

MINISTRY OF HEALTH



ENVIRONMENTAL AND SOCIAL MANAGEMENT FRAMEWORK

ESWATINI COVID-19 EMERGENCY RESPONSE PROJECT (P173883)

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Table of Contents

ABBREVIATIONS AND ACRONYMS	5
EXECUTIVE SUMMARY	7
Chapter 1 - BACKGROUND.....	22
1.1. Introduction.....	22
2.1 Project Objective	27
2.2 Project Components.....	27
Chapter 3 – POLICY, LEGAL AND REGULATORY FRAMEWORK	44
3.1 International Conventions, Protocols and Standards	44
3.2 Applicable World Bank Environmental and Social Standards	45
3.3 Environmental and Social Risk Classification (ESRC).....	48
3.4 Applicable WHO Standards.....	53
3.5 Key Applicable National Laws, Policies and Regulations	53
3.6 Comparison of ESSs and National Legislation	56
3.7 Institutional Framework	57
Chapter 4 - ENVIRONMENTAL AND SOCIAL BASELINE.....	61
4.1 Physiography and Climate.....	61
4.2 Administrative Regions and Tinkhundla	62
4.3 Socio-economic Context	64
4.4 Demographics	64
4.5 Poverty	66
4.6 Disadvantaged and or Vulnerable Groups	69
4.7 Sexual Exploitation, Harassment and Abuse and Gender Based Violence	70
4.8 Water, Sanitation and Hygiene	71
4.9 Health and Nutrition	72
4.10 Health Care Management.....	74
4.11 Health Care Waste Management.....	86
CHAPTER 5: ENVIRONMENTAL AND SOCIAL RISK AND IMPACT MITIGATION.....	87
5.1 Environmental and Social Management Plan	87

5.2 Budget for Environmental and Social Management Plan	111
5.3 Monitoring and Evaluation Plan for E&S Activities	116
Chapter 6 - PROCEDURES TO ADDRESS ENVIRONMENTAL AND SOCIAL ISSUES	122
6.1. Key Steps to be Followed	122
6.2 Key Principles for Subproject Engineering Design.....	128
6.3 Consultation and Disclosure Requirements	128
6.4 Integration of ESMP into Bidding Documents.....	128
Chapter 7: CONSULTATION AND PUBLIC DISCLOSURE	130
7.1 THE ESWATINI COVID 19 VACCINATION COMMUNICATION PLAN	132
Chapter 8 - Stakeholder Consultation	142
8.1 Stakeholder Consultation	142
8.1.1 SEP UPDATE	143
8.2 . Stakeholder Engagement Overview	150
8.2.1 Principles for Effective Stakeholder Engagement.....	150
8.2.2 Overall Objectives	151
8.3 Stakeholder Identification	151
8.3.1 Project Affected Parties	152
8.3.2 Other Interested Parties	153
8.3.3 Disadvantaged / Vulnerable Individuals or Groups	153
8.4 Stakeholder Analysis.....	154
8.5 Stakeholder Engagement	156
8.5.1 Stakeholder Engagement.....	156
8.5.2 Implementation of Social Distancing Measures and Strengthening Communication Preparedness	157
8.5.3 Vaccine Acceptance and Uptake (Demand).....	158
8.5.4 Information Disclosure.....	166
8.5.5 Resources and Responsibilities for Implementing Stakeholder Engagement Activities.....	166
8.6 Management functions and responsibilities	166
8.7 Grievance Mechanism.....	166
8.7.1 Structure of Grievance Mechanism (GM)	167
8.7.3 Sexual exploitation and abuse and Sexual Harassment:	173
8.7.4 World Bank Grievance Redress System:	173

8.7.5 Awareness raising and disclosure of the GM.....	173
8.7.6 Roles and Responsibilities.....	174
8.8 Monitoring and Reporting.....	175
8.8.1 Reporting back to stakeholder groups.....	175
8.8.2 Monitoring and Evaluation Plan.....	175
Chapter 9 - INSTITUTIONAL ARRANGEMENTS	177
9.1 Implementation Arrangements	177
9.2 Monitoring Arrangements for Effective Environmental and Social Management	187
9.3 Measures to Strengthen Institutional Capacity	187
9.4 ESMP Implementation Cost/Budget.....	188
ANNEX 1 – Additional Resources	189
ANNEX 2 -- Generic Terms of Reference for Conducting an ESIA/ESMP	191
ANNEX 3 – Detailed Environment and Social Screening Guidance Note	196
ANNEX 4 – Guidance Note for Incorporation of the ESMP into Contract Documents	202
ANNEX 5 – Archaeological Chance Finds Procedure	205
ANNEX 6 – Labor Management Procedures	206
ANNEX 7 – SEA/SH and GBV Action Plans	227
ANNEX 8 – Infection Control and Waste Management Plan (ICWMP) for Covid-19 Outbreak.....	234
ANNEX 9 - Findings from Stakeholder Consultations.....	260

ABBREVIATIONS AND ACRONYMS

CDC	Centers for Disease Control and Prevention
CIT	Core Implementation Team
COVID-19	Coronavirus disease caused by the 2019 novel coronavirus (SARS-CoV-2)
EDCU	Epidemiology and Disease Control Unit
EEA	Eswatini Environment Authority
EHS	Environment Health and Safety
ESF	Environmental and Social Framework
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
ESS	Environmental and Social Standard
FM	Financial Management
FTCF	Fast Track COVID-19 Facility
GBV	Gender Based Violence
GDP	Gross Domestic Product
GHSA	Global Health Security Agenda
GOKE	Government of the Kingdom of Eswatini
GRM	Grievance Redress Mechanism
HCI	Human Capital Index
IAP	Incident Action Plan
IBRD	International Bank for Reconstruction and Development
ICWMP	Infection Control and Waste Management Plan
ICU	Intensive Care Unit
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
IMF	International Monetary Fund
IMT	Incident Management Team
IPF	Investment Project Financing
KPIs	Key Performance Indicators
LMP	Labor Management Procedures
M&E	Monitoring and Evaluation
MOH	Ministry of Health

MPA	Multiphase Programmatic Approach
NDMA	National Disaster Management Agency
NEMC	National Emergency Management Committee
NETT	National Emergency Task Team
NGO	Non-governmental organization
NPHEMC	National Public Health Emergency Committee
NRL	National Reference Laboratory
PDO	Project Development Objective
PHEIC	Public Health Emergencies of International Concern
PHEMC	Public Health Emergency Management Committee
PHEOC	Public Health Emergency Operations Committee
PHO	Port Health Officer
PIU	Project Implementation Unit
PIM	Potentially Infected Materials
PoE	Points of Entry
RFMH	Raleigh Fitkin Memorial Hospital
RHMT	Regional Health Management Team
RRT	Regional Response Team
SEA	Sexual Exploitation and Abuse
SEP	Stakeholder Engagement Plan
SMT	Senior Management Team
SOE	State Owned Enterprises
SPRP	Strategic Preparedness and Response Program
UN	United Nations
VESC	Valued Environment and Social Component
WHO	World Health Organization
WBG	World Bank Group

EXECUTIVE SUMMARY

The COVID-19 emergency response project financed by the Bank will support the Kingdom of Eswatini effort to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness. The project will contribute and be implemented under the Coronavirus disease (COVID-19) Strategic Preparedness and Response Program (SPRP) using the Multiphase Programmatic Approach (MPA), approved by the World Bank's Board of Executive Directors on April 2, 2020. This project is prepared under the global framework of the World Bank COVID-19 Response financed under the Fast Track COVID-19 Facility (FTCF). The Ministry of Health (MOH) is implementing the Project and will house the project implementing unit (PIU). The Parent Project financing envelope was US\$6 Million. An additional financing of US\$5 million for COVID-19 vaccine deployment and a US\$3 million grant from the Health Emergency Preparedness and Response Multi-Donor Trust have been made available and thus the total financing envelope is US\$13.5 million. The closing date has been extended to March 31, 2024 to accommodate the additional activities. The primary objectives of the AF are to enable affordable and equitable access to COVID vaccines, help ensure effective vaccine deployment through enhanced vaccination system strengthening, and to further strengthen preparedness and response activities in the Kingdom of Eswatini. As the proposed activities to be funded under the AF for the Eswatini COVID-19 Emergency Response Project are aligned with the original PDO, the PDO would remain unchanged.

The Program Development Objective is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Eswatini. The project components are aligned with the objectives of the COVID-19 Strategic Preparedness and Response Program (SPRP) and comprise 2 components: (1) Emergency COVID-19 Response; and (2) Implementation Management and Monitoring and Evaluation. In addition, the Additional Financing (AF) includes another component to Strengthen Capacity in Preparedness for Health Emergencies. The AF will expand Eswatini's COVID-19 response through (a) co-financing vaccine procurement, (b) strengthening the systems required to support effective and efficient vaccine deployment; and (c) strengthening public structures for the coordination and management of the project.

Component 1: Emergency COVID-19 Response (US\$10 million)

This component will provide support to Eswatini to minimize the risk of further imported cases and limit local transmission through containment strategies. It will support the implementation of Eswatini's COVID-19 National Contingency Plan in close coordination and with strong support from UN agencies and other partners. This component supports: (i) strengthening COVID-19 case detection, confirmation, case tracing, recording and reporting; (ii) health systems strengthening for COVID-19 preparedness planning; and (iii) improving the implementation of social distancing measures and strengthening communication preparedness. An increase in the scope of the component has been made to accommodate COVID-19 Vaccine Deployment. This will include (i) vaccine and drug purchase; (ii) upgrading the cold chain for the vaccines; (iii) strengthening service delivery to ensure effective vaccine deployment; and (iv) monitoring, tracking of vaccines use and recording of any adverse reactions to vaccination.

Component 2: Strengthening Capacity in Preparedness for health emergencies (additional financing of US\$3 million) Supports the strengthening of Eswatini's capacity in preparedness for health emergencies, including: (i) strengthening the surveillance system and enhancing analytical capacity for real-time rapid reporting and analysis of surveillance data; (ii) supporting simulations to regularly evaluate and enhance health emergency preparedness; (iii) preparing and equipping the health system and facilities to respond

to future health emergencies; and (iv) strengthening capacity for national health emergency rapid procurements. To support the Government's vaccination planning, the AF will finance upfront technical assistance to support Eswatini to establish institutional frameworks for the safe and effective deployment of vaccines. These will include: (a) upgrading regulatory standards at the national level, including pharmacovigilance, and authorization mechanisms; (b) preparation of appropriate minimum standards for vaccine management including cold chain infrastructure (with financing for the investment to meet those standards as described below); and (c) creation of accountability, grievances, and citizen and community engagement mechanisms.

Component 3 Implementation Management and Monitoring and Evaluation (US\$ 1 million)

Support for the strengthening of public structures for the coordination and management of the project will be provided, including central and local (decentralized) arrangements for coordination of activities, financial management (FM) and procurement. The MOH's implementation team will be strengthened through capacity building and recruitment of consultants responsible for overall administration, procurement, and FM of the project. To this end, the project will support costs associated with project coordination. This component will also support the M&E of prevention and preparedness, building capacity for clinical and public health research, and joint learning across and within countries. This component will support training in participatory M&E at all administrative levels, evaluation workshops, and development of an action plan for M&E and replication of successful models.

The Environmental and Social Management Framework Approach

Since the project responds to an emerging pandemic situation and in absence of specific locations and detailed information about the subprojects, an Environmental and Social Management Framework (ESMF) has been prepared for managing the identified risks and impacts. This ESMF sets out principles, rules and guidelines and procedures to assess and manage expected environmental and social risks and impacts during project implementation. The ESMF was prepared through a literature review of relevant documentation, consultations with key stakeholders and visits to potential sites for observations. The ESMF contains risks and impacts, provisions for estimating and budgeting the costs of such measures, and information on the agency or agencies responsible for addressing project related environmental and social risks and impacts, including its capacity to manage environmental and social risks and impacts. It provides adequate information on the area in which subprojects are expected to be sited, including any potential environmental and social vulnerabilities of the area; and on the potential impacts that may occur and mitigation measures that might be expected to be used. Once subproject locations are determined, a site-specific ESMP will be prepared and implemented to manage any arising risks during construction and operation.

Environmental and Social Standards Applicable to the Project

The overall Environmental and Social Risk Rating associated with the Project is classified as Substantial. Five of the ten Environmental and Social Standards (ESSs) of the WB's Environmental and Social Framework (ESF) are relevant to the project:

- ESS 1 – Assessment and Management of Environmental and Social Risks and Impacts
- ESS 2 – Labour and Working Conditions
- ESS 3 – Resource Efficiency and Pollution Prevention and Management
- ESS 4 – Community Health and Safety
- ESS 10 – Stakeholder Engagement and Information Disclosure

WBG Environment, Health, and Safety (EHS) Guidelines will apply to the extent relevant as well as current WHO Guidance on COVID-19 (see resources appendix) including those on "healthcare facilities", "waste

management”, “hazardous materials management”, and “construction and decommissioning”. In addition to World Bank ESSs, the project shall comply with the Eswatini’s environmental and social regulatory framework i.e. applicable laws and regulations.

Baseline Information

Eswatini lies between latitudes 25 and 28 degrees south, and 31 and 32 degrees east in the south eastern part of Africa. The country is land locked and covers an area of 17364 km². The land is classified into six physiographic zones. Highveld, Upper Middleveld, Lower Middleveld, Western Lowveld, Eastern Lowveld and Lubombo Range. Each of the physiographic regions has its own climate. In terms of altitude, Eswatini’s highest summit point stands at 1 862m above sea level, and the lowest point is at 152.4 m, with four ecosystems (aquatic, forest montane grassland and woodland-savannah mosaic represented in the steep gradient). Eswatini has a subtropical climate with summer rains. About 75 percent of the precipitation falls from October to March. The climatic conditions range from subhumid and temperate in the Highveld to semi-arid in the Lowveld.

Eswatini has four (4) administrative regions namely: Hhohho, Manzini, Lubombo and Shiselweni and fifty-nine (59) Tinkhundla centres. Land tenure is broadly of two types, Swazi National Lands (SNL) and Title Deed Land (TDL), which account for 54 and 46 per cent of land area respectively. Although classified as a lower middle-income country (gross national income (GNI) per capita US\$2,960), high poverty rates and income inequality (Gini coefficient of 49.3) challenge Eswatini’s economic and human development potential. If a prolonged crisis leads to higher inflation and potential labour market impacts, these may have knock-on effects on vulnerable households. Eswatini has a population of 1,093,238 people. There are 562,127 females and 531,111 males. This effectively means that the population of Eswatini increased by 74,789 persons in the ten-year period 2007 to 2017. This represents an annual growth rate of 0.7 percent. While the national poverty rate has fallen in recent years from 63 percent in 2010 to 59 percent in 2017, however, it remains very high, particularly in rural areas at approximately 70 percent as well as in the two regions of Lubombo and Shiselweni where the poverty rate is 72 percent and 67 percent respectively. The level of hunger is classified as “serious” in the 2018 Global Hunger Index, where Eswatini has a score of 22.5. About 70 percent of the rural population depend mainly on agriculture for livelihood while nationally Eswatini people earn a living through formal employment, remittances, business, agriculture (livestock, poultry and crop/vegetable farming), grants, casual labour, skilled labour, pension and petty trade.

Eswatini has made considerable achievements in HIV treatment, such as antiretroviral therapy (ART) coverage of 82 percent and a significant reduction in mother-to-child transmission, however, the country still has the highest HIV prevalence in the world, with 26 percent of the adult population infected. Women are disproportionately affected, with 35 percent living with HIV compared to 19 percent of men. About 59 percent of orphans in the country have lost parents to HIV- and AIDS-related deaths. Over 25 percent of women 25 years and older and 50 percent of women 15–24 are unemployed. Female-headed households, children and the elderly are disproportionately affected by poverty, food insecurity and disease. Vulnerable groups often left behind or at risk of being left behind are more dramatically affected by COVID-19 pandemic. Those groups include Women, Children, Elderly, Youth, Extreme poor and near poor, Persons with Disability, Informal sector workers, Migrants, SMEs/Entrepreneurs, People affected and Infected by HIV, Persons with TB, people in close setting (e.g. Prisons) and rural populations. Baseline information on social aspects to be specific to the project areas

Clean water, basic toilets and good hygiene practices are essential for the survival of Eswatini children. Water and sanitation-related diseases are one of the leading causes of death for children under five years of age. Achieving universal access to drinking water and sanitation by 2030 will be challenging given

current levels of investment, coordination, national partnerships and climate variability. Eswatini has a clear gap in the access drinking water and sanitation between Urban and Rural communities as well as the growing informal settlement around the major urban centers. Only 69 per cent of Eswatini's population has access to basic water services and only 58% have access to sanitary services where 11 per cent is without proper toilet facilities (open defecation). Taking hygiene access using hand washing as a proxy indicator, only 24 per cent of Eswatini households practice safe handwashing.

Eswatini is under constant threat from infectious diseases, food contamination, antimicrobial resistance, traffic accidents and other emergencies. Humanitarian crises due natural disasters, disease outbreaks and other hazards are a major and growing contributor to ill health and vulnerability. According to the latest Service Availability and Readiness Assessment done in 2017, over a period of 10 years (2006-2017), the number of health facilities have doubled in Eswatini from 154 to 327. Eswatini attends to 3700 people per clinic which is well within the guideline stipulated by the WHO (10, 000 people per clinic). The Manzini Region has the highest number of facilities (130) and Shiselweni has the least (45) which correlates with the respective populations. A total of 81% of facilities had basic amenities for general services available, of which, 74% were ready to provide the service. Seventy-four (74%) percent of health facilities had basic equipment available, only 81% were ready to use the equipment. There were 75% of facilities that had standard precautions for infection control, of which 81% were ready to use. Sixty (60%) of health facilities had diagnostic capacity, of which 60% had it ready to use. Sixty (60%) of health facilities had on average all essential medicines in the facility, of which 33% were ready to use. The Mean availability of Infection Prevention Precaution items was high ($\geq 75\%$) across all levels of health facilities except specialized clinics.

Eswatini is not adequately equipped to respond to a global pandemic of this nature and this magnitude. Moreover, while the population is concentrated in the valleys, 75% of people live in rural areas; the mountainous terrain of the country makes it difficult for the population to access health facilities¹. Eswatini currently has 11 hospitals and five health centers that provide secondary care, providing an average of 2.1 hospital beds per 1000 population (compared to an average of 2.4 and 4.1 beds per 1000 population in low- and middle-income countries and high-income countries respectively). Only two hospitals have an intensive care unit (ICU) - Mbabane Government Hospital (MGH), the national referral hospital, and Raleigh Fitkin Memorial Hospital (RFMH), a mission hospital, providing a total of 14 ICU beds. Eswatini recorded the first case of COVID-19 on 13th March 2020. Subsequently, His Majesty King Mswati III invoked section 29 of the Disaster Management Act 2006 and declared the COVID-19 pandemic a National Emergency in the Kingdom of Eswatini from the 17th of March 2020. Even though the country is implementing comprehensive public health measures – such as rapid case identification, rapid testing and isolation of cases, comprehensive contact tracing and quarantine of contacts – the country has not managed to suppress the spread of COVID-19. Eswatini has sadly incurred losses at a high level in Government when the Prime Minister Ambrose Dlamini died in December 2020 due to COVID-19 complications. The loss of the Prime Minister and two other members of Cabinet has increased awareness within Eswatini and beyond. As of March 17, 2021, the country of 1.16 million had recorded 17,257 confirmed cases, and 663 deaths, figures which show a sharp escalation from the previous months, surpassing the July 2020 peak of both daily confirmed cases and deaths.

Eswatini's need for COVID-19 Vaccine cannot be overstated. Eswatini's health system has established expertise and skills for childhood immunizations, however expertise and skill in adult immunization is

¹ United Nations. 2020. ECONOMIC SITUATION REPORT #1—COVID-19. United Nations, Mbabane

limited. While the regulation of medicinal products in Eswatini is provided for in the Medicines and Related Substances Control Act No.9 of 2016 the Regulatory Authority (National Medicines Regulatory Authority (NMRA)), has currently not been established and the provisions in this Act are currently implemented by the Ministry of Health (MOH) through the Medicines Regulatory Unit (MRU). The current capacity of the MRU to adequately implement the regulation of medicinal products is constrained due to limited resources (human, financial and infrastructure). These challenges coupled with functional and technical challenges in the supply chain, render the country unprepared to procure and effectively deploy a COVID-19 vaccine. However, even though Eswatini does not actively register medical products, the national labelling requirements for the supply of COVID-19 vaccines procured through the COVAX Facility will be waived. Authorization will be given for vaccines distributed by the COVAX Facility to be labelled in compliance with the WHO Labelling Model.

To facilitate the regulatory, import, vaccine lot release testing and labelling requirements for the roll out of COVID-19 vaccines in Eswatini activities in the regulatory approval and importation plan will be implemented. The capacity to conduct vaccine lot release testing is currently not in place in the MRU in Eswatini. The immunization programme in the country is currently only utilizing WHO Prequalified vaccines, the regulatory requirement for vaccine lot release is therefore waived for all vaccines imported into the country. The same approach would be employed for COVID-19 vaccines supplied through the COVAX Facility; batch to batch verification would also be waived. This approach is supported by the advice from WHO which states that vaccines procured from assured sources, like WHO prequalified vaccines, vaccines listed as EUL, or vaccines approved by SRAs, should not be tested again by receiving countries as they have been tested and released already by NMRAs with stable, formal approaches for vaccine approval. The lot release certificate of the responsible NRA/NCL of the producing country will however be required for submission to the MRU. A mechanism for lot release testing of vaccines received through self-procurement, donations and/or UN supply outside the COVAX Facility would be investigated and the best option adopted.

The MOH, with support from DPs has conducted a vaccine readiness assessment, initially using the COVID-19 Vaccine Introduction Readiness Assessment Tool (VIRAT) and the Vaccines Readiness Assessment Framework (VRAF), to identify gaps, costs and options to manage the COVID-19 vaccine deployment. Four Core Activity Areas were assessed, and these include A. Planning and Management, B. Supply and Distribution, C. Program Delivery and D. Supporting systems and infrastructure. The findings of the assessment showed that Eswatini is still not prepared for the vaccine deployment but much of the preparation is under way.

In response to the Pandemic the Government of Eswatini has developed and established a National Contingency Response Plan and a National Vaccine Deployment Plan. Both plans set out activities, responsibilities, timeframes, budgets and suitable institutional arrangement for implementation. The Ministry of Health has gone ahead to identify potential health care facilities for quarantine, isolation, treatment and vaccination purposes in all four regions of the country. These include 1x National Referral Hospital, 3x Regional Hospitals, 5x Health Centres, 3x Private Clinics, 2x Isolation Centres, 1x EMS Centre and 1x Quarantine Centre. These are located in the 4 regions of the country. The Health Care Facilities are as follows: in Hhohho district: Mbabane Government Hospital, Mbabane Clinic, Malagwane EMS, Piggs Peak Government Hospital, Emkhuzweni Health Centre, Dvokolwako Health Centre. The hospitals that have been identified in the Manzini Region are: Raleigh Fitkin Memorial Hospital, Mankayane Government Hospital, Manzini Clinic, Luke Commission, Zakhele Treatment Centre and Mavuso. The hospitals in the Lubombo Region are: Lubombo Referral Hospital, The Good Shepherd Hospital and Sithobela Health Centre. The hospitals identified in the Shiselweni Region are: Hlathikhulu Government

Hospital, Nhlangu Health Centre and Matsanjeni Health Centre. The National Laboratory within the Mbabane Government Hospital was identified for upgrading to test for COVID-19. To respond to the Pandemic, a range of functional and technical enhancements have to be implemented in these centres. These enhancements include minor rehabilitations, procurement of equipment and material, reagents, IPC material and equipment.

Most of these facilities (especially the hospitals and Health Centres) have a working health care waste management system with suitable facilities and personnel. There are however challenges in the management and these include incinerator lack of fuel for operation of incinerators, breakdowns due to poor maintenance and depreciation, lack of waste containment, waste not being segregated, treated and disposed of correctly in some facilities leading to unsafe and environmental risky conditions; there are no responsible persons designated for the management of waste in some healthcare facilities and in rural areas general waste is not collected from the premises of the health facilities. One (1) Local Authority (Mbabane) where the centres are located has a well-designed landfill for waste, the rest have controlled waste dumpsites. The quarantine and isolation centres will need a well-designed health care waste system and will have to be integrated into the central infectious waste collection schedule by the Environmental Health Department.

Environmental and Social Screening

Environmental and social screening is/will be undertaken to determine the key environmental and social issues/concerns and the nature and magnitude of the potential environmental and social risks and impacts that are likely to arise on account of proposed project/sub-project interventions. The key environmental and social issues to be identified will be determined by the type, location, sensitivity and scale of the project/sub-project. The key sub-steps involved in the screening exercise are outlined below:

- i. Ascertain presence of any environmental/social sensitive areas (as detailed in screening checklist) through primary/secondary information;
- ii. Confirm applicability of regulation, policies and standards in context of broad sub-project interventions;
- iii. Conduct reconnaissance site visits for ground-truthing and incorporate required/additional information in the screening format;
- iv. Obtain details about land availability and broad categories of ownership (forest/govt./private);
- v. Preparation of a screening report.
- vi. Identify risks associated with: i) social and economic barrier to equitable and inclusive access to vaccine, ii) lack of engagement with vulnerable and marginalized groups, iii) weak accountability in vaccine distributions and delivery and, iv) failure to address exclusion of vulnerable/marginalized groups from vaccine.

The results/findings from this exercise are used to determine:

- The extent and type of ESIA/ESMPs required;
- The environmental and social risks and impacts rating of the project/sub-project.

The screening result will also be an important input for analyzing the 'feasibility' of the project/sub-project along with engineering/economics and social criteria. The project was screened, and the risk was substantial for both the environmental and social risk ratings and an ESMF was prepared to mitigate risks. The sub-project activities were also accorded a risk rating from low to substantial and mitigation measures were proposed. Eswatini has developed a National Contingency Plan to address COVID-19 and the MOH has been effectively managing its implementation, with support from development partners (DPs). However, the recent increase in daily confirmed COVID-19 cases, the advent of a second wave and

threat of a third wave indicate that further investments are required. Preparation for rolling out vaccines is in its final phase, with the draft National Deployment and Vaccination Plan (NDVP) prepared in late December 2020 and finalized in February 2021 and operational planning ongoing under considerable uncertainty regarding when and how many doses of vaccine would be made available. The World Bank team has been working closely with key DPs and donors supporting the MOH in health emergency preparedness and response, particularly for the ongoing COVID-19 emergency, including WHO, United Nations Children's Fund (UNICEF), Global Alliance for Vaccines and Immunizations (GAVI), the United States President's Emergency Plan for HIV/AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), and Clinton Health Access Initiative.

Summary of Key Environmental and Social Issues

This operation is being processed as an emergency response using condensed procedures under the Fast Track COVID-19 Facility (FTCF). The project is expected to result in positive environmental and social impacts as it seeks to improve planning, processes and on-ground service delivery for COVID-19 surveillance, monitoring, containment and response and, deployment of a safe and effective. The project will be national in coverage and scope. No major civil works are expected in this project, only minor renovation or rehabilitation of existing health facilities. The minor civil works include Air Conditioning Rehabilitation and Plumbing reconditioning in certain health facilities. The Project will support the rehabilitation of existing buildings within state land only; no land acquisition or involuntary resettlement impacts are envisaged so far. Moreover, there are no anticipated impacts or risks to critical natural habitats, protected areas or cultural sites. However, the COVID-19 Preparedness and Response operations of laboratories (equipment, reagents/chemicals) as well as quarantine and isolation centers may have considerable environmental and social impacts, such as those related to medical and general waste disposal, and the potential for transmission of the COVID-19 virus if prevention protocols are not followed. The rehabilitation, upgrade or renovation of health care facilities may generate limited adverse impacts such as dust, noise, vibration, construction waste, wastewater, traffic disturbances, and safety issues to the environment and surrounding residents. These impacts are expected to be site-specific, temporary and can be mitigated with good design and construction practices using Environmental and Social Management Plans (ESMPs) or checklists. Support for water supply, sanitation and hygiene is anticipated within existing health care facilities and not expected to include any major greenfield civil works. Activities include support for provision of hand washing stations and bulk water supply from existing commercially operating vendors with no water supply expected from new sources. Water, Sanitations and Hygiene facilities to be rehabilitated or constructed will be required to follow principles of 'universal design' guidelines. The project shall be required to provide equitable access by all and to all WASH facilities.

Risks related to occupational and community health and safety are anticipated due to the dangerous nature of the pathogen (COVID-19) and reagents and other materials to be used in the hospitals, health facilities, quarantine, and screening posts. Diagnosis, testing, treatment, and providing isolation of patients can generate biological, chemical, and hazardous medical wastes. Vaccine usage that will be procured under the Additional Financing activities are also expected to generate residual medical wastes. However, these impacts are expected to be site specific, and manageable with the implementation of established mitigation measures. Other major risks expected include Climate Change and Gender Based Violence. To mitigate against these risks, the ESMF will also include climate change mitigation like waste minimization, cleaner technology and climate smart strategies to cope with possible risks. Infection Control and Waste Management Plan (ICWMP) will be implemented to manage risks related to exposure to COVID-19 virus from diagnosis, testing, treatment, of patients generating biological, chemical, hazardous medical wastes, incorporating WHO guidelines establishing good international industry

practice for COVID-19 response, including Guidelines for Quarantine, Biosafety, and Code of Ethics and Professional Conduct. This ESMF also has a Labour Management Procedure (LMP) embedded in it as Annex 6. The LMP specifies terms and conditions for labour employment as well as how labour is managed in the project, including measures to prevent and address any potential incidents that are contrary to good practices.

It will also clearly outline the implementation arrangements to be put in place for environmental and social risk management; training; and compliance monitoring and reporting requirements. Procurement of goods and equipment may be initiated prior to preparation of the ESMF; however no goods and equipment will be deployed until the ESMF is approved. In the case of health care services, the Project will strictly follow the current WHO Guidance and avoid activities such as the establishment of isolation units and treatment facilities at scale until ESMF approval.

On the social side, the key social risks associated with the Project are: i) COVID-19 disproportionate impact on women, ii) exclusion of vulnerable groups from vaccine, iii) misinformation and challenge of vaccine dissemination, iv) SEA/SH and, v) violence against children and child sexual abuse.

Disproportionate impact on women and girls: 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. As schools close and family members fall sick, the burden of care is likely to fall on women. Domestic violence may increase with stress and anxiety. Adolescent pregnancies may increase with school closures. Global evidence suggests that rates of GBV, especially Intimate Partner Violence, have increased as people stay at home and change behavior in response to the spread of COVID-19. Other types of GBV are sexual assaults against children, disabled and the elderly. To manage the SEA/SH risks during Project implementation a SEA/SH Action Plan has been developed and will be implemented to facilitate assessment and provide mitigation measures of the risks in general of Sexual Exploitation, Harassment, and Abuse.

Exclusion of vulnerable groups from vaccine: Vulnerable groups often left behind or at risk of being left behind are more dramatically affected by COVID-19 pandemic and are likely to be excluded from vaccine. The rural populations, particularly the vulnerable (HIV infected, poor, disabled, elderly, women and children) are unable to access facilities and services designed to combat the disease due to distance, location and, affordability, in a way that undermines the central objectives of the project. Making the vaccine accessible, affordable, inclusive and responsive to the needs of the most marginalized and excluded groups is critical. In this regard the project will be encouraged to adapt an inclusive national vaccine strategy including: i) addressing immediate policy issues to ensure vaccine eligibility policies are equitable and inclusive at the national level, ii) reaching and engaging with excluded and marginalized groups and developing innovative model to provide last mile service delivery, iii) monitoring who is being included and ensuring accountability and, iv) addressing institutional challenges to inclusion.

Misinformation and challenge of vaccine dissemination: There are also significant risks associated with vaccine dissemination that relate to misinformation leading to lack of public willingness to participate in a vaccination campaign; ensuring that those in greatest need of health services and vaccinations receive it first and in a timely fashion; health services and vaccinations are performed effectively; and the results of these support services are thoroughly captured, analysed and used to inform service delivery, government policy and positions as to how to control and defeat the pandemic and return to a more normal way of life.

Sexual Exploitation Abuse/Sexual Harassment SEA/SH a): One in three Swazi girls will experience some form of sexual violence by the time they are 18 years old, while almost half of Swazi women will experience some form of sexual violence over their lifetime. Intimate partners, such as husbands and boyfriends, are most likely to be the perpetrators of sexual violence against women, making a woman's home often a very dangerous place. The SEA/SH risks in this project arise primarily from the large workforce of health care workers (direct, contract and community workers) and the quarantine/isolation of patients. The project will also ensure that the medical isolation of individuals does not increase their vulnerability (for example, to GBV), especially in rural areas of the country. Handling of quarantining interventions (including dignified treatment of patients; attention to specific, culturally-determined concerns of vulnerable groups; and prevention of SEA and SH as well as minimum accommodation and servicing requirements) can also be listed as issues that will require close attention while managing the social risks of the project. SEA and SH risks will be assessed and addressed during implementation through the Action Plan, including screening and putting in the corresponding measures to prevent and mitigate the SEA/SH risks. The MOH in the ESCP will commit to the implementation of the WHO Code of Ethics and Professional Conduct which includes provisions for SEA/SH prevention.

Violence against children and child sexual abuse: Rates of violence against children and child sexual abuse in Eswatini are staggering, with nearly nine in ten children experiencing some form of physical violence or psychological aggression. Sexual exploitation, harassment and abuse cases are already increasing due to the restrictions imposed. Abuse cases doubled to at least 40 cases between 30 March and 24 April 2020 and this number might have increased since then. The cases reported were for emotional and sexual abuse.

