The Republic of Uganda

MINISTRY OF HEALTH

Environmental and Social Management Framework (ESMF)

For

Additional Financing to Uganda COVID-19 Response and Emergency Preparedness Project (P177273)

Updated MAY 2024

Acronyms

ACT: Artemisinin Combination Therapies
AF: Additional Financing
AHIP: Avian and Human Influenza Preparedness and Response
AMC: Advance Market Commitment
AMC: Advance Market Commitment Facility
ART: Anti-retroviral Therapy
ARVs: Antiretroviral Drugs
AVAT: African Union Vaccines Acquisition Trust
BOR: Beds Occupancy Rate
CERC: Contingency Emergency Response Component
CHEW: Community Health Extension Workers
COVAX: COVID-19 Vaccines Global Access Facility
COVID-19: Coronavirus disease 2019
CRVS: Civil Registration and Vital Statistics
DHT: District Health Team
District Health Management Team (DHMT
DLI: Disbursement Linked Indicators
DRC: Democratic Republic of Congo
DTFs: District COVID-19 Task Forces
EAPHLNP: East Africa Public Health Laboratory Networking Project
EEP: Eligible Expenditure Programs
EHS: Environmental, Health and Safety
EMS: Emergency Medical Services
ESIA: Environmental and Social Impact Assessment
ESMF: Environmental and Social Management Framework
ESMP: Environmental and Social Management Plan
FPIC: Free Prior Informed Consent
GBV: Gender Based Violence
GDP: Gross Domestic Product
GEMS: Geo-Enabling Monitoring and Supervision
GFF: Global Financing Facility
GIIP: Good International Industry Practice
GoU: Government of Uganda
GRM: Grievance Redress Mechanism
HAART: Highly Active Anti-Retroviral Therapy
HCF: Healthcare Facilities
HCIV: Health Center Type Four
HCW: Healthcare Waste
HCWM: Health Care Waste Management
HID: Health Infrastructure Division
HMIS: Health Management Information System
HNP: Health Nutrition and Population
HPAC: Health Policy Advisory Committee
HRH: Human Resources for Health
HRHMIS: Human Resources for Health Management Information System
HSDP: Health Sector Development Plan
ICD: International Classification of Diseases
ICT: Information and Communication Technologies
ICU: Intensive Care Unit
ICWMP: Infections Control & Waste Management Plan
IDA: International Development Association
iHIRS: Integrated Human Resource Information System
IMR: Infant Mortality Rate
IPD: In-Patient Department
IPT: Intermittent Preventive Treatment
LMP: Labor Management Procedures
MoH: Ministry of Health
MoWE: Ministry of Water and Environment
National Information Technology Agency Uganda (NITA-U
NCD: Non-communicable Diseases
NCD: Non-communicable diseases
NDA: National Drug Authority
NECOC: National Emergency Coordination and Operations Centre
NEMA: National Environment Management Authority
NHCWMP: The National Health Care Waste Management Plan
NIRA: National Identification and Registration Authority
NMS: National Medical Stores
NUDIPU: National Union of Disabled Persons of Uganda,
OPD: Out-Patients Department
OPM: Office of Prime Minister
PEFF: Pandemic Emergency Financing Facility
PHE: Primary Health Emergency
PMDU: Prime Minister's Delivery Unit
PNFP: Private Not for Profit
Project Development Objective (PDO
Project Implementation Unit (PIU
PWD: People with Disabilities
RDO: Refugee Desk Officer
ReHoPE: Refugees and Host Population Empowerment
RHD: Refugee Hosting District
RRH: Regional Referral Hospital
SEA: Sexual Exploitation and Abuse
SH: Sexual Harassment
SOP : Standard Operating Procedure
SPRP: COVID-19 Strategic Preparedness and Response Program
SUO: Standard Unit of Output
TB: Tuberculosis
TSR: Treatment Success Rate
UBOS: Uganda Bureau of Statistics
UCREPP: Uganda COVID-19 Response and Emergency Preparedness Project
UgIFT: Uganda Intergovernmental Fiscal Transfers Program
UNFCCC: UN Framework Convention on Climate Change
UNHCR: United Nations High Commission for Refugees,
UPDF: Uganda Peoples Defense Forces
URMCHIP: Uganda Reproductive, Maternal, Neonatal and Child Health Improvement Project
VAC: Vaccine Advisory Committee for Uganda
VAC: Vaccine Approval Criteria for the World Bank
VHT: Village Health Teams
VMG: Vulnerable and Marginalized Groups
WASH: Water Sanitation and Hygiene
WB: World Bank
WHO: World Health Organization
WHR: Window for Host Communities and Refugees
World Bank's Environmental and Social Standard ESS

Contents

List of Boxes

List of Tables

List of Figures

Executive Summary

The novel human Corona Virus Disease 2019 (COVID-19) is highly infectious and given the number of travelers coming from affected countries, the risk of importation of COVID-19 into the country is considered very high by WHO. If not averted, COVID-19 can affect Uganda's economy in several ways, some of which are: by directly affecting production, by creating supply chain and market disruption, and by its financial impact on firms and markets. With disruption of several facets of life such as closure of schools, workplaces and banning of public gatherings, the health, socio-economic and environmental impact of COVID-19 cannot be underestimated.

It is therefore critically important that Uganda implements a national preparedness and response plan to enable high alertness and operational readiness. The goal is to provide a framework for prevention and rapid control of COVID-19 by delaying importation, enabling timely response and containment, reducing of morbidity and mortality and mitigation of economic and social disruption resulting from COVID-19 outbreak. Response to COVID-19 outbreak will be multi-sectoral involving Ministries, Departments, Agencies, Development Partners, private sector entities and other stakeholders.

The first case of COVID-19 was reported in Uganda on March 21, 2020, with the number of cases reaching peaks of the first and second waves in December 2020 and July 2021, respectively. As of December20, 2021, Uganda had registered 129,061 cases and 3273 deaths, from all the 136 districts,[1] translating into a case fatality rate of 2.5 percent. The second wave, which started in May 2021, was aggressive, and accounted for 65 percent of all cases and 89 percent of all deaths registered to date. Infections were also more widespread, affecting younger populations than seen in the previous wave. The second wave was driven by a combination of factors, including: the spread of more transmissible variants of COVID-19; low case detection, inadequate tracing and treatment capacity; sub-optimal adherence to public health and social measures; and low coverage of COVID-19 vaccination. The high rates of infection and death, during the second wave, threatened to overwhelm the national health system as hospitals were filled, forcing government to institute a second lockdown (for 42 days) and opt for home-based COVID-19 case management, among other measures. The lockdown ended on July 31, 2021

Prior to the onset of the second wave of COVID19, Uganda had started on vaccination drive; first targeting the most vulnerable and essential workers (which included the elderly above 60 years, doctors, and different security personnel, those with other underlying conditions among other). So far, about 7,888,584 people have been vaccinated. It's against this background, that an Additional Financing (AF) under the Uganda COVID-19 Response and Emergency Preparedness Project (UCREPP-parent project) was considered to cater and procure vaccines. The primary objectives of the AF are to enable affordable and equitable access to COVID-19 vaccines, to help ensure effective vaccine deployment in Uganda through vaccination system strengthening, and to further strengthen preparedness and response activities under the parent Project. The AF will ensure refugees are included within this objective. The parent project UCREPP, in the amount of SDR 9.2 million (US$12.5 million equivalent) plus US$2.7million in grant from the Pandemic Emergency Financing Facility (PEFF), was approved on July 15, 2020 prepared under the COVID-19 Strategic Preparedness and Response Program (SPRP). The PEFF component of the Project became effective on August 31, 2020. The IDA credit became effective on August 3, 2021. PEFF closing on 31 March 2021.

Government of Uganda (GoU) obtained financing from the World Bank (The Bank) to support national capacity to contain COVID-19 pandemic through the COVID-19 Response and Public Health Emergencies Systems Strengthening Project. This new operation will complement the support provided through the

[1] WHO. COVID-19 Daily Situational Report Uganda 05 September 2021.

Contingency Emergency Response Component (CERC) which was activated in March 2020 in an ongoing project[2]. This was to further enhance prevention and early detection, but focusing more on health system readiness with emphasis on case management and psychosocial support—areas that are currently underfunded in the national response. Specific areas of support include: (i) infection prevention and control: (ii) contact tracing; (iii) point of entry screening; case management, psychosocial support, and gender-sensitive interventions; (iv) disease surveillance and laboratory capacity strengthening.

1. **The purpose of the proposed AF is to provide upfront financing to help the GoU purchase and deploy COVID-19 vaccines that meet the Bank's vaccine approval criteria (VAC), to strengthen relevant health systems that are necessary for a successful deployment and, to prepare for the future.** The GoU has set a target to vaccinate, by December 31, 2022, 22 million people (equivalent to 49.6 percent of the national population[3]), representing the portion of the population aged 18 years and above. This national target includes all refugees residing in Uganda, including in refugee hosting districts (RHDs). The Government of Uganda is financing vaccination through a number of sources, including: (a) the COVAX Advance Market Commitment (AMC) Facility, which will provide doses to vaccinate 9 million people (or 20.3 percent of the population); (b) domestic resources and donations for doses to cover 5 million people (11.3 percent of the national population); and (c) Additional Financing through the UCREPP to vaccinate 8 million people (18 percent of the national population). Bank financing for the COVID-19 vaccines and deployment will follow Bank's VAC.

The country has so far received 31,392,940 doses out of which 27,982,540 doses are from donors while 3,410,400 have been procured by the government of Uganda. These include Johnson and Johnson and Sinopharm[4]. The doses that have been booked amount to 9,000,000 of Johnson and Johnson with 15% payment on order already covered. The balance of the 85% of the order made will be paid by the AF under the Project. 17,829,600 doses of Sinopharm vaccines booked and out of which only 2,060,400 doses have so far been paid for with only 1,224,000 has been delivered and the balance of 836,400 doses is expected. As of December 12, 7,880,584 people have been vaccinated translating into 17.8% of the total population to be vaccinated. As of December 14th, 11,827,257 doses were available in stock. The vaccine campaign thus far has prioritized five main high-risk groups: security personnel, health care workers, teachers, people above 50 years, and people with comorbidities. Of this group the highest uptake has been among the essential workers with coverage rates (fully vaccinated) of 45 percent for health care workers, 28 percent for security personnel and 22 percent for teachers. The government accelerated its efforts to vaccinate all teachers, prior to the reopening of schools in 2022, and as of 6th February 2022, has vaccinated 422,769 teachers (76% of the targeted 550,000 teachers) had received their first dose with 201,241 having received their second dose. . In contrast vaccination of people above 50 years and people with comorbidities by 6th February stood at 57.9% (1,938,072 people) having received their first dose and 11.4% (382,659 people) having received their second dose. While for security forces out of 250,000 personnel, 161,491 (64.6%) had received their first doze as of 6th February 2022, and 73,470 personnel (29.4% having received their second doze.

- **The PDO of the parent Project and of this AF is to prevent, detect and respond to COVID-19 and strengthen national systems for public health emergency preparedness in Uganda.** The purpose of the proposed AF to the UCREPP is to provide upfront financing to help the GoU purchase and deploy COVID-19 vaccines that meet the Bank's vaccine approval criteria (VAC), to strengthen relevant elements in the health system that are necessary for a successful deployment, and, to prepare for the future. It will support investments to bring immunization systems and service delivery capacity to the level required to successfully deliver COVID-19 vaccines at scale and

2 Uganda Reproductive Maternal and Child Health Services Improvement Project (P155186)
3 National population estimated at 44.4 million.
4 MFPED 14th December 2021

strengthen pandemic preparedness, through all the components of the parent Project while supporting their ability to reach host communities and refugees. The overall project components have been enhanced to include vaccine acquisition and deployment and strengthening continuity of health services as listed below: Component 1: Case Detection, Confirmation, Contact Tracing, Recording, Reporting

- Component 2: Strengthening Case Management and Psychosocial Support
  - Component 2a: *Strengthening COVID-19 Case Management*
  - *Component 2b: Psychosocial Support and Gender-Sensitive Considerations*
  - *Component 2c: Strengthening Emergency Medical Services (EMS)*
  - *Component 2d: Health Systems Strengthening in Refugee Hosting Communities and Districts*
- Component 3: Project Management, Monitoring and Evaluation
- Component 4: Vaccine Acquisition and Deployment
- Component 5: Strengthening Continuity of Essential Health Services

The proposed AF, through the WHR Regional Sub-Window (RSW) for COVID-19, will support Uganda's inclusive approach to refugees, by strengthening GoU efforts to protect hosting districts/communities and refugees from the effects of COVID-19. The objectives of the RSW are to: (i) create social and economic development opportunities for host communities and refugees; (ii) facilitate sustainable solutions to protracted refugee situations, including through sustainable socioeconomic inclusion of refugees in the host country; and (iii) enhancing COVID-19 recovery efforts.

In order to comply with GoU and WB's environmental and social requirements and to aid various stakeholders to identify and effectively manage potential environmental and social impacts of the proposed project and more so the AF, this Environmental and Social Management Framework (ESMF) has been updated to capture the additional activities under AF to guide COVID-19 outbreak response activities. This ESMF outlines the framework and mechanisms for environmental and social impact screening, determining extent of required environmental assessment and assessment of environmental and social impacts arising from proposed project implementation, and gives generic guidance on appropriate mitigation measures, and institutional arrangements for monitoring. This framework is needed since specific project locations under the proposed Additional Financing are yet to be determined. Where necessary, different levels of Environmental and Social Assessment, site specific Environmental and Social Management Plans shall be prepared during project implementation. In terms of COVID-19 outbreak response, a National Response Plan has been prepared by GoU (Ministry of Health) and follows set Standard Operating Procedures (SOPs) recognized by WHO.

In March 2024, following the enactment of the Anti-Homosexuality Act, 2023, this document and its annexes were updated to include specific measures to mitigate the risk of discrimination against or exclusion of any affected individuals or groups in providing or receiving benefits in World Bank–financed projects and program in Uganda. These measures are described in various sections of this document including section 5 and annexes 16 and 17.
Key stakeholders to be involved with implementation or monitoring this project are:

- Ministry of Health
- District Environment Officers and District Community Development Officers
- District Health Officers
- Health workers in the participating Health facilities
- Members of Vulnerable and Marginalized Groups (Batwa and Ik) and their representatives at the respective areas/districts
- Vulnerable or marginalized individuals or groups.

- Office of the Prime Minister (OPM)
- UNHCR (for refugee inclusion in the vaccines programme)
- National Drug Authority
- National Medical Stores
- Village Health Teams
- NGOs working in health sector

Capacity building will be essential for effective implementation of the ESMF. MoH will utilize Environmental Safeguards Specialist and a Social Safeguards Specialist already working under URMCHIP to undertake implementation of environmental and social aspects of the project as outlined in this ESMF. The Social Safeguards Specialist will be supported by a GBV/SEA Specialist/Consultant to be hired for the Project Implementation Unit (PIU). S/he will be the focal point for GBV/SEA related GRM and responsible for the management, monitoring, reporting and coordination of all GBV/SEA related aspects. To ensure effective monitoring of construction activities, operation and decommissioning phase socio-environmental impacts as provided in this ESMF, capacity enhancement is recommended for the Environmental Health Division, Health Infrastructure Division (HID) of MoH, the District and OPM in areas of:

a) ESIA process in Uganda and Environmental and Social screening of different subprojects
b) Legal, environmental and other regulatory requirements
c) Environmental aspect-impact relationship
d) Impact assessment
e) World Bank ESF requirements
f) ESHS requirements of different subprojects including safety concerns during vaccine deployment
g) Environmental and Social monitoring and Implementation and adoption of World Bank's ESS Geo-Enabling Monitoring and Supervision (GEMS) of Projects
h) Stakeholder engagement and Risk communication and community engagement including security management plan
i) Management of Sexual Exploitation and Abuse (SEA) and Sexual Harassment (SH)
j) Grievance redress mechanisms
k) Grievance management including GBV/SEA cases
l) Management of environmental and social aspects of civil works management in health care facilities
m) WHO and Africa CDC guidelines on quarantine including case management
n) Infection Control and Waste Management Plan (ICWMP)
o) Healthcare waste management
p) Emergence Response Mechanism
q) Social Inclusion

Main generic impacts associated with the project are discussed in Chapter 5 following a project life-cycle approach entailing planning, construction, operation and decommissioning. The potential environmental, health and safety (EHS) concerns associated with the AF activities may include: (i) risks related to inadequacy availability, supply and appropriate use of PPE, new infections, injuries and accidents while handling and administering of vaccines, handling of medical machinery and equipment, testing and potential unsafe handling and use of these supplies by health workers and laboratory technicians; The project will ensure that the frontline health workers are adequately equipped with appropriate PPE; (ii) risks associated with increased spread of COVID-19 during the vaccination campaigns, vaccine safety and efficacy, risks associated with transportation of the vaccines and associated hazardous/infectious waste. There will be strict adherence and observance of COVID-19 SOPs; (iii) risks from poor handling, storage, transportation and disposal of medical and pharmaceutical waste, The project will ensure that there will be strict adherence to the Infections Control & Waste Management Plan, and ensuring that a licensed medical waste handler is used; (iv) impacts related to construction such as air and noise emissions; disposal and management of rehabilitation and construction waste; traffic management; OHS issues; CHS issues, and

environmental pollution; the project will ensure that the Contractors' ESMP and the NEMA Certificate mitigation measures are adhered to.

The potential social impacts include: (i) difficulties in access to vaccines and other services especially VMGs (the poor, refugees, indigenous peoples, migrants, the elderly among others); (ii) patient-centric risks for those receiving treatment for COVID-19 symptoms, including GBV or SEA of patients in quarantine; (iii) limited communication channels to inform VMG's communities of preventive measures against COVID-19 contagion; (iv) risks of increased incidence of retaliations particularly against health care workers and researchers; (v) risks related to any mandatory national vaccination program that may be imposed to citizens which might disregard their cultural, social and traditional community practices and values. Effective communication and disclosure of COVID-19 information and implementation of the Stakeholder Engagement Plan will be used; (vi) risk of exclusion of vulnerable or marginalized individuals or groups Potential risk of exclusion from employment opportunities or the benefits of the project or discrimination based on age, gender, status under AHA, ethnicity, Disability, etc.

The project will ensure the operationalization the Grievance Redress Mechanism (GRM). In addition, the World Bank will support the strengthening of the GRM to ensure it includes an effective, safe, ethical, and confidential mechanism to receive, manage, refer, and monitor grievances related to exclusion and discrimination. Further details of this support can be found at Annex 18. For grievances associated with discrimination or exclusion of vulnerable or marginalized individuals or groups, the grievance will be passed to an appropriate referral pathway to ensure it is resolved in a safe, ethical, and confidential manner.

Clauses for construction work contracts on environmental compliance are provided in Annex 5 while Code of Practice for Construction Workers is outlined in Annex 6. A template/ guidance on healthcare waste management in line with national requirements is provided in Annex 3. Annex 7 provides guidelines on use of security forces in COVID-19 emergency operations.

A consultation questionnaire was emailed to entities (under parent project) below to obtain views about issues related to COVID-19 emergency operations including existing facilities/ resources, challenges, resource needs and general state of preparedness:

- National Union of Disabled Persons of Uganda, NUDIPU
- United Nations High Commission for Refugees, UNHCR
- Green Label Services LTD (a medical waste company)
- Batwa Development Project (an association of Batwa, a vulnerable and marginalized tribe in Uganda)
- Regional Referral Hospitals (Mbale, Gulu, Masaka, Mbarara, Moroto)

A summary of stakeholder views is presented in Chapter 7 while a detailed consultation record is provided in Annex 8. Concerns of people with disabilities (PWD) and refugees should particularly be considered when planning COVID-19 control measures.

In January 2024, additional consultations were undertaken on the project to specifically discuss the vulnerability of some individuals or groups to exclusion or discrimination. A summary of these consultations is available on the World Bank Uganda Website with the following link:

https://www.worldbank.org/en/country/uganda/brief/consultations.

During the consultations, key issues raised relating to UCREPP included:

a. How is MoH holding medical doctors and others accountable in terms of ensuring non-discrimination.
b. How is MoH ensuring data is collected in a respectful and accurate manner.
c. Fear of going to facilities as vulnerable or marginalized individuals might be reported, or they feel like they need to lie about what they are experiencing.
d. The need for sensitization and training of relevant health care providers/workers and other stakeholders on confidentiality, non-discrimination, and inclusion.
e. The need for additional sensitization, communication, and further dissemination to all relevant stakeholders, particularly law enforcement entities and district government officials, on the content of the MoH issued circulars.
f. The need to further assess and disseminate the MoH developed 2020 guidelines 2020 for the establishment and Operation of Drop-in-Centers for Key Populations

The approach to managing these issues and other issues raised during the consultations are found at section 5 of this ESMF.
Implementation of the project activities shall also follow set operational guidance by the Ministry of Health, and in general by the Government of Uganda, while cognizant of WHO overall guidelines on management of COVID-19 pandemic.

In addition, the World Bank will provide support for enhanced monitoring of the risk of exclusion or discrimination for individuals or groups who may be vulnerable or marginalized. Further details of this support are found at Annex 17.

An estimated budget for implementing this ESMF including costs of monitoring and capacity building is estimated USD **2,636,595** detailed in table 17.

1 Background

This chapter provides the rationale of the World Bank updating of the ESMF, support to the project, the project context, amount of financing, and the nature of Bank support.

1.1 Rationale of the World Bank support for Additional Financing

The first case of COVID-19 was reported in Uganda on March 21, 2020, with the number of cases reaching peaks of the first and second waves in December 2020 and July 2021, respectively. The second wave was driven by a combination of factors, including: the spread of more transmissible variants of COVID-19; low case detection, inadequate tracing and treatment capacity; sub-optimal adherence to public health and social measures; and low coverage of COVID-19 vaccination.

The GoU initiated its COVID-19 vaccination campaign in March 2021, with the aim to vaccinate 22 million people by December 31, 2022.
The country has so far received 31,392,940 doses out of which 27,982,540 doses are from donors while 3,410,400 have been procured by the government of Uganda. These include Johnson and Johnson and Sinopharm[5]. The doses that have been booked amount to 9,000,000 of Johnson and Johnson with 15% payment on order already covered. The balance of the 85% of the order made will be paid by the AF under the Project. The target is to have all the target priority population (22,000,000 people) fully vaccinated by December 31, 2022.

The low uptake of vaccines point to challenges in vaccine deployment, which has been adversely impacted by initial delays in vaccine delivery schedules, initial hesitancy (especially by high-risk groups such as teachers and health care workers), and low motivation/staff (vaccinators) morale, which is impacting the roll out of the vaccination campaign. In view of the overall low uptake of available vaccines, however, the country faces the risk of vaccine expiries, particularly of Pfizer and AstraZeneca doses. There remains a significant gap in risk communication to increase vaccine uptake in the elderly and people with comorbidities. In case of vaccines expiry, there will raise an issue of disposal especially large volumes of doses.

Given the low coverage of vaccines in-country, and the persisting threat of recurring surges, the proposed AF will also provide support to scale up efforts to detect, prevent and respond to the pandemic, as well as strengthen national health systems and service delivery as envisioned in the parent Project. In this regard, the AF will form part of an expanded health response to the pandemic and support the scale up of a limited set of interventions, aligned with the national COVID-19 Resurgence Plan (June 2021 – June 2022).[6] Importantly, the AF will allow the expansion of coverage to include vulnerable communities, refugee settlements and RHDs. Uganda hosts almost 1.5 million refugees, making it the third largest refugee hosting country in the world.[7] Reduced global humanitarian finance combined by increased global demand driven by COVID-19 has impacted on Uganda's refugees, causing gaps in the refugee response, and making it difficult to meet essential needs and to sufficiently invest in long-term solutions.

[5] MFPED 14th December 2021
[6] The Resurgence Plan is costed at US$358.9 million. Whereas partners have committed up to US$ 215 million towards this plan, a funding gap of approximately US$ 144 million remains.
[7] Office of the Prime Minister & UNHCR (July, 2021) https://ugandarefugees.org/en/country/uga

Ongoing essential health services for refugees have been stretched by additional COVID-19 demands on limited resources.

1.2 Project context

The Project will provide resources to support Uganda's response to the COVID-19 pandemic. It builds upon ongoing support related to outbreak prevention, detection and response. The Project includes critical interventions around disease surveillance, case management, psychosocial support, and laboratory capacity strengthening. Interventions are aligned with the national COVID-19 preparedness and response plan but are also targeted towards interventions that will strengthen core public health functions more generally and help Uganda better confront future outbreaks. The Additional Financing to the Project, focuses primarily on scaling up Uganda's COVID-19 vaccination program, as well as strengthening the provision of COVID-19 and broader health services to refugees and refugee hosting districts.

However, the COVID 19 pandemic has posed unique challenges to existing capacities hence necessitating enhanced response systems and additional financing that is the subject of the update of this ESMF.

1.3 Description of Additional Financing and nature of Bank support

Additional Financing (AF) is an IDA grant in the amount of SDR 116.1 million (US$164.3 million equivalent), of which $27 million is from the Window for Host Communities and Refugees [WHR] COVID-19 Sub-window) for host communities and refugees, and a grant of US$16 million from the Global Financing Facility (GFF) Essential Health Services Grant.

The World Bank's policy on rapid response to crises and emergencies rests on four guiding principles[8]:

a) Application of the rapid response policy to address major adverse economic and/or social impacts resulting from an actual or imminent natural or man-made crisis or disaster;
b) Continued focus of the bank's direct assistance on its core development and economic competencies and always in line with its mandate, including in all situations where the bank supports peace-building objectives and relief to recovery transitions;
c) Close coordination and establishment of appropriate partnership arrangements with other development partners, including United Nations (UN), in line with the comparative advantage and core competencies of each such partner; and
d) Appropriate oversight arrangements, including corporate governance and fiduciary oversight, to ensure appropriate scope, design, speed, and monitoring and supervision of emergency operations.

1.3.1 Proposed changes

The changes proposed with the AF entail: (i) expanding the *scope* of the parent project to include interventions linked to vaccination and continuity of essential health services; (ii) expanding the *coverage* of interventions to address the needs of host communities and refugees more explicitly; and adjusting the overall design to align with epidemiological trends. Proposed activities under the AF are well aligned with the original Project Development Objective (PDO), therefore the PDO will remain unchanged. The content of the components (see Annex 3) and the Results Framework of the parent project are adjusted to reflect the expanded scope and new activities proposed under the AF. The proposed changes are summarized as follows:

[8] WB Investment Project Financing, paragraph 12: https://ppfdocuments.azureedge.net/796071c4-6875-4b6f-b9ba-5eeeb8de20a4.pdf

- **Additional Financing:** Increase the overall cost of the Project to US$195.5 million (consisting of US$15.2 million in the parent project plus US$180.3 million AF), by scaling up existing activities, adding new activities, and expanding coverage to host communities and refugee settlements.
- **Level II Restructuring:**
    - Reallocate costs across components,
    - Add a new component (Component 4) on vaccine acquisition and deployment to introduce activities related to Uganda's COVID-19 vaccine program. A total of US$137.15 million (out of the US$ 180.3 million, 76 percent) is envisioned for this new component,
    - Add a new component (Component 5) on Continuity of Essential Health Services,
    - Update the Results Framework to accommodate the expanded scope and coverage of the Project. This included revision of targets for existing indicators and including new indicators linked to the new activities, and
    - Extend the Project's closing date by 24 months to December 31, 2024

The proposed activities will build on activities under the parent project and other existing projects under the World Bank Health portfolio in the country. These complementary projects include the URMCHIP, (P155186) and the Uganda Intergovernmental Fiscal Transfers Program (UgIFT, P160250). The proposed AF builds on the recommendations of the GFF-funded technical assistance valued at US$300,000 that particularly informed the additional activities on continuity of essential health services. Activities proposed for support to refugees and host communities will also build on the lessons learned from other RSW/WHR financed projects in Uganda (notably, UgIFT) to build on the strong coordination structures between GoU and other partners under the CRRF. (Already highlighted above).

1.4 Rationale of using a framework instead of subproject-specific plans

An ESMF is prepared instead of subproject-specific plans for the following reasons:

- *Rationale of a framework* is that specific locations and detailed information about the subprojects is currently not available and will only be known during implementation.
- *Purpose of a framework* is to guide the Implementing Agency (Ministry of Health) on the environment and social screening and subsequent assessment of subprojects during implementation, including the relevant subproject-specific plans that have to be developed in compliance with the Bank policies.
- *Scope of a typical framework* includes environmental and social screening to determine subproject environmental and social (ES) risks, potential ES issues and subproject-specific instruments (plans).

Following the World Bank Group's communication of its concerns with the enactment of the AHA, the Government of Uganda issued five Circulars (see Annex 16). Of particular importance is the Circular on Uganda's Social Safeguard Policies issued on September 21, 2023, by the Ministry of Finance Planning and Economic Development, to all Accounting Officers, Ministries, Departments and Agencies and Local Governments which states that:

- "All World Bank-financed projects must be implemented in a manner consistent with the principles of non-discrimination as provided Article 21 of the Constitution of the Republic of Uganda. These projects should also be implemented in accordance with World Bank policies and applicable Legal Agreements.

- Under these projects, no one will be discriminated against or stigmatized, and the principles of non-discrimination and inclusion will be adhered to. Support should be provided to all project beneficiaries.
- All implementing entities of World Bank projects will implement specific mitigation measures to address non-discrimination.
- These mitigation measures will require enhancing project grievance redress mechanisms as well as strengthening existing project monitoring by implementing entities including third-party monitoring [the Enhanced Implementation Support Mechanism] where applicable.
- Each project implementation entity shall develop comprehensive guidelines to address non-discrimination."

The environmental and social risk management documents including this ESMF have been updated to identify the additional risks and describes mitigation measures to address these risks. They include the implementation, monitoring, and reporting arrangements, and roles and responsibilities to assess the efficacy of the additional mitigation measures being implemented. They also include the risks identified in the public consultations on these documents involving the Government of Uganda and civil society organizations.

Noteworthy is that the World Bank will provide support to the Government of Uganda, particularly its Project Implementation Units, to help them to implement the additional mitigation measures for this project.

2 Project Description

The Uganda COVID-19 Response and Emergency Preparedness Project is designed to fit within the context of Uganda's overall COVID-19 preparedness and response plan, as well as its broader readiness for public health emergencies. It builds upon prior interventions funded through the Government, the World Bank, and other partners to respond to COVID-19. Its scope and components are fully aligned with the World Bank's COVID-19 Strategic Preparedness and Response Program (SPRP), and focus on areas that: (i) are currently underfunded in the national plan (i.e. case management, laboratory capacity strengthening, and psychosocial support); (ii) scale up prevention and early detection efforts in a quest to better control the spread of the pandemic; and (iii) are geared towards strengthening core public health functions and health systems for COVID-19; (iv) Vaccines Acquisition and Deployment (NEW added component). In addition, it provides resources for supporting areas like Water Sanitation and Hygiene (WASH) and communications, that are essential to complement the national response.

The Additional Financing to Uganda COVID-19 Response and Emergency Preparedness Project (UCREPP), will complement and will leverage on achievements of the two IDA supported sister projects URMCHIP and EAPHLNP in Uganda that have made extensive contribution in strengthening the following areas: (i) infrastructural development for health services [upgrading Health facilities from level 3 to 4]; (iii) surveillance, preparedness and outbreak response capacities; (iii) medical laboratory systems improvement [infrastructure at five selected RRHs and equipment at RRHs); (iv) medical waste management; (v) biosafety and biosecurity improvement; (vi) human capacity improvement and (vii) conducting of twelve operational research studies.

2.1 Development Objectives

The Project Development Objective (PDO) remains unchanged and is to prevent, detect and respond to COVID-19 and strengthen national systems for public health emergency preparedness in Uganda. The parent Project12 supported the three components namely Component 1 (Case Detection, Confirmation, Contact Tracing, Recording, Reporting); Component 2 (Strengthening Case Management and Psychosocial Support); and Component 3 (Project Management, Monitoring and Evaluation). The AF will add two components. These are Component 4 (Vaccine Acquisition and Deployment) and Component 5 (Strengthening Continuity of Essential Health Services). It also seeks to scale up interventions under all these components in the RHDs. Detailed description of activities under the Project are provided in the following section.

2.2 Description of Project Components

Component 1: Case Detection, Confirmation, Contact Tracing, Recording, Reporting
[*Total Financing of US$9.3 million of which Additional Financing is US$3 million (consisting of US$2 million from the WHR and US$ 1 million from matching IDA grant for host communities and refugees)]:*
This component focuses on strengthening disease surveillance capacity, including for climate-related diseases. It will expand coverage of existing activities to host communities and refugee settlements, which remain vulnerable given the constant threat of cross-border transmission (of COVID-19 and other diseases). The component will scale up COVID-19 testing capacity, strengthen Point of Entry screening, provide training/capacity building for field epidemiology, enhance laboratory diagnostics capacity, and build the capacity of Village Health Teams (VHTs) and other community health actors to perform community surveillance (using

IDSR version 3 guidelines) within 12[9] RHDs. Further, as part of the proposed Level II restructuring of the parent Project, the component costs under the parent Project will be revised to a total of US$6.3 million, consisting of US$ 4.6 million in IDA credit and US$1.7 million in PEFF funds.

Component 2: Strengthening Case Management and Psychosocial Support [*US$ 22.95 million, of which AF is US$15.15 million (consisting of US$ 9.15 million IDA grant, 5 million from the WHR and US$1 million from the matching IDA grant for host communities and refugees* : The objective of this component is to: (i) respond to the disease burden of COVID-19; (ii) improve infection prevention control within hospitals; enhance clinical and intensive care capacity; and (iii) equip key personnel to adequately manage COVID-patients and their families. The component also provides resources for psychosocial support for clinicians and care providers, interventions to address sexual exploitation and gender-based violence, and introduces new activities around strengthening emergency medical services. The component has two sub-components and two additional ones are added through this AF to address activities specific to the RHDs and for new activities on Emergency Medical Services (EMS).

- ***Subcomponent 2a: Strengthening COVID-19 Case Management [Total financing of US$21.75 million, of which AF is US$14.15 million (consisting of US$9.15 million from IDA grant and US$ 5 million from WHR]*: Under the AF,** this sub-component will scale up activities to strengthen the national capacity to provide key infrastructure and quality services to support COVID-19 patients, especially those who are severely ill and in Intensive Care Units or High Dependency Units. It will: (i) increase the volume of inputs such as Personal Protective Equipment, supplies, medicines, consumables for management of COVID-19 cases and comorbidities; (ii) expand training in critical care delivery models, and COVID-19 case management, and emergency response to climate shocks; (iii) provide hazard allowances to frontline workers and rapid response teams and; (iv) expand the number of intensive care units to be refurbished under the parent Project. Intensive care units will be refurbished in a climate-sensitive manner.

- ***Subcomponent 2b: Psychosocial Support and Gender-Sensitive Considerations [Total Financing of US$1.2 million, of which AF is US$ 1 million from the IDA grant for host communities and refugees]:*** US$1 million will be used to provide psychosocial support to residents of host communities and refugee settlements. Linked to Subcomponent 5b, the Project, in coordination with the Ministry of Gender, Labor and Social Development (MoGLSD), will: (i) train health care workers in host communities and refugee settlements on managing GBV cases; (ii) provide psychosocial and other support (e.g. GBV kits) to survivors; (iii) sensitize host communities and refugees on GBV and resources for accessing protection services (hotlines, community mechanisms, etc.); (iv) improve the quality of data on gender-based violence in host communities and refugee settlements, in order to inform interventions. In addition to the new activities proposed, the component costs under the parent Project will be revised to US$7.8 million, consisting of US$7.1 million under IDA credit and US$0.7 million under PEFF.

Component 3 Project Management, Monitoring and Evaluation *[Total Financing of US$4.1 million of which AF is US$3 million (consisting of US$1 million from the WHR; US$1 million from the IDA grant; and US$1 million from the GFF)].* The AF will support: (i) recruitment of additional staff under the existing PIU which will ensure effective management and monitoring of activities; (ii) procurement of ICT tools to facilitate data capture, analysis, and reporting; and (iii) strengthening of internet connectivity to allow real-time data reporting from the sub-national levels (including RHDs) to the central database. Coordination and implementation between MoH, OPM, UNHCR and other refugee-hosting stakeholders will be strengthened through: (i) appointing a program officer, within the PIU, for the refugee related activities linked to the HSIRRP

[9] These activities will not include Kampala, the thirteenth refugee hosting district, which by GoU's current policy does not receive refugee support from UNHCR or the World Food Program (WFP).

secretariat; (ii) improving the governance and leadership mechanisms at central to district level, necessary to implement the HSIRRP; (iii) appointing designated liaisons at the district-level, who working with District Health Officers, will monitor and ensure the integration of Project-funded activities within refugee health services; (iv) covering all logistical and implementation costs associated with activities in RHDs and refugee settlements.

In order to enhance MoH's monitoring and evaluation (M&E) capacity, the GFF grant will support: (i) finalization and dissemination of the National Health Digitalization Strategy, the development of which is already underway and will help bolster the dissemination of health data (including on COVID-19); (ii) development of national protocol/guidelines/tools for health data analysis, information synthesis and data utilization; (iii) training of HMIS managers, health sector managers and other key stakeholders on insight-driven health data analysis, information synthesis and data utilization and; (iv) upgrading of the DHIS-2 (to incorporate COVID-19 indicators). Finally, the resources will help to improve the quality of national health surveys such as the demographic and health surveys, including updating modules – where necessary – to better capture and interpret impacts of COVID-19. Furthermore, under the proposed Project restructuring, the component cost of the parent project, will be revised to US$1.1 million, consisting of US$0.8 million in IDA credit and US$0.3 million in PEFF**.**

Component 4: Vaccine Acquisition and Deployment [US$137.15 million, of which US$124.15 million is IDA grant, US$10 million is from the WHR, US$1 million is from IDA grant for host communities and refugees, and US$ 2 million is from the GFF]: The AF will introduce a new component focused on vaccine purchase and deployment. Under this component, the government of Uganda will procure vaccines to vaccinate 11.7 million people (26.4 percent of the population), in Phase 2 of its vaccination campaign, scheduled to begin in January 2022. The vaccines acquired will be available to everyone under the eligibility criteria, including refugees. The policies for prioritizing intra-country vaccine allocations in Uganda have been completed and were informed by WHO's Framework for the allocation and prioritization of COVID-19 vaccination. For vaccine acquisition, a total of US$10 million from the WHR has been earmarked, and will be sufficient to vaccinate a total of 1.5 million host community members and refugees within the 12 RHDs of focus10.

A total of US$20.15 million of IDA and GFF resources from this component, will be dedicated to vaccine deployment nationwide (including in refugee settlements and RHDs11), with emphasis on strengthening critical areas such as: vaccine delivery and immunization; risk communication and community sensitization; strengthening supportive supervision; enhancing reporting and immunization data management (including engaging data entrants for expedited data capture); payment of hazard allowances; and strengthening pharmacovigilance to address adverse events following immunization.

Component 5: Strengthening Continuity of Essential Health Services [US$ 22 million, of which US$9 million is from the WHR and US$13 million is from the GFF]. This component will enhance continuity of services across four priority areas. The sub-components are described as follows:

- **Sub-component 5a**: Upgrade Health Infrastructure and Equipment for Enhanced Service Delivery (US$10 million, including US$6 million from WHR and US$4 million from GFF): This sub-component will support infrastructure upgrades in hosting communities and refugee settlements. A total of US$6 million from WHR will support: (i) renovation of selected health facilities; (ii) support blood collection, procure blood storage equipment and blood administration supplies for health center IVs in RHDs and refugee settlements; (iii) renovation of isolation and other facilities located near points of entry (borders) routinely used by refugees and asylum seekers. The proposed interventions complement ongoing support

[10] The RHDs are Adjumani, Yumbe, Isingiro, Kyegegwa, Kikuube, Obongi, Kamwenge, Kiryandongo, Lamwo, Koboko, Madi Okollo, and Terego.

[11] The deployment systems for refugee settlements are those of national systems, which at the district level work closely with UNHCR, OPM and NGOs in the health sector to reach people of concern across host communities and refugees.

provided through UgIFT and UNHCR, both of whom are providing wage and non-wage recurrent expenditure to RHDs. In addition to support from WHR, US$4 million from the GFF will be used to upgrade, equip, and refurbish operating theatres in at least one General Hospital and/or one Health Center IV. The refurbished theatres are intended to enhance the management of obstetric emergencies, a leading cause of maternal death in Uganda. The GFF resources will also support blood collection and storage equipment as needed, to improve availability of blood.

- **Sub-component 5b: Strengthen Emergency Medical Services (US$4.4 million, of which US$2.4 million is from the GFF, and US$2 million from the WHR).** This sub-component will support: (i) the finalization of EMS policy, guidelines, and standards (including establishment of a toll-free emergency number); (ii) procurement of ambulances equipped with supplies and products for pre-hospital care; (iii) finalization and dissemination of updated guidelines on referral pathway, including development of Standard Operating Procedures; (iv) training EMS personnel and sensitizing community members on first aid response; (v) establishment of Regional and National Ambulance Call and Dispatch Centers in the East and West regions; (vi) improvement of dispatch and fleet information management systems, ensuring integration of emergency service and related surveillance metrics into the national HMIS, and supporting the expansion of these services into underserved parts of the country. Similar interventions will be supported in refugee hosting districts and refugee settlements, with the WHR supporting: (i) establishment of Regional and National Ambulance Call and Dispatch Centers serving RHDs in the North and South regions; and (ii) acquisition and equipment of new ambulances for selected Health Center IVs and hospitals within the 12[12] RHDs to support routine referrals and the COVID-19 response.

- **Sub-component 5c: Improve the availability of essential health commodities (US$3 million from the GFF and US$1 million from WHR):** This sub-component will support the procurement of drugs, commodities and supplies for other essential health services (e.g. RMNCAH, NCDs) to compensate for acute shortages, exacerbated by the COVID-19 shock, and a decline in donor financing. Besides procuring these supplies, the sub-component will also provide technical assistance to explore feasible options for enhancing pharmaceutical procurement and supply chain management, which remains a key driver of frequent stock-out of essential medicines and supplies. Given the significant demand for these commodities nationally, additional funds will be mobilized by the MoH through other development partners. The WHR resources will support availability of specified essential health commodities in RHDs and refugee settlements,

- **Sub-component 5d: Strengthening Community Systems for Continuity of Essential Health Services (US$1.6 million from GFF).** Drawing from the National Community Engagement Strategy, the AF will strengthen structures for community health and enhance the capacity of VHTs and other community actors to: support demand generation for health services; mobilize eligible populations for vaccinations; and provide integrated community-based health services for COVID-19, community-case management of childhood illnesses, TB, pneumonia, malaria, non-communicable diseases, and sexual and reproductive health interventions.

- **Sub-component 5e: Strengthening infection prevention and control in health facilities through multi-sectoral engagement (US$2 million from the GFF).** The activity will build off initial engagements between HNP, the GFF and the WASH GP to address water and sanitation gaps in the health sector. Specifically, the Project will procure critical WASH amenities (e.g., waste disposal bins and liners) for national referral hospitals and COVID-19 treatment units as well as train health care workers on norms to prevent microbial resistance in the health facilities.

[12] Including Kampala as the twelfth RHD.

2.3 Project Beneficiaries

The Project is nationwide in scope, and the expected primary beneficiaries will be the general population, suspected and confirmed COVID-19 cases, medical and emergency personnel, port of entry officials, medical and testing facilities, and other public health agencies engaged in the response. The Project will also benefit refugee hosting communities and refugees in line with the Government policy of integrating refugee health services into the routine service delivery systems. Vaccines acquired under the project will primarily support eligible populations (indicated in table 2 below) including those in refugee settlements, refugee hosting communities and non-refugee hosting districts. However, it is understood that the definition of priority population will keep evolving as the nature of the pandemic changes.

Table 1: Priority Groups for National COVID-19 Vaccination Uganda (including refugees)[13]

Ranking of Vulnerable Groups	Population Group	Number of People	% of the Population
First	Health Workers	150,000	0.34%
Second	Security personnel	250,000	0.57%
Third	Teachers	550,000	1.24%
Fourth	Persons aged>50	3,348,500	7.57%
Fifth	Persons aged 18-50 with comorbidities	500,000	1.1%
Sixth	Persons between 18 and 50 not covered in the above groups	17,138,011	38.8%
TOTAL		**21,936,011**	**49.6%**

2.4 Project Cost and Financing

The increase in scope and coverage as outlined above will be reflected in an increase in indicative Project cost from US$15.20 million to US$195.50 million with the full amount of the AF being added across all components (see Table 3 below). While the allocation to Component 4 will be US$137.15 million to reflect the additional financing made available for vaccine acquisition and deployment, the additional allocation to Components 1, 2, 3 and 5 will be US$3 million, US$15.15 million, US$3 million, and US$22 million, respectively with a focus on scaling up existing programs in disease surveillance and case management, and expanding these services to host communities and refugees as well as enhancing the continuity of essential health services.

[13] Under Uganda's 'Open Door' policy, all refugees are integrated and considered as part of the national population. The national target for vaccination therefore includes all residing in Uganda, as well as refugees—who are considered a part of society and cut across each of the six areas already identified above. See Annex 4 for more details in RHDs.

Table 2: Summary of COVID-19 Vaccine Sourcing and Bank Financing (as of October 6, 2021)

National plan target (population (percent)	Source of vaccine financing and population coverage (percent)					Specific vaccines and sourcing plans	Doses purchased with World Bank finance (2 doses assumed)	Estimated allocation of World Bank financing
	COVAX grant	World Bank-financed			Other*			
		Through COVAX	Through direct purchase	Through AVAT				
Phase 1: By end of December 2021 19.1%	9.1%				10%	Uganda has planned for a total of 14,420,869 vaccines in the first phase of its vaccination efforts that began in March 2021 and are expected to end in December 2021. These are comprised of a mixture of vaccines that all meet VAC requirements, namely AstraZeneca, SINOVAC, Moderna, Pfizer, Johnson and Johnson (J&J) and SINOPHARM. Of these, the country has so far received 8,891,410 COVID-19 vaccines most (about 6.5 million) as COVAX Facility donations. Other sources are GoU direct purchases from both the AVAT mechanism and COVAX. Uganda has also received a total of 2,435,500 vaccine doses as donations from the governments of India, China and Ireland.	N/A	N/A
Phase 2: By end of December 2023 48.6%	11.6%		13.7%	12.7 %	10.6 %	During Phase 2, GoU shall procure 37,140,631 vaccine doses from the AVAT mechanism, and through direct purchase from COVAX. Of these, 17.7 million doses will be procured using Bank financing. The country is also expected to receive its final quota of COVAX Facility donation.	5,599,777 (J&J); 12,140,000 (Sinopharm)	Purchase: US$ 117 million Deployment: US$ 20.15 million Other: US$ 43.15
Total							**17,739,777**	**180.3 million**

2.5 Environmental and social risk classification of the project

The overall ES risk to achieving the PDO, with the expanded scope and AF for vaccination, is **Substantial,** even after considering mitigation measures. This is due to the dangerous nature of the pathogen (COVID-19), reagents and equipment used in the project-supported activities as well as a broader social risk of exclusion and discrimination in access to vaccines by groups that require it most and Vulnerable and Marginalized Groups (VMGs). The AF will finance infrastructure for COVID-19 isolation, labs, and ICU units, procurement of medicines, supplies, and medical equipment, vaccine acquisition and deployment. For the AF, in addition to the risks from the parent project that are relevant to the planned activities in the RHDs and refugee settlements, there are additional risks with the vaccination program under Component 4. The environmental, health and safety risks will mainly be associated with civil works, the operation of the labs, the quarantine and isolation centers, screening posts, and management of generated medical waste (biological, chemical waste, and other hazardous by-products) by the participating facilities in RHDs that will be used for COVID-19 diagnostic testing, isolation of patients, and vaccination sites.

The environmental risks associated with the proposed AF activities include: (i) occupational health and safety (OHS) risks related to the pandemic and dependent on the availability, supply and appropriate use of PPE for healthcare workers, new infections, injuries and accidents while handling and administering of vaccines, handling of medical machinery and equipment, testing and potential unsafe handling and use of these supplies by health workers and laboratory technicians; (ii) community health and safety risks (CHS) associated with increased spread of COVID-19 during the vaccination campaigns, vaccine safety and efficacy (potential adverse health effects from procuring unsafe vaccines and inadequate vaccine storage, handling and transportation practices may lead to vaccine quality deterioration), traffic and road safety risks from transportation of vaccines, handling and transportation of medical waste for off-site disposal; (iii) soil and water contamination due to poor disposal of healthcare waste and improper handling of vaccines; (iv) construction-related impacts (air and noise emissions, disposal and management of rehabilitation and construction waste, traffic management, OHS issues, CHS issues, and environmental pollution) from the upgrading works at health facilities in RHDs. The vaccination campaign will increase the environmental repercussions of plastic waste including syringes and empty vaccine vials, which adds to the waste already generated by single-use PPE. Waste materials generated from laboratories, quarantine facilities, screening, treatment and vaccination campaigns to be supported by the parent project and AF require special handling and awareness, as they may pose an infectious risk to healthcare workers in contact or handling the waste. Effective administrative and infectious controlling and engineering controls would be put in place to minimize these risks, which are outlined in this updated ESMF. With the identified mitigants put in place, the environmental risk including the AF supported activities is rated **Substantial**.

The anticipated social risk is substantial considering capacity challenges faced by GoU to manage the pandemic especially where the case load is elevated, and response capacity is overwhelmed during waves of the pandemic. In the current COVID-19 context, potential social risks associated with the UCREPP AF include: (i) increased incidence of reprisals and retaliation especially against healthcare workers and researchers which may be mitigated through inclusion in a robust stakeholder identification and consultation processes; (ii) patient-centric risks for those receiving treatment for COVID-19 symptoms, including Gender Based Violence (GBV) or Sexual Exploitation and Abuse (SEA) or Sexual Harassment (SH) of patients in quarantine centers which may be mitigated through operating an appropriate Grievance Redress Mechanism (GRM) for project affected persons; (iii) discrimination towards ethnic minority groups or limited communication channels to inform their communities of preventive measures against COVID-19 contagion which may be mitigated through implementing inclusive measures targeting them contagion which will be mitigated through implementing inclusive measures targeting them as outlined in this ESMF; (iv) risks related to any mandatory national vaccination program that may be imposed to citizens which might disregard their religious, cultural, social and traditional community practices and values.

In view of these social risks, the Project will put in place measures to ensure that vaccine delivery targets the most vulnerable populations, particularly women, the elderly, poor, refugees, vulnerable and underserved populations (Indigenous People) and other minorities in accordance with criteria specified in the NVDP. The NVDP appropriately prioritizes heath workers, other essential workers, and the most vulnerable populations, including the elderly, people with co-morbidities, and people in high-population density locations such as slums and refugee settlements.

Currently, there is no mandatory and/or forced vaccination in Uganda. However, in the event that mandatory vaccination is declared in Uganda, the following due process protocol will be undertaken to: (i) obtain consent; (ii) enable affected persons to seek justified exceptions; and (iii) differentiate between mandatory schemes (allowed with due process) and forced vaccination (not allowed). The risk of misinformation ("fake news") in social media networks may also impede national outbreak efforts, and can be mitigated through mounting an extensive campaign to counter misinformation and raise awareness. In addition, the grievance mechanisms required under the World Bank Environmental and Social Framework (ESF) should be in place and equipped to address community, worker, and/or individual grievances related to such issues. This includes requirements related to being able to have GRMs in place to address labor and working conditions, and SEA/SH.

Role of Military/Security Forces in Vaccination The role of the military in the vaccination program has been limited to the use of military health personnel (doctors, nurses) to administer vaccines in health facilities [military hospitals] and sites, and within their catchment areas, including barracks. Given the limited availability of vaccines in country, and as the number of vaccines and demand for country-wide distribution increases, the government may consider the use security forces (notably, the police) to protect these valuable commodities. Should that occur, the government would be required to specify the mitigation measures to be undertaken in line with the World Bank's ESS4 on Community health and safety and proceed to develop (and submit to the Bank) a detailed Security Management Plan. The Project's Environmental and Social Commitment Plan (ESCP) will be accordingly modified/updated to reflect the mitigation measures that the relevant agencies, including the Ministry of Defense and Veterans' Affairs will undertake to manage any new associated E & S risks and to align with the ESF. As part of this AF, this is partly why the ESMF of the parent project has been updated to incorporate core principles for managing potential security risks.

The Role of the Military in Construction.
On July 1, 2021, H.E. the President issued a directive to Ministries of Education and Health to the effect that construction of Schools and Health facilities be undertaken by the Army Construction Brigade. On October 11, 2021 Ministry of Finance. Planning and Economic Development (MoFPED) advised that the directive not be applied to activities supported by Development Partners, and be limited to projects financed 100% by GoU until a mutual agreement has been reached with Development Partners.

Gender Tagging: Gender inequalities and norms are critical considerations when designing policies and interventions in emergency situations and pandemics. They play an important role in who gets access and how fast, to critical health services. In a pandemic, this has multiple implications. On the one hand, pandemic response has to be cognizant of the gender-based differences in access to and use of services due to limited mobility and financial capacity; and on the other hand, support needs to be provided to at-risk groups such as family caregivers (the majority of whom are women) to reduce their risk of getting ill and/or passing it on to others. Moreover, pandemics can create or exacerbate the conditions that especially put women and girls at greater risk of GBV. Efforts are thus necessary to provide opportunities to sensitize and empower communities on GBV/SEA risks and provide avenues for victims to seek care and recourse. In view of these disparities in access and disproportionate impact of gender-related violence, this Project is gender-tagged.

In summary, the measures to address social and environmental risks in the parent project remain relevant. This updated ESMF has taken in consideration the additional risks, introduced as part of the new activities under the AF, specifically the expanded civil works and the vaccination exercise. This Update has covered impacts of the AF activities in RHD and refugee settlements. The ESMF (including the Infection Control and Waste Management Plan (ICWMP), Labor Management Procedures (LMP), GBV/SEA/SH Action Plans, Security Management Plan and other updates, as required by the World Bank Environmental and Social Standards, will be consulted upon, finalized, and disclosed by project effectiveness. It should also be noted that the AF financing new activities will not trigger the World Bank's Environmental and Social Standard five (ESS 5) on Land Acquisition, Restrictions on Land Use and Involuntary Resettlement as indicated in Table 5.

Other Risks:

Refugee Protection:[14] **[**Residual Risk: **Moderate]**. The AF introduces a new risk to the Project, focused on refuge protection. Though the residual risk is considered moderate, a full explanation and mitigants are explained in the Project Paper, since this is a new risk being included to the Project. The World Bank, in consultation with UNHCR, confirmed in August 2021 that Uganda's protection framework is adequate for accessing funding under the WHR with no significant changes from the last assessment. UNHCR has provided the World Bank with an overall positive assessment of Uganda's protection framework indicating that Uganda is adopting comprehensive humanitarian and development programs aimed at mitigating protection risks faced by refugees. However, in the event of a change in policy making, there is a risk that Uganda's asylum space and refugee policies could become more restrictive in response to the strain on services and the natural environment, continuing refugee population growth, COVID-19 and political pressure. Additional refugee specific risks include: the high proportion of women and girls and other vulnerable people within the refugee population which poses specific protection challenges, including GBV and access to health services strained under the pressure of COVID-19. These risks are being jointly managed through effective in-country coordination mechanisms which include UNHCR, OPM, MoH, development and humanitarian partners and other GoU stakeholders under the CRRF Steering Group. The World Bank co-chairs the CRRF Development Partners Group which provides another effective platform to ensure joint management of the above risks, including on protection issues, with the GoU and other humanitarian and development organizations. The Project will work through these forums and the Health Sector Integrated Refugee Response Plan which was developed to institutionalize refugee health support within national systems. The World Bank will work closely with UNHCR to continually monitor the protection environment throughout project implementation.

Data Protection: [Residual Risk: Moderate] Large volumes of personal data, personally identifiable information and sensitive data are likely to be collected and used in connection with the management of the COVID-19 outbreak - including in the course of deploying and administering COVID-19 vaccines - under circumstances where measures to ensure the legitimate, appropriate and proportionate use and processing of that data may not feature in national law or data governance regulations, or be routinely collected and managed in health information systems. In order to guard against abuse of that data, the Project will incorporate good international practices for dealing with such data in such circumstances. Such measures may include, by way of example, data minimization (collecting only data that is necessary for the purpose); data accuracy (correct or erase data that are not necessary or are inaccurate), use limitations (data are only used for legitimate and related purposes), data retention (retain data only for as long as they are necessary), informing data subjects of use and processing of data, and allowing data subjects the opportunity to correct information about them, etc. In practical terms, operation will ensure that these principles apply through inter alia assessments of existing or development of new data governance mechanisms and data standards for emergency and routine healthcare, data sharing protocols, rules or regulations, revision of relevant regulations, training, sharing of global experience, unique identifiers for health system clients and strengthening of health information systems.

[14] This is an "other" risk within the World Bank's Systematic Operations Risk Rating Tool code classification.

Climate

The Project has been screened for short- and long-term climate change and disaster risks, and droughts, extreme precipitation, and flooding were identified as potential high risk factors. Uganda is a land-locked country in East Africa with a primarily tropical climate and two rainy seasons per year. Future projections indicate that monthly temperatures are expected to increase by 1.8˚C by 2050.[15] Monthly annual precipitation is expected to decrease in some areas and increase in others, particularly on the western shores of Lake Victoria. While Uganda's natural climate is moderate, the country is susceptible to climate hazards like mudslides, landslides, flooding, and droughts, which have occurred with increased frequency and severity over the last 30 years. In particular, flooding has become more frequent, largely due to increases in intense rainfall, impacting 200,000 Ugandans annually over the last twenty years, and exacerbating the country's climate hazards.[16] The country's vulnerability to natural disasters is magnified by high levels of poverty and high dependence on climate-sensitive sectors: agriculture, fisheries, tourism, and forestry. Rising heat conditions are increasing the country's vulnerability to drought, which affected close to 2.4 million people between 2004 and 2013, leading to human and livestock deaths, diminished water levels, and crop failures.[17] Additionally, non-climate stressors, like inadequate infrastructure, render the country ill-equipped to manage the growing population in conjunction with possible climatic shocks, particularly in urban areas.

Drought and floods also exacerbate the spread of climate-related diseases, particularly vector borne and diarrheal diseases, which are estimated to cause 6.4% of deaths (2017) in Uganda, primarily among children under five years of age.[18] Uganda reports an estimated 11,000 Cholera cases annually, concentrated in rural, refuge hosting districts that border the Democratic Republic of Congo (DRC), South Sudan, and Kenya, as well as Kampala's crowded urban slums.[19] In addition, the country has among the highest rates of malaria, globally. The country's malaria incidence is 289 per 1,000 people, comprising 5 percent of the global malaria burden.[20] Meningitis is also endemic in the country, which is one of the 26 countries in Africa comprising the 'meningitis belt', vulnerable to the disease.[21] Further, Uganda is also at high risk for importation of Ebola Virus Disease (EVD) from neighboring DRC. Researchers predict climate change will increase in frequency and intensity of EVD outbreaks.[22]

The GoU has shown its commitment to address climate change and the AF is fully aligned with the country's climate priorities. Uganda ratified the Paris Agreement and submitted its Nationally Determined Contributions to the UN Framework Convention on Climate Change (UNFCCC) in 2016, in support of the country's efforts to realize its development goals as laid out in its Poverty Reduction Strategy Paper (2010) and its National Climate Change Policy (NCCP; 2015). The AF, particularly adaptation measures and climate-related disease surveillance measures to be implemented through the project, are fully aligned with the NCCP's health sector priority to "strengthen adaptive mechanisms and enhance early-warning systems and adequate preparedness for climate change–related disease" The AF is also fully aligned with climate priorities in Uganda's CPF, including ensuring infrastructure investments are climate proof and strengthening adaptation for climate change.

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22 Redding, D.W., Atkinson, P.M., Cunningham, A.A. et al. Impacts of environmental and socio-economic factors on emergence and epidemic potential of Ebola in Africa. Nature Communications 10, 4531 (2019). https://doi.org/10.1038/s41467-019-12499-6.

Table 3: The AF will address the above vulnerabilities and enhance climate resilience and adaptation through the following measures.

CLIMATE ADAPTATION ACTIVITIES FINANCED BY THE PROJECT			
Project Component	**Activity**	**Climate-related action**	**How will activity address climate-related vulnerabilities?**
Component 1: Case Detection, Confirmation, Contact Tracing, Recording, and Reporting (US$ 1 million IDA)	• Strengthen surveillance of climate-related diseases (Cholera, meningitis, malaria, Typhoid, and EVD)	• Include specific modules on surveillance of climate-related diseases in surveillance training • Expand laboratory capacity to include diagnostics for climate-related diseases • Include climate-related diseases in screening and surveillance materials developed	• Improve detection of climate related diseases towards increased resilience
Component 3: Project Management, Monitoring and Evaluation (US$1 million, IDA)	• Monitor climate activities under the project	• Monitor implementation of climate related activities in the project	• Strengthen project capacity to adapt to, prepare for, and respond to climate risks
Component 4: Vaccine Procurement and Deployment (US$18.15 million, IDA towards deployment)	• Climate sensitive planning	• Planning for vaccine deployment will make adjustments to ensure vaccines are delivered during floods, contingency plans are in place during floods, and vaccines adequately reach flood-prone areas • The MoH is also using climate-friendly cold chain facilities for the storage of vaccines.	• Ensure adequate distribution of vaccines to flood prone areas and continuation of vaccination during flooding

Table 4: The Project intends to mitigate against the impacts of climate change through the following measures which aim to contribute to greenhouse gas reductions

CLIMATE MITIGATION ACTIVITIES FINANCED BY THE PROJECT			
Project Component	***Activity***	***Climate-related action***	***Intended mitigation***
Component 2, Sub-component 2a: Strengthening COVID-19 Case Management (US$9.15 million, WHR)	Rehabilitation to improve the energy efficiency of intensive care units	• Install LED lights to improve energy efficiency of facilities • Use reflective paint on facilities to improve passive cooling • Solar panels may be installed in select intensive care units	Contribute to reductions in greenhouse gas emission by shifting intensive care units from lighting that uses more energy to LED lighting, which uses less energy and reducing the amount of energy used for cooling by reducing the temperature of intensive care units through reflective paint
Component 5, Subcomponent 5a: Upgrade of Health Infrastructure in Refugee Settlements and RHDs (US$6 million, WHR; US$4 million GFF)	Rehabilitation to improve the energy efficiency of primary healthcare facilities	• Install LED lights to improve energy efficiency of facilities • Use reflective paint on facilities to improve passive cooling • Solar panels may be installed in select facilities	Contribute to reductions in greenhouse gas emission by shifting facilities from lighting that uses more energy to LED lighting, which uses less energy and reducing the amount of energy used for cooling by reducing the temperature of facilities through reflective paint

3 Policy, Legal and Regulatory Framework

3.1 Policy Framework in Uganda

3.1.1 The National Environment Management Policy, 1994

The overall goal of this policy is the promotion of sustainable economic and social development mindful of the needs of future generations and the EIA is one of the vital tools it considers necessary to ensure environmental quality and resource productivity on a long-term basis. It calls for integration of environmental concerns into development policies, plans and projects at national, district and local levels. The policy requires that projects likely to have significant adverse ecological or social impacts undertake an ESIA before their implementation. This is also reaffirmed in the National Environment Act No.5 of 2019 which repealed the National Environment Act, Cap 153 which makes ESIA a requirement for eligible projects (*Fourth and fifth Schedule*).

> ***Relation to the project:*** *This policy is the foundation of all laws and regulations associated with environmental management in Uganda.*

3.1.2 The National Health Policy, 2010

The overall objective of health sector policy is to reduce mortality, morbidity and fertility, and the disparities therein. Ensuring access to the minimum health care package is a central strategy to this goal. The focus of NHP II is on health promotion, disease prevention, early diagnosis, and treatment of diseases. It specifically priorities the effective delivery of the Uganda National Minimum Health Care Package (UNMHCP), more efficient use of available health resources, strengthening public and private partnerships for health and strengthening of health systems.

Relation to the project: *This policy is the foundation of health laws in Uganda. The Goal of the NHP is to attain a good standard of health for all people in Uganda to promote healthy and productive lives. The policy puts the client and community at the forefront and adopts a client-centered approach with consideration of both the supply and demand side of healthcare, highlighting the social values, as detailed in the Constitution of the Republic of Uganda and Uganda's Patients' Charter.*

3.1.3 The National Medical Equipment Policy, 2009

The objective of the policy is to ensure equipment and furniture are managed economically, efficiently, effectively and sustainably through guided;

a) acquisition of medical equipment and furniture,
b) utilization, regulation and quality assurance of medical equipment and furniture,
c) maintenance of medical equipment and furniture,
d) monitoring and evaluation of performance of medical equipment and furniture and
e) disposal of medical equipment and furniture.

Relation to the project: *This policy guides acquisition, utilization, maintenance monitoring and disposal of medical equipment and furniture.*

3.1.4 National Health Care Waste Management Plan (2009/2010–2011/2012)

The National Health Care Waste Management Plan (NHCWMP) was prepared and disclosed under previous IDA projects to guide healthcare facilities and personnel in safe and proper management of healthcare waste.

In addition to NHCWMP, MoH developed the following documents to guide proper healthcare waste management and infection control:

- Approaches to Health Care Waste Management (HCWM), Health Workers Guide, Second Edition (2013);
- Uganda National Infection Prevention and Control Guidelines (December 2013);
- National Policy on Injection Safety and Health Care Waste Management (2014).

Key considerations in managing COVID-19 health-care waste entail having a detailed HCW management plan during the design of Ebola treatment facilities. There are WHO SOPs for management of COVID-19 related medical waste and therefore what is needed is training local healthcare staff and availing the necessary resources. It is also noted that all major hospitals in Uganda have onsite incinerators for healthcare waste incineration.

Relation to the project: *The NHCWMP and other guidebooks listed above were prepared to enhance capacity of healthcare facilities and personnel in safe and proper management of healthcare waste.*

3.1.5 National Technical Guidelines for Integrated Disease Surveillance and Response, 2012

These guidelines aim at addressing how to implement national emergency response as well as international health regulations requirements for disease surveillance and response. The guidelines reflect national priorities, set policies and standards. The guidelines are intended for use as:

- A general reference for surveillance activities at all levels in Uganda
- A set of definitions for threshold levels that trigger some action for responding to specific diseases
- A resource for developing training, supervision and evaluation of surveillance activities
- A guide for improving early detection, preparedness for outbreak response and case management.

Relation to the project: The guideline lists viral communicable diseases to continually undertake surveillance for effective and timely management.

3.1.6 Uganda Refugee Policy, 2006

The Uganda Refugee Policy, embodied in the 2006 Refugees Act and 2010 Refugees Regulations includes: (1) opening Uganda's door to all asylum seekers irrespective of their nationality or ethnic affiliation; (2) granting refugees relative freedom of movement and the right to seek employment; (3) providing prima facie asylum for refugees of certain nationalities, and; (4) giving a piece of land to each refugee family for their own exclusive (agricultural) use. One significant limitation of the legal framework is that it does not provide the permanent solution of citizenship for refugees who can neither repatriate nor be resettled elsewhere.

