gaynet	8	2	
		Farta	10		
		Guna Begemdir	4		
		Esete	11		
		Tach Gaynet	7		
		Ebinat	7		
		Mena Meketewa	2		
		Sedie Muja	3		
		Simada	8		
		Debre Tabor Town	2		
	South Wollo	Delanta	6	14	
		Ambasel	8		
		Worebabo	4		
		Tehuledere	6		
		Dessie Zuria	8		
		Kombolcha Town	4		
		Kallu	9		
		Tenta	10		
		Wereillu	6		
		Kelala	8		
		Jamma	7		
		Albuko	4		

		Argoba	2		
		Legambo	9		

. . . . . Continued

Region	*Zone*	*Woreda*	*Number of Health Institution Affected*		
			Health Centers	*Hospitals*	*Health Posts*
		Mekidela	7		
		Legehida	4		
		Kutaber	5		
		Sayint	7		
		Mehal Sayint	5		
		Borena	7		
		Wegdi	6		
	North Gondar	Beyeda	4	6	
		Dabat	6		
		Adiarkay	4		
		Debark Town	1		
		Debark Zuriya	8		
		Janamora	6		
		Telemt	5		
		Misrak Telemt	3		
		Mirab Telemt	3		
Region Total	***7***	***89***	***432***	***38***	***1,728***
Oromia	Kelem Wollega	Gidame	1	6	685
		Sayo	Damage not identified		
		Anfilo	3		
		Hawagelane	2		
		D/Wabera	Damage not identified		
		J/Horro	“		
		Y/Welel	“		
		G/Kibe	3		
		Sasiga	3		
	East Wollega	Leka Dalacha	2		
		Jima Arjo	1		
		Boneya Boshe	1		
		Sibusire	2		
		Limu	1		
		Haro Limu	2		
		Gudeyabela	1		
		Gutogida	1		
		Kiramu	3		
		Gida Ayana	2		
		Ebantu	Damage not identified		
		Gobbu Sayyo	1		

		Nunukumba	Damage not identified		
	West Wollega	Kondala	“		
		Begi	“		
		Jarso	“		
		Haru	“		

. . . . . Continued

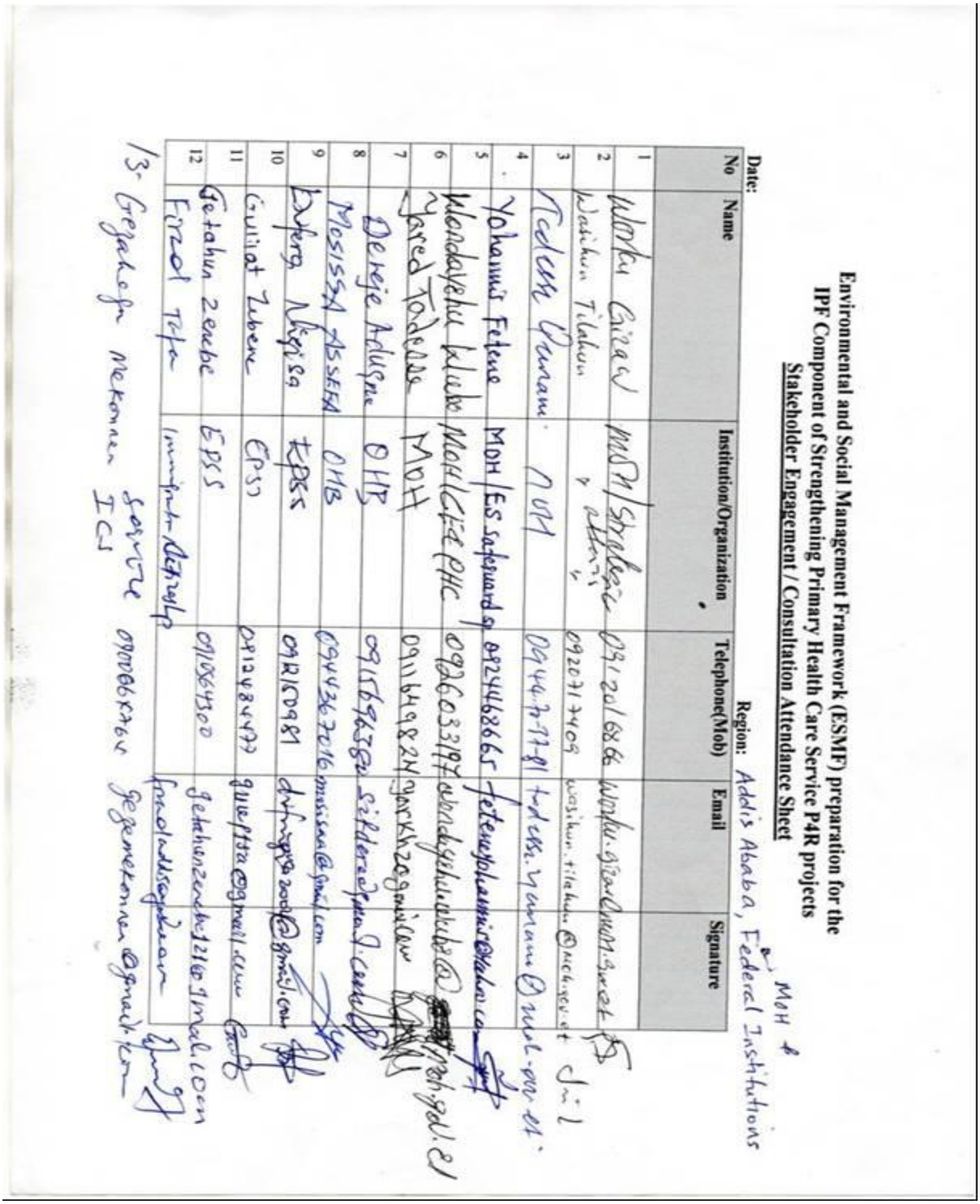
Region	*Zone*	*Woreda*	*Number of Health Institution Affected*		
			Health Centers	*Hospitals*	*Health posts*
		LaloAsabe	Number not identified		
		Yubdo	“		
		S/Nole	“		
		N/Kaba	“		
		Ayera	“		
		Manasibu	“		
		K/kara	“		
		Homa	“		
		A/Nejo	“		
		B/Gmabil	“		
		Ganji	“		
		B/Dirmaji	“		
		B/Chekores	“		
		Guliso	“		
		Gimbi	2		
		Letasibu	Number not identified		
		M/Nejo	“		
		M/Mendi	“		
		M/Gimbi	“		
	West Guji	Bule Hora	3		
		Abaya	1		
		Galana	1		
		Haro Buluke	1		
		Haro	1		
		Guduru	Number not identified		
		Jardaga Jarte	5		
	North Shewa	Kuyu	2		
		H/Abote	Number not identified		
		W/Jarso	1		
		Degem	Number not identified		
		Y/Gulele	“		
	Borena	Moyale	“		
		Arero	1		

		Goro Dola	2		
	Guji	Liban	2		
		Seba Boru	2		
		Wadara	2		
		Gumi Eldalo	1		
Region Total	***7***	***64***	***107***	***6***	***685***
Benishangul-Gumuz	Metekele	Dangur	1	0	171
		Wombera	1		
		Bullen	2		

. . . . . Continued

Region	***Zone***	***Woreda***	***Number of Health Institution Affected***		
			Health Centers	***Hospitals***	***Health Posts***
		Dibatie	1		
		Guba	1		
	Kemashi	Zay/Yaso	1		
		Dembe/Aglo	1		
		Kamashi	1		
		Sedal	1		
		Miziga/Belo	2		
	Assosa	Mao Komo Special Woreda	3		
Region Total	***3***	***11***	***15***	***0***	***171***
Tigray	Western Tigray	Setit Humera	5	2	
		Tsegedie	7		
		Wolkayet	8		
Grand Total		***176***	***598***	***48***	***2,643***

ANNEX XI: Attendance List of Stakeholder and Community Consultations



Environmental and Social Management Framework (ESMF) preparation for the IPF Component of Strengthening Primary Health Care Service P4R projects

Stakeholder Engagement / Consultation Attendance Sheet

Date:

Region: Addis Ababa, MOH & Federal Institutions

No	Name	Institution/Organization	Telephone(Mob)	Email	Signature
1	Worku Gizaw	MOH/Strategic affairs	0912016866	worku.gizaw@moh.gov.et	
2	Wasihun Tilahun	" "	0920717409	wasihun.tilahun@moh.gov.et	
3	Tadesse Yunam	MOH	0944-70-77-81	tadesse.yunam@moh.gov.et	
4	Yohannis Fetene	MOH/ES safeguard sp	0924468665	feteneyohannis@yahoo.com	
5	Wondayehu Wubo	MOH/CEE PHC	0926033197	wondayehu.wubo@moh.gov.et	
6	Yared Tadesse	MOH	0911649824	yarkhz@gmail.com	
7	Dereje Adugna	OHB	0915696380	sifdere@gmail.com	
8	MOSISSA ASSEFA	OHB	0944367016	mosissa@gmail.com	
9	Dufera Nigisa	EPSS	0912150981	dufnigisa2004@gmail.com	
10	Guliat Zebene	EPSS	0912484477	guleptsa@gmail.com	
11	Getahun Zenebe	EPSS	0910564300	getahunzenebe1216@gmail.com	
12	Firzol Tafa	Immigration Affairs Sp		firzoladdis@yahoo.com	
13	Gezahegn Mekonnen	Service ICS	0900064764	gezemekonnen@gmail.com	

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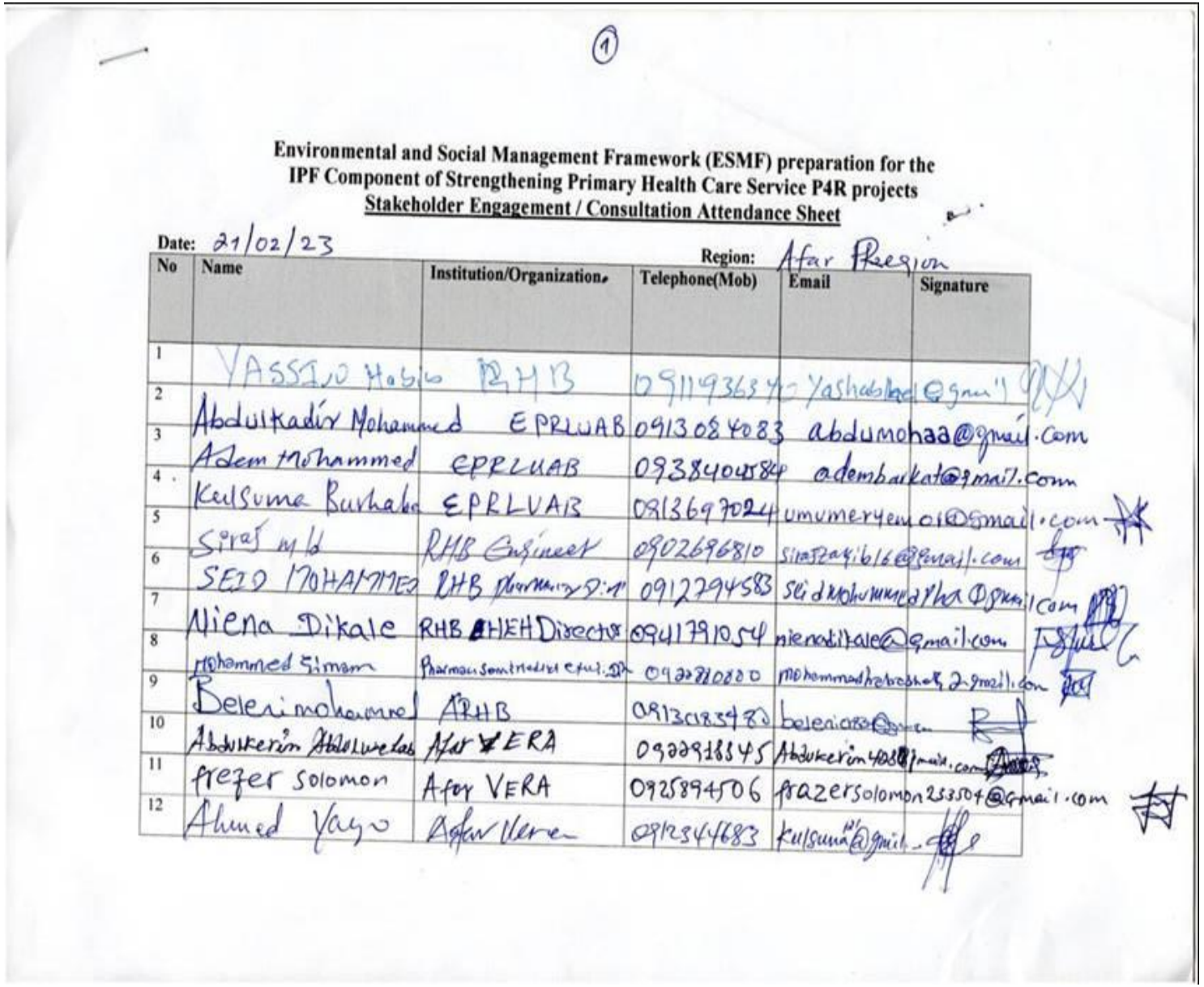

Environmental and Social Management Framework (ESMF) preparation for the IPF Component of Strengthening Primary Health Care Service P4R projects

Stakeholder Engagement / Consultation Attendance Sheet

Date: 21/02/23 Region: Afar Region

No	Name	Institution/Organization	Telephone(Mob)	Email	Signature
1	YASSIN Habib	RHB	0911936340	yashabhel@gmail	
2	Abdulkadir Mohammed	EPRLUAB	0913084083	abdumohaa@gmail.com	
3	Adem Mohammed	EPRLUAB	0938404584	adembarkat@gmail.com	
4	Kulsuma Burhaba	EPRLUAB	0913697024	umumeryem01@gmail.com	
5	Siraj m/d	RHB Engineer	0902696810	sirajzakib16@gmail.com	
6	SEID MOHAMMED	RHB Pharmacy Dir	0912794583	seidmohammedpha@gmail.com	
7	Niena Dikale	RHB HEH Director	0941791054	nienadikale@gmail.com	
8	Mohammed Simam	Pharmacy Sanitation Dir	0922880800	mohammedhabashek2@gmail.com	
9	Beleni mohammed	ARHB	0913083480	beleni0834@gmail.com	
10	Abdulkerim Abdulwedab	Afar VERA	0922918345	Abdukerim4080@gmail.com	
11	frezer solomon	Afar VERA	0925894506	frazersolomon233504@gmail.com	
12	Ahmed Yayo	Afar Vera	0912344683	kulsuma121@gmail.com	

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Environmental and Social Management Framework (ESMF) preparation for the IPF Component of Strengthening Primary Health Care Service P4R projects

Stakeholder Engagement / Consultation Attendance Sheet

Date: 23/02/23 Region: Afar Region

No	Name	Institution/Organization	Telephone(Mob)	Email	Signature
1	Mohammed Hussie	AF-DEMC	0910322097	kuulawidal@gmail	
2					
3					
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5					
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7					
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11					
12					

Environmental and Social Management Framework (ESMF) preparation for the IPF Component of Strengthening Primary Health Care Service P4R projects

Stakeholder Engagement / Consultation Attendance Sheet

Date: 17/02/2023 **Region:** UNICEF Consultations

No	Name	Institution/Organization	Telephone(Mob)	Email	Signature
1	Taha Al-Mulla	unicef	0944122988	talmulla@unicef.org	
2	Andarge Siye	UNICEF	0967131921	anayele@unicef.org	
3					
4					
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Environmental and Social Management Framework (ESMF) preparation for the IPF Component of Strengthening Primary Health Care Service P4R projects

Stakeholder Engagement / Consultation Attendance Sheet

Date: 09/02/23 **Region:** Oromia Region

No	Name	Institution/Organization	Telephone(Mob)	Email	Signature
1	Adane Desisa	Oromia Health Bureau	0913255341	adanedesisa32@gmail.com	[signature]
2	Olkeba Begna	Oromia health Bureau	0917814783	begna olkeba @gmail.com	[signature]
3					
4	Wondwossen Asnake	Amhara Region	0910306201	[illegible]	[signature]
5	Bewket Belachew	Unicef (Amhara)	0911908464	bewketbalem@gmail.com	[signature]
6	Alebachew Kalla	Naid HC	0919996612	alebachewkalla66@gmail.com	[signature]
7					
8					
9					
10					
11					
12					

a) Oromia Health Bureau Consultation pictures

b) MoH Public Health Directorate Consultation

c) Consultations at EPSA

d) Consultation at Federal CVRS (Immigration and Citizenship)

e) Consultation in Afar Health Bureau

f) Consultation at Afar Vital registration office

G) Consultation in Afar Women affairs

Annex XII: Occupational Health and Safety (OHS) Guidelines

1. Introduction

Given the nature of activities under the IPF Sub-components I and II, it was assessed that occupational health hazards may arise from materials (for example, chemical, physical, and biological substances and agents), environmental or working conditions (for example, working at heights in line with construction works or in confined spaces, excessive hours of work, night work, mental or physical factors, oxygen-deficient environments, excessive temperatures, improper ventilation, poor lighting, faulty electrical systems or trenches), or work processes (for example, tools, machinery, and equipment). Accordingly, OHS measures include the identification of potential hazards and responses including design, testing, choice, substitution, installation, arrangement, organization, use, and maintenance of workplaces, working environment, and work processes to eliminate sources of risk or minimize project workers exposure.

2. Objectives

Measures relating to IPF project OHS are aimed at protecting project workers from injury, illness, or impacts associated with exposure to hazards encountered in the workplace or while working. Such measures take into account the requirements of national low, ESS2 (Section D), the General Environmental Health and Safety Guidelines (EHSGs) and, as appropriate, the industry-specific EHSGs and other Good International Industry Practice (GIIP).

3. OHS Guidelines

The way in which the OHS provisions apply in the IPF project depends on the nature and severity of the hazards, risks, and impacts; and the types of workers involved. To this end, appropriate OHS measures are incorporated into the design and implementation of the project to prevent and protect workers from occupational injuries and illness. Among other things, these include the following OHS guidelines.

3.1 Apply the mitigation hierarchy

Preventive and protective measures should be introduced according to the following order of priority:

- *Elimination:* Eliminating the hazard by removing the activity from the work process. Examples include substitution with less hazardous chemicals, using different manufacturing processes, etc.
- *Controlling:* Controlling the hazard at its source through use of engineering controls. Examples include local exhaust ventilation, isolation rooms, machine guarding, acoustic insulating, etc.
- *Minimize:* Minimizing the hazard through design of safe work systems and administrative or institutional control measures. Examples include job rotation, training safe work

procedures, lock-out and tag-out, workplace monitoring, limiting exposure or work duration, etc.

- *Protection:* Providing appropriate personal protective equipment (PPE) in conjunction with training, use, and maintenance of the PPE.
- The application of prevention and control measures to occupational hazards should be based on comprehensive job safety or job hazard analyses. The results of these analyses should be prioritized as part of an action plan based on the likelihood and severity of the consequence of exposure to the identified hazards.

3.2 General facility design and operation

Among other things, the general facility design and operation should be guided by the following OHS principles.

Integrity of workplace structures

Permanent and recurrent places of work should be designed and equipped to protect OHS. That is:

- ✓ Surfaces, structures and installations should be easy to clean and maintain, and not allow for accumulation of hazardous compounds.
- ✓ Buildings should be structurally safe, provide appropriate protection against the climate, and have acceptable light and noise conditions.
- ✓ Fire resistant, noise-absorbing materials should, to the extent feasible, be used for cladding on ceilings and walls.
- ✓ Floors should be level, even, and non-skid. ·
- ✓ Heavy oscillating, rotating or alternating equipment should be located in dedicated buildings or structurally isolated sections.

Workspace and exist

- ✓ Passages to emergency exits should be unobstructed at all times. Exits should be clearly marked to be visible in total darkness.
- ✓ The number and capacity of emergency exits should be sufficient for safe and orderly evacuation of the greatest number of people present at any time.
- ✓ Facilities also should be designed and built taking into account the needs of disabled persons.

Fire precautions

The workplace should be designed to prevent the start of fires through the implementation of fire codes applicable to industrial settings. Other essential measures include:

- ✓ Equipping facilities with fire detectors, alarm systems, and fire-fighting equipment. The equipment should be maintained in good working order and be readily accessible. It should be adequate for the dimensions and use of the premises, equipment installed, physical and chemical properties of substances present, and the maximum number of people present.

- ✓ Provision of manual firefighting equipment that is easily accessible and simple to use.
- ✓ Fire and emergency alarm systems that are both audible and visible.

Safety access

- ✓ Passageways for pedestrians and vehicles within and outside buildings should be segregated and provide for easy, safe, and appropriate access.
- ✓ Equipment and installations requiring servicing, inspection, and/or cleaning should have unobstructed, unrestricted, and ready access.
- ✓ Hand, knee and foot railings should be installed on stairs, fixed ladders, platforms, permanent and interim floor openings, loading bays, ramps, etc.

First Aid

- ✓ The employer should ensure that qualified first-aid can be provided at all times. Appropriately equipped first-aid stations should be easily accessible throughout the place of work.
- ✓ Where the scale of work or the type of activity being carried out so requires, dedicated and appropriately equipped first aid room(s) should be provided. First aid stations and rooms should be equipped with gloves, gowns, and masks for protection against direct contact with blood and other body fluids.
- ✓ Remote sites should have written emergency procedures in place for dealing with cases of trauma or serious illness up to the point at which patient care can be transferred to an appropriate medical facility.

Air supply

- ✓ Sufficient fresh air should be supplied for indoor and confined work spaces. Factors to be considered in ventilation design include physical activity, substances in use, and process related emissions. Air distribution systems should be designed so as not to expose workers to draughts.
- ✓ Mechanical ventilation systems should be maintained in good working order. Point-source exhaust systems required for maintaining a safe ambient environment should have local indicators of correct functioning.
- ✓ Re-circulation of contaminated air is not acceptable. Air inlet filters should be kept clean and free of dust and microorganisms. Heating, ventilation and air conditioning (HVAC) and industrial evaporative cooling systems should be equipped, maintained and operated so as to prevent growth and spreading of disease agents (e.g., Legionnella pneumophilia) or breeding of vectors (e.g. mosquitoes and flies) of public health concern.

3.3 Communication and OHS training

Communicate Hazard Codes

- Copies of the hazard coding system should be posted outside the facility at emergency entrance doors and fire emergency connection systems where they are likely to come to the attention of emergency services personnel.

- Information regarding the types of hazardous materials stored, handled or used at the facility, including typical maximum inventories and storage locations, should be shared proactively with emergency services and security personnel to expedite emergency response when needed. ·

OHS training

- Provisions should be made to provide OHS orientation training to all new employees to ensure they are apprised of the basic site rules of work at/on the site and of personal protection and preventing injury to fellow employees.
- Training should consist of basic hazard awareness, site-specific hazards, safe work practices, and emergency procedures for fire, evacuation, and natural disaster, as appropriate. Any site-specific hazard or color coding in use should be thoroughly reviewed as part of orientation training.

3.4 Physical hazards

Physical hazards represent potential for accident or injury or illness due to repetitive exposure to mechanical action or work activity. Single exposure to physical hazards may result in a wide range of injuries, from minor and medical aid only, to disabling, catastrophic, and/or fatal. Multiple exposures over prolonged periods can result in disabling injuries of comparable significance and consequence.

Rotating and moving equipment

Injury or death can occur from being trapped, entangled, or struck by machinery parts due to unexpected starting of equipment or unobvious movement during operations. Recommended protective measures include but not limited to:

- ✓ Designing machines to eliminate trap hazards and ensuring that extremities are kept out of harm's way under normal operating conditions.
- ✓ Turning off, disconnecting, isolating, and de-energizing (Locked Out and Tagged Out) machinery with exposed or guarded moving parts, or in which energy can be stored (e.g. compressed air, electrical components) during servicing or maintenance, in conformance with a standard such as CSA Z460 Lockout or equivalent ISO or ANSI standard.

Noise

- ✓ No employee should be exposed to a noise level greater than 85 dB(A) for a duration of more than 8 hours per day without hearing protection.
- ✓ The use of hearing protection should be enforced actively when the equivalent sound level over 8 hours reaches 85 dB(A), the peak sound levels reach 140 dB(C), or the average maximum sound level reaches 110dB(A). Hearing protective devices provided should be capable of reducing sound levels at the ear to at least 85 dB(A)

Electrical

Electrical Exposed or faulty electrical devices, such as circuit breakers, panels, cables, cords and hand tools, can pose a serious risk to workers. Recommended safety actions include:

- ✓ Marking all energized electrical devices and lines with warning signs.

- ✓ Locking out (de-charging and leaving open with a controlled locking device) and tagging-out (warning sign placed on the lock) devices during service or maintenance.
- ✓ Checking all electrical cords, cables, and hand power tools for frayed or exposed cords and following manufacturer recommendations for maximum permitted operating voltage of the portable hand tools.
- ✓ Double insulating / grounding all electrical equipment used in environments that are, or may become, wet; using equipment with ground fault interrupter (GFI) protected circuits.

Working at height

Fall prevention and protection measures should be implemented whenever a worker is exposed to the hazard of falling more than two meters; into operating machinery; into hazardous substances; or through an opening in a work surface. Fall prevention/protection measures may also be warranted on a case-specific basis when there are risks of falling from lesser heights. Fall prevention may include:

- ✓ Proper use of ladders and scaffolds by trained employees.
- ✓ Use of fall prevention devices, including safety belt and lanyard travel limiting devices to prevent access to fall hazard area, or fall protection devices such as full body harnesses used in conjunction with shock absorbing lanyards or self-retracting inertial fall arrest devices attached to fixed anchor point or horizontal life-lines.
- ✓ Appropriate training in use, serviceability, and integrity of the necessary PPE.
- ✓ Inclusion of rescue and/or recovery plans, and equipment to respond to workers after an arrested fall.

3.5 Personal Protective Equipment (PPE)

Personal Protective Equipment (PPE) provides additional protection to workers exposed to workplace hazards in conjunction with other facility controls and safety systems. PPE is considered to be a last resort that is above and beyond the other facility controls and provides the worker with an extra level of personal protection. Recommended measures for use of PPE in the workplace include:

- ✓ Active use of PPE if alternative technologies, work plans or procedures cannot eliminate, or sufficiently reduce, a hazard or exposure.
- ✓ Identification and provision of appropriate PPE that offers adequate protection to the worker, co-workers, and occasional visitors, without incurring unnecessary inconvenience to the individual.
- ✓ Proper maintenance of PPE, including cleaning when dirty and replacement when damaged or worn out.
- ✓ Proper use of PPE should be part of the recurrent training programs for employees.

4. Monitoring

Occupational health and safety monitoring programs should verify the effectiveness of prevention and control strategies. The selected indicators should be representative of the most significant occupational, health, and safety hazards, and the implementation of prevention and control strategies. The occupational health and safety monitoring program should include:

- ✓ *Safety inspection, testing and calibration:* This should include regular inspection and testing of all safety features and hazard control measures focusing on engineering and personal protective features, work procedures, places of work, installations, equipment, and tools used. The inspection should verify that issued PPE continues to provide adequate protection and is being worn as required. All instruments installed or used for monitoring and recording of working environment parameters should be regularly tested and calibrated, and the respective records maintained.
- ✓ *Surveillance of the working environment:* Employers should document compliance using an appropriate combination of portable and stationary sampling and monitoring instruments. Monitoring and analyses should be conducted according to internationally recognized methods and standards. Monitoring methodology, locations, frequencies, and parameters should be established individually for each project-related activities following a review of the hazards. Generally, monitoring should be performed during commissioning of facilities or equipment and at the end of the defect and liability period, and otherwise repeated according to the monitoring plan.
- ✓ *Surveillance of workers health:* When extraordinary protective measures are required (for example, against biological agents Groups 3 and 4, and/or hazardous compounds), workers should be provided appropriate and relevant health surveillance prior to first exposure, and at regular intervals thereafter. The surveillance should, if deemed necessary, be continued after termination of the employment.

Training: Training activities for employees and visitors should be adequately monitored and documented (curriculum, duration, and participants). Emergency exercises, including fire drills, should be documented adequately. Service providers and contractors should be contractually required to submit to the employer adequate training documentation before start of their assignment.

Annex XIII: Outline / Table of Content for full ESIA report

Abbreviations/ Acronyms **Error! Bookmark not defined.**

Executive summary

1. Introduction/**Error! Bookmark not defined.**Background

1.1 Objectives of the ESIA study

1.2 General objective

1.3 Specific objectives

1.4 Justification or need of the ESIA

1.5 Scope of the study **Error! Bookmark not defined.**

2. Methodology and approach of the study including**Error! Bookmark not defined.**

- Assumptions and /or gaps in knowledge

- Public and stakeholders consultations

3. Description of the project

3.1 Location of Project Area

3.2 Project Beneficiaries

3.3 Project Components and sub-components

3.4 Implementation arrangements

4. Baseline information on biophysical & socio-economic environment situation

5. Policy, Legal and Institutional Framework**Error! Bookmark not defined.**

6. Analysis of alternatives

7. Assessment of environmental and social impacts and their mitigation measures

8. Stakeholder and community consultations

9. Environmental and social management plans **Error! Bookmark not defined.**

10.1 Environmental and social monitoring plan **Error! Bookmark not defined.**

11. Training and Capacity Building

12. Conclusion and recommendations

13. References

14. Annexes **Error! Bookmark not defined.**

Annex XIV: Indicative outline of ESMP

An ESMP consists of the set of mitigation, monitoring, and institutional measures to be taken during implementation and operation of a project to eliminate adverse environmental and social risks and impacts, offset them, or reduce them to acceptable levels. The ESMP also includes the measures and actions needed to implement these measures. The Borrower will (a) identify the set of responses to potentially adverse impacts; (b) determine requirements for ensuring that those responses are made effectively and in a timely manner; and (c) describe the means for meeting those requirements.

Depending on the project, an ESMP may be prepared as a stand-alone document47 or the content may be incorporated directly into the ESCP. The content of the ESMP will include the following:

(a) *Mitigation*

• The ESMP identifies measures and actions in accordance with the mitigation hierarchy that reduce potentially adverse environmental and social impacts to acceptable levels. The plan will include compensatory measures, if applicable. Specifically, the ESMP:

(i) identifies and summarizes all anticipated adverse environmental and social impacts (including those involving indigenous people or involuntary resettlement);

(ii) describes—with technical details—each mitigation measure, including the type of impact to which it relates and the conditions under which it is required (e.g., continuously or in the event of contingencies), together with designs, equipment descriptions, and operating procedures, as appropriate;

(iii) estimates any potential environmental and social impacts of these measures; and

(iv) takes into account, and is consistent with, other mitigation plans required for the project (e.g., for involuntary resettlement, indigenous peoples, or cultural heritage).

(b) *Monitoring*

• The ESMP identifies monitoring objectives and specifies the type of monitoring, with linkages to the impacts assessed in the environmental and social assessment and the mitigation measures described in the ESMP.

Specifically, the monitoring section of the ESMP provides (a) a specific description, and technical details, of monitoring measures, including the parameters to be measured ,methods to be used, sampling locations, frequency of measurements, detection limits (where appropriate),

and definition of thresholds that will signal the need for corrective actions; and (b) monitoring and reporting procedures to (i) ensure early detection of conditions that necessitate particular mitigation measures, and (ii) furnish information on the progress and results of mitigation.

(c) *Capacity Development and Training*

• To support timely and effective implementation of environmental and social project components and mitigation measures, the ESMP draws on the environmental and social assessment of the existence, role, and capability of responsible parties on site or at the agency and ministry level.

• Specifically, the ESMP provides a specific description of institutional arrangements, identifying which party is responsible for carrying out the mitigation and monitoring measures (e.g., for operation, supervision, enforcement, monitoring of implementation, remedial action, financing, reporting, and staff training).

• To strengthen environmental and social management capability in the agencies responsible for implementation, the ESMP recommends the establishment or expansion of the parties responsible, the training of staff and any additional measures that may be necessary to support implementation of mitigation measures and any other recommendations of the environmental and social assessment.

(d) *Implementation Schedule and Cost Estimates*

• For all three aspects (mitigation, monitoring, and capacity development), the ESMP provides (a) an implementation schedule for measures that must be carried out as part of the project, showing phasing and coordination with overall project implementation plans; and (b) the capital and recurrent cost estimates and sources of funds for implementing he ESMP. These figures are also integrated into the total project cost tables.

(e) *Integration of ESMP with Project*

• The Borrower's decision to proceed with a project, and the Bank's decision to support it, are predicated in part on the expectation that the ESMP (either stand alone or as incorporated into the ESCP) will be executed effectively. Consequently, each of the measures and actions to be implemented will be clearly specified, including the individual mitigation and monitoring measures and actions and the institutional responsibilities relating to each, and the costs of so doing will be integrated into the project's overall planning,

Annex XV: Quarterly and Annual Environmental Compliance Reporting Template

Monitoring of implementation of the ESMF, ESMP and ESIA is an important aspect of ensuring that the commitment to environmental sustainability of the project / program is being met. The regular monitoring of implementation of the ESMF and ESMP will be prepared at regional and federal levels by the project implementing entities and the third party implementer (UNICEF). The environmental specialists from the MoH, EPSA, RHBs, third party implementer and ICS have the responsibility to prepare quarterly, biannual and annual report to submit to the MoH GMU and ICS.

General

Institution/ Region: [Type the correct name here]

Reporting Quarter/Year: [type here]

Date of the report: [Type here]

Report summary (narrative):

Here narrative of the overall environmental and social managment implementation during the reporting period is summarized. Activities carried out in implementing the ESMF (including aspects monitored), issues identified, proposed solutions and follow up activities are summarized here. Figures will be discussed in the reporting table below. Please also consider other issues, like for e.g.:

1. Types of training provided or training demands;
2. If an environmental permit was not granted by EPA, explain why;
3. If no objection is obtained for ESIA studies from the World Bank, and whether these documents are disclosed on time both through the implementing agencies website and the World Bank info shop (please refer Disclosure requirements);
4. Documentation practices for environmental instruments (ESS reports, ESMP, ESIA, etc.); and, Specific challenges encountered in the course of project implementation processes.

Environmental Compliance Reporting Format to be completed at Federal Levels

Name of Ministry: ----------
Program/Project Type; …….: ---------- Date: ----------

S/N	Name of subproject site	Types of subprojects	Screened & approved (Yes/No)	Environmental Category	ESIA Prepared & approved (Yes/No)	ESMP implemented (Yes/No)	Remark
1							
2							
3							
4							
6							
Total							

List of Outstanding Issues and Responsible Body for Implementation

S/N	Name of subproject site	Type of subproject	Outstanding Issues	Recommended actions	Responsible body for implementation	Time schedule
1						
2						
3						
4						
5						

Completed by: Name ----------Email: ----------Phone: ----------

Annex XVI: Labor Management Plan

FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA

MINISTRY OF HEALTH

Ethiopia Hybrid PforR (P175167)

IPF Program for Strengthening Primary Health Care Services in the Conflict-Affected Parts of Ethiopia

LABOR MANAGEMENT PROCEDURES (LMP)

Draft

May 2023

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List of Acronyms

CoC	Code of Conduct
EHSGs	World Bank Group Environmental, Health and Safety Guidelines
EHS	Environmental Health and Safety
ESCP	Environmental and Social Commitment Plan
ESF	Environmental and Social Framework
ESIA	Environmental and Social Impact Assessment
ESMF	Environmental and Social Management Framework
ESS	Environmental and Social Standards
ESSS	Environmental and Social Safeguard Specialists
FDRE	Federal Democratic Republic of Ethiopia
GBV	Gender Based Violence
GFP	Grievance Focal Point
GoE	Government of Ethiopia
GFP	Grievance Focal Person
GIIP	Good International Industry Practice
GMU	Grants Management Unit
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
HR	Human Resource
IA	Implementing Agencies
ILO	International Labor Organization
LIMP	Labor Influx Management Plan
LMP	Labor Management Procedure
MoF	Ministry of Finance
MoH	Ministry of Health
MoLS	Ministry of Labor and Skill
NGO	Non-Governmental Organization
OHS	Occupational Health and Safety
PCD	Partnership and Cooperation Directorate
PDO	Project Development Objective
PCU	Project Implementation Unit
PIM	Project Implementation Manual

POM	Project Operation Manual
PPE	Personal Protective Equipment
RRT	Rapid Response Team
SA	Social Assessment
SEA/SH	Sexual Exploitation and Abuse/Sexual Harassment
SEP	Stakeholders Engagement Plan
SOP	Standard Operation Protocols
SPRP	Strategic Preparedness and Response Plan, also known as Global COVID-19
TA	Technical Assistance
TTL	Task Team Leaders
UNICEF	UNICEF United Nations International Children's Emergency Fund
WB	World Bank
WBG	World Bank Group
WGM	Worker Grievance Mechanism
WGRM	Worker Grievance Redress Mechanism
WHO	World Health Organization

1. Introduction

Ethiopia has made remarkable progress in achieving significant health outcomes over the past two decades including attaining the fourth Millennium Development Goal (MDG)-reducing child mortality-three years ahead of target, and it made good progress towards achieving MDG 5-improving maternal health. However, it is lagging behind in some of the health targets. The rate of neonatal and under-five children mortality remains high, the prevalence of stunting remains stagnant and Reproductive, Maternal, Newborn, Child, Adolescent and Youth Health (RMNCAYH) outcome is still lingering. Besides, the health and nutrition outcomes show the overwhelming gaps between income groups and geographic areas or regions. Given this situation, the Government of Ethiopia (GoE) has adopted a second Health Sector Transformation Plan (HSTP II) aiming to accelerate achievements in strategic priorities including maternal and child health performance.

The GoE through MoH requested the Bank for finance to address the priority needs of the HSTPII through the Sustainable Development Goals Performance Fund (SDG PF). The goals of the SDG PF are to augment financial gaps of HSTP II in priority areas. In response to it, the Ethiopia Strengthening Primary Health Care Services (SPHCS) project was developed which consists of both PforR and IPF components. The PDO of the SPHCS project is to improve access to and equitable provision of high-quality PHC services, with a focus on RMNCAH+N, while strengthening health systems. The main focus of the IPF component is on emergency health and nutrition response in conflict-affected areas, having a total allocated fund of US 124 million to be financed by the International Development Association (IDA). Both the Health PforR and IPF components will be implemented from 2021-2025 through the Ministry of Health (MoH), the Immigration and Citizen Service and their regional counterparts.

The purpose of this LMP is to facilitate the planning and implementation of the IPF project. It identifies the main labor requirements and risks associated with the project and help to determine the resources necessary to address project labor issues. LMP lays out the project's approach on national requirements, as well as the objectives of the WB's ESF, specifically "Environmental and Social Standard 2- "Labor and Working Conditions (**ESS2**)". This LMP sets out the terms and conditions of employment for employing or otherwise engaging workers on the project, specifies the requirements and standards to be met and policies and procedures to be followed, assesses risks, and proposes implementation of compliance measures.

2.
2Institutional and Implementation Arrangements

MOH has functional Directorates following the nationwide health sector reform. The Directorates were established based on their functions, under the Office of the Minister and the State Ministers. MOH has seven agencies that are responsible for guiding and implementing health and health-related activities. MOH also supports regions in systems development and developing health sector programs aligned with national plans and goals. It mobilizes additional resources to improve service delivery and creates platforms for mutual accountability, information flow, and efficient use of resources.

MOH-Regional Health Bureaus (RHBs) Joint Steering Committee: The Minister of Health chairs this forum that meets every two months to facilitate smooth, effective implementation of HSTP priority activities. The meetings focus on the implementation and progress of the plan and challenges faced during its implementation.

MOH will be responsible for planning, budgeting, and reporting funds released from the pooled fund, through which IDA and GFF funding will be disbursed under the IPF operation. The Joint Consultative Forum (JCF), which is the highest governance body for dialogue, oversees the implementation of HSTP II.

The implementation of the EHS to conflict-affected areas (IPF sub-component I) will be conducted through a third-party implementing agency with proven access into these hot spots. The implementation in Tigray will be conducted by UNICEF, as per the agreement with MOH and MOF, while MOH will be responsible for implementation of services in all other regions covered by the IPF sub-component I. Furthermore, a well-defined transition plan will be developed to make sure that a handover process is clearly defined up front that helps the government take over the implementation responsibility when the situation improves. The details will be included in the contract agreement.

The implementation of CRVS activities (IPF sub-component II) will be conducted by Immigration and Citizenship Service (ICS). The ICS management will provide overall strategic guidance for the implementation of the project. A technical committee will be established to provide support on technical issues during implementation of the project. Among other responsibilities, the committee will monitor and evaluate the implementation of the project; facilitate exchange of information on best practices; provide technical advice on activities of the project; and make recommendations for consideration by the

CRVS federal steering committee. A Project Operation Manual (POM) that details project implementation arrangements will be adopted before the Program becomes effective. ICS will develop a budgeted annual work plan to be submitted to the World Bank for its no objection. It will produce quarterly financial reports and annual audit reports.

3. Rationale of the LMP

The IPF component project employs and deploys project workers at Federal and regional IPF project offices, medical staffs at mobile health clinics serving IDPs in conflict affected areas, engages IT and Management Information System (MIS) consultants, contractors, and third party project implementing partner workers. The project carries potential risks to labor and working conditions applicable for direct, contracted and third party implementing workers including the consultants who will be engaged in the technical assistance activities. Health and safety hazards may affect health care providers, cleaning and maintenance personnel, workers involved in waste handling and management, construction workers who are involed in health care facilities restoration and rehabilitation in conflict affected areas. This Labor Management Plan (LMP) is necessary to manage labor related risks and to promote sound worker management relationships during the implementation of the IPF Component Project. The purpose of this LMP is to facilitate the planning and implementation of subprojects by identifying the main labor requirements and the associated risks and determining the resources necessary to address the project-related labor issues.

The Labor Management Plan is prepared in accordance with the World Bank Environmental and Social Framework (ESF) requirements and consistent with provisions in the Environmental and Social Standards including ESS2, ESS4 and other relevant ESSs. The LMP is intended to promote health and safety of all project workers and project affected communities during implementation. The LMP is designed to promote fair treatment, non-discrimination and equal opportunity of all project workers; to protect vulnerable workers such as women, persons with disabilities, children of working age, migrant workers, contracted workers, community workers and primary supply workers; to prevent the use of forced labor and child labor; to support the principles of freedom of association and collective bargaining of project workers in a manner

consistent with pertinent national laws and to provide project workers with accessible means to raise workplace concerns.

4. Overview of Labor Use on the Project

The Project will use direct workers, contracted workers, third party workers (i.e. through UNICEF) and primary supply workers. However, it will not use community workers and migrant workers. The majority of workers are expected to be existing government civil servants, especially those working in the heath sector. Existing civil servants will remain subject to the terms and conditions of their existing sector employment. Additional staff who may be directly engaged (Direct workers) to support the project will need to be contracted in line with the requirements of ESS2 in relation to Labor and working conditions, non-discrimination and equal opportunities and occupational health and safety.

The project implementing agencies including the third party implementer (i.e., UNICEF) are responsible to ensure compliance by their employees as well as potential contracted institutions. Labor and working conditions in the project are relevant to direct workers (including government civil servants seconded from their home agencies to work concerning the IPF project) employed or engaged by the project implementing agencies, contracted workers, third party workers and primary supply workers. These will include construction workers hired for the planned restoration of Health Care Facilities civil works.

This LMP will also include potential labor risks anticipated in the IPF project; terms and conditions that will be applicable for workers, as per the Government of Ethiopia Labor Proclamation; Government of Ethiopia's (GoE) legal frameworks on Occupational Health and Safety (OHS); and responsibility of staff management and Workers Grievance Mechanism. As per paragraph 9 of ESS2, Labor Management Procedure should be developed and implemented for project-related workers. Thus, MoH have prepared this LMP which will be implemented by defining the potential project workers, the risks, and impacts with issues of labor and working conditions. The procedures identified in this LMP apply to the direct, contracted, third party and primary supply workers. The project components' activities will involve workers which include both males and females.

Direct Workers: these include the grant coordinators and project managers at MoH and EPSA, the IPF Project management and technical committee staff at Immigration and Citizenship Services (ICS), the Environmental Safeguard Specialist and Social Development and GBV Specialist at MoH, ICS and EPSA, as well as the health workers involved in providing services at Mobile clinics in IDP areas. .

Contracted workers: are those who will be recruited by the IPF project management of ICS and Grant Management Unit of MoH, as well as by the third party implementer (UNICEF) for the key implementation activities of the Project. If the contracted workers are going to be sourced through an employment agency (broker), information regarding the number, type and duration of contracts must be clearly communicated to the Bank. As it stands now these workers include: (i) Health Care Workers providing essential health services at mobile clinics including psychosocial support and physical rehabilitations; Technical Assistants for ICS; (ii) support staff such as data management and IT technicians, and Finance officers at Federal and Regional levels; and (iii) workers contracted for construction related activities by MoH and the third party implementer (UNICEF). At this time, it is difficult to estimate the number of contracted workers that will be engaged in the IPF Component project as it targets five conflict affected regions and multiple subprojects.

Primary supply workers: A "primary supply worker" is a worker employed or engaged by a primary supplier, providing goods and materials to the IPF component project, over whom a primary supplier exercises control for the work, working conditions, and treatment of the person. It is expected that sub-project activities will entail the engagement of primary supply workers such as those provide pharmaceuticals, medical supplies, transporters operating trucks and vehicles, etc.

Workforce requirement: the requirement of the work force at different levels will be determined by the scope of the IPF Component project activities operated by each implementing institution (MoH, ICS, EPSA and RHBs) which is variable over time. Most of these workers are government civil servants who will remain subject to the terms and conditions of their existing sector employment. Direct workers who may be directly engaged as additional staff will need to be contracted in line with the requirements of ESS2 in relation to labor and working conditions, non-discrimination and equal opportunities and occupational health and safety. All contractors and sub-contractors that will be involved in this project adhere to the legal frameworks of both the GoE and the WB's provisions of ESS2 (Labor and Working Conditions).

5. Assessment of key potential Labor risks

Most activities supported by the IPF Component project are being conducted by health care workers; construction workers engaged in HCF restoration/rehabilitation construction activities, workers with special technical expertise (IT and MIS consultants) as well as civil servants employed by the Government of Ethiopia. Activities include providing essential health service in

IDP sites and conflict affected areas as well as damaged HCFs restoration construction. Key risks related to the IPF component project are presented as below.

5.1. Risks Associated with Direct Workers

Direct workers of the IPF Component project may face potential labor related risks such as in connection with the process of hiring and employment (terms in conditions of contracts), discriminations, health and safety risks, accidents, gender based violence, child labor, worker's organization and absence of grievance redress mechanisms.

A. **Risks of inadequacy in terms and conditions of employment:** risks of exclusions or omissions of basic rights of workers related benefits, work hours, wages, compensation, etc., in employment contracts in violation of national labor law provisions; engaging workers without a valid contract agreement in place; un-clarity in the language of the contract; lack of awareness and understanding on the terms and conditions (rights and obligations); lack of awareness on the relevant labor laws and procedures.
B. **Risks of discrimination and deprivation of equal opportunity**: workers may face this risk during hiring and recruitment of employees and while at work. There might be discrimination of workers based on their identity, physical ability or disability, political affiliation, HIV/AIDS, religion, and gender; discrimination can also happen in relation to provision of compensations, benefits and other opportunities such as access to training, job assignment, promotions; application of disciplinary measures and penalties; termination of employment or retirement, working conditions and terms of employment; discriminations may arise due to favoritism, nepotism and corruption.
C. **Risks of child labor and forced labor:** though it is legally prohibited to formally employ a worker of underage, there might be cases of engaging underage as direct worker. In the Ethiopian civil servant proclamation, any person less than 18 years of age is not legally allowed to be employed. Testimonials or credentials from legally authorized body should be provided as proof of proper age in cases of doubtful or contentious age claims.
D. **Risks of restrictions on worker's organization**: employer may interfere and restrict workers from forming worker's organization or joining other similar organization for

collective rights negotiations, to express grievances, to enable collective voicing on conditions of work, benefits, protection of rights, etc.

E. **Gender-Based Violence, Risks of sexual harassment and assault**: women workers may face risks of sexual harassment and assault by employees, clients, work colleagues, visitors, during hiring and employment process, and/or while at work in office and/or outside of office during field works in project implementation areas.

F. **Risk of absence of a mechanism to express grievances and to protect rights of workers**: labor related grievance redress mechanism may not be in place at work place and workers may not be aware of how and where to file complaints, violations of rights and prevention of harassments.

G. **Risks related to occupational health and safety**

Exposure to Infections / Diseases: Health care providers and personnel may be exposed to general infections, blood-borne pathogens, and other potential infectious materials (OPIM) during care and treatment, as well as during collection, handling, treatment, and disposal of health care waste.

Exposure to Hazardous Materials and Waste: HCF workers may be exposed to hazardous materials and wastes, including glutaraldehyde (toxic chemical used to sterilize heat sensitive medical equipment), ethylene oxide gas (a sterilant for medical equipment), formaldehyde, mercury (exposure from broken thermometers), chemotherapy and antineoplastic chemicals, solvents, and photographic chemicals, among others.

Risks associated with medical waste management. The conflict affected Regional Health Bureaus shall put in place and monitor an appropriate Environmental Health and Safety (EHS) risk management system for proper collection, transportation, and disposal of hazardous medical wastes and for minimization of occupational health and safety risks, which will be strictly adhered to and monitored by all project implementation units.

H. **Risks related to external security threats**: project workers will travel throughout the conflict affected areas in the five regions and there might be risks of violent attacks, ambushes and robberies from irregular armed groups in the conflict affected areas. In addition, because of the current situation of political instability, ethnic violence might be risk

which leads to increased distance between people and a climate of suspicion and distrust developed.

I. **Risks of traffic accidents:** workers may be exposed to traffic accidents related to travel (ambulances, motorcycles, and cargo truck for medical supplies') and field work in remote landscapes during restoration construction of HCFs, distribution of medicine and medical supplies, facilitation of Woreda level vital statstics registrations, as well as during monitoring and routine facilitation and coordination activities of program.

5.2 Risks Associated with Contract Workers

i. Occupational Health and Safety

There may potentially be OHS risks associated with the rehabilitation of health care facilities/ civil works/ to be financed by the IPF component project. Improper work procedures during such civil works can cause OHS risks on site workers, health care providers and visitors including persons with disabilities. Workers participating in these construction activities may be exposed to various occupational accidents and health risks due to low level of awareness on safety precautions and lack of personal protective equipment (PPE). COVID-19 exposure and infection is another risk. Key potential risks as per the WB EHSG include:

- **Physical hazards**: including risk from rotating and moving equipment, noise, vibration, electrical, eye hazards, welding / hot work, vehicle driving and site traffic, manual handling, working at heights, over-exertion, slips and falls, struck by objects, confined spaces and excavations.
- **Chemical Hazards**: including risks from Poor air quality, Fire and Explosions, Corrosive, oxidizing, and reactive chemicals, Asbestos Containing Materials (ACM)
- **Biological Hazards**: Biological agents that represent potential for illness or injury due to single acute exposure or chronic repetitive exposure.
- **Radiological Hazards**: Radiation exposure can lead to potential discomfort, injury or serious illness to workers.

- OHS related risks due to travel of site workers, construction materials and use of trucks and vehicles by Project (e.g., road safety, accidents)
- OHS related risks associated with disaster and emergency circumstances such as draught, flooding, etc.

ii. **Risk of Gender-Based Violence, Sexual Exploitation and Abuse, and Sexual Harassment**: Contract workers from sub-contractors may be exposed to this risk. Workers from third parties may be engaged in social service structures to be conducted or maintained in the IPF project implementation areas (in the field), where there is a chance that workers and beneficiary communities interact in isolations, which might cause potential risks of Gender-Based Violence, Sexual Exploitation and Abuse, Sexual Harassment in the IPF project implementing areas.

iii. **Risk of non-compliance by the contracting entity**: in case of sub-contracting and outsourcing HCFs restoration construction works of the IPF component project areas, sub-contractors will be required to be legitimate sources and reliable entities, present evidences of compliance to the ESS2, incorporate the requirements of the ESS2 into contractual agreements.

iv. **Risk of absence of access to grievance mechanisms during engagement**: Workers from sub-contractors and third party implementers may not have appropriate access to grievance mechanisms and may not be able to file complaints. The sub-contractor will be required to provide grievance mechanisms for such workers and/or they will be provided access to existing grievance mechanisms.

v. **Risks related to Community Health and Safety:** Contracted workers from sub-contractors or third parties may live in IPF Component subproject implementation areas during HCF restoration construction works. This could be a possibility of contract for workers to be exposed to and/or expose others to a risk of transmission of communicable diseases such as Sexually Transmitted Diseases (STDs), HIV/AIDS, and COVID-19 in the subproject implementation areas.Members of the surrounding communities to the subproject site may also enter into construction premises and may get exposed to various hazards and risks such as falling objects.

vi. **Labor Influx**: It is unlikely that the IPF Component project area will experience Labor influx since, apart from small scale restoration of the damaged health care infrastructure, no new civil works will be financed by the IPF Component.

vii. **Risk of discrimination:** This includes potential inappropriate treatment or harassment of project workers on basis of gender, age, disability, ethnicity, or religion. No discrimination is acceptable as per the Ethiopian Labor Law and ESS2 and the Project supports equal opportunities for women and men, with emphasis on equal criteria for selection, remuneration, and promotion, and equal application of those criteria. Measures to prevent harassment of project workers, including sexual harassment, in the workplace is addressed through code of conduct trainings, including messaging in the communication.

5.3 Risks Associated with Primary Suppliers' Workers

i. **Risk of child labor and forced labor:** supply workers may face such risks. The Ethiopian Labor Law prohibits children under the age 18 years to be considered as able workers, cannot be engaged in contract agreements. The law also requires any work assigned to workers should be done voluntarily, without any form of threat of force or penalty. Primary supply workers will be required to comply with the requirements of the ESS2 and be consistent with the Ethiopian Labor Law and relevant proclamations. If child labor or forced labor cases are identified, the supplier will be required to take remedial measures.

6. Overview of Labor Legislation and WB's ESS2

The Ethiopian government has enacted laws and policies governing labor and associated rights in the past decades pursuant to the constitution; and in accordance/in conformity with the international conventions and other legal commitments to which Ethiopia is a party. The policies and laws emanated from the 1995 Federal Constitution, which contains full articles on fundamental rights and freedoms, including the right to equality without discrimination, the rights of women and children, the right to access to justice, and economic, social and cultural rights. Exclusively on labor, Article 42 describes "Rights of labor", including the rights of

workers to form associations, improve conditions of employment and economic well-being, limitation of working hours, remuneration for public holidays and a healthy and safe working environment.

The relevant laws, proclamations and directives applicable to the implementation of the labor management procedure to address labor related risks in the IPF component project are:

- Labor Proclamation No. 1156/2019
- Federal Civil Servants Proclamation 1064/2017
- Proclamation No. 568/2008, Right to Employment of Persons with Disability
- Proclamation No. 632/2009, Employment Exchange Service Proclamation,
- Occupational Safety and Health Directive, 2008 (Federal Ministry of Labor and Social Affairs)
- National Comprehensive COVID-19 Management Hand Book_2020 (MoH)
- National Comprehensive Guideline for HIV/AIDS prevention_2018

6.1 Worker-Employer relations

Worker - employer relations are governed by basic principles of rights and obligations stipulated under the Labor Proclamation No. 1156/2019 and Federal Civil Servants Proclamation 1064/2017. “Worker” means a person who has an employment relationship with an employer in accordance with Article 4 of the Proclamation; and an “employer” is defined as a person or an undertaking that employs one or more natural persons in accordance with Article 4 of the Proclamation.

The Proclamation specifies **“Work rules”** which govern working hours, rest period, payment of wages and methods of measuring work done, maintenance of safety and prevention of accidents, disciplinary measures and their enforcement as well as other conditions of work. “Condition of work” are also elaborated as the full account of labor relations between workers and employers including hours of work, wage, leave, payments due to dismissal, workers health and safety, compensation to victims of employment injury, dismissal because of redundancy, grievance procedure and any other similar matters.

Article 4 of the Proclamation No. 1156/2019 stipulates that a contract of employment shall be deemed formed where a natural person agrees directly or indirectly to perform work for and under the authority of an employer for a definite or indefinite period or piece of work in consideration for wage; a contract of employment shall be stipulated clearly and in such manner that the parties are left with no uncertainty as to their respective right and obligation under the terms thereof; a contract of employment shall specify the type of employment and place of work, the rate of wages, method of calculation thereof, manner and interval of payment and duration of the contract. A contract of employment shall not be concluded for the performance of unlawful or immoral acts and the contract of employment shall not lay down less favorable conditions for employee than those provided for by law, collective agreement or work rules.

Further, Ethiopia is a signatory to the international UN conventions and has ratified the major international human rights instruments. Ethiopia has also ratified the following ILO conventions:

- Forced Labor Convention No. 29/1930;
- Freedom of Association and Protection of the Right to Organize Convention, No. 87/1948;
- Employment Service Convention, No. 88/1948;
- Right to Organize and Collective Bargaining Convention, No. 98/1949;
- Abolition of Forced Labor Convention, No.105/1957;
- Minimum Age Convention No. 138/1973;
- Occupational Safety and Health Convention, No. 156/1981;
- Termination of Employment Convention, No. 158/1982;
- The Rights of the Child Convention, 1989; and
- The Worst Forms of Child Labor Convention No. 182/1999.

Project workers of the IPF Component must have a binding contract agreement that encompasses the details of rights (hours of work, overtime payments, wages), benefits (compensation benefits, severance payments, allowances, etc.), obligations, responsibilities and accountabilities (violations of rules, causing damages to property, etc.) of the employee and the employer. In compliance to the requirements in the ESS2, project workers need to be engaged with a legally binding contract agreement that clearly states the terms and conditions of employment as per the

appropriate Civil Servant law and Labor law. The conditions of the contract should clearly inform the employee about the rights and obligations in understandable language. The contract agreement should be signed at the beginning of the employment and whenever changes are made within the provisions and the terms of employment changes.

6.2 The Right to Form Associations

Under Article 113 of the Labor law, workers have the right to form associations and Trade Unions. Workers can organize themselves into collective relations through trade unions and associations.

6.3 World Bank Standard on Labor and Working Conditions (ESS2)

ESS2 recognizes the importance of employment creation and income generation in the pursuit of poverty reduction and inclusive economic growth. Borrowers can promote sound worker management relationships and enhance the development benefits of a project by treating workers in the project fairly and providing safe and healthy working conditions. The objectives of ESS2 are:

- To promote safety and health at work.
- To promote the fair treatment, non-discrimination and equal opportunity of project workers.
- To protect project workers, including vulnerable workers such as women, persons with disabilities, children (of working age, in accordance with this ESS) and migrant workers, contracted workers and primary supply workers, as appropriate.
- To prevent the use of all forms of forced Labor and child Labor.
- To support the principles of freedom of association and collective bargaining of project workers in a manner consistent with national law.
- To provide project workers with accessible means to raise workplace concerns.

7 Terms and Conditions

The terms of condition follow stringent international requirements where the gaps of the national law are filled by WB requirements and ILO convention. Hence, the terms and condition include the name and legal domicile of the employer; the worker's name; the worker's job title; the date

employment began; where the employment is not permanent, the anticipated duration of the contract; the place of work or, where the work is mobile, the main location; benefit packages; hours of work, rest breaks, leave entitlements and other related matters; rules relating to overtime and overtime compensation; the pension and other welfare arrangements applicable to the worker; the length of notice that the worker can expect to give and receive on termination of employment; the disciplinary procedures that are applicable to the worker, including details of representation available to the worker and any appeals mechanism; and details of grievance procedures, including the person to whom grievances should be addressed.

Specifically, labor relations shall be governed by the relevant Ethiopian legislation. As per Labor Proclamation No.1156/2019, the normal working hour for project workers shall not exceed 8 hours a day or 48 hours a week. Work done in excess of the normal daily hours of work fixed in accordance with the provisions of this Proclamation shall be deemed to be overtime and overtime work shall be paid as per the provisions of the proclamation. If collective agreements are entered between workers and contractors, these shall follow the provisions of the relevant Ethiopian labor laws.

The following general terms and condition should be followed as per the relevant Ethiopian labor laws.