To mitigate these social risk, the ESMP, will commit to ensuring that individuals or groups who, because of their particular circumstances, may be disadvantaged or vulnerable have access to the development benefits resulting from the Project.

Eswatini's health system has established expertise and skills for childhood immunizations, which creates a strong foundation, but modifications will be required to vaccinate a large number of adults in a short time period. COVID-19 vaccines are aimed at a larger proportion of the total population and will need to be deployed within a short time period in order to have the public health impact required to reduce the burden on health and the economy. Even if implemented in a phased manner, an intense focus on expanding immunization capacity is necessary to ensure that the health system can effectively implement a comprehensive COVID-19 vaccine deployment strategy.

Implementation Arrangements and Responsibilities

As it was the case with the Parent Project, the existing PIU will continue to be used for the AF. The MOH is also working closely with other DPs located in-country, especially UNICEF and WHO, who are providing technical assistance on aspects that include procurement, vaccine registration and risk communication. A Project Operational Manual (POM) was also issued and shared with the Bank on June 21, 2020. These documents will be further updated and finalized incorporating modifications introduced through the proposed AF and finalized by January 15, 2021. A PIU induction was conducted between August 28 and September 7, followed by trainings on Environmental and Social Standards. Additional trainings to support fiduciary control functions are scheduled for January 2021.

The PIU comprises of an agile implementation team established to support project effectiveness. The core team comprises primarily of MOH staff (civil servants). The implementation team is led by a Coordinator. For effective and timely decision making the Coordinator reports to the Principal Secretary

of the MOH, who serves as a member of the NETT. With oversight by the Coordinator, the implementation team comprises of specialists for fiduciary controls (FM and Procurement), M&E, and environmental and social risk management. For critical functions where the MOH technical capacity or knowledge of World Bank procedures and standards is limited, the project will provide surge capacity for a specified duration through specialist consultants. For operational efficiency, it is proposed that some technical roles (fiduciary, environmental and social) are shared between this emergency project implementation team and the project implementation unit (PIU) proposed for the health sector project under preparation (P168564). Sharing technical staff is expected to reduce overhead costs across the two projects, and by tapping into retroactive financing, it can provide surge capacity early on to accelerate effectiveness. The Coordinators for the two projects (P173883 and P168564) will ensure that the project implementation responsibilities are organized in a way to harness operational benefits while advancing ESF/ESSs works. The Eswatini Environment Authority (EEA) will be responsible for the review and approval of ESMPs and overall compliance monitoring of ESMPs.

The National Contingency Response Plan structure is as follows:

Cabinet-level inter-sectoral coordination and steering oversight will be provided by the *National Emergency Management Committee* (NEMC, Cabinet sub-committee), chaired by the Deputy Prime Minister. To support the NEMC, the *National Emergency Task Team* (NETT) was formed, which is comprised of members of different sectors, and representation from the National Disaster Management Agency NDMA.² The NETT is tasked to implement the National and Regional Emergency Plans and Procedures and coordinate the preparedness and response activities. As the primary crisis is health, the lead technical agency for project implementation will be the MOH. To ensure robust technical oversight and agility, the following two bodies will support project implementation:

The MOH Senior Management Team (SMT), chaired by the Principal Secretary, provides overall strategic implementation of the COVID-19 sector response. They are responsible for providing the necessary resources, strategic guidance and facilitating the feedback loop between the Cabinet-level inter-sectoral coordination and steering committee and the National Public Health Emergency Committee (NPHEMC) tasked with the technical response for the sector. The NPHEMC is chaired by the MOH (Senior Medical Officer, Public Health Lead). The committee is comprised of MOH technical leads and experts critical for response to public health emergencies and representatives from Development Partners (UN agencies and the World Bank). To support regional preparedness and response, the NPHEMC has regional response committees that are chaired by the emergency response and preparedness officers in each region and comprise of regional nurse managers and designated allied workers responsible for the evacuations, isolation of patients and contact tracing. The regional chairpersons are members of the regional health management teams thus provide feedback to the regional health administrators on the response while being members of the NPHEMC.

A National Deployment and Vaccination Structure has been established for the roll out of the COVID-19 vaccination. The structure is detailed below:

² NDMA is a standing body with a mandate to provides coordination across relevant sectors and actors to implement a response to emergencies, including public health emergencies of international concern (PHEIC) and pandemics.

In preparation for the COVID-19 Vaccine introduction the Ministry of Health appointed a National Coordination Committee which is chaired by the Deputy Director Pharmaceutical Services. This committee has a multisectoral representation composed of senior-level officials from relevant ministries (Deputy Prime Minister, development partners, representatives from private sector and NGOs. In the context of this plan, the function of the NCC is to provide overall oversight in the introduction of the COVID-19 Vaccine. In addition, the COVID-19 Vaccine technical working group (TWG) to support the implementation of the pre, intra and post introduction of the Vaccine was established. Eswatini National Immunization Technical Advisory Groups (NITAG) will provide evidence-based recommendations and policy guidance specifically related to COVID-19 Vaccines, to facilitate fully informed decision-making by the government.

The PIU supports the implementation of the National Contingency Response Plan and National Vaccine Deployment Plan. Members of the PIU are strategically placed within decision-making and working groups within the organizational structures of the two plans to contribute to decisions made and technically support implementation.

The implementation of the Parent Project has not been without challenges. The table below summarizes the challenges and lessons learnt:

Challenges	Lessons Learnt
- Outdated procurement plan due to delayed approvals and actioning of items using other donor funds	- Improved approval process in step for efficient use of resources
- Unclear budget allocation for E&S activities	- Developed an action plan with budget for E&S activities
- Increasing number of cases which ultimately over-stretch the health system;	- Vaccination must be prioritized - Capacitating of the COVID-19 Wing at Lubombo referral and procurement of additional equipment and material
- Continued infection of health workers;	- IPC investigated the problem and the general finding was that health workers are negligent
- Supply chain challenges when procuring supplies; Market cannot meet demand (IPC products)	- Early procurement and establishment of larger inventory/storage facilities
- No Isolation Camps at the Ports of entry. The available ones (which were tents) are missing	- Procure semi-permanent structures to serve as isolation camps at ports of entry.
- Increased pressure on Waste Management System due increase in waste volumes and depreciation of waste treatment facilities	- Need to install/replace 2 Incinerators at 2 locations - Procure additional waste receptacles - Procure 2 additional vehicles to support

	collection - Funding to procure fuel for Incinerators - Funding for repairing incinerator parts - Monitoring of emissions from Incinerator
- There was no clear command structure for the operational Health Sector to ensure leadership and coordination of the COVID-19 response	- A proper organizational leadership and coordination that is inline with the WHO Incident Management System. - An Incident Management Team led by a senior MOH official as Incident Manager was appointed and integrated
- Lack of a system to enable data integration	- Need for a comprehensive data management system that will incorporate all areas of data generation
- The surveillance and rapid Response operational structure is not clear	- Develop a proper operational structure for Rapid Response Team
- Non-compliance on rational use for PPEs	- IPC has to train staff in health facilities on the appropriate
- Inadequate PPE commodities for health workers and frontline staff	- Procure and timely supply essential items for COVID-19 IPC
- Health promotion is short staffed, and it affects provision of service	- Need to recruit additional human resource for Health Promotion Unit to enhance communication

Monitoring, Supervision and Reporting

M&E activities will be the responsibility of the MOH Epidemiology and Disease Control unit within the Strategic Information Department. Since the project focuses on COVID-19 preparedness and response, the Epidemiology and Disease Control Unit (EDCU) is mandated to coordinate efforts and strengthen public health surveillance through implementing Integrated Disease Surveillance and Response (IDSR) to fulfil requirements of the 2005 International Health Regulations (IHRs) and the Global Health Security Agenda (GHS). Since the COVID-19 outbreak, the unit has coordinated closely with WHO and the MOH COVID-19 Task Team to mount an effective response and set up the surveillance systems in the country. To this end, the unit will provide routine monitoring support for COVID-19 and vaccination and will receive backstopping from the MOH M&E unit once the pandemic has been contained. Tools for surveillance and reporting are already in place and shall be used as the data sources for the results framework indicators in this project.

Capacity Building

The MoH has experience with implementing one World Bank supported project under the Bank's safeguards policies, they have no experience in applying the ESF. The first ESF project to be implemented

by MOH, Health System Strengthening for Human Capital Development in Eswatini (P168564), is currently under preparation. Given the expanded scope of the ESF and the client's unfamiliarity with its requirements, overall, the Borrower's institutional capacity to oversee the implementation and monitoring of E&S issues under the new ESF is considered weak. The project has, for critical functions where the MOH technical capacity or knowledge of World Bank procedures and standards is limited, committed to provide surge capacity for a specified duration through specialist short term consultants to help launch and implement the COVID-19 project, under the Parent Project. The E&S specialists have since been recruited and engaged since the 1 November 2020. The CIT for the Eswatini COVID-19 Emergency Response Project (P173883) and the PIU for the Health System Strengthening for Human Capital Development in Eswatini (P168564), shall share services provided by the two E&S specialists. The Task team held a PIU training workshop on Grievance Redress Mechanisms in November 2020, resulting in an Action Plan that has been developed by the PIU on steps being taken to further strengthen awareness raising and the GRM effectiveness. The Action Plan is being used the ongoing monitoring of the project. As it was the case with the Parent Project, the existing PIU will continue to be used for the AF. The MOH is also working closely with other DPs located in-country, especially UNICEF and WHO, who are providing technical assistance on aspects that include procurement, vaccine registration and risk communication. A Project Operational Manual (POM) was also issued and shared with the Bank on June 21, 2020. These documents will be further updated and finalized incorporating modifications introduced through the proposed AF and finalized by January 15, 2021. A PIU induction was conducted between August 28 and September 7, followed by trainings on Environmental and Social Standards. Additional trainings to support fiduciary control functions are scheduled for January 2021.

Consultation and Stakeholder Engagement

The project has prepared and consulted on a Stakeholder Engagement Plan (SEP), which defines a program for stakeholder engagement, including public information disclosure and consultation, throughout the entire project cycle. It also outlines a communication strategy with the project stakeholders, and offers mechanisms for them to raise concerns, provide feedback, or make complaints about project. The SEP is a living document with objectives to:

- Identify all project stakeholders including their priorities and concerns, and ensure the project has ways to incorporate these;
- Identify strategies for information sharing and communication to stakeholders in ways that are meaningful and accessible;
- Specify procedures and methodologies for stakeholder consultations, documentation of the proceedings and strategies for feedback;
- Establish an accessible, culturally appropriate and responsive grievance mechanism, and
- Develop a strategy for stakeholder participation in the monitoring of project impacts.

Stakeholder engagements were done at planning stages of the project and the outcomes of the engagements were incorporated into this ESMF. The findings of the engagements included: issue of stigmatization, lack of psychological support, needs of frontline workers (including supply of relevant PPE), management of grievances and issues on confidentiality, coordination, communication and unclear division of roles in response. The ESMF through the SEP and ESMP seeks to mitigate these issues identified.

The SEP has been updated and redisclosed on the 11th of September 2020. Vaccines shall be allocated proportionally to ensure equitable access, fairness and considerable impact on morbidity and mortality. The vaccination will be deployed in the following manner:

Table 1: Models for reaching the target populations- Phases 1 and 2

PHASE	CATEGORY OF TARGET POPULATION	METHOD OF REACHING TARGET POPULATION
PHASE 1 Stage 1	Frontline Health Care Workers: Paramedics Rapid Response teams Nurses Doctors Laboratory staff Pharmacy staff Radiology staff Support staff Community health workers	Use all public and private health care facilities as vaccination sites • Vaccination sites in health facilities to be used for health education and promotion • Individual and group education about the vaccine observing social distancing • Use mobile site to reach senior policy makers
	Senior policy makers	
	Stage 2 Essential Workers: Police, Army, Correctional , Immigration ,fire fighter, officer and undertakers	Outreach and fixed vaccination sites
	People living in congregate settings	Outreach programme to all congregate settings that will not be vaccination sites. Work closely with correctional services for the inmates and their staff members.
	People over the age of 60 years	Outreach - Use elderly social grants pay points as vaccination sites or halls, churches and constituencies
PHASE 2	People over 18 years with comorbidities	Fixed and outreach sites-Use the health facilities where they collect their medicines and be vaccinated on the day of collecting their medicines
	People over the age of 18 years	Outreach, mobile and fixed (facility based) vaccination sites. People will be vaccinated in their geographical areas of residence, guided by RHMs in all the constituencies.
	Key Populations	Outreach, mobile and fixed (facility based) vaccination sites. People will be vaccinated in their geographical areas of residence, guided by

		RHMs in all the constituencies.
	*People below the age of 18 years	Outreach, mobile and fixed (facility based) vaccination sites. People will be vaccinated in their geographical areas of residence, guided by RHMs in all the constituencies.

The project plan to vaccinate a total of 343,000 people under the AF. The vaccine roll out will be linked to the project SEP. The Table 2 below shows the national vaccine coverage and purchase plan to be covered by the AF.

Table 2: Total Cost of the COVID-19 Vaccine at \$37.00 per dose

DIRECT COSTS	2021 Introduction	2022 Routine	2023 Routine
<i>A. Vaccine</i>	\$32,632,520	\$33,937,821	\$34,955,955
<i>B Injection Equipment and Logistics</i>	\$3,665,290	\$3,811,902	\$3,964,378
<i>C. Program Management</i>	\$855,552	\$889,774	\$925,365
<i>D. Cold Chain Expansion</i>	\$78,125	\$0	\$0
<i>E. Communication and Community Engagement</i>	\$160,967	\$167,406	\$174,102
<i>F. Service Delivery</i>	\$656,151	\$682,397	\$709,693
<i>G. EPI HR Capacity and T/A</i>	\$54,000	\$56,160	\$58,406
Grand Total in USD	\$38,102,605	\$39,545,459	\$40,787,899

Grievance Redress Mechanism

A grievance redress mechanism (GRM) is part of the project ESMF and SEP and has been established to resolve complaints and grievances in a timely, effective and efficient manner. Project related grievances can be submitted to the various GRCs and the procedures for filing complaints are clearly stated in the project's SEP. The GRM is accessible to all affected and interested parties for no cost and aims to minimize or avoid the need to resort to judicial proceedings. Grievances are handled at each health facilities and at the national level by a Grievance Redress Committee (GRCs) to be established by MoH and shall include a dedicated hotline to receive complaints.

Chapter 1 - BACKGROUND

1.1. Introduction

The COVID-19 emergency response project financed by the Bank will support the Kingdom of Eswatini effort to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness. The project will contribute and be implemented under the Coronavirus disease (COVID-19) Strategic Preparedness and Response Program (SPRP) using the Multiphase Programmatic Approach (MPA), approved by the World Bank's Board of Executive Directors on April 2, 2020. This project is prepared under the global framework of the World Bank COVID-19 Response financed under the Fast Track COVID-19 Facility (FTCF).

The Parent Project financing envelope was US\$6 Million. An additional financing of US\$5 million for COVID-19 vaccine deployment and a US\$3 million grant from the Health Emergency Preparedness and Response Multi-Donor Trust have been made available and thus the total financing envelope is US\$13.5 million. The closing date has been extended to March 31, 2024 to accommodate the additional activities. The primary objectives of the AF are to enable affordable and equitable access to COVID vaccines, help ensure effective vaccine deployment through enhanced vaccination system strengthening, and to further strengthen preparedness and response activities in the Kingdom of Eswatini. This ESMF has been developed due to lack of specific project locations and detailed information about the subprojects which could only be determined during implementation. Site specific impacts and risks could not be determined initially due to the nature of the project (being an emergency project) and its spatial influence (which is national). The Framework will therefore guide the Project Implementation Unit (PIU) and the Subproject Proponents on the E&S screening and subsequent subproject assessment during implementation, including subproject-specific plans in accordance with the ESF. This ESMF will apply during the implementation of component 1-3 and more especially to the construction, expansion, rehabilitation and/or operation of healthcare facilities, the deployment of a safe and effective vaccine in response to COVID-19, and in developing the environmental and social (E&S) management plans in accordance with the World Bank's Environmental and Social Framework (ESF).

The Framework includes procedures relevant to the development of the subprojects, including how to conduct screening of subprojects to assess the environmental risks and impacts and identify mitigation measures, as part of subproject-specific assessment and plans. It also contains measures and plans to reduce, mitigate and/or offset adverse risks and impacts, provisions for estimating and budgeting the costs of such measures, and information on the agency or agencies responsible for addressing project risks and impacts, including on its capacity to manage environmental and social risks and impacts. It includes high-level information on the area in which subprojects are expected to be sited, including any potential environmental and social vulnerabilities of the area; and on the potential impacts that may occur and mitigation measures that might be expected to be used. Once each subproject location is determined and potential environmental and social impacts are assessed, site-specific ESMPs will be prepared and implemented to manage any arising risks during pre-construction, construction and operation phases. This ESMF has benefited from the Stakeholder Engagement Plan (SEP) and other specific plans (such as ESCP, LMP, ESHS, etc.) that have been prepared for the Project. The Framework will be applied to all activities (works, good/services, technical assistance and research activities) to be financed by the Project and/or its subprojects.

The application and implementation of the ESMF therefore, will:

- Support the integration of environmental and social aspects into the decision-making process at all stages related to planning, design, execution, operation and maintenance of sub-projects, by identifying, avoiding and/or minimizing adverse environmental and social impacts early-on in the project cycle.
- Enhance the positive/sustainable environmental and social outcomes through improved/sensitive planning, design and implementation of sub-activities.
- Minimize environmental degradation as a result of either individual sub-projects or through their indirect, induced and cumulative effects, as much as possible.
- Avoid or minimize negative social impacts including impacts from land acquisition, or restriction to land use, labour influx to community health and safety to protecting and including in project benefits vulnerable and marginalized groups such as women, children, elderly and disabled persons in order to enhance social inclusion – for all groups of people.
- Minimize impacts on cultural heritage both tangible and intangible.
- Help identify vulnerable people and provide means to support their ability to access vaccine in inclusive and equitable fashion including mitigation measures to: i) to remove barrier to and ensure equitable and inclusive access to vaccine, ii) outreach and engagement plan with excluded and marginalized groups, iii) ensuring accountability and, iv) addressing exclusion.

Specifically, the Environmental and Social Management Framework includes the following:

- Information on Government of Eswatini 's environmental legislation, standards and policies and the World Bank Environmental and Social Standards that are applicable to the project;
- Process to be followed for environmental screening to guide decision-making about proposed sub-projects;
- Steps and process to be followed for conducting environmental and social assessment and preparation of Environmental and Social Management Plans for selected sub-projects;
- Preliminary assessment of anticipated environmental and social impacts in the context of broad/known project interventions;
- Generic environment and social management measures to avoid, minimize and mitigate anticipated impacts;
- Institutional arrangements for environment and social management, including monitoring and reporting;
- Information on most vulnerable and marginalized people;

The methodology applied during the development of this ESMF included:

- Literature review:
 - Applicable international and national standards, policies and regulatory framework;
 - Applicable International and National Agendas, Policies and Strategies;
 - Eswatini COVID-19 Emergency Response Project documents;
 - ESMFs from other projects in the country and beyond;
 - The World Bank ESMF Guidelines;
 - Relevant Environmental and Social Reports;

- Consultations with:
 - o Potential Project affected parties;
 - o Other Interested parties and
 - o Potential Disadvantaged and Vulnerable Individuals and Groups.
- Site visits to potential Health Care Facilities for observations:
 - o Lubombo Referral Hospital;
 - o Mavuso Trade Fair;
 - o National Quarantine Sites;
 - o Ports of Entry;
 - o Waste Disposal Facilities;
 - o Premises belonging to suppliers.

This ESMF includes guidelines for development and implementation of (i) an Infectious Control and Waste Management Plan (ICWMP) which will help strengthening the function of the existing health-care infectious control and waste management system including facilities and human capacity and establish the system for new provinces; (ii) Community Health and Safety measures; (iii) Labor Management Procedures (LMP); iv) guidance note on developing an inclusive national vaccine strategy; and (iv) an E&S risk management Capacity Building Plan. The ESMF also includes a social baseline and an analysis of key social risks of the project, including the risk of the most vulnerable not being able to access project benefits - vaccine. Gender and climate change plans are also included in the ESMF.

The ESMF will be an “up-to-date” or a “living document” enabling revision, when and where necessary. Unexpected situations and/or changes in the project or sub-component design would therefore be assessed and appropriate management measures will be incorporated by updating the ESMF. Such revisions will also cover and update any changes/modifications introduced in the legal/regulatory regime of the country/ state. Also, based on the experience of application and implementation of this framework, the provisions and procedures would be updated, as appropriate in consultation with the World Bank and the implementing agencies/departments.

The Parent Project was launched in April 2020 and it supports the National Contingency Response Plan and significant progress towards meeting the project development objective (PDO) has been made with 76.05% (US\$4.56 million) of the total funds (US\$6 million) disbursed to date. Currently, the implementation progress is rated as *moderately satisfactory*. The personal protective equipment procured through Bank Facilitated Procurement has been fully delivered and payments were made to both the supplier and World Food Program for transportation. Several other contracts had also been signed: (a) two out of 10 4X4 vehicles were delivered and eight will be delivered by end of February 2021; (b) contract for procurement of ambulances is signed; (c) installation of HVAC system at the Raleigh Fitkin Memorial Hospital intensive care unit and renal wards is ongoing; (d) WASH consumables have been delivered and plumbers have been hired in 14 facilities; and (e) tablets for field work had been delivered. The use of STEP has improved; out of 15 activities, 10 have road maps fully populated to signed contract stage and, five are pending implementation and are behind schedule. The Procurement risk is assessed as *Moderate* and performance rating is *Moderately Satisfactory*.

The environmental and social safeguards performance of the project is *Satisfactory*. The Environmental and Social Management Framework (ESMF) and Stakeholder Engagement Plan (SEP) to manage and mitigate the project risks and impacts have been updated with components relating to the additional financing (AF) for vaccines. Both these plans which now serve the parent COVID and the AF project(s) will be re-disclosed in February 2021. In compliance with the WB’s ESS-10, a project specific GRM has been

set up by the PIU to handle concerns, complaints, suggestions and questions raised by project affected people, and all stakeholders. The GRM will serve all the WB supported projects. It builds on an existing national COVID-19 Hotline that is already operational with timelines within which disputes must be resolved and additional channels to improve access allowing for in person complaints and email complaints. As the PIU technical role of the Social Officer is being shared between the COVID-19 ERP and HSS4HCDP, it was strongly recommended that the PIU hire an additional social specialist to support the PIU, primarily in ensuring that the GRM is effective and can be managed and monitored on an ongoing basis. However, this recommendation was denied in favor of an MoH officer to play that role. A Communications Officer will be engaged (to cover both projects) to elevate the profile of the projects and recognition of its impact.

The implementation of the project has not been without challenges. Table 3 below summarizes the challenges and lessons learnt:

Table 3: Challenges and lessons Learnt in the Parent Project

Challenges	Lessons Learnt
- Outdated procurement plan due to delayed approvals and actioning of items using other donor funds	- Improved approval process in step for efficient use of resources
- Unclear budget allocation for E&S activities	- Developed an action plan with budget for E&S activities
- Increasing number of cases which ultimately over-stretch the health system;	- Vaccination must be prioritized - Capacitating of the COVID-19 Wing at Lubombo National Referral Hospital and procurement of additional equipment and material
- Continued infection of health workers;	- IPC investigated the problem and the general finding was that health workers are negligent
- Supply chain challenges when procuring supplies; Market cannot meet demand (IPC products)	- Early procurement and establishment of larger inventory/storage facilities
- No Isolation Camps at the Ports of entry. The available ones (which were tents) are missing	- Procure semi-permanent structures to serve as isolation camps at ports of entry.
- Increased pressure on Waste Management System due increase in waste volumes and depreciation of waste treatment facilities	- Need to install/replace 2 Incinerators at 2 locations - Procure additional waste receptacles - Procure 2 additional vehicles to support collection - Funding to procure fuel for Incinerators

	- Funding for repairing incinerator parts - Monitoring of emissions from Incinerator
- There was no clear command structure for the operational Health Sector to ensure leadership and coordination of the COVID-19 response	- A proper organizational leadership and coordination that is in line with the WHO Incident Management System. - An Incident Management Team led by a senior MOH official as Incident Manager was appointed and integrated
- Lack of a system to enable data integration	- Need for a comprehensive data management system that will incorporate all areas of data generation
- The surveillance and rapid Response operational structure is not clear	- Develop a proper operational structure for Rapid Response Team
- Non-compliance on rational use for PPEs	- IPC has to train staff in health facilities on the appropriate
- Inadequate PPE commodities for health workers and frontline staff	- Procure and timely supply essential items for COVID-19 IPC
- Health promotion is short staffed, and it affects provision of service	- Need to recruit additional human resource for Health Promotion Unit to enhance communication

Chapter 2 - PROJECT DESCRIPTION

2.1 Project Objective

The Program Development Objective (PDO) is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Eswatini.

2.2 Project Components

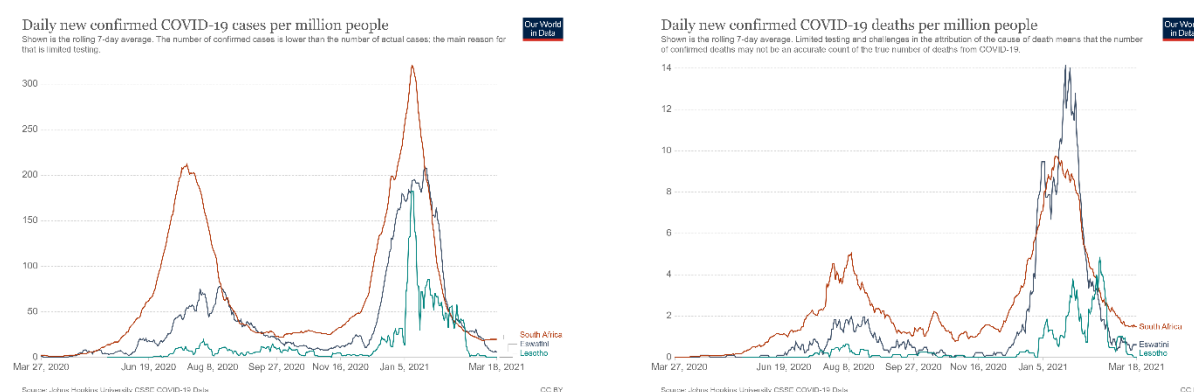
The Parent Project components are aligned with the objectives of the COVID-19 SPRP and comprise two components: (1) Emergency COVID-19 Response; and (2) Implementation Management and Monitoring and Evaluation. The components aim to strengthen Eswatini's health system preparedness to respond to the COVID-19 emergency and potential future emergencies. The components will include climate-change adaptation measures and will address gender issues, as necessary. The proposed project will be financed by an IBRD loan totaling US\$13.5 Million, using an IPF instrument under the MPA. The closing date has been extended to March 31, 2024 to accommodate the additional activities.

The AF entail expanding the scope of activities in the parent project, the Eswatini COVID-19 Emergency Response Project and adjusting its overall design. An increase in scope and cost will be required to support: (i) vaccine and drug purchase; (ii) upgrading the cold chain for the vaccines; (iii) strengthening service delivery to ensure effective vaccine deployment; and (iv) monitoring, tracking of vaccines use and recording of any adverse reactions to vaccination. Additional financing is also required to extend the testing, PPE, and sustained communications and promotions around NPIs which are essential to sustain throughout the vaccine roll-out. Furthermore, a new component has been added for activities to strengthen capacity in preparedness for future health emergencies supported by the HEPRTF grant. As the proposed activities to be funded under the AF for the Eswatini COVID-19 Emergency Response Project are aligned with the original PDO, the PDO would remain unchanged.

1. Component 1: Emergency COVID-19 Response (US\$5.5 million initially, and US\$ 4.5 million for additional financing. Total of US\$10.0 million). Eswatini recorded the first case of COVID-19 on 13th March 2020. Subsequently, His Majesty King Mswati III invoked section 29 of the Disaster Management Act 2006 and declared the COVID-19 pandemic a National Emergency in the Kingdom of Eswatini from the 17th of March 2020. Even though the country is implementing comprehensive public health measures – such as rapid case identification, rapid testing and isolation of cases, comprehensive contact tracing and quarantine of contacts – the country has not managed to suppress the spread of COVID-19. Eswatini has sadly incurred losses at a high level in Government when the Prime Minister Ambrose Dlamini died in December 2020 due to COVID-19 complications. The loss of the Prime Minister and two other members of Cabinet has increased awareness within Eswatini and beyond. As of March 17, 2021, the country of 1.16 million had recorded 17,257 confirmed cases, and 663 deaths, figures which show a sharp escalation from the previous months, surpassing the July 2020 peak of both daily confirmed cases and deaths (Figure 2.1). The Eswatini situation mirrors observations made in neighboring South Africa, where a large second wave unfolded at a concerning rate, exacerbated further by the December holidays and the spread of a new variant of concern, the B.1.351, which is likely to be highly transmissible, quickly

becoming the predominant variant in South Africa³. As of March 2, 2021, it has been identified in 56 countries, including Botswana, Ghana, Kenya, the French Indian Ocean region of Mayotte, Zambia, Malawi, Tanzania, and other non-African nations^{4,5}. The B.1.351 variant was also common in Eswatini in a recent genomic surveillance, given its close proximity and economic linkages with South Africa. While there are signs the second wave is abating, there is a continuing risk of increased escalation of the epidemic. In addition to the increased transmission, the B.1.351 variant is of immense concern due to its potential for vaccine escape. It will be critical for Eswatini to quickly scale up effective and safe vaccines while continuing to strengthen the overall COVID-19 response. Eswatini has an established relationship with South Africa for the sharing of medicine product registration information. Due to South Africa's more developed medicines and related products registration capacity, it is able to share information with the Eswatini MOH on items that have either been approved or rejected and the reasons thereof. The collaboration is being implemented for vaccines.

Figure 2.1. Daily New Confirmed COVID-19 Cases and Deaths per Million People



Eswatini is not adequately equipped to respond to a global pandemic of this nature and this magnitude. Moreover, while the population is concentrated in the valleys, 75% of people live in rural areas; the mountainous terrain of the country makes it difficult for the population to access health facilities⁶. Eswatini currently has 11 hospitals and five health centers that provide secondary care, providing an average of 2.1 hospital beds per 1000 population (compared to an average of 2.4 and 4.1 beds per 1000 population in low- and middle-income countries and high-income countries respectively). Only three hospitals have intensive care units (ICUs) namely Mbabane Government Hospital (MGH), the Lubombo National Referral Hospital and Raleigh Fitkin Memorial Hospital (RFMH), a mission hospital, all providing a total of 14 ICU beds.

The Ministry of Health has come up with a potential list of Health Facilities and Centres that will be

³ Tegally H., Wilkinson E., Giovanetti M., et al. Emergence and rapid spread of a new severe acute respiratory syndrome-related coronavirus 2 (SARS-CoV-2) lineage with multiple spike mutations in South Africa. medRxiv 2020.12.21.20248640; doi: <https://doi.org/10.1101/2020.12.21.20248640>

⁴ CDC Africa region

⁵ <https://www.who.int/publications/m/item/weekly-epidemiological-update---2-february-2021>

⁶ United Nations. 2020. ECONOMIC SITUATION REPORT #1—COVID-19. United Nations, Mbabane

supported under the project according to the administrative regions. In response to the Pandemic the Government of Eswatini has developed and established a National Contingency Response Plan and a National Vaccine Deployment Plan. Both plans set out activities, responsibilities, timeframes, budgets and suitable institutional arrangement for implementation. The MOH has gone ahead to identify potential health care facilities for quarantine, isolation, treatment and vaccination purposes in all four regions of the country. These include 1x National Referral Hospital, 3x Regional Hospitals, 5x Health Centres, 3x Private Clinics, 2x Isolation Centres, 1x EMS Centre and 1x Quarantine Centre. These are located in the 4 administrative regions of the country and they include Mbabane Government Hospital, Mbabane Clinic, Malagwane EMS, Piggs Peak Government Hospital, Emkhuzweni Health Centre, Dvokolwako Health Centre in the Hhohho Region; Raleigh Fitkin Memorial Hospital, Mankayane Government Hospital, Manzini Clinic, Luke Commission, Zakhele Treatment Centre and Mavuso Trade Centre in the Manzini Region; Lubombo National Referral Hospital, The Good Shepherd Hospital and Sithobela Health Centre in the Lubombo Region; and Hlathikhulu Government Hospital, Nhlangano Health Centre and Matsanjeni Health Centre in the Shiselweni Region. The National Laboratory within the Mbabane Government Hospital was identified for upgrading to test for COVID-19. To respond to the Pandemic, a range of functional and technical enhancements have to be implemented in these centres. These enhancements include minor rehabilitations, procurement of equipment and material, reagents, IPC material and equipment. No major civil works are expected in this project, only minor renovation or rehabilitation of existing health facilities. The minor civil works include Air Conditioning Rehabilitation and Plumbing reconditioning in certain health facilities.

Most of these facilities (especially the hospitals and Health Centres) have a working health care waste management system with suitable facilities and personnel. There are however challenges in the management and these include lack of fuel for operation of incinerators, breakdowns due to poor maintenance and depreciation, lack of waste containment, waste not being segregated, treated and disposed of correctly in some facilities leading to unsafe and environmental risky conditions; there are no responsible persons designated for the management of waste in some healthcare facilities and in rural areas general waste is not collected from the premises of the health facilities. One (1) Local Authority (Mbabane) where the centres are located has a well-designed landfill for waste, the rest have controlled waste dumpsites. The quarantine and isolation centres will need a well-designed health care waste system and will have to be integrated into the central infectious waste collection schedule by the Environmental Health Department.