Relevancy: This is the main policy in relation to refugee settlement in Uganda and will ensure that part of this AF caters for the rights of refugees including free vaccination and upgrading of health infrastructure in refugee settlements and host districts

3.1.7 Uganda Gender Policy, 2007

The overall goal of this policy is to achieve gender equality and women's empowerment as an integral part of Uganda's socio-economic development. Its main purpose is to establish a clear framework for identification, implementation and coordination of interventions designed to achieve gender equality and women's empowerment in Uganda. The policy is a guide to all stakeholders in planning, resource allocation, implementation and monitoring and evaluation of programmes with a gender perspective.

Relevancy: *Gender will be mainstreamed throughout the assessment and fully embedded in recommendations to promote and enhance gender equality.*

3.1.8 National Refugee Regulations, 2010

Provides key refugee protection principles and freedoms: (1) the right to own and dispose of movable property and to lease or sublease immoveable property; (2) the right to engage in agriculture, industry, and business; to practice one's profession; and to access formal and informal employment opportunities; (3) the right to economic, social, and cultural benefits, including access to elementary education, protection of intellectual property rights (e.g., copyright protection for musicians and artists), and the issuance of a United Nations convention travel document for the purpose of travel outside of Uganda; among others.
Relevancy: *Refugee rights to be considered in the assessment.*

3.1.9 Refugees and Host Population Empowerment (ReHoPE), 2017

ReHoPE is a self-reliance and resilience strategic framework targeting refugees and host communities in Uganda, with a focus on protection and sustainable development.
Relevancy: *Such measures will need to be incorporated into livelihood related recommendations.*

3.1.10 Uganda Refugee Policy, 2006

The Uganda Refugee Policy, embodied in the 2006 Refugees Act and 2010 Refugees Regulations includes: (1) opening Uganda's door to all asylum seekers irrespective of their nationality or ethnic affiliation; (2) granting refugees relative freedom of movement and the right to seek employment; (3) providing prima facie asylum for refugees of certain nationalities, and; (4) giving a piece of land to each refugee family for their own exclusive (agricultural) use. One significant limitation of the legal framework is that it does not provide the permanent solution of citizenship for refugees who can neither repatriate nor be resettled elsewhere.
Relevancy: *This is the main policy in relation to refugee settlement in Uganda.*

3.1.11 National Policy on Disability in Uganda, 2006

The policy recognizes the fact that People With Disabilities (PWD) receives less education and skills training, which reduced their employment opportunities and probably results in secondary disabilities and sometimes early death. The policy ensures that PWD are taken care of and considered in all programs targeting society.

Relevancy: *The assessment will include a review of access and discrimination issues related to disabled people. Will also identify key programs targeting PWD.*

3.1.12 The National Policy on Elimination of Gender Based Violence in Uganda 2019

The policy objectives are to reduce the prevalence of gender-based violence and foster a zero-tolerance environment, promote comprehensive care and support services to survivors/victims of gender-based violence, and provide a framework for ensuring accountability and elimination of impunity for gender-based violence.
Relevancy: *The project will ensure to reduced negative attitudes and practices that fuel Gender Based Violence particularly against women and girls; reduced prevalence of Gender Based Violence, and support access to justice, health and other psychosocial services among GBV victims/survivors.*

3.1.13 National HIV/AIDS and World of Work, 2007

This policy contributes towards the national response to HIV/AIDS by promoting decent work in the face of the epidemic which is set within the framework of the national overarching policy on HIV/AIDS. It is a joint effort of representatives of government, employers, workers, faith-based organizations, civil society organisations, People Living with HIV/AIDS networks, the private sector and the United Nations agencies

in Uganda to ensure a uniform and fair approach to the management of HIV/AIDS and its effects in the world of work.

Relevancy: *In the Project the policy on HIV/AIDS and the world of work will cover aspects of: Non-discrimination on the basis of known or perceived HIV status; Confidentiality; HIV testing within the workplace; Greater involvement of people living with HIV/AIDS; Promotion of prevention, treatment, care and support; and Gender concerns in the world of work*

3.1.14 National AIDS Policy (2004) and National Strategic Framework for HIV/AIDS activities in Uganda

This provides overall policy framework for national HIV/AIDS response, including influx of migrant workers who may be exposed, managing HIV/AIDS pandemics, prevention.

Relevancy: *Highlights the need to identify strategies to address exposure and management of HIV/AIDS.*

3.1.15 The Uganda National Culture Policy (2006)

The Uganda National Culture Policy (2006) seeks to promote community action on cultural practices that promote and that impinge on human dignity.

Relevancy: *The project will consider aspects of Traditional Cultural Expressions and Traditional Knowledge (Intangible Cultural Heritage), Indigenous Peoples, Languages, Physical Cultural Heritage, Culture and Creative Industry, Technological Advancement and Demographics. The policy will help in the identification, safeguarding and protection of traditional cultural expressions and traditional knowledge.*

3.1.16 The Equal Opportunities Policy (2006)

The policy provides that gender is one of the priority areas with a focus on equitable access and control of resources and addressing negative cultural practices that limit opportunities for marginalized men and women. The National Equal Opportunities Policy aims at promoting equality of opportunities for all persons in Uganda, irrespective of gender, age, physical ability, health status or geographical location, in all activities, programmes, plans and policies of Government, private sector and Non-Governmental Organizations.

Relevancy: *The Project will ensure to prevent discrimination and its duty to make reasonable adjustments in the workplace. The Contractors will show a commitment to equal opportunity and diversity within the workplace with a clear and fair equal opportunities policy as indicated in their C-ESMP and Code of Conduct.*

3.1.17 The National Building Control Regulations (2020):

The regulations cover all aspects of construction, including foundations, damp proofing, the overall stability of the building, insulation, ventilation, heating, fire protection and means of escape in case of fire. They also ensure that adequate facilities for people with disabilities are provided in certain types of buildings. The building regulations will help ensure that new buildings, remodeling, renovations and extensions are going to be safe, healthy and high-performance.

Relevancy: *In the Project the regulations provide structural integrity, fire protection, accessibility, energy performance, acoustic performance, protection against falls, electrical and gas safety. They also lay standards for drains, ventilation, protection against the ingress of water and protection against contamination including methane and radon gas.*

3.1.18 The Building Control (Accessibility Standards for Persons with Disabilities) Code, 2019

The code provides for access by PWDs to public premises and/or constructions sites.

Relevancy: *The Project will ensure the needs of people with disabilities are specifically considered, and products, services, and facilities are built or modified so that they can be used by people of all abilities such as signage for PWDs, reserved Parking for PWDs, Ramps and Accessible route, Doorway and door, Toilet facilities (Wheelchair-accessible toilet, Toilet seat, Backrest, Washbasin height), Size of pit latrine room.*

3.2 Legal Framework in Uganda

3.2.1 Constitution of the Republic of Uganda, 1995

The 1995 Uganda Constitution provides that every person has a right to own property [Section 26.1] and that no person shall be deprived of property or any interest in or right over property without payment of fair and adequate compensation. The same constitution gives government powers to acquire land (compulsory acquisition) in public interest [Article 273(a)]. The Constitution [Chapter 3, Article 17J] entrusts Government with the duty of ensuring that Ugandans enjoy a healthy environment. Article 36 of the Constitution provides that minorities have a right to participate in decision making processes and their views and interests shall be taken into account in the making of national plans and objectives.
Relation to the project: *The Constitution is the cardinal law onto which the National Environment Act No.5 of 2019 is based.*

3.2.2 National Environment Act, No.5 of 2019

The National Environment Act No.5 of 2019 establishes and defines functions of NEMA as a body responsible for management, monitoring and supervision of all environmental conservation activities (Section 8). This Act provides for various strategies and tools for environment management, which also includes the ESIA (Section 110) for projects likely to have significant environmental impacts. The Act also provides and screens projects for different ESIA levels; it provides for projects in Schedule 4 to require ESIA at a level of Project Brief and Schedule 5 for projects that require detailed and mandatory ESIA. The Act also mandates NEMA with a leading role to review environmental impact statements.

Relation to the project: *This Act formed the basis for enactment of the Environmental Impact Assessment Guidelines, 1997 and The National Environment (Environmental and Social Assessment) Regulations, 2020 that together prescribe the ESIA process in Uganda. Fifth Schedule of the Act (Part 5c) requires that construction or modification of healthcare facilities requires an ESIA. The planned ICUs and isolation units are listed in schedule 4 hence will require preparation of the ESIAs at the level of the Project Briefs for all the sites earmarked for upgrade under this Additional Financing.*

3.2.3 Land Act, Cap 227

The Land Act provides for tenure, ownership and management of land. Land is to be used in compliance with relevant national laws such as listed in Section 43 including the Water Act and National Environment Act. Section 44 reiterates the constitutional mandate for government or a local government to protect environmentally sensitive areas for the common good of the people in Uganda. The Act describes land ownership types of tenure and echoes the requirement of the Constitution to equitably compensate persons losing land to a given development.

Relation to the project: *This Act guides about landownership under various tenure systems, namely: mailo, lease, customary and freehold. The land for earmarked sites/health centres and hospitals whose Intensive Care Units and Isolation units will be established is available and in the names of the hospitals or health centres in question, hence there will be no need for land take or compensation.*

3.2.4 Local Governments Act, Cap 243

This Act provides for decentralized governance and devolution of central government functions, powers and services to local governments that have own political and administrative set-ups. According to Section 9 of the Act, a local government is the highest political and administrative authority in its area of jurisdiction and shall exercise both legislative and executive powers in accordance with the Constitution.

Relation to the project: *This Act means that local governments have administrative control and monitoring responsibility over projects or emergency operations implemented in areas of their jurisdiction.*

3.2.5 Public Health Act, Cap 281

Section 105 of this Act, 1964 requires local authorities to take measures to prevent pollution of public water resources. This Act aims at avoiding pollution of environmental resources that support health and livelihoods of communities.

Relation to the project: *In respect to this project this Act will relate to management of healthcare waste generated by COVID-19 emergency operations.*

3.2.6 National Environment (Standards for Discharge of Effluent in Water or on Land) Regulations, 2020

(1) A person whose activities are likely to produce effluent shall put in place measures to prevent and mitigate pollution in accordance 7290 with the Act, the National Environment (Waste Management) Regulations 2020, the Petroleum (Waste Management) Regulations 2019, the Water (Waste Discharge) Regulations and environmental standards, including by:—

(a) employing the best available technologies and cleaner production techniques; and

(b) installing effluent treatment equipment and facilities for effluent emanating from the activities of their industry or any other facility.

(2) In this regulation, "cleaner production techniques" includes process efficiency improvements, material substitution, inventory control, preventive maintenance, improved housekeeping, and in-process recycling. Section 6 (2) details maximum permissible limits for 54 regulated contaminants which must not be exceeded before effluent is discharged into water or on land. For this project, this standard is applicable to sewage disposal from healthcare facilities (laboratories, regional hospitals and general hospitals)

Relation to the project: *In respect to this project this Act best relates to management of healthcare waste and any health care or constructed liquid waste generated by the project.*

3.2.7 National Environment (Waste Management) Regulations, 2020

Section 4 requires waste to be disposed in a way that would not contaminate water, soil, air or impact public health. This is in relation to onsite waste storage, haulage and final disposal. According to the regulations, hazardous waste haulage and disposal should be done by licensed entities. Wastes considered to be hazardous are listed within these regulations. Regulation 7(1) states that a person who generates waste, a waste handler or a product steward shall manage waste in accordance with the Act and these Regulations through the application of the following hierarchical waste management practices:—

a) prevention;
b) reduction and recovery at source;
c) re-use;
d) recycling;
e) other recovery;
f) treatment; and
g) responsible disposal.

Relation to the project: *Waste is to be generated during upgrade (construction and renovation) works by contractors and it should be appropriately disposed of. Any medical waste or oil contaminated materials is considered hazardous by these regulations and such will be handled appropriately by engaging a licensed hazardous waste handler.*

3.2.8 Employment Act, 2006

Employment Act, 2006 repeals the Employment Act (Cap 219) enacted in 2000. This Act is the principal legislation that seeks to harmonize relationships between employees and employers, protect workers' interests and welfare and safeguard their occupational health and safety.

Relation to the project: *In the project implementation phase this Act guides the relationship between contractors and construction workers while in the operation phase it manages the legal relationship between medical facilities and healthcare workers. In this regard, all construction workers including casual labourers will be required to sign a work contract and a code of conduct.*

3.2.9 National Building Control Act 2013

The goal of the Act is to consolidate, harmonise and amend the law relating to the erection of buildings; to provide for building standards. It is meant to promote and ensure planned, decent and safe building structures that are developed in harmony with the environment; and for other related matters.

Relevancy: *They Acts provides that contractors and developers require permits for: Site operations, Temporary sanitary facilities, Temporary builders shed, Demolition work, Revocation of a building permit, Civil or structural plans, Electrical engineering installation plans.*

3.2.10 Penal Code Act, 1950/ Penal Code (Amendment) Act, 2007

The Penal Code Act, 1950 was amended in 2007 and only a few sections were replaced, amended and/or repealed. The principal Act was amended by substituting for section 129 a section for "Defilement of persons less than eighteen years of age. Section 129 (1) spells out the punishment for defilement.
Relevancy: *Children and young girls in camps are vulnerable to sexual harassment and Gender Based Violence (GBV). Such risks will be reviewed as part of the assessment.*

3.2.11 Occupational Safety and Health Act (2006)

The Act provides for prevention and protection of persons at all workplaces from injuries, diseases, death and damage to property. Provisions of this Act also apply to construction works. Employers must protect workers from adverse weather and provide clean and healthy work environment, sanitary conveniences and protective gear.

Relation to the project: *For this project this Act is applicable in relation to protection of health workers (and medical waste collectors) against secondary injuries during execution of their work.*

3.2.12 The Children's Act (1997); Amendment Act (2016)

The act aims at providing for the care, protection and maintenance of children; to provide for local authority support for children; to establish a family and children court; to make provision for children charged with offences and for other connected purposes. The amendment Act also aims at enhancing the protection of children; to strengthen the provision for guardianship of children; to strengthen the conditions for intercountry adoption; to prohibit corporal punishment.

Relevancy: *the Project will ensure that the rights of the children are not violated and more so safeguard against harmful employment, zero tolerance to child labor, sexual exploitation and abuse and protection of children with disabilities.*

3.2.13 The Equal Opportunities Commission Act, 2007

The Act makes provision for the composition and functions of the Commission; to give effect to the State's constitutional mandate to eliminate discrimination and inequalities against any individual or group of persons on the ground of sex, age, race, colour, ethnic origin, tribe, birth, creed or religion, health status, social or economic standing, political opinion or disability, and take affirmative action in favour of groups marginalized on the basis of gender, age, disability or any other reason created by history, tradition or custom for the purpose of redressing imbalances which exist against them; and to provide for other related matters.

Relevancy: *The Act will help the project and particularly the contractors to ensure that people especially the project affected persons are provided opportunity to access work on the project construction sites without discrimination and inequalities against any individual or group of persons. This will also enhance the local content for local communities for work.*

3.2.14 The Historical Monuments Act, 1967

The Act provides for the preservation and protection of historical monuments and objects of archaeological, paleontological, ethnographical and traditional interest and for other matters connected therewith.
Relevancy: *The Act informs the Project on how to handle discovered physical cultural resources and relevant to discovery, removal, relocation, protection and preservation of monumental objects and artifacts within the project site.*

3.2.15 The Refugees Act 2006.

The Act provides for matters relating to refugees, in line with the 1951 Convention relating to the status of refugees and other international obligations of Uganda relating to the status of refugees; to establish an Office of Refugees; to repeal the Control of Alien Refugees Act, Cap. 62; and to provide for other related matters.

Relevancy: *Granting of refugee status, Entitlement of refugees, Group recognition, mass influx and temporary protection, Family of recognized refugee and Reunion of family of recognized refugees, Rights of refugees while in Uganda, Freedom of movement, Right to travel document, Rights of refugee children, Rights of women refugees, Duties and obligations of refugees, Extradition of refugees, refugee Settlements and transit centres,*

3.2.16 The United Nations Declaration on the Rights of Indigenous Peoples (2007)

Uganda is signatory recognizes that special measures are required to address the many issues which are common to the majority of the ethnic minorities i.e., identity and recognition, political representation, education and language, access to land among other rights.

Relevancy: *The VMGs identified in the project such as the IPs (Ik, Benet, and Batwa) and the refugees will be given special attention to access vaccines and other project deliverables.*

3.3 Institutional Framework in Uganda

3.3.1 National Environment Management Authority (NEMA)

NEMA is the principal agency responsible for coordination, monitoring and supervision of environmental conservation activities. NEMA is under the Ministry of Water and Environment (MoWE) but has a cross-sectoral and regulatory mandate for overall environmental management in the country including overseeing

the conduct of ESIAs through issuance of guidelines, regulations and registration of practitioners. It reviews and approves environmental assessments in consultation with any relevant lead agencies. It undertakes follow up monitoring to ensure implementation of mitigation measures for projects. NEMA works with District Environment Officers and local environment committees at local government levels who also undertake inspection, monitoring and enforce compliance on its behalf. In Government ministries, NEMA works with Environmental Liaison Units to ensure incorporation of environmental issues in their activities, policies and programs.

Relation to the project: *NEMA is the national agency responsible for setting environmental laws, regulations, managing and monitoring environmental performance in Uganda.*

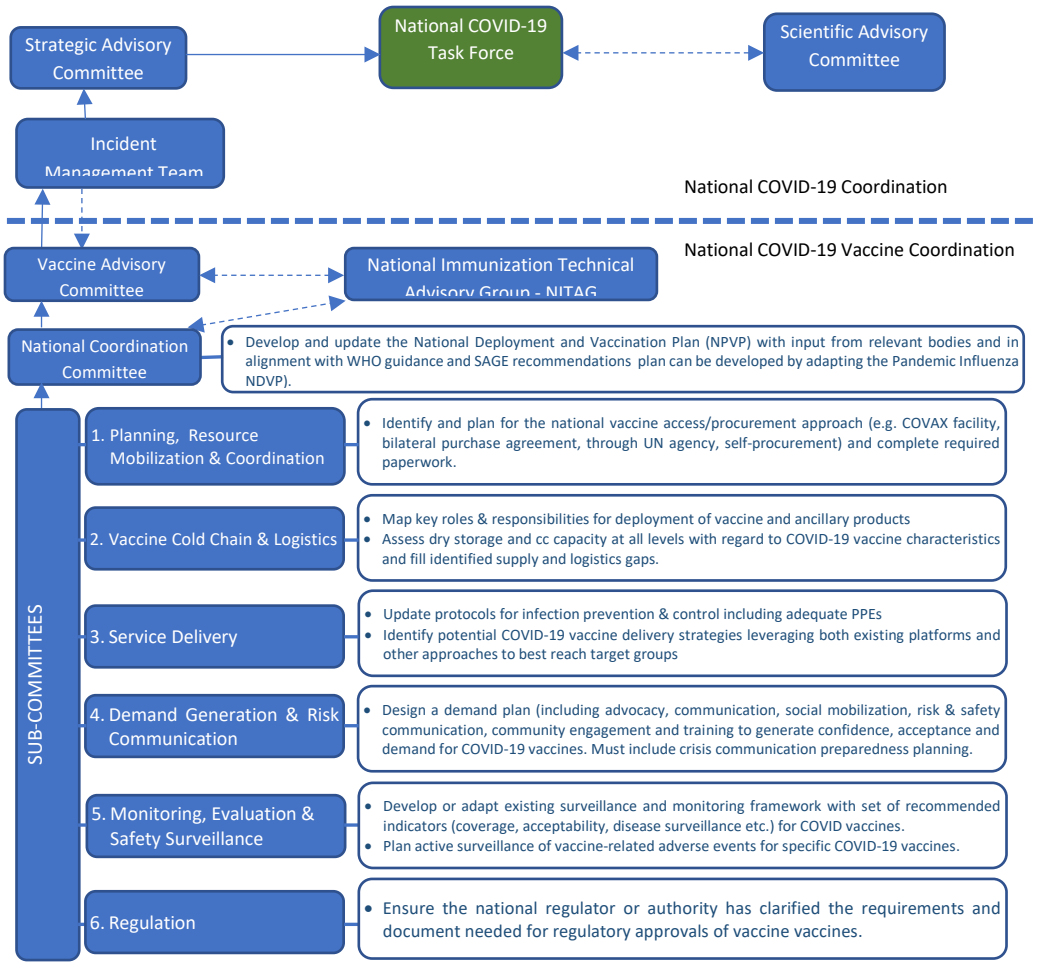
3.3.2 Ministry of Health (MoH)

The Ministry of Health (MOH) is the implementing agency for the Project and the overall implementation arrangements: The UCREPP and AF is fully embedded in the institutional and coordination structures in the health sector. At Project level, the Project Implementation Unit (PIU) at the MoH undertakes day to day management and coordination of the Project including the associated fiduciary, safeguard, monitoring and evaluation functions in collaboration with relevant departments under the ministry. The original implementation and institutional arrangements for the parent Project will be enhanced to accommodate the expanded scope and coverage of the AF. Specifically, implementation arrangements will be enhanced by: (i) recruiting additional personnel to support implementation; (ii) strengthening collaboration across the different departments within the MoH and with OPM and UNHCR for refugee issues; (iii) enhancing supervision of the various components through component leads; and (iv) strengthening stakeholder engagement with development partners and civil society organizations.

At sector level, the MoH has enhanced institutional and coordination arrangements for the immunization program to incorporate requirements for COVID-19 vaccination. Specifically, the following structures have been set up or strengthened to provide oversight and technical leadership of the vaccination campaign, under the overall leadership of the National COVID-19 Response Task Force. These structures are: (i) National Vaccine Advisory Committee (VAC); (ii) Strategic Committee of the Ministry of Health; (iii) COVID-19 Incidence Management Team; (iv) National Coordination Committee; and (iv) National Immunization Technical Advisory Committee. These include refugees as further outlined below. Key partners supporting the COVID-19 response in Uganda include WHO, USAID, World Bank, Africa CDC, UNICEF, GAVI (through the COVAX Facility), Global Fund, and UNHCR.**.**

The MoH, National Medical Stores (NMS) and the National Drug Authority (NDA) are responsible for inspection, verification, monitoring and supervision of vaccines while political and technical leaders oversees similar functions at the sub national level. Figure 1 provides an organogram for the implementation and oversight of the NVDP and its relationship to the overall COVID Task Force. NMS has the legal mandate and track record in procurement and distribution of essential medicines and vaccines and is responsible for the distribution of vaccines acquired through the COVAX facility. Its human resource and supply chain management capacities have improved considerably over the past few years through enhanced use of IT platforms (eLMIS) and better fleet management for vaccine distribution. However, inadequate operational funds constrain the organization. The NDA has developed guidance on emergency and compassionate use authorization, upgraded its pharmacovigilance tools and, printed and distributed AEFI guidance to health facilities. The NVDP was developed with the support of development partners addressing areas of population targeting, vaccine delivery strategies and logistics and supply chain systems that include refugees.

Figure 1: Organogram for Vaccine Deployment Implementation and Oversight



Relation to the project: *Ministry of Health is the implementation agency responsible for execution of this project. The Project's Steering Committee will be expanded in order to ensure representation from the key departments including OPM; the Steering Committee—chaired by the Permanent Secretary—will meet quarterly to oversee Project implementation and provide policy guidance as needed.*

UNHCR participated in the inter-agency and IDP cluster coordination in Uganda contributing to its strategic direction, inter-agency response in emergencies and providing technical support. UNHCR co-chaired protection and camp coordination and camp management clusters ensuring coordinated approaches in humanitarian interventions. A Comprehensive Refugee Response Framework (CRRF) Steering Group was established to ensure efficiency of the CRRF application and coordination of the roll out at national and subnational level. Chaired at the ministerial level by both the Office of the Prime Minister and the Ministry of Local Government (MoLG), the CRRF Steering Group is a policy and decision making body, which enjoys active participation by whole of government representatives from the Office of the Prime Minister (OPM), all key line ministries, national planning authority, as well as bilateral partners, international financial institutions, UN, national and international NGOs, private sector, local governments and host communities representatives and refugees.

The Office of the Prime Minister (OPM) provides the over-arching policy and coordination framework of the refugee response in Uganda. Operational coordination takes place within the framework of a refugee coordination structure dedicated specifically to refugee-hosting Districts (RHDs). Health partners will continue to enhance coordination and inter-sectoral collaboration; strengthen the provision of equitable, safe, quality and sustainable health services in RHDs, and reinforce health systems in refugee-hosting area.

District COVID-19 Task Forces (DTFs) coordinate overall COVID-19 response, including vaccination in refugee hosting local governments. The OPM, UNHCR, and other key implementing agencies involved in the delivery, integration, and coordination of health and vaccination services are members of the DTFs thereby ensuring adequate follow up of refugee health and vaccination issues at district, facility, and settlement levels. The MoH will be working closely with the District Health Officers (DHO) and the Refugee Desk Officers (RDO) through the Project Refugee Liaison Officer, in liaison with the refugee welfare committees at the lower levels. This arrangement will help to increase equitable access to and utilization of integrated quality health services for refugees and host communities and strengthen the health care system to cope with the increased demand for health services by refugees and host communities.

3.3.3 Ministry of Gender, Labor & Social Development

This ministry sets policy direction and monitoring functions related to labor, gender and general social development. The OHS unit in the ministry is responsible for inspection and mentoring of occupational safety in workplaces and this could be during project construction and operation of the healthcare facilities. Close coordination with the Ministry of Health will continue at national with other line ministries (such as the Ministry of Gender Labor and Social Development), district and local level to ensure that health care services for refugees and host communities in refugee-hosting areas are in line with government policies, guidelines, and standards.

Relation to the project: *The OHS in Ministry of Gender, Labor and Social Development is mandated to supervise all workplaces for safety of workers both during construction and operation.*

3.3.4 District Local Administration Structures

The proposed project is within a number of jurisdictions of a number of Districts headed by a Local Council 5 (LC5), City mayors, municipalities, Chairpersons and Chief Administration Officers (CAOs) who are the political head and technical head respectively. Various district, city and municipal offices whose functions would be relevant to the project include offices of Natural Resources/Environment, District Health Officer, or City Medical Officers, District health inspector/educator, District Planner, District or City Community Development Officers, Refugee Desk Officer, Wetlands Officer, Land Office, District Water Officer, Town Council and District Engineer. Equally important are village-level local council administration (LC I and LC III). Leaders at these levels of local administration are closer to residents and therefore important in effective community mobilization, sensitization and dispute resolution. The District and Local/Health Management Unit Teams will also be involved in project implementation. The Project Refugee Liaison Officer in liaison with settlement commandants will be very instrumental in ensuring that all the refugees' related concerns are integrated into the sub-project components.

Existing structures in the RHDs comprise of Refugee Welfare Committees (RWC) at settlement level that have been established equivalent to Local Council structures in other districts. The RWCs comprising settlement commanders and representatives from host and refugee communities, including youth, women, persons with disability (PWD) and older persons, are responsible for effective planning and delivery of support services including protection, security, livelihoods, health and education. Uganda has a Refugee Health Integration Steering Committee and a secretariat that oversee implementation of the HSIRRP. Implementation of the refugee health is integrated into MoH systems, and the steering committee will also help strengthen coordination and integration between host communities and refugees on refugee health issues. The DHOs organize regular meetings aimed at coordination and monitoring implementation of service delivery in the settlements and host communities through the refugee welfare committees at the lower levels. Health centers in the refugee settlements and those shared by refugees and host communities have health unit management committees (HUMCs) coordinated by the DHO's office. Refugees have representation on the HUMCs.

Relation to the project: *Local governments have administrative authority over projects implemented in respective areas of their jurisdiction and are expected to participate in supervision and monitoring project implementation and operation. In case of a COVID-19 outbreak, assistance of local governments would be essential in identifying location of isolation areas, coordination and communication between the Public Health Emergency Operations Centre (PHEOC), health workers in COVID-19 Treatment Units and at Points of Entry (PoEs) to enable quick identification, notification, transfer and management of patients or suspected victims, including surveillance.*

3.4 World Bank Environmental and Social Framework

3.4.1 Environmental and Social Standards (ESS)

The World Bank's Environmental and Social Standards are designed to help ensure that programs proposed for Bank financing are environmentally and socially sustainable, and thus facilitates informed decision-making. These Environmental and Social Standards are outlined below and ones that are applicable/ relevant to the proposed project operations are indicated:

Table 5: World Bank environmental and social standards showing ones relevant to the proposed project

ESS	Relevant?		Reason
	Yes	No	
ESS1: Assessment and Management of Environmental and Social Risks and Impacts	X		The project will entail facilitating proper management of medical waste generated by COVID-19 emergency operations. Should there be any set up (and decommissioning) of waste disposal systems (e.g. onsite incinerators), environmental assessment will be necessary Part of AF will be used construct Intensive Care Units at Regional Referral Hospitals, Isolation units at some health centres, upgrade of some health centres or hospitals and isolation units in Refugee Host Districts or settlements. This will require carrying environmental and social assessments as either full ESIA or Project Brief/ and preparation of Environmental and Social Management Plan. Other risks and impacts include EHS risks due to the dangerous nature of the pathogen (COVID-19) and reagents and equipment to be used in the project-supported activities; The major healthcare related risks and impacts arise from managing the highly infectious COVID-19, from case detection, confirmation, tracing, testing, isolation, and case management. Healthcare waste has a substantial potential of carrying micro-organisms that can infect people exposed to it, as well as the community if not properly disposed of. Laboratories using COVID-19 diagnostic testing will generate biological waste, chemical waste, and other hazardous by-products and represent pathways for exposure to the virus. Health care waste management will be of priority and will follow the well laid strategies in place and as per the National Waste management Regulations 2020 Also, the parent project provides interventions for capacity enhancement including additional training of health workers in vaccination centers on infection prevention and control and infectious/hazardous waste management. The MoH upgrading standard provides for incinerators at HC IVs and IIIs. All the

ESS	Relevant?		Reason
	Yes	No	
			facilities to be upgraded or constructed, will have a component of modern waste incinerators accompanied by training on sustainable use and management of such facilities. However, for the vaccination centres or facilities without incinerator, such waste will be appropriately collected and transported to the nearest centre with such facilities. Since other participating health facilities are not yet determined or known, Environmental and Social Management Framework has been prepared to guide management of environmental and social aspects. Once the specific sites and respective activities have been identified, ESIAs if required shall be undertaken and ESMPs developed before start of any works.
ESS2: Labor and Working Conditions	X		Healthcare workers hired for COVID-19 emergency response programs including the military as health professionals [limited to military hospitals with oversight from MoH] vaccinating eligible persons in their catchment areas such as barracks; and security personnel who are normally engaged to safeguard the safe delivery of vaccines during transportation will require safe working conditions that protect them from infections while on duty. Risky environments include laboratories, hospitals and health care centers, isolation centers and the broader community where project workers may be exposed to the virus. Health facilities treating patients or administering vaccines may also generate biological, chemical waste, and other hazardous by-products that could be injurious to human health. Transportation of COVID-19 vaccines from one location to the other may present risks of accidents to drivers. A clear interpretation of Occupational Safety and Health Act will be done to respond to the specific health and safety issues, and protect workers' rights as set out in ESS2. Staff of health facilities as well as all other workers involved in the procurement, delivery, training, use, supervision/monitoring, and/or handling and disposal of medical supplies, equipment, or waste products will receive necessary training on protecting themselves and others from COVID-19 infection, as well as other relevant OHS risks and management measures. The same will apply to workers that will be employed by contractors upgrading some of the facilities yet to be identified. AF will aim at Psychosocial Support and Gender-Sensitive Considerations, will finance psychosocial support to health care providers and residents of host communities and refugee settlements. The Project will strengthen existing mechanisms for the prevention and response to GBV in coordination with the MoGLSD and districts, including referral systems, use of response hotlines and community mobilization activities.
ESS3: Resource Efficiency and Pollution Prevention and Management	X		Emergency operations will utilize resources and generate waste, some of which would be hazardous waste requiring appropriate waste management protocols including prevention (of waste generation) and resource efficiency. Medical wastes and chemical wastes (including water, reagents, infected

ESS	Relevant?		Reason
	Yes	No	
			materials, etc.) from the labs, quarantine, and screening posts can have significant impact on the environment and human health. Informal disposal may lead to contamination of soil and groundwater, and to further spreading of the virus to nearby communities. Also some civil works to be carried out under AF will generate some waste that would require appropriate management. Wastes that may be generated from medical facilities/ labs/quarantine and isolation centers could include liquid contaminated waste, chemicals and other hazardous materials, and sharps used in diagnosis and treatment..Each beneficiary health facility/lab is expected to follow the requirements of this ESMF prepared under this AF. The parent project ESMF, which includes an Infection Control Medical Waste Management Plan(ICWMP) includes WHO COVID-19 guidance and other international good practice, to prevent or minimize contamination from inadequate waste management. Transporting vaccines across the country will require efficient cold-chain infrastructure in place which comes with an environmental cost, including energy consumption and indirect Greenhouse gas (GHG) emissions. However, Uganda has a well established medicines transport system under National Medical Stores with a responsibility of storage and distribution to different centres. The MoH is also using climate-friendly cold chain facilities for the storage of vaccines. Should there be a need for procuring of more storage and transportation facilities, then they will also be climate friendly fridges.
ESS4: Community Health and Safety	X		COVID emergency operations including construction works, increase the volume of inputs such as PPE, supplies, medicines, consumables for management of COVID-19 cases and comorbidities; delivery of vaccines will necessitate measures to adequately protect health and safety of communities concerned including against the spread of HIV/AIDS and disease prevention within 12 RHDs. As noted under ESS2, medical wastes and general waste from the labs, health centers, quarantine and isolation centers have a substantial potential of carrying micro-organisms that can infect the community at large if they are not properly disposed of. This is of particular concern in the RHDs with the risk of improper waste disposal due to lack of incinerators at some health centers. There is a possibility for the infectious microorganism to be introduced into the environment if not well contained within the laboratory or due to accidents/emergencies. Therefore laboratories, quarantine and isolation centers, and screening posts, will have to follow respective procedures with a focus on appropriate waste management of contaminated materials as well as protocols on the transport of samples and workers cleaning before leaving the workplace back into their communities. The new component of vaccine acquisition and deployment lead to failure to store and handle vaccines properly thereby reducing vaccine potency, resulting in inadequate immune responses in

ESS	Relevant?		Reason
	Yes	No	
			patients and poor protection against disease. This would lead to potential community health and safety risks related to increased risk of spread of COVID-19 during the vaccine campaigns and administration unless appropriate risk management measures are put in place, and adverse events following immunization (AEFI). However, Uganda's vaccine preference is vaccines whose cold chain requirements align with Uganda's current cold chain capacity. Few vaccines that require ultra-cold conditions will be procured to match with the country's capacity. All health workers at vaccination sites have been trained in AEFI surveillance and provided with AEFI kits which include guidelines, and tools for data collection on AEFI. More health workers will be under the same training in case of new vaccination centres At the moment, there is no mandatory and forced vaccination in Uganda. However, in the event that mandatory vaccination is required, it will require to take the following due process protocol to 1) obtain consent; 2) enable affected persons to seek justified exceptions; 3) differentiate between mandatory schemes (allowed with due process) and forced vaccination (not allowed).
ESS5: Land Acquisition, Restrictions on Land Use and Involuntary Resettlement		X	Because construction activities are expected to be carried out within the footprint of existing facilities, they are not expected to require land acquisition and/or cause physical and economic displacement. As such this standard is currently not relevant to the project. It should also be noted that World Bank's Environmental and Social Standard five (ESS 5) on Land Acquisition, Restrictions on Land Use and Involuntary Resettlement will not be triggered by the activities of the AF.
ESS6: Biodiversity Conservation and Sustainable Management of Living Natural Resources		X	It is expected that existing healthcare facilities or hospitals will be used for all emergency operations therefore it is not anticipated that COVID-19 activities will be carried out on sites with natural resources of conservation concern. No works or project activities are expected to be undertaken in natural resources and biodiversity areas, including forests, lakes or protected areas. However, if medical and chemical wastes are not properly disposed of, they can have impacts on living natural resources. The procedures outlined in the infection control and waste management plan will be applied to minimize such impacts.
ESS7: Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	X		AF aims at Strengthening COVID-19 Case Management, scaling up activities in refugee settlements and the RHDs to strengthen the national capacity to provide key infrastructure and quality services to support COVID-19 patients, including those in intensive and critical care and home-based care. The AF will also target the vulnerable and marginalized groups (Batwas. Benets, Tepeths and the Ik) and refugees in their areas, the planned vaccination activities will ensure that these marginalized groups are also given a priority due to challenges faced like; ▪ Difficulties in access to services;

ESS	Relevant?		Reason
	Yes	No	
			▪ Discrimination towards ethnic groups or where communication channels may be limited. ▪ Conflict between different groups including *Batwas, Benets, Tepeth* and the *Ik* and refugees AF will also provide hazard allowances to frontline workers and rapid response teams; expand the number of selected health center IVs and other treatment and isolation facilities within RHDs and high-risk entry points. Additionally, the SEP has provisions to equally target members of Vulnerable and Marginalized Groups (Batwas, Benets, Tepeths and the Ik, female headed households, refugees, those in difficult to access rural and remote areas etc.). Lastly, grievance redress management systems should be culturally appropriate and accessible to marginalized groups, taking into account their customary dispute settlement mechanism. Response to COVID-19 emergencies shall entail involvement of *Batwas, Benets, Tepeths* and the *Ik* and there will be special attention paid where they do not have access to conventional redress mechanism
ESS8: Cultural Heritage	X		Burial ceremonies and practices are part of people's intangible cultural heritage; making ESS8 relevant. In addition, in case of chance finds at construction sites makes this ESS relevant.
ESS10: Stakeholder Engagement and Information Disclosure	X		A key pillar in controlling COVID-19 is creating awareness in the general public and stakeholder engagement. In this lies the importance of ESS10. AF will also include training in critical care delivery models, and COVID-19 case management, and emergency response to climate shocks; Strengthen Emergency Medical Services will support: finalization of EMS policy, guidelines, and standards (including establishment of a toll-free emergency number); procurement of ambulances equipped with supplies and products for pre-hospital care; finalize and disseminate updated guidelines on referral pathway (including clarifying roles and functions of different stakeholders); conduct simulation exercises as necessary to train clinical and EMS personnel; improve dispatch and fleet information management systems, ensuring integration of emergency service and related surveillance metrics into the national HMIS, and supporting the expansion of these services into underserved parts of the country.

A detailed assessment of the applicable Standards is provided below.

i) ESS1: Assessment and Management of Environmental and Social Risks and Impacts

The major and serious health care related risks and impacts arise from managing the highly infectious COVID-19 epidemic, right from case detection, confirmation, tracing, testing, isolation, and case management. WHO has reported that 20% of total healthcare waste would be infectious waste, and improper handling of health care waste can cause serious health problem for workers, community and the

environment. Medical wastes have a substantial potential of carrying micro-organisms that can infect people who are exposed to it, as well as the community at large if it is not properly disposed of. Wastes that may be generated from labs, quarantine facilities and screening posts to be supported by the COVID-19 response project may include liquid contaminated waste (e.g. blood, other body fluids and contaminated fluid) and infected materials (water used; lab solutions and reagents, syringes, bed sheets, majority of waste from labs and quarantine and isolation centers, etc.), which requires special handling and awareness, as it may pose an infectious risk to healthcare workers and the public. It is also important to ensure that sharps are properly disposed of.

In sum, the medical wastes from COVID-19 could cause substantial environmental and social risk, if they are not properly handled, treated or disposed. To mitigate and manage the project's environmental and social risks as described above, this ESMF has been prepared to provide guidance on assessment and management of likely environmental and social impacts, before commencement of project implementation. All project activities shall be subjected to environmental and social screening and where necessary specific instruments shall be prepared before commencement of applicable project activities. Specific mitigation measures will be outlined in the site-specific ESIAs or ESMPs and implemented, when necessary. This ESMF recommends measures to isolate construction sites from the public (fencing) and ensuring segregation of workers and pedestrian traffic from active civil works sites and moving equipment. Safe work protocols shall be developed and implemented for hazardous tasks such as work-at-heights, confined spaces, hot-works or those involving electrical circuits. Health screening and COVID-19 prevention measures for workers have been incorporated into the OHS procedures outlined in this ESMF. Emergency response and handling procedures shall be developed by Contractors to handle any accidents onsite. Construction waste shall be managed in line with the local provisions at each site, but in overall compliance with the National Waste Management Regulations and the World Bank's Environmental, Health and Safety Guidelines.

The ESMF Annex 4 provides infections prevention and control measures and procedures for the safe handling, storage, and processing of COVID-19 materials and techniques for preventing, minimizing, and controlling associated impacts, including management of civil works to be undertaken at the selected Hospitals/ Health Facilities. The project could also cause EHS risks due to the dangerous nature of the pathogen (COVID-19) and reagents and equipment to be used in the project-supported activities, construction activities, and the additional risks related to the procurement, distribution and administration of vaccines.

The major healthcare related risks and impacts arise from managing the highly infectious COVID-19, from case detection, confirmation, tracing, testing, isolation, and case management. Healthcare waste has a substantial potential of carrying micro-organisms that can infect people exposed to it, as well as the community if not properly disposed of. Health care facilities which will treat COVID-19 exposed patients and laboratories using COVID-19 diagnostic testing will generate biological waste, chemical waste, and other hazardous by-products and represent pathways for exposure to the virus. Given that existing capacity for ensuring proper medical waste management at health facilities across Uganda varies, this is a key area of focus of capacity building and supervision under the parent project. This ESMF clearly outline the implementation arrangements to be put in place by the Ministry of Health; provisions for training programs focused on COVID-19 laboratory biosafety, operation of quarantine and isolation centers and screening posts, as well as compliance monitoring and reporting requirements. It also includes under Annex 3 relevant guidance on health care waste management in an Infection Control and Medical Waste Management Plan (ICMWP) that is guided by the Uganda National Infection Prevention and Control Guidelines, 2013, adheres to SOPs on laboratory and medical waste management detailed in Uganda's *Standard Operating Procedures and Guidelines for Responding to Ebola/Marburg Virus Disease Outbreaks in Uganda-A Guide for National Response, 2015*, and build on other good international industry practice (GIIP), especially WHO guidance.

Social risks and impacts will be mitigated through a (i) robust and coordinated national communication strategy promoting the Project's objectives, tailored to various audiences to address issues of access, discrimination, and ethnicity; (ii) continuous education and awareness raising campaigns; (iii) development of materials (radio, infographics, TV broadcasts); and (iv) a grievance redress mechanism that will provide real time feedback including a mechanism for GBV/SEA cases with separate referral paths/channels. These aspects are detailed in the project's Stakeholder Engagement Plan. In addition, this ESMF provides guidance on management of the social issues, particularly those associated with the potential exclusion of vulnerable or marginalized individuals or groups from project benefits, and a small influx of laborers into the selected facilities and affected communities. It will include measures to mitigate risks of GBV/SEA and VAC, HIV/AIDS, labor issues, social exclusion, and guidelines for the establishment of a functioning grievance redress mechanism for project workers. In addition to this ESMF, MoH will implement activities set out in the ESCP and all project activities shall be subjected to environmental and social screening and additional specific instruments developed, reviewed and approved by both Government and the Bank.

ii) ESS2: Labor and Working Conditions:

This Standard is relevant. Most activities supported by the project will be conducted by publicly employed health and laboratory workers, though some construction will be outsourced to third parties. The key risk is contamination with COVID-19 (or other contagious illnesses as patients taken seriously ill with COVID-19 are likely to suffer from illnesses which compromise the immune system, which can lead to illness and death of workers). Staff of health facilities (including military personnel in benefiting military hospitals) as well as all other workers involved in the procurement, delivery, training, use, supervision/monitoring, and/or handling and disposal of medical supplies, equipment, or waste products will receive necessary training on protecting themselves and others from COVID-19 infection, as well as other relevant OHS risks and management measures. The Project will ensure the application of OHS measures as outlined in WHO guidelines which are captured in the ESMF (Annex 4).

This encompasses procedures for entry into health care facilities, including minimizing visitors and undergoing strict checks before entering; procedures for protection of workers in relation to infection control precautions; provision of immediate and ongoing training on the procedures to all categories of workers, and mandating hand hygiene and personal protective equipment (PPE); ensuring adequate supplies of PPE (particularly facemask, gowns, gloves, handwashing soap and sanitizer); and overall ensuring adequate OHS protections in accordance with General EHSGs and industry specific EHSGs and following evolving international good practice in relation to protection from COVID-19.

During implementation, the ESMPs will furthermore be regularly reviewed and updated to integrate the latest guidance by WHO as it evolves over time and experience addressing COVID-19 globally. Risky environments include laboratories, hospitals and health care centers, isolation centers and the broader community where project workers may be exposed to the virus. Health facilities treating patients or administering vaccines may also generate biological, chemical waste, and other hazardous by-products that could be injurious to human health. Staff of health delivery facilities will receive training under the project on how to use the medical equipment and supplies financed through the Project in a way that protects their health and safety. A code of practice has been provided under Annex 6 to regulate conduct of workers at the construction sites, and at the same time provide guidance to workers on requirements (SOPs) that they will be expected to observe in order to ensure their own safety from COVID-19 infection. During implementation of this project, all participating facilities shall establish written procedures for protection of workers in relation to infection control precautions and include these in the labor management procedures and in contracts as appropriate; provide immediate and ongoing training on the procedures to all categories of workers, and post signage in all public spaces mandating hand hygiene and PPE usage; develop a basic, responsive grievance mechanism to allow workers to quickly inform management of labor issues, such as a lack of PPE, delayed payment of salaries, unreasonable overtime, etc.; ensure adequate supplies of PPE

(particularly facemask, gowns, gloves, handwashing soap and sanitizer) are available; ensure adequate OHS protections in accordance with General Environmental, Health and Safety Guidelines (EHSGs) and industry specific EHSGs and follow evolving international best practice in relation to protection from COVID-19; and require staff to follow protocols. The use of child or forced labor will be forbidden in accordance with ESS2 and Ugandan labor laws.

iii) ESS3: Resource Efficiency and Pollution Prevention and Management:

This standard is relevant. Medical wastes and chemical wastes (including water, reagents, infected materials, etc.) from the labs, quarantine, and screening posts to be supported (drugs, supplies and medical equipment) can have substantial impact on environment and human health. Wastes that may be generated from medical facilities/ labs could include liquid contaminated waste, chemicals and other hazardous materials, and other waste from labs and quarantine and isolation centers including of sharps, used in diagnosis and treatment. Each beneficiary medical facility/lab, following the requirements of this ESMF, WHO COVID-19 guidance documents, and other international good practices, will prepare and follow an Infection Control and Medical Waste Management Plan (ICMWP) to prevent or minimize such adverse impacts, in line with the guidance contained under Annex 3. This also provides guidance on site-specific instruments (ESMPs) covering key aspects such as transportation and management of samples including vaccines and medical goods or expired chemical products. Resources (water, air, etc.) used in quarantine facilities and labs will follow standards and measures in line with CDC and WHO environmental infection control guidelines for medical facilities. Existing capacity for ensuring proper medical waste management at hospitals across Uganda varies, and will therefore be a key area of focus of capacity building and supervision under the project, considering in particular the risks of further COVID-19 spread if waste is not handled properly.

Rollout of the vaccines will result in increase of medical waste, including used vials, sharps, needles, and other infected materials, which might overwhelm the capacity for management of health care waste. Indiscriminate disposal of unused, expired and unsafe vaccines can be harmful to humans, environment, and wildlife. Vaccination activities will increase the environmental repercussions of plastic waste including syringes, which adds to the waste already generated by single-use PPE. To reduce vaccine rollout related wastes, the project will adopt the World Health Organization guidelines on stock records management for immunization and Monitoring vaccine wastage at country level. Given that existing capacity for ensuring proper medical waste management at health facilities across Uganda varies, this is a key area of focus of capacity building and supervision under the parent project. The parent project provides interventions for capacity enhancement including additional training of health workers in vaccination centers on infection prevention and control and infectious/hazardous waste management. The MoH upgrading standard provides for incinerators at HC IVs. All the facilities to be upgraded or constructed, will have a component of modern waste incinerators accompanied by training on sustainable use and management of such facilities.

Furthermore, both the parent project and AF will leverage the on-going URMCHIP that supports the required investments in medical waste management through the provision of new incinerators for all the 81 health centers being upgraded. The strategy provided is that every vaccination center/point without an incinerator will have their waste collected and deposited to the nearest facility with an incinerator by a licensed hazardous waste handler who will transport the ashes to the designated disposal area at Nakasongola.

Transporting vaccines across the country will require efficient cold-chain infrastructure in place which comes with an environmental cost, including energy consumption and indirect greenhouse gas (GHG) emissions. Uganda has a well established vaccines logistics system in the NMS for primary storage and distribution of COVID-19 vaccines and the MoH policy for managing waste is provided in the EPI Guidelines. GoU will strengthen and expand the existing cold chain system (+2o C to +8o C and capacity at <-15o C). The MoH is also using climate-friendly cold chain facilities for the storage of vaccines.

To reduce the project related GHG emissions, the project will incorporate the use of solar energy as an alternative
energy use on healthcare facilities to be renovated/upgraded as is currently being done on the renovation of the 81 maternity units under URMCHIP. The designs to be adopted are incorporating an element of natural aeration and light especially during day. The project will also Install LED lights to improve energy efficiency of intensive care units and healthcare facilities and use reflective paint on facilities to improve passive cooling.

iv) ESS4: Community Health and Safety:

MoH will design, construct, operate, and decommission the structural elements of the project in accordance with national legal requirements, the EHSGs and other GIIP, taking into consideration safety risks to third parties and affected communities. medical wastes and general waste from the labs, health centers, quarantine and isolation centers have a substantial potential of carrying micro-organisms that can infect the community at large if they are not properly disposed of. Where the project includes new buildings and structures that will be accessed by the public, MoH will consider incremental risks of the public's potential exposure to operational accidents or natural hazards, including extreme weather events. MoH will engage one or more independent experts with relevant and recognized experience in similar projects, separate from those responsible for the design and construction, to conduct a review as early as possible in project development and throughout the stages of project design, construction, operation, and decommissioning.

In providing emergency COVID-19 health services to communities, MoH will establish and implement appropriate quality management systems to anticipate and minimize risks and impacts that such services may have on community health and safety. This is of particular concern in the RHDs with the risk of improper waste disposal due to lack of incinerators at some health centers. Also, Laboratories, quarantine and isolation centers, and screening posts, will follow respective procedures with a focus on appropriate waste management of contaminated materials as well as protocols on the transport of samples and workers cleaning before leaving the workplace back into their communities.

With the introduction of a new component on vaccine acquisition and deployment under the AF, there are potential community health and safety risks related to increased risk of spread of COVID-19 during the vaccine campaigns and administration unless appropriate risk management measures are put in place, and adverse events following immunization (AEFI). Failure to store and handle vaccines properly can reduce vaccine potency, resulting in inadequate immune responses in patients and poor protection against disease.

According to the Uganda National Covid-19 Vaccine Deployment Plan (NVDP), Uganda's vaccine preference is vaccines whose cold chain requirements align with Uganda's current capacity. This currently includes AstraZeneca and to also include three additional vaccines, with similar cold chain requirements: Sinopharm, Sinovac, and Johnson & Johnson. Vaccine cold-chain and distribution capacity, notably for ultra-cold chain, are currently inadequate in Uganda and could pose hindrances to national roll out of vaccines like Pfizer and Moderna. Limited donations of mRNA vaccines (like Pfizer through the USA) will be stored using existing ultra-cold chain capacity. With regards to the current vaccination procedures, once procured, the vaccines are received, stored and distributed to the health facilities by the NMS and the micro plans of the respective entities.

In line with safety provisions in ESS4, it is equally important to ensure the safety of communities from infection with COVID19 but also from the risks associated with the influx of labor. As noted under ESS2, medical wastes and general waste from the labs, health centers, and quarantine and isolation centers have a substantial potential of carrying micro-organisms that can infect the community at large if they are not properly disposed of. There is a possibility for the infectious microorganism to be introduced into the environment if not well contained within the laboratory or due to accidents/ emergencies e.g. a fire response

or natural phenomena event (e.g., seismic). The Infection Control and Waste Management Plan therefore describes: how Project activities will be carried out in a safe manner with (low) incidences of accidents and incidents in line with Good International Industry Practice (WHO guideline); measures in place to prevent or minimize the spread of infectious diseases and emergency preparedness measures. Laboratories, quarantine and isolation centers, and screening posts, will thereby have to follow respective procedures with a focus on appropriate waste management of contaminated materials as well as protocols on the transport of samples, vaccines and workers cleaning before leaving the workplace back into their communities. The project will thereby follow the provisions outlined in this ESMF, noted in ESS1.

Laboratories, quarantine and isolation centers, and screening posts, will thereby have to follow respective procedures with a focus on appropriate waste management of contaminated materials as well as protocols on the transport of samples and workers cleaning before leaving the workplace back into their communities. Secondly, the operation of quarantine and isolation centers, ICUs shall be implemented in a way that both the wider public, as well as the quarantined or under treatment patients are treated in line with respective facilities SOPs and international best practice as outlined in WHO guidelines. This includes the following requirements: ***Infrastructure:*** there is no universal social distance guidance regarding the infrastructure for a quarantine facility or isolation centre/unit, but space should be respected not to further enhance potential transmission and the living placement of those quarantined or under treatment should be recorded for potential follow up in case of illness or re-infection.

Accommodation and supplies: quarantined persons should be provided with adequate food and water, appropriate accommodation including sleeping arrangements and clothing, protection for baggage and other possessions, appropriate medical treatment, means of necessary communication if possible, in a language that they can understand and other appropriate assistance. Further information is also included in the *CDC Interim Infection Prevention and Control Recommendations for patients with confirmed COVID-19 or persons under investigation for COVID-19 in Healthcare Settings;*

Communication: establish appropriate communication channels to avoid panic and to provide appropriate health messaging so those quarantined can timely seek appropriate care when developing symptoms;

Respect and Dignity: quarantined persons should be treated, with respect for their dignity, human rights and fundamental freedoms and minimize any discomfort or distress associated with such measures, including by treating all quarantined persons with courtesy and respect; taking into consideration the gender, sociocultural, ethnic or religious concerns of quarantined persons.

The project will ensure the avoidance of any form of SEA of patients and community members at large by relying on (i) the WHO Code of Ethics and Professional conduct for all workers including health professionals in the quarantine facilities as well as the provision of gender-sensitive infrastructure such as segregated toilets and enough light in quarantine and isolation centers and (ii) World Bank guidelines on the mitigation of SEA such as the signing of enforceable workers' codes of conduct, sensitization of workers and affected communities, and establishment of referral pathways. Provisions to prevent GBV/SEA/SH shall be incorporated in the CoC for staff and contractors' workers. The project will also ensure via the above noted provisions, including stakeholder engagement, that quarantine and isolation centers and screening posts are operated effectively throughout the country, including in remote and border areas, without aggravating potential conflicts between different groups, including host communities, refugees/IDPs, and members of Vulnerable and Marginalized Groups (Batwas, Benets, Tepeths and the Ik) during vaccination.

In case quarantine and isolation centers are to be protected by security personnel, it will be ensured that the security personnel follow strict rules of engagement and avoid any escalation of the situation, taking into consideration the above noted needs of quarantined persons as well as the potential stress related to it. If

Uganda's military forces or police are mobilized as part of the government's response to the emergency, the Project will shall take measures to ensure that, prior to deployment such personnel are: (i) screened to confirm that they have not engaged in past unlawful or abusive behavior, including SEA, sexual harassment (SH) or excessive use of force; (ii) adequately instructed and trained, on a regular basis, on the use of force and appropriate behavior and conduct (including in relation to SEA and SH), as set out in ESMF Annex 7; and (iii) deployed in a manner consistent with applicable national law (UPDF Act).

Vaccines are escorted by security personnel during transportation to ensure their safe delivery. There are no plans to use security personnel and/or the military in the vaccination program except in escorting vaccines during transportation and as health professionals [in military hospitals with oversight from MoH] vaccinating eligible persons in their catchment areas such as barracks respectively. Note that the military can only be included in the vaccination program outside their area of jurisdiction in a war zone and there are no war zones in Uganda currently. The likely use of the military and/or the security forces will be reassessed as part of updating the ESMF and appropriate mitigation measures implemented consistent with ESS4 and associated Bank guidance.

Regarding infrastructure and equipment design and safety MoH will design, construct, operate, and decommission the structural elements of the project in accordance with national legal requirements, the Environmental Health and Safety Guidelines (EHSGs) and other GIIP, taking into consideration safety risks to third parties and affected communities. Structural elements of a project will be designed and constructed by competent professionals, and certified or approved by competent authorities or professionals. Structural design will take into account climate change considerations, as appropriate. Where the project includes buildings and structures that will be accessed by members of the public, MoH will consider the incremental risks of the public's potential exposure to operational accidents or natural hazards, including extreme weather events. Where technically and financially feasible, MoH will also apply the concept of universal access to the design and construction of such new buildings and structures. When structural elements or components of a project are situated in high-risk locations, including those with risk of extreme weather or slow onset events, and their failure or malfunction may threaten the safety of communities, MoH will engage one or more independent experts with relevant and recognized experience in similar projects, separate from those responsible for the design and construction, to conduct a review as early as possible in project development and throughout the stages of project design, construction, operation, and decommissioning.

Where the project involves provision of services to communities, MoH will establish and implement appropriate quality management systems to anticipate and minimize risks and impacts that such services may have on community health and safety. In such circumstances, MoH will also apply the concept of universal access, where technically and financially feasible

v) ESS7 Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities

This ensures that the development process fosters full respect for human rights, dignity, aspirations, identity, culture, and natural resource-based livelihoods of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities. ESS7 is also meant to avoid adverse impacts of projects on Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities, or when avoidance is not possible, to minimize, mitigate and/or compensate for such impacts. ESS7 will be triggered as explained in **Table 5** above, and especially in ensuring that all indigenous peoples and other vulnerable groups like refugees are not discriminated and should also be give a priority during vaccination.

In Uganda VMGs include: the poor, refugees, indigenous peoples, migrants, the elderly, minorities, and the disabled, those with underlying medical conditions, and others who would be most at risk in the event of a pandemic outbreak. The Project will focus on specifically refugees and refugee host communities as well as the IP who include the Batwa, Benets, Tepeths, and the Ik. None of the facilities envisaged to undergo remodeling are in Districts known to host members of VMGs i.e., the Batwa, IK, Benets, and Tepeth and therefore, these groups will not be impacted by the civil works. The project will however, put in place measures to ensure that they are targeted and receive benefits from the operation in an inclusive and culturally appropriate manner. This will be done by ensuring that their views are sought as specified in the SEP to be updated, and more specifically, that public consultations with their representatives and organizations will be carried out including during planned vaccination campaigns in which consultations will clearly communicate that there are policies ensuring that there is no forced vaccination. The consultations and vaccinations within the IPs communities will be conducted with extra precautions to minimize COVID-19 transmission risks. The project will also ensure that all other relevant activities related to sensitization on prevention/response, GBV/SEA, etc.) include provisions to specifically target these groups as well.

The Additional Financing to the Project, focuses primarily on scaling up Uganda's COVID-19 vaccination program, as well as strengthening the provision of COVID-19 and broader health services to refugees and refugee hosting districts. Difficult access in rural and remote areas or in refugee settlements can also pose a challenge for service and supply delivery, which could be a deterrent for an effective national response. The AF will therefore be implemented nationwide, including the 12 RHDs of Adjumani, Arua, Yumbe, Moyo and Koboko in north-western; Lamwo in the northern; Kiryandongo and Kikuube in mid-western; Kyegegwa and Kamwenge in western; Isingiro in south-western and Kampala in central Uganda (which host refugees, in designated settlements and among communities, (mainly from South Sudan, Democratic Republic of Congo, Burundi, Rwanda, Somalia, Eritrea and Ethiopia). Some of these districts are in the poorest and most under-developed areas of Uganda which places pressure on host communities, creates challenges in public service delivery and natural resources management.

Sufficient funds under the Project have been allocated to vaccinate a total of 700,000 refugees and host community members within the 12 RHDs of focus. UNHCR will be engaged closely in the implementation of activities in the refugee settlements and hosting districts and ensure effective coordination with the Refugee Inter-Agency Health and Nutrition Working Group. The Project activities envisioned take into consideration current and planned investments on refugee health being supported by UNHCR and are intended therefore to complement an overall framework of development assistance meeting the needs of host communities and refugees.

vi) ESS10 Stakeholder Engagement and Information Disclosure

The project has already established a structured approach to engagement with stakeholders that is based upon meaningful consultation and disclosure of appropriate information, considering the specific challenges associated with COVID-19 (associated lockdown, quarantines, curfews and social distancing guidelines). Similarly, it will provide affected persons and communities' accessible and inclusive means to raise concerns and grievances and also to be considered for vaccination. The Project's Stakeholder Engagement Plan (SEP, Nov 2021)[23] of this AF has already been prepared and disclosed. This describes the framework for these activities, following the guidance provided under ESS10 and by the WHO. Any other emerging issue will also be incorporated and updated to cater in line with AF additional component on vaccine acquisition and deployment. It is meant to ensure that information is meaningful, timely, and accessible to all affected stakeholders, using the whole range of available media (Television, Radio, mobile phone, etc.). It includes specific provisions such as: (i) the use of relevant languages, (ii) culturally

[23] http://library.health.go.ug/publications/disease-survielance-outbreaks/stakeholder-engagement-plan-sep-uganda-covid-19-response

appropriate methods, (iii) accessibility to those who might be illiterate or be limited by certain disabilities. More specifically in the context of Uganda, the SEP has provisions to equally target members of Vulnerable and Marginalized Groups (Batwas, Benet and Iks, female headed households, refugees, children among others) and making the GRM culturally appropriate and accessible to these groups, taking into account their customary dispute settlement mechanism.

In addition, project activities meant to provide stakeholders with resources (toll free numbers for reporting, seeking psychosocial support, etc.) on how to deal with trauma from potential instances of GBV/SEA and VAC that can result from the government-imposed measures to contain the spread of the virus (lockdown, quarantine, curfew, etc.), and burnout for health providers will be rolled out through the implementation of the SEP. The approaches indicated in the SEP will ensure that information is meaningful, timely, and accessible to all affected stakeholders and sensitive to cultural differences, as well as challenges deriving from illiteracy or disabilities, to the extent feasible given advised constraints on in-person contact. Due to the expected country-wide implementation of activities, the differences across geographic areas and socioeconomic groups will equally be taken into consideration during rollout of the communications strategy, as well as tailored messaging to mitigate GBV and SEA. The disclosed SEP highlights the importance of systematic management of information flows for patients under managed care in quarantine and isolation centers, as well as to patients' relatives to get necessary information about the quarantined. It also highlights need for effective communication and information accessibility especially in relation to vaccines. It also includes basics on resources and responsible personnel to ensure its implementation as well as guidelines for monitoring and reporting along with a more elaborate Grievance Redress Mechanism for addressing any concerns and grievances raised in relation to the project, during implementation.

3.4.2 World Bank Environmental, Health and Safety (EHS) Guidelines and WHO Guidelines for the COVID-19 Waste Management

The World Bank EHS Guidelines contain the performance levels and measures that are generally considered to be achievable. The applicability of the EHS Guidelines is tailored to the hazards and risks established for the project on the basis of the results of the environmental and social assessment. The World Bank has several guidelines which are applicable to various components of the project detailed in **Annex 12,** and these include the environmental, health and safety (EHS) guidelines on: "Air emissions and ambient air quality"; "Waste management"; Industry Specific for "Healthcare facilities" and Vaccination Centers*;* "Hazardous materials management"*;* and "Construction and decommissioning".

4 Environmental and Social Baseline Conditions

This chapter provides general information of environmental and social baseline conditions relevant to the project. Considering that the project is nation-wide in geographical scope, the baseline is discussed at a national level. Discussion of baseline conditions in this section is limited to four thematic categories which specifically influence or support efforts to control the spread of COVID-19, and these are:

a) **Transport infrastructure**: This influences access to places or patients with COVID-19 emergencies including vaccine transport and delivery different vaccinating centres or facilities.
b) **Healthcare services and facilities**: Absence or lack of healthcare facilities determines efficiency of COVID-19 emergency response activities.
c) **Social and economic conditions**: Population, water and sanitation, health, ICT, literacy, economy, incomes and poverty levels, disease prevalence, food and nutrition, community geniality and gender considerations all can influence success of COVID-19 control. For instance, information dissemination campaigns are more effective in literate communities. High poverty levels correlate with prevalence of underlying diseases which are now known to significantly influence recovery and mortality rates among COVID-19 patients.

Supporting infrastructural services: COVID-19 emergency activities will use resources and generate waste. As WHO guides (see Section 3.5 above), sanitation and proper management of healthcare waste from COVID-19 is essential for occupational and public health. Hence this section also provides information about presence of waste management facilities such as third-party sanitary landfills, incinerators, or wastewater treatment plants that are available to support the project.

4.1 Transport infrastructure in Uganda

In Uganda, existing transport services include road, air, railway and water. Their historical perspective and current state are discussed in sections below.

a) Roads

In 1986, the total national road network was 7,900 km and of the 1,900 km that had been tarmacked, only 114 Km was in fair condition. The remaining 1,786 km was in a poor state. In 2019, Uganda's total road network is 129,469 km long. Of this, community access roads constitute 50%, district roads 26%, urban roads 7% and national roads 17%. The improved road network has attracted more vehicles on roads increasing volume of goods and passengers moving across the country in a fairly shorter time than in the past. Today there are slightly over one million vehicles in Uganda up from 50,102 vehicles that plied Ugandan roads in 1999. The paved trunk road network has improved tremendously and people can move from one border to another on a paved road across the country. Considerable investment is also being made to improve districts and communities' road networks. Uganda's transit modes of transport are mainly: buses and mini-buses; privately owned cars, cargo vehicles, commuter motorcycles *(Boda-Boda*) and bicycles in rural areas.

b) Water transport

In 1986, Uganda had only two train ferries and for a country with more than 50 waterbodies, including lakes Victoria, Kyoga, Albert, Edward, George and the mighty River Nile, this exemplified a serious infrastructure shortfall. Today, 12 ferries ply watercourses in various parts of the country easing communication and trade. The ferry services across the country are offered at no cost to the public. Some water routes are served by wagon ferries while others are served by road bridge vehicle ferries. The wagon ferry routes are Port Bell - Mwanza and Port Bell-Kisumu which also connect to the rail network. There are seven bridge vehicles ferries including three on Lake Victoria, two on Victoria Nile, one on Lake Albert and one on Albert Nile.