Table 16: General Labor Terms and Conditions

Issue	Terms and Conditions
Wages	Wages should be in cash on a working day at the workplace unless otherwise agreed; should be directly to the worker or to the person authorized by the worker. Wages are to be paid at such intervals as required under the national law, collective agreement or employment contract. Employer is not allowed to make deductions from wages except where it is provided by the law or collective agreement or work rules or in accordance with a court order or a written agreement with the worker.
Deduction from wages	The employer shall not deduct from, attach or set off the wages of the worker except where it is provided otherwise by law or collective agreement or work rules or in accordance with a court order or a written agreement of the worker concerned. Unless the worker expresses his consent in writing, the amount that may be deducted at any one time, from the worker's wage shall in no case exceed one-third of his

	monthly wage.
Hours of work	Normal hours of work shall not exceed 8 hours a day or 48 hours a week. Hours of work shall spread equally over the working days of a week, provided, however, where the nature of the work so requires, hours of work in any one of the working days may be shortened and the difference be distributed over the remaining days of the week without extending the daily limits of eight hours by more than two hours.
Rest	Workers are entitled to a weekly rest period consisting of not less than twenty-four non-interrupted hours in the course of each period of seven days.
Documentation	Contracts of employment made in writing should contain proper documentation, including the following information. 1/The name and address of the employer; 2/ The name, age, addresses and work card number, if any, of the worker; 3/ the agreement of the contracting parties made in accordance with Article 4 (3) of this Proclamation; and 4/ The signature of the contracting parties.
Termination	A contract of employment shall only be terminated upon initiation by the employer or worker and in accordance with the provisions of the relevant Ethiopian law or a collective agreement or by the agreement of the parties. Termination may arise by operation of the law, by agreement, or initiation of the parties. In all cases, termination shall be affected as per stipulation of the relevant Ethiopian laws.
Leave	A worker shall be entitled to uninterrupted annual leave with pay. Such leave shall in no case be less than: a) Sixteen (16) working days for the first year of service; b) Sixteen (16) working days plus one working day for every additional two years' service. In addition, workers are entitled to various other leaves including family leave, maternity leave, union leave, sick leave, and other special leaves as per the relevant Ethiopia labor laws.
Medical coverage	Where a worker sustains employment injury, the employer shall cover the following medical service expenses: 1/ General and specialized medical and surgical care; 2/ Hospital and pharmaceutical care; 3/ Any necessary prosthetic or orthopedic appliances.
OHS	OHS measures of the Project shall include the requirements of the relevant sections of ESS2. The OHS measures will be designed and implemented to address: • Identification of potential hazards to project workers, particularly those that may be life-threatening. • Provision of preventive and protective measures, including modification, substitution, or elimination of hazardous conditions or substances. • Training of project workers and maintenance of training records. • Documentation and reporting of occupational accidents, diseases and incidents. • Emergency prevention and preparedness and response arrangements to emergencies; and • Remedies for adverse impacts such as occupational injuries, deaths,

	disability, and disease.

7.1 Non-discrimination and equal opportunity

The Federal Civil Servants Proclamation No. 1064/2017 promulgated a law that establishes a system of recruitment and selection of civil servants that guarantees diversity and that improves conditions of work. Sub-article (2) of Article 13 in the proclamation clearly state that there shall be no discrimination among job seekers or civil servants in filling vacancies because of their *ethnic origin, sex, political outlook, religion, HIV/AIDS, disability and or any other ground.* Article 8 of the proclamation states '*equal pay for equal work'* regardless of any other ground than the professional requirements.

7.2 Sexual harassment and sexual violence

The labor proclamation No. 1156/2019 on sexual harassment and sexual assault has several provisions. Under section three, article 14 and sub-article (h), sexual harassment or sexual assault by any worker or employer or employee manager is clearly listed as a legally prohibited act at work place. Further in sub-section two, on termination of contract by worker, under article 32 and sub-article (b), a worker who has been a victim of sexual harassment or sexual violence by an employer or employee manager can terminate his/her contract without any prior notice.

7.3 Affirmative action to the underserved

The Federal Civil Servants Proclamation No. 1064/2017, under section five, article 50 about conditions of work applicable to minority nations, nationalities and peoples state that the sub-article (1) placement of personnel in government institutions shall take into account fair representation of nations, nationalities and peoples, and under sub-article (2) it state that nations, nationalities and peoples having lesser representation in government institutions shall be given the advantage of affirmative action in recruitment, promotion, transfer, redeployment, education and training.

7.4 Age of Employment

Ethiopia has ratified ILO Minimum Age Convention No. 138/1973. As per the Ethiopian Labor Proclamation No.1156/2019 Article 89 (1-4) minimum age for employment is 15 years for young workers. The relevant labor law and civil servant law declare that any person below the age of 15 years of age is considered child labor. Young worker, with restricted types of work and defined hours of work can be engaged as formal labor. According to the civil servant law, children below 18 years of age are not legally allowed to become civil servants. Under Article 14 of the Civil Servants Proclamation No. 1064/2017, all persons less than 18 years of age cannot be employed as a civil servant. However, the Labor Law (Labor proclamation 1156/2019), Article 89 has a provision for "Yong Worker". A young worker is a person who has attained an age of 15 years but less than 18 years. The law has put restrictions on the types of work and hours of work in a day for young workers. The law prohibits assigning any work that may endanger the lives and health of young workers.

The minimum Age for Hazardous Work is set as 18 years. It is prohibited to employ young workers to carry out work which on account of its nature such as possible exposure to COVID-19 or due to the condition in which it is carried out (i.e., hazardous nature of the work, e.g., in health care facilities and medical waste treatment), endangers the life or health of the young workers.

Proc. No.1156/2019 states that: Normal working hours for young persons may not exceed seven hours a day. It is prohibited to employ young workers on night work between 10 p.m. and 6 a.m.; overtime work; weekly rest days; and public holidays. *Because the project mainly mobilizes government civil servants and adult health care professionals and IT experts, expatriates included, it will not employ/engage any person under 18 years of age.*

The MoH GMU, RHBs and ICS E&S staff will undertake monitoring, at a minimum every six months, of all project workers, to ensure that there are no direct hires under 18 years of age and that all contractors and subcontractors involved in the project are not employing/engaging anyone under 18 years of age for the project work. Further, awareness-raising sessions will be conducted regularly among the IPF implementing institutions in the target regions, as well as for third party implementing agencies (UNICEF) and contractors to sensitize on prohibition and negative impacts of child and forced Labor.

The Project will use the following process, prior to the employment or engagement of an applicant for work on the project, to verify the person's age. The MoH GMU, RHBs and ICS E&S staff will ensure that each contractor/subcontractor also uses this process and provides it with written confirmation that each worker they employ or engage in relation to the project is at least the minimum age of 18 years. The following information will be kept on file in the IPF Component Project administrative offices:

- Written confirmation from the applicant of their age; and
- Where there is reasonable doubt as to the age of the applicant, requesting and reviewing available documents to verify age (such as a birth certificate, national identification card, medical or school record, or other document or community verification demonstrating age).

If a person under the minimum age of 18 years is discovered working in relation to the IPF Component project, the MoH GMU, RHBs, and ICS will take measures to terminate the employment or engagement of that person in a responsible manner, considering the best interest of that person.

To ensure that the best interests of the child under 18 years are considered, the MoH GMU, RHBs, and ICS will undertake, and ensure that all contractors/subcontractors also undertake, remediation within a reasonable time period agreeable to the World Bank. The remediation activities could include, among other options:

- Enrolling the child in a vocational training/apprenticeship program, but which does not interfere with the child's completion of compulsory school attendance under national law.
- Employment of a member of the child's family, who is at least 18 years of age, by the primary supplier, contractor, or subcontractor for project-related or other work.

7.5 Prohibition of Child and Forced Labor

Ethiopia has ratified ILO Conventions related to Child Labor and Forced Labor such as ILO Convention 182 on the Worst Forms of Child Labor; Minimum Age Convention No. 138/1973; The Rights of the Child Convention, 1989; Forced Labor Convention No. 29/1930; and

Abolition of Forced Labor Convention, No.105/1957. Art. 89(3) of Labor Proclamation 1156/2019, prohibits assigning young workers on work, which on account of its nature or due to the condition in which it is carried out endangers their lives or health. Further, Sub-Article 4(a-d) outlines the barred areas for young workers. Further, Art.91(1- 4) states that, young workers should not be assigned to night and overtime work, of the following nature; (i) night work between 10 pm and 6 am; (ii) over time work; and, (iii) work done on weekly rest days; or (iv) work done on Public Holidays.

WB ESS2 states that the minimum age of employment is 14 years while the newly revised Ethiopian Labor Law has extended the minimum year of employment to 15 years. However, both WB and Ethiopian law prohibit the engagement of children less than 18 years of age in works that have hazardous nature. The other gap between the WB and Ethiopian law is the fact that the national law does not indicate that it prohibits an employer to retaliate against a worker or reporting a dangerous work situation or removing himself/herself from a dangerous work situation. ESS2 of the World Bank ESF provides that project workers will not be retaliated against or otherwise subject to reprisal or negative action for reporting a dangerous work situation or removing them from a dangerous work situation. The MoH GMU, RHBs and ICS will ensure that all project workers, including those engaged by contractors, will have the right to report and remove themselves from dangerous work situations without being subject to reprisal or negative action.[51] This and other provisions of the LMP will be part of the awareness-raising and training sessions of the project. In such case of differences between the international conventions, national legislation, regulation, and the World Bank Environment and Social Standards, the more rigorous provision will be applied. Given the nature of the workforce involved, the IPF Component Project will not recruit children for project related works and project monitoring will include this aspect.

8. Occupational safety and health and working environment

Ethiopia has legal frameworks on OHS. The parent legislative framework of the land is the Constitution of the FDRE Proc. No. 1/1995 (21st August, 1995). This grand legislation has

[51] ESS2, paragraph 26 and 37.

several articles pertaining to matters of Decent Work in general and of Safety, Health and Working Environment in particular. Article 42(2) provides that "workers have the right to reasonable limitation of working hours, to rest, leisure, to periodic leaves with pay, to remuneration for public holidays as well as healthy and safe work environment". Article 89(8) provides "Government shall endeavor to protect and promote the health, welfare and living standards of the working population of the country."

The Constitution has numerous articles that ensure the protection of citizens and workers from environmental and work-related hazards. The Ethiopian Labor Proclamation no. 1156/2019 has established the provisions of OHS in workplaces. It clearly indicates the duties and responsibilities of the three parties: employer, employee and the government inspectors as stakeholders (FDRE, 2004). There are OHS directives and guidelines used by OHS inspectors and safety officers to ensure the protection of workers (MoLS, 2008).

Further, Part Seven, Articles 92-106 of Proc. No. 1156/2019 defines the occupational safety and health and working environment focusing on: (i) preventive measures (Art. 92-4); (ii) occupational injuries (Art. 95-8); (iii) defining degree of disablement (99-102); (iv) benefits to employment injuries (103-4); (v) medical services (105-6). Articles 107-112 provide for '***Various Kinds of Cash Benefits***' to which workers are entitled.

There are also different policy frameworks and procedures on OHS which include: The National Occupational Health Policy and Strategy, Occupational Health and Safety Directive (2008), Occupational Health and Safety Policy and Procedures Manual, and On Work Occupational Health and Safety Control Manual for Inspectors (2017/18) which will apply to the IPF Component project. OHS promotion is also included as a priority in the National Health Policy Statement (1993).

Ministry of Labor and Skill (MoLS) and its regional counterparts are responsible for OHS at Federal and Regional levels. MoLS have OHS & Working Environment Department responsible for OHS. Each administrative region has an OHS department within the Labor and Skill development Bureau with the responsibilities of inspection service.

As stated in Article 52 of the Proclamation No. 1064/2017, the OHS is applicable to civil servants including temporary workers. The objective of the OHS is to maintain the safety and health of civil servants and to enhance their productivity; to arrange, improve and keep suitable work place for the safety and health of civil servants; to guarantee high level of performance of a government institution on social wellbeing. In subsequent articles from 53-59, definitions of *accident and injury, list of the types of accidents, necessary safety measures, worker's rights in cases of accidents that result in different levels of disability (partial, temporary, permanent, etc…),* benefits and leaves, claims of compensation from third party, and other benefits to the employee are provided in details and in cases of accidents, this law is applicable.

The health and safety of workers while at work are protected with provisions from the **Labor proclamation No. 1156/2019**. It provides the measures to be taken to prevent occupational accidents and injuries. The Employer has the obligation to ESM the safety and health of workers, particularly to:

(i) Comply with the occupational health and safety requirements provided for in this Proclamation.
(ii) Take appropriate steps to ensure that workers are properly instructed and notified concerning the hazards of their respective occupations; and assign safety officer; and establish an occupational health and safety committee.
(iii) Provide workers with protective equipment, clothing and other materials and instruct them of their use.
(iv) Register employment accidents and occupational diseases and report same to the labour inspection service.
(v) Arrange, according to the nature of the work, at his own expense for the medical examination of newly employed workers and for those workers engaged in hazardous work, as may be necessary with the exception **of HIV/AIDS,** unless and otherwise the country has obligation of international treaty to do so.
(vi) Ensure that the work place and premises of the undertaking do not pose threats to the health and safety of workers.

(vii) Take appropriate precautions to ensure that all the processes of work in the undertaking shall not be a source or cause of physical, chemical, biological, ergonomic and psychological hazards to the health and safety of the workers.

(viii) Implement the instructions given by the Competent Authority in accordance with this Proclamation;

Workers (all types of workers in the IPF Component project including third party project implementing workers to be hired by UNICEF) are required to comply with the requirements of the law. Hence, any worker engaged in the IPF component project activities has the obligation to:

(i) Co-operate in the formulation of work rules to safeguard the workers' health and safety, and implement same;

(ii) Inform forthwith to the employer any defect related to the appliances used and incidents of injury to health and safety of workers that he is aware of in the undertaking;

(iii) Report to the employer any situation which he may have reason to believe could present a hazard and which he cannot prevent on his own, and any incident of injury to health which arises in the course of or in connection with work;

(iv) Make proper use of all safety devices and other appliances furnished for the protection of his health and safety or for the protection of the health and safety of others;

(v) Observe all health and safety instructions issued by the employer or by the Competent Authority.

In Chapter 13 of the proclamation, workers are entitled to the forms of benefits in the case of employment injuries which include obligations of the employer, medical service benefits, various kinds of cash benefits including dependent's benefits.

It is prohibited that no worker shall:

(i) Interfere with, remove, displace, damage, or destroy any safety devices or other appliances furnished for his protection or the protection of others; or

(ii) Obstruct any method or process adopted to minimize occupational hazards.

The Labor proclamation gives the power for Regional Bureaus to determine standards and measures for the safety and health of workers and follow up on their implementation. It is also indicated that regional bureaus must collect, compile and disseminate information on the safety and health of workers.

It is unlawful for an employer to (a) impede the worker in any manner in the exercise of his rights or take any measure against him because he exercises his right; (b) discriminate against female workers, in matters of remuneration, on the ground of their sex; (c) terminate a contract of employment contrary to the provisions of the Labor Proclamation No. 1156/2019; (d) coerce any worker by force or in any other manner to join or not to join or to cease to be a member of a trade union or to vote for or against any given candidate in elections for trade union offices; (e) require any worker to execute any work which is hazardous to his life; (f) discriminate between workers based on nationality, sex, religion, political outlook or any other conditions.

Therefore, during IPF component project activities implementation, the following activities need to be performed: (i) identification of OHS risks at the project design stage; (ii) provision of PPEs and health, safety, and security arrangements; and (iii) training at regular intervals to workers to enhance their skills.

Ethiopian law does not specifically state that it prohibits an employer to retaliate against a worker for reporting a dangerous work situation or removing himself/herself from a dangerous work situation. Therefore, this gap in the National legislation will be filled in by applying the World Bank requirement in para 27 of ESS 2. It is required that project workers who remove themselves from such situations will not be required to return to work until necessary remedial action to correct the situation has been taken. In addition, project workers will not be retaliated against or otherwise subject to reprisal or negative action for such reporting or removal.

In addition, ESS2, under section D: ‘Occupational Health and Safety (OHS)’, para. 24-30 outlines the following mitigation measures to be applied during IPF Project Implementation as found appropriate:

(24) Measures relating to occupational health and safety will be applied to the project. The OHS measures will include the requirements of this Section, and will take into account the General EHSGs and, as appropriate, the industry-specific EHSGs and other GIIP. These will include WB EHSG for Health Care Facilities (including those related to HCF operations).

(25) The OHS measures will be designed and implemented to address: (a) identification of potential hazards to project workers, particularly those that may be life threatening; (b) provision of preventive and protective measures, including modification, substitution, or elimination of hazardous conditions or substances; (c) training of project workers and maintenance of training records; (d) documentation and reporting of occupational accidents, diseases and incidents; (e) emergency prevention and preparedness and response arrangements to emergency situations; and (f) remedies for adverse impacts such as occupational injuries, deaths, disability and disease.

(26) All parties who employ or engage project workers will develop and implement procedures to establish and maintain a safe working environment, including that workplaces, machinery, equipment and processes under their control are safe and without risk to health, including by use of appropriate measures relating to chemical, physical and biological substances and agents. Such parties will actively collaborate and consult with project workers in promoting understanding, and methods for, implementation of OHS requirements, as well as in providing information to project workers, training on occupational safety and health, and provision of personal protective equipment without expense to the project workers.

(27) Workplace processes will be put in place for project workers to report work situations that they believe are not safe or healthy, and to remove themselves from a work situation which they have reasonable justification to believe presents an imminent and serious danger to their life or health. Project workers who remove themselves from such situations will not be required to return to work until necessary remedial action to correct the situation has been taken. Project workers will not be retaliated against or otherwise subject to reprisal or negative action for such reporting or removal.

(28) Project workers will be provided with facilities appropriate to the circumstances of their work, including access to canteens, hygiene facilities, and appropriate areas for rest. Where

accommodation services are provided to project workers, policies will be put in place and implemented on the management and quality of accommodation to protect and promote the health, safety, and well-being of the project workers, and to provide access to or provision of services that accommodate their physical, social and cultural needs.

(29) Where project workers are employed or engaged by more than one party and are working together in one location, the parties who employ or engage the workers will collaborate in applying the OSH requirements, without prejudice to the responsibility of each party for the health and safety of its own workers.

(30) A system for regular review of occupational safety and health performance and the working environment will be put in place and include identification of safety and health hazards and risks, implementation of effective methods for responding to identified hazards and risks, setting priorities for taking action, and evaluation of results.

Inorder to implement the above OHS and work environment provisions of the national legislations and ESS2, the following approaches shall be applied by each subprojects:

- For project construction works, a subproject ESMP will be developed according to the ESMF and this will include subproject OHS measures. The bid and contract for such works will include OHS terms and conditions including for the Contractor to prepare and implement a CESMP which shall include an C-OHS Plan. The C- OHS plan shall also consider applying relevant mitigation actions of the general or Health Care facilities EHS guideline,
- For all subprojects involving HCFs an operation phase OHS plan shall be prepared and implemented. The OHS plan shall also consider applying relevant mitigation actions of the general or Health Care facilities EHS guideline,
- For all project activities that involve travel or use of trucks and vehicles, a set of traffic safety measures shall be developed and implemented (including training). In all subproject sites, a separate and reasonably distant eating (canteen) room will be provided for the workers;

- In the case of any significant OHS incident or accident related to the IPF Component Project, the Bank should be notified no later than 48 hours after learning of the incident or accident, and that a subsequent report should be provided within a timeframe acceptable to the Association. The client shall provide sufficient detail regarding the scope, severity, and possible causes of the incident or accident, indicating immediate measures taken or that are planned to be taken to address it, and any information provided by any contractor and/or supervising firm, as appropriate. Subsequently, at the WB's request, prepare a report on the incident or accident and propose any measures to address it and prevent its recurrence
- Third Party Project Implementers (UNICEF) and Primary Suppliers of the IPF Component Project shall comply with ESS2 requirements (See ESS2 for details)

8.1 COVID-19 Prevention at Workplace

The Ministry of Health has published a national guideline "National Comprehensive COVID-19 Management Handbook" in April 2020 for health care professionals, decision makers and the larger public to prevent the spread of COVID-19. The Hand book has various protocols and procedures for prevention practices. The guideline is implemented at national level and the prevention protocols for the larger public are provided in section IV of the guideline.

Section IV: Protocol for infection prevention and control during healthcare when sars cov-2 infection is suspected

This Infection Prevention and Control (IPC) protocols are based on WHO infection prevention and control during health care SARS CoV-2 infection interim guidance, Ethiopian National Infection Prevention and Control Guideline, WHO guideline on hand hygiene in health care.

i. General Precautions

The general precaution part of the protocol will be applicable after the infection is confirmed in country. Once the outbreak is declared:

- Cough hygiene should be implemented by the general public including covering mouth during coughing and sneezing with tissue or flexed elbow.

- All personnel should wear surgical masks.
- Do not shake hands, and if you do Apply ABHR or wash hands thoroughly with soap and water
- Avoid contact with a patient who is suspected or conformed for COVID-19
- Limit movement to essential purpose only
- Ensure adequate ventilation at homes
- Avoid thirst of throat, maintain rehydration

ii. List of IPC Materials Required

- N95 mask
- Long sleeved disposable gown
- Disposable glove
- Temperature monitoring device
- Alcohol Based Hand Rub (ABHR)/ Sanitizer
- 70% Alcohol
- Leak proof biohazard bag
- 0.5% Chlorine Solution

iii. Hand Hygiene Procedures

- All team members should perform consistent and appropriate hand hygiene procedures:
- Hand hygiene is the process of removing soil, debris, and microbes by cleansing hands using soap and water, ABHR, antiseptic agents, or antimicrobial soap.
- Hand washing is the process of mechanically removing soil, debris, and transient flora from hands using soap and clean water
- Alcohol-Based Hand Rub (ABHR)is a fast-acting, antiseptic hand rub that does not require water to reduce resident flora, kills transient flora on the hands, and has the potential to protect the skin (depending on the ingredients).

The MoH GMU, RHBs and ICS provide protective materials; providing illustrative procedures for hand washing, social distancing and other procedures; enforce compliance to COVID-19

protocols in all work places. All workers of the IPF Component project including third party project implementing workers will be required to comply with the COVID-19 procedures.

The MoH GMU, RHBs and ICS will provide training to community workers and local community members to create awareness on the prevention, precautions and procedures of COVID-19 protocols.

9. Roles and Responsibilities for LMP Implementation

The main implementing agency of Subcomponent-I and III of the IPF Component Project is the Ministry of Health (MoH) in collaboration with the five conflict affected Regional Health Bureaus. Ethiopian Pharmaceutical Supply Agency (EPSA), which is one of the Agencies accountable to the MoH, will be a partner implementing institution under the MoH in the areas of procurement and distribution of medical supplies and equipment. UNICEF will also act as third party implementing entity for subcomponent-1 of the IPF Component project in Tigray region. The main implementing agency for Subcomponent II of the IPF Component project will be the Immigration and Citizenship Services (ICS).

Notwithstanding the above, this section briefly outlines the roles and responsibilities of project implementing entities in: (i) engagement and management of project workers, including direct hires and workers employed/engaged in relation to third party project implementer workers; (ii) engagement and management of construction contractors/subcontractors; (iii) occupational health and safety (OHS); (iv) training of workers; and (v) addressing worker grievances. The source of budget for the implementation of OHS measures is the part of the IPF Component project cost.

The responsible body for workers management varies depending on the types of IPF Component subprojects and the location. The direct workers will be managed by the MoH GMU, EPSA, ICS and Regional Health Bureaus pursuant to the Federal Civil Servants Proclamation 1064/2017 and the Labor Proclamation no.1156/2019 as appropriate at the National and regional states levels as key implementing entities. Whereas, the contracted workforce's contract terms and conditions

would be determined by the laws and WB's ESS2 requirements specified under *chapter 7* above, respectively, the MoH and its partner implementing agencies, will provide the required workers' training and occupational health and safety equipment and procedure to address worker grievances. This responsibility of managing staff will also pass to the third party project implementer (i.e., UNICEF) and contractors and sub-contractors.

Contractors must engage a minimum of one health and safety representative, which is responsible for monitoring the day-to-day compliance to safety precautionary measures indicated in the ESMF, SEP and LMP, and records of any incidents and report to the MoH GMU. The MoH GMU is responsible to promptly notify the incidence and accident to the WB within 48 hours, which will be followed by formal investigation of the causes and identification of a set of corrective actions. Besides the MoH GMU, EPSA, RBH and ICS E&S staff monitors labor and working conditions quarterly, and annually throughout the project implementation period. Any identified non-compliance will be included in these monitoring reports accompanied by relevant corrective actions. More specifically, the MoH GMU, EPSA, RBH and ICS E&S staff will be responsible for the following:

- Develop, maintain, implement, update, and control this LMPs document;
- Provide project-specific training on GBV-SEA/SH and OHS requirements to project workers periodically throughout the project life cycle, including on-the-job trainings. The MoH GMU and ICS will provide such training by its E&S specialists, however, it also will consider procuring specialized GBV-SEA/SH and OHS trainings from eligible consultancy firms, where necessary;
- Ensure, monitor, and verify that all health care facility workers, contractors / subcontractors , chain suppliers, and community workers comply with these LMPs;
- Ensure, monitor, and verify that the contracts with the contractors are developed in line with the provisions of these LMPs, and that contractors include enough obligations toward providing GBV-SEA/SH related training to their workers and inclusion of obligation to draft C-OHS in the bidding ToR ;
- Ensure that the grievance redress mechanism for project workers is established and implemented and that workers are informed of its purpose and how to use it; Have a

system for regular monitoring and reporting on labor and OHS performance. Contractors and sub-contractors should report monthly to MoH and that every three and six months, they should submit environmental and social performance reports to the Bank.

- Monitor implementation of the Worker Code of Conduct.

The International competitive procurement will use the World Bank's Standard Procurement Documents (according to the New Procurement Framework and Regulations for Projects After July 1, 2016)[52]. However, when approaching the national market, as shall be agreed in the Procurement Plan, the country's own procurement procedures may be applied, provided that such procedure shall be subject to the requirements as provided in section 5 paragraph 5.3 to 5.6 of the Procurement Regulations for IPF Borrowers.

As such, the project will use contracting templates provided by the Procurement Framework and Regulations. The Contracting Agreement will include conditions and clauses on Forced Labor/Child Labor, Trafficking-in-person and GBV-SEA/SH as well as on obligations to Health and Safety, to which the contractors will need to commit and adhere.

The LMP and OHS responsibilities of all implementing agencies including the contractors will include the following:

- Develop and implement an OHS plan, which aims to avoid, minimize and mitigate the risk of workplace accidents. This would include identifying potential risks and identifying safe working practices, using only trained workers, using safe machinery and equipment and providing necessary personal protective equipment (PPE). The development of such plans should be based on WB EHSG for Health Care Facilities, and the General EHSG.
- Develop and implement an OHS plan for the restoration construction and operation phase of all HCFs and Civil registration data entry centers.
- Comply with all national and good practice regulations regarding workers' safety.
- Prepare an action plan to cope with risk and emergency (e.g., fire, earthquake, floods, and disease outbreak).

[52] https://www.worldbank.org/en/projects-operations/products-and-services/brief/procurement-new framework

- Provide minimum required training or orientation on occupational safety regulations and use of personal protective equipment; and OHS requirements in this LMP, and any subproject specific OHS plan.
- The contractor(s) shall provide preventive and remedial safety measures as appropriate during works such as fire extinguishers, first aid kits, restricted access zones, warning signs, overhead protection against falling debris, lighting system to protect hospital staff and patients against construction risks as stated in WB EHSG General, and WB EHSG for Health Care Facilities.
- Follow the Labor Management Procedures and occupational health and safety requirements as stated in the contracts signed with the MoH;
- Contractors will keep records detailing the specifications of the job description of each worker;
- MoH, RHB and third party project implementing institutions shall supervise the subcontractors' implementation of LMPs and OHS requirements;
- Maintain records of employment, and training of contracted workers as provided in their contracts;
- Communicate clearly job descriptions and employment conditions to all workers; including worker and employer rights and responsibilities related to OHS.
- Make sure every project worker hired by contractor/subcontractor is aware of the MoH/ICS's dedicated call center, hotline, email address, and web portal through which any worker can submit his/her grievances; and
- Provide induction and monthly training to employees on labor law protections in relation to occupational health and safety, including training on their rights to safe and healthy working conditions under Ethiopia labor laws, World Bank ESS2 requirements, this LMP and any sub project specific OHS plans on the risks of job-related injuries and accidents, and on measures to reduce risks to acceptable levels, as well as periodical trainings on GBV/SEA/SH.
- Report on OHS performance and
- Report any OHS significant incident or accident. no later than 48 hours after learning of the incident or accident

- x Communicate clearly the Code of Conduct to all workers; including their rights and responsibilities, and ensure it is signed by each worker.

Note: The child labor and forced labor (if any) as well as GBV/SEA/SH and OHS requirements apply to all categories of workers in the project activities.

10. Worker Grievance Redress Mechanism (WGRM)

10.1 Worker Grievance Mechanism: General Description

The IPF Component project recognizes the vulnerability of the target conflict affected communities, beneficiaries and the different types of workers to be involved in the IPF Component project activities. Effective worker grievance redress mechanism (WGRM) for addressing and managing workplace and employment related conflicts or a complaint as well as gender-based violence (GBV) is crucial for the Project. Typical workplace grievances include demand for employment opportunities; labor wage rates; delays of payment; disagreement over working conditions; and health and safety concerns in the work environment.

A grievance structure will be established for project workers (direct workers and contracted workers), as required in ESS2. Handling of grievances should be objective, prompt and responsive to the needs and concerns of the aggrieved workers. The worker Grievance Redress Mechanism (WGRM) will also allow for anonymous complaints to be raised and addressed. Individuals who submit their complaints or grievances may request that their names be kept confidential, and this should be respected. The workers will be informed of the WGRM at the time of recruitment and the measures put in place to protect them against reprisal for its use.

According to ESS2 paragraphs 21-23, different types of workers (including all direct workers and contracted workers, and, where relevant, their organizations) may approach the workers' GRM for the following key reasons, among many others:

- Demand for employment opportunities.
- Labor wage rates and delays in payment of wages;
- Disagreements over working conditions;

- GBV/SEA/SH in the workplace; and
- Health and safety concerns in work environment.

The MoH and ICS, under whose leadership the IPF Component project will be implemented, will establish an accessible and functional WGRM for all categories of workers described in this LMP, including direct hires, and workers hired through third party project implementer (UNICEF), contractors and subcontractors. Labor Proclamation No. 1156/2019 provides "Employers and workers or their respective associations may introduce social dialogue in order to prevent and resolve labor disputes amicably" (Art.141). The government civil servants seconded to this project will also have access to grievance procedures under Ethiopian government public service laws.

The worker GRM, which is different from the public GRM, will leverage existing procedures and systems, and will be established in early stages of the IPF Component project and will serve throughout the IPF project implementation. The worker GRM will be based on the requirements of the WB's ESS2 – Labor and Working Conditions.

10.2 Principles of the WGRM

Specifically, the worker GRM will operate according to the following ***key principles***:

- The workers GRM is not same as the grievance mechanism to be established for project affected stakeholders.
- It will be made available for all direct and contracted workers (and where relevant their organizations);
- It will be proportionate to the nature and scale and the potential risks and impacts foreseen from the project;
- It will be designed to promptly address concerns using an understandable and transparent process that provides timely feedback to those concerned in a language that they understand, without any retribution;
- It will operate in an independent and objective manner;
- It will be a free system. Complaining workers will not pay fees to use the worker GRM;

- It will utilize existing grievance systems and experiences. In this context, the worker GRM will leverage human resource (HR) complaining procedures for direct workers that are available at their respective Health Ministry/ICS/Regional Health Bureaus and EPSA, and will ensure HR procedures at contractors' organizations are consistent with the official worker GRM system characterized in this document, which will be further referenced in their working agreements, and monitored accordingly;
- Anonymous grievances are also allowed and facilitated, and will be treated equally as other grievances, whose origin is known, however, a suitable contact information is a must to be able to communicate responses back;
- There will be no discrimination against those who express grievances, and any grievances will be treated confidentially;
- To avoid the risk of stigmatization, exacerbation of the mental/psychological harm and potential reprisal, the worker GRM will have a different and sensitive approach to GBV/SEA/SH-related cases;
- It does not replace or override the requirements to provide workplace processes to report work situations that a project worker believes are not safe or unhealthy;
- Workers will be able to raise concerns regarding unsafe or unhealthy work situations through this system; and
- It will not impede access to other judicial or administrative remedies that might be available under the law or through existing arbitration procedures, or substitute for grievance mechanisms provided through collective agreements.

10.3 Worker Grievance Mechanism Structure

The project specific WGM will be established at three levels: (1) at the national level in MoH, EPSA, and ICS; (2) Regional Administration level at Health Bureaus and Regional CRVS offices; and (3) at the *woreda* level Health and CRVS Offices. It should be emphasized that this WGRM is not a substitution to legal system for receiving and handling grievances. However, this is formed to mediate and seek appropriate solutions to labor related grievances, without escalating to higher stages. At the national level, to be housed in MoH, the members of the Worker Grievance committees include: (i) HR heads of MoH and EPSA (ii) Grievance focal

officer; (iii) representative of Health Workers Union; and (iv) MoH GMU representative. The ICS and Regional Administration and *Woreda* level WG Committees follow the principles adopted at the federal level in constituting their membership. The National and the Regional Administration GR Committees will be chaired by the HR heads of their respective health institutions, and the *Woreda* level GR Committees by the *woreda* administration representative.

Table 17: Worker GRM Structure

Woreda level	The project focal person at the *woreda* level will serve as Grievance Focal Point (GFP) to file the grievances and appeals of the project workers. He/she will be responsible for coordinating with relevant Labor and Social Affairs offices and persons to facilitate addressing these grievances. If the issue cannot be resolved at the *woreda* level within five working days, then it will be escalated to the *Regional Administration level*.
Regional Administration levels	If there is a situation in which there is no response from the *woreda* level GR committee, or if the response is not satisfactory then complainants and feedback providers have the option to contact the Focal Person at *Regional Administration level*, i.e., Human Resources Directorate of the Health Bureau/Regional CRVS office directly to follow upon the issue.
Federal level	The Federal GR committees housed in the MoH and ICS will provide an overall oversight on workers' grievances handling of the project, and will examine and decide on grievance cases of the complainants dissatisfied with the decisions of the Regional Administration Grievance committees.
MoLS	Workers who are not satisfied with the decisions of the Federal level GR Committees could take their cases to the Labor dispute court at the MoLS. This could be dealt with at two levels: (i) by taking the case to the formal Labor division courts; and (ii) through the Labor relations board for conciliation.

10.4 Procedures of the WGRM

The WGRM will have the following design and procedural features:

- Information about the existence of the grievance mechanism will be readily available to all project workers (direct and contracted) through notice boards, the presence of "suggestion/complaint boxes", and all pertinent information, such as: designated call centers, hotline numbers, email addresses, office work hours, comment/complaint forms, suggestion display boxes, stipulated timeframes to respond to grievances; info on a register to record and track the timely resolution of grievances; the responsible department to receive, record and track resolution of grievances, and other means as needed.
- Grievance handling will be transparent and aggrieved workers will be informed within 10 days of their grievance application, either with a respective solution or with a request of extension if more time is needed to investigate and decide upon the case.

- The aggrieved party will have the option to refer to a grievance log with key information that will be established by the Federal and Regional Implementing institutions and quarterly reported upon.
- Grievance logbook will be maintained in the project office at Federal and regional level IPF Project Implementing institutions.
- The WGRM, however, does not replace or override the requirement that the MoH GMU and ICS provides for workplace processes for project workers to report work situations that they believe are not safe or healthy, such as reporting requirements regarding workplace injuries and accidents.
- The WGRM will not prevent workers to use judicial procedure or administrative remedies that might be available under the law or existing arbitration procedures or substitute for collective agreements grievance mechanisms, if preferred.
- The quarterly environment and social implementation monitoring will include reports on grievances related to project labor and working conditions issues.
- If not satisfied with the outcome of the Regional State level, the aggrieved party will be able to access a second level committee on the Federal level within the MoH and ICS.

10.5 Capacity Building for Worker GRM's Responsible Staff

The Project will develop a capacity building plan for WGRM responsible bodies and ensure that the GRM officers receive adequate training on their roles and responsibilities as well as the overall procedures of the GRM. The WGRM will be described in staff induction and on-the-job trainings, which will be provided to all project workers. Further, the project will ensure that adequate resources are available for running and managing the WGRM, including building capacities of WGRM officers. Training topics would include workers' rights and pertinent national legislations and international conventions/standards; receiving, filing, and closing work-related complaints; dealing with complaints raised by vulnerable workers (including female and young workers of working age, as well as workers with disabilities); and IT and communication skills.

On GBV/SEA/SH, there will be a need to ensure that GRM procedures and mechanisms for reporting allegations of GBV/SEA/SH are known to all GRM Focal Persons. And most importantly to fulfill the role of addressing GBV/SEA/SH, focal persons will be trained (and/or have previous knowledge and experience) on GBV/SEA/SH related Guiding Principles including those of confidentiality and safety of complainants/survivors, on the survivor-centered approach. This set of skills will help GRM Focal Persons to support the quality of the complaint mechanism, while at the same time ensuring the adherence to GBV/SEA/SH related Guiding Principles and a survivor-centered approach, including right to safety, respect, and confidentiality, of the complaint intake and management.

10.6 Promotion of the worker GRM

The worker GRM messaging will be incorporated into the wider project Communication Strategy. Information on the various channels to submit grievances, complaints, and concerns will be publicized through meetings, monthly information brochures and posters explaining the GRM process in languages understood by project workers, and through one-on-one meetings during recruitment. Those posters will be displayed in accessible places, and suggestion boxes will be also available in each locality, state level responsible health and CRVS offices and all implementing agencies' (EPSA, Woreda level CRVS) offices. Meetings will be held at least quarterly; announcements will also be placed on Notice Boards. Other sensitization methods such as print media as well as electronic media such as adverts on local radio will be used.

10.7 World Bank Grievance Redress System

Communities and individuals who believe that they are adversely affected by a WB supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an

opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit, http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the World Bank Inspection Panel, please visit, www.inspectionpanel.org.

11 Contractor Management

11.1 Selecting Contractors

When contractors are hired, MoH GMU and ICS will undertake due diligence assessment of the contractors' Labor practice and adherence to the international conventions Ethiopia has ratified, national law, ESMF, ESS2 and this LMP. The contract agreement to be signed between MoH and the contractor will include clauses that refer to the Environmental and Social Commitment Plan (ESCP), Stakeholders Engagement Plan (SEP), and the LMP requirements including those related to OHS in section 6.2, 6.3, and 9..

Moreover, the MoH GMU will make reasonable efforts to ascertain third parties including UNICEF who engage contracted workers are legitimate and reliable entities and have in place Labor management Procedures applicable to the project that will enable them to operate in accordance with the requirements of ESS2 and WBG EHS Guidelines Specifically, the IPF Component Project will ensure the project National contractors (including third party suppliers) provide the following information as part of the contracting process:

- Business licenses, necessary registrations, permits, and approvals;
- Proofs of having a Labor management system in place, including OHS-related management systems and associated procedures, templates and forms;
- Qualifications and certifications of Labor management, safety and health personnel;
- Certifications, necessary permits and training qualifications of workers, who will perform the required work;
- Records of safety and health violations and responses (corrective and preventive measures);
- Identification of safety committee members and records of meetings, as seen appropriate by the project management, to the nature of goods and services to be rendered; and

- Copies of similar engagement with other employers, showing adequate experience and compliance with sensitive work issues, such as, child Labor, forced Labor, GBV/SEA/SH, OHS, and others, as required by the provisions of ESS2 (all except paras. 34-38).

The MoH GMU and ICS will ensure that the requirements of the Environmental and Social Standard (ESS2) on Labor and working conditions and non-compliance remedies are incorporated into the Contractors' contractual agreements. Construction contractors will be required to develop and sign a contractors' CESMP that will also include issues of GBV/SEA/SH, child and forced Labor, child protection and accessibility of GRM at contractor's worksite, OHS, as well as a specific worker code of conduct. Similarly, MoH GMU and ICS will ensure that issues concerning subcontracting are done with the written consent of the relevant public health inspectorates of MoH, as well as Labor inspectorates of the MoLS.

11.2 Managing and Monitoring Performance

The MoH GMU and ICS will manage and monitor the performance of contractors in relation to contracted workers, focusing on compliance by contractors with their contractual agreements (obligations, representations, and warranties) and Labor management procedures. The MoH GMU, ICS, RHBs and EPSA E&S staff will undertake due diligence assessment of the engaging contractors on their Labor practices and adherence to the national law, the Environmental and Social Management Framework (ESMF), the ESS2 provisions, and to these LMPs. This will include periodic audits and spot-checks on project locations as appropriate. Specifically, the MoH GMU, ICS, RHBs and EPSA E&S staff will look how the following obligations are fulfilled by the Contractors:

- *Labor conditions*: records of workers engaged under the Project, including sample contracts, registry of induction of workers, and working hours' logs;
- *Workers*: number of workers, indication of origin (expatriate, local, nonlocal nationals), gender, age with evidence that no child Labor is involved, and skill level (unskilled, semiskilled, skilled, supervisory, professional, managerial);

- *Training/induction*: dates, number of trainees and topics, records on training provided for contracted workers that were tailored to educate workers on occupational health and safety risks and applying corrective and preventive measures;
- *Incidents and safety*: records of incidents, such as, lost time incidents, medical treatment cases, first aid cases, remedial and preventive activities taken, as well as reports relating to safety inspections, including fatalities and incidents and implementation of corrective actions, records relating to incidents of non-compliance with national law;
- *Details of any security risks*: details of the risks the Contractors may be exposed to, while performing their work—the threats may come from third parties, external to the project; and
- *Worker grievances*: details including occurrence date, grievance description, and date submitted; actions taken and dates; resolutions/referrals (if any) and progress dates; and follow-up yet to be taken. Grievances listed should include those received since the preceding report and those that were unresolved at the time of preparing the new report.
- *OHS Monitoring:* details include monitoring of requirements outlined in the OHS plan. Indicators to be monitored and frequency of monitoring will be outlined in the OHS plan.

In ensuring that there is compliance with the requirements of ESS2 by service providers, the IPF component project will regularly monitor and evaluate activities of contractors in line with the project's M&E framework. The project will also ensure that there is a comprehensive and continuous awareness raising among workers, about their entitlements. The ICS, RHBs and EPSA subsequently will provide regular reports (on monthly, quarterly and annual basis) regarding the performance of the contractors to the MoH GMU which then will be compiled together and reported to the office of the state Minister.

11.3 Accessing Worker GRM by third party workers

Where third parties are engaged in the project (e.g., UNICEF as third party implementer), the MoH GMU will ensure that these parties report regularly on concerns raised by their workers, and how their grievances were resolves. These requirements will be included in the third party's terms and conditions. However, in case the third party doesn't possess any dedicated worker grievance mechanism, the MoH GMU will ensure this project's worker GRM included in the

third party's agreement, and that it is used accordingly during the course of the contract period. As a result, the MoH GMU will communicate back all concerns received by the workers of the third party to the attention of their respective employers for resolution. Similarly, these requirements will be included in the terms and conditions.

12 Primary Supply Workers

It is expected that sub-project activities will entail the engagement of primary supply workers such as those provide medicine and medical supplies, lab and other equipment, operate trucks and vehicles, etc.

When sourcing for primary suppliers, the project will require such suppliers to identify the risk of child labor/forced labor and serious safety risks. The MoH GMU will review and approve the purchase of primary supplies from the suppliers following such risk identification/assessment. Where appropriate, the project will be required to include specific requirements on child labor, forced labor and work safety issues in all purchase orders and contracts with primary suppliers. The MoH GMU will, as part of its monitoring, include indicators for assessing the functions of primary supply workers.

In cases where contractors purchase materials from suppliers, contractors shall be required to carry out due diligence procedure to identify if there are significant risks that the suppliers are exploiting child or forced labor or exposing worker to serious safety issues. If there are any risks related to child and forced labor, and safety identified, the Contractor will notify MoH GMU and will address these risks and may avoid such suppliers, where possible.

13 Disclosure

These Labor Management Procedures will be approved by the GoE and WB and disclosed locally with translation into Amharic and the Working Languages of the respective Regional States and City Administrations. These LMPs will be disclosed on the MoH website and through the World Bank's external website.

14.Annexes

Annex I: Sample of a contractors Code of Conduct

AIM OF THE CODE OF CONDUCT

The main aim of the Code of Conduct is to prevent and/or mitigate the social risks within the context of project interventions for the IDRMP. The Codes of Conduct are to be adopted by contractors.

KEY DEFINITIONS

The following definitions apply:

Gender-Based Violence (GBV) This is defined as any conduct, comment, gesture, or contact perpetrated by an individual (the perpetrator) on the work site or in its surroundings, or in any place that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to another individual (the survivor) without his/her consent, including threats of such acts, coercion, or arbitrary deprivations of liberty.

Violence Against Children (VAC) This may be defined as physical, sexual or psychological harm of minor children (i.e. under the age of 18), including using for profit, labor, sexual gratification, or some other personal or financial advantage. This also includes other activities such as using computers, mobile phones, or video and digital cameras appropriately, and never to exploit or harass children or to access child pornography through any mediums.

Child Labor This involves employment of underage. Any person under the age of 18 should not be employed in the project sites.

Child Protection (CP) An activity or initiative designed to protect children from any form of harm, particularly arising from VAC, and child labor.

Child The word is used interchangeably with the term 'minor' and, in accordance with the United Nations Glossary on Sexual Exploitation and Abuse, refers to a person under the age of 18.

Grooming This is defined as behaviors that make it easier for a perpetrator to procure a child for sexual activity. For example, an offender might build a relationship of trust with the child, and then seek to sexualize that relationship (for instance by encouraging romantic feelings or exposing the child to sexual concepts through pornography).

Online Grooming This is the act of sending an electronic message with indecent content to a recipient who the sender believes to be a minor, with the intention of procuring the recipient to

engage in or submit to sexual activity with another person, including but not necessarily the sender.

Perpetrator This is defined as the person(s) who commit(s) or threaten(s) to commit an act or acts of GBV, VAC, and child labor.

Work site This is defined as the area in which infrastructure development works are being conducted, as part of interventions planned under the ETUSNJP, funded by the World Bank.

Work site surroundings These are defined as the 'Project Area of Influence' which is any area, urban or rural, directly affected by the project, or located within the distance of three kilometres' radius from the work site and/or worker's camps, including all human settlements found on it.

Consent This word is defined as the informed choice underlying an individual's free and voluntary intention, acceptance, or agreement to do something. No consent can be found when such acceptance or agreement is obtained through the use of threats, force or other forms of coercion, abduction, fraud, deception, or misrepresentation. Any use of a threat to withhold a benefit, or of a promise to provide a benefit, or actual provision of that benefit (monetary and non-monetary), aimed at obtaining an individual's agreement to do something, constitutes an abuse of power; any agreement obtained in presence of an abuse of power shall be considered non-consensual. In accordance with the United Nations, the World Bank considers that consent cannot be given by children under the age of 18, which is consistent with the legislation of the country. Mistaken belief regarding the age of the child and consent from the child is not a defence.

Contractor This is defined as any firm, company, organization or other institution that has been awarded a contract to conduct infrastructure development works in the context of the ETUSNJP and has hired managers and/or employees to conduct this work.

Manager The word is used interchangeably with the term 'supervisor' and is defined as any individual offering labor to the contractor, on or off the work site, under a formal employment contract and in exchange for a salary, with responsibility to control or direct the activities of a contractor's team, unit, division or similar, and to supervise and manage a pre-defined number of employees.

Employee This is defined as any individual offering labor to the contractor on or off the work site, under a formal or informal employment contract or arrangement, typically but not necessarily in exchange for a salary (e.g. including unpaid interns and volunteers), with no responsibility to manage or supervise other employees.

Workers Committee

A team established by the Contractor to address GBV, VAC, child labor and other relevant issues with the work force.

Contractors Code of Conduct

Contractors are obliged to create and maintain an environment which prevents social risks. They have the responsibility to communicate clearly to all those engaged on the project the behaviors which guard against any form of abuse and exploitation. In order to prevent social risks, the following core principles and minimum standards of behavior will apply to all employees without exception:

1. GBV or VAC constitutes acts of gross misconduct and are therefore grounds for sanctions, penalties and/or termination of employment and/or contract. All forms of social risks including grooming are unacceptable be it on the work site, the work site surroundings, or at worker's camps of those who commit GBV or VAC will be pursued.
2. Treat women, children (persons under the age of 18) and people with disability with respect regardless of race, color, language, religion, political or other opinion, national, ethnic, cultural beliefs/practices, or other status.
3. Do not use language or behavior towards men, women or children that is inappropriate, harassing, abusive, sexually provocative, demeaning or culturally inappropriate.
4. Sexual activity with children/learners under 18 (including through digital media) is prohibited. Mistaken belief regarding the age of a child and consent from the child is not a defence.
5. Exchange of money, employment, goods, or services for sex, including sexual favors or other forms of humiliating, degrading or exploitative behavior is prohibited.
6. Sexual interactions between contractor's employees and communities surrounding the workplaces that are not agreed to with full consent by all parties involved in the sexual act are prohibited (see definition of consent above). This includes relationships involving the withholding, promise of actual provision of benefit (monetary or non-monetary) to community members in exchange for sex.
7. Where an employee develops concerns or suspicions regarding acts of GBV or VAC by a fellow worker, whether in the same contracting firm or not, he or she must report such concerns in accordance with established Grievance Redress Mechanism (GRM) that protects the identities of victims and whistle-blowers.
8. All contractors are required to attend an induction prior to commencing work on site to ensure they are familiar with the social risks and Codes of Conduct.
9. All employees must attend a mandatory training once a month for the duration of the contract starting from the first induction prior to commencement of work to reinforce the understanding of the institutional social risks and Code of Conduct.
10. The Contractor shall ensure provision of financial resources and support compliance to occupation health and safety requirements for all workers.
11. The Contractor shall ensure that workers dress appropriately i.e. dress in a way that:-

- Is unlikely to be viewed as offensive, revealing, or sexually provocative.
- Does not distract, cause embarrassment or give rise to misunderstanding
- Is absent of any political or otherwise contentious slogans • Is not considered to be discriminatory and is culturally sensitive

12. The Company shall ensure provision of financial resources and trainings to prevent spread of HIV and AIDS.
13. Contractors should provide all necessary PPE and ensure EHS at workplace and give regular Health and safety training to workers
14. The company shall comply with the national, international labor laws and all applicable laws.
15. All contractors must ensure that their employees sign an individual Code of Conduct confirming their agreement to support prevention of social risks activities.
16. The contractor should ensure equitable access to limited natural resources (e.g. water points) to avoid conflicts with local communities

16. Where possible, the contractor should ensure employment of local workforces especially where unskilled labor is required to mitigate social risks I do hereby acknowledge that I have read the foregoing Code of Conduct, do agree to comply with the standards contained therein and understand my roles and responsibilities. I understand that any action inconsistent with this Code of Conduct or failure to take action mandated by this Code of Conduct may result in termination of the contract.

x

FOR THE CONTRACTOR

Signed by: _____

Signature: _____

Title: _____

Date: _____

Signed by: _____

Signature: _____

Date: _____

Annex II: Workers Code of Conduct

I, _____, acknowledge that preventing any misconduct as stipulated in this code of conduct, including gender-based violence (GBV), child abuse/exploitation (CAE) are important. Any activity, which constitute acts of gross misconduct are therefore grounds for sanctions, penalties or even termination of employment. All forms of misconduct are unacceptable be it on the work site, the work site surroundings, or at worker's camps. Prosecution of those who commit any such misconduct will be pursued as appropriate.

I agree that while working on this project, I will:

1. Consent to security background check;
9. Treat women, children (persons under the age of 18) and persons with disability with respect regardless of race, color, language, religion, political or other opinion, national, ethnic or social origin, property, birth or other status;
10. Not use language or behavior towards men, women or children/learners that is inappropriate, harassing, abusive, sexually provocative, demeaning or culturally inappropriate;
2. Not participate in sexual activity with children/learners—including grooming or through digital media. Mistaken belief regarding the age of a child and consent from the child is not a defence;
3. Not exchange money, employment, goods, or services for sex, with community members including sexual favours or other forms of humiliating, degrading or exploitative behavior;
11. Not have sexual interactions with members of the communities surrounding the work place, worker's camps and fellow workers that are not agreed to with full consent by all parties involved in the sexual act (see definition of consent above). This includes relationships involving the withholding, promise of actual provision of benefit (monetary or non-monetary) to community members in exchange for sex - such sexual activity is considered "non-consensual" within the scope of this Code;
12. Attend trainings related to HIV and AIDS, GBV/SAE, occupational health and any other relevant courses on safety as requested by my employer;
13. Report to the relevant committee any situation where I may have concerns or suspicions regarding acts of misconduct by a fellow worker, whether in my company or not, or any breaches of this code of conduct provided it is done in good faith;
14. Regarding children (under the age of 18):

- Not invite unaccompanied children into my home, unless they are at immediate risk of injury or in physical danger.
- Not sleep close to unsupervised children unless necessary, in which case I must obtain my supervisor's permission, and ensure that another adult is present if possible.
- Refrain from physical punishment or discipline of children.
- Refrain from hiring children for domestic or other labour, which is inappropriate given their age, or developmental stage, which interferes with their time available for education and recreational activities, or which places them at significant risk of injury.
- Comply with all relevant local legislation, including labour laws in relation to child labour.

15. Refrain from any form of theft for assets and facilities including from surrounding communities.
16. Remain in designated working area during working hours;
17. Refrain from possession of alcohol and illegal drugs and other controlled substances in the workplace and being under influence of these substances on the job and during workings hours;
18. Wear mandatory PPE at all times during work;
19. Follow prescribed environmental occupation health and safety standards;
20. Channel grievances through the established grievance redress mechanism.

I understand that the onus is on me to use common sense and avoid actions or behaviours that could be construed as misconduct or breach this code of conduct.
I acknowledge that I have read and understand this Code of Conduct, and the implications have been explained with regard to sanctions on-going employment should I not comply.
Signed by: _____
Signature: _____
Date: _____

FOR THE EMPLOYER
Signed by: _____
Signature: _____
Date: _____

ANNEX XVII: SOCIAL ASSESSMENT

ACRONYMS AND ABBREVAIATION

ANC	Antenatal Care
CERC	Contingent Emergency Response Component
CPR	Contraceptive Prevalence Rate
CR	Civil Registration
CRVS	Civil Registration and Vital Statistics
CIARP	Ethiopia Conflict Impact Assessment and Recovery and Rehabilitation Plan
EDHS	Ethiopian Demographic and Health Survey
EHRC	Ethiopian Human Rights Commission
EHS	Essential Health Service
EHSG	Environmental, Health, and Safety Guidelines
EPHI	Ethiopian Public Health Institute
ESF	Environmental and Social Framework
RDR	Repetition and Dropout Rate
ESSs	Environmental and Social Standards
GBV	Gender-Based Violence
GoE	Government of Ethiopia
GPI	Gender Parity Index
GPN	Good Practice Note
HCs	Health Centers
HEP	Health Extension Program
HPs	Health Posts
HSDP	Health Sector Development Program
HSTP	Health Sector Transformation Plan
HUCs	Historically Underserved Communities
HUCP	Historically Underserved Community Plan
HUCPF	Historically Underserved Community Planning Framework
ICS	Immigration and Citizenship Service

IDA	International Development Association
IDPs	Internally Displaced Peoples
IPF	Investment Project Financing
JCCC	Joint Core Coordinating Committee
JCF	Joint Consultative Forum
LMP	Labor Management Procedures
MoH	Ministry of Health
NER	Net Enrolment Rate
OHS	Occupational Health and Safety
PCSRs	Project's Contextual Security Risks
PforR	Program for Results
PHC	Primary Health Care
PLW	Pregnant and Lactating Women
PNC	Postnatal Care
PPD	Policy Planning Directorate in the Ministry of Health
RBoWCA	Regional Bureau of Women and Children Affairs
RCRVSA	Regional Civil Registration and Vital Statistics Agency
RHBs	Regional Health Bureaus
RMNCAH+N	Reproductive, Maternal, Neonatal, Child, and Adolescent Health Plus Nutrition
RWSBs	Regional Women and Social Affairs Bureaus
SA	Social Assessment
SDGs	Sustainable Development Goals
SEA	Sexual Exploitation and Abuse
SEP	Stakeholder Engagement Plan
SGBV	Sexual and Gender-Based Violence
SH	Sexual Harassment
TFR	Total Fertility Rate
TRS	Traffic and Road Safety
U-5	Under Five Children

VGs	Vulnerable Groups
VS	Vital Statistics
UCs	Underserved Communities
UNOHCHR	Office of the United Nations High Commissioner for Human Rights
WB	World Bank
WHOs	Woreda Health Offices
WWSAOs	Woreda Women and Social Affairs Offices

EXECUTIVE SUMMARY

CHAPTER 1: INTRODUCITON

Project Background

In Ethiopia there is an urgent need to support the health system that resulted from the devastation of the conflicts in different parts of the country. Specially, the war in the northern Ethiopia that broke out in Tigray on November 04, 2020 and escalated into Amhara and Afar regions with active war for two years resulted in a huge damage and looting to health facilities and infrastructure that halted PHC services. This Social Assessment (SA) focuses on the IPF Sub-components that will support the provision of health and nutrition services as well as medicines, medical consumables, equipment, and conflict-related health emergency response plan to ensure access in conflict-affected areas and IDP settings.

The IPF Sub-components

The IPF program interventions have four sub-components. With the need to address the emerging issues as a result of the conflict in the country, the IPF sub-components have been updated in November 2021(during pre-appraisal). The update added sub-component one that aims to address the emergency situation in conflict affected areas of the country. Accordingly, IPF Sub-component I support provision of EHS focusing on Reproductive, Maternal, Neonatal, Child, and Adolescent Health plus Nutrition (RMNCAH+N); IPF Sub-component II supports CRCS; IPF Sub-component III provides technical assistance and capacity building; and IPF Sub-component IV aims to improve the country emergency response.

IPF Program Target Areas

The IPF program targets the conflict-affected areas in Ethiopia. Specifically, the SA covers the situation in Tigray, Afar, Amhara, Oromia, and Benishangul-Gumuz regional states. These are where close to 24 million people have been adversely impacted in term of access to Essential Health Services and an estimated 5.7 million people were forcibly displaced due to conflict. The impact of the conflict has been critical for Tigray, Afar and Amhara regions where 80.4%, 70% and 39.6% of the total population lacked access to PHC service, respectively.

Project Beneficiaries

IPF program is expected to benefit population in conflict-affected areas. The direct beneficiaries are women, newborns, children, and adolescents in the conflict-affected areas. **T**he findings of the SA analyzed that the conflict has strained the health system, worsened maternal, child health and nutrition outcomes, and crippled delivery of basic and emergency health services in the conflict-affected areas.

The Key Implementing Agencies for the IPF Component of SPHCP

The MoH is the main agency responsible for the implementation of the EHS to conflict-affected areas (IPF sub-component I) and Contingent Emergency Response (IPF Sub-component IV). Immigration and Citizenship Service (ICS) is responsible for the implementation of CRVS activities (IPF sub-component II). The implementation of the IPF Sub-component III is the joint responsibility of the MoH and ICS.

CHAPTER 2: OBJECTIVES AND METHODOLOGY OF THE SOCIAL ASSESSMENT

Objectives of the Social Assessment

The objectives of the SA are to: review national and World Bank legal frameworks pertinent to the project, describe the social and economic characteristics of the project affected persons/population and provide the baseline information for designing the social development strategy, and identify potential social risks and

impacts from the implementation of the IPF Sub-components that may trigger World Bank Environmental and Social Standards and finally to propose mitigation measures for the identified risks and impacts .

Methodology

The preparation of the SA depends on the use of both primary and secondary methods of data collection. As the primary sources: (a) clan leaders, elders, religious leaders and women were consulted to consider the views and special concerns of the project-affected HUCs; (b) separate interview was arranged for vulnerable groups including Pregnant and Lactating Women (PLW), returnee IDPs, women, people with chronic illnesses including the elderly, and people with disabilities to ensure that their views are obtained and their special needs factored into the social assessment; and (c) officials and expertise from the organizations for the disadvantaged or vulnerable groups including Ministry of Women and Social Affairs and the line regional bureau and woreda office were interviewed to assess their views and concerns on behalf of disadvantaged or vulnerable groups. The use of secondary sources involve the review of: (a) IPF program related documents with aim to provide program background information, and development objective and components; (b) national legislations and policies and the World Bank's Environmental and Social Framework pertinent to the IPF project, as well as the broader institutional context within which the project takes place; and (c) available health sector assessments and empirical studies were reviewed to describe the socio-cultural, institutional, historical, and political contexts in which the proposed IPF project operates.

CHAPTER 3: POLICY, LEGISLATIVE, REGULATORY AND INSTITUTIONAL FRAMEWORK

National Policies and Legal Frameworks

Article 89 of the Ethiopian Constitution recognizes that there are historical, political, social, and economic factors contributing to the unequal development opportunities in Afar, Benishangul-Gumuz, and parts (Borena and Guji Zones) of Oromia. Given this fact, Article 89 of the Constitution incorporates the legal provisions for the IPF program that requite the existing uneven development opportunities in the Historically Underserved Regions. Underpinning this Constitutional provision, the Ethiopian Health Sector Development Program I, II, III and IV (1997–2015) and Health Sector Transformation Plan I and II (2015-2025) provides a comprehensive national policy framework for the proposed IPF program interventions. The review includes specific national strategies and programs enacted to materialize the mission, objectives and strategic directions issued in a comprehensive national policy framework.