This component will therefore provide support to Eswatini to minimize the risk of further imported cases and limit local transmission through containment strategies. It will support the implementation of Eswatini's COVID-19 National Contingency Plan in close coordination and with strong support from UN agencies and other partners. This component will support: (i) strengthening COVID-19 case detection, confirmation, case tracing, recording and reporting. The component will also support (ii) health systems strengthening for COVID-19 preparedness planning and (iii) improving the implementation of social distancing measures and strengthening communication preparedness. The support for vaccines will be scaled up as part of the containment and mitigation measures to prevent the spread of COVID-19 and deaths under Component 1: Emergency COVID-19 Response. An increase in the scope of the component has been made to accommodate COVID-19 Vaccine Deployment. This will include (i) vaccine and drug purchase; (ii) upgrading the cold chain for the vaccines; (iii) strengthening service delivery to ensure effective vaccine deployment; and (iv) monitoring, tracking of vaccines use and recording of any adverse reactions to vaccination. The delivery strategy for the COVID-19 vaccine that shall be used to achieve the highest possible coverage include: i) Fixed Health Facility Based: This approach shall extend COVID-19

vaccination to eligible health workers; ii) Fixed Health Facility, Outreach, Temporary/mobile clinics: This strategy shall intend to cover targeted older population and persons with underlying medical conditions; iii) Mass campaign Mode: This shall be in a form of a campaign for other target essential workers, social employment groups unable to social distance, age groups of high risk to transmit disease, border protection staff and travelers. The rest of the financing will continue activities under the parent project including management of health care waste and infection prevention and control.

(1) Strengthen COVID-19 Case Detection, Confirmation, Contact Tracing, Recording, and Reporting. The project will provide technical assistance and procure goods and equipment to (i) strengthen disease surveillance systems and the in-country testing capacity through scale up of rapid near patient molecular testing and other testing technology – including engaging the private sector – as appropriate and strengthening of health facilities and the National Reference Laboratory (NRL) (and other public health laboratories as deemed necessary) in specimen collection, packaging, storage, shipment and epidemiological capacity for early detection and confirmation of cases; (ii) combine detection of new cases with active contact tracing; (iii) support epidemiological investigation; (iv) strengthen risk assessment; (v) strengthen screening, isolation and follow up of travelers at point of entry; and (vi) provide on-time data and information for guiding decision-making and response and mitigation activities.

(2) Health System Strengthening for COVID-19 Preparedness Planning. Technical and financial assistance will be provided to the health care system for preparedness planning to provide optimal medical care, maintain essential community services and to minimize risks for patients and health personnel, including training health facilities' staff and front-line workers on risk mitigation measures and providing them with the appropriate protective equipment, as well as with water supply, sanitation and hygiene materials, and health care waste management services. Strengthened clinical care capacity will be achieved through financing plans for establishing specialized units in selected hospitals, treatment guidelines, clinical training of health workers and hospital infection control guidelines. Local containment will be supported through the establishment of local isolation units in hospitals. Widespread infection control training and measures will also be instituted across health facilities and ambulances. As COVID-19 would place a substantial burden on inpatient and outpatient health care services, support would be provided for temporary surge capacity for service delivery, reorganizing and repurposing/equipping the Lubombo National Referral Hospital and the RFM hospital to increase ICU capacity, as well as other selected sites as deemed necessary, for the delivery of critical medical services and to cope with increased demand of services posed by the outbreak, develop intra-hospital infection control measures, and procure ambulances fully equipped for highly infectious diseases.

(3) Improve Implementation of Social Distancing Measures and Strengthen Communication Preparedness. The project will provide technical assistance to support improvements in the implementation of 'social distancing measures' already in place in country by developing a well-designed communication strategy targeting parents, traditional and religious leaders and the general public, guidelines for the management of at risk groups such as guidelines for elderly isolation and pension pick-up, and guidelines for alternative drug pick-up for people living with HIV and other chronic conditions. It is important to clarify that the World Bank will not support the enforcement of social distancing measures when they involve actions by the police or the military, or otherwise that require the use of force. The project will also provide technical and financial assistance for behavior change communication activities that will support cost-effective and sustainable methods such as promotion of handwashing, food hygiene, and safe water practices through various communication channels via mass media, counseling, schools, workplace, and integrated into specific interventions as well as ongoing outreach activities of ministries and sectors, especially ministries of health, education, agriculture, and transport. In coordination with other development partners, complementary support will be provided for information

and two-way communication activities to raise awareness, knowledge and understanding among the general population about the risk and potential impact of the pandemic. Community mobilization will take place through trained community health workers and community volunteers, religious leaders and traditional healers. In addition, support will be provided for: (i) the development and distribution of basic communication materials (such as question and answer sheets and fact sheets in Siswati on COVID-19, and (ii) general preventive measures such as “dos” and “don’ts” for the general public; (iii) information and guidelines for health care providers; (iv) training modules (web-based, printed, and video); (v) presentations, slide sets, videos, and documentaries; and (vi) symposia on surveillance, treatment and prophylaxis. Activities related to improving implementation of social distancing measures and strengthening communication preparedness shall be linked to the project’s SEP and its mode of virtual and face-to-face communication strategy as it deems appropriate.

(4) COVID-19 Vaccine Deployment. The project will also support the deployment of a COVID-19 vaccine for Eswatini. The support for vaccines when available, which was anticipated in the initial Global COVID-19 MPA, will be added as part of the containment and mitigation measures to prevent the spread of COVID-19 and deaths under Component 1: Emergency COVID-19 Response. As one of 92 countries eligible to receive donor-financed vaccines under the COVAX-AMC mechanism, Eswatini will access vaccines to cover 20 percent of its population. A request to access vaccines through the COVAX AMC was submitted to Gavi on December 7, 2020. Based on the information currently available and given market unpredictability and the size of the country limiting Eswatini’s negotiating power, the COVAX Facility is expected to be the main mechanism to purchase COVID-19 vaccines for doses beyond the initial 20 percent of the population. However, the country is exploring other direct purchase options, as approved by the Board, to procure additional vaccines beyond what is offered by the COVAX AMC, including: (a) from vaccine manufacturers, either individually or jointly with other countries; and (b) from countries that have reserved excess doses. Also, the GoKE is in discussions with partners and organizations for in-kind contributions of COVID vaccines. The World Bank will support the MOH in considering the options to access vaccines, and the GoKE will ultimately decide which options to use. Use of project resources for vaccine purchases will be acceptable to the World Bank if World Bank’s vaccine approval criteria are used.

To support the Government’s vaccination planning, the AF will finance upfront technical assistance to support Eswatini to establish institutional frameworks for the safe and effective deployment of vaccines. These will include: (a) upgrading regulatory standards at the national level, including pharmacovigilance, and authorization mechanisms; (b) preparation of appropriate minimum standards for vaccine management including cold chain infrastructure (with financing for the investment to meet those standards as described), with a focus on climate friendly cold chain; and (c) creation of accountability, grievances, and citizen and community engagement mechanisms. AF for Component 3 of the parent project would support the continued coordination and management of project activities. Further, this component will strengthen existing data and monitoring systems (immunization and public health) to accommodate the monitoring of COVID-19 vaccines deployment and therefore improve data collection, analysis, reporting and use of data for action and decision-making. Vaccine deployment and planning support will incorporate strengthening the country’s ability to respond to vaccine preventable diseases cause by climatic events.

The AF will support investments to bring immunization systems and service delivery capacity to the level required to successfully deliver COVID-19 vaccines at scale, through Components 1 and 3 of the project. To this end, the proposed AF is geared to assist the GoKE, working with WBG, WHO, UNICEF, GAVI and other technical partners, to overcome bottlenecks as identified in COVID-19 vaccine readiness assessment in the country (see table 1). The AF will support Eswatini to address these critical gaps,

through inter alia: (a) strengthening of planning and management of vaccination plans, regulations and standards, M&E and budgeting; (b) procurement, supply and distribution of COVID-19 vaccines, energy efficient cold storage technologies and other goods, services and operating costs necessary for safe immunization service delivery; and (c) supporting program delivery, including risk communication and advocacy, training of health personnel, supervisory activities, transport and logistics, climate sensitive medical waste management, and upgrading of existing management information systems for registration and enhanced surveillance systems to accommodate COVID-19 vaccines including for the tracking of AEFI. Component 1 will also continue supporting the activities under the parent project including management of health care waste and infection prevention and control.

The AF will support the population groups as summarized in Table 2.1 below. As indicated in the NDVP for COVID-19, the GoKE aims to vaccinate its population in a phased manner, first prioritizing the populations at highest risk of COVID-19.

Table 2.1. Priority populations for receiving the COVID-19 vaccine in Eswatini (as identified in the NDVP as of Feb 2021)

Priority population	Population group to be covered	Share of population	Number of populations
1.	Frontline health workers, including non-clinical staff at the frontline and Community Health Volunteers and Senior Policy Makers	3%	34,810
2.	Essential Workers (Army, Police, Correctional, Fire-fighting), Elderly (60 years and above) and people with comorbidities and people living in congregate settings	17%	197,261
3.	Other essential and priority groups and groups above and below the age of 18.	60%	696,217

The plan is to vaccinate a total 343,000 people in two phases. This will include (i) vaccine and drug purchase; (ii) upgrading the cold chain for the vaccines; (iii) strengthening service delivery to ensure effective vaccine deployment; and (iv) monitoring, tracking of vaccines use and recording of any adverse reactions to vaccination. Eswatini's health system has established expertise and skills for childhood immunizations, which creates a strong foundation, but modifications will be required to vaccinate a large number of adults in a short time period. COVID-19 vaccines are aimed at a larger proportion of the total population and will need to be deployed within a short time period in order to have the public health impact required to reduce the burden on health and the economy. Even if implemented in a phased manner, an intense focus on expanding immunization capacity is necessary to ensure that the health system can effectively implement a comprehensive COVID-19 vaccine deployment strategy. This includes a critical assessment and actions to ensure functional, end-to-end supply chain and logistics management systems for effective vaccine deployment. The large number of staff and temporary volunteers required to perform the vaccination will need orientation and training. Likewise, large-scale

communication and outreach campaigns, which will target household, community and national stakeholder including the political leadership, will be needed to ensure robust governance, accountability, and citizen engagement mechanisms. People-centered, innovative modes of communication will be required to counter any vaccine resistance and ensure the program can reach the hard to reach. National and local roll-out plans will be prepared which also include adequate monitoring as well as safe disposal of sharps and other biological wastes. This AF will support the GoKE's vaccine deployment up to 30 percent of the target population (.34 million), which represents 55 percent of the adult population (above 18 years of age), subject to availability of vaccines and supplies for deployment.

As guided by WHO, the Kingdom of Eswatini will follow Strategic Advisory Group of Expert (SAGE) policy as recommendation and use available doses for target groups defined by SAGE. The country is a participant in the COVAX Facility as an AMC Group Participant. Eswatini will follow the COVID-19 vaccine allocation on fair allocation planned in two phases.

Phase 1: Vaccines shall be allocated proportionally as follows:

i. Stage 1: Initially cover 3% of the national population.

The MOH aims to initially provide access to vaccines to cover 20 percent of the population. The focus will be on priority populations, starting with an initial 3 percent coverage targeting senior policy makers and frontline healthcare workers including non-clinical staff at the frontline and Community Health Volunteers. It is anticipated that this initial allocation will be for senior policy makers to promote uptake and frontline health workers who are at high risk (close contact with patients) both public and private. By choosing to set a 3% benchmark, as guided by WHO the MoH wants to ensure that volumes meet the needs of the target populations of health workers at risk. According to CSO the projected population for 2021 is 1 145 4040.

Phase 1 will target front line health workers (about 8,000 clinical and non-clinical staff and 5,000 Community Health Volunteers) Eswatini defined its health workers, including in the private sector, who are at higher risk of COVID-19 infection than the general population due to the nature of their work, and more likely to be affected by COVID-19. In addition, health workers infected with COVID-19 may contribute to health care-associated infection transmission of infection to their patients and people they care for, including those at high risk for developing severe COVID-19 disease and complications. To ensure targeted use of COVID-19 vaccination of health workers in different settings of the kingdom of Eswatini (e.g. primary health care facilities, hospitals, long-term care facilities) and to address potential uptake issues, a National Health and Safety Policy and the EEPI: the classification of different health worker categories based on assessment of risk; the policy for vaccination for each category; and strategies for managing non-compliance of health workers.

ii. Stage 2: Incremental shipments to reach a further 17% of a country's population will follow.

It is anticipated that this will likely be for elderly people and individuals with comorbidities on evidence-based information. Eswatini defines its elderly people by age-based risk specific to the Eswatini (60 years and above) and those with comorbidities who are at high risk of serious health outcomes and mortality due to COVID-19. According to STEPS (2014) the burden of hypertension and type 2 diabetes as comorbidities of COVID-19 is extremely high in the population. The majority people living with NCD in Eswatini (>80%) are undiagnosed resulting to complications

such as Kidney disease. Other groups that could be considered at this phase are the most exposed and vulnerable populations, including essential workers whose professions leave them most exposed (e.g., those working in abattoirs (# to be determined), and those in high-population density locations, such as prisoners and staff (3,500 estimated).

Phase 2: The NDVP for COVID-19 (January 2021) targets 60 percent of the population to receive COVID-19 vaccines during this stage, taking into consideration the uncertainties around herd-immunity and impact of the COVID-19 vaccination on disease transmission. The country is intending to cover an additional 60% of the total population which shall include vulnerable populations as well as those above 18 years without comorbidities. Specific considerations will include but not limited to gender, socioeconomic status, residents in long-term care facilities, those living in informal settlements, LGBTI, people living with disabilities, refugees, Key populations, homeless persons, asylum seekers, marginalized ethnic or religious groups, those affected by humanitarian emergencies, and other hard-to-reach population groups. Eswatini has an immunization delivery system and the required infrastructure is in place to ensure equitable access to COVID-19 Vaccines for these vulnerable populations. Individuals less than 18 years will also be considered in this phase as more evidence on efficacy and safety in this population becomes available.

The MoH will ensure that communities are engaged in a transparent manner and that the public is made aware of the identification criteria and how doses are administered. This will ensure that there is a clear communication strategy explaining the selection of the priority groups and why certain groups are not receiving the vaccine. Eswatini will use the WHO SAGE values framework which contain lists of over 20 subgroup populations that, if prioritized, would advance one or more of the principles and objectives identified within the framework. Eswatini will use the following six guiding principles: human well-being, global equity, reciprocity, equal respect, national equity and legitimacy, to determine who should be given the vaccines, and when. Following guidance on the SAGE prioritization roadmap and with the Eswatini-specific nuances in epidemiological settings and different levels of vaccine availability, these priority groups will need to be further interpreted at all levels and the MoH will lead this process in wide consultation with key stakeholders.

The delivery strategy for the COVID-19 Vaccine that shall be used to achieve the highest possible coverable include:

- Fixed Health Facility Based: This approach shall extend COVID-19 vaccination to eligible health workers;
- Fixed Health Facility, Outreach, Temporary/mobile clinics: This strategy shall intend to cover targeted older population and persons with underlying medical conditions;
- Mass campaign Mode: This shall be in a form of a campaign for other target essential workers, social employment groups unable to social distance, age groups of high risk to transmit disease, border protection staff and travellers.

Table 2.2 below summarizes the vaccination strategies to be applied by Eswatini:

Table 2.2: Models for reaching the target populations- Phases 1 & 2

PHASE	CATEGORY OF TARGET POPULATION	METHOD OF REACHING TARGET POPULATION
PHASE 1 Stage 1	Frontline Health Care Workers: Paramedics Rapid Response teams Nurses Doctors Laboratory staff Pharmacy staff Radiology staff Support staff Community health workers	Use all public and private health care facilities as vaccination sites • Vaccination sites in health facilities to be used for health education and promotion • Individual and group education about the vaccine observing social distancing • Use mobile site to reach senior policy makers
	Senior policy makers	
	Stage 2 Essential Workers: Police, Army, Correctional, Immigration, fire-fighter, officer and undertakers	Outreach and fixed vaccination sites
	People living in congregate settings	Outreach programme to all congregate settings that will not be vaccination sites. Work closely with correctional services for the inmates and their staff members.
	People over the age of 60 years	Outreach - Use elderly social grants pay points as vaccination sites or halls, churches and constituencies
PHASE 2	People over 18 years with comorbidities	Fixed and outreach sites-Use the health facilities where they collect their medicines and be vaccinated on the day of collecting their medicines
	People over the age of 18 years	Outreach, mobile and fixed (facility based) vaccination sites. People will be vaccinated in their geographical areas of residence, guided by RHMs in all the constituencies.
	Key populations	Outreach, mobile and fixed (facility based) vaccination sites. People will be vaccinated in their geographical areas of residence, guided by RHMs in all the constituencies.

	*People below the age of 18 years	Outreach, mobile and fixed (facility based) vaccination sites. People will be vaccinated in their geographical areas of residence, guided by RHMs in all the constituencies.
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Component 2: Strengthening Capacity in Preparedness for health emergencies (additional financing of US\$3 million) Supports the strengthening of Eswatini's capacity in preparedness for health emergencies, including: (i) strengthening the surveillance system and enhancing analytical capacity for real-time rapid reporting and analysis of surveillance data; (ii) supporting simulations to regularly evaluate and enhance health emergency preparedness; (iii) preparing and equipping the health system and facilities to respond to future health emergencies; and (iv) strengthening capacity for national health emergency rapid procurements. To support the Government's vaccination planning, the AF will finance upfront technical assistance to support Eswatini to establish institutional frameworks for the safe and effective deployment of vaccines. These will include: (a) strengthening the surveillance system and enhancing analytical capacity for real-time rapid reporting and analysis of surveillance data; (b) supporting simulations to regularly evaluate and enhance health emergency preparedness; (c) preparing and equipping the health system and facilities to respond to future health emergencies; (d) strengthening capacity for national health emergency rapid procurements; and (e) strengthening capacity of frontline health workers to respond effectively to victims of violence through a training program that incorporated good practices.

Financing from the Health Emergency Preparedness and Response Trust Fund (HEPRTF) of US\$3 million complements the IBRD Additional Financing and strengthens the project's likelihood of attaining the PDO by supporting:

- Strengthening surveillance: expanding and linking existing surveillance systems; piloting advanced geo-enabled surveillance platforms and early warning systems; strengthening surveillance at ports of entry; community-based surveillance through development and use of social listening tools and the monitoring of information channels, to detect and rapidly respond to health emergencies; build institutional capacity at the health facility, regional and national levels for surveillance and advanced data analytics, interpretation and use; and institutionalizing traceability of medical countermeasures to improve: i) distribution to end-users; ii) prevent diversion; iii) identify false and sub-standard products; and (iv) monitor adverse events following immunization (AEFI) for all national vaccines under the expanded program for immunization (EPI).
- Health emergency simulations at national, regional and local levels to test operational readiness and build human resource capacity to strengthen preparedness to health emergencies.
- Health system and facility capacity for health emergency preparedness: strengthen health management and information systems to accommodate health emergency preparedness; digital solutions including use of GIS mapping; and collaboration mechanisms with the private sector.
- Expedited procurement of medical countermeasures in an emergency: quantification and forecasting of supply needs; national health emergency budgeting and budget tracking capacity; coordination

between national health and finance authorities; streamlining of budget execution processes; and support flexible procurement processes, product registration, and streamlined customs procedures.

- Strengthening capacity of frontline health workers to respond effectively to victims of violence through a training program that incorporated good practices.

Component 3: (Component 2 in parent project): Implementation Management and Monitoring and Evaluation (current allocation US\$0.5 million; proposed additional financing of US\$0.5 million for a total of US\$1.0 million). Support for the strengthening of public structures for the coordination and management of the project will be provided, including central and local (decentralized) arrangements for coordination of activities, financial management (FM) and procurement. The MOH's implementation team will be strengthened through capacity building and recruitment of consultants responsible for overall administration, procurement, Environment and Social safeguards and FM of the project. To this end, the project will support costs associated with project coordination. This component will support the M&E of prevention and preparedness, building capacity for clinical and public health research, and joint learning across and within countries. This component will support training in participatory M&E at all administrative levels, evaluation workshops, ESF/ESSs, and development of an action plan for M&E and replication of successful models. Additional financing for Component 3 of the parent project would support the continued coordination and management of project activities. Further, this component will strengthen existing data and monitoring systems (immunization and public health) to accommodate the monitoring of COVID-19 vaccines deployment and therefore improve data collection, analysis, reporting and use of data for action and decision-making.

In establishing the E&S risk classification for each subproject, the Project Implementation Unit (PIU) will use the form in Annex 3 screen for the potential environmental and social risks and impacts of a proposed subproject. The form will assist the PIU in identifying the relevant Environmental and Social Standards (ESS), establishing an appropriate E&S risk rating for these subprojects and specifying the type of environmental and social assessment required, including specific instruments/plans. It will assist to form an initial view of the potential risks and impacts of a subproject. It is important to note that given the project focus is on immediate priority activities, the project should avoid activities or subproject with complex environmental and social aspects, and the items and activities identified in Table 2.2 below are ineligible for financing by the project.

Table 2.2: Ineligible Activities to be financed by the Project

• Any major construction works • Activities that may cause long term, permanent and/or irreversible (e.g., loss of major natural habitat) adverse impacts; • Activities that have high probability of causing serious adverse effects to human health and/or the environment not related to treatment of COVID19 cases; • Activities that may have significant adverse social impacts and may give rise to significant social conflict; • Activities that may affect lands or rights of vulnerable minorities; • Activities that may involve permanent resettlement or land acquisition or adverse impacts on cultural heritage; • All other activities excluded under the ESMF of the Project.

Project Area and Beneficiaries

The project will be implemented countrywide. The expected project beneficiaries will be the population at large given the nature of the disease more especially infected people, at-risk populations, particularly the elderly and people with chronic conditions including HIV, medical and emergency personnel, medical and testing facilities, and public health agencies engaged in the response. Table 2.3 below details the project beneficiaries and relevant benefits.

Table 2.3 Summary of Project Beneficiaries and Benefits

Project Beneficiary	Analysis	Project Benefit
1. Eswatini Government	The GoKE was not prepared for the COVID-19 Pandemic hence there was no specific budget set aside for emergency response. Emergency funding was needed by GoKE to respond to the Pandemic.	- Funding (US\$14 Million, US\$3Million is a grant)
2. Health System/Facilities - MoH - Emergency Coordination Committee - Hospitals - Health Centres and clinics - Isolation Centres (Mavuso, Zakhele) - Ports of Entry - Quarantine Sites - Rapid Response Teams - National Laboratory - Environmental Health Department	The Eswatini health system was not prepared to respond to the COVID-19 Pandemic. While MoH administers vaccination to minors, the capacity to administer vaccination to adults and in large numbers within a short period is limited. It therefore needs strengthening to cope with the Pandemic and capacity to vaccinate adults and large numbers within a limited period.	The project is therefore assisting to strengthen case detection, confirmation, contact tracing, recording and reporting. The project is also assisting in the strengthening for COVID-19 Preparedness Planning, Improve Implementation of Social Distancing Measures and Strengthen Communication Preparedness and Vaccine Deployment. Specific benefits include: - Upgrading of National Laboratory to test for COVID-19 - Rehabilitation of Hospitals - Procurement of equipment and Material for Hospitals and Response Teams - Continual Training of health personnel on the Pandemic - Engagement of EHOs and Hospital Staff on short term contracts - Expansion of surveillance systems - Emergency Response Simulations during emergency - Strengthening health management and information systems - Expedited procurement of medical countermeasures in an emergency - Promotion of sanitation and hygiene
3. Health personnel	Eswatini has a total of 13774 Health	- Prioritized Vaccination

- Hospital staff (Doctors, Nurses, Orderlies etc) - IPC Personnel - Community Health Care Workers - EHOs	care workers (8774 clinical and non-clinical and an additional 5000 community health care workers). The health personnel within the health system have limited capacity to respond to the Pandemic. Laboratory, Rapid Response Teams, Hospital Staff, Environmental Health Officers needed to be capacitated to respond to the Pandemic. they are at high risk of contracting infection, severe disease and transmitting to vulnerable individuals including patients and family members. They need to be protected against infection and be provided psychological assistance as they respond to the Pandemic	- Training or upskilling to cope with Pandemic - PPE, Sanitizers - Psychological support/ Wellness - Exclusive Isolation Centre for Frontline Workers (Siteki Hotel) - Education on sanitation and hygiene
4. Infected People	A total of 16, 505 confirmed cases have been reported to date. All these individuals need medical attention, vaccination, space and a functional health care system.	- Prioritized vaccination - Isolation camps - Hospital treatment - Home-based care - Education on prevention against COVID-19 - Education on sanitation and hygiene
5. Elderly People	Individuals above 60 years are at high risk of serious health outcomes and mortality due to COVID-19. Therefore, these individuals need special attention pre-, during and post treatment.	- Prioritized vaccination - Prioritized hospital treatment - Home-based care - Education on prevention against COVID-19 - Education on sanitation and hygiene

6. People Chronic Illnesses	The majority of the people living with NCD in Eswatini (>80%) are undiagnosed (STEPS, 2014), the burden of hypertension and type 2 diabetes as comorbidities of COVID-19 is extremely high in the population and often results in complications such as kidney related diseases. The common comorbidities associated with severe disease and mortality includes the following: Hypertension, Diabetes mellitus, chronic respiratory disease (asthma, TB, silicosis, COPD) cardiac disease and cancers	- Prioritized vaccination - Prioritized hospital treatment - Home-based care - Education on prevention against COVID-19 - Education on sanitation and hygiene
7. Eswatini People	The Eswatini Population stands at 1,145, 404,00. COVID-19 is the first Pandemic to affect the nation in such a manner and magnitude. The nation was unprepared and ignorant in responding to advice regarding the Pandemic. The result was the increasing number of cases due to poor adherence to stipulated controls.	- Vaccination - Isolation camps - Hospital treatment - Home-based care - Education on prevention against COVID-19 - Education on good sanitation and hygiene practices

Figure 2.2 below depicts the distribution of tentative health facilities and centres that will benefit from the project.

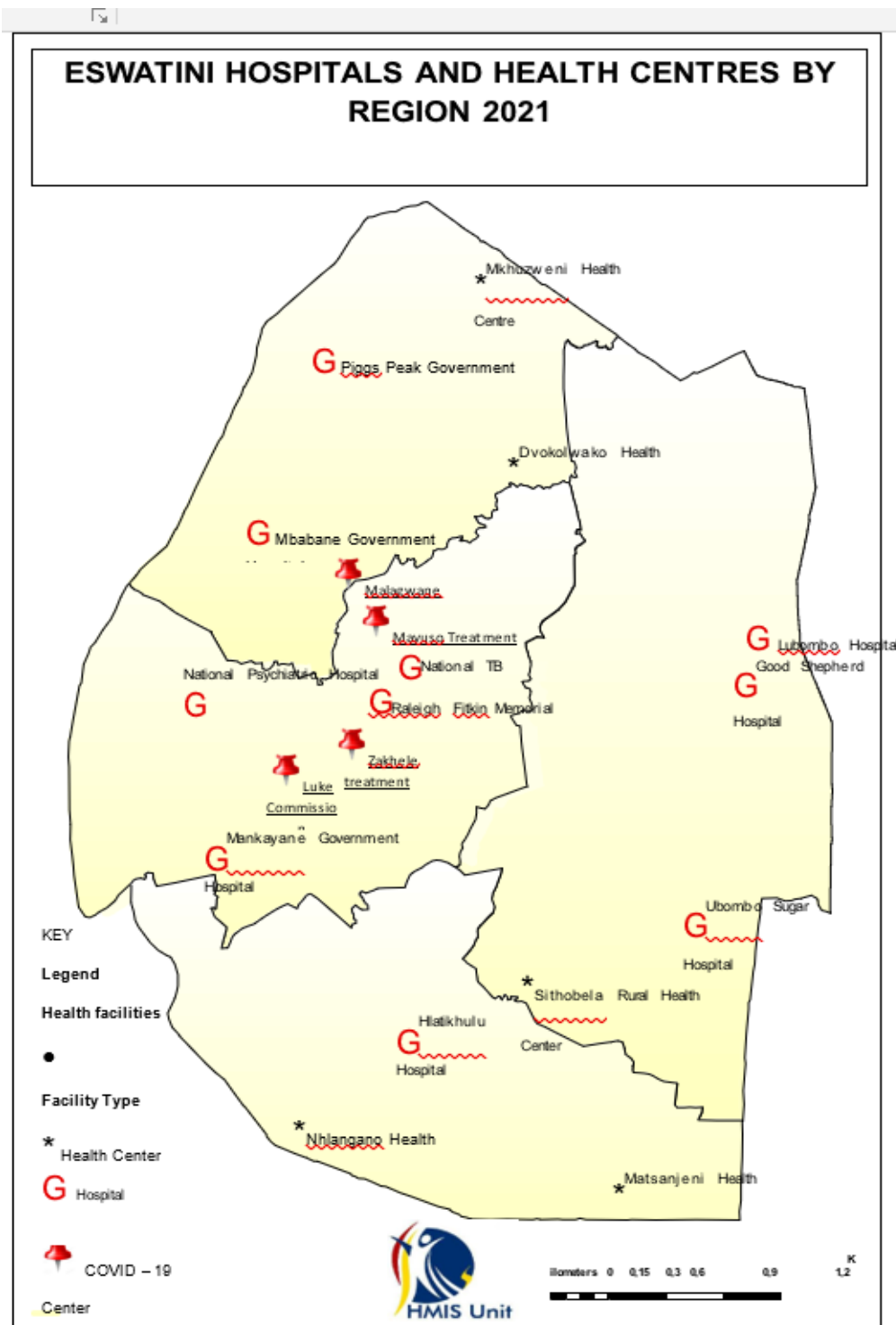


Figure 2.2: Distribution of Health Facilities and COVID-19 Centres

Chapter 3 – POLICY, LEGAL AND REGULATORY FRAMEWORK

The proposed project must be consistent with all applicable laws, regulations, and notifications that are relevant in the context of the proposed project interventions. It is the responsibility of the MoH to ensure that proposed activities are consistent with the regulatory/legal framework, whether national or regional. Additionally, it is also to be ensured that activities are consistent with the applicable World Bank's environmental and social standards and guidelines. This section is not a legal opinion on the applicability of the law but serves as guidance in the application of the law to the current project context.

3.1 International Conventions, Protocols and Standards

Table 3.1 below summarizes the applicable treaties, conventions and protocols:

Table 3.1: Summary of International Treaties, Conventions and Protocols

Convention	Objective
Sustainable Development Goals (3, 6, 12, 13, 14 & 15)	In support of: - good health and well-being - Clean water and sanitation - Responsible consumption and production - Climate action - Life below water - Life on land
The African Convention on the Conservation of Nature (1968)	To encourage individual and joint action for the conservation, utilization and development of soil, water, flora and fauna for the present and future welfare of mankind, from an economic, nutritional, scientific, educational, cultural and aesthetic point of view.
The Ramsar Convention (1971) on wetlands of International Importance	To stop the progressive encroachment on and loss of wetland now and in the future, recognizing the fundamental ecological functions of wetlands and their economic, cultural, scientific and recreational values
The Protection of World and Cultural Heritage convention (1972)	to establish an effective system of collective protection of the cultural and natural heritage of outstanding universal values
The Convention on the International Trade in Endangered Species of Wild Flora and Fauna (CITES, 1973)	to protect certain endangered species from over-exploitation by means of a system of import/export permits
The Convention on the conservation of migratory species of wild animals (1979).	to protect those species of that migrate across or outside national boundaries
The Vienna Convention for the protection of the Ozone Layer (1985)	To protect human health and the environment against adverse effects resulting from modification of the ozone layer
Montreal Protocol on Substances that deplete the Ozone layer (1987)	To protect the ozone layer by taking precautionary measures to control global emissions of substances that deplete it.

The Basel Convention on the trans-boundary Movement of Hazardous Wastes and their disposal	To reduce trans-boundary movements of waste subject to a minimum consistent to the environmentally sound and different effects of such wastes and to minimizing the amount and toxicity of hazardous wastes generated and ensuring their environmentally sound management
Convention on Biological Diversity- (CBD 1992)	To promote diversity and sustainable use and encourage equitable sharing of benefits arising out of the utilization of genetic resources
United Nations Framework Convention on Climate Change (UNFCCC, 1992)	To regulate the levels of green-house gases concentration in the atmosphere to avoid the occurrence of climate change on a level that would impede sustainable economic development, or compromise initiative in food production
United Nations Convention to combat Desertification (UNCCD, 1994)	To combat desertification and mitigate the effects of drought in countries experiencing serious drought and or desertification

3.2 Applicable World Bank Environmental and Social Standards

Five of the ten Environmental and Social Standards (ESSs) of the WB's Environmental and Social Framework (ESF) have been considered as relevant. The Project is not expected to impact natural habitats or cultural sites. WBG EHS Guidelines will apply to the extent relevant as well as appropriate current WHO Guidance (see Resources appendix). Beyond this immediate concern, project implementation needs also to be responsive to the needs of marginalized and vulnerable social groups who may be unable to access facilities and services designed to combat the disease. To mitigate this risk MOH, in the ESCP, is committed to the provision of services and supplies based on the urgency of the need, in line with the latest data related to the prevalence of the cases.

The World Bank Environmental and Social Standards and their respective applicability and relevance to the proposed project are presented in the following table.