4.2 Healthcare Services and Facilities

Under the NDP III HCDP, the health sector contributes directly to 6 key result areas (KRAs) with a total of 31 indicators. The sector achieved targets for 12 (38.7%) indicators, made some progress in 4 (12.9%) and equally did not achieve 6 (19.3%) of the targets. The sector was not able to assess 9 (29.3%) of the indicators due to lack of data. According to the HMIS reports, public facilities deliver about 75% of the services, PNFP facilities 20% and PHP facilities about 5% of the services. The total Standard Unit of Outputs (SUO) for the General Hospitals increased minimally by only 0.9% to 20,623,516 from 20,441,585 the previous FY. There was notable increase in total immunizations by 28.4% and major surgeries by 18.6% compared to the previous FY. Postnatal care attendances reduced by 30.5% and this may have negative effect on the neonatal outcomes. The total SUO for HC IVs increased to 17,340,414 in FY 2020/21 from 15,264,466 the previous year. There was marked increase in the number of total ANC attendances and immunizations. The SUO from the different HC IVs ranged from 229,337 at Kawaala HC IV to 676 in Hope HC IV, whereas the average for all reporting HC IVs was 70,166.[24]

According to the Annual Health Sector Performance Report, 2020/2021, there was an improvement in maternal deaths that are reviewed from 66% in 2019/20 to 75%; deliveries in health facilities increased from 59% to 62.4%; approved posts filled increased from 68% to 74% and ANC4 coverage increased from 42% to 48.2%; while pentavalent vaccine vaccination coverage remained stagnant at 87%. Given the challenges brought about by the Covid 19 pandemic and its control measures the LGs did a commendable job in ensuring that other health services continued to be delivered. By ranking 37% (50/136) of the districts scored above the national average of 64.4%.Clearly the health sector in Uganda faces challenges which need support to ensure effective delivery of COVID-19 emergency services including vaccines administration. It should also be noted, that Uganda currently has only 280 ICU beds that can currently be used for managing severe COVID-19 cases. There are only about 280 ventilators currently available in the country for use in COVID-19 emergencies and mostly in Regional Referral Hospitals. Key attributes of Uganda's health sector are outlined in sections below.

a) Service coverage

Environmental, health and safety performance at Uganda's government hospitals is generally satisfactory especially after almost all of them underwent extensive renovation since 2010 under *Uganda Health Systems Strengthening Project*, a USD 130 million project funded by International Development Association (IDA)[25]. Consequently, they have satisfactory indoor air quality, potable water supply and OHS of medical workers. However, wastewater management, solid waste management and healthcare waste management are still major challenges at many general hospitals and health centers for example many of health centre three (HC III) do not have or have a malfunctioned incinerator.

Table 6: HIV Status in Uganda

Adults and children living with HIV	**1 400 000 [1 300 000 - 1 600 000]**
Adults aged 15 and over living with HIV	1 300 000 [1 200 000 - 1 500 000]
Women aged 15 and over living with HIV	820 000 [760 000 - 910 000]
Men aged 15 and over living with HIV	490 000 [460 000 - 550 000]
Children aged 0 to 14 living with HIV	98 000 [88 000 - 110 000]
Adults and children newly infected with HIV	**38 000 [31 000 - 48 000]**
Adults aged 15 and over newly infected with HIV	33 000 [26 000 - 42 000]

[24] Annual Health Sector Performance Report 2020/2021

[25] https://www.health.go.ug/projects/completed-projects/uganda-health-system-strengthening-project-uhssp/

Women aged 15 and over newly infected with HIV	21 000 [17 000 - 28 000]
Men aged 15 and over newly infected with HIV	11 000 [8900 - 16 000]
Children aged 0 to 14 newly infected with HIV	5300 [4300 - 8100]
HIV testing and treatment cascade	
People living with HIV	**1 400 000 [1 300 000 - 1 600 000]**
People living with HIV who know their status	**1 300 000**
Percent of people living with HIV who know their status	91 [86 - >98]
People living with HIV who are on ART	**1 300 000**
Percent of people living with HIV who are on ART	90 [85 - >98]
People living with HIV who have suppressed viral loads	**1 200 000**
Percent of people living with HIV who have suppressed viral loads	82 [76 - 90]
Antiretroviral therapy (ART)	
Coverage of adults and children receiving ART (%)	**90 [85 - >98]**
Adults aged 15 and over receiving ART	93 [87 - >98]
Women aged 15 and over receiving ART	96 [89 - >98]
Men aged 15 and over receiving ART	86 [81 - 95]
Children aged 0 to 14 receiving ART	63 [56 - 71]
Number of adults and children receiving ART (#)	**1 279 427**
Adults aged 15 and over receiving ART	1 217 677
Women aged 15 and over receiving ART	791 717
Men aged 15 and over receiving ART	425 960
Children aged 0 to 14 receiving ART	61 750
Elimination of mother-to-child transmission	
Coverage of pregnant women who receive ARV for PMTCT (%)	**>98 [80 - >98]**
Pregnant women who received ARV for PMTCT (#)	90 941
Pregnant women needing ARV for PMTCT (#)	91 000 [73 000 - 100 000]
Early infant diagnosis (%)	**66 [59 - 82]**
Final vertical transmission rate including during breastfeeding	**5.85 [4.94 - 7.81]**
New HIV infections averted due to PMTCT (%)	**19 000 [16 000 - 30 000]**
Number of HIV-exposed children who are uninfected	1 100 000 [900 000 - 1 200 000]
HIV prevalence (%)	31.3
HIV testing and status awareness (%)	88
Antiretroviral therapy coverage (%)	65
Condom use (%)	69.4
Active syphilis (%)	6.3
Population size estimate (#)	24 100
HIV prevalence (%)	13.2
HIV testing and status awareness (%)	54
Antiretroviral therapy coverage (%)	66
Condom use (%)	39
Active syphilis (%)	2.8
Population size estimate (#)	7400
HIV prevalence (%)	17

HIV testing and status awareness (%)	45
Antiretroviral therapy coverage (%)	78
Condom use (%)	4
Coverage of HIV prevention programmes (%)	8
Population size estimate (#)	151 000
HIV prevalence (%)	4
Antiretroviral therapy coverage (%)	89.1
HIV prevention programmes in prisons: condoms distributed (#)	85 178
Prevalence of hepatitis C infection among prisoners (%)	7
HIV testing and status awareness (%)	100
Antiretroviral therapy coverage (%)	13
People receiving pre-exposure prophylaxis (PrEP) (#)	58 428
Condom use at last high-risk sex among adults aged 15 to 49 (%)	50.7
- Condom use at last high-risk sex among women aged 15 to 49 (%)	38.3
- Condom use at last high-risk sex among men aged 15 to 49 (%)	62.4

Source: https://www.unaids.org/en/regionscountries/countries/uganda

The Annual Health Sector Performance Report 2020/2021 provides detailed statistics on Access and Quality of Care, Medicines and Health Supplies, Quality of Care, Health Risks and Social Determinants, Health Financing, Health Human Resource, Health Infrastructure, Regional Referral & Large PNFP Hospital and General Hospital Performance, Health Centre IV Performance, Non-communicable diseases (NCD) in Uganda.[26]

4.3 COVID-19 Situation in Uganda

4.3.1 COVID-19 Cases

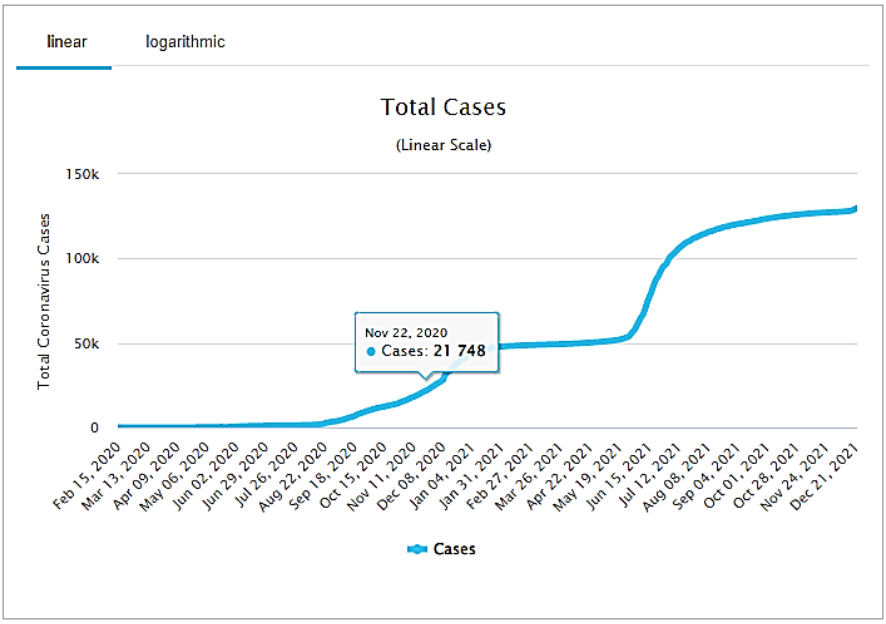
Uganda reported the first case of COVID-19 on March 20, 2020, signaling the beginning of the first wave of the epidemic. This was initially dominated by imported cases especially along the border districts and cargo truck routes from neighboring countries, but gradually transitioned to sustained community transmission. It was further compounded by the election process for national and sub-national leaders. As of December 21, 2021, Uganda had registered 129,676 cases, 3274 deaths, and 98,079 recoveries from all the 136 districts,27 translating into a case fatality rate of 2.5 percent. On 7th December 2021, the Ugandan Health Ministry announced the first cases (seven in total) of Omicron variant had been detected in the country.[28]

[26] http://library.health.go.ug/publications/performance-management/annual-health-sector-performance-report-financial-year-202021

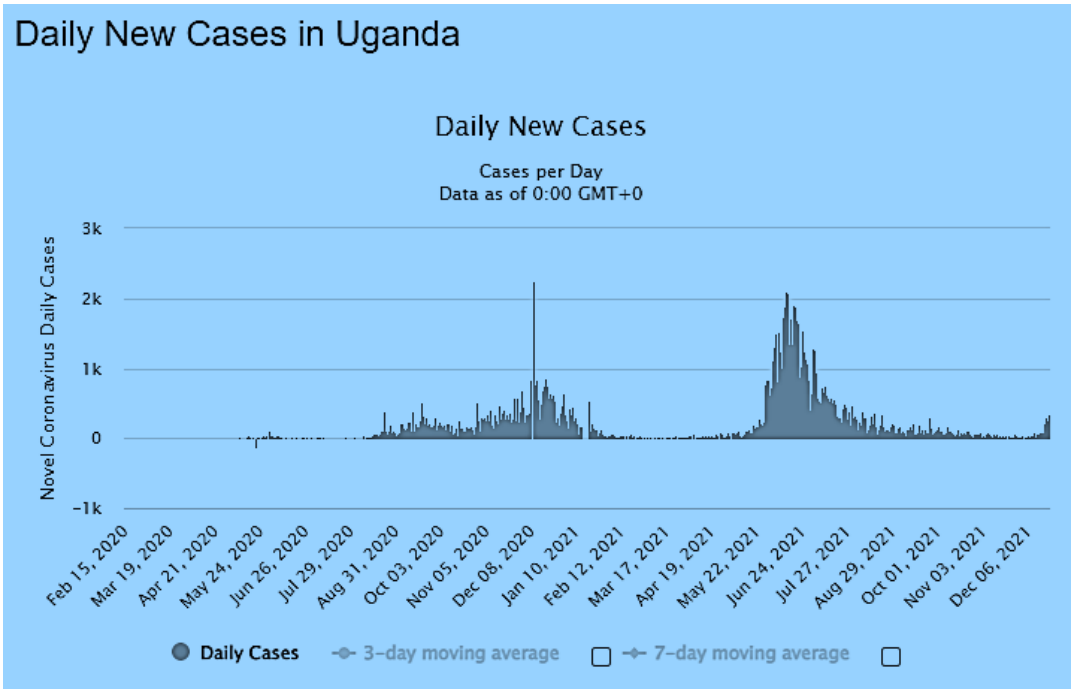
[27] WHO. COVID-19 Daily Situational Report Uganda 05 September 2021.

[28] "Uganda detects first Covid-19 Omicron variant cases". *The Citizen*. 7 December 2021. Retrieved 8 December 2021.

Total Coronavirus Cases in Uganda



Daily New Cases in Uganda

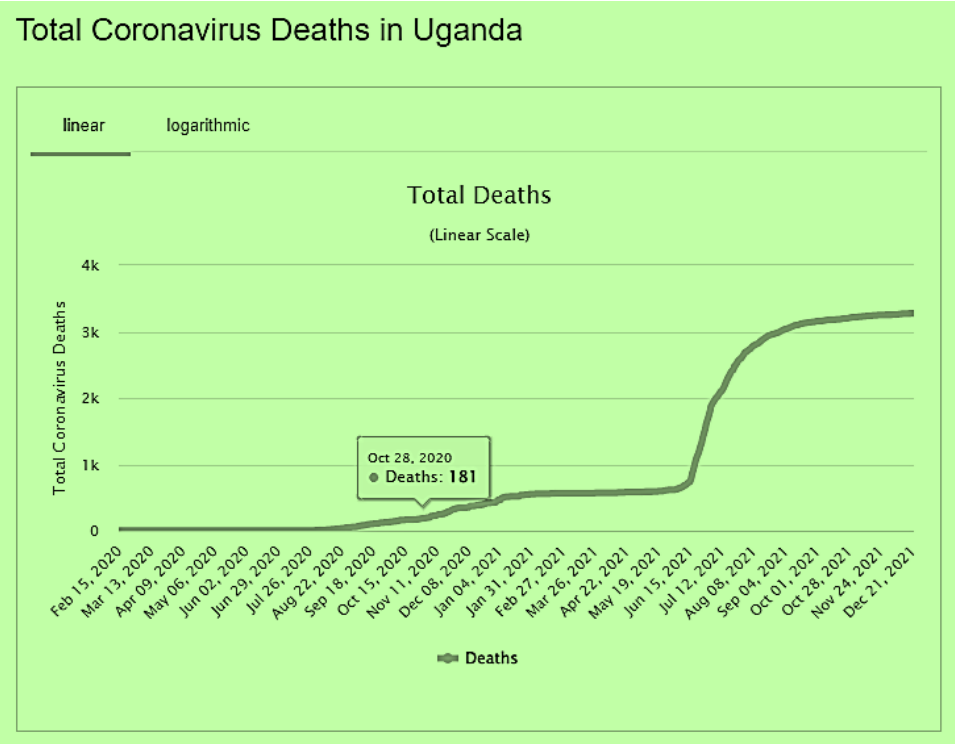


As of August 1st, 2021, the resurgence is attributed to:

- Poor adherence to non-pharmaceutical public health measures (social distancing, use of masks and hand hygiene);
- The opening up of economic activities (workplaces, schools, travel, etc.); and

- The emergence of SARS-COV2 variants of concern[29]

The second wave of the pandemic saw a bigger proportion of COVID-19 cases present in the moderate, severe, and critical categories. The case management pillar of the COVID-19 response continues to manage these at 18 designated treatment centers and 6 non-traditional isolation facilities which include all regional referral hospitals as well as at the Mulago National Referral Hospital. COVID-19 treatment units (CTUs) have also been set up at some general hospitals. The non-traditional treatment centers were set up at the national stadium— Namboole — and at 3 prison centers, a utility building camp and at a refugee settlement. Up to 1,600 health care staff have been trained in case management; 5 ambulances mobilized for emergency long distance evacuations, and more than 144 ICU beds set up and assorted equipment and supplies procured including PPE, medicines, ventilators, oxygen, patient beds, mattresses and other medical consumables. However, not all the ICUs are functional due to shortage of qualified critical care staff, and lack of connectivity to oxygen.



Due to the unprecedented high hospitalization and death rates and the health system rapidly getting over-strained, GoU re-introduced stringent measures to stem the epidemic. These included a partial lockdown on June 8, 2021 followed by a more stringent lockdown for 42 days beginning on June 18, 2021. The lockdown entailed in-country and out-country travel restrictions, closure of schools, prohibition of social gatherings and limitations in numbers aggregating for necessary functions like weddings and funerals, as well as closures of major business and trade centers in the Capital City, Kampala. As of July 31, when the lockdown was eased, the number of new cases per day had dropped from over 1,500 to about 250. Uganda is now easing from the second wave of the COVID-19 epidemic which has been more aggressive, with the cumulative number of cases and deaths reaching about 125,758 cases and 3,200 deaths, from all the 136 districts,[30] translating into a case fatality rate of 2.5 percent as of December 21, 2021 and about 98,079 recoveries COVID-19 testing, surveillance, and treatment capacity in the country remains inadequate. For example, since the outbreak in Uganda, only about 1.8 million tests have been conducted, translating to between 2,000-3,000 tests per day. There are only 25 designated referral hospitals (including private ones) to treat COVID-19 cases due to shortage of resources

[29] 5 variants including the Delta variant have been identified in the country

[30] WHO. COVID-19 Daily Situational Report Uganda 05 September 2021.

thus affecting access to care especially in rural areas. The low testing and treatment capacity is mainly attributed to inadequate staff numbers and skills mix for acute/intensive/emergency care; medicines and essential supplies such as test kits, PPEs, intensive care units, and oxygen. Funding for surveillance, coordination, risk communication and community engagement is also significantly inadequate. Strengthening sub national response capacity is key to enhancing surveillance, treatment and vaccination interventions.

4.3.2 Vaccine Acquisition and Deployment in Uganda

The country has so far received 31,392,940 doses out of which 27,982,540 doses are from donors while 3,410,400 have been procured by the government of Uganda. These include Johnson and Johnson and Sinopharm[31]. The doses that have been booked amount to 9,000,000 of Johnson and Johnson with 15% payment on order already covered. The balance of the 85% of the order made will be paid by the AF under the Project. 17,829,600 doses of Sinopharm vaccines booked and out of which only 2,060,400 doses have so far been paid for with only 1,224,000 has been delivered and the balance of 836,400 doses is expected. As of December 12, 7,880,584 people have been vaccinated translating into 17.8% of the total population to be vaccinated. As of 19 December 2021, a total of 9,763,030 vaccine doses have been administered[32]. As of December 14th, 11,827,257 doses were available in stock.

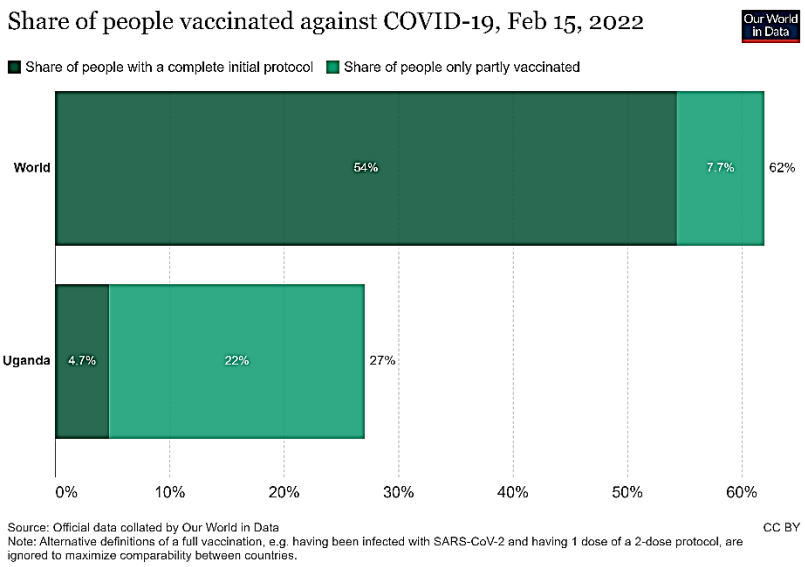
The vaccines received in November include 900,000 doses of AstraZeneca through the EU-dose sharing and the COVAX-dose sharing from France and Italy, 3.4 million doses of Pfizer from the USA, 1.9 million doses of Moderna from Canada, 100,000 doses of Johnson & Johnson from Belgium, and 600,000 doses of Sinovac from the Chinese government. In December, the Government of Uganda received 2.9 million doses of Pfizer through the COVAA, and 1.7 million doses of Sinopharm through government purchase.

In October 2021, the country had received a total of 8,891,410 doses of COVID-19 vaccines comprising of AstraZeneca, Moderna and Pfizer from the COVAX Facility, donations from the Governments of India, the United States of America, Norway, the United Kingdom, China, France and Ireland. The government had also made commitments to and purchased vaccines from the AVAT mechanism and COVAX.

Between March 2021 and October, Uganda received a total of 8.89 million doses of vaccines which include 657,600 doses of Johnson & Johnson, 346,800 doses of Sinopharm, 3.9 million doses of Astrazeneca, 647,080 doses of Moderna, 1.6 million doses of Pfizer, 1 million doses of Sinovac and another 589,400 doses of AstraZeneca.

[31] MFPED 14th December 2021

[32] Uganda: WHO Coronavirus Disease (COVID-19) Dashboard With Vaccination Data | WHO Coronavirus (COVID-19) Dashboard With Vaccination Data, 22nd December 2021



There have been 163,231 confirmed cases of COVID-19 with 3,585 deaths, reported to WHO. As of 20th February 2022, a total of 16,254,268 vaccine doses have been administered[33]. The total dozes given are 15 Million, with 2,219,214 (4.9%) of the total population fully vaccinated and 12,742,231 (27.9%) of the total population with at least one dose. The vaccine campaign thus far has prioritized five main high-risk groups: security personnel, health care workers, teachers, people above 50 years, and people with comorbidities. Of this group the highest uptake has been among the essential workers with coverage rates (fully vaccinated) of 97,072 (64.7 percent) for health care workers with 170,076 (113.4%) received the 1st dose, 73,470 (29.4%) for security personnel are fully vaccinated with 161,491 (64.6%) received one dose, and 201,241 (36.6%) for teachers are fully vaccinated with 4,22,769 (76.9%) received one dose.

The main bottlenecks for the vaccination program are financial and logistical and they include inadequate and irregular supply of vaccines; weak data collection and analysis on vaccine deployment statistics, gaps, challenges, and opportunities; poor reporting of adverse events following vaccination; limited staffing to deliver vaccines at scale and concurrently manage routine service delivery; and inadequate operational funds for vaccine delivery and the overall COVID-19 response. These bottlenecks are further discussed below:

Inadequate and irregular supply of vaccine doses. The low uptake of vaccines points to challenges in vaccine deployment, which has been adversely impacted by initial delays in vaccine delivery schedules, initial hesitancy (especially by high-risk groups such as teachers and health care workers), and low motivation/staff (vaccinators) morale, which is impacting the roll out of the vaccination campaign. Within the last month, though the GoU has made significant improvements in vaccinating essential workers with the first doses, notably health care workers (90 percent), teachers (66 percent) and security personnel (63.5 percent). In view of the overall low uptake of available vaccines, however, the country faces the risk of vaccine expiries, particularly of Pfizer and AstraZeneca doses. There remains a significant gap in risk communication to increase vaccine uptake in the elderly and people with comorbidities.

Post vaccination information management and adverse events surveillance weaknesses. Uganda relies on both paper-based and electronic information management tools to document and monitor the vaccination program, including adverse events following immunization (AEFIs). Transmission and analysis of information as well as reporting on AEFIs is low. These information management challenges are being addressed through the following actions: (i) use of SMS for transmission of summary information to the national District Health Information System (DHIS2), (ii) phone calls from the EPI to the districts, and (iii) provision of computers and tablets to districts and health facilities. Despite these actions, which are being supported by various parties including the National Information Technology Agency Uganda (NITA-U), uptake of electronic tools is still low, and this is compounded by low internet connectivity in some remote

[33] https://covid19.who.int/region/afro/country/ug, 28th February 2022

areas. There are ongoing discussions at the Bank to help strengthen data collection and use, through enhanced interventions supported by the pipeline AF to the Uganda COVID-19 Response and Emergency Preparedness Project.

AEFI monitoring is being addressed by ensuring that each client receiving COVID-19 vaccination remains at the site for at least 30 minutes for close observation and monitoring. Once discharged, they are encouraged to report any adverse or unusual event to the health facility mainly through telephone call or SMS or physical visit to the health facility. Cases of AEFIs are documented and transmitted to the MoH as part of the routine reports on the immunization activity. The reports reach the MoH through the DHIS2 e-tracker or phone call to the National Drug Authority (NDA), which enters the client and AEFIs particulars in a VIGIBASE database. Each serious AEFI case is investigated by a national investigation team with regional presence. A national causality assessment committee is in place to assess the potential causes of the AEFIs.

Inadequate operational funds for vaccine delivery and the overall COVID-19 response. Deployment of COVID-19 vaccines (AstraZeneca) has been affected by shortage of funding for operational activities including training and deployment of personnel, distribution of vaccines and supplies, provision of health information management tools, monitoring and adverse events, coordination, and risk communication and community engagement. The overall test-trace-treat response strategy has also been affected by lack of funding; most of the response pillars are operating sub optimally. The government is actively mobilizing funds from domestic resources and partners; as of July 6, Ministry of Finance Planning and Economic Development announced release of 206 billion UGX (approx. US$ 58.8 million) for the overall response and 218 billion UGX (approx.US$ 61.6 million) for procurement of COVID-19 vaccines, essential medicines and supplies. GAVI also committed US$11.4 million to support vaccine deployment and supplies.

4.3.3 Management and Oversight of the Pandemic Response

The COVID-19 response in Uganda follows WHO guidelines. There are several coordination and implementation structures in place with the President leading the fight through the National COVID-19 Task Force (NTF). The NTF brings together relevant ministries, departments, and agencies; private sector; civil society, and development partners. The World Bank, UN Agencies (WHO, UNICEF, UNDP), US Government Agencies (CDC, USAID), Global Fund, GAVI, and bilateral partners have been instrumental in supporting the national response through various structures that are linked to the NTF. This includes the Incidence Management Team that provides day-to-day technical oversight to the overall response. The national response is guided by the National COVID-19 Preparedness and Response Plan (July 2020 – June 2021), the COVID-19 Resurgence Plan (July 2021 – June 2022), and the National COVID-19 Vaccine Deployment Plan. These instruments focus on building capacity for prevention, testing, tracing/surveillance, treatment, and vaccination. To complement public health measures, several lockdowns have been instituted since the outbreak of the pandemic in Uganda in March 2020. The latest stringent lockdown of 42 days ended on July 31, 2021 and was partially uplifted with a view of follow up reviews to determine further actions.

4.3.4 Population and demographics

According to 2020 estimates, the population of Uganda is about 45.74 million[34]. The total area of Uganda is 241,038 square kilometers hence a population density of 183 individuals per square kilometer. While 84% of residents live in rural areas instead of the developing urban areas, the major cities still boast a large number of inhabitants. With over 80% of Ugandan citizens living in rural areas, there isn't much as far as large cities. The largest, by far is the capital, Kampala with a night population of 1,659,600. Table 7 below

[34] Source: https://worldpopulationreview.com/countries/uganda-population/ (Accessed 12 April 2020)

and Figure 6 show population densities in Uganda. The densities show where COVID-19 would easily spread quickly and impacts potentially severest.

Table 7: Population density in regions of Uganda

Region	Capital	Area (km2)	Population	Population density
Central	Kampala	40 579	11 184 500	275.62
Eastern	Jinja	31 809	10 512 200	330.48
Northern	Gulu	85 287	8 346 600	97.86
Western	Mbarara	51 345	10 264 700	199.92
Total		**209 020**	**40 308 000**	**192,84**

Uganda has a rich ethnic and cultural diversity, which includes most of its population speaking three major languages - Bantu, Nilotic and Central Sudanic. Furthermore, the number of ethnic groups present in Uganda is very large, making it one of the most ethnically diverse countries in the region. The main ethnic group is called the Baganda, which makes up 16.9% of the population, followed by the Banyankole, Basoga and Bakiga tribes, which make up 9.5%, 8.4% and 6.9% respectively. There are many other tribes; however, they constitute a very small percentage of the total population. Where aggressive sensitization and enforcement is weak to the rich cultural diversity could pose challenges for COVID-19 control activities with some cultures choosing to resort to traditional medicines and spiritual incantations to heal COVID-19 disease.

Uganda's life expectancy is 58.5 years (56.7 years for males and 60.5 years for females). Due to the high marriage rate in the country, the age structure is skewed towards the younger generations with 48.47% of the Uganda's population being in the 0-14-year-old age group. After that, 28.34% of the population of Uganda is in the 25-64-year age group. Lastly, 21.16% of the total population is dominated by the 15-24-year age group. Just 2.04% of the population is 65 or older. These statistics show that Uganda can boast about a large population that can be classified as a workforce, which could in turn help in its growth and economic stability. However, with a huge percentage of the population being so young (0-14 years old) and unemployed, it is clear that the pandemic hitting such a dependent population would have devastating socio-economic impacts.

Baseline Conditions of the VMGs/IPs: The Batwa, a historically marginalized community that was forcefully evicted from their ancestral lands in southwestern Uganda without prior informed consent and due compensation. After the evictions, which started as far back as the 1930s colonial Uganda, the ancestral lands of the Batwa were turned into the present-day Bwindi Impenetrable and Mgahinga Gorilla national park, and Echuya central forest reserve. Left landless after the evictions and f facing discrimination by dominant ethnic groups in southwestern Uganda, the Batwa live on the fringes of society[35]. The Benets, who number just over 8,500, live in the northeastern part of Uganda. The Batwa, who number about 6,700, live mainly in the southwest region. They were dispossessed of their ancestral land when the Bwindi and Mgahinga forests were declared national parks in 1991. The Ik number is approximately 13,939 and lives on the edge of the Karamoja / Turkana region along the border between Uganda and Kenya. The Karamojong live in the northeast and total about 988,429. The Basongoras, who number 15,897, are a livestock community that lives in the lowlands adjacent to Rwenzori Mountain in western Uganda.

In Uganda VMGs include: the poor, refugees, indigenous peoples, migrants, the elderly, and the disabled, and those with underlying medical conditions who would be most at risk in the event of a pandemic outbreak. The Project will focus specifically refugees and refugee host communities as well as the IP who

[35] Heath and education: Indigenous communities want action from the Government of Uganda ahead of upcoming UN review - Minority Rights Group, 2021

include the Batwa, Benets, Tepeths, and the Ik. None of the facilities envisaged to undergo remodeling are in Districts known to host members of VMGs i.e., the Batwa, IK, Benets, and Tepeth and therefore, these groups will not be impacted by the civil works. The project will however, put in place measures to ensure that they are targeted and receive benefits from the operation in an inclusive and culturally appropriate manner.

The Vulnerable and Marginalized Groups (VMGs)/ Indigenous peoples in Uganda include former hunter/gatherer communities, such as the Batwa, Benet, Tepeth and the Ik. The Batwa who live in south-western Uganda have an estimated population of 6700. These were dispossessed of their ancestral land when Bwindi and Mgahinga forests were gazzetted as national parks in 1991. The Ik number about 13939 and live on the edge of the Karamoja region along the Uganda-Kenya border[36].

The Benets, who number just over 8,500, live in the northeastern part of Uganda. The Batwa, who number about 6,700, live mainly in the southwest region. They were dispossessed of their ancestral land when the Bwindi and Mgahinga forests were declared national parks in 1991. The Ik number is approximately 13,939 and lives on the edge of the Karamoja / Turkana region along the border between Uganda and Kenya. The Karamojong live in the northeast and total about 988,429. The Basongoras, who number 15,897, are a livestock community that lives in the lowlands adjacent to Rwenzori Mountain in western Uganda.

All these communities have a common experience of state-induced landlessness and historical injustices caused by the creation of conservation areas in Uganda. They have experienced various human rights violations, including continued forced evictions and/or exclusions from ancestral lands without community consultation, consent or adequate (or any) compensation. Other violations include violence and destruction of homes and property, including livestock, denial of their means of subsistence and of their cultural and religious life through their exclusion from ancestral lands and natural resources. All these violations have resulted in their continued impoverishment, social and political exploitation and marginalization.

The safety of the Ik peoples is at risk in large part due to their different positions between two communities. Iks are often caught in the crossfire between the two communities, making them very vulnerable. In addition, their land tenure remains insecure because neighboring pastoralists and agro pastoralists invade their land. In addition, 70% of the land of Ik has been lost due to conservation initiatives. The Benet peoples have had a long-standing dispute with the authorities over their ancestral lands, which was declared a protected area in 1926 without their consent or compensation. In 2005, the Supreme Court ordered the government to return the protected lands to the community of Benet. However, the failure has not yet been implemented.

Minorities and indigenous communities have minimal access to socio-economic programmes due to their historical background and way of life. The schools available are universal primary free schools. These are often characterized by poor quality, in some cases lack of infrastructure, teachers and children of ethnic minority have to trek long distances to reach these schools. Although all communities in Uganda access available health services without discrimination, notably there is limited statistics on the levels of access and use of health services by ethnic minorities. Land as a natural resource is very important for incomes for majority rural populations. Most of the minority and indigenous peoples were evicted from their ancestral land with an aim of creating national parks. When emergencies occur, minorities and indigenous peoples are at risk of being excluded from life-saving humanitarian interventions. The current COVID-19 pandemic is no different and it is our moral obligation to ensure national responses leave no one behind.

Implication on the project:

[36] IWGIA – The Indigenous World – 2020

COVID-19 would spread more easily and faster in areas or districts with high population densities. It is therefore important to focus control information campaigns (handwashing, social distancing, vaccination etc.) in the Central, Eastern and Western areas of Uganda.

4.3.5 Water and sanitation

Handwashing is a key strategy in controlling COVID-19, which expresses the importance of availability of clean water and high levels of sanitation in the populace. Ministry of Water and Environment (MWE) developed a new set of Sector Performance Indicators (SPIs) in FY 2017/18 which replaced the golden and platinum indicators. The Sector Performance Report 2018 highlights the performance of some indicators by end of June 2018 as discussed below.

a) Access to Water

The government is committed to ensure universal access to an improved drinking water source. This has been done through several interventions including: construction of mini-solar powered water schemes countrywide, and large gravity flow schemes that cover several sub-counties. The Presidential Directive of *'one water source per village'* also addresses the same cause especially in the local governments. The percentage of population using an improved drinking water source was good in both rural and the urban areas (70% and 77% respectively). Access to safe water supply during the first four years of NDP II (2015/16 - 2018/19) in urban areas increased from 73% in 2016 to 81% in 2018/19. The NDP II target was to increase access to safe water supply in urban areas to 100%. The growth in rural water coverage has been much more abysmal during the period under review from 67% to 73%. The NDP II target was to increase access to safe water supply in rural areas to 79%. Development partners such as UNICEF and European Union support several healthcare facilities in Uganda to have access to water. For example, Palabek Gem Health Centre III in Lamwo District now has adequate clean and safe water from a recently (2019) constructed mini solar water supply system by UNICEF with European Union humanitarian assistance. Provision of clean and safe water in health facilities addresses several health risks that would deter patients from seeking health care, prevents infections and spread of diseases due to poor hygiene conditions, which would otherwise compromise the quality of health care provided.

Implication on the project:

Clearly, hand washing campaigns and resources aimed at controlling the spread of COVID-19 will be more critically important in districts will low (under 20%) water access such as Kaabong, Yumbe, Kotido, Nakapiripirit, Bugiri, Mubende, Kiruhura and Isingiro and most of which are Refugee host districts.

b) Basic Sanitation

Urban areas in Uganda still prevalently face poor sanitation conditions. A dismal 36.3% of the population used an improved sanitation facility, and only 26% of human excreta was safely managed. Open defecation was practiced by 8% rural population, and 12.6% of people in urban areas. In addition, the sector target for safely managed sanitation is low (50%). As of May 2019, at a nation al level, hand washing with soap and water was poor in rural areas (36.5%), urban areas (39.6%) and in schools (40%)[37].

Implication on the project:

With all other conditions favorable, it is expected that control of COVID-19 will be easier in districts with relatively high levels of sanitation.

[37] Source: BMAU (MOFPED) Briefing Paper (18/19) May 2019: Can Uganda achieve SDG 6 on Water and Sanitation? (Accessed 12 April 2020)

4.3.6 Information and communications technology (ICT)

ICT will be important in COVID-19 control campaigns in so far as it enables quick information dissemination among the populace, for instance via social media. With the statistics pointing at a national population of 44.5 million, the internet penetration stands at 19 million users, of which 2.5 million are active social media users. This implies that 42% of the population has access to the internet and 5.6% uses the access for *Facebook, Instagram, Twitter, WhatsApp* and *Telegram*[38] through which useful information about COVID-19 could be disseminated.

Implication on the project:

COVID-19 control information campaigns would benefit from the country's high internet penetration, phone usage and falling internet prices.

4.3.7 Literacy

Literacy rates in Uganda are rising, a trend in a great part, attributed to Universal Primary Education policy introduced in January 1997. Once literate, children grow into literate adults. Figure 8 below shows primary school enrolment in Uganda as of 2017 with the central, southwestern and eastern regions generally having greater enrollment levels compared to northern and northeastern regions.

Uganda's literacy levels (defined by people of age 15 and above being able to read and write) are as follows:

- Total population: 76.5%
- Male: 82.7%
- Female: 70.8% (2018)[39]

The ethnic minority and indigenous pastoralists are found in the remotest parts of the country. The schools available are universal primary free schools. These are often characterized by poor quality, in some cases lack of infrastructure, teachers and children of ethnic minority must trek long distances to reach these schools. For example, the Batwa who live at the peripheral of other communities walk long distances to access schools. The historical rampant poverty among minority and indigenous peoples emanating from lack of land limiting economic opportunities has negatively affected their education. Children of ethnic minorities like Batwa do not attend school regularly and experience high school dropout rates since they cannot afford the cost of education such as school uniform, scholastic materials among others[40]. The literacy rate for the Batwa is extremely low – in 2012, just 12 percent of Batwa surveyed in one Ugandan region could read and write (compared with over 75 percent of non-Batwa in the same area. Lack of income make it impossible for minority peoples to afford quality education majorly offered in private schools concentrated in urban areas and very expensive. Tuition fees for higher institutions like universities and colleges are considerably too high to be afforded by already poverty stricken Ik, Batwa and Benet parents. In such circumstances, majority of them do not complete education level hence becoming victims of child labor in search of a better life or resorting to early marriages for girls.

The current primary school curriculum is designed in such a way that the language of the majority community is taught at the detriment of the language spoken by minority hence depriving children of fully learning their mother tongues. This kind of forced assimilation is experienced, for example, by the Ik (language not written) in Kaabong district, and Basongora in Kasese district who taught Karimojong instead of Ik and Lukozo instead of Rusongora their mother tongues respectively.

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[38] Source: https://techjaja.com/2019-jumia-mobile-report/ (Accessed 12 April 2020)

[39] Source: https://www.cia.gov/library/publications/the-world-factbook/fields/370.html#UG (Accessed 12 April 2020)

[40] The Indigenous World 2020, 37th Edition, General Editor: Dwayne Mamo and The International Work Group for Indigenous Affairs (IWGIA), 2020.

Implication on the project:

Literacy is an important factor in the fight against COVID-19 pandemic. Myths and stereotypes (about COVID-19) will be easily rebutted when logical information or explanations are provided to a literate populace. A local community would for example have no reason to raze down a COVID-19 test center if they are fully knowledgeable that its activities cannot be a source of community health risk. A less literate community would on the other hand assume such a center would have the virus escape and engulf the entire community. In addition, measures and guidelines designed to control the disease would be better appreciated by literate communities.

4.3.8 Economy, Incomes and poverty levels

According to a National Household Survey Report published by UBOS Uganda's population was estimated at 40.9 million persons in 2019/20 indicating an increase of about 3.2 million persons from 37.7 million estimated from the 2016/17 survey. The sex ratio was estimated at 97 females per 100 males. The proportion of the population aged below 14 years constituted slightly less than half of the total population (44 %). The urban population increased by two percentage points from 25 percent in 2016/17 to 27 percent in 2019/20. The dependency ratio decreased between the two survey periods from 97 in 2016/17 to 92 in 2019/20. [41]

Looking ahead, real GDP is expected to grow by 5.5% in 2018 and accelerate to between 5% to 7% per year in the period 2018 to 2022. In spite of the projected recovery in economic growth, wealth levels measured by GDP per capita are likely to remain below the magic number of USD 1,026 required to attain middle income status by 2020. This means we will most likely not attain middle income status by our target date of 2020. Uganda's public debt burden as a percentage of GDP has risen by 12.7% in the last four years from 25.9% in financial year (FY) 2012/13 to 38.6% as at the end of FY 2016/17. This figure is expected to continue rising and is projected to peak at 42.6% in FY 2019/20 before declining to 28.4% by FY 2024/25.

Overall, 8.4 percent of the households moved out of poverty whereas 10.2 percent slipped into poverty. A large percentage (72.9%) of the households was never poor compared with the chronically poor (8.5%). In terms of rural urban divide, the proportion of the chronically poor was more in the rural areas compared to the urban areas (9.7% and 6.8% respectively). A higher percentage (85.0%) of households that were never poor was in urban areas compared with the 66.7 percent of rural areas. (UBOS 2020)[42]

Regional variation shows that the most chronically poor were in the Northern region (21.6%), followed by Eastern region (10.7%), Western (4.9%) and Central (0.5%). The largest proportion of the never poor population was in Central region (91.8%), followed by western region (81.1%), with Northern region at 48.1 percent. The most chronically poor were more likely to be those with no formal education (21.3%), or those with some primary education (9.8%). There was no difference in chronic poverty between female headed and male headed households with male headed household slightly better off. The percentage of adults in chronic poverty was marginally higher than that of youths (8.5% and 7.5% respectively). By occupation, we see that only five in every ten persons in clerical occupation are likely to be never poor compared with nine in ten among the category of professionals.

While the proportion of people defined as 'poor' has fallen, the proportion of people who live above the poverty line but remain vulnerable to falling below it has increased. People who are not poor but are vulnerable to poverty are most likely to fall below the poverty line due to negative shocks, such as the effects of Covid-19. This gutted the largely informal economy, and the Ministry of Finance's growth projections for 2020 were reduced from 6% to 4%. The government of Uganda estimates that poverty

[41] https://www.ubos.org/wp-content/uploads/publications/09_2021Uganda-National-Survey-Report-2019-2020.pdf
[42] 11_2020 STATISTICAL__ABSTRACT_2020.pdf (ubos.org)

numbers, according to the national poverty line, could increase by 2.6 million people. The socioeconomic impact of Covid-19 in Uganda Report provides additional details on the effects of Covid-19 on poverty. Although northern and western regions have seen a decrease in the share of population in poverty since the 1990s, the eastern region has recorded an increase in poverty (from 24.3% in 1999/2000 to 35.7% in 2016/17), overtaking the northern region as the poorest. Similarly, poverty rates in the central region increased from 10.7% in 1999/2000 to 12.7% in 2016/17.[43] The data shows that most of Uganda's poverty remains concentrated in northern and eastern parts of the country. While the poverty rates in central and western regions have historically been lower than that of eastern and northern Uganda, these two regions have recently recorded increases in poverty.

Regarding manufacture and availability of supplies required for COVID-19 control, Uganda currently has 13 factories involved in the production of soaps (solid and liquid) and detergents[44]. These businesses are mostly located in central and eastern Uganda but have well established distribution channels all over the country. Uganda had only two companies producing alcohol-based hand sanitizers but in March 2020 following the COVID-19 outbreak, Government introduced tax incentives which saw over 48 companies registering to produce sanitizers[45]. Ugandan spirits (alcohol) manufacturers also agreed to convert 7.3 million litres of ethanol into hand sanitizers to fight the spread of COVID-19 in the country. Therefore, Uganda has no shortage of soap or alcohol-based hand sanitizers.

Implication on the project:
Poor and marginalized people are likely to be hit hardest by COVID-19 because they live in communities without easy and affordable access to healthcare, with low-income and crowded living conditions that lack basic opportunities for health and wellness. Poor people are more likely to have low-paying jobs (e.g. taxi drivers, market vendors, etc.) that do not allow remote "work-at-home" options or offer health insurance. In addition, poor and marginalized already bear the brunt of other diseases such as tuberculosis, respiratory infections, certain kinds of cancers and cardiovascular disease. Such chronic conditions often result in compromised immunity, making individuals more vulnerable to infectious diseases. Underlying diseases have a strong influence on survival of COVID-19 patients.
As seen above, the nature of occupations women are involved in make it hard for them to work at home yet are still expected to earn a living to support their homes and indisposed patients in their homes. This gender impact of COVID-19 is discussed further in Gender Section (Section 4.3.11) of this ESMF.
Regarding availability of supplies required for COVID-19 control, Uganda currently has no shortage of soap or alcohol-based hand sanitizers.

4.3.9 Disease Prevalence

Uganda's disease burden is dominated by communicable diseases which account for over 50% of morbidity and mortality. Malaria, HIV/AIDS, TB, respiratory infections, diarrheal, epidemic-prone and vaccine-preventable diseases are the leading causes of illness and death. There is also a growing burden of non-communicable diseases (NCDs) including mental health disorders[46]. Furthermore, there are wide disparities in health status across the country, closely linked to underlying socio-economic, gender and geographical disparities. The disease burden is fueled by major challenges such as lack of resources to recruit, deploy, motivate and retain human resources for health, particularly in remote localities; ensuring quality of the health care services delivered; ensuring reliability of health information in terms of the quality, timeliness and completeness of data; and reducing stock-out of essential/tracer medicines and medical supplies. The emergence of antimicrobial resistance due to the rampant inappropriate use of medicines, irrational

[43] Poverty in Uganda: National and regional data and trends - Development Initiatives (devinit.org)
[44] Source: https://www.yellow.ug/category/soap (Accessed 14 April 2020)
[45] Source: https://www.monitor.co.ug/News/National/Government-manufacturers-ethanol-hand-sanitizers-Covid-19/688334-5501390-r8lgrb/index.html (Accessed 14 April 2020)
[46] WHO 2018: Uganda Country Cooperation Strategy at a Glance

prescription practices and inadequate control of substandard, spurious, falsely labeled, counterfeit medicines are also key problems in Uganda's health sector.

Among adults aged 15 to 64, the prevalence of HIV varies geographically across Uganda, ranging from 3.1% in West Nile to 8.0% in Central region[47].

Implication on the project:
The Presence of underlying diseases (especially TB, HIV/AIDS, diabetes and cardiovascular ailments) in COVID patients has a strong influence on their recovery or mortality rates.

4.3.10 Food and Nutrition

The Ugandan diet is mainly composed of plantain, starchy roots (cassava, sweet potatoes) and cereals (maize, millet, sorghum). Pulses, nuts and green leafy vegetables complement the diet. In urban areas, which are undergoing a nutrition transition, food consumption patterns are changing, and rice is gaining importance. Overall, the diet remains poor in micronutrient-rich foods. Food insecurity persists in some parts of the country, mainly due to poverty, adverse climatic conditions and low agricultural productivity. Fruits and vegetables are an important source of vitamins, vital minerals and dietary fiber which has been associated with lower incidence of obesity. Despite the importance of consuming fruits and vegetables to human health. The dominant fruit and vegetables are pineapples, passion fruits, tomatoes, onions, and cabbages. Vegetables and fruit are less frequently consumed. Unlike in refugee camps where frequency of consumption of fruit is very low, among the VMGs such as the Batwa, IK and Benet consumption is higher due to their dependency on forest fruits and vegetables. Low intake of fruit and vegetables rich in vitamin A (dark green leaves - such as those of amaranth and spinach -, mangoes, papayas, etc.) is also a contributor to night blindness. In Uganda, the low availability of fruits and vegetables could be attributed to the limited knowledge about their nutritional value and the emphasis of cultivating commercial agricultural products such as roots/ tubers and cereals from which farmers earn income.

These factors combine in Karamoja where food insecurity remains widespread. The country's diet generally meets the population's energy needs, but the share of lipids and that of protein are lower than daily recommended limits. Undernourishment is estimated to affect about 15% of the population[48]. Generally, the northern, eastern and northeastern regions of Uganda commonly suffer food poverty than any other areas in Uganda. According to Uganda food security outlook update (FEWS NET, 2019), food security has deteriorated in bimodal eastern Uganda, resulting in "Stressed" (IPC Phase 2) classification in much of Eastern region and parts of Northern region.

Through the Uganda Multisectoral Food Security and Nutrition Project the World Bank is supporting Uganda to increase production and consumption of micronutrient-rich foods and utilization of community-based nutrition services in smallholder households in project areas. The intervention is aimed at enhancing households with minimum dietary diversity; women participating in community-based nutrition activities in project areas and households reporting year-round production of at least three micronutrient rich crops in project areas.[49] The delivery of multi-sectoral nutrition services at community levels as per the approved Project Implementation Manual (PIM); demonstration and adoption of agricultural good practices; and utilization of community-based health and WASH services at project sites also as avenues to manage impacts of COVID-19 on food and nutrition.

[47] Source: The Uganda Population-Based HIV Impact Assessment (UPHIA), a household-based national survey 2017.
[48] Source: http://www.fao.org/ag/agn/nutrition/uga_en.stm
[49] World Bank Document; documents1.
worldbank.org/curated/en/099655012132181751/pdf/Disclosable0Ve0286000Sequence0No014.pdf

Implication on the project: *While there is currently no expert evidence that any food or dietary pattern can 'boost' immunity against COVID-19, several nutrients (copper, iron, selenium, zinc and vitamins: A, B6, B12, C and D) boost the human immune system. Therefore, communities with low food poverty and can have access to a healthy balanced diet rich in fruits and vegetables which avails these nutrients will be better off in event of a COVID-19 outbreak.*
Good nutrition is intricately linked to immunity and to the risk and severity of infections. Poorly nourished individuals are at a greater risk of various bacterial, viral, and other infections. Consuming good quality diets is always desirable, and this is particularly important during the COVID-19 pandemic. A healthy diet emphasizes fruits, vegetables, whole grains, legumes, and nuts, moderate consumption of fish, dairy foods, and poultry, and limited intake of red and processed meat, refined carbohydrates and sugar. Such a diet will provide appropriate amounts of healthy macronutrients and essential minerals and vitamins. Adequate amounts of minerals and vitamins provided by a healthy diet helps to ensure sufficient numbers of immune cells and antibodies, which are important as the body mounts a response to infections[50].

4.3.11 Community geniality and gender equality

Community geniality and gender (equality, violence) considerations are important lessons for Uganda. In Abidjan, Ivory Coast residents violently destroyed a COVID-19 testing center in their area fearing it would be a source of infection[51]. Sexual and other forms of violence against women have devastating impacts such as physical, mental, sexual, reproductive health problems including sexually transmitted infections (HIV/AIDS) and unplanned pregnancies. However, restrictions on people movement as a COVID-19 pandemic control measure will make it difficult for sexual or gender-based violence victims to report abuse or quickly get medical help. With limited and commonly shared spaces (kitchens, bathrooms, living rooms) in COVID-19 Quarantine Centres, it should be important to institute measures to prevent SH and GBV in these facilities. Implications of COVID-19 outbreak for women and girls might include increased caregiving and household roles such as tending to sick family members which can limit women and girls' access to services, including critical health services. Inadequate living conditions (especially in vulnerable female-headed households) might increase risk of infection in absence of adequate space for observance of the 2-meter social distance.

Gender equality (also known as sexual equality or equality of sexes) is the state of equal ease of access to resources and opportunities regardless of gender, including economic participation and decision-making; and the state of valuing different behaviors, aspirations and needs equally, regardless of gender. Community geniality refers to level of friendliness of people in a given community. These aspects are discussed below.

a) Gender equality

In spite of decades of women empowerment, it is true that gender disparities continued to persist in Uganda[52]. Sexual and Gender Based Violence (SGBV) in Uganda is high with 60 percent of women recorded to have experienced violence compared to 53% of men.

According to 2018 Annual Crime report, fatalities at a national level through Domestic Violence reported to police in 2018 were 362 compared to 361 cases in 2017, an increase of 0.3%. The highest number of death by domestic violence were in Amuru with 16 cases, Oyam with 14 cases, Arua with 12 cases, Kole and Agago registered 11 cases each. Districts of Mbarara, Gulu and Ntungamo registered 10 cases each.

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[50] Source: https://www.hsph.harvard.edu/nutritionsource/2020/04/01/ask-the-expert-the-role-of-diet-and-nutritional-supplements-during-covid-19/ (Accessed 13 April 2020)
[51] Source: https://www.africanews.com/2020/04/07/photos-ivory-coast-protesters-destroy-coronavirus-facility-in-abidjan// (accessed 12April2020)
[52] Source: https://uganda.unfpa.org/en/topics/gender-equality-4 (Accessed 13 April 2020)

b) Community geniality and violence

Community violence will generally be high in localities with:

- Low access to social services,
- Low literacy rates,
- Low employment opportunities,
- Low-income peri-urban and slum areas.

Communities in these areas are more likely to take the law in their own hands and incidents of mob-justice are common. According to 2018 Annual Crime report, Uganda registered a total of 636 cases of death by mob action in 2018 compared to 603 cases in 2017, an increase by 5.5%. Murders by mob action are mainly a result of thefts, robbery, dissatisfaction with judicial system, murders, witchcraft and burglary among others.

Most of mob-action killings took place in the Districts of:

- Arua with 19 cases, followed by,
- Mbarara with 18 cases
- Luweero with 17 cases,
- Mayuge had 15 cases,
- Mukono, Nakaseke, Lira, Kiryandongo and Kiboga registered 11 cases each.

At a district level, the Annual Crime Report 2018 indicates that Mbarara continues to register high number of Homicide cases since 2011 followed by Arua. In fact the 2017 national crime report named the five *most dangerous districts* that continue to register highest crimes over the years as Lira, Ntungamo, Mbarara, Mbale and, Gulu[53].

c) Refugee situation in Uganda

Lastly, issue of refugees is a critical social consideration in controlling COVID-19 outbreak in Uganda. Space limitation in refugee camps can lead to rapid spread of the virus in a large confined settlement. Hand-washing is one of the key strategies in the fight against COVID-19 yet access to water, soap and sanitizers are known challenges in refugee camps. Also since there is a limited vaccines and majority of the citizens are yet to be vaccinated, by including refugees in the vaccination programmes would be bring some social issues and in relation to discrimination.

Uganda hosts the largest number of refugees in Africa. Their number has more than doubled since 2015 to over 1.5 million with South Sudanese making up the largest nationality (924,835 people), followed by those from the Democratic Republic of the Congo (433,062) and Burundi (51,039).[54] A further 90,629 refugees come from Eritrea, Ethiopia, Rwanda, Somalia, Sudan and 23 other countries. Ninety-four percent of the refugees live in settlements across 12 RHDs with a population of 4,437,500 people (excluding Kampala), while the remainder live among mainly urban communities.
Continuous instability in Eastern DRC, fueled by armed conflict and ethnic tensions, prevents refugees from returning. The Congolese refugee population consists of comparatively large numbers of survivors of trauma and violence, including SGBV, unaccompanied or separated children, single parents, and persons with medical needs.

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[53] Source: https://trumpetnews.co.ug/lira-mbarara-ranked-as-most-dangerous-districts-in-uganda/ (Accessed 12 April 2020)
[54] Office of the Prime Minister/UNHCR. 2021. Uganda Comprehensive Refugee Response Portal. https://data2.unhcr.org/en/country/uga.

The protracted nature of the civil war in South Sudan has heavily impacted on the most vulnerable groups. The vast majority of South Sudanese (SSD) refugees have arrived from 2016 onwards. Many refugees are survivors or witnesses of serious human rights violations, including SGBV. Many have been displaced over the course of the conflict and have experienced the breakdown of traditional social structures and sources of livelihoods as a result. UNHCR has identified high numbers of separated and unaccompanied children, single parents, women at risk and persons with medical conditions amongst the SSD refugee community in Uganda.

All aforesaid refugees have vulnerabilities and protection needs. Refugees of all nationalities in all locations are identified for resettlement based on vulnerabilities and protection needs. A high number of refugees have experienced severe trauma including SGBV and torture. Refugees with acute protection concerns include women and girls at risk of abuse and exploitation, children at risk and other vulnerable or marginalized individuals or groups. UNHCR Uganda has also identified refugees with serious medical needs which cannot be addressed in Uganda.

The project will, as case-by-case basis assessment requires, institute measures to ensure that services are provided to all patients regardless of their personal status.

Implication on the project:
Community geniality and gender (equality, violence) considerations are important lessons for Uganda. In Abidjan, Ivory Coast residents violently destroyed a COVID-19 testing center in their area fearing it would be a source of infection[55]. Sexual and other forms of violence against women have devastating impacts such as physical, mental, sexual, reproductive health problems including sexually transmitted infections (HIV/AIDS) and unplanned pregnancies. However, restrictions on people movement as a COVID-19 pandemic control measure will make it difficult for sexual or gender-based violence victims to report abuse or quickly get medical help. With limited and commonly shared spaces (kitchens, bathrooms, living rooms) in COVID-19 Quarantine Centres, it should be important to institute measures to prevent sexual harassment and gender-based violence in these facilities. Implications of COVID-19 outbreak for women and girls might include increased caregiving and household roles such as tending to sick family members which can limit women and girls' access to services, including critical health services. Inadequate living conditions (especially in vulnerable female-headed households) might increase risk of infection in absence of adequate space for observance of the 2-meter social distance.

Lastly, issue of refugees is a critical social consideration in controlling COVID-19 outbreak in Uganda. Space limitation in refugee camps can lead to rapid spread of the virus in a large confined settlement. Hand-washing is one of the key strategies in the fight against COVID-19 yet access to water, soap and sanitizers are known challenges in refugee camps. Figure 12 below shows that the largest concentration of refugees is found in Northwestern Uganda, which is also a region with a high economic and water poverty levels.

4.4 Supporting infrastructural services

Most hospitals in Uganda have rudimentary medical waste treatment and disposal facilities such as masonry incinerators, waste pits and sewage lagoons. Therefore, management of healthcare waste is prevalently still a big challenge with waste commonly dumped without treatment (Lawrence Muhwezi L et al., 2014).

A key shortcoming of masonry incinerators commonly used at medical facilities in Uganda is they simply convert solid infectious waste into objectionable air emissions since they lack air scrubbing provision for *acid gases* (e.g. oxides of Sulphur, nitrogen oxides). Combustion in masonry incinerators is commonly at lower temperatures than necessary to destroy *dioxins* which are potent cancer-causing agents (carcinogens). Dioxins will only be destroyed in a high-temperature zone above 850 °C (1,560 °F). Therefore, only modern incinerators operating at 850–1100°C and fitted with gas-cleaning units are able to comply with

[55] Source: https://www.africanews.com/2020/04/07/photos-ivory-coast-protesters-destroy-coronavirus-facility-in-abidjan// (Accessed 12 April 2020)

international emission standards for dioxins. However, alternatives to incineration are now available, such as autoclaving, microwaving and chemical treatment[56].

According to National Environment Management Authority (NEMA)'s Corporate Report (2017/18)[57], about 99% of government and private hospitals did not have facilities to safely manage healthcare waste (HCW) while 85% used rudimentary methods such as open air burning and disposal of partially burnt waste at open dumps. The report indicated that waste from medical facilities was becoming increasingly a major public risk because of limited infrastructure for its safe management. The report was prepared after NEMA officials and its technical committee on licensing of pollution undertook inspections of hospitals around the country including: Masaka Referral Hospital, Kitovu Hospital, Mbarara Regional Referral Hospital, Itojo Hospital, Kawolo General Hospital, Jinja Regional Referral Hospital, Iganga General Hospital, Kiryandongo General Hospital, Gulu Independent Hospital, Holy Innocent Children's Hospital and Pentecostal Assemblies of God Hospital in Lira District. The inspection team noted limited infrastructure for storage, segregation and final disposal of HCW. Common methods at these facilities included open burning and use of pits to dispose of the infectious waste. NEMA attributed this dearth of requisite infrastructure to financial constraint, non-functional waste facilities (incinerators), inadequate logistical supplies and limited technical support/ capacity building.

Uganda has very weak centralized private sector medical waste management system. Private sector companies such as *Green Label Services Ltd (GLSL)* and a military hazardous waste disposal facility at Nakasongola have limited capacity to handle medical waste generated at a national level.

According to the Uganda National Supply Chain Assessment report 2018, only 23% of the regional referral hospitals met the requirements for healthcare waste management. Further to that, according to a waste assessment report 2020 carried out by M/s Resources and Waste Advisory Group, the sampled Regional Referral Hospitals had a rapid assessment score of 47% and almost all areas assessed required priority improvement for proper health care waste management.

Basic buildings at a typical RRH, all of which generate HCW, are listed below:

a) Medical buildings:

i) Administrative offices
ii) OPD with laboratory, pharmacy, accident and emergency unit
iii) Intensive care unit
iv) Radiology
v) Operation theatre
vi) Female ward
vii) Male ward
viii) Pediatric ward
ix) Maternity ward
x) Mortuary
xi) Placenta pit and medical waste pit

For general hospitals that are part of this project, information in Table 8 below should be obtained by MoH through field inspection or environmental audits.

[56] Source: https://www.sciencedirect.com/topics/earth-and-planetary-sciences/incineration-of-waste
[57] Source: https://www.pmldaily.com/features/health/2019/11/99-hospitals-in-uganda-lack-systems-to-dispose-of-medical-waste-report.html (Accessed 13 April 2020)

Table 8: State of incineration facilities at various regional referral hospitals

#	Name of RRH	Does RRH have an incinerator? Y/N	If yes, what type of incinerator?	Is incinerator functional? Y/N	Personnel available to run the incinerator?	Other existing conditions
1.	Arua	Yes	Brick (masonry) incinerator that uses fuel for burning.	Yes	2 hired personnel on contract run the incinerator.	Iron sheets over the incinerator are rusted.
2.	Fort Portal	Yes	Imported model and uses a burner and fuel.	Yes	1 hired person	Diesel fuel expensive for incinerator operation
3.	Gulu	Yes	Imported type that uses a burner.	No	Yes	The incinerator has not been functional for years
4.	Hoima	Yes	German made model HWI-5 incinerator that uses a diesel burner.	Yes	1 hired person	▪ Incinerator has a very low capacity for a RRH. ▪ Frequently breaks down and is 20 years old.
5.	Kabale	Yes	Ugandan made MAKVI incinerator without emissions scrubbing provision	Yes	I trained hospital staff.	▪ Incinerator recently installed under COVID response program and working well for COVID-19 waste and hospital waste. ▪ Incinerator used daily including night time so capacity may be stretched.
6.	Lira	Yes	Imported model that uses a burner and diesel fuel.	No	Yes	▪ Incinerator not functional due to faulty components and needs to be relocated due to the ongoing expansion work under JICA.
7.	Masaka	Yes	Imported model and uses a burner and diesel fuel.	Yes	1 dedicated hospital staff.	▪ Newly installed incinerator for Covid response waste, barely 6 months old. ▪ Reported to be small for hospital waste but has a capacity of 50kg per hour. ▪ Incinerator not used for hospital waste.
8.	Mbale	Yes	Imported type and uses a burner and diesel fuel.	Yes		▪ Incinerator not used because it has a high fuel consumption and too expensive to operate
9.	Mbarara	No	-	-	-	▪ Non-incineration plant under construction to serve the region. ▪ Plans underway to construct an incinerator away from the hospital site. ▪ Currently infectious waste carried away for incineration by Green Label Services Ltd.

#	Name of RRH	Does RRH have an incinerator? Y/N	If yes, what type of incinerator?	Is incinerator functional? Y/N	Personnel available to run the incinerator?	Other existing conditions
10.	Moroto	Yes	Imported incinerator (HWI5) and uses a burner and fuel	Yes	Cleaners	▪ Neighboring community are always complaining about noxious incinerator emissions.
11.	Mubende	Yes	Imported incinerator (HWI5) and uses a burner and fuel	No		▪ Incinerator has been broken down for about 2 years.
12.	Soroti	No	N/A	N/A	N/A	▪ Hospital waste burnt in open air.
13.	Jinja	Yes	Imported incinerator and uses a burner and fuel.	No		▪ Incinerator has been down for some time. ▪ Currently infectious waste carried away for incineration and disposal by Green Label Services Ltd under USAID support.
14.	Naguru	No	Not applicable	Not applicable		▪ Non incineration technology at the facility broke down and not functional.

4.4.3 HCW incineration improvement interventions

4.4.3.1 Immediate interventions

To improve state of HCW incineration at RRHs, MoH will adopt the following three approaches:

a) Procure and install mobile incinerators at Naguru, Soroti, Mbarara and Gulu,
b) Repair, replace defective parts of incinerators at Jinja, Mubende and Lira,
c) GoU provides designated budget line of operational funds to restore functionality of incinerators at Mbale, Hoima, Arua and Fort Portal.

Mobile HWCs are suggested in a) above for the reason that they can also be used (on fee-basis) by other healthcare facilities in locale of a RRH, which ensures that HCW incineration at any RRH is self-sustaining in terms of cost expenditure.

While cost of the mobile HCW incinerators is readily available and provided in budget of this ESMF, repair and restoration of functionality of dysfunctional incinerators at RRFs first requires a technical assessment to verify and quantify specific parts to be procured hence derive accurate costs. This assessment may also advise if it is cheaper to repair existing incinerators or procure new ones that are cheaper and easier to operate. Therefore, for items b) and c) a lump sum cost for this technical appraisal study has been suggested in the ESMF budget.

4.4.3.2 Medium and long-term intervention

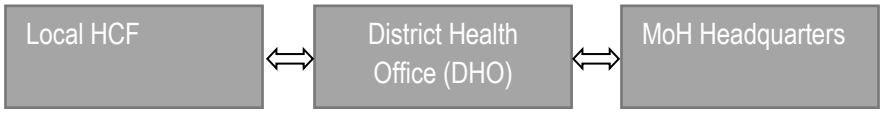
The medium and long-term intervention is for MoH, with support of development partners, to conduct regular s (annual) for HCW management facilities at all National Referral, Regional Referral and General Hospitals across the country. A lump sum estimate for this audit is provided in the ESMF budget.

4.5 COVID-19 Surveillance Channels in Uganda

MoH has developed a two-pronged approach for COVID-19 surveillance shown below. Both approaches should help communities and healthcare workers to know who to contact in-case of suspected COVID-19 case in a given area:

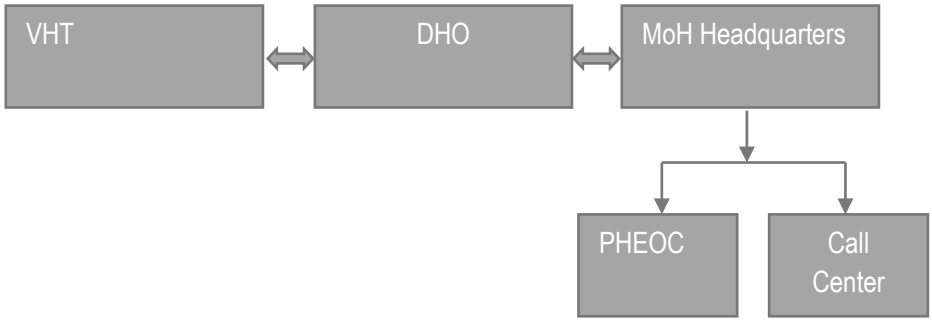
i) **Indicator-based surveillance:**

In this approach the reporting channels are from local healthcare facilities to District Health Office and finally to Ministry of Health headquarters in Kampala City.



ii) **Event-based surveillance**

In this approach, information from village health teams (VHT) is transmitted to the District Health Office and onward to Ministry of Health Headquarters' Public Health Emergency Operations Center (PHEOC) and Call Center and relayed to National Covid19 taskforce.



iii) **Toll-free numbers**

Ministry of health issued to the public toll free numbers and SMS lines[58] to report suspected COVID-19 cases for its immediate action at the start of the pandemic in March 2020 and the same is still available.

4.6 Challenges and lessons learnt from the Parent Project

Due to the delay in project effectiveness, E&S activities under the parent project have been limited to preparation of the ESIA for the proposed construction of laboratories at Lira and Fort Portal Regional Referral Hospitals.

From the Parent Project inclusion of migrants/ refugees remained a challenge due to the limited doses and there was no earmarked funding for these categories hence need to strengthen efforts to enhance accessibility to vaccines.

In the implementation of the Parent Project there was inadequate technical support and capacity building for frontline health and non-health workers on environmental and social safeguards.

Due to the emergency situation of the COVID-19 pandemic, the E&S safeguards requirements of the response were not considered especially in setting up boarder check points for screening for COVID-19 among others.

[58] For information on COVID-19, call Ministry of Health toll free: 0800 100066, 0800 203033 or send a free SMS to UReport on 8500

5 Environment and Social Risks and Mitigation

This section describes in general terms potential environment and social risks and impacts of the proposed project. Impacts have been discussed based on project cycle under themes of: *Planning, Construction, Operation* and *Decommissioning* stages.