Applicable World Bank Environmental and Social Standards (ESSs)

Out of the ten ESSs set out in the World Bank's ESF, ESS1 and ESS7 are applicable to the requirement of the Social Assessment. ESS1 sets out the MoH's responsibilities for assessing, managing, and monitoring social risks and impacts associated with the Sub-components I and II of the IPF project. Once the potential risks and impacts are assessed and identified, ESS1 requires the MoH implementing mitigation hierarch before the activities of the Sub-components I and II commence: (a) anticipate and avoid risks and impacts; (b) where avoidance is not possible, minimize or reduce risks and impacts to acceptable levels; (c) once risks and impacts have been minimized or reduced, mitigate; and (d) where significant residual impacts remain, compensate for or offset them, where technically and financially feasible. The applicability of the ESS7 concerns the project-affected pastoral and agro-pastoral communities in Afar, Benishangul-Gmuz, and parts (Borena and Guji) of Oromia. These are recognized as a distinct social and cultural group as per the defining features given in paragraph 8 the ESS7. The provisions of the ESS7, therefore, establish the requirements for the MoH to assess, manage, and monitor and evaluate the disproportionate social risks and impacts on Historically Underserved

Communities (HUCs)[53] associating with the implementation of Sub-components I and II of the proposed IPF project.

CHAPTER 4: STAKEHOLDER CONSULTATION AND ENGAGEMENT IN THE SOCIAL ASSESSMENT

Objectives of the stakeholder consultation

The objectives of the stakeholder consultation in the social assessment are to: develop a list of project-affected and other interested parties for stakeholder consultation and engagement; disclose project information to allow stakeholders to understand the risks and impacts of the project, and potential opportunities. Making available project-related information as early as possible in the project cycle and in a manner, format, and language appropriate for each stakeholder group; undertake a process of meaningful consultation in a manner that provides stakeholders with opportunities to express their views on potential project risks and impacts and allows MoH to consider and respond to them through designing appropriate mitigation measures; accommodate the views and circumstances of different stakeholders, paying special attention to the concerns and special needs of the disadvantaged or vulnerable individuals or groups. It takes into account the different access and communication needs of various groups and individuals, especially those more disadvantaged or vulnerable, including consideration of both communication and physical accessibility challenges; and provides the social baselines and inputs for the preparation of ESMF, RF, SMP, SEP and GBV Risk Assessment, Prevention and Response Action Plan.

IPF project-related information disclosure

As required in ESS10, meaningful stakeholder engagement depends on timely, accurate, accessible, and comprehensible information. Therefore, making available project-related information as early as possible in the project cycle and in a manner, format, and language appropriate for each stakeholder group is important. As part of this early project information disclosure, before directly jumping to consultation, stakeholders were provided with relevant IPF project-related information: (a) the purpose, scale, and duration of the project; (b) IPF Sub-components and the nature of the proposed activities under each Sub-component; (c) potential IPF project benefits and opportunities; (d) potential risks and impacts of the project on local communities, and the proposals for mitigating these; (f) the proposed stakeholder engagement process highlighting the ways in which stakeholders can participate; and (g) the process and means by which grievances can be raised and will be addressed.

Framework to engage with HUC

The framework to engaging with HUCs in general adopts a meaningful consultation tailored to HUCs. That is: (a) approaches to meaningful consultation are most effective when they build on existing customary institutions and decision-making processes utilized by the project-affected HUCs; (b) the consultation with the IPF project-affected HUCs is conducted in a gender-inclusive manner, so that the interests of both genders are considered in all aspects of project planning and implementation; (c) there may be divergent views and

[53]ESS7 (paragraph 6) acknowledge that the use of the terminology to refer to Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities (IP/SSAHUTLCs) may varies widely from country to country. For instance, the use of the terminology IP/SSAHTLCS is not preferred by the Government of Ethiopia (GoE). To adhere to the preference of the Go and as per the direction given during the meeting of the Social Safeguard Team held on October, 2022 at Skylight Hotel, the term Historically Underserved Communities (HUCs) is used in this social assessment instead of IP/SSAHUTLCs.

opinions within the project-affected HUCs and a meaningful consultation takes into account these different viewpoints and opinions while respecting traditional cultural approaches to consultations and decision making; and (d) in addition to those general requirement set out in ESSs 1 and 10, the MoH will obtain Free Prior Informed Consent (FPIC) of the affected HUCs.

Summary of stakeholders' consultation on IPF project: Views, concerns and responses given

Interviewed officials/expertise and community consultation participants alike expressed their feeling of appreciation and thankful about the proposed IPF project interventions focusing on the special needs of conflicted affected areas and vulnerable individuals and groups. Given the critical health problems owing to a huge damage to health facilities in conflict, all the participants in the consultation invariably felt even the delay of the proposed IPF project interventions. However, both the officials/expertise and community members in the consultation raised their concerns on how the project shall be promptly and effectively implemented. Responses were given on these concerns that the World Bank is highly committed in providing technical assistance in conducting the environmental and social assessment and preparation of the required E&S management plans for speedily project disbursement. Besides, the proposed institutional and implementation arrangements for the effective execution of the project were discussed with the participants.

One of the key issues emphasized by the participants of community consultation and interviewed community representatives raised in relation with project land acquisition for the civil works under the IPF Sub-component I. The participants expressed that the proposed PHC interventions through the reconstruction of conflict-damaged health facilities and establishment of temporary or satellite clinics at IDP Camps are of top priority for the local communities and the project land acquisition for these purposes are welcomed in this respect. But, the consulted members of local community consistently raised the major concern regards what measures will be put in place by the project to address the risks and adverse impacts associating with involuntary resettlement. Responding to this concern, participants were informed that the project will prepare and implement an RF and RAPs/LRPs to guide the resettlement and compensation process.

Justifying the special circumstances and needs they have, members of vulnerable groups and historically underserved communities approached through a separate interview expressed their serious concerns on how the IPF project implementation will overcome the social, cultural, and economic constraints with disproportionate impacts on them. Response was given highlighting the potential risks and impacts that might disproportionately affect vulnerable and disadvantaged groups, and describing the differentiated measures taken to avoid or minimize these including deployment of mobile health and CRVS teams, preparation of Underserved Community Plan, and establishment of temporary or satellite clinics to reach out to the special needs of vulnerable groups and HUCs. Participants' expression of acknowledgement for the differential mitigation measures proposed in the IPF project concludes on the concerns of the members of vulnerable groups and HUCs.

CHAPTER 5: KEY FINDINGS OF THE SOCIAL ASSESSMENT AND CONSULTATION

Socio-economic and Demographic Baseline Information

According to the 2007 Population and Housing Census: in Tigray region, the overwhelming majority (96.6%) of population is ethnic Tigray and 95.6% people were Orthodox Christian; in Amhara region, 91.5% of the total population is ethnic Amhara and 82.5% of the total population belong was Orthoxox Christian; the overwhelming majority (88.7%) of the population in Afar region belongs to the Afar ethnic group and 93.83% of the population adhere to Muslim religion; in Oromia region, 87.8% of the total population make-up ethnic

Oromo and Muslim, Orthodox and Protestant Christianity comprised 47%, 30.5%, and 18%, respectively; and Benishangul-Gumuz is a region with more ethnic diversity, the Berta (25 .9 %), Gumuz (23.3%), Shinasha (7.6%), Mao (1.9%), Komo (0.96%), Amhara (22.1 %) and Oromo (8.93%).

Description of the Socio-cultural, Institutional, Historical and Political Context

Social Organization: The agricultural-based communities in Tigray, Amhara and Oromia regions share the same system; the social networks through kinship and lineage provide the bases for social organization. In contrast, clan system is the most important form of social organization among the agro-pastoral and pastoral communities in Afar, Borena, Guji, and Benishangul-Gumuz.

Institution: Common to all the IPF project-affected communities, the roles and practice of informal institutions that are constituted by conventions, norms, values and accepted ways of doing things, whether people's everyday economic, political or social lives dominate over formal institutions. Traditional conflict resolution mechanism, the system of household property ownership, control and decision making, and the system of social diversity and gender relations are all reflecting the wider acceptance and effectiveness of informal institutions over the formal institutions.

Livelihood activities: The project target areas are characterized by diverse livelihood activities: pastoralism, agro-pastoralism, agriculture, and non-agricultural occupation. The implementation of the IPF program can be affected based on the kind of livelihood practiced in specific project target region, zone or woreda. The ways for PHC delivery and CRVS can be significantly affected whether the project target communities are mobile pastoralist or sedentary agriculturalist.

Vulnerable and Disadvantaged Groups

People are the reason for and the means of development. Their cultures, societies, and organizations provide the foundation on which development programs such as the IPF project rest. Likewise, the varied needs, aspirations, beliefs, and expectations of the people are among the factors that influence the implementation of development projects. Backdrop to this, Pregnant and Lactating Women (PLW), newborns, under-five children, Internally Displaced People (IDPs), women and girls in general, the elderly, people with disabilities, and HUCs comprised vulnerable individuals and groups. These are targeted as the direct project beneficiaries. Because the findings of the SA reveal that, these are individuals and groups with special needs and, thus, more likely to be adversely affected due to the disruption of EHS services as the consequences of conflict. Also, these individuals and groups are those who more limited than others in their ability to take advantage of the IPf project's benefits.

Access to Basic Services in the Program Target Regions

Achieving Primary Health Care (PHC) is not just the availability of health facilities. Rather, it is inevitably interrelated to and understood as the outcome of access to other basic services including drinking water, education, sanitation and hygiene, and electricity. Contrary to this, findings of the SA reveals that the IPF project target regions are areas with the least access to basic services compared to the national average even prior to conflict or without the impacts of conflict. Consequently, the already poor PHC services are getting worsened or totally halted following the impacts of conflict.

CHAPTER 6: INSTITUTIONAL AND IMPLEMENTING ARRANGEMENTS FOR THE IPF PROJECT

At the Federal Level

The MoH: It is the main agency responsible for the implementation of the EHS to conflict-affected areas (IPF sub-component I) and Contingent Emergency Response (IPF Sub-component IV). Following the nationwide health sector reform, MoH has seven functional Directorates established based on their functions, under the Office of the Minister and the State Ministers. These functional Directorates are responsible for: the overall fiduciary arrangement of the IPF Program and reporting funds under the IPF operation; guiding, implementing, monitoring and evaluating the environmental and social performance of the IPF program; supporting regions in systems development and developing health sector programs aligned with national plans and goals; and mobilize additional resources to improve service delivery and creates platforms for mutual accountability, information flow, and efficient use of resources.

Immigration and Citizenship Service (ICS): It is responsible for the implementation of CRVS activities (IPF sub-component II). The ICS management will provide overall strategic guidance for the implementation of the IPF Sub-component II. Also, ICS will develop a budgeted annual work plan for the activities of the IPF Sub-component II to be submitted to the World Bank for its no objection. Accordingly, it will produce a quarterly financial reports and annual audit reports. The implementation of the IPF Sub-component III is the joint responsibility of the MoH and ICS.

At the Regional Level

MoH-RHBs Joint Steering Committee: The MoH-RHBs Joint Steering Committee is a forum that brings together the Ministry of Health and the Regional Health Bureaus. The meeting is chaired by the Minister of Health, and the participants include the State Ministers of Health, Regional Health Bureau Heads and heads of departments/services of the Ministry and the RHBs. The Committee shall meet every two months. The basic objective of this forum is to facilitate the effective and smooth implementation of the IPF program priority issues. This is done by bridging communication gaps between the two levels; by improving internal harmonization and coordination; by closely monitoring progress and problems at the operational level and by taking joint corrective measures.

Establish ICS-RCRVSAs Joint Steering Committee: A technical committee will be established to provide support on technical issues in the implementation of the CRVS at the regional level. Among other responsibilities, the committee will monitor and evaluate the implementation of the CRVS in the respective IPF project target regions; facilitate exchange of information on best practices; provide technical advice on activities of the project; and make recommendations for consideration by the CRVS federal steering committee.

At the Woreda Level

Establish Woreda PHC Task Force: One of the institutional gaps reveal in the finding of the social assessment is lack of IPF project implementing arrangements at the woreda level. Therefore, it is recommended to establish respective Woreda PHC Task Force comprising the heads of the Woreda Health Office, Women and Children Affairs Office, Land Use and Administration Office, Peace and Security Office, CEOs of the respective health centers and primary hospital, and representatives of local community and vulnerable groups. The main responsible of this Task Force is to monitor the day-to-day performance of the PHC service provision at the grassroots, respective woreda, health facilities, and IDP camps. The Task Force will be chaired

by the respective head of Woreda Health Office and will have a regular communication with the respective RHBs for administrative measures.

Deploy Woreda CRVS Focal Person: Another finding of the social assessment is that ICS the main agency responsible for IPF Sub-component II has no institutional structure at the woreda or kebele levels. Whereas, these are the lower government structures where the CR is entirely done. Therefore, it is strongly recommended to deploy a Woreda CRVS Focal Person that coordinate day-to-day CRVS activities at the grassroots level (woreda or kebele) and communicate monitoring report with the RCRVSA.

The SA also assessed numerous capacity gaps and forwarded key recommendation to enhance the existing institutional and implementing arrangements. See chapter 6 for details.

The implementation of IPF program in Tigray region

The health system and facilities in Tigray region are not fully under the administrative reach of the MoH due to the security concerns and other restrictions following the war in the north. Thus, the monitoring of the IPF program in Tigray region will be conducted through a third-party implementing agency (TPIA). As per the agreement with MoH and MoF, UNICEF Ethiopia Country Office will take the responsibilities as a third party for the implementation, monitoring and reporting of the overall performance of the IPF program in Tigray region.

CHAPTER 7: IPF PROJECT-SPECIFIC GRM

IPF project-specific GRM will be designed based on an understanding of the issues that are likely to be the subject of concerns and grievances. Grievance about the IPF project may arise for different reasons. How the IPF project responds when grievances surface is important and can have significant implications for the overall implementation of the project. Thus, key considerations in the design of the project GRM include: accessible and inclusive GRM, grievance submission method, registration of grievances, response time and transparency matters, gender-sensitive, grievance reporting mechanism. The World Bank Grievance Service will also be accessible. Complaints may be submitted at any time after concerns have been brought directly to the Bank's attention and Bank Management has been given an opportunity to respond.

CHAPTER 8: POTENTIAL SOCIAL BENEFITS, RISKS AND MITIGATION MEASURES

Potential Social Benefits

Potential social benefits resulting from undertaking of the IPF Sub-component I include: improved access to pharmaceuticals and medical devices and their rational and proper use; improved access to Antenatal Care (ANC) and reduced number of material health risks during pregnancy; improved access to Postnatal Care (PNC) and reduced number of postnatal maternal and neonatal deaths; improved access to child health and reduced number of child mortality; improved nutritional status of children and prevent contributing factors to child mortality; improved access to and use of family planning and reduced number of maternal mortality from unwanted pregnancies, unsafe abortion and shorter birth spacing; and equitable PHC service delivery to vulnerable groups and Historically Underserved Regions and Communities. In line with the implementation of IPF Sub-component II, expected social benefits are: improved system and management of CRVS; enhanced application and use of CRVS data; and improved inter-agency cooperation and applications of CRVS. Backdrop to this, the table below summarized the social benefits as the result of the implementation of the Sub-components of the IPF project. IPF Sub-component III will enhance the overall performance of the institution and project workers through technical assistance and capacity building.

Potential social risks and proposed mitigation measures

In line with the potential project social risks identified based on the Social Assessment, the Matrix in the below table presents specific social management plan (either stand alone or as incorporated into the ESCP) that details: (i) the measures to be taken during the implementation and operation of the IPF project to eliminate or offset adverse social impacts, or to reduce them to acceptable levels; and (ii) the actions needed to implement these measures. As the differentiated measures are integrated into the project design and implement the adverse impacts do not fall disproportionately on the disadvantaged or vulnerable groups. The Social Development Plan will be continuously updated during the life of the program.

Components/ Issues	Potential Social Risks, Impacts and Challenges	Mitigation Measures	Responsible Body	Budge	Timeline
IPF Sub-component I: *Provision of EHS Focusing on RMNCAH+N to Conflict-Affected population and IDPs (US$89 million IDA equivalent)*	Child labour or employing children under the minimum age in the civil works of the project. Inherent push factors in the project areas include the existence of large number of children out of school, extreme household poverty or loss of household livelihood due to conflict.	• The project's LMP specify the minimum age for employment or engagement in connection with the project as the age specified in national law or in ESS2 (the age of 14), whichever is higher. • Verification of age prior to employment of the project workers by requesting the applicant to provide a legal confirmation such as birth certificate, Kebele ID Car, school certificate, or other official documents demonstrating age. • Document the personal records of the project workers for official inspection. • Sudden inspection by the project Social Safeguard Specialist or local implementing partner (Woreda Women and Children Affairs). If a child under the minimum age is discovered working on the project, terminate the employment of the child. The project LMP incorporate the requirement to terminate the engagement with the Contractors violating the rule.	-Project Social Safeguard Specialist in the MoA -Contractors -Respective Regional and Woreda Women and Social Affairs Bureau/Office	Core activity of IPF Sub-component I	During the construction phase
	Children over the minimum age (i.e., age of 14) and under the age of 18 may be employed or engaged in connection with the project civil works. The same inherent push factors mentioned for child labour applies here.	• A child over the minimum age and under the age of 18 will not be employed or engaged in connection with the project in a manner that is likely to be hazardous, interfere with the child's education, or be harmful to the child's health or physical, mental, spiritual, moral, or social development. The project LMP specify the type of project activities considered hazards in this regard. • To support monitoring, the Contractors outsource for the project civil works create and maintain a separate record of all project workers over the minimum age and under 18. Accordingly, inspection of the working conditions by the project Social Safeguard Specialist or local implementing partner (Woreda Women and Children Affairs).			
	The establishment of temporary or satellite clinics to provide essential health	• Resettlement Framework (RF) is prepared for project-related land acquisition with potential resettlement impacts whose exact nature and locations are not yet known and the scope and scale of resettlement aspects cannot be determined as a result. The RF	-The Social Safeguard Specialist	Potential costs are estimated	Begins before start of civil works and

	services in IDP camps and reconstruction health facilities may requires land acquisition with potential risks and impacts of involuntary resettlement.	establish general principles, procedures, and organization arrangement compatible with relevant national law and the World Bank ESS2. • Once the number of temporary satellite clinics required for the IPF program is decided and the exact locations are known, the RF will be expanded into a specific Resettlement Plan. The scope and level of detail of the resettlement plan varies with the magnitude of displacement and complexity of the measures required to mitigate adverse impacts. Project activities that will cause physical and/or economic displacement will not commence until such specific plans have been finalized and approved by the Bank. • The consultation process ensure that women's perspectives are obtained and their interests factored into all aspects of resettlement planning and implementation. • The preparation and implementation of an RF and RAPs/LRPs to guide the resettlement and compensation process.	in the MoH -Respective target Regions -Respective target Woreda or Urban Land Administration Office	early in the project design phase and integrated into project design and development.	continue throughout the project implementation period
	Involuntary resettlement from the project land acquisition for the establishment of temporary or satellite clinics and reconstruction of health facilities may have disproportionate risks and impacts for the affected HUCs.	• As the IPF project is under preparation, the design or exact location of the project civil works require land acquisition cannot be known during project preparation and that will only be designed during the project implementation. For this reason, the finding of the social assessment proposes the preparation of the Historically Underserved Community Planning Framework (HUCPF). The framework specifies resettlement principles, design criteria applied to the civil work activities of the IPF Sub-component I to be prepared during project implementation, the timing for completion of any specific plans and includes a clear statement of roles and responsibilities, budget, and commitment for funding. • However, a stand-alone Historically Underserved Community Plan (HUCP) is prepared once the exact location of the civil work activities of the IPF Sub-component require land acquisition is known and the presence of the HUCs in or around the specified project site is confirmed. • The preparation of the HUCP is proportionate to the nature and scale of the resettlement risks and impacts. More importantly, the HUCP design mitigation measures that consider how loss of land/restriction of access to natural resources inextricably impacts on the economies, modes of production, social organization, and cultural and spiritual lives of the affected pastoral and agro-		Core activity of IPF Sub-component I	Begins before start of civil works and continue throughout the project implementation period

		pastoral communities. • Preparation and implementation of a HUCPF and sub-project HUCPs. • As per ESS10 and ESS7 the IPF program will engage with HUCs in a meaningful, culturally appropriate and gender and inter-generationally inclusive manner. • The IPF program will obtain the FPIC of the affected HUCs in circumstances in which the project will: (a) have adverse impacts on land and natural resources subject to traditional ownership or under customary use or occupation; (b) cause relocation of HUCs from land and natural resources subject to traditional ownership or under customary use or occupation; or (c) have significant impacts on HUCs' cultural heritage that is material to the identity and/or cultural, ceremonial, or spiritual aspects of the affected HUCs' lives.			
	The excavations or other physical changes involving the civil works may cause risks to unanticipated discovery or recognition of cultural heritage.	A Chance Finds Procedure is developed as part of the Environmental and Social Commitment Plan (ESCP). Project-specific procedure to be followed if previously unknown cultural heritage is encountered during the excavations involving the project civil works include: ✓ Notify Woreda Culture and Tourism Office of found objects or sites on the same day. ✓ Fence-off the area of finds or sites to avoid further disturbance. ✓ Cooperate with cultural heritage experts (at woreda, regional or national organization as appropriate) in assessment of found objects or sites, identifying and implement actions consistent with the requirements of the ESS8 and national law. ✓ Train project personnel and project workers on chance find procedures ✓ Obtaining FPIC is required in the case where the project may impact on the cultural heritage of affected HUCs.	-The Social Safeguard Specialist in the MoH -Respective Regional/Woreda Culture and Tourism Bureau/Office	Core activity of IPF Sub-component I	During the construction phase
	HUCs may not receive equitable access to the project PHC services as that is significantly constrained by exceptionally poor health facilities and infrastructure in	• The physical investment in IPF Sub-component I pays a due attention and address the constraints of PHC services inherent to the poor health facilities in HUCs areas. This includes establishment of temporary or satellite clinics beyond rehabilitating conflict damaged heath facilities. • Apply innovative PHC delivery approaches such as deployment of mobile health team to reach out to the project areas with	-The Social Safeguard and GBV Specialists in the MoH	Core activity of IPF Sub-component I	Throughout the project implementation period

	their areas. Also, the project PHC services and benefits such as child nutrition may not devised or delivered in a form that is culturally appropriate to HUCs or their relative low social status (e.g. higher proportion of both illiterate women and men HHs) may impede on HUCs' equal access to the Project PHC services	transhumance pastoral communities or where health facilities are basically inaccessible and establishment of temporary or satellite clinics is infeasible. • Behavioral change communications on RMNCAH+N in a form that is culturally appropriate and meaningful consultation (e.g. using local languages, consider the local literacy level, food habits, lifestyles, and gender sensitive) tailored to HUCs.	-Respective RHBs -Respective WHOs -Respective WWSAOs		
IPF Sub-component II: Civil Registration and Vital Statistics(CRVS)	For the same reasons mentioned just before, HUCs such as pastoral and agro-pastoral communities may not receive equitable access to the project CRVS services due to the exceptional poor infrastructure and basic social services supporting the system. This may widen the gaps in the HUCs and brings disproportionate development benefits of the IPF program interventions.	• Strengthen basic facilities such as ICTs that in the project areas with pastoral and agro-pastoral communities that support the automation of CRVs. • Apply innovative CRVS approaches such as deployment of mobile CRVS team to reach out to the project areas with transhumance pastoral communities or where basic facilities such as ICTs are basically lacking to support digitized CRVS. • Behavioral change communications on the vital relevance of the CRVS for health, social, legal and social policy planning in a way that is culturally appropriate and meaningful consultation (e.g. using local languages, consider the local literacy level, socio-cultural attitudes, and gender sensitive) tailored to HUCs.	-The Social Safeguard and GBV Specialists in the MoH -Respective RHBs -Respective WHOs -Respective WWSAOs	Core activity of IPF Sub-component I	Throughout the implementation project period
	Risks from working conditions and management of worker	Prepared the labor management procedures which set out a systematic approach to the management of labour issues in the project. More	-Social Safeguard Specialist in the	I and II	Throughout the

	relationships involving multiple parties and categories of project workers.	specifically, the LMP identify the different categories of project workers that are likely to be involved in the project. Accordingly, set out the ways to manage the sources (e.g. Terms and Conditions of Employment) of disagreement and conflict of interest at work place.	MoH -Contractors		project period
Common issues for IPF Sub-component I and II or cross-cutting social issues	Occupational Health and Safety (OHS) risks involving project civil works and PHC delivery	The project LMP incorporate specific/appropriate OHS measures to prevent and protect workers from occupational injuries and illness based on the following underlying principles and procedures: • The way in which the OHS provisions apply in the IPF project depends on the nature and severity of the hazards, risks, and impacts; and the types of workers involved. • It is good practice to avoid or eliminate sources of hazards to project workers health and safety, rather than simply addressing the hazard through preventive and protective measures such as personal protective equipment. However, when it is not feasible to avoid or eliminate the hazard, appropriate protective measures are included in the projects OHS measures including but not limited to: ✓ Controlling the hazard at its source through the use of protective solutions (e.g. work place ventilation systems for health staffs working in harsh environment such as Afar or guarding construction machines); ✓ Providing adequate personal protective equipment (e.g. helmet for motorcyclists and construction workers) at no cost to the project worker. ✓ Provide adequate first aid facilities and relevant training. ✓ Protective measures would include hazard labeling in languages understandable to the project workers, and training and equipment to prevent occupational exposure to hazardous materials. ✓ Project workers receive OHS training at the start of their employment or engagement, and thereafter on a regular basis and when changes are made in the workplace, with records of the training kept on file. ✓ Further OHS measures are set out in the project's LMP as per the requirements provided in the national laws, ESS2, EHSGs and other Good International Industry Practice (GIIP).	-Social Safeguard Specialist in the MoH -Contractors -Workers' Representative/OHS Committees -Respective Woreda Women and Social Affairs, Work Place Safety Inspection Team.	Core activity of IPF Sub-component I and II	Throughout the project implementation period

		• Monitoring and follow-up on the performance of OHS measures.			
	Increased TRS risks from motorized transportation in project civil works, PHC services, and mobile CRVS	• Beyond the TRS mitigation measures (see Sub-section 5.3.2) proposed based on the social assessment and incorporated as part of health and safety or traffic management in ESMF, the preparation of project TRS risk management plan that set out specific safety measures, for example, measures necessary to manage traffic speeds. • But, the need for specific TRS risk management plan will be decided based on further project-related TRS risks assessment considering the following key aspects: ✓ Information on traffic incidents and accidents from heavy vehicles (such as construction vehicles and trucks carrying heavy construction materials) used by the Contractors for the project civil works, ambulance services, and motorcycles and field vehicles used to facilitate mobile PHC services and mobile CRVS inaccessible project areas such as remote and transhumance pastoral communities; and ✓ Vehicle mix, volume, speed, and condition (including vehicle weight, height, length, and any hazardous materials likely to be carried), and TRS status of the existing roads (including availability of road signs and signals, lane widths, slopes, speed management, roadside uses, pedestrian usage and facilities, air pollution, and any risks that these may pose).	-Social Safeguard Specialist in the MoH -Contractors outsourced for the project civil works -Drivers hired by the MoH and Contractors	Core activity of IPF Sub-component I and II	During the construction phase and continue throughout the project implementation period
	Potential threats to the project workers, sites, assets and activities as well as to project-affected communities are expected due to the Contextual Security Risks in general, project service-induced conflicts, and risks from the use of security personnel for the safeguard of the project.	• Project Security Risk Assessment (SRA) is conducted focusing on an analysis of PCSRs (the Fragile, Conflict and Volatile situations at the country, region and local level) that the IPF project does not control but which can significantly impede on the implementation of the project; risks to workers and local communities from the use of security personnel for the need of safeguarding the project; project service-induced security risks; and risks from other external threats. Building on the SRA, a stand-alone Security Management Plan (SMP) containing all the procedures and protocols related to security for the project is prepared. • Monitoring of project security commitments and performance; review the SMP if significant changes (e.g. armed conflict or when the level of security risks is increased) occur in the project's security situation; prepare Site-Specific Security Management Plan if required; and incorporate the changes into and update the project	-The MoH -Contractors outsourced for project civil works -Respective Regional Peace and Security Bureaus -Respective Woreda Peace and Security Offices	Core activity of IPF Sub-component I and II	Throughout the project implementation period

		ESCP accordingly.			
	Women and girls in the project target areas are at particularly high risks of GBV because of societal norms that perpetuate power differentials between males and females. The implementation of the IPF project can exacerbate or add to a new GBV risks through labour influx.	• Assessment of the project-related risk of exacerbating SEA/SH involves three essential issues. First, the country and/or regional/local context in which the project takes place, multiple risk factors for GBV at the individual, relationship, community, institutional and policy levels; second, the potential risks that the IPF project may bring or exacerbate existing GBV risks; and third, the local capacity of formal systems to prevent and respond to GBV. • Based on the assessment of the GBV risks, prepare a stand-alone project GBV-SEA/SH Preventive and Response Action Plan Which outlines: how the project will put in place the necessary protocols and mechanisms to address the SEA/SH risks; and how to address any SEA/SH allegations that may arise in the course of the IPF project implementation. • Assessment of GBV-SEA/SH risks throughout the project's life by monitoring the situation, assessing the effectiveness of risk mitigation measures, and adapting them accordingly. • Workers to understand and sign CoC with SEA/SH provisions.	-GBV Specialist in the MoH -Respective RHBs -Respective WHOs -Contractors outsourced for the project civil works. -Respective RWSBs	Core activity of IPF Sub-component I and II	Throughout the project implementation period
	The risks and impacts of undesired contact and social conflict that may arise due to the socio-cultural differences between project workers and remote pastoral communities with limited external contacts.	• Training for project workers on distinct socio-cultural norms, lifestyles, and traditional institution of the project-affected communities, particularly remote pastoral communities or people of voluntary isolation.	-The Social Safeguard and GBV Specialists in the MoH -Respective RHBs -Contractors of project civil works -Respective WHOs -Respective WWSAOs	Core activity of IPF Sub-component I and II	Throughout the project implementation period
	Risk related to lack of access to or exclusion from consultation	The process of preparing the SEP is inclusive, and is designed to accommodate the needs and circumstances of different stakeholders, paying special attention to identified disadvantaged or vulnerable	The Social Safeguard and GBV		Throughout the project

	activities	individuals or groups. Specific mitigation measures include: • Depending on the societal context, HUCs, women, children, youth, the elderly, and people with disability will be considered as stakeholder groups of their own, and separate consultation formats (e.g. separate interview or focus group discussion) will be arranged to capture their special needs and concerns. • Consultation process will take into account the different access and communication needs of vulnerable or disadvantaged individuals and groups, including consideration of both communication and physical accessibility challenges. • Meaningful consultation that build on existing customary institutions and decision-making processes utilized by the IPF project affected HUCs. • The project will devise specific stakeholder engagement arrangements communicated in formats suitable to and understandable for vulnerable or disadvantaged individuals and groups. This may include the use of project leaflets and pamphlets, community notice board, community radio, project webpages and telephone hot lines. • Relevant project documents will be accessible for stakeholders with sensory disabilities, for instance, through providing documents in Braille or engaging a sign language interpreter at a consultation meeting, as appropriate. • In cases where literacy levels are low, additional formats like location sketches, physical models, and film presentations may be useful to communicate relevant information.	Specialists in the MoH		implementation period
IPF Sub-component III: Technical Assistance and Capacity Building (US$5 million IDA equivalent)	The risk of discrimination and unequal opportunity among the project workers in relation to technical assistance and capacity building trainings.	• The IPF program identifies measures that support equal opportunities for women and men, with emphasis on equal criteria of selection for the project technical assistance and capacity building trainings. • As allowed by the national law, the IPF program will implement specific measures that provide for preferential treatment of female, people with disability or other individuals or groups of project workers who have been the subject of prior discrimination or disadvantage	The Social Safeguard and GBV Specialists in the MoH	Core activity of IPF Sub-component III	Throughout the project implementation period
	Project's Contextual Security	• Engage a Third-Party Implementing Agency, in situations where the MoH has limited capacity to manage the social	Ministry of Health		Throughout the project

	Risks	risks or in situations of fragility, conflict, and violence (FCV) where access to project sites is limited due to high Project's Contextual Security Risks. • Map out' warring factions, individuals, organizations and strategies that could help resolve border or inter-ethnic conflicts in the project areas. • Early identification and management of conflict Intensifying factors: ethnic conflict, recent violence, historic animosity, weakness of claimant groups (to control potential break-outs) • Proactive security measures. For examples, relocation or evacuation of project staff during such conflicts, defining 'triggers' for suspension of activity/relocation/evacuation.			implementation period
	Project service-induced conflict	The target of the interventions of the IPF project is planned based on Ethiopia Conflict Impact Assessment and Recovery and Rehabilitation Planning (CIARP) as of as of November 2021. However, after November 2021, the conflict has expended to several Zones and Woredas, particularly in Oromia regional state. So, to mitigate project service-induced conflict or conflict due to benefiting some conflict-affected areas while excluding the others, it highly recommended to extend the interventions of the IPF project to those recently-affected areas as well.			Throughout the project implementation period

CHAPTER 9: MONITORING AND REPORTING ARRANGEMENTS

The MoH will monitor the social performance of the project on a continuous process. Monitoring arrangement is designed in a way that help to track the social performance of the IPF project, to determine whether it is achieving its outcomes and meeting various the social requirements shown in this Social Assessment, and whether additional measures need to be implemented.

The MoH will ensure that adequate institutional arrangements, systems, resources, and personnel are in place to carry out monitoring before commencing the IPF Sub-components. In case of the project implementing activities in Tigray region where UNICE is in charge as Third-Part Implementing, the MoH will be responsible for the overall supervision and collaborate with UNICE staff to establish and monitor project social mitigation measures.

The IPF project Social Safeguard staff in the MoH is responsible to compile monitoring resulting and prepare the quarterly report. The frequency of the report to the Bank will be on a quarterly basis. The format and content of monitoring report may compile details of relevant information but should satisfy the monitoring indicators identified in Section 7.1 at a minimum.

CHAPTER 10: KEY RECOMMENDATIONS

The implementation of the IPF project requires to adopt differentiated measures so that adverse impacts do not fall disproportionately on the disadvantaged or vulnerable, and they are not disadvantaged in sharing development benefits and opportunities resulting from the project. To this end, Section 8 provides several specific differential mitigation measures informing the findings of the Social Assessment. The matrix in the following table summarizes potential social risks along with proposed mitigation measures, responsible bodies, and budget.

CHAPTER I: INTRODUCITON

1.1 Project Background

1. In Ethiopia there is an urgent need to support the health system that resulted from the devastation of the conflicts in different parts of the country. This has led to significant disruptions in the delivery of essential health services (EHS) including key reproductive, maternal, neonatal, child, and adolescent health plus nutrition (RMNCAH+N) services. As justified in the IPF program design, conflicts have had devastating impacts on people's lives, both from direct physical harm and the collapse of the health system[54].

2. The proposed IPF interventions are built on the recently closed Ethiopia Health Sustainable Development Goals Program-for-Results (PforR) that performed well and built strong institutional arrangements while bringing consistency to the health sector. While complementing the PforR, the proposed IPF program will support the government emergency health and recovery plan for the conflict-affected areas. It will support and enhance the development of a resilient health service delivery system in the conflict-affected parts of the country which require huge investments. Backdrop to this, the need for conducting this Social Assessment (SA) is justified in line with the Environmental and Social (E&S) requirements of the World Bank (WB) for its Investment Project Financing (IPF). The World Bank's Environmental and Social Framework (ESF) sets out the mandatory requirements of the MoH to carry out the SA for the proposed IPF project to assess the social risks and impacts of the project throughout its life cycle. Also, based on the findings of the SA, MoH is required to devise appropriate mitigation and management measures to be taken during the implementation of the project to address the identified risks and impacts of the project in accordance with the mitigation hierarchy—first avoidance of risks, if avoidance is not possible minimize the project risks, once minimized devise mitigation measures and compensate, where avoidance, minimization, or mitigation is not adequate to manage significant adverse risks and impacts of the project.

1.2 IPF Program Target Areas

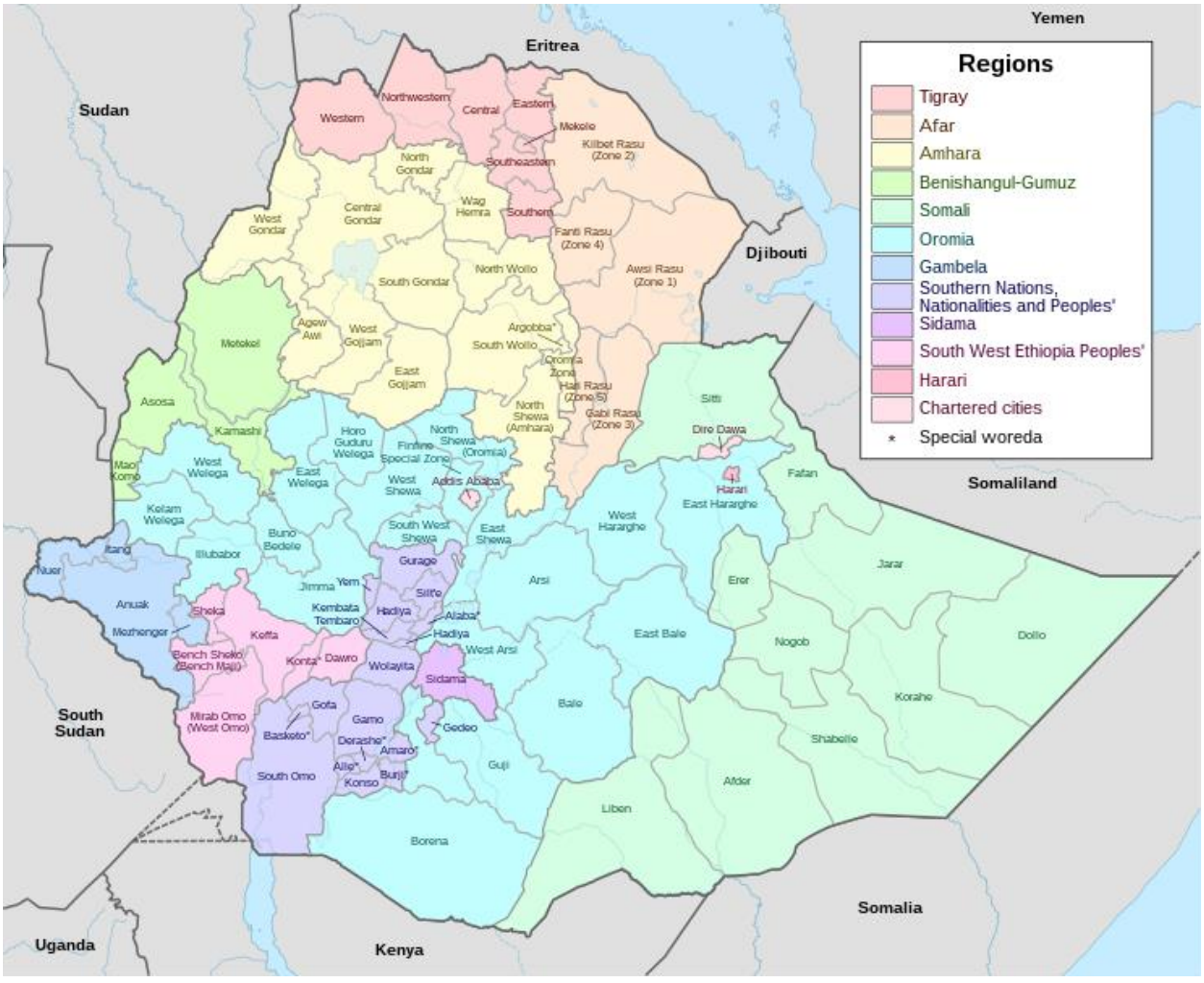
3. To help identify the IPF program target areas, Ministry of Health Ethiopia Conflict Impact Assessment and Recovery and Rehabilitation Planning (CIARP)[55] has identified conflict-affected areas in the country based on data collected from November 2020 to December 2021. Accordingly, Tigray, Afar, Amhara, Oromia, and Benishangul-Gumuz regional states are identified for the IPF project target areas. The findings of the CIARP have shown that the conflicts in these regional states adversely affected access, availability, and provision of essential health services, and negatively impacted on the health and nutrition outcomes. Also, the CIARP estimated that close to 24 million people have been adversely impacted in term of access to Essential Health Services and an estimated 5.7 million people were forcibly displaced at various stages of the conflicts across the five target regional states. The same data source further indicates, it is challenging to accurately state the level of conflict-related morbidity and mortality and the impact of the war in the overall health system. But, the readiness of the health system to deliver essential health services has been hampered due to the damage caused to health facilities and infrastructure, widespread looting of medical equipment and medicines, insecurity, and displacement of households and

[54] Program Appraisal Document for Ethiopia Program for Results (Hybrid) for Strengthening Primary Health Care Services, November 15, 2022.

[55] Ministry of Health Ethiopia. (2022). Ethiopia Conflict Impact Assessment and Recovery and Rehabilitation Planning (CIARP): Final Health Sector Report and Costs, June, 2022.

health workers. The below stated findings of the SA provide details of information on the conflict-affected areas and the health sector impacts in each IPF project target region.

4. ***Conflict-affected areas and the health sector impacts in Tigray region:*** The political disagreement between the regional state and federal government has led to the outbreak of the war in the north on Nobember 4, 2020. The conflict that has been fought for two years impact on the entire region. As a result, 32 hospitals, 107 health centers, and 537 health posts have been damaged completely or partially affecting about 5.6 million people in the region. Therefore, the proposed IPF program interventions target the entire Tigray region: all the six Administrative Zones (North Western Tigray-Zone, Central Tigray-Zone, Eastern Tigray-Zone, Sothern Tigray-Zone, Western Tigray-Zone and Mekele Special-Zone) and the 48 Woredas under these Zones.



A Map of the country showing the targeted zones in the five regions

5. **Conflict-affected areas and the health sector impacts in Amhara region:** The violent conflict broke out in Tigray region on November 04, 2020 immediately spread to the adjacent areas of Amhara and escalated into seven administrative zones and the impacts covered 89 woredas out of the total 139

Woredas in the region. Consequently, about 40 hospitals, 452 Health Centers, and 1,728 health posts were damaged or looted disrupting the provision of EHS to about 8.9 million. ***Annex 4*** displays the list of conflict-affected Woredas in Amhara region disaggregated by Zone and number of hospitals, health centers, and health posts affected.

6. **Conflict-affected areas and the health sector impacts in Afar region:** Afar is the third regional state affected due to the war in the northern Ethiopia. Following the recent administrative restructure by the Afar regional state, Based on the interview with the regional and woreda stakeholders, both the number of conflict-affected woredas and health facilities in Afar region outweighs what is documented in the Master List by MoH (see ***Annex 4***). As to the finding of the social assessment, out of the total six Zonal Administrations in Afar region, the impacts of the war in the northern Ethiopia covered four (Zone 1, Zone 2, Zone 4, and Zone 5) and about 23 woredas in these Zones were impacted. In consequence of the war, 3 hospital, 47 health centers, and 17 1 health posts were damaged and looted with different degree. This led to the disruption of PHC services for a total of 1.4 million population in the region. The input of the social assessment can be used to update the Master List of damages to health facilities in the region reported in CIARP.

7. ***Conflict-affected areas and the health sector impacts in Oromia region:*** As assessed in CIARP, the conflict-affected areas in Oromia include a total of 64 woredas located in seven zones, namely: West Guji, North Shewa, Borena, Guji, Kelem Wollega, East Wollega, and West Wollega. As per this assessment about 8.5 million people have been affected as the result of conflict. As per the assessment of CIARP, ***Annex 4*** shows the list of conflict-affected Woredas in Oromia region disaggregated by Zone and number of HPs, HCs and Hospitals affected. However, the assessment and report in CIARP was based on data collected on damage and loss sustained by the health sector from November 2020 to December 2021. Thus, the CIARP based on which the design of the IPF program is based did not include the dynamics and geographic expansion of the impacts of conflict in Oromia region over the last couple of years. To address this data gap, the social assessment captured the recent conflict situation in the region. Based on informants from Oromia Regional Health Bureau, over the last couple of years, the impacts of the conflict have been expanded to five additional zones, namely: Horo Gudru Welega, Illu Aba Bora, Bunno Bedele, West Shewa, and South West Shewa-Zone. The impacts and security threats of conflict covers most woredas in each of these zones. Informants stated two more zones with serious impacts of conflict in their some places, Bosset woreda in East Shewa zone and Hetossa wored in Arsi zone. Therefore, informants recommend that the design of the IPF program needs to consider the input of the social assessment with regards targeting zones in Oromia region. That is because, informants provide the justification that all conflict-affected areas face the same critical health problems from conflict. The IPF project interventions in one conflict-affected zone and excluding another may lead to project service-induced conflict. Also, informants emphasized that it is likely that the excluded communities feel the sense of unfair treatment and, thus, lack the trust on the government.

8. ***Conflict-affected areas and the health sector impacts in Benishangul-Gumuz region:*** Despite recent improvements in security, studies (Tsegaye 2022[56]; Jan 2021[57]) have shown that little has been done to

[56]Tsegaye Birhanu. (2022). Conflict Trends Analysis in Benishangul-Gumuz Regional State. Rift Valley Institute: The UK.

[57]Jan Nyssen (2021). The marginalized Gumuz communities in Metekel (Ethiopian western lowlands), Ghent University, January 2021. https://www.researchgater.net/publicaiton/347983365.

address the political root causes of the conflict in Benishangul-Gumuz region. Consequently, over the last five years, the conflict in Benishangul-Gumuz affected all its three administrative zones (Assossa, Kamashi, and Metekel). First, the violence in the Assosa zone emerged as a result of conflict among the settlers of the Amhara and Oromo origin and the Berta community living in the zone. This was initially sparked in June 2018 and escalated to a deadly violence conflict since then. The conflicts in Kamashi zone have taken place in an area that is inhabited by a Gumuz majority and is the most economically underdeveloped of the three zones. Metekel is a much more ethnically diverse administrative zone. The conflict there started in April 2019 between the Gumuz community and Amhara and Oromo settlers in the zone. Consequently, the conflict in Benishangul-Gumuz region involve an array of actors. ***Annex 4*** provides the list of conflict-affected Woredas in Benishangul-Gumuz region disaggregated by Zone and number of damaged HPs, HCs and Hospitals.

1.3 Project Beneficiaries

9. IPF Sub-component I is expected to benefit population in conflict-affected areas. The direct beneficiaries are women, newborns, children, and adolescents in the conflict-affected areas. As assessed based on primary and secondary sources, overall, out of 71 million population living in the aforementioned conflict affected regional states, about *24,852,959* million people were affected by the conflict as of 2021. ***Table 1*** presents the number of conflict-affected population by regions. As discussed later, the findings of the SA analyzed that the conflict has strained the health system, worsened maternal, child health and nutrition outcomes, and crippled delivery of basic and emergency health services in the conflict-affected areas. Thus, the IPF program provide need-based essential health services and other key inputs (medicines, medical consumables, equipment) to ensure access to basic health services for population in conflicted-affected areas in the country with the emphasis on vulnerable groups.

Table 18 Number and proportion of conflict-affected Population by Region from 2020-2021

Region	***Total Population in the Region***	***Population Affected by Conflict in Million***	***Number of People Displaced in Million***	***Percentage of Conflict Affected People***
Tigray	5,600,00	4,500,000	2,000,000	80.4
Afar	2,000,000	1,400,000	300,000	70
Amhara	22,500,00	8,900,000	2,300,000	39.6
Oromia	39.100,000	8,600,000	600,000	22
Benishangul-Gumuz	1,200,000	400,000	400,000	33
Total	***70,400,000***	***23,800,000***	***5,700,000***	***33.8***

Source: *Ministry of Health Ethiopia Conflict Impact Assessment and Recovery and Rehabilitation Planning, June 2022.*

1.4 The Key Implementing Agencies for the IPF Component of SPHCP

10. The MoH is the main agency responsible for the implementation of the EHS to conflict-affected areas (IPF sub-component I) and Contingent Emergency Response (IPF Sub-component IV). Following the nationwide health sector reform, MoH has seven functional Directorates established based on their functions, under the Office of the Minister and the State Ministers. These functional Directorates are responsible for: the overall fiduciary arrangement of the IPF Program and reporting funds under the IPF operation; guiding, implementing, monitoring and evaluating the environmental and social performance of the IPF program; supporting regions in systems development and developing health sector programs aligned with national plans and goals; and mobilize additional resources to improve service delivery and creates platforms for mutual accountability, information flow, and efficient use of resources.

11. Immigration and Citizenship Service (ICS) is responsible for the implementation of CRVS activities (IPF sub-component II). The ICS management will provide overall strategic guidance for the implementation of the IPF Sub-component II. Also, ICS will develop a budgeted annual work plan for the activities of the IPF Sub-component II to be submitted to the World Bank for its no objection. Accordingly, it will produce a quarterly financial reports and annual audit reports.

12. The implementation of the IPF Sub-component III is the joint responsibility of the MoH and ICS. To institutionalize the CRVS system, MoH and ICS need to collaborate on respective civil registration activities in an integrated and harmonized manner. Hence, the MoH and ICS will be responsible for the implementation of the Technical Assistance and Capacity Building (IPF Sub-component III). In particular, the MoH and ICS will cooperate on how to integrate the CRVS into the health sector. The two implementing agencies will also jointly work in developing appropriate automation system that support the integration of CRVS and health sector and institutional capacity building in this respect.

CHAPTER 2: OBJECTIVES AND METHODOLOGY OF THE SOCIAL ASSESSMENT

2.1 Objective of the Social Assessment

13. The overall objective of the SA is to provide analytical and operational elements that make the project responsive to concerns related to EHS and CRVS, combining (a) the *analysis* of context and social issues with (b) a participatory *process* of stakeholder consultations and involvement, to provide (c) *operational* guidance on developing strategy to achieve social development outcomes, implementation, and monitoring and evaluation (M&E) frameworks for the project. The social development strategy includes measures that strengthen the social inclusion underserved communities and vulnerable groups for the benefits and access to opportunities created by the IPF project.

14. The specific objectives of the SA are to:
    i. Review national and World Bank legal frameworks pertinent to the project, as well as the broader policy and reform context within which the project takes place. Pay particular attention to the legal frameworks underlying differential measures for the disproportionate impacts and benefits of the project.
    ii. Describe the social and economic characteristics of the project affected persons/population and provide the baseline information for designing the social development strategy.
    iii. Identify potential social risks and impacts from the implementation of the IPF Sub-components that may trigger World Bank Environmental and Social Standards. Drawing on this, the SA recommends appropriate risk management plans.
    iv. Analyze what the key social and institutional issues are in relation to project objectives; identify the key stakeholder groups in this context and determine how relationships between stakeholder groups will affect or be affected by the project
    v. Advise on procedures and steps to be taken to address the requirements of the World Bank Environment and Social Framework (ESS1, ESS5, ESS7 and ESS10) triggered by the projects early during project preparation.
    vi. Provide inputs for the design of an appropriate institutional arrangements to implement, monitor, and evaluate the project on the achievement of social outcomes.

2.2 Scope of the Social Assessment

15. *Review of the project background information*: Provide a full description of the project to the extent known when the social assessment is undertaken. Include the following information: location, size, schedule and planned sequence of activities, resources available, expected implementation arrangements and life span.

16. *Review of Environmental and Social Framework:* Review of the GoE's environmental and social Framework includes those aspects of the country's policy, legal and institutional framework applicable to the implementation of the proposed IPF program. Likewise, reviewing the World Bank's Safeguard Policy, ESS1, ESS7 that set out the requirements for the GoE relating to the identification and assessment of environmental and social risks and impacts associated with the implementation of the proposed IPF Sub-components.

17. *Description of the socio-cultural, institutional, historical and political context:* Review of available sources of information to describe the socio-cultural, institutional, historical and political context within

which the project operates. The review include qualitative descriptions and quantitative indicators of development trends relevant to the project, such as significant demographic changes, patterns of asset ownership and livelihoods, external political or economic environment, etc. The purpose of this exercise is to describe what constraints and opportunities the context poses to the implementation of the IPF project.

18. *Identify key social issues:* The social assessment provides the baseline information for designing the social development strategy. The analysis determine what the key social and institutional issues are in relation to the project objectives; identify the key stakeholder groups in this context and determine how relationships between stakeholder groups will affect or be affected by the project; and identify expected social development outcomes.

19. *Identification of social risks:* Identify project-related social risks that may trigger World Bank's ESF. Social risk analysis examines the social groups that may be differentially access to and impacted by the IPF project interventions and the underlying factors that contribute to this vulnerability. Drawing on this, appropriate risk management plans will be proposed with an eye to addressing the identified social risks during project design, implementation, and monitoring and evaluation.

20. *Identify strategy to achieve social development outcomes:* Identify the likely social development outcomes of the project and propose a social development strategy, including recommendations for institutional arrangements to achieve them, based on the findings of the social assessment. The social development strategy include measures that strengthen social inclusion by ensuring that both the vulnerable groups and intended beneficiaries have equal access to the primary health care services proposed by the IPF interventions.

21. *Recommendations for project implementation arrangements:* Provide guidance to project management and other stakeholders on how to integrate social development issues into project design and implementation arrangements. As much as possible, suggest specific action plans or implementation mechanisms to address relevant social issues and potential impacts from the IPF program.

22. *Developing a monitoring plan:* Through the social assessment process, a framework for monitoring and evaluation will be developed. The indicators will include outputs to be achieved by the proposed social development plans; indicators to monitor the process of stakeholder participation in the implementation of these plans; indicators to monitor social risk and social development outcomes; and indicators to monitor impacts of the project's social development strategy.

2.3 Methodology for the Social Assessment

23. The preparation of the social assessment depends on the use of both primary and secondary methods of data collection. The following sub-sections provide further methodological description in this respect.

2.3.1 Desk Review

24. The desk review involve in-depth assessment of relevant documents and empirical studies. Among other things, the review of secondary sources include:
    - *IPF program related documents:* The review of IPF program related documents aims to provide program background information, development objective and components. Project-related

documents reviewed include draft Program Appraisal Document (PAD), draft Environmental and Social System Assessment (ESSA), draft Environmental and Social Review Summary (ESRS) appraisal state, Environmental and Social Commitment Plan (ESCP), and Stakeholder Engagement Plan (SEP).

- *Legal and institutional frameworks*: Review national legislation and the World Bank policies pertinent to the project, as well as the broader institutional context within which the IPF project takes place. The review pay particular attention to laws and regulations governing the project's implementation and the access of the vulnerable or disadvantaged groups to services and opportunities provided by the IPF project. In addition, review the enabling environment for public participation and development planning. Thus, the social assessment builds on strong aspects of the legal and institutional systems to facilitate the IPF program implementation and identify weak aspects while recommending alternative arrangements.
- *Previous assessments and empirical studies*: Available health sector assessments and empirical studies were reviewed to describe socio-cultural, institutional, historical, and political context in which the IPF project operates. The review includes qualitative descriptions and quantitative analysis of development trends relevant to the IPF project, such as the status of basic social services before and after conflict, significant demographic changes, patterns of asset ownership and livelihoods, external political or economic environment, etc. The purpose of this review is to describe what existing situations are there to pose constraints or create opportunities towards the successful implementation of the IPF project.

2.3.2 Key Informant Interview

25. Consultation with relevant stakeholders from federal to community level was conducted to assess conflict damages and looting to health facilities, infrastructure, and medical equipment; the challenges of essential health service provision in general and disproportionate impacts on vulnerable groups (i.e., PLW, newborns, IDPs, under five children (U-5), the elderly, and people with disabilities) in particular due to disruption of PHC services from conflict-damages and looting to health facilities; project implementing capacity of the MoH and line regional and woreda level agencies; the political, social and institutional context within which the IPF project operate; and other health related issues that may require expertise explanation.

2.3.3 Phone Interview, Virtual Consultation and Email Exchanges

26. Following the advice from the Bank Country Security and the obvious security risks discussed under the Sub-section 5.2.2 (B), face-to-face interview with stakeholders in some IPF project target regions was not possible. Alternatively, phone interview, virtual consultation platform, and email exchanges were employed. Accordingly: (a) consultation with regional-level stakeholders in Amhara was conducted using phone interview and email exchanges (i.e. relevant desk review and documents were shared using email exchanges with the expertise); (b) virtual consultation platform was used to reach out the stakeholders in conflict-affected zones and woredas of Oromia region. A telegram group was created through the support of the Deputy Head of Oromia Health Bureau. About 23 participants with diverse responsibilities including heads of zonal health department and woreda health offices and health workers took part in this on-line forum platform from almost all the conflict-affected zones in Oromia and selected woredas.

2.3.4 Methods for the Tigray Region

27. The health system and facilities in Tigray region are not under the administrative control of the MoH due to the security concerns and other restrictions following the war in the north. To mitigation this, therefore, the social assessment in Tigray region employed two alternative methods. The first method was the Interview with the management and expertise of the UNICEF Ethiopia Country Office, a third-party implementing agency (TPIA) engaged by the MoH for its projects in Tigray region including the IPF program. Head of UNICEF Ethiopia Country PHC Program Head and Program Assistant were interviewed to assess the implementation approach of the TPIA, institutional capacity, challenges and experience from the implementation of previous development projects in Tigray region and lessons for the IPF program. The second method employed secondary sources. The impacts of the war on the health facilities and infrastructure were analyzed depend on the earlier reports and dataset on the humanitarian situation analysis in Tigray region as conducted by the MoH and various international humanitarian organizations and partners including UNICEF, WFP, and OCHA.

2.3.5 Key Informant Interview with the Community Representatives

28. Key informant interview was conducted with community representatives such as elders and clan leaders with the aim to assess the socio-cultural features that differentiate social groups in the project areas; and social groups' characteristics, intra-group and inter-group relationships, and the norms, values and behavior that have been institutionalized through those relationships.

2.3.6 Interview with Vulnerable Groups

29. As indicated in the National Health Equity Strategic Plan 2020/21-2024/25 and reaffirmed through primary sources, the social determinants of health continued to hinder the path towards addressing health inequity and socio-cultural attitudes that threaten health and wellbeing of the population. Added to structural inequalities, the disruption of essential health services due to conflict-caused damages and looting to health facilities would have disproportionate impacts for vulnerable groups such as PLW, households with U-5, IDPs, and the elderly owing to their special health needs. Backdrop to this fact, a separate interviews were arranged in the sampled woredas for vulnerable groups to ensure that their views are obtained and their special needs factored into the planning and implementation of the IPF project. Taking the various methods highlighted so far into account, **Annex 5** provides signed form with the full contact address of the stakeholders consulted from federal to woreda levels.

2.3.7 Community Consultation

30. Community consultation was a method for gathering socio-economic information, understanding the social norms and values of the project-affected communities, assessing project-related social risks, and prioritizing the needs that require mitigation measures. Participants of the community consultation composed of community representatives (clan leaders, community elders, religious leaders) and members of vulnerable groups including PLW, returnee IDPs, and the elderly with special needs. To this end, the target regions were clustered into two following the below sampling procedures and one community consultation was conducted per cluster. Accordingly, convenient to security and safety matters, Chifra woreda from Afar region and Tehuledere woreda from Amhara were purposely selected to represent the pastoral/agro-pastoral and agricultural based-communities:
    - The first community consultation was held in Chifra woreda on February 23, 2023 and about 15 participants took part in. The participants were selected from five different kebeles (Chifra town, Ander Kello, Weama, Teabay, and semsem). Participants' gathering at Chifra primary hospital

seeking for health service was used as a good opportunity to allow the selection of community consultation participants from different kebeles. The selection was done with the support of the Head of Chifra Woreda Health Office and the CEO of Chifra Primary Hospital.

- The second community consultation was conducted in Tehuledere woreda on February 20, 2023. About 20 participants were took part in this community consultation selected from six different kebeles, namely: Jari, Wahelo, Gobeya 012, Kete, Godguadit 05, and Amumo. The same selection approach as Chifra was used: Participants were met at Hayq Health Center waiting for health service and selected for community consultation by the help of the health workers. ***Annex 6*** provides community consultation participants' attendance. ***Annex 8*** provides sample photos.