Table 3.2 – Applicable World Bank Environmental and Social Standards

Relevant Environmental & Social Standard	Applicability
ESS1 Assessment and Management of Environmental and Social Risks and Impacts	Applicable because the construction works will lead to social and environmental impacts, risks, and opportunities in the project's area of influence which need to be identified and managed throughout the project life cycle. Other environmental and social risks and impacts are related to (i) hazardous and medical waste management regarding transportation, storage, distribution, and disposal of COVID-19 vaccines; (ii) occupational health and safety (OHS), including the risk of spread of the virus among health care workers; and (iii) community health and safety, including the risk of the spread of COVID-19 among the population at large.
ESS2 Labor and Working Conditions	Applicable because labor is required for the project.
ESS3 Resource Efficiency and Pollution Prevention and Management	Applicable because construction equipment, wastewater, biohazard waste treatment technology (Incineration) and electronic waste could be sources of air emissions and leach into the ground.
ESS4 Community Health and Safety	Applicable because construction and rehabilitation works, as well as COVID-19 testing, treatment and quarantining lead to community health and safety risks.
ESS10 Stakeholder Engagement and Information Disclosure	Applicable because the proposed project will require extensive stakeholder engagement because its success will depend on how it is received by the communities.

ESS 1: Assessment and Management of Environmental and Social Risks and Impacts: This standard evaluates the potential environmental and social risks and impacts associated with each stage of a project (the project lifecycle) in its area of influence. It examines project alternatives; identifies ways of improving projects selection, siting, planning, design, and implementation by preventing, reducing, mitigating, or compensating for adverse environmental and social impacts and enhancing positive impacts. It includes the process of mitigating and managing adverse impacts throughout the project implementation so that the project is environmentally and socially sound and sustainable. ESS1 considers the human and natural environment (air, water, and land); human health and safety; social aspects (involuntary resettlement, indigenous people, community health, inclusion and exclusion, SEA/SH and physical cultural resources); and trans-boundary and global environmental aspects.

This standard is relevant to the project. The standard provides guidance on assessing the Project's potential environmental risks and impacts and addressing potential impacts through planning and mitigation hierarchy approach. The project is expected to result in positive environmental and social impacts as it seeks to improve service delivery for COVID-19 surveillance, monitoring, containment and response and, provide safe vaccine. This includes additional financing activities and plans for COVID-19 vaccine procurement and deployment. However, project activities also present substantial environmental, social, health and safety risks for the project workforce and communities. Therefore, the sub-project environment and social risk assessments shall be carried out in accordance with the applicable requirements of ESS1. The ESS1 sets out the Borrower's responsibilities for assessing, managing and monitoring environmental and social risks and impacts associated with each stage of project supported by WB through Investment Project Financing, in order to achieve environmental and social outcomes consistent with the Environmental and Social Standards (ESSs).

ESS 2: Labour and Working Conditions: The World Bank through the ESS2 promotes the fair treatment, non-discrimination and provision of equal opportunities for workers engaged on projects it supports. It strongly encourages protection of all project workers, including vulnerable groups such as women, persons with disabilities, children (of working age) and migrant workers, contracted workers and primary supply workers, as appropriate. It provides certain requirements that the project must meet in terms of working conditions, protection of the work force (especially the prevention of all forms of forced and child labour), and provision of a grievance mechanism that addresses concerns on the project promptly and uses a transparent process that provides timely feedback to those concerned.

This standard is relevant to Project. The standard provides guidance on promoting the safety and health of the project workers and recognises the need for the project to create employment and income generation opportunities that will lead to poverty alleviation and economic growth of project stakeholder communities.

Most activities to be supported under this sub-project include treatment of patients, handling and transportation of samples and vaccines in health facilities as well as capacity building and trainings on diagnosis and treatment. The sub-project is expected to use direct workers and contracted workers. Most activities, especially during operation stage, will be conducted by direct workers such as health and laboratory technicians and civil servants employed by the MOH. The sub-project will outsource minor civil works contractors for activities such as constructing minor civils works and rehabilitation of facilities. Therefore, in order to minimize or prevent any impacts associated with labor and working conditions, the

sub-project shall be carried out in accordance with the applicable requirements of ESS2, in a manner acceptable to the World Bank including through, inter alia, implementing adequate occupational health and safety measures (including emergency preparedness and response measures), setting out grievances redress arrangements for sub-project workers and incorporating labor requirements into the ESHS specifications of the procurement documents and contracts with contractors.

ESS 3: Resource Efficiency and Pollution Prevention and Management: This standard works to promote the sustainable use of resources, including energy, water, and raw materials. It provides guidance on avoiding or minimizing generation of hazardous and non-hazardous waste and other environmental pollution sources that potentially cause adverse impacts on human health and environment. Medical and hazardous chemical wastes are expected to be generated from hospitals, health facilities, labs, and screening posts. The improper handling, transporting, and disposal of these hazardous and medical waste streams may result in adverse impacts to human health and the environment. The updated ICWMP will be implemented will follow WHO guidance on COVID-19 and other Good Industry International Practice (GIIP). In addition, should there be a need for rehabilitation of selected health facilities, site-specific ESMPs (see Annex 3) will be prepared based on the provisions of this ESMF to manage general pollution impacts related to these small-scale works.

ESS 4: Community Health and Safety: This standard recognizes that project activities, project equipment and infrastructure of increase the exposure of project stakeholder communities to various health, safety and security risks and impacts and thus recommends that projects implement measures that avoids or limits the occurrence of such risks. It provides further requirements or guidelines on managing safety, including the need for projects to undertake safety assessment for each phase of the project, monitor incidents and accidents and preparing regular reports on such monitoring. ESS4 also provides guidance on emergency preparedness and response. It also provides guidance on how to prevent sexual exploitation and abuse (SEA) and sexual harassment by project workers.

This standard is relevant to the project. The project will be guided by this standard in managing and/or addressing issues relating to the health and safety of the project's workers and communities within the proximity of the project sites with attention to people who, because of their particular circumstances, may be vulnerable including SEA/SH.

Vulnerable and marginalized groups are at the risk of being left out from the vaccine program because of their economic and social status, including women, Children, Elderly, Youth, Extreme poor and near poor, Persons with Disability, Informal sector workers, Migrants, SMEs/Entrepreneurs, People affected and Infected by HIV, Persons with TB, people in close setting (e.g. Prisons) and rural populations. These factors are likely to limit vulnerable/marginalized groups' ability to be qualified and receive the vaccine in equitable fashion. Making the vaccine affordable, inclusive and responsive to the needs of the most marginalized and excluded groups is critical. The ESMP will mitigate this risk and the project will be required to develop an inclusive national vaccine strategy/plan. In addition, large-scale communication and outreach campaigns, which will target household, community and national stakeholders including the political leadership, will be implemented to ensure robust governance, accountability, and citizen engagement mechanisms. People-centered, innovative modes of communication will be required to counter any vaccine hesitancy and ensure that MOH/PIU obtains consent for vaccination amongst the public.

ESS 10: Stakeholder Engagement and Information Disclosure: The World Bank through the ESS10 seeks to encourage open and transparent engagement between the Borrower and the project stakeholders (project-affected and project interest parties) throughout the project life cycle. The standard establishes a systematic approach to stakeholder engagement that potentially helps the Borrower to identify stakeholders and build and maintain a constructive relationship with them, as well as disclose information on the environmental and social risks and impacts to stakeholders in a timely, understandable, accessible and appropriate manner and format. It recommends that stakeholder engagements are commenced as early as possible in the project development process and continued throughout the lifecycle of the Project. This allows for all stakeholders' views on environmental and social aspects to be treated as sustainable and relevant inputs to the project during its early project design and implementation phases. The Borrower is also expected to create and operationalize Grievance Redress Mechanism (GRM) to address project related disputes at no cost.

Through this AF, the project has also committed to identify and engage community groups and local networks to promote accurate information on COVID-19 vaccines; Develop and use two-way 'channels' for community and public information sharing; Monitor information channels, as well as social and traditional media, to detect and rapidly respond to and counter misinformation; Support establishment of national, regional, and community information and feedback and grievance redressal mechanisms; Support capacity building of frontline workers and equipping them with interpersonal and community engagement skills and tools to reach target populations, track vaccine coverage, and report adverse events; Update national HRH registries, and expand to include community health volunteers. More details on the application of this standard and the corresponding mitigation measures planned and undertaken under the project are provided for in the Stakeholder Engagement Plan (SEP). This standard is relevant to the project. The Project will engage with various stakeholders at the project design, planning and project implementation stages. The Project will be guided by this standard in undertaking all project-related consultations and engagements given that this enhances the environmental and social sustainability of the Project. In line with this, a standalone Stakeholder Engagement Plan (SEP) has been prepared.

World Bank Group Environmental Health and Safety Guidelines (EHS Guidelines)

The World Bank Group's (WBG) Environmental, Health and Safety Guidelines also known as the (EHS Guidelines) are applicable to the project. These guidelines entail technical reference documents with general and industry-specific examples entailing Good International Industry Practice (GIIP). The GIIP are deemed achievable in new facilities at reasonable costs by employing the use of existing technologies.

When host country regulations differ from the levels and measures presented in the EHS Guidelines, project will be expected to achieve whichever is more stringent. If less stringent measures than those provided in the EHS guidelines are deemed appropriate for the project, then a detailed justification must be provided for any proposed alternatives through the environmental and social risks and impacts assessment process. The general EHS guidelines and the specific EHS Guidelines for Health Care Facilities will be applied to the project.

3.3 Environmental and Social Risk Classification (ESRC)

As per WB environmental and social due diligence, the overall E&S risk classification for the project is "Substantial". The classification has considered the E&S risks and impacts of the proposed activities and the institutional capability of responsible implementation partners.

Environmental Risk Rating

The environmental risk rating is Substantial. The project is associated with environment, health and safety risks due to the proposed activities to control COVID-19. The four major areas of environmental risks for the project are related to: (i) the reorganizing and repurposing/equipping of selected hospitals including the RFMH and the Lubombo National Referral Hospital; (ii) inadequate adherence to occupational health and safety standards associated with use and generation of hazardous and medical waste; (iii) occupational health and safety including the risk of spread of the virus among health care workers; and (iv) community health and safety including the risk of the spread of COVID-19 among the population at large. Small scale infrastructure works for the rehabilitation and equipping of selected hospitals will be undertaken within the premises of existing facilities and therefore, environmental risks and impacts are expected to be site-specific, temporary and manageable. Risks related to occupational and community health and safety are anticipated due to the dangerous nature of the pathogen (COVID-19) and reagents and other materials to be used in the hospitals, health facilities, labs, quarantine, and screening posts. Diagnosis, testing, treatment, vaccination and providing isolation of patients can generate biological, chemical, hazardous medical wastes. Improper handling of hazardous materials and samples and inadequate disposal of medical wastes can cause infections and health problems for workers, the community and pollution of the surrounding environment. Laboratory accidents and/or emergencies such as fires or chemical leaks could also be an associated risk. These risks will be mitigated with occupational health and safety standards and specific infectious-control strategies, guidelines and requirements as recommended by WHO and CDC. Effective administrative and infectious-controlling and engineering controls would be put in place to minimize these risks. The current healthcare waste management systems in health facilities in Eswatini are not standardized, and the implementation and monitoring of safe management has been weak. Waste minimization practices and treatment facilities need serious improvement. Health Care Waste Management Regulations are not in place.

Exposures to climate and disaster risks are predicted to have a moderate effect on the project's target population and a moderate risk to project activities. More than 75 percent of Eswatini's population lives in rural areas, which are vulnerable to risk of climate change. Negative health impacts come from extreme climate events, such as heat waves, hurricanes/storms, floods, and droughts. Some of the possible direct threats that climate change could pose on human health in Eswatini include morbidity due to thermal stress, vector-borne infectious diseases, diarrhea, and malnutrition. According to the WHO, outbreak of human diseases such as malaria, dengue, diarrhea, cholera, typhoid, and other vector-borne diseases coincide with the occurrence of extreme climate events such as droughts and floods. Project activities, particularly vaccine distribution, may be temporarily delayed due to climactic events such as flooding and extreme heat. Other activities such as training of health workers and supervision may be temporarily delayed due to climate hazards. In Eswatini, there is a high density of existing health facilities, which improves the populations' access to health services. The Country has an existing surveillance system that tracks diarrheal disease and other disease outbreaks, which mitigates against the health risks of climate and geophysical hazards. Eswatini's National Climate Change Policy recognizes the emerging impacts of climate change on key sectors and prioritizes building resilience. Although the country is highly vulnerable to the impacts of climate change, the above development context in Eswatini decreases the risks on vulnerable populations.

The AF intends to address these vulnerabilities and enhance climate resilience and adaptation through the following activities. Under Component 1: Emergency COVID-19 Response, vaccination will be prioritized for the elderly and those with pre-existing conditions, the same populations which are also the

most vulnerable to climactic shocks, reducing the populations' vulnerability to the health impacts of climactic shocks. COVID-19 vaccination planning under this component will incorporate contingency plans for activities in case of climatic events such as flooding and extreme heat. Under Component 2: Strengthening Capacity in Preparedness for Health Emergencies, climate adaptation curricula in training and emergency simulation activities for health professionals will be incorporated. Strengthening health professionals' capacity is key to preparing the health system to identify and respond to climate-related risks. Under Component 3, Implementation Management and Monitoring and Evaluation, the CMIS will be strengthened to assist the project in detecting climate-related disease outbreaks, strengthening the existing system to monitor outbreak prone-disease by analyzing data corresponding to climate hazards, and efficiently coordinating rapid responses to the health impacts of climate shocks. The CMIS will also strengthen the health system to analyze and use information for local response to health threats from climate hazards. Under Component 1, the purchase of COVID-19 vaccines will consume US\$0.8 million while shipping is expected to cost up to an additional ten percent. In order to protect vaccines from exposure to extreme temperatures, per WHO requirements, the vaccines are kept cool during transport with non-energy consuming coolant packs inside shipping units. This is a climate adaptation measure since WHO requires temperature monitoring devices in all vaccine shipments. With respect to safety boxes for the disposal of syringes, this is also an adaptation measure as this reduces the risk of exposure to medical waste during flooding and other climate related extreme events. The total estimate for climate adaptation for these measures, as part of the vaccine price, is estimated at 10 percent of Component 1. Please see table 6 for further information on component costs.

Climate change mitigation activities are planned to focus on reductions in greenhouse gas (GHG) emissions through the utilization of climate-friendly incineration and HMIS. Under Component 1: Emergency COVID-19 Response, the project will support provision of adequate waste management capacity to enhance the country's climate resilience. The project will purchase climate-friendly incineration equipment to reduce the projects emission of GHG emissions that increase climate disaster risks on vulnerable populations. In addition, the project will finance programs to minimize waste production, and monitor waste incineration including construction of waste storage and sorting centers, training on proper waste management, and monitoring incineration emissions. Two energy efficient vehicles will be purchased to support climate friendly incineration activities. Support for appropriate minimum standards for cold chain equipment under this component will focus on use of climate friendly cold chain equipment to reduce greenhouse gas emissions. Under Component 3, Implementation Management and Monitoring and Evaluation, the strengthening of the CMIS enhances Eswatini's climate-smart mitigation strategies through the reduction in the use of paper, contributing to prevention of deforestation. As described above, under Component 1 the purchase of the COVID-19 vaccines will consume US\$0.8 million while shipping is expected to cost up to an additional ten percent. The use of non-energy consuming coolant packs inside shipping units is a climate mitigation measure as (a) this ensures a reduction in possible vaccine wastage due to exposure to climate-related extreme heat events and (b) the vaccine is kept in non-energy-consuming cool packs thereby reducing GHGs through reduced energy use. Further, WHO also requires temperature monitoring devices in all vaccine shipments which is another climate mitigation measure to prevent wastage. With respect to safety boxes for the disposal of syringes, this is also a mitigation measure as disposal of syringes in this manner does not require incineration and hence would reduce GHG emissions. The total estimate for climate mitigation for these measures, as part of the vaccine price, is estimated at 10 percent of Component 1.

Given these factors, the Borrower's unfamiliarity with the WBG Environmental and Social Framework and the infectious nature of the COVID-19, the environmental risk is rated as **Substantial**.

Social Risk Rating

The social risks associated with the Project are: i) COVID-19 disproportionate impact on women, ii) exclusion of vulnerable groups from vaccine, iii) misinformation and challenge of vaccine dissemination, iv) SEA/SH and, v) violence against children and child sexual abuse. The proposed AF also recognizes that when emergencies occur, such as the COVID-19 health emergency in the country, they occur against a backdrop of pre-existing gender inequality. As existing systems and structures to protect women and girls are weakened, without gender based violence (GBV) specific programming integrated into preparedness and response activities, first responders who by virtue of their direct access to communities are well placed to provide immediate support may not be trained to do so or may be inadvertently exposing women and girls to additional risks; weakening the foundation for their resilience and health; and/or creating barriers to reconstructing the lives and livelihoods of individuals, families and communities. Available sources on GBV prevalence in Eswatini suggest that levels could be high compared to the region and globally. The most recent national survey of S/GBV is from a 2007 UNICEF National Study on Violence Against Children and Young Women (UNICEF 2007), which reported that 35.6 percent of women experienced sexual violence before age 18. Lifetime prevalence of sexual violence was 48.2 percent. Additionally, 25 percent of women had experienced physical violence as a child, and 3 in 10 experienced emotional abuse. These compare to global prevalence rates of 35 percent for sexual or physical violence (WHO 2013).

Global evidence suggests that since the beginning of the COVID-19 pandemic and particularly during the lockdowns, incidence of GBV has increased globally. As pressures from lack of income and job security increase, tensions in households increase and with it the likelihood of domestic violence. In Eswatini given that women are more likely than men to also take care of elderly family members (a high-risk group), it can create unusually high levels of stress and tensions within a family and put women disproportionately at risk of verbal or even physical abuse. The Women and Law in Southern Africa have reported an increase in the number of GBV cases in Eswatini since the COVID-19 pandemic, and that those cases mostly affect women and children.

Drivers of GBV in Eswatini appear related to institutional and community-level drivers such as lack of confidential reporting mechanisms for both adults and children and community reluctance to get involved in family matters.⁷ Eswatini has in place legislation, namely the *Sexual Offences and Domestic Violence Act (2018)* that is seen as an important step toward addressing S/GBV as a serious barrier to women's empowerment, especially given that penalties for S/GBV perpetrators under customary law are very lenient. It has also developed a *National Strategy and Action Plan to End Violence (2017-2022)* which is a comprehensive five-year plan identifying strategic intervention areas in ending violence in Eswatini, providing targets to be met by various stakeholders. The strategy identifies key result areas, namely in-service provision, advocacy, lobby and prevention, management, co-ordination and collaboration, research and evaluation. In line with Eswatini's national strategy and action plan to end violence and the rise of GBV, particularly against women since the start of the pandemic, the AF will support building frontline health workers' capacity to be able to respond effectively to victims of violence through a

7 The Swaziland Deputy Prime Minister's Office (DPMO), the University of Edinburgh (UoE), the University of Swaziland (UNISWA)

and the United Nations Children's Fund (UNICEF) Swaziland (UNICEF Swaziland). *The Drivers of Violence Affecting Children in Swaziland: Synthesis of Findings*, Mbabane: UNICEF, 2016.

training program that incorporates good practices. The training program will include for instance ensuring that GBV survivors know how they can access appropriate services in a safe and timely manner, and that coordination and advocacy are undertaken to reduce risks to women and girls. The project will provide direct support to the MOH in coordination with its GBV focal point to strengthen and expand training targeting frontline health workers on GBV mitigation and response.

The Social risk rating of the AF continues as Substantial. In addition to risks posed in the Parent project, there are substantial risks associated with exclusion of vulnerable/marginalized groups from vaccine, misinformation and vaccine dissemination challenges proposed in the AF. In addition to the heightened risk that COVID-19 has had on rural populations, particularly vulnerable persons (HIV infected, poor, disabled, elderly, women and children), new risks now associated with vaccine dissemination relate to misinformation leading to lack of public willingness to participate in a vaccination campaign; ensuring that those in greatest need of health services and vaccinations receive it first and in a timely fashion; health services and vaccinations are performed effectively; and the results of these support services are thoroughly captured, analysed and used to inform service delivery, government policy and positions as to how to control and defeat the pandemic and return to a more normal way of life.

Preparation for rolling out vaccines is in its early phase in the country, with the first draft of the National Deployment and Vaccination Plan (NDVP) prepared in late December 2020. Operational planning is ongoing under considerable uncertainty, particularly regarding when and how many doses of vaccines would be made available.

Risks are being mitigated through support being provided to MOH on communications and awareness-raising by UNICEF and WHO. On access to vaccination, the NDVP plan prioritizes groups for vaccination in accordance with WHO guidelines. There is consensus to first target health workers, other essential workers, and the most vulnerable populations, which include a mix of the elderly, people with co-morbidities, and people in high-population density. However, it is not clear to what extent the NDVP will: i) address immediate policy issues to ensure vaccine eligibility policies are equitable and inclusive at the national level, ii) address concerns of excluded and marginalized groups and provide last mile service deliver, iii) monitor who is being included/excluded and ensure accountability and, iv) address institutional challenges to inclusion.

A technical working group to inform community engagement and communications around vaccine dissemination led by MOH that includes WHO and UNICEF, is providing support on the technical content of risk communication, advocacy materials and is coordinating with MOH to identify and engage community groups, influencers, and networks to promote accurate information on COVID-19 vaccines. The technical working group community engagement effort will be linked to and guided by the updated Stakeholder Engagement Plan (SEP). The PIU housed in MOH is also collaborating closely with the working group to ensure vulnerable groups are adequately targeted in the relevant communication campaigns on vaccine. Another particular risk that has come to the fore based on the ongoing implementation experience of Global COVID-19 MPA is the increased incidence of reprisals and retaliation especially against healthcare workers and researchers. This risk will be mitigated through explicit inclusion in robust stakeholder identification and consultation processes, which will continue while complying with World Bank COVID-19 guidelines around stakeholder engagement.

Environmental and Social Commitment Plan (ESCP): An Environmental and Social Commitment Plan (ESCP) has been prepared and consulted on, which considers the need to ensure adequate budget,

staffing and operational arrangements for Project E&S risk management. The ESCP has been updated based on the additional financing activities.

Stakeholder Engagement Plan (SEP): The project has prepared a SEP which serves the following purposes: (i) stakeholder identification and analysis; (ii) methods for stakeholder engagement, including effective communication tools for consultations and disclosure; (iii) defining roles and responsibilities of different actors in implementing the Plan and (iv) a grievance redress mechanism (GRM). Provisions have been included to reach and meaningfully engage vulnerable and disadvantaged groups (elderly, children who are high risk such as those who are malnourished, poor households, ethnic minorities, resident in rural areas, people living with a disability, female-headed households and those with chronic illnesses). Considering the serious challenges associated with COVID-19, dissemination of clear messages around social distancing, high risk demographics, self-quarantine, vaccination and, when necessary, mandatory quarantine is critical. The project will also strive to address other communication messages that may be needed, such as around mental health, support to parents and Gender-Based Violence, particularly if social isolation restrictions and school closures continue.

3.4 Applicable WHO Standards

Several WHO resources are available for reference and adoption during project implementation. To help countries navigate through the challenges of COVID-19, WHO has updated operational planning guidelines in balancing the demands of responding directly to COVID-19 while maintaining essential health service delivery and mitigating the risk of system collapse. This includes a set of targeted immediate actions that countries should consider at national, regional, and local level to reorganize and maintain access to high-quality essential health services for all. In response to COVID-19 India has also updated several national guidelines that are aligned with those of the WHO. The WHO is maintaining a website specific to the COVID-19 pandemic with up-to-date country and technical guidance. Some of the technical guidance available are: (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) COVID-19 Vaccines. As the situation remains fluid it is critical that those managing both the national response as well as specific health care facilities and programs keep abreast of guidance provided by the WHO. The dedicated WHO website can be accessed at <https://www.who.int/emergencies/diseases/novelcoronavirus-2019/technical-guidance> and <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-vaccines>. Specifically WHO resources that will apply 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](#)⁸.

3.5 Key Applicable National Laws, Policies and Regulations

The following paragraphs highlight some salient features of select laws, which have a particularly important bearing on the design and implementation of the proposed project.

⁸ https://www.who.int/vaccine_safety/publications/aefi_surveillance/en/

Constitution of Eswatini (2005)

The Constitution of Eswatini does not specifically state the right to medical care for all Eswatini people nor does it allocate the responsibility to ensure medical care to the state but Article 15. (1) states that “A person shall not be deprived of life intentionally save in the execution of the sentence of a court in respect of a criminal offence under the law of Swaziland of which that person has been convicted”. Article 16. (1) states that “a person shall not be deprived of personal liberty save as may be authorized by law...” except according to Article 16. (1) (g) “for the purpose of preventing the spread of an infectious or contagious disease”. Article 26. (1) states that “a person shall not be deprived of the freedom of movement, that is to say, the right to move freely throughout Swaziland, the right to reside in any part of Swaziland, the right to enter Swaziland, the right to leave Swaziland and immunity from expulsion from Swaziland” except according to Article 26. (1) (a) “for the imposition of restrictions on the movement or residence within Swaziland of any person or on the right of any person to leave Swaziland that are reasonably required in the interests of defence, public safety or public order”.

Article 25. (1) states that “a person has the right to freedom of peaceful assembly and association” except according to Article 25. (1) (a) states that “is reasonably required in the interests of defence, public safety, public order, public morality or public health”. Article 20. (1) 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. (2) For the avoidance of any doubt, a person shall not be discriminated against on the grounds of gender, race, colour, ethnic origin, tribe, birth, creed or religion, or social or economic standing, political opinion, age or disability”. In relation to environmental protection, the constitution according to Article 216. (1) states that “Every person shall promote the protection of the environment for the present and future generations”

Environmental Assessment, Review and Permitting

Environmental Audit, Assessment and Review Regulations (2000) – These regulations give guidance on the implementation of projects and the attendant environmental considerations. The Regulations outline how projects are to be categorized according to the extent and significance of the likely impacts and define the processes and procedures to be followed in generating environmental assessment documents. The Regulations also provide guidelines on the time limits for each stage of the project.

The Eswatini Environmental Management Act (2002) – The Act establishes the Eswatini Environmental Authority (EEA), formerly known as the Swaziland Environmental Authority (SEA), as a corporate body and promotes the enhancement, protection and conservation of the country’s natural resources. It outlines the EEA’s powers, functions, principles, regulations, strategies, and practices regarding environmental assessment, compliance issues and promotes integrated environmental management.

Disaster management and coordination

Disaster Management Act 2006

The Act provides for the integration and coordination of disaster management in Swaziland, and for the establishment, structure, organization, powers, functioning and responsibilities of the National Disaster Management Council, National Disaster Management Agency, National Emergency Committee, Regional Disaster Management Committee, Disaster Management Fund. It is through this Act that a Declaration of a National Emergency in Response to Coronavirus (Eswatini) was made by His Majesty King Mswati III according to Section 29 of the Act.

The Coronavirus Covid-19 Regulations 2020

The regulations stipulate countering measures against Covid-19 which include: prevention of spread of Corona strategies, compulsory notification on suspected cases, screening of persons, handling of test samples, notification of development of symptoms, isolation of symptomatic and asymptomatic persons, examination, quarantine and isolation. The regulations also stipulate measures to control internal and external travel, consumer protection and general provisions which include restrictions to gatherings, duties of port health officers, operation of social and public facilities, management of information and penalties. Government ministries periodically develop guidelines to effect the regulations.

National Contingency Plan to Address COVID-19

The plan's general objectives are to: (i) Effectively provide all the relevant technical expertise to strengthen COVID-2019 Preparedness and Response and enhance the implementation of the International Health Regulations (2005) through resilient public health systems; (ii) Support capacity building of health workers at all levels in public health surveillance, outbreak investigation and response to COVID-2019 and other public health emergencies; (iii) Improve diagnostic capacity through supply of laboratory consumables and supplies for a proper referral of samples; (iv) Enhance risk communication, and community engagement; (v) Enhance COVID-2019 event management at points of entry, entry screening for COVID-2019 at airports and ground crossings, as well as exit screening in case of introduction of an COVID-2019 case; and (vi) Comprehensively monitor the coverage, quality and impact of preparedness, response and systems building activities. The Plan includes three response levels (alert, serious and emergency).

Infection Prevention and Control and Health Care Waste Management

Public Health Regulations (1935) – These regulations aim to prevent the spread of plague, cholera, yellow fever, smallpox and venereal diseases (sexually transmitted infections). Medical health facilities, by virtue of dealing with people affected by infections of all kinds, are obligated to ensure that infectious and venereal diseases are treated and controlled appropriately to prevent epidemics and thus promote compliance with these regulations.

National Health Care Waste Management Policy (2018) – The National Health Care Waste Management Policy expresses the commitment of the Ministry of Health in ensuring that all waste generated within the health sector is handled and managed in a manner that it has not adverse effects on human health and the environment.

The Waste Regulation (2000) – The Regulation standardizes the management of solid waste and liquid wastes disposed on land and are binding also on the states. The Waste Regulation provides definitions of the different classes of waste including the minimum requirements for the management of each type of waste. They provide guidelines for the management of waste in urban areas, in waste control areas, the construction and operation of waste disposal facilities, recovery of waste, and many other aspects related to waste handling and disposal.

Occupational Health and Safety Act (2001) – This Act provides for the safety and health of persons at work and at workplaces and the protection of persons other than workers against hazards to safety and health arising from activities in the workplace. It also outlines duties of the employer in ensuring the safety of all persons in the workplace including work done outside the employer's premises as long as it is based on the employer's instruction.

Conveyance and Burial of Dead Bodies Act (1970) – This Act makes provision for the conveyance of dead bodies, their burial and incidental or connected matters; removal of bodies of persons who died of infectious diseases; and the keeping of dead bodies pending burial.

The Public Health Act, No.5 (1969) – The Public Health Act makes provisions for public health and incidental or connected matters. It details what diseases are termed as communicable diseases, the management procedures of any related incident, and the responsibilities of public individuals and officers in public health matters. The Act also covers the definition and examples of nuisances, relevant procedures relating to nuisances, and general provisions relating to buildings used for storage of food and powers given to public officials.

Labor Legislation

Factories, Machinery and Construction Works Act of 1972 – The act deals with the regulation of working conditions and the use of machinery at factories and construction sites. Section 19 requires the reporting of accidents in the workplace and therefore any accident during the project is to be formally reported. Section 20 requires that safety devices not be interfered with, that employees shall use safety equipment provided and that no persons shall do anything that places their own safety and that of others at risk.

Workmen’s Compensation Act of 1983 – The Act provides for the compensation and medical treatment of workmen who suffer injury or contract work-related diseases in the course of their employment. Relevant to this project is section 25 which requires the employer to be insured against liability for work-related injuries.⁹

Sexual Offenses and Domestic Violence Act 2018 – This act, inter alia, provides new legal protections for child victims of commercial sexual exploitation.

3.6 Comparison of ESSs and National Legislation

Table 3.6 below compares the ESS with National Legislation and an analysis of the applicable framework.

Table 3.6: A Comparison between the ESSs and National Legislation

World Bank Environmental and Social Standard	National Legislation	Recommendation
ESS1 Assessment and Management of Environmental and Social Risks and Impacts	Environmental Audit, Assessment and Review Guidelines of 2000	Since the project has no determined site or location, the ESMF will be applied.
ESS2 Labor and Working Conditions	Occupational Safety and Health of 2001, Industrial Act of 2008, Employment Act of 2000, Workmen’s Compensation Act of 1983, Sexual Offenses and Domestic Violence Act 2018, National Health Care Waste	The local legislation is insufficient to cover all aspects. The ESSs will apply and align with national legislation where applicable. WHO technical guidance will apply where gaps

⁹ A full list of laws and regulations relevant to labor and employment is available in the Labour Management Procedures (See annex 7).

	Management Policy (2018)	are identified.
ESS3 Resource Efficiency and Pollution Prevention and Management	Environmental Management Act of 2002, Waste Regulations of 2000, Conveyance and Burial of Dead Bodies Act (1970), National Health Care Waste Management Policy (2018)	The local legislation is insufficient to cover all aspects. The ESSs will apply and align with national legislation where applicable. WHO technical guidance will apply where gaps are identified.
ESS4 Community Health and Safety	The Public Health Act, No.5 (1969), Public Health Regulations (1935), Sexual Offenses and Domestic Violence Act 2018, Conveyance and Burial of Dead Bodies Act (1970), National Health Care Waste Management Policy (2018), Disaster Management Act 2006, The Coronavirus Covid-19 Regulations 2020, National Contingency Plan to Address COVID-19	The local legislation is insufficient to cover all aspects. The ESSs will apply and align with national legislation where applicable. WHO technical guidance will apply where gaps are identified.
ESS10 Stakeholder Engagement and Information Disclosure		No national regulatory framework addresses stakeholder engagement and management in Eswatini. The ESS 10 will be adopted.

3.7 Institutional Framework

As it was the case with the Parent Project, the existing PIU will continue to be used for the AF. The MOH is also working closely with other DPs located in-country, especially UNICEF and WHO, who are providing technical assistance on aspects that include procurement, vaccine registration and risk communication. A Project Operational Manual (POM) was also issued and shared with the Bank on June 21, 2020. These documents will be further updated and finalized incorporating modifications introduced through the proposed AF and finalized by January 15, 2021. A PIU induction was conducted between August 28 and September 7, followed by trainings on Environmental and Social Standards. Additional trainings to support fiduciary control functions are scheduled for January 2021. The PIU now has in place both a Social Development Specialist, an Environmental Specialist, and is in the process of engaging an Assistant Social Specialist and Communications Specialist. The Task team held a PIU training workshop on Grievance Redress Mechanisms in November 2020, resulting in an Action Plan that has been developed by the PIU on steps being taken to further strengthen awareness raising and the GRM effectiveness. The Action Plan is being used for the ongoing monitoring of the project.