5.1 Planning and Design Stage

Ideally, the planning process is based on baseline information of the Parent Project and insights are provided in Chapter 4 above. MoH opened Covid-19 none-health facility vaccination centers to boost vaccine uptake. For example, more vaccination centers in the capital, Kampala, in efforts to inoculate more people against COVID-19. Uganda has set to initially immunize about 21 million people including health workers, security operatives, the elderly and those that live with pre-existing conditions that lower their immunity.

The project provides interventions for capacity enhancement including additional training of health workers in vaccination centers other treatment and isolation facilities on infection prevention and control and infectious/hazardous waste management. The strategy provided is that every vaccination center without an incinerator will have their waste collected and deposited to the nearest facility with an incinerator by a licensed hazardous waste handler who will transport the ashes to the designated disposal area at Nakasongola. Component 4 will finance the purchase of COVID-19 vaccines, including logistical activities rollout and vaccine administration which may present adverse events following immunization (AEFI). The activities will also present OHS risks during handling and administering the vaccine to the population and CHS risks such as a possible increase in the spread of COVID-19 during immunization which will also increase the environmental repercussions of plastic waste including syringes. To mitigate these risks and ensure vaccine safety and efficacy, the project funds will only be used to procure tested and approved vaccines that have received WHO Emergency Use Listing (EUL).

It is therefore, recommended that sub-project designs to be prepared for this project take into consideration the following key environmental and social aspects:

a) Proper design and functional layout of healthcare facilities, which may involve several aspects: i) structural and equipment safety, universal access; ii) nosocomial infection control and necessary safety gear and protocols. This should also include the design of new or modifications to existing medical waste disposal facilities (e.g. incineration).
b) Location and scale of healthcare facilities and associated waste management facilities, including transport routes.
c) Consideration of differentiated treatment for groups of higher sensitivity or vulnerability including refugees, vulnerable or marginalized individuals or groups including VMGs i.e. the Batwa, Tepeth, Benet, Ik (also including persons with disabilities, elderly people and those with preexisting conditions).
d) Estimate healthcare waste streams and quantities including wastewater, solid wastes and air emissions (if significant) in healthcare facilities.
   Plan for procurement and deployment of vaccines. The AF will introduce a new component focused on vaccine purchase and deployment. Under this component, the GoU will procure vaccines to vaccinate 11.7 million people (26.4 percent of the population), in Phase 2 of its vaccination campaign, scheduled to begin in January 2022.

5.2 Construction stage

Component 1 (*Case Management*) of this project will provide infrastructure support to remodel key infrastructure such as isolation ICUs at regional referral hospitals, upgrading of health facilities or hospitals in 11RHDs:

Component 2 (*Surveillance and laboratory diagnosis*) will entail remodeling laboratory spaces, ICUs, upgrading of health centres in RHDs.

In this section therefore key environmental and social (E&S) impacts associated with construction (including expansion, upgrading and rehabilitation) of healthcare facilities and onsite or off-site waste management facilities are assessed and generic mitigation measures provided. These include, among others:

- Environmental considerations such as resource efficiency and material supply; construction related solid wastes, wastewater, noise, dust and emission management; hazardous materials management;
- Occupational Health and Safety (OHS) aspects;
- Community health and safety considerations such as pollutants, road safety and security personnel;
- Social issues such as, labor influx, HIV/AIDS, GBV/SEA risks, Violence Against Children (VAC) including child labour and Sexual VAC, gender-related impacts;
- Labor and working conditions; including potential exclusion of vulnerable or marginalized individuals or groups during recruitment processes and
- Cultural heritage impacts.

Potential construction phase impacts are discussed in sections below.

5.2.1 Positive social impacts

5.2.1.1 Income to material/ equipment suppliers and contractors

Proposed remodeling of, ICUs at RRHs, isolation units and upgrade of health facilities in construction of blood bank in West Nile, upgrading of key health centers in RHDs will necessitate procurement of equipment, construction materials and services, providing income to suppliers and contractors. This is a positive but short-term and reversible impact. AF will have interventions geared towards (i) renovation of selected health facilities; (ii) blood collection and procurement of blood storage equipment and blood administration supplies for health center IVs in RHDs and refugee settlements; (iii) renovation of isolation and other facilities located near points of entry (borders) routinely used by refugees and asylum seekers. Considering that construction labor would be local or national but medical equipment procured internationally, this impact might have local, national and international spatial extent. This impact would be enhanced by recommendations below:

Enhancement measure

Earth materials needed for construction e.g. murram, aggregate (stone, sand) are obtained from legitimate/ licensed quarry operations. Conscious or unwitting purchase of these materials from unlicensed operations indirectly supports, encourages and promotes environmental degradation at illegal quarry sites and can cause medium- to long-term negative impacts that also pose reputational risks to MoH. It should therefore be a contractual obligation for contractors to procure construction materials from licensed sources (as advised by respective district or municipal/city environmental officers).

5.2.2 Negative environmental and social impacts

Impact analysis in this section applies to all construction activities at any identified health center or hospital including the blood bank that are associated with AF. In addition, it should be noted that some mitigation measures apply to only specific sub-projects and may not be required for all subprojects. Should a full ESIA be required for any subproject, then an ESMP specific to that project component will be developed.

Box 1: Anticipated Negative Environmental and Social Impacts and Proposed Mitigation Measures during construction

Temporary disruption of healthcare services

Remodeling or upgrading of some infrastructure buildings or remodeling of ICUs in which medical services are provided may entail moving patients or equipment from one area or room to another. This may cause temporary disruption in delivery of health services to patients. Temporary rearrangement of service areas can have the undesirable consequence of slowing down emergency services or cause inability among health workers to efficiently offer necessary treatment for visiting patients. Moving or relocating medical equipment may cause their damage, and some patients might choose to transfer to alternative healthcare facilities, leading to their congestion.

Mitigation Measures

- Plan pre-construction activities early to identify suitable rooms or adjoining buildings into which patients or service areas can be relocated with minimal inconvenience, especially to patients under intensive care. Advance relocation information should be shared with potentially affected patients for their advance planning mental preparedness.
- Contractors should work closely and harmoniously with RRHs administrators to devise practical ways to minimize social cost of temporary disruption of services. A grievance mechanism to address complaints from community shall be instituted.
- By investing in the continuum of RMNCAH services, diseases and deaths that have arisen due to the disruption of health services since the advent of COVID-19 will be averted.

Note: For construction related impacts refer to the Parent Project ESMF

5.3 Operational Stage

This section presents analysis of operational impacts with the guiding principle being use of a "*cradle-to-grave*" approach to management of infection control and healthcare waste to avoid/minimize cross-infection in hospital and communities. For this purpose, an infection control and waste management plan (ICWMP) is annexed to this ESMF. Impacts have been assessed considering envisaged:

- **Transport** and storage of supplies, including samples, vaccines, pharmaceuticals, reagents and other hazardous materials; The military is expected to partner with MoH in their capacity as health professionals in military hospitals vaccinating eligible persons in their catchment areas such as barracks and detaches. Additionally, due to the scarcity and uncertainty of global vaccine stocks, increased demand for vaccination services has led to increased security around vaccination, such vaccines have to be escorted by security personnel to ensure their safe delivery. The eventual use of the military and/or the security forces in the vaccination program will require the existing MoU protocol with the UPDF to be review and update as need be in line for the vaccine administration activities.
- **Waste management**: Generation, minimization, reuse and recycling as well as waste segregation, packaging, collection, storage and transport;
- **Onsite waste treatment**: healthcare facilities should have onsite disinfection and waste handling equipment such as autoclave; and may have onsite treatment facilities such as small-scale incinerator and wastewater treatment works. Their adequacy and compliance should be assessed, and proper measures proposed as necessary. If a healthcare facility does not have an incinerator, it will have to rely on an offsite facility.
- **Offsite waste treatment and disposal**: (residual) healthcare wastes will have to be transported and disposed of in off-site disposal facilities. This link in the chain is often beyond the control of the project proponent and tends to be the weakest link. It is therefore critical to assess the adequacy and compliance with transport and disposal regulations for the transport vehicles and the offsite disposal facilities. Measures should be identified and arranged to meet these requirements.

- Indoor air quality risks, especially considering COVID-19 and how it transmitted.

- Waste from COVID-19 emergency operations will not be transported from Uganda to other countries hence international or regional conventions, such as Basel Convention and Bamako Convention (for Africa) for trans-boundary movement and disposal of hazardous waste will not apply, and therefore, are not discussed here.

Potential Risks Associated with Mandatory Vaccination

1. Contractual risk would tantamount to breach of the contractual obligations especially for employed workers. If such happens then someone forced to vaccinate can seek legal redress especially there was no such clause in their contract
2. Forced vaccination will lead to human rights violation especially where is no enabling law.
3. Risk of personal injury including unforeseen side effects to the vaccinated person; the available vaccine may not necessarily be suitable for all people.
4. Mistrust in the whole process and the agenda behind mandatory vaccination especially where is no adequate flow of right information.
5. Some people may have cultural or religious or moral objections to the vaccine and these may amount to protected religious or philosophical beliefs.

Mitigation measures:

In case of mandatory vaccination, then, there should be put in place an enabling law that would allow due process to be followed including;

1) Obtaining consent;
2) Enabling the affected persons to seek justified exceptions;
3) Differentiate between mandatory schemes (allowed with due process); where say a certain group considered more vulnerable like front line workers, teachers among others are mandated to be vaccinated.

Gender-related Impacts

COVID-19 is expected to have different impacts on women and men, girls and boys. Women will be more affected in systems with more female health workers. Domestic violence may increase with stress and anxiety. Sexual and other forms of violence against women have impacts such as physical, mental, sexual, HIV/AIDS and unplanned pregnancies. Implications of COVID-19 outbreak for women and girls might include increased caregiving and household roles such as tending to sick family members which can limit women and girls' access to services, including critical health services. Inadequate living conditions, especially in vulnerable female-headed households, might increase risk of infection in absence of adequate space for observance of social distance. Impacts such as injuries, psychological scars, family breakups, missed schooling opportunities or denial for vaccination etc.) could result. The impact could potentially occur within affected families/communities and may be more pronounced in already vulnerable communities like refugees among others. Likelihood of the impact occurring is *high* and significance is therefore predicted to be *medium-high*.

Impact evaluation

Sexual Exploitation, Abuse and Harassment: The risks of sexual exploitation, harassment, and abuse will be assessed, and mitigation measures put in place.

Gender-Based Violence (GBV): Rates of GBV, especially intimate partner violence may increase as people stay home, in quarantine centers and isolation units/ hotels and change behavior in response to COVID-19 as a result of movement restrictions. Other types of GBV are sexual assaults against children, disabled and elderly people. Mental Health: Epidemics can cause stress, anxiety and fear. Sources of stress in households' level may arise from children stay home and creating competing demands for time or when incomes diminish following job loss or wage cuts.

Routine Health Care and Essential Services: Resources might be diverted from routine healthcare services toward containing and responding to COVID-19 outbreak.

Women's Leadership and Representation: When women are under-represented in decision making in outbreak prevention and response measures, their needs are less likely to be considered or met.

Data and Monitoring Systems: Sex- and age-disaggregated data is required to examine and respond to gendered patterns in mortality and vulnerability to COVID-19.

Patient-centric risks for those receiving treatment for COVID-19 symptoms, including GBV or Sexual Exploitation and Abuse (SEA) of patients in quarantine.

Difficulties in access to vaccines and other services by vulnerable or marginalized individuals or groups (i.e., the poor, refugees, indigenous peoples, migrants, the elderly, and the disabled), and those with underlying medical conditions who would be most at risk in the event of a pandemic outbreak.

Discrimination towards ethnic minority groups or limited communication channels to inform their communities of preventive measures against COVID-19 contagion.

Risks of increased incidence of retaliations particularly against health care workers and researchers which may be mitigated through inclusion in a robust stakeholder identification and consultation processes.

Impact mitigation measures
With limited and commonly shared spaces (kitchens, bathrooms, living rooms) in COVID-19 Quarantine Centres and isolation centers, it is recommended to institute measures to prevent sexual harassment and gender-based violence in quarantine facilities and isolation units.

Inadequate risk communication and community engagement
Emergency response interventions to COVID-19 outbreak have involved immediate top-down mobilization of medical teams and strict enforcement measures such as government prohibition of people movement and socio-cultural practices such as burial ceremonies weddings, religious gatherings, schools etc. Only efficient local engagement and effective communication as has been done by MoH and President's Office could forestall widespread confusion, fear and misinformation. There is also a potential risk of not having a functional and accessible GRM.

Misinformation can endanger medical teams when their activities are misunderstood or not known. Vaccine hesitancy and denial could also result due to misinformation. Effective public sensitization is essential for COVID-19 control and will particularly be important for hard-to-reach communities and *Vulnerable Marginalized Groups like refugees, Batwa, Benets, Tepeth and the Ik* that lack access to formal communication channels (print and electronic mass media). Additionally, once people are not educated about COVID-19 vaccination especially the relevancy of vaccination, COVID-19 potency, how it is spread and control measures, they would not participate in its control and vaccinations. It would for example be difficult for families to isolate themselves or a relative or relegate their right to bury a deceased family member unless they are fully aware of inherent risk; the same is true with COVID-19 vaccination.

Misinformation ("fake news") in social media networks which may contribute to propagate contagion. Difficult access to health in rural and remote areas of the country or in refugee settlements can also pose a challenge for service and supply delivery, which could be a deterrent for an effective national response

Risks related to any mandatory national vaccination program that may be imposed to citizens which might disregard their cultural, social and traditional community practices and values; and

Impact severity: While inadequate communication itself would be short-lived, its effects would be long-term in some cases involving death of people, especially when they were family heads earning the household incomes. Likelihood of the impact occurring is moderate if sensitization is inadequate. In so far as inadequate communication and information dissemination of COVID-19 risk will impede effective vaccination and control of the pandemic hence lead to loss of lives and harm (violent attack) to medical teams, this *negative* social-economic impact will have *high* significance.

Mitigation

Ministry of Health shall:

- For effective risk communication and community engagement, MoH should resource and implement the Stakeholder Engagement Plan (SEP) developed and disclosed for this Additional Financing. The SEP provides guidance on:
    - Stakeholder engagement during project preparation and implementation,
    - Methods, tools and techniques for stakeholder engagement,
    - Strategy for information disclosure,
- Involve local opinion leaders such as LC 1 Chairpersons, Women Leaders, Youth Leaders, Members of Parliament, business associations and representatives of members of Vulnerable and Marginalized Groups (*Batwa, Benet, Tepeth* and *Ik*) and refugees in COVID-19 risks communication strategies.
- Intensify media campaigns mainly in rural areas, such as wireless radio and social media using new information technologies (cellular phones);
- Maintain a team responsible for harmonizing media actions (broadcasting rates, dissemination formats, journalistic ethics control, etc.).
- Train and sensitize response teams and security forces involved in COVID-19 control for strict compliance with the Code of Conduct to avoid violence, gender violence, sexual abuse, or unethical behavior and to ensure follow up of complaints from the population.
- Ensure regular communication and community engagement training for stakeholders and communities on common myth, questions and appropriate responses, so they are able to answer questions about the multiple aspects of COVID-19.
- Institute a Grievance Redress Mechanism to be used by any persons affected by COVID-19 operations, paying special attention to vulnerable and marginalized people (e.g. Batwa, Benets, Tepeth and *Ik*) who may not access conventional redress mechanisms available to the wider community. The GRM for parent project will be updated for AF.

Guidance on development of a detailed GRM is provided in Box below.

Box 2: Guidance on development of a detailed GRM

A Grievance Redress Mechanism (GRM) will help MoH reduce projects risk and provide communities with an avenue for expressing their concerns and obtaining due redress, A GRM will also promote a mutually constructive relationship between stakeholders and Ministry of Health (MoH). Stakeholders will need a trusted way to air concerns linked to this project and have them resolved. A grievance redress mechanism will provide an avenue by offering reliable approaches where healthcare stakeholders and MoH can together find effective solutions. The GRM will operate at three levels right from: i) the Contract Workers' GRM at site level, ii) the District GRM and, iii) GRM at the MoH. GBV related complaints will also be categorically handled depending on the gravity of the issues as provided in the Project GRM already prepared. Affected persons can also log in their complaints to the World Bank's corporate Grievance Redress Service (GRS).

A well-functioning GRM will:

a) Provide a predictable, transparent and credible process to all parties, resulting in outcomes that are seen as fair, effective, and lasting
b) Build trust as an integral component of broader community relations activities
c) Enable more systematic identification of emerging issues and trends, facilitating corrective action and pre-emptive engagement across the country and within refugee settlements.

Four phases below are recommended for designing and implementing an effective grievance mechanism:

a) Phase 1. **Define scope and determine goals**: The entity developing the GRM should develop the overarching purpose and goals for the grievance mechanism and makes sure that design decisions flow from its purpose.
b) Phase 2. **Design**: There should be designed a preliminary plan that outlines the purpose, goals, scope, resolution approaches, structure, and specifics about how the GRM will function. This preliminary plan should be tested and refined through consultation with stakeholders (including in refugee settlements) to ensure it is effective.
c) Phase 3. **Implement**: MoH and relevant stakeholders should work together to introduce, refine, and institutionalize the grievance mechanism.
d) Phase 4. **Monitor, report, and learn**: Information should be collected on effectiveness of the mechanism in particular and, more generally, on MoH's ability to prevent and address grievances. This information is used to refine the GRM.

Ideally an effective GRM should have attributes below:

- Coherent process
- It is scaled to project needs
- It is in writing and adequately publicized
- Brings in third parties if needed
- It is easily accessible by stakeholders
- Assures timely response and transparency
- It enables keeping good records and reporting back
- Doesn't impede access to legal remedies

Impact of COVID-19 testing laboratories and vaccination centers

It is essential that laboratory analysis is carried out to immediately ascertain or rule out suspected COVID-19 cases. It is expected that COVID-19 samples collected during an outbreak will be transported by Ministry of Health or certified company to a specialized reference laboratory for analysis in accordance with WHO and MoH standard operating procedures. COVID-19 samples will be tested at Uganda Virus Research Institute (UVRI) and other certified laboratories which have all requisite facilities and protocols to control laboratory waste from COVID emergency operations. This will avoid the potential impact of improper laboratory waste disposal in communities. Vaccination centres or facilities should as well have the capacity to control and manage the infectious waste like syringes and empty vaccine bottles.

Impact evaluation:

Improper management of laboratory and other vaccination related waste (syringes, waste vaccine bottles, GeneExpert cartridges etc.) would not only lead to offsite COVID-19 transmission slowing effective containment of the outbreak but would also have a dire effect on the environment.

Impact severity:

Unplanned disposal of COVID-19 related waste would be a negative impact with potentially long-term and irreversible socio-economic impact with have *high* significance.

Mitigation Measures

Ministry of Health shall ensure:

- Transportation of samples should not expose personnel to risk either during normal handling or in case of an accident.
- Vaccine handling and administering should also not expose personal to most cross contamination or cross infection.
- Vaccination centers established outside health facilities shall segregate and collect waste using coded receptacles as is the norm for all health care related waste. COVID-19 related waste shall be separated (highly infectious) and sent to nearby health facilities or hospital that have operational incinerators.
- Appropriate waste segregation in healthcare facilities shall be emphasized.
- Ensure appropriate siting of incinerators to avoid affecting surrounding communities/neighbors with smoke or bad odors.
- Ensure appropriate disposal of bottom ash from incinerators.

Note: *Mitigation measures apply to COVID-19 emergency waste. Through other projects, MOH is supporting healthcare facilities through National Medical Stores (NMS) to improve their waste management infrastructure and practices by distributing code waste bins/containers It should also be noted that MoH is already installing incinerators for 81 health facilities in another related project (URMCHIP-P155186) where the incinerators will handle all hazardous and highly infectious waste including COVID-19 related waste.*

Impact mitigation

Continue building the capacity of laboratory staff to meet necessary standards, including:

- Ensure waste management in accordance with existing WHO standard operating procedures (SOPs);
- Adhere to SOPs on laboratory and medical waste management detailed in Uganda's *Standard Operating Procedures and Guidelines for Responding to Ebola/Marburg Virus Disease Outbreaks in Uganda. A Guide for National Response, 2015;*
- Daily monitoring of laboratory capacity to ensure they are all able to accommodate the number of samples collected;
- Organizing sample management (collection, storage, packaging and transport);
- Organizing training for COVID-19 diagnosis and sample management;
- Providing adequate resources to testing laboratories and vaccination centres or to liaise with hazardous and infectious waste handler to manage all waste associated with COVID-19.

Improper clinical care including vaccination, isolation of cases and follow-up of survivors

The aim of clinical care for COVID-19 patients will be to provide quality, safe care and individualized patient-centred care in a bio-secure environment to minimize the risk of spreading these diseases to other patients or health workers. Clinical care includes medical, nursing, nutritional and psychosocial care - taking into account specific needs of indigenous people (Batwa, Benet, Tepeth & Ik), disabled persons, children and women, including pregnant and lactating mothers and refugees. If this important undertaking is not planned or carried out with due caution, there is a big risk of transmitting COVID-19 infection to healthcare workers or other people such as ones working in quarantine centers.

Impact severity:

Onward infection of medical workers or other people due to improper clinical care, isolation of suspected cases and follow-up of survivors would be a negative impact with long-term and irreversible (if death occurred) socio-economic impact with have *high* significance.

Mitigation Measures

MoH shall:

- Take special effort to ensure that services are amenable and accessible to *Ik*, Tepeth, Banet and *Batwa* and the refugees who are vulnerable and marginalized people in Uganda. For example, in case of an COVID-19 outbreak in marginalized communities, health personnel with specific knowledge of their social customs and culture should be included in teams providing emergency services to communities in which *Batwa, Tepeth, Banet* and *Ik* people live. Special consideration should also be done for the refugees especially when it comes to vaccination; they should not be discriminated and denied vaccine.
- Improve bio-security and harmonize care protocols to avoid risk of infections of medical workers and other people. This measure is as applicable to quarantine centers as is to hospital environment
- Use the already set up management system specific to case, management structures under the management of MOH (finance, logistics, administration, etc.)
- Integrate survivors' follow-up programmes into the clinical care.

Weak infection prevention and control measures

Infection prevention and control (IPC) measures and water, sanitation and hygiene (WASH) aim to prevent and control nosocomial (originating in a hospital) and community transmission of COVID-19. Absence of effective IPC and WASH measures would curtail efforts to control COVID-19. This reiterates the importance of precautions such as avoiding handshaking, hand washing with soap and use of alcohol-based sanitizers. In addition, burial of COVID-19 victims should be left to specialized healthcare teams or trained personnel.

Impact severity:

Absence or weak COVID-19 infection prevention and control measures would lead to uncontrolled spread of COVID-19, a negative long-term and irreversible (if death occurred) socio-economic impact with have *high* significance.

Mitigation Measures

a) Main activities in the health facilities:

- Strengthen training activities of healthcare providers and IPC supervisors.
- Implement the IPC package that includes standard operating procedures (SOPs), tools, rapid diagnostic tests.
- Strengthen the IPC / WASH support system in health facilities based on health facility assessments, training supervision with corrective actions, and the establishment of a quality assurance system in close collaboration with the independent monitoring and evaluation team.
- Evaluate and enforce WASH infrastructures and services all over the country.
- Provide health facilities with IPC / WASH inputs (soap, water) as needed and monitor their use.
- Ensure the decontamination of health facilities that have received confirmed COVID-19 cases.
- Ensure implementation of the IPC ring approach around each confirmed case of COVID-19.

b) IPC in affected communities

In communities, IPC activities should be carried out in households and in public places. These include:

- Ensuring access to water and sanitation in schools and public places
- Ensuring decontamination of households and public places that have had confirmed COVID-19 cases
- Providing hygiene kits to households, schools and public places
- Strengthening the monitoring and evaluation system
- Training community leaders in COVID-19 control approaches (handwashing, social distancing, etc.)
- MoH should take special effort to ensure that VHT or other healthcare providers effectively include Indigenous Peoples communities. For example, in case of COVID-19 outbreak, health personnel

with specific knowledge of their social customs and culture should be included in teams providing emergency services to indigenous and marginalized peoples.

Impact of COVID-19 on the Refugee Situation

Uganda has over 1.5 million refugees within its borders (see Figure 12). The impact of COVID-19 both exacerbates and is exacerbated by conditions in which refugees live. Several factors make them vulnerable to the spread of COVID-19 and four are discussed here. *Firstly,* factor is population density since refugees live in cramped conditions, including formal camps, informal settlements, or population-dense urban spaces. *Secondly*, refugees generally have difficulty accessing basic services especially healthcare and when they have access, it is limited to primary healthcare. Intensive care, the kind of care that COVID-19 patients need when they develop acute respiratory distress, is nonexistent in refugee settlements. These underlying conditions make them more vulnerable to COVID-19. *Thirdly*, limited access to reliable information for displaced communities will complicate efforts to respond. Misinformation, mistrust of authorities, absence of communication networks, and language barriers can all prevent accurate COVID-19 control information campaigns and vaccination in refugee settlements. *Fourthly*, the humanitarian supply chain may be challenged by COVID-19 outbreak. Health services in refugee settlements are provided by NGOs, UNHCR, Department of Refugees and Ministry of Health in coordination, COVID-19 has stretched services and coordination. Relief workers may reduce or cut contact with displaced communities so as to help prevent spread of the virus. Space limitation in refugee camps can lead to rapid spread of the virus in a large confined settlement. Hand-washing is one of the key strategies in the fight against COVID-19 yet access to water, soap and sanitizers are known challenges in refugee settlements.

Impact severity: Absence of resources including access to health facilities in refugee settlements and host districts would impede effective control and vaccination to COVID-19 of refugees, a negative but long-term whose consequences (death) are irreversible. Therefore, impact significance will be *high*.

Mitigation Measures

The following measures are proposed for controlling COVID-19 in refugee settlements:

i) **Enhance communications and the flow of information**: Government and international refugee agencies (UNHCR) should develop information campaigns to ensure displaced communities have accurate and current information about COVID-19, vaccination and response efforts. Coordination and accountability needs to be clear between MoH, OPM (DoR), UNHCR and INGOs supporting refugee health services through District-settlement health coordination meetings. Where possible, they should work with local civil society and displaced persons themselves to ensure language and means of communications are easily accessible and widely disseminated.

ii) **Deploy medical personnel, supplies, and personal protective equipment**: GoU and refugee agencies should prioritize deployment of medical personnel to refugee along with personal protective equipment and other medical supplies such as gloves and masks for humanitarian health workers to ensure their safety in addressing COVID-19 outbreaks in refugee settlements.

iii) **Prioritize hygiene and WASH interventions**: GoU and refugee agencies should improve access to water, sanitation and hygiene (WASH) facilities in refugee settlements. This should include the distribution of essential personal hygiene items including soap. The response should also recognize best practices for response for particularly vulnerable populations, such as women and girls.

iv) **Enhance surveillance capabilities:** GoU and refugee agencies should institute means to ensure rapid collection of samples for COVID-19 testing in refugee settlements.

v) Prioritize a special package providing refugees vaccination and management.

Impact of COVID-19 on VMGs/IPs

There is need to analyze the COVID-19 pandemic impacts on and dynamics among the world's most vulnerable groups and peoples. Indigenous peoples have been recognized as one of the groups at heightened

risk for COVID-19 and its many adverse socio-economic and other impacts. Indigenous communities have resulted in the rapid spread of misinformation about COVID-19, increasing their vulnerability to the virus. There are perceptions among some people that VMGs/IP are reservoirs of dangerous viruses, amplifying contemptuous beliefs that they are dirty, backward, unsanitary, and bereft of the skills and knowledge to prevent COVID-19.[59] Batwa women were overlooked in the distribution of COVID-19 relief materials. Highlighting a pervasive feeling among the Batwa that they are at higher risk of dying from lack of food than from the virus.

While several urban-based facilities and health centers that serve non-Indigenous people across the region have been equipped to respond to COVID-19, little investments have gone into equipping health centers in IP communities to offer COVID-19 testing, vaccination, treatment, and care. While pre-existing multiple vulnerabilities shape VMGs' ability to cope with COVID-19, the pandemic is also exacerbating threats to their wellbeing. Urgent action is needed to address the vulnerabilities that expand COVID-19 risks, tackle the emerging impacts of COVID, and ensure that Indigenous populations are not excluded from existing and future COVID-19-related investments and responses.

Mitigation Measures

- to ensure access to testing, treatment, and vaccination.
- Prioritization of support and capacity strengthening to VMGs/IPs organizations and organizations working with VMGS/IP on health, livelihood, and other issues
- A gender- and culture-sensitive strategy for ongoing COVID-19-related relief, support, and engagement with Indigenous peoples.
- Support for VMGs/IPs access to quality COVID-19 control, prevention, vaccination, and treatment.
- design and implementation of evidence-based programs to prevent violence, mitigate socio-economic and livelihood challenges, strengthen social protection mechanisms, and promote access to health, including maternal reproductive health and GBV services among VMGs/IPs.
- Continuing consultation with VMGs/IPs and their groups to secure and integrate their views of equity in the design, implementation, and evaluation of COVID-related interventions.

Safe and dignified burials (SDB)

For many tribes and religions in Uganda, a common traditional practice is to wash bodies before burial. However, the risk of contracting COVID-19 is high if handling of dead bodies is not minimized. Therefore, the objective of safe and dignified burials (SDB) is to prevent transmission of COVID-19 through safe and dignified burial of confirmed, probable or suspected cases. People whose lives have been claimed by COVID-19 are buried by specialized healthcare teams wearing necessary PPE and with only a few family members. Inadequate sensitization about the practice and its importance has in some community caused consternation about SDB. Once these myths are not cleared through comprehensive sensitization of local communities, misconceptions, fear, anguish and in some cases, violent attacks on SDB teams can happen.[60]

Impact severity:

While social stigma associated with burials is strong in many Ugandan communities, it is even greater if families do not pay last respects to their deceased members. This leaves a long-term negative social impact of high significance, on affected families. However, when communities are given prior sensitization about SDB and its importance to public health this social stigma would be lessened.

Mitigation Measures

- Ensure local communities are satisfactorily sensitized and aware of SDB and its importance;
- Adhere to WHO Safe Burial Protocol;

[59] COVID19_Indigenous_Women_East_Africa.pdf (reliefweb.int)

[60] Source: https://www.tandfonline.com/doi/full/10.1080/10810730.2016.1209601 (Accessed: 14 April 2020)

- Train and pre-position an SDB Team in local communities, preferably adopting a member of the local community on this team;
- Ensure SDB teams are fully knowledgeable about WHO SDB protocols and associated activities including decontamination, community involvement and psychosocial support.

Impact of inadequate logistics or their inefficient management

Inefficient logistics would slow COVID-19 emergency response efforts, possibly leading to higher mortality than would otherwise occur. Managing emergency response might also entail supply of associated necessities such as food, clothing, beddings and utensils to COVID-19 survivors all of which require efficient management of logistics. The same impact would arise if required resources were inadequate to suitably contain an outbreak commonly, inefficiencies can arise from:

- The mismatch between the volume of leased vehicles at very high overall cost and the volume of work;
- Insufficient number of ambulances, and motorcycles, particularly in the new response areas;
- Lack of information regarding medical stocks or supplies;
- Untimely breaks in the stocks of medical supplies;
- Absence of standard operating procedures (SOPs) for logistics that govern all response stakeholders.

Impact severity:

Inadequate logistics (or inefficient management thereof) would slow response operations, potentially leading to higher-than-expected COVID-19 mortalities. This would be a negative, irreversible socio-economic impact with a *very high* impact significance and social cost at local and national levels.

Mitigation Measures

Vaccine logistics for Covid-19 will pose challenges along the supply chain that must be jointly addressed by governments, NGOs, pharmaceutical companies, and logistics players urgently. But even should they succeed, there are considerable complexities in ramping up and distributing the vaccine, with the pandemic itself still crippling much of our supply and distribution workforce numbers and efficiencies. Health workers should have safe access to the vaccine and risk of disease transmission is minimized. MoH will test their supply chain's ability to receive, store and distribute COVID-19 vaccines and relevant ancillary products to identify and address any bottlenecks, and to inform the deployment plan. The volumes of incoming shipments for both COVID-19 vaccines and ancillary products and their delivery frequencies should be aligned to existing storage and distribution capacity at the initial and final delivery point destinations, and in consideration with the strategy to reach target populations. Whenever applicable, the MoH will seek additional storage and distribution capacity from their partners, including outsourcing from the private sector. The central level stores will have to manage high volumes of vaccines and ancillary products during the COVID-19 vaccination campaigns. An increase in storage capacity requirements is to be expected.

The subnational stores will have to manage higher than usual volumes of vaccines and ancillary products during the COVID-19 vaccination campaigns. A need to increase storage capacity requirements is to be expected. It is suggested that district meetings are leveraged to target health workers who are part of the target group for vaccination. This will affect district storage points; however, significant capacity at -20 °C and 2 °C to 8 °C exists at this level and has recently been reinforced with the Cold Chain Equipment Optimization Platform (CCEOP) in Gavi eligible countries. At Health Facility/ Vaccination Center level, VMGs/IPs and special interest groups and those over-65 years old target group will be accessed through a combined fixed posts and outreach strategy During the COVID-19 vaccination campaigns. MoH should ensure an efficient logistics system by:

Standardization of inventory management tools and mechanisms;

- Checking needs for medicines, specific inputs and consumables;

- Empowering partners to take over the supply of inputs for the activities for which they are responsible;
- Independent responsibility of each partner for its activities (logistical support: accommodation, means of communication and IT, transport, etc.);
- Strengthening the package of shared logistics services for efficient response.

Improper Healthcare Waste Management

It is known that many hospitals in Uganda have rudimentary medical waste treatment and disposal facilities. While their quantities and types are not known at this time, medical waste will be generated by COVID-19 emergency operations, requiring safe and proper management to avoid occupational and public health risks. Improper healthcare waste management poses a secondary infection risk to healthcare workers and general public.

Impact severity: Secondary infections arising from improper management of waste from COVID-19 emergency operations could lead to negative and potentially irreversible impacts (e.g. death of infected persons). This would be a negative, irreversible socio-economic impact with a *very high* impact significance and social cost.

Mitigation Measures

It is recommended that the project procures own (preferably mobile) safe medical waste incinerators and other required HCW management requirements. Additional mitigation measures to be considered are:

- Regular environmental audits,
- Follow requirements in WHO COVID-19 guidance documents and World Bank's ESS3 on Pollution Prevention and Management,
- Prepare and follow an Infection Control and Medical Waste Management Plan (ICMWP).

5.4 Non-Discrimination of Vulnerable or Marginalized Individuals or Groups.

The following section relates to vulnerable or marginalized individuals or groups.

Potential risk of exclusion or discrimination based on age, gender, ethnicity, Disability, etc. from the project benefits refers to vulnerable or marginalized individuals or groups who, by virtue of, for example, their age, gender, ethnicity, religion, physical, mental or other disability, social, civic or health status, economic disadvantages, and/or dependence on unique natural resources, may be more likely to be adversely affected by the project impacts and/or more limited than others in their ability to take advantage of a project's benefits. Such an individual/group is also more likely to be excluded from/unable to participate fully in the mainstream consultation process and as such may require specific measures and/or assistance to do so.

The Government of Uganda notes that discrimination or exclusion of any Ugandan contravenes Article 21 of the Ugandan Constitution. The Republic of Uganda (the "Borrower") has committed to uphold the Bank's policy requirements for inclusion and non-discrimination on all World Bank financed projects. The measures outlined below are intended to ensure that mechanisms exist to identify potential discrimination and to promptly remediate its impacts. Specifically, these mitigation measures will ensure that:

- an individual or groups with concerns or grievances would be afforded appropriate avenues to submit their grievances or concerns including through the grievance mechanism corresponding to World Bank financed project.
- the operators of the referred mechanisms, the World Bank and the Government of Uganda will do what is required of them to ensure that such concerns or grievances are addressed promptly and effectively.

Background and progress to date:

Following the World Bank Group's communication of its concerns with the enactment of the AHA, the Government of Uganda issued five Circulars (see Annex 8). Of particular importance is the Circular on Uganda's Social Safeguard Policies issued on September 21, 2023, by the Ministry of Finance Planning and Economic Development, to all Accounting Officers, Ministries, Departments and Agencies and Local Governments which states that:

- "All World Bank-financed projects must be implemented in a manner consistent with the principles of non-discrimination as provided Article 21 of the Constitution of the Republic of Uganda. These projects should also be implemented in accordance with World Bank policies and applicable Legal Agreements.
- Under these projects, no one will be discriminated against or stigmatized, and the principles of non-discrimination and inclusion will be adhered to. Support should be provided to all project beneficiaries.
- All implementing entities of World Bank projects will implement specific mitigation measures to address non-discrimination.
- These mitigation measures will require enhancing project grievance redress mechanisms as well as strengthening existing project monitoring by implementing entities including third-party monitoring where applicable.
- Each project implementation entity shall develop comprehensive guidelines to address non-discrimination."

The updated environmental and social risk management documents identify the additional risks and describes mitigation measures to address these risks. They include the implementation, monitoring, and reporting arrangements, and roles and responsibilities to assess the efficacy of the additional mitigation measures being implemented. They also include the results of the public consultations on these documents involving the Government of Uganda and civil society organizations.

Noteworthy is that the World Bank will provide support to the Government of Uganda, particularly its Project [Program] Implementation Units, to help them to implement the additional mitigation measures for this project [program].

Risks

These risks were identified through a process of stakeholder engagement conducted from March 2023 to January 2024 with civil society organizations, donors and other interested parties. Stakeholder engagement on the mitigation measures and updating of instruments took place between June 12 and June 23, 2023, as well as between August 28 and September 22, 2023. This engagement was led by the World Bank and included meetings with government of Uganda representatives, other Development Partners and NGOs/CSOs. In addition, in January 2024, the GoU led consultations on the whole World Bank portfolio with key community stakeholders. A summary of the consultations can be found on the World Bank Uganda Website through the following link https://www.worldbank.org/en/country/uganda/brief/consultations.

Identified risks include:

(i) Health service providers denying access to vulnerable or marginalized individuals or groups beneficiaries.

(ii) Vulnerable or marginalized individuals or groups declining to access project services for fear of rejection, retaliation, or being reported to the police.

(iii) The need for a circular from MoIA to prevent against arrests.

(iv) Fear of going to facilities as vulnerable or marginalized individuals or groups might be reported, or they feel like they need to lie about what they are experiencing.

(v) Vulnerable or marginalized individuals or groups patients being reported to the police if their status is disclosed or suspected in the course of health services.

(vi) Medical facilities who provide health guidance and services to vulnerable or marginalized individuals or groups (e.g., reproductive health) being shut down for allegedly "promoting homosexuality" or illegally keeping "premises."

(vii) How MoH is holding medical doctors and others accountable in terms of ensuring non-discrimination.

(viii) How MoH is ensuring data is collected in a respectful and accurate manner.

(ix) The need for sensitization and training of relevant health care providers/workers and other stakeholders on confidentiality, non-discrimination, and inclusion.

(x) The need for additional sensitization, communication, and further dissemination to all relevant stakeholders, particularly law enforcement entities and district government officials, on the content of the MoH issued circulars.

(xi) In the case of Covid-19 isolation centers, how are vulnerable or marginalized individuals or groups now going to be protected? Will there be training for Medical Officers and those who manage isolation centers, so they do not discriminate?

(xii) The need to further assess and disseminate the MoH developed 2020 guidelines 2020 for the establishment and Operation of Drop-in-Centers for Key Populations

(xiii) how to ensure the safety and security of health workers and that they are not going to be held as criminals for providing these services.

(xiv) That the government agency has the capacity to implement the mitigation measures.

Mitigation measures

The following mitigation measures are proposed to manage the risk of exclusion and discrimination of individual and groups who may be vulnerable or marginalized.

These mitigations will be implemented by the Project Implementation Unit with the support of an international organization (firm, agency, or consortium) to be hired by the World Bank and IFC with a strong track record of providing implementation support and monitoring project performance and knowledge of the Ugandan context. This organization is expected to work with NGO/CSOs and country-based development partners in implementing these mitigation measures.

Specifically, the organization will:

- Assist project teams to enhance existing project-level grievance mechanisms and develop and operate an independent mechanism that would identify, manage, and monitor cases of exclusion and discrimination.
- Assist the WB in strengthening the capacity of Project Implementation Units, workers, and contractors, subcontractors, and service providers.
- Ensure contracts, codes of conduct, hiring procedures, whistle-blower protection protocols, and other measures, as needed, are in place to require remediation of cases of exclusion and discrimination.
- Develop a strong data management system and process that secures personal data and information in a manner that is safe, ethical, and confidential.
- Where cases of exclusion and discrimination are reported through the above mechanism, the EISM will report the grievances to the Bank, propose appropriate remediation, and follow up on agreed actions to resolve the case.

- Support the WB/IFC to monitor the efficacy of the agreed mitigation measures on WB/IFC financed operations.

A more detailed explanation of the enhanced implementation support and monitoring this organization will provide is found at Annex 17.

Mitigation measures to be implemented by PIUs with the support from the organization listed above include:

- Develop training, sensitization and Information, Education and Communications material on the obligations of project participants to ensure non-discrimination of vulnerable or marginalized individual or groups and to ensure they have access to appropriate expertise to help them do that.
- Undertake targeted consultations with external stakeholders, including as appropriate NGO/CSOs, local governments and other stakeholders to ensure there is broad understanding of the obligations of project participants to ensure non-discrimination under the project.
- Additional sensitization, communication, and dissemination of all relevant stakeholders, particularly law enforcement entities and district government officials, on the content of the MoH issued circulars will be carried out under the EISM.
- Further assessment and dissemination of the MoH developed guidelines for the establishment and Operation of Drop-in-Centers for Key Populations in Uganda.
- Dissemination of the service delivery guidelines by the DG to the local governments and health facilities, as well as sensitization of key stakeholders including local authorities.
- As part of the EISM, MOH will work with service providers to simplify the content of the circulars, carry out further dissemination, and produce IEC materials to be displayed at health facilities.
- Review all contracts, Codes of Conducts, human resource procedures and protocols, whistle-blower protection protocols, and other measures, as needed, to ensure they require remediation of cases of discrimination.
- Include contract provisions on inclusion and non-discrimination including enhanced hiring procedures (LMP e.g., TORs, advertisements.
- Review the human resource procedures and protocols, whistle blower protections and other relevant policies and protocols of all project participants to ensure appropriate principles of inclusion and non-discrimination are being followed.
- Augment the project Grievance Redress Mechanism includes an effective, safe, ethical and confidential referral pathway to ensure that vulnerable or marginalized individuals or groups are comfortable reporting incidents of discrimination and that such grievances are addressed quickly, efficiently and appropriately.
- Facilitate the monitoring of implementation of all measures to promote non-discrimination under the project by supporting the World Bank financed organization to ensure all measures are implement and all reported incidents are shared with the Bank and addressed in a timely fashion.
- Issuance of guidelines for the heath sector by the Health Ministry to address risks to vulnerable or marginalized individuals or groups.
- Identification of good practices (e.g., training, protocols, and outreach efforts) to provide health services to vulnerable or marginalized populations in the sector.
- Adaptation of strategy developed by the Global Fund to ensure provision of medical care targeted at vulnerable or marginalized individuals or groups, including HIV prevention and treatment.
- Collaborate with stakeholders, including NGO/CSOs to enhance access to GRMs, in particular in refugee and host communities.
- Coordinate with Ministry of Health and development partners (e.g., UNICEF, USAID) on health projects.

- Update the Stakeholder Engagement Plan to include communications and engagements of vulnerable or marginalized individuals or groups, including NGO/CSOs.

5.5 Decommissioning Stage

Facilities such as temporary healthcare facilities, waste management facilities and medical equipment that were used during a COVID-19 outbreak and vaccination require decommissioning. Due to inherent similarities between COVID-19 emergency operations, information provided in this section is based on WHO's Rapid Guidance on the Decommissioning of Ebola Care Facilities March 2015 whose key guiding principles are discussed below.

5.5.2 Community Engagement

The first step in COVID-19 facilities decommissioning should be community engagement and should follow the SEP prepared for the parent project and updated to cater for AF activities. Community engagement refers to the process, principles and techniques of community mobilization and participation. This involves recognizing the community, its leadership and culture (knowledge, beliefs and customs) and adopting the most appropriate approach in meeting, educating, interacting and working with them. The community engagement process targets communities living in areas where COVID-19 facilities to be decommissioned are found. The engagement process should be mindful of individual perceptions regarding the decommissioning exercise and particular attention must be given to conveying the right message. Discussions with the community must include its opinions on the exercise, safety and health of the community and environment, including its role in supporting safe decommissioning of the facilities and any feasible alternatives. Essential steps in this community engagement process are as follows:

The project will follow the following principles for stakeholder engagement:

- **Openness and life-cycle approach**: Public consultations about project/subproject facilities to decommission in an open manner, free of external manipulation, interference, coercion or intimidation;
- **Informed participation and feedback**: Information will be provided to and widely distributed among all stakeholders in an appropriate format; opportunities are provided for communicating stakeholders' feedback, for analyzing and addressing comments and concerns;
- **Inclusiveness and sensitivity**: Stakeholder identification will be undertaken to support better communication and build effective relationships.

For effective engagement, stakeholders of the proposed project(s) can be divided into the following categories:

- **Affected Parties:** Persons, groups and other entities within the Project Area of Influence (PAI) that are directly influenced (actually or potentially) by the project and/or have been identified as most susceptible to change associated with decommissioning activities, and who need to be closely engaged in identifying impacts and their significance, as well as in decision-making on mitigation and management measures;
- **Other Interested Parties**: Individuals/groups/entities that may not experience direct impacts from the decommissioning; and
- **Vulnerable Groups**: Persons who may be disproportionately impacted or further marginalized the decommissioning activities.

5.5.3 Decommissioning process

"Decommissioning" is intended as the technical process in which COVID-19 care facilities are assessed, dismantled and/or repurposed after a proper decontamination phase aiming to prevent possible exposure to contaminated structures, equipment or material. Areas of a COVID-19 care facility can also be

decommissioned during the operational phase when they are no longer required and/or their physical status is visibly deteriorated. Such areas should be cordoned off to prevent unauthorized re-entry in order to avoid recontamination.

The decommissioning process can be divided into four phases as illustrated in figure below to cover removal of physical structures and equipment.

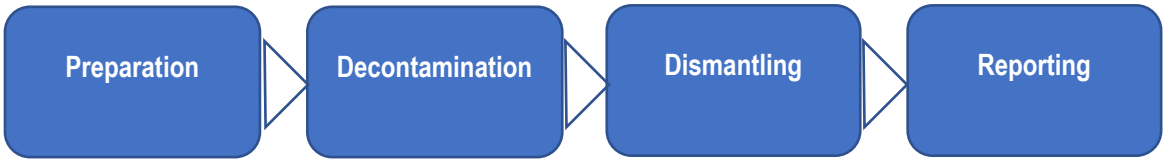


Figure 1: Decommissioning process

a) Preparation

Preparation for decommissioning should be undertaken well in advance of the authorization for decontamination to ensure stakeholders' buy-in. This phase includes the planning of the required pre-and post-decontamination actions as follows:

- Access control should be maintained throughout the whole process to guarantee smooth running of operations, safety of the staff involved and to manage the perception of the process within the local community.
- The facility manager should brief the decommissioning team. The briefing should focus on infrastructures and method of construction, areas, and identification of a "clean zone" for the reception and temporary storage of disinfected material.
- Community engagement should aim to inform, consult, engage and reassure the surrounding community in regards to the decommissioning process.
- Avail all PPE necessary for personnel that will carry out decommissioning.

b) Decontamination

The following precautions should be taken:

- Use of tape or rope to demark areas where decommissioning will take place
- Creation of a dedicated space for the drying of equipment/materials during the cleaning phase.
- The facility manager/ designee should observe the cleaning and disinfection process as a way to validate that the surfaces have been properly cleaned and disinfected.

c) Dismantling/repurposing

The dismantling phase refers to disassembly of temporary infrastructures and potential reuse and/or recycling of material or its disposal. It should start only after validation of the proper cleaning and decontamination of structures by the site officer/designee. Creation of a well demarcated "clean" zone (e.g., fenced with plastic tape) within the low-risk area where disinfected equipment and materials from the low-risk area can be temporary stored. No equipment or material should be abandoned on site without the approval of the relevant regulatory authorities.

d) Reporting

A final report of the entire decommissioning process should provide records of all activities, final dispositions
of waste and recycled products. It should include:

- The completed checklist approved by the designated facility manager/ officer and by MOH or NEMA.
- Organization and management of occupational health and safety during decommissioning process.
- Site plans, including power supply, concrete structures, water points and location of waste disposal areas.

- Waste management process.
- Photo journal.
- Conclusions and recommendations.

5.5.4 Decommissioning E&S impacts

Likely impacts during decommissioning to be looked out for and mitigated:

a) Waste impacts
b) Water pollution
c) Air impacts
d) Noise impacts
e) Soil contamination
f) Visual blight (view similar to a demolition site)
g) Occupational risks below:

i) *Biological hazards*
- COVID-19 virus.
- Other pathogens: hepatitis virus, bacteria, etc.
- Hazardous insects – mosquitoes, bees, wasps, scorpions, ants, etc.

ii) *Ergonomic hazards*
- Lifting and moving heavy and unwieldy objects can result in musculoskeletal injuries.
- Fatigue resulting from long work hours in hot and humid environments.

iii) *Psychosocial hazards*
- Fear of contamination with COVID-19 virus.
- Working under pressure and short deadlines.

iv) *Mechanical hazards*
- Slips and falls associated with poor housekeeping, excessive waste debris, loose construction materials, liquid spills, and uncontrolled use of electrical cords and ropes on the ground.
- Work at heights: working with ladders, scaffolding, and partially built or demolished structures.
- Struck by objects: potential fall of materials or tools, ejection of solid particles from abrasive or other types of power tools, which may result in injury to the head, eyes and extremities.

v) *Electrical hazards:* Contact with live electrical lines, use of electrical saws, drills or any power tools.

vi) *Chemical hazards*
- Dust from soil or building structures.
- Toxic fumes from burning objects, particularly those containing plastics.
- Organic solvents used for degreasing or in paints.
- Splashes of hazardous chemicals during the mixing and application of detergents causing irritation and burns to eyes and skin.

vii) *Physical hazards*
- Heat stress, particularly working in a hot climate with full PPE.
- Excessive noise from cutting tools and equipment.
- Exposure to hand vibration from tools.

5.6 Environmental and Social Management Plan

For each subproject when necessary, an Environmental and Social Management Plan (ESMP) will be prepared to ensure implementation of environmental and social management of its activities. An ESMP translates recommended mitigation and monitoring measures into specific actions that will be carried out by the proponent.

Should any subproject necessitate a full ESIA, an ESMP relevant to the subproject should be prepared as part of ESIA and implemented throughout the subproject life-time. The main components of an ESMP are described in table below (and example provided in Annex 2), which reflects practice at the World Bank. Ideally the ESMP should contain the following:

- Summary of the potential impacts of the proposal;
- Description of the recommended mitigation measures;
- Description of monitoring activities and plan;
- Allocation of resources and institutional responsibilities for plan implementation and training;
- Implementation Schedule of the actions to be taken and reporting procedures;
- Program for surveillance, monitoring and auditing; and
- Contingency plan when impacts are greater than expected.
- Estimated related costs and sources of funds

Table 9: Components of ESMP

ESMP Component	**Components of ESMP**
Summary of impacts	The predicted adverse environmental and social impacts for which mitigation is required should be identified and briefly summarized. Cross referencing to the ESIA report or other documentation is recommended.
Description of mitigation measures	Each mitigation measure should be briefly described with reference to the impact to which it relates and the conditions under which it is required (for example, continuously or in the event of contingencies). These should be accompanied by, or referenced to, project design and operating procedures which elaborate on the technical aspects of implementing the various measures.
Description of monitoring programme	The monitoring program should clearly indicate the linkages between impacts identified in the EIA report, measurement indicators, detection limits (where appropriate), and definition of thresholds that will signal the need for corrective actions.
Institutional arrangements	Responsibilities for mitigation and monitoring should be clearly defined, including arrangements for co-ordination between the various actors responsible for mitigation.
Implementation schedule and reporting procedures	The timing, frequency and duration of mitigation measure should be specified in an implementation schedule, showing links with overall project implementation. Procedures to provide information on the progress and results of mitigation and monitoring measures should also be clearly specified.
Cost estimates and sources of funds	These should be specified for both the initial investment and recurring expenses for implementing all measures contained in the ESMP, integrated into the total project costs, and factored into loan negotiations.

Source: World Bank, 1999

The Environment and Social Management Plans (ESMP) developed in accordance with this ESMF will contain specific provisions on the management of inclusion and non-discrimination of individuals or groups vulnerable or marginalized individuals or groups. These provisions are consistent with recent GoU measures to ensure non-discrimination and inclusion in accordance with Article 21, including circulars issued by the GOU included in Annex 16.

The purpose and objective of these provisions is to ensure that in accordance with World Bank policies and the Article 21 of the Ugandan Constitution: (i) project impacts do not fall disproportionately on individuals or groups who, because of their particular circumstances, may be vulnerable or marginalized ; (ii) there is no prejudice or discrimination toward individuals or groups in providing access to development resources and project benefits, particularly in the case of those who may be vulnerable or marginalized; (iii) Bank financed operations are implemented through their respective life cycles in a manner that is aligned with the inclusion and non-discrimination principles embedded in applicable Bank requirements including the Environmental and Social Standards in line with WB Policy paragraph 4 (b) ESF paragraph 28 (b) of ESS1 on Assessment and Management Environment and Social Risk and Impacts.

5.7 Mitigation measures and monitoring indicators for each subproject ESMP

A summary of mitigation measures and monitoring indicators for each sub-project ESMP is provided in

Table 10 below. This information will help in developing effective sub-project plans. The summary integrates information from ESMF sections 3.4; 5 and Annexes 4; 5 and 6. The summary also utilizes information from Uganda National Health Care Waste Management procedures, WHO documents and World Bank guidance documents related to COVID-19.

Risk and mitigation measures related to vulnerable or marginalized individuals or groups are described in section 5.4. The ESMPs where relevant will be updated or developed to include specific risk and mitigation measures identified for vulnerable or marginalized individuals or groups including monitoring indicators for each mitigation measures.

Table 10: A summary of mitigation measures and monitoring indicators for each sub-project ESMP

Sub-project/ *(Refer to Section 2.2)*	Socio-environmental aspects excerpted from description of the sub-projects	Mitigation measures	Monitoring indicators
Component 1: Case Detection, Confirmation, Contact Tracing, Recording and Reporting	i) **Disease Surveillance** ▪ Refresher training of PoE screeners at sites of thermal scanner installation. ▪ Support deployment of Surge Contact tracing teams. ▪ Orientation of District Health Teams in Integrated Disease Surveillance and Response Version 3. ii) **COVID-19 Testing and Laboratory Capacity Strengthening:** ▪ Expand existing laboratory capacity in two RRHs (Lira, Fort Portal) and provide/ensure continued operations of water supply, sanitation, and handwashing facilities. ▪ Training of laboratory staff from 16 RRH in COVID-19 diagnosis and response on IDSR version. iii) **Communication Preparedness**: Science has proved that that principal preventive interventions for COVID-19 rests on social distancing, personal hygiene, cough etiquette and disinfecting potentially infected surfaces in public disposal. This behavioral change communication will focus messaging on social distancing (as a core preventative measure), sanitation/hand washing behavior change promotion, food hygiene and safe water practices, as well as personal hygiene practices to reduce infection and transmission (wearing of masks, covering of mouth, etc.).	Remodeling laboratory spaces at Lira and Fort Portal RRHs, ICUs and construction of blood bank have potential construction impacts that can be abated with mitigation measures below: a) Contractors should provide all workers with requisite PPE. b) Contractor should provide onsite toilet and wash water for workers. c) Minimize temporary disruption of disruption of laboratory services. d) Minimize visual blight at construction sites. e) Workers should be sensitized of potential OHS risks (including in HIV/AIDS, COVID-19) and worker rights associated with these risks. f) Contractors should consider additional mitigation measures in Annex 5 and Annex 6 (some of these are excerpted below): ▪ Ensure a safe work environment (prevent risks of working at heights, electrocution, slips/ falls/ wet surfaces, etc.) ▪ Minimize dust from construction sites ▪ Minimize construction noise ▪ Ensure responsible construction waste management ▪ Maintain proper site drainage during construction ▪ Obtain construction material from approved sources ▪ Avoid impact on traffic circulation in on the hospital/ laboratory campus ▪ Sensitize construction workers on COVID-19 risks ▪ Prior to start of any construction works, the Contractor shall prepare an EHS-MP to ensure the adequate management of the health, safety, environmental and social aspects ▪ Zero tolerance to Child Labour ▪ Provide First Aid kits at work sites ▪ Ensure workers are provided with contracts including signing a code of conduct.	▪ Number of complaints about disruption of laboratory services during remodeling of laboratories ▪ Number of workers without PPE on site. ▪ Absence of sanitary facilities for workers on construction sites. ▪ Visible dust and number of dust-related complaints recorded per day. ▪ Noise levels measured on site and at nearest receptor. ▪ Waste littered on site. ▪ Ponded water on site ▪ Visual blight at construction sites ▪ Impeded traffic flow on site and number of traffic-related complaints recorded per day. ▪ Number of workers who are not aware of the three basic COVID-19 control measures like: social distancing, washing hands and wearing face masks. ▪ Absence of a contractor's EHS-MP ▪ Absence of First Aid kits ▪ Presence of persons below age of 18 working on construction sites ▪ Signed contracts and CoC
Component 2: Strengthening Case Management and Psychosocial Support	Specific activities to be funded under Sub-Component 2a (*Strengthening COVID-19 Case Management*) are: i) **Infrastructure, Equipment & Medical Supplies:** This will focus primarily on procurement of equipment and supplies, as well as refurbishing of selected facilities. It will include: a. Remodeling of isolation facility infrastructure in selected regional referral and general hospitals, construction of blood, upgrading of health facilities in RHDs as well as provision of continued operations of water supply, sanitation, and handwashing facilities within the targeted RRHs and General Hospitals and refugee settlements.	Mitigations are similar to ones above.	Indicators are similar to ones above.
Component 3: Implementation Management, Monitoring and Evaluation	No adverse socio-environmental impacts are associated with this sub-project	None	None

Sub-project/ *(Refer to Section 2.2)*	Socio-environmental aspects excerpted from description of the sub-projects	Mitigation measures	Monitoring indicators
Component 4: Vaccine acquisition and administration	The earmarked doses in millions will have a far much reaching effect in terms of managing the after effect; used medical syringes, waste vaccine bottles, waste medical gloves among others The key OHS risks include contamination with the dangerous and highly infectious COVID-19 or other contagious illnesses which can lead to illness and death of workers, and reagents and equipment used in the project-supported activities. Risky environments include laboratories, hospitals and health care centers, isolation centers and the broader community where project workers may be exposed to the virus. Health facilities treating patients or administering vaccines may also generate biological, chemical waste, and other hazardous by-products that could be injurious to human health. Transportation of COVID-19 vaccines from one location to the other may present risks of accidents to drivers. The key social risks under ESS2 relate to health care front line workers who may face increased incidences of retaliations Transporting vaccines across the country will require efficient cold-chain infrastructure in place which comes with an environmental cost, including energy consumption and indirect greenhouse gas (GHG) emissions.	• There should be restrict adherence and management of health care waste; this should include establishing appropriate incinerators at different health centres especially those in RHDs; where medical incinerators establishment is not feasible, then measures should be put in place to effectively collect and transport such waste to RHHs with such facilities. • Use of services of a licensed infectious, hazardous and biowaste handler should be sought about as temporal measure • A clear interpretation of Occupational Safety and Health Act will be done to respond to the specific health and safety issues, and protect workers' rights as set out in ESS2. Staff of health facilities as well as all other workers involved in the procurement, delivery, training, use, supervision/monitoring, and/or handling and disposal of medical supplies, equipment, or waste products will receive necessary training on protecting themselves and others from COVID-19 infection, as well as other relevant OHS risks and management measures • Integrating the WHO guidance tools for COVID-19 preparedness and healthcare facility management with the information, procedures, and tools required to safely and effectively work and specific infectious-control strategies, guidelines and requirements as recommended by WHO and other recommended OHS measures based on the World Bank EHS guidelines into the trainings and other management plans. • Other measures include posting of signages in all public spaces mandating hand hygiene and use of PPEs particularly face masks, gowns, gloves, hand washing soap and sanitizers and detergents). This encompasses procedures for entry into health care facilities, including minimizing visitors and undergoing strict checks before • entering; procedures for protection of workers in relation to infection control precautions. • The MoH is also using climate-friendly cold chain facilities for the storage of vaccines. • The project will incorporate the use of solar energy as an alternative energy use on healthcare facilities to be renovated/upgraded, and also use of LED lights in the ICUs and isolation units	• Visible and coded infectious waste bins • Availability of medical incinerators at the facility where mass vaccination is taking place • Contract with a licensed infectious and bio-waste handler • All involved in vaccination exercise having appropriate PPE • All staff and other personnel involved in vaccination exercise having been trained on how to handle vaccines, waste related or from vaccination exercise • LMP updated to capture all the new components related to vaccine acquisition and deployment
Component 5: Strengthening Continuity of Essential Health Services. The AF will introduce a new component to enhance continuity of services across four priority areas.	Sub-Component 5a: Upgrade Health Infrastructure and Equipment for Enhanced Service Delivery will support infrastructure upgrade in refugee settlements and RHDs, and in selected facilities outside of the RHDs. Within refugee settlements, project will support upgrade/renovation of selected health facilities in refugee settlements and RHDs; and remodeling of isolation facilities located near points of entry (borders). The Renovation/upgrade of selected health facilities in refugee settlements, construction/remodeling of isolation facilities at selected health facilities located near points of entry (border posts) will be carried out by contractors who may hire and use local labor for the civil works Sub-Component 5b: Strengthen Emergency Medical Services will support: finalization of EMS policy, guidelines, and standards (including establishment of a toll-free emergency number); procurement of ambulances equipped with supplies and products for pre-hospital care; finalize and disseminate updated guidelines on referral pathway (including clarifying roles and functions of different stakeholders); conduct simulation exercises as necessary to train clinical and EMS personnel; improve dispatch and fleet information management systems, ensuring integration of	• The ESMF including the LMP will be updated to include guidance related to the identified potential social risks. In addition, the anticipated civil works of AF are expected to induce a minimal influx of labor (10 to 15 workers) into the selected facilities and potentially impacting the neighboring communities during both construction and operation phases (hence no large-scale labor influx is expected). • MOH will include Labor Management Plans (LMPs) in contracts that will spell out the way in which project workers will be managed in accordance with the requirements of national law and the ESS2. • MOH will ensure that the contractors put in place adequate OHS measures to protect workers from injuries, accidents and COVID-19 infections and establish workers grievance mechanisms to resolve workers complaints. • All workers will be required to sign workers code of conduct to prevent incidents of SEA/SH among others. • The use of child or forced labor will be prohibited in accordance with ESS2 and Ugandan labor laws	• LMP developed • Percentage of Local Content of the Contract workers. • No. of GBV/SEA/SH cases handled and resolved. Including those that received psychosocial support. • Functionality of the workers' GRM • No. of facilities remodeled/ renovated/ constructed within the VMGs/IPs communities. • No. of trainings conducted in VMGs/IPs communities and refugee host communities and settlements.

Sub-project/ *(Refer to Section 2.2)*	Socio-environmental aspects excerpted from description of the sub-projects	Mitigation measures	Monitoring indicators
	emergency service and related surveillance metrics into the national HMIS, and supporting the expansion of these services into underserved parts of the country. Similar interventions will be supported in refugee settlements and refugee hosting districts, with the WHR supporting: establishment of a Regional and National Ambulance Call and Dispatch Center serving the Northern region, and covering a population of at least 856,000 refugees and 2 million residents of host communities; improvement of case referral services through acquisition of new ambulances for selected Health Center IVs and hospitals within the 12 RHDs to support routine referrals and the COVID-19 response. Sub-Component 5c: Improve the availability of essential health commodities. Beyond a focus on health commodities, the resources will also support the procurement of equipment and other supplies, as needed, to support the delivery of essential health services. Sub-Component 5d: Strengthening Community Systems for Continuity of Essential Health Services. Drawing from the National Community Engagement Strategy, the AF will strengthen structures for community health and enhance the capacity of VHTs and other community actors to support demand generation for health services; mobilize eligible populations for vaccinations; and provide integrated community-based health services for COVID-19, community-case management of childhood illnesses, TB, pneumonia, malaria, non-communicable diseases, and sexual and reproductive health interventions. Sub-Component 5e: Strengthening infection prevention and control in health facilities through multi-sectoral engagement. The activity will: complete the application of the WASH toolkit in Uganda; allocate resources for improved water and sanitation, medical waste management, as well as address persistent shortages in PPE for health workers to properly triage and manage patients at public health facilities; and introduce/reinforce norms to prevent microbial resistance in the health facilities.	• These include stigma associated with the proximity to COVID 19 infected patients, sexual/ harassment and exploitation and abuse, potential labor related issues, inadequate engagement /sensitization of both workers and communities, and lack of access to functioning GRMs. • None of the facilities envisaged to undergo remodeling/renovation/ construction are in Districts known to host members of VMGs i.e., the Batwa, IK, Benets, and Tepeth and therefore, these groups will not be impacted by the civil works. • The Project, in coordination with the Ministry of Gender, Labor and Social Development (MoGLSD), will: (i) train health care workers in host communities and refugee settlements on managing GBV cases; (ii) provide psychosocial and other support (e.g. GBV kits) to survivors; (iii) sensitize host communities and refugees on GBV and resources for accessing protection services (hotlines, community mechanisms, etc.); (iv) improve the quality of data on gender-based violence in host communities and refugee settlements, in order to inform interventions. • Contribute to reductions in greenhouse gas emission by shifting facilities from lighting that uses more energy to LED lighting, which uses less energy and reducing the amount of energy used for cooling by reducing the temperature of facilities through reflective paint.	

6 Procedures to Address E&S Issues

This section defines steps, actions and responsibilities screening potential environmental and social (E&S) issues and classifying risk levels. The same process and procedures as for parent project still suffice.

6.1 The Environmental and Social Screening Process

The sections below illustrate the stages (steps 1-7) of the environmental and social screening process leading to the review and approval of the project activities. The purpose of this screening process is to determine which activities are likely to have negative environmental and social impacts; to determine the level of required environmental assessment; to determine appropriate mitigation measures for activities with adverse impacts; to incorporate mitigation measures into the sub- program as appropriate; to review and approve the sub-program's proposals; to monitor and report environmental parameters during the implementation of activities. The extent of environmental and social work that might be required prior to the commencement of the sub-programs will depend on the outcome of the screening process. However, in accordance to the National Environment Act No. 5 of 2019, all possible projects in Uganda are already screened as per schedule 4, where the ESIA as a way of Project Briefs are required as listed in the schedule. Schedule 5 lists projects where mandatory ESIA is required by way of preparing a scoping report and terms of reference and thereby carrying out the impact assessment.

According to section 112 of the National Environmental Act (2019) screen of projects is already implied by the categorization in schedule 4 and 5. Section 112 indicates that the developer of a project set out in Schedule 4, shall undertake an environmental and social impact assessment by way of project brief which is submitted to the Authority in the manner prescribed by regulations.