2.3.8 Sampling Procedure

31. The methodology for the social Assessment employed different sampling procedures that allow representativeness both in terms of project target areas and stakeholder groups. First, as to the coverage of the IPF target areas, all the conflict-affected regions (Tigray, Amhara, Afar, Benishangul-Gumuz and Oromia) were included. Consultation with the heads and health expertise in the respective Regional Health Bureaus (except Tigray) were conducted. For Tigray region, information was obtained through interview with the PHC program head and expertise of UNICEF, a third party implementing agency in the region. Region-context assessment and views of the impacts of conflict-caused damages and looting to health facilities and disruption of PHC delivery were incorporated. Second, the sampling procedure represents the views of relevant stakeholder group from federal to local/community level. Third, the sampling procedure applied ways of representation for community consultation considering the socio-cultural similarities among the beneficiary communities (such as the level of infrastructure and economic development, livelihood, land tenure system, and system of social organization), the project target regions were clustered into two. Accordingly, Afar, Benishangul-Gumuz, and Borena and West Guji Zones of Oromia region were grouped into one to represent the special needs and views of the pastoral and agro-pastoral communities. Whereas, Amhara, Tigray and non-pastoral areas of Oromia region were categorized under the same cluster to capture the views of the IPF project-affected agricultural communities. Finally, the sampling of the social assessment applied different procedures to include the special needs and views of vulnerable groups: (a) separate key informant interviews were arranged to allow vulnerable groups (pregnant and lactating women (PLW), women, returnee IDPs, and people with chronic illness including the elderly) make their voice heard; and (b) organizations for the disadvantaged or vulnerable groups (such as Ministry of Women and Social Affairs and the line regional bureau and woreda office) were consulted with regard to the special needs of vulnerable groups and way forward for effective project implementation in this regard.

Table 19 Participants of the Stakeholder consultation

Organization	*Informant*	*Number*	*Date of Consultation*
Federal Level			
Ministry of Health	Project Management and Strategic Head Environmental Safeguard Specialist GBV Specialist CE and PHC	4	January 31, 2023
Ethiopian Pharmaceutical Supply Agency	Expertise	3	February 10, 2023
Citizenship and Immigration Services	Deputy Director Research Department Head	2	February 10, 2023
Ministry of Women and Social Affairs	Gender Expertise Planning and Strategic Director	2	February 9, 2023
UNICEF Country Office	PHC Program Head PHC Program Assistant	2	February 14, 2023
Regional Level			
Oromia Region Health Bureau	Deputy Head Public Health Emergency Assessment Team	3	February 03, 2023
Afar Region Health Bureau	EPRLUB (3 expertise) Health and Environmental Hygiene Director GBV Director	5	February 21, 2023
Afar Region land Use, Administration and Environmental Protection Authority	Deputy Head Environmental Protection Director	2	February 21, 2023
Afar Region Civil Registration and Vital Statistics Agency	Database Admin. System Admin.		February 22, 2023
Afar Region Women and Social Affairs Bureau	Planning and Monitoring Director	1	February 22, 2023

Afar Region Disaster Risk Management Commission	Commissioner	1	February 22, 2023
Amhara Regional Health Bureau	Expertise	1	February 15, 2023
Woreda Level			
Chifra Woreda, Zone 1, Afar Region	Wored Health Office Head	4	February 23, 2023
	Chifra Primary Hospital CEO		
	Chifra Woreda Education Office Head		
	Chifra Woreda Women and Children Office head		
Tehuledere Woreda, South Wollo Zone, Amhara Region	Woreda Health Office Head	4	February 27, 2023
	Hayik Health Center CEO		
	Senior Nurse		
	Psychosocial Expertise, UNICEF Mobile Team		
	Based on Hayik Health Center		
Community Level			
Community Consultation in Chifra	Clan leaders, community elders, religious leaders) and members of vulnerable groups including women, PLW, and returnee IDPs	15	February 23, 2023
Community Consultation in Hayik	Clan leaders, community elders, religious leaders) and members of vulnerable groups including women, PLW, and returnee IDPs	20	February 28, 2023

CHAPTER 3: POLICY, LEGISLATIVE, REGULATORY AND INSTITUTIONAL FRAMEWORK

32. This section devotes to review the national and World Bank Environmental and Social Standards pertinent to the IPF component of SPHCP, as well as the broader policy and reform context within which the project takes place.

3.1 National Policies and Legal Frameworks Applicable to the IPF Program

33. The health care delivery system of Ethiopia has been historically unable to respond to the health needs of the people. It was highly centralized, and relied on a fragmented vertical programs delivery system with little collaboration between the public and the private sectors. Backdrop to this, the review that follow reveals, the Government of Ethiopia issued a number of policy measures over the last two decades with the aim to reform the health sector of the country in general and provision of PHC in particular.

3.1.1 The Ethiopian Constitution

34. The current constitution of the Federal Democratic Republic of Ethiopia came into force in August 1995. It sets out the supreme law of Ethiopia, providing basic and comprehensive principles and guidelines for environmental and social protection and management in the country. The relevant provisions of the Constitution to guide the Social Assessment for the IPF project are contained in the following Articles:

Article 40 on* the *Right to Property stipulates:

- Ethiopian peasants have right to obtain land without payment and the protection against eviction from their possession (Sub-Article 4).
- Ethiopian pastoralists have the right to free land for grazing and cultivation as well as the right not to be displaced from their own lands (Sub-Article 4).
- Without prejudice to the right to private property, the government may expropriate private property for public purposes subject to payment in advance of compensation commensurate to the value of the property (Sub-Article 8).

Article* 41 on *Economic, Social and Cultural Rights states

- The State shall, within available means, allocate resources to provide rehabilitation and assistance to the physically and mentally disabled, the aged, and to children who are left without parents or guardian (Sub-Article 5)
- The State has the responsibility to protect and preserve historical and cultural legacies (Sub-Article 9).

Article* 42 on *Rights of Labour has the provisions that:

- Workers have the right to reasonable limitation of working hours, to rest, to leisure, to periodic leaves with pay, to remuneration for public holidays as well as healthy and safe work environment (Sub-Article 2)
- Employer (be it government or private) is obliged to take all necessary measures to ensure that workplaces are safe, healthy, and free of any danger to the well-being of workers (Sub-Article 3).

Article 43 on the Right to Development

- The Peoples of Ethiopia as a whole, and each Nation, Nationality and People in Ethiopia in particular have the right to improved living standards and to sustainable development (Sub-Article 1)

- Nationals have the right to participate in national development and, in particular, to be consulted with respect to policies and projects affecting their community (Sub-Article 2).
- The basic aim of development activities shall be to enhance the capacity of citizens for development and to meet their basic needs (Sub-Article 4).

Article 44 on Resettlement and Compensation has the provision that:

- All persons who have been displaced or whose livelihoods have been adversely affected as a result of State programmes have the right to commensurate monetary or alternative means of compensation, including relocation with adequate State assistance (Sub-Article 2)
- All persons have the right to a clean and healthy environment (Sub-Article 1).

Article 89 on Economic Objectives has the provisions about the Disadvantaged/Historically Underserved Groups:

- Government shall provide special assistance to Nations, Nationalities, and Peoples least advantaged in economic and social development (Sub-Article 4)
- Government shall ensure the participation of women in equality with men in all economic and social development endeavours (Sub-Article 7).

Article 90 on Social Objectives:

- To the extent the country's resources permit, policies shall aim to provide all Ethiopians access to public health and education, clean water, housing, food and social security (Sub-Article 1)
- Education shall be provided in a manner that is free from any religious influence, political partisanship or cultural prejudices (Sub-Article 2)

Article 91 on Cultural Objectives

- Government shall have the duty to support, on the basis of equality, the growth and enrichment of cultures and traditions that are compatible with fundamental rights, human dignity, democratic norms and ideals, and the provisions of the Constitution (Sub-Article 1)
- Government and all Ethiopian citizens shall have the duty to protect the country's natural endowment, historical sites and objects (Sub-Article 2)
- Government shall have the duty, to the extent its resources permit, to support the development of culture arts (Sub-Article 3).

Constitutional provisions on Citizens' Engagement/Consultation

- Government shall at all times promote the participation of the People in the formulation of national development policies and programmes; it shall also have the duty to support the initiatives of the People in their development endeavours (Article 89, Sub-Article 6)
- People have the right to full consultation and to the expression of views-in the planning and implementation of environmental policies and projects that affect them directly (Article 92, Sub-Article 3).

35. Article 89 of the Constitution recognizes that there are historical, political, social, and economic factors contributing to the unequal development opportunities in some regions of the country. The IPF project target areas Afar, Beninshangul-Gumuz, and parts (Borena and Guji zones) of Oromia are among these regions while Gambella, Somali, and South Omo zone of the South Nation, Nationalities and People's Region include the remaining. Compared to other regions in Ethiopia, these regions struggle with less developed infrastructure, the pace of their development in many sectors is relatively slow and boarder related conflicts further affect their development status. Given this fact, the government of Ethiopia

recognizes the aforesaid regions as least advantaged or historically underserved regions. Consequently, Article 89 of the Constitution incorporates the legal provisions that requite the existing uneven development opportunities in the Historically Underserved Regions. In line with this, the legal provision under Article 89, Sub-article 4 set out what is directly applicable to the IPF Program Development Objective. It states that: "Government shall provide special assistance to Nations, Nationalities, and Peoples least advantaged in economic and social development". The legislation in Article 89 referred not only to HUCs but also other vulnerable groups. For instance, in accordance with the Sub-article 7: "Government shall ensure the participation and benefits of women in equality with men in all economic and social development endeavours". Therefore, it is against this backdrop of the national legal framework that the IPF program target vulnerable groups and HUCs as the direct beneficiaries.

3.1.2 Health Sector Transformation Plan I and II (2015-2025)

36. The MoH assessed that remarkable progress has been achieved in the coverage of PHC as the result of the implementation of the successive HSDPs highlighted just before almost for two decades, from 1997 to 2015. Then, the implementation of Ethiopian Health Sector Transformation Plans (HSTP I and HSTP II) followed not as the new health policy framework but as continuation of the HSDP I, II, III, and IV. The HSTP I (2015/16 - 2019/20 FY) in line with Ethiopia's second Growth and Transformation Plan (GTP II) has set three key areas of focus for PHC: quality and equity; universal health coverage, and transformation. To this end, the HSTP sets out four pillars of excellence. These are excellence in: health service delivery; quality improvement and assurance; leadership and governance; and health system capacity. In each of these pillars, reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAH+N) continued to be top priority for the HSTP.

37. Having the same pillars of PHC just stated, the implementation of HSTP II (2020/2021-2024/2025 FY) pays due attention to enhance: health equity; public health emergency management system; management and use of health information systems; evidence informed decision making and innovation; and strengthen enabling health regulatory system. Thus, as part of the HSTP II, the government of Ethiopia has put in place the National Health Equity Strategic Plan (2020/21-2024/25) with the goal to narrow the existing inequities in essential health care services in terms of access, uptake, and quality including contributing towards addressing the social determinants of health by the end of 2025. Likewise, the implementation of Health Information System Strategic Plan (2020/21-2024/25) is commenced to ensure evidence-based decision making through improving and promoting access to and use of quality data at all levels of the health system by nurturing digital health information technologies, mobilizing adequate resources and improving management of the health information system. In sum, as for the earlier health policies, the national policy framework in the HSTP I and II directly align with the four IPF Sub-components.

38. There are policy provisions and strategic directions in the HSDP vital to guide the implementation of the proposed IPF program including:
    - During HSTP II Equity will continue positioned as one of the transformation agenda to ensure healthy lives and wellbeing for all at all ages in Ethiopia.
    - The HSTP underlines the need to pay special attention for the disadvantaged and vulnerable groups. For instance, the provisions in HSDP states that pastoral communities have many special health needs that are not completely met by the largely static facility-based health system that has been established for the none pastoral areas. This gap prompted MoH to establish two core objectives under the HSDP: a) to establish an appropriate health service delivery for the

pastoralist population and; b) to increase coverage and utilization of health services in pastoralist areas. Working toward these aims, the MoH developed a concept paper, "Health Service Delivery to Pastoralists".

- As justified in the HSTP, the issue of gender has remained a crucial cross cutting concern. This prompted the MoH to set clear objectives for gender mainstreaming at all levels of the health interventions through the implementation period of the HSTP.
- Reproductive, Maternal, Neonatal, Child, Adolescent and Youth Health (RMNCAYH) focusing on conflict-affected areas are at the core of the HSTP.
- In HSTP, the government will devote to pharmaceutical services ensuring community access to essential medicines that are safe, effective and of assured quality.

3.1.3 National Health Equity Strategic Plan (2020-2025)

39. As national contexts, National health Equity Strategic Plan (NHESP) considers horizontal health equity as equal access to essential health service, equal utilization for equal need, and equal quality of care for all. Whereas, it conceives vertical equity as a financial equity, which means peoples has to pay according to affordability in a way that it will not create financial impoverishment (p. 3).

40. The NHESP recognize the existence of health access disparities based on geographic areas (between urban and rural, across regional states), demographic/age wise disparity, gender disparity, socio-economic disparity, disparity for people with special need—for example, persons with disabilities are faced with a range of barriers when they seek healthcare. Cognizant to this, the NHESP set strategies to address the aforesaid Health Equity Stratifiers. Among the strategies include mobilizing resources and actions that promote maternal health services, contraceptive prevalence rate, antenatal care, immunization service, child nutrition, communicable diseases prevention and control, health infrastructure in areas with poor coverage such as pastoral areas, pharmaceutical supply, and health digital transformation. These strategic guidelines directly overlaps with the interventions of the IPF project.

3.1.4 Health Information System Strategic Plan (2020-2015)

41. The plan document justifies that health information system is among the six building blocks of the health system that plays crucial roles in helping the health system to provide equitable quality health care through proper use of quality data in service provision, planning, performance monitoring, evaluation, and evidence-based decision-making. The plan assessed, to provide better quality of care and value for money, several efforts have been exerted on improving the health information systems since the instalment of reformed HMIS. More investments were also in place in the first Health Sector plan (HSTP I) period with due attention to the information system by making information revolution (IR) among the four transformation agendas. Then after, huge improvements have been achieved in health data management, HIS infrastructure, creating stewardship at all levels and assuring the basic principles of the health management information system reform that include standardization, integration, simplification and institutionalization. However, there are still areas for improvements, which include data access, quality and use as well as coordination of efforts in digitalizing the information system to have proper data storage, evidence generation, visibility, easy communication and use of information for evidence-based decision.

42. Therefore, to address the current weak HIS at the national level in general and the disparities in historically underserved regions (including Afar, Benishangual-Gumuze regions and parts of Oromia (Borena and Guji Zones)) in particular, the plan set out strategic directions that will be implemented to achieve the objectives of the HIS strategic plan. To this end, there are eight strategic directions

identified: (i) improve culture of information use; (ii) improve routine Data management and quality; (iii) nurture digitalization for data management and use; (iv) improve HIS Infrastructure; (v) strengthen vital statistics, surveillance, survey, research and innovation; (vi) improve HIS financing; (viii) improve HIS capacity of Health Workforce; and (ix) improve HIS governance.

3.2 Applicable World Bank Environmental and Social Standards (ESSs)

43. The World Bank Environmental and Social Framework (ESF) sets out the World Bank's commitment to sustainable development, through a Bank Policy comprising ten Environmental and Social Standards (ESSs). Out of the ten ESSs set out in the ESF, ESS1 and ESS7 are applicable to the requirement of the Social Assessment. The discussion that follow highlight on the provisions of the two ESSs.

3.2.1ESS1: Assessment and Management of Environmental and Social Risks and Impact

44. ESS1 sets out the MoH's responsibilities for assessing, managing, and monitoring social risks and impacts associated with each stage of the IPF project. The description of the activities of the Sub-components I and II of the IPF project discussed earlier provides the basis for the social assessment. As per the provision in paragraph 26, the social assessment takes into account in an appropriate manner all issues relevant to the project, including: (a) the country's applicable policy framework, national laws, and regulations, and institutional capabilities (including implementation) relating to social issues; variations in country conditions and project context; and socio-economic baseline information. As requirements of the ESS1, therefore, the social assessment is made up of analytical, process, and operational elements, combining (a) the analysis of context and social issues with (b) a participatory process of stakeholder consultations and involvement, to provide (c) operational guidance on developing the project design, implementation, and monitoring and evaluation (M&E) framework.

45. Once the potential risks and impacts of the Sub-components I and II of the IPF project are assessed and identified, Paragraph 16 emphasizes the importance of implementing mitigation hierarch before these Sub-components commence. As stated in paragraph 27, the mitigation hierarchy represents a systematic and sequenced approach to managing the potential social risks and impacts of the Sub-components I and II includes actions for: (a) avoiding adverse risks and impacts and enhancing positive socio-economic impacts and benefits to communities, to the greatest extent feasible; (b) minimizing adverse social risks and impacts that cannot be avoided; (c) remedying or mitigating the residual adverse social risks and impacts to an acceptable level; and (d) compensating or offsetting for those residual social risks and impacts that cannot be remedied. Further, knowledge about previous social assessments on similar IPF projects, success or failure of the relevant mitigation measures, and consultations with local communities to understand local context will be useful in designing an acceptable mitigation hierarchy.

3.2.2 ESS7: Historically Underserved Communities (HUCs) [58]

[58]ESS7 (paragraph 6) acknowledge that the use of the terminology to refer to Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities (IP/SSAHUTLCs) may varies widely from country to country. For instance, the use of the terminology IP/SSAHTLCS is not preferred by the Government of Ethiopia (GoE). To adhere to the preference of the Go and as per the direction given during the meeting of the Social Safeguard Team held on October, 2022 at Skylight Hotel, the term Historically Underserved Communities (HUCs) is used in this social assessment instead of IP/SSAHUTLCs.

46. The applicability of the ESS7 concerns the project-affected pastoral and agro-pastoral communities in Afar, Benishangul-Gmuz, and parts (Borena and Guji) of Oromia. Because, these are recognized as a distinct social and cultural group as per the defining features given in paragraph 8 the ESS7. The provisions of the ESS7, therefore, establish the requirements for the MoH to assess, manage, and monitor and evaluate the disproportionate social risks and impacts on Historically Underserved Communities (HUCs) associating with the implementation of Sub-components I and II of the proposed IPF project. ESS7 (paragraph 3) recognizes that HUCs have identities and aspirations that are distinct from mainstream groups in national societies and often are disadvantaged by traditional models of development. In many instances, they are among the most economically marginalized and vulnerable segments of the population.

47. For the aforesaid reason, if HUCs are present in, or have collective attachment to, the project area, ESS7 (paragraph 11) requires the MoH to undertake a targeted social assessment. A key aspect of the targeted social assessment is understanding the relative vulnerabilities of the IPF project-affected HUCs and how the project may affect them. The assessment is proportionate to the nature and scale of the proposed project's potential risks to, and impacts on, as well as the vulnerability of, the HUCs in association with the undertaking of the Sub-components I and II of the proposed IPF project. Likewise, the assessment considers differentiated gender impacts of the activities of Sub-components I and II on potentially disadvantaged or vulnerable groups within the HUCs. On the basis of the findings of the social assessment, paragraph 18 set out that adverse impacts on HUCs will be avoided where possible. Where alternatives have been explored and adverse impacts are unavoidable, the project implementing agency MoH will minimize and/or compensate for these impacts in a culturally appropriate manner proportionate to the nature and scale of such impacts and the form and degree of vulnerability of the affected HUCs.

CHAPTER 4: STAKEHOLDER CONSULTATION AND ENGAGEMENT IN THE SOCIAL ASSESSMENT

48. In accordance with the World Bank's ESS10, the IPF project recognizes that stakeholder engagement is the continuing and iterative process. In this sense, IPF project-related stakeholder engagement starts at project identification; proceeds through the development of the project, the environmental and social assessment; and project implementation; and ends with the closure and decommissioning of the project. As part of this continuing and interactive process, the social assessment has conducted stakeholder consultation. Accordingly, summary findings on the views and concerns of the different stakeholder groups are documented as follow.

4.1 Objectives of the stakeholder consultation

49. As per the provision set out in the ESS10, engagement begins as early as possible in project preparation because early identification of and consultation with affected and interested parties allows stakeholders' views and concerns to be considered in the project design, implementation, and operation. Backdrop to this provision, the objectives of the stakeholder consultation in the social assessment are to:

- develop a list of project-affected and other interested parties for stakeholder consultation and engagement.
- disclose project information to allow stakeholders to understand the risks and impacts of the project, and potential opportunities. Making available project-related information as early as possible in the project cycle and in a manner, format, and language appropriate for each stakeholder group.
- undertake a process of meaningful consultation in a manner that provides stakeholders with opportunities to express their views on potential project risks and impacts and allows MoH to consider and respond to them through designing appropriate mitigation measures.
- accommodate the views and circumstances of different stakeholders, paying special attention to the concerns and special needs of the disadvantaged or vulnerable individuals or groups. It takes into account the different access and communication needs of various groups and individuals, especially those more disadvantaged or vulnerable, including consideration of both communication and physical accessibility challenges.
- Provides the social baselines and inputs for the preparation of ESMF, RF, SMP, SEP and GBV Risk Assessment, Prevention and Response Action Plan.

4.2 Stakeholder identification and analysis

50. To facilitate a meaningful consultation for this social assessment and provide inputs for a process of preparing inclusive SEP, the social assessment identify the various stakeholder groups, those who are likely to be affected by the IPF project, as well as those that may influence the project's outcomes. The stakeholder groups are referred as the ***project-affected parties.*** These are identified as those likely to be affected by the project because of actual impacts or potential risks to their physical environment, health, security, cultural practices, well-being, or livelihoods. The stakeholder identification under this category include those individuals, groups or local communities who, because of their particular circumstances or special needs may be disadvantaged or vulnerable: PLW, newborns, U-5 children, IDPs, women and girls in general, the elderly, people with disabilities, conflict-affected communities as a whole. The stakeholders under this category include individuals, groups, historically underserved communities, the rural poor, and local communities in general. These individuals and groups make-up stakeholder group

who may have different concerns and priorities about the IPF project impacts, mitigation mechanisms, and benefits, and who may require different, or separate, forms of engagement. The discussions under Section 4.1 provide detail stakeholder analysis in this respect.

51. Whereas, ***other interested parties*** in the IPF project comprise individuals, groups, or organizations with an interest in the project, which may be because of the project location, its characteristics, its impacts, or matters related to public interest. These may be partner organizations, regulatory bodies, local government officials, community leaders, and civil society organizations, particularly those who work in or with the conflict=affected communities. While these groups may not be directly affected by the project, they may have a role in the project preparation or implementation. Thus, ***Annex 5*** compiles those other interested parties who may have in-depth knowledge about the environmental and social characteristics of the project area and populations and can help play a role in identifying risks, potential impacts, and opportunities for the project implementing organization MoH to consider and address in the assessment process.

4.3 IPF project-related information disclosure

52. As required in ESS10, meaningful stakeholder engagement depends on timely, accurate, accessible, and comprehensible information. Therefore, making available project-related information as early as possible in the project cycle and in a manner, format, and language appropriate for each stakeholder group is important. As part of this early project information disclosure, before directly jumping to consultation, stakeholders were provided with relevant IPF project-related information: (a) the purpose, scale, and duration of the project; (b) IPF Sub-components and the nature of the proposed activities under each Sub-component; (c) potential IPF project benefits and opportunities; (d) potential risks and impacts of the project on local communities, and the proposals for mitigating these; (f) the proposed stakeholder engagement process highlighting the ways in which stakeholders can participate; and (g) the process and means by which grievances can be raised and will be addressed.

4.4 Framework to engage with HUC

53. The framework to engaging with HUCs in general adopts a meaningful consultation tailored to HUCs. That is: (a) approaches to meaningful consultation are most effective when they build on existing customary institutions and decision-making processes utilized by the project-affected HUCs; (b) the consultation with the IPF project-affected HUCs is conducted in a gender-inclusive manner, so that the interests of both genders are considered in all aspects of project planning and implementation; and (c) there may be divergent views and opinions within the project-affected HUCs and a meaningful consultation takes into account these different viewpoints and opinions while respecting traditional cultural approaches to consultations and decision making.

54. The engagement with HUCs underlines that the HUCs may be particularly vulnerable to the loss of, alienation from, or exploitation of their land and access to natural and cultural resources associating with land acquisition for the activities of Sub-component I of the IPF project. In recognition of this vulnerability, in addition to those general requirement set out in ESSs 1 and 10, the MoH will obtain Free Prior Informed Consent (FPIC) of the affected HUCs in circumstances in which the civil works of Sub-component I will: (a) have adverse impacts on land and natural resources subject to traditional ownership or under customary use or occupation; (b) cause relocation of Indigenous HUCs from land and natural resources subject to traditional ownership or under customary use or occupation; or (c) have significant

impacts on HUCs' cultural heritage that is material to their identity and/or cultural, ceremonial, or spiritual aspects of the affected HUCs. In these circumstances, the project implementing agency MoH will engage independent specialists to assist in the identification of the project risks and impacts on HUCS.

55. FPIC is established as follows:
    (a) The scope of FPIC applies to project design, implementation arrangements, and expected outcomes related to social risks and impacts on the affected HUCs;
    (b) FPIC builds on and expands the process of meaningful consultation described earlier, and will be established through good faith negotiation between the MoH and project-affected HUCs;
    (c) The MoH will document: (i) the mutually accepted process to carry out good faith negotiations that has been agreed upon between the MoH and project-affected HUCs; and (ii) the outcome of the good faith negotiations between the MoH and project-affected HUCs, including all agreements reached as well as dissenting views; and
    (d) FPIC does not require unanimity and may be achieved even when individuals or groups within or among affected HUC explicitly disagree. Thus, consent refers to the collective support of the project-affected HUCs for the project activities that affect them, reached through a culturally appropriate process despite some individuals or groups object to such project activities.

4.5 Summary of stakeholders' consultation on IPF project: Views, concerns and responses given

56. For the purpose of IPF project social assessment, the selection of relevant stakeholders and participants of community consultation was done as per the requirements of the ESSs 1, 4, 5, 7 and 10. With this key note, summary views and concerns raised by the participants and responses given are presented below.

57. Interviewed officials/expertise and community consultation participants alike expressed their feeling of appreciation and thankful about the proposed IPF project interventions focusing on the special needs of conflicted affected areas and vulnerable individuals and groups. Given the critical health problems owing to a huge damage to health facilities in conflict, all the participants in the consultation invariably felt even the delay of the proposed IPF project interventions. However, both the officials/expertise and community members in the consultation raised their concerns on how the project shall be promptly and effectively implemented. Responses were given on these concerns that the World Bank is highly committed in providing technical assistance in conducting the environmental and social assessment and preparation of the required E&S management plans for speedily project disbursement. Besides, the proposed institutional and implementation arrangements for the effective execution of the project were discussed with the participants. Particularly, the health management members and workers consulted at the woreda and health facilities level raised further concerns on how to overcome the constraining factors of institutional gaps for the successful execution of the proposed IPF project interventions. Responding to this concern, the innovative approaches to reach out to the inaccessible conflict-affected areas/communities and technical assistance and capacity building activities proposed in the IPF project to strengthen the institutional capacity were shared with the participants. At the end, mutual understanding was made on the point and the officials/expertise and local community members agreed to play their roles and responsibilities for strengthening the project grassroots implementing arrangements.

58. One of the key issues emphasized by the participants of community consultation and interviewed community representatives raised in relation with project land acquisition for the civil works under the IPF Sub-component I. The participants expressed that the proposed PHC interventions through the reconstruction of conflict-damaged health facilities and establishment of temporary or satellite clinics at

IDP Camps are of top priority for the local communities and the project land acquisition for these purposes are welcomed in this respect. But, the consulted members of local community consistently raised the major concern regards what measures will be put in place by the project to address the risks and adverse impacts associating with involuntary resettlement. Responding to this concern, response was given that the IPF project will apply the mitigation hierarchy: avoid, minimize, and compensate the resettlement risks and impacts. Participants were explained that: following mitigation hierarchy approach, MoH will prepare resettlement plan (RP) for any IPF project activity that results in economic or physical displacement; project affected persons (PAPs) will actively engaged in the planning and implementation of the RP; no physical and/or economic displacement will occur without proper compensation measures; and accessible and inclusive IPF project specific grievance redress mechanism will be established. After clarifying with these responses, the participants acknowledge they are awareness of the project mitigation measures and their concerns addressed.

59. Justifying the special circumstances and needs they have, members of vulnerable groups and historically underserved communities approached through a separate interview expressed their serious concerns on how the IPF project implementation will overcome the social, cultural, and economic constraints with disproportionate impacts on them. Response was given highlighting the potential risks and impacts that might disproportionately affect vulnerable and disadvantaged groups, and describing the differentiated measures taken to avoid or minimize these including deployment of mobile health and CRVS teams, preparation of Underserved Community Plan, and establishment of temporary or satellite clinics to reach out to the special needs of vulnerable groups and HUCs. Participants' expression of acknowledgement for the differential mitigation measures proposed in the IPF project concludes on the concerns of the members of vulnerable groups and HUCs.

CHAPTER 5: KEY FINDINGS OF THE SOCIAL ASSESSMENT AND CONSULTATION

60. People are the reason for and the means of development. Their cultures, societies, and organizations provide the foundation on which development programs such as the IPF project rest. Likewise, the varied needs, aspirations, beliefs, and expectations of the people are among the factors that influence the implementation of development projects. Backdrop to this, Section 4 discusses the key findings of the social assessment.

5.1 Socio-economic and Demographic Baseline Information

61. The Ministry of Health assessed the impact of the conflict in Ethiopia on the health sector from November 2020 to December 2021. Accordingly, Tigray, Afar, Amhara, Benishangul-Gumuz, and Oromia are identified as the conflict-affected areas with huge damage to public health infrastructure and disruption to health service deliver. As per the Conflict Impact Assessment and Recovery and Rehabilitation Planning (CIARP)[59], the aforesaid regional states are identified as the target areas for the IPF program interventions. In this Section, a clear description of these regions about the locations, demographic characteristics and socio-economic profiles of the people will be reviewed. These helps to recognize the beneficiary profile, which are quite diverse comprising a number of sub-groups identifiable on the basis of their differential endowment, gender, ethnicity, different economic groups and other regional features.

5.1.1 Tigray Region

62. The Tigray region is located in the northern tip of the country. According to the CSA (2013)[60], the region has a total area of 53,000 km^2. The Tigray region shares a longer border with Amhara regional in the south, west and north-west, with Afar region in the east and north-east, with Eritrea in the north and with Sudan in the west. Administratively, Tigray region is divided into sex zones. As per the CSA Population Projection of Ethiopia for All Regions at Wereda Level in 2017, Tigray region has a ***total population*** of 5,247,005 out of which 2,587,003 are male and 2,660,002 female. Out of the total population of the region, the ***urban resident*** comprise 1,400,000 (690,000 male and 710,000 female) vis-à-vis 3,847,000 (1,400,000 male and 1,950,000 female) ***rural residents.*** As to the CSA forecast, Tigray is among the regions in Ethiopia with high rate of urbanization: the proportion of urban resident was 13.69% in 1994. 16.18% in 2007, 28.68% in 2017 and estimated to be 38.3% in 2032 and 42.7% in 2037.

63. According to the 2007 Population and Housing Census, in ethnic composition, the overwhelming majority (96.6%) of the total population is ethnic Tigray, followed by Amhara 1.6% and Irob 0.71%. Other ethnic groups comprised only 1.09% of the total population. In terms of religious composition ***(Table 3)***, 95.6% of the total population were Orthodox Christian and the proportion of other religious groups was meager: Muslim 3.9%, Catholics 0.7%, and Protestant 0.08%.

[59] Ministry of Health Ethiopia. (2022). Ethiopia Conflict Impact Assessment and Recovery and Rehabilitation Planning (CIARP): Final Health Sector Report and Costs, June, 2022.

[60] Federal Demographic Republic of Ethiopia Central Statistical Agency Population Projection of Ethiopia for All Regions at Wereda Level from 2014 – 2017

64. Education is a key social factor influencing an individual's awareness and attitudes for accessing essential health service. As per the 2016 EDHS, respondents who completed secondary or more than secondary school were assumed to be literate. All other respondents were given a sentence to read, and they were considered literate if they could read all or part of the sentence. To know the household heads' level of education, the EDHS sampled women and men aged 15-49. The data in ***Table 4*** reveals the proportion of the household heads with no education (illiterate) compose the majority: 72.2% for women and 68.7% for men age 15-49. Given the national average 48% of women and 28% of men age 15-49 with no education, the proportion of illiterate household heads is significantly higher for the Tigray region.

65. The 2016 EDHS categorized occupation as professional/technical/managerial, clerical, sales and services, skilled manual, unskilled manual, domestic service, and agriculture. In assessing occupational status, the survey sampled women and men age 15-49 who were currently employed or had worked in the 12 months before the survey. Accordingly, only 37.4% of women in Tigray region was currently employed vis-à-vis those who were not current employed (24.1%) and not employed in the 12 months preceding the survey (38.6%). There are notable variations in the proportion of currently employed women and men (74.9%) in the region. The 2016 EDHS further showed that agriculture is the dominant occupation in Tigray region. Out of those 426 women currently employed, 41% of them engaged in agriculture. Likewise, of those 709 men currently employed, more than half (52%) were engaged in agriculture.

5.1.2 Amhara Region

5.1.2.1 Socio-economic overview of the region

66. The Amhara Region is located in the Northwestern part of Ethiopia. The region covers a total area of approximately 154,000 km^2. It borders Tigray Region in the North, Afar Region in the East, Oromia Region in the South, Benishangul-Gumuz Region in the Southwest and the country of Sudan in the West. Amhara region is divided into eleven Administrative Zones and one Special Woreda with a total of 139 woredas. According to the CSA Population Projection of Ethiopia for All Regions at Wereda Level in 2017, Amhara region has a total population of 21,134,988 of which 10,585,995 are male and 10,548,993 female. Regarding the distribution of population by place of residence, the source of data shows that 3,682,000 (1,844,000 male and 1,838,000 female) reside in urban place while 17,453,000 (8,742,000 male and 8,711,000 female) live in rural area. The demographic dynamics based on the place of resident shows that the increment of urban resident in Amhara region had been low over the last two decades, 13.4% of the total population in 1994 census, 16.5% in 2007 and17.2% in 2017. Conversely, as estimated by CSA (2017), the proportion of urban population in the region will drastically increase for the next two decades: 26.4% in 2027 and 37.1% in 2037.

67. Based on the 2007 Population and Housing Census data, Amhara ethnic group is numerically dominant in the region comprising 91.5% of the total population. Next to the Amhara, Agew (4.9%), Oromo (2.6%), Argoba (0.5%), and Tigray (0.2%) make-up the largest number, respectively. Other Ethiopian national groups constitute only 0.3% of the total population in the region. With regards to religious composition *(see **Table 3**)*, Orthodox Christianity is numerically dominant in the region—82.5% of the total population belong to this religious group. Muslim adherent constitute the next larger number (17%) in the region. The proportion of other religious groups is insignificant, Protestant and Catholic Christianity make-up 0.02% each and other religious groups 0.07% altogether.

68. The occupational status of the household heads (women and men age 15-49) in Amhara region revealed the highest for women. Out of those 3,714 women sampled in the 2016 EDHS, 38.5% of them had no employment in the 12 months preceding the survey while 34.5% were not employed in the 7 days before the survey. In contrast, out of those 2,914 men age 15-49 sampled in the survey, the percentage of those who were not employed in the 12 months and 7 days preceding the survey was small, 5.9% and 4.8%, respectively. For those 966 women and 2611 men employed, the 2016 EDHS further assessed the type of occupation. The fining showed agriculture is the dominant occupation, 61.8% of women and 76.8% of men engaged.

69. With regards education status in Amhara region, ***Table 4*** presents percent distribution of household heads (women and men age 15-49) by highest level of schooling attended or completed. For both sex, the data shows the vast majority of household heads had no education, 80.4% of women and 77.6% of men were illiterate. As showed in the 2016 EDHS, access to all components of PHC (family planning, ANC, PNC, child health and nutrition) mostly varies based on the education status of household heads (women and men age 15-49). Given this fact, the higher proportion of household heads in the region with no education has a vital impact for the implementation of the proposed IPF program interventions. This requires means of mitigation measures in the design and implementation of the project.

5.1.2.2 Sampled Woreda: Tehuledere Woreda in South Wollo Zone

70. Tehuledere is one of the 20 woredas in South Wollo Zone. Geographically, it is situated at 11.4965° N, 39.5842° E. Tehuledere is bordered on the south by Dessie Zuria woreda, on the southwest by Kutaber woreda, on the northwest and the north by the Mille River, on the north east by Were Babu woreda, and on the southeast by Kalu woreda. The Mille River separates Tehuledere woreda from Amba Sel woreda to the northwest. Hayq town is the capital of the woreda and it is named after Lake Hayq which lies 2 kms east of the town. Other towns in Tewuledere woreda include Baso Mille, Boru Selassie, and Sulula. The altitude of Tehuledere woreda range from 500 meters above sea level along its south part to 2700 meters along its southwest border. The hydrology of the Tewuledere woreda includes two lakes: Hayq, which lies entirely within the woreda and it is the home of Istifanos Monastery an important landmark in Ethiopian Church history; and Ardibbo which lies to the south of Hayq, defining part of the border with Kalu woreda.

71. According to the CSA population projection values of 2017 at zonal and wereda levels, Tehuledere woreda has a total population of 144,860 out of which 72,903 male and 71,957 female. The same data source shows that the majority of the woreda population is rural—119,131 out of which 59,531 male and 59,600 female. Whereas, the urban population make-up only 25,729 of this 13,372 are male and 12,357 female. As per the desk review obtained from the Woreda Administration Office, with an area of 405.37 square kilometers, Tehuledere has a population density of 290.79, which is greater than the Zone average of 147.58 persons per square kilometer. A total of 28,780 households were counted in this woreda, resulting in an average of 4.1 persons to a household, and 27,643 housing units. In terms of religious composition, the majority (90.43%) of the inhabitants are Muslim while the remaining (9.35%) are believers of the Ethiopian Orthodox Christianity.

5.1.3 Afar Region

5.1.3.1 Socio-economic and demographic overview of the region

72. Afar regional state is situated in the northeastern part of Ethiopia with an area of around 150,000 km^2 that stretches into the lowlands covering the Awash Valley and the Danakil Depression. Geographically, the

region is situated longitudinally between 39°34' and 42°28' East and Latitudinally between 8°49' and 14°30' North. The region is bordered to the northwest by Tigray region, to the southwest by Amhara region, to the south by Oromia region and to the southeast by the Somali region of Ethiopia. It is also bordered to the east by Djibouti and to the northeast by Eritrea. Based on the CSA Population Projection in 2017[61], the total population for Afar region is 1,812,002 out of which 991,000 are male and 821,002 female. The same data source reveals that 346,000 (189,000 male and 157,000 female) of the total population are urban resident in comparison to 1,466,000 (802,000 male and 664,000 female) rural resident. The proportion of urban population in Afar had been small as reported in the 1994 and 2007 census, 7.5% and 13.4%, respectively. But, the rate of urbanization for the region in the coming decades is estimated as significantly high. The approximation of the proportion of urban population is 29.3% in the year 2027 and will increase to 40.4% in a short time, in 2037 (CSA 2013)[62].

73. According to the 2007 Ethiopian Population and Housing Census data, the overwhelming majority (88.7%) of the population in the region belongs to the Afar ethnic group. Next to the Afar, Amhara (5.1%), Argoba (1.53%) and Tigray (1.3%) comprised the major ethnic groups in the Region. In terms of religious composition ***(see Table 3)***, the proportion (93.83%) of the Muslim believer tremendously dominate in the region. Orthodox Christianity makes the second largest religion with 3.9% while other religious groups comprised only 2.27% of the total population.

74. Within the program target regions, the highest proportion of women (89.1%) and men (81.3%) age 15-49 with no education is in Afar region ***(see Table 4).*** The data in the same table further shows that educational attainment varies based on gender not only in Afar but also in all conflict-affected regions targeting in the IPF program. That is, men are much more literate than women at each level of education. The finding of the 2016 EDHS revealed that access to PHC is significantly higher in all measurements for educated people in comparison to non-educated. For instance, use of a skilled provider for ANC services increases with mother's level of education. Only about half (53%) of women with no education obtained ANC services from a skilled provider compared with 98% of women with more than secondary education. Therefore, the higher proportion of illiterate household heads in Afar and other regions means the use of ANC and PNC services is significantly low for the IPF program target areas, particularly in Afar region even in situation without the effect of conflict. This recommends that the design and implementation of the IPF program requires to take into account the vital role of social determinants of health such as education and gender.

75. In terms of economic activity, over 90% of the Afar people are pastoralist. They are highly dependent on extensive livestock production; other employment opportunities are limited. The mobile lifestyles of the Afar pastoralist are associated with very limited and often difficult and expensive access to social services. To worsen the matter, there is increasing environmental degradation and vulnerability to

[61]Central Statistical Agency (2017). Population Projection of Ethiopia for All Regions at Wereda Level from 2014 – 2017. Addis Ababa: CSA

[62]Central Statistical Agency (2013). Population Projections for Ethiopia 2007-2037. Addis Ababa: CSA

drought and flooding, exacerbated by climate change, and interacting with other factors to cause disease outbreaks, pressure and conflicts over resources such as water and grazing land (UNICEF 2019)[63].

5.1.3.2 Sampled Woreda: Chifra Woreda in Zone 1

76. Chifra is one of the seven Woredas administratively classified under Zone 1. Chifra is the name of the woreda as well as the capital of the province. Chifra is the woreda that borders between the Afar and Amhara regional states. It borders Worebabo and Habru woredas of the South Wollo zone in the south west, Ewa woreda in the north, and Mile and Bati woredas in the south. It is located at about 174 Km west of the regional Capital Semera and 650 km east of Addis Ababa. Geographically, Chifra is located between Latitudes 11^0 05^1 48^{11} and 11^0 46^1 06^{11} North and Longitude 39^0 53^1 49^{11} and 40^0 30^1 39^{11} East. The total area of the Woreda is about 151,902 hectares, stretching in 19 Kebeles. Based on the desk review information obtained from Chifra Woreda Administration Office, currently, Chifra woreda has a total population of 119,331. As Chifra town is the only urban area in the woreda, the vast majority (86%) of population is living in rural area.

77. The interview with the Head of Chifra Woreda Administration glimpsed the socio-economic description of the woreda as follows. The agro-ecology of the Chifra woreda is characterized as typical arid for rain fed crop production to serve as a basis for subsistence. Consequently, more than 80% of the people depends on pure pastoralism as a means of survival. Cattle, camel, goats and sheep make-up the composition of the herd animal. The main product for subsistence is milk and cattle are rarely slaughtered for their meat, but emergency slaughters occur. Sheep and goat are frequently slaughtered for household consumption as well as for sell to fulfil household cash demands. Camels are often for wealth display and lorry during mobility, they are occasionally slaughtered following marriage ceremony or death of household head and/ or religious holidays. Whereas, the agro-pastoral system is a set of practices that join pastoral livelihoods with that of irrigated crops production. By diverting the perennial flow at small scales along the Mille and Waama Rivers, some households cultivate maize as a supplementary food crop, while vegetables like tomato and onion and to some extent fruits such as mango, papaya and avocado are produced for marketing. However, as the informant explained, agro-pastoralism is a new phenomenon in the woreda that pastoralist residing along perennial rivers developed as an opportunity and/or coping mechanism to drought.

5.1.4 Oromia Region

5.1.4.1 Socio-economic and demographic overview of the region

78. Extending from west to east and to the southern borders of the country, Oromia is the largest regional state in Ethiopia with a total area of approximately 353,000km^2. Accordingly, Oromia is bordered by all regional states of the country with the exception of Tigray: to the east, it borders on the Somali and Afar regional states; to the north, it borders on the Amhara and Benishangul-Gumuz regions; to the west, it borders on the Gambella region. Oromia region has also international boundaries, Sudan on the west; Kenya on the south; and Somalis on the south-east. Administratively, Oromia region is divided into 20 Zones, 30 town administrations, 287 rural and 46 town Woredas. Oromia region is the largest in Ethiopia not only in terms of geographic area but also in terms of population size. According to the CSA Population Projection of Ethiopia for All Regions at Wereda Level in 2017, the total population in

[63]UNICEF. (2019). Situation Analysis of Children and Women: Afar Region. https://www.unicef.org/ethiopia/media/2326/file/Afar%20region%20.pdf, Accessed January 17, 2023.

Oromia is 35,467,001 of which 17,788,003 are male and 17,678,998 female. The same data source shows that the overwhelming number of population in Oromia region live in rural area: 30,113,000 (15,103,000 male and 15,010,000 female) *vis-à-vis* only 5,354,000 (2,685,000 male and 2,669,000 female) urban resident.

79. As reported in the 2007 Population and Housing Census, making 87.8% of the total population in the region the Oromo ethnic group overwhelmingly dominate followed by Amhara (7.2%), Guragie (0.93%), Gedeo (0.9%), and Somalie (0.33%). All together, the number of other Ethiopian national groups comprised 2.84% of the total population. As can be referred from ***Table 3,*** Muslim, Orthodox and Protestant Christianity were the major religious groups in Oromia region making 47%, 30.5%, and 18%, respectively. As shown in *Table 4,* among the program target areas, Oromia region is where the highest proportion of illiterate household heads (women and men age 15-49). According to the 2016 EDHS, 83.8% of women and 79% of men age 15-49 had no education or illiterate. As education is the key social determinant of health, the existence of higher percentage of household heads with no education in the region would negatively impact on the implementation of PHC services proposed in the IPF program. Thus, measures to mitigate the differential impact of education need to be designed in the program implementation. The occupational status of the household heads (women and men age 15-49) revealed a visible differences between women and men. As per the finding of the 2016 EDHS, 54.3% of women were unemployed in the 12 months preceding the survey while 12.8% were unemployed in the 7 days before the survey. Comparatively, the proportion of unemployed men in the last 12 months (4.8%) and 7 days (2.9%) before the survey was very low.

5.1.4.2 Sampled Woreda: Gida Kiremu Wereda

Gida Kirem is one of the 17 woreda located in East Wollega Zone. According to the CSA Population Projection of Ethiopia for All Regions at Wereda Level in 2017, Gida Kirem woreda has a total population of 211,035, out of which 105,790 are male and 105,245 female. The same data source reveal that the majority of the total population in the woreda reside in rural area, that is, 167,274 (83,861 male and 83,413 female). Whereas, about 43,761 (21,929 male and 21,832 female) people are urban resident.

Gida Keremu woreda is focused as a case illustration of the impacts of conflict on the health sector. For the security risks consultation through face-to-face interview was not possible. Alternatively, the data about the overview of the PHC services in the woreda was obtained through virtual consultation with informant from this area: A telegram group was created by the support of Oromia Regional Health Bureau as a mitigation measure to reach out to the conflict-affected zones and woredas with high security risks. This is substantiated with the information obtained from informants in Oromia Regional Health Bureau. Accordingly, the social assessment in the woreda illustrate the worst case scenario of the impacts of conflict. That is, the health facilities and infrastructure in the woreda are out of the administrative control of the Regional Health Bureau. It was noted that the health facilities and infrastructure are under the control of the armed group in the areas and, thus, managed to provide essential health services to the members of the armed group. There are cases where the health workers forced to serve for the health needs of the local armed groups.

5.1.5 Benishangul-Gumuz Region

80. The Benishangul-Gumuz regional state is located in the western frontier of Ethiopia. The region has a total surface of 50.380 $km^{2.}$ It shares borders with Sudan in the north-west, South Sudan in the west, Amhara regional state in the east, and Oromia region in the south. The region is organized into three administrative zones (Metekel Zone, Assosa Zone, and Kemashi Zone) and 20 Woredas. According to the CSA Population Projection of Ethiopia for All Regions at Wereda Level in 2017 the total population of the region is 1,066,001 (541,002 male and 524,999 female). Out of the total population 230,000 (117,000 male and 113,000 female) are urban resident and the remaining 836,000 (424,000 male and 412,000 female) are living in rural area.

81. Interestingly, the Constitution of the Benishangul-Gumuz regional state explicitly differentiates between endogenous and other peoples. *Article 2* of the Regional Constitution classifies the following five ethnic groups as endogenous: the Berta, Gumuz, Shinasha, Mao and Komo. However, none of those five ethnic groups has a numerical majority: the three most numerous endogenous groups are the Berta (25 .9 %), the Gumuz (23.3%) and the Shinasha (7.6%). The Mao constitute 1.9% and Komo (0.96) count for less than 1% of the total population. Striking is the large number of Amhara (22.1 %) and Oromo (8.93%), an illustration of the impact of migration (Census 2007). Benishangul-Gumuz is a sparsely populated region. This, together with its fertile soil, makes the region attractive to many Ethiopian farmers from other regions who wish to leave their own small and exhausted plots behind. This interregional migration is clearly reflected in the ethnic composition of the region's population. According to recent study, the number of Oromo ethnic groups in the region increase from 8.93% in 2007 to 20.9% in 2021. Thus, the current number of Amhara and Oromo constitute 43% of the total population in the region. As can be seen from ***Table 3,*** Muslim and Orthodox Christianity are the major religious groups in the region comprising for 45% and 33%, respectively.

82. The 2016 EDHS reported the occupational status of the household heads of both sexes in Benishangul-Gumuz region as follows. More than half (51.3%) of women and 10.1% of men age 15-49 were unemployed. The fining shows, like for other program target regions, the occupational status in Benishangul-Gumuz region varies between women and men with the former significantly represented as unemployed. Among those employed, the survey further revealed, agriculture is the major type of occupation for both women (71.1%) and men (70%).

Table 20 Number and percentage distribution of religion by the project target regions

Region	**Total population as per 2007 Census**	***Religious group***									
		Orthodox		***Muslim***		***Protestant***		***Catholic***		***Others***	
		No.	***%***	***No.***	***%***	***No.***	***%***	***No.***	***%***	***No.***	***%***
Tigray	4,314,456	4,123,087	95.6	171,219	3.9	3,635	0.08	15,616	0.7	899	0.02
Afar	1,411,092	54,675	3.6	1,324,050	94	9,344	0.7	989	0.1	624	0.04
Amhara	17,214,056	14,208,067	82.5	2,952,775	17	30,240	0.2	4,270	.02	13,037	0.07

Oromia	27,158,471	8,269,813	30.5	12,886,961	4.7	4,818,842	18	122,700	0.5	1,060,155	3.9
Benishangul-Gumuz	670,847	221,168	33	304,432	45	90,272	14	4,191	0.6	50,784	7.6

Source: The 2007 Ethiopian Population and Housing Census.

Table 21 Percent distribution of women and men age 15-49 by highest level of schooling attended or completed

Region	***Highest level of schooling***								***Number sampled***	
	Percent of women age 15-49				***Percent of men age 15-49***					
	No Education	*Primary*	Secondary & above	Total	*No education*	*Primary*	Secondary & above	Total	***Women***	***Men***
Tigray	72.2	20.4	7.4	100.0	68.7	21.5	8.9	100.0	1,129	708
Afar	91.1	6.8	2.0	100.0	81.3	11.7	7.0	100.0	128	82
Amhara	80.4	13.6	6.0	100.0	77.6	14.3	8.0	100.0	3,714	2,914
Oromia	83.8	11.2	4.9	100.0	79	16.2	4.8	100.0	5,701	4,409
Benishangul-Gumuz	83.1	10.7	6.2	100.0	67.9	19.9	12.2	100.0	160	118

Source: *Compiled based on the 2016 Ethiopian Demographic and Health Survey (EDHS)*

5.2 Description of the Socio-cultural, Institutional, Historical and Political Context

83. The social assessment provides the baseline information for designing the social development strategy. The analysis helps to determine what the key social and institutional issues are in relation to the project objectives; identify the key stakeholder groups in this context and determine how relationships between stakeholder groups will affect or be affected by the project; and identify expected social development outcomes. The key elements and entry points for the social analysis relevant to the project encompass the following ones.

5.2.1 Social organization

84. A social organization is a pattern of relationships between and among individuals and social groups in a given society. The concept of social organization comprehends the system of obligation-relations existing in a given society at a given time; this system of obligation-relations is most adequately evidenced by the commonly held sets of behavior anticipations (Durkheim 1933)[64]. Broadly speaking, the bases of social organization in the project target communities differ based on place of residence (urban versus rural) and type of livelihood (agriculture versus agro-pastoral/pastoral). As they constitute the vast majority of the

[64]Durkheim, Emile [1893] 1933. The Division of Labour in Society. New York: The Free Press.

project target areas, the social assessment pay a due attention to the system of social organization in the rural communities.

85. As per the finding of the social assessment, the agricultural-based communities in Tigray, Amhara and highland areas of Oromia regions share the same system of social organization. Informants from Amhara and Oromia explained kinship and lineage as the major bases of social organization for local communities in their respective areas. As to the informants, ***kinship*** is a social network of relatives formed based on blood and marriage affinities among individuals. The social network through kinship provides individuals with certain mutual rights and obligations. One's place in this network or kinship status determines what these rights and obligations are. Providing groups of relatives with a social structure, kinship helps shield them from the dangers of disorganization and access essential resources such as land. Whereas, a ***lineage*** is a corporate descent group or a unified body or corps of consanguineal relatives who trace their genealogical links to a common ancestor and associate with one another for a shared purpose. Informants expressed that a lineage is a kind of social network in which being in the direct line of descent from a particular real or mythical ancestor is a criterion of membership. Kinship and lineage are thus the most significant social and cultural features that differentiate among individuals in these project target areas. Those individuals who belong to the social network through kinship or lineage are privileged to access vital resources such as land while those who are excluded have not rights to access such vital resources. The key take away for the IPF program is that individual's inclusion and exclusion based on the kinship and lineage may reflect in the access to project services and benefits. There is also the second key take away. That is, common to the project target agricultural-based communities in Tigray, Amhara and Oromia a decent group membership is traced through the male-line or patrilineal descent system. This means, the social network through lineage that provide individuals with key resources make distinction between men and women. As informants explained, in the patrilineal group, authority over the vital resources (e.g. land) and children rests with the father or men. As frequently explained earlier and also below, such differential social and economic status of women has important implication for the implementation of the IPF Sub-component I.

86. In contrast, ***clan system*** is the most important form of social organization among the agro-pastoral and pastoral communities in Afar, Borena, Guji, Gumuz, Berta and Mao. For these communities, clan is understood as identifiable mechanisms of identity reproduction and embedded in the territorial, social, economic, political, and spiritual collective attachment. According to the clan system in these communities, consideration is given to the fact that such groups live under many different circumstances with varying levels of attachment to the areas in which they live. Collective attachment signifies that the groups generally consider their lands and resources to be collective assets, and that they see their culture and identity as a function of the group rather than as individuals. It also signifies that these groups' economies, modes of production, social organization, and cultural and spiritual circumstances are generally linked to particular territories and natural resources. The concept of collective attachment through clan system refers to geographically distinct habitats or ancestral territories, or areas of seasonal use or occupation and the natural resources therein. In short, the social organization based on clan system defines the agro-pastoral and pastoral communities in Afar, Borena, Guji and Benishangul-Gumuz as a Historically Underserved Communities (HUCs) or a distinct social and cultural group identified in accordance with paragraphs 8 and 9 of the ESS7. Given this fact, there are key social issues implying for the IPF program. The implementation of the IPF Sub-component I (RMNCAH+N) needs to devise special measures that fits to the distinct social and economic interest of the agro-pastoral and pastoral

communities. As just stated, the life of these communities are inextricably linked to the land on which they live and the natural resources on which they depend. They are therefore particularly vulnerable if their land and resources are affected due to land acquisition related to restoration or reconstruction of health service facilities and infrastructure.

87. Interviewed clan leaders and community elders described further commonalities of social organization among the project target agro-pastoral and pastoral communities. Central to the social organization of all, they have a ***patrilineal descent*** system based on which a person belongs to a particular clan. Settlements are composed of residents either belong to the same clan or are marital relatives. As informants justify, this makes it easier to organize social, economic and political support in times of crisis. Clan members are expected to share resources and help each other in emergencies. Such support becomes practically difficult to claim when members of a kinship group or a particular clan are far apart. In all the project target agro-pastoral and pastoral communities, clans are represented by clan heads, who access leadership status based on their age, strength in decision making and overall credibility in the community. Clan leadership positions are sometimes accessed through inheritance. Upon the death of a clan head, his sons will be considered for the position. Clan heads are entrusted with the overall social, economic and political responsibilities. It is clan leader's duties to regulate the behaviours of clan members and mobilise clan members for some positive pursuits, including co-operation in resource management activities and raising money for compensation for any physical or psychological damage caused upon others during violent conflict. They make sure that every clan member is socially, economically and politically secure. Further, land cannot be owned or claimed exclusively either by an individual or as a family holding, nor can it be sold. Instead, land and natural resources are communal property belonging to the clan members. Clan leaders and council of elders are the traditional authorities entrusted with the power to control access to and use of land and natural resources. But, the system of social organization exclude women from the social, economic and political arenas. This shows that women can be double-disadvantaged, marginalized both within their own communities and mainstream society. Consequently, women's ability to actively participate in and equally benefit from the IPF program interventions may seriously restricted unless considering their specific needs in this regard.

88. The social assessment further explored that some of the project target pastoral communities have developed a unique and long lasting system of social organization. The ***Gadaa*** system is worth to mention here. *Gadaa* system is an indigenous institution among the Borena and Guji pastoral communities through which the community administered, defended their territory, maintained and developed their economy. It is a comprehensive and self-sufficient system that influences people's day-to-day life. *Gadaa* is a system of socio-cultural organization based on age-grade of the male members of the community that succeeds each other every 8 years in assuming economic, political, military and social responsibilities accordingly. Once again, the social organization of *Gadaa* system differentiate between men and women with the former dominating the social, economic and political power. This can make the participation and influence women in the project implementation.

5.2.2 Institutions

89. All human societies are characterized by more or less complex and overlapping networks of regular social interactions and practices. Whether economic, political or cultural, such repeated interactions require agreed and predictable rules – ways of doing things; such sets of rules constitute institutions. Thus, ***institutions*** are systems of established and embedded social rules that structure social interactions

(Hodgson 2006)[65]. There is a widespread consensus that institutions matter crucially for development endeavors. Because, in an interactive process between individual and group institutions are developed that mold human motivations and channel human actions in such a way that basic needs can be satisfied more efficiently. Examining social groups' characteristics, intra-group and inter-group relationships, and the relationships of those groups with household and public decision process helps to identify possible institutional constraints and barriers to project success as well as methods to overcome them. Also, it helps to identify what opportunities are there to utilize the potential of existing institutions to strengthen the implementing capacity of the project. The descriptions below consider the presence and function of both formal and informal institutions in the project target communities.

5.2.2.1 Formal institutions

90. Formal institutions are normally established and constituted by binding laws, regulations and legal orders which prescribe what may or may not be done. They are well constituted body established on mutual agreement with an oath of allegiance to accomplish a pre-determined goal or purpose. This implies that the functioning of a formal institutions is based on a well-defined organizational structure managed and coordinated by specialists and practitioners in its various areas of operations (Kaufmann et al 2018)[66]. During the interview, federal and regional level stakeholders were asked to identify what public, civic society organizations (CSOs) and community-based organizations (CBOs) operate in the project target areas that may promote the effective implementation of the project. Besides the main implementing agency MoH and its line regional and woreda offices, informants discussed the presence and function of various government organizations having structure starting from federal to Kebele level. The operation of the Ministry of Women and Social Affairs (MoWSA) and its line regional and woreda offices align with the project objectives, particularly the activities under Component I (Provision of EHS Focusing on RMNCAH+N to Conflict-Affected women, children, youth, IDPs and other vulnerable and marginalized groups). Justifying this, the informant from the Ministry stated:

> *The MoWSA and its regional and woreda structures are responsible for the Affairs of Women, Children, Youth and the overall Social Affairs of Persons with Disabilities, the Elderly, the poor, and other vulnerable and marginalized segments of the Population. The MoWSA and its regional and woreda structures are committed to avoid any societal system that constrains the equal participation and development benefits of these vulnerable and marginalized groups of people.*

91. Interviews with federal, regional and woreda level stakeholders reveals that there are numerous development partners and international and national humanitarian organizations operate to improve humanitarian assistance focusing on RMNCAH+N to Conflict-Affected women, children, youth, IDPs and other vulnerable and marginalized groups. Among others, UNICEF, OCHA, WFP, USAID, Ethiopian Red Cross Society, and international and local NGOs actively operate in improving access to Essential Health Services including medical supplies, maternal and child health care, nutrition, psychosocial support, child protection and GBV during and after conflict in the project target areas. The existence and function of these development partners and NGOs could be opportunities to work with and coordinate efforts to strengthen the implementing capacity of the IPF program.

[65]Hodgson, Geoffrey (2006). What are Institutions? *Journal of Economic Issues,* Vol. XL No. 1: 1-25

[66]Kaufmann et al (2018). Formal institutions, informal institutions, and red tape: A comparative study. *Wiley Public Administration*, vol. 96:386–403.

92. Other potentially relevant institutions operating in the project target areas include private institutions working in the health sector. The existence and function of private health facilities, drug stores, and medical equipment suppliers is a good opportunity to strengthening public-private partnerships in improving RMNCAH+N service delivery, the CRVS system in the IPF sub-component and technical capacity towards effective implementation of the project.