The Core Implementation Team (CIT) or Project Implementation Unit (PIU), an agile implementation team, will be established to support project effectiveness. The core team is to be comprised primarily of MOH staff (civil servants). The implementation team will be led by a Coordinator. For effective and timely decision making the Coordinator will report to the Principal Secretary of the MOH, who serves as a member of the NETT. With oversight by the Coordinator, the implementation team will be comprised of specialists for fiduciary controls (fiduciary management and procurement), M&E, and environmental and social risk management. Due to the AF, capacity of the PIU will be enhanced to include technical expertise in logistics, procurement and vaccine implementation. The MOH is also working closely with other DPs located in-country, especially UNICEF and WHO, who are providing technical assistance on aspects that include procurement, vaccine registration and risk communication. For critical functions where the MOH technical capacity or knowledge of World Bank procedures and standards is limited, the project will provide surge capacity for a specified duration through specialist consultants. For operational efficiency, it is proposed that some technical roles (fiduciary, environmental and social) are shared between this emergency project implementation team and the project implementation unit (PIU) proposed for the health sector project under preparation (P168564). Sharing technical staff is expected to reduce overhead costs across the two projects, and by tapping into retroactive financing, it can provide surge capacity early on to accelerate effectiveness. The Coordinators for the two projects (P173883 and P168564) will ensure that the project implementation responsibilities are organized in a way to harness operational benefits and reduce operating costs.

For effective management of environmental aspects, the Environmental Specialist will support the Environmental Health Department in identifying gaps, planning and execution of environmental and waste management related aspects. The support will be accorded to the national focal office, regional Environmental Health Offices and Incinerator Operators in each facility. The structure and personnel is already existent and functional. Training on COVID-19 related environmental and waste management aspects will be done. Improvements to reporting, waste minimization, storage and treatment will also be necessary for the health care waste management system to cope with additional volumes. The Specialist will also support the Quality Management Office responsible for Infection Prevention and Control. The support will be accorded to the national focal office, regional and health facility focal persons. These structures are already in place and are functioning, support needed will be in the form of training on the ICWMP, reporting improvements and supply of PPE will have to be done.

The Social Specialist will work closely with the Rural Health Manager, Health Promotion and Deputy Prime Minister's GBV Unit. To effectively execute the Stakeholder Engagement Plan with the GRMs, the Specialist together with the Assistant Social Specialist will be working close with the Rural Health Manager. Training and capacity on GRMs will be necessary for the Rural Health Manager. For Risk Communication, the Health Promotion Unit will be supported by the Social Specialist together with the Communications Specialist. The Health Promotion Unit is well capacitated and already has a Risk Communication plan to be supported. The GBV Unit is well capacitated and already has a plan for support that the Social Specialist will assist on.

MOH, working together with the social and environmental experts, will:

- Ensure integration of the ESIA/ESMP into the project design and implementation plans (contract documents);
- Monitor implementation of the mitigation measures by the contractors;
- Assist contractors by providing appropriate environmental advice, and developing/revising environmental mitigation measures for the sub-projects;

- Assist the PIU to carry out participatory consultation during planning, design and implementation of sub-project;
- Document experiences associated with and lessons learned from environmental mitigation and prepare useful training materials for both internal and external capacity building; and
- Prepare regular or periodic progress reports on the implementation of the ESMPs throughout project implementation process.

M&E activities will be the responsibility of the MOH Epidemiology and Disease Control unit within the Strategic Information Department. Because the project focuses on COVID-19 preparedness and response, the Epidemiology and Disease Control Unit (EDCU) is mandated to coordinate efforts and strengthen public health surveillance through implementing IDSR to fulfill requirements of the 2005 IHRs and the GHSA. Since the COVID-19 outbreak, the unit has coordinated closely with WHO and the MOH COVID-19 Task Team to mount an effective response and set up the surveillance systems in the country. To this end, the unit will provide the routine monitoring support for COVID-19 and will receive backstopping from the MOH M&E unit once the pandemic has been contained. Tools for surveillance and reporting are already in place and shall be used as the data sources for the Results Framework indicators in this project.

Actual construction work will be carried out by the consultants/contractors under the direct supervision of supervision consultants/supervising firms. The environmental and social experts on both the Contractor and MoH teams will ensure strict compliance with the environmental and contractual clauses in the Bid documents and the ESCP and will report on progress.

For operational efficiency, the Core Implementation Team's technical roles (fiduciary, M&E, environmental and social) are shared between this project and the project implementation unit for the Eswatini Strengthening the Health System and Nutrition for Human Capital Development in Eswatini Project (P168564). Sharing MOH staff and technical consultants will improve the strategic scope while reducing the overhead costs across the two projects. Tapping into technical surge capacity early on will accelerate effectiveness. The Coordinators for the two projects (P173883; P168564) will ensure that the project implementation responsibilities are organized in a way to harness operational benefits and reduce operating costs.

The National Contingency Response Plan structure is as follows:

Cabinet-level inter-sectoral coordination and steering oversight will be provided by the *National Emergency Management Committee* (NEMC, Cabinet sub-committee), chaired by the Deputy Prime Minister. To support the NEMC, the *National Emergency Task Team* (NETT) was formed, which is comprised of members of different sectors, and representation from the National Disaster Management Agency NDMA.¹⁰ The NETT is tasked to implement the National and Regional Emergency Plans and Procedures and coordinate the preparedness and response activities. As the primary crisis is health, the lead technical agency for project implementation will be the MOH. To ensure robust technical oversight and agility, the following two bodies will support project implementation:

¹⁰ NDMA is a standing body with a mandate to provides coordination across relevant sectors and actors to implement a response to emergencies, including public health emergencies of international concern (PHEIC) and pandemics.

The MOH Senior Management Team (SMT), chaired by the Principal Secretary, provides overall strategic implementation of the COVID-19 sector response. They are responsible for providing the necessary resources, strategic guidance and facilitating the feedback loop between the Cabinet-level inter-sectoral coordination and steering committee and the National Public Health Emergency Committee (NPHEMC) tasked with the technical response for the sector. The NPHEMC is chaired by the MOH (Senior Medical Officer, Public Health Lead). The committee is comprised of MOH technical leads and experts critical for response to public health emergencies and representatives from Development Partners (UN agencies and the World Bank). To support regional preparedness and response, the NPHEMC has regional response committees that are chaired by the emergency response and preparedness officers in each region and comprise of regional nurse managers and designated allied workers responsible for the evacuations, isolation of patients and contact tracing. The regional chairpersons are members of the regional health management teams thus provide feedback to the regional health administrators on the response while being members of the NPHEMC.

A National Deployment and Vaccination Structure has been established for the roll out of the COVID-19 vaccination. The structure is detailed below:

In preparation for the COVID-19 vaccine introduction the country the Ministry of Health appointed a National Coordination Committee which is chaired by Deputy Director Pharmaceutical Services. This committee has a multisectoral representation composed of senior-level officials from relevant ministries (Deputy Prime Minister, development partners, representatives from private sector and NGOs. In addition, the COVID-19 vaccine technical working group (TWG) to support the implementation of the pre, intra and post introduction of the vaccine was established. The NTWG report to the National Coordinating Committee. The TWG is responsible for collecting data on sero-epidemiology of Covid-19, hospitalization and deaths associated with Covid-19 by age, sex, underlying conditions, ethnicity and deprivation and proportion of immune; analyze this data and advise the coordinating committee on priority groups to be vaccinated based on the evidence collected. The TWG will also update the National Coordinating Committee on new information on characteristics of vaccine candidates under development, safety and immunogenicity data for Covid-19 vaccines, effectiveness of the vaccine in identified priority groups, doses available, co administration with other vaccines on market and programs, side effects, public acceptance. They will also guide the National Coordinating Committee on the communication strategies regarding Covid-19 vaccine introduction.

Eswatini national immunization technical advisory groups (NITAG) will provide evidence-based recommendations and policy guidance specifically related to COVID-19 vaccines, to facilitate fully informed decision-making by the government. The chair, or core members, of the NITAG have been invited to participate in the national coordination mechanism to ensure adequate information flow between the planning, policy and implementation levels. The NITAG will refine, revise and update their recommendations to national policy-makers regularly as new evidence becomes available and it was set up to make recommendations for childhood vaccinations. In its evidence-based, independent, advisory role, will provide transparency and credibility to the decision-making process and contribute to building public confidence in the vaccination programme. Furthermore regional (RHMT) level meetings will be convened to discuss and operationalize the implementation plan for COVID-19 vaccine introduction. The EEPI programme will lead and be convener of the various committee meetings. To ensure optimal participation notification of meetings and an agenda will be distributed to members at least 10 working days prior to the meeting. Subcommittee leads will be identified to oversee key components of the vaccination program including provider outreach and enrolment, data systems, vaccine management, and vaccine communications. The lead technical agency for project implementation will be the MOH. To

ensure robust technical oversight and agility, the following two bodies will support project implementation:

The Eswatini Environment Authority (EEA). The Eswatini Environment Authority is the legal body entrusted with ensuring that the project meets the environmental obligations contained within this document. The EEA will approve all ESMPs developed under this project and will be responsible for overall compliance monitoring with periodic inspections to sites under the project. The EEA will also review and comment on all environmental reports from the project and advise accordingly on related matters.

The PIU supports the implementation of the National Contingency Response Plan and National Vaccine Deployment Plan. Members of the PIU are strategically placed within decision-making and working groups within the organizational structures of the two plans to contribute to decisions made and technically support implementation. They will work in close liaison with the Eswatini Environment Authority.

Chapter 4 - ENVIRONMENTAL AND SOCIAL BASELINE

This section provides general information on relevant baseline conditions. Since the project is in response to a Pandemic, the baseline information will be at the national level except in aspects where detailed information could be obtained.

4.1 Physiography and Climate

Eswatini lies between latitudes 25 and 28 degrees south, and 31 and 32 degrees east in the south eastern part of Africa. The country is land locked and covers an area of 17364 km². It is bounded by South Africa in the north, west and south and by Mozambique on the east¹¹. Although Eswatini is a small country, with its divergent geology, climate and subsequent landforms, the physiographic regions within the boundaries are very distinct. Eswatini's amazing variety of reliefs has four well-defined physiographic regions, extending longitudinally from north to south in roughly parallel belts. The land is classified into six physiographic zones. Highveld, Upper Middleveld, Lower Middleveld, Western Lowveld, Eastern Lowveld and Lubombo Range. Each of the physiographic regions has its own climate. In terms of altitude, Eswatini's highest summit point stands at 1 862m above sea level, and the lowest point is at 152.4 m, with four ecosystems (aquatic, forest montane grassland and woodland-savannah mosaic represented in the steep gradient).

The country is divided into four agro-ecological zones, based on elevation, landforms, geology, soils and vegetation. The Highveld, Middleveld and Lowveld occupy about one-third of the country each, while the Lubombo Plateau occupies less than one-tenth of the country. Eswatini has a sub-tropical climate with summer rains (with 75% in the period between October and March) and distinct seasons. It has 4 distinct ecological zones with different climatic conditions that range from temperate and sub-humid in the Highveld to semi-arid in the Lowveld. The country is influenced by air masses from different origins: equatorial convergence zone, sub-tropical eastern continental moist maritime, dry continental tropical

¹¹ Manyatsi, A. M., Mhazo, N., and Masarirambi, M. T. 2010. Climate Variability and Change as Perceived by Rural Communities in Swaziland. Research Journal of Environmental and Earth Sciences, 2(3), 165- 170

and marine west Mediterranean¹². Mean annual rainfall ranges from about 1 500 mm in the northern Highveld to 400 mm in the southern Lowveld. Precipitation varies considerably however from year to year, which leads to increases instances of flash flooding or drought. High recorded rainfall variation makes it difficult to identify trends with a high degree of certainty. Drought is an inherent feature of the current semi-arid climate. Rainfall levels have consistently reduced over the last five years (since the 2011/12 season). The El Niño phenomenon has exacerbated the drought during the period, where the lowest rainfall levels over the five-year period occurred during the 2015/16 season. The recorded and projected climate trends indicate that the Kingdom of Eswatini is particularly vulnerable to the effects of climate change. Measures to improve the functioning and wider disbursement of meteorological stations will assist the country to monitor and record climate related trends¹³.

Eswatini has a subtropical climate with summer rains. About 75 percent of the precipitation falls from October to March. The climatic conditions range from sub-humid and temperate in the Highveld to semi-arid in the Lowveld. The national long-term average rainfall is 788 mm/year. Table 4.2 below details the rainfall for the different ecological zones¹⁴.

Table 4.2: Rainfall ranges according to the ecological regions in Eswatini

Ecological Region	Rainfall (mm)/ Year
Highveld	700 – 1550
Middleveld	550 – 850
Lowveld	400 – 550
Lubombo Plateau	550 – 850

4.2 Administrative Regions and Tinkhundla

Eswatini has four (4) administrative regions namely: Hhohho, Manzini, Lubombo and Shiselweni and fifty-nine (59) Tinkhundla centres (See Figure 4.1 below). Regional Administration is the second level of government after National Government, established by Section 82 (1) of the Constitution of Eswatini, 2005. It provides structures for national government to allocate resources in an efficient, effective and more equitable way to communities in the country. Regional Administration structures and Institutions are created to administer and co-ordinate socio-economic development in the respective regions through community-based initiatives specifically targeting at improving the standard of living of the people¹⁵.

¹² Sweet and Khumalo, 1994 Sweet, R.J. and Khumalo S. 1994. Range Resources and Grazing Potentials in Swaziland. FAO Report, Ministry of Agriculture and Co-operatives, Mbabane.

¹³ Government of the Kingdom of Eswatini. 2020. Eswatini National Drought Plan. Ministry of Agriculture, Mbabane

¹⁴ Government of the Kingdom of Eswatini. 2020. Eswatini National Drought Plan. Ministry of Agriculture, Mbabane

¹⁵ Government of the Kingdom of Eswatini. 2020. Regional Administration. <http://www.gov.sz/index.php/ministries-departments/ministry-of-tinkhundla-administration/regional-administration> accessed 10/11/20

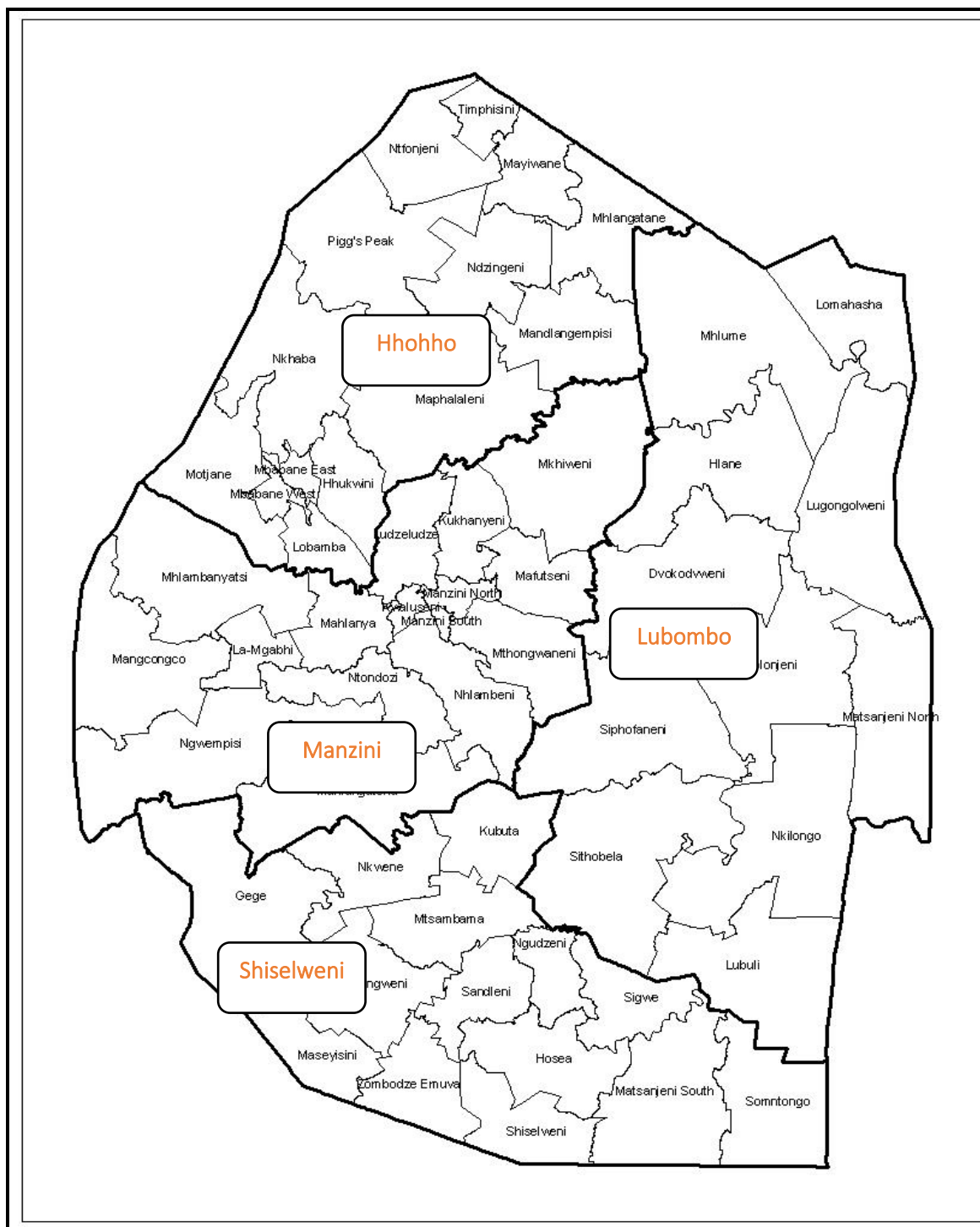


Figure 4.1: Eswatini Administrative Regions and Tinkhundla Centres¹⁶

¹⁶ UNDP, 2010. 2010 SWAZILAND CENSUS-BASED POVERTY and MDG MAPS: Region, Inkhundla and Major Area. UNDP, Mbabane

Land ownership and use

Land tenure is broadly of two types, Swazi National Lands (SNL) and Title Deed Land (TDL), which account for 54 and 46 per cent of land area respectively. Tenure over SNL is not defined by legislation, the land is being controlled and held in trust by the King and allocated by tribal chiefs according to traditional arrangements. There is a structural divide between large-scale TDL and small-scale SNL with its predominantly smallholder agriculture. Sixty-one per cent of SNL farm holdings are less than one hectare in size. Most farms are thus very small. The rapid population increase is, in turn, exerting pressure on land availability for cropping and grazing, forcing households to produce crops on increasingly fragile lands. The Land Policy drafted in 1999 intends to address several issues, i.e. improving gender equity in land allocation and protection of property rights; the use of SNL as collateral for loans, and the introduction of an efficient, effective and comprehensive system of land administration, rangeland management issues. Unfortunately, the policy was never formally endorsed, and land tenure and land reform remain one of the most controversial national policy issues¹⁷.

4.3 Socio-economic Context

Although classified as a lower middle-income country (gross national income (GNI) per capita US\$2,960), high poverty rates and income inequality (Gini coefficient of 49.3) challenge Eswatini's economic and human development potential. If a prolonged crisis leads to higher inflation and potential labor market impacts, these may have knock-on effects on vulnerable households. The rate of growth of the country's economy has been very weak over the last 3-5 years and this has influenced several productive and social sectors. Between 2016 and 2018, the recorded levels of growth fell below the 2 percent mark and into the medium-term prospects of speedy recovery remain bleak owing to the persistent fiscal challenges experienced by Government, thus resulting in reduced economic activity. The COVID-19 pandemic has had a negative effect on the economy since all economic activity had to be halted. The effect on the economy is felt from both the supply and the demand-side, as both international and domestic supply chains of goods and services were disrupted. While movements of people were being restricted in several countries, trade across borders continued. The supply shock will, in turn, affect household consumption, which will have a ripple on effect on the demand. As demand falls, the economy will experience a slowdown. International Monetary Fund (IMF) reviewed 2020 global growth projections to 3.3 percent (January 2020 projections) from 3.4 percent (October 2019 projections) considering the slow performance in emerging market economies¹⁸.

4.4 Demographics

Eswatini has a population of 1,145, 404 people. In terms of regions, Manzini remains the most populous region with 355,945 inhabitants, followed by Hhohho with a population of 320,651. Lubombo is next with a population of 212, 531 and the least populated region is Shiselweni with 204,111 inhabitants. Figure 4.2 below displays the population pyramid for Eswatini.

¹⁷ IFAD, 2020. Land and Natural Resources in Swaziland.

<http://www.ifad.org/documents/38714170/39150184/Land+and+natural+resources+in+Swaziland.pdf/9e2afa0e-1ce8-4b4b-bfb1-e0498f3eca91>. Accessed 10/11/20.

¹⁸ United Nations. 2020. ECONOMIC SITUATION REPORT #1—COVID-19. United Nations, Mbabane

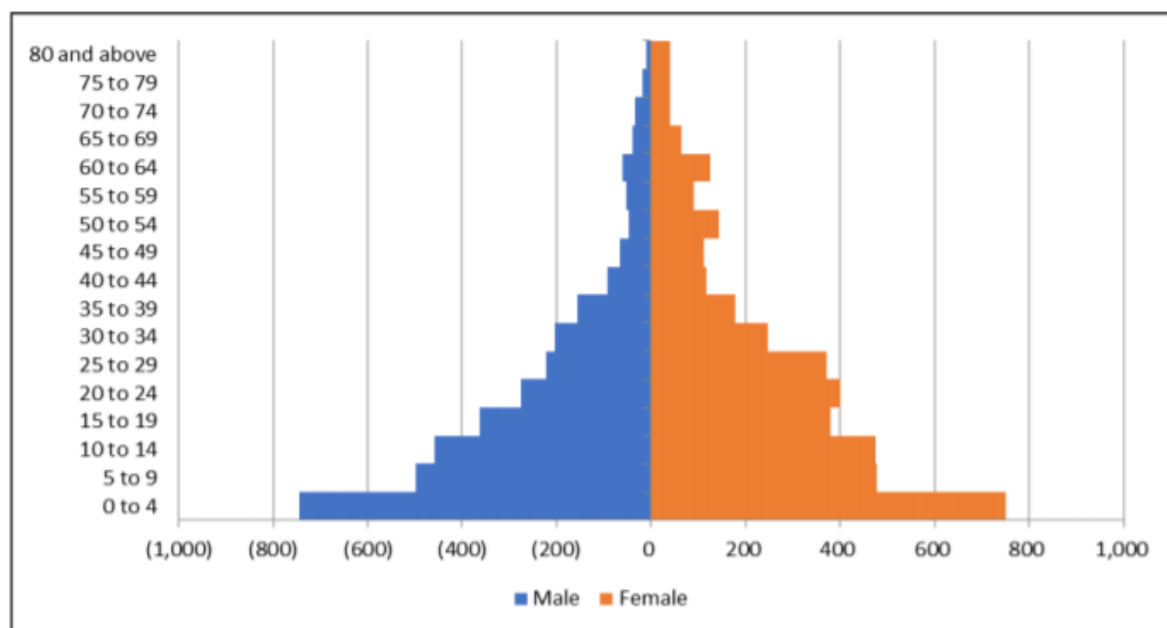


Figure 4.2: Eswatini Population Pyramid¹⁹

From the Figure above, the population of Eswatini is extremely young. The median age is 20.5 years, and about 40% of the population is under 15 years of age, resulting in a relatively high dependency ratio. The young population faces a high level of unemployment (53% of 15-24-year-olds are unemployed)²⁰. It is also evident that numbers of females are higher than their male counterpart. For the economically active population, Eswatini population is dominated by females. However, a high proportion of the females are unemployed compared to their male counterparts. Figure 4.3 depicts the employment status of males and females in Eswatini²¹.

¹⁹ GoKE.2019. Annual Vulnerability Assessment & Analysis Report 2019. Deputy Prime Minister's Office, Mbabane

²⁰ United Nations. 2020. ECONOMIC SITUATION REPORT #1—COVID-19. United Nations, Mbabane

²¹ GoKE.2019. Annual Vulnerability Assessment & Analysis Report 2019. Deputy Prime Minister's Office, Mbabane

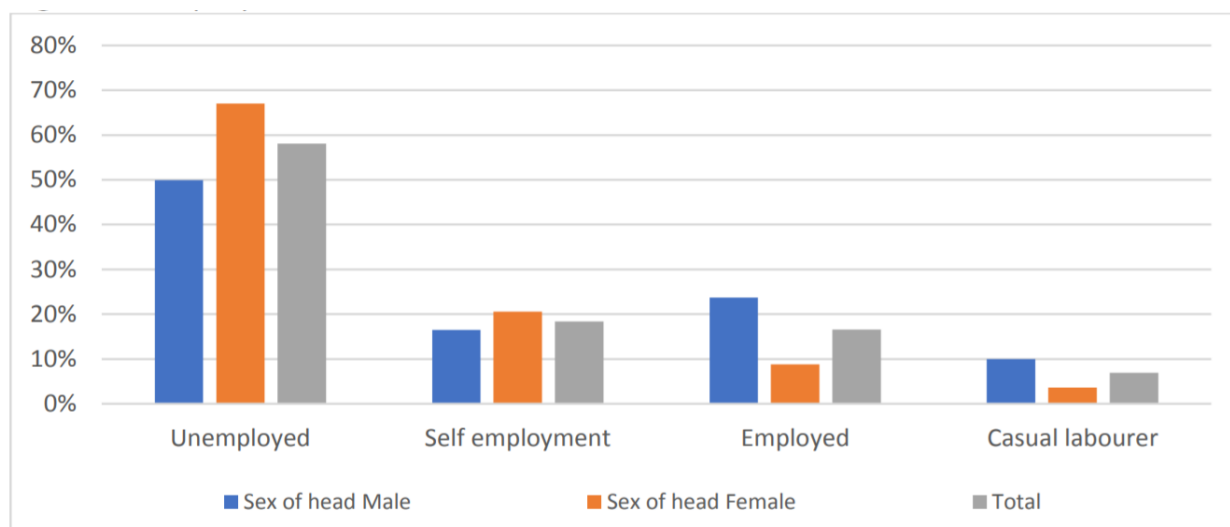


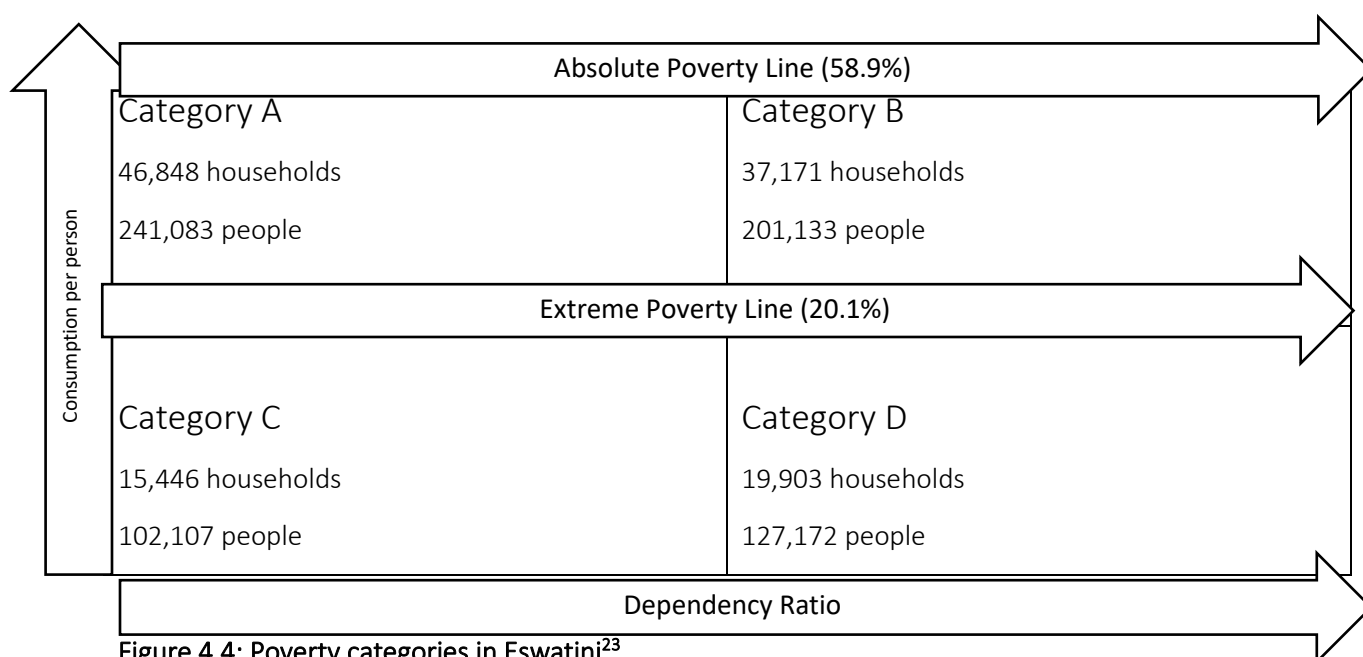
Figure 4.3: Employment status of Males and Females in Eswatini²²

A high proportion (>55%) of males and females in Eswatini are unemployed, <20% are employed, <20% are self-employed and <10% are casual laborers.

4.5 Poverty

While the national poverty rate has fallen in recent years (from 63 percent in 2010 to 59 percent in 2017) even though it remains very high (70 percent), particularly in rural areas and in two regions (Lubombo (72 percent) and Shiselweni (67 percent)). The level of hunger is classified as “serious” in the 2018 Global Hunger Index, where Eswatini has a score of 22.5. In addition, annual vulnerability analyses indicate that an average of 35,451 very poor and poor households have experienced food insecurity in the past 10 years; a similar number of households (35,349) have been identified as “extremely poor” in a quantitative assessment of social assistance. Figure 4.4 below summarizes the four categories of poverty in Eswatini:

²² GoKE.2019. Annual Vulnerability Assessment & Analysis Report 2019. Deputy Prime Minister’s Office, Mbabane



The 46,848 households in category A are in a relatively favorable situation. They are moderately poor and include household members able to do productive work. They are able to respond to self-help-oriented projects and programmes in order to overcome their poverty. The 37,171 moderately poor category B households are labor constrained and are therefore unable to respond to labour-based interventions. Households headed by a pensioner, who receives a small pension, or households regularly supported by the extended family are typical for this group. The 15,446 category C households suffer from extreme poverty although they have household members able to perform productive work. Many small-scale farmers fall into this category. To improve the economic situation of these households, they must be targeted by labor-based programmes specifically tailored for vulnerable but viable households. The 19,903 households in category D are in the most unfavorable situation. They suffer from extreme poverty. At the same time, they cannot respond to development projects or programmes because they have no household members able to perform productive work. They have no or little self-help capacity. This group – the 7% worst off households in Eswatini – most urgently requires social assistance interventions. Most of the approximately 127,172 persons living in category D households are children²⁴.

According to Figure 4.5 below Eswatini people earn a living through formal employment, remittances, business, agriculture (livestock, poultry and crop/vegetable farming), grants, casual labor, skilled labor, pension and petty trade.

²³ UNICEF. 2017. Quantitative Assessment of the Social Assistance System in the Kingdom of Eswatini. UNICEF, Mbabane

²⁴ UNICEF. 2017. Quantitative Assessment of the Social Assistance System in the Kingdom of Eswatini. UNICEF, Mbabane

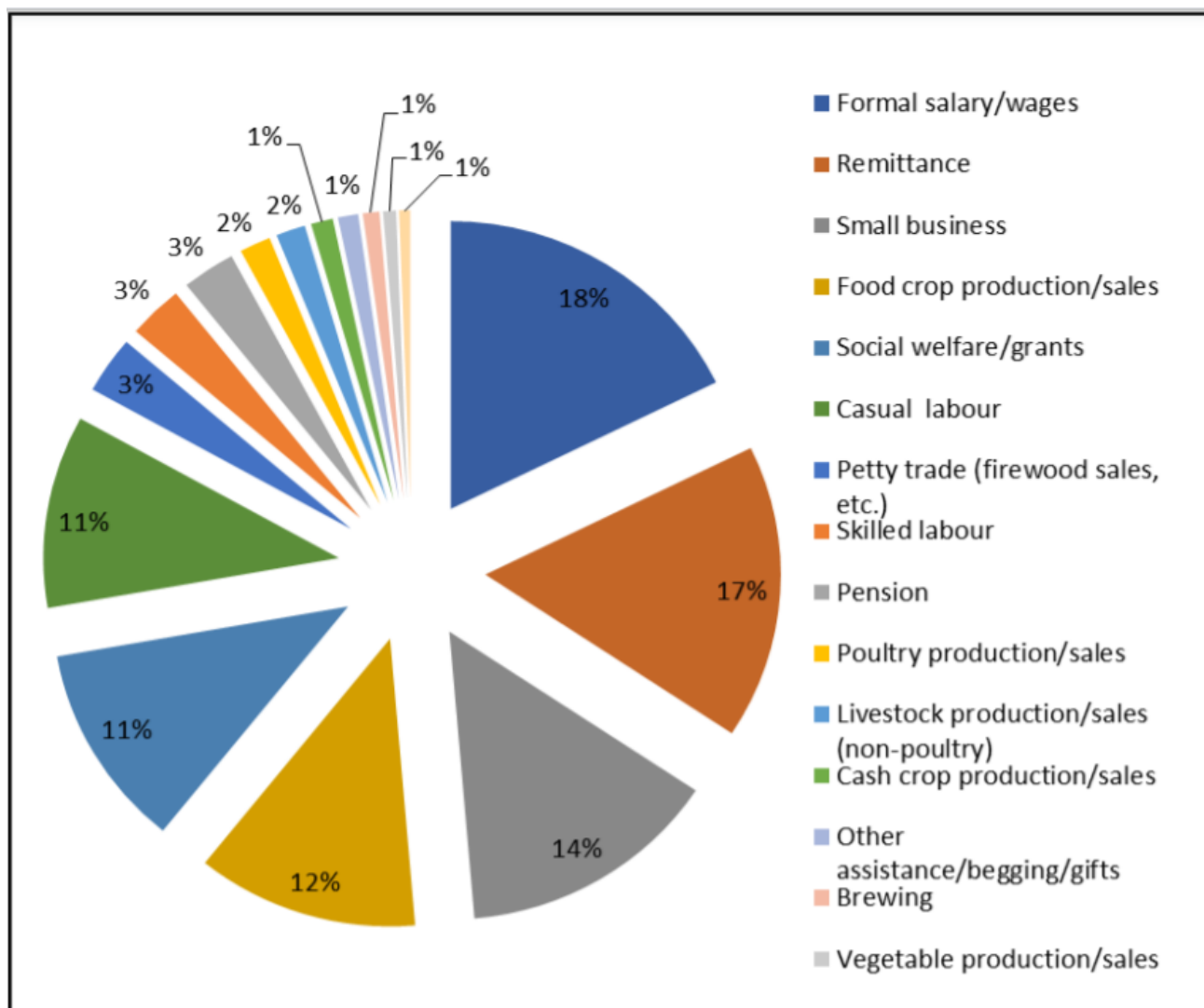


Figure 4.5: Eswatini Livelihood Status²⁵

Formal employment, remittances, business, food crop production, grants and casual labour amount to 80% of the total livelihoods activities in Eswatini. Reported key drivers of food insecurity i.e. loss of employment, drought/prolonged dry spells and death of household breadwinner and other external factors will significantly affect the household sources of livelihood. According to the 2019 Vulnerability and Livelihoods Assessment, there were no significant changes in livelihood coping strategies in Eswatini in 2018 and 2019²⁶.