Section 113, categorization of projects for purposes of environmental and social impact assessments. Schedule 5 provides that the developer shall conduct an environmental and social impact assessment by way of scoping; prepare terms of reference for an environmental and social impact study; and undertake an environmental and social impact study as prescribed by regulations. The environmental and social impact assessment undertaken, shall assess the potential impacts of individual projects and their contribution to the total cumulative effect.

For projects involving multiple small subprojects, that are identified, prepared and implemented during the course of the project, the Borrower will carry out appropriate environmental and social assessment of subprojects, and prepare and implement such subprojects, as follows: (a) *High Risk* subprojects, in accordance with the ESSs; (b) *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. If the risk rating of a subproject increases to a higher risk rating, the Borrower will apply the relevant requirements of the ESS and the ESCP will be updated as appropriate.

Box 3: E&S risk classification according to World Bank's Environmental and Social Framework

Aspect	High Risk Projects	Substantial Risk Projects
Project type, location, sensitivity, scale	"Complex large to very large scale in sensitive location(s)".	"Not as complex; large to medium scale not such sensitive location".
Nature & magnitude of risks & impacts, available mitigation	Mitigation unproven: unable to entirely address significant risk; high residual value.	Mitigation more reliable: significant risks but possible to avoid or address.

Borrower capacity and commitment	Challenges and concerns about track record regarding E&S issues, significant stakeholder engagement capacity, commitment, track record concerns.	Some concerns about borrower track record, engagement capacity but readily addressed.
Context of risk relevant to ES measures	Significant effects on ability to mitigate risk - significant contextual risks outside project control impacting on E&S performance and outcomes.	Some effects on ability to mitigate risk - known and reliable mechanisms to prevent or minimize, enforcement is weak in some respects, some stakeholder engagement concerns but readily addressed.
Aspect	**Moderate Risk Projects**	**Low Risk Projects**
Project type, location, sensitivity, scale	"No activities with high potential for harming people or environment; located away from sensitive areas".	"Few or no adverse risks and impacts.
Nature & magnitude of risks & impacts, available mitigation	Easily mitigated: site specific, low magnitude risks.	No further assessment after screening but Some basic EHS measures are often necessary.
Borrower capacity and commitment	Sufficient borrower experience, track record, stakeholder engagement capacity.	Minimal or negligible risks to and impacts on human populations and/or the environment
Context of risk relevant to ES measures	No effects on ability to mitigate risk – no contextual risks with effects on E&S performance	Negligible risk.

Step 2: Assigning of Environmental and Social Risk Categories

Given the highly infectious nature of COVID-19, its EHS risks and impacts and the resultant HCW management requirements, the current overall Project E&S Risk Classification is **Substantial**. The Bank will review the risk classification assigned to the overall Project on a regular basis, including during implementation, and will change the classification where necessary, to ensure that it continues to be appropriate. Any change to the classification will be disclosed on the Bank's website.

Step 3: Carrying out Environmental and Social Assessment

A Project Brief containing an ESMP shall be developed and submitted to NEMA for review and approval. In case of subproject activities falling under schedule 5 of the National Environment Act (2019) an Environmental and Social Impact Assessment (ESIA) will be out by a certified Environmental practitioner approved by NEMA. The ESIA will be undertaken in accordance with the NEMA's approved scoping report and terms of reference.

The ESIA will identify and assess the potential environmental impacts for the planned activities, assess alternative solutions and will design the mitigation, management and monitoring measures to be adopted. These measures will be quoted in the Environmental and Social Management Plan (ESMP) that will be prepared as part of the ESIA for each sub-program. The preparation of the ESIA and the ESMP will be done in consultation with all relevant stakeholders, public institutions, including the people likely to be affected by the sub- program, and will be provided to the WB for a "no-objection" before commencing project implementation. The ESIA will follow the national procedure established in the framework of the National Environment Act No.5 of 2019, National Environment (Environmental and Social Assessment) Regulations, 2020, Guidelines and consistent with the WB ESS1 and all other relevant ESSs. The anticipated facilities to be remodeled or upgraded are listed under 4th schedule and hence would require and ESIA at the level of Project Brief.

Step 4: Review and Approval

Review: At the district or municipal level, the City/ Municipal/ District Environment Officer, City/ Municipal/ District Community Development Officers and communities will review the environmental and social screening forms and will make recommendations as to whether the results of the screening process, including ESMPs where necessary (see Annex 2) are acceptable. If a Project Brief was prepared to facilitate screening, it will be submitted to NEMA for review and/or approval. In case an ESIA needs to be undertaken, the ToR's for the study will be prepared by Environmental and Social Safeguards Specialists or Environmental Health Division (EHD) of the MoH, reviewed and approved by NEMA, with modifications where necessary. High/Substantial Risk Projects will require their ESIA TORs to be approved by the WB.

Approval/Rejection: The ESIA study will be undertaken by the EIA practitioner in accordance with the ToRs approved by NEMA and report submitted to NEMA for review. A Project Brief on the other hand may be prepared by either the client or hired consultant/s and the report submitted to NEMA for review/approval. NEMA will then forward copies to relevant Lead Agencies and Local Authority (MEO/DEO and MCDO/DCDO) for comments. Comments from the Lead Agency/ Local Authority will be considered by NEMA in making a final decision on project implementation. If the ESIA is approved, NEMA issues an environmental permit that confirms the EIA has been satisfactorily completed and the proposed sub-program implementation may proceed.

Step 5: Public Consultations and Disclosure

Public consultations will take place during the environmental and social screening process, and the input from the public consultations will be reflected in the design of the mitigation and monitoring measures. The City/ Municipal/ District Environment Officer and City/ Municipal/ District Community Development Officers will communicate the results of environment and social screening to the Town Clerk/ Chief Administrative Officer (CAO) who will in thereafter, communicate the result to the MOH and Local Governments. According to the procedures governing the ESIA, public information and participation must be ensured during the scoping period and the preparation of the terms of reference of the Environmental and Social Impact Assessment. This will be done by ESIA practitioner. The involvement of District/Municipal Environment Officer, District/Municipal Community Development Officer, Health Officers level will be encouraged. World Bank requires disclosure of the environmental assessment report and/or ESMP both in-country by the client (MoH) and at WB's website.

Step 6: Environmental Monitoring

Environmental monitoring aims at checking the effectiveness and relevance of the implementation of the proposed mitigation measures. Local councilors, District Environment Officers and local government Health Officers as well as concerned citizens will undertake monitoring exercises as provided for by the National Environment Act No.5 of 2019. The Municipal/ District Environment Officer and the Municipal/ District Community Development Officer in conjunction with the District Health Officer /Inspector will monitor implementation of environment mitigation measures based on the contractor's work plan. In the RHDs, there will liaise with the RDO to monitor the implementation of the environmental and social mitigation measures in the refugee settlements. MOH in collaboration with NEMA will monitor implementation of the environmental mitigation measures on a sample of project sites on quarterly basis. Using the Geo-Enabling Monitoring and Supervision (GEMS) of Projects, site/field/district level data on implementation of mitigation measures will be regularly collected/filled at the District level and filtered at the MoH level. On annual basis the Municipal/ District Environment Officers, MOH in collaboration with NEMA will carry out a national assessment of project performance in environment and natural resource management using the indicators mentioned in Step 7.

Step 7: Monitoring indicators

Monitoring indicators to use under ESMP for assessing environmental management for the project are provided in **Table 10** (Section 5.6).

MoH's Social and Environmental Specialist will be responsible for collecting the data for the monitoring indicators, and what monitoring indicators (data) would be collected and submitted by construction contractors to the PIU (or whomever) and medical facilities (i.e., Hospitals) associated with their operational phase. Use of the indicators for environmental monitoring will be included in the training and capacity building program.

It is recommended that MoH's Project Implementation Unit (PIU) develops a standard set of indicators applicable to all subprojects, and some optional ones that may be apply to only specific subprojects.

6.2 Protocol to Manage Chance Finds

The civil works which will be limited to existing government health facilities in the refugee settlements and near border points will be limited in scope with minimal environmental footprint; the potential impact on known or tangible cultural resources is likely to be minimal. The project will avoid adverse risks and impacts of the project activities on cultural heritage and where such avoidance is not possible, will identify and implement measures to address these impacts in accordance with the mitigation hierarchy. The Chance Finds Procedure included in this ESMF will be followed for the project and also included in ESMPs that will be developed during project implementation to provide guidance on identification and handling of any chance encounters during site excavation works. The project will to the extent possible protect and support the preservation of intangible cultural heritage of VMG/IPs from any likely adverse risks and impacts of the national vaccination program which may not be in line with their traditional medicinal practices. The provisions in the updated SEP that target members of Vulnerable and Marginalized Groups including Indigenous Peoples will address any infringement of intangible cultural heritage of IPs.

This protocol will apply where healthcare facilities are to be constructed, especially when earthworks are carried out at any COVID-19 emergency facility site. Earthworks may encounter cultural and archaeological resources or chance finds. Construction can also reveal these buried resources, necessitating "salvage archaeology" for their recovery and protection. Once first stages of earthworks show signs of likely presence of archaeological resources, salvage entails quick excavation to remove artifacts or other traces of human settlement before extensive earth-moving continues. As a general construction principle, any archaeological "chance finds" should be handed to the Department of Museums and Monuments in the Ministry of Tourism, Trade & Industry (MITI). A protocol for managing chance finds developed based on The Historical Monuments Act, 1967 is given in Box 3.

Box 4: Suggested protocol to manage "chance finds"

1. The contractor shall not perform excavation, demolition, alteration or any works that may harm resources of cultural importance without authorization of the Engineering Assistant or officials from the Department responsible for museums and monuments.

2. In case of chance finds, the Contractor shall mark, cordon and secure the subject site(s) to avoid damage in the course of construction and immediately notify the Department responsible for museums and monuments.

3. Opening of a new borrow or quarry site shall be witnessed and inspected by official(s) from the Department responsible for museums and monuments for the first 2 days of site opening. The official(s) shall maintain watching briefs during works, with clear procedures for protection and documentation of any "chance finds" encountered.

4. The contractor is obliged to provide for and ensure archaeological intervention in case they come across new finds. This involves immediate discontinuation of works and notifying the Department responsible for museums and monuments about any discoveries.

5. "Chance finds" encountered in presence of official(s) from the Department of Museums and Monuments shall be handed to them for transfer to the national museum.

6. "Chance finds" encountered in absence of these official shall be handed over to supervising Engineering Assistant, Environmental Officer or District Engineer who would immediately notify officials of the Department of Museums and Monuments.

7. The Contractor, and supervising engineer shall maintain contact details of the Department of Museums and Monuments to quickly notify it in case chance finds are encountered.

6.3 Grievance Management

6.3.1 Managing Grievances

6.3.1.1 General grievances

If any grievances arise during implementation of this project, there should be a redress mechanism that affected parties can use. The grievance redress mechanism (GRM) should provide avenues for affected persons to lodge complaints or grievances against the project or contractors working on the project. It also should describe procedures, roles and responsibilities for managing grievances and resolving disputes. Every aggrieved person shall be able to trigger this mechanism to quickly have their complaints resolved. The GRM needs to also respond to the refugee settlement structures and function effectively within settlements in coordination with refugee stakeholders. This also should apply to communities of VMGs – Batwa, Benet, Tepeth and the Ik that have their own traditional structures and leaders useful for dispute resolution.

Key objectives of the grievance process are supposed to be:

i) Provide affected people with avenues for making a complaint or resolving any dispute that may arise during project implementation, including provisions for confidentiality for sensitive grievances;
ii) Ensure that appropriate and mutually acceptable corrective actions are identified and implemented to address complaints;

iii) Verify that complainants are satisfied with outcomes of corrective actions;
iv) Avoid the need to resort to judicial (legal court) proceedings.

If a complaint is not related to construction activities, it should be addressed directly to the medical facility In-Charge. As provided in the SEP for AF, GRM will include the following steps:

Step 1: Submission of grievances:
Anyone from the affected communities or anyone believing they are affected by the Project can submit a grievance:

- By completing a written grievance registration form that will be available at the PIU offices, and with GCs at District Hospitals and Health Centers/clinics representing the lowest level of public health services provider.
- Submitting the complaint electronically via the electronic grievance form that will be available at the MoH website.
- Telephone and mobile numbers assigned for complaints at the PIU.

Where complaints apply to IPs/ VMGs, such as the Ik, Batwa and the Benet, the GRM Focal Person will need to assess and/or seek advice as to whether a specific grievance mechanism needs to be taken up by IPs/VMGs or not. This may be the case if certain aspects of the general community grievance process (such as language issues or the need to file a grievance in writing) are deemed unsuitable for the indigenous community in question. The GRC will be put in place starting from the community level from within the IP/VMGs community including a clear tier for escalation of cases to the national level. Regardless of the arrangement, the GRM should be able to accommodate any specific cultural requirements of IPs/VMGs.

Grievances from anonymous complainants will be received by the site supervising engineer (or contractor's sociologist) and recorded in a complaints log kept on site. Where possible it is desirable that complaints are submitted in writing by the complainant. Should the complainant not wish to comply with this request and submit the complaint verbally, then the complainant information and the details of the complaint should be entered in the GM log.

All contact names, addresses, numbers and websites/emails will be made available in the Project SEP once it is updated.

Step 2: Recording of grievance and providing the initial response:
The complainant will fill a form in writing and signs it as an option, or fill it electronically including all personal information of the complaint. Affected persons can also log in their complaints verbally using the available structures in the community within their reach or at site. Where possible the complainant will attach all copies of documents that support their complaints. The GRM Focal Person at site or at the district level will update the complaint record as appropriate. Responsible officers/ project representative and GCs will ensure that the form is filled accurately. The complainant will receive a copy of receipt or a confirmation of acknowledgment with a reference number/ID number to track their complaint(s).

The following information will be registered in the grievance log:
a) Complaint Reference/ID Number
b) Date of receipt of complaint
c) Name of complainant (Depending on sensitivity of the complaint details will be kept anonymous)
d) Confirmation that a complaint is acknowledged
e) Brief description of Complaint
f) Details of internal and external communication
g) Action taken: (Including remedies / determinations / result)

h) Date of finalization of complaint

The PIU staff or GC members will inform the complainant that an investigation is underway within seven business days. The complainant shall be informed of the estimated duration for resolving their complaint, which is no later than fourteen business days from the date of receipt of the complaint. Where the complaint is unlikely to be resolved within the estimated duration, the staff or GRC members will promptly contact the complainant to request additional time and explain the delay. In any event, the complaint must be resolved no later than twenty-one days from the date of receipt of the complaint.

Step 3: Investigating the grievance:

The staff at PIU or GC members will investigate the grievance by following the steps below:

- Verify the validity of information and documents enclosed.
- Ask the complainant to provide further information if necessary.
- Refer the complaint to the relevant department.
- The relevant department shall investigate the complaint and prepare recommendation to the PIU or GC of actions to be taken and of any corrective measures to avoid possible reoccurrence.
- The PIU staff or GC shall register the decision and actions taken in the GM log.

Step 4: Communication of the Response:

The PIU staff or GC shall notify the complainant of the decision/solution/action immediately either in person, writing, or by calling or sending the complainant a text message. When providing a response to the complainant, the PIU staff or GC will include the following information:

- A summary of issues raised in the initial complaint;
- Reason for the decision.

Step 5: Grievance closure or taking further steps if the grievance remains open:

A complaint is closed in the following cases:

- Where the decision/solution of complaint is accepted by the complainant.
- A complaint that is not related to the project or any of its components.
- A complaint that is being heard by the judiciary.
- A malicious complaint.

Step 6: Appeals process:

Where the complainant is not satisfied with the outcome of his/her complaint after it is addressed by GCs, staff in charge for complaints at the PIU advise the complainants that if they are not satisfied with the outcome of their complaint, they may re-address the issue to the Minister of Health. Once all possible redress has been proposed but the complainant is still not satisfied then they will be advised by MoH of their right to legal recourse in courts of law.

6.3.1.2 GBV complaints

a) Handling a GBV complaint

During COVID-19 lockdown in Uganda, GBV (men meting violence onto women and vice-versa) has been widely reported. It is therefore important that a GBV Complaints team proposed in the grievance committee has both a male and female representative. It is important that people both inside and outside the project operations have channels through which they can report GBV, including options to report anonymously.

COVID-19 has increased tension within households, multiplying triggers for abuse; how young girls have been sexually abused during this period, child marriage and early pregnancies are on the rise with school

closures among others. In addition, the inability to meet basic needs has forced women and girls to undertake more risky activities and provided additional opportunities for men to sexually exploit women and girls in exchange for basic needs. It is therefore important that the GRM is well equipped to support GBV/ SEA Complaints. The Project specific GRM will be developed and will consist of GBV/SEA reporting channels/entry points which include:

- All project staff/workers will have signed Codes of Conduct per ESMF/LMP and will be trained to refer GBV/SEA cases to a focal point (GBV/SEA Service Provider who must immediately and confidentially report cases to MoH and through MoH to the WB while safeguarding confidentiality);
- Survivors must be offered referral to support services; and
- Sanctions against perpetrators must proceed at the personal or institutional level with consent of the victim, or where consent is not given, anonymously where possible.
- Trained GRM committee members as focal points whose role is to receive and refer cases appropriately to GBV service providers.
- At the PIU, MoH will hire a GBV Consultant who will be responsible for the management of all GBV/SEA related risks and impacts. The Consultant will be the focal point/entry point for the implementation of GBV/SEA activities, monitoring, coordination, and reporting. Project workers and other stakeholders including district local governments will be informed of the GBV Consultant's role. She/he will be trained to facilitate a survivor centered approach ensuring safe and confidential referrals and case follow up either from the community or from project workers.
- Contractors are required to sign a code of conduct that clearly prohibits GBV/SEA in line with the ESMF and awareness sessions/training will be conducted on GBV/SEA with workers. The SOPs include issues regarding health, GBV/ SEA, child protection, education among others.
- Additional refugee specific risks include: the high proportion of women and girls and other vulnerable people within the refugee population which poses specific protection challenges, including GBV/ SEA and access to health services strained under the pressure of COVID-19.
- For workers: independent helplines, an email address or whistleblowing line, health and safety committees. It is important that these channels provide anonymity for the aggrieved persons.
- For service users or community members: feedback boxes, telephone numbers, a designated community organization, or local women's organization. Reporting channels need to include anonymous options and operate within refugee settlements.

The GRM aims to support GBV victims by referring them to GBV Services Provider (this can be a local NGO already working with GBV) for support immediately after receiving a complaint from a victim. Support options include:

i) Medical support for incidents involving sexual violence, which may include treatments that need to be administered within 72 hours of the incident to be effective, such as:
   - Emergency contraception to prevent unwanted pregnancy
   - Post-exposure prophylaxis treatment to reduce the chances of HIV infection.
ii) Psychological support for victims and witnesses, which may need to include trauma counseling for victims of sexual violence or harassment
iii) Legal advice for victims, whistleblowers, witnesses and alleged perpetrators
iv) Measures that support reintegration into the workforce (e.g. counseling)
v) Child-protection support services and/or expertise for reports involving children.

There are at three key actors involved in handling GBV complaints: (i) GRM system administrator; (ii) GBV Services Provider and, (iii) representative of MoH. It is therefore essential that prior to GBV complaints being received, it is clear who specifically will be responsible for handling the complaint:

who will assess nature of the complaint, appropriate action to be applied to the perpetrator and verifying that the victim has received support.

While the process for grievance resolution and people involved may vary, the key guiding principle for resolution should be to ensure complete confidentiality of the victim, a victim centered approach and speedy resolution. The process for addressing complaints should entail:

- The GRM operator will keep GBV allegation reports confidential and, unless the complaint was received through the GBV Services Provider or other identified reporting channels, refer the victim immediately to the GBV Services Provider.
- If a case is first received by the GBV Services Provider or through other identified reporting channels, the report will be sent to the GBV operator to ensure it is recorded in the system.
- The GBV Services Provider provides the necessary support to the victim until it is no longer needed

b) Resolving and closing a GBV case

There are two elements related to resolving and closing a GBV case:

- The internal project system, in which the case is referred to the GBV Services Provider for victim support, and through the established GBV resolution mechanism appropriate actions are taken against perpetrators,
- The support that the victim receives from the GBV Services Provider.

When a complaint is received, it should be registered in the project GRM and referred to the GBV Complaints Team with the consent of the complainant. The GBV Complaints Team will initiate accountability proceeding (with the victim's consent), as follows:

- If the victim does not wish to place an official complaint with the project, the complaint is closed.
- When the victim proceeds with the complaint, the case is reviewed through the established GBV resolution mechanism and a course of action is agreed upon.

A process to resolve GBV complaints is shown in figure below.

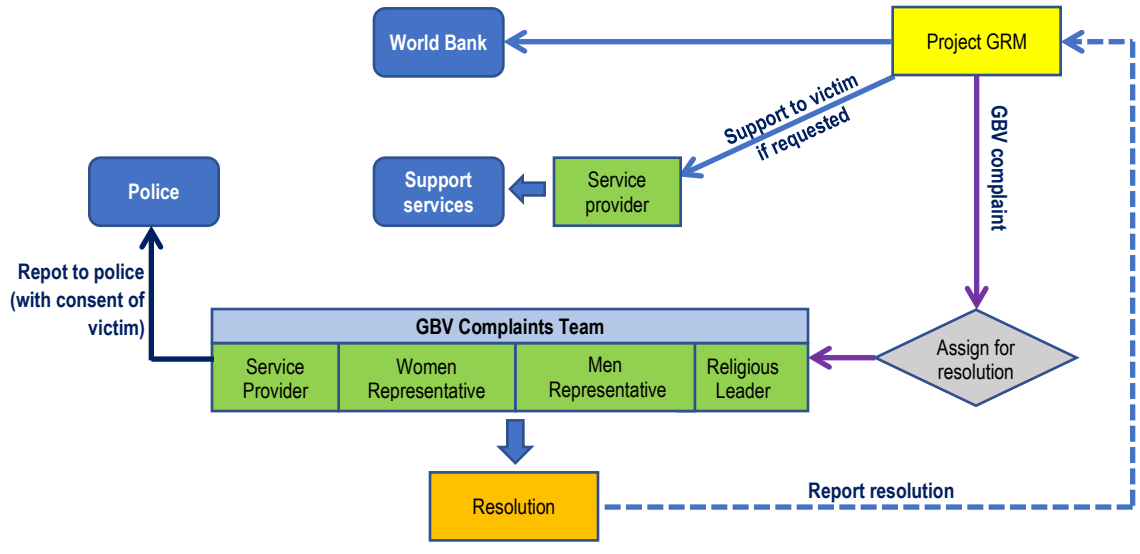


Figure 2: Process of resolving GBV complaints

6.3.2 Composition of Grievance Committee for COVID-19

GRM will be culturally appropriate and accessible to these groups, considering their customary dispute settlement mechanisms. The United Nations High Commission for Refugees-UNHCR and the Office of the Prime Minister have established a refugee complaints desk in all refugee hosting districts. The desk will handle complaints within refugee settlement and host communities. The strengthened registration and case management systems will improve service and assistance delivery, including distribution of food.

Vulnerable Marginalized Groups may encounter a grievance or a complaint against the project, its staff or contractors during project implementation. To address or resolve the grievance, a mechanism describing procedures, roles and responsibilities in grievance management process is given below. To be effective, the mechanism shall utilize existing local administrative and community structures. All grievances concerning non-fulfillment of contracts, levels of compensation, exclusion from subproject benefits, or seizure of assets without compensation shall be addressed.

Considering the diversity of local conditions and communities especially if refugee settlement or host community or VMGs/IPs community, a grievance committee in each community should be formed under aegis of MoH to reflect expectations of all parties, local circumstances and equitable representation of all stakeholders involved. At the local grievance committee should include:

- Local chairperson of the community/ village
- District Health Officer
- District Internal Security Officer
- GBV/ SEA Complaints Team (comprising a women representative, men representative, religious leader and all should preferably have experience with GBV/ SEA grievance resolution)
- Youth representative
- Refugee Desk Officer/ Community Development Officer/ Labor Officer
- At least two representatives of the refugees and VMGs/IPs

Local leaders and representatives of the VMGs/IPs and refugees will be instrumental in choosing a youth and women representatives of at least 30% suitable to be co-opted to the grievance committees.

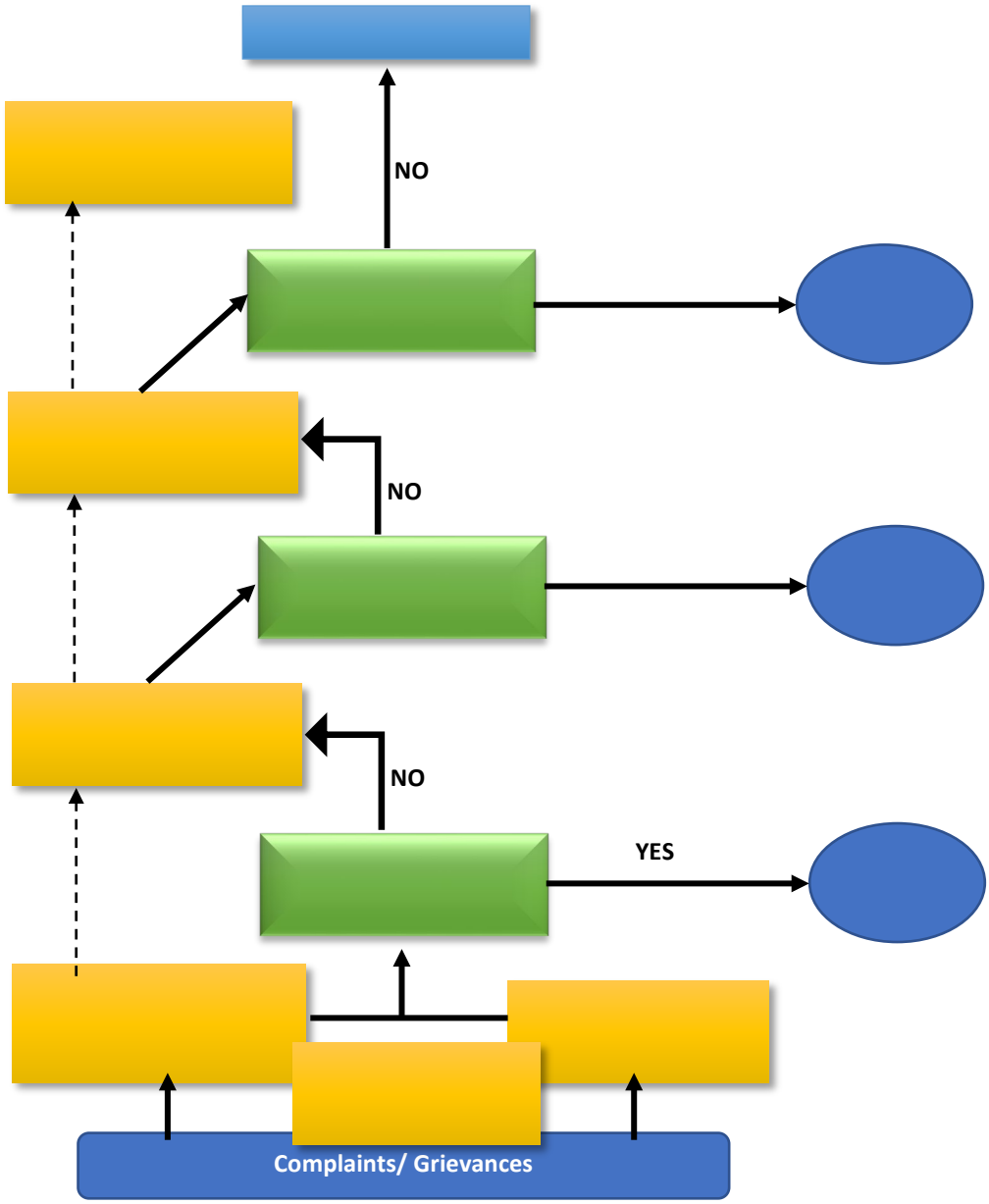


Figure 3: GRM Structure

6.4 Estimation of HCW at Medical Facilities

Determination of healthcare waste streams and quantities including wastewater, solid wastes and air emissions (if significant) at healthcare facilities involved with this project shall be done through an environmental audit (by a consultant hired by MoH) as suggested and budgeted for in Chapter 10.

6.5 Preparation of sub-project ESMP and Project Implementation Manual

For each subproject, when necessary, an Environmental and Social Management Plan (ESMP) will be prepared following template in Annex 2.

The Environment and Social Management Plans (ESMP) developed in accordance with this ESMF will contain specific provisions on the management non-discrimination of vulnerable or marginalized individuals or groups. These provisions are consistent with recent GoU measures to ensure non-discrimination in accordance with Article 21, including circulars issued by the GOU included in Annex 16.

The purpose and objective of these provisions is to ensure that in accordance with World Bank policies and Article 21 of the Ugandan Constitution: (i) project impacts do not fall disproportionately on individuals or groups who, because of their particular circumstances, may be vulnerable or marginalized; (ii) there is no prejudice or discrimination toward individuals or groups in providing access to development resources and project benefits, particularly in the case of those who may be vulnerable or marginalized; (iii) Bank financed operations are implemented through their respective life cycles in a manner that is aligned with the non-discrimination principles embedded in applicable Bank requirements.

To facilitate the implementation of the provisions for non-discrimination that cover vulnerable or marginalized individuals or groups, the Project Implementation Manual (PIM) will be updated to specify how the mitigation measures will be implemented. The Project Operation Manual will clearly lay out how the project will ensure non-discrimination of individuals or groups.

The Project Operation Manual will provide details of how the mitigation measures will be implemented. Furthermore, it will specify the timelines and roles and responsibilities to implement the different mitigation measures. The Project Operation Manual will also provide detailed information on how exactly the project will support and interact with the World Bank Enhanced Implementation Support and Monitoring. The Project Operation Manual will be developed or updated no later than two months after the redisclosure of the project's instruments or before the Enhanced Implementation Support and Monitoring mitigation measures are agreed to and in place.

7 Consultation and Disclosure

Consultations done for the parent project still apply but will be enhanced and updated during assessment of subprojects following the Stakeholder Engagement Plan that has been developed and updated for AF. Below is the consultation done for the parent project and the respective responses. A consultation questionnaire was used with entities/ individuals below to obtain views about issues related to COVID-19 emergency operations including existing facilities/ resources, challenges, resource needs and general state of preparedness:

- National Union of Disabled Persons of Uganda, NUDIPU
- United Nations High Commission for Refugees, UNHCR
- Green Label Services LTD (a medical waste company)
- Batwa Development Project (an association of Batwa, a vulnerable and marginalized tribe in Uganda)
- Ik Agenda Development Initiative-IADI
- The Mount Elgon Benet Indigenous Ogiek Group
- Regional Referral Hospitals (Mbale, Gulu, Masaka, Mbarara, Moroto)
- Refugee Host Districts (Yumbe, Adjumani, Madi-Okollo & Terego, Isingiro, Kikuube, Kyegegwa, Obongi, Kampala, Kamwenge, Kiryandongo, Lamwo and Koboko).

Feedback was obtained from the following entities:

- RRH (Mbale, Masaka, Mbarara,)
- Green Label
- NUDIPU
- UNHCR

Majorly the stakeholders consulted were those at service level. During the Environmental and Social Impact Assessment of the sub-projects, detailed consultation will be carried out from which the project briefs/ ESIA Reports will be derived. Opinions captured from the consultations will be integrated in the designs and implementation of the sub-projects. More consultations will be carried out to capture the view of more stakeholders especially in regard to the social and environmental issues that may affect the designs of the sub-projects. A summary of key responses comprised in feedback provided by respondents is provided in table below.

Table 11: Key issues from consulted parties

#	Issue	Response
1	**State of preparedness:**	a) Mbale had converted its mental unit into a temporary 50-bed isolation unit for COVID-19 patients. ABSA Bank had also committed to donate a 20-bed tent to compliment the aforesaid 50-bed unit. b) Masaka RRH had also converted its Mental Health unit and the TB ward into COVID-19 treatment facilities with 32 beds. Additional isolation capacity/ units had been pledged by: ▪ ABSA Bank: 8 bed capacity tent. ▪ World Food Program (WFP): 30 bed tent. c) Mbarara RRH's state of preparedness is described by the following: ▪ Isolations unit available to managed COVID-19 related issues ▪ Staff available such as doctors, nurses and social worker to handle COVID-19 patients ▪ Some PPE gears was available

#	Issue	Response
		▪ RRH has COVID-19 Management Team comprising of case management, psychosocial and IPCs.
2	**Main challenges:**	***Masaka RRH:*** At Masaka RRH, main challenges were constraints in steady supply of PPEs, food and other social needs for COVID-19 patients and the staff caring for them. The RRH also lacked an intensive care unit (ICU) in case such services was required. The RRH has been using the School of Nursing for quarantining suspected cases, but this will not be possible when nursing students return ***Mbarara RRH:*** ▪ Inadequate staffing levels ▪ Standard of isolation is inadequate critical care equipment, space is limited ▪ Long turn around for COVID-19 laboratory results 3- 7 days ▪ Inadequate PPE ▪ Inadequate vital signs monitoring equipment ▪ Homeless people and illegal refugees pose a challenge in COVID-19 control ***Mbale RRH:*** ▪ Lacked ICU ▪ Conversion of mental unit into COVID-19 isolation unit delimits the RRH's capacity to provide services to mental patients.
3	**Resources required for effective management of COVID-19 emergencies**	▪ Adequate staffing / human resources ▪ Personal Protective equipment ▪ Food for patients and staff ▪ Transport for contact tracing and community integration of COVID-19 affected persons
4	**COVID-19 waste management**	***Mbarara RRH*** ▪ Uses a pit for medical waste disposal. ▪ It does not own medical waste incinerator or any other alternative waste disposal method. ***Mbale RRH*****:** Has a medical waste incinerator but decries its high fuel costs. ***Masaka RRH*****:** This RRH also has an incinerator but incurs similar high fuel costs as does Mbale RRH.
5	**Managing special COVID-19 patients**	Special patients in this category include pregnant women, people with disabilities and indigenous people. All RRH contacted indicated limited capability to manage COVID-19 patients that were pregnant. In one case at Mbale RRH a baby was delivered by a mother in an isolation unit and remained with the mother notwithstanding the risk of it getting COVID-19 infection. All RRH reported limited or no special provisions in place for people with disabilities. However none had special provisions for indigenous people.
6	**Waste contractor's view**	Green Label has facilities below and is able to manage COVID-19 waste. ▪ Incinerator in Iganga ▪ Incinerator with disposal capacity of one ton per hour located in Iganga district ▪ Autoclave with disposal capacity of one ton per hour located in Mbarara district.
7	**NUDIPU**	Person with disabilities are hugely affected by the COVID 19 as compared to other citizens. In fact, the pandemic as exposed the already bad situation impacting PWDs in Uganda. The mitigation and prevention measures are hugely not accessible to persons with disabilities. The information on radios and TV is not automatic to PWDs. The deaf communities are lacking this information. Sign language interpretation services and captioning is missing on most TVs. This means they have missed out on mitigation measures and prevention strategies

#	Issue	Response
		announced from time to time. Furthermore, PWDs have fallen victims to security agencies. In Agago, a deaf person riding a motorcycle was short in the leg and it has since been amputated. The overzealous LDU short him because the disabled person was not able to talk or explain anything to the security operative. Such incidences are many in communities. This as result of lack of ability to communicate and lack of sensitivity by the security teams. The issue of masks has also been another issue that has affected persons with disabilities. A number of PWDs use lip reading to get an idea of what is being talked or communicated. The available masks are not transparent to allow access to such information. The communities where there is no sign language, some PWDs do lip reading to get such information. There is need to supply transparent masks and those communicating COVID information should use transparent masks quite often. Whereas physical distancing is recommended as good strategy to mitigate spread of pandemic, this is not easy to observe by person with disabilities. Most PWD use personal assistants either as guides or helpers. Guides for blind people and helpers for those using assistive devices such as wheel chairs and tricycles. So social distancing is very difficult among person with disabilities due to barriers and challenges they face. This means there is need for SOPs around such people to enable them not infect the people they support. A number of PWDs who were involved SMEs business have since lost them. The money has been used at home for food and little is available, if any, to bring them back to a state that they could again make a living. Most of them have been involved in hand to mouth businesses in urban and peri-urban areas. This implies that their means of livelihood has collapsed and therefore economic recovery stimulus intervention should ensure that person with disabilities are not left behind. Furthermore, disabled persons who had other illnesses have not been able to visit health facilities due to lack of means of transport. Also, during stoppage of public and private transport many PWDs suffered hugely because of their nature of disability which cannot allow them to walk to health facilities and yet there was no SOPs or guidelines on disability and COVID 19 from ministry of health during this pandemic. Lastly, communication channels used to share information and disseminate COVID-19 strategies are not disability-inclusive or sensitive. Videos, adverts and posters are silent about persons with disabilities. No person with disability has been used in adverts, videos or posters as role model to encourage people with disabilities relate with or embrace the messages.
8	**UNHCR**	Currently refugees risk communication is mainly done by the village health team who do not have adequate remuneration, adequate tools and materials. The risk communication through radio and Television does not adequately reach refugees because of extremely low coverage of radio and TVs. While there are posters printed for the national languages, the refugee languages are not all covered in the current poster materials. The posters are not enough in number and refugee language coverage for the 1.4 million refugees and surrounding host population in Uganda. The mounted vehicle rides (boda-boda and vehicles) are only limited in specific parts of the settlements with inadequate frequencies of covering the settlements. Refugee community radios that are the first point of mass media are few in the settlements with inadequate air play for COVID-19 information. Challenges specific to refugees Uganda Government should solve when planning and implementing COVID-19 control measures include: *Risk communication* – intensity and language translations to the refugee languages including materials and support to the village health team members

#	Issue	Response
		Surveillance – intensification of community, health facilities and other institutional especially use of the Village health teams (VHT) for identification/referral and truck drivers and recent traveler surveillance among the refugees. Provision of adequate COVID testing kits for refugee new arrival testing and routine settlement surveillance within the settlements. *Case management* – This should be prioritized especially equipping of isolation facilities, improvement of infrastructure at health facilities and support to district isolation facilities. *Infection prevention and control /WASH* – prioritization of WASH in the community, health facilities, institutions to contribute to infection prevention and control measures and reduce water-borne related diseases. There are inadequate re-usable masks for refugee new arrivals and existing refugees in the settlements amount to 1,200,000 masks to protect refugee population at the same level as nationals. *Continuation of health services* – especially for malaria (prevention, Integrated community case management commodities, early diagnosis and treatment, Indoor residual spraying), provision of adequate stocks of HIV/AIDS and TB medicines and management of chronic condition through distribution. *Containment* – support to the quarantine (improvement in the infrastructure in quarantine centres in Kisoro, Isingiro, Kikuube, Kamwenge, Kyegegwa, Adjumani, Parolinya, Yumbe, Koboko and Arua as well as feeding and COVID testing) and isolation facilities in the refugee settlements *Other refugee specific areas* - Shielding of the critically elderly and those will the chronic illness and feeding for the refugees in the situation of reducing food ration UNCHR was of the view that based on aforementioned challenges, refugee settlements are inadequately prepared to manage COVID-19 related emergencies and appealed for support for surveillance (including quarantine centres) and case management.

A full record of stakeholder consultation is presented in Annex 8.

8 Stakeholder Engagement

Information in this chapter reflects the content of a standalone stakeholder engagement plan (SEP) which was prepared for this additional financing (disclosed) project, which should be referred to where specific detail is required. The Project SEP provides an adequate and detailed plan that will ensure culturally appropriate engagement is undertaken with the Batwa, Benet, and the Ik; as well as the refugee communities.

8.1 Stakeholder identification and analysis

Project stakeholders are defined as individuals, groups or other entities who:

- Are impacted or likely to be impacted directly or indirectly, positively or adversely, by the Project (also known as 'affected parties'); and
- May have an interest in the Project ('interested parties'). They include individuals or groups whose interests may be affected by the Project and who have the potential to influence the Project outcomes in any way.

Engagement with stakeholders throughout the Project cycle necessitates identification of persons within the groups who act as legitimate representatives of their respective interests. Community representatives may provide helpful insight into local settings and act as main conduits for dissemination of the Project-related information and as a primary communication/liaison between the Project and target communities. The Project SEP provides specific measures on consultations with the VMGs to ensure they benefit from the project. Verification of stakeholder representatives (i.e. confirming that they are legitimate advocates of stakeholders they represent) is an important undertaking in establishing contact with stakeholders.

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8.2 Methodology

The project will follow the following principles for stakeholder engagement:

- **Openness and life-cycle approach**: Public consultations for the project(s) will be arranged during the whole life-cycle, carried out in an open manner, free of external manipulation, interference, coercion or intimidation;
- **Informed participation and feedback**: Information will be provided to and widely distributed among all stakeholders in an appropriate format; opportunities are provided for communicating stakeholders' feedback, for analyzing and addressing comments and concerns;
- **Inclusiveness and sensitivity**: Stakeholder identification is undertaken to support better communications and build effective relationships. The participation process for the projects is inclusive. All stakeholders at all times are encouraged to be involved in the consultation process. Equal access to information is provided to all stakeholders. Sensitivity to stakeholders' needs is the key principle underlying the selection of engagement methods. Special attention is given to vulnerable groups, in particular women, youth, elderly and the cultural sensitivities of diverse ethnic groups. including Batwa, Benet, Tepeth, IK and refugees.

For effective engagement, stakeholders of the proposed project(s) can be divided into the following categories:

- **Affected Parties:** Persons, groups and other entities within the Project Area of Influence (PAI) that are directly influenced (actually or potentially) by the project and/or have been identified as most susceptible to change associated with the project, and who need to be closely engaged in identifying

impacts and their significance, as well as in decision-making on mitigation and management measures;

- **Other Interested Parties**: Individuals/groups/entities that may not experience direct impacts from the Project but who consider or perceive their interests as being affected by the project and/or who could affect the project and the process of its implementation in some way; and
- **Vulnerable Individuals or Groups**: Persons who may be disproportionately impacted or further marginalized by the project as compared with any other groups due to their vulnerable status[61], and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project including women, elderly, PWDs, Batwa, Benet, Tepeth and the IK. Refugees are noteworthy as the projects key vulnerable individuals or groups.

8.2.1 Affected parties

Affected parties include local communities and other parties that may be subject to direct impacts from the Project. Specifically, the following individuals and groups fall within this category:

a) People under COVID-19 quarantine, including workers in quarantine centers
b) Patients
c) Relatives of COVID-19 infected people
d) Relatives of people under COVID-19 quarantine
e) Neighboring communities to laboratories, quarantine centers, and screening /testing posts
f) Workers at construction sites of laboratories, quarantine centers and screening posts
g) People at COVID-19 risk (travelers, inhabitants of areas where cases have been identified, etc.)
h) Healthcare workers
i) Municipal waste collection and disposal workers
j) Airline and border control staff
k) People affected by or involved in project-supported activities
l) Workers handling COVID-19 healthcare waste
m) Prisoners
n) Education institutions
o) Healthcare service volunteers
p) People eligible for vaccine who should have priority (elderly, immune-compromised)
q) People likely to have less access (poorest, women, youth, PWD, Batwa, Benets, Tepeth, Ik etc.,)
r) Refugees and host communities
s) Humanitarian workers supporting refugee services

8.2.2 Other interested parties

The projects' stakeholders also include parties other than the directly affected communities, such as:

- Electronic and print media
- Politicians
- National and international health NGOs
- Other national & International NGOs
- Faith Based Organizations (FBOs)

[61] Vulnerable status may stem from an individual's or group's race, national, ethnic or social origin, color, gender, language, religion, political or other opinion, property, age, culture, literacy, sickness, physical or mental disability, poverty or economic disadvantage, and dependence on unique natural resources.

- Religious Leaders
- Businesses community and industries
- The general public
- Researchers institutions
- Academia

8.2.3 Vulnerable and Marginalized Groups (VMG)

It is particularly important to understand whether project impacts may disproportionately affect disadvantaged or vulnerable individuals or groups, who often do not have a voice to express their concerns or understand project impacts. This would help ensure that particular concerns and cultural sensitivities of VMGs are understood and catered for in project planning and implementation. Arrangements under the parent project to target the IPs included sensitizations about the COVID-19 and the use of Standard Operating Procedures (SOPs) to prevent infections from the disease.

AF shall deliberately target the VMGs specifically the Indigenous Peoples (IPs) the Batwa, Ik, Benets and Tepeths not only with the vaccination campaign messages to mobilize them but also enabling them to access vaccines and be voluntarily vaccinated. Indigenous Peoples will be engaged through their traditional structures, clans, and their community-based organizations.

The following measures shall be undertaken to ensure VMGs/ IPs such as the Batwa, Ik, Benets and Tepeths benefit from the project;

i) targeted vaccination outreaches shall be conducted within communities of the VMGs/IPs and also the refugee settlements, since most of these are remote and hard to reach areas - the districts have already mapped out these IP communities and need to share with the district health teams to plan these outreaches in a deliberate manner;
ii) vaccination campaign messages to reach the VMGs shall be made in their appropriate local language(s) - this means these messages need to be translated into the vernacular that can be understood by the VMGs/IPs be it IEC materials or radio/TV or social media messages;
iii) VMGS/IPs have their own leadership structures which should be the main avenues to reach out to them for mobilizing them for the vaccination campaign - the IPs have clan leaderships and representatives, and also have community-based organizations and lobby groups that are very instrumental in mobilizing the VMGs; and
iv) the expansion of the designated vaccination sites under the AF shall focus on targeting specific VMGs/IP communities and refugee settlements. These should have volunteers/ VHTs and health workers from within their communities. This would encourage and increase the uptake of vaccines among the VMGs/IPs.

Vulnerable or Marginalized Individuals or Groups may include and are not limited to the following: refugees, the elderly, ethnic and religious minorities, people with disabilities, those living in remote or inaccessible areas, care takers of persons with disabilities; female headed households or single mothers with underage children; Child-headed households; jobless people; persons living with HIV/AIDS but also the indigenous people/ ethnic minority groups.

8.3 Stakeholder Engagement Program

8.3.1 Stakeholder engagement done during project preparation

Due to the emergency situation, including the restrictions on public gatherings and the need for social distancing, no consultations beyond technical meetings by MOH with relevant government agencies and

health experts have been conducted so far. There will be continuous consultations and further updates of the ESMF incorporating the views of the refugees and the other VMGs/IPs. The Ministry of Health has prepared a Stakeholder Engagement Plan (SEP) which was updated and disclosed on 9th November 2021.[62] ().

8.3.2 Methods, tools and techniques for stakeholder engagement

World Health Organisation (WHO) "COVID-19 Strategic Preparedness and Response Plan OPERATIONAL PLANNING GUIDELINES TO SUPPORT COUNTRY PREPAREDNESS AND RESPONSE" (2020) outlines the following approach in ***Pillar 2: Risk Communication and Community Engagement***, which will be the basis for the Project's stakeholder engagement:

> *"It is critical to communicate to the public what is known about COVID-19, what is unknown, what is being done, and actions to be taken on a regular basis. Preparedness and response activities should be conducted in a participatory, community-based way that are informed and continually optimized according to community feedback to detect and respond to concerns, rumours and misinformation. Changes in preparedness and response interventions should be announced and explained ahead of time and be developed based on community perspectives. Responsive, empathic, transparent and consistent messaging in local languages through trusted channels of communication, using community-based networks and key influencers and building capacity of local entities, is essential to establish authority and trust".*

Table below outlines envisaged stakeholders, their characteristics and preferred means of engagement.

Table 12: Stakeholders, their characteristics and preferred means of engagement

Stakeholder	Key characteristics	Preferred engagement means
Infected persons and their families	Persons tested positive for COVID-19 who are hospitalized or kept in isolation facilities and their families.	Phone calls, text messages and emails.
Emergency medical personnel, clinical and laboratory staff	These include doctors, nurses, laboratory workers, administrators, cleaners, etc. This group will be trained to manage COVID-19 incidents such as case detection, diagnosis, referral and clinical management for mild, severe and critical cases, development of risk communication plan, information, education and communication materials, clinical guidance and protocols, assessments of available medical equipment, commodities and supplies at clinical care settings, mapping of human resources for COVID-19 response, management of medical waste.	Official letters, emails, phone calls text messages, emails and individual meetings (if needed).
The general public	The project will target the general population which will be kept informed of the latest information on the COVID-19 outbreak, precautions and recommended hygiene/ control practices.	Local radios and TV stations, Information leaflets, posters and brochures; audio-visual materials, social media; telephone calls, SMS, etc.; Public notices; electronic publications and press releases

[62] https://www.health.go.ug/resources/

Stakeholder	Key characteristics	Preferred engagement means
		on the MoH and hospital websites.
Government officials, Civil Society Organizations, NGOs, development partners involved in the health sector and Private Sector	These include MoH staff, immigration and police officials, environmental protection authorities, local and international NGOs working in the health sector and community outreach. The private sector includes private health facilities and factories manufacturing hygiene and medical supplies.	Official letters; emails, phone calls, (virtual) meetings.
Vulnerable individuals and groups	This include elderly persons and persons with pre-existing medical conditions (e.g. HIV/AIDS, diabetes, hyper-tension, respiratory disease etc.)" who may be more susceptible to COVID 19.); persons with disabilities and their care takers; women/child-headed households or single mothers with underage children; vulnerable or marginalized individuals or groups and communities in crowded areas (i.e. prisons, refugee camps);	Local radios and TV stations, Information leaflets, posters and brochures; audio-visual materials, social media; telephone calls, SMS, etc.; Public notices.
VMGs	Batwa, Benets, Tepeth and the Ik Social groups with identities that are distinct from dominant groups in national societies, are often among the most marginalized and vulnerable segments of a population.	Through their traditional structures, clans, their community based organizations
Refugees	Refugees within settlements including people with specific needs like people with disabilities, pre-existing medical conditions, and a high percentage of female headed households.	Community radio, and mobile loudspeakers in local languages.
Business owners and providers of services, goods and materials	Business owners and service providers will be involved in the project's wider supply chain or may be considered for the role of project's suppliers in the future	Official letters, emails and phone calls, SMS, Social media.
Mass media and associated interest groups	Including local and national printed and broadcasting media, digital/web-based entities, and their associations.	Official letters, emails, and phone calls.

8.3.3 Proposed strategy for information disclosure

Table below shows proposed information disclosure plan

Table 13: Information disclosure strategy

Project stage	Target stakeholders	Information to be disclosed	Methods and timing
Project Inception	▪ MoH and MDAs; ▪ National and international health organizations ▪ National & International NGOs; ▪ Education institutions ▪ Faith Based Organizations (FBOs) ▪ Healthcare service volunteers ▪ Healthcare workers	▪ PAD; ▪ ESMF ▪ SEP; ▪ ICWMP ▪ ESCP	▪ Press releases in the local media; ▪ Consultation meetings; ▪ Roundtable discussions. ▪ Virtual meetings ▪ MoH website

Project stage	Target stakeholders	Information to be disclosed	Methods and timing
	▪ Refugees and host communities ▪ Humanitarian workers supporting refugee services ▪ People affected by or involved in project-supported activities ▪ People at COVID-19 risk (travelers, inhabitants of areas where cases have been identified, etc.) ▪ People eligible for vaccine who should have priority (elderly, immune-compromised) ▪ People likely to have less access (poorest, women, youth, PWD, Batwa, Benets, Tepeth, Ik etc.,) ▪ People under COVID-19 quarantine, including workers in quarantine centers ▪ Workers handling COVID-19 healthcare waste ▪ Workers at construction sites of laboratories, quarantine centers and screening posts		
Project Implementation	▪ Project affected person; and ▪ Other interested Parties ▪ Politicians ▪ Academia ▪ Airline and border control staff ▪ Businesses community and industries ▪ Electronic and print media ▪ Municipal waste collection and disposal workers ▪ National and international health NGOs ▪ Neighboring communities to laboratories, quarantine centers, and screening /testing posts ▪ Other national & International NGOs ▪ Patients ▪ Prisoners ▪ Relatives of COVID-19 infected people ▪ Relatives of people under COVID-19 quarantine ▪ Religious Leaders ▪ Researchers institutions ▪ The general public	▪ Various awareness messages on case detection, confirmation, contact tracing, recording, reporting strategies; ▪ Awareness on social distancing strategy; ▪ Grievance Redress Procedures; ▪ Update on project implementation and progress; ▪ Relevant E&S documents; ▪ Update on technical designs of the isolation units and quarantine facilities	Information leaflets, posters and brochures; audio-visual materials, social media and other direct communication channels such as mobile/ telephone calls, SMS, etc; Public notices; Electronic publications and press releases on the MoH websites; Press releases in the local media (both print and electronic); Consultation with vulnerable groups using mobile/ telephone calls, SMS, etc.; training and meetings; help desk mechanism; virtual meetings; roundtable discussions

Project stage	Target stakeholders	Information to be disclosed	Methods and timing
Supervision & Monitoring	▪ Project affected person; and ▪ Other interested Parties • Faith Based Organizations (FBOs) • Healthcare service volunteers • Healthcare workers • Refugees and host communities • Humanitarian workers supporting refugee services • People affected by or involved in project-supported activities People at COVID-19 risk (travelers, inhabitants of areas where cases have been identified, • Workers handling COVID-19 healthcare waste • Workers at construction sites of laboratories, quarantine centers and screening posts • Politicians • Municipal waste collection and disposal workers • National and international health NGOs • Neighboring communities to laboratories, quarantine centers, and screening /testing posts	Project's outcomes, overall progress and major achievements	Roundtable discussions; Press releases; Press conferences; Public meetings; Reports; MoH website;
Project Close Out	▪ MoH and ministries, departments and agencies (MDAs); ▪ Project affected persons; and ▪ Other interested Parties	▪ Project exit strategy; and ▪ Dissemination of final project reports. ▪ Decommissioning plans and schedules	Consultation meetings; information leaflets, posters and brochures; audio-visual materials, social media; Electronic publications and press releases on the MoH websites; Press releases in local media (both print and electronic); media; roundtable discussions

8.3.4 Stakeholder Engagement Plan

Table below shows proposed stakeholder engagement plan details of which are embedded in the Project Stakeholder Engagement Plan.

Table 14: Stakeholder engagement plan

Project stage	Topic of consultation	Method to use	Stakeholders	Responsibilities
Project Inception	Introduction of the project and information about time and venue of training, Health & safety and sub-management plans grievance redress management (GRM) tools for filing complaints and providing feedback	Emails, official letters, consultation meetings, phone calls, SMS, Social media.	Health personnel Other government personnel such as Immigration, police, local council officers Contractors, service providers, suppliers and their workers	MoH
	General information of the project as stipulated in the PAD; fiduciary considerations; schedules of planned activities, associated risks and mitigation measures.	Emails, official letters and virtual meetings and round table discussions with relevant organizations	Government officials; media, private sector; civil society groups and NGOs; national and international health organizations (WHO, UNICEF)	MoH
Project Implementation	▪ Project status ▪ Project progress in containing and treating the infection ▪ Risks and mitigation measures ▪ Communication campaign: Press releases in the local media (both print and electronic), written information will be disclosed including brochures, flyers, posters, etc. MoH website, to be updated regularly	Information leaflets, posters and brochures; audio-visual materials, social media and other direct communication channels such as mobile/ telephone calls, SMS, etc.; Public notices; Electronic publications and press releases on the MoH websites; Press releases in the local media (both print and electronic)	General population, including Vulnerable households Government agencies, media, private sector etc.	MoH
	Information about Project development updates, health and safety, employment and procurement, environmental and social aspects, Project-related materials.	Official letters, emails, phone calls and individual meetings (if needed)	General population, Government agencies, media, private sector, NGOs, actors.	MoH
Supervision & Monitoring	Project's outcomes, overall progress and major achievements	Press releases in the local media; Consultation meetings (virtual); Round table discussions	Government officials; Civil society groups and NGOs; National and international health organizations	MoH

8.3.5 Future of the project

Stakeholders will be kept informed as the project develops, including reporting on project environmental and social performance and implementation of the SEP and grievance redress mechanism. This will be important for the wider public, but equally and even more so for suspected and/or identified COVID-19 patients' treatment, management and then later vaccination of the targeted population.

8.4 Resources and Responsibilities for implementing SEP

8.4.1 Resources

Ministry of Health will be in charge of stakeholder engagement activities and provide necessary financial and human resources to undertake stakeholder engagement. The Budget for implementing the SEP is provided for in the separate Project SEP.

8.4.2 Management functions and responsibilities

The MoH will be the implementing agency and will be in charge of implementing the SEP while working closely with other relevant MDAs and District Health Officers. All stakeholder engagement activities will be documented through quarterly progress reports to be shared with the World Bank.

Table 15: Roles of Stakeholders

Stakeholder	Roles	Specific Tasks
Ministry of Health	The UCREPP is fully embedded in the institutional and coordination structures in the health sector. At Project level, the Project Implementation Unit (PIU) at the MoH undertakes day to day management and coordination of the Project including the associated fiduciary, safeguard, monitoring and evaluation functions in collaboration with relevant departments and agencies under the ministry. The original implementation and institutional arrangements for the parent Project has a limited scope and coverage than the AF project.	(i) recruiting additional personnel to support implementation; (ii) strengthening collaboration across the different departments within the MoH and with OPM and UNHCR for refugee issues; (iii) enhancing supervision of the various components through component leads; and (iv) strengthening stakeholder engagement with development partners and civil society organizations.
	MoH has enhanced institutional and coordination arrangements for the immunization program to incorporate requirements for COVID-19 vaccination. Specifically, the following structures have been set up or strengthened to provide oversight and technical leadership of the vaccination campaign, under the overall leadership of the National COVID-19 Response Task Force. These include refugees as further outlined below. Key partners supporting the COVID-19 response in Uganda include WHO, USAID, World Bank, Africa CDC, UNICEF, GAVI (through the COVAX Facility), Global Fund, and UNHCR.	These structures are: (i) National Vaccine Advisory Committee (VAC); (ii) Strategic Committee of the Ministry of Health; (iii) COVID-19 Incidence Management Team; (iv) National Coordination Committee; and (v) National Immunization Technical Advisory Committee.
National Vaccine Advisory Committee	The National Vaccine Advisory Committee (VAC), National Immunization Technical Advisory Committee (NITAG), and the National Coordination Committee (NCC) together provide oversight on the	The National Vaccine Advisory Committee is made up of the top management of the MoH, heads of key development partner agencies (e.g., UN agencies, USAID, CDC, World Bank, civil society)

	deployment of COVID-19 vaccines. These three committees feed data/information on the national vaccination campaign to the COVID-19 Incidence Management Team and the Strategic Committee, which are some of the operational arms of the overall National COVID-19 Task Force.	
refugee health integration steering committee	MoH has a refugee health integration steering committee and a secretariat that oversees the implementation of the Health Sector Integrated Refugee Response Plan (HSIRRP).	The AF project will be coordinated under the HSIRRP frameworks and structures. Implementation of the refugee health is integrated into MoH systems with 76% of the refugee serving health facilities already managed by MoH.
Project Implementation Unit	The PIU is responsible for project management. The implementation and institutional arrangements in the parent Project will be enhanced to reflect the expanded scope with inclusion of COVID-19 vaccination and deployment including refugees and Refugee Host Districts. Specifically, Uganda National Expanded Program for Immunization (UNEPI), which will provide technical leadership on Component 3, Vaccine Acquisition and Deployment).	The PIU will also do the following to enhance Project implementation: (i) recruit additional staff; and (ii) appoint leads to oversee activities under each of the four components, against the approved work plan. The Project's Steering Committee will be expanded to ensure representation from the key departments including OPM. Other departments that will be involved in Project implementation include: Health Sector Partners and Multi-Sectional Coordination, which directly interfaces with both OPM and UNHCR (due to inclusion of host communities and refugees within RHDs) and has appointed a lead person to the PIU for operational coordination with UNHCR; Emergency Medical Services; Maternal and Child Health; and Planning, Financing and Policy. Given the increased activities and complexities of managing different stakeholders.
National Medical Stores	National Medical Stores (NMS) and the National Drug Authority (NDA) are responsible for inspection, verification, monitoring and supervision of vaccines while political and technical leaders oversees similar functions at the sub national level.	National Medical Stores; NMS has the legal mandate and track record in procurement and distribution of essential medicines and vaccines and is responsible for the distribution of vaccines acquired through the COVAX facility. Its human resource and supply chain management capacities have improved considerably over the past few years through enhanced use of IT platforms (eLMIS) and better fleet management for vaccine distribution. However, inadequate operational funds constrain the organization.
National Drug Authority	The country has previously established regulatory standards at national level with the National Drug Authority (NDA) serving as the lead agency in pharmacovigilance.	The NDA has developed guidance on emergency and compassionate use authorization, upgraded its pharmacovigilance tools and, printed and distributed AEFI guidance to health facilities. The NVDP was developed with the support of development partners addressing areas of population targeting, vaccine delivery strategies and logistics and supply chain systems that include refugees.

Ministry of Gender, Labor and Social Development	The MoGLSD sets policy direction and monitoring functions related to labor, gender and general social development. The OHS unit in the ministry is responsible for inspection and mentoring of occupational safety in workplaces and this could be during project construction and operation of the healthcare facilities.	The OHS in Ministry of Gender, Labor and Social Development is mandated to supervise all workplaces for safety of workers both during construction and operation.
NEMA	NEMA is the national agency responsible for setting environmental laws, regulations, managing and monitoring environmental performance in Uganda.	
Local Governments	The proposed project is within a number of jurisdictions of a number of Districts headed by a Local Council 5 (LC5) Chairman and Chief Administration Officer (CAO) who are the political head and technical head respectively. Various district offices whose functions would be relevant to the project include offices of Natural Resources/Environment, District Health Officer, District health inspector/educator, District Planner, Community Development Officer, Wetlands Officer, Land Office, District Water Officer, Town Council and District Engineer. Equally important are village-level local council administration (LC I and LC III). Leaders at these levels of local administration are closer to residents and therefore important in effective community mobilization, sensitization and dispute resolution. The District and Local/Health Unit Health Teams will also be involved in project implementation.	Local governments have administrative authority over projects implemented in respective areas of their jurisdiction and are expected to participate in supervision and monitoring project implementation and operation. In case of a COVID-19 outbreak, assistance of local governments would be essential in identifying location of isolation areas, coordination and communication between the Public Health Emergency Operations Centre (PHEOC), health workers in COVID-19 Treatment Units and at Points of Entry (PoEs) to enable quick identification, notification, transfer and management of patients or suspected victims, including surveillance. The project will target the general population which will be kept informed of the latest information on the COVID-19 outbreak, precautions and recommended hygiene/ control practices. Local radios and TV stations, Information leaflets, posters and brochures; audio-visual materials, social media; telephone calls, SMS, etc.; Public notices; electronic publications and press releases on the MoH and hospital websites.
International Agencies (WHO JICA (through UNICEF) Global Fund GAVI COVAX UNHCR USAID CDC CHAI/Bill & Melinda Gates Foundation) UNHCR	UNICEF and UNHCR will play important collaborative roles in Project implementation. UNICEF will be contracted directly, through the MoH, to support the procurement and deployment of vaccines, per the agreements made through the COVAX Facility, and through AVATT. The government may explore additional arrangements beyond these two for UNICEF. UNHCR will be engaged closely in the implementation of activities in the refugee settlements and hosting districts and ensure effective coordination with the Refugee Inter-Agency Health and Nutrition Working Group. The Project activities envisioned take into consideration current and planned investments on refugee health being	Providing technical leadership for vaccine introduction, providing technical support to National Immunization Technical Advisory Group to define COVID-19 vaccination policy objectives, strategy, targets and vaccine safety issue; Developing guidelines and conducting training on AEFI surveillance for COVID-19 vaccine related issues and other issues of vaccine pharmacovigilance, etc. Supporting the development of a roadmap for improved integration of COVID-19 vaccine deployment with EPI and other primary health care (PHC) services, supporting the quantification and forecasting of supply needs, support to procure and install quality cold chain rooms at national level.

	supported by UNHCR and are intended therefore to complement an overall framework of development assistance.	Provision of supplies for vaccination, in particular data collection equipment and supplies. Provision of cold chain equipment including medical equipment for cold-storage facilities at national and sub-national levels, and transportation to ensure vaccination in the country. Support towards procurement of COVAX vaccines. Support towards all pillars of the resurgence plan, in particular continuity of essential services for TB, HIV and malaria; support to the scale up of COVID-19 Testing, Procurement of Personal Protective Equipment (PPEs). Oxygen delivery capacity. Support to national and district monitoring, supervision and performance management of vaccine activities to improve delivery and management, including post-market surveillance inspection and rapid assessments to determine barriers to vaccine deployment and uptake. UNHCR also plays a key role in management of refugee issues in coordination with DoR and is a key stakeholder that will be engaged in settlement implementation and coordination between DoR and District health officials
Office of the Prime Minister – Department of Refugees	Department of Refugees has a Camp Commandant responsible for the refugee settlement management and coordination with local government.	DoR is mandated with authority within the settlement and coordination with MoH on health related services. Close coordination is needed between DoR and district officials including the district health officer. The project will specifically target the refugee population which will be kept informed of the latest information on the COVID-19 outbreak, precautions and recommended hygiene/ control practices in coordination between DoR and District health officials.

8.5 Monitoring and Reporting

8.6.1 Involvement of stakeholders in monitoring activities

The Project will provide opportunity to stakeholders, especially Project Affected Parties to monitor certain aspects of project performance and provide feedback. GRM will allow stakeholders to submit grievances and other types of feedback. Due to the high risk of contamination, frequent and regular meetings and interactions with stakeholders will be suspended until decided otherwise by MoH.

The process for involving project affected parties and what they will monitor, how and when in the Project cycle is outlines below:

a) Avenues of involvement:

- Direct communication channels with MoH headquarters or Project Implementation Teams,
- Reporting and communication with District Environmental Officers to report ongoing impacts or check on mitigation and control processes,
- Interaction with the grievance redress committees,

- Attending project progress update meetings when called by Ministry of Health.

b) Aspects to monitor, how and frequency

i) Improper COVID-19 related waste disposal:

- *What to monitor:* Number of cases, number of people vaccinated and doses and locations where waste from COVID operations is dumped in undesignated / unauthorized locations
- *How:* Visual observation, verifying community reports and grievances
- *Frequency:* Weekly or as and when community complaints are raised

ii) Working conditions/ Occupational safety of COVID-19 response teams:

- *What to monitor:* Number of COVID-19 workers without requisite PPE
- *How:* Visual and record of complaints from health workers
- *Frequency:* Daily or as and when complaints are raised

iii) Gender-based violence in COVID-19 response operations:

- *What to monitor:* Number of COVID-19 workers and community members reporting GBV complaints
- *How:* Verbal complaints or written *r*ecords held with Grievance Management Committees (GMC)
- *Frequency:* Weekly or as and when complaints are raised

iv) Inefficient COVID-19 response operations:

- *What to monitor:* How fast MoH responds to COVID-19 emergency calls and delivery of required services (isolation, testing, collection of patients needing medical attention). How fast (response time in hours) and effectively (total attention) services are delivered to hotspots such as refugee settlements and prisons.
- *How:* Visual and records
- *Frequency:* Daily

Examples of activities to "monitor" EHS performance include review of EHS performance reports from construction contractors and medical facilities (related to operational impacts/risks); site visits and review of grievance process outcomes.

8.6.2 Reporting back to stakeholders

The SEP will be periodically revised and updated as necessary during project implementation in order to ensure that information presented herein is consistent and is the most recent, and that the identified methods of engagement remain appropriate and effective. Any changes in project activities or schedules will be duly amended in the SEP.