93. Community-based Organizations (CBOs) provide another type of formal institutions with the opportunity for cooperation to strengthen the implementation capacity of the project. Community-based organizations are a non-profit organizations whose activities are based primarily on volunteer efforts and aims to promote the mutual benefits of the members. CBOs are a strategic asset capable of aligning the goals, objectives and resources of non-locally based entities such as federal and state programs, development partners, and NGOs (Yukio 2018)[67]. Examples of CBOs include Women and Youth Associations formed at the Kebele level working to protect the right and mutual benefits of the members. As they represent the interest of vulnerable groups, working with CBOs such as Women and Youth Association can play an important role in strengthening the implementing capacity of the IPF program. However, the function of Women and Youth Associations are not active in agro-pastoral and pastoral based communities and that may be a constraint.

5.2.2.2 Informal institutions

94. Informal institutions, on the other hand, are constituted by conventions, norms, values and accepted ways of doing things, whether economic, political or social; these are embedded in traditional social practices and culture which can be equally binding (Hodgson 2006)[68]. The social assessment highlights important customary institutions in all project target communities (see the discussion under ***Section 5.4***). Also, the interview with stakeholders from federal to woreda level and consultation with local communities uncover that the existence and function of information institutions could create opportunities in strengthening the implementing capacity of the IPF program. As discussed under the ***Section 5.5*** below, the existence and function of informal social institution can also constrain on the project implementing capacity.

95. Research findings show that access to and use of PHC services such as family planning, maternal, child and youth health care and nutrition of children (IPF Sub-component I) and civil registration and vital statistics (IPF Sub-component II) significantly associated with women's and men's age 15-49 exposure to Mass Media, particularly radio, television, internet and newspapers (EPHI 2019)[69]. Contrary to this, the social assessment found out that the project target areas and population are predominantly rural where exposure to Mass Media such as radio and television is basically lacking. Also, because of the low literacy rate among the women and men age 15-49 **(see Table 4),** the use of internet and print media is not popular. Given this, the project target communities basically depend on traditional means of communication for essential everyday life. Thus, the existence and function of the informal system of communication can effectively boost the implementation of the IPF Sub-component I and Sub-component II. ***Dagu,*** the traditional institution of information exchange among the Afar pastoral communities

[67] Yukio Miyawaki (2018). Development of Community-Based Organization by Agro-Pastoral Women: A Case in Southwestern Ethiopia. *Nilo-Ethiopian Studies*, vol. 23: 1-21.

[68] Hodgson, Geoffrey (2006). What are Institutions? *Journal of Economic Issues,* Vol. XL No. 1: 1-25

[69] Ethiopian Public Health Institute (EPHI) (2019). Ethiopia Mini Demographic and Health Survey. Addis Ababa: EPHI

provide a typical case in point. An explanation of the key informant Afar elderly from Chifra on the point went as follows:

> *Modern means of communication such as radio, television and telephone are lacking among the Afar who live in rural place. An important traditional mechanism that the people use as a replacement for modern communication technology is the Dagu. This is a way of information exchange through the relaying of news about important events from one person to another. When two Afar people meet, they sit down and spend some time (usually about half an hour or more) discussing the major economic, social and political events that took place recently in their respective localities. This takes place all the time without exception: whether the individuals knew each other previously or not is immaterial. It does not matter if one is in a hurry or not. A stranger who makes his way to Afar land is also expected to adopt the system and behave in a similar fashion. Until he gives all the information or news about latest development in his place, he can never be trusted and the Afar refrain from effectively interacting with the new comer.*

96. One of the opportunities to utilize existing informal institutions in strengthening the implementing capacity of the IPF program relates to nutrition. In an effort to accelerate the reduction of undernutrition, the Government of Ethiopia developed the National Nutrition Strategy in 2008. This is followed by the second phase of National Nutrition Program (NNP II), which covers the period from 2016 to 2020. It aimed to addresses the multi-sectoral and multi-dimensional nature of nutrition, and guides policies, strategies, programs, and partnerships that deliver cost-effective nutrition interventions. Yet, nutrition is fully integrated in the HSTP IV and one of the supports under IPF Sub-component concern nutrition. However, studies of have shown that nutrition is highly associated with household income and food security status (EDHS 2016; EPHI 2018). Contradicting this, besides the impacts of the conflict, the social assessment find out that the agro-pastoral and pastoral areas, particularly the entire Afar region and Borena and Guji areas in Oromia are characterized by recurrent drought and chronic food security. Whereas, poor agricultural practice coupled with land fragmentation, shortage of rainfall, lack of modern agricultural inputs and plant epidemic causes serious household food insecurity in Amhara, Tigray, Benishangul-Gumuz and agricultural based conflict-affected areas in Oromia. The situation differentially increased the vulnerability of Pregnant and Lactating Women, under-5 children, the elderly, and people with disabilities to undernutrition. In such the case, the project target communities have various forms of informal mutual economic and social support for the vulnerable groups. An informant from Oromia Women and Social Affairs Bureau discussed a striking informal institution used among the Borena and Guji pastoral communities:

> *The Borana and Guji pastoral communities are known for their strong social networks, which provide mutual social and economic support for vulnerable people and households. Marro is women's social security network in accessing resources to overcome household food security. It is a voluntary social support network between friends, neighbours and families in which all women participate, regardless of livelihood bases, economic status and age differences. The majority of women use marro when need arises, while a significant number of poor and elderly women depend on it for daily survival. Marro relations resemble both bonding and bridging networks in which resources are mobilized and shared between neighbouring and far-distant households, respectively. In both bonding and bridging marro, women share resources such as food items, labour and cash on the basis of trust and solidarity. The primary aim of the shared resources is to overcome household food shortages that increase during drought.*

97. Similar informal institutions with mutual social and economic support exist in the agricultural-based communities in Amhara, Tigray and Oromia. There are common forms of labor sharing such as *debo, jige* and *wanfe* often during planting, weeding or harvesting and sometimes for house building that are either reciprocal, usually between two individuals or households, or festive, in exchange for food and drink, often called by wealthier households. Some of these are forms of religiously prescribed charity, as in the case of Zakat or Fidri gifts at the end of Ramadan in Islam, or gifts during Saints days in the Orthodox Christian tradition. Some local institutions have specific purpose, notably credit and saving *(eqqub),* pooling resources in turn (women's butter or spinning groups), or for burial *(iddir),* which may also play a role of support for the vulnerable.

5.2.3 Conflicts

98. Various social assessments and informants consulted listed various reasons for the presence of conflicts in the pastoral, agro-pastoral and farming communities of Ethiopia. It is therefore important to know the sources of conflicts during the implementation of the project in the areas it covers. The following discussions provide an overview of the sources of conflicts in the IPF project target areas.

99. According to the information obtained from the interviews with the stakeholders (regional and woreda), community consultation and previously conducted studies in the areas, the sources of conflicts in the respective project target regions are diverse. Some of the causes of conflicts (such as conflicts related to grazing/farmland, water and other vital natural resources) are common across the project target regions. While some conflicting factors are related to the social and political dynamics particular to certain project target Region, Zones or Woredas. Yet, the causes of conflicts vary depend on the livelihood system (pastoral versus agricultural) of the project target communities. Backdrop to this, the findings of the social assessment are presented below.

5.2.3.1 Resources

100. Pastoralists are defined variously in the literature as those who entirely or predominantly obtain their means of livelihood from livestock and livestock products and who characteristically practice mobility to avoid risk, respond to variable climatic conditions and ensure healthy livestock and rangelands (Coppock 1994)[70]. Owing to this mode of life, informants explained, access to vital resources such as grazing land, water and natural resources is the root cause of recurring conflicts in the project areas with pastoral communities, particularly in Afar and Borena and Guji Zones of Oromia. As to the informants, within the extensive rangelands of these areas, scarce and variable rainfall dictates the presence or absence of pasture on which livestock depend. The rainy season permits pastoralists to disperse over a wide area, while the grazing range contracts in the dry season around permanent water sources such as rivers or groundwater-fed wells. This has been exacerbated by the continuous environmental degradation and reduced carrying capacity of the rangelands combined with overgrazing by large cattle herds. Consequently, competition over access to water and land resources is the root cause of conflicts between clans and ethnic groups such as between Afar and Isa clan of Somali, Borena and Gerri clan of Somali.

[70]Coppock, D.L (1994) 'The Borana Plateau of Southern Ethiopia: Synthesis of Pastoral Research, Development and Change. Addis Ababa: ILCA.

5.2.3.2 Territorial claims

101. The social assessment depicts, besides being valuable sources of livelihood, many natural resources such as rivers and forests or grazing areas serve as the boundaries between neighboring pastoral groups in the project areas. For instance, consciousness of clan 'territory' is more intense nearer to the water source such as the Awash River in Afar region, whereas exclusive rights to land are less important farther from the water source, The illustrate the significance of the nexus between water resources and territorial definition as the recurring conflict between the Afar and Isa clan of Somali along the Awash River. Hence, among the pastoral communities such as Afar, Borena, and Guji, conflicts over access to natural resources often transform into more protracted boundary and territorial conflicts.

102. Informants expressed, in some project target communities, this territorial risk factor has historical, political, social and economic roots. The recurring inter-ethnic conflicts and tensions between the neighboring Borana (in Oromia region) and Digodi and Gerri (in Somali region) the dominant pastoral groups in the area provides a legendry case in point. An explanation by an expertise interviewed from Oromia Regional State Bureau of Pastoral Communities' Development went as follows on the point:

> *Though the Borena, Digodi and Gerri pastoral groups share common pastoral resources not only in Ethiopia but also across the border in Kenya, the recurrent conflicts between the Borana on the one hand and Digodi and Gerri on the other is caused not solely due to ethnic divisions or disputes over resources. In addition, the conflicts between the groups have been intensified and shaped by political factors, particularly, the interventions of the government and local administrations, changes in administrative boundaries, and competition over the economic control of the trade activities along the Ethio-Kenya borders.*

5.2.3.3 Socio-political based conflicts

103. The major sources of conflicts in Tigray, Amhara, Afar and non-pastoral areas of Oromia are associated with the socio-political contextual security risk factors. These are security risks in the external environment (at regional/subnational or local level) that the IPF project does not control but which could negatively impact the project's ability to meet the E&S requirements.

104. The basic source of conflict in Tigray, Amhara and Afar is related to the recent war in the northern Ethiopia. The political disagreement between the Federal Government and Tigray regional administration led by Tigray People's Liberation Front (TPLF). The political divergence that began in 2018 culminate in the violent war on 4 November 2020. The violent conflict broke out in Tigray region continued to escalate with active fighting and expanding across areas of the Afar and Amhara regions. The conflict that has been fought for two years greatly damaged the basic social services in the entire Tigray region and conflict-affected areas in Amhara and Afar regions.

105. According to studies, the inter-ethnic and armed group conflicts have been increasing in Oromia region over the past five years. Available researches assessed different socio-political contexts in this regard. The dynamics of political violence in the region underlines the first reason. It is caused due to the battles being fought between the law enforcement agencies (National Army, Federal Police, and Oromia Regional Special Forces) and the armed group Oromo Liberation Front dubbed "OLF-Shane" (Tegbaru 2021)[71]. The second major reason and parallel to the first is the changing trends in the inter-ethnic relations among

[71] Tegbaru Yared. (2021). Conflict dynamics in Ethiopia: 2019-2020. Institute of Security Studies: East Africa Report 44: 1-11.

diverse communities inhabiting the region (Omni Consult 2021)[72]. The emergence of informal forces and youth groups coupled with the institutional fragility and complicity reveals the third cause of conflict in Oromia region (Institute for Security Studies 2021)[73].

106. Besides the resource and territorial based conflicts highlighted above, the sources of conflict in Benishangul-Gumuz are rooted in socio-political contexts. According to studies, these are related to an accumulation of unresolved political tensions that built up over three decades and linked to issues of underdevelopment, ethnic marginalization and the expansionism of settlers (primarily Amhara and Oromo) into the region (Jan 2021)[74]. The indigenous ethnic groups feel that the increasing quest for fairer representation among numerically increasingly dominant but non-indigenous groups in the region may ultimately override their right to self-administration. While indigenous groups want to preserve their status and accordingly their right to self-administration, non-indigenous ethnic groups feel politically marginalized. These contending positions have been the most common cause of mistrust and ethnic rivalry in the region (Christophe 2007)[75]. Given this reason, the conflict first broke out in Assosa town in 2018, spread to Metekel Zone in April 2019, and eventually to Kemashi Zone. The conflict in Benishangul-Gumuz involve an array of actors from members of different ethnic groups including Gumuz, Berta, Amhara and Oromo to armed groups including Gumuz Militias, Benishangul People's Liberation Army (BPLA), Oromo Liberation Army (OLA), regional and federal forces (Tsegaye 2022)[76].

5.2.4 Traditional conflict resolution mechanism

107. The type of conflict resolution mechanism in the project target areas depend on the scale of conflicts. As we have seen in the preceding discussions, the scale of conflicts in the project target areas involves micro and macro level. *Micro level conflicts* are small-scale conflicts that occur with community members, among community groups/clans and inter-ethnic conflicts. Small-scale conflicts of these sorts are mainly caused due to the competition of actors over basic resources such as grazing/farming land, water and other natural resources. While *macro level conflicts* are large-scale conflicts that occur among armed groups such as Oromo Liberation Army commonly known as *Shane* and government law enforcement bodies (Oromia Police/Special Force, Federal Police, and National Defense Army). As the causes of large-scale conflicts of this kind are rooted in complex socio-political factors, their resolution mechanism depend on formal legal system. Thus, the focus of the social assessment concerns the traditional mechanism that are widely used among the project target communities to resolve every-day life conflicts involving interpersonal reasons and competition over access to basic resources.

[72] Omni Consult. Conflict mapping and context analysis for peace building program in Ethiopia. https://www.kirkensnodhjelp.no/, Accessed January 13, 2023.

[73] Institute for Security Studies. Drivers of ethnic conflict in contemporary Ethiopia. Monograph 202, December 2021.

[74] Jan Nyssen. (2021). The marginalized Gumuz communities in Metekel (Ethiopian Western lowlads). https://www.researchgate.net/publicaiton/34798365, accessed January 13, 2023.

[75] Christophe Van der Beken (2007). Ethiopia: Constitutional protection of ethnic minorities at the regional level. *Africa Focus*, 20 (1-2): 105-151.

[76] Tsegaye Birhanu. (2022). Conflict Trends Analysis in Benishangul-Gumuz Regional State. Rift Valley Institute: UK

108. There exist various traditional institutions in the project target communities that have their own customary methods of settling conflict**.** *Gadaa* is the traditional mechanisms of resolving conflicts and managing natural resources among the Borena and Guji pastoral communities. The foundation of the gadaa system is rooted in the informal or customary Oromo institutions of aadaa (custom or tradition), seera (informal laws), safuu (or the Oromo concept of Ethics), heera (justice) and the associated cultural administrative structure. By establishing the rules and regulations that determine individuals' and groups' rights to access natural resources, the *Gadaa* indigenous institution effectively resolves conflicts. The Gadaa system of conflict resolution has levels of administrative structure, the councils of elders and Ababa Gadaa. The councils of elders are responsible to resolve every-day based conflicts. Any problem regarding which could not be solved by the councils of elders would be handled by the higher authority of the Gadaa system known as Abba Gadaa. Particularly, when conflict breaks out between clans of the same ethnic, the Abbaa Gadaa will rule on the case. More importantly, if there is conflict between ethnic groups, the mediating role of the Aba Gadaa will be called in to help make peace.

109. As the key informant clan leader explained, the dispute resolution mechanism of the Afar pastoral communities in Chifra shared the same traditional institution practiced in other areas of the region. It is known as *Mada'a* which is governed by an unwritten Afar law that is transmitted from generation to generation orally. As to the key informant, the system of *Mada'a* law is of two types: dispute-resolution laws that concern intra-ethnic group disputes and laws concerning inter-ethnic group disputes. In the former case, the law is called *afare* while it is termed as *adanle* in the latter case. When the Mada'a involves dispute resolution within the family, between neighbours, and within a clan (sub-clan) it is known as the ***maro*** institution. It is the session held under a tree to resolve conflicts. A *makaban* (judge), the elders, the disputants, witnesses and observers sit in a circle (from which the term maro derives). The makaban is a clan leader who knows the Afar customs very well. Depending on the gravity of the case, the number of makaban may vary from one to ten. Besides, the makaban may select elders who have a good reputation within the community to assist him. The *maro* institution is used to resolve criminal cases that range from insult to homicide and every civil case, without taking into account the amount of money involved. Whereas, the system of *mada'a abba* (the father of the law) will be referred in case of: (a) major litigation or of a previously unheard-of case, or when the various clan leaders have been unable to impose their judgment on the litigants; (b) inter-clan disputes usually arise from conflict over boundaries; and (c) inter-ethnic despites that occur with neighboring ethnic groups bordering Afar territory including Tigrean, Amhara, Oromo and Somali often over homicide, grazing land and territories. *Mada'a abba* is a clan chief (*kedo abba*) chosen and backed by the elders for his knowledge of the mada'a. When an appeal is made to him in an unprecedented case, he gathers an assembly known as *malla* which functions as a legal body to pronounce a brand-new judgment. The traditional conflict resolution mechanism is highly effected as decision made through maro and malla is usually accepted by both parties in despite.

110. Traditional conflict resolution is also widely practiced among the ethnic groups in Benishangul-Gumuz. One typical example is the *Mangima institution.* It is the traditional mechanism for resolving intra-ethnic conflicts within the Gumuz societies. *Mangima* literary means assembly and the name of the assembly site is called *Tämba.* Mangima institution played a significant role in resolving conflicts as well as contributed to the establishment of peaceful relations within Gumuz communities in each districts of the

region (Bogale 2020)[77]. Similar traditional conflict resolution mechanisms exist in other ethnic groups in the region. Disputes within the Mao society are resolved by the *Qallu institution* which compose of nine elders recruited from different clans. It is led by the religious leader of the Mao is known who is highly respected because he is considered as a source of peace and wellbeing. The Shinashas have a well-established traditional court-like system known as *Nemo.* The majority of the Berta communities are Muslims. Hence, disputes within Berta society are solved according to the Qoran. The councils of religious elders that constitute the traditional conflict resolution system in Berta communities is called ***Shiyabe*** *(Alula and Getchew 2006)*[78]*. Common to the aforesaid traditional conflict resolution mechanisms they are all highly effective and preferred over the modern conflict resolution system such as the Court.*

111. The finding of the social assessment explored that *shimigilina* (eldership) is the common traditional conflict resolution mechanism in Amhara region in general and Debre Tabor area in particular. *Shimigilina* is widely used to settle disputes ranging from a simple insult to complex murder cases. Disputes include civil, criminal and commercial disputes arising between individuals and between groups. Marital conflicts, matters of insult and injury, theft and disputes over land and property rights are commonly resolved through this traditional system. As informants discussed, *shimigilina* is operated by elders selected by the parties in dispute themselves. The mediating elders are selected for their qualifications and experience and because both parties believe that they can help them. The criteria for the selection include prestige, popularity in the society, and maturity. Usually three are selected but in some cases the number will be five or seven. The basic tenet of *shimigilina* is rested on the principle of reconciliation and restoring accord.

112. As assessed based on interview with informants and available studies, common to the communities in Debre Tabor (Amhara region) and Tigray region is the key role of religious institution in dispute resolution. The overwhelming majorities of people in both areas are believers of Orthodox Christianity. Besides mediating inter-personal conflict through *Yenebs Abat* (religion father), the Church uses a combination of religious teachings and public pray that promote peace and social solidarity. Also, available studies (e.g. (Bisrat 2020)[79] revealed, various traditional conflict resolution mechanisms are practiced in different Zones in Tigray region. The *Abo-gereb* institution is worth to mention here. Abo-gereb comes from two Tigrigna words, *abo (*means father*)* and *gereb* (means river). Abo- means "father", and gereb is "river". Therefore, abo-gereb is etymologically defined as the father/chief/leader of the river. The members of the abo-gereb traditional conflict resolution have different members: leader or administrative of the gereb, deputy administrative and ordinary members. The selection of these members of the councils considers the following qualities; who are most esteemed, wise, treat all fairly and native elder men. The abo-gereb traditional institution is effective in despites resolution ranging from inter-personal issues to inter-ethnic conflicts such as territorial based conflicts between Tigreans and the neighboring Afar.

[77] Bogale Aligaiz (2020). Conflict Resolution among the Gumuz Communities. Advances in Research and Reviews, ARR 2020, 1:11.

[78] Alula Pankhurst and Getachew Assefa (eds.) (2006).Grass-Root Justice in Ethiopia: The Contribution of Customary Dispute Resolution. Addis Ababa: Centre français des études éthiopiennes.

[79]Bisrat Tesfay (2020). Indigenous Administration and Dispute Resolution System of the "Abo Gereb" and Its Essence of Democracy from the Modern Philosophical Perception. Journal of Political Science and International Relations 2020, 3(2): 36-43.

5.2.5 Social diversity and gender

113. In the project implementation regions as stated earlier, the people regard their social diversity and gender relations in several forms. The social assessment explored the project target communities have developed distinctive pattern of ideas, beliefs, and cultural norms which characterize men and women into a different social groups. Culturally determined gender ideologies define rights and responsibilities and what is 'appropriate' behaviour for women and men. They also influence access to and control over resources, and participation in decision-making. As discussed next these gender ideologies often reinforce male power and the idea of women's inferiority.

114. ***System of gender relations:*** Gender relation refers to the hierarchical relations of power between women and men that tend to disadvantage women (Holmes 2009)[80]. Interview with the stakeholders at various level and consultation with local the community explored existing socio-cultural system operate to institutionalize gender difference in many ways. *The system of property relation is the first way that may constrain on the effective implementation of the IPF program*. As repeatedly stated, use of PHC services is significantly associated with household wealth. The 2016 EDHS measured household wealth as a composite of multiple indicators including income, the number and kinds of consumer goods own, types of occupation, ownership of assets (such as agricultural land and farm animals), and decision making over household income. Wealth quintiles are then compiled by assigning the household score to women and men. The finding of the survey shows that women equal rights of household property ownership significantly increases their access to PHC services. For instance, women in the highest wealth quintile (85%) are more likely than those in the lowest quintile (48%) to receive ANC from a skilled provider. The social assessment found out what is contrary to this fact. That is, the customary system of property ownership in all the project target communities operates against women's equal rights of property ownership. The basic household resources are mainly under the control of men who are responsible for the major economic decisions of purchasing and marketing of proceeds. Although women are excluded from major decision-making and control limited resources, they, make decisions and have control on the income from petty household assets such as sales of milk products and chicken. Among the pastoral communities of Afar, Borena, Guji, Berta, Mao, and Komo, the system of property ownership reinforce a further gender discrimination. In these communities it is often the case that women do not have the right of property inheritance. They are also less likely to be treated equally before the traditional jurisdiction. Hence they tend to be submissive and timid.

115. *The patriarchal system is the second way of institutionalizing gender inequalities.* This is true for all the project target communities. The system of patriarchy operate as male domination, to the power relationships by which men dominate women and to characterize a system whereby women are kept subordinate to men in a number of ways. Linked to this social system is the ideology that man is superior to women that women are and should be controlled by men. This thinking forms the basis of many of the social practices that confine women to the home, and control their lives. The patriarchy system allows the subordination of women in both the private and public sphere.

116. *The system of gender role refers to the third common ways.* It is understood as the socially determined ideas and practices which define what roles and activities are deemed appropriate for women and men.

[80] Holmes, Mary (2009). Gender and Every Day Life. London and New York: Routledge

Gender socialization is the process by which individuals learn to differentiate between what the society regards as acceptable versus unacceptable behavior of men and women so to act in a manner that is appropriate for the needs of the community (Holmes 2009). It was assessed that all the project target communities exercise the social system that differentiate the division of labour between women and men. Accordingly, male adults are responsible for activities household home. In rural areas, husbands undertake the management of farming and herding. The wife, on the other hand, responsible for reproductive and domestic chores such as taking care of kids, cleaning, cooking and fetching water. The gender role among the Afar and Gumuz communities differ in some way. Besides their contribution to reproductive and domestic chores, the construction of the traditional mat house is exclusive to the Afar women. While women in Gumuz communities are largely responsible for farming activities. Nevertheless, despite their vital role in reproductive and productive activities, women occupy a marginal social status in the project target communities.

117. ***Household decision making:*** The availability of health facilities alone does not ensure access to PHC services. Besides, the use of PHC services depends on household decision. This is typically true for the IPF Sub-component I. If we take the reproductive health intervention as an example, women may aware that the use of contraception helps avoid unplanned or unwanted pregnancies, and prevent unsafe abortions. Additionally, contraceptive use helps women space the births of their children, which benefits the health of the mother and child. Confirming this, the 2016 EDHS states knowledge of contraceptive methods is almost universal in Ethiopia, with 99% of currently married women and men age 15-49 knowing at least one method of contraception. Despite having knowledge, the Contraceptive Prevalence Rate (percentage of women who use any contraceptive method) is low for all the project target regions as compared to the national level (See Table 11). The social assessment uncovered the function of the socio-cultural norms related to household decision making as a key constraint. Common to all the project target communities, men are heads of respective families. Men are generally accepted as an authority figure and have the greatest share of power in making decision whether to use contraceptive or not. The interviewed married women on the point stated that their husbands do not let them use contraceptive.

5.2.6 Livelihood activities

118. The project target areas are characterized by diverse livelihood activities: pastoralism, agro-pastoralism, agriculture, and non-agricultural occupation. The implementation of the IPF program can be affected based on the kind of livelihood practiced in specific project target region, zone or woreda. For instance, the provision of EHS and CRVS can be significantly affected whether the project target communities are mobile pastoralist or sedentary agriculturalist. Therefore, the assessment of the livelihood activities would help the IPF program in devising innovative ways to reach out to the most vulnerable groups (e.g. mobile pastoral communities) such as deployment of mobile health teams, linking civil registration services to mobile services in the health sector, and using mobile registration tools such as laptops and tablets. This point will be discussed in detail latter on under the key social considerations. The below social assessment describes the major livelihood activities in the project target areas.

5.2.6.1 Pastoralism

119. Pastoralism is a means of livelihood that entirely or predominantly depend on the livestock production. Pastoral production remains the dominant land use in Ethiopia's arid and semi-arid areas, which occur below an elevation of 1500m and constitute between 54% and 61% of the country's surface area. Empirical evidence has shown that the direct contribution of livestock to the Ethiopian GDP is estimated

at ETB 150.7 billion per year, which amounts to 17% of GDP and 39% of the agricultural GDP (International Livestock Research Institute (ILRI) 2017)[81].

120. Afar, parts of Oromia (Borena and Guji Zones), and Benishangul-Gumuz (Kurmuk and Kamashi districts areas with very hot and arid agro-ecology) that have the pastoral farming system characteristicsare the project target areas where people predominant subsist based on livestock production. The composition of the livestock species herd include camel, cattle, goat and sheep. People subsist off their animals both directly through drinking milk and eating meat, and indirectly by exchanging livestock or their products for grains and other goods and services. In terms of number of people, livestock and size of area occupied, the Afar (29%) and Borena-Guji (18%) make-up the second and third largest pastoral communities in Ethiopia next to the Somali pastoralist (47%) (ILRI 2017). According to studies (ILRL 2017; Solomon 2020[82]), there are key features of the livelihood common to the stated project areas. First, pastoralism is a natural resource-based substance pattern in which people make their living by keeping herds of animals in a communal or free-range land system. Second, pastoral livelihood involves mobility (trans-humans) to track seasonally available natural pastures and water. Third, the performance of livestock rearing is based on traditional practice yielding low production compared to the number of herd. Fourth, the areas are characterized by frequent drought with high livestock mortality, famine, and chronic food insecurity causing numerous deaths in human population.

5.2.6.2Agro-pastoral

121. Agro-pastoral livelihood is based on livestock production and involved in some form of crop cultivation and occurs in areas with relatively high rainfall, but also involves some form of seasonal movement of livestock to grazing areas. According to available evidence, among the project target areas, the largest agro-pastoral groups are found in Benishangul-Gmuz. About 65% of the livelihood in the region is categorized under agro-pastoral farming condition. This covers districts bordering Oromia and the central parts of the region such as Mao-Komo, Assosa, Bambasi and Homosha (Regasa et al 2021)[83]. Likewise, in Borena and West Guji Zones, agro-pastoral livelihood is practiced by those people occupying the middle stream of the Genale-Dawa basin with semi-arid areas and relative amount of rainfall and cultivable/fertile land. Despite mixing the two, livestock production is the major means of livelihood for agro-pastoralists in this areas. Where it is practice, crop production is a recent phenomenon (of 1-2 decades) as a supplementary to livestock rearing and to minimise the risk of food insecurity (ibid).

5.2.6.3Agriculture

122. Agriculture is practiced as the major means of livelihood in Tigray, Amhara and Oromia. Accordingly, ***Table 5*** presents the proportion of household with farming activities as predominant means of livelihood by these project target regions based on the 2013 Ethiopia Rural Socioeconomic Survey. The data shows that 89% of the household in Tigray was predominantly based on farming activities by the time of the survey. The proportion of households primarily subsist based on farming activities was almost similar in Oromia (87%) and Amhara (87%). The subsequent social assessment further substantiate the data in Table 17 based on the findings from stakeholder consultation and previous evidence.

[81]International Livestock Research Institute (ILRI) (2017). Ethiopia livestock sector analysis. Addis Ababa: ILRI.

[82]Solomon Desta (2020). Pastoral Development in Ethiopia. *Economic Focus,* vol. 9 No. 3: 12-20

[83]Solomon Desta (2020). Pastoral Development in Ethiopia. *Economic Focus,* vol. 9 No. 3: 12-20

Table 22 Percentage of households predominantly based on farming activities by project target regions

Region	*Percentage of Farming Activities*	*Percentage of Non-Farming Activities*	*Total*
Tigray	89.0	11.0	100.0
Amhara	87.0	13.0	100.0
Oromia	87.4	12.6	100.0

Source: *The 2013 Ethiopia Rural Socioeconomic Survey, Central Statistical Agency and the World Bank*

123. Previous social assessments for other World Bank financed development projects in Tigray region such as Tigray Integrated Agro-Industrial Park (IAIP) and Rural Transformation Center (RTC) projects revealed that rain fed crop production is the main economic activity for over 85% of the population, supplemented by livestock rearing. The main crops cultivated in the region are wheat and barley. Small amounts of vetch, teff and lentils are produced to supplement income. The findings of these social assessments identified the major bottlenecks to the agricultural productive in Tigray. Land fragmentation is the first one. The average land holding in the region is less than 0.75 hectare. Second Tigray region is most known for its serious land degradation problems. Much of the woodland in Tigray started to disappear in the early 1960s under the pressure from rapid population growth. Yet, a short and variable rainy season in combination with degraded soils resulted in low soil productivity and frequent crop failures. As a result, the local population is structurally dependent on food aid.

124. A recent study in Amhara region shows that cereals account for more 80% of cultivated land and 85% of total crop production. The principal cereal crops in the region are teff, barley, wheat, maize, sorghum and finger millet. Pulses and oil crops are the other major categories of field crops (Daregot and Nega 2021)[84]. Contrary to the overwhelming percentage of household depend on agriculture as the major means of livelihood, the Head of the Regional Food Security Coordinator expressed that Amhara region is one of the regions facing critical food insecurity in Ethiopia. An informant mentioned frequent drought, poor farming practice, environmental degradation and land fragmentation as the underlying reasons in this respect. As to the informant, many households are only able to produce sufficient food to meet their food requirements for less than six months of the year. Consequently, 87 out of the total 127 woredas in the region are drought-prone and areas of extreme poverty targeting for the livelihood supports in productive safety net program.

125. Yet, agriculture remains the predominant means of earning in North Showa and the three Wollega-Zones targeting in the IPF program. Of all the project target areas, the Wollega-Zones (Kelem, East and West) are areas with fertile land and longer months of rainfall. Small-scale farming constitute the dominant means of livelihood for more than two-third (67.8%) of the household in the Zones. Maize, tef, finger millet, nug, hot-pepper, and potato are the most important crops in these Wollega-Zones. While wheat, barley, faba bean, and field pea are mainly grown in districts with highland and midland agro-ecologies

[84]Solomon Desta (2020). Pastoral Development in Ethiopia. *Economic Focus,* vol. 9 No. 3: 12-20

(Kifle et al 2020)[85]. Besides, West and Kelem Wollega Zones are among the major coffee growing areas in Ethiopian. However, it was assessed that coffee production is dominated by smallholder farmers, and the market participation of those farmers is limited (Samuel et al 2017)[86]. Despite such conducive situations, agricultural productive is low in all the Zones. An interviewed expertise from Oromia Regional State *Bureau* of *Agriculture* and Natural Resource identified multiple-factors in this regard:

> *The prevailing socio-political tensions and active conflicts, poor farming practice, land fragmentation, shortage/lack of improved varieties, weed infestation, high cost of modern agricultural inputs, lack of marketing linkage due to poor road and communication infrastructure and low price of output are multiple factors that constraint agricultural production across the Wollega-Zones.*

5.2.6.4 Shifting cultivation

126. The economy of the Gumuz people is based almost exclusively on agriculture. But, the way they practice agriculture is different from other project areas described ahead to constitute a distinct livelihood activity. Agricultural activity in Gumuz society depend on the shifting cultivation. Shifting cultivation is a form of agriculture in which farm plots are shifted regularly to allow soil fertility to recover. Shifting cultivation also called slash and burn agriculture involved successive activities that include cutting or cleaning, burning, planting, weeding and harvesting (Bogale 2021)[87].

127. In the process of hoe cultivation, Gumuz people periodically rotate agricultural plots. Usually the land cultivated for three or four years, would be left fallow for six to ten years. Every year each farming household clear and use new plots and leave fallow old ones for a longer years. The social assessment based on existing empirical evidence (Wagino and Amanuel 2021)[88] exposed, it is normal for the Gumuz farming household to have two types of plot. The first type is called kancha, a freshly cleared plot of land used to grow finger millet as the main crop. In the second year, the *Kancha* plot is used to grow sorghum as the main crop. The second type of plot is known as *bakuna*. At the third year, a kancha plot is turned to *bakuna* and left fallow for a period of six to ten years. A shifting cultivation based agriculture is unproductive as it uses rudimentary agro-technologies such as hoe. Thus, vulnerability to household food insecurity is common.

5.3 Vulnerable and Disadvantaged Groups

128. The IPF supports aim to improve access to and strengthen the delivery of quality PHC services for the vulnerable and disadvantaged individuals and groups in the conflict-affected areas focusing on RMNCAH+N services. As per the World Bank ESS1 *Footnote 28*, *vulnerable or disadvantaged* refers to those who may be more likely to be adversely affected by the project impacts and/or more limited than

[85]Kifle et al (2020). Farming System Characterization and Analysis of East Wollega Zone, Oromia, Ethiopia. International Journal of Management and Fuzzy Systems 2020; 6(2): 14-28

[86]Samuel et al (2017). Share of coffee market outlets among smallholder farmers in Wollega, western Ethiopia. *Int. J. Adv. Multidiscip. Res, vol.* 4(8): 100-108.

[87]Daregot Berihun and Nega Ejigu (2021). Food security and rural livelihood analysis of the Amhara region, Ethiopia. Bahir Dar University: IER Research report- 03.

[88]Northwest Ethiopia. In: Oguge, N., Ayal, D., Adeleke, L., da Silva, I. (eds) African Handbook of Climate Change Adaptation. Springer, Cham. https://doi.org/10.1007/978-3-030-45106-6_244

others in their ability to take advantage of the project's benefits. In line with this definition, ***Table 6*** identifies the number of Vulnerable Groups (VGs) disaggregated by the project target regions.

Table 23 Type and Number of Vulnerable Groups in the Target Conflict-Affected Areas, as of December 2021

Region	***Total number of population affected***	***Number of Vulnerable Groups (VGs)***		
		PLW	***U-5 Children***	***IDPs***
Tigray	5,600,00	78,000	163,196	1,800,000
Amhara	8,906,051	79,228	343,850	2,356,587
Afar	1,370,133	79,00	257,000	367,659
Oromia	8,615,000	298,940	141,530	559,122
Benishangul-Gumuz	361,775	19,889	56,880	193,040
Grand Total	***24,852,959***	***454,857***	***962,456***	***5,286,408***

Sources: *Compiled based on CIARP, MoH (2022) and, for Tigray region, UNHCR (2022)*[89].

5.3.1 Pregnant and Lactating Women (PLW)

129. As can be seen from ***Table 6,*** a total of 454,857 PLW are reported in the five project target regions as of December 2021. According to WHO recommendations on antenatal care for a positive pregnancy experience (2016), health care services during pregnancy and after delivery are important for the survival and wellbeing of both the mother and the infant. Skilled care during pregnancy, childbirth, and the postpartum period are important interventions in reducing maternal and neonatal morbidity and mortality. This fact reveals the special health needs for the PLW. Contrary to this, informants from the respective RHBs discussed that ANC and PNC services to PLW in the conflict-affected areas have been halted or significantly hampered due to the damage to health facilities, looting of medical equipment, and/or displacement of the health workforce in fear of security risks and threats. As the result, informants have discussed increased number of perinatal deaths, maternal and neonatal mortality from the health complication occurred during pregnancy, upon delivery and in postnatal period that can simply be avoided by ANC and PNC services. Even more seriously, interviewed health expertise in the RHBs and WHOs unanimously emphasized PLW in conflict-affected areas will continue to be vulnerable in particular unless the provision of PHC is restored promptly.

5.3.2 Newborns

130. Studies (EDHS 2016[90]; WHO 2017[91]) have shown that the days and weeks following childbirth—the postnatal period—are a critical phase in the lives of mothers and newborn babies. The findings of these

[89] UNHCR: Tigray Region Situation Update 31 March 2022. https://reporting.unhcr.org, Accessed January 14, 2023.

[90] WHO (2017). Postnatal Care Guidelines. Geneva: WHO

[91] Ethiopian Demographic and Health Survey (EDHS), 2016.

studies underscore that most maternal and infant deaths occur in the first month after birth: almost half of postnatal maternal deaths occur within the first 24 hours, and 66% of infant mortality occur during the first week. For both the mother and newborn, therefore, prompt postnatal care is important for the identification and treatment of complications that arise from delivery and providing the mother with important information on caring for herself and her baby. But, as the health facilities significantly damaged, looted or health workforce displaced, postnatal car to mothers and newborns in the conflict-affected areas has been disrupted. As expressed by the key informants, the disruption of PHC services makes mothers and newborns in conflict-affected areas a special vulnerable groups with increased risks of death. The below quotations capture some of the informants expressions on the point:

- *Quite in many woredas in the four Wollega-Zones, the health facilities are not under the administrative reach of the RHB while the PHC services are stopped in several other conflict-affected areas due to damage of health facilities or security risks and threats to health workers. Given these conflict posed circumstances, the provision of postnatal health check for newborns (a full clinical examination around 1 hour after birth), postnatal checkups for a mother and newborn baby in the first 24 hours, tetanus infection injection, all basic vaccination and other essential postnatal care services are almost halted. The preliminary findings of the ongoing assessment by Public Health Emergency Team with regards the impacts of the conflict indicate a significant increment in number of maternal and newborn deaths. Evidently, lack of PNC services for early identification and initiation of appropriate medical treatment to mothers and newborns is account for this (quoted from interviewed health expertise, Oromia RHB).*
- *The TPF led war has been fought in Afar region in three rounds each lasted for several months enormously hampered on essential health delivery. In the absence of institutional delivery and PNC services in the 23 woredas under the impacts of the war, affected community members have witnessed that mothers were resort to deliver under trees, caves, temporary escaping sites such as schools and IDP Camps with no medical facilities. Several mothers and newborns have been died from the absence of appropriate medical care while many more suffered from chronic health complication such as physical disabilities (quoted from interviewed health expertise, Afar RHB).*
- *I gave birth to a baby girl while trying to escape from the threats of the war. It was while on travel and at a remote desert place with extreme harsh condition. After a couple of hours, a newborn baby can't properly breathe, can't feed breast either. But the struggle to survive lasted only for two days and half (witness by survivor mother, Chifra woreda, Afar region).*

5.3.3 Under-Five (U-5) Children

131. As can be referred from ***Table 6***, the conflict in different parts of the country impacted on a total of 962,456 U-5 children out which the larger number is in Amhara followed by Afar, Oromia and Tigray regions. Evidences have shown multiple risk factors for the U-5 children based on the differential impacts of conflict. The primary window of vulnerability for U-5 is stunting from poor nutrition, repeated infection, and inadequate psychosocial stimulation. A usual pathways to acute (wasting) and chronic (stunting) malnutrition are complex in conflict-affected areas. On the distal level, they can include socio-economic and political determinants, such as limited food supplies in conflict environments. On the proximate level, factors such as dietary intake, infections and illness, and care seeking are at play (UNICEF 2019)[92]. In line with is, assessments on the impacts of conflicts in Ethiopia have been conducted. The resulting findings reveals that U-5 acute malnutrition from the conflicts in different parts

[92]UNICEF. (2019). Children, Food and Nutrition: The State of World's Children. New York: UNICEF.

of Ethiopia is exacerbated by pre-conflict existing poor nutritional status of children (WHO 2017)[93]. Further, communicable diseases and vector borne illness including acute respiratory illness, diarrhoea, malaria and measles coupled with disruption of essential health services increased the risk factors for the U-5 in the conflict-affected areas in the country. These are the most common causes of U-5 child mortality in conflict-affected areas. Yet, children, especially those under the age of five are particularly vulnerable to conflict. They are more likely to be injured, or exposed to greater danger through separation from their families or caregivers (UNICEF 2023)[94].

5.3.4 Internally Displaced Peoples (IDPs)

132. According to the data in *Table 2*, a total of 5,286,408 have been displaced from their home due to the conflict in various parts of the Ethiopia. Out of this, the largest number (2,356,587)) is reported in Amhara region followed by Tigray (1,800,000), Oromia (559,122), Afar (367,659) and Benishangul-Gumuz (193,040) IDPs as of December 2021. As further analyzed in the IPF Program Appraisal Document, out of the total conflict-caused IDPs, more than two million were children under five years and 477,048 were PLW. This means that nearly 80% of the affected IDP population were women, children, and youth who bear the impact of forced displacement.

133. A profound review into the available assessments (Global Projection Cluster 2022[95]; UNICEF 2022[96]) of the impacts of conflicts in various parts of Ethiopia on the IDPs has shown that 40% of the IDPs reside in collective centers, such as schools and other facilities that serve as temporary shelters. These are often severely overcrowded and lacking adequate facilities. The conflict resulted in damage to infrastructure, impacting delivery of life-saving services to IDPs. Access to critical services such as healthcare, portable water, adequate shelter and sanitation, has been significantly curtailed by looting and damage to public infrastructure. Security measures imposed in the conflict affected areas, active conflict and lack of functional local administrative bodies for coordination have had serious implications on the IDPs' access to essential health care and other basic social services. The remaining 60 % of the IDPs in the conflict-affected areas live with host communities, where scarcity of resources and limited or lack of access to essential services, particularly health care.

134. Despite on-going IDP returns in some of the regions, the humanitarian environment remains challenging. Lack or inadequate shelter, food insecurity and deprivation of basic social services including essential health care are all threats, likely to lead to secondary displacement. In line with this argument, for instance, the interview with the key informant from Afar Regional Disaster Risk Management Commission went as follows:

> *Currently, there is no active IDP Camps in Afar region. Out of the total 867, 688 conflict-caused IDPs in the region, 725,230 of them returned to their place. However, the return of the IDPs does not make any difference in terms of the access to basic services including health. The damaged public infrastructure are not renovated and, thus, basic services in the returnees' place of origin are not restored yet and the critical problem continues.*

[93]WHO. (2017). Recommendation on Child Health. Geneva: WHO.

[94]UNICEF (2023). Humanitarian Action for Children. https://www.unicef.org/media/131956/file, accessed March 24, 2023.

[95]Global Protection Cluster. Protection Analysis Update for Ethiopia May 2022. https://www.globalprotectioncluster.org. accessed January 16, 2023.

[96]UNICEF (2022). Ethiopia Humanitarian Situation Report No. 7, July 2022. https://www.unicef.org, accessed March 24,2023.,

5.3.5 Women and Girls in General

135. The social assessment analyzed the differential vulnerability of women and girls from the conflicts based interview with the GBV Directorate/Planning and Monitoring Directorate in the sampled IPF project target Regional Bureau of Women and Children Affairs (RBoWCA), GBV Team Leaders in the sampled Regional Health Bureaus (RHBs), and various secondary sources including government's own assessment, and reports by UN agencies and various humanitarian organizations. The finding reveals that incidents of conflict-related GBV have been reported in various IPF target Woredas in all regions implicating all parties to the conflict. However, all the interviewees invariably underscore the underreported of the GBV cases for various constraints. As an empirical illustrative, the Planning and Monitoring Directorate Director, Afar RBoWCA mentioned the conflict-related GBV cases officially reported to the Bureau and explained the reasons for underreporting:

> *Nine women with rape cases from Ewa and Gulina Woredas in Zone 4, six rape cases in Abala, Berhale and Megale woredas from Zone 2, and one rape case in Chifra woreda Zone 1 have been officially reported to our Bureau for medical and psychosocial support. The number of the reported cases is misleading to depict the whole picture. Based on the Bureau's own assessment, conflict-related GBV incidents including sexual rape occurred in all the 23 woredas affected by the war in the northern Ethiopia which has been fought in Afar region for three rounds. But, the GBV cases are by far underreported and various constraining factors contributed for this: fear of social stigma and discrimination to the victim as well as family, lack of awareness about where and how to report the case, and inaccessibility to the health facilities and police for the immediate reporting as these organizations were not functioning in the course of the war, to mention but only the major reasons*.

136. Informants from Oromia region have witnessed even a more severe cases of conflict-related SGBV. From the discussion during interview, it was learnt that there are women and young girls who have been kidnapped by the members of armed groups in different areas of the region for their sexual service. Information from secondary sources generally supported the testimonies given by the primary sources. For instance, the JIT (2021)[97] has conducted an assessment into alleged human rights violations and abuses including GBV during the war in the northern Ethiopia. For this purpose, the JIT interviewed and received information from survivors of sexual violence, witnesses, family members, service providers, humanitarian organizations, regional and federal state institutions, and other secondary sources. Accordingly, the finding of the report revealed:

> *Various acts of SGBV including physical violence and assault; attempted rape; rape including gang rape, oral and anal rape; insertion of foreign objects into the vagina; intentional transmission of HIV; verbal abuse including ethnical slurs; abduction; and other violations have been committed. Some of the reported accounts of rape were characterized by appalling levels of*

[97] Report of the Ethiopian Human Rights Commission (EHRC)/Office of the United Nations High Commissioner for Human Rights (OHCHR) Joint Investigation into Alleged Violations of International Human Rights, Humanitarian and Refugee Law Committed by all Parties to the Conflict in the Tigray Region of the Federal Democratic Republic of Ethiopia

brutality. Acts of rape were frequently intended to degrade and dehumanize an entire ethnic group (JIT 2021 p. 40).

137. In Tigray region, nearly half of the survivors that the JIT interviewed were survivors of gang rape. The JIT reported, the ENDF, EDF, and TSF are implicated in multiple reports of gang rape, although the gravity and brutality of the reported cases vary. As the illustrative case, the JIT report presented, one woman survivor informed the JIT that she was taken from a minibus by 4 EDF soldiers and kept for 11 days, and gang raped by 23 EDF soldiers who also inserted foreign objects into her vagina. The soldiers left her for dead when she fell unconscious and she was found and taken to a Hospital in Mekelle where she was treated for 4 months (JIT 2021, p. 42).

138. Likewise, the Tigrayan fighters affiliated with the Tigrayan People's Liberation Front (TPLF) deliberately commit gang raped and sexually assaulted women and girls in Kobo, a town in the northeast of Amhara region, seemingly in revenge for lossess among their ranks at the hands of Amhara militias and armed farmers (Amnesty International 2022)[98]. The same report exposed that:

> *In and around Chenna, a village north of the Amhara regional capital Bahir Dar, Tigrayan forces raped and sexually assaulted at least 30 women and girls as young as 14, often in their own homes after having forced them to provide food and cook for them. Fourteen of the 30 survivors interviewed by Amnesty International said that they were gang raped by multiple Tigrayan fighters, who often threatened them and used ethnic slurs (p. 4).*

139. To substantiate the above cited primary sources with regard to underreporting, various reports by the humanitarian organizations revealed that due to humanitarian access challenges, insecurity and lack of services to address GBV, information documented does not capture the full scale and magnitude of the violations in different conflict-affected areas in Ethiopia. However, as access improves, reports of GBV incidents among women and young girls, continue to emerge. For example, a rapid assessment in Tigray region by a consortium of humanitarian organizations exposed that 566 women and young girls were raped by all the armed parties to the conflict (Global Protection Cluster 2022)[99]. While, a desk review obtained from the Amhara Region Bureau of Women, Children and Social Affairs indicates 1328 GBV survivors in the region, 1254 women and 113 girls, who reported the incidents to the one stop centers and various health facilities.

5.3.6 The Elderly and People with Disabilities (PWDs)

140. The elderly and People With Disabilities (PWDs) are a diverse groups, and people with different impairment types may be particularly vulnerable to certain types of barriers to accessing services including lack of accessible transport, or lack of nearby facilities and lack of information on the availability of health

[98]Amnesty International (2022). Ethiopia: Summary Killings, Rape and Looting by Tigrayan Forces in Amhara. https://www.amnesty.org/en/documents/afr25/5218/2022/en/, accessed March 22, 2023.

[99]Protection Analysis Update in Northern Ethiopia. https://www.globalprotectioncluster.org/sites/default/files/2022-07/. Accessed February 22, 2023.

services accessible to persons with disabilities in accordance with their need, interest and disability types (MoH 2020)[100].

141. Data on the number of the elderly and PWDs affected due to the conflict in the project target areas could not obtained. However, the Global Projection Cluster report indicated that the parties to the conflict failed to provide special protection to older persons and PWDs. There are reported incidents of direct attacks against older persons and PWDs, including physical assault and rape. The same report also show that the elderly and PWDs walked for long hours and even days to arrive in IDP sites. IDPs arrived at displacement locations traumatized, exhausted, at times, physically injured or having experienced separation from family members, loss of homes, documentation, and other belongings. Many persons with disabilities fleeing lost their assistive devices and face an on-going disadvantage. Older persons expressed a feeling of abandonment due to the conflict.

5.3.7 Historically Underserved Communities

142. Besides the impacts of the war, as per the provisions in Article 89 of the Ethiopian Constitution some of the project target conflict-affected areas are recognized as the emerging regions in Ethiopia where Historically Underserved Communities (HUCs) are living. Accordingly, the local communities of all the project target Woredas in Afar and Benishangul-Gumuz Regions and parts (West Guji, Guji and Borena Zones) of Oromia Region are recognized as HUCs. They fit to the World Bank's defining characteristics of a distinct social and cultural group identified in accordance with ESS7, paragraph 8: (a) self-identification as members of a distinct social and cultural group and recognition of this identity by others; (b) collective attachment to geographically distinct habitats, ancestral territories, or areas of seasonal use or occupation, as well as to the natural resources in these areas; (c) customary cultural, economic, social, or political institutions that are distinct or separate from those of the mainstream society or culture; and (d) a distinct language or dialect, often different from the official language or languages of the country in which they reside. The different HUCs in the project target regions include the following:

- ***The Afar pastoral communities:*** Central to the Afar social structure are descent and affinal ties. The Afar have a patrilineal descent system based on which a person belongs to a particular clan (*mela*). Afar settlements are composed of a mixture of clans although each locality is identified with a major clan and affines. This makes it easier to organize social, economic and political support in times of crisis[101]. According to the 2007 Ethiopian Housing and Population Census, over 90% of the Afar people are pastoralist, where livestock rearing is the dominant form of production to sustain the livelihood with no or little cropping practice. The main product is milk and the main function of livestock is to support subsistence, although social and cultural functions are also important. One of the source of vulnerability among the Afar pastoral communities is that the livestock management is characterized by adaptation of feed requirements of animals to the environment through migration and mobility, communal grazing or communal land tenure and sharing of water points. In particular, the mobile lifestyles of the Afar pastoralist are associated with very limited and often difficult and expensive access to social services. To worsen the matter, there is increasing environmental degradation and vulnerability to drought and flooding, exacerbated by

[100]Ministry of Health. National Health Equity Strategic Plan 2020/21-2024/25 December, 2020 Addis Ababa

[101]Kelemework Tafere. (2015). Social organization and cultural institutions of the *Afar* of Northern Ethiopia. *Global Journal of Sociology and anthropology*, Vol. 4 (8): 1-7.

climate change, and interacting with other factors to cause disease outbreaks, pressure and conflicts over resources such as water and grazing land[102].

- ***Indigenous groups in Benishangul-Gumuz:*** The Constitution of the Benishangul-Gumuz regional state explicitly differentiates between indigenous and other peoples. *Article 2* of the Regional Constitution classifies the following five ethnic groups as indigenous: the Berta, Gumuz, Shinasha, Mao and Komo. The economy of the Gumuz people is based almost exclusively on agriculture. But, the way they practice agriculture is different from the other ethnic groups. That is, agricultural activity in Gumuz society depend on the shifting cultivation. Shifting cultivation is a form of agriculture in which farm plots are shifted regularly to allow soil fertility to recover. It involve successive activities that include cutting or cleaning, burning, planting, weeding and harvesting. Whereas, the Berta, Shinasha, Mao and Komo are agro-pastoralist communities (Bogale 2021)[103]. Common to all these ethnic groups are: (a) their economic and social status is frequently limits their capacity to defend their rights to, and interests in, land, territories, and natural and cultural resources. Also, that restrict their ability to participate in and benefit from the proposed development interventions; (b) the groups generally consider their lands and resources to be collective assets, and that they see their culture and identity as a function of the group rather than as individuals; (c) the groups' economies, modes of production, social organization, and cultural and spiritual circumstances are generally linked to the land and natural resources they occupy.

- ***The Borena:*** The Borenas occupy in the southern part of Oromia region. They are largely pure pastoralist with the collective attachment to land. The Rangeland and water resources belong to the clan, and is allotted to members of the community through decisions by the elders, known as the *Jarsa Reera*. While most grazing land is open to all, the Jarsa Reera fences off an area to be reserved for the dry season, and access to this land, called the "*kalo*", is controlled though the elders. Like the Afar, the Borenas depend on seasonal mobility. Before moving to potentially better pasture, the leader of the community sends a group of men to scout out the various migration locations. This group, called *aburu*, determines the presence of natural resources, the carrying capacity of the rangeland, and the presence of any livestock disease. Once the migratory area is selected and the elders have negotiated the move with the locals in the migration place, the boys and men set off with the animals, while the women and elderly stay at the permanent homestead. In years of intense drought or conflict, a more permanent move may need to occur. There are negative effects of mobility. Competition for grazing land and water with the host community is a serious concern, which often spurs ethnic conflict. Greater environmental damage can occur with the greater volume of animals. The spread of disease is also a concern, with more possibility of transmission between herds[104].

[102]Solomon Desta (2020). Pastoral Development in Ethiopia. *Economic Focus,* vol. 9 No. 3: 12-20

[103]Daregot Berihun and Nega Ejigu (2021). Food security and rural livelihood analysis of the Amhara region, Ethiopia. Bahir Dar University: IER Research report- 03.

[104]Kejela Gemtessa, Bezabih Emana and Waktole TikiLivelihood. Diversification in Borana: Pastoral Communities of Ethiopia – Prospects and Challenges. Retrieved from http://www.saga.cornell.edu/saga/ilri0606/brief11.pdf, June 28, 2023.

- ***The Guji:*** The Guji are not only the neighbors of the Borena but the two share similar social and economic organization. More than 65% of the Guji people practice animal rearing or pure pastorialism as a major economic activity. Goat, sheep, camel, donkey, horse, mules and cattle are the main livestock types up on which the livelihood of the Guji is depended. However, the livelihoods of the Guji pastoralists is characterized by vulnerability and food insecurity mainly because of recurrent drought, land degradation, high population pressure, high livestock population and market prices fluctuation contexts and trends. In times of drought and hardship, those pastoralist people always move up to 60 km far away from home and families in search of available water and grass or pasture for their livestock, since their life is solely depends on livestock survival[105]. Due to the occurrences of frequent droughts, hardships and famines the Guji communities considered themselves as people born and grow in hardship, lead a life of misery, and thus enabled them to develop various home grown hardship surviving mechanisms and tactics[106].

5.3.8 Brief summary findings from consultation with HUCs

143. The findings based on community consultation and interview with the representatives of the HUCs (clan leaders and community elders) revealed that access to Primary Health Care (PHC) services such as family planning, ANC, PNC, and child health and nutrition had been very much limited in pastoral areas even before without the impacts of conflicts. According to the key informants, the problem of access to PHC services manifests in different ways: (a) mobile pastoral communities could not find health institutions in the nearby for their basic need of PHC services; and (b) in pastoral areas where health center or health post exist at a relatively distance, PHC services are effectively provided due to lack of health staff; and (c) even with the existence of health institutions and health staff, the provision of quality PHC services are not provided in pastoral areas due to lack of medical equipment, basic social services (such as electricity, water and ambulance service) and drugs. To worsen the matter, even the existing poor PHC services have been halted owing to the damages and looting to health institutions from the war in the northern part of Ethiopia that the entire Tigray region and most areas of the Amhara and Afar regions. In the absence of PHC services, participants of community consultation and key informants interviews conclude, pregnant women resort to home deliver that caused multifaceted health problem to the mothers and newborns. Likewise, consultation with the HUCs/representatives depicts that access to Civil Registration and Vital statistics (CRVS) services in pastoral areas is nil whether before or after the impacts of conflicts.

144. Below are a couple of direct quotes from the informant and participant of community consultation held with HUCs:

- *I am a nine month pregnant. I did not receive any ANT service yet as there is no health facilities nearby my place of residence. I feel pain since the fifth month of the pregnancy and it is getting serious after the eighth month. I travelled for about 23 kms from my place of resident to Chifra Primary Hospital seeking for medical treatment. I arrived in the hospital at 11: 30 am and that was late to get test in ultrasound, the morning service is only from 10:00 am-11:00 am. So, I am waiting*

[105] Jemjem U. (2011). Gadaa Democratic Pluralism with a particular reference to the Guji Socio-Cultural and Polio-Legal System. Addis Ababa: Rela Printing Press.

[106] Ayinalem Temesgen (1998). "Guji pastoralist Women's Success Story on Key Drought Reserve and Protection Program from 1991--1998: The Kobadi enclosure Women's Model group". Nagale: Nagale Borana Printing Press.

for the afternoon ultrasound service time which is from 4:00 pm-5:00 pm. Then, to back home I have to travel another 23 kms which may takes until the mid-night (a mother interviewed from Chifra Woreda, Afar region, February 23, 2023).

- *I gave birth to a baby girl while trying to escape from the threats of the war. It was while on travel and at a remote desert place with extreme harsh condition. After a couple of hours, a newborn baby can't properly breathe, can't feed breast either. But the struggle to survive lasted only for two days and half (a mother witnessed during community consultation held in Chifra woreda, Afar region, February 23, 2023).*

5.3.9 Summary findings of informants from the representative organizations of HUCs

145. Expertise from the representative organizations of HUCs were interviewed including Ministry of Women and Social Affairs and line Regional Bureaus and Woreda Health Office and RHBs on the differential access to PHC and CRVS services in pastoral communities. The summary finding illustrate that there is a disparity in access, coverage and provision of quality of PHC services in the areas of pastoral communities. As to the informants, a large number of factors continue to undermine progress to close the equity gaps including insufficient human resources for health (HRH), poor healthcare infrastructure, inadequate financial allocations, weak leadership capacity, poor planning and execution and weak delivery of drugs and medical supplies systems. In addition, non-health sector factors have contributed for the low health access of pastoral communities. The findings of the key informants support that social determinants of health including education, employment status, income, gender, ethnicity and religion have a marked influence regarding access to PHC in pastoral communities. For instance, informants illustrate that the percentage of newborn check-ups within the first 2 days in among the households of pastoral communities is differentially low due to the high illiteracy of both spouses.

5.4 Access to Basic Services in the Program Target Regions

146. Basic Social Services refer to public service provision systems that meet human basic needs including education, drinking water, health care, energy, and sanitation and hygiene. The provision of these basic social services are the building blocks for human development and welfare (UNICEF 2000)[107]. Bearing this in mind, this Section assesses the state of access to basic social services in the IPF project target regions before and following conflict.

5.4.1 Assessment in pre-conflict situation

147. As stated by WHO and UNICEF (2018), achieving PHC is not just the availability of health facilities. Rather, it is inevitably interrelated to and understood as the outcome of access to other basic services including drinking water, education, sanitation and hygiene, and electricity. Assessing the situation of basic services in the IPF program target regions before conflict helps to understand the differential level of access already exist even without the effects of conflict.

[107] UNICEF. (2000). Basic Social Services for All: Public Spending and the Social Dimension of Poverty. New York: UNICEF.