²⁵ GoKE.2019. Annual Vulnerability Assessment & Analysis Report 2019. Deputy Prime Minister's Office, Mbabane

²⁶ GoKE.2019. Annual Vulnerability Assessment & Analysis Report 2019. Deputy Prime Minister's Office, Mbabane

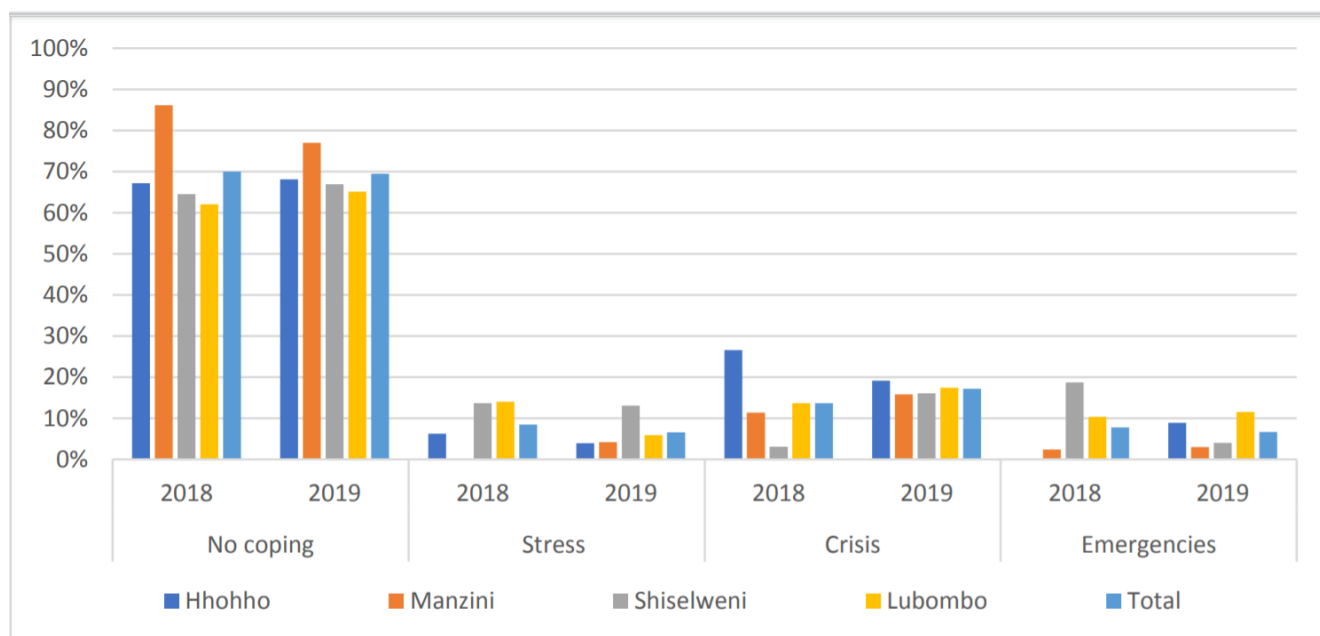


Figure 4.6: Coping Strategies for Families in Eswatini per Region²⁷

More than 60% of families did not need to apply coping strategies in 2019 and less than 30% of families had to be adopt stress, crisis and emergency strategies to cope with food supply challenges. COVID-19 has already adversely impacted the economy through the restrictions imposed by government. Production and supply of food has been heavily disturbed. There has been several job losses observed over the past 8 months due to businesses scaling or closing down and most livelihood activities have been reduced or halted. Jobs losses and lower demand for businesses tend to feed into each other. In Eswatini, a clear majority of businesses can be categorized as micro and small enterprises. Owners of such businesses may not have the necessary and enough cushions or safety nets to resist the shock. Many households to engage stress, crisis and emergency coping mechanisms. At present, 59% of Swazis are living below the nationally defined poverty line. Those ones will be even more vulnerable to the economic shocks emanating from COVID-19. Among the poor, levels of deprivations and vulnerabilities vary. For those close to the poverty line, COVID-19 may easily bring them further below the poverty threshold. In Eswatini, close to 29% of the population is living in extreme poverty. The Government has been driven to disburse aid to small businesses and grants to households under extreme poverty in Eswatini. If the pandemic prevalence continues, the situation will worsen²⁸.

4.6 Disadvantaged and or Vulnerable Groups

Eswatini has considerable achievements in HIV treatment, such as antiretroviral therapy (ART) coverage of 82 percent and a significant reduction in mother-to-child transmission, however, the country still has the highest HIV prevalence in the world, with 26 percent of the adult population infected. Women are disproportionately affected, with 35 percent living with HIV compared to 19 percent of men. About 59 percent of orphans in the country have lost parents to HIV- and AIDS-related deaths. HIV and AIDS have

²⁷ GoKE.2019. Annual Vulnerability Assessment & Analysis Report 2019. Deputy Prime Minister's Office, Mbabane

²⁸ United Nations. 2020. ECONOMIC SITUATION REPORT #1—COVID-19. United Nations, Mbabane

destabilized families and communal support systems, as evidenced by a dramatic increase in the number of vulnerable children and households headed by children and elderly people. National estimates indicate that there are presently 90,127 orphans and vulnerable children (OVC) in Eswatini. OVCs either have HIV or are negatively affected by the epidemic, and their caregivers often suffer from ill health and economic challenges that result in reliance on elderly family members, the community or the Government to provide the support and protection that they need. Pervasive structural disparities have led to gender inequalities that disadvantage women, and the country's dual legal system, which is based on a constitutional legal framework and traditional and customary laws, provides women and girls with limited protection. This is evident in the limited access of women to economic opportunities, productive assets, agricultural value chains and education and health care. Over 25 percent of women 25 years and older and 50 percent of women 15–24 are unemployed. Female-headed households, children and the elderly are disproportionately affected by poverty, food insecurity and disease. Vulnerable groups often left behind or at risk of being left behind are more dramatically affected by COVID-19 pandemic. Those groups include Women, Children, Elderly, Youth, Extreme poor and near poor, Persons with Disability, Informal sector workers, Migrants, SMEs/Entrepreneurs, People affected and Infected by HIV, Persons with TB, people in close setting (e.g. Prisons) and rural populations²⁹.

Vulnerable and marginalized groups are likely to be left out from the vaccine program because of their social and economic status. Their ability to access or be qualified for the vaccine would likely get constrained by factors such as gender, race, ethnicity, socioeconomic status, religion, sexual orientation, disability, location, residence status. These factors are likely to limit individual's ability to be qualified and receive the vaccine in equitable fashion. Making the vaccine affordable, inclusive and responsive to the needs of the most marginalized and excluded groups is critical. In this regard the NVDP will be required to: i) address immediate policy issues and ensure vaccine eligibility policies are equitable and inclusive at the national level, ii) address concerns of excluded and marginalized groups and make effort to provide last mile service deliver, iii) monitor who is being included/excluded and ensure accountability and, iv) address institutional challenges to inclusion.

4.7 Sexual Exploitation, Harassment and Abuse and Gender Based Violence

Eswatini has very insignificant cases of conflict-related deaths of about 0.0017%. The Number of victims of intentional homicide per year in the country increased from 112 in 2016 to 123 in 2018 which is an increase by 8.9%. There is evident increase in domestic related abuse, reported cases of abuse increased from 7729 in 2015 to 10504 in 2016 this is an increase by 26.4%. Rates of GBV in Eswatini and these include violence against children and child sexual assault are alarmingly high. The mechanisms needed to prevent and respond to these atrocities, and the legal framework necessary to punish those who perpetrate these acts are inadequate and, in some cases, entirely non-existent. In Eswatini, it is expected that one in three Swazi girls will experience some form of sexual violence by the time they are 18 years old, while almost half of Swazi women will experience some form of sexual violence over their lifetime. Intimate partners, such as husbands and boyfriends, are most likely to be the perpetrators of sexual violence against women, making a woman's home often a very dangerous place³⁰. Available sources on GBV prevalence in Eswatini suggest that levels could be high compared to the region and globally. The most recent national survey of S/GBV is from a 2007 UNICEF National Study on Violence Against Children and Young Women (UNICEF 2007), which reported that 35.6 percent of women experienced sexual

²⁹ United Nations. 2020. ECONOMIC SITUATION REPORT #1—COVID-19. United Nations, Mbabane

³⁰ SWAGAA. 2020. Gender Based Violence. <http://www.swagaa.org.sz/gender-based-violence/> accessed 11/10/20

violence before age 18. Lifetime prevalence of sexual violence was 48.2 percent. Additionally, 25 percent of women had experienced physical violence as a child, and 3 in 10 experienced emotional abuse. These compare to global prevalence rates of 35 percent for sexual or physical violence (WHO 2013).

Global evidence suggests that since the beginning of the COVID-19 pandemic and particularly during the lockdowns, incidence of GBV has increased globally. As pressures from lack of income and job security increase, tensions in households increase and with it the likelihood of domestic violence. In Eswatini given that women are more likely than men to also take care of elderly family members (a high-risk group), it can create unusually high levels of stress and tensions within a family and put women disproportionately at risk of verbal or even physical abuse. The Women and Law in Southern Africa have reported an increase in the number of GBV cases in Eswatini since the COVID-19 pandemic, and that those cases mostly affect women and children.

Drivers of GBV in Eswatini appear related to institutional and community-level drivers such as lack of confidential reporting mechanisms for both adults and children and community reluctance to get involved in family matters.³¹ Eswatini has in place legislation, namely the *Sexual Offences and Domestic Violence Act (2018)* that is seen as an important step toward addressing S/GBV as a serious barrier to women's empowerment, especially given that penalties for S/GBV perpetrators under customary law are very lenient. It has also developed a *National Strategy and Action Plan to End Violence (2017-2022)* which is a comprehensive five-year plan identifying strategic intervention areas in ending violence in Eswatini, providing targets to be met by various stakeholders. The strategy identifies key result areas, namely in-service provision, advocacy, lobby and prevention, management, co-ordination and collaboration, research and evaluation.

Rates of violence against children and child sexual abuse in Eswatini are staggering, with nearly nine in ten children experiencing some form of physical violence or psychological aggression. Unfortunately, most of these cases are never reported and no counselling services are provided for the victims. Sexual exploitation, harassment and abuse cases are already increasing due to the restrictions imposed. Swaziland Action Group Against Abuse (SWAGAA) reported that abuse cases doubled to at least 40 cases between 30 March and 24 April 2020. The cases reported were for emotional and sexual abuse³².

4.8 Water, Sanitation and Hygiene

Clean water, basic toilets and good hygiene practices are essential for the survival of Eswatini children. Water and sanitation-related diseases are one of the leading causes of death for children under five years of age. Achieving universal access to drinking water and sanitation by 2030 will be challenging given current levels of investment, coordination, national partnerships and climate variability. Influencing national behaviour change toward good hygiene practice and ending open defecation remain a national challenge. Eswatini has clear gap in the access between Urban Rural communities and growing informal settlement around the urban centers. Only 69 per cent of Eswatini's population have access to basic water services and only 58% have access to sanitary services (11 per cent open defecation) and hygiene

31 The Swaziland Deputy Prime Minister's Office (DPMO), the University of Edinburgh (UoE), the University of Swaziland (UNISWA)

and the United Nations Children's Fund (UNICEF) Swaziland (UNICEF Swaziland). *The Drivers of Violence Affecting Children in Swaziland: Synthesis of Findings*, Mbabane: UNICEF, 2016.

³² All Africa. 2020. Swaziland: Domestic Abuse Cases Double in Swaziland During Coronavirus Lockdown. <https://allafrica.com/stories/202005060645.html> Accessed 11/10/20

access using hand washing as a proxy indicator only 24 per cent of Eswatini households practice handwashing (WHO, 2019). Table 4.3 below summarizes access to water and sanitation in urban and rural households in Eswatini.

Table 4.3: Access to Water and Sanitation in Urban and Rural Households in Eswatini³³

	Urban (%)	Rural (%)
Access to improved sources of water	96	63
Access to piped water on premises	95	28
Access to improved sanitation	94	78

Sanitation coverage nationally is relatively low in rural areas based on available data. Of the 78 percent of the rural population with access to improved sanitation, 2 percent is connected to sewerage systems, 4 percent use septic tanks, and 72 percent use latrines and other improved types of facilities, of which 29 percent are shared. The remaining 22 percent of the rural population either have access to unimproved facilities (8 percent) or practice open defecation (14 percent). In addition, only 25 percent of the population in rural areas have handwashing facilities³⁴. Poverty prevalence and access to water supply, sanitation, and hygiene are strongly correlated, with the lowest quintiles having the least access. The data available do not provide clear diagnostics for the level of sanitation service across the service chain (containment, conveyance, transport, treatment, and reuse) and how poor sanitation and hygiene are affecting health. The COVID-19 pandemic will require improvements in water, hygiene and sanitation in a bid to contain the virus through proper hand washing and sanitary practices. A clean water supply and properly constructed and managed sanitary facilities will be needed especially in the rural areas where access to water and sanitary facilities is still wanting.

4.9 Health and Nutrition

Eswatini is under constant threat from infectious diseases, food contamination, antimicrobial resistance, traffic accidents and other emergencies. Humanitarian crises due natural disasters, disease outbreaks and other hazards are a major and growing contributor to ill health and vulnerability. The country has made significant progress in the health sector. The average life expectancy at birth stands at 59 years compared to 54 years in 2014. Infant mortality and under-five mortality rates have reduced from 79 and 104 per 1000 live births in 2014 to 42.7 and 56.3 per 1000 live births respectively. Despite these positive strides, maternal mortality ratio estimated at 320 per 100,000 live births in 2010 currently stands at 389 per 100,000 live births while neonatal mortality rate estimated at 19 per 1000 live births in 2014 stands at 19.5 per 1000 live births. The HIV prevalence estimated at 26% among the sexually active population in 2014 now stands at 27%. However, the HIV incidence among adults and children per 1,000 uninfected populations which was 2.2 in 2014 has reduced to 1.85 and ART retention rate has increased from 82% in 2014 to 88%. Tuberculosis burden including Multi Drug Resistant (MDR-TB) declined by 30% with 70% of cases bacteriologically confirmed. TB treatment outcomes were 52% cured and 33% completed. Percentage of children who are fully immunized increased from 75 in 2014 to 89 in 2016. Malaria deaths per 1,000 of population have reduced from 0.006 in 2014 to 0.002. Non-Communicable diseases

³³ World Bank. Eswatini Water Supply and Sanitation Access Project. World Bank

³⁴ World Bank. Eswatini Water Supply and Sanitation Access Project. World Bank

particularly hypertension, diabetes and cancers are becoming a growing problem and have not received adequate attention in the last years (WHO, 2018). The disparity in access to social services and gender distribution of wealth and social services is an important determinant for health³⁵.

Although The majority of the people living with NCD in Eswatini (>80%) are undiagnosed (STEPS, 2014), the burden of hypertension and type 2 diabetes as comorbidities of COVID-19 is extremely high in the population and often results in complications such as kidney related diseases. Routine data confirms the increasing burden of non-communicable diseases. The common comorbidities associated with severe disease and mortality includes the following: Hypertension, Diabetes mellitus, chronic respiratory disease (asthma, TB, silicosis, COPD) cardiac disease and cancers.

Table 1: Distribution of the number of NCD clients seen at OPD in CMIS facilities by region, 2018-2019

Region and condition	Asthma		Diabetes		Hypertension	
	2018	2019	2018	2019	2018	2019
Hhohho	16	978	343	917	5326	5720
Lubombo	38	1242	447	1260	5824	7309
Manzini	17	930	200	473	4383	4985
Shiselweni	40	1264	708	1373	6912	8155
National	109	4342	1663	3974	22161	25555

Malnutrition, which affects both children and adults, has significant adverse consequences by impaired cognitive development and reduced adult productivity leading to poor economic performance. According to the Cost of Hunger report of 2013, Eswatini lost about 783 Million emalangeni (3.1 percent GDP) in the year 2009 because of under-nutrition. Chronic malnutrition, whose prevalence is about 20 percent (EHIES 2017) among children under the age of two years, has remained high. A recent shift in malnutrition indicators has been noticed around the four regions in the country. The prevalence of stunting and overweight in children is high in Hhohho region which is a region that is known to perform well when it comes to food and nutrition security issues. The prolonged prevalence of the COVID-19 Pandemic will disturb food supply systems and the economy and this will ultimately impact and leave lasting impressions especially on the vulnerable groups with health conditions³⁶.

³⁵ GoKE.2019. Annual Vulnerability Assessment & Analysis Report 2019. Deputy Prime Minister's Office, Mbabane

³⁶ GoKE.2019. Annual Vulnerability Assessment & Analysis Report 2019. Deputy Prime Minister's Office, Mbabane

4.10 Health Care Management

According to the latest Service Availability and Readiness Assessment done in 2017, over a period of 10 years (2006-2017), the number of health facilities have doubled in Eswatini from 154 to 327³⁷. Table 4.4 below details the number of facilities per region.

Table 4.4: Number of Health Facilities by Region³⁸

Region	Number
Hhohho	130
Manzini	100
Shiselweni	45
Lubombo	52
Total	327

From the above table, Eswatini attends to 3700 people per clinic which is well within the guideline stipulated by the WHO (10, 000 people per clinic). The Manzini Region has the highest number of facilities (130) and Shiselweni has the least (45) which correlates with the respective populations.

There are several types of Health Facilities in Eswatini and these are summarized in Table 4.5 below.

Table 4.5: Distribution and readiness of health care facilities for COVID-19³⁹

Health Facility Type	Number	COVID-19 services provided
National Referral Hospital	1	Screening, Testing, Isolation, Case Management, Referral
Regional Referral Hospital	5	Screening, Testing, Isolation, Case Management, Referral
Specialized Hospital	3	Screening, Testing, Isolation, Referral
Health Centre	5	Screening, Testing, Isolation, Case Management, Referral
Public Health Unit	7	
Clinic with maternity	29	Screening, Testing, Isolation, Referral
Clinic without maternity	203	Screening, Testing, Isolation, Referral
Specialized Clinic	65	Screening, Testing, Isolation, Referral
Other	9	Screening, Testing, Isolation, Referral
Total	327	

As expected, the number of clinics is high compared to the larger facilities but what is of grave concern is limited number of referral hospitals. There is only one national and 2 regional referral hospitals. Almost all the HCFs screen, test, isolate and refer COVID-19 cases but only the regional health centres and hospitals have the capacity to manage cases. Complicated cases are referred to the Mavuso Trade Centre and Lubombo Referral Hospital. Figure 4.7 below shows hospital (referral and regional) distribution in the country:

³⁷ GoKE. 2017. Service Availability and Readiness Assessment. Ministry of Health. Mbabane

³⁸ GoKE. 2017. Service Availability and Readiness Assessment. Ministry of Health. Mbabane

³⁹ GoKE. 2017. Service Availability and Readiness Assessment. Ministry of Health. Mbabane

Figure 4.7: Distribution of Hospitals in Eswatini

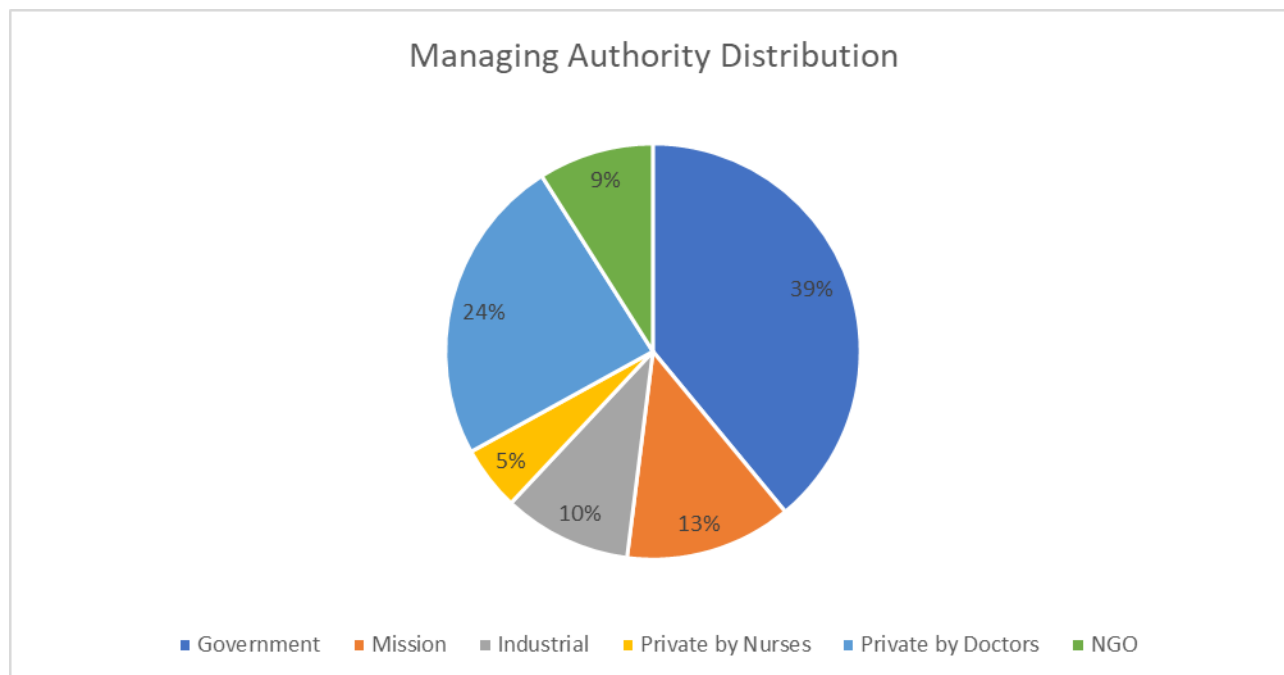


Figure 4.8: Managing Authority Distribution of Health Facilities⁴⁰

Most of the facilities are owned by government which translates to improved access to health services due to affordability but decreased efficiency. The presence of NGO and Mission managed facilities also translates to improved access for all. Industrial and privately managed facilities assist in lessening the pressure on public facilities. In some cases, the private and industrial facilities provide additional services that are lacking in public facilities. A total of 81% of facilities had basic amenities for general services available, of which, 74% were ready to provide the service. Seventy-four (74%) percent of health facilities had basic equipment available, only 81% were ready to use the equipment. There were 75% of facilities that had standard precautions for infection control, of which 81% were ready to use. Sixty (60%) of health facilities had diagnostic capacity, of which 60% had it ready to use. Sixty (60%) of health facilities had on average all essential medicines in the facility, of which 33% were ready to use. The Mean availability of Infection Prevention Precaution items was high ($\geq 75\%$) across all levels of health facilities except specialized clinics.

The COVID-19 Pandemic will inevitably impact the health care system in Eswatini. All available health centres including the National Laboratory, resources and processes will have to be readied, improved and or aligned to cope with related challenges. Eswatini is not adequately equipped to respond to a global pandemic of this nature and this magnitude. Moreover, while the population is concentrated in the valleys, 75% of people live in rural areas; the mountainous terrain of the country makes it difficult for the population to access health facilities⁴¹. Eswatini currently has 11 hospitals and five health centers that

⁴⁰ GoKE. 2017. Service Availability and Readiness Assessment. Ministry of Health. Mbabane

⁴¹ United Nations. 2020. ECONOMIC SITUATION REPORT #1—COVID-19. United Nations, Mbabane

provide secondary care, providing an average of 2.1 hospital beds per 1000 population (compared to an average of 2.4 and 4.1 beds per 1000 population in low- and middle-income countries and high-income countries respectively). Only two hospitals have an intensive care unit (ICU) - Mbabane Government Hospital (MGH), the Lubombo National Referral Hospital, and Raleigh Fitkin Memorial Hospital (RFMH), a mission hospital – providing a total of 14 ICU beds. Due to ICU demand from non-COVID-19 cases at MGH, the GoKE has decided to increase ICU bed capacity in RFMH and introduce ICU services in the Lubombo National Referral Hospital.

COVID-19 Status Quo

Eswatini recorded the first case of COVID-19 on 13th March 2020. Subsequently, His Majesty King Mswati III invoked section 29 of the Disaster Management Act 2006 and declared the COVID-19 pandemic a National Emergency in the Kingdom of Eswatini from the 17th of March 2020. Even though the country is implementing comprehensive public health measures – such as rapid case identification, rapid testing and isolation of cases, comprehensive contact tracing and quarantine of contacts – the country has not managed to suppress the spread of COVID-19. Eswatini has sadly incurred losses at a high level in Government when the Prime Minister Ambrose Dlamini died in December 2020 due to COVID-19 complications. The loss of the Prime Minister and two other members of Cabinet has increased awareness within Eswatini and beyond. As of March 17, 2021, the country of 1.16 million had recorded 17,257 confirmed cases, and 663 deaths, figures which show a sharp escalation from the previous months, surpassing the July 2020 peak of both daily confirmed cases and deaths (Figure 2.1). The Eswatini situation mirrors observations made in neighboring South Africa, where a large second wave unfolded at a concerning rate, exacerbated further by the December holidays and the spread of a new variant of concern, the B.1.351, which is likely to be highly transmissible, quickly becoming the predominant variant in South Africa⁴². As of March 2, 2021, it has been identified in 56 countries, including Botswana, Ghana, Kenya, the French Indian Ocean region of Mayotte, Zambia, Malawi, Tanzania, and other non-African nations^{43,44}. The B.1.351 variant was also common in Eswatini in a recent genomic surveillance, given its close proximity and economic linkages with South Africa. While there are signs the second wave is abating, there is a continuing risk of increased escalation of the epidemic. In addition to the increased transmission, the B.1.351 variant is of immense concern due to its potential for vaccine escape. It will be critical for Eswatini to quickly scale up effective and safe vaccines while continuing to strengthen the overall COVID-19 response. Eswatini has an established relationship with South Africa for the sharing of medicine product registration information. Due to South Africa's more developed medicines and related products registration capacity, it is able to share information with the Eswatini MOH on items that have either been approved or rejected and the reasons thereof. The collaboration is being implemented for vaccines.

⁴² Tegally H., Wilkinson E., Giovanetti M., et al. Emergence and rapid spread of a new severe acute respiratory syndrome-related coronavirus 2 (SARS-CoV-2) lineage with multiple spike mutations in South Africa. medRxiv 2020.12.21.20248640; doi: <https://doi.org/10.1101/2020.12.21.20248640>

⁴³ CDC Africa region

⁴⁴ <https://www.who.int/publications/m/item/weekly-epidemiological-update---2-february-2021>

Figure 4.9 Daily New Confirmed COVID-19 Cases and Deaths per Million People

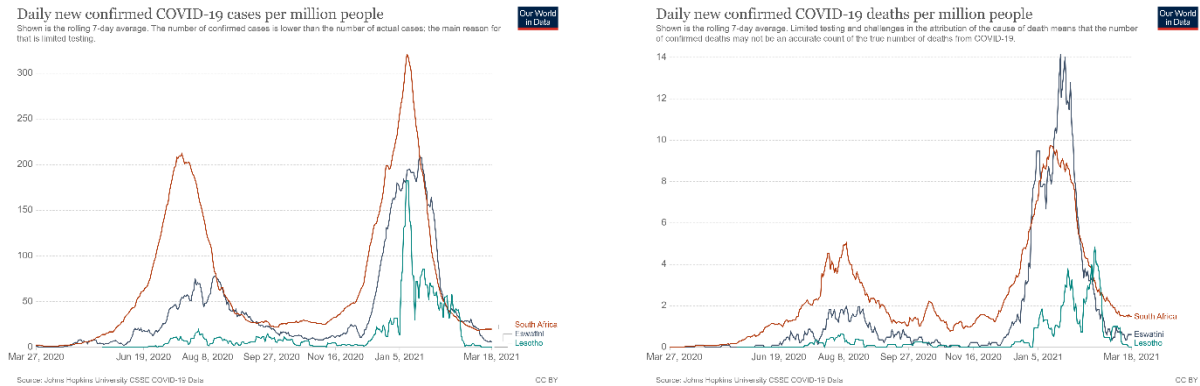


Figure 4.10 below shows the distribution of COVID’s impact by region. Hhohho has the highest number of cases whilst Shiselweni has the least number of cases. Hhohho and Manzini cases have more than tripled cases in Shiselweni and Lubombo. This could be due to the high number of daily movements especially in the two major cities (Mbabane and Manzini) within the two regions.

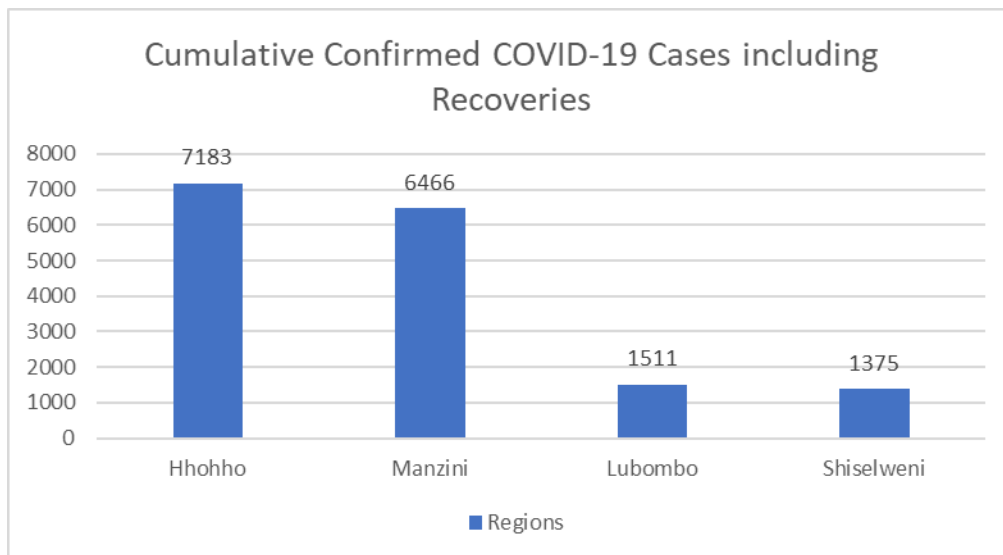


Figure 4.10: Confirmed COVID-19 Cases including Recoveries Per Region

Age-sex distribution of COVID-19 cases (Cumulative)

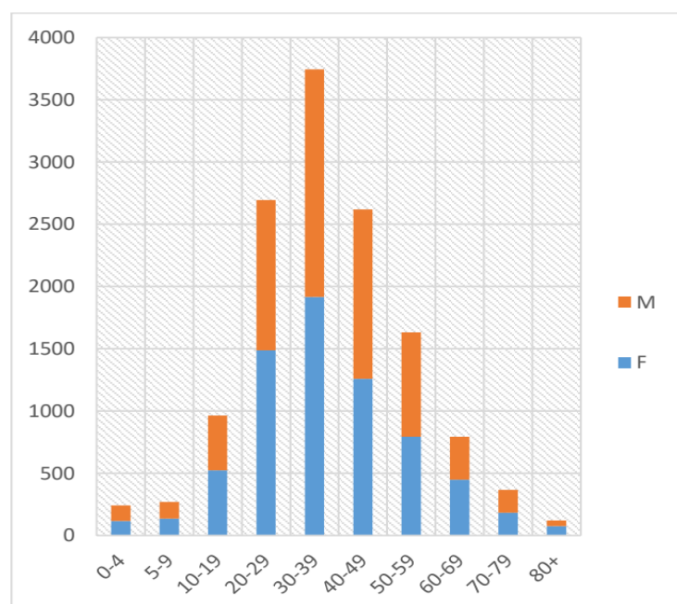


Figure 4.11: Age-Sex Distribution of COVID-19 Cases (Cumulative)

The age 30-39 Years has the highest infection rate which is the highly mobile age group and Fifty-two Percent (52%) of the cases are female and 48% are male. The sharp increase in confirmed cases overly stretched the health system and this resulted in a sharp increase in the case fatality rate. The increase in cases prompted the re-instating of partial lockdown restrictions which exerted further pressure on the socio-economic environment. Travelling, schools, religious gatherings and liquor outlets were restricted. An increase in GBV cases was noted.