Monthly summaries and internal reports on stakeholder grievances, feedback or inquiries, together with the status of implementation of associated corrective/preventative actions will be collated and documented by relevant MoH project implementation staff. The monthly 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.

Information on stakeholder engagement activities undertaken by the Project during the year may be conveyed to the stakeholders in two possible ways:

a) Publication of a standalone annual report on project's interaction with the stakeholders.
b) A number of Key Performance Indicators (KPIs) will also be monitored by the project on a regular basis, including the following parameters:
   - Frequency of public engagement activities;
   - Number of grievances received and resolved within a reporting period (e.g. monthly, quarterly, or annually) and number of those resolved within the prescribed timeline;

- Number of press materials published/broadcasted in the local, and national media

9 Implementation Arrangements, Responsibilities and Capacity Building

This section describes institutional arrangements to implement the ESMF from the screening of subprojects (project components) for environment and social issues, preparation of and consultation for subproject instruments, disclosure, review and clearance of subprojects to monitoring the implementation of the ESMP.

For planning and design, and construction stage, an institutional arrangement for authorities, project proponent, consultants, contractors, and supervision. For operational stage, the following aspects have been considered:

- Definition of roles and responsibilities along each link of the chain along the cradle-to-crave infection control and waste management process;
- Appraisal to ensure adequate and qualified staff are in place, including those in charge of infection control and biosafety and waste management facility operation.
- Involvement of all relevant departments in RRFs, and intra-departmental team to manage, coordinate and regularly review the issues and performance;
- Establishment of an information management system to track and record waste streams in HCF; and
- Capacity building and training involving medical workers, waste management workers and cleaners. In addition third-party waste management service providers should be provided with relevant training.
- The purchase, storage, transportation and handling of medical equipment, potentially infected samples to testing facilities and vaccines in a safe manner and in accordance with the EHSGs.
- The role of responsible local governments in the vaccination campaigns, selection of deployment sites or other relevant reference points under the subproject activities.

9.1 Institutional and Implementation Arrangements

9.1.1 Implementation Arrangements

The Project will be fully embedded within the MoH Long-Term Institutional Arrangements (LTIA) which aim to strengthen ministry structures and ensure broad-based ownership. The project will be under the supervision of the Permanent Secretary/Accounting Officer, MoH and implemented through the Department of Integrated Epidemiology, Disease Surveillance and Public Health Emergencies. Where necessary, the PIU will liaise with other sectors on the cross-sectoral determinants for effective prevention and response.

The existing Project Implementation Unit (PIU) of the parent project will be enhanced with more staff to lead coordination and implementation of the project-funded activities. Fiduciary activities for the project will be managed by a dedicated team in the MoH under the Accounting and Procurement units. A similar arrangement will be used for Social and Environmental Safeguards. The Fiduciary, infrastructural and Safeguards Specialists are consultants, whose costs are currently covered through URMCHIP (these include; engineer, architect, Quantity surveyor, Environmental Safeguards and Social Safeguards Specialists). Their full costs will be absorbed by this project once URMCHIP closes in December 2022. The costs of PIU staff previously covered by the parent project will be covered by this Project after the Project becomes effective. However, there will be some addition of personnel The GBV/SEA Specialist and the Refugees Liaison Officer to strengthen the PIU especially in regard to component 4 of vaccine acquisition and administration.

The PIU consists of a Project Coordinator, Operations Officer, Monitoring and Evaluation Specialist, six Laboratory Mentors, ICT Officer, a Project Administrative Officer, and two Drivers. For the purposes of this project, additional technical experts including a Medical Epidemiologist may be recruited to support the PIU. This PIU will perform the following functions: (i) preparation and implementation of annual work plans and budgets; (ii) implementation of the project against the agreed work plan; (iii) monitoring and evaluation of project performance against the Results Framework; and (iv) preparation of the Implementation Completion Report.

Implementation of environmental and social frameworks will be led by Ministry of Health's Environmental Safeguards Specialist and Social Safeguards Specialist who will be accountable for operational roles, grievance management and monitoring as required in the ESMF, ESCP and SEP.
The National COVID-19 Taskforce will provide overall oversight for the implementation of the project. Key roles of the COVID-19 Task force will include:

- Ensuring availability and proper use of PPE.
- Proper waste management
- Assist MoH in service delivery and running response centers

9.1.2 Uganda refugee health integration steering committee

The AF will contribute to the implementation of the plan and will therefore be coordinated under the above frameworks and structures. Implementation of the refugee health is integrated into MoH systems with 76 percent of the refugee serving health facilities already managed by MoH. The refugee health integration steering committee will also help strengthen coordination and integration between host communities and refugees on refugee health issues.

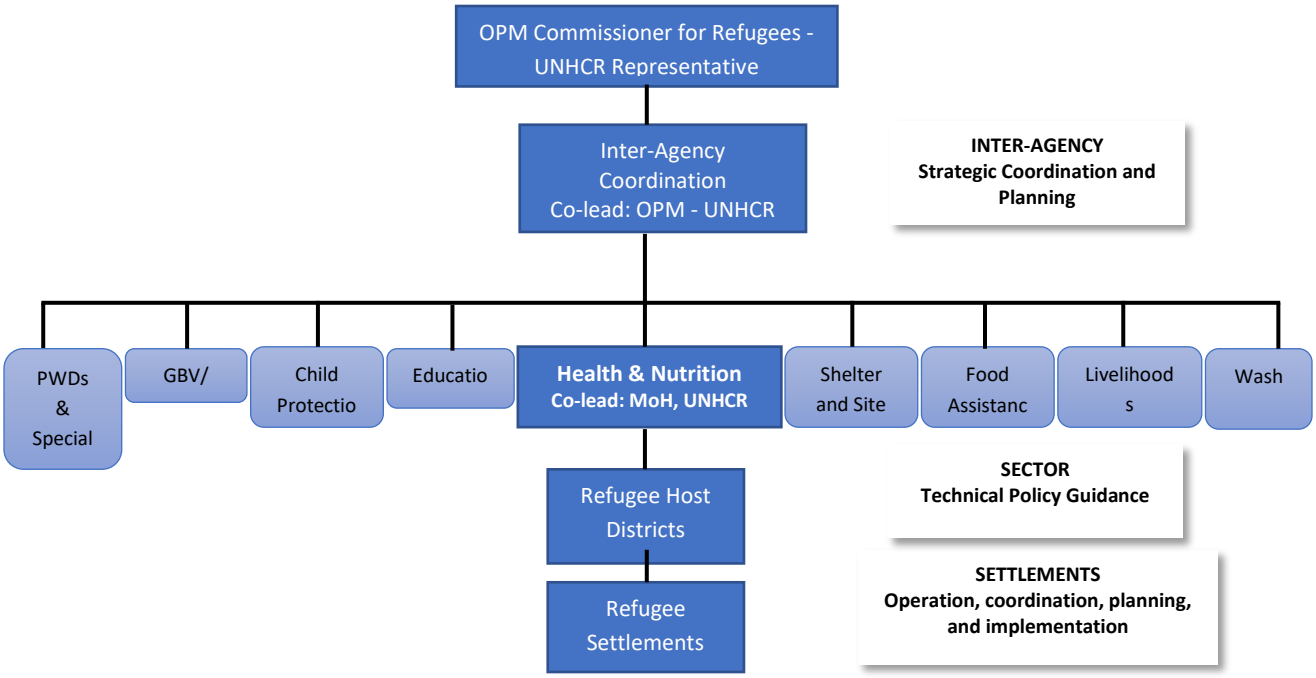

Figure 4: Interagency Coordination for Refugees

Uganda has a Refugee Health Integration Steering Committee and a secretariat that oversee implementation of the HSIRRP. Implementation of the refugee health is integrated into MoH systems, and the steering committee will also help strengthen coordination and integration between host communities and refugees on refugee health issues. The refugee settlements have structures in place and the host villages have Refugee Welfare Committees that feed into the structure. The Project will work through these forums and the Health Sector Integrated Refugee Response Plan which was developed to institutionalize refugee health support within national systems. These can be strengthened under the project to pay special attention to the interventions in the RHD and refugee settlements. OPM plays a lead role in Government on the management and protection of refugees and management of refugee settlements. They work closely with MoH to deliver health services and vaccines to refugees. UNHCR will be engaged closely in the

implementation of activities in the refugee settlements and hosting districts and ensure effective coordination with the Refugee Inter-Agency Health and Nutrition Working Group.

UNHCR participated in the inter-agency and IDP cluster coordination in Uganda contributing to its strategic direction, inter-agency response in emergencies and providing technical support. UNHCR co-chaired protection and camp coordination and camp management clusters ensuring coordinated approaches in humanitarian interventions. A Comprehensive Refugee Response Framework (CRRF) Steering Group was established to ensure efficiency of the CRRF application and coordination of the roll out at national and subnational level. Chaired at the ministerial level by both the Office of the Prime Minister and the Ministry of Local Government (MoLG), the CRRF Steering Group is a policy and decision making body, which enjoys active participation by whole of government representatives from the Office of the Prime Minister (OPM), all key line ministries, national planning authority, as well as bilateral partners, international financial institutions, UN, national and international NGOs, private sector, local governments and host communities representatives and refugees.

The Office of the Prime Minister (OPM) provides the over-arching policy and coordination framework of the refugee response in Uganda. Operational coordination takes place within the framework of a refugee coordination structure dedicated specifically to refugee-hosting Districts (RHDs). Health partners will continue to enhance coordination and inter-sectoral collaboration; strengthen the provision of equitable, safe, quality and sustainable health services in RHDs, and reinforce health systems in refugee-hosting area.

District COVID-19 Task Forces (DTFs) coordinate overall COVID-19 response, including vaccination in refugee hosting local governments. The OPM, UNHCR, and other key implementing agencies involved in the delivery, integration, and coordination of health and vaccination services are members of the DTFs thereby ensuring adequate follow up of refugee health and vaccination issues at district, facility, and settlement levels. The MoH will be working closely with the District Health Officers (DHO) and the Refugee Desk Officers (RDO) through the Project Refugee Liaison Officer, in liaison with the refugee welfare committees at the lower levels. This arrangement will help to increase equitable access to and utilization of integrated quality health services for refugees and host communities and strengthen the health care system to cope with the increased demand for health services by refugees and host communities.

9.1.3 Results Monitoring and Evaluation Arrangements

To measure overall progress in the coverage and deployment of COVID-19 vaccines, and gender gaps that the project can address, the following **new** indicators have been added to the Project's Results Framework:

PDO-level indicator:

- Percentage of population vaccinated, which is included in the priority population targets defined in national plan [disaggregated by gender]

Intermediate Results Indicators:

- Number of refugee hosting local government health centers refurbished and expanded
- Number of emergency call and dispatch centers established and functional
- Number of ambulances procured through the Project
    - Number of ambulances procured for refugee settlements and RHDs
- Blood bank upgraded/constructed and equipped to service refugees and host communities
- Proportion of Grievances captured in the Complaints Register for UCREPP that have been "CLOSED OUT" in accordance with GRM under the Project
- Number of vaccine doses procured
- Number of multimedia campaigns, funded through the Project, to provide accurate information on COVID-19 vaccination

- Number of eligible refugees vaccinated through the Project
- Number of people in refugee hosting districts vaccinated through the Project.

9.1.4 Sustainability

There is strong political commitment in Uganda to mobilize financial resources for COVID-19 response, including for vaccine purchase and deployment. Having the funds through the proposed AF for vaccine purchase and deployment will establish an enabling environment for other donors, multilateral development banks and UN agencies to also support efforts in the country. Investments under the parent Project and the AF are expected to strengthen the health system in the country, ensuring institutional sustainability to deal with infectious diseases.

9.2 Monitoring socio-environmental aspects comprised in this ESMF

As part of the updating of this ESMF, the World Bank will provide support for enhanced implementation support and monitoring of the risk of exclusion or discrimination for individuals or groups who may be vulnerable or marginalized. Further details of this support are found at Annex 17.

As the environment regulatory authority, NEMA will be the lead agency mandated with monitoring socio-environmental aspects of the project. In addition, MoH Environmental Safeguards Specialist and Social Safeguards Specialist as part of the project support team who will take lead in guiding and implementing environmental and social requirements of the project, working in close collaboration with the respective District Local Governments. Town/Municipal or District Environment Officers , Community Development Officer, Probation and Social Welfare Officer, Labor Officers and the Refugee Desk Officers for RHDs, will be the key personnel responsible for assessing and monitoring the environmental and social impacts of the project. Examples of activities to "monitor" EHS performance include review of EHS performance reports from construction contractors and medical facilities (related to operational impacts/risks); site visits and review of grievance process outcomes.

MoH will hire Supervising Consultants to monitor construction activities and these will be required to have Environmental and Social Specialists on their teams to monitor environmental and social aspects respectively. As earlier indicated, Town/City/Municipal or District Environmental Officers and Town/City/Municipal/ District Community Development Officers have requisite training and expertise to undertake necessary monitoring and undertake this within refugee settlements. However, their technical capacity will be enhanced by induction training at the beginning of project implementation. This will facilitate a better understanding and appreciation of safeguard requirements through discussion of modalities for implementation of the project ESMF provisions. Financial facilitation would however be necessary for their effective participation.

The following are important for successful monitoring process:

- At each healthcare facility to be upgraded, the Environmental health and safety Officer will be responsible for EHS management and monitoring.
- Construction contractors will be required to submit routine EHS performance reports to MoH (per Annex 5 and 6)
- MoH's PIU will be required to regularly ESHS Project Performance reports to the Bank.
- World Bank requires the Project to report to it within 48 hours when significant ESHS incidents occur

9.3 Capacity Enhancement Needs

Assessments undertaken during compilation of this ESMF indicate a need to strengthen capacity of Environmental Health Division, Infrastructure Department and Environmental Safeguards and Social

Safeguards Specialists' capabilities in MOH for effective execution of project activities. The Safeguards Specialists will undertake periodic training and capacity building of key UCREPP implementers at National and enterprise levels on implementing ESS under the project, including orienting them on the application of the Environment and Social Management Framework (ESMF). Training required entails:

- ESIA process in Uganda and Environmental and Social screening of different subprojects
- Legal, environmental and other regulatory requirements
- Environmental aspect-impact relationship
- Impact assessment
- World Bank ESF requirements
- ESHS requirements of different subprojects including safety concerns during vaccine deployment
- Environmental and Social monitoring and Implementation and adoption of World Bank's ESSGeo-Enabling Monitoring and Supervision (GEMS) of Projects
- Stakeholder engagement and Risk communication and community engagement including security management plan
- Management of Sexual Exploitation and Abuse (SEA) and Sexual Harassment (SH)
- Grievance redress mechanisms
- Grievance management including GBV/SEA cases
- Management of environmental and social aspects of civil works management in health care facilities
- WHO and Africa CDC guidelines on quarantine including case management
- Infection Control and Waste Management Plan (ICWMP)
- Healthcare waste management
- Emergence Response Mechanism
- Social Inclusion

As a guideline, initial awareness training at the onset of project implementation can be undertaken as follows:

i. A half day briefing of Environmental and Social Safeguards Requirements, potential project environmental and social impacts and proposed mitigation plans including the pertinent policy, laws and regulations for all PIU and HID staff other participating departments.
ii. A two-day introductory/orientation workshop on the ESMF and the environmental and social safeguard issues.
iii. One day introductory workshops in each of the participating RHD and refugee settlements to raise awareness of environmental and social issues and introduce the project\s approach to managing potential environmental and social impacts.
iv. On the basis of the above, further trainings will be organized with more specific focus to strengthen awareness and ability within the districts where civil works is going to be undertaken.

The Safeguards Specialists will be responsible for organizing and coordinating and training of personnel in all aspects of the safeguard issues creating a general awareness of environmental and social management throughout the project implementation stages including key implementing stakeholders (Local Governments, RHDs, Consultants, and Contractors), partner organizations and the beneficiary communities. There may be a requirement to continue some aspects of capacity building, of the communities and after project completion.

9.4 Labor Management Procedure

The Labor Management Procedure (LMP) will be developed by the contractors to manage labor risks during the implementation of the project. The LMP is in line with national requirements as well as the objectives

of the World Bank's Environmental and Social Framework, specifically objectives of Environmental and Socials Standard 2: Labor and Working Conditions (ESS2) and Standard 4: Community Health and Safety (ESS4).

The LMP should to be used alongside other requisite plans expected of contractors involved in this project, namely (but not limited to):

a) Emergency Response Management Plan (ERMP): Emergency Response Plan (ERMP) is to provide a systematic approach to the protection of employees, assets and the environment from impact of serious incidents and minimize damage to property and the environment.
b) Traffic Management Plan
c) Security Management Plan
d) Occupational Health and Safety Management Plan: which takes care of the safety and health of the workforce while in the project.
e) Waste Management Plan: This Hazardous Materials Management Plan defines the minimum requirements for hazardous materials management and monitoring and is applicable to the construction and operational phases of the project.
f) Workers Accommodation Plan: Describes the requirements and expectations in terms of compliance, reporting, roles, supervision and training with respect to labor and working conditions, including camp/accommodation.
g) Gender Violence Based Action Plan: The GBV Action Plan (see Annex 11)details the operational measures that will be put in place to assess and mitigate the risks of gender-based violence, including sexual exploitation and abuse (SEA) and sexual harassment that are project related and how they will be integrated over the life of the project. This includes procedures for preventing and responding to SEA/SH including managing these grievances.
h) Stakeholder Engagement Plan (SEP): The SEP describes the stakeholder identification and prioritization, engagement approaches and strategies for the national, regional and local stakeholders
i) Healthcare Waste Management Plan:
j) Physical Cultural Resources Management Plan/Chance Finds Procedures: Linkages with other Plans

Aside construction activities, it is noted that Gender-Based Violence (GBV) and sexual exploitation and abuse (SEA) can occur in project's interactions and among other staff. A GBV/SEA Specialist will be hired as part of the PIU. This reinforces the importance of the grievance mechanism to control GBV provided in Section 6.4.1.2.

A concise LMP developed for the project is provided in Annex 9.

9.5 Frequency of reporting

The ESCP requires quarterly reporting of overall ESHS performance by the PIU to World Bank, Implementation of this ESMF shall comply with this requirement.

9.6 Project Implementation Manual

To facilitate the implementation of the provisions for non-discrimination that cover vulnerable or marginalized individuals or groups, the Project Implementation Manual (PIM) will be updated to specify how the mitigation measures will be implemented. The Project Operation Manual will clearly lay out how the project will ensure non-discrimination of individuals or groups.

The Project Operation Manual will provide details of how the mitigation measures will be implemented. Furthermore, it will specify the timelines and roles and responsibilities to implement the different mitigation measures. The Project Operation Manual will also provide detailed information on how exactly the project will support and interact with the World Bank Enhanced Implementation Support and Monitoring. The Project Operation Manual will be developed or updated no later than two months after the redisclosure of the project's instruments or before the Enhanced Implementation Support and Monitoring mitigation measures are agreed to and in place.

10 ESMF Implementation Budget

The quantities, specifications and estimated costs of design measures to avoid or mitigate negative impacts of each project component site will be assessed by the civil design consultants together with their socio-environmental specialist and incorporated into bidding documents. The contractor will execute all required works and reimbursed through pay items in the bill of quantities financed by the project. Table 17 below shows a budget breakdown of the cost for implementing the ESMF. This budget also entails interventions to improve HCW incineration at RRHs (budget lines 10-12).

Table 16: Budget estimate for implementing the ESMF

	Item	Cost estimates (US $)	Notes
1	Budget for position of Environmental Safeguards Specialist and Social Safeguard Specialist	249,600	Budgeted at USD 5,200 for each of the two staff gross monthly salary for 2 years
2	Budget for the GBV/SEA Specialist/ Consultant	187,200	Budgeted at USD 5,200 for each of the two staff gross monthly salary for 3 years
3	Environmental and Social Impact Assessment Payment for ESIA Certificates	400,000	Consultants' fees for carrying out ESIA Payment of NEMA fees Monitoring and supervision for the implementation of ESMPs
4	Support Supervision and Monitoring the implementation of Social and Environmental Safeguards of sub-projects including construction/ remodeling of facilities like isolation units, labs and ICUs;	200,000	Lumpsum for entire project period – 3years
6	Implementation of the Stakeholder Engagement Plan (SEP)	1,091,795	Lumpsum budget for the implementation of the SEP
11	Support of the Implementation of the Grievance Redress Mechanism; Stakeholder Engagement of the IPs/ VMGs and refugee communities Safeguards Management Training for Contractors and Supervising Consultants Safeguards awareness and training for District Stakeholders and Health workers GBV/SEA training for District Stakeholders and Health workers, ESS information disclosure and Dissemination of ESS tools and guidelines.	300,000	For medical, contractors' staff and community sensitization in Ebola-prone districts (Including culturally/language appropriate activities for the marginalized and vulnerable groups like Batwas and Ik and refugees and training in management of COVID-19-generated wastes.
12	Budget for position of Refugee Liaison Officer	108,000	Budgeted at USD 3,000 gross monthly salary for 3 years
13	Environmental and Social Audit of project activities	100,000	To assess the environmental and social compliance of the project components for AF activities.
	TOTAL (US $)	**2,636,595**	

Note: the budget line for the AF has changed from the one of the parent Projects due to: removal of budget for laboratories and ICUs was removed, increase in budget for safeguard specialist was increased from $144,000 to $249,600; inclusion of budget for Refugee Liaison Officer and GBV/SEA Specialist were added, inclusion of budget for the implementation of the SEP and the GRM were included, and removal of budget for mobile incinerators. Therefore, the Budget has changed with a difference of $304,395.

Annex 1: Screening Form for Potential Environmental & Social Safeguards Issues

This form is to be used to screen potential environmental and social risk levels of a proposed subproject, determine the relevance of Bank environmental and social standards (ESS), propose its E&S risk levels, and the instrument to be prepared for the sub project.

Subproject Name:	
Subproject Location:	
Subproject Proponent:	
Estimated Investment:	
Screening done by:	
Screening approved by:	
Start/Completion Date	

Questions	Answer		ESS relevance	Due diligence / Actions
	Yes	No		
Does the subproject involve civil works including new construction, expansion, upgrading or rehabilitation of healthcare facilities and/or associated waste management facilities?			ESS1	ESIA/ESMP, SEP
Does the subproject involve acquisition of assets/land to hold patients (including yet-to-confirm cases for medical observation or isolation purpose)?			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 sound regulatory framework, institutional capacity in place for healthcare facility infection control and healthcare waste management?			ESS1	ESIA/ESMP, SEP
Does the subproject involve recruitment of workforce including direct, contracted, primary supply, and/or community workers?			ESS2	LMP, SEP
Does the subproject involve transboundary transportation of specimen, samples, infectious and hazardous materials?			ESS3	ESIA/ESMP, SEP
Does the subproject involve use of security personnel during construction and/or operation of healthcare facilities?			ESS4	ESIA/ESMP, SEP
Are there any vulnerable groups present in the subproject area and are likely to be affected by the proposed subproject negatively or positively?			ESS7	Vulnerable Groups Plan/IPDP
Is the subproject likely to generate air emissions?			ESS1	ESIA/ESMP, SEP
Is there a risk of degraded indoor air quality?			ESS1	ESIA/ESMP
Are there OHS risk?			ESS1	ESIA/ESMP
Are there potential traffic impacts?			ESS1	ESIA/ESMP
Is there potential risk of disrupting healthcare services at the hospital?			ESS1	ESIA/ESMP, SEP
Is there potential for projects activities to cause visual blight?			ESS1	ESIA/ESMP, SEP
Does the project area present considerable Gender-Based Violence (GBV) and Sexual Exploitation and Abuse (SEA) risk?			ESS1	ESIA/ESMP, SEP

Are there potential barriers for VMGs community members to access services?			ESS 7	ESIA/ESMP, SEP
Does the project pose potential threat to the respect, recognition and preservation of the culture, knowledge, and practices of VMGs/ IPs?			ESS 7	ESIA/ESMP, SEP
Does the project present potential impacts on the customary cultural, economic, social, or political wellbeing of the VMGs/IPs?			ESS 7	ESIA/ESMP, SEP

Conclusions:

1. **Proposed Environmental and Social Risk Ratings (Substantial, Moderate or Low). Provide Justifications.**

2. **Recommended E&S Instruments (tick box): .**

ESMP	
Project Brief	
ESIA	
ICWMP	
Other (Specify)	

Annex 2: ESMP Template

Guidance note: *The template provided in this section is not meant to be this project's ESMP but a template to guide development of any subproject's ESMP, when necessary.*

The ESMP template includes a matrix of E&S mitigation measures throughout the project lifecycle. A full-fledged ESMP should include other key elements such as institutional arrangement, capacity building and training plan, and background information. The Borrower may incorporate pertaining sections in the ESMF into this ESMP, with necessary updates. Such information is listed below:

- ESMF Sections 3.4 and Section 5
- ESMF Annexes 4, 5 and 6
- National Health Care Waste Management procedures
- WHO documents
- World Bank guidance documents related to COVID

The ESMP matrix indicates the management of E&S risks, including planning and design, construction, operational and decommissioning stages. Because COVID-19 is a latest threat to global public health, preparedness and responses vary across countries. Nonetheless, avoiding and minimizing chances of infection and protecting public health sit at the core. Properly managing E&S risks associated with COVID-19 responses serves the purpose. Thus professional efforts should be made throughout the project lifecycle. The issues and risks presented in the matrix are based on studies of COVID-19 responses thus far, issues of similar Bank financed healthcare sector projects. They should be expanded and/or updated during the project environmental and social assessment process, including stakeholder engagement.

Many pertaining mitigation measures and good practices are well documented in WBG EHS Guidelines, WHO guidelines and other GIIPs. They should be followed in general, taking into account country context. Proper stakeholder engagement including close involvement of medical and healthcare waste management professional should be conducted in determining the mitigation measures.

The Infection Control and Waste Management Plan is considered part of this ESMP.

The ESMP should make reference to pertaining E&S instruments as required by ESF, including LMP and RAP.

Environmental and Social Risks and Mitigation Measures during Planning and Designing Stage					
Key Activities	**Potential E&S Risks and Impacts**	**Proposed Mitigation Measures**	**Responsibilities**	**Timeline**	**Budget**
Identify the type, location and scale of healthcare facilities (HCF) or facilities to be used for deployment of vaccines					
Identify the need for new construction, expansion, upgrading and/or rehabilitation					
Identify the needs for ancillary works and associated facilities, such as access roads, construction materials, supplies of water and power, sewage system					
Identify the needs for acquisition of land and assets (e.g. acquiring existing assets such as hostel, stadium to hold potential patients)					
Identify onsite and offsite waste management facilities, and waste transportation routes and service providers	Inadequate facilities and processes for treatment of waste	➢ Estimate potential waste streams, including sharps and vaccine program wastes ➢ Consider the capacity of existing facilities, and plan to increase capacity, if necessary, through construction, expansion etc. ➢ Specify that the design of the facility considers the collection, segregation, transport and treatment of the anticipated volumes and types of healthcare wastes ➢ Require that receptacles for waste should be sized appropriately for the waste volumes generated, and color coded and labeled according to the types of waste to be deposited. Develop appropriate protocols for the collection of waste and transportation to storage/disposal areas in accordance with WHO guidance. Design training for staff in the segregation of wastes at the time of use			
Identify needs for transboundary movement of samples, vaccines, specimen, reagent, and hazardous materials					

Identify needs for workforce and type of project workers		➢ **Identify numbers and types of workers** ➢ **Consider accommodation and measures to minimize cross infection** ➢ **Use the COVID-19 LMP template to identify possible mitigation measures**			
Identify needs for using security personnel during construction and/or operation of HCF					
HCF design – general	- **Structural safety risk;** - **Functional layout and engineering control for nosocomial infection**				
HCF design - considerations for differentiated treatment for groups of higher sensitivity or vulnerability (the elderly, those with preexisting conditions, vulnerable or marginalized individuals or groups **or the very young) and those with disabilities**	**Some groups may have difficulty accessing health facilities**				

Design of facility should reflect specific treatment requirements, including triage, isolation or quarantine		➢ The design, set up and management of will take into account the advice provided by WHO guidance for Severe Acute Respiratory Infections Treatment Center. ➢ Hand washing facilities should be provided at the entrances to health care facilities in line with WHO Recommendations to Member States to Improve Hygiene Practices. ➢ Isolation rooms should be provided and used at medical facilities for patients with possible or confirmed COVID-19. ➢ Isolation rooms should: ✓ be single rooms with attached bathrooms (or with a dedicated commode); ✓ ideally be under negative pressure (neutral pressure may be used, but positive pressure rooms should be avoided) ✓ be sited away from busy areas or close to vulnerable or high-risk patients, to minimize chances of infection spread; ✓ have dedicated equipment (for example blood pressure machine, peak flow meter and stethoscope ✓ have signs on doors to control entry to the room, with the door kept closed; have an ante-room for staff to put on and take off PPE and to wash/decontaminate before and after providing treatment.			
Design to consider mortuary arrangements	Insufficient capacity Spread of infection	➢ Include adequate mortuary arrangements in the design ➢ See WHO Infection Prevention and Control for the safe management of a dead body in the context of COVID-19)			

Identify the needs for an effective communication campaign on vaccination, including tailored outreach to different groups (including vulnerable or marginalized individuals or groups), with different partners					
Assess the capacity of the Borrower to establish effective vaccine cold chain temperature monitoring	Failure to store and handle vaccines properly can reduce vaccine potency, resulting in inadequate immune responses in patients and poor protection against disease	➢ Support the Borrower to design and establish or improve vaccine cold chain temperature monitoring plan. ➢ See WHO guidance on temperature monitoring63 and CDC Vaccine storage and Handling toolkit64			
Assess the capacity of the Borrower to monitor adverse events following immunization (AEFI) in line with WHO guidelines	Insufficient capacity for ensuring immunization safety through detecting, reporting, investigating and responding to AEFI.	➢ Support the Borrower to design and establish or improve surveillance system of AEFI. ➢ See WHO Global manual of surveillance of adverse events following immunization65.			

[63] https://apps.who.int/iris/bitstream/handle/10665/183583/WHO_IVB_15.04_eng.pdf;jsessionid=9F079AFFA760DBD35C08B13930268B01?sequence=1
[64] https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/index.html
[65] https://www.who.int/vaccine_safety/publications/Global_Manual_revised_12102015.pdf?ua=1

Environmental and Social Risks and Mitigation Measures during Construction Stage					
Activities	**Potential E&S Risks and Impacts**	**Proposed Mitigation Measures**	**Responsibilities**	**Timeline**	**Budget**
Clearing of vegetation and trees; Construction activities near ecologically sensitive areas/spots	- Impacts on natural habitats, ecological resources and biodiversity				
General construction activities Foundation excavation; borehole digging	- Impacts on soils and groundwater; - Geological risks				
General construction activities	- Resource efficiency issues, including raw materials, water and energy use; - Materials supply				
General construction activities – general pollution management	- Construction solid waste; - Construction wastewater; - Nosie; - Vibration; - Dust; - Air emissions from construction equipment				
General construction activities – hazardous waste management	- Fuel, oils, lubricant				

General construction activities – Labor issues	- Workers coming from infected areas - Co-workers becoming infected - Workers introducing infection into community/general public	- Refer to COVID-19 LMP if available. - Consider ways to minimize/control movement in and out of construction areas/site. - If workers are accommodated on site require them to minimize contact with people outside the construction area/site or prohibit them from leaving the area/site for the duration of their contract - Implement procedures to confirm workers are fit for work before they start work, paying special to workers with underlying health issues or who may be otherwise at risk - Check and record temperatures of workers and other people entering the construction area/site or require self-reporting prior to or on entering - Provide daily briefings to workers prior to commencing work, focusing on COVID-19 specific considerations including cough etiquette, hand hygiene and distancing measures. - Require workers to self-monitor for possible symptoms (fever, cough) and to report to their supervisor if they have symptoms or are feeling unwell - Prevent a worker from an affected area or who has been in contact with an infected person from entering the construction area/site for 14 days - Preventing a sick worker from entering the construction area/site, referring them to local health facilities if necessary or requiring them to isolate at home for 14 days			
General construction activities – Occupational Health and Safety (OHS)					
General construction activities – traffic and road safety					
General construction activities – security personnel					
General construction activities – land and asset	Acquisition of land and assets				

General construction activities	GBV/SEA issues				
General construction activities – cultural heritage	Cultural heritage	Chance-finds procedure			
General construction activities – emergency preparedness and response					
Construction activities related to onsite waste management facilities, including temporary storage, incinerator, sewerage system and wastewater treatment works					
Construction activities related to demolition of existing structures or facilities (if needed)					
To be expanded					

Environmental and Social Risks and Mitigation Measures during Operational Stage					
Activities	**Potential E&S Risks and Impacts**	**Proposed Mitigation Measures**	**Responsibilities**	**Timeline**	**Budget**
General HCF operation – Environment	General wastes, wastewater and air emissions				
General HCF operation – OHS issues	- Physical hazards; - Electrical and explosive hazards; - Fire; - Chemical use; - Ergonomic hazard; - Radioactive hazard				
HCF operation – Labor issue					
HCF operation - considerations for differentiated treatment for groups with different needs (e.g. the elderly, those with preexisting conditions, the very young, people with disabilities)					
HCF operation – cleaning		• Provide cleaning staff with adequate cleaning equipment, materials and disinfectant. • Review general cleaning systems, training cleaning staff on appropriate cleaning procedures and appropriate frequency in high use or high-risk areas. • Where cleaners will be required to clean areas that have been or are suspected to have been contaminated with COVID-19, provide appropriate PPE: gowns or aprons, gloves, eye protection (masks, goggles or face screens) and boots or closed work shoes. If appropriate PPE is not available, provide best available alternatives. • Train cleaners in proper hygiene (including handwashing) prior to, during and after conducting cleaning activities; how to safely use PPE (where required); in waste control (including for used PPE and cleaning materials).			
HCF operation - Infection control and waste management plan					
Mass vaccination program involving deployment of vaccines from many facilities (not just HCF), vehicles and locations	Mass vaccination provides a vector for the spread of disease	Develop infection control and waste management plan for vaccination program to consider the use of non-HCF for deployment			

Waste minimization, reuse and recycling	Use of incinerators results in emission of dioxins, furans and particulate matter	➢ Where possible avoid the use of incinerators ➢ If small-scale incineration is the only option, this should be done using best practices, and plans should be in place to transition to alternative treatment as soon as practicable (such as steam treatment prior to disposal with sterile/non-infectious shredded waste and disposed of in suitable waste facilities) ➢ Do not use single-chamber, drum and brick incinerators ➢ If small-scale incinerators are used, adopt best practices to minimize operational impacts.			
Procurement, delivery and set up of equipment for the storage and handling of vaccines and associated medical equipment	Surfaces of imported materials may be contaminated and handling and processing may result in spread of COVID-19	Technical specifications for procuring equipment should require good hygiene practices in line with WHO technical guidance to be observed when preparing the procured goods. Check national and WHO technical guidance for latest information regarding transmission of COVID on packaging prior to finalization of working protocols at facilities receiving procured goods and update working methods as necessary.			
Transport of goods or supplies, including the delivery, storage and handling of vaccine, specimen, samples, reagents, pharmaceuticals and medical supplies	COVID-19 is spread by drivers during the transport and distribution of goods or supplies. Traffic accidents occur during transportation of goods	Good hygiene and cleaning protocols should be applied. During the transport, truck drivers should be required to wash hands frequently and /or be provided with hand sanitizer, and taught how to use it. Measures to minimize impacts during transportation, including hazardous materials can be found in the EHSGs.			
Waste segregation, packaging, color coding and labeling					
Onsite collection and transport					
Waste storage					
Onsite waste treatment and disposal					
Waste transportation to and disposal in offsite treatment and disposal facilities					
Transportation and disposal at offsite waste management facilities					

HCF operation – transboundary movement of vaccine, specimen, samples, reagents, medical equipment, and infectious or hazardous materials					
Operation of acquired assets for holding potential COVID-19 patients					
Emergency events	- Spillage; - Occupational exposure to infectious disease; - Exposure to radiation; - Accidental releases of infectious or hazardous substances to the environment; - Medical equipment failure; - Failure of solid waste and wastewater treatment facilities - Fire; - Other emergent events	➢ Emergency Response Plan			
Mortuary arrangements	- Arrangements are insufficient - Processes are insufficient	➢ Implement good infection control practices (see WHO Infection Prevention and Control for the safe management of a dead body in the context of COVID-19) ➢ Use mortuaries and body bags, together with appropriate safeguards during funerals (see WHO Practical considerations and recommendations for religious leaders and faith-based communities in the context of COVID-19)			
Vaccination campaign - considerations for communication and outreach for vulnerable or marginalized individuals or groups					
Stakeholder engagement – considerations for simple, accurate, accessible and culturally appropriate information dissemination; combating misinformation; responding to grievances					

Targeting of beneficiaries is not done in a fair, equitable and inclusive manner	Lack of transparency about the vaccination program	Outreach/communication tools to make potential beneficiaries aware of the eligibility criteria, principles and methods used for targeting Ensure project includes a functional Grievance Mechanism			
	Poorest / most needy households are left out	See above. Clear, transparent and unambiguous eligibility criteria Use good quality Government data combined with geographical targeting Use local community structures to identify and select beneficiaries, based on inclusive consultations			
	Lack of diversity and inclusion in vaccination program, resulting in inadequate benefits for other vulnerable groups	Ensure women participate in the program and, where possible, give preference to women within households as transferees Work with community representatives/NGOs so that vulnerable groups such as unaccompanied children, youth, Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH) survivors, Indigenous Peoples, refugees, internally displaced peoples, etc. are included in project activities and benefits			
	SEA/SH increase in project area (e.g. requests for sexual favors to receive vaccinations)	Consultations to discuss process for identifying vaccination prioritization Grievance Mechanism (GM) to be established as soon as possible to handle complaints Provide information to potential beneficiaries on eligibility criteria and GM process via various media (radio, SMS, television, online, posters) Work with local NGOs to provide social services for affected beneficiaries, as well as assistance to register			

Table 4 Environmental and Social Risks and Mitigation Measures during Decommissioning

Key Activities	Potential E&S Issues and Risks	Proposed Mitigation Measures	Responsibilities	Timeline	Budget
Decommissioning of interim HCF, blood bank					
Decommissioning of medical equipment					
Regular decommissioning					
To be expanded					

Annex 3: Infection Control and Waste Management Plan (ICWMP) Template

Guidance Note: *This is a template to guide formulation of an ICWMP and should not be taken to be this project's ICWMP.*

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;
- *Special type of HCF in response to COVID-19: E.g. existing assets may be acquired to hold yet-to-confirm cases for medical observation or isolation;*
- 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 and vaccination centers.

- Type, source and volume of healthcare waste (HCW) generated in the HCF and vaccination centers, including solid, liquid and air emissions (if significant);
- Classify and quantify the HCW (infectious waste, pathological waste, sharps, liquid and non-hazardous) following WGB 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 and vaccination centers, 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 and vaccination centers if available;
- Describe applicable performance levels and/or standards;
- Describe institutional arrangement, roles and responsibilities in the HCF and vaccination centers for infection control and waste management.

2.2 Management Measures

- Waste minimization, reuse and recycling: HCF and vaccination centers should consider practices and procedures to minimize waste generation, without sacrificing patient hygiene and safety consideration.
- Delivery and storage of specimen, samples, reagents, pharmaceuticals and medical supplies: HCF and vaccination centers should adopt practice and procedures to minimize risks associated with delivering, receiving and storage of the hazardous medical goods.
- Waste segregation, packaging, color coding and labeling: HCF and vaccination centers 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 and vaccination centers 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 and vaccination center 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/ and vaccination centers' storage area for disposal within 24 hours.
- Onsite waste treatment and disposal (e.g. an incinerator): Many vaccination centers /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. For new HCF financed by the project, waste disposal facilities should be integrated into the overall design and ESIA developed. Good design, operational practices and internationally adopted emission standards for healthcare waste incinerator can be found in pertaining EHS Guidelines and GIIP.
- 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 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 the 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 and vaccination centers 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 and vaccination centers should build and proper 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 HCF and vaccination centers 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 occurred in an HCF and vaccination centers 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, community, 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 an HCF takes overall responsibility for infection control and waste management;
- Involve all relevant departments in a healthcare facility, and build an intra-departmental team to manage, coordinate and regularly review the issues and performance;
- Establish an information management system to track and record the waste streams in HCF and vaccination centers; 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 and vaccination centers 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. HCF is encouraged to develop an IT based information management system should their technical and financial capacity allow.

As discussed above, the vaccination centers or 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 system should be in place.
Externally, reporting should be conducted per government and World Bank requirements.

ICWMP		
Activities	***Potential E&S Issues and Risks***	***Proposed Mitigation Measures***
General HCF/ vaccination centers operation – Environment	*General wastes, wastewater and air emissions*	
General HCF and vaccination centers operation – OHS issues	*Physical hazards* *Electrical and explosive hazards* *Fire* *Chemical use* *Ergonomic hazard* *Radioactive hazard*	
HCF and vaccination centers vaccine campaigns and operation - Infection control and waste management plan	-	
Waste minimization, reuse and recycling	-	
Delivery and storage of specimen, samples, reagents, pharmaceuticals and medical supplies	-	
Storage and handling of specimen, samples, reagents, and infectious materials	-	-
Waste segregation, packaging, color coding and labeling	-	
Onsite collection and transport		
Waste storage		
Onsite waste treatment and disposal		
Waste transportation to and disposal in offsite treatment and disposal facilities		
HCF operation – transboundary movement of specimen, samples, reagents, medical equipment, and infection materials		
Emergency events	- *Spillage,* - *Occupational exposure to infectious* - *Exposure to radiation, Accidental releases of infectious or hazardous substances to the environment,* - *Medical equipment failure,* - *Failure of solid waste and wastewater treatment facilities, -fire* *-Other emergent events*	*Emergency response plan*
Operation of acquired assets for holding potential COVID-19 patients		

Annex 4: Infection and Prevention Control Protocol

(Adapted from the CDC Interim Infection Prevention and Control Recommendations for patients with confirmed COVID-19 or persons under investigation for COVID-19 in Healthcare Settings)

HEALTH CARE SETTINGS

1. **Minimize Chance of Exposure (to staff, other patients and visitors)**
   - Upon arrival, make sure patients with symptoms of any respiratory infection to a separate, isolated and well-ventilated section of the health care facility to wait, and issue a facemask
   - During the visit, make sure all patients adhere to respiratory hygiene, cough etiquette, hand hygiene and isolation procedures. Provide oral instructions on registration and ongoing reminders with the use of simple signs with images in local languages
   - Provide alcohol-based hand sanitizer (60-95% alcohol), tissues and facemasks in waiting rooms and patient rooms

- Isolate patients as much as possible. If separate rooms are not available, separate all patients by curtains. Only place together in the same room patients who are all definitively infected with COVID-19. No other patients can be placed in the same room.

2. Adhere to Standard Precautions

- Train all staff and volunteers to undertake standard precautions - assume everyone is potentially infected and behave accordingly
- Minimize contact between patients and other persons in the facility: health care professionals should be the only persons having contact with patients and this should be restricted to essential personnel only
- A decision to stop isolation precautions should be made on a case-by-case basis, in conjunction with local health authorities.

3. Training of Personnel

- Train all staff and volunteers in the symptoms of COVID-19, how it is spread and how to protect themselves. Train on correct use and disposal of personal protective equipment (PPE), including gloves, gowns, facemasks, eye protection and respirators (if available) and check that they understand
- Train cleaning staff on most effective process for cleaning the facility: use a high-alcohol based cleaner to wipe down all surfaces; wash instruments with soap and water and then wipe down with high-alcohol based cleaner; dispose of rubbish by burning etc.

4. Manage Visitor Access and Movement

- Establish procedures for managing, monitoring, and training visitors
- All visitors must follow respiratory hygiene precautions while in the common areas of the facility, otherwise they should be removed
- Restrict visitors from entering rooms of known or suspected cases of COVID-19 patients Alternative communications should be encouraged, for example by use of mobile phones. Exceptions only for end-of-life situation and children requiring emotional care. At these times, PPE should be used by visitors.
- All visitors should be scheduled and controlled, and once inside the facility, instructed to limit their movement.
- Visitors should be asked to watch out for symptoms and report signs of acute illness for at least 14 days.

Annex 5: COVID-19 Considerations in Construction/ Civil Works Projects

ESF/SAFEGUARDS INTERIM NOTE:
COVID-19 CONSIDERATIONS IN CONSTRUCTION/CIVIL WORKS PROJECTS

1. INTRODUCTION

The COVID-19 pandemic presents Governments with unprecedented challenges. Addressing COVID-19 related issues in both existing and new operations starts with recognizing that this is not business as usual and that circumstances require a highly adaptive responsive management design to avoid, minimize and manage what may be a rapidly evolving situation. In many cases, we will ask Borrowers to use reasonable efforts in the circumstances, recognizing that what may be possible today may be different next week (both positively, because more supplies and guidance may be available, and negatively, because the spread of the virus may have accelerated).

This interim note is intended to provide guidance to teams on how to support Borrowers in addressing key issues associated with COVID-19, and consolidates the advice that has already been provided over the past month. As such, it should be used in place of other guidance that has been provided to date. This note will be developed as the global situation and the Bank's learning (and that of others) develops. This is not a time when 'one size fits all'. More than ever, teams will need to work with Borrowers and projects to understand the activities being carried out and the risks that these activities may entail. Support will be needed in designing mitigation measures that are implementable in the context of the project. These measures will need to take into account capacity of the Government agencies, availability of supplies and the practical challenges of operations on-the-ground, including stakeholder engagement, supervision and monitoring. In many circumstances, communication itself may be challenging, where face-to-face meetings are restricted or prohibited, and where IT solutions are limited or unreliable.

This note emphasizes the importance of careful scenario planning, clear procedures and protocols, management systems, effective communication and coordination, and the need for high levels of responsiveness in a changing environment. It recommends assessing the current situation of the project, putting in place mitigation measures to avoid or minimize the chance of infection, and planning what to do if either project workers become infected or the work force includes workers from proximate communities affected by COVID-19. In many projects, measures to avoid or minimize will need to be implemented at the same time as dealing with sick workers and relations with the community, some of whom may also be ill or concerned about infection. Borrowers should understand the obligations that contractors have under their existing contracts (see Section 3), require contractors to put in place appropriate organizational structures (see Section 4) and develop procedures to address different aspects of COVID-19 (see Section 5).

2. CHALLENGES WITH CONSTRUCTION/CIVIL WORKS

Projects involving construction/civil works frequently involve a large work force, together with suppliers and supporting functions and services. The work force may comprise workers from international, national, regional, and local labor markets. They may need to live in on-site accommodation, lodge within communities close to work sites or return to their homes after work. There may be different contractors permanently present on site, carrying out different activities, each with their own dedicated workers. Supply chains may involve international, regional and national suppliers facilitating the regular flow of goods and services to the project (including supplies essential to the project such as fuel, food, and water). As such there will also be regular flow of parties entering and exiting the site; support services, such as catering, cleaning services, equipment, material and supply deliveries, and specialist sub-contractors, brought in to deliver specific elements of the works.

Given the complexity and the concentrated number of workers, the potential for the spread of infectious disease in projects involving construction is extremely serious, as are the implications of such a spread. Projects may experience large numbers of the work force becoming ill, which will strain the project's health facilities, have implications for local emergency and health services and may jeopardize the progress of the construction work and the schedule of the project. Such impacts will be exacerbated where a work force is large and/or the project

is in remote or under-serviced areas. In such circumstances, relationships with the community can be strained or difficult and conflict can arise, particularly if people feel they are being exposed to disease by the project or are having to compete for scarce resources. The project must also exercise appropriate precautions against introducing the infection to local communities.

3. DOES THE CONSTRUCTION CONTRACT COVER THIS SITUATION?

Given the unprecedented nature of the COVID-19 pandemic, it is unlikely that the existing construction/civil works contracts will cover all the things that a prudent contractor will need to do. Nevertheless, the first place for a Borrower to start is with the contract, determining what a contractor's existing obligations are, and how these relate to the current situation.

The obligations on health and safety will depend on what kind of contract exists (between the Borrower and the main contractor; between the main contractors and the sub-contractors). It will differ if the Borrower used the World Bank's standard procurement documents (SPDs) or used national bidding documents. If a FIDIC document has been used, there will be general provisions relating to health and safety. For example, the standard FIDIC, Conditions of Contract for Construction (Second Edition 2017), which contains no 'ESF enhancements', states (in the General Conditions, clause 6.7) that the Contractor will be required:

- to take all necessary precautions to maintain the health and safety of the Contractor's Personnel
- to appoint a health and safety officer at site, who will have the authority to issue directives for the purpose of maintaining the health and safety of all personnel authorized to enter and or work on the site and to take protective measures to prevent accidents
- to ensure, in collaboration with local health authorities, that medical staff, first aid facilities, sick bay, ambulance services and any other medical services specified are available at all times at the site and at any accommodation
- to ensure suitable arrangements are made for all necessary welfare and hygiene requirements and for the prevention of epidemics
- These requirements have been enhanced through the introduction of the ESF into the SPDs (edition dated July 2019). The general FIDIC clause referred to above has been strengthened to reflect the requirements of the ESF. Beyond FIDIC's general requirements discussed above, the Bank's Particular Conditions include a number of relevant requirements on the Contractor, including:
- to provide health and safety training for Contractor's Personnel (which include project workers and all personnel that the Contractor uses on site, including staff and other employees of the Contractor and Subcontractors and any other personnel assisting the Contractor in carrying out project activities)
- to put in place workplace processes for Contractor's Personnel to report work situations that are not safe or healthy
- gives Contractor's Personnel the right to report work situations which they believe are not safe or healthy, and to remove themselves from a work situation which they have a reasonable justification to believe presents an imminent and serious danger to their life or health (with no reprisal for reporting or removing themselves)
- requires measures to be in place to avoid or minimize the spread of diseases including measures to avoid or minimize the transmission of communicable diseases that may be associated with the influx of temporary or permanent contract-related labor
- to provide an easily accessible grievance mechanism to raise workplace concerns

Where the contract form used is FIDIC, the Borrower (as the Employer) will be represented by the Engineer (also referred to in this note as the Supervising Engineer). The Engineer will be authorized to exercise authority specified in or necessarily implied from the construction contract. In such cases, the Engineer (through its staff on site) will be the interface between the PIU and the Contractor. It is important therefore to understand the scope of the Engineer's responsibilities. It is also important to recognize that in the case of infectious diseases such as COVID-19, project management – through the Contractor/subcontractor hierarchy – is only as effective as the weakest link. A thorough review of management procedures/plans as they will be implemented through the entire contractor hierarchy is important. Existing contracts provide the outline of this structure; they form the basis for the Borrower to understand how proposed mitigation measures will be designed and how adaptive management will be implemented, and to start a conversation with the Contractor on measures to address COVID-19 in the project.

4. WHAT PLANNING SHOULD THE BORROWER BE DOING?

Task teams should work with Borrowers (PIUs) to confirm that projects (i) are taking adequate precautions to prevent or minimize an outbreak of COVID-19, and (ii) have identified what to do in the event of an outbreak. Suggestions on how to do this are set out below:

- The PIU, either directly or through the Supervising Engineer, should request details in writing from the main Contractor of the measures being taken to address the risks. As stated in Section 3, the construction contract should include health and safety requirements, and these can be used as the basis for identification of, and requirements to implement, COVID-19 specific measures. The measures may be presented as a contingency plan, as an extension of the existing project emergency and preparedness plan or as standalone procedures. The measures may be reflected in revisions to the project's health and safety manual. This request should be made in writing (following any relevant procedure set out in the contract between the Borrower and the contractor).
- In making the request, it may be helpful for the PIU to specify the areas that should be covered. This should include the items set out in Section 5 below and take into account current and relevant
- guidance provided by national authorities, WHO and other organizations. See the list of references in the Annex to this note.
- The PIU should require the Contractor to convene regular meetings with the project health and safety specialists and medical staff (and where appropriate the local health authorities), and to take their advice in designing and implementing the agreed measures.
- Where possible, a senior person should be identified as a focal point to deal with COVID-19 issues. This can be a work supervisor or a health and safety specialist. This person can be responsible for coordinating preparation of the site and making sure that the measures taken are communicated to the workers, those entering the site and the local community. It is also advisable to designate at least one back-up person, in case the focal point becomes ill; that person should be aware of the arrangements that are in place.
- On sites where there are a number of contractors and therefore (in effect) different work forces, the request should emphasize the importance of coordination and communication between the different parties. Where necessary, the PIU should request the main contractor to put in place a protocol for regular meetings of the different contractors, requiring each to appoint a designated staff member (with back up) to attend such meetings. If meetings cannot be held in person, they should be conducted using whatever IT is available. The effectiveness of mitigation measures will depend on the weakest implementation, and therefore it is important that all contractors and sub-contractors understand the risks and the procedure to be followed.
- The PIU, either directly or through the Supervising Engineer, may provide support to projects in identifying appropriate mitigation measures, particularly where these will involve interface with local services, in particular health and emergency services. In many cases, the PIU can play a valuable role in connecting project representatives with local Government agencies, and helping coordinate a strategic response, which takes into account the availability of resources. To be most effective, projects should consult and coordinate with relevant Government agencies and other projects in the vicinity.
- Workers should be encouraged to use the existing project grievance mechanism to report concerns relating to COVID-19, preparations being made by the project to address COVID-19 related issues, how procedures are being implemented, and concerns about the health of their co-workers and other staff.

5. WHAT SHOULD THE CONTRACTOR COVER?

The Contractor should identify measures to address the COVID-19 situation. What will be possible will depend on the context of the project: the location, existing project resources, availability of supplies, capacity of local emergency/health services, the extent to which the virus already exist in the area. A systematic approach to planning, recognizing the challenges associated with rapidly changing circumstances, will help the project put in place the best measures possible to address the situation. As discussed above, measures to address COVID-19 may be presented in different ways (as a contingency plan, as an extension of the existing project emergency and preparedness plan or as standalone procedures). PIUs and contractors should refer to guidance issued by relevant authorities, both national and international (e.g. WHO), which is regularly updated.

Addressing COVID-19 at a project site goes beyond occupational health and safety, and is a broader project issue which will require the involvement of different members of a project management team. In many cases, the most effective approach will be to establish procedures to address the issues, and then to ensure that these procedures are implemented systematically. Where appropriate given the project context, a designated team should be established to address COVID-19 issues, including PIU representatives, the Supervising Engineer, management (e.g. the project manager) of the contractor and sub-contractors, security, and medical and OHS professionals. Procedures should be clear and straightforward, improved as necessary, and supervised and monitored by the COVID-19 focal point(s). Procedures should be documented, distributed to all contractors, and discussed at regular meetings to facilitate adaptive management. The issues set out below include a number that represent expected good workplace management but are especially pertinent in preparing the project response to COVID-19.

(a) ASSESSING WORKFORCE CHARACTERISTICS

Many construction sites will have a mix of workers e.g. workers from the local communities; workers from a different part of the country; workers from another country. Workers will be employed under different terms and conditions and be accommodated in different ways. Assessing these different aspects of the workforce will help in identifying appropriate mitigation measures:

- The Contractor should prepare a detailed profile of the project work force, key work activities, schedule for carrying out such activities, different durations of contract and rotations (e.g. 4 weeks on, 4 weeks off).
- This should include a breakdown of workers who reside at home (i.e. workers from the community), workers who lodge within the local community and workers in on-site accommodation. Where possible, it should also identify workers that may be more at risk from COVID-19, those with underlying health issues or who may be otherwise at risk.
- Consideration should be given to ways in which to minimize movement in and out of site. This could include lengthening the term of existing contracts, to avoid workers returning home to affected areas, or returning to site from affected areas.
- Workers accommodated on site should be required to minimize contact with people near the site, and in certain cases be prohibited from leaving the site for the duration of their contract, so that contact with local communities is avoided.
- Consideration should be given to requiring workers lodging in the local community to move to site accommodation (subject to availability) where they would be subject to the same restrictions.
- Workers from local communities, who return home daily, weekly or monthly, will be more difficult to manage. They should be subject to health checks at entry to the site (as set out above) and at some point, circumstances may make it necessary to require them to either use accommodation on site or not to come to work.

(b) ENTRY/EXIT TO THE WORK SITE AND CHECKS ON COMMENCEMENT OF WORK

Entry/exit to the work site should be controlled and documented for both workers and other parties, including support staff and suppliers. Possible measures may include:

Establishing a system for controlling entry/exit to the site, securing the boundaries of the site, and establishing designating entry/exit points (if they do not already exist). Entry/exit to the site should be documented.

- Training security staff on the (enhanced) system that has been put in place for securing the site and controlling entry and exit, the behaviors required of them in enforcing such system and any COVID - 19 specific considerations.
- Training staff who will be monitoring entry to the site, providing them with the resources they need to document entry of workers, conducting temperature checks and recording details of any worker that is denied entry.
- Confirming that workers are fit for work before they enter the site or start work. While procedures should already be in place for this, special attention should be paid to workers with underlying health issues or who may be otherwise at risk. Consideration should be given to demobilization of staff with underlying health issues.
- Checking and recording temperatures of workers and other people entering the site or requiring self-reporting prior to or on entering the site.

- Providing daily briefings to workers prior to commencing work, focusing on COVID-19 specific considerations including cough etiquette, hand hygiene and distancing measures, using demonstrations and participatory methods.
- During the daily briefings, reminding workers to self-monitor for possible symptoms (fever, cough) and to report to their supervisor or the COVID-19 focal point if they have symptoms or are feeling unwell.
- Preventing a worker from an affected area or who has been in contact with an infected person from returning to the site for 14 days or (if that is not possible) isolating such worker for 14 days.
- Preventing a sick worker from entering the site, referring them to local health facilities if necessary or requiring them to isolate at home for 14 days.

(c) GENERAL HYGIENE

Requirements on general hygiene should be communicated and monitored, to include:

- Training workers and staff on site on the signs and symptoms of COVID-19, how it is spread, how to protect themselves (including regular handwashing and social distancing) and what to do if they or other people have symptoms (for further information see WHO COVID-19 advice for the public).
- Placing posters and signs around the site, with images and text in local languages.
- Ensuring handwashing facilities supplied with soap, disposable paper towels and closed waste bins exist at key places throughout site, including at entrances/exits to work areas; where there is a toilet, canteen or food distribution, or provision of drinking water; in worker accommodation; at waste stations; at stores; and in common spaces. Where handwashing facilities do not exist or are not adequate, arrangements should be made to set them up. Alcohol based sanitizer (if available, 60-95% alcohol) can also be used.
- Review worker accommodations, and assess them in light of the requirements set out in IFC/EBRD guidance on Workers' Accommodation: processes and standards, which provides valuable guidance as to good practice for accommodation.
- Setting aside part of worker accommodation for precautionary self-quarantine as well as more formal isolation of staff who may be infected (see paragraph (f)).

(d) CLEANING AND WASTE DISPOSAL

Conduct regular and thorough cleaning of all site facilities, including offices, accommodation, canteens, common spaces. Review cleaning protocols for key construction equipment (particularly if it is being operated by different workers). This should include:

- Providing cleaning staff with adequate cleaning equipment, materials and disinfectant.
- Review general cleaning systems, training cleaning staff on appropriate cleaning procedures and appropriate frequency in high use or high-risk areas.
- Where it is anticipated that cleaners will be required to clean areas that have been or are suspected to have been contaminated with COVID-19, providing them with appropriate PPE: gowns or aprons, gloves, eye protection (masks, goggles or face screens) and boots or closed work shoes. If appropriate PPE is not available, cleaners should be provided with best available alternatives.
- Training cleaners in proper hygiene (including handwashing) prior to, during and after conducting cleaning activities; how to safely use PPE (where required); in waste control (including for used PPE and cleaning materials).
- Any medical waste produced during the care of ill workers should be collected safely in designated containers or bags and treated and disposed of following relevant requirements (e.g., national, WHO). If open burning and incineration of medical wastes is necessary, this should be for as limited a duration as possible. Waste should be reduced and segregated, so that only the smallest amount of waste is incinerated (for further information see WHO interim guidance on water, sanitation and waste management for COVID-19).

(e) ADJUSTING WORK PRACTICES

Consider changes to work processes and timings to reduce or minimize contact between workers, recognizing that this is likely to impact the project schedule. Such measures could include:

- Decreasing the size of work teams.
- Limiting the number of workers on site at any one time.

- Changing to a 24-hour work rotation.
- Adapting or redesigning work processes for specific work activities and tasks to enable social distancing, and training workers on these processes.
- Continuing with the usual safety trainings, adding COVID-19 specific considerations. Training should include proper use of normal PPE. While as of the date of this note, general advice is that construction workers do not require COVID-19 specific PPE, this should be kept under review (for further information see WHO interim guidance on rational use of personal protective equipment (PPE) for COVID-19).
- Reviewing work methods to reduce use of construction PPE, in case supplies become scarce or the PPE is needed for medical workers or cleaners. This could include, e.g. trying to reduce the need for dust masks by checking that water sprinkling systems are in good working order and are maintained or reducing the speed limit for haul trucks.
- Arranging (where possible) for work breaks to be taken in outdoor areas within the site.
- Consider changing canteen layouts and phasing meal times to allow for social distancing and phasing access to and/or temporarily restricting access to leisure facilities that may exist on site, including gyms.
- At some point, it may be necessary to review the overall project schedule, to assess the extent to which it needs to be adjusted (or work stopped completely) to reflect prudent work practices, potential exposure of both workers and the community and availability of supplies, taking into account Government advice and instructions.

(f) PROJECT MEDICAL SERVICES

Consider whether existing project medical services are adequate, taking into account existing infrastructure (size of clinic/medical post, number of beds, isolation facilities), medical staff, equipment and supplies, procedures and training. Where these are not adequate, consider upgrading services where possible, including:

- Expanding medical infrastructure and preparing areas where patients can be isolated. Guidance on setting up isolation facilities is set out in WHO interim guidance on considerations for quarantine of individuals in the context of containment for COVID-19). Isolation facilities should be located away from worker accommodation and ongoing work activities. Where possible, workers should be provided with a single well-ventilated room (open windows and door). Where this is not possible, isolation facilities should allow at least 1 meter between workers in the same room, separating workers with curtains, if possible. Sick workers should limit their movements, avoiding common areas and facilities and not be allowed visitors until they have been clear of symptoms for 14 days. If they need to use common areas and facilities (e.g. kitchens or canteens), they should only do so when unaffected workers are not present and the area/facilities should be cleaned prior to and after such use.
- Training medical staff, which should include current WHO advice on COVID-19 and recommendations on the specifics of COVID-19. Where COVID-19 infection is suspected, medical providers on site should follow WHO interim guidance on infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected.
- Training medical staff in testing, if testing is available.
- Assessing the current stock of equipment, supplies and medicines on site, and obtaining additional stock, where required and possible. This could include medical PPE, such as gowns, aprons, medical masks, gloves, and eye protection. Refer to WHO guidance as to what is advised (for further information see WHO interim guidance on rational use of personal protective equipment (PPE) for COVID-19).
- If PPE items are unavailable due to world-wide shortages, medical staff on the project should agree on alternatives and try to procure them. Alternatives that may commonly be found on constructions sites include dust masks, construction gloves and eye goggles. While these items are not recommended, they should be used as a last resort if no medical PPE is available.
- Ventilators will not normally be available on work sites, and in any event, intubation should only be conducted by experienced medical staff. If a worker is extremely ill and unable to breathe properly on his or her own, they should be referred immediately to the local hospital (see (g) below).
- Review existing methods for dealing with medical waste, including systems for storage and disposal (for further information see WHO interim guidance on water, sanitation and waste management for COVID-19, and WHO guidance on safe management of wastes from health-care activities).

(g) LOCAL MEDICAL AND OTHER SERVICES

Given the limited scope of project medical services, the project may need to refer sick workers to local medical services. Preparation for this includes:

- Obtaining information as to the resources and capacity of local medical services (e.g. number of beds, availability of trained staff and essential supplies).
- Conducting preliminary discussions with specific medical facilities, to agree what should be done in the event of ill workers needing to be referred.
- Considering ways in which the project may be able to support local medical services in preparing for members of the community becoming ill, recognizing that the elderly or those with pre-existing medical conditions require additional support to access appropriate treatment if they become ill.
- Clarifying the way in which an ill worker will be transported to the medical facility, and checking availability of such transportation.
- Establishing an agreed protocol for communications with local emergency/medical services.
- Agreeing with the local medical services/specific medical facilities the scope of services to be provided, the procedure for in-take of patients and (where relevant) any costs or payments that may be involved.
- A procedure should also be prepared so that project management knows what to do in the unfortunate event that a worker ill with COVID-19 dies. While normal project procedures will continue to apply, COVID-19 may raise other issues because of the infectious nature of the disease. The project should liaise with the relevant local authorities to coordinate what should be done, including any reporting or other requirements under national law.

(h) INSTANCES OR SPREAD OF THE VIRUS

WHO provides detailed advice on what should be done to treat a person who becomes sick or displays symptoms that could be associated with the COVID-19 virus (for further information see WHO interim guidance on infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected). The project should set out risk-based procedures to be followed, with differentiated approaches based on case severity (mild, moderate, severe, critical) and risk factors (such as age, hypertension, diabetes) (for further information see WHO interim guidance on operational considerations for case management of COVID-19 in health facility and community). These may include the following:

- If a worker has symptoms of COVID-19 (e.g. fever, dry cough, fatigue) the worker should be removed immediately from work activities and isolated on site.
- If testing is available on site, the worker should be tested on site. If a test is not available at site, the worker should be transported to the local health facilities to be tested (if testing is available).
- If the test is positive for COVID-19 or no testing is available, the worker should continue to be isolated. This will either be at the work site or at home. If at home, the worker should be transported to their home in transportation provided by the project.
- Extensive cleaning procedures with high-alcohol content disinfectant should be undertaken in the area where the worker was present, prior to any further work being undertaken in that area. Tools used by the worker should be cleaned using disinfectant and PPE disposed of.
- Co-workers (i.e. workers with whom the sick worker was in close contact) should be required to stop work, and be required to quarantine themselves for 14 days, even if they have no symptoms.
- Family and other close contacts of the worker should be required to quarantine themselves for 14 days, even if they have no symptoms.
- If a case of COVID-19 is confirmed in a worker on the site, visitors should be restricted from entering the site and worker groups should be isolated from each other as much as possible.
- If workers live at home and has a family member who has a confirmed or suspected case of COVID-19, the worker should quarantine themselves and not be allowed on the project site for 14 days, even if they have no symptoms.
- Workers should continue to be paid throughout periods of illness, isolation or quarantine, or if they are required to stop work, in accordance with national law.
- Medical care (whether on site or in a local hospital or clinic) required by a worker should be paid for by the employer.

(i) CONTINUITY OF SUPPLIES AND PROJECT ACTIVITIES

Where COVID-19 occurs, either in the project site or the community, access to the project site may be restricted, and movement of supplies may be affected.