5.4.1.1 Safe drinking water

148. WHO (2011)[108] underscores water is essential to sustain life, and a satisfactory (adequate, safe and accessible) supply must be available to all. Improving access to safe drinking-water can result in tangible benefits to health. Hence, every effort should be made to achieve drinking-water that is as safe as practicable. As defined by WHO, ***improved sources*** of drinking water Include piped water into dwelling/yard/plot, piped water into neighbor, public tap/standpipe, tube well or borehole, protected dug well, protected spring and rainwater. ***B****asic drinking water services* assesses the proportion of households with drinking water from an improved soruce, provided either water is on the premises or round-trip collection time is 30 minutes or less. Whereas, *limited drinking water service* measures the proporiton of households with drinking water from an improved source and round-trip collection time is more than 30 minutes (EDHS 2016). Accordingly, *Table 7* provides data for the IPF program target regions based on the 2016 EDHS.

Table 24 Percent distribution of household in the program target regions by drinking water source and sanitation facilities

Region	Type of drinking water source		Type of sanitation facility			Accessibility	
	Improved	Unimproved	Improved	Unimproved	Open defecation	% with basic drinking water service	% with limited drinking water service
Tigray	75.4	24.6	29.5	19.8	50.7	55.5	23.7
Afar	54.5	45.5	16.3	14.0	69.7	15.2	38.7
Amhara	65.0	35.0	17.7	48.0	34.3	37.0	27.9
Oromia	65.2	34.8	12.6	61.5	25.9	31.5	33.7
Benishangul-Gumuz	82.9	17.1	12.7	71.1	16.2	73.8	9.0

Source: *The 2016 Ethiopian Demographic and Health Survey (EDHS)*

149. The proportion of the population with access to safe drinking-water is an indicator of the extent to which basic needs of PHC are met. The finding of the 2016 EDHS revealed that 69% of households have access to an improved source of drinking water at the national level. Compared to this, the data in ***Table 7*** shows that the percentage of households in the IPF project target regions with access to improved sources of drinking water is low for Amhara, Oromia and Afar regions. The same data depicts, of all the program target regions, the proportion of household with access to improved sources of drinking water is the least in Afar. As to WHO (2011), diseases related to contamination of drinking-water constitute a major burden on human health. Therefore, the existence of larger proportion of households lacked access to improved sources of water suggest significant health risks from water-borne diseases in the project areas even prior to the impacts of conflict.

[108]WHO (2011). Guidelines for Drinking-water Quality, Fourth Edition. Genève: WHO.

5.4.1.2 Sanitation

150. Access to improved sanitation is an essential component of providing basic health services. ***Improved toilet facilities*** include any non-shared toilet of the following types: flush/pour flush toilets to a piped sewer system, septic tank, pit latrine, or unknown destination; ventilated improved pit (VIP) latrines; pit latrines with slabs; and composting toilets. On the contrary, ***unimproved toilet facilities*** include any toilet of the following types shared by two or more households: flush/pour flush not to a sewer/septic tank/pit latrine, pit latrines without slabs/open pits, buckets, hanging toilets/hanging latrines, and open defecation (Ethiopian Public Health Institute (EPHI)) 2019)[109]. As can be referred from the data in ***Table 8,*** the proportion of household that use improved sanitation facility is lower for all project target regions except Tigray as compared with national level. Instead, a significantly large percentage of household use open defecation ranging from a high of 69.7% in Afar to a low of 34.2% in Amhara region. Poor sanitation from the open defecation, therefore, would be a serious health repercussions.

Table 25 Sanitation facility type according to project target areas

Region	***Percentage of household in type of sanitation facility***				***Number of sampled households***
	Improved	*Unimproved*	*Open defecation*	*Total*	
Tigray	29.5	19.8	50.7	100.0	2,509
Afar	16.3	14.2	69.7	100.0	418
Amhara	17.7	48.1	34.2	100.0	8,358
Oromia	12.6	51.5	35.9	100.0	16,575
Benishangul-Gumuz	12.7	36.2	51.1	100.0	439
National level	20	53	27	100.0	40,929

Source: *Ethiopia Mini Demographic and Health Survey, Ethiopian Public Health Institute 2019.*

5.4.1.2 Education

151. Equitable access to quality education provides people with the knowledge, skills, attitudes and creativity needed to solve problems locally and globally, and actively contributes to the sustainable and democratic development of societies. Education is both a goal in itself and a means for attaining all the other Sustainable Development Goals (SDGs). It is not only an integral part of sustainable development but also a key enabler for it (UNESCO 2017)[110]. Backdrop to this, the discussions below assess access and equity in education in the project target areas.

152. ***Net Enrolment Ratio (NER):*** It is the number of children of official age group for a given level of education (i.e., pre-primary school, primary or secondary school) who are enrolled in that level of education to the total population of children of official school age for that level of education, expressed as

[109] Ethiopian Public Health Institute (EPHI) (2019). Ethiopia Mini Demographic and Health Survey 2019. Addis Ababa: EPHI.

[110] UNESCO. (2017). Education for Sustainable Goals: Learning Objectives. Paris: UNESCO.

a percentage. Net enrolment rate below 100 per cent provide a measure of the proportion of school age children who are not enrolled in school. As stated in the 1994 Education and Training Policy of Ethiopia, pre-primary education covers 4-6 years of age. Early Childhood Care and Education plays a crucial role in preparing children for primary education, and has the potential to increased levels of enrolment and reduced incidences of drop out and grade repetition. The official primary school age is 7 – 14 years. The primary education offers basic and general education to prepare students for further education and training. The secondary education covers students between the ages of 15 and 18. Secondary education offers a wide range of subjects and prepares students for higher education and the world of work. Accordingly, ***Tables 9, 10 and 11*** show the NER for the project target areas.

153. The data in ***Table 9*** reveals that the project target regions were characterized by lower NER in pre-primary school. The overwhelming majority of children aged 4-6 are not enrolled in school hence missing the basic opportunities for improving child growth and development and preparation for primary education through Early Childhood Care and Education service delivery. Within the project target regions, the situation in Tigray is better with the NER of 71.6% in total while Afar shows the worst with only NER of 11.5% in total.

Table 26 Pre-School Program Net Enrolment Ratio Disaggregated by Project Target Regions and Sex, 2019/20 Academic Year

Region	Population Age (4-6)			Net Enrolment)			Net Enrolment Rate%		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Tigray	203,458	197,221	400,679	146,213	140,837	287,050	71.9	74.4	71.6
Afar	70,085	66,413	136,498	9,181	6,539	15,720	13.1	9.8	11.5
Amhara	853,675	819,536	1,673,211	154,142	145,326	299,468	18.1	17.7	17.9
Oromia	1,601,848	1,558,648	3,160,496	323,866	290,830	614,696	20.2	18.7	19.44
Benishangul-Gumuz	11,761	10,413	22,174	46,151	44,450	90,601	25.5	23.4	24.5

Source: *Federal Democratic Republic of Ethiopia Ministry of Education. (2020). Education Statistics Annual Abstract September 2019-March 2020.*

Table 27 Primary Net Enrolment Ration Disaggregated by Project Target Regions and Sex, 2019/20 Academic Year

Region	Population Age (7-14)			Net Enrolment (G1-8)			Net Enrolment Rate%		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Tigray	510,585	496,827	1,007,412	517,972	516,955	1,034,927	101.4	104.1	102.7
Afar	173,834	160,731	33,565	83,534	66,760	150,294	48.1	41.5	44.9
Amhara	2,170,079	2,105,890	4,275,969	1,882,202	1,807,721	3,689,923	86.7	86.8	86.3

Oromia	3,916,560	3,831,223	7,747,783	4,148,438	3,585,610	7,734,048	105.9	93.6	99.8
Benishangul-Gumuz	114,029	110,181	224,210	109,966	96,006	205,972	96.4	87.1	91.9

Source: *Federal Democratic Republic of Ethiopia Ministry of Education. (2020). Education Statistics Annual Abstract September 2019-March 2020.*

Table 28 Secondary Net Enrolment Ratio Disaggregated by Project Target Regions and Sex, 2019/20 Academic Year

Region	***School Age Population (15-18)***			***Net Enrolment (G9-12)***			***Net Enrolment Rate%***		
	Male	***Female***	***Total***	***Male***	***Female***	***Total***	***Male***	***Female***	***Total***
Tigrary	249,050	242,508	491,558	95,582	99,396	194,978	38.4	41.0	39.7
Afar	77,057	64,922	141,979	7,135	4,850	11,985	9.3	7.5	8.4
Amhara	942,275	926,424	1,868,699	312,060	350,402	662,462	33.1	37.8	35.5
Oromia	1,840,428	1,805,615	3,646,043	509,225	415,736	924,961	27.7	23.0	25.4
Benishangul-Gumuz	53,772	52,086	105,858	14,685	13,478	28,163	27.3	25.9	26.6

Source: *Federal Democratic Republic of Ethiopia Ministry of Education. (2020). Education Statistics Annual Abstract September 2019-March 2020.*

154. Compared to national primary NER 95.3%, there is a wide variation in the project target regions. As can be seen from the data in ***Table 10,*** with a total of 44.9% in primary NER, Afar is the lowest not only among the project target regions but among all regions in Ethiopia. Amhara and Benishangul-Gumuz regional states characterize the second and third lowest in primary education enrollment, having 86.3% and 91.9% primary NER in total, respectively. Tigray and Oromia regions had 100%, 99.8% primary NER, respectively.

155. As shown in ***Table 11***, the overall trend in the secondary NER for the project target regions was the lowest. Similar to primary education, the Afar region has the lowest NER in secondary education at 8.4%. This means only 8.4% of those secondary school age population was enrolled for the 2019/20 academic year. The secondary NER for Oromia (25.4%) and Benishangul-Gumuz (26.6%) regions scored the second and third lowest among the project target regions. Relative to other project target regions, Tigray and Amhara had better secondary NER recording 39.7% and 35.5%, respectively.

5.4.1.3 Health Service

156. As stated in Health Sector Transformation Plan (HSTP IV) of Ethiopia, among the key components of the PHC in focus include Reproductive, Maternal, Neonatal, Child, Adolescent, Youth Health and Nutrition (RMNCAYH+N). Given this, the assessment that follow provides the baseline information about the PHC in the project target regions in pre-conflict situation.

A. Maternal Health Care (MHC)

157. Health care services during pregnancy and after delivery are so vital for the survival and wellbeing of both the mother and the newborn. Skilled care during pregnancy, childbirth, and the postpartum period are important interventions in reducing maternal and neonatal morbidity and mortality. The assessment that follows provide the baseline information on the status of MHC in the IPF project target regions.

158. ***Antenatal Care (ANC)***: Access to ANC is measured as the percentage of women age 15-49 received pregnancy care from skilled providers, such as doctors and nurses/midwives, health officers, and health extension workers (EDHS 2016). In line with this, standard guidelines for ANC in Ethiopia emphasize that every pregnant mother should receive ANC from a skilled provider that includes a thorough physical examination, blood tests for infection screening and anaemia, a urine test, tetanus toxoid injections, iron and folate supplements, and deworming medications. Contrary to the standard guidelines, the data in ***Table 12*** shows, a significant percentage of women in the project target regions do not receive ANC: nearly half of the women in Oromia (48.8%) and Afar (48.4%), more than one-third of women from Benishangul-Gumuz (34.8%) and Amhara (32.4%), and 9.6% in Tigray did not receive any ANC during their last live birth. Therefore, the low ANC suggest higher risks of maternal and neonatal mortality for the target regions in general.

Table 29 Percent distribution of sampled women age 15-49 who had a live birth in 5 years before the survey by antenatal care and project target regions

Region	*%Antenatal care provider*								*% Receiving ANC from skilled provider*	*Sample Size*
	Doctor	*Nurse*	*HO*	*HEW*	*TBA*	*Other*	*No ANC*	*Total*		
Tigray	10.6	71.4	1.3	6.7	0.0	0.4	9.6	100.0	90.0	537
Afar	7.0	35.8	0.0	0.5	10.0	0.3	48.4	100.0	41.3	71
Amhara	6.9	48.4	0.7	11.1	0.1	0.4	32.4	100.0	67.1	1,632
Oromia	3.1	32.4	1.4	13.8	0.5	0.1	48.6	100.0	50.7	3,129
Benishangul-Gumuz	3.8	40.5	2.6	17.9	0.3	0.2	34.8	100.0	64.7	81

Source: *Compiled based on the 2016 Ethiopian Demographic and Health Survey (EDHS)*
NB: *HO abbreviate Health Officer; HEW Health Extension Worker; TBA Traditional Birth Attendant*

159. ***Institutional Deliveries:*** Institutional delivery is a delivery that takes place at any medical facility staffed by skilled delivery assistance. It is estimated that using institutional delivery could reduce 16% to 33% of maternal and neonatal mortality (WHO/UNICEF 2018)[111]. Trends in the national level revealed that institutional deliveries have increased from 5% in 2000, 10% in 2011, and 26% in the 2016 EDHS. However, as can be observed from ***Table 13***, institutional delivery is below the national average for all the project target regions except in Tigray region where 56.9% of women delivered in health facilities. Instead, home delivery is the common practice in the IPF project target regions. The percentage of women delivered at home for Afar is 85.1%, Oromia 80.5%, Benishangul-Gumuz 73.3% and Amhara 71.4%.

[111] WHO and UNICEF (2018). A Vision for Primary Health Care in the 21st Century. Geneva: WHO and UNICEF

Evidently, the use of home delivery can increase the risk of maternal and neonatal mortality in the project target regions.

Table 30 Percent distribution of live births in the 5 years before the 2016 EDHS by place of delivery and project target regions

Region	*% in Place of Delivery*					*% Delivered in a Health Facilities*	*Number of Birth*
	Public Health Facilities	*Private Health Facilities*	*Home*	*Other*	*Total*		
Tigray	56.5	0.4	41.0	2.0	100.0	56.9	716
Afar	12.9	1.8	85.1	0.2	100.0	14.7	114
Amhara	26.4	0.7	71.4	1.5	100.0	27.1	2,072
Oromia	17.8	1.0	80.5	0.8	100.0	18.8	4,851
Benishangul-Gumuz	25.4	0.3	73.3	1.1	100.0	25.7	122

Source: *Compiled based on the 2016 Ethiopian Demographic and Health Survey (EDHS)*

160. ***Postnatal Care (PNC):*** Postnatal care is a care given to the mother and her newborn baby immediately after the birth of the placenta and for the first six weeks of life. The days and weeks following childbirth—the postnatal period—are a critical phase in the lives of mothers and newborn babies. According to the 2016 EDHS, most maternal and infant deaths occur in the first month after birth: almost half of postnatal maternal deaths occur within the first 24 hours, and 66% occur during the first week. For both the mother and infant, therefore, prompt postnatal care is important for treating complications that arise from delivery and providing the mother with important information on caring for her baby.

Table 31 Percent distribution of most recent live births in the 2 years before the 2016 EDHS by time after birth of first postnatal check-up and project target regions

Region	*% of time after delivery of newborn's first postnatal check*								*% of births with a postnatal check during the first 2 days after birth*	*Number of births sampled*
	> 1 Hour	*1-3 Hours*	*4-23 Hours*	*1-2 Days*	*3-6 days*	*Don't Know*	*No postnatal Check-up*	*Total*		
Tigray	5.5	19.2	3.6	2.9	1.6	0.2	67.0	100.0	31.2	314
Afar	2.3	2.8	1.2	0.3	0.2	1.2	92.1	100.0	6.5	43
Amhara	2.9	6.7	0.9	0,9	1.3	0.3	87.0	100.0	11.4	789
Oromia	1.8	3.6	2.2	0.9	0.0	0.2	91.4	100.0	8.4	1,915
Benishangul-Gumuz	3.4	6.8	2.3	2.3	2.4	0.0	82.9	100.0	14.7	45

Source: *Compiled based on the 2016 Ethiopian Demographic and Health Survey (EDHS)*

161. Contrary to the critical role of PNC, as shown in ***Table 14***, the proportion of women who received postnatal check-ups was significantly low for all project target regions compared to the national average (30.4%) with exception to Tigray (31.25%). Among the IPF project target regions, the proportion of women who received PNC was the least for Afar (6.5%) and Oromia (8.4%) while the proportion for Amhara (11.4%) and Benishangul-Gumuz (14.7%) was better than the two regions. One major reason for the low PNC in the target regions is a home delivery. As shown in ***Table 13***, the majority of women in the target regions deliver at home. Therefore, it is unlikely that mothers and newborns receive postnatal health checks within 2 days of delivery increasing the risks of material and neonatal death in the target regions in general terms.

B. Family Planning

162. The use of contraception helps women avoid unplanned or unwanted pregnancies, and prevent unsafe abortions. Additionally, contraceptive use helps women space the births of their children, which benefits the health of the mother and child (WHO and UNICEF 2018). In developing HSTP IV, the MoH assessed that bearing many children are among the factors which affect maternal health status. For Ethiopian women, the trend in the last two decades was to give birth to an average of seven children in their lifetime (Total Fertility Rate (TFR)). Owing to this, HSTP IV aimed to increase the Contraceptive Prevalence Rate (CPR)—the percentage of women who use any contraceptive method—of the country to 55%[112]. To access the CPR, EDHS sampled all women age 15-49, currently married women age 15-49, and sexually active unmarried women age 15-49. As to the finding, at the national level, modern contraceptive use by currently married and sexually active unmarried Ethiopian women has steadily increased over the last 15 years, jumping from 6% of women using modern contraceptive method in 2000 to 36% in 2016. Taking this national average as a baseline, the data in **Table 15** display the use of contraceptive method in the project target regions.

Table 32 Percentage of women aged 15-49 by knowledge and current use of contraceptive, mean number of children ever born to women, birth intervals and project target regions

Region	***Knowledge***		***Current use***		***Unmet Need***	***Mean number of children ever born to women***	***Birth intervals in year***				***Number of Sampled Women***
	Heard of any method	Heard of any modern method	Any method	Any modern method			*1*	*2*	*3*	*3+*	
Tigray	99.6	99.6	36.3	35.2	11.0	6.1	4.2	7.6	58.2	29.9	658
Afar	89.6	89.2	11.6	11.6	13.1	6.5	14.3	35.1	19.3	19.3	96
Amhara	99.9	99.9	47.3	32.9	11.9	6.2	10.6	23.4	43.0	22.9	2,414
Oromia	99.3	99.2	28.6	28.1	21.1	6.7	11.3	36.8	21.8	13.7	3,987
Benishangul-Gumuz	97.6	97.6	28.5	28.4	15.5	6.7	10.3	32.3	42.5	14.7	114

[112]Federal Democratic Republic of Ethiopia Ministry of Health: Health Sector Transformation Plan 2015/16 - 2019/20, October 2015

Source: *Compiled based on the 2016 Ethiopian Demographic and Health Survey (EDHS)*

163. Knowledge of contraceptive methods does not vary between the national and project target regions: the overwhelming majority of women in the project target areas know at least one method of contraceptive. However, as can be referred from the data in ***Table 15***, the CPR for all the project target regions is below the national average. Among the project target areas, the Contraceptive Prevalence Rate is the least for Afar region with only 11.6% uses modern contraceptive. Further, the TFR for all the project target regions is greater than the national average 4.6 children per women as reported in the 2016 EDHS. Whereas, the TFR for Benishangul-Gumuz and Oromia was 6.7 children per women, Afar 6.5, Amhara 6.2, and Tigray 6.1 children per women. Likewise, a significant proportion of women in all the IPF project target regions had shorter birth intervals, below two years. Quite a noticeable percentage of women in each target regions reported unmet need as a reason for not using contraception. But, the use of modern contraceptive is more determined by socio-economic factors, particularly place of residence, wealth, and educational status. Women living in urban areas, in the higher wealth quintiles and secondary plus education tend to have smaller number of children, with education being the most correlated with a decrease in the number of children due to the use of modern contraception (EPHI 2019)[113]. However, discussed earlier, all the IPF project target regions had lower score in these key socio-economic determinants of family planning recommending areas of emphasis for the IPF project interventions in this regard.

C. Child Health

164. Child Health (CH) ***r***efers to pro-active identification of risk factors and undertaking appropriate interventions for the promotion of child health and prevention of childhood illnesses (WHO 2017)[114]. Among the key elements of the CH include coverage of all basic vaccination of children and prevalence and treatment of childhood illnesses.

Table 33 Percentage of children age 12-23 months who received all basic vaccinations, had vaccination card and prevalence and treatment of illnesses for children age under 5

Region	***% of coverage of all basic vaccination***	***% of children who have vaccination card***	***Prevalence and treatment of illnesses***		***Number of sampled children***
			% with symptoms of illnesses	*% for whom treatment was* sought same day	
Tigray	67	53.9	50.7	28.2	683
Afar	15	9.2	61.3	10.5	105
Amhara	36	33.7	56.9	19.1	1,967

[113]Ethiopian Public Health Institute (EPHI) (2019). Ethiopia Mini Demographic and Health Survey 2019. Addis Ababa: EPHI.

[114]WHO Recommendations on Child Health Updated May 2017 *http://whqlibdoc.who.int/publications/2010/9789241500449*. Accessed January 11, 2023

Oromia	25	17.6	65.4	17.7	4,571
Benishangul-Gumuz	27	21.3	60.6	18.0	113

Source: *Compiled based on the 2016 Ethiopian Demographic and Health Survey (EDHS)*

165. The 2016 EDHS has shown that the percentage of children age 12-23 months who received all basic vaccinations increased from 14% in 2000, to 20% in 2005, 24% in 2011, and 39% in 2016 at the national level. In comparison, as can be observed from ***Table 16***, the coverage of all basic vaccination for the IPF project target regions was below the national average except for Tigray (67%). Within the project target areas, the least coverage of all basic vaccination was shown for Afar with only 15% followed by Oromia and Benishangul-Gumuz having 25% and 27% coverage, respectively. The coverage in Amhara is close to the national average, which is 36%. The data in ***Table 16*** further shows that a significant percentage of parents reported symptoms of illnesses for their children under-five age. To the opposite, only a few parents visited health facilities seeking treatment for their children. Overall, the assessment infers, low coverage of all basic vaccination coupled with low health treatment can result in differentially higher rate of child mortality in the project target regions showing an emphasis for the IPF program interventions in this regard.

D. Nutritional Status of Children

166. Child growth is internationally recognized as an important indicator of nutritional status and health in populations. Underweight, Stunting and Wasting are used as the common indicators to measure nutritional imbalance resulting in child undernutrition (WHO 2010)[115]. For empirical assessment, WHO's Nutrition Landscape Information System operationalize the three anthropometric indices as stated below.

167. ***Stunting (assessed via height-for-age)*** is a measure of linear growth retardation and cumulative growth deficits. Children whose height-for-age Z-score is below minus two standard deviations (-2 SD) from the median of the reference population are considered short for their age (stunted), or chronically undernourished. Children who are below minus three standard deviations (-3 SD) are considered severely stunted. The percentage of children with a low height for age (stunting) reflects the cumulative effects of undernutrition and infections since and even before birth.

168. ***Wasting or weight-for-height*** index measures body mass in relation to body height or length and describes current nutritional status. Children whose Z-score is below minus two standard deviations (-2 SD) from the median of the reference population are considered thin (wasted), or acutely undernourished. Children whose weight-for-height Z-score is below minus three standard deviations (-3 SD) from the median of the reference population are considered severely wasted. Wasting in children is a symptom of acute undernutrition, usually as a consequence of insufficient food intake or a high incidence of infectious diseases, especially diarrhoea. Wasting in turn impairs the functioning of the immune system and can lead to increased severity and duration of and susceptibility to infectious diseases and an increased risk for death.

Table 34 Percentage of children under age 5 classified as malnourished according to three anthropometric indices of nutritional status

[115]WHO (2010). Nutrition Landscape Information System (NLIS): Country Profile Indicators Interpretation Guide. Geneva: WHO.

Region	*Height-for-age*			*Weight-for-height*			*Weight-for-age*			*Number of sampled Children*
	% below -3 SD	% below -2 SD[2]	Mean Z-score (SD)	% below -3 SD	% below -2 SD[2]	Mean Z-score (SD)	% below -3 SD	% below -2 SD[2]	Mean Z-score (SD)	
Tigray	13.4	39.3	-1.5	3.4	11.1	-0.6	9.2	28.0	-1.3	699
Afar	22.3	41.1	-1.6	7.3	17.7	-0.1	14.4	36.2	-1.6	100
Amhara	19.6	46.3	-1.8	5.9	19.8	-0.6	8.3	31.4	-1.4	2,107
Oromia	17.1	41.5	-1.3	6.5	10.6	-0.4	7.6	32.5	-1.1	4,573
Benishangul-Gumuz	21.7	42.7	-1.7	7.1	11.5	-0.6	11.9	34.5	-1.4	108

Source: *The 2016 Ethiopian Demographic and Health Survey (EDHS)*

169. ***Underweight or weight-for-age*** is a composite index of height-for-age and weight-for-height that accounts for both acute and chronic undernutrition. Children whose weight-for-age Z-score is below minus two standard deviations (-2 SD) from the median of the reference population are classified as underweight. Children whose weight-for-age Z-score is below minus three standard deviations (-3 SD) from the median are considered severely underweight. WHO's evidence has shown that the mortality risk of children who are even mildly underweight is increased, and severely underweight children are at even greater risk. ***Table 17*** presents the nutritional status of the project target areas taking these anthropometric indices into account.

170. As can be seen from the data in ***Table 17***, the overall trend shows that the nutritional status of children under-5 in all the project target regions is significantly low. Also, for all the project target regions, the percentage of children under-5 stunted and severely stunted, wasted (thin) and severely wasted, and underweight and severely underweight is high. To note the differential low nutritional status of children in the project target regions, the data in ***Table 17*** are compared with the nutritional status at the national level. According to the 2016 EDHS, at the national level, 38% of children under-5 are stunted or too short for their age, and 15% severely stunted. One out of ten (10%) are wasted or too thin for their height, and 3% severely wasted. About one-fourth (24%) of children under-5 are underweight or too thin for their age, with 7% severely underweight. Findings from scientific studies (Ayele 2022[116]; UNICEF and WHO 2020[117]) have confirmed a strong relationship between under-5 child mortality rate and low nutritional status of children. For the project target regions, the low nutritional status is coupled with multiple risk factors based on the characteristics of the mother and child described earlier that disproportionately elevate the child mortality rate even in pre-conflict time.

[116]Ayele et al. (2022). Determinants of under-five mortality in Ethiopia. *Arch Public Health* **80**, 137 (2022). https://doi.org/10.1186/s13690-022-00896-1

[117]UNICEF and WHO (2020). Levels and Trends in Child Mortality: Report 2020. New York: UNICEF and WHO.

5.4.2 Assessment in post-conflict situation

171. As the assessment findings in the preceding section reveal, access to basic social services including PHC in the project target regions has been low in comparison with the national level even in pre-conflict period. The impacts of the conflict further complicated the matter: The already poor PHC services in the conflict affected Zones and Woredas are getting worsened or health services are totally halted following the impacts of the conflict. The assessment that follow provides an overview of the impacts of the conflict on PHC service in the project target areas.

5.4.2.1 Impacts of the conflict on the health system

172. A recent assessment by the MoH (2022)[118] reported that the primary healthcare system was significantly damaged in most of the conflict-affected woredas. As shown in ***Table 18***, a total of 76 hospitals, 709 Health Centers (HCs) and 3,213 Health Posts (HPs) have been partially or completely damaged in the project target regions. The impacts of the conflict were severe in Tigray region where 82.9% of the total hospitals, 76% of HPs, and 50% of the HCs were damaged (partially or completely). The impacts immensely constraining the health service all over the region. The impacts of the conflict were severe for Amhara region next to Tigray. More than half (51.5%) of the HCs, 48.5% of HPs and 45.5% of hospitals damaged from the conflict and health service has been interrupted as a result. The damage of health facilities in Afar region is also devastating, 28.6% of the hospitals, 21.6% of HCs, and 17.2% of the HPs interrupt services as a consequence. The conflict in Benishangul-Gumuz and Oromia did not affect hospitals but brought considerable damage to HCs and HPs. More than one-fourth (26.7%) of the HCs and 40.6% of HPs in Benishangul-Gumuz and 7.5% of the HCs and 9.6% of HPs in Oromia region stopped functioning due the damage from the conflict. In addition to direct damage to public health facilities, the conflict has also brought devastation to private health facilities and pharmacy/drug stores in the conflict affected areas. For instance, the MoH reported in CIARP that 466 private health facilities in Amhara and 3 in Afar were damaged and looted during the conflict. The situation further limited the opportunity for PHC services in the conflict-affected areas.

Table 35 Percentage of physically damaged health facilities out of the total available by region

Region	***Health facility Type***	***Partial Damaged***	***Complete Damaged***	***Total***	***Percentage***
Tigray	Hospital	32	2	34/41	82.9
	Health Center	107	6	113/226	50.0
	Health Post	537	28	565/743	76.0
Afar	Hospital	2	-	2/7	28.6
	Health Center	20	1	21/97	21.6

[118]Ministry of Health (2022). Ethiopia Conflict Impact Assessment and Recovery and Rehabilitation Planning (CIARP), July 2022.

	Health Post	56	3	59/343	17.2
Amhara	Hospital	38	2	40/88	45.5
	Health Center	429	23	452/877	51.5
	Health Post	1,642	86	1728/3,565	48.5
Oromia	Hospital	-	-	-	-
	Health Center	105	2	107/1,411	7.5
	Health Post	549	136	685/7,099	9.6
Benishangul-Gumuz	Hospital	-	-	-	-
	Health Center	4	12	16/60	26.7
	Health Post	17	155	172/424	40.6
Total	Hospital	72	4	76/176	55.9
	Health Center	665	44	709/2,671	26.5
	Health Post	2,801	408	3213/12,174	26.4

Source: Ministry of Health, Ethiopia Conflict Impact Assessment and Recovery and Rehabilitation Planning, July 2022.

173. Besides the physical damage to the health facilities, the damage to or looting of medical equipment (such as X-ray machines, Ultrasound machines, laboratory machines, Microscopes, and computers) and ambulances especially in Amhara and Afar regional states, was extremely devastating to the PHC system. Electric generators, kitchen equipment, and vehicles belong to the health facilities were also primary targets for looting. Similar damage and lootings were reported from Tigray regional state based on an assessment by humanitarian organizations such as UNICEF, WFP and OCHA but could not be verified on the ground due to inaccessibility of the health facilities yet. Supporting the case, the RHB Heads described the looting and destruction to other health infrastructure. For instance, the Amhara Regional Health Bureau mentioned that one pharmaceutical store belonging to the Ethiopia Pharmaceutical Supply Agency (EPSA) in Dessie hub was damaged and completely looted during the few days that the Tigrayan armed group control the city. Also, ventilators and anaesthesia equipment from Dessie Specialized Hospital were looted by the armed force which preventing all surgical operations from being performed by the time. All the RHB Heads of the project target regions mentioned the damage and looting to such health infrastructure as Blood Banks, Ambulances, Pharmaceutical Stores, and Zonal/Woreda Health Offices as the consequence of the conflict. With these health infrastructure being damaged or looted, PHC services are hardly possible and the essential health needs of population in the conflict-affected Zones and Woredas are denied. The information in ***Table 19*** expose the damage to and looting of health infrastructure by project target regions.

Table 36 Damage to health infrastructure by project target regions

Facility Type	Number of health infrastructure loss per region					Total
	Tigray	Afar	Amhara	Oromia	Benishangul-Gumuz	
Blood Bank	-	-	5	-	-	5
EPSA Stores	-	1	1	-	-	2
Woreda/Zonal Health Office	-	-	64	-	4	68
Ambulances	-	20	124	53	51	248

Source: Ministry of Health, Ethiopia Conflict Impact Assessment and Recovery and Rehabilitation Planning, July 2022.

5.4.2.2 Impacts of the conflict on the health workers

174. The interview with the Heads of the Regional Health Bureau (RHB) ads reveals that the provision of PHC services in the respective conflict-affected regions has been halted not only because of the aforesaid damages to health facilities and infrastructure but also due to the violence against the health staff by all parties to the conflict. Despite admitting sexual violence, physical attacks, and even death as the major violence targeting at the health staff by the armed groups to the conflict, RHB Heads could not provide data on the number of health staff victims in their respective region.

175. However, there are reports produced by humanitarian organizations and dedicated human right organizations on the violence against the health staff. Most incidents against health staff reported in Tigray, Amhara, and Afar the three regions severely affected from the war in the Northern Ethiopia. For instance, [119]the 2021 Ethiopia Safeguarding Health in Conflict Coalition Factsheet reported that sexual violence was routinely used against civilian populations during the conflict, including health workers. In 2021 there were three incidents of rape affecting 13 health workers. Two of the victims were female doctors and 11 were female medical students. All the reported incidents occurred inside health facilities in Tigray region and were committed by armed soldiers. According to the United Nation Organization for Coordination for Humanitarian Assistance (OCHA), health care workers in Tigray, Amhara and Afar regions were killed in the North Ethiopia war while on their duties. Particular, the number is large for Tigray region where 37 public health workers, 23 humanitarian aid workers, and three MSF healthcare workers were killed just within the first year of the war, from November 4, 2020 to September 21, 2022. A report by the Afar RHB shows that 3 health workers were killed from the armed attacks of the war in the north that has been fought in the region for several months.

176. Similarly, the conflict-related crisis disrupted the local health system due to the displacement of the health workforce in fear of security threats. As reported by the MoH in CIARP assessed from November 2020 to December 2021, 10,160 health workers have left the conflict area in Oromia, Amhara and Benishangul Gumuz, of which, 9,888 were from Amhara region. It is not only community members but also health

[119]Safeguarding Health in Conflict Coalition. Ethiopia Violence Against Health Care in Conflict 2021. https://insecurityinsight.org/wp-content/uploads/2022/05/2021-Ethiopia-SHCC-Factsheet.pd, Accessed January 28, 2023.

professionals serving the community who have been displaced due to the conflict. Owing to this impact, for instance, the report of A Doctors of the World – France in June 2021 showed that only 30 percent of healthcare workers in Tigray Region were working in the healthcare system due to security and access restrictions. These all happened even though health workers are badly needed in conflict affected areas to treat wounded soldiers and civilians without discrimination on either side of the fighters or supporters.

5.4.2.3 The number of population affected

177. The study on the impact of conflict on the health sector in Afar, Amhara, Benishangul-Gumuz, Oromia, conducted by the government and development partners including the World Bank from November 2020 to December 2021 indicates that the PHC system has collapsed in most of the conflict-affected woredas. Out of the total 70.4 million in the five project target regions, about 23.8 or 33.8% ***(see Table 20)*** lacked access to PHC service for the reasons described above. The impact of the conflict has been critical for Tigray, Afar and Amhara regions where 80.4%, 70% and 39.6% of the total population lacked access to PHC service, respectively. The massive destruction of health facilities and infrastructure together with the displacement of health workers in fear of security threats from the war has all led to the complete collapse of the healthcare system in the project affected woredas. This all had a disastrous impact on the right to health for the local people i.e. health outcomes of the population.

Table 37 Number and proportion of conflict-affected Population by Region from 2020-2021

Region	***Total Population in the Region***	***Population Affected by Conflict in Million***	***Number of People Displaced in Million***	***Percentage of Conflict Affected People***
Tigray	5,600,00	4,500,000	2,000,000	80.4
Afar	2,000,000	1,400,000	300,000	70
Amhara	22,500,00	8,900,000	2,300,000	39.6
Oromia	39.100,000	8,600,000	600,000	22
Benishangul-Gumuz	1,200,000	400,000	400,000	33
Total	***70,400,000***	***23,800,000***	***5,700,000***	***33.8***

Source: *Ministry of Health Ethiopia Conflict Impact Assessment and Recovery and Rehabilitation Planning, June 2022.*

178. The adverse impacts of the conflict on PHC service can be visible by comparing the availabilities and use of PHC for the project target regions before and after the conflict. In Tigray region, just in the first year of the war (from November 4, 2020 to October 31, 2021, antenatal care reduced from 94% to 16%, facility based delivery reduced from 81% to 21%; full vaccination rate reduced from 73% to 27%, and acute malnutrition increased from 32% to 78%. Moreover, the regular follow up of people with chronic conditions was highly interrupted, if not, stopped. The consequences are alarming; the recorded death of

1,598 diabetes and 2,385 hypertension patients (Gesesew et al 2021)[120]. During the months of September and October 2021, the humanitarian situation in Northern Ethiopia deteriorated as the conflict extended into Amhara and Afar regions. In locations with multiple clashes in these two regions including North Gondar, Wag Hemra, North and South Wello Zones in Amhara and Zone 1, Zone 2 and Zone 3 in Afar, availability and access to all PHC services suddenly dropped to none. In October 2021, the Displacement Tracking Matrix (DTM) statistics revealed that there were 1,301,100 IDPs in Amhara and 335,341 IDPs in Afar. Although a majority of the displaced persons were living within host communities, crowded collective centers and schools, their needs are immense and far from being satisfied by the thin presence of PHC services in the host-communities (Health Cluster Partners 2021)[121]. In addition, recently observed IDP returnees in some areas in Afar and Amhara regions lacked access to basic services including PHC (UNICEF 2022)[122]. Whereas, the conflict situation in Benishangul-Gumuz and Oromia regions is sporadic to make the before-after comparison of the PHC service.

[120]Gesesew et al (2022). The impact of war on the health system of the Tigray region in Ethiopia: an assessment. BMJ Global Health. doi:10.1136/bmjgh-2021-00732

[121]Health Cluster Partners (2021). Northern Ethiopia (Tigray, Amhara, Afar regions) Health Cluster Bulletin October 2021 Edition HEALTH CLUSTER BULLETIN October 2021 Edition. https://healthcluster.who.int. Accessed January 28, 2023.

[122]UNICEF Ethiopia Humanitarian Situation Report No. 5. https://reliefweb.int/report/ethiopia/unicef-ethiopia-humanitarian-situation-report-no-5-may-2022, Accessed January 27, 2023.

CHAPTER 6: INSTITUTIONAL AND IMPLEMENTING ARRANGEMENTS FOR THE IPF PROJECT

6.1 Institutional and Implementation Arrangements

6.1.1 At the federal level

179. ***The MoH:*** It is the main agency responsible for the implementation of the EHS to conflict-affected areas (IPF sub-component I) and Contingent Emergency Response (IPF Sub-component IV). Following the nationwide health sector reform, MoH has seven functional Directorates established based on their functions, under the Office of the Minister and the State Ministers. These functional Directorates are responsible for: the overall fiduciary arrangement of the IPF Program and reporting funds under the IPF operation; guiding, implementing, monitoring and evaluating the environmental and social performance of the IPF program; supporting regions in systems development and developing health sector programs aligned with national plans and goals; and mobilize additional resources to improve service delivery and creates platforms for mutual accountability, information flow, and efficient use of resources.

180. ***Immigration and Citizenship Service (ICS):*** It is responsible for the implementation of CRVS activities (IPF sub-component II). The ICS management will provide overall strategic guidance for the implementation of the IPF Sub-component II. Also, ICS will develop a budgeted annual work plan for the activities of the IPF Sub-component II to be submitted to the World Bank for its no objection. Accordingly, it will produce a quarterly financial reports and annual audit reports.

181. The implementation of the IPF Sub-component III is the joint responsibility of the MoH and ICS. To institutionalize the CRVS system, MoH and ICS need to collaborate on respective civil registration activities in an integrated and harmonized manner. Hence, the MoH and ICS will be responsible for the implementation of the Technical Assistance and Capacity Building (IPF Sub-component III). In particular, the MoH and ICS will cooperate on how to integrate the CRVS into the health sector. The two implementing agencies will also jointly work in developing appropriate automation system that support the integration of CRVS and health sector and institutional capacity building in this respect.

182. ***Joint Consultative Forum (JCF):*** The JCF is the highest governance body which decides, guides, oversees and facilitates the implementation of the HSTP in general and the IPF program in particular. Members of the JCF comprise high level representatives of the appropriate federal government bodies, representatives of the Health, Population and Nutrition (HPN) multilateral and bilateral partners, NGOs, the private sector and health professionals associations. The JCF shall be chaired by the Minister of the MoH while the Policy and Planning Directorate (PPD) of the MoH serves as the Secretariat of the JCF and of the HSTP

183. ***The Joint Core Coordinating Committee (JCCC):*** The members of the JCCC composed of PPD staff and 7 senior staff (with HSTP experience) from the HPN Group. Staff from other MoH Directorates can be invited as required. The Director of PPD in the MoH is the chair of the JCCC. The JCCC is a committee that serves as the technical arm of the JCF. The JCCC assists and works closely with the Secretariat of the HSTP in following up the implementation of the decisions of the JCF and recommendations of the various review missions of the HSTP in general and the IPF program in particular.

184. ***Establish CRVS Federal Steering Committee:*** A technical committee will be established to provide support on technical issues in the implementation of the project. Among other responsibilities, the committee will monitor and evaluate the implementation of the project; facilitate exchange of information on best practices; provide technical advice on activities of the project; and make recommendations for consideration by the CRVS federal steering committee. A Project Operation Manual (POM) that details project implementation arrangements will be adopted before the Program becomes effective.

6.1.2 At the regional level

185. ***MoH-RHBs Joint Steering Committee:*** The MoH-RHBs Joint Steering Committee is a forum that brings together the Ministry of Health and the Regional Health Bureaus. The meeting is chaired by the Minister of Health, and the participants include the State Ministers of Health, Regional Health Bureau Heads and heads of departments/services of the Ministry and the RHBs. The Committee shall meet every two months. The basic objective of this forum is to facilitate the effective and smooth implementation of the IPF program priority issues. This is done by bridging communication gaps between the two levels; by improving internal harmonization and coordination; by closely monitoring progress and problems at the operational level and by taking joint corrective measures.

186. ***Establish ICS-RCRVSAs Joint Steering Committee:*** A technical committee will be established to provide support on technical issues in the implementation of the CRVS at the regional level. Among other responsibilities, the committee will monitor and evaluate the implementation of the CRVS in the respective IPF project target regions; facilitate exchange of information on best practices; provide technical advice on activities of the project; and make recommendations for consideration by the CRVS federal steering committee.

6.1.3 At woreda level

187. ***Establish Woreda PHC Task Force:*** One of the institutional gaps reveal in the finding of the social assessment is lack of IPF project implementing arrangements at the woreda level. Therefore, it is recommended to establish respective Woreda PHC Task Force comprising the heads of the Woreda Health Office, Women and Children Affairs Office, Land Use and Administration Office, Peace and Security Office, CEOs of the respective health centers and primary hospital, and representatives of local community and vulnerable groups. The main responsibility of this Task Force will be to monitor the day-to-day performance of the PHC service provision at the grassroots, respective woreda, health facilities, and IDP camps. The Task Force will be chaired by the respective head of Woreda Health Office and will have a regular communication with the respective RHBs for administrative measures.

188. ***Deploy Woreda CRVS Focal Person:*** Another finding of the social assessment is that ICS, the main agency responsible for IPF Sub-component II, has no institutional structure at the woreda or kebele levels. Whereas, these are the lower government structures where the CR is entirely done. Therefore, it is strongly recommended to deploy a Woreda CRVS Focal Person that coordinate day-to-day CRVS activities at the grassroots level (woreda or kebele) and communicate monitoring report with the RCRVSA.

6.1.4 The implementation of IPF program in Tigray region

189. As already stated, the health system and facilities in Tigray region are not fully under the administrative reach of the MoH due to the security concerns and other restrictions following the war in the north. Thus,

the monitoring of the IPF program in Tigray region will be conducted through a third-party implementing agency (TPIA). As per the agreement with MoH and MoF, UNICEF Ethiopia Country Office will take the responsibilities as a third party for the implementation, monitoring and reporting of the overall performance of the IPF program in Tigray region. Also, UNICEF will develop a well-defined transition plan to make sure that a handover process is clearly defined up front that helps the government take over the implementation responsibility when the situation improves. However, further details will be agreed between the MoH and UNICEF in the contract agreement reflecting the scope of the roles and responsibilities of UNICEF as a TPIA, the number of locations and sites to visit, the frequency of the monitoring, the type and skill required of third-party monitors, and the timing and reporting lines.

190. Head of UNICEF Ethiopia Country PHC Program Head and Program Assistant were interviewed to assess on UNICEF's TPIA approach, implementation arrangements, institutional capacity, challenges and experience from the implementation of previous development projects including World Bank financed project (PforR) in Tigray region and lessons learned for the implementation of the IPF program. As to the informants, UNICEF has a long experience in managing a donor funded projects as a TPIA across the global. In its TPIA approach, UNICEF uses own staff where security clearance obtained and with special agreement with the parties in conflict. Where UNICEF staffs could not access to project sites for security threats or another other reason, it recruits competent local staff who are the members of conflict-affected communities and, thus, their movement cannot be limited by the UNDSS Clearance or parties in conflict to access project sites for monitoring.

191. The informants explained, in Tigray region UNICE has proven access to all the woredas in the region. It has been implementing its own humanitarian intervention projects and engaged as a TPIA for donor funded projects even during the active war of the north. The experience and lessons learned from previous projects in Tigray region are very helpful for effectively managing the IPF project. To this end, UNICE has adequate number and well-trained staffs who have been engaged in a third party monitoring of previous projects in the region, PforR is a typical case in point. Further, UNICEF has well established institutional capacity with proven effectiveness in TPI. The implementing arrangements are comprehensive with well-coordination from Country Office to local level: Donor Relation and Report Writing Unit, Program Monitoring Unit, PHC Strengthening Unit, Regional Field Office, and Sub-Office in the Region.

6.2 Assessment of capacity gaps

192. Consulted stakeholders expected for the institutional and implementing arrangements from federal to local level were asked to discuss on existing capacity gaps that constrain effective management of the project from their respective roles and responsibilities. The summary findings are stated under the following headings.

193. ***Lack or limited working space:*** As compiled in ***Annex 4*** thousands of health facilities in conflict-affected areas were damaged fully or partially. The renovation of many of these health facilities has not been undertaken yet. As a result, informants explained that the capacity of the health facilities to provide proper PHC services for clients is severely constrained due to the limit of the working space. During the field visit, it was seen that some of the health facilities restored the provision of essential health services in medical rooms with broken doors and windows. In some cases, medical services are provided in rooms meant for other purposes and, thus, are not convenient for the delivery of PHC. Evidently, this would

have adverse impacts to effectively implement the activities of the IPF Sub-component I unless renovation measures are taken.

194. ***Inadequate manpower:*** Informants invariably discussed the shortage of manpower as a critical capacity gaps to effectively implement both the provision of EHS services and CRVS activities of the IPF program. The following quotations can provide an empirical illustration:
    - ✓ *Chifra health center is upgraded to primary hospital this year. This decision was made just in an effort to address the existing health needs of the inhabitants of Chifra woreda but not in line with the staff requirements. Maternal Health Care (MHC) and outpatient service require obstetrician and gynecologist but Chifra primary hospital has none. Also, experienced and senior Health Officers were quit job following the security risks and threats from the recent war in the woreda (informant from Chifra Primary Hospital).*
    - ✓ *The health workers were displaced or quite job following the war but no recruitment of new staff in their place. Thus, the health center has no General Physician (GP) while the standard of PHC delivery necessitate 3, only 4 pharmacists are on job out of the required 8, 4 laboratory technicians of the expected 8, and 5 midwife nurses while the standard demand 8 (Informant from Hayq Health Center).*
    - ✓ *The Regional Civil Registration and Vital Statistics Agency (RCRVSA) has only two technical personnel (one database admin and system admin). Whereas, the activities of CRVS are done manually.*

195. ***Lack or inadequate medical equipment and kits:*** As stated by informants, the necessary medical equipment and kits in the health facilities in conflict-affected woredas were looted or damaged. Despite supports received from government and none government partners in restoring PHC, the necessary medical equipment and kits are lacking or inadequate in all the health facilities of conflict-affected areas. As a result, the access to and quality of PHC services are seriously impeded.

196. ***Lack of basic services:*** It was noted from the consultation with the informants that, even prior to the effects of conflict, some health centers and most health posts in the IPF project target areas had no access to basic services (such as electricity and water) or basic services were supplied with recurring outage. Thus, even before the impacts of conflict, many health facilities were depend on alternative means of supply for basic services such as diesel generators, solar refrigerators, and IBC water tank. Informants stated that the existing poor basic services are worsened due to the looting or damage to these alternative means supply. Similarly, though the degree is not the same, informants discussed the problem of basic services in those health facilities that have had access to regular supply. Because, the damages and looting to electrical installation and networks within some health facilities are not fully restored yet. Therefore, informants emphasized that lack or inadequate supply of basic services significantly hampered the delivery of PHC.

197. ***Inadequate supply of drugs:*** As discussed by the health managements and expertise, shortage of drugs is a bottleneck for all health facilities in the conflict-affected areas to provide a quality health care services. According to these informants, patients undergo the necessary medical examination but could not find the prescribed medicine in the pharmacies of the health facilities. Likewise, interviewed community members expressed that most drugs are not available in public pharmacies. Consequently, community members resort to buy medicine from private drug stores which is not affordable to most people. The finding

concludes that health facilities can hardly provide quality PHC services unless measures are taken to improve the means of drug supply.

198. ***Staff turn-over:*** Staff turn-over was discussed as a common problem that impede on the institutional capacity to effectively implement the IPF project activities both in line with the PHC delivery and CRVS. Among the expressions of the key informants, the following quotations can give the empirical illustration:
    - ✓ *Staff turn-over soberly constrained the efforts of our hospital to provide quality PHC services. Even more impeding to the hospital is the turn-over of relatively well trained and senior medical staffs. We advertise job vacancies repeatedly but could not find applicants in place of those resigned senior specialists (Quote: CEO, Chirfa Primary Hospital).*
    - ✓ *CRVS is done by the lower government structure, Kebeles. These are entities not under the direct budget and management mandate of the ICS. The mandate of the ICS is to provide capacity building trainings for kebele leaders and CRVS expertise on CRVS. But, as these are usually political leaders turn-over of the position is common. Hence, the awareness raising trainings and technical capacity building lacks continuity to administer a quality CRVS (Quote: Deputy Director, ICS).*

199. ***Technical gap:*** Interviewed informants in line with both PHC and CRVS stressed technical gaps to effectively implement the IPF program in this regard. With regards PHC system, IPF program supports MoH efforts to establish Health Information System (HIS) governance structures to ensure the HIS implementation in alignment with health system strategies with the aim to enhance: leadership and oversight of the accomplishment of the HIS throughout the country; health procurement and financial management system, and public health emergency preparedness and response. But, as informants stressed, the health facilities have no technical capacity for the effective implementation these HIS. Most health facilities lacked health information workforce and health workers lacked the technical know-how in this regard. Likewise, the efforts for the standardization of CRVS began seven years ago through the pilot program at the national level. Yet, the standardization and automation of the CRVS is not progressed as per the plan due to CRVS workers' lack of technical skills, particularly at the regional and kebele levels.

200. ***Poor digital infrastructure and supporting ICT system:*** Among others, interviewed health workers explained, Key infrastructures such as power, connectivity, electronic devices, Electronic Medical Record system, Electronic Community Health Information System, Electronic Health Surveillance and Survey Systems, Integrated Financial Management Information System, Human Resource Information System, Medical Equipment Management System, HIS logistic and hardware/devices, data center and servers, and systems hosting are essential for optimal operation of the Health Information System (HIS). However, these digital infrastructure and supporting ICT system are not developed within the health facilities in conflict-affected areas. In relation to CRVS, respective informants justified the same problem for effective CRVS management and operation system. Among the common limitations informants stated include: (a) the ICS has no institutional capacity to develop appropriate digital infrastructure, facilities, and ICT system to effectively directing, coordinating and monitoring nationwide civil registration; (b) numerous bottlenecks hinder the efforts to the standardization of CRVS that began seven years ago through the nation-wide pilot program, thus, civil registration is still paper-based manual records; (c) no system for integrating civil registration, vital statistics, population registers and identity management; (d) no system for inter-agency applications of civil registration information and vital statistics; (d) no

effective system for the application and use of civil registration and vital statistics information; (e) no digitized system for civil registration certification management ensuring efficient customer service to the public. Therefore, supports to strengthening digital infrastructure and supporting ICY system is highly recommended in the IPF program.

201. ***Problem of office materials and facilities:*** As to the discussions of the informants, other than the medical equipment mentioned earlier, the necessary office facilities such as computers, printers, photo copy machines, tables, chairs, file cabinets, drug shelves, and other materials were damaged or looted in conflict. This basically affected the provision of PHC services and administrative and management works in the health facilities.

202. ***Poor institutional coordination:*** As shown in the findings of the social assessment, the existence of poor institutional communication and coordination is analyzed from different dimensions: (a) poor *horizontal* communication and coordination of activities within the respective IPF project implementing agencies; (b) poor *hierarchical* communication and coordination of activities among the implementing agencies from the MoH down to woreda level; and (c) poor *inter-agency or inter-sectoral* communication and coordination of activities among the relevant partner implementing organizations. It is worth to take the case of MoH to exemplify poor horizontal communication and coordination of activities. The existing implementing arrangement is based on expert pool system than the usual approach of establishing a dedicated Project Implementing Unit (PIU). That is, the system brings together environmental, social, and GBV expertise in different Directorate for the joint responsibilities. But, in practice, the institutional mechanism for effective communication and coordination of project activities among these work units is not established.

203. ***Institutional structure gap:*** The finding of the social assessment showed some institutional structure gap that can significantly hinder the effective implementation of the IPF program. In particular, this has been revealed in line with the institutional and implementing arrangement for the IPF Sub-component II. That is, the ICS the main agency responsible for this Sub-component has no institutional structure at the woreda and kebele levels. Whereas, these are the lower government structures where the CR is entirely done. Consequently, illustrated based on the experience of how the CR is currently done, interviewed informants emphasized that the standardization, efficiency, quality and timely transfer of CR data from kebele or woreda hierarchically to the ICS would significantly impacted.

204. ***Inaccessibility and limited capacity of the GBV service provision:*** The findings based on stakeholders consultation and field visit reveal some encouraging efforts to improve a GBV service provision. A One-stop service exists in all the IPF project target areas. Also, the inauguration of GBV survivor rehabilitation center was seen in Semera, Afar region. However, the overall local capacity of formal systems to prevent and respond to GBV, including SEA/SH, and the availability of safe and ethical service provision for survivors was assessed as weak. The following quotes from the informants provide the reasons in this respect:
    - ✓ A One-stop service centers in Afar regions are limited in number, established only in referral and general hospitals and, thus, inaccessible to the GBV victims. In line with this establishment, there are only four One-stop service centers in Afar region—one each in Dubti, Asayita, Kalwan and Dalifage Hospitals. Whereas, the GBV victims exist too far from these centers, usually in remote pastoral kebeles. Even then, only a One-stop center in Dubti referral hospital provides with

relative service. A One-stop service center in the later three hospitals lacked the basic requirements for safe and ethical service provision for the GBV survivors. Also, the GBV survivor rehabilitation center in Semera is inaugurated but the required facilities are not fulfilled to begin services (Quote: informant from Afar RHB).

- ✓ *We have seen diverse health impacts to the conflict-caused GBV victims. Some of the health consequences such as intentional transmission of HIV, uterine prolapse and fistula from group rape, and fissure due to rape in anal intercourse have lifelong health threatening. Unwanted pregnancy, psychosocial stress, and sexually transmitted diseases other than HIV are common health impacts to the GBV victims we have seen in the course of medical examination. On the contrary, access to medical and institutional care for the GBV survivors is very much limited in Amhara region in general. If I witness you this based on my experience in Tehuledere woreda, none government partner support mobile health team is the only efforts for the psychosocial support to the GBV victims. So, I am extremely worried that the psychosocial supports for the GBV survivors may be discontinued after the phase of supports by none government mobile health team.*

6.3 Recommended measures to improve implementing capacity

205. Strong institutional structure and implementing arrangements is vital for the effective and successful execution of the proposed IPF program interventions. To strengthen the existing institutional structure and implementing arrangements by way of addressing the aforesaid capacity gaps, the social assessment recommends the following boosting measures:

- To address lack or limitation of the working space, undertake the reconstruction or rehabilitation of the health facilities damaged due to the conflict.
- Solve the critical constraints of lack of or inadequate qualified health manpower as well as health admin personnel, particularly health information management and digitized CRVS management expertise in the conflict-affected health facilities. To this end, the MoH in cooperation with the federal and respective regional governments should commit itself and mobilize the necessary budget for new staff recruitment. The findings of the social assessment as discussed in the preceding sub-section can give inputs to identify areas of specialty and type of health facility to prioritize in this regard. Other strengthening measures include: (a) IPF program support for the deployment of mobile health teams and establishment of district emergency management team to continue delivery of IDP essential health and nutrition services; and (b) support for mobile CRVS team to ensure continuous provision of civil registration services in conflict-affected areas and for IDPs and pastoralist population.
- To enhance the existing capacity gaps related to lack or inadequate medical equipment, kits, reagents and other medical inputs such as drugs the MoH should find financial resources for the procurement of these medical equipment. Besides, the MoH should continue the current resource mobilization (in kind and cash) for restoring medical equipment with more coordination among fragmented supports from partners, donors, public and private organizations.
- MoH and respective RHBs need to closely work with and coordinate the efforts of the public organizations providing basic services such as water and electricity in prioritizing the critical problems of conflict-damaged health facilities.
- Measures to improve the technical gaps may include TA supports through the IPF program for: (a) the digitization of the CRVS system, converting the manual paper-based registration system to a digital, interoperable CRVS system in consultation with key stakeholders, including the MoH,

Regional Vital Events Registration Agencies, and the Ethiopian Statistical Service; (b) enhancing areas of medical financial management (FM) and procurement capacity at EPSA and MoH, health data and management information systems including MoH vital events notification function, M&E, health care financing, and strengthening public-private partnerships; and (c) capacity building trainings to health workers in the conflict-affected health facilities and CRVS workers in conflict-affected areas on the use and skills of digitization system and respective areas of specialty in PHC services.

- Poor digital infrastructure and associated ICT facilities in with PHC can be enhanced through support for HIS logistic and hardware/electronic devices facilitating Electronic Medical Record system, Electronic Community Health Information System, Electronic Health Surveillance and Survey Systems, Integrated Financial Management Information System, Human Resource Information System, and Medical Equipment Management System. Likewise, measures to enhance the poor CRVS digital logistics and facilities may include supports for electronic devices such as high speed desktop computers and data routers supporting high volume CVRS data storage and fast interoperable CRVS system; and support provisions of laptops, tablets with compatible CM Cards , power banks, external hard-desk facilitating effective digitized mobile CR.
- Support for the reestablishment of damaged or looted health infrastructure and services such as Ethiopian Pharmaceutical Supply Agency Hubs, Zonal and Woreda Health Offices, Ambulances, solar refrigerators, IBC water reservoirs, and diesel generators.
- Support provision of necessary office equipment and facilities such as computers, printers, photocopy machines, tables, chairs, file cabinets, drug shelves, and other materials that were damaged or looted during conflict.
- Institutional capacity building measures proposed before can also significantly enhance the existing poor horizontal, hierarchical and inter-agency institutional coordination of the project activities.
- To address the institutional structural gap, establish ICS-RCRVSAs Joint Steering Committee, establish Woreda PHC Task Force, and deploy Woreda CRVS Focal Person with the membership and responsibilities described above (see 9.9.4.1 B and C).
- To improve the constraints of the inaccessibility and limited institutional capacity of the GBV service provision, it is highly recommended to establish a GBV survivor psychosocial support center in the respective health centers that can provide appropriate medical and psychosocial treatment and follow-up to the extent possible or facilitate a referral system to a nearby One-Stop service. To maintain the privacy and social dignity of the victim, it is suggested to arrange a dedicated GBV service room within the respective health centers and fulfil it with the required equipment and materials to the extent possible. Provide training to health workers on survivor-centered care to enhance their technical capacity.

CHAPTER 7: IPF PROJECT-SPECIFIC GRM

7.1 Project-Specific GRM

206. A grievance mechanism for the IPF project is designed based on an understanding of the issues that are likely to be the subject of concerns and grievances. Grievance about the IPF project may arise for different reasons. The project information may not be disclosed in relevant local languages and in a manner that is accessible and culturally appropriate, taking into account any specific needs of groups that may be differentially or disproportionately affected by the project or groups of the population with specific information needs. The process may not encourage stakeholders' feedback, particularly those vulnerable individuals and groups (identified under Section 4.1 as a direct beneficiaries of the project) as a way of informing project design and implementation. The project-affected communities and vulnerable groups may raise concerns about equitable access and quality PHC services. More importantly, grievances and disputes may arise in the course of the implementation of IPF Sub-component I involving involuntary resettlement. The reasons, among others, may be related to the issues of valuation of assets and compensation and successions, divorces, and other family issues resulting in disputed ownership or disputed shares between inheritors or family members.