The following progress was observed within the context of the National Contingency Response Plan have been actualized:

COORDINATION, PLANNING AND MONITORING

- The country has adopted an incident management approach for responding to emergencies that established the Incident Management Team (IMT) that meets on a daily basis at the PHEOC.
- The national Incident Action Plan (IAP) has been finalized for period 20th January to 20th February 2021.
- The pillars review and reports on implementation progress of the Incident Action Plan (IAP) every two weeks.
- The IMT Managers reports progress on the COVID-19 response to Senior Staff of MoH every Monday and to Cabinet every Tuesday.
- RHMTs and regional PHEMCs provide feedback to IMT every week.
- Development partners participate in IMT meetings virtually during the thematic presentation.
- The country has received technical experts for critical care from WHO to assist the country in management of COVID-19 critical patients.

RISK COMMUNICATION, COMMUNITY ENGAGEMENT & SOCIAL MOBILISATION

- The national campaign "Umgcini Wesive" for COVID-19 prevention was launched by His Excellency the Right Honorable Prime Minister of the Kingdom of Eswatini and implementation is ongoing.

- Risk communication messages continue to be aired in all media houses and the Risk Communication Team is working on reviewing and updating messages to address emerging issues

SURVEILLANCE AND RESPONSE

- COVID -19 screening is ongoing in all health facilities to identify suspect cases.
- EFTTIT teams are continuing with the door-to-door screening and testing for COVID-19 in identified hotspots as well as congregate settings.
- The RRTs continue to do case investigation, contact tracing and screening of suspected cases in all regions.
- There have been some efforts to step up contact tracing through establishment of contact tracing stations “kiosks” in selected areas in the Hhohho region. Index cases are called, screened and referred for testing and such strategies will be rolled out to other regions as per the need.

POINTS OF ENTRY

- Screening of travelers is ongoing in all presently opened Formal 7 Points of Entry (PoE) by Port Health Officers (PHOs).

LABORATORY

- Antigen testing of inbound travelers at Ngwenya Boarder Gate is ongoing.
- Antigen testing has been adopted as one of the testing strategies in the country and has been introduced in all hospital and health centres (private and public).

INFECTION PREVENTION AND CONTROL

- The IPC team continue to conduct supportive supervision in health facilities and IPC training of health care workers is ongoing.
- The E&S Team met with the Quality Management Team (IPC National Focal Person and Client Care) to identify gaps and offer support planned activities;
- A Monitoring and Evaluation Framework has been prepared by the IPC National Focal for monitoring purposes and it will be rolled out to the rest of the team.

CASE MANAGEMENT

- The Hhohho and Manzini Regional Health Management Teams are working with Regional Hospitals and Health Centre to decentralize management of confirmed COVID-19 cases. The teams were oriented on updated case management guidelines.
- The ministry has established a site for initiation of care at the EPR site in Malagwane and Zakhele Hall for COVID-19 positive patients registered under home care.
- The case management team is conducting supportive supervision on COVID-19 case management to health facilities.
- A weekly platform (Wednesdays) has been formulated to discuss COVID-19 issues and share clinical experience with a focus.

Vaccine Preparedness

Eswatini's health system has established expertise and skills for childhood immunizations. Expertise and skill in adult immunization is limited. The regulation of medicinal products in Eswatini is provided for in the Medicines and Related Substances Control Act No.9 of 2016. This Act provides for the establishment of a National Medicines Regulatory Authority (NMRA); it also has provisions for a number of medicinal product regulation including product registration and patient safety monitoring. The NMRA has currently not been established, the provisions in this Act are currently implemented by the Ministry of Health (MOH) through the Medicines Regulatory Unit (MRU). The current capacity of the MRU to adequately implement the regulation of medicinal products is constrained due to limited resources (human, financial and infrastructure). There are currently 2 pharmacists responsible for pharmacovigilance issues in the Unit (one engaged by government and the other is partner supported), these are supported by 2 data officers (one engaged by government on a short-term contract and the other is partner funded). The other 2 pharmacists, both engaged by government, are responsible for all the other regulatory functions of the Unit. These include registration of pharmaceutical establishments, inspections, product listing procedure, import/export control and clinical trial oversight among other duties.

Section 34(1) of the Medicines and Related Substances Control Act of 2016 states that "a person shall not sell any medicine or medical device unless the immediate container and the package in which it is sold are labelled with its registered name, registered number and any other prescribed particulars". The prescribed particulars are currently in a draft regulation. Section 34(3) of this Act further states that "the Minister may, after consultation with the Authority, by regulation, provide for exemptions to subsection (1)". As the country is currently not actively registering products, the national labelling requirements for the supply of COVID-19 vaccines procured through the COVAX Facility will be waived. Authorization will be given for vaccines distributed by the COVAX Facility to be labelled in compliance with the WHO Labelling Model.

To facilitate the regulatory, import, vaccine lot release testing and labelling requirements for the roll out of COVID-19 vaccines in Eswatini activities in the regulatory approval and importation plan will be implemented. The capacity to conduct vaccine lot release testing is currently not in place in the MRU in Eswatini. The immunization programme in the country is currently only utilizing WHO Prequalified vaccines, the regulatory requirement for vaccine lot release is therefore waived for all vaccines imported into the country. The same approach would be employed for COVID-19 vaccines supplied through the COVAX Facility; batch to batch verification would also be waived. This approach is supported by the advice from WHO which states that vaccines procured from assured sources, like WHO prequalified vaccines, vaccines listed as EUL, or vaccines approved by SRAs, should not be tested again by receiving countries as they have been tested and released already by NMRAs with stable, formal approaches for vaccine approval. The lot release certificate of the responsible NRA/NCL of the producing country will however be required for submission to the MRU. A mechanism for lot release testing of vaccines received through self-procurement, donations and/or UN supply outside the COVAX Facility would be investigated and the best option adopted.

The MOH, with support from DPs has conducted a vaccine readiness assessment, initially using the COVID-19 Vaccine Introduction Readiness Assessment Tool (VIRAT) and the Vaccines Readiness Assessment Framework (VRAF), to identify gaps, costs and options to manage the COVID-19 vaccine deployment. Table 4.5 below summarizes the findings:

Table 4.5: Vaccination readiness findings from the VIRAT/VRAF 2.0 assessment

Core Activity Areas	Assessment Area	Readiness and Measures to Address Key Gaps
A. Planning and Management	A1. Vaccination objectives and targets	• <u>Readiness</u>: In progress, maturity stage • <u>Key gaps and measures to address them</u>: The COVID-19 vaccine introduction plan is yet to be developed along with the other required strategy documents including the priority target groups identification strategy, risk communication and demand creation strategy and the vaccine deployment strategy/standard operating procedures (SOPs). To address these gaps, the GoKE through the MOH has appointed a NCC, a national TWG and the national immunization technical advisory group (NITAG) to lead various aspects of the country's readiness agenda with support from development partners including the World Bank Group (WBG), WHO, UNICEF, CHAI and PEPFAR. To build on existing experience for immunization, the MOH has appointed the EPI to be the implementing agency for the vaccine introduction and roll-out plan. Clear timelines have been set for the vaccine plan to be ready and costed, the inception meeting for the TWG has taken place and subcommittees for the different pillars of the introduction plan have been appointed. First draft of the costed vaccine introduction plan is expected by mid-December 2020.
	A2. Regulation and Standards	• <u>Readiness</u>: In progress, early stage • <u>Key gaps and measures to address them</u>: There are no regulatory measures in place for approval of COVID-19 vaccines, but the MOH through the Medicines Regulatory Unit is putting together plans to conduct assessment of vaccine candidates, when they become available, with support from the WHO and the technical advice of the NITAG. The MOH is committed to only allow the use of WHO approved vaccine candidates in Eswatini. To ensure a smooth delivery of vaccines once available, the MOH has included COVID-19 vaccines in the list of health products that are tax free and is working on developing regulations to guide who will have access, how and when for the vaccines.
	A3. Performance management and M&E	• <u>Readiness</u>: In progress, early stage • <u>Key gaps and measures to address them</u>: The gap analysis of delivery capacity is not yet known though a cold chain inventory assessment has been recently conducted by the EPI. Existing M&E systems do not currently include data elements relating to COVID-19 vaccines and the outreach schedule for target populations is yet to be developed pending finalization of the vaccines introduction plan. Measures taken to address these gaps to date include the appointment of a surveillance and M&E subcommittee to work on the performance management and M&E of the vaccine's introduction plan, identification of technical assistance required to support the analysis and identification of the cold chain gaps from the recent inventory assessment

		conducted by EPI as well as the planned development of the M&E framework for the vaccines introduction plan.
	A4. Budgeting	• <u>Readiness:</u> In progress, early stages • <u>Key gaps and measures to address them:</u> The costs for the vaccine program are unknown pending development and costing of the vaccine introduction plan scheduled for mid-December 2020. The MOH is aiming to integrate the budget for vaccines into the current COVID-19 response budget that is already part of government's annual allocation to health. A costing team will be appointed as part of the vaccine introduction plan development process and the final budget will be submitted for approval by cabinet through the MOH principal secretary's office.
B. Supply and Distribution	B1. Vaccines, PPEs and other medical and non-medical supplies	• <u>Readiness:</u> In progress, early stages <u>Key gaps and measures to address them:</u> The GoKE has committed to procure COVID-19 vaccines through the COVAX facility and has submitted the request to GAVI as part of the requirements for countries under this mechanism. However, the procurement plan is yet to be developed as part of documents to be prepared once the vaccine introduction plan has been developed. PPE, syringes and safety boxes needs have been identified but these are yet to be fully costed. These activities will be completed once the priority target population is finalized and identified.
	B2. Logistics and cold chain	• <u>Readiness:</u> In progress, early stages <u>Key gaps and measures to address them:</u> The country is yet to develop a distribution strategy from points of entry to the front-line although transport, stocking and other components of the supply chain have been preliminarily identified, pending finalization by the TWG when developing the vaccine introduction plan. Cold chain requirements at all locations have been discussed but not finalized pending analysis of the inventory assessment data during the vaccine introduction plan development. The country is gearing up to strengthen the existing systems for tracking and monitoring the distribution of vaccines and key supplies by introducing a vaccines logistics management and information system for the EPI.
	B3. Waste management	• <u>Readiness:</u> In progress, advanced stages <u>Key gaps and measures to address them:</u> the GoKE has already developed and disclosed a waste management plan for COVID-19. However, this will have to be revised to include specific waste generated under the vaccine program and the practices and guidelines on disposal routes thereto. As part of measures to address this, the TWG has appointed a subcommittee to ensure appropriate waste management systems in all relevant sites are in place and that human resource capacity is available and adequately trained.
C. Program Delivery	C1. Community engagement and advocacy	• <u>Readiness:</u> In progress, early stages • <u>Key gaps and measures to address them:</u> A subcommittee on community engagement and advocacy has been appointed but the social mobilization and engagement strategy is yet to be developed. Human resources needed for community outreach is yet to be determined and resources to deploy are yet to be sourced. It is expected that the subcommittee will produce the strategy alongside the vaccine introduction plan and identify the

		risk communication materials and platforms to be used as part of the social mobilization strategy. The human resource need for to manage social media rumor and assess behavioral issues has been communicated by the subcommittee for MOH's consideration.
	C2. Points of delivery	• <u>Readiness:</u> In progress, early stages <u>Key gaps and measures to address them:</u> the GoKE is yet to decide on points of delivery best suited to deliver the vaccines, to all the priority target groups, and design and implementation modality of monitoring tools including vaccination cards/certificates (awaiting the finalization of the deployment strategy and M&E framework for the vaccination program). Delivery protocols are yet to be developed and disseminated. Although qualified healthcare workers are available to deliver safe injections across all facilities, adequate trainings are yet to be conducted; this will also be completed after the vaccine introduction plan and deployment strategies are finalized.
	C3. Vaccine safety surveillance	• <u>Readiness:</u> In progress, early stages <u>Key gaps and measures to address them:</u> The country has an AEFI committee providing oversight for adverse events for routine vaccines but not for COVID-19 vaccination and the training they received does not include COVID-19 vaccines yet. Protocols for adapting surveillance systems for vaccine preventable diseases are still to be developed. The country intends to expand the current AEFI committee in scope and numbers to streamline the surveillance of adverse events for vaccines within the MOH and to increase efficiencies.
D. Supporting Systems and Infrastructure	D1. Data quality	• <u>Readiness:</u> In progress, early stages <u>Key gaps and measures to address them:</u> Although there is an electronic management system for medical records in the country (the client management information system [CMIS]), in its current form vaccinations for COVID-19 have not been included though routine vaccinations are included. Coverage of CMIS in health facilities is also limited though greatly improved in recent years (~70 percent of health facilities currently covered). As part of surveillance and M&E activities, the MOH, with support of the subcommittee, is gearing up to ensure real-time capturing of vaccine data in platforms that will be compatible with the existing CMIS and roll-out of the system to 100 percent of health facilities in 2021.
	D2. Infrastructure	• <u>Readiness:</u> In progress, early stages <u>Key gaps and measures to address them:</u> Inputs related to infrastructure for energy, communications and water are yet to be fully assessed although under the current COVID-19 response project, inputs for water were assessed and costed in tertiary and secondary level health facilities across the country. As part of the inventory analysis, the TWG is expected to provide details on inputs for back-up power in locations where vaccines will be stored at all levels.

According to the above Table, Four Core Activity Areas were assessed and these include A. Planning and Management, B. Supply and Distribution, C. Program Delivery and D. Supporting systems and

infrastructure. The findings of the assessment showed that Eswatini is still not prepared for the vaccine deployment but much of the preparation is under way.

The Ministry of Health has come up with a potential list of Health Facilities and Centres that will be supported under the project according to the regions. In response to the Pandemic the Government of Eswatini has developed and established a National Contingency Response Plan and a National Vaccine Deployment Plan. Both plans set out activities, responsibilities, timeframes, budgets and suitable institutional arrangement for implementation. The Ministry of Health has gone ahead to identify potential health care facilities for quarantine, isolation, treatment and vaccination purposes in all four regions of the country. These include 1x National Referral Hospital, 3x Regional Hospitals, 5x Health Centres, 3x Private Clinics, 2x Isolation Centres, 1x EMS Centre and 1x Quarantine Centre. These are located in the 4 regions of the country. The Health Care Facilities are as follows: in Hhohho district: Mbabane Government Hospital, Mbabane Clinic, Malagwane EMS, Pigg's Peak Government Hospital, Emkhuzweni Health Centre, Dvokolwako Health Centre. The hospitals that have been identified in the Manzini Region are: Raleigh Fitkin Memorial Hospital, Mankayane Government Hospital, Manzini Clinic, Luke Commission, Zakhele Skills Centre and Mavuso. The hospitals in the Lubombo Region are: Lubombo Referral Hospital, The Good Shepherd Hospital and Sithobela Health Centre. The hospitals identified in the Shiselweni Region are: Hlathikhulu Government Hospital, Nhlanguano Health Centre and Matsanjeni Health Centre. The National Laboratory within the Mbabane Government Hospital was identified for upgrading to test for COVID-19. To respond to the Pandemic, a range of functional and technical enhancements have to be implemented in these centres. These enhancements include minor rehabilitations, procurement of equipment and material, reagents, IPC material and equipment.

Most of these facilities (especially the hospitals and Health Centres) have a working health care waste management system with suitable facilities and personnel. There are however challenges in the management and these include incinerator lack of fuel for operation of incinerators, breakdowns due to poor maintenance and depreciation, lack of waste containment, waste not being segregated, treated and disposed of correctly in some facilities leading to unsafe and environmental risky conditions; there are no responsible persons designated for the management of waste in some healthcare facilities and in rural areas general waste is not collected from the premises of the health facilities. One (1) Local Authority (Mbabane) where the centres are located has a well-designed landfill for waste, the rest have controlled waste dumpsites. The quarantine and isolation centres will need a well-designed health care waste system and will have to be integrated into the central infectious waste collection schedule by the Environmental Health Department.

COVID-19 Testing

The country has prepared a laboratory to manage large-scale testing for COVID-19. Initially, tests were done in South Africa but through the assistance of the Bank and other DPs, the National Laboratory has been capacitated to test for COVID-19. The laboratory is located at Mbabane within the Mbabane Government Hospital. Rapid collection and testing of appropriate specimens from suspected cases is a priority and is guided by a laboratory expert. All specimens collected for laboratory investigations should be regarded as potentially infectious, and HCWs who collect, or transport clinical specimens should adhere rigorously to infection prevention and control guidelines and national or international regulations for the transport of dangerous goods (infectious substances) to minimize the possibility of exposure to pathogens. Timely and accurate laboratory testing of specimens from cases under investigation is an essential part of the management of emerging infections. Access to reliable testing, either locally or internationally, in laboratories willing to perform primary detection or confirmatory testing, and novel pathogen detection should be ensured. Antigen testing of inbound travelers at Ngwenya Boarder Gate is

done. Antigen testing has been adopted as one of the testing strategies in the country and has been introduced in all hospital and health centres (private and public).

4.11 Health Care Waste Management

Due to interventions from recent projects, health care waste management has improved. Eswatini has Health Care Waste Guidelines in force and Institutional and budgetary arrangements have been introduced to manage health care waste in Eswatini. The public health facilities are under monitoring for health care waste management at varying degrees by the Environmental Health Department and designated Public Health Inspectors. Each facility has a IPC Committee trained and supported by the Environmental Health Department to manage health care waste with proper procedures and schedules from generation to treatment. Arrangements to temporarily store on site, transport and treat health care waste are available. Health Centres and Referral Hospitals have incinerators (13 in total) to treat hazardous or infectious waste, and. Four vehicles for each region are available to collect hazardous and or infectious waste to treatment facilities.

However, the increased volumes of waste due to COVID-19 and vaccination are already putting a strain on the health care waste management system. There is a need for additional waste containment receptacles in each centre, the vehicles that transport infectious waste have become inadequate. There is a need for an additional 2 vehicles. Two health centres either need an installation of an Incinerator or replacing of a non-functional Incinerator. Most of the Incinerators have worn out inner walls and broken burners. The worn-out parts have not been replaced in while. There are also fuel shortages to operate the Incinerators due to Government financial constraints. There is no air quality monitoring programme to monitor the emissions from the Incinerators. Other challenges include waste not being segregated, treated and disposed of correctly in some facilities leading to unsafe and environmental risky conditions; there are no responsible persons designated for the management of waste in some healthcare facilities and in rural areas general waste is not collected from the premises of the health facilities. In addition, inspections of health care facilities in the country undertaken by the Environmental Health Department of the Ministry of Health in 2018 revealed that several health facilities had malfunctioning or non-functioning septic tanks which were posing potential risks to human health as well as the natural environment. COVID-19 waste and waste from vaccination activities i.e. needles, and syringes and disposable PPE will add pressure on the existing health care waste management system due to increased generation of different types of waste including infectious/ hazardous and general waste. There will a need for improvement in management processes, facilities and resources to effectively manage pandemic.

CHAPTER 5: ENVIRONMENTAL AND SOCIAL RISK AND IMPACT MITIGATION

This section describes in general terms the potential environmental and social risks and impacts of the types of/eligible subprojects that will be supported by the project. The identification of the potential risks and impacts are grouped into different stages: Planning, Construction (should any civil works be involved), Operational and Decommissioning. The ESMP below (Table 5.1) discusses the risks and impacts and required mitigation measures as well as provides the implementing and monitoring responsibilities and timelines for applying the suggested mitigation measures.

5.1 Environmental and Social Management Plan

Table 5.1: Environmental and Social Management Plan

Key Activities	Potential E&S Risks and Impacts	Proposed mitigation measures	Implementing Party	Monitoring Party	Timeline
Planning and Design Stage					
Procurement of goods and services for all Health Care Facilities and Centres. While GoKE through the National Contingency Response Plan has already started procuring goods and services towards Covid-19, there is still a growing need for additional funding for goods and services. Additional goods and services will need to be procured to attend to structural and functional challenges in these facilities. The project will procure a variety of goods and services to strengthen the health care system and for the deployment of vaccines. The goods include: ICU equipment, IPC material, vaccines, vehicles, medical and laboratory equipment and reagents, isolations tents, vaccine storage and distribution equipment, incinerators	- Unplanned procurement of goods and services - Procurement of goods and services out of specifications - No proper storage facilities for goods procured - Procurement of goods and services that exacerbate environmental impacts	- Develop and establish a procurement plan incorporating healthy lead times for delivery of all goods and services; - Develop and establish proper and accurate specifications for all goods and services; - Determine and establish adequate space that meets requirements for storage of goods procured; - Where possible, procure goods and services that minimize waste production and pollution i.e. cleaner technology, recycling, re-usable goods.	CMS/PIU	Project Coordinator/ World Bank	Planning

and vehicles, waste containment etc. The services include Technical Assistance for training and support, rehabilitation, plumbing, cleaning services etc.					
Planning for Health Facilities and Centres (Including Isolation, quarantine and vaccination centres) Potential health facilities, and centres that will be used include 1x National Referral Hospital, 3x Regional Hospitals, 5x Health Centres, 3x Private Clinics, 2x Isolation Centres, 1x EMS Centre and 1x Quarantine Centre. These are located in the 4 regions of the country. - 2x of the Regional Hospitals need support with ICU equipment and accessories - All Health Facilities and Centres need Wheeler Bins - All Health Facilities need Sanitizers, screening equipment, PPE - 1x Regional Hospital (RFM) needs to air conditioning refurbishment. - 1x Regional Hospital (Mankayane) needs a new Incinerator. - 1x Health Centre (Sithobelweni) needs a new Incinerator - All Incinerators (13) need repairs and fuel for operation	- Design of healthcare facilities does not meet layout and engineering requirements for infection control, increasing risk of spreading COVID-19 in health facilities. Design of new facilities does not consider universal access.	Design of facility should meet national guidelines for IPC in healthcare facilities and consider guidance from WHO and/or CDC on COVID-19 management and infection control: • WHO guidance for <u>Severe Acute Respiratory Infections Treatment Center</u>. • WHO interim guidance on <u>Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected</u>. • WHO technical brief <u>water, sanitation, hygiene and waste management for COVID-19</u>. • WHO guidance on <u>infection prevention and control at health care facilities (with a focus on settings with limited resources)</u>. • CDC Guidelines for <u>isolation precautions: preventing transmissions of infectious agents in healthcare settings</u>. • CDC <u>guidelines for environmental infection control in healthcare facilities</u>. For patients with possible or confirmed COVID-19, isolation rooms	Health Facilities/PIU	Project Coordinator/ World Bank	Planning

- An additional 2 vehicles for infectious waste collection are needed due to increased volumes of waste - All Health Facilities need IPC IEC material and health and safety signage - Plumbers to assist with plumbing issues are needed for all facilities - All Health Facilities need Secure Infectious Waste Storage Cages - All Health Facilities need Skips for incinerator ash storage - A skipper truck to collect ash is needed		should be provided and used at medical facilities. 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 (areas used by many people) 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), but should avoid excess equipment or soft furnishings; • have signs on doors to control entry to the room, with the door kept closed; and • have an ante-room for staff to put on and take off PPE and to wash/decontaminate before and after providing treatment. An operation manual should be prepared prior to the opening of isolation rooms to describe the working procedures to be taken by healthcare workers to protect themselves and prevent infection			
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		escape while providing treatment. - Hand washing facilities should be provided at the entrances to and in health care facilities in line with WHO <u>Recommendations to Member States to Improve Hygiene Practices</u>. 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,			
Planning and Design of Civil Works under the project. No major civil works are expected in this project, only minor renovation or rehabilitation of existing health facilities. The minor civil works include Air Conditioning Rehabilitation, Plumbing reconditioning in certain health facilities, Installation of Incinerators and Waste Storage Centres	- Environmental and social requirements that must be incorporated during the design of the works might be overlooked	- Site-specific ESMPs must be developed for each site. - The ESMP must be incorporated into the designs of the projects and costed - The ESMPs must be included in the bidding documents and contracts of the Contractors	PIU	Project Coordinator/ World Bank	Planning
Planning and Design of COVID-19 Testing facility Eswatini did not have a laboratory suitable for COVID-19 Testing. The One (1) Potential laboratory located within the Mbabane Government Hospital (National Laboratory) needed to be	- Design of laboratory does not meet requirements for biosafety	The design for upgrading of the laboratory must consider guidance from WHO on: Laboratory biosafety guidance related to COVID-19. laboratory biosafety WHO; Prioritized Laboratory Testing	National Laboratory/ PIU	Project Coordinator/ World Bank	Planning

capacitated to test for COVID-19. The improvements to be made were in the equipment, methods and personnel		Strategy According to 4Cs Transmission Scenarios WHO Covid-19 Technical Guidance: Laboratory testing for 2019-nCoV in humans: WHO Laboratory Biosafety Manual, 3rd edition USCDC, EPA, DOT, <i>et al</i>; Managing Solid Waste Contaminated with a Category A Infectious Substance			
Vaccination Deployment Planning; Vaccine type, storage, distribution and administration and post-vaccination monitoring. Eswatini does not have adequate capacity in the immunization of adults, large numbers and within a limited period. There are still gaps in regulation, function and administration of vaccines in adults. - The Medical Regulatory Authority and regulatory framework needs improvement; - Vaccine purchasing, storage and distribution practices, methods and equipment need improvement - Tents and accessories during Vaccine Campaigns - Waste Containers for Syringes and Needles and general waste for all sites - IPC Material and Equipment (PPE, Sanitizers, Screening Equipment)	- Poor deployment of the vaccine leading to financial losses and continual adverse impact of the Pandemic - No surveillance post vaccination	The planning and design of the deployment of the COVID-19 vaccines and post-vaccination surveillance must consider the following guidelines: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-vaccines Vaccine readiness assessment, surveillance of adverse events following immunization A National Vaccine Deployment Plan must be developed for pre-, during and post vaccination administration.	NTWG/PIU	National Coordination Committee/ Project Coordinator	Planning

Planning and design for Risk Communication and engagement The GoKE through the Health Promotion Unit and DPs, has developed a risk communication plan. The Project will support the Implementation of this plan.	- Ineffective risk communication and engagement which may result in further spread of the Pandemic	Planning for risk communication will include other DP's and consider the following guidelines on as recommended by WHO: https://www.who.int/publications/i/item/covid-19-global-risk-communication-and-community-engagement-strategy The communication should be for health personnel and community at large and should promote the 3Ws i.e. Wear a mask, Wash your hands, Watch your distance A Stakeholder Engagement Plan (SEP) must be developed for proper and effective engagement of key stakeholders in the project. The SEP must contain an effective Grievance Redress Mechanism (GRM). Labour Management Procedures must be developed as well to manage labor related matters. The procedures must be developed according to the: ILO Standards and Covid-19 (Corona Virus) https://www.ilo.org/global/standards/WCMS_739937/lang--en/index.htm	Health Promotion/PIU	Project Coordinator/ World Bank	Planning
Planning and Design for Training and Capacity Building. A Training plan for all Role Players is existent within the National Contingency Response Plan. The plan	- Poor implementation leading to increased infection rate and death due to lack of knowledge	A Training and Capacity building plan for key stakeholders must be developed to deliver training on all aspects of the Pandemic including: - Continuous training to Frontline Workers on new information on	E&S/ PIU	Project Coordinator/ World Bank	Planning

has a revolving element to reinforce learning. The project will support this plan where gaps are identified.		COVID-19; - COVID-19 Case Management - Vaccine Immunization - IPC and Waste Management - WASH - ESMF - SEP and other			
Hiring of existing assets such as hiring of buildings as temporary measures. The project may hire buildings for quarantine purposes. Potential buildings to be hired include: - Mavuso Trade Centre (Isolation Centre); - Siteki Hotel (Isolation Centre); - Zakhele Skills Centre (Quarantine) - Pigg's Peak Orion Hotel (Quarantine) The sites will need to be supported with the following: - IPC Material and Equipment (PPE, Sanitizers, Screening Equipment); - Food/Refreshments; - Testing	Hiring of an existing asset such as a hotel or stadium for quarantine, isolation or treatment purposes could pose risk to local habitation, other visitors, expose staff to infection risk	- Ensure that access to the hired facility is restricted and controlled. - Ensure that the facility is connected to municipal waste disposal network, and / or properly constructed and authorized private waste disposal system - Ensure complete and regular disinfection of the hired facility, especially before vacating and allowing the facility to remain in lock for at least one week after vacating - Relevant training and orientation of staff of the hired facility	- Procurement /PIU	- Project Coordinator/ World Bank	Planning
Planning for Vaccine Uptake	The uptake of the vaccine could be poor due to misinformation and skepticism	- Incorporate an effective engagement strategy for vaccination in the SEP - Obtain consent for vaccination as early as possible or develop a beneficiary-driven vaccination plan	- Epidemiology / PIU	- Project Coordinator/ World Bank	Planning Stage
Operation of medical procedures such	- Risk of COVID-19	- Estimate numbers and type of	MOH/PIU	Project	Planning Stage

as testing and vaccinating COVID-19 involving healthcare staff and other workers, including healthcare staff at COVID-19 designated hospitals and isolation/ quarantine coaches and other associated staffs	infection - Altercation with resident communities - Risk of workplace and/or sexual harassment	project workers - Assess whether temporary accommodation and/or labor camp will be required - Select suitable location for accommodation - Prepare gender sensitive work plans - Ensure parity with respect to usage of PPE among all workers irrespective of being regular or contracted - Ensure timely payout to health workers fighting COVID-19. - No child labor, forced or conscripted labor used - Develop and establish a proper site-specific grievance redress management plan - Setting up gender-sensitive infrastructure such as segregated toilets and well-lit quarantine and isolation centers and other mitigation measures addressing SEA/ SH issues. - Develop a Labor Management Plan (LMP) for the project to be referred for further details.		Coordinator/ World Bank	
Use of materials and resource efficiency	Risk of high resource consumption (energy and water)	- Review water and energy supply and capacity in all health centers. - Plan for contingency i.e. temporary water storage and installation of solar water heating, LED lighting and use natural elements in design of the building where possible (large windows for natural light, proper air	MOH/PIU	Project Coordinator/ World Bank	Planning Stage

		ventilation and circulation, landscaping with canopy trees).			
Operation of medical procedures such as testing and vaccinating COVID-19 involving production of biomedical wastes	- Inadequate biomedical waste management capacity - Risk of mixing of Covid-19 biomedical waste with other medical and general waste	- Review health care waste management in all facilities - Develop and implement an Integrated Waste Management Plan - Waste disposal, including biomedical waste, facilities to be part of design of the healthcare facility, including temporary storage. - Plan waste transport routes within and outside facility as part of design - Setting up a waste disposal/treatment unit within healthcare facility should be subject to local laws (for example incinerator)	National Laboratory/PIU	Project Coordinator/ World Bank	Planning Stage
Operation of medical procedures including potential risks such as Occupational Health & Safety (OHS) and Community Health & Safety	- Inadequate entry and exit route may clog traffic posing accident hazard for nearby residential/commercial areas - Risk of fire, earthquake, waterlogging etc. - Lack of or inadequate mortuary capacity	- Ensure road safety in and around healthcare facility through a traffic circulation plan while designing entry/exit points - Provide ample parking space within healthcare facility - Ensure that building design comply with earthquake specifications, fire escapes and other fire prevention requirements, have proper drainage etc. - Include adequate mortuary arrangements in the design (refer to WHO Infection Prevention and Control for the safe management of a dead body in the context of	MoH/PIU	Project Coordinator/ World Bank	Planning Stage

		COVID-19) - Keep a comprehensive register/ documentation system to capture all necessary information of the covid-19 dead body (incoming and collection info.)			
Operating healthcare facilities involving access to services for the poor, vulnerable and marginalized social groups	- Risk of inadequate access to healthcare services for people below poverty and in remote locations. - Limited testing due to lack of availability of kits and trained personnel at remote locations - Lack of accessibility for persons with special needs in existing healthcare facilities	- Wide media campaign for informing vulnerable groups about the services made available across healthcare facilities, including dedicated COVID-19 facilities; - Set up help lines for vulnerable groups; - Ensuring adequate health care services in each of the regions, and in municipal areas based on its risk profile with specifically targeting poor and vulnerable population including migrants and urban poor population groups. - Health care providers sensitized towards services to poor and vulnerable including providing psychosocial support where needed. - All healthcare facilities to be compliant with universal access provisions through retrofitting. - Mechanism for provision of health services in an inclusive manner that addresses the differential needs of the vulnerable population including risk of receiving a disparity based on financial or social	MOH/ PIU	Project Coordinator/ World Bank	Planning Stage

		characteristics such as age, race, gender, ethnicity, sexual orientation, spirituality, disability, or socioeconomic or insurance status. Also, wherever possible linkages with other government departments and schemes to be done to address the differential needs of the vulnerable groups. - Ensuring safety of vulnerable population especially women in quarantine and isolation centers from any sexual exploitation and abuse (SEA) and sexual harassment (SH) and mechanism to access redressal services - Addressing social tension and conflicts associated with handling medical isolation of individuals with quarantine interventions and using dignified quality treatment of patients and building awareness about these services. - This will be part of Stakeholder Engagement Plan (SEP) and will also be guided by the GoKE on Information, Communication and Public Awareness.			
Engaging direct and indirect workers with potential behavioral risks induced by livelihood related issues	- Informal sector and daily wage earners whose livelihoods are at stake in the short and medium term may tend to flout the health advisories posing higher risk of being infected and/ or infecting others.	- Use all administrative mechanism to ensure prescribed norms of maintaining social distancing, using masks, washing hands at frequent intervals etc. - To support GOKE's initiative in enhancing livelihood and social protection measures; - Communication activities	MOH/PIU	Project Coordinator/ World Bank	Planning Stage