- Identify back-up individuals, in case key people within the project management team (PIU, Supervising Engineer, Contractor, sub-contractors) become ill, and communicate who these are so that people are aware of the arrangements that have been put in place.
- Document procedures, so that people know what they are, and are not reliant on one person's knowledge.
- Understand the supply chain for necessary supplies of energy, water, food, medical supplies and cleaning equipment, consider how it could be impacted, and what alternatives are available. Early pro-active review of international, regional and national supply chains, especially for those supplies that are critical for the project, is important (e.g. fuel, food, medical, cleaning and other essential supplies). Planning for a 1-2 month interruption of critical goods may be appropriate for projects in more remote areas.
- Place orders for/procure critical supplies. If not available, consider alternatives (where feasible).
- Consider existing security arrangements, and whether these will be adequate in the event of interruption to normal project operations.
- Consider at what point it may become necessary for the project to significantly reduce activities or to stop work completely, and what should be done to prepare for this, and to re-start work when it becomes possible or feasible.

(j) TRAINING AND COMMUNICATION WITH WORKERS

Workers need to be provided with regular opportunities to understand their situation, and how they can best protect themselves, their families and the community. They should be made aware of the procedures that have been put in place by the project, and their own responsibilities in implementing them.

- It is important to be aware that in communities close to the site and amongst workers without access to project management, social media is likely to be a major source of information. This raises the importance of regular information and engagement with workers (e.g. through training, town halls, tool boxes) that emphasizes what management is doing to deal with the risks of COVID-19. Allaying fear is an important aspect of work force peace of mind and business continuity. Workers should be given an opportunity to ask questions, express their concerns, and make suggestions.

- Training of workers should be conducted regularly, as discussed in the sections above, providing workers with a clear understanding of how they are expected to behave and carry out their work duties.
- Training should address issues of discrimination or prejudice if a worker becomes ill and provide an understanding of the trajectory of the virus, where workers return to work.
- Training should cover all issues that would normally be required on the work site, including use of safety procedures, use of construction PPE, occupational health and safety issues, and code of conduct, taking into account that work practices may have been adjusted.
- Communications should be clear, based on fact and designed to be easily understood by workers, for example by displaying posters on handwashing and social distancing, and what to do if a worker displays symptoms.

(k) COMMUNICATION AND CONTACT WITH THE COMMUNITY

Relations with the community should be carefully managed, with a focus on measures that are being implemented to safeguard both workers and the community. The community may be concerned about the presence of non-local workers, or the risks posed to the community by local workers presence on the project site. The project should set out risk-based procedures to be followed , which may reflect WHO guidance (for further information see WHO Risk Communication and Community Engagement (RCCE) Action Plan Guidance COVID-19 Preparedness and Response). The following good practice should be considered:

- Communications should be clear, regular, based on fact and designed to be easily understood by community members.
- Communications should utilize available means. In most cases, face-to-face meetings with the community or community representatives will not be possible. Other forms of communication should be used; posters, pamphlets, radio, text message, electronic meetings. The means used should take into

account the ability of different members of the community to access them, to make sure that communication reaches these groups.

- The community should be made aware of procedures put in place at site to address issues related to COVID-19. This should include all measures being implemented to limit or prohibit contact between workers and the community. These need to be communicated clearly, as some measures will have financial implications for the community (e.g. if workers are paying for lodging or using local facilities). The community should be made aware of the procedure for entry/exit to the site, the training being given to workers and the procedure that will be followed by the project if a worker becomes sick.
- If project representatives, contractors or workers are interacting with the community, they should practice social distancing and follow other COVID-19 guidance issued by relevant authorities, both national and international (e.g. WHO).

6. EMERGENCY POWERS AND LEGISLATION

Many Borrowers are enacting emergency legislation. The scope of such legislation, and the way it interacts with other legal requirements, will vary from country to country. Such legislation can cover a range of issues, for example:

- Declaring a public health emergency
- Authorizing the use of police or military in certain activities (e.g. enforcing curfews or restrictions on movement)
- Ordering certain categories of employees to work longer hours, not to take holiday or not to leave their job (e.g. health workers)
- Ordering non-essential workers to stay at home, for reduced pay or compulsory holiday

Except in exceptional circumstances (after referral to the World Bank's Operations Environmental and Social Review Committee (OESRC)), projects will need to follow emergency legislation to the extent that these are mandatory or advisable. It is important that the Borrower understands how mandatory requirements of the legislation will impact the project. Teams should require Borrowers (and in turn, Borrowers should request Contractors) to consider how the emergency legislation will impact the obligations of the Borrower set out in the legal agreement and the obligations set out in the construction contracts. Where the legislation requires a material departure from existing contractual obligations, this should be documented, setting out the relevant provisions.

Annex 6: Code of Practice for Construction Workers

Guidance note: *Clauses in this Annex 6 as well as content in Annex 5 should form part of contractors' contracts. Considered separately, each Annex serves its own complete purpose but when used jointly e.g. for formulation of contractor contracts, some overlapping topics will be found and these should not be replicated. In addition, This Code (Annex 6) should be used in conjunction with the project's Labor Management Plan (Annex 9).*

Part I: Code of Practice

Part I: Code of Practice

This provides general operational guidance to contractors related to worker health and safety

Part II: Code of Conduct

This entails governance/management and regulation of social behavior of contractors at work.

1. INTRODUCTION

This code of practice provides guidance to contractors who will undertake construction of healthcare facilities associated with this project.

Construction work is work carried out in connection with construction, alteration, conversion, fitting-out, commissioning, renovation, repair, maintenance, refurbishment, demolition, decommissioning or dismantling of a structure.
Construction workers must always:

- take reasonable care for their own health and safety
- take reasonable care that their acts or omissions do not adversely affect the health and safety of other persons, and
- comply with any reasonable instruction and cooperate with any reasonable policy or procedure relating to health and safety at the workplace.

This Code should also accommodate provisions for grievance redress for workers in case of any complaint from direct or indirect workers.

2. MANAGING RISKS WITH CONSTRUCTION WORK

The first step in risk management is to identify the hazards associated with construction work. Examples of hazards include:

- collapse of trenches
- falling objects, for example tools, debris and equipment
- hazardous manual tasks
- structural collapse
- the construction workplace itself, including its location, layout, condition and accessibility
- the handling, use, storage, and transport or disposal of hazardous chemicals
- the interface with other works or trade activities
- the physical working environment, for example the potential for electric shock, immersion or engulfment, fire or explosion, slips, trips and falls, people being struck by moving plant, exposure to noise, heat, cold, vibration, radiation (including solar UV radiation), static electricity or a contaminated atmosphere, and the presence of a confined space.
- the presence of asbestos and asbestos-containing materials
- the use of ladders, incorrectly erected equipment, unguarded holes, penetrations and voids, unguarded excavations, trenches, shafts and lift wells, unstable structures such as incomplete scaffolding or mobile platforms, fragile and brittle surfaces such as cement sheet roofs, fiberglass roofs, skylights and unprotected formwork decks
- welding fumes, gases and arcs
- COVID and other infectious disease risks that may be present in medical facilities.

3. SAFE WORK METHOD STATEMENTS (SWMS)

All persons involved in construction work must develop and implement arrangements to ensure the work is carried out. This necessitates a SWMS, which is a written document that details high risk construction work activities to be undertaken, hazards or risks arising from those activities and measures to control the risks. All workers who will be involved in high risk construction work must be provided with information and instruction so they:

- know what to do if the work is not being conducted in accordance with the Safe Work Method Statements (SWMS).
- understand and implement the risk controls in a SWMS
- understand the hazards and risks arising from the work

This information and instruction may be provided during general construction induction training, workplace-specific training or during a toolbox talk by the principal contractor, contractor or subcontractor.

4. OCCUPATIONAL HEALTH SAFETY (OHS) MANAGEMENT PLANS FOR CONSTRUCTION PROJECTS

An OHS management plan is a written plan that sets out the arrangements for managing some site health and safety matters. The intention of an OHS management plan is to ensure the required processes are in place to manage the risks associated with a complex construction project, as there are usually many contractors and subcontractors involved and circumstances can change quickly from day to day. An OHS management plan must be in writing and must be prepared by the principal contractor before a project commences. It should be easily understood by workers (including contractors and subcontractors). It may not be necessary to communicate the entire OHS management plan to all workers; however, they must be made aware of the parts that are applicable to the work they are carrying out. The OHS Management Plan must contain:

- arrangements for consultation, cooperation and coordination
- arrangements for managing incidents
- arrangements to collect and assess, monitor and review SWMS.
- names of persons at the workplace whose positions or roles involve specific health and safety responsibilities, for example site supervisors, project managers, first aid officers
- site-specific health and safety rules and how people will be informed of the rules

While a OHS management plan is required for every construction project, a principal contractor may prepare a generic OHS management plan that applies to several construction projects, if the arrangements to manage work health and safety are the same for each construction project. However the principal contractor must review and revise the plan to ensure it addresses the risks of the actual workplace.

5. INFORMATION, TRAINING, INSTRUCTION AND SUPERVISION

All contractors and subcontractors must provide relevant information, training, instruction and supervision to protect all persons from risks to their health and safety arising from construction work carried out. In addition, workers should be sensitized of potential OHS risks (including in COVID-19) and worker rights associated with these risks.

A range of activities can assist in ensuring people have the necessary knowledge and skills to complete the work safely, including general construction induction training and other training that may be specific to the workplace or the task the person is performing. Information that might be provided includes workplace health and safety arrangements and procedures, such as for emergency evacuations. Information can be provided in various forms, including written formats or verbally, for example during workplace-specific training, pre-start meetings or toolbox talks. General construction induction training provides basic knowledge of construction work, the work health and safety laws that apply, common hazards likely to be encountered in construction work, and how the associated risks can be controlled. Any person who is to carry out construction work must successfully complete general construction induction training, for example project managers and engineers, foreman, supervisors, surveyors, and labourers.

6. GENERAL WORKPLACE MANAGEMENT ARRANGEMENTS

The principal contractor must put in place arrangements for ensuring compliance with the following duties:

- providing a safe working environment
- Zero tolerance to Child Labour
- providing and maintaining adequate and accessible facilities
- providing first aid
- preparing, maintaining and implementing emergency plans
- providing workers with PPE, if PPE is to be used to minimize a risk to health and safety
- managing risks associated with airborne contaminants
- managing risks associated with hazardous atmospheres including ignition sources
- storage of flammable and combustible substances
- managing risks associated with falls, and
- managing risks associated with falling objects.

The principal contractors may put in place arrangements for ensuring compliance with the above requirements through contractual arrangements, but they cannot rely only on these arrangements to ensure compliance. The

principal contractor may also coordinate with other subcontractors, and check compliance whenever the principal contractor attends the construction site.

Part II: Code of Conduct for Contractors

Guidance note: *This Code conforms to World Bank's ESS2 and aims to address any other sub-project and project-specific social aspects. I also should be used in conjunction with a robust Labor Management Plan (LMP).*

Just like ESS2, the Code applies to project workers including fulltime, part-time/ temporary workers as follows:

- Direct workers (refer to paragraphs 9 to 30 of ESS2.
- Contracted workers (refer to paragraphs 9 to 33 of ESS2)
- Community workers (refer to paragraphs 34 to 38 of ESS2)
- Primary supply workers (refer to paragraph 39 to 42 of ESS 2)

Note: ESS2 will not apply to such government civil servants, except for the provisions of paragraphs 17 to 20 (Protecting the Work Force) and paragraphs 24 to 30 (Occupational Health and Safety).

Each employee including trainee or volunteer of a **Contractor** who have interaction with the project must sign this "Code of Conduct."

In this Code, "Contractor" shall mean and apply to the contractor, its employees, sub-contractor, officers, agents, representative or those contracted through the Contractor to perform services authorized by the contract.

The contractor agrees to adhere to this Code of Conduct when providing services to this project. The Code of Conduct is in addition to all other contract requirements, policies, rules and regulations governing delivery of services. The purpose of the code is to protect vulnerable people from abuse, neglect, maltreatment and exploitation. It clarifies expectation of conduct of the parties and their employees, which includes administrative staff, care staff, support services staff and any others when interacting with the project.

Contractor, its agents or representatives authorized through it shall not abuse, sexually abuse or sexually exploit, neglect, exploit or maltreat any fellow employees or people from general public/ community. Additionally, no person shall cause physical injury to any other person.

The Contractor shall not by acting, failing to act, encouragement to engage in, or failure to deter from will cause any person to be subject to physical or mental abuse, sexual abuse or sexual exploitation, neglect, exploitation, or maltreatment. The Contractor shall not engage any person as an observer or participant in sexual acts.

Contractor understands and acknowledges that failure to comply with this Code of Conduct may result in corrective action, probation, suspension, and/or termination of contract.

Equally important to realize is that this Code also protects any person under the age of 18 years and any person 18 years of age or older who is physically or mentally **handicapped or impaired** due of mental illness, mental deficiency, physical illness or disability, or other temporary or permanent cause, to the extent that he is unable to care for his own personal safety.

1) Abuse shall include the following, but is not limited to:

a) Harm or threatened harm, meaning damage or threatened damage to physical or emotional health and welfare of any person.
b) Unlawful confinement.
c) Deprivation of life-sustaining treatment.

d) Physical injury including, but not limited to, any contusion of the skin, laceration, malnutrition, burn, fracture of any bone, subdural hematoma, injury to any internal organ, any injury causing bleeding, or any physical condition which imperils a person's health or welfare.
e) Any type of physical hitting or corporal punishment inflicted in any manner upon the body.

2) Sexual misdemeanor will include, but not be limited to:
a) Engaging in exploitive or manipulative sexual intercourse with any person. There will be zero tolerance to sexual misdemeanor including rape, defilement of minors/ sexual child abuse, sexual harassment and elopement.
b) Taking indecent liberties with a person, or causing an individual to take indecent liberties with a person, with the intent to arouse or gratify sexual desire of any person.
c) Employing, using, persuading, inducing, enticing, or coercing a person to pose in the nude.
d) Employing, using, persuading, inducing, enticing or coercing a person to engage in any sexual or simulated sexual conduct for the purpose of photographing, filming, recording, or displaying in any way the sexual or simulated sexual conduct. This includes displaying, distributing, possessing for the purpose of distribution, or selling material depicting nudity, or engaging in sexual or simulated sexual conduct.
e) Use of profanities and obscene language in communities or when instructing others.

3) Neglect may include but is not limited to:
a) Denial of sufficient nutrition to any person.
b) Denial of sufficient sleep to nay person.
c) Denial of sufficient protective gear to any person.
d) Failure to provide adequate supervision; leading to drug use in workplaces, accidents and impairment of employees.
e) Failure to arrange for medical care and/or medical treatment for any person in an emergency.
f) Failure to drive courteously at all times, leading to accidents.
g) Failure to avoid damage public property.
h) Neglecting public and employee complaints.

4) Drug abuse may include but is not limited to:
a) Smoke in public or smoking in undesignated areas
b) Consumption of alcohol while on duty/at work
c) Use and trading in narcotics

5) Illegal trade activities without necessary licenses:
a) Trade in protected fauna or flora species
b) Trade in ivory or similar regulated wildlife products including game meat
c) Trade in processed, semi-processed minerals and their ores

6) Financial exploitation will include, but is not limited to:
Utilizing labor of without paying for it, or at a non-commensurate financial rate/ wage.

7) Mistreatment will include, but is not limited to:
a) Physical exercises, such as running laps or performing pushups,
b) Unauthorized chemical, mechanical or physical restraints except,
c) Assignment of unduly physically strenuous or harsh work.
d) Failure to behave in a polite and courteous manner to the general public
e) Requiring or forcing the individual to take an uncomfortable position, such as squatting or bending, or forcing people to repeat physical movements when used solely as a means of punishment.
f) Group punishments for misbehavior of individuals except in accordance with the written policy.
g) Verbal abuse: engaging in language whose intent or result is demeaning
h) Denial of any essential service solely for disciplinary purposes
i) Denial of visiting or communication privileges with family or significant others

j) Requiring the individual to remain silent for long periods of time solely for the purpose of punishment.

Contractor agrees to document and report abuse, sexual abuse and sexual exploitation, neglect, maltreatment and exploitation as outlined in this Code and cooperate fully in any resulting investigation. Contractor shall prominently display a poster, notifying contractor employees of their responsibilities and to report violations and giving appropriate phone numbers.

Contractor/ Employee/ Volunteer/ subcontractor	
Signed: …….	Date (dd/mm/yyyy):
Name: …….	

Annex 7: Technical Note on Use of Security Forces in COVID-19 Emergency Operations

Suggestions on how to Mitigate Risks

It is common practice for Governments to utilize military or security personnel during public health emergencies. The ability to do this, and the requirements relating to such mobilization, are often set out in executive orders or instructions. A '*public health emergency*' will usually be defined under national law. For example, the US Department of Defense (DoD Instruction 6200.03, March 28, 2019) defines a public health emergency to include *"the occurrence or imminent threat of an illness or health condition that poses a high probability of a significant number of deaths, serious or long-term disabilities, widespread exposure to an infectious or toxic agent, overwhelmed health care resources, or severe degradation of mission capabilities".*

For the reasons set out in section 1 below, it is expected that military or security forces will be utilized in different ways in response to COVID-19. They may be used directly to carry out activities in a World Bank-supported project. Or they may be mobilized more generally to implement Government programs, which are also supported by the Bank. Where military/security forces are utilized, either directly or indirectly, in connection with Bank-supported operations, questions will arise about the risk of the operation. Is it automatically high or are there effective ways of mitigating the risk? This guidance sets out suggestions for due diligence and mitigation measures to address the risk.

1. WHAT ARE THE POSITIVE ASPECTS ABOUT USING THE MILITARY?

Where relevant, consider the following and document relevant details:

- **Human rights:** Depending on the country, military personnel may be aware of the need to respect human rights and received relevant training.
- **"NBC" capabilities:** Many military forces have nuclear, biological and chemical capabilities. They may have existing biological defense capabilities e.g. ability to deploy with personal protective equipment (PPE); training in decontamination; procedures or advice on how to carry out relevant activities.
- **Medical expertise:** Medical and other professionals within the military are likely to be trained to deal with medical emergencies, and therefore may be better able to cope in situations in which there may be mass casualties.
- **Disciplined response:** Generally, military personnel are expected to respond in a disciplined manner to commands and will have capabilities which will be useful in these types of emergencies (medical, engineering, construction).
- **Civic action programs:** Military may also have specific civic action programs and infrastructure to support these (e.g. mobile clinics/communication procedures).

2. WHAT ARE THE THINGS TO WATCH FOR?

(a) ***Diversion of materials, aid and assistance*:** Diversion can take the form of confiscations and re-use, misappropriation and theft. While a certain level of diversion may be inevitable in certain circumstances, this issue is likely to present reputational issues (especially when the crisis dissipates).

(b) ***Allegations of human rights violations:*** This will be a risk, including as it relates to Sexual Exploitation and Abuse and Sexual Harassment (SEA/SH), and the Bank needs to be clear and transparent about what measures are being adopted to minimize these risks. Tools that should be considered include the ESF Good Practice Note (GPN) on Use of Security Forces, on SEA/SH, and

the IFC Good Practice Handbook on the Use of Security Forces: Assessing and Managing Risks and Impacts.

(c) ***Putting World Bank staff at risk*:** This is particularly a concern where military/security forces are likely to be undisciplined. The risk may be heightened when Bank staff are trying to address the risk of diversion referred to above. While staff may try to address this risk by avoiding direct interaction with the military, this is not likely to be feasible in a project setting.

(d) ***International media comment and reaction***: This will be a challenge, and it may not be possible to avoid negative comment entirely. It is important to be transparent about the activities the World Bank is supporting and the mitigation measures that are being implemented to address risks.

3. WHAT ARE THE WAYS TO ADDRESS THE RISKS?

(a) ***Get a view of the reputation and capability of the military*:** Talk to those who might have up to date and accurate information: e.g. the Defense Attaché at the relevant Embassy; the US or UK Government; refer to Jane's Defense Weekly.

(b) ***Identify the structure under which the military will be operating***: While they will continue to abide by their own rules and procedures, it is likely that the military will also be subject to relevant national requirements relating to the public health emergency and the specific activities that they are required to carry out e.g. instructions issued by public health officials. In the context of a Bank-supported operation, it is good practice to document (as far as possible) the structure under which the military are operating, including the chain of command, with specific reference to the activities they will or are likely to carry out (see paragraph (i) below).

(c) ***Clarify who is responsible for human rights issues nationally*:** Many countries have a Human Rights Commission. If such commissions do not exist, there is usually an Ombudsman, Human Rights office or inspector general at the national level with jurisdiction to deal with such issues. Identify the relevant parties and consider whether it would be appropriate to consult them for advice.

(d) ***Identify other specialized parties and ask for advice***: There are both national and international NGOs which follow and support these issues (e.g. Human Rights Watch (HRW), Amnesty). There is also the International Committee of the Red Cross (ICRC) and the International Crisis Group. Identify relevant parties, with reference to the context and nature of the operations, who may be in a position to provide valuable advice.

(e) ***As required under the ESF, cooperate with relevant stakeholders on a risk assessment*:** Carry out a risk assessment to identify the specific risks associated with the proposed use of military. This assessment needs to be conducted with those that are involved in the operation, including Government counterparts, to ensure that an accurate picture of the risks emerge, that appropriate mitigation measures are identified and that both the risk assessment and the mitigation measures are owned by the project and the Government.

(f) ***Be transparent about what the World Bank is required to mitigate the risks***: Document this, setting out key aspects in the ESRS and other project documentation. Consider the following:

- procedures relating to: e.g. risk assessment; how allegations of HR/SEA/SH violations will be dealt with, including through the project Grievance Mechanism (GM); preventing diversion of materials, aid and assistance (build on existing requirements)

- presence of World Bank representatives/third party monitors on the ground
- cooperation with specialist institutions/NGOs/Government agencies
- specific obligations set out in the legal agreement and (if possible and appropriate) a Memorandum of Understanding (see paragraph (k) below)
- monitoring and reporting

(g) ***Consider asking a credible party to act as an observer/third party monitor***: This can be considered under the ESF provisions for third party monitoring as noted in ESS1 and ESS10, as well as the ESF Good Practice Note on Third Party Monitoring. Relevant groups with experience in this field will depend on the context, and may include the parties referred to in paragraph (d) above.

(h) ***Establish a procedure to be followed in cases of allegations of HR/SEA/SH violations or misbehavior***: This should reflect the ESF Good Practice Note on SEA/SH and may include reference to the institutions referred to in paragraph (c) above. Include a specific HR and SEA/SH procedure in the project GM to address these allegations and identify specific individuals who have the expertise to address such allegations credibly. Understanding relevant Code of Conduct (CoC) requirements pertaining to such behavior is important, and, where necessary, improving the form and substance of such CoC.

(i) ***Be clear on what the military will do***: Identify the activities and set them out clearly in the legal agreement: e.g. construction, enforcing quarantine restrictions, distribution of medical supplies or vaccines, distribution of other supplies. This will support a more accurate risk assessment. Note that in some circumstances, what could otherwise be viewed as inappropriate behavior by the military (or at an extreme, a possible abuse of rights) may be authorized and necessary in situations of a public health emergency. This will depend on the activities that the military is required to carry out and will be particularly relevant where they are required to enforce public order or quarantine restrictions.

(j) ***Set out specific requirements as covenants in the legal agreement and in the ESCP as appropriate:*** The provisions should set out the 'ground rules' for military engagement, including: (i) requirements to comply with ESS4; (ii) reporting obligations (specify on what, how often, to whom); (iii) specific prohibitions e.g. no child labor, no forced labor, restrictions on what military personnel under the age of 18 can do (if anything); (iv) health and safety requirements; (v) Code of Conduct (CoC) type obligations; (vi) requirements for the GM; (vii) training required and how often (specify on what – e.g. Voluntary Principles on Security and Human Rights, interactions with the community, operation of the GM, use of personal protective equipment (PPE), CoC).

(k) ***Where possible, and if not already covered by applicable law/regulation, the Government should consider executing a Memorandum of Understanding (MoU) with the military:*** This should reflect the 'ground rules' set out in the legal agreement (see paragraph (j) above). An example of a MoU is available in the IFC Good Practice Handbook on the Use of Security Forces: Assessing and Managing Risks and Impacts. Even where it is not possible for individual military personnel to sign a CoC, the requirements should be set out in the MoU, and training should cover these obligations (amongst others).

ANNEX

Set out below is suggested wording on HR/SEA/SH:

- Prior to deploying military or security personnel, the [Borrower/Recipient] shall take measures to ensure that such personnel are:

  (i) screened to confirm that they have not engaged in past unlawful or abusive behavior, including sexual exploitation and abuse (SEA), sexual harassment (SH) or excessive use of force;

  (ii) adequately instructed and trained, on a regular basis, on the use of force and appropriate behavior and conduct (including in relation to SEA and SH), as set out in the [*Training Procedure*, *Project Operational Manual, ESMF, Security Management Plan, MoU*]; and

  (iii) deployed in a manner consistent with applicable national law.

- The [Borrower/Recipient] shall promptly review all allegations of unlawful or abusive acts of any military/security personnel, take action (or request appropriate parties to take action) to prevent recurrence and, where necessary, report unlawful and abusive acts to the relevant authorities.

Set out below is suggested wording on reporting: Frequency of reporting will depend on the context and the risks associated with the activities the military is carrying out, and may be required monthly, weekly or even daily. Requirements should include:

- Immediate reporting (within 24 hours) of any serious incident
- A written weekly or monthly report (depending on the risk) covering:
  - status of activities being conducted by the military
  - training conducted (specifying subject matter)
  - current status of review of serious incidents (if any) and any relevant reporting
  - a summary of any minor (but reportable) issues, suspected incidents or potential issues
  - details of any incidents involving use of force or weapons
  - details of upcoming activities which may pose a risk (e.g. distribution of supplies) and measures being put in place to reduce such risk
  - lessons learnt, to inform conduct of future activities

Other reference documentation: The International Code of Conduct under the Montreux Document. While this relates to private security, it contains useful material.

Annex 8: Consultation Record

1. Mbale Regional Referral Hospital

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REPUBLIC OF UGANDA
MINISTRY OF HEALTH

Meeting Record

Project name	**Environmental and Social Management Framework for Uganda COVID-19 Response and Public Health Emergencies Systems Strengthening Project (P174041)**		
Organisation/ Stakeholder	**MBALERegional Referral Hospital**	Meeting date	**15 June 2020**
		Recorded by	**Dr. Lam Kajubi**
Meeting/subject	**Stakeholder consultation**		
Background to this consultation	Government of Uganda (GoU) obtained financing from the World Bank to support national capacity to contain COVID-19 pandemic through the COVID-19 Response and Public Health Emergencies Systems Strengthening Project. This new operation will complement the support provided through the Contingency Emergency Response Component (CERC) which was activated in March 2020 in an ongoing project, by further enhancing prevention and early detection, but focusing more on health system readiness with emphasis on case management and psychosocial support—areas that are currently underfunded in the national response. Specific areas of planned support are in: (i) infection prevention and control: (ii) contact tracing; (iii) point of entry screening; case management, psychosocial support, and gender-sensitive interventions; (iv) disease surveillance and laboratory capacity strengthening. The project will cost USD 12.5 million and has four components below which are described in detail in Chapter 2: a) Component 1: Case Detection, Confirmation, Contact Tracing, Recording and Reporting b) Component 2: Case Management and Psychosocial Support c) Component 3: Implementation Management, Monitoring and Evaluation d) Component 4: Contingency Emergency Response Component (CERC) As per Word Bank standards, such support requires preparation of an ESMF to guide proper management of social and environmental issues. Preparation of an ESMF entails stakeholder consultations and engagement.		

Present	Apology	Copy	Name(s) of respondent/ meeting participant
☒	☐	☐	Dr Tugaineyoltuuza Emmanuel. Hospital Director.
☒	☐	☐	
☒	☐	☐	
☒	☐	☐	
☒	☐	☐	
☒	☐	☐	
☒	☐	☐	
☒	☐	☐	
☒	☐	☐	

Item	Issues discussed
1	**State of preparedness: facilities in place to handle COVID-19 emergencies**

REPUBLIC OF UGANDA
MINISTRY OF HEALTH

Item	Issues discussed
	1. One temporary Isolation unit for Covid-19 patients of about 50 beds in place. This was formerly the Mental unit for the Hospital.
	b. Preparing to receive a 20 bed tent from Absa Bank annexed to the covid-19 treatment unit which will increase the bed capacity for the Isolation unit to 70 beds.
2	**Challenges faced or foreseen in effective management of COVID-19 emergencies** A) No ICU equipment in place in case we get a very seriously sick covid-19 patient that requires intensive care services. B) The isolation unit has a very limited capacity in case of an increase in Covid-19 patient numbers given that we are serving several border crossing points that are quite busy.
	C) The Isolation unit in use was not meant for management of other medical conditions but mental conditions this is in terms of its design structurally.
3	**Resources required for effective management of COVID-19 emergencies**
	1) Human resources. More medical workers need to be recruited to take charge of covid-19 management so as to relieve the Hospital staff to do the general Hospital services so as not to compromise on other health services.
	2) Financial resources are very much required to help sustain the feeding of Covid-19 patients, pay the allowances of health workers dealing with Covid-19 patient services, and buying consumables used in the isolation unit.
	3) Resources are required for fuel for the vehicles and the Ambulance which are involved in responding to emergency alerts, picking patients and dropping and resettling those discharged from the isolation unit. Resources are also required for maintenance and repairs done on these vehicles.
	4) Financial resources are also required for support supervision and training of health of Health workers within the region supervised by Mbale RRH.
4	**Does hospital have a functioning medical waste incinerator on site?**

REPUBLIC OF UGANDA
MINISTRY OF HEALTH

Item	Issues discussed
	The Hospital has a functional incinerator but it has a high fuel consumption which poses a financial challenge while operating it. Hence some financial support would be required.
5	**Challenges faced in operating the incinerator (if it is on site)**
	1) High fuel consumption
6	**Are there any special provisions for managing COVID-19 patients in distinct groups below?:**
a	Pregnant women
	There are special provisions for managing pregnant women, but the team tries to improvise. Recently a delivery was successfully conducted in the isolation unit and the baby is still with the mother there.
b)	Disabled persons
	No special provisions for the different types of disabilities, however, the facility is easily accessible.
c)	COVID-19 patients with HIV/AIDS
	Patients with HIV/AIDS are well catered for, they easily access their medications and services of the doctors.

Meeting Record

2. Masaka Regional Referral Hospital

Project Name	**Environmental and Social Management Framework** **for Uganda COVID-19 Response and Public Health Emergencies Systems Strengthening Project (P174041)**		
Organisation/ Stakeholder	**MASAKA Regional Referral Hospital**	Meeting date	**15 June 202015 June 2020**
		Recorded by	**Dr. Lam Kajubi**
Meeting/subject	**Stakeholder consultation**		
Background to this consultation	Government of Uganda (GoU) obtained financing from the World Bank to support national capacity to contain COVID-19 pandemic through the COVID-19 Response and Public Health Emergencies Systems Strengthening Project. This new operation will complement the support provided through the Contingency Emergency Response Component (CERC) which was activated in March 2020 in an ongoing project, by further enhancing prevention and early detection, but focusing more on health system readiness with emphasis on case management and psychosocial support—areas that are currently underfunded in the national response. Specific areas of planned support are in: (i) infection prevention and control: (ii) contact tracing; (iii) point of entry screening; case management, psychosocial support, and gender-sensitive interventions; (iv) disease surveillance and laboratory capacity strengthening. The project will cost USD 12.5 million and has four components below which are described in detail in Chapter 2: Component 1: Case Detection, Confirmation, Contact Tracing, Recording and Reporting Component 2: Case Management and Psychosocial Support Component 3: Implementation Management, Monitoring and Evaluation As per Word Bank standards, such support requires preparation of an ESMF to guide proper management of social and environmental issues. Preparation of an ESMF entails stakeholder consultations and engagement.		

Present	Apology	Copy	**Name(s) of respondent/ meeting participant**
☒	☐	☐	Dr Nathan Onyachi, Hospital Director
☒	☐	☐	

Item	**Issues discussed**
1	**State of preparedness: facilities in place to handle COVID-19 emergencies**

Meeting Record

Item	Issues discussed
	We had to convert the Mental Health unit and the TB ward into covid19 treatment facilities with up to 32 beds. We additionally received an 8 bed capacity tent from the bank Absa. We expect to get a 30 bed tent from WFP. The displaced TB and Mental patients will ultimately need care to reduce morbidity and mortality among them. So far we have sufficient numbers of willing staff, to provide care without significantly affecting other services. Main challenges lie in having a steady supply of PPEs and provision of food and other social needs for the patients and the staff caring for them.
	Cases treated so far have been mild but the hospital lacks an ICU in case we required such services. We have a 400 bed ward under construction by government of Uganda and 90% completion. We have identified its first floor as convertible into ICU, but the contractor has requested for an additional bill of Ugx 1.5 billion to do this in the next 60 days if funds are availed.
	We have been using the school of Nursing for quarantining suspected cases, but this will not be possible when nursing students return.
2	**Challenges faced or foreseen in effective management of COVID-19 emergencies**
	1. We need a steady flow of PPEs and sample collection swabs. These have not been consistent 2. Money for feeding patients and staff involved is a challenge 3. Allowances for staff manning the isolation units, they are always expectant 4. Fuel for transporting COVID-19 patients from areas of identification to our hospital or other hospitals, transporting discharged patients and doing contact tracing, incineration of waste materials 5. Costs involved in setting up and expanding treatment facilities
3	**Resources required for effective management of COVID-19 emergencies**
	1. Trained and motivated human resources 2. Infrastructure in good condition 3. PPEs 4. Support equipment and facilities like ICU 5. Relevant medicines 6. Food 7. Fuel 8. Money
4	**Does hospital have a functioning medical waste incinerator on site?**
	Yes
5	**Challenges faced in operating the incinerator (if it is on site)**
	High fuel consumption
6	**Are there any special provisions for managing COVID-19 patients in distinct groups below?:**
a)	Pregnant women.
	These have not been many, but we have midwives and doctors and a maternity nearby in case of need.

Meeting Record

Item	Issues discussed
b)	Disabled persons.
	No special facilities so far for the disabled.
c)	COVID-19 patients with HIV/AIDS
	We have had these, both newly diagnosed and those already in care. ART services are available in the hospital for them. Those already on medication have taken their medication concurrently.

- **Mbarara Regional Referral Hospital**

Meeting Record

Project name	Environmental and Social Management Framework for Uganda COVID-19 Response and Public Health Emergencies Systems Strengthening Project (P174041)		
Organisation/ Stakeholder	**MBARARA Regional Referral Hospital**	Meeting date	**15 June 202015 June 2020**
		Recorded by	**Dr. Lam Kajubi**
Meeting/subject	**Stakeholder consultation**		
Background to this consultation	Government of Uganda (GoU) obtained financing from the World Bank to support national capacity to contain COVID-19 pandemic through the COVID-19 Response and Public Health Emergencies Systems Strengthening Project. This new operation will complement the support provided through the Contingency Emergency Response Component (CERC) which was activated in March 2020 in an ongoing project, by further enhancing prevention and early detection, but focusing more on health system readiness with emphasis on case management and psychosocial support—areas that are currently underfunded in the national response. Specific areas of planned support are in: (i) infection prevention and control: (ii) contact tracing; (iii) point of entry screening; case management, psychosocial support, and gender-sensitive interventions; (iv) disease surveillance and laboratory capacity strengthening. The project will cost USD 12.5 million and has four components below which are described in detail in Chapter 2: Component 1: Case Detection, Confirmation, Contact Tracing, Recording and Reporting Component 2: Case Management and Psychosocial Support Component 3: Implementation Management, Monitoring and Evaluation Component 4: Contingency Emergency Response Component (CERC) As per Word Bank standards, such support requires preparation of an ESMF to guide proper management of social and environmental issues. Preparation of an ESMF entails stakeholder consultations and engagement.		

Present	Apology	Copy	**Name(s) of respondent/ meeting participant**
☒	☐	☐	AKENA DENIS UMA
☒	☐	☐	WANOK STEPHEN
☒	☐	☐	RITAH ABER

Meeting Record

Item	Issues discussed
1	**State of preparedness : facilities in place to handle COVID-19 emergencies**
	Isolations unit available to managed COVID-19 related issues
	Staffing available such as doctors, nurses and social worker.
	Few Personal Protective gears were available
	COVID-19 Management Team comprising of case management, psychosocial and IPCs.
	Strong support from the hospital top management
	CMEs on Covid 19 management that is the hospital trained staff at the hospital and the lower facilities
2	**Challenges faced or foreseen in effective management of COVID-19 emergencies**
	Inadequate staffing level.
	Standard of isolation is inadequate critical care equipment, space is limited.
	Long turn around for COVID -19 laboratory results 3- 7 days.
	Inadequate personal protective gears / equipment although currently is available.
	Inadequate vital signs monitoring equipment.
	Homeless people and illegal immigrants posed a challenge in community integration.
3	**Resources required for effective management of COVID-19 emergencies**
	Staffing / human resources.
	Knowledge and skills.
	Personal Protective equipment.
	Food for patients and staff.
	Transport for contact tracing and community integration of COVID-19 affected persons
4	**Does hospital have a functioning medical waste incinerator on site?**
	No, the hospital does not have functioning waste incinerator on site. It has only a pit
5	**Challenges faced in operating the incinerator (if it is on site)**
6	**Are there any special provisions for managing COVID-19 patients in distinct groups below:**
a)	Pregnant women
	Yes, but it is crippled with limited space.
b)	Disabled persons
	Yes, physiotherapist is included in the team
c)	COVID-19 patients with HIV/AIDS
	Yes, ensuring they ART drugs and conducting clinical investigation

Meeting Record

Project name	**Environmental and Social Management Framework** **for Uganda COVID-19 Response and Public Health Emergencies Systems Strengthening Project (P174041)**		
Organisation/ Stakeholder	**MBARARA Regional Referral Hospital**	Meeting date	**15 June 202015 June 2020**
		Recorded by	**Dr. Lam Kajubi**
Meeting/subject	**Stakeholder consultation**		
Background to this consultation	Government of Uganda (GoU) obtained financing from the World Bank to support national capacity to contain COVID-19 pandemic through the COVID-19 Response and Public Health Emergencies Systems Strengthening Project. This new operation will complement the support provided through the Contingency Emergency Response Component (CERC) which was activated in March 2020 in an ongoing project, by further enhancing prevention and early detection, but focusing more on health system readiness with emphasis on case management and psychosocial support—areas that are currently underfunded in the national response. Specific areas of planned support are in: (i) infection prevention and control: (ii) contact tracing; (iii) point of entry screening; case management, psychosocial support, and gender-sensitive interventions; (iv) disease surveillance and laboratory capacity strengthening. The project will cost USD 12.5 million and has four components below which are described in detail in Chapter 2: Component 1: Case Detection, Confirmation, Contact Tracing, Recording and Reporting Component 2: Case Management and Psychosocial Support Component 3: Implementation Management, Monitoring and Evaluation Component 4: Contingency Emergency Response Component (CERC) As per Word Bank standards, such support requires preparation of an ESMF to guide proper management of social and environmental issues. Preparation of an ESMF entails stakeholder consultations and engagement.		

Meeting Record

4. Green Label Services Ltd (Medical Waste Company)

Project name	**Environmental and Social Management Framework for Uganda COVID-19 Response and Public Health Emergencies Systems Strengthening Project (P174041)**		
Organization/ Stakeholder	**Managing Director** **Green Label Services LTD** Tel: +256414531135 green.2000.label@gmail.com info@greenlabelservices.com admin@greenlabelservices.com	Meeting date	**15 June 2020**
		Recorded by	**Dr. Lam Kajubi**
Meeting/subject	**Stakeholder consultation**		
Background to this consultation	Government of Uganda (GoU) obtained financing from the World Bank to support national capacity to contain COVID-19 pandemic through the COVID-19 Response and Public Health Emergencies Systems Strengthening Project. This new operation will complement the support provided through the Contingency Emergency Response Component (CERC) which was activated in March 2020 in an ongoing project, by further enhancing prevention and early detection, but focusing more on health system readiness with emphasis on case management and psychosocial support—areas that are currently underfunded in the national response. Specific areas of planned support are in: (i) infection prevention and control: (ii) contact tracing; (iii) point of entry screening; case management, psychosocial support, and gender-sensitive interventions; (iv) disease surveillance and laboratory capacity strengthening. The project will cost USD 12.5 million and has four components below which are described in detail in Chapter 2: Component 1: Case Detection, Confirmation, Contact Tracing, Recording and Reporting Component 2: Case Management and Psychosocial Support Component 3: Implementation Management, Monitoring and Evaluation Component 4: Contingency Emergency Response Component (CERC) As per Word Bank standards, such support requires preparation of an ESMF to guide proper management of social and environmental issues. Preparation of an ESMF entails stakeholder consultations and engagement.		

Present	Apology	Copy	Name(s) of respondent/ meeting participant
☒	☐	☐	Dr. Grace Mugume, Managing Director

Item	Issues discussed
1	**State of preparedness: What facilities do you have in place to handle COVID-19 waste?**
	Incinerator With Disposal Capacity Of One Ton Per Hour Located in Iganga District
	Autoclave With Disposal Capacity Of One Ton Per Hour Located In Mbarara District
2	**Challenges faced or foreseen in effective management of COVID-19 waste**
	Poor Segregation From Most Facilities Hence Increasing Disposal Costs
3	**Resources required for effective management of COVID-19 waste by your company?**
	Funding Of Collection, Transportation And Disposal Of Covid – 19 Waste
4	**Does your company have a functioning medical waste incinerator on site?**
	Yes, Located In Iganga District
5	**Challenges faced in operating the incinerator (if any)**
	Operates At Under Capacity Yet Maintenance Costs Are High
6	**Which areas or regions of Uganda can your company serve regarding collection and treatment of medical waste?**

Meeting Record

	All Regions, We Current Do Collection From All Regions In 405 Health Facilities
7	**What other medical waste facilities does your company own?**
	Only Incinerator And Autoclave

5. National Union of Disabled Persons of Uganda (NUDIPU)

Project name	Environmental and Social Management Framework (ESMF) for Uganda COVID-19 Response and Public Health Emergencies Systems Strengthening Project (P174041)		
Organisation/ Stakeholder	National Union of Disabled Persons of Uganda (NUDIPU)National Union of Disabled Persons of Uganda (NUDIPU)National Union of Disabled Persons of Uganda (NUDIPU)National Union of Disabled Persons of Uganda (NUDIPU)National Union of Disabled Persons of Uganda (NUDIPU)National Union of Disabled Persons of Uganda (NUDIPU) (NUDIPU)National Union of Disabled Persons of Uganda (NUDIPU)National Union of Disabled Persons of Uganda T: +256 (0) 414540179 info@nudipu.org	Meeting date	**15 June 202015 June 202015 June 202015 June 202015 June 202015 June 202015 June 202015 June 2020**
		Recorded by	**Dr. Lam Kajubi**
Meeting/subject	**Stakeholder consultation**		
Background to this consultation	Government of Uganda (GoU) obtained financing from the World Bank to support national capacity to contain COVID-19 pandemic through the COVID-19 Response and Public Health Emergencies Systems Strengthening Project. This new operation will complement the support provided through the Contingency Emergency Response Component (CERC) which was activated in March 2020 in an ongoing project, by further enhancing prevention and early detection, but focusing more on health system readiness with emphasis on case management and psychosocial support—areas that are currently underfunded in the national response. Specific areas of planned support are in: (i) infection prevention and control: (ii) contact tracing; (iii) point of entry screening; case management, psychosocial support, and gender-sensitive interventions; (iv) disease surveillance and laboratory capacity strengthening. The project will cost USD 12.5 million and has four components below which are described in detail in Chapter 2: a) Component 1: Case Detection, Confirmation, Contact Tracing, Recording and Reporting b) Component 2: Case Management and Psychosocial Support c) Component 3: Implementation Management, Monitoring and Evaluation d) Component 4: Contingency Emergency Response Component (CERC) As per Word Bank standards, such support requires preparation of an ESMF to guide proper management of social and environmental issues. Preparation of an ESMF entails stakeholder consultations and engagement.		

Present	Apology	Copy	**Name(s) of respondent/ meeting participant**
☒	☐	☐	Ngirabakunzi Edson, Executive Director, NUDIP

Meeting Record

Item	Issues discussed
1	**Are people with disabilities (PWD) getting effective information that would help them prevent COVID-19 infection?**
	Persons with disabilities are likely to be affected disproportionately by the Pandemic due to inadequate access to information. The information about mitigation measures and risks are not in accessible formats. The sign language interpretation and personal assistants' services are not readily available. The messages communicated on radios and TVs are not inclusive of persons with disabilities. Persons with disabilities are not used in the MOH adverts as a means of mobilising persons with disabilities. TVs have no captioning for people of "*heard of hearing*" and in many cases no sign language interpretation is provided. The large print materials are not in place. Under the circumstances persons with disabilities are likely to be more affected and in some MOH COVID 19 briefings and those of the President on TVs sign language interpretation and captioning has not been observed to enable PWDS access the necessary information on prevention. Organisations of persons with disabilities have not been consulted on how best to provide effective information to person with disabilities during this pandemic and they have expert opinions and ideas on disability issues. All the videos, messages and posters on COVID 19 should be disability sensitive.
2	**How is COVI-19 pandemic affecting (PWD) differently compared to other citizens?**
3	**Are current COVID-19 control measures disability-friendly and inclusive of needs and concerns of PWD?**
	The control measures are silent on disability concerns and issues. Masks are generic and therefore not inclusive. There are not masks that are transparent to allow those who access information through lip reading.
	Social distancing did not consider the unique needs of person with disabilities especially PWDs who use third parties such as helpers and guides. The MOH did not provide guidance on how this should be managed. This is new pandemic and therefore PWDs did not know how to manage the situation.
	Hand washing and sanitising is good but most places are not accessible
4	**What disability-specific barriers do you suggest Uganda Government should consider to remove when planning and implementing COVID-19 control measures?**
a	All quarantine centres should be accessible to person with disabilities
b	Provide masks that are transparent to PWDs who need and use them
c	Government officials providing information to use transparent masks
d	All information mediums to be accessible and disability sensitive eg videos and Posters. Plan for use of sign language interpretation and personal assistants' services throughout.
e	Effective and full involvement and participation of organisations of person with disabilities and their leaders during planning and implementation of the control measures. This will enable provide expert opinion and advice on the proposed measures.
f	Capturing data and statistics of PWDs during planning and implementation of the control measures. This will enable easy targeting of PWDs with specific needs and concerns.
g	Ensure persons with disabilities are represented on at all levels of implementation framework of the control measures.
h	Need for ministry of health to develop a management and operation plans on disability during the COVID 19. These will provide for guidance on how person with disabilities access treatment both as inpatient and out patients. Australia is an example to learn from during this pandemic.

Meeting Record

Item	Issues discussed
i	Provide regular and accessible information on covid 19 to the extremely vulnerable pwds in communities.
j	MOH should ensure there is a desk allocated to address disability relate concerns during the pandemic. The justification this that during the risky situation PWDs suffer more and are less attended too due to emergency nature of service delivery. However, this does not mean that PWDs cannot be attended to by the mainstream service points.
k	Ensure all guidelines and directives are disability inclusive and sensitive to disability issues and concerns.
l	Ensure non-discrimination in access and allocation to scarce medical resources
m	Make mental health services or interventions inclusive of PWDs during pandemic. This is because lockdowns and anxiety impact hugely on PWDs.
n	Launch national programme to test PWDs in their homes. This would be a good pilot to know how COVID 19 has affected PWDs.
o	Ensure inclusive and accessible victim support or assistance services
p	Need to track inclusion and empowerment of persons with disabilities in national response and recovery plans.
5	**What resources are required for PWD at quarantine and treatment centers**
a	Sign language interpretation and personal assistants' services and ensure their continuity
b	Physical Accessible centres with ramps and handrails and toilets that are disability friendly or designed for this purpose.
c	COVID 19 messages that are disability inclusive and sensitive
d	Health workers that are disability friendly and sensitive.
e	Health workers that are trained about disability management
f	Assistive devices such as wheelchairs etc
g	Drugs or Sackets that are brailed to enable easy reading by PWDs
h	Information in accessible formats to allow regular access to COVID 19 updates.
i	Keeping records of PWDs to allow easy contact tracing
j	PPEs for PWDs and accessible hand washing facilities and sanitisers.
k	Deinstitutionalisation strategies need to be accelerated and reinforced with clear timelines and concrete benchmarks.
6	**Are COVID-19 reporting channels easily accessed and used by PWD?**
	Reporting channels are not easily accessed by PWDs. Various sub committees of COVID 19 national response are silent on disability in their reports. The national COVID briefings are equally silent on disability.

Meeting Record

6. Batwa Development Project

Project name	**Environmental and Social Management Framework** **for Uganda COVID-19 Response and Public Health Emergencies Systems Strengthening Project (P174041)**		
Organisation/ Stakeholder	Vulnerable and Marginalized Groups (VMG) /Batwa Development ProjectVulnerable and Marginalised Groups (VMG) /Batwa Development ProjectVulnerable and Marginalised Groups (VMG) /Batwa Development ProjectVulnerable and Marginalised Groups (VMG) /Batwa Development Projectment ProjectVulnerable and Marginalised Groups (VMG) /Batwa Development ProjectVulnerable and Marginalised Groups (VMG) /Batwa Development ProjectVulnerable and Marginalised Groups (VMG) /Batwa Development ProjectVulnerable and Marginalised Groups (VMG) /Batwa Develop	Meeting date	**15 June 202015 June 202015 June 202015 June 202015 June 202015 June 202015 June 202015 June 2020**
		Recorded by	**Dr. Lam Kajubi**
Meeting/subject	**Stakeholder consultation**		
Background to this consultation	Government of Uganda (GoU) obtained financing from the World Bank to support national capacity to contain COVID-19 pandemic through the COVID-19 Response and Public Health Emergencies Systems Strengthening Project. This new operation will complement the support provided through the Contingency Emergency Response Component (CERC) which was activated in March 2020 in an ongoing project, by further enhancing prevention and early detection, but focusing more on health system readiness with emphasis on case management and psychosocial support—areas that are currently underfunded in the national response. Specific areas of planned support are in: (i) infection prevention and control: (ii) contact tracing; (iii) point of entry screening; case management, psychosocial support, and gender-sensitive interventions; (iv) disease surveillance and laboratory capacity strengthening. The project will cost USD 12.5 million and has four components below which are described in detail in Chapter 2: Component 1: Case Detection, Confirmation, Contact Tracing, Recording and Reporting Component 2: Case Management and Psychosocial Support Component 3: Implementation Management, Monitoring and Evaluation Component 4: Contingency Emergency Response Component (CERC) As per Word Bank standards, such support requires preparation of an ESMF to guide proper management of social and environmental issues. Preparation of an ESMF entails stakeholder consultations and engagement.		

Item	Issues discussed
1	How is COVI-19 pandemic affecting Batwa indigenous people ?
2	Are current COVID-19 control measures understood, useful and inclusive of needs and concerns of Batwa people?
3	What specific barriers do Batwa indigenous people suggest Uganda Government should consider to remove when planning and implementing COVID-19 control measures?
3	What resources are required by Batwa indigenous people at quarantine and treatment centers?

Meeting Record

7. United Nations High Commissioner for Refugees (UNHCR)

Project name	**Environmental and Social Management Framework (ESMF)** **for Uganda COVID-19 Response and Public Health Emergencies Systems Strengthening Project (P174041)**		
Organisation/ Stakeholder	United Nations High Commission for Refugees (UNHCR)United Nations High Commission for Refugees (UNHCR)United Nations High Commission for Refugees (UNHCR)United Nations High Commission for Refugees (UNHCR)United Nations High Commission for Refugees (UNHCR)United Nations High Commission for Refugees (UNHCR)nited Nations High Commission for Refugees (UNHCR)United Nations High Commission for Refugees (UNHCR)U ugaka@unhcr.org	Meeting date	**14 July 202014 July 202014 July 202014 July 202014 July 202014 July 202014 July 202014 July 2020**
		Recorded by	**Dr. Lam Kajubi**
Meeting/subject	**Stakeholder consultation**		
Background to this consultation	Government of Uganda (GoU) obtained financing from the World Bank to support national capacity to contain COVID-19 pandemic through the COVID-19 Response and Public Health Emergencies Systems Strengthening Project. This new operation will complement the support provided through the Contingency Emergency Response Component (CERC) which was activated in March 2020 in an ongoing project, by further enhancing prevention and early detection, but focusing more on health system readiness with emphasis on case management and psychosocial support—areas that are currently underfunded in the national response. Specific areas of planned support are in: (i) infection prevention and control: (ii) contact tracing; (iii) point of entry screening; case management, psychosocial support, and gender-sensitive interventions; (iv) disease surveillance and laboratory capacity strengthening. The project will cost USD 12.5 million and has four components below which are described in detail in Chapter 2: e) Component 1: Case Detection, Confirmation, Contact Tracing, Recording and Reporting f) Component 2: Case Management and Psychosocial Support g) Component 3: Implementation Management, Monitoring and Evaluation h) Component 4: Contingency Emergency Response Component (CERC) As per Word Bank standards, such support requires preparation of an ESMF to guide proper management of social and environmental issues. Preparation of an ESMF entails stakeholder consultations and engagement.		

Pre	Apo	Cop	Name(s) of respondent/ meeting participant
☒	☐	☐	Julius Kasozi
☒	☐	☐	David Githiri
☒	☐	☐	Lilian Achieng Otiego
☒	☐	☐	Rocco Nuri
☒	☐	☐	Yoko Iwasa
☒	☐	☐	Miriam Malmqvist
☒	☐	☐	Vick Ikobwa

Meeting Record

Item	Issues discussed
1	Are refugees getting effective information to help them prevent COVID-19 infection?
	Currently refugees risk communication is mainly done by the village health team who do not have adequate remuneration, adequate tools and materials. The risk communication through radio and Television does not adequately reach refugees because of extremely low coverage of radio and TVs. While there are posters printed for the national languages, the refugee languages are not all covered in the current poster materials. The posters are not enough in number and refugee language coverage for the 1.4 million refugees and surrounding host population in Uganda. The mounted vehicle rides (boda-boda and vehicles) are only limited in specific parts of the settlements with inadequate frequencies of covering the settlements. Refugee community radios, that are the first point of mass media are few in the settlements with inadequate air play for COVID-19 information.
2	How is COVID-19 pandemic affecting refuges differently from other Ugandan citizens?
	a) Social and Economic Impact of COVID-19 on Refugees: On 18th March 2020, Government of Uganda declared COVID-19 a national emergency and proceeded to institute several measures aimed at containing the pandemic including closure of schools, entry into the country, public and social gatherings and restriction of movement including of refugees. Like in many other countries the pandemic, is having far-reaching socio-economic consequences which threaten to significantly widen existing inequalities and derail the country's progress. Emerging analysis reveal that beyond the health system and human capital loss, the negative impact is being felt across society. Many people are losing a significant share of their income and livelihoods, including women, youth, and those employed in the informal sectors such as agriculture, retail, transport, trade, tourism, logistics and to some extent manufacturing. The pandemic is impacting vulnerable people, including elderly, women and girls, children, refugees, migrants, vulnerable or marginalized individuals or groups, people living with disabilities, HIV/AIDS; and those displaced by natural disasters. The situation particularly presents an unprecedented challenge for international protection of refugees resulting from the closure of borders and restriction of movements, which significantly impedes access to asylum and overall access to rights for refugees and asylum seekers. The 1.4 million refugees in Uganda are amongst the population groups considered to be most at risk of the socio-economic impacts of the outbreak as they occupy areas prone to shocks with limited capacities and opportunities to cope and adapt. Although all refugees are affected, the pandemic situation in the refugee settlements is expected to disproportionally impact women, children, older persons, persons with disabilities, medically at risk and other groups with specific protection needs. Women are also expected to take on a heavier burden of caring for the sick and thus further limit their ability to engage in livelihood and other meaningful activities and limit their access to information, services, including critical health services and education The risks of disruption and limited availability of essential care and support to refugees with specific needs as well as disruption of existing learning systems, social networks and support mechanisms due to social distancing and shifts in social safety nets, are likely to expose these vulnerable groups to increased risks of rights violations.

Meeting Record

Item	Issues discussed
	b) Food insecurity: Food insecurity is particularly identified as a major challenge having a higher impact on the vulnerable groups including refugees. Most of the refugees living in Kampala depend on informal jobs. Due to the COVID -19 restrictions, most of them have lost their jobs and with limited aid are at risk of destitution, currently manifested by an increased inability to pay their rent, access food, health care and other basic services. In the rural areas refugees rely on livelihood activities in the settlements to complement the general food assistance provided through WFP. The COVID restrictions on movement- closing of small businesses and the general disruption on livelihood activities, the food security of refugees is expected to worsen. For instance, some of the refugee heads of families were cut off from their various settlements and have no access to their monthly WFP rations, while others who had small-businesses or employed in the informal sector can no longer move around the settlement to earn an income. Also, due to lack of inputs and supply chain disruption, an estimated 75 percent of refugees who are engaged in small-scale agriculture will not plant any crop in the first season of 2020. This coupled with low production and productivity, high vulnerability to climate change and post-harvest losses, will expose refugees to increased food insecurity. Women, and youth will be most affected due to their inability to access, control and own assets and resources (including land, tools, equipment) and services. Moreover, this loss of livelihoods especially for women, is likely to lead to increase in negative coping mechanisms including; skipping meals, eating once a day, engaging in survival sex and transactional sex to earn some money. Coincidentally, the pandemic hit at a time when WFP is reducing refugee lifesaving food assistance rations from 100% to 70% and anticipated to further reduce to 50%. This anticipated increase in household food insecurity is also expected to aggravate both acute and chronic malnutrition.
	c) Child Protection: A total of 54,266 refugee children are registered as at risk or separated from parents or caregivers. Refugee children face various protection risks in the different settlements, including exposure to physical, sexual and/or emotional violence, children separated from parents or other relatives, children facing serious forms of neglect by caregivers, child marriage and child labour as well as emotional distress and children in conflict with the law. Refugee child protection response is coordinated by UNHCR and UNICEF in close coordination with the relevant national bodies (including District Local Governments and OPM) and the national child protection working Group. The current COVID restrictions implies a significant impact on the rights and protection of refugee and host community children with regard to their right to play, leisure and development, education, care as well as access to child protection. Due to the movement restrictions and the reduced access of UNHCR partner and governmental services - identification, monitoring and management of child protection risks has been significantly reduced, expected to result in increased separation, neglect, psychological distress, exploitation and violence against children. For example, the country-wide lock down has led to cases of separation of children from their parents /caregivers who have been unable to return to the settlement and family reunification procedures have been put on hold. There is a heightened risks of violence, abuse and/ or neglect by parents or caregivers due to constrained resources, and a lack of alternative care arrangements due to disruption of traditional care arrangements through grandparents or other family members due to the fear of and likelihood of disease transmission etc. In case of a large-scale COVID19 outbreak and considering available health services, children might also face longer-term separation from parents or being left without care due to parents being placed in quarantine or in the unfortunate case of the death. Also, parents face aggravated challenges in providing for their families and children may resort to day-to-day work to support their families. Birth registration services for children will also be delayed with longer-term negative impact on the child's right to acquire nationality. This requires close follow up to ensure parental awareness and means to register children born during the COVID19 outbreak. The limited capacities in the health and social services sector, as well as the drastic reduction in services and limited outreach to the affected population will significantly aggravate existing child protection concerns and result in high number of children in need of protection services

Meeting Record

Item	Issues discussed
	d) Gender Dimension: Notably, 82 percent of the refugee population are women and girls. Gender analysis demonstrate the existence of already deeply rooted discriminatory gender norms in refugee communities, and conclude that women suffer entrenched inequality in all spheres of life while men's worth is largely based on the capacity to provide for and protect his family. The COVID restrictions are expected to further threaten men's roles as 'providers' causing frustration and exacerbating tensions. This could in turn lead to economic violence against women and girls, such as the denial of resources or services and social exclusion, negatively impacting the economic empowerment of women. It also puts women and girls at heightened risk of Sexual and Gender Based Violence (SGBV) particularly intimate partner violence, psychological violence and other forms of domestic violence. Emerging evidence suggests that COVID-19 will further exacerbate existing gender inequalities (which are already acute) and has the potential to diminish progress made on gender equality and women's (economic) empowerment. Among the refugee population, women and girls are more likely to live in poor households. Women also seem to disproportionally work in the informal sector, making them more vulnerable to the economic impacts of the COVID measures. The negative economic impacts may increase the likelihood of survival sex, transactional sex and risks of sexual exploitation and abuse. School closures and a reduction in health services (e.g. SRPH services) is also likely to affect women more than men; and there are valid concerns that the drop-out rates of girls will increase significantly, as many girls may not return to school due to SGBV or lack of funds.
	e) Education: Refugee education is delivered within the framework of the national education system, and is bound by the decisions of national government regarding school closures, Ministry of Health (MOH) guidelines and measures taken by the Ministries of Education and Sports (MoES). With the closure of schools and learning institutions at all levels in Uganda, MOES in coordination with UN and NGO partners, have put in place a Preparedness and Response Plan for COVID -19. This plan aims to ensure continuity of learning at home whilst addressing challenges affecting teachers, students, caregivers and parents resulting from school closures, such as children's right to play, leisure and development, child labour and exploitation. UNHCR and partners are exploring several distance and remote learning options to enable children continue self-paced learning from home by supporting and making linkages with Government led on-going learning programmes through radio, home self-learning packages, TV and digital Ed tech solutions. The situation is evolving rapidly and likely to have significant impacts on the delivery of education programmes for refugees and host community children and youth.
	f) WASH: The refugee population in Uganda is supplied with water through a variety of water systems including handpumps, motorized boreholes and piped schemes. The pandemic has increased demand for water for hygiene activities resulting in an increase in pumping hours for the 167 water schemes in the 33 settlements translating in additional fuel costs, increase frequency of repairs and servicing of schemes and recruitment of additional water technicians and pump attendants . The hygiene activities have also resulted in doubling of soap for distribution and other handwashing and hygiene supplies coupled with the scaling up of hygiene promotion and COVID related Behavior Change Communication (BCC) activities in all the refugee settlements. Following the COVID measures restricting movement and promoting social distancing, coupled with the ongoing integrated WASH campaigns at the settlements, it is anticipated that the large scale adoption of positive hygiene and behavior change may translate into reduced disease burden particularly in the reduction of water borne - diarrheal diseases. On the flipside, sanitation services have been deprioritized in favor of scaling up water supply, handwashing supplies and related infrastructure. The pandemic has also been concurrent with heavy and sustained rainfall which introduces other risks such as proliferation of mosquito breeding and collapsing of simple family latrines. Resources meant to counter seasonal cyclic risks are diverted to direct COVID 19 response heightening malaria and diarrhea diseases risks. Momentum towards inclusion and long-term sustainability of WASH services from an institutional and community participation perspective has stalled re-introducing emergency relief mode. This has rolled the sector back several months if not years and regaining traction will indeed be a slow and painstaking process as the attendant economic downturn will weigh in on perceptions and viability of timelines.

Meeting Record

Item	Issues discussed
	g) Public Health: Prior to the declaration of the pandemic the health sector priorities were to reduce mortality and morbidity caused by the high prevalence of communicable diseases like malaria, maternal and newborn health challenges. However, with the advent of COVID -19 the Ministry of Health developed the COVID response plan which includes refugees and cascades to the district preparedness plans. These require the strengthening of coordination, community and facility surveillance, preparation for case management, infection prevention and control, as well as risk communication. The implementation of the response plan literally meant a switch from preparedness to response mode. The refugee health system which was already dealing with the yellow fever outbreak and the risk of Ebola importation from DRC, had to re-directed much needed energy into readiness to manage the COVID outbreak. This re-direction coupled with the attendant restrictions has resulted in an upsurge of the communicable and non-communicable diseases like malaria whose interventions previously required close community engagement; disruption hence reorganization of certain health services to refugees such as nutrition, maternal newborn health services, HIV/AIDS support , TB and non-communicable diseases, which are interrupted by the ban on mass gathering and public transport; and reduced access to health services since most common means of transport to the health facilities are no longer available; The situation has also execrated the inadequacy of the already stretched health infrastructure (outpatients, inpatients, ambulance services and staff accommodation) which now require more space to reduce the overcrowding and potential for cross-infections. Cumulatively, the shifts and changes are likely to result in an increase in morbidity and mortality among the refugee population.
3	Are current COVID-19 control measures effective in refugee settlements and inclusive of needs and concerns of displaced persons/ refugees?
	Yes, the current measures are effective but inadequately cover the needs of refugees are stipulated in section 4 below.
4	What challenges specific to refugees do you suggest Uganda Government should solve when planning and implementing COVID-19 control measures?
a	Risk communication – intensity and language translations to the refugee languages including materials and support to the village health team members
b	Surveillance – intensification of community, health facilities and other institutional especially use of the Village health teams (VHT) for identification/referral and truck drivers and recent traveler surveillance among the refugees. Provision of adequate COVID testing kits for refugee new arrival testing and routine settlement surveillance within the settlements.
c	Case management – Prioritized especially equipping of isolation facilities, improvement of infrastructure at health facilities and support to the district isolation facilities.
d	Infection prevention and control /WASH – prioritization of WASH in the community, health facilities, institutions to contribute to infection prevention and control measures and reduce water-borne related diseases. There inadequate re-usable masks for refugee new arrivals and existing refugees in the settlements amount to 1,200,000 masks to protect refugee population at the same level as nationals.
e	Continuation of health services – especially for malaria (prevention, Integrated community case management commodities, early diagnosis and treatment, Indoor residual spraying), provision of adequate stocks of HIV/AIDS and TB medicines and management of chronic condition through distribution.
f	Containment – support to the quarantine (improvement in the infrastructure in quarantine centres in *Kisoro, Isingiro, Kikuube, Kamwenge, Kyegegwa, Adjumani, Parolinya,Yumbe, Koboko and Arua* as well as feeding and COVID testing) and isolation facilities in the refugee settlements
g	Other refugee specific areas - Shielding of the critically elderly and those will the chronic illness and feeding for the refugees in the situation of reducing food ration
5	What resources are required specifically for refugees at quarantine and treatment centers?
	UNHCR appeal for surveillance (including quarantine centres) and case management is USD 9,055,381.

Meeting Record

Item	Issues discussed
6	Are all refugees settlements in Uganda well prepared and suitably equipped to handle COVID-19 emergencies?
	Based on the challenges above, refugees settlements are inadequately prepared to handle COVID-19 related emergencies and therefore require support.

Annex 9: Labor Management Procedures

LABOR MANAGEMENT PROCEDURES

These procedures should apply to any project component where labour management aspects need consideration. For the reason that this ESMF has been prepared before full knowledge of all project details, the labour management procedures should be revised annually to cater for any emerging labour issues not evident at this stage.

1. OVERVIEW OF LABOR USE ON THE PROJECT

a) Number of staff: The number of staff at each site where COVID-19 emergency operations are executed is currently not known.

b) Characteristics of Project Workers:

- COVID-19 emergencies will be handled by qualified MOH medical staff
- Construction work required in emergency situations will be undertaken by local contractors.

c) Timing of Labor Requirements: This will correspond to timing of emergency operations.

d) Contracted Workers:

- This will only apply to construction work that will be undertaken by local contractors.

2. ASSESSMENT OF KEY POTENTIAL LABOR RISKS

Under Component 1, selected hospitals will have laboratory spaces remodelled/upgraded and meeting the national WASH standards. Remodelling works will entail demolition, finishing, electricity, plumbing, external works, and furnishing. These pose same risks as typical construction projects such as:

- Possible accidents/ injuries from tools and machinery.
- Absence/ lack of insurance for construction workers.
- Exclusion of workers from vulnerable or marginalized individuals or groups from recruitment processes.