207. How the IPF project responds (or is perceived to be responding) when such grievances surface is important and can have significant implications for the overall implementation of the project. Thus, proposed Grievance Redress Mechanism (GRM) for the IPF project was explained to the project-affected communities during the interview with clan leaders, community elders, vulnerable individuals, and community consultation. They were informed that the IPF project will put in place a grievance mechanism with accessible and inclusive system, process, or procedure that receives and acts upon complaints and suggestions for improvement in a timely fashion, and facilitates resolution of concerns and grievances arising in connection with the IPF project, in particular about the project's environmental and social performance. Also, the affected-communities were informed that the grievance mechanism will be proportionate to the potential risks and impacts of the IPF project. ***Table 21*** outlines key consideration for the IPF project-specific grievance redress mechanism that will be established/strengthened to allow PAPs to complain about any decision or activities regarding the project.

Table 38 Key Considerations for IPF Project GRM Procedure

No.	Key considerations	Detail about the GRM procedure
1	**Disclosure of the GRM**	A grievance mechanism is established as early as possible in project development. GRM uptake locations need to be established at Regional and Woreda levels and Kebele Appeals Committee (KAC). The existence and condition of access to register (how, where, and when) shall be widely disseminated within the IPF implementation areas. To make IPF project grievance mechanisms accessible to all stakeholders, it is helpful to advertise them publicly and broadly via newspapers, radio broadcasts, or other accessible and appropriate channels.
2	**Expectation When Grievances Arise**	Affected or concerned persons expect to be heard and taken seriously. Thus, the MoH (Social Safeguard and GBV Specialists) and other respective regional, *Woreda*, and Kebele Appeals Committee levels implementing agencies and stakeholders need to provide adequate information to people

		that they can voice grievances and work to resolve without fear of retaliation.
3	**Grievance Submission Method**	It is helpful to make the procedures to submit project-related grievances simple and easy to understand. Thus, IPF project-related complaints can be submitted formally and informally through telephone (hotline), e-mail, MoH websites, program staff, text message (SMS), suggestion/complaint boxes, grievance form or in person. However, once the complaint is received, it will have to be documented in writing using a standard format containing detailed timeline for resolving conflict/complaint. Grievance mechanisms take into account the cultural attributes of HUCs and their traditional mechanisms for raising and resolving issues.
4	**Registration of Grievances**	Complaints will be recorded in a log using standard format, examined, investigated and remedial actions will be taken.
5	**Management of Reported Grievances**	The procedure for managing grievances is expected to be as follows: • The affected or concerned person files his/her grievance, relating to any issue associated with the IPF project in writing or phone to the KAC. Where it is written, the grievance note should be signed and dated by the aggrieved person. In addition, where it is phone, the receiver should document every detail. • Where the affected or concerned person is unable to write, the KAC will write the note on the aggrieved person's behalf. • Assigned/focal staffs at Regional and Woredas level will collaborate with *Kebele* administrators/KACs by giving them awareness training on how to document and report grievance.
6	**Integrating IPF project's GRM with traditional grievance resolution system**	The project-affected communities have a long established traditional mechanism of conflict resolution. In all project areas, the traditional forms of managing grievances can even be recognized and used by the government structures. Thus, existing informal conflict resolution mechanisms identified as part of the social assessment under the Sub-section 4.4.3.2 can be used, provided they are deemed suitable for the project's purposes and, as needed, can be supplemented with project-specific arrangements. In some instances, it may be cost effective and sustainable to build on and improve the formal-informal mechanisms for the project grievance redress.
7	***Gender-sensitive***	The project will ensure that the Grievance Mechanism is gender-sensitive during committee formation and implementation. It will ensure that women are represented in the GRM committee and the GRM equally address grievances received from men and women as well as vulnerable groups.
8	***Response time and transparency matter***	It is good practice for the project GRM to publicly commit to a certain time frame in which all recorded complaints will be responded to and to ensure this response time is enforced. This helps allay frustration by letting people know when they can expect to be contacted by the project area focal personnel and/or receive a response to their complaint. Combining this with a transparent process by which stakeholders can understand how decisions

		are reached inspires confidence in the project's GRM system
9	**Grievances Reporting Mechanism**	The grievance reporting mechanism is as follows: • The KAC report the complaints registered, addressed and review unresolved appeals and forward them to the Woreda Appeal Committee (WAC) every two weeks. • The WAC forward the list of grievances, their resolution and any unresolved cases to the Regional Appeal Committee (RAC) every month. • The RAC will be responsible for compiling submitted and processed complaints/grievances on regular basis and report to the environmental and social safeguard specialists in the MoH every two months. • The environmental and social safeguard specialists in the MoH compile grievance reports from the respective IPF target regions and submit to the World Bank on a quarterly basis.
10	***Don't impede access to legal remedies***	If the project is unable to resolve a complaint, it may be appropriate to enable complainants to have recourse to external experts. These may include public defenders, legal advisors, legal NGOs, or university staff. The Environmental and Social Safeguard specialists in the MoH are required to work in collaboration with these third parties and affected communities to find successful resolution of the issues. However, this is not always possible, and situations may arise where complainants will choose to pursue further legal system. In such a case, MoH will inform the person with complaints his right to resort to the formal Court System.

7.2 The World Bank Group Grievance Service

208. According to World Bank Grievance Redress, communities and individuals who believe they are adversely affected by a Bank-supported project may submit complaints to existing project-level grievance redress mechanisms or the Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed to address project-related concerns and impacts. Project affected communities and individuals may submit their complaint to the Bank's Independent Inspection Panel, which determines whether harm occurred, or could occur, because of the Bank's noncompliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the Bank's attention and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the Bank's corporate GRS, see http://www.worldbank.org/GRS, and Bank's Inspection Panel, see www.inspectionpanel.org. The Bank's GRS will be shared with the project affected community as part of project information disclosure. Considering the very low literacy level of the project affected communities to access the Bank's GRS through website, the GRM provide alternative means including but not limited to posting the phone number of the Bank's GRS and Inspection Panel at the Country Office on community notice board.

CHAPTER 8: POTENTIAL SOCIAL BENEFITS, RISKS AND MITIGATION MEASURES

209. From the analyses of the key findings in this social assessment, supporting the government emergency health and recovery plan through the IPF program would have numerous positive social outcomes that generally improve the provision of EHS to the conflict-affected areas of the country. On the other hand, there are potential social risks of the project including but not limited to those that may trigger World Bank Environmental and Social Standards. The below sub-sections identify potential positive and negative project social impacts following with proposed mitigation measures.

8.1 Potential Social Benefits or development outcomes

210. As the analyses of the findings of the social assessment reveal, access to PHC service in the project target regions has been low in comparison with the national level even in pre-conflict period. The impacts of the conflict further complicated the matter: The already poor PHC services are getting worsened. In line with each IPF Sub-components, the implementation of the IPF program would have several positive outcomes that cumulatively improve the provision of PHC services in conflict-affected areas of the country.

A. IPF Sub-component I: Provision of EHS Focusing on RMNCAH+N to Conflict-Affected population and IDPs

211. ***Improved access to pharmaceuticals and medical devices and their rational and proper use.*** Improved access to pharmaceuticals and medical devices in the conflict-damaged health facilities through supporting procurement and distribution of medical supplies and equipment. Consequently, improved capacity of health facilities in the provision of PHC services and easier access of medical drugs for the service recipients in the conflict-affected areas.

212. ***Improved access to Antenatal Care (ANC) and reduced number of material health risks during pregnancy.*** Increased number of women in conflict-affected areas who received ANC including pregnancy care from skilled providers, such as doctors and nurses/midwives, health officers, and health extension workers, and institutional deliveries resulting from the interventions (such as restoration of the damaged health facilities, mentorship program, and deployment of mobile health teams) of the IPF Sub-component I. Increased access to ANC in turn would significantly reduce the risks of maternal and neonatal mortality.

213. ***Improved access to Postnatal Care (PNC) and reduced number of postnatal maternal and neonatal deaths.*** Increased proportion of women in the conflict-affected areas and newborns received a postnatal check-up from a skilled provider within the right time and increased mothers informed about danger signs of maternal and newborns health after delivery due to due to restoration of health service infrastructure and deployment of mobile health teams for inaccessible areas such as pastoral areas. Increased access to PNC can significantly reduce postnatal maternal and neonatal deaths that occur in the conflict-affected areas due to lack of PNC from a skilled provider.

214. ***Improved access to child health and reduced number of child mortality***. Reduced number of children with low birth weight (weigh less than 2.5); increased number of children age 12-23 months who received all basic vaccinations; increased uptake of the newly introduced vaccines such as pneumococcal conjugate vaccine (PCV) and monovalent human rotavirus vaccine (RV) for children age 12-23 months; increased number of children age 12-35 months possessed vaccination cards; and increased number of

children received treatment of acute respiratory infection (ARI) symptom, fever, diarrhoeal disease and childhood illnesses in the conflict-affected areas resulting from improved access to child health interventions supported by IPF Sub-component I. Improved access to these child health services can significantly reduce the number of child mortality in the conflict-affected areas.

215. ***Improved nutritional status of children and prevent contributing factors to child mortality***. Improved child feeding practices and minimum acceptable dietReduced proportion of children under age 5 who are stunted (assessed via height-for-age), wasted (assessed via weight-for-height), and underweight (assessed via weight-for-age) in the conflict-affected areas in the country as the result of the nutritional interventions of the IPF Sub-component I. Consequently, prevent contributing factors to child mortality, disease and disability in the conflict-affected areas in Ethiopia.

216. ***Improved access to and use of family planning and reduced number of maternal mortality from unwanted pregnancies, unsafe abortion and shorter birth spacing***. Due to the family planning interventions of the IPFI Sub-component I, improved access to or source of modern contraceptive methods including male and female sterilisation, injectables, intrauterine devices (IUDs), contraceptive pills, implants, female and male condoms, standard days method, lactational amenorrhoea method, and emergency contraception; and increased Contraceptive Prevalence Rate (CPR), that is, increased percentage of married and unmarried women age 15-49 in the conflict-affected areas who use contraceptive method depend on informed choice. This helps women avoid unplanned or unwanted pregnancies, prevent unsafe abortions, and manage birth spacing and, thereby, improved maternal and child health status.

217. ***Equitable PHC service delivery to vulnerable groups and Historically Underserved Regions and Communities*.** The understanding of this potential positive social impact has twofold. First, equal access to PHC services by addressing the special needs and social inclusion of the marginalized and vulnerable groups among the population in conflict-affected areas including pregnant and lactating women (PLW), newborns, children, adolescents, girls and women in general, people with disability, the elderly and IDPs. Second, address disparities of access to PHC services in Historically Underserved Regions including Afar, Benishangul-Gumuz and the pastoral areas (Borena and West Guji Zones) in Oromia through the interventions of the IPF Sub-component I such as deployment of mobile health team and strengthen facility disaster preparedness, response, and regional emergency coordination cells.

B. IPF Sub-component II: Civil Registration and Vital Statistics

218. ***Improved system and management of Civil Registration and Vital Statistics (CRVS).*** Efficient system and management of CRVS by replacing manual paper-based CRVS with digitization. IPF Sub-component II supports developing a technology platform that automate the national system of registration, management, and interoperable of CRVS. This enables all components to integrate and coordinate business process on a robust foundation: Daily registration operational activities, manage record volumes, number of requests for registration services, coding, data entry, validation, record changes and updates of CRVS.

219. ***Enhanced application and use of CRVS data.*** Established automated CRVS database containing micro-data (individual level) for the preparation of vital statistics data files covering for example, nationality, fertility, mortality, marriage, divorce and selected population profiles serving a multitude of public

purposes in quantitative terms: offering the capacity to extrapolate, estimate or project selected demographic characteristics, and planning for public policy (e.g. social, economic, and health services).

220. ***Enhanced institutional capacity of the national agency for a centralized administration of CRVS***. Immigration and Citizenship Service institutional capacity developed for a centralized administration, directing, coordinating and monitoring nationwide CRVS due to the technical and material supports provide by IPF Sub-component II including staff training and procurement of motorcycles and field vehicles to facilitate supervision and monitoring of registration activities as well as transfer of registration document between kebeles, woredas, zones, and regional and federal offices including procurement of motorcycles and field vehicles to facilitate supervision and monitoring of registration activities as well as transfer of registration document between kebeles, woredas, zones, and regional and federal offices

221. ***Improved inter-agency cooperation and applications of CRVS.*** Strengthened interaction and coordination between Immigration and Citizenship Service (ICS) and other government agencies that support the civil registration system, municipal function of civil registration that register the occurrence of acts and events that constitute the source of civil status (e.g., marriage, birth, divorce . . . etc) and to issue certificates including Ethiopia Immigration and Citizenship Service mandated to register and administer legal permits for foreign nationals living in Ethiopia, the health services that report the occurrence of vital events and certify causes of death, and the courts that deal.

C. IPF Sub-component III: Technical Assistance and Capacity Building

222. Strengthened the project implementation and M&E capacity**.** Boosted institutional capacity of the project implementing agencies, MOH, Regional Health Bureaus (RHBs), and other implementing agencies in the health sector including Ethiopian Pharmaceutical Supply Agency (EPSA) including: improved institutional financial management (FM) and procurement capacity (at EPSA and MoH); enhanced data and management information systems, enriched staffs' technical capacity of project M&E, increased institutional capacity of health care financing, and public-private partnerships.

D. IPF Sub-component IV: Contingent Emergency Response

223. Improved country response capacity in the event of an eligible emergency such as epidemic or other health emergency with the potential to cause major adverse social and economic impacts through request and access rapid World Bank support for mitigation, response, and recovery in the affected areas.

8.2 Potential social risks

224. Despite the potential social benefits or development outcomes stated above, the findings of the social assessment reveal potential social risks to vulnerable individuals or groups, workers, and surrounding community resulting from the activities of IPF program. The following analyses identify expected social risks that trigger World Bank Environmental and Social Standards.

8.2.1 Risks related to Labor and Working Conditions

225. Risks related to Labour and Working Conditions are expected from IPF Sub-component I and Sub-component II. The undertaking of the activities of these IPF Sub-components require the project hiring of direct and contracted workers involving with the following risks:

- ***Child labour:*** *IPF Sub-component I* has civil works for renovation of the health facilities (conflict-damaged Hospitals, Health Centers, and Health Posts) and establishment of temporary Health Post to reach out to the basic health needs for vulnerable groups (such as IDPs in Camps)

in the conflict-affected areas. As the MoH outsource these civil works to third-party, the contracted organization may employ children for construction works. The social assessment explored obvious push factors for child labour on the side of the contracted organization: It may employ children seeking to make advantage of hiring cheap child labour or due to lack/shortage of labour workers, particularly for the civil works in remote rural and pastoral areas. Also, there are inherent push factors to child labour within the communities in the project areas. The project target regions have low Net Enrolment Rate (NER) in primary school. The entire school system in Tigray has been stopped following the war in the north and did not open yet. Afar, Amhara and Benishangul-Gumuz regional states rank the first three lowest NER in primary school in Ethiopia (see ***Sub-section 4.3.1.3*** for detail). This means that a proportion of children are out of school and easily available for child labour needed for the project civil works. Yet, the extreme poverty level in most of the project target regions coupled with the loss of household livelihood due to conflicts can add to push factor or exacerbate risk of child labour.

- ***Minimum age:*** For the same push factors stated both on the side of contracted organization and local communities, a child over the minimum age and under the age of 18 may be employed or engaged in connection with the project civil works in a manner that is likely to be hazardous or interfere with the child's education or be harmful to the child's health or physical, mental, spiritual, or social development.

- ***Risks from working conditions and management of worker relationships:*** Risks related to working conditions and management of worker relationships concerns those project workers involving formal contractual arrangements as direct workers or contracted workers. Both IPF Sub-component I and Sub-component II engage ***direct workers***, worker with whom the MoH and ICS has a directly contracted employment relationship and specific control over the work, working conditions, and treatment of the project workers. Accordingly, *IPF Sub-component I* will engage: (a) health work force as RMNCAH+N experts, mobile health teams and district emergency management team to continue delivery of IDP essential health and nutrition services and provide training to health workers on survivor-centered care and provide psychosocial support; (b) PIU (E&S Safeguard Specialists, Gender and GBV specialist); and (c) technical assistants in the health sector such as Financial Management (FM) and procurement experts (at the federal and regional levels). *IPF Sub-component II* will employ data and management information systems experts to ensure operational continuity and institut9ionalize the CRVS system. In addition, Mobile CRVS Officers will be employed to ensure continuous provision of civil registration services in conflict-affected areas and for IDPs and mobile pastoralist population. Besides the aforesaid direct workers, *IPF Sub-component I* involve contracted workers for the civil works. ***Contracted workers*** are workers employed by a third party (i.e., contracted organization) to perform the civil works, where contracted third party exercises control over the work, working conditions, and treatment of the project workers. Owing to such contractual arrangements involving multiple parties, disagreements and conflict of interest can occur over the terms and conditions of employment resulting in strained project worker-management relationships.
- ***Occupational Health and Safety (OHS) risks:*** Expected OHS risks to project workers include injury, illness, or other adverse health impacts associated with exposure to hazards encountered in the workplace or while working. Given the nature of the project activities highlighted earlier, the sources OHS risks to workers are diverse: project environmental conditions (e.g. working in a

harsh and extremely hot temperature areas such as Afar and Borena); working conditions (e.g. working at heights/roof involving project civil works); fine particles (e.g. dust from construction works); work processes (e.g. use of tools, construction machinery, and medical equipment); lack of awareness and/or skills (e.g. lack of know-how on how to operate with construction machineries); unavailability of Personal Protective Equipment (PPE) at work place; and lack of emergency prevention and preparedness and response arrangements to emergency situations at work place

8.2.2 Community Health and Safety (CHS) risks

226. Risks related to Community Health and Safety are associated with the project activities under IPF Sub-component I and II. The findings of the social assessment examined that Community Health and Safety (CHS) risks from these project activities can differ within affected-communities depending on various factors that can contribute to vulnerability, including age, gender, or physical disability.

A. Traffic and Road Safety risks

227. Project traffic and road safety risks are associated with the activities of IPF Sub-component I and II that use motorized transportation of different kinds. Under IPF Sub-component I, the civil works can use construction vehicles such as trucks, PHC delivery include ambulance services procured for the project, and the transportation for mobile health team services to IDPs and remote/mobile pastoral communities depend on procured vehicles. Whereas, the support of IPF Sub-component II include procurement of motorcycles and field vehicles to facilitate mobile CRVS (continuous provision of civil registration services in conflict-affected areas and for IDPs and pastoralist population), supervision and monitoring of registration activities as well as transfer of registration document between kebeles, woredas, zones, and regional and federal offices. The use of these motorized transportations can cause traffic and road safety risks to project workers, affected- communities, and road users. The level of risks may vary depend on specific circumstance. Higher risk of traffic accidents is expected at construction sites or on the roads serving these sites, particularly in areas where the road network is already limited, and which are usually occupied by pedestrians. Similarly, some groups within the affected-communities may be particularly vulnerable to project-related traffic accidents, for example, children, the early, people with disability, and pregnant women.

B. Security risks

228. ***Project's Contextual Security Risks (PCSRs):*** The social assessment explored that there are external social and political factors (at the country, regional, zonal or woreda/local level) that the IPF project does not control but which can significantly impede on the implementation of the project. The PCSRs are rooted in the Fragile, Conflict and Volatile situations in the project target regions and/or specific zones/woredas:

- Despite peace agreement is signed between the federal government and TPLF, the health facilities in Tigray region are still not under the reach of the administrative control of the MoH.
- The current security situation in Amhara region depicts either the state of socio-political tensions and instabilities or recurring active conflict. Several project target Woredas in North Wollo, North Gonder, and South Gonder Zones represent the former case arising from the territorial clam with the Tigray region and active armed informal groups. Whereas, quite many woredas in North Showa Zone (e.g. Efratana Gidim, Antsokiya, Showa Robit Town) and Oromia Special Zone (e.g. Senbete and Ataye Towns) face security threats from the recurring armed attack by armed group.

- The health facilities in many Woredas of all the Wollega Zones (Kelem, Horo Guduru, East and West) are not under the reach of the Regional Health Bureau owing to the security risks and threats to the health workers and local political administration from the armed groups. The PHC delivery in several Woredas of North Shawa Zone has been halted due the physical violence and kidnapping against the health workers by the armed groups.

229. ***Project service-induced conflict:*** Informants have been explained that the IPF program interventions make distinction among the conflict-affected Zones or Woredas. For example, informants from Oromia Regional Health Bureau explained that several neighboring conflict-affected areas in Oromia region face the same impacts of conflict. For example, the four Wollega-Zones and the neighboring Buno Bedele and Illubabor Zones face critical health problem due to damages to health facilities. But, the IPF program interventions target the former while exclude the latter. The same is true in other conflict-affected Zones, North Shawa is included while the neighboring Zones (West-Shawa and South-West Shaw) are excluded from the proposed IPF program interventions and benefits. It is likely that the excluded communities feel the sense of unfair treatment leading them to tension and conflict with the government and neighboring communities included in the project benefits. Also, project service-induced conflict may exacerbate existing tensions and inequality between the project beneficiary and non-beneficiary communities escalate to have a negative effect on the stability and human security. Analyzed this way, security risks from project service-induced conflict can significantly affect the project implementation.

230. ***Social conflict:*** The sources of social conflict with adverse security impacts on the project implementation are more common among the communities in pastoral areas including Afar, Benishangul-Gumuz and Borena and West Guji Zones of Oromia region. The social assessment findings based on interview with the key informants (from the regional and woreda Peace and Security Office, clan leaders/the elderly in the respective regions) reveal different sources of social conflict pertaining to the pastoral areas. First, scarcity coupled with recurring drought from continuous environmental degradation in pastoral areas, makes competition over access to vital resources such as grazing land, water and natural resources the root cause of recurring conflicts. Second, besides being valuable sources of livelihood, natural resources such as rivers, grazing and forests areas serve as the boundaries between the neighboring pastoral groups or clans. Hence, inter-group conflicts from clams over territory is more intense nearer to vital natural resources. Yet, the socio-cultural practices among the pastoral communities such as retaliation or blood feuds and cattle raiding sever as the major source of inter-ethnic conflicts in the project target pastoral areas. Security risks to the project workers and, thereby, adverse impact on the project implementation are likely as the inter-ethnic conflicts for the aforementioned reasons sometime lasts for days.

C. Risks from the use of security personnel

231. The social assessment reconnoitered obvious security risks that require the government (federal, regional, or local government) to engage security personnel to safeguard the project workers, assets and activities. The project will operate under known high Contextual Security Risks. These are: (a) continuing security risks and threats from the war in the northern Ethiopia; (b) as shown earlier, quit many project target areas are in active conflict and volatile situation involving organized and armed groups; (c) the nature of some project activities engage mobile teams requiring them travel to remote areas where the movement of armed groups exist; and (d) the IPF has the civil works. Given these security scenarios, the government will seek to retain public security force or private security personnel. Depending on the level of security risk, the use of public security force for the project safeguarding purpose may include Local Militias,

Regional Police/Special Force, Federal Police or Defense Army. Public security may also be assigned to provide regular—or extra—support to a local community where the operation of the IPF project exists, but not be involved in protecting the specific project on a regular basis. Whereas, the project may use private security personnel (e.g. in-house employees or contracted security providers) for minor security risks such as for example guarding building materials at the project construction site located in a safe town.

232. Therefore, the presence of security person can pose risks to, and have unintended impacts on, both the project workers and local communities from different perspective. The social assessment expects the risks of the use of security personnel for the purpose of the project from different dimensions:
    - In undertaking the daily duties, the way in which the project security personnel interact with communities and project workers may appear threatening to them or may lead to conflict.
    - In particular, interaction with public security forces can be the most challenging aspect for the project implementing agency the MoH as it does not control the decisions or behavior of public security personnel and may have limited influence in this regard.
    - For the high Contextual Security Risks just mentioned, it is likely to make the decision to arm the project security personnel that may lead to inappropriate security response.
    - Project security personnel can be engaged both by the government and project contractor, a third party to which the MoH outsource the project civil works. This may create gaps in the management of project security personnel giving ways to security risks.
    - Interactions between communities and project security personnel can lead to tensions if the security personnel are involved in enforcing land acquisition and resettlement or preventing access to cultural heritage sites. Therefore, if not properly managed, risks from the use of security personnel may have a repercussion on the project implementation.

D. External security risks

233. Owing to the FCV situation in the project target areas, external Risks, such as those caused by the actions of people outside the project who seek to take advantage of opportunities presented by the development and operation of the project, such as common criminal activity; disruption of the project for economic, political, or social objectives; and other deliberate actions that have a negative impact on the effective, efficient, and safe operation of the project. In particular, poor governance system in project areas (e.g. all the project target Woredas in Benishangul-Gumuz; the four Wollega Zones, Borena, West Guji and South Shawa Zones in Oromia region) where the movement of armed groups exist can fuel the effect of external risks.

8.2.3 GBV-SEA/SH Risks

234. The project-related risks of GBV-SEA/SH are expected from IPF Sub-component I and Sub-component II. Besides the GBV risks associated with the two IPF Sub-components, the below social assessment provides the local context GBV risks. In doing so, the assessment of GBV risks for the IPF program depend on the Ecological Framework Model recommended in the revised World Bank Good Practice Note on the Environmental and Social Framework for IPF Operations (2020). This means that the effects of the project cut across the local context GBV risks with potential to exacerbate existing GBV risks or can create new ones in both public and private spaces, by a range of perpetrators and in a number of ways. It is for these reasons that the social risk classification for the project is rated as High.

235. ***Local context GBV risks:*** The local context GBV is that women and girls are at particularly high risk of GBV because of societal norms that perpetuate power differentials between males and females and support or condone males' violence against women and girls. The assessment of the *existing social, political, and economic system organization* (see sub-section 4.4.1 and sub-section 4.4.3.2) in all project-affected communities reinforce the vulnerability of women and girls to GBV. The kinship and patrilineal descent system practiced in the entire Amhara and Tigray regions, the clan system and land tenure institution common to all the pastoral communities in the project areas, the Gadaa system among the Borena and Guji communities, the Mada'a institution among the Afar, and the Mangima institution of the Gumuz communities promote the superiority of men while institutionalized the submissiveness of women. Likewise, the *system of gender relations* (see sub-section 4.4.6) across the project target communities are based on the patriarchy system that promote the power relationships by which men dominate over women. As a result, men have an upper-hand over the control of household properties (income, land, livestock and other assets) and decision making. The project-related GBV risks can be extrapolating from the aforesaid local context of GBV risks. For instance, women have no equal power with men over the decision to use modern contraceptive and household income for proper child nutrition. Thus, the implementation of the project may exacerbate existing GBV risks.

236. ***GBV risks related to labour influx:*** As repeatedly explained, IPF Sub-component I involve civil works. The program intends to support the reconstruction (if complete damage) or renovation (if partial damage) of a total of 3,289 health facilities (48 Hospitals, 598 Health Centers, and 2,643 Health Posts) across 176 conflict-affected woredas. This figure excludes the civil works related to the reconstruction or renovation of damaged health infrastructure such as Zonal and Woreda Health Offices, Blood Banks and Drug Stores intended for support in the IPF program. In addition, both IPF Sub-component I and Sub-component II involve deployment of health work force including mobile health team (for PHC delivery and psychosocial supports for IDP Camps, transhumance and inaccessible/remote pastoral communities), district emergency management team, and mobile CRVS team. Thus, GBV risks from the project labour influx can be expected in many ways: (a) large influx of workers may increase the demand for sex work; (b) increased risk of early marriage in project-affected communities where marriage to an employed man is seen as the best livelihood strategy for an adolescent girl; (c) relative higher wages for project workers can lead to an increase in transactional sex; and (d) the risk of incidents of sexual activity between laborers and minors, even when it is not transactional, can also increase. Several additional risk factors that aggravate the vulnerability of women and girls to SEA committed by project workers include: high levels of poverty aggravated by loss of household livelihood due to the impacts of the conflict in the project areas; large population of young women who are not enrolled or dropped school due to conflicts; low levels of education among women and girls; low rates of employment among women; and high crime levels/violence in the project target communities in general, particularly resulting from the conflict.

237. ***Forms of project-related SEA risks:*** Some of the forms of SEA that may be committed by the project workers against women and girls in the community include: rape and sexual assault; sexual harassment; unwanted sexual advances including touching; physical violence/assault; use of abusive, demeaning or culturally inappropriate language; and other forms of humiliating, degrading or exploitative behavior.

238. ***SH risks related to project work environments:*** Risk factors for SH for the IPF project include female laborers working alongside male laborers without adequate supervision of work sites; without separate latrine and other sanitation facilities for males and females; and without specific mechanisms, for females to share concerns about their working environments, including concerns about sexual harassment. Given

the nature of the IIPF activities, additional SH may be environments that are stringently hierarchal, give significant and/or undue power to management, and do no promote and reflect female leadership.

239. ***Security posed GBV risks:*** Both project physical security measures and security guards can have particularly significant impacts on women, who are likely to be traversing distances for domestic tasks. They may be disproportionately affected by the presence of (typically male and potentially armed) security guards, whom they may encounter daily in following their routine. In some cases, women may be subjected to gender-related harassment or intimidation or may be the victims of sexual violence.

240. ***Unequal treatment and differential access to project benefits:*** For the socio-cultural and economic factors analyzed in ***Sub-section 4.4.1*** and ***Sub-section 4.4.5,*** women have limited capacity to defend their interest in and benefits from the IPF project. When land redistribution occurs—for example due to resettlement for civil works in Sub-component I—women may be extremely vulnerable to GBV. This is particularly true in most project-affected communities where the legal system precludes women from holding land titles. Also, as per the interview with the social experts from the Regional and Woreda Women and Children Affairs Bureau/Office, women are not always be adequately consulted about the design and implementation of development projects that would profoundly affect their lives.

241. ***Weak GBV prevention and response mechanism:*** Prevention and response to project-related risks of GBV require multipronged efforts and sectors, including the government who are critical to ensuring that SEA and SH prevention and accountability mechanisms are in place. However, the assessment of the local capacity to prevent and respond to GBV, including SEA/SH, and the availability of safe and ethical service provision for survivors are found to low across all the project implementing areas.

8.2.3 Involuntary resettlement risks

242. Potential involuntary resettlement risks and adverse Impacts arise in association with the undertaking of the civil works of the IPF Sub-component I. The restoration/construction of the damaged health facilities (Hospitals, Health Centers, Health Posts, and infrastructure (such as Blood Banks, Drug Stores, and Zonal and Woreda Health Offices) will be carried within the same compound. Thus, issues of project-related land acquisition or restrictions on land use are unlikely. Consequently, no significant involuntary resettlement risks are expected by way of physical displacement (relocation, loss of residential land, or loss of shelter) or economic displacement (loss of land, assets, or access to assets leading to loss of income sources or other means of livelihood). Likewise, no substantial risks of restrictions on land use or prohibitions on the use of agricultural, residential, commercial, or other land can be directly introduced and put into effect as part of the restoration/construction of conflict damaged health facilities and infrastructure.

243. However, the establishment of temporary satellite clinics for the provision of essential health services in IDP camps will envisage the issues of project-related land acquisition and restriction on land use and access to communal resources. The associated involuntary resettlement risks (physical and economic displacement) would be significant as well. This is because, as to the finding of the social assessment, the current number of IDPs in the conflict-affected areas is by far more than what has been assessed by the MoH in CIARP covering the period from November 2020 to December 2021 and used in the preparation of the IPF project. The case of Oromia region provides a typical example here. According to the desk review from Oromia Health Bureau, currently, there are 1,187, 341 IDPs in the region with a critical need of PHC compared to 600,000 planned in the PAD. More importantly, the number of the IDPs is expected

to continuously increasing as the impact of the conflict has been expanded to five more Zones (Bunno Bedele, Illubabor, West Shawa, South-west Shawa, and East Shawa) than what is considered during the project design. The increment of the number of the IDPs in the conflict-affected areas implies the need for establishing more temporary satellite clinics which in turn require more project-related land acquisition. Therefore, the risks of the physical and economic displacement can be significant.

8.2.4 Anticipated risks to Historically Underserved Communities (HUCs)

244. Land acquisition related to the establishment of temporary satellite clinics may have disproportionate impacts for the pastoral and agro-pastoral communities in Afar, Benishangul-Gumuz and parts (Borena and Guji Zones) of Oromia. The differential impacts of the project-related land acquisition are expected from the collective attachment that inextricably link the lives of the pastoral communities to the land on which they live and the natural resources on which they depend. The concept of collective attachment justifies that the economies, modes of production, social organization, and cultural and spiritual lives of the project-affected pastoral and agro-pastoral communities are generally linked to the particular territories and natural resources they occupy. For pastoral and agro-pastoral communities, therefore, involuntary resettlement risk from project-related land acquisition goes beyond the physical and economic displacement.

245. Disproportionate risks and impacts for the pastoral and agro-pastoral communities may also arise due to unequal opportunity of access to the PHC and CRVS services and development benefits intended in the IPF program interventions. As already stated, the pastoral and agro-pastoral communities in the project target areas are historically underserved communities. They are typically characterized by poor infrastructure and basic social services. More importantly, the existence of poor health facilities may not allow equal and quality PHC and CRVS. Adding to this, the project-affected pastoral communities are mostly transhumance and their economic, social, and legal status frequently limits their capacity to defend their rights to, and interests in development projects. Unless properly mitigated, therefore, the interventions of the IPF program can further widen the opportunity to access quality of PHC in the project target pastoral areas.

246. The differential risks and impacts of the project may take the form of undesired contact and conflict of cultural norms. There are communities in remote pastoral project target woredas such Adar and Barahle in Zone 1 Afar region, and Jardaga Jarte in Borena Zone Oromia region with limited external contact or people in voluntary isolation. Undesired contact with these people due to labour influx from the project civil works and mobile health team (IPF Sub-component I) and mobile CRVS team (IPf Sub-component II) may lead to adverse socio-cultural impacts on them. For example, the coming of the project workers having different socio-cultural backgrounds with largely isolated pastoral communities may undermine the local language, cultural practices, institutional arrangements, and religious or spiritual beliefs which the people in voluntary isolation view as essential to their identity or well-being. As these groups of people are likely to defend undesired contact with the project workers, that may lead to conflicts and instability with adverse impacts on the project implementation. Undesired contact could pose significant health risks to such communities as many may not have developed immunity to viruses and diseases common among mainstream populations.

8.2.5 Risks to Cultural heritage

247. The risks to cultural heritage are expected in association with the civil works of the IPF Sub-component I. The social assessment is conducted in the recognition that cultural heritage provides continuity in tangible

and intangible forms between the past, present, and future lives of the project-affected communities. People identify with cultural heritage as a reflection and expression of their constantly evolving values, beliefs, knowledge, and traditions. Cultural heritage, in its many manifestations, is important as a source of valuable scientific and historical information, as an economic and social asset for development, and as an integral part of people's cultural identity and practice.

248. The civil works proposed in the IPF Sub-component I may involve excavations, demolitions, or other physical changes with potential risks to the cultural heritages in the project target areas. Analysis of national legislation, Proclamation No. 839/2014 on Classification of Cultural Heritages into National and Regional Cultural Heritages, review of available studies in the area, and key informant interview with regional and local stakeholders were used to identify the tangible and intangible cultural heritages in the project target areas that may be affected due to the undertaking of the civil works of the IPF project. Tangible cultural heritage assessed includes movable or immovable objects, sites, structures, groups of structures, and natural features and landscapes that have archaeological, paleontological, historical, architectural, religious, aesthetic, or other cultural significance. Intangible cultural heritage encompasses practices, representations, expressions, knowledge, and skills—as well as the instruments, objects, artifacts, and cultural spaces associated therewith—that the project-affected communities and groups recognize as part of their cultural heritage, as transmitted from generation to generation and constantly recreated by them in response to their environment, their interaction with nature, and their history.

249. As the reconstruction or renovation activities of the damaged health facilities and infrastructure will be carried within the prior sites, none of those cultural heritages recognized in Article 2 of the Ethiopian Proclamation No. 839/2014 can be at risk. Impacts on cultural heritage that are recognized by local communities as important need to be considered even if the cultural heritage is not legally recognized or protected. This consideration is important because the cultural heritage may be designated, protected, or managed by religious, tribal, ethnic, or other community authorities, and therefore recognized in accordance with tradition and customs. In some communities, the character, location, and use of heritage sites and objects may be kept secret or known only to authorized persons. Yet again, the key informants identified no cultural heritage and no concerns were expressed either. Thus, no risks of the project to known cultural heritages are expected. However, previously unknown cultural heritage may be discovered while excavation for the project civil works or tangible cultural heritage may be located under the surface. A chance finds may include the discovery of a single artifact, an artifact indicating the presence of a buried archaeological site, human remains, fossilized plant or animal remains or animal tracks, or a natural object or soil feature that appears to indicate the presence of archaeological material.

8.2.6 Risk related to lack of access to or exclusion from consultation activities

250. Project affected vulnerable and disadvantaged groups such as HUCs, women, youth, people with disability, the elderly, and minority groups are more likely to be excluded from or unable to participate fully in the consultation process. Various types of barriers (e.g. cultural or normative discrimination, low educational status, communication or language problem, physical inaccessibility for people with mobility impairment or low income to access information through Mass Media) may influence the capacity of disadvantaged or vulnerable groups to articulate their concerns and priorities about the IPF project impacts.

8.2.7 Risks related to technical assistance and capacity building (IPF Sub-component III)

251. The risk of discrimination and unequal opportunity among the project workers in relation to technical assistance and capacity building trainings. Distinction, exclusion, or preference may be done on the basis of personal characteristics such as gender, religion, ethnicity, migrant project workers and other factors unrelated to inherent work requirements, which nullify or impair equality of opportunity or treatment in employment.

8.3 Proposed mitigation measures

252. Drawing on the above assessed potential social risks and adverse impacts from the IPF project, the following mitigation measures are proposed with an eye to addressing these concerns during project design, implementation, and monitoring and evaluation.

8.3.1 Proposed Mitigation Measures to Risks related to Labor and Working Conditions

253. *Measures to mitigate risks of child labour and minimum age:* The project develop and implement a written Labour Management Procedures (LMP) that specify the minimum age for employment or engagement in connection with the project as set out in the World Bank ESS2, which is the age of 14. Whereas, a child over the minimum age and under the age of 18 will not be employed or engaged in connection with the project in a manner that is likely to be hazardous, interfere with the child's education, or be harmful to the child's health or physical, mental, spiritual, moral, or social development.

254. *Measures to mitigate the risks from working conditions and management of worker relationships:* Develop and implement a written Labor Management Procedures (LMP) applicable to the project. The project labor management procedures set out a systematic approach to the management of labor issues in the project and reflect the requirements of national law, applicable collective agreements, and requirements of ESS2. To mitigation the disagreements and conflict of interest at work place, the project LMP incorporate a contractual arrangement that set out the ways in which the project workers are managed regarding performance of the work, terms and conditions of employment, remuneration and other benefits in accordance with the different types of project workers that are likely to be involved in the project, and set out the ways of meeting the requirements of the World Bank ESS2 that apply to the different types of workers. In case the project employment involving multiple parties such as the project civil works that may engage the MoH, Contractors, and Sub-contractors, the contractual arrangements for the workers incorporate a clear provisions as to which party is responsible for implementing the requirements in the project LMP.

255. *Measures to mitigate Occupational Health and Safety (OHS) risks:* The OHS measures will be designed and implemented to address: (a) identification of potential hazards to project workers, particularly those that may be life-threatening (e.g. working at heights involving project construction works); (b) provision of preventive and protective measures (modification, substitution, or elimination of hazardous conditions or substances in PHC institutions); (c) training of project workers and maintenance of training records; (d) documentation and reporting of occupational accidents, diseases and incidents; (e) emergency prevention and preparedness and response arrangements to emergency situations; and (f) remedies for adverse impacts such as occupational injuries, deaths, disability, and disease.

8.3.2 Proposed Mitigation Measures to Community Health and Safety (CHS) Risks

256. *Measures to mitigate Traffic and Road Safety (TRS) risks:* As the IPF project is still under the preparation phase, detail information on the Traffic flow or volume on existing roads from the project-related motorized transportation could not be obtain. For this reason, the social assessment proposes a general

TRS measures. Proposed TRS measures related to project-related construction vehicles include placing appropriate road signs and signals on the roads to project construction sites, junction layout, and alignments; provision of pedestrian footways and crossings; barriers (for pedestrians and vehicles); and provide access to public transport. To mitigate TRS risks from the vehicles used in PHC services (e.g. ambulances, motorcycle, and field vehicles) proposed measures include fixing controlling technologies (e.g. fixing GPS in ambulances) and processes designed to promote driver and vehicle safety would provide for vehicles to be maintained and inspected/tested regularly, and for drivers to have appropriate government licensing or certification and be provided with appropriate training. Mitigation measures to the TRS risks from both the use of vehicles for project civil works and PHC service include drivers' compliance with speed limits, seatbelt use, helmet use for motorcycle riders, driver fitness assessments, and control of infractions received may also form part of monitoring programs. On the side of the project-affected communities, proposed mitigation measures include TRS awareness creation activities (e.g. through community meeting, brochures and flyers, and community radios) to the communities affected by project-related TRS risks including those alongside or bisected or fragmented by a road associated with the project construction works; and the requirements for vulnerable groups, such as adequate lighting in public areas, suitable ablution facilities near transport, and adequate road crossing structures. Yet, both the MoH and outsourced project civil work Contractors consider the safety record or rating of vehicles in purchase or leasing decisions and require regular maintenance of all project vehicles.

257. *Measures to Risks from the Use of Security Personnel:* A stand-along project Security Management Plan is the overarching guidance on relevant legal provisions and international standards, procedures and protocols related to project security management. Specific risk mitigation measures and management procedures are prepared depending on whether the project engages public or private security personnel. Given the scenarios of the security risks in the project target areas outlined under the Sub-section 5.2.2 (c), the project may engage public security personnel (such as local Militia/Police, Regional Police/Special Force, Federal Police or Defense Army). In such case, a binding memorandum of understanding (MoU) is signed between the MoH or its local level implementing agency (Woreda Health Office) and the cooperating public security organization, committing the public security force to the project's Code of Conduct and proportional use of force in case of accidents in and around project areas. Alternatively, the Contractors for civil works may hire private security personnel to guard the properties at the project construction sites. In this case, the procurement document incorporate on the responsibilities and procedures for the private security personnel.

8.3.3 Proposed mitigation measures to Project's Contextual Security Risks

258. Engage a Third-Party Implementing Agency, in situations where the MoH has limited capacity to manage the social risks or in situations of fragility, conflict, and violence (FCV) where access to project sites is limited due to high Contextual Security Risks. Depending on the level of Project's Contextual Security Risks, the Terms of Reference (TOR) will specify the scope of the monitoring assignment, the number of locations and sites to visit, the frequency of the monitoring, the budget and timing of the assignment, and the type and skill sets required of third-party implementing agency.

259. Other proposed mitigation measures may include:
- Conducting socio-economic conflict analysis to understand the root cause of conflict and fragile situations in program implementation areas.
- Map out' warring factions, individuals, organizations and strategies that could help resolve border or inter-ethnic conflicts in the project areas.

- Early identification and management of conflict Intensifying factors: ethnic conflict, recent violence, historic animosity, weakness of claimant groups (to control potential break-outs)
- Proactive security measures. For examples, relocation or evacuation of project staff during such conflicts, defining 'triggers' for suspension of activity/relocation/evacuation.

8.3.4 Proposed mitigation measures to project service-induced conflict

260. The target of the interventions of the IPF project is planned based on Ethiopia Conflict Impact Assessment and Recovery and Rehabilitation Planning (CIARP) as of November 2021. However, after November 2021, the conflict has expanded to several Zones and Woredas, particularly in Oromia regional state. So, to mitigate project service-induced conflict or conflict due to benefiting some conflict-affected areas while excluding the others, it is highly recommended to extend the interventions of the IPF project to recently affected areas as well.

8.3.5 Measures to address GBV-SEA/SH risks

261. Assessment of the project-related risk of exacerbating SEA/SH involves three essential issues. First, the country and/or regional/local context in which the project takes place, multiple risk factors for GBV at the individual, relationship, community, institutional and policy levels; second, the potential risks that the IPF project may bring or exacerbate existing GBV risks; and third, the local capacity of formal systems to prevent and respond to GBV. Based on the assessment of the GBV risks, prepare a stand-alone project GBV-SEA/SH Preventive and Response Action Plan Which outlines: how the project will put in place the necessary protocols and mechanisms to address the SEA/SH risks; and how to address any SEA/SH allegations that may arise in the course of the IPF project implementation.

8.3.6 Proposed Mitigation Measures to Involuntary Resettlement Risks

262. As a general principle, the project applies a mitigation hierarchy. To avoid involuntary resettlement or, when unavoidable, minimize involuntary resettlement by exploring project design alternatives. After the avoidance and minimization steps, mitigate adverse social and economic impacts from land acquisition or restrictions associating with IPF Sub-component I by: (a) providing timely compensation for loss of assets at replacement cost; and (b) assisting displaced persons in their efforts to improve, or at least restore their livelihoods and living standards in real terms, to pre-displacement levels or to levels prevailing prior to the beginning of project implementation, whichever is higher.

263. The preparation and implementation of an RF and RAPs/LRPs to guide the resettlement and compensation process.

8.3.7 Proposed Mitigation Measures to the Disproportionate Risks and Impacts on HUCs

264. A targeted social assessment for the purposes of ESS7 is conducted when HUCs are present in, or have collective attachment to, the land required for the project purposes. A key aspect of the targeted social assessment is understanding the relative vulnerabilities of the affected HUCs and how the project may affect them. Accordingly, the determination, delivery, and distribution of compensation and shared benefits to affected HUCs will take account of the institutions, rules, and customs of these HUCs, as well as their level of collective attachment to the land required for the purposes of the project. Guided by the findings of the targeted social assessment, eligibility for compensation can either be individually or collectively based, or be a combination of both. Where compensation occurs on a collective basis, as far as practicable mechanism that

promote the effective distribution of compensation to all eligible members, or collective use of compensation in a manner that benefits all members of the group, will be defined and implemented.

265. Preparation and implementation of a HUCPF and sub-project HUCPs.

266. As per ESS10 and ESS7 the IPF program will engage with HUCs in a meaningful, culturally appropriate and gender and inter-generationally inclusive manner.

267. The IPF program will obtain the FPIC of the affected HUCs in circumstances in which the project will: (a) have adverse impacts on land and natural resources subject to traditional ownership or under customary use or occupation; (b) cause relocation of HUCs from land and natural resources subject to traditional ownership or under customary use or occupation; or (c) have significant impacts on HUCs' cultural heritage that is material to the identity and/or cultural, ceremonial, or spiritual aspects of the affected HUCs' lives.

8.3.8 Proposed Mitigation Measures on Cultural Heritage

268. Preparation of a chance finds procedure or the project-specific procedure which will be followed if previously unknown cultural heritage is encountered during the undertaking of the civil works associated with the IPF Sub-component I and integrated into the project ESMF. Among other things, a chance finds procedure for the project covers the identification, notification, documentation, and management of chance finds in accordance with national laws and, where applicable, internationally accepted practice and local customs. Accordingly, it is included in relevant procurement documents and instructions to contractors of the project civil works.

269. Obtaining FPIC is required in the case where the project may impact on the cultural heritage of affected HUCs.

8.3.9 Mitigation measures for the risk related to lack of access to or exclusion from consultation activities

270. The process of preparing the SEP is inclusive, and is designed to accommodate the needs and circumstances of different stakeholders, paying special attention to identified disadvantaged or vulnerable individuals or groups. Specific mitigation measures include:

- Depending on the societal context, HUCs, women, children, youth, the elderly, and people with disability will be considered as stakeholder groups of their own, and separate consultation formats (e.g. separate interview or focus group discussion) will be arranged to capture their special needs and concerns.
- Consultation process will take into account the different access and communication needs of vulnerable or disadvantaged individuals and groups, including consideration of both communication and physical accessibility challenges.
- Meaningful consultation that build on existing customary institutions and decision-making processes utilized by the IPF project affected HUCs.
- The project will devise specific stakeholder engagement arrangements communicated in formats suitable to and understandable for vulnerable or disadvantaged individuals and groups. This may include the use of project leaflets and pamphlets, community notice board, community radio, project webpages and telephone hot lines.
- Relevant project documents will be accessible for stakeholders with sensory disabilities, for instance, through providing documents in Braille or engaging a sign language interpreter at a consultation meeting, as appropriate.
- In cases where literacy levels are low, additional formats like location sketches, physical models, and film presentations may be useful to communicate relevant information.

8.3.10 Measures for risks related to technical assistance and capacity building (IPF Sub-Component III)

271. The IPF program identifies measures that support equal opportunities for women and men, with emphasis on equal criteria of selection for the project technical assistance and capacity building trainings. Also, as allowed by the national law, the IPF program will implement specific measures that provide for preferential treatment of female, people with disability or other individuals or groups of project workers who have been the subject of prior discrimination or disadvantage.

8.4 Social Development Plan: Potential social risks/impacts, Mitigation measures, Responsible Body and Budget

272. The Social Development Plan identifies measures and actions in accordance with the mitigation hierarchy that reduce potentially adverse social impacts to acceptable levels. Accordingly, in line with the potential project social risks identified based on the social assessment, the Matrix in ***Table 22*** presents specific social management plan (either stand alone or as incorporated into the ESCP) that details: (i) the measures to be taken during the implementation and operation of the IPF project to eliminate or offset adverse social impacts, or to reduce them to acceptable levels; and (ii) the actions needed to implement these measures. As the differentiated measures are integrated into the project design and implement the adverse impacts do not fall disproportionately on the disadvantaged or vulnerable groups. The Social Development Plan will be continuously updated during the life of the program.

Table 39 The Matrix of the Project's Social Development Plan

Components/ Issues	Potential Social Risks, Impacts and Challenges	Mitigation Measures	Responsible Body	Budge	Timeline
IPF Sub-component I: *Provision of EHS Focusing on RMNCAH+N to Conflict-*	Child labour or employing children under the minimum age in the civil works of the project. Inherent push factors in the project areas include the existence of large number of children out of school, extreme household poverty or loss of household livelihood due to conflict.	• The project's LMP specifies the minimum age for employment or engagement in connection with the project as the age specified in national law or in ESS2 (the age of 14), whichever is higher. • Verification of age prior to employment of the project workers by requesting the applicant to provide a legal confirmation such as birth certificate, Kebele ID Car, school certificate, or other official documents demonstrating age. • Document the personal records of the project workers for official inspection. • Sudden inspection by the project Social Safeguard Specialist or local implementing partner (Woreda Women and Children Affairs). If a child under the minimum age is discovered working on the project, terminate the employment of the child. The project LMP incorporate the requirement to terminate the engagement with the Contractors violating the rule.	-Project Social Safeguard Specialist in the MoA -Contractors -Respective	Core activity of IPF Sub-component I	During the construction phase
	Children over the minimum age (i.e., age of 14) and under the age of 18 may be employed or engaged in connection with the project	• A child over the minimum age and under the age of 18 will not be employed or engaged in connection with the project in a manner that is likely to be hazardous, interfere with the child's education, or be harmful to the child's health or physical, mental, spiritual, moral, or social development. The project LMP specify the type of project activities considered hazards in this regard.			

Affected population and IDPs (US$89 million IDA equivalent)	civil works. The same inherent push factors mentioned for child labour applies here.	• To support monitoring, the Contractors outsource for the project civil works create and maintain a separate record of all project workers over the minimum age and under 18. Accordingly, inspection of the working conditions by the project Social Safeguard Specialist or local implementing partner (Woreda Women and Children Affairs).	Regional and Woreda Women and Social Affairs Bureau/Office		
	The establishment of temporary or satellite clinics to provide essential health services in IDP camps and reconstruction health facilities may requires land acquisition with potential risks and impacts of involuntary resettlement.	• Resettlement Framework (RF) is prepared for project-related land acquisition with potential resettlement impacts whose exact nature and locations are not yet known and the scope and scale of resettlement aspects cannot be determined as a result. The RF establish general principles, procedures, and organization arrangement compatible with relevant national law and the World Bank ESS2. • Once the number of temporary satellite clinics required for the IPF program is decided and the exact locations are known, the RF will be expanded into a specific Resettlement Plan. The scope and level of detail of the resettlement plan varies with the magnitude of displacement and complexity of the measures required to mitigate adverse impacts. Project activities that will cause physical and/or economic displacement will not commence until such specific plans have been finalized and approved by the Bank. • The consultation process ensure that women's perspectives are obtained and their interests factored into all aspects of resettlement planning and implementation. • The preparation and implementation of an RF and RAPs/LRPs to guide the resettlement and compensation process.	-The Social Safeguard Specialist in the MoH -Respective target Regions -Respective target Woreda or Urban Land Administration Office	Potential costs are estimated early in the project design phase and integrated into project design and development.	Begin before start of civil works and continue throughout the project implementation period
	Involuntary resettlement from the project land acquisition for the establishment of temporary or satellite clinics and reconstruction of health facilities may have disproportionate risks and impacts for the affected HUCs.	• As the IPF project is under preparation, the design or exact location of the project civil works require land acquisition cannot be known during project preparation and that will only be designed during the project implementation. For this reason, the finding of the social assessment proposes the preparation of the Historically Underserved Community Planning Framework (HUCPF). The framework specifies resettlement principles, design criteria applied to the civil work activities of the IPF Sub-component I to be prepared during project implementation, the timing for completion of any specific plans and includes a clear statement of roles and		Core activity of IPF Sub-component I	Begins before start of civil works and continue throughout the project implementation period

		responsibilities, budget, and commitment for funding. • However, a stand-alone Historically Underserved Community Plan (HUCP) is prepared once the exact location of the civil work activities of the IPF Sub-component require land acquisition is known and the presence of the HUCs in or around the specified project site is confirmed. • The preparation of the HUCP is proportionate to the nature and scale of the resettlement risks and impacts. More importantly, the HUCP design mitigation measures that consider how loss of land/restriction of access to natural resources inextricably impacts on the economies, modes of production, social organization, and cultural and spiritual lives of the affected pastoral and agro-pastoral communities. • Preparation and implementation of a HUCPF and sub-project HUCPs. • As per ESS10 and ESS7 the IPF program will engage with HUCs in a meaningful, culturally appropriate and gender and inter-generationally inclusive manner. • The IPF program will obtain the FPIC of the affected HUCs in circumstances in which the project will: (a) have adverse impacts on land and natural resources subject to traditional ownership or under customary use or occupation; (b) cause relocation of HUCs from land and natural resources subject to traditional ownership or under customary use or occupation; or (c) have significant impacts on HUCs' cultural heritage that is material to the identity and/or cultural, ceremonial, or spiritual aspects of the affected HUCs' lives.			
	The excavations or other physical changes involving the civil works may cause risks to unanticipated discovery or recognition of cultural heritage.	A Chance Finds Procedure is developed as part of the Environmental and Social Commitment Plan (ESCP). Project-specific procedure to be followed if previously unknown cultural heritage is encountered during the excavations involving the project civil works include: ✓ Notify Woreda Culture and Tourism Office of found objects or sites on the same day. ✓ Fence-off the area of finds or sites to avoid further disturbance. ✓ Cooperate with cultural heritage experts (at woreda, regional or national organization as appropriate) in assessment of found objects or sites, identifying and implement actions consistent	-The Social Safeguard Specialist in the MoH -Respective Regional/Woreda Culture and Tourism Bureau/Office	Core activity of IPF Sub-component I	During the construction phase

		with the requirements of the ESS8 and national law. ✓ Train project personnel and project workers on chance find procedures ✓ Obtaining FPIC is required in the case where the project may impact on the cultural heritage of affected HUCs.			
	HUCs may not receive equitable access to the project PHC services as that is significantly constrained by exceptionally poor health facilities and infrastructure in their areas. Also, the project PHC services and benefits such as child nutrition may not devised or delivered in a form that is culturally appropriate to HUCs or their relative low social status (e.g. higher proportion of both illiterate women and men HHs) may impede on HUCs' equal access to the Project PHC services	• The physical investment in IPF Sub-component I pays due attention and addresses the constraints of PHC services inherent to the poor health facilities in HUCs areas. This includes establishment of temporary or satellite clinics beyond rehabilitating conflict damaged heath facilities. • Apply innovative PHC delivery approaches such as deployment of mobile health team to reach out to the project areas with transhumance pastoral communities or where health facilities are basically inaccessible and establishment of temporary or satellite clinics is infeasible. • Behavioral change communications on RMNCAH+N in a form that is culturally appropriate and meaningful consultation (e.g. using local languages, consider the local literacy level, food habits, lifestyles, and gender sensitive) tailored to HUCs.	-The Social Safeguard and GBV Specialists in the MoH -Respective RHBs -Respective WHOs -Respective WWSAOs	Core activity of IPF Sub-component I	Throughout the project implementation period
IPF Sub-component II: Civil Registration and Vital Statistics(CRVS)	For the same reasons mentioned just before, HUCs such as pastoral and agro-pastoral communities may not receive equitable access to the project CRVS services due to the exceptional poor infrastructure and basic social services supporting the system.	• Strengthen basic facilities such as ICTs in the project areas with pastoral and agro-pastoral communities that support the automation of CRVs. • Apply innovative CRVS approaches such as deployment of mobile CRVS team to reach out to the project areas with transhumance pastoral communities or where basic facilities such as ICTs are basically lacking to support digitized CRVS. • Behavioral change communications on the vital relevance of the CRVS for health, social, legal and social policy planning in a way that is culturally appropriate and meaningful consultation (e.g. using local languages, consider the local literacy level, socio-	-The Social Safeguard and GBV Specialists in the MoH -Respective RHBs -Respective WHOs -Respective	Core activity of IPF Sub-component I	Throughout the implementation project period

	This may widen the gaps in the HUCs and brings disproportionate development benefits of the IPF program interventions.	cultural attitudes, and gender sensitive) tailored to HUCs.	WWSAOs		
Common issues for IPF Sub-component I and II or cross-cutting social issues	Risks from working conditions and management of worker relationships involving multiple parties and categories of project workers.	Prepare and implement the labor management procedures which set out a systematic approach to the management of labour issues in the project. More specifically, the LMP identifies the different categories of project workers that are likely to be involved in the project. Accordingly, set out the ways to manage the sources (e.g. Terms and Conditions of Employment) of disagreement and conflict of interest at work place.	-Social Safeguard Specialist in the MoH -Contractors	I and II	Throughout the project period
	Occupational Health and Safety (OHS) risks involving project civil works and PHC delivery	The project LMP incorporates specific/appropriate OHS measures to prevent and protect workers from occupational injuries and illness based on the following underlying principles and procedures: • The way in which the OHS provisions apply in the IPF project depends on the nature and severity of the hazards, risks, and impacts; and the types of workers involved. • It is good practice to avoid or eliminate sources of hazards to project workers health and safety, rather than simply addressing the hazard through preventive and protective measures such as personal protective equipment. However, when it is not feasible to avoid or eliminate the hazard, appropriate protective measures are included in the projects OHS measures including but not limited to: ✓ Controlling the hazard at its source through the use of protective solutions (e.g. work place ventilation systems for health staffs working in harsh environment such as Afar or guarding construction machines); ✓ Providing adequate personal protective equipment (e.g. helmet for motorcyclists and construction workers) at no cost to the project worker. ✓ Provide adequate first aid facilities and relevant training.	-Social Safeguard Specialist in the MoH -Contractors -Workers' Representative/OHS Committees -Respective Woreda Women and Social Affairs, Work Place Safety Inspection Team.	Core activity of IPF Sub-component I and II	Throughout the project implementation period

		✓ Protective measures would include hazard labeling in languages understandable to the project workers, and training and equipment to prevent occupational exposure to hazardous materials. ✓ Project workers receive OHS training at the start of their employment or engagement, and thereafter on a regular basis and when changes are made in the workplace, with records of the training kept on file. ✓ Further OHS measures are set out in the project's LMP as per the requirements provided in the national laws, ESS2, EHSGs and other Good International Industry Practice (GIIP). • Monitoring and follow-up on the performance of OHS measures.			
	Increased TRS risks from motorized transportation in project civil works, PHC services, and mobile CRVS	• Beyond the TRS mitigation measures (see Sub-section 5.3.2) proposed based on the social assessment and incorporated as part of health and safety or traffic management in ESMF, the preparation of project TRS risk management plan that set out specific safety measures, for example, measures necessary to manage traffic speeds. • But, the need for specific TRS risk management plan will be decided based on further project-related TRS risks assessment considering the following key aspects: ✓ Information on traffic incidents and accidents from heavy vehicles (such as construction vehicles and trucks carrying heavy construction materials) used by the Contractors for the project civil works, ambulance services, and motorcycles and field vehicles used to facilitate mobile PHC services and mobile CRVS inaccessible project areas such as remote and transhumance pastoral communities; and ✓ Vehicle mix, volume, speed, and condition (including vehicle weight, height, length, and any hazardous materials likely to be carried), and TRS status of the existing roads (including availability of road signs and signals, lane widths, slopes, speed management, roadside uses, pedestrian usage and facilities, air pollution, and any risks that these may pose).	-Social Safeguard Specialist in the MoH -Contractors outsourced for the project civil works -Drivers hired by the MoH and Contractors	Core activity of IPF Sub-component I and II	During the construction phase and continue throughout the project implementation period
	Potential threats to the project workers, sites, assets and activities as well as to project-affected communities are	• Project Security Risk Assessment (SRA) is conducted focusing on an analysis of PCSRs (the Fragile, Conflict and Volatile situations at the country, region and local level) that the IPF project does not control but which can significantly impede on the implementation	-The MoH -Contractors outsourced for	Core activity of IPF Sub-component I	Throughout the project implementation

	expected due to the Contextual Security Risks in general, project service-induced conflicts, and risks from the use of security personnel for the safeguard of the project.	of the project; risks to workers and local communities from the use of security personnel for the need of safeguarding the project; project service-induced security risks; and risks from other external threats. Building on the SRA, a stand-alone Security Management Plan (SMP) containing all the procedures and protocols related to security for the project is prepared. • Monitoring of project security commitments and performance; review the SMP if significant changes (e.g. armed conflict or when the level of security risks is increased) occur in the project's security situation; prepare Site-Specific Security Management Plan if required; and incorporate the changes into and update the project ESCP accordingly.	project civil works -Respective Regional Peace and Security Bureaus -Respective Woreda Peace and Security Offices	and II	period
	Women and girls in the project target areas are at particularly high risks of GBV because of societal norms that perpetuate power differentials between males and females. The implementation of the IPF project can exacerbate or add to a new GBV risks through labour influx.	• Assessment of the project-related risk of exacerbating SEA/SH involves three essential issues. First, the country and/or regional/local context in which the project takes place, multiple risk factors for GBV at the individual, relationship, community, institutional and policy levels; second, the potential risks that the IPF project may bring or exacerbate existing GBV risks; and third, the local capacity of formal systems to prevent and respond to GBV. • Based on the assessment of the GBV risks, prepare a stand-alone project GBV-SEA/SH Preventive and Response Action Plan Which outlines: how the project will put in place the necessary protocols and mechanisms to address the SEA/SH risks; and how to address any SEA/SH allegations that may arise in the course of the IPF project implementation. • Assessment of GBV-SEA/SH risks throughout the project's life by monitoring the situation, assessing the effectiveness of risk mitigation measures, and adapting them accordingly. • Workers to understand and sign CoC with SEA/SH provisions.	-GBV Specialist in the MoH -Respective RHBs -Respective WHOs -Contractors outsourced for the project civil works. -Respective RWSBs	Core activity of IPF Sub-component I and II	Throughout the project implementation period
	The risks and impacts of undesired contact and social conflict that may arise due to the socio-cultural differences between project workers and remote pastoral communities	• Training for project workers on distinct socio-cultural norms, lifestyles, and traditional institution of the project-affected communities, particularly remote pastoral communities or people of voluntary isolation.	-The Social Safeguard and GBV Specialists in the MoH -Respective RHBs -Contractors of	Core activity of IPF Sub-component I and II	Throughout the project implementation period

	with limited external contacts.		project civil works -Respective WHOs -Respective WWSAOs		
	Risk related to lack of access to or exclusion from consultation activities	The process of preparing the SEP is inclusive, and is designed to accommodate the needs and circumstances of different stakeholders, paying special attention to identified disadvantaged or vulnerable individuals or groups. Specific mitigation measures include: • Depending on the societal context, HUCs, women, children, youth, the elderly, and people with disability will be considered as stakeholder groups of their own, and separate consultation formats (e.g. separate interview or focus group discussion) will be arranged to capture their special needs and concerns. • Consultation process will take into account the different access and communication needs of vulnerable or disadvantaged individuals and groups, including consideration of both communication and physical accessibility challenges. • Meaningful consultation that build on existing customary institutions and decision-making processes utilized by the IPF project affected HUCs. • The project will devise specific stakeholder engagement arrangements communicated in formats suitable to and understandable for vulnerable or disadvantaged individuals and groups. This may include the use of project leaflets and pamphlets, community notice board, community radio, project webpages and telephone hot lines. • Relevant project documents will be accessible for stakeholders with sensory disabilities, for instance, through providing documents in Braille or engaging a sign language interpreter at a consultation meeting, as appropriate. • In cases where literacy levels are low, additional formats like location sketches, physical models, and film presentations may be useful to communicate relevant information.	The Social Safeguard and GBV Specialists in the MoH		Throughout the project implementation priod
IPF Sub-component III:	The risk of discrimination and unequal opportunity among the	• The IPF program identifies measures that support equal opportunities for women and men, with emphasis on equal	The Social Safeguard and GBV	Core activity of IPF Sub-	Throughout the project

Technical Assistance and Capacity Building (US$5 million IDA equivalent)	project workers in relation to technical assistance and capacity building trainings.	criteria of selection for the project technical assistance and capacity building trainings. • As allowed by the national law, the IPF program will implement specific measures that provide for preferential treatment of female, people with disability or other individuals or groups of project workers who have been the subject of prior discrimination or disadvantage	Specialists in the MoH	component III	implementation period
	Project's Contextual Security Risks	• Engage a Third-Party Implementing Agency, in situations where the MoH has limited capacity to manage the social risks or in situations of fragility, conflict, and violence (FCV) where access to project sites is limited due to high Project's Contextual Security Risks. Depending on the level of Project's Contextual Security Risks, the Terms of Reference (TOT) will specify the scope of the monitoring assignment, the number of locations and sites to visit, the frequency of the monitoring, the budget and timing of the assignment, and the type and skill sets required of third-party monitors. • Conducting socio-economic conflict analysis to understand the root cause of conflict and fragile situations in program implementation areas. • Map out' warring factions, individuals, organizations and strategies that could help resolve border or inter-ethnic conflicts in the project areas. • Early identification and management of conflict Intensifying factors: ethnic conflict, recent violence, historic animosity, weakness of claimant groups (to control potential break-outs) • Proactive security measures. For examples, relocation or evacuation of project staff during such conflicts, defining 'triggers' for suspension of activity/relocation/evacuation.	Ministry of Health		Throughout the project implementation period
	Project service-induced conflict	The target of the interventions of the IPF project is planned based on Ethiopia Conflict Impact Assessment and Recovery and Rehabilitation Planning (CIARP) as of as of November 2021. However, after November 2021, the conflict has expended to several Zones and Woredas, particularly in Oromia regional state. So, to mitigate project service-induced conflict or conflict due to benefiting some conflict-affected areas while excluding the others, it highly recommended to			Throughout the project implementation period

		extend the interventions of the IPF project to those recently-affected areas as well.			

CHAPTER 9: MONITORING AND REPORTING ARRANGEMENTS

273. The MoH will monitor the social performance of the project on a continuous process. Monitoring arrangement is designed in a way that help to track the social performance of the IPF project, to determine whether it is achieving its outcomes and meeting various the social requirements shown in this Social Assessment, and whether additional measures need to be implemented.

9.1 Monitoring Indicators

274. Project monitoring will normally include recording information to track performance, and establishing relevant operational controls to verify and compare compliance and progress. Monitoring will be adjusted according to performance experience, as well as actions requested by the Bank and relevant regulatory authorities and feedback from the vulnerable and historically underserved individuals and groups identified in this Social Assessment. To this end, specific monitoring indicators include the following:

- ***Proposed differential measures:*** To enhance equitable services, the IPF project is required to devise differentiated measures so that adverse impacts do not fall disproportionately on the disadvantaged or vulnerable, and they are not disadvantaged in receiving project's PHC and CRVS services. Based on this indicators, monitoring tasks will: (a) focus on checking whether mobile PHC and CRVS service team are deployed on time and whether the team in each case composed of adequate number and qualified staffs as the level of the service required; (b) checking whether temporary or satellite PHC service clinics in areas with poor health facilities are established and whether such differential health facilities are provided with adequate number and qualified staff as per the plan in the project; (c) if the involuntary resettlement associated with project land acquisition for IPF Sub-component I affect Historically Underserved Communities, observing whether the determination, delivery, and distribution of compensation and shared benefits take account of the institutions, rules, and customs of these communities; and (d) whether the proposed differential inclusion strategies arranged and properly implemented to allow the target vulnerable individuals and groups including women, IDPs, and Historically Underserved Communities express their concerns and special need in the course of project implementation.

- ***Access to project's PHC services:*** The progress of the IPF project performance will be monitored in terms of improvement in the provision of each element (RMNCAH+N) of the PHC service is accessible to the vulnerable individuals and groups identified in Section 7.1 of this Social Assessment. To objectively assess the effectiveness of the IPF project in terms of the PHC services to vulnerable individuals and groups, the monitoring results will be compared against the baseline conditions documented in the Social Assessment in this regard.

- ***Access to project's CRVS services:*** This indicator helps to monitor the project performance in terms of the extent to which vulnerable individuals and groups equitably receive CRVS services. Monitoring results could be analyzed in terms of the proportional discrepancy for the target vulnerable individuals and groups.
- ***The ESCP:*** The staff of the MoH will monitor the project social performance of the project in accordance with other indicators specified in including the ESCP relating to the project target vulnerable individuals and groups.

9.2 Means of Verification

275. The means of verification for the project monitoring results will depend on triangulating between different sources including:

- The number of mobile PHC and CRVS service team deployed as per the adequate number and composition of expertise required in the project.

- Established number of temporary or satellite PHC service clinics versus project areas with constraints of poor health facilities.
- The proportion of target vulnerable individuals and groups who have received the project PHC and CRVS services.
- Number of separate focus group discussion and/or individual interview arranged for the target vulnerable individuals and groups.
- Number of project-affected vulnerable individuals and groups received timely, concise, indicative information on resettlement and compensation.
- Where appropriate and as set out in the ESCP, the MoH will engage stakeholders and third parties, such as independent experts, local communities, or nongovernmental organizations (NGOs), to complement or verify its own monitoring activities.
- The MoH may require to facilitate site visits by Bank staff or consultants acting on the Bank's behalf.

9.3 Monitoring Arrangements

276. The MoH will ensure that adequate institutional arrangements, systems, resources, and personnel are in place to carry out monitoring before commencing the IPF Sub-components. In case of the project implementing activities in Tigray region where UNICE is in charge as Third-Part Implementing, the MoH will be responsible for the overall supervision and collaborate with UNICE staff to establish and monitor project social mitigation measures.

9.4 Reporting

277. The IPF project Social Safeguard staff in the MoH is responsible to compile monitoring resulting and prepare the quarterly report. The frequency of the report to the Bank will be on a quarterly basis. The format and content of monitoring report may compile details of relevant information but should satisfy the monitoring indicators identified above at a minimum.

278. Based on the results of the monitoring, the MoH will identify any necessary corrective and preventive actions, and will incorporate these in an amended ESCP or the relevant management tool, in a manner acceptable to the Bank. The MoH will implement the agreed corrective and preventive actions in accordance with the amended ESCP or relevant management tool, and monitor and report on these actions.

CHAPTER 10: KEY RECOMMENDATIONS

279. The implementation of the IPF project requires to adopt differentiated measures so that adverse impacts do not fall disproportionately on the disadvantaged or vulnerable, and they are not disadvantaged in sharing development benefits and opportunities resulting from the project. To this end, the findings of the Social Assessment recommend the following specific mitigation strategies:

- The MoH will apply innovative PHC delivery approach such as establishment of temporary or satellite clinics and deployment of Mobile Health Team to address the disproportionate access of vulnerable groups to the PHC services inherent to exceptionally poor health facilities and infrastructure in their areas.
- To ensure equitable PHC services of the IPF program, the MoH should promptly hire staff in health institutions (hospitals, health centers, and health posts) where the workforce have been displaced in association with conflicts in the respective region or woreda.
- Deploy Mobile CRVS Team to reaching out to the IPF project areas with transhumance pastoral communities or where CRVS service institution is lacking or inaccessible.
- To ensure equitable PHC and CRVS benefits, undertake behavioral change communications on RMNCAH+N and CRVS in a form that is culturally appropriate and meaningful consultation (e.g. using local languages, consider the local literacy level, food habits, lifestyles, and gender sensitive) tailored to vulnerable individuals (such as household where both spouses are illiterate) and groups (such as pastoral communities) with low socio-economic status to realize the benefits of PHC and CRVS services.
- Strengthen basic CRVS facilities such as ICTs t in the project areas with remote rural place, pastoral and agro-pastoral communities that support the automation of CRVs.
- The staff in the MoH will ensure key project stakeholders, principally representatives of RHBs, local government and principal private sector partners, are sensitized by a consultant with propriate experience of vulnerable communities in Ethiopia on relevant groups to ESS7, and the ESF requirements under WB projects. This will also be a key intervention to ensure vulnerable communities' inclusion in discussions, policy development and investment within IPF Sub-components I and I, and wider inclusion in project processes and benefits.
- As a strategy to ensure equitable distribution project benefits from IPF Sub-components I and II, the determination, delivery, and distribution of compensation and shared benefits to affected Historically Unserved Communities will take account of the institutions, rules, and customs of these communities.
- It is recommended that affected disadvantaged or vulnerable individuals or groups including women have a voice in consultation in the planning and implementation of the project Social Development Plan. Differential strategy may include arranging a separate focus groups or individual interview with members of disadvantaged or vulnerable groups to allow them express their special concerns and needs.
- To build local project support or ownership, and to reduce the risk of project-related delays or controversies, the MoH will follow an approach of meaningful consultation tailored to the project affected vulnerable and historically underserved groups. This strategy is based on the prior disclosure and dissemination of relevant, transparent, objective, meaningful, and easily accessible information on Social Development Plan in a time frame that enables meaningful consultations with affected vulnerable and historically underserved groups identified in this Social Assessment in a culturally appropriate format, in relevant local language(s) and understandable to the stakeholders.
- As a proactive approach to mitigation of community-based conflicts, establish a Grievance Redress Mechanism (GRM) as early as possible. The existence and condition of access to register (how,

where, and when) shall be widely disseminated within the IPF implementation areas. To make IPF project grievance mechanisms accessible to all stakeholders, it is helpful to advertise them publicly and broadly via newspapers, radio broadcasts, or other accessible and appropriate channels.

- Implementing relevant mitigation measures before any IPF project activities that could cause social risks or impacts commence. In particular, this strategy is expected in line with the civil works of the IPF Sub-component I that may arise serious disappoints and grievances of the project-affected communities due to process of involuntary resettlement related project land acquisition.
- To address emerging social issues and recognizing the dynamic nature of the IPF project implementation process, the project implementing in the MoH depend on management tools that will take a long-term and phased approach, and be designed to be responsive to changes in project circumstances, unforeseen events, regulatory changes, and the results of monitoring and review.
- In monitoring the IPF project social impacts, the staff of the project implementing agency apply management tools that define desired outcomes in measurable terms for example, against the baseline conditions documented in the Social Assessment to the extent possible, with elements such as targets and performance indicators that can be tracked over defined time periods.
- Adaptive management approach that improving management by learning from project outcomes and new information. It focuses on learning and adapting and can be applied to respond to project changes or unforeseen circumstances. As a strategy, an adaptive management approach incorporates processes to monitor environmental and social mitigation measures compared to expected outcomes, to detect and learn from changes to those outcomes, and to make decisions to realign project outcomes with SA objectives. Recommended strategies of adaptive management approach also include flexible and iterative design, and support systematic monitoring and modifications.

ANNEXES

Annex 1: Desk Review Checklist and Interview Guiding Points for Stakeholder Consultaiton

I. Project Briefing

Investment Project Financing (IPF) is part of Program for Results (PforR) designed to support the government emergency health and recovery plan for conflict-affected areas. The IPF program will support -and enhance the development of a resilient health service delivery system in the conflict-affected parts of the country, requiring huge investments. The IPF will allow MoH to continually adjust to the changing situation in the conflict affected areas through implementing four components which are: (a) Sub-component I: Provision of EHS Focusing on RMNCAH+N to Conflict-Affected population and IDPs; (b) Sub-component II: Civil Registration and Vital Statistics; (c) Sub-component III: Technical Assistance and Capacity Building; and (d) Sub-component IV: Contingent Emergency Response.

II. Purpose

The purpose of the below desk review checklist and guiding points is to generate information for the preparation of Environmental and Social Management Plans required by the World Bank for Disbursement. Also, the obtained information and inputs will be used to update the program design. Dr. Deribe Teshome, Zereu G/Silassie, and Tsion Getachew are the World Bank Consultants for technical supports to the Ministry of Health, the main implementing agency at the national level. Given the tight schedule for this assignment, we would like to appreciate for your precious time and prompt response in providing the required information.

III. Checklist for Desk Review: Updating on the Damage to Health Facilities and Workers in the Conflict-Affected Areas

	Specific Conflict-Affected Areas		*Conflict-Damaged Health Institutions*			*Number of Health Workers Impacted due to Conflict*		
Region	***Name of Zone***	***Name of Woreda***	***Name of Hospital***	***Name of Health Center***	***Name of Health Post***	***Quit Job***	***Displaced***	***Conflict-Threatened***

Note:

- The act of conflict threated includes kidnapping, physical attacks, verbal abuse (insult, degrading and the like), psychological stress, Gender-Based Violence (rape, attempted rape, verbal and sexual harassment against female health workers) and any disrespectful experienced by the health workers in association with the conflict in and around their work place.
- You can add rows in the table as needed.

IV. Guiding Points for Detail Discussion

1. Given the damage to health facilities and disruption of PHC services, how do the local communities access to Essential Health Services?
2. What are the differential health impacts for vulnerable groups due to disruption of PHC services:
    - Pregnant and Lactating Women (PLW)
    - Newborns
    - Under-5 children
    - People with disabilities
    - People with chronic illness
    - The elderly
    - Women in general and young girls
    - IDPs
3. What is the extent of the current security risks and threats to the health workers from the conflict to restore PHC services? What are the on-going efforts or intended measures to mitigate security risks and threats to health workers due to the current conflict?
4. Reported GBV risks and impacts (rape, unwanted pregnancy, exposure to STDs, physical violence, verbal abuse/psychological consequences) due to the conflict.

V. Expertise Providing Information

- Region: _____
- Position: _____
- Phone: _____
- Email: _____

Thank you so much for your precious time and prompt response!!

Annex2: Discussion Guiding Points for Community Consultation

I. Sample Kebeles

Considering the socio-cultural similarities (such as livelihood, land tenure system, and social organization), the project target regions will be clustered into two: Afar, Benishangul-Gumuz and pastoral areas of Oromia in one group and Amhara and Tigray in the other. Then, one Kebele will be purposely selected from each cluster for community consultation.

II. Composition of the Community Consultation Participants

The composition of the community consultation participants will include community representatives (clan leaders, community elders, and religious leaders), members of project-affected communities, women, IDPs, and People with Disabilities, and pastoral communities. The total number of participants per community consultation session is expected to be 15-20.

III. Basic Information

- Name of selected region: _____
- Name of selected zone: _____
- Name of selected woreda: _____
- Name of selected kebele: _____
- Date of consultation conducted: _____
- Consultation start time: _____
- Consultation end time: _____
- Venue: _____
- Name of consultation moderator: _____

IV. Consultation Guiding Points

Code	Social Topics	*Questions*	*Response*
KCC 1	General project over view	Views &Information about the proposed project	
		How do you evaluate the development activities in your area?	
KCC 2	Project benefit	What the project would benefit	
KCC 3	Risks and Concerns	What adverse effects would result from the project (Risks ,Concern)	
KCC 4	Mitigate the adverse effects	What solutions would there be to mitigate the adverse effects	
KCC 5	Social dynamics	Social structure: organization, roles, values, norms	
		Inter and intra-group relationships and dynamics	

		Is there social cohesion (or lack of) among social groups in the community?	
		Are there specific groups that are likely to lose-out (not benefit) from specific types of development?	
		Are there any biases against those defined as the most vulnerable in the community? What is the relationship between groups, if relevant?	
		What are the most significant social and cultural features that differentiate social groups and do the differences result in exclusion of vulnerable groups?	
		Are there any cultural factors affecting women's access?	
		Opportunities and conditions for vulnerable stakeholder participation in the development process?	
KCC 6	Vulnerable PAP	Who are the most vulnerable and underserved groups? [Probe for: the poor, the poorest of the poor, women, orphans, children, girls, elderly, disabled, female-headed households; polygamous households, PLHIVs, outcast and underserved occupational or livelihood groups, households facing conflicts over natural resources, particular cultural, religious groups, new residents, others…]	
		Do specific groups (minorities, women, FHHs, youth) are likely to lose-out from specific types of development in the intervention areas?	
KCC 7	Physical and cultural resources	Are there physical cultural resources that have or will likely to be impacted? If so, list the name, type, age, ownership, short description of the cultural resource, etc	
KCC 8	Social institutions	Are there institutions in the area; consider both the presence and function of public, private and social institutions relevant to the operation?	
KCC 9	Social problems and development issues	What is the existing status and major challenges related to water, irrigation, electricity, road, health, education, agriculture, livestock and market services in the area?	
		What are water supply and irrigation scheme services related challenges faced by the community?	
		Could you list down development priorities of the community?	
		Are you willing to donate your land if it is needed for community development?	

		How is land or other asset compensation effected?	
		What development priorities do both male and female youths have?	
KCC 10	Community Experience on the implementation of similar WB financed projects	Issues in handling Land acquisition & resettlement in other projects	
		Issues in handling property valuation and compensation	
		Issues on the existing GRM systems to handle complaints	
		Issues existing mechanisms to prevent Child Labor	
		Issues on existing mechanisms for Gender mainstreaming and GBV/SGBV/SEA/VAW/VAC/SH prevention at work place	
		Issues on stigmatization and tensions over access to resources and power and Intra or inter-ethnic conflict in relation to ICT use and management?	
		Issues in relation to the effects of COVID-19 on previous WB financed project implementation	
KCC 11	Additional comment	You are cordially invited to suggest if there is any additional idea.	

Annex 3: Historically Underserved Community Planning Framework

1. Introduction

The preparation of this guidelines applies to a distinct social and cultural group, which has been identified as set out in paragraphs 8 and 9 of the ESS7. The use of the term Indigenous People is not preferred by the Ethiopian government. Alternatively, the terminology Underserved Communities (UCs) is used in this guidelines to refer to the pastoral and agro-pastoral communities in Afar, Benishangul-Gumuz and parts (Borena and Guji Zones) of Oromia region targeted in the IPF program. As per the findings of the social assessment, risks and adverse impacts of the IPF program on these Underserved Communities (UCs) are expected from the undertaking of both IPF Sub-component I and II. With regards to IPF Sub-component I, land acquisition related to the civil works, particularly the establishment of temporary or satellite clinics to address the PHC needs of the displaced UCs may have disproportionate impacts. The differential impacts of the project-related land acquisition are expected from the collective attachment that inextricably link the lives of the UCs to the land on which they live and the natural resources on which they depend. The concept of collective attachment justifies that the economies, modes of production, social organization, and cultural and spiritual lives of the project-affected UCs are generally linked to the particular territories and natural resources they occupy. Given this fact, for the UCs, the risks and adverse impacts from involuntary resettlement would go beyond the physical and economic displacement.

As to the findings of the project social assessment and ESMF, disproportionate risks and adverse impacts for the UCs in the project target areas may also arise due to unequal opportunity of access to the PHC and CRVS services (IPF Sub-component II) and development benefits intended in the IPF program interventions. As discussed in the findings of the project social assessment and ESMF, affected UCs are typically characterized by poor infrastructure and basic social services that may not allow for equitable access and quality PHC and CRVS intended in the IPF program. Adding to this, the project-affected UCs are mostly transhumance and their economic, social, and legal status frequently limits their capacity to defend their rights to, and interests in the development benefits from the project. Also, the project PHC and CRVS services may not devised or delivered in a form that is culturally appropriate (e.g. considering the relative low educational status of the women and men) to HUCs. This may impede on the UCs' equal access to the Project PHC and CRUS services. Therefore, the interventions of the IPF program can further widen the disparities in the affected UCs unless properly mitigated. The Guidelines for Underserved Community Plan (GUCP) describe the frameworks to promote equitable access to the benefits and mitigate the disproportionate adverse project impacts on UCs.

As the IPF project is under preparation, the design or exact location of the project civil works require land acquisition cannot be known at this stage and that will only be designed during the project implementation. For this reason, the findings of the social assessment proposes the preparation of the GUCP that provide a framework for the UCP.

2. The General Principles of Underserved Community Plan (UCP)

If it is known that the IPF project has impacts on lands and natural resources subject to traditional ownership or under customary use or occupation, the need for the preparation of Underserved Community Plan (UCP) is guided by the following general principles:

- First, UCP for the IPF program is prepared and implemented in the recognition that UCs have identities and aspirations that are distinct from mainstream groups in national societies and often are disadvantaged by traditional models of development. In many instances, they are among the most economically marginalized and vulnerable segments of the population. Their economic,

social, and legal status frequently limits their capacity to defend their rights to, and interests in, land, territories and natural and cultural resources, and may restrict their ability to participate in and benefit from development projects. In many cases, they the UCs do not receive equitable access to project benefits, or benefits are not devised or delivered in a form that is culturally appropriate, and they may not always be adequately consulted about the design or implementation of projects that would profoundly affect their lives or communities.

- Second, the need for the preparation and implementation of the UCP for the IPF program makes the principle that UCs have their own understanding and vision of their well-being and that, broadly, this is a holistic concept that relates to their intrinsic relationship to lands and traditional practices and is reflective of their way of life. This captures their core principles and aspirations of reaching harmony with their surroundings, and achieving solidarity, complementarity and communal living.

- Third, besides the environmental and social assessment for the IPF project in general, understanding the particular environmental, social and economic situations of affected UCs needs the undertaking of Targeted Social Assessment (TSA). The preparation and implementation of the UCP depend on detailed information generated through TSA.

- Fourth, the preparation and implementation of the UCP depends on the principle that the roles of men and women in UCs' culture are often different from those in the mainstream groups, and that women and children have frequently been marginalized both within their own communities and as a result of external developments, and may have specific needs.

- Finally, the preparation and implementation of the UCP contributes to poverty reduction and sustainable development by ensuring that the undertaking of the IPF program enhance opportunities for UCs to participate in, and benefit from, the development process in ways that do not threaten their unique cultural identities and well-being.

3. Objectives of the UCP

- To ensure that the development process from the implementation of the IPF program fosters full respect for the human rights, dignity, aspirations, identity, culture, and natural resource-based livelihoods of the UCs in the project areas.
- To avoid adverse impacts of the project activities on the UCs or when avoidance is not possible, to minimize, mitigate, and/or compensate for such impacts.
- To promote sustainable development benefits and opportunities for the UCs in a manner that is accessible, culturally appropriate, and inclusive.
- To improve project design and promote local support by establishing and maintaining an ongoing relationship based on meaningful consultation with the UCs affected by the project throughout the project's life cycle.
- To obtain the Free, Prior, and Informed Consent (FPIC) of the affected UCs in the case of project-related land acquisition and/or restriction on land use following the circumstances described in ESS7.
- To recognize, respect, and preserve the culture, knowledge, and practices of the project-affected UCs.

4. Scope of Application for UCP

The scope of the IPF project's UCP applies to the distinct social and cultural groups residing in Afar, Benishangul-Gumuz, and parts (Borena and Guji Zones) of Oromia. In determining the inclusion for the

IPF project's UCP, the screening criteria for the project-affected UCs will be in line with the provisions set out in paragraphs 8 and 9 of the World Bank's ESS7. That is, to be included in the UCP, the project-affected UCs refer to those pastoral and agro-pastoral communities living in the aforesaid target areas possessing the following distinct socio-cultural and economic characteristics in varying degrees:

a) Self-identification as members of a distinct social and cultural group and recognition of this identity by others;
b) Collective attachment to geographically distinct habitats, ancestral territories, or areas of seasonal use or occupation, as well as to the natural resources in these areas;
c) Customary cultural, economic, social, or political institutions that are distinct or separate from those of the mainstream society or culture; and
d) A distinct language or dialect, often different from the official language or languages of the country or region in which they reside.

As per the provision set out in paragraph 9 of the ESS7, the screening criteria for the IPF project's UCP also applies to communities or groups of who, during the lifetime of members of the community or group, have lost collective attachment to distinct habitats or ancestral territories in the IPF project target areas because of forced severance, conflict, government resettlement programs, dispossession of their land, natural disasters, or incorporation of such territories into an urban area. Yet, the screening for the project UCP applies to forest dwellers, hunter-gatherers, or other mobile groups subject to satisfaction of the criteria in paragraph 8 cited just before.

MoH's proposed mitigation measures and actions in the IPF project UCP will be developed in consultation with the affected communities as defined above and contained in a time-bound plan. The scope and scale of the plan will be proportionate to the potential risks and impacts of the IPF project.

5. Requirements for the Project UCP

The preparation of the guidelines or the use of the framework approach is preferred as the preparation of the IPF is undergoing and, thus, the design or location of the IPF project activities that require land acquisition or with adverse impacts on the UCs in the project areas cannot be known. Likewise, the findings of the social assessment reveal, the use of the framework approach is appropriate at this phase because the IPF project has multiple activities both under IPF Sub-components I and II that will only be designed and their exact adverse impacts are known during the project implementation.

However, following the identification of the exact project impacts from the undertaking of the activities of the IPF Sub-components I and II and confirmation that UCs are present in or have collective attachment to the project areas specified earlier, a stand-alone UCP, proportionate to the potential risks and impacts of the project, is prepared. IPF Project activities that may affect UCs do not commence until such specific plans are finalized and approved by the Bank.

When determining collective attachment for the project UCP, consideration is given to the fact that such groups live under many different circumstances with varying levels of attachment to the land or natural resources adversely impacted due to the civil works of the IPF Sub-component I. In this sense, collective attachment signifies that the project-affected UCs generally consider their lands and resources to be collective assets, and that they see their culture and identity as a function of the group rather than as individuals. It also signifies that the affected UCs' economies, modes of production, social organization, and cultural and spiritual circumstances are generally linked to particular territories and natural resources.

The concept of collective attachment refers to geographically distinct habitats or ancestral territories, or areas of seasonal use or occupation and the natural resources therein, and therefore, groups with collective attachment may include:

a) Groups resident upon the lands affected by the project. This could include those who are mobile or who seasonally migrate, and whose attachment to the area affected by the IPF project may be periodic or seasonal in nature. This could also include those who reside in mixed settlements on the lands affected by the project, such that they only form one part of the broader community; or
b) Groups that do not live on the lands affected by the project but that retain ties to those lands through traditional ownership and/or customary usage, including seasonal or cyclical use.

A key purpose in the project UCP is to ensure that the UCs present in or with collective attachment to the land or natural resources under the impacts of the project are fully consulted about, and have opportunities to actively participate in, project design and the determination of project implementation arrangements. The scope and scale of consultation, as well as subsequent project planning and documentation processes, will be proportionate to the scope and scale of potential project risks and impacts as they may affect UCs.

6. Steps in the Preparation and Implementation of the Project UCP

As identified in the project social assessment, ESMF, RF, and GBV risk assessment, prevention and response action plan, the proposed IPF program interventions have various activities that might give rise to an adverse and positive impacts on the UCs inhabiting the project areas in Afar, Benishangul-Gumuz, and Borena and Guji Zones in Oromia. The guidelines for the project UCP set out that the design and implementation of these activities adhere to the basic principles outlined above, requirements of the ESS7, and relevant laws of Ethiopia. To this end, the framework within which the implementation of the proposed IPF Sub-components avoid, minimize or mitigates adverse impacts on UCs involve the following steps.

6.1 Step one: Targeted Social Assessment

Undertaking a Targeted Social Assessment (TSA) for the purpose of ESS7 is the first step. MoH will conduct a TSA that assess the nature and degree of the expected direct and indirect economic, social, cultural (including cultural heritage), and environmental impacts of the IPF project on UCs who are present in, or have collective attachment to, the project area. A key aspect of the TSA is understanding the relative vulnerabilities of the affected UCs and how the IPF project may affect them. The assessment is proportionate to the nature and scale of the proposed project's potential risks to, and impacts on, as well as the vulnerability of, the UCs. The assessment should consider differentiated gender impacts from the project activities and impacts on potentially disadvantaged or vulnerable groups within the UCs such as PLW, newborns, children, people in chronic health care, the elderly, and people with disabilities. Input from qualified specialists and accompanying meaningful consultations with the project-affected UCs are important to inform and support the assessment.

6.2 Step two: Obtaining Free Prior Informed Consent (FPIC)

As identified in the project social assessment, ESMF, and RF, pastoral and agro-pastoral communities may be particularly vulnerable to the loss of, alienation from, or exploitation of their land and access to natural and cultural resources. In recognition of this vulnerability, in addition to the General Requirements set out in ESSs 1 and 10, the IPF project is required to obtain the Free, Prior and Informed

Consent (FPIC) of the affected UCs in circumstances in which the project civil works under IPF Sub-component I will:

a) Have adverse impacts on land and natural resources subject to traditional ownership or under customary use or occupation;
b) Cause relocation of UCs from land and natural resources subject to traditional ownership or under customary use or occupation; or
c) Have significant impacts on UCs'cultural heritage that is material to the identity and/or cultural, ceremonial, or spiritual aspects of the affected UCs' lives.

FPIC is the process that aims to ensure that the consent must be obtained without coercion, prior to the commencement of the proposed project activities with potential risks and impacts, and after the full disclosure of the intent and scope of the proposed project activities, in a language and process understandable to the affected UCs. To this end, FPIC is established as follows: (a) the scope of FPIC applies to the project design, implementation arrangements, and expected outcomes related to risks and impacts on the affected UCs; (b) FPIC builds on and expands the process of meaningful consultation established through good faith negotiation involves, on the part of all parties, willingness to engage in a process and availability to meet at reasonable times and frequency, sharing of information necessary for informed negotiation, use of mutually acceptable procedures for negotiation, willingness to change initial positions and modify offers where possible, and provision of sufficient time for the process; (c) achieving FPIC requires paying attention to, and documenting, both process and outcome; and (d) documenting the process and outcome establishes a record of agreements reached, as well as dissenting views.

6.3 Step three: UCP Preparation

On the basis of the findings and inputs from a TSA, MoH will identify mitigation measures in alignment with the mitigation hierarchy described in ESS1, as well as opportunities for culturally appropriate and sustainable development benefits for the affected UCs. The scope of the mitigation plan will include the cultural as well as physical risks and impacts of the project for the affected UCs.

In case of the involuntary resettlement risks and adverse impacts associated with the civil works of the IPF Sub-component I, the findings of the TSA help determine the eligibility and the appropriate structure and mechanisms for the delivery and management of compensation and shared benefits. Opportunities for benefit sharing are considered as distinct from compensation for adverse impacts, and address the longer term sustainable development of the affected UCs.

The determination, delivery, and distribution of compensation and shared benefits to affected UCs will take account of the institutions, rules, and customs of these UCs. Eligibility for compensation for the resettlement risks from the project civil works of IPF Sub-component can either be individually or collectively based, or be a combination of both. Where compensation occurs on a collective basis, as far as practicable means that promote the effective distribution of compensation to all eligible members, or collective use of compensation in a manner that benefits all members of the group, will be defined and implemented.

6.4 Step four: Implementation and Monitoring of the UCP

Step four is to effectively implement the UCP for the IPF project. To build local project support or ownership, and to reduce the risk of project-related delays or controversies, MoH will undertake an engagement process with affected UCs. This engagement process will include stakeholder analysis and engagement planning, disclosure of information, and meaningful consultation in a culturally appropriate and gender and inter-generationally inclusive manner.

Approaches to meaningful consultation and active participation are most effective when they build on existing customary institutions and decision-making processes utilized by the affected UCs. Further, the means by which to promote the capacity of the existing institutions and decision-making processes to promote the active participation and contribution of the affected UCs in implementing and monitoring the project UCP is assessed and applied.

6.5 Engaging Competent and Independent Expertise/Specialist

MoH engage competent and independent expertise for undertaking a TSA and FPIC preparation of UCP for the IPF project. Competent implies to a person or firm with the necessary combination of skills, education and experience to investigate, assess, summarize and make recommendations on a particular topic or scope of work. An expert or specialist team should include individuals familiar with the local context, as well as individuals knowledgeable about World Bank requirements. Independent refers to an expert or specialist individual or firm that is able to provide professional, objective, and impartial advice, without consideration of future work, and avoiding conflicts with other assignments or their own business or personal interests. Such independence supports the objectivity of the environmental and social assessment, without regard to vested interests and without reason to influence the outcome of the assessment.

7. Grievance Mechanism

MoH will ensure that a grievance mechanism is established for the project. This can be integrated into a comprehensive Grievance Redress Mechanism (GRM) for the IPF project. A key consideration is that: (a) the grievance mechanism is proportionate to the potential risks and impacts of the project, and should be accessible and inclusive to the affected UCs; (b) a well-functioning mechanism receives and facilitates resolution of grievances promptly and protects against reprisals for the use of its services; (c) grievance mechanisms take into account the cultural attributes of the affected UCs and their traditional mechanisms for raising and resolving issues; and (d) the grievance mechanism should be designed in consultation with project-affected UCs.

8. Indicative Outlines of UCP

In most cases, the UCP includes the following elements, as needed:

a. A summary of the Targeted Social Assessment, including the applicable legal and institutional framework and baseline data.
b. A summary of the results of the meaningful consultation tailored to the affected UCs and if the project involves the three circumstances specified in paragraph 24 of ESS7, then the outcome of the process of FPIC carried out with the affected UCs during project preparation.
c. A framework for meaningful consultation tailored to UCs during project implementation.
d. Measures for ensuring UCs receive social and economic benefits that are culturally appropriate and gender sensitive and steps for implementing them. If necessary, this may call for measures to enhance the capacity of the project implementing agencies.

e. Measures to avoid, minimize, mitigate, or compensate UCs for any potential adverse impacts that were identified in the TSA, and steps for implementing them.
f. The cost estimates, financing plan, schedule, and roles and responsibilities for implementing the IP/SSAHUTLC Plan. g. Accessible procedures appropriate to the project to address grievances by the affected UCs arising from project implementation, as described in paragraph 35 of ESS7 and in ESS10.
g. Mechanisms and benchmarks appropriate to the project for monitoring, evaluating, and reporting on the implementation of the project UCP, including ways to consider input from project-affected UCs in such mechanisms.

Annex 4: Conflict Affected Areas and Damages to Health Facilities Master List

Region	*Zone*	*Woreda*	*Number of Health Institution Affected*		
			Health Centers	*Hospitals*	*Health Posts*
Afar	Zone 1	Adar	1	-	59
		Chifra	4		
	Zone 2	Barahle	1	1	
		Abeala	2		
	Zone 4	Yallo	3	1	
		Golina	2		
		Awra	3		
		Ewa	2		
	Zone 5	Telalk	2	-	
		Hadalela	1		
		Samurobi	2		
		Dawe	1		
Region Total	***4***	***12***	***24***	***2***	***59***
	Oromo Special Zone	Jile Timuga	4	2	
		Artuma Fursi	6		
		Bati Town	1		
		Bati Rural	7		
		Kemisie Town	1		
		Dewa Chefa	7		
		Dewie Harwa	2		
		Antsokia Gemza	4		
		Efrata Gidem	7		

Amhara	North Shewa	Gishi	4	4	1,728
		Qewet	3		
		Menz Gera	4		
		Menz Qeya	4		
		Menz Lalo	3		
		Menz Mama	4		
		Mida Weremo	5		
		Mojana Wedera	3		
		Shewarobit	1		
		Tarmaber	4		
	North Gonder	Setit Humera	5	2	
		Tsegedie	7		
		Wolkayet	8		
	Dessie	Dessie Town	8	1	
	North Wollo	Rata Kobo	9	4	
		Kobo Town	1		
		Lalibela Town	1		
		Angot	4		
		Woldia	2		
		Gazo	3		
		Meket	7		

. . . . . Continued

Region	*Zone*	*Woreda*	*Number of Health Institution Affected*		
			Health Centers	*Hospitals*	*Health Posts*
		Lasta	8		
		Habru	8		
		Gubalafto	7		
		Gidan	6		
		Wadla	6		
		Bugina	3		
		Dawunt	4		
		Raya Alamata	4		
		Raya Chercher	2		
	Wagehemera	Abergelie	5	5	
		Tagbji	3		
		Sekota Town	1		
		Sekota Zuriya	6		
		Gazgibila	5		
		Ziquala	5		
		Dehana	6		
		Sehala	3		
		Korem Town	1		
		Oflla	6		
		North Gaynet	8		
		Farta	10		
		Guna Begemdir	4		

	South Gonder	Esete	11	2	
		Tach Gaynet	7		
		Ebinat	7		
		Mena Meketewa	2		
		Sedie Muja	3		
		Simada	8		
		Debre Tabor Town	2		
	South Wollo	Delanta	6	14	
		Ambasel	8		
		Worebabo	4		
		Tehuledere	6		
		Dessie Zuria	8		
		Kombolcha Town	4		
		Kallu	9		
		Tenta	10		
		Wereillu	6		
		Kelala	8		
		Jamma	7		
		Albuko	4		
		Argoba	2		
		Legambo	9		

. . . . . Continued

Region	*Zone*	*Woreda*	*Number of Health Institution Affected*		
			Health Centers	*Hospitals*	*Health Posts*
		Mekidela	7		
		Legehida	4		
		Kutaber	5		
		Sayint	7		
		Mehal Sayint	5		
		Borena	7		
		Wegdi	6		
	North Gondar	Beyeda	4	6	
		Dabat	6		
		Adiarkay	4		
		Debark Town	1		
		Debark Zuriya	8		
		Janamora	6		
		Telemt	5		
		Misrak Telemt	3		
		Mirab Telemt	3		
Region Total	***9***	***89***	***452***	***40***	***1,728***
	Kelem Wollega	Gidame	1		
		Sayo	Damage not identified		
		Anfilo	3		
		Hawagelane	2		
		D/Wabera	Damage not identified		

Oromia		J/Horro	"	6	685
		Y/Welel	"		
		G/Kibe	3		
		Sasiga	3		
	East Wollega	Leka Dalacha	2		
		Jima Arjo	1		
		Boneya Boshe	1		
		Sibusire	2		
		Limu	1		
		Haro Limu	2		
		Gudeyabela	1		
		Gutogida	1		
		Kiramu	3		
		Gida Ayana	2		
		Ebantu	Damage not identified		
		Gobbu Sayyo	1		
		Nunukumba	Damage not identified		
	West Wollega	Kondala	"		
		Begi	"		
		Jarso	"		
		Haru	"		

. . . . . Continued

Region	*Zone*	*Woreda*	*Number of Health Institution Affected*		
			Health Centers	*Hospitals*	*Health posts*
		LaloAsabe	Number not identified		
		Yubdo	"		
		S/Nole	"		
		N/Kaba	"		
		Ayera	"		
		Manasibu	"		
		K/kara	"		
		Homa	"		
		A/Nejo	"		
		B/Gmabil	"		
		Ganji	"		
		B/Dirmaji	"		
		B/Chekores	"		
		Guliso	"		
		Gimbi	2		
		Letasibu	Number not identified		
		M/Nejo	"		
		M/Mendi	"		
		M/Gimbi	"		
		Bule Hora	3		
		Abaya	1		
		Galana	1		

	West Guji	Haro Buluke	1		
		Haro	1		
		Guduru	Number not identified		
		Jardaga Jarte	5		
	North Shewa	Kuyu	2		
		H/Abote	Number not identified		
		W/Jarso	1		
		Degem	Number not identified		
		Y/Gulele	“		
	Borena	Moyale	“		
		Arero	1		
		Goro Dola	2		
	Guji	Liban	2		
		Seba Boru	2		
		Wadara	2		
		Gumi Eldalo	1		
Region Total	***7***	***64***	***107***	***6***	***685***
Benishangul-Gumuz	Metekele	Dangur	1	0	171
		Wombera	1		
		Bullen	2		

. . . . . Continued

Region	*Zone*	*Woreda*	*Number of Health Institution Affected*		
			Health Centers	*Hospitals*	*Health Posts*
		Dibatie	1		
		Guba	1		
	Kemashi	Zay/Yaso	1		
		Dembe/Aglo	1		
		Kamashi	1		
		Sedal	1		
		Miziga/Belo	2		
	Assosa	Mao Komo Special Woreda	3		
Region Total	***3***	***11***	***15***	***0***	***171***
Tigray	***6***	***55***	***107***	***32***	***537***
Grand Total	***29***	***231***	***705***	***80***	***3,180***

Annex 5: Attendance Sheet for Stakeholders Consulted

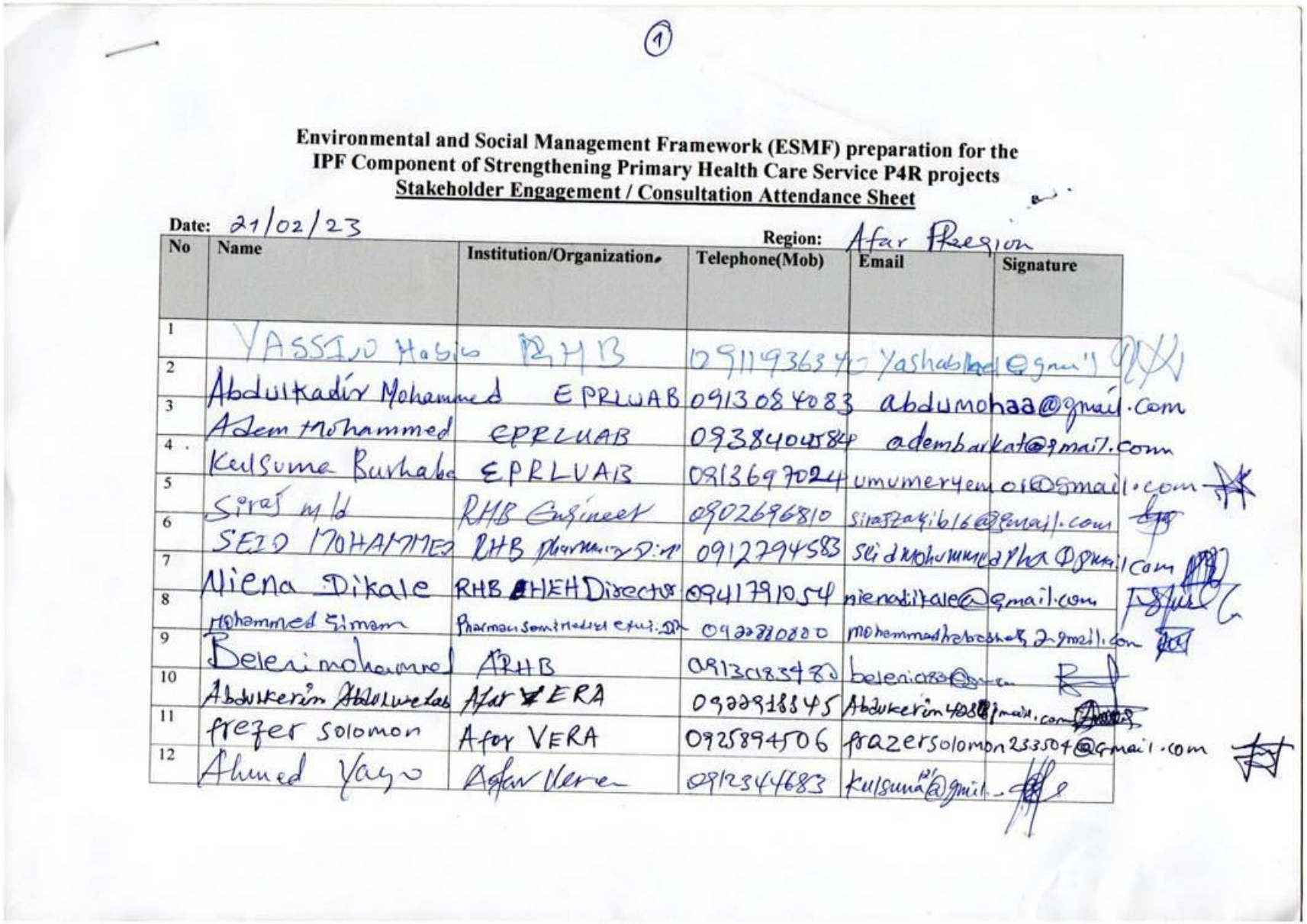
Environmental and Social Management Framework (ESMF) preparation for the IPF Component of Strengthening Primary Health Care Service P4R projects

Stakeholder Engagement / Consultation Attendance Sheet

Date:

Region: Addis Ababa, Federal Institutions MOH &

No	Name	Institution/Organization	Telephone(Mob)	Email	Signature
1	Worku Gizaw	MOH/Strategic	0912016866	worku.gizaw@moh.gov.et	
2	Wasihun Tilahun	" affairs "	0920717409	wasihun.tilahun@moh.gov.et	
3	Tadessa Yunam	MOH	0944-70-77-81	tadessa.yunam@moh.gov.et	
4	Yohannis Fetene	MOH/ES safeguard sp	0924468665	feteneyohannis@yahoo.com	
5	Wondayehu Wubo	MOH/GE&PHC	0926033197	wondayehu.wubo@moh.gov.et	
6	Yared Tadesse	MOH	0911649824	yarkhz@gmail.com	
7	Dereje Adugna	OHB	0915696380	sifdere@gmail.com	
8	MOSISSA ASSEFA	OHB	0944367016	mosissa@gmail.com	
9	Dufera Nigisa	EPSS	0912150981	dufnigisa2002@gmail.com	
10	Gulilat Zebene	EPSS	0912484477	gulepssa@gmail.com	
11	Getahun Zenebe	EPSS	0910564300	getahunzenebe1216@gmail.com	
12	Firad Tafa	Immigration Citizenship		firadaddis@yahoo.com	
13	Gezahegn Mekonnen	Service ICS	0900664764	gezemekonnen@gmail.com	



(1)

Environmental and Social Management Framework (ESMF) preparation for the IPF Component of Strengthening Primary Health Care Service P4R projects

Stakeholder Engagement / Consultation Attendance Sheet

Date: 21/02/23 **Region:** Afar Region

No	Name	Institution/Organization	Telephone(Mob)	Email	Signature
1	YASSIN Habib	RHB	0911936340	Yashabhel@gmail	
2	Abdulkadir Mohammed	EPRLUAB	0913084083	abdumohaa@gmail.com	
3	Adem Mohammed	EPRLUAB	0938404584	adembarkat@gmail.com	
4	Kulsuma Burhaba	EPRLUAB	0913697024	umumeryem01@gmail.com	
5	Siraj m/d	RHB Engineer	0902696810	sirajzakib16@gmail.com	
6	SEID MOHAMMED	RHB Pharmacy Dir	0912794583	seidmohammedpha@gmail.com	
7	Niena Dikale	RHB HEH Director	0941791054	nienadikale@gmail.com	
8	Mohammed Eimam	Pharmacy Sem & Medical Exec. Dir	0922880800	mohammedhabashek2@gmail.com	
9	Beleri mohammed	ARHB	0913018348	beleri0883@gmail.com	
10	Abdulkerim Abdulwehab	Afar VERA	0922918845	Abdukerim4088@gmail.com	
11	frezer solomon	Afar VERA	0925894506	frazersolomon233504@gmail.com	
12	Ahmed Yayo	Afar Vera	0912344683	kulsuma121@gmail.com	

Environmental and Social Management Framework (ESMF) preparation for the IPF Component of Strengthening Primary Health Care Service P4R projects

Stakeholder Engagement / Consultation Attendance Sheet

Date: 09/02/23 **Region:** Oromia Region

No	Name	Institution/Organization	Telephone(Mob)	Email	Signature
1	Adane Desisa	Oromia Health Bureau	0913255341	adanedesisa32@gmail.com	[signature]
2	Olkeba Begna	Oromia health bureau	0917814783	begna olkeba @gmail.com	[signature]
3					
4	Wondwossen Asnake	Amhara Region	0910306201	Wondeasnake88@gmail.com	[signature]
5	Benket Belachew	Unicef (Amhara)	0911903464	benketvalem@gmail.com	[signature]
6	Alebachew Kassa	Naid HC	0919996612	alebachewkassa66@gmail.com	[signature]
7					
8					
9					
10					
11					
12					

(2)

Environmental and Social Management Framework (ESMF) preparation for the IPF Component of Strengthening Primary Health Care Service P4R projects

Stakeholder Engagement / Consultation Attendance Sheet

Date: 23/02/23 **Region:** Afar Region

No	Name	Institution/Organization	Telephone(Mob)	Email	Signature
1	Mohammed Huse	Af-DEMC	0910320097	kuulawidal@gmail	
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

Annex 6: Community Consultation Attendance Sheet

Attendance Form for Community Consultation

I. Composition of the Community Consultation Participants

The composition of the community consultation participants will include community representatives (clan leaders, community elders, and religious leaders), members of project-affected communities, women, IDPs, and People with Disabilities, and pastoral communities. The total number of participants per community consultation session is expected to be 15-20.

II. Basic Information

- Name of selected region: Amhara
- Name of selected zone: South Wolo
- Name of selected woreda: Haik
- Name of selected kebele: _____
- Date of consultation conducted: 28/02/2023
- Consultation start time: 02:30 AM
- Consultation end time: 05:45 AM
- Venue: Haik Health Center
- Name of consultation moderator: Dr. Dereba & Tsion.

III. List of Participants

S/No	Name	Sex	Social Status	Phone Number	Signature
1	Zehabu Ali	F	OPD		
2	Ibrahim Ahmed	M	OPD		
3	Belay Yimam	M	OPD		
4	Ahmed Ali	M			
5	Getachew Tehon	M	Com'y Rep		
6	Fufi Ence	F	Pregnant		
7	Yerute Nuri	F	Pregnant & lactating		
8	Tajudin Endris	M	Elderly		
9	Abdu Ahmed	M	Elderly		
10	Shemsheddin Mohammed	M	Religious leader		
11	Sebsebe Lemq	M	Youth		
12	Tesfaye Mehiletu	M	Youth		
13	Ahmed Yimer	M	Youth		
14	Sheh Hussen Mohammed	M	Religious leader		
15	DemeAu Yimam	F	OPD		
16	Enderas Mamo	M	Patient		
17	Hawa Mohamed	F	Youth		
18	Aregu Seid	F	Patient		
19	Hussen Ibrahim	M	Patient		
20	Seid Anwol	M	Community Representative		

Attendance Form for Community Consultation

I. Composition of the Community Consultation Participants

The composition of the community consultation participants will include community representatives (clan leaders, community elders, and religious leaders), members of project-affected communities, women, IDPs, and People with Disabilities, and pastoral communities. The total number of participants per community consultation session is expected to be 15-20.

II. Basic Information

- Name of selected region: Afar
- Name of selected zone: _____
- Name of selected woreda: Chifra
- Name of selected kebele: _____
- Date of consultation conducted: 23/02/2023
- Consultation start time: 10:15 AM
- Consultation end time: 12:30
- Venue: Chifra Primary Hospital
- Name of consultation moderator: Dr. Deribe & Tsion

III. List of Participants

S/No	Name	Sex	Social Status	Signature
1	Fatuma Ahmed	F	Lactating Woman	
2	Hawa Warie	F		
3	Hasena Wetika	F	Pregnant & Lactating woman	
4	Hasena Hamedo	F	"	
5	Amina Hamed	F	"	
6	Hawa Ahmed	F	Person w/ disability	
7	Hassen Mura	M	Patient	
8	Musa Mohamed	M	Youth	
9	Amina Ali	F	Patient	
10.	Muris Wopros	M	Community Elder	
11	Aserebe Sultan	F	Elder Person	
12	Ahmed Agli	M	Community Elder	
13	Haseer Tadess	M	Person with disability	
14	Momin Wetika	M	Elder	
15	Meseret Metema	M	Youth	
16				
17				
18				
19				
20				

Annex 7: Community Consultation Sample Minutes

I. Participant selection

Community consultation was held with the members of HUCs in Chifra woreda on February 23, 2023 where 15 participants took part in. The participants were selected from five different kebeles (Chifra town, Ander Kello, Weama, Teabay, and semsem). Participants' gathering at Chifra primary hospital seeking for health service was used as a good opportunity to allow the selection of community consultation participants from different kebeles. The selection was done with the support of the Head of Chifra Woreda Health Office and the CEO of Chifra Primary Hospital. Accordingly, the participants composed of community representatives (clan leaders, community elders, religious leaders) and members of vulnerable groups including PLW, women, returnee IDPs, and people with chronic illness including the elderly.

II. Project information disclosure

Before directly going to community consultation, participants were introduced with the nature, scale and potential positive social and economic impacts of the proposed project. This was followed by description of the potential negative impacts of from the activities of Sub-components I and II of the IPF project. Finally, the participants were let to express their views and concerns.

III. Community context guiding points

Guiding point: Describe the most significant social and cultural features that differentiate social groups in pastoral communities.

Response: The participants described numerous socio-cultural, institutional, historical and political context that determine social organization.

- The system of social organization: c***lan system*** is the most important form of social organization among in pastoral community that make distinction between men and women. Ass expressed the participant clan leaders and community elders, can is understood as identifiable mechanisms of identity reproduction and embedded in everyday social, cultural, economic, and political lives of the pastoral community.
- Settlements are composed of residents either belong to the same clan or are marital relatives. As informants justify, this makes it easier to organize social, economic and political support in times of crisis. Clan members are expected to share resources and help each other in emergencies.

Guiding point: Discuss how the above described system of social organization may create differential interests in the project benefits, and the levels of influence among different groups in the implementation of the project.

Response: As the participants of community consultation expressed, the existing socio-cultural system operate to institutionalize gender difference in many ways*:*

- The social organization based on clan system gives no places for women in the social, cultural, and political life of the community.
- The system of property ownership excludes women.
- The system of patriarchy operate as male domination, to the power relationships by which men dominate women and to characterize a system whereby women are kept subordinate to men.

- Differential gender role between men and women are determined based on socio-cultural norms and values.

IV. Project-specific guiding points

Discussion point: Describe the state of PHC and CRVS services in the pastoral communities.

Response: Participants expressed that access to Primary Health Care (PHC) services such as family planning, ANC, PNC, and child health and nutrition had been very much limited in pastoral areas even before without the impacts of conflicts. According to the participants, the problem of access to PHC services manifests in different ways:

- Mobile pastoral communities could not find health institutions in the nearby for their basic need of PHC services;
- In pastoral areas where health center or health post exist at a relatively distance, PHC services are effectively provided due to lack of health staff; and
- Even with the existence of health institutions and health staff, the provision of quality PHC services are not provided in pastoral areas due to lack of medical equipment, basic social services (such as electricity, water and ambulance service) and drugs.
- To worsen the matter, even the existing poor PHC services have been halted owing to the damages and looting to health institutions from the war with the TPLF.
- In the absence of PHC services, pregnant women resort to home delivery that caused multifaceted health problem to the mothers and newborns.

Discussion point: What benefits do you expect from the undertaking of the Sub-component I (Provision of EHS Focusing on RMNCAH+N to Conflict-Affected population and IDPs) and Sub-component II of the proposed IPF project?

Responses: Responding to the discussion point, the participants expressed different social benefits:

- The rehabilitation of damaged health facilities would re-store the provision of PHC services.
- Women would have better access to ANC and PNC.
- Pastoral community, particularly mothers, children, people with special health need such as people with chronic illness will have better access to medical treatment.
- Mobile CRVS team would facilitate pastoral community with easy access to CRVS services.
- The deployment of mobile health team and mobile CRVS team would allow equitable PHC and CRVS service delivery for the remote and mobile pastoral communities.

Discussion point: What potential risks do you perceive as a result of the implementation of Sub-components I and II of the IPF project?

Response: Participants expressed potential social risks of the project from different perspectives:

- The project may reinforce the unequal treatment and differential access to social benefits. For the socio-cultural and economic factors described earlier, women may have limited capacity to defend their interest in and benefits from the project.
- Women may not have equal participation with men in the planning and implementation of the project Social Management Plans that create differential social impacts for women.

- The provision of PHC and CRVS services may not effectively implemented in pastoral communities owing to lack or poor infrastructure. In this case, the implementation of the project can widen the existing gaps of PHC and CRVS services in pastoral community.

Discussion point: For the project social risks identified earlier, what mitigation measures do you propose?

Response: Participants have suggested several mitigation measures including:

- Engaging with the pastoral communities in the planning and implementation of the project SMPs.
- Devise an all-inclusive and accessible project Grievance Redress Mechanism (GRM).
- Devise a different strategies to make the provision of PHC and CRVS accessible tailored to the life of remote and mobile pastoral communities.

Discussion point: What methods of engagement/means of communication are preferred by the local community?

Response: The participants' preference include community meeting, engaging through community representative, tradition means of information sharing such as *Dagu*, and community notice board, and community radio.

Annex 8: Sample Photos Taken from Stakeholders and Community Consultation

C. Consultation at the Federal Level

Consultation at MoH Public Health Directorate

Consultation at EPSA

Consultation at Federal CVRS (Immigration and Citizenship)

D. Consultation at Regional Level

Consultation at Afar Regional Health Bureau

Consultation with Sector Bureaus at Afar Region

Consultation at Afar Regional CRVS Agency

Consultation at Oromia Regional Health Bureau

E. Consultation at Woreda Level

Consultation with Chifra Woreda Officials

Consultation at South Wolo Zone Health Department

F. Consultation at Community Level

G. Community Consultation (Chifra Woreda)

Community Consultation at Haik Woreda