	- Potential risk of social tension and conflict within communities due to the adverse impacts of containment strategies on people's livelihoods and health seeking behavior particularly when it comes to marginalized and vulnerable group	targeting behavioral health along with psychosocial support addressing social stigma associated with COVID-19			
Construction Stage					
Implementation of Civil Works under the project. No major civil works are expected in this project, only minor renovation or rehabilitation of existing health facilities. The minor civil works include Air Conditioning Rehabilitation, Plumbing reconditioning in certain health facilities, Installation of Incinerators and Waste Storage Centres	- Environmental and social impacts could result due to lack of proper management of related issues	- Compliance to ESMPs developed for each site must be enforced through regular monitoring and correction of deviations.	Contractor/PIU	Project Coordinator/ World Bank	Construction
Scaling up and refurbishing healthcare facilities involving waste management	- Hazardous wastes and materials management - Provisioning for biomedical wastes inside rooms/wards and within facility	- Use Good International Industry Practices for managing construction waste, including reuse at site to the extent possible - Ensure good housekeeping and clean operations always/immediately removing rubble strewn outside construction areas - Build biomedical waste holding area near separate service exit - Use of Asbestos is prohibited	Contractor(s)	PIU/World Bank	Construction Stage

		- Fine earth materials (sand, etc) should be covered during haulage to facilities under renovation to prevent spillage			
Scaling up and refurbishing healthcare facilities involving pollution management during construction	- Risk of pollution from construction solid waste, dust, wastewater, noise, lubricants and oils, air emissions from heavy equipment and diesel generators	- Use screens or nets to avoid flying debris and dust and use of regular water sprays to suppress dust - Hazardous waste separated from nonhazardous waste on site and disposed off to designated sites - Measure and report noise (decibel) levels regularly - Manage oil leaks/spills from heavy machinery	Contractor(s)	PIU/World Bank	Construction Stage
Scaling up and refurbishing healthcare facilities involving material use and resource efficiency	- Risks and impacts associated with resource efficiency and material supply	- Adopt installation of solar panels and LED lighting wherever possible for ensuring energy efficiency - Use adequate insulation for ambient temperature control and reducing the energy requirement for heating and cooling	Contractor(s)	PIU/World Bank	Construction Stage
Scaling up and refurbishing healthcare facilities involving labor employment	- Workers coming from infected areas - Co-workers becoming infected - Workers introducing infection into community/general public - Social issues, including in relation to labor influx, GBV/ Sexual Exploitation and Abuse/ Sexual Harassment (SEA/SH) risks, gender or disability	- Include additional clauses for contractors in bid document for all construction contracts which also prohibits employment of child labor and/or forced labor in construction in line with government norms. - Labour influx is not foreseen given widespread small size construction activities. However, in case any such occurrences, will be addressed and monitored through ESIA/ESMP measures - Refer to COVID-19 Labour	Contractor(s)	PIU/World Bank	Construction Stage

	- Arrangements for employment and accommodation of workers to be engaged in project activities, and issues relating to working conditions (including in relation to periods of sickness and quarantine), particularly if these are impacted by emergency legislation - Involvement of child labor and/or forced labor - Labour influx	Management Plan - Adequate hand-washing and sanitization facilities provided during construction - 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			
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		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 - The process of screening, investigation, resolution of grievances, documentation, and reporting of grievances to follow existing GRM. - Sensitization of construction workers and health care staffs must be done - Set up gender-sensitive infrastructure such as segregated toilets and well-lit living areas/ camps (if any). - Ensuring safety of women from any sexual exploitation and abuse (SEA) and sexual harassment (SH), sensitizing health care staffs on SEA/ SH, and mechanism to access redressal services including building linkages to DPM's Social Welfare and Gender Departments.			
Scaling up and refurbishing healthcare facilities involving Occupational Health & Safety (OHS) and Community Health & Safety	- Health and safety risks to construction workers and others Sanitary related problem - Traffic and road safety due to increase in number of heavy	- The contractor (in cases of civil works) shall prepare a site specific COVID19 Action Plan. - Provide relevant PPE to all workers with onsite toilet and washing facilities - Cordon off areas under	Contractor(s)	PIU/World Bank	Construction Stage

	vehicles Risk of traffic related accidents and incidents on and off site	construction and provide signage to warn of ongoing construction works Ensure drivers respect speed limits through built areas and urban centers - Employ safe traffic control measures, including road signs and flag persons to warn of dangerous conditions and children crossings - Road safety awareness training for staff, workers and nearby communities - Create water trough for disinfecting vehicle tyres as they exit			
Historical and Cultural Artefacts/Heritage During earth removal and digging of trenches cultural artefacts or sites of significance	- Destruction of artefacts or sites with historic value leading to disputes and legal suits.	- The artefacts or sites must be treated according to Annex 5 (Archeological Chance Finds Procedure)	Contractor	PIU/World Bank	Construction Stage
Sexual Exploitation and Abuse and Gender Based Violence	- Related incidences could occur during construction amongst contractor workers and or with community people	- An LMP specific for each site with SEA/SH and GBV mitigation measures must be applied	Contractor	PIU/World Bank	Construction Stage
Operational Stage					
Operation of enhanced or installed services i.e. Air Conditioning, Plumbing maintenance, Incinerators and Waste Storage centers. The operators of the air conditioners, incinerators and waste centres will need training. All the enhancements will need proper maintenance	- Environmental and social impacts could result due to lack of proper operation and maintenance of enhanced or installed services	- Compliance to ESMPs developed for each site must be enforced through regular monitoring and correction of deviations. - Operators must be trained to operate the services and maintain them - A maintenance schedule must be	Operators/PIU	HCFs/ MoH	Operation

		developed and adhered to for all the services.			
Vaccine Uptake	- The uptake of the vaccine could be poor due to misinformation and skepticism	- Incorporate an effective engagement strategy for vaccination in the SEP - Obtain consent for vaccination as early as possible or implement a beneficiary-driven vaccination plan	Epidemiology/PIU	Project Coordinator/ World Bank	Planning Stage
Testing, treating, and vaccinating COVID-19 related patients involving biomedical, chemical, COVID19 waste generation	- Delivery and storage of goods, including samples, pharmaceuticals, reagents, vaccines and other hazardous materials - Healthcare treatment practices, including provision and use of PPE, appropriate cleaning procedures, testing for COVID-19, vaccination, and transportation of samples to testing facilities - Generation of biomedical waste, specifically COVID-19 infectious waste - Chance of infection to other wards from COVID-19 treatment areas	- Prepare a facility specific Integrated Waste Management Plan for healthcare facilities - Strict segregation of COVID-19 biomedical waste from other biomedical and general solid wastes - Have dedicated equipment (for example blood pressure machine, peak flow meter and stethoscope) for COVID-19 treatment areas - Ensure an anteroom for staff to put on and take off PPE and to wash/decontaminate before and after providing treatment - Designate separate areas for holding biomedical wastes - Adopt waste minimization, reuse and recycling best practices - Develop capacity of onsite disinfection and waste handling equipment such as autoclave - Onsite treatment facilities which may include small-scale incinerator and wastewater treatment works, should comply with local laws and necessary	PIU/MOH/HCF	Project Coordinator/ World Bank	Operational Stage

		statutory approvals to be obtained, where healthcare wastes will be transported and disposed - The adequacy and compliance with transport and disposal regulations and licensing for the transport vehicles and the offsite disposal facilities should be assessed and verified - Driver training on responding to accidents - Waste bags and containers should be in compliance with the National Health Care Waste Management guidelines and the Waste regulations 2000, and /or labeled with the date, type of waste and point of generation to allow them to be tracked through to disposal (bar coding if possible)			
Testing, treating, and vaccinating COVID-19 related patients involving hazardous waste, chemicals, biological samples etc., including radioactive material used in labs	- Risk of mixing of hazardous and nonhazardous waste (also with COVID-19 waste)	- Ensure segregation, transportation and disposal of hazardous wastes separately - Regularly monitor ambient air and water quality including testing of sewage samples for presence of Corona virus - Prepare and make workers/staff aware of an emergency response protocol	PIU/MOH/HCF	PIU/World Bank	Operational Stage
Testing, treating, and vaccinating COVID-19 related patients involving healthcare facility capacity for biomedical waste management and infection control	- Inadequate capacity may increase spread of COVID-19 and expose healthcare staff to risk of infection - Exclusion of	- Regularly assess capacity of the healthcare facility to manage waste and make improvements	PIU/MOH/HCF	PIU/World Bank	Operational Stage

	vulnerable/marginalized people				
Medical activities within Biosafety Level 3 laboratory	- Risk of accidental escape of hazardous pathogens and exposure of laboratory personnel and public	Follow the Laboratory biosafety guidance related to COVID-19. laboratory biosafety	PIU/MOH/HCF	PIU/World Bank	Operational Stage
Procurement and usage of medicine, consumables, and paramedics for facilities and premises for COVID-19 activities	- Exposure of paramedic staff to COVID-19 infection - Accidental use of expired medicines - Exposure of passengers with asymptomatic staff	- Proper PPE for all paramedics working in isolation centres - Dispose expired medicines as per ICWMP - Ensure minimum exposure of staff and paramedics with people - Procure re-usable, recyclable and recoverable products	PIU/MOH/HCF	PIU/World Bank	Operational Stage
Sanitization of Premises and vehicles	- Chance contact of people with chemical sprays - Risk of food material contamination - Traffic and people management	- Proper PPE for all staff/service providers/cleaning workers in relation to isolation centres - Ensuring traffic flow during sanitization of outside areas (parking, driveway, entry/exit gates etc.) - Manage people with social distancing norms during sanitizing station platforms, waiting rooms etc. - Ensuring that all food materials and utensils etc. are adequately covered and protected from chemical sprays during sanitization - Sensitization and training of security forces on code of conduct in managing COVID-19 patients	PIU/MOH/HCF	PIU/World Bank	Operational Stage
Engaging workers/staff and visitors	- Risk of infection for staff and visitors in HCFs and	- Guidelines for best practice in avoiding or minimizing the spread	PIU/MOH/HCF	PIU/World Bank	Operational Stage

	Laboratories - Social issues such as labor influx, GBV/ Sexual Exploitation and Abuse/ Sexual Harassment (SEA/SH) risks, gender or disability,	of infectious diseases, specifically about cross infection between healthcare facilities and the community (must be contained in the ICWMP). - Adequate PPE for professionals responsible for testing to be provided - Labor Management Plan (LMP) to include OHS and labor and working conditions - Decentralize the GRM to cater for all parties involved. - Sensitization of health care providers on SEA/ SH along with other mitigation measures - Sensitization and capacity building of the health care staffs and others associated with COVID19 operations. - Setting up gender-sensitive infrastructure such as segregated toilets and well-lit quarantine and isolation centers. - Building linkages to DPM's Gender Unit Department and Social Welfare and Gender Unit for addressing violence against women in districts where it is operational.			
Psycho-social support for Health Workers/Frontline Workers and Patients There are many unknowns regarding the Pandemic which are associated with many fears by all parties involved.	- Physical stresses and psychological effects - High number of resignations/redeployments in the health care system leading to further system strains	- Provide continual training on COVID-19 and its psychological impacts; - Risk communication and change management to promote vaccination; - Engage a Psychologist for each	HCF/PIU	Project Coordinator/ World Bank	Operational Stage

Working in that environment, being infected and treated for COVID-19 can have a negative psychological impact. The negative publicity on the vaccines will also add to the psychological impacts.	- High number of mistakes during case management - Stigmatization for those who were infected	HCF; - Provide a comprehensive wellness programme for each HCF; - Assess Psychological impacts of the Pandemic on health personnel, front liners and patients. - Provide leisure and relaxation facilities and activities for health personnel, Front liners and Patients - Provide incentives to Health personnel and Frontline workers			
The Vulnerable/Marginalized group care The Pandemic will affect the marginalized group. This group includes the elderly, woman and key populations. Impaired access to medical support, domestic violence and other impacts will be observed.	- Access to COVID-19 information will be hard; - Access to medical support will be affected due to stretched health care system and restrictions - Domestic violence fueled by frustrations against restrictions.	- Engage the Vulnerable Group Representative Associations for effective communication channels and messages; - Train health personnel to deal with domestic violence cases; - Prioritize medical attention towards vulnerable groups (even during COVID-19 Vaccination); - Regional Response Teams must identify and prioritize cases involving the vulnerable groups - Means to reach vaccination sites must be made for vulnerable groups	HCF/PIU	Project Coordinator/ World Bank	Operational Stage
Sexual Exploitation and Abuse and Gender Based Violence	- As in many countries, most frontline health workers are female, exposing them disproportionately to the virus and the risk of getting infected. - health workers, majority	- Ensuring equitable distribution of vaccines even in the case of shorter supplies will be critical as rank and gender differences could influence who gets the vaccine first and potentially negatively affect the female health care work force.	HCF/PIU	Project Coordinator/ World Bank	Operational Stage

	of whom are female, might be perceived as a health risk in social settings due to their occupation working in the health sector in general or stigmatized because they would be among the early recipients of the vaccine. This could potentially exacerbate already existing inequalities or power dynamics in their community and household. - Given that these women are more likely than men to also take care of elderly family members (a high-risk group), it can create unusually high levels of stress and tensions within a family and put women disproportionately at risk of verbal or even physical abuse - The frontline workers could also be exposed to patients who are victims of GBV or SEA/SH	- Campaigns that will incorporate specific approaches to reach women through engaging female and male leaders as positive role models. - To address the stigmatization of health workers who are mainly female, the use of multiple outreach mediums adapted to the local context and languages, such as radio programs, and community-based platforms, to dispel misinformation. - To address the increased risk of verbal and physical abuse to women, the project as part of the overall communication will include messages related with GBV and referral services. - Attention will also be paid to maternal health clinics where immunization information is also accessible to pregnant women who may have specific needs. - Gender inputs into the terms of reference of the communications plan will be detailed in the PIM. The AF will also support better targeting and tracing of vaccine administration with strengthened M&E capacity. All data collection and monitoring will be done in a sex-disaggregated way wherever possible, including for the PDO 'percentage of the population vaccinated'. - A training program with good practices on handling GBV and			
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		SEA/SH cases will be done for health workers - A SEA/SH and GBV action plan has been annexed (Annex 7) to manage related cases			
Cleaning and maintenance of health care facility	- Risk of exposure to COVID-19 for cleaning staff and workers	- 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 - Training of cleaners in proper hygiene (including hand washing) 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) - Test cleaning staff for COVID-19 when symptoms appear	HCF/PIU	Project Coordinator/ World Bank	Operational Stage
Climate change impacts	- Climate change impacts due to pollution from greenhouse gas (GHG) emissions; - Negative health impacts on vulnerable groups from extreme climate events, such as heat waves, hurricanes/storms, floods, and droughts. - Project activities, particularly vaccine distribution, may be	- The project will purchase climate-friendly incineration equipment to reduce the projects emission of GHG emissions that increase climate disaster risks on vulnerable populations. - The Incinerators will have a self-monitoring device to monitor GHG emission estimates for improved management - Minimize waste production, and monitor waste incineration including construction of waste storage and sorting centers,	HCF/PIU	Project Coordinator/ World Bank	Operational Stage

	temporarily delayed due to climactic events such as flooding and extreme heat. Other activities such as training of health workers and supervision may be temporarily delayed due to climate hazards	training on proper waste management, and monitoring incineration emissions; - Two energy efficient vehicles will be purchased to support climate friendly incineration activities. - Support for appropriate minimum standards for cold chain equipment under this component will focus on use of climate friendly cold chain equipment to reduce greenhouse gas emissions. - Response, vaccination will be prioritized for the elderly and those with pre-existing conditions - COVID-19 vaccination planning under this component will incorporate contingency plans for activities in case of climatic events such as flooding and extreme heat. - climate adaptation curricula in training and emergency simulation activities for health professionals will be incorporated. - Strengthening health professionals' capacity is key to preparing the health system to identify and respond to climate-related risks - the CMIS will be strengthened to assist the project in detecting climate-related disease outbreaks, strengthening the existing system to monitor outbreak prone-disease by			
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		analyzing data corresponding to climate hazards, and efficiently coordinating rapid responses to the health impacts of climate shocks. The CMIS will also strengthen the health system to analyze and use information for local response to health threats from climate hazards. - The vaccines are kept cool during transport with non-energy consuming coolant packs inside shipping units. This is a climate adaptation measure since WHO requires temperature monitoring devices in all vaccine shipments.			
Decommissioning Stage					
Decommissioning of temporary facilities (isolation, quarantine, screening and treatment etc.)	- Risk of spread of infection from nondisinfected materials, PPE, bed linen and other fabrics and clothing - Generation of plastic and disposable wastes, expired medicines, disposable kits and food articles etc.	- Prepare a decommissioning plan accounting for all disposable items to be sent to respective disposable sites – municipal landfill, biomedical waste disposal facility, and/or as required - All reusable items to be thoroughly disinfected and left unused for up to a week after decommissioning the facility - Expired equipment and/or PPE to be decommissioned and disposed properly	MOH/PIU	Project Coordinator/ World Bank	Decommissioning Stage

5.2 Budget for Environmental and Social Management Plan

Table 5.2: Budget for Environmental Management Plan

Main Task	Activities	Budget
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1. Infection Prevention and Control	- Procure PPE - Procure Sanitizers - Procure Thermometers	E2, 000, 000.00
	- Procure Tablets for IPC and Customer Care Personnel for reporting purposes	E200, 000.00
2. Waste Management (with Climate Change Adaptation)	Maintain and support incinerator operation in all health facilities	E1, 500, 000
	- Replacing worn out parts (Chimneys, walls, burners) - Fuel for all 13 Incinerators for a year	E2, 000, 000
	Install/replace 4 Incinerators at Hlathikhulu, TB Hospital and Nhlanguano Health Centre and Mankayane	E5, 000, 000
	- 2x 250kg/hr incinerators - 1x 150kg/hr incinerator Refurbishment and /or extension of incinerator houses at the 3 health facilities	E900,000
	Programme to periodically monitor the quality of emissions from Incinerators (Bi-annually)	E800, 000
	Waste Minimization Programme - Procurement and application of clean goods/technologies - Procurement and use of reusable, recyclable goods - Construction of partitioned Waste Storage Centers for waste sorting at source	E1, 000, 000

		E2, 000, 000
	Waste Collection and offsite transportation	
	- Procurement of 2 back-up vehicles for infectious waste collection to serve all four regions	E1,500, 000
3. Training	- Training of PIU, Role Players on ESMF, ICWMP Plans	E200, 000.00
4. Develop, establish and maintain IEC material for all sites	- Review situation and develop content - Design and Print material - Publicize material	E200, 000.00

Table 5.2 below details the course of action for social management budget.

Table 5.2: Social Management Action Budget

Main Task	Activity	Activities
1. Community Engagement and Communication	Risk communication, vaccine communication, campaigns etc	E1, 000, 000
2. Gender Based Violence and SEA/SH	Training and engagement of women and women CBOs in the response to GBV Training of Frontline Workers to attend to victims of GBV	E500, 000.00
3. Stakeholder engagement	Community/Citizen engagement on GBV	E200 000.00
4. Grievance Redress Mechanism	Response to GRM Issues	E300, 000.00

Table 5.3: Training plan for the project

Training Topic	Responsibility	Resources/ Budget (E)
1. ESMF	E&S Project Officers/ MoH	50, 000
2. ESMPs	E&S Project Officers/ MoH	300, 000
3. ICWMP and its procedures, waste management and pollution control basics	E&S Project Officers/ MoH	
4. SEP	E&S Project Officers/ MoH	300, 000
5. GRM and sub-GRMs	E&S Project Officers/ MoH	
6. Risk Communication Plan	E&S Project Officers/ MoH	
7. Labor Management and its procedures	E&S Project Officers/ MoH	
8. Monitoring, Evaluation and Reporting Plan and Monitoring and Evaluation Basics	E&S Project Officers/ MoH	100, 000
9. Psycho-social support for front liners and vulnerable groups	Consultant	300, 000 (Consultancy/Training Fees)

5.3 Monitoring and Evaluation Plan for E&S Activities

Table 5.3 below details the monitoring and evaluation plan for the project.

Table 5.3: Monitoring and Evaluation Plan for the project

Monitoring Indicator	Monitoring Targets	Monitoring Frequency	Monitoring Method	Responsibility
1. Compliant waste management practices	100% compliance with ICWMP, procedures and schedules	Monthly	Document review	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of recyclable waste identified, quantified, separated and recycled	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of re-usable waste identified, quantified, separated and re-used	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of infectious waste generated, identified, quantified, safely contained, stored, transported and treated	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of syringes and needles for vaccination stored in appropriate containers on site	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of syringes and needles for vaccination collected and treated in Incinerators	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of hazardous waste generated identified, quantified and safely contained, stored, transported and treated	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of municipal waste generated, identified, quantified and safely contained, stored, transported and disposed off	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	Adequate and proper waste containment equipment and material as per NHCWM Guidelines	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	Clear and safe routes for transporting hazardous and infectious waste	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	Appropriate hazardous and infectious waste transportation	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	Safe and proper storage sites for hazardous and infectious waste	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	Well-functioning and compliant treatment facilities	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E

				Officer/Health Centres/MoH
	Trained waste management personnel	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	An emergency response plan with resources and procedures is developed, established and maintained	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	No mixing of waste	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	All stakeholders safely dispose of masks	Monthly	Consultations	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	No illegal waste practices	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	No pollution due to due to poor waste management	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	No COVID-19 infections due to poor waste management	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	No health and safety incidences due to poor waste management	Daily	Site Visit/Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	An up-to-date ICWMP and procedures	Quarterly	Document review	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	Monthly reporting as per World Bank requirement	Monthly	Document review	Senior Environment Officer/ M&E Officer/Health Centres/MoH
2. COVID-19 Transmission contained/ Controlled	100% compliance with ICWMP, procedures and schedules	Monthly	Document review	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of employees (especially front-line workers and cleaning employees) are supplied with appropriate and adequate PPE	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of employees (especially front-line workers and cleaning employees) always wear appropriate PPE	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of employees put on, remove and dispose or store PPE appropriately	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of employees (especially front-line workers and cleaning employees) use well-functioning equipment and material	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of health centres have access to potable and adequate water supply where needed	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of health facilities have appropriate and adequate hygiene and sanitary facilities	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH

	100% employees practice the 3G or hygiene and sanitary measures stipulated	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% employees are monitored against COVID symptoms (before and after work). A record must be kept	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of office, corridors and convening spaces, equipment and material are sanitized daily before operation and after	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of people entering and leaving health centres are wearing appropriate PPE, practice hygiene and sanitary practices and are monitored for symptoms	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of health centres have appropriate warning and guiding notifications at strategic places	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	An Emergency Response Plan developed, established and maintained for all health centres	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% of civil works sites compliant with ESMPs	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	No COVID infections due to health and safety mismanagement	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	No health and safety incidences due to poor management practices	Daily	Site visits/ Checklist	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	Monthly reporting as per World Bank requirement	Monthly	Document review	Senior Environment Officer/ M&E Officer/Health Centres/MoH
3. Effective and efficient vaccine deployment	3% of the population including frontline workers are vaccinated under Phase 1 of the NDVP	Phase 1	Document review	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	17% of the population including the elderly and people with comorbidities are vaccinated under Phase 2 of the NDVP	Phase 2	Document review	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	60% of the population including other essential and priority groups are vaccinated under Phase 3 of the NDVP. These include vulnerable and marginalized groups like women, children and key populations	Phase 3	Document review	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	100% coverage of national population with correct vaccine information	Weekly	Document Review	Senior Environment Officer/ M&E Officer/Health Centres/MoH
4. Preservation of the environment and compliance	100% compliance to project ESMPs	Monthly	Document review	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	No pollution of resources i.e. water, air, soil	Weekly	Site Visit	Senior Environment Officer/ M&E

with other health and safety requirements				Officer/Health Centres/MoH
	No destruction/preservation of natural habitats	Weekly	Site Visit	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	Effective management of health and safety related incidences during case management (e.g. road accidents etc.)	Weekly	Site Visit	Senior Environment Officer/ M&E Officer/Health Centres/MoH
	Effective management of crime and dispute during case management	Weekly	Site Visit	Senior Environment Officer/ M&E Officer/Health Centres/MoH
5. Effective engagement of Stakeholders	100% compliance with Stakeholder Engagement Plan	Monthly	Document review	Social Officer/ M&E Officer/MoH
	100% compliance with GRMs	Weekly	Document review	Social Officer/ M&E Officer/MoH
	100% compliance with Labour Management Procedures	Weekly	Document review	Social Officer/ M&E Officer/MoH
	100% compliance to risk communication plan	Weekly	Document review	Social Officer/ M&E Officer/MoH
	100% engagement, capturing, routing, management and feedbacking to key stakeholder comments, concerns and issues as per the standards in GRM	Daily	Consultations	Social Officer/ M&E Officer/MoH
	100% of stakeholders have easy access to COVID related information	Weekly	Review of Platforms	Social Officer/ M&E Officer/MoH
	100% of stakeholders understand the GRM and can easily and without intimidation lodge complaints	Weekly	Review of platforms	Social Officer/ M&E Officer/MoH
	All stakeholders comply with COVID-19 management requirements	Quarterly	Behavioral assessment	Social Officer/ M&E Officer/MoH
	100% of lodged complaints or concerns are attended to	Daily	Review of complaints registers	Social Officer/ M&E Officer/MoH
	100% alignment of project stakeholder engagement activities to coordination and communication plans from the National Contingency Plan	Weekly	Aligning plans	Social Officer/ M&E Officer/MoH
	An up-to-date SEP document	Quarterly	Document review	Social Officer/ M&E Officer/MoH
	Monthly reporting as per World Bank requirement	Monthly	Document review	Social Officer/ M&E Officer/MoH
Effective management of GBV and SEA/SH	100% of Health Workers and Rural Health Motivators trained on handling GBV/SEA/SH issues	Once off	Training registers	Social Officer/ M&E Officer/MoH
	80% coverage of national population made aware of GBV/ SEA/SH issues and management thereof	Monthly	Document review	Social Officer/ M&E Officer/MoH
	80% of GBV/SEA/SH cases reported are handled	Daily	Document review	Social Officer/ M&E Officer/MoH
	80% of reported cases on violence against children and child sexual abuse are handled	Daily	Document Review	Social Officer/ M&E Officer/MoH

E&S Evaluation	Project 100% compliant with E&S Standards	Quarterly	Document review/Site Visit	M&E Officer/MoH/World Bank
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In compliance with the requirements of the Project Environmental and Social Commitment Plan (ESCP), the Ministry of Health (MoH) will prepare and submit to the Bank quarterly monitoring reports on the environmental, social, health and safety (ESHS) performance of the Project, including but not limited to, stakeholder engagement activities and grievances log. Furthermore, MoH will promptly notify the Bank of any incident or accident related to the Project which has, or is likely to have, a significant adverse effect on the environment, the affected communities, the public or workers, including, inter alia, any COVID-19 outbreak in the Project area. The incidents reports will provide sufficient detail regarding the incident or accident, indicating immediate measures taken or that are planned to be taken to address it, and any information provided by any contractor and supervising entity, as appropriate. Subsequently, as per the Bank's request, MoH will prepare a report on the incident or accident and propose any measures to prevent its recurrence.

Chapter 6 - PROCEDURES TO ADDRESS ENVIRONMENTAL AND SOCIAL ISSUES

The Chapter describes the principles and approach to be followed for selecting, avoiding, minimizing and/or mitigating the adverse environmental and social impacts that are likely to arise as a result of the project. It set out in detail the procedures to be followed in identifying, preparing and implementing the subprojects, including the following:

- Preliminary screening of potential subprojects in relation to eligibility
- Detailed screening of each subproject for potential E&S risks and impacts and classifying each subproject according to risk (Annex 2, Screening Form)
- Conducting E&S assessment for each subproject
- Developing project specific E&S management plans/instruments
- Consultation and disclosure of E&S plans and instruments
- Review and approval of E&S plans and instruments
- Implementation and monitoring of E&S plans and instruments

Each of the sub-projects proposed under the project will follow the approach suggested here to achieve the objectives of environmental and social management.

6.1. Key Steps to be Followed

A comprehensive environmental and social management approach for the project will involve the following key steps and processes:

Step 1: Preliminary Environmental and Social Screening;

Step 2: Detailed Environmental and Social Screening;

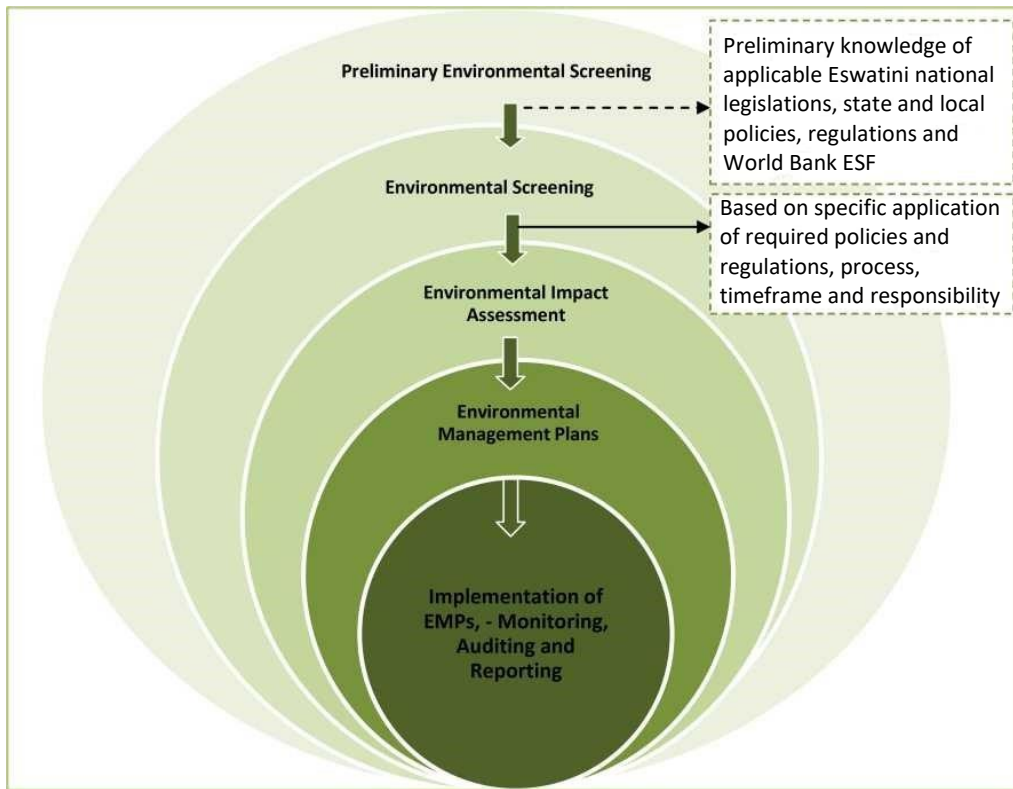
Step 3: Environmental and Social Impact Assessment (ESIA);

Step 4: Preparation of Environmental and Social Management Plan (ESMP);

Step 5: Consultation of prepared ESMP/instruments;

Step 6: Review and approval of ESMP/instruments; and

Step 7: Implementation and monitoring of ESMP/instruments



This section will describe the environment and social management approach and tools to evaluate the potential impacts from the proposed project interventions. The Environment and social Management tools will offer support at the early stages of planning and decision-making and selection of environmental and social measures including mitigation/technologies based on the nature and scale of identified potential impacts.

Step 1: Preliminary Environmental and Social Screening

This step will involve an initial desk review of the available information about the project and the sub-project areas. A preliminary environment and social screening format would be filled-up using such available information. Field visits would be undertaken to understand the general overview in the context of the scope of the proposed operation. The exercise will help in identifying the key/significant potential environmental impacts and in determining the project specific context and the focus required for carrying out the detailed environmental screening exercise. Without narrowing the focus of the detailed field investigations/assessments, having this knowledge provides an early sense on the spatial and temporal dimension about the likely issues on-hand.

Step 2: Detailed Environmental and Social Screening

Detailed screening exercise is the second step in the ESMF process. The purpose of environmental and social screening is to get an overview of the nature, scale and magnitude of the issues in order to determine the project feasibility and further if findings permit. It allows for proper scoping of detailed ESIA/ESMPs that would be subsequently carried out. After identifying key issues, the applicability of the Bank's Environmental and Social Standards will be established along with Government of Eswatini's regulatory requirements. Subsequently, boundaries and focus areas for the detailed ESIA/ESMPs along with the use of specific instruments would be determined (See Annex 3).

The key sub-steps involved in the screening exercise are outlined below:

- i. Ascertain presence of any environmental and social sensitive areas (as detailed in screening checklist) through primary/secondary information.
- ii. Confirm applicability of regulation, policies and standards in context of broad sub-project interventions.
- iii. Conduct reconnaissance site visits for ground-truthing and incorporate required/additional information in the screening format.
- iv. Obtain details about land availability and broad categories of ownership (forest/govt./private)
- v. Preparation of a screening report.

The outcome of the screening process will help select and/or prioritize the various investments and where required, start the clearance process in a timely manner.

The Bank's ESS screening usually consists of checking and identifying environmental and social risks, impacts and opportunities and the requisite measures that are applicable within the local context for addressing them. Findings from the screening will be used to determine the ecological as well as social and economic viability of the various sub-projects.

To ensure well targeted field assessment during the screening process, the World Bank's Environmental and Social Framework (ESF) establishes a set of Guidance Notes that outlines the steps and key data that is to be collected for determining the feasibility of the sub-project from an environmental and social standpoint. The guidance notes provide detailed guidelines for collecting information on environmental, natural, biological, physical and socio-economic conditions without which it becomes cumbersome to determine the likely potential impacts that may result from the project interventions. The process enables proper targeting of issues requiring further technical research and in-depth assessments during the ESIA preparation. Without proper screening, deficient planning and engineering design of sub-projects using unreliable information can result in weak arrangements to conserve critical natural ecosystems and may result in creating adverse environmental and social impacts.

Key outputs of detailed environmental and social screening would include:

- a. Determination of all national and local regulations and policies that will apply to the sub-projects,