3. OVERVIEW OF LABOR LEGISLATION: TERMS AND CONDITIONS

Terms and conditions of employment of workers shall be according to Uganda's *Employment Act, 2006,* Workers Compensation Act 2000 and FIDIC; in consistence with the requirements of ESS2. Key aspects to pay attention to are:

- Clear contracts will be entered into with workers; stipulating their rights according to the Employment Act, 2006 mentioned above.
- Method of payments to workers, clear procedures on any deductions of their wages and clear procedures of rests, leaves and holidays, are to be provided to the workers according to Parts V and VI of the Employment Act, 2006 mentioned above.
- Procedures of termination of employment, shall be clear and understandable.

4. OVERVIEW OF LABOR LEGISLATION: OCCUPATIONAL HEALTH AND SAFETY

Managing occupational health and safety procedures will be based on Uganda's *Occupational Safety and Health Act, 2006* and FIDIC 1999 clause 4.8 and 6.7 Key OHS measures are as follows:

- Procedures to ensure establishing and maintaining safe working conditions.
- Reporting channels for workers to report work situations that they see are not safe or healthy.
- Compliance to requirements of the OHS Act by employers (contractor and sub-contractors).
- A system for continual review of OHS performance and conditions in workplace environment.

5. RESPONSIBLE STAFF

Table below shows entities and roles in managing workers or staff of this project. This table can be updated as project circumstances deem necessary. The LMP (and PIM) will be updated with standard template of contracts.

Table LMP1: Entities and roles in managing project workers or staff

Activity	Responsible entity
Engagement and management of project workers	Contractors who will be supervised by MOH
Engagement and management of contractors/subcontractors	Supervising consultants, who will be supervised by the MOH
Occupational health and safety (OHS)	Ministry of Gender Labor and Social Development
Training of healthcare staff	MoH
Addressing worker grievances	MoH

6. POLICIES AND PROCEDURES

Measures that should be followed during project implementation to address labor risks are provided below:

a) All employers on this project shall develop and implement procedures to establish and maintain safe workplaces;
b) All parties involved in employing or engaging project workers shall make sure to provide full information to workers, and conduct training for them about OHS requirements.
c) Personal protective equipment should be provided to workers without expense to them.
d) Clear (and confidential where required) processes and procedures shall be available to workers to enable them to report work situations that they believe are discriminatory, not safe or healthy, and accordingly remove themselves.
e) Facilities appropriate to the circumstances of the works will be provided to the project workers.
f) A system of regular review of OHS performance and the working environment will be put on place.
g) A safety Plan shall be provided before the beginning of these works in the project.
h) Insurance of project workers, equipment and machinery.

7. CHILD LABOR AND AGE OF EMPLOYMENT

i) Persons under the age of 18 will not be employed or engaged in connection with this project.
ii) Age of workers will be verified from their national identity documents.
iii) If an underage worker is found on the project, the contractor who employed such workers shall be stopped from working and be given a notification to change such workers.

8. TERMS AND CONDITIONS

- Wages shall be paid to the project workers by the contractors according to Ugandan laws.
- Maximum number of hours that can be worked on the project is 8 hours a day.
- All other terms and conditions specified in the Ugandan labor law, FEDIC 1999 and World Bank OHS requirements apply to the project.

9. GRIEVANCE S MANAGEMENT

All workers will have liberty to communicate their grievances to the employer, MOH or World Bank. Grievances shall be communicated by complainants verbally or using telephone, email, by letter to either or all of the aforementioned entities.

Annex 10: Grievance Redress Log

UCREPP Grievance Redress Register

#	ID/ Case Ref. Number	Date Received	Received by	Name of Complainant	Community	Brief Description of Concern	Category	Date Acknowledged	Responsible Unit or Contractor	Responsible Officer	Referred or turned legal	Proposed Resolution/ Feedback to Complainant	Date of Resolution	Date Closed	Satisfied with Process (yes/no)?	If no, why not?	Satisfied with Outcome (yes/no)?	If no, why not?
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		

Annex 11: Sample Grievance Resolution Form

Ministry of Health
Uganda COVID-19 Response and Emergency Preparedness Project (P177273)
UCREPP

Sample Grievance Resolution Form

(A copy of this form to be provided to the complainant)

Name (Filer of Complaint/ complainant): _____ *(Optional)*
ID Number: _____ (PAPs ID number)
Contact Information: _____ (Village; mobile phone)
Disclose ☐ Remain Anonymous ☐

Nature of Grievance or Complaint:

_____

Date Individuals Contacted Summary of Discussion _____
Signature_____ Date: _____
Signed (*Complainant/Filer of Complaint*): _____(*Optional)*
Name of Person Filing Complaint: _____*(if different from Filer/ complainant)*
Position or Relationship to Filer: _____

Review/Resolution
Date of Conciliation Session: _____
Was Filer Present? : Yes No
Was field verification of complaint conducted? Yes No
Findings of field investigation:

_____

_____

Summary of Conciliation Session

Discussion: _____

_____

Issues _____
Was agreement reached on the issues? Yes No
If agreement was reached, detail the agreement below:

If agreement was not reached, specify the points of disagreement below:
Signed (Conciliator): _____ Signed (Filer): _____

Signed: _____
Independent Observer/ Local Authority
Date: _____

Signed: _____
Project Representative
Date: _____

Signed: _____(Optional)
Complainant
Date: _____

Disclaimer: *the complainant wishing to treat the case as confidential has the right not to sign and his details should be kept anonymous.*

Annex 12: Grievance Registration Form

Ministry of Health

Uganda COVID-19 Response and Emergency Preparedness Project (P177273)

UCREPP

Grievance Registration Form

(A copy of this form to be provided to the complainant)

REFERENCE NUMBER:		**Details**
NAME OF COMPLAINANT: *(Optional)* Disclose ☐ Remain Anonymous ☐		
CONTACT INFORMATION: *(Please mark how you would like to be contacted: mail, telephone, email, in person)*	By Post: Please provide mailing address	
	By Telephone:	
	By Email	
TYPE OF GRIEVANCE:		
DESCDOIPTION OF INCIDENCE OR GRIEVANCE:	*What happened? Where did it happen? Who did it happen to? What Is the result of the problem?*	
HAS THIS GRIEVANCE BEEN RAISED PREVIOUSLY BY YOU OR ANYONE? ELSE?	No Yes Details:	
DATE OF INCIDENCE GRIEVANCE:		
WHAT WOULD YOU LIKE TO SEE HAPPEN TO RESOLVE THE PROBLEM?	One time incidence/grievance (date …) Happened more than once (how many times …) On-going (currently experiencing problem)	
ASSESSMENT CATEGORY GRIEVANCE ACCEPTED Yes / No RESPONSE/ FOLLOW UP *(summary of response and corrective actions taken) response to application)*	Date: Person: Observations:	
CORRECTIVE ACTION AND SIGN-OFF	Applicant satisfied with corrective action: **Yes / No** (Details) Is further action required: **No / Yes** (Details) If Yes, date sign-off received from Application:	

Signed: _____ Signed: _____

Project Representative *Local Authority*

Date: _____ Date: _____

Signed: _____(Optional)

Complainant

Date: _____

Disclaimer: *the complainant wishing to treat the case as confidential has the right not to sign and his details should be kept anonymous.*

Annex 13: Outline of the GBV/ SEA/ SH Prevention and Response Action Plan

1. Introduction and Context
   1.1. Background
   1.2. Description of the Project
2. Addressing Gender Based Violence (GBV) and Sexual Exploitation and Abuse (SEA) Risks in UCREPP
3. GBV Risk Mitigation, Prevention and Response for UCREPP
   - Strengthen institutional capacity for GBV/SEA/SH risk mitigation and response
   - GBV/SEA/SH capacity building of project implementing partners (IPs)
   - Establishment of GBV/SEA/SH channels and procedures for the Grievance Mechanism
   - Communication to project affected communities about GBV/SEA/SH risks and mechanisms:
   - Sensitization and capacity building of contractors and suppliers on GBV/SEA/SH in the project:
   - Roll-out of GBV requirements in tender processes
   - Conduct GBV risks assessments at project sites
   - Strengthening GBV services provision and referral pathways
   - Establishment of a Reporting Protocol
   - SEA/SH Referral Pathway
4. Operationalization of this GBV/SEA/SH Prevention and Response Plan: Project Annual Work Plan and Budget
5. Detailed Action Plan GBV/SEA/SH Prevention and Response Plan
   - Accountability Framework
   - Monitoring and Supervision Action Plan

Action to Address GBV Risks	Time Frame	Responsible Person(s)	Budget	Monitoring Indicator	Remarks
1. Create awareness on GBV in IA and contractors and the mechanisms that will be implemented					
2. GBV Risks adequately addressed in safeguards instruments					
3. Stakeholder consultations to inform those affected by the project of GBV risks					
4. Map out GBV prevention and response service providers					
5. GBV sensitive channels for reporting in the Grievance Redress Mechanism (GRM)					
6. Code of Conduct					
7. Separate toilet and shower facilities for men and women					

Annex 14: World Bank Group Environmental, Health and Safety Guidelines and WHO Guidelines for COVID-19 Waste Management

The World Bank has several guidelines below, many of which are applicable to various components of the proposed project namely:

i) Air emissions from onsite waste combustion units ("incinerators")
ii) Hazardous waste management
iii) Noise
iv) Occupational health and safety (against biological and radiological hazards).
v) Community health and safety including traffic safety such as during project construction or disease prevention (where incinerators emission waft into and affect not only local communities but also patients visiting healthcare facilities).
vi) Construction and decommissioning.

While most of above WBG guidelines apply to the proposed project in one way or the other, in sections below are discussed five environmental, health and safety (EHS) guidelines, namely:

- EHS Guidelines - AIR EMISSIONS AND AMBIENT AIR QUALITY
- EHS Guidelines - WASTE MANAGEMENT
- EHS Guidelines - HEALTH CARE FACILITIES
- EHS Guidelines - HAZARDOUS MATERIALS MANAGEMENT
- EHS Guidelines - CONSTRUCTION AND DECOMMISSIONING

2.1 WBG EHS Guidelines: "Air emissions and ambient air quality"

a) General approach

These guidelines require projects with "significant"[66] sources of air emissions, and potential for significant impacts to ambient air quality to prevent or minimize impacts by ensuring that emissions do not result in pollutant concentrations that reach or exceed relevant ambient quality guidelines and standards by applying national legislated standards (or in their absence, the current WHO Air Quality Guidelines, or other internationally recognized sources). Uganda currently has (draft) national air quality standards applicable to this project, specifically incinerator emissions. The standards however make no mention of dioxins which are potent cancer-inducing, expected in incineration emissions.

In these guidelines "significant" refers to sources which can contribute a net emissions increase of one or more of the following pollutants within a given air shed:

- Particulate matter of size 10 microns (PM_{10}): 50 tons per year (tpy);
- Oxides of nitrogen (NOx): 500 tpy;
- Sulphur dioxide (SO_2): 500 tpy; or as established through national legislation;
- Equivalent heat input of 50 MWth or greater.

Going by this classification, all onsite incineration units at existing healthcare facilities are "*non-significant*" sources since no unit at any of the project facilities had capacity to generate the foregoing levels of air pollutants. Two national documents[67] on healthcare waste indicate that healthcare facilities, depending on their service level, generate the following average quantities of medical waste:

- Hospital: 0.1 kg/bed/day (excluding pathological waste)

[66] ***Significant*** *sources of point and fugitive emissions in these (WBG) guidelines are considered to be general sources which can contribute a net emissions increase of one or more of the following pollutants within a given airshed: PM10: 50 tons per year (tpy); NOx: 500 tpy; SO2: 500 tpy; or as established through national legislation; and combustion sources with an equivalent heat input of 50 MWth or greater. The significance of emissions of inorganic and organic pollutants should be established on a project-specific basis taking into account toxic and other properties of the pollutant.*

[67] "National Healthcare Waste Management Plan (2007/8-2009-2010)" and "Improvement of Healthcare Waste Management in Uganda (July 2005, Updated Mar 2009) by Carl Bro.

- Health center 4 (HC IV): 1.5 kg/day
- Health center 3 (HC III): 0.6 kg/day
- Health center 2 (HC II): 0.5 kg/day

Incineration emissions from healthcare facilities may contain particulate matter, heavy metals, dioxins, furans, sulfurdioxide and hydrochloric acid. Of key concern are dioxins which are cancer-inducing compounds[68]. The temperatures needed to breakdown dioxin are typically not reached when burning waste in open air (200-400°C) causing high dioxin emissions. Dioxin can only be destroyed above 850°C, otherwise it remains in atmosphere emissions or in incineration ash where it can leach into groundwater when rain falls on ash piles.

b) Implication for this project

It is essential that all medical waste incineration facilities meet national and WHO emissions standards. This is the reason why WBG EHS Guidelines discourage open-burning of solid wastes, whether hazardous or non-hazardous, as the generation of polluting emissions from this type of source cannot be controlled. The management including disposal of healthcare waste has become an issue of growing concern in many places in Uganda. Infectious medical waste has been dumped indiscriminately, burned uncontrollably and buried irresponsibly posing considerable public health risk.

The WBG EHS Guidelines: "Healthcare facilities" give air emission limits for hospital waste incineration facilities shown in table below, which any incineration units used by in the project should comply with.

Table 17: Air emission levels for hospital waste incineration facilities (WBG Guidelines)

Pollutant	Unit	Guideline value
Total Particulate matter (PM)	mg/Nm^3	10
Hydrogen Chloride (HCl)	mg/Nm^3	10
Total organic carbon (TOC)	mg/Nm^3	10
Hydrogen Fluoride (HF)	mg/Nm^3	1
Sulfur dioxide (SO2)	mg/Nm^3	50
Carbon Monoxide (CO)	mg/Nm^3	50
NOX	mg/Nm^3	200-400[a]
Mercury (Hg)	mg/Nm^3	0.05
Sb, As, Pb, Cr, Co, Cu, Mn, Ni, and V	mg/Nm^3	0.05
Polychlorinated dibenzodioxin and dibenzofuran (PCDD/F)	ng/Nm^3TEQ	0.1

Notes:

a. 200 mg/m^3 for new plants or for existing incinerators with a nominal capacity exceeding 6 tonnes per hour; 400 mg/m^3 for existing incinerators with a nominal capacity of 6 tonnes per hour or less.

b. Oxygen level for incinerators is 7 percent.

2.2 WBG EHS Guidelines: "Waste management"

a) General approach

Regarding the proposed project, this section considers only construction waste (section 3.4.2.3 covers waste from operations at medical facilities) originating from repairs, renovations and building of healthcare facilities. The guidelines advocate for waste management planning where waste should be characterized according to composition, source, types, and generation rates.

These guidelines call for implementation of a waste management hierarchy that comprises prevention, recycling/reuse; treatment and disposal. The guidelines require segregation of conventional waste from hazardous waste streams. Examples of hazardous construction waste are waste oil from vehicles and machinery paint waste, thinners and concrete wash water (e.g. from cleaning concrete mixers).

a) Implication for this project

Improper management of construction waste would pose environmental and public health impacts. Contractors and their primary suppliers will have a contractual obligation to ensure proper construction waste management.

[68] Note that WBG EHS Guidelines: "Healthcare facilities" give air emission levels for hospital waste incineration facilities.

To this end, guidelines provided in Annex 5 (Clauses for Construction Work Contracts on Environmental Compliance) and Annex 6 (Code of Practice for Construction Workers) of this ESMF should be utilized as vital guiding documents.

2.3 Industry Specific WBG EHS Guidelines for "Healthcare facilities" and Vaccination Centers

a) Applicability

The EHS Guidelines for healthcare facilities include information relevant to management of EHS issues associated with healthcare facilities (HCF) which includes a diverse range of facilities and activities involving general hospitals and small inpatient primary care hospitals, as well as outpatient facilities. Ancillary facilities may include medical laboratories and mortuary centers.

These guidelines are applicable for planning new HCFs or renovation of existing facilities.

b) Healthcare facility design considerations[69]

These guidelines advise that design and functional layout of HCFs should ensure the following:

- Separation of clean / sterilized and dirty / contaminated materials and people flows;
- Development and inclusion of adequate disinfection / sterilization procedures and facilities;
- Adequate space for the storage of recyclable materials (e.g. cardboard and plastic) for pickup;
- Ventilation systems that provide isolation and protection from airborne infections;
- Design of water systems to provide adequate supplies of potable water to reduce risks of exposure waterborne pathogens;
- Provision of hazardous material and waste storage and handling areas;
- Selection of easily cleaned building materials that do not support microbiological growth, are slip-resistant, non-toxic, and non-allergenic, and do not include volatile organic compound (VOC)-emitting paints and sealants.

c) Waste management

Waste from health care facilities (HCF) and vaccination centers can be divided into two groups:

- General waste similar in composition to domestic waste, generated during administrative, housekeeping, and maintenance functions.
- Specific categories of hazardous healthcare waste.

Infection prevention and control improvements in health facilities and vaccination centers, such as assessment and mitigation measures for medical waste risk management that will be expanded as inoculation sites expand and implementation of occupational health and safety standards and specific infectious-control strategies, guidelines and requirements as recommended by WHO. Community health and safety (CHS) risks associated with increased spread of COVID-19 during the vaccination campaigns, vaccine safety and efficacy (potential adverse health effects from procuring unsafe vaccines and inadequate vaccine storage, handling and transportation practices may lead to vaccine quality deterioration), traffic and road safety risks from transportation of vaccines and transportation of hazardous/infectious waste for off-site treatment and disposal; Environmental, Social and Health risks from poor handling, storage, transportation and disposal of medical and pharmaceutical waste such as sharps, needles, packaging, used, expired or damaged vaccine vials and PPE from vaccination centers, soil and water contamination due to poor disposal of healthcare waste and improper handling of vaccines will be taken care of by the Project. The vaccination campaign will increase the environmental repercussions of plastic waste including syringes, which adds to the waste already generated by single-use PPE. The Project will require special handling of waste materials generated from laboratories, quarantine facilities, screening, treatment and vaccination campaigns and awareness, as they may pose an infectious risk to healthcare workers in contact or handling the waste. Health care facilities and vaccination centers should establish, operate and maintain a health care waste management system (HWMS) adequate for the scale and type of activities and identified hazards but entailing:

i) Waste minimization, reuse, and recycling

[69] Internationally recognized guidelines for design and construction of hospitals and HCFs include American Institute of Architects (AIA) and the Facility Guidelines Institute (FGI), the American Society for Healthcare Engineering (ASHE) of the American Hospital Association (AHA), and the Green Guide for Healthcare.

ii) Waste segregation at the point of generation,
iii) On-site handling, collection, transport and storage based on safe practices below

- 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.
- Transport waste to storage areas on designated trolleys / carts, which should be cleaned and disinfected regularly.
- Waste storage areas should be located within the facility and sized to the quantities of waste generated.
- Unless refrigerated storage is possible, storage times between generation and treatment of waste should not exceed (in Warm climate) 48 hours during cool season, 24 hours during hot season.
- Store radioactive waste in containers to limit dispersion, and secure behind lead shields.
- Packaging containers for sharps should be puncture-proof.

These guidelines recognize incineration as a key source of air emission at healthcare facilities and pollutants emitted from incineration include:

i) Heavy metals
ii) Organics in flue gas
iii) Various organic compounds (dioxins and furans)
iv) Hydrogen chloride (HCl) and fluorides and potentially other halogens-hydrides (e.g. bromine and iodine)
v) Typical combustion products such as sulfur oxides (SOx), nitrogen oxides (NOx), volatile organic compounds, monoxide (CO), carbon dioxide (CO_2), and nitrous oxide (N_2O).
vi) Incineration residues such as fly ash and bottom ash may contain high concentrations of persistent organic pollutants (POPs).

Ambient air controls (including ventilation, discharge to environment) are already included in the draft designs for laboratories). Doors and windows shall be fixed and not openable unless conditions require them to be opened. If openable shall be self-closing and they will be fitted with screens as per the new guidelines. Vacuum-lines shall be protected with high efficiency particulate air filters so as to ensure that exhaust air doesn't recirculate to any other areas of the building.

For being ineffective in regard to emissions control, these WBG Guidelines caution against use of single-chamber Also masonry (brick) incinerators should be used only as a last resort option. The Guidelines advise against mixing domestic and hazardous waste. Waste should be segregated at point of generation and non-hazardous waste, such as paper and cardboard, glass, aluminum and plastic, should be collected separately for possible recycling. 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. If different types of waste are mixed accidentally, waste should be treated as hazardous.

d) Occupational health and safety

HCF health and safety hazards may affect healthcare providers, cleaning and maintenance personnel, and workers involved in waste management handling, treatment and disposal. Typical hazards which should be prevented with proper safety gear and practices include:

- Exposure to infections and diseases (blood-borne pathogens, and other potential infectious materials (OPIM)[70]
- Exposure to hazardous materials / waste
- Fire safety
- Exposure to radiation

[70] According to US Occupational Safety and Health Administration (OSHA), blood-borne pathogens are pathogenic microorganisms that are present in human blood and can cause disease in humans, including human immunodeficiency virus (HIV), hepatitis B virus (HIB), and hepatitis C virus (HCV). Other potentially infectious materials (OPIM) refers to (1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, anybody fluid that is visibly contaminated with blood, and all body fluids in situations Where it is difficult or impossible to differentiate between body fluids; (2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and (3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or hepatitis B virus (HBV) -containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

Occupational radiation exposure may result from equipment emitting X-rays and gamma rays (e.g. CT scanners), radiotherapy machines, and equipment for nuclear medicine activities. HCF operators should develop a comprehensive plan to control radiation exposure in consultation with the affected workforce. This plan should be refined and revised as soon as practicable on the basis of assessments of actual radiation exposure conditions, and radiation control measures should be designed and implemented accordingly.

e) Air emission levels for hospital waste incineration facilities

WBG Guidelines advise the following emission levels of healthcare waste incinerators.

Table 18: Air emission levels for hospital waste incineration facilities (WBG Guidelines)

Pollutant	Unit	Guideline value
Total Particulate matter (PM)	mg/Nm^3	10
Hydrogen Chloride (HCl)	mg/Nm^3	10
Total organic carbon (TOC)	mg/Nm^3	10
Hydrogen Fluoride (HF)	mg/Nm^3	1
Sulfur dioxide (SO2)	mg/Nm^3	50
Carbon Monoxide (CO)	mg/Nm^3	50
NOX	mg/Nm^3	200-400[a]
Mercury (Hg)	mg/Nm^3	0.05
Sb, As, Pb, Cr, Co, Cu, Mn, Ni, and V	mg/Nm^3	0.05
Polychlorinated dibenzodioxin and dibenzofuran (PCDD/F)	ng/Nm^3TEQ	0.1

Notes:
a. 200 mg/m^3 for new plants or for existing incinerators with a nominal capacity exceeding 6 tonnes per hour; 400 mg/m^3 for existing incinerators with a nominal capacity of 6 tonnes per hour or less.
b. Oxygen level for incinerators is 7 percent.

Implications for the project:

During project implementation, healthcare facilities should satisfy WB EHS Guidelines discussed in this section, especially where national guidelines fall short.

2.4 WBG EHS Guidelines: "Hazardous materials management"

a) Application and approach

These guidelines apply to projects that use, store, or handle any quantity of hazardous materials (Hazmats), defined as materials that represent a risk to human health, property, or the environment due to their physical or chemical characteristics. Hazmats can be classified according to the hazard as explosives; compressed gases, including toxic or flammable gases; flammable liquids; flammable solids; oxidizing substances; toxic materials; radioactive material; and corrosive substances.

Note: WBG EHS Guidelines will apply to construction works as well as all medical facilities.

b) General hazardous materials management

Facilities which manufacture, handle, use, or store hazardous materials should establish management programs that are commensurate with the potential risks present. The main objectives of projects involving hazardous materials should be the protection of the workforce and the prevention and control of releases and accidents. These objectives should be addressed by integrating prevention and control measures, management actions, and procedures into day-to-day business activities.

2.5 WBG EHS Guidelines: "Construction and decommissioning"

These provide guidance, specific guidance on prevention and control of community health and safety impacts that may occur during new project development or due to expansion or modification of existing facilities. By thematic categories, they address three major aspects (environment, OHS and community health and safety) below.

ii) *Environment:*

- Noise and Vibration: During construction and decommissioning activities, noise and vibration may be caused by the operation of pile drivers, earth moving and excavation equipment, concrete mixers, cranes and the transportation of equipment, materials and people.

- Air Quality: Project will involve demolition of walls inside existing healthcare facilities and this could generate fugitive dust affecting adjoining rooms or service areas. A secondary source of emissions may include exhaust from diesel engines of earth moving equipment, as well as from open burning of construction and demolition waste on-site.
- Solid Waste: During project implementation, non-hazardous solid waste generated at construction sites would include, scrap wood, glass cullet and metal and demolition rubble.
- Hazardous Materials: Asbestos might be encountered where entire buildings will be demolished and rebuilt. In case of this encounter, well laid down procedures and in consultation with NEMA shall provide written guidance (work procedure) on handling and disposal of asbestos materials.

iii) *Occupational Health and Safety*

Likely OHS risks during proposed construction of isolation units, upgrading of hospitals and other health facilities in Refugee Hosting Districts, construction of blood bank among others could include over-exertion, slips and falls, work at heights, hot works (welding), electrocution, being struck by objects, injury by moving machinery and dust from demolition activities.

iv) *Community Health and Safety:*

The guidelines recommend implementation of risk management strategies to protect general community from physical, chemical, or other hazards associated with sites under construction and decommissioning. Key areas to consider are:

- *General site hazards*: where renovation activities can injure people in or near buildings under renovation or construction.
- *Disease Prevention*: ensuring that risk of disease from construction-related activities (e.g. from water ponding).
- *Traffic Safety:* Construction activities may result in a significant increase in movement of heavy vehicles for the transport of construction materials and equipment increasing the risk of traffic-related accidents and injuries to workers and local communities.

3.5 WHO Guidelines

The World Health Organization (WHO) has developed a number of country and technical guidance notes on coronavirus disease (COVID-19). These notes are shown in figure below and accessible in detail from WHO website WHO resources include technical guidance on: (i) laboratory biosafety, (ii) infection prevention and control, (iii) rights, roles and responsibilities of health workers, including key considerations for occupational safety and health, (iv) water, sanitation, hygiene and waste management, (v) quarantine of individuals, (vi) rational use of PPE, (vii) oxygen sources and distribution for COVID-19 treatment centers, (viii) vaccine readiness assessment, (ix) surveillance of adverse events following immunization .

> WHO guidance note on *Water, sanitation, hygiene, and waste management for the COVID-19 virus Interim guidance (19 March 2020)*[71] instructs about safe management of health care waste and best practices for safely managing health care waste, including assigning responsibility and sufficient human and material resources to dispose of such waste safely.

The guidance note indicates that while there is no evidence that direct, unprotected human contact during handling of health care waste results in transmission of the COVID-19 virus, all health care waste produced during the care of COVID 19 patients should be collected safely in designated containers, treated, and then safely disposed of or treated, or both, preferably onsite. If waste is moved off-site, it is critical to understand where and how it will be treated and destroyed. All persons who handle healthcare waste should wear appropriate PPE (boots, apron, long-sleeved gown, thick rubber gloves, mask, and goggles or a face shield) and perform hand hygiene after removing it.

Best practices for safely managing health care waste should be followed, including assigning responsibility and sufficient human and material resources to dispose of such waste safely. There is no evidence that direct, unprotected human contact during the handling of health care waste has resulted in the transmission of the

COVID-19 virus[72]. All health care waste produced during the care of COVID 19 patients should be collected safely in designated containers and bags, treated, and then safely disposed of or treated, or both, preferably onsite.

If waste is moved off-site, it is critical to understand where and how it will be treated and destroyed. All who handle health care waste should wear appropriate PPE (boots, apron, long-sleeved gown, thick gloves, mask, and goggles or a face shield) and perform hand hygiene after removing it. (For more information refer to the WHO guidance, Safe management of wastes from health-care activities).

As part of an integrated public health policy, wastewater carried in sewerage systems should be treated in well-designed and well-managed centralized wastewater treatment works. Each stage of treatment (as well as retention time and dilution) results in a further reduction of the potential risk. A waste stabilization pond (an oxidation pond or lagoon) is generally considered a practical and simple wastewater treatment technology adequate to destroy pathogens, as relatively long retention times (20 days or longer) combined with sunlight, elevated pH levels, biological activity, and other factors serve to accelerate pathogen destruction. A final disinfection step may be considered if existing wastewater treatment plants are not optimized to remove viruses. The designs for the laboratories caters for wastewater pre-treatment including vulcathene piping autoclaves, and pre-treatment chambers with anti-siphon traps for waste water. The Project also provides for annual bio-waste management audits.

[72] Source: WHO, 2020: Water, sanitation, hygiene, and waste management for the COVID-19 virus Interim guidance 19 March 2020

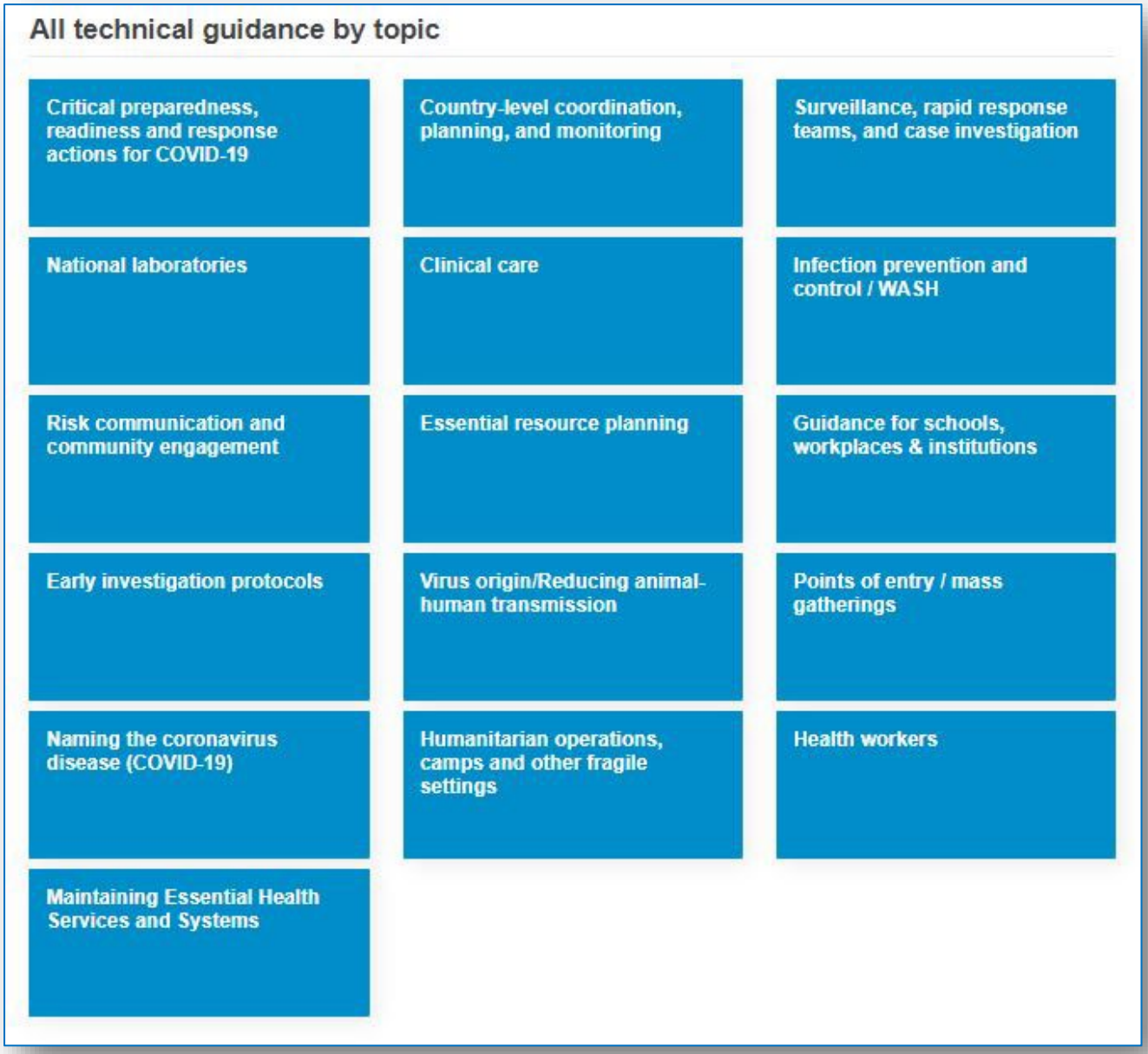

Figure 5: WHO country and technical guidance notes on COVID-19

Annex 15: Management and Removal of Asbestos Materials Guide

1. Management of Asbestos Roof Materials

1.2 Asbestos Health Risks

Asbestos-containing materials can release fibers into the surroundings due to wear and tear and deterioration or when they are disturbed, damaged or broken. These fibers, when inhaled, may lead to serious lung diseases such as asbestosis (scarring and fibrosis of the lung tissues), *mesothelioma* (a cancer of the lining covering the surface of the lung and inside the chest wall) and lung cancer. The symptoms of these incurable diseases can take up to several years to appear after the first exposure to asbestos dust.

All types of asbestos can be dangerous if disturbed. The danger arises when asbestos fibers become airborne. They form a very fine dust which is often invisible. Breathing asbestos dust can cause serious damage to the lungs and cause cancer. There is no known cure for asbestos-related disease. The more asbestos dust inhaled, the greater its risk to one's health. Therefore, precautions should always be taken to prevent exposure or where this is not practicable, to keep it to a minimum.

In general, the softer the material, the more easily it is damaged and the more likely it is to release fibers when disturbed or worked on. The greater the fiber release, the greater the risk to health it will generate and the higher the standard of precautions required when working with that material. Contractors should take all practicable safety precautions during the three main phases of asbestos removal work, namely when preparing the site, removing the asbestos and cleaning-up of the site after removal.

1.3 Management and Precautions

In view of the associated health risks, care must therefore be taken when removing, dismantling, demolishing, renovating, maintaining and altering structures containing asbestos. The contractor should take all practicable safety precautions during the three main phases of working with asbestos removal. The process of asbestos removal should be carried out and supervised by a person/contractor with the supervision of an Occupational Health and Safety Specialist or Environmental Specialist of a requisite qualification and experience.

1.3 Stages during asbestos removal

1.3.1 Preparation at affected site

As part of the preparation for the exercise of removing asbestos, the following have to be undertaken:

- Ensuring that there is no occupant in the house; the occupant must be temporarily given where to stay during that exercise;
- Map out or establish asbestos work area in which, risks of exposure to airborne asbestos fibers are bound to reach is determined. During asbestos removal, only workers who are likely to be directly involved in the asbestos work should be allowed to enter the mapped out asbestos work area;
- Isolate the asbestos work area using enclosures or barriers. The use of barricades assists with traffic control and prevents access to the asbestos removal site. The purpose of barricades is to delineate and isolate the asbestos removal area with appropriately placed barricades. Barricades can take various forms; from tape to solid hoarding with corrugated galvanized iron sheets of preferable.
- Shut down any ventilation and door in the nearby building's close asbestos work area. For the health center, all the buildings close by should be closed for at least a week during the removal of the asbestos roofing's;
- Display warning signs posted in the work area both in English and local language until the work site has been cleaned up and is certified free of any asbestos materials by a qualified Supervisor/Occupational Health and Safety Specialist or approved person with expertise;
- Warning signs must be placed so they inform all people nearby that asbestos roofing's removal work is taking place in the area. Signs should be placed at all of the main entry points to the

asbestos removal work area where asbestos is present. These signs should be weatherproof, constructed of light-weight material and adequately secured so they remain in prominent locations;
- Set up proper and specific changing and washing facilities for the workers close to the work site as possible;
- The pit for the disposal of asbestos pipes has to be excavated measuring 2x3m. The wall of the pit will be built of concrete blocks and cemented up to 2 meters' height from bottom or materials taken to a designated hazardous waste disposal site.
- It is advisable to engage the services of a professional hazardous waste handler to carry out this exercise. The contractor must engage a licensed hazardous waste handler by NEMA to carry out such activities.

1.4 Procedure to be followed during and after Asbestos Removal

- Establish a washing and changing facility for workers to change and after, wash themselves off any asbestos materials that could have got on to them;
- Workers must put on appropriate personal protective equipment (PPEs) inside the clean area before entering the work area;
- Before and during asbestos removal, use low-pressure water sprays to wet all asbestos roofing's once they are exposed during excavations;
- Immediately wrap up the removed asbestos pipes in impermeable polyethylene sheets while they are wet. It is best if the sheets are wrapped in a second layer of polyethylene sheets of 1,500g so that, there is little risk of asbestos debris or dust spillage. The wrapped asbestos waste must be affixed with proper warning labels;
- Wet and collect all broken pieces of asbestos roofing's debris in suitable impermeable disposal bags with a double lining. Do not leave them lying around in the work site where they may be further broken or crushed, thus creating more asbestos dust. These bags should also be properly sealed and affixed with proper warning labels;
- Break up asbestos roofing's that are too long to fit into the disposal bags and cannot be wrapped properly. Do this only in an enclosed space (e.g. a tent) within the asbestos work area. Keep the roofing's wet throughout the breaking process;
- After a day's removal and wrapping of the removed asbestos roofing's together with a pack and seal used coveralls in impermeable bags, which are also affixed with proper labels, at the end of each work shift and dispose of together with the asbestos waste for the day; and
- Once dropped in the pit, the asbestos waste should be covered with 10cm of cement concrete.

1.5 Final phase of the asbestos removal

- Clean all equipment used in the asbestos removal work using water or a vacuum including the house that has just been reroofed. This must be done before removal from the asbestos work site. This includes pick axes, hoes and cutters;
- Wet-wipe or clean the outer surfaces of the disposal bags containing the asbestos waste before giving lowering them into the pits;
- Caution must be borne in mind in that, there should be no overfilling of bags and that, and care should be taken to ensure sharp edges of asbestos do not puncture the plastic bags;
- Only new bags and heavy-duty 200µm (minimum thickness) polythene sheeting should be used;
- The polythene sheeting should be of a height of less than 1 m and completely wrapped;
- The pack should be properly sealed with adhesive tape;
- Packages should be small enough to be handled easily;
- The packages are then clearly labelled with the asbestos warning mark. The height of this marking should be bigger enough to anyone to read.

Annex 16: Actions taken by GOU to ensure inclusion and non-discrimination.

Annex 16 highlights recent actions taken by the GOU to ensure inclusion and non-discrimination of vulnerable or disadvantaged individuals or groups. It also includes transcripts of relevant Guidelines and Circulars issued by the GOU.

The Anti-Homosexuality Act was passed on May 26, 2023. The government has continued to ensure inclusion and non-discrimination in all its projects and consistent with this, the government has taken the following measures:

- **Letter of Assurance** (Sept 21, 2023) to all Ministries, Agencies, and local governments to implement mitigation measures on non-discrimination in WB-financed operations.
- **Budget execution circular** (July 10, 2023) to all public servants to ensure that projects are in line with Ugandan Constitution which emphasizes equality of all persons without prejudice or discrimination.
- **Circular on provision of health services** (June 5, 2023) that includes measures not to discriminate or stigmatize any individuals who seek health care for any reason.
- **Circular on provision of education** (August 18, 2023) services to all people without discrimination and exclusion in the delivery of education services, programs, and projects.
- **Circular issued by the Director of Public Prosecutions** (August 25, 2023) stating that prosecutors should seek guidance from ODPP before decision to charge is made under the AHA.

Of particular importance is the Letter of Assurance of September 21, 2023, from the Permanent Secretary/Secretary to the Treasury on Uganda's Social Safeguard Policies following excepts:

"*Following the World Bank Group's concern with Uganda's enactment of the Anti-Homosexuality Act, 2023 and as communicated in the budget Execution Circular 2023 of FY 2023/2024 on 18th July 2023, we guide:*

- *All World Bank-financed projects must be implemented in a manner consistent with the principles of non-discrimination as provided under Article 21 of the Constitution of the Republic of Uganda. These projects should also be implemented in accordance with World Bank policies and applicable Legal Agreement*
- *Under these projects, no person will be discriminated against or stigmatized, and the principles of non-discrimination and inclusion will be adhered to. Support should be provided to all project beneficiaries.*
- *All implementing entities of World Bank projects should agree and implement specific mitigation measures to address non-discrimination.*
- *These mitigation measures will require enhancing project grievance redress mechanisms as well as strengthening existing project monitoring by implementing entities including a World Bank enhanced implementation support and monitoring where applicable.*
- *Each project implementing entity shall develop comprehensive guidelines to address non-discrimination."*

The following transcripts of relevant Guidelines and Circular issued by the GOU are included this annex: Letter of Assurance; Circular on provision of health services; Circular on provision of education; Circular issued by the Director of Public Prosecutions, and relevant excerpts from the Circular on Budget Execution.

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ALD 141/259/01 TC

Ministry of Finance, Planning &
Economic Development,
P.O. Box 8147
Kampala, Uganda

21st September 2023

All Accounting Officers

All Ministries, Departments and Agencies

All Local Governments

UGANDA'S SOCIAL SAFEGUARD POLICIES

I am writing in reference to the above subject. Further reference is made to the Anti-Homosexuality Act, 2023 (AHA) that came into force on 30th May 2023.

Following the World Bank Group's concern with Uganda's enactment of the Anti-Homosexuality Act, 2023 and as communicated in the Budget Execution Circular of FY 2023/2024 on 18th July 2023, we guide that;

- All World Bank-financed projects must be implemented in a manner consistent with the principles of non-discrimination as provided under Article 21 of the Constitution of the Republic of Uganda. These projects should also be implemented in accordance with World Bank policies and applicable Legal Agreements.

- Under these projects, no person will be discriminated against or stigmatized and the principles of non-discrimination and inclusion will be adhered to. Support should be provided to all project beneficiaries.

- All implementing entities of World Bank projects will implement specific mitigation measures to address non-discrimination.

- These mitigation measures will require enhancing project grievance redress mechanisms as well as strengthening existing project monitoring by implementing entities including third-party monitoring where applicable.

- Each project implementing entity shall develop comprehensive guidelines to address non-discrimination.

Specific Measures for High Risk Sectors

Health

- The Ministry of Health issued a circular on August 8, 2023 that guarantees access to health care services for all and prohibits the discrimination or stigmatization of any individual who seeks health care services on any grounds.

- The Ministry of Health will widely disseminate and socialize health sector guidelines for the effective implementation of the circular.

- Implementating entities should strengthen grievance redress mechanisms, and third-party monitoring systems in collaboration with national and international partners.

Education

- The Permanent Secretary in the Ministry of Education and Sports on 18th August 2023 issued a circular stating that the Ministry of Education and Sports does not permit any form of discrimination against any persons in the delivery of education services, programs and projects.

- In light of that circular, the Ministry should ensure that there is no discrimination (including any form of bullying) against teachers and students on any grounds.

- The Ministry of Education and Sports will prepare project specific guidelines to address non-discrimination.

- Implementating entities should strengthen grievance redress mechanisms, including an independent hotline and third-party monitoring systems where necessary.

Ramathan Ggoobi
PERMANENT SECRETARY/SECRETARY TO THE TREASURY

Rt. Hon. Prime Minister, Office of the Prime Minister

Attorney General, Ministry of Justice and Constitutional Affairs

Hon. Minister of Finance, Planning and Economic Development

Hon. Minister of Education and Sports

Hon. Minister of Health

Hon. Minister of Gender, Labour and Social Development

Hon. Minister of Energy and Mineral Development

The Principal Private Secretary to H.E. the President

The Solicitor General, Ministry of Justice and Constitutional Affairs

The Permanent Secretary, Ministry of Health

The Permanent Secretary, Ministry of Education and Sports

The Permenant Secretary, Ministry of Gender, Labour and Social Development

The Director of Public Prosecutions

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This subject please quote No.

BPD 86/179/01

Ministry of Finance, Planning & Economic Development,
P.O. Box 8147
Kampala, Uganda

10th July, 2023

All Accounting Officers (Central Government, Missions Abroad, and Local Governments)

All Chief Executive Officers of State-Owned Enterprises and Public Corporations

THE BUDGET EXECUTION CIRCULAR (BEC) FOR FINANCIAL YEAR 2023/2024

A. INTRODUCTION

1. This Circular is issued in fulfilment of Article 155 (1) of the Constitution, and Sections 13 (5) and 14 (1) of the Public Finance Management Act, 2015 (Amended).
2. The theme for the FY 2023/2024 Budget has been retained as: "***Full Monetization of the Ugandan Economy through Commercial Agriculture, Industrialization, Expanding and Broadening Services, Digital Transformation and Market Access***". The Budget for FY 2023/2024 was approved to address the strategic mission of facilitating more Ugandans to join the money economy.
3. The purpose of this Circular is to communicate the following:
   i. The FY 2023/2024 Annual Cash Flow Plan **(Annex 1)**;
   ii. The Policy, Operational and Administrative Guidelines for execution of the Budget in FY 2023/2024.
4. As you execute the Budget for FY 2023/2024, I urge all Accounting Officers to ensure that all program activities contribute towards addressing the following objectives:
   i. Completion of public investments with higher multiplier effects on attainment of NDPIII and the NRM 2021-2026 Manifesto;
   ii. Full-scale implementation of the Parish Development Model (PDM);
   iii. Enhanced revenue mobilization and collection; and

iv. Ensuring efficiency and effectiveness of Government through rationalization of public expenditure.

5. The key priorities to achieve the above objectives are detailed in the approved Budget for FY 2023/2024. For ease of reference, please follow the link **https//www.budget.finance.go.ug** to access the following key documents, among others:

i. The Budget Speech for FY 2023/2024;
ii. Approved Estimates of Revenue and Expenditure Volume I (Central Government Votes and Missions Abroad);
iii. Approved Estimates of Revenue and Expenditure Volume II (Local Governments); and
iv. Approved Estimates of Revenue and Expenditure Volume III for the State-Owned Enterprises and Public Corporations.

B. THE ANNUAL CASH FLOW PLAN FOR FY 2023/2024

6. In accordance with Section 36 (b) of the PFM Act 2015 (Amended), the Annual Cash Flow Plan for FY 2023/2024 has been generated off the Program Budgeting System (PBS) based on the quarterly projections in your respective Vote work plans for FY 2023/2024.

7. The purpose of the Cash Flow Plan is to guide and ensure that Government maintains sufficient liquidity to be able to sustain and make timely payments to meet service delivery requirements by aligning Vote cash inflows and outflows to your respective Program Implementation Action Plans (PIAPs).

8. In view of the above, and in line with Sections 15 and 21 (i) of the PFM Act, 2015 (Amended), all Accounting Officers are urged NOT to overcommit the vote budgets beyond the Annual Cash Flow Plan issued in this Circular. Furthermore, you should submit expenditure commitments, in line with the PIAPs, indicating the actual forecast commitments and the cash position of your respective Votes as per Section 16 (i) of the PFMA, 2015 (Amended) to inform decision-making on the subsequent quarterly expenditure releases.

C. POLICY DIRECTIVES, ADMINISTRATIVE AND OPERATIONAL GUIDELINES FOR IMPLEMENTATION OF THE BUDGET FOR FY 2023/2024

Policy Directives

9. The FY 2023/2024 Budget allocations directed resources to program areas meant for enhanced socio-economic transformation for all Ugandans through job and wealth creation, and increasing household incomes, by targeting the 39% of Ugandans still in the non-money economy. All Accounting Officers are urged to adhere to the following policy directives that guided the preparation of the Budget for FY 2023/24:

i. Fund key Government priorities to increase the momentum in socio-economic transformation, for example: the standard-gauge railway, the meter-gauge railway, solar-powered irrigation, PDM, *Emyooga*, road maintenance, coffee value addition, vaccines and pharmaceutical manufacturing etc.;
ii. Support development initiatives that drive private sector growth;
iii. Implement only ongoing projects and other multi-year commitments as approved in the Budget;
iv. Halt new non-concessional projects, except those already provided for in the fiscal framework, or those with no direct or indirect claim on the Consolidated Fund;
v. Hold back any recruitment plans in FY 2023/2024 except on a replacement basis where the resources are already available;
vi. No travel abroad, except for critical positions of the Executive, Legislature, Judiciary, security, diplomatic relations and resource mobilization; and
vii. **NO** purchase of new vehicles except hospital ambulances, tailored vehicles for medical supplies/distribution, and for agricultural extension services, security and revenue mobilization.

Non-Discrimination

10. Accounting Officers should ensure that all projects (whether Government of Uganda or externally funded) are implemented within the provisions of Article 21 (1) and (2) of the Constitution and Section 13 (11) (e) (i-ii) of the Public Finance Management Act, 2015 (Amended). This emphasizes equality of all persons in access to all opportunities and benefits presented by the above projects, without prejudice and discrimination on the ground of sex, race,

color, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability.

Advertising by Ministries, Agencies and Local Governments

11. In his letter of Ref. No. PO/3 dated 6th March 2023, H.E. The President directed that in FY 2023/2024, **"all Government advertising must be through the Uganda Broadcasting Corporation. Any Accounting Officer who deviates from this will be sanctioned including dismissal"**. Print media advertising should be done through the New Vision. I therefore urge all Accounting Officers to strictly adhere to this directive.

Contracting in Ugandan Shillings versus Foreign Currencies

12. I have received numerous requests from a number of Ministries, Departments and Agencies (MDAs) to undertake contracts in foreign currency, especially in United States Dollars and Euros. In line with the fiscal and monetary policies agreed with Bank of Uganda, I wish to reiterate this Ministry's position that no procurements should be undertaken in foreign currency as previously communicated in FY 2016/17, FY 2017/18 and FY 2018/19. Contracting in the local currency, is meant to preserve the sanctity and value of the Shilling since the budget is appropriated in the local currency which is easily convertible.

13. Therefore, this is to guide all Accounting Officers as follows:

i. **That all contracts for works, goods and services shall be awarded in Ugandan Shillings to hedge against cost overruns due to global forex rates fluctuations that impact on the stability of the Shilling; and**

ii. **All contracts, including those that follow international competitive bidding procedures, shall be quoted in Ugandan Shillings. The only exemption will be where it is clearly expressed in the financing agreements with Development Partners to use other currencies in the bidding process, if necessary. This should be strictly the exception and not the norm. I request the Honorable Attorney General's chambers to take note and enforce this guideline while approving agreements.**

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IN ANY CORRESPONDENCE ON

Ministry of Health
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UGANDA

THE REPUBLIC OF UGANDA

THIS SUBJECT PLEASE QUOTE NO. **ADM:180/01**

5th June 2023

Circular

All Hospital Directors, National and Regional Referral Hospitals
All District Health Officers
All Medical Superintendents
All Health Facility In-charges
Executive Directors of Implementing Partners
Executive Directors of Faith Based Medical Bureaus
The Executive Director Uganda Healthcare Federation

PROVISION OF SERVICES TO ALL PEOPLE WITHOUT DESCRIMINATION

The constitution of the republic of Uganda recognises that health is a fundamental right and guarantees access to health care services for all. The Ministry of Health is mandated to provide Preventive, Promotive, Curative and Rehabilitative Health Services to all people in Uganda in their diversity **without any form of discrimination**. Furthermore, all services should be provided in a manner that ensures **Safety, Privacy and Confidentiality to all clients that seek health services in all facilities, both Public and Private.**

The Ministry of Health therefore reminds all health care workers and stakeholders about the above National commitments, and reiterates the following;

- **Not to deny services to ANY client who present themselves for services.**
- **Not to discriminate or stigmatize any individual who seeks health care services, for any reason – gender, religion, tribe, economic status, social status or sexual orientation.**
- **Patient rights and ethical values – Confidentiality, Privacy, Patient Safety as stipulated in the Patient's Charter should be upheld each time a patient seeks health care services at your facility**

Your cooperation in this matter is of great importance to improving access to service delivery for all our people.

Dr. Henry G. Mwebesa
DIRECTOR GENERAL HEALTH SERVICES

cc. Hon. Minister of Health
Hon. Minister of State for Health (GD)
Hon. Minister of State for Health (PHC)
Permanent Secretary, Ministry of Health
All UN Agencies
PEPFAR Coordinator
Head Country Team Global Fund, Geneva
Country Manager, World Bank
Country Director – CDC, USAID, DOD
Director General, Uganda AIDS Commission
Directors, Ministry of Health
All Chief Administrative Officers
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THE REPUBLIC OF UGANDA

Ministry of Education and Sports
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Kampala, Uganda

18th August 2023

All Heads of Education Institutions

PROVISION OF EDUCATION SERVICES TO ALL PEOPLE WITHOUT DISCRIMINATION

The Government of Uganda recognizes the Constitutional social objective to ensure all Ugandans enjoy rights, opportunities and access to education. Under our education objectives, the State is obligated to promote free and compulsory basic education, afford every citizen equal opportunity to attain the highest educational standard possible, and facilitate individuals, religious bodies and other non-governmental organizations to found and operate educational institutions if they comply with the general educational policy of the country and maintain national standards.

The Ministry is implementing the Gender in Education Policy which provides for equitable access to education for all without discrimination. To operationalize the Policy a number of policy strategies and guidelines exist including the National Strategy of Elimination of Violence Against Children, the Life Skills Toolkit, manuals on growth and sexual maturation. In addition, the Ministry has incorporated Sexuality Education into the curriculum to ensure age-appropriate information to enable young people to maneuver through the different challenges of life.

The purpose of this Circular, therefore, is to reiterate Article 21 (1) of our constitution with states that "All persons are equal before and under the law in all spheres of political, economic, social and cultural life and in every other respect and shall enjoy equal protection of the law". The Ministry does not condone any forms of discrimination and exclusion of any persons, in delivery of education services, programs and projects.

You are, therefore, called upon to observe and ensure the above standards in the delivery of education services, programmes and projects.

Ketty Lamaro
PERMANENT SECRETARY

Cc: First Lady and Hon Minister of Education and Sports
Ministers of State, Education and Sports

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THE REPUBLIC OF UGANDA

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Our Ref: ADM 12/01
Your Ref:

Date: 25th August, 2023

CIRCULAR NO.18/2023

All Prosecutors,
Office of the Director of Public Prosecutions.

RE: MANAGEMENT OF CASES WITH CHARGES PREFERRED UNDER THE ANTI-HOMOSEXUALITY ACT 2023.

The Anti-Homosexuality Act (AHA) came into force on 30th May 2023. It has come to the attention of management that a number of charges of Homosexuality and Aggravated Homosexuality are now being preferred by some officers without internalizing some crucial aspects of the act.

It is important to note that the AHA only criminalises offences where a sexual act has been performed. The term "*sexual act*" is defined under Section **1** of the Act.

It is also important to note that Sections **2 (5)** and **3 (5)** of the AHA provide that "*for the avoidance of doubt, a person who is alleged or suspected of being a homosexual, who has not committed a sexual act with another person of the same sex, does not commit the offence of homosexuality under this section*".

Officers are therefore advised to peruse files with offences under the AHA cautiously while taking into account the abovementioned provisions.

You are hereby directed to ensure that all files with charges preferred under the AHA should first be submitted to Headquarters with a written legal opinion for further guidance before a decision to charge is made.

Management will soon organize sensitization meetings for all officers on the key aspects of the AHA.

Jane Frances ABODO
DIRECTOR OF PUBLIC PROSECUTIONS

Annex 17: Enhanced Implementation Support and Monitoring of Non-Discrimination

1. Background and Objectives

The World Bank and IFC will hire an international and credible entity (firm, agency) with a strong knowledge of the Ugandan context and a track record of enhanced third-party implementation support and performance monitoring to undertake the tasks described in this section for all projects presently being implemented in the Uganda portfolio. The entity is expected to work with NGO/CSOs and country-based development partners.

The Enhanced Implementation Support and Monitoring (EISM) will primarily focus on supporting project teams to implement mitigation measures to address grievances and concerns from beneficiaries, communities, and workers relating to discrimination from project benefits.
The objectives of the Enhanced Implementation Support and Monitoring include:

- Assisting project teams to enhance existing project-level grievance mechanisms and develop and operate an independent mechanism that would identify, manage, and monitor cases of discrimination.
- Assisting the WB in strengthening the capacity of Project Implementation Units (PIUs), workers, and contractors, subcontractors, and service providers.
- Ensuring contracts, codes of conduct, hiring procedures, whistle-blower protection protocols, and other measures, as needed, are in place to allow remediation of cases of discrimination.
- Develop a strong data management system and process that secures personal data and information in a manner that is safe, ethical, and confidential.
- Where cases of discrimination are reported through the above mechanism, the EISM will report the grievances to the Bank, propose appropriate remediation, and follow up on agreed actions to resolve the case.
- Support the WB/IFC to monitor the efficacy of the agreed measures to mitigate the impacts on WB/IFC financed operations.

Figure 6 illustrates the enhanced implementation support and monitoring steps. Figure 7 contains the enhanced implementation support and monitoring process. Figure 8 contains the Complaint Management for Vulnerable or Marginalized Individuals or Groups.

2. Scope of Work and Activities

To provide enhanced implementation and monitoring support to the World Bank/IFC operations in Uganda the EISM will:2.1 Establish an effective and confidential mechanism to receive, manage, refer, and monitor grievances related to discrimination across the WB/IFC portfolio.

To do so the EISM will:

- **Enhance existing project-level grievance redress mechanisms** to safely, ethically, and confidentially receive cases related to discrimination on World Bank/IFC financed operations and refer them to an appropriate grievance handling mechanism.
- **Design and operate a mechanism for receiving grievances** related to discrimination on WB/IFC financed operations (including from project level grievance mechanisms noted above).
- **Establish a hotline or an alternative complaint mechanism**, for individuals to lodge complaints of discrimination on WB/IFC financed projects or voice their concerns without fear of reprisal. The EISM is an alternative to lodging complaints through a GoU-led project-level GRMs.

Figure 6: Enhanced Implementation Support and Monitoring Steps

Enhanced Implementation Support and Monitoring Steps	
Act as a key first step in the referral process from project-level GRMs	Designed specifically to handle complaints restricted to WB/IFC projects
Step 1	Receives and document complaints of discrimination in accessing WB/IFC projects' benefits, services, and opportunities,
Step 2	Develops specific security protocols to ensure that communications are safe, ethical, and confidential.
Step 3	Establishes a data management system on an international server guaranteed by the provider as safe and secure encryption and privacy.
Step 4	Implements a data privacy and protection policy to include confidentiality clauses to be signed by all personnel entrusted with managing referrals or referral-related information.
Step 5	Handles complaints in a confidential, anonymous, and non-judgmental manner which is sensitive to local context and in local languages
Step 6	Provides detailed monthly reports of complaints received to the WB/IFC
Step 7	Provides ad hoc incident reports of all allegations to WB/IFC within 48 hours of receipt
Step 8	Reports grievances to the WB/IFC, proposes appropriate remediation, and follows up on agreed actions to resolve the case.
Step 9	Maps available services for vulnerable or marginalized individuals or groups including counselling, legal services, protection, and other services,
Step 10	Refers individuals to the appropriate local services or organizations as needed
Step 11	Reports grievances to the WB/IFC, proposes appropriate remediation, and follows up on agreed actions to resolve the case.
Step 12	Regularly evaluates the effectiveness of mitigation measures to determine whether and how well the mitigation measures are functioning.
Step 13	Recommends and supports the implementation of adjustments to mitigation measures based on regular evaluations and their impact.

2.2 Outreach and sensitization to project beneficiaries and communities involved with the World Bank/IFC Portfolios

Activities related to Outreach and sensitization to project beneficiaries and communities include:

- **Assist the WB/IFC to prepare and implement a plan to disseminate information** about the support provided by the entity including support to existent GRMs.
- **Prepare community/beneficiary information materials** on their rights within the Constitution of Uganda and World Bank/IFC policies informed by various official circulars issued by the GoU on non-discrimination and World Bank/IFC policies.
- **Develop and implement a methodology to conduct periodic outreach to beneficiaries/communities** to hold consultations on non-discrimination to identify issues and risks in a safe, ethical, and confidential manner.

2.3 Capacity strengthening and technical support

Activities related to capacity strengthening and technical support include:

- **Support to the WB/IFC on training** of government staff and private sector consultants/clients, workers, and contractors on non-discrimination by developing training materials, identifying venues, providing trainers, etc.
- **Support to the WB/IFC with training project level GRMs** on non-discrimination in World Bank and IFC financed Projects by developing training materials, identifying venues, providing trainers, etc.
- **Preparing training modules for call center operators, data management personnel, and community outreach personnel** on appropriate handling of sensitive information.
- **Providing technical support to the GoU for the development of Guidelines** on Non-discrimination of Workers.

2.4 Monitoring and Evaluation

Activities related to monitoring and evaluation include:

- **Developing a system to regularly monitor WB/IFC projects** for 1) implementation of agreed GoU actions to mitigate the risk of discrimination on WB/ IFC projects, 2) incidents of discrimination on World WB/IFC financed projects.
- **Regularly evaluating the effectiveness of mitigation measures** to determine whether and how well the mitigation measures are functioning to improve WB/IFC awareness of incidents of discrimination on WB/IFC financed operations.
- **Recommending and supporting the implementation of adjustments to mitigation measures** based on regular evaluations and their impact.

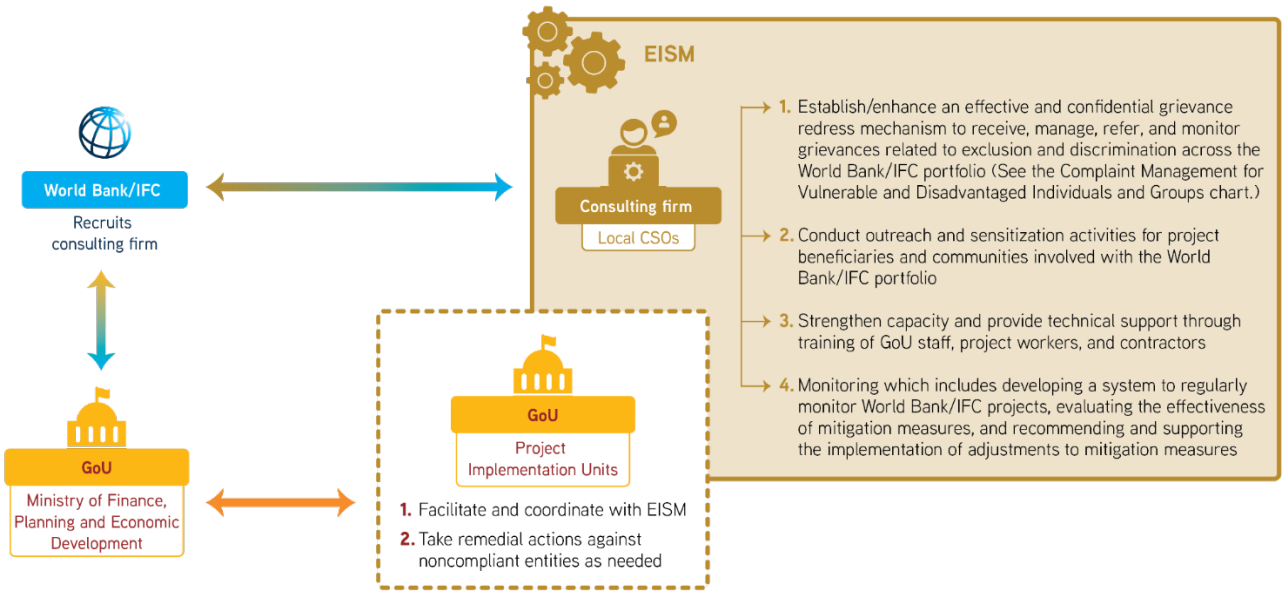
3. Roles and Responsibilities

The GOU and its PIUs remain responsible for the implementation of all project activities including mitigation measures supported by the EISM. The enhanced implementation and monitoring support mandate is specifically focused on:

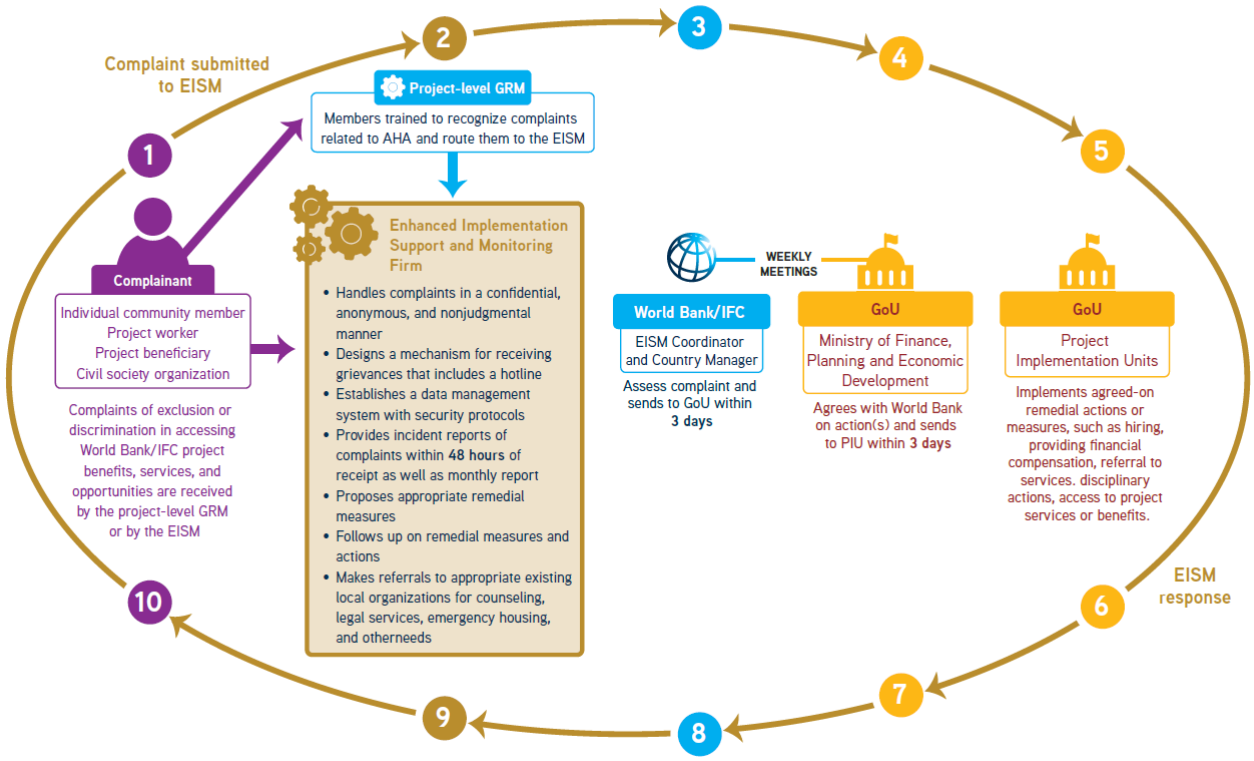
1) supporting the WB/IFC to ensure the agreed measures on non-discrimination in the portfolio are implemented fully, ethically, safely, and to an appropriate standard of quality; and
2) to support the WB/IFC to enhance our awareness of cases of discrimination across the WB/IFC portfolio.

The GOU will facilitate the work of the entity and collaborate as needed on all activities requiring their direct involvement, such as outreach and sensitization activities, capacity strengthening and technical support as well as the monitoring and evaluation of mitigation measures. The GoU will also ensure that the work under the EISM can be undertaken safely in accordance with existing circulars and their dissemination.

Description of Enhanced Implementation Support and Monitoring (EISM) Process



Complaint Management for Vulnerable or Marginalized Individuals or Groups



Note: For the IFC, the complaint management process is similar, but instead of government, it is done through private sector borrowers.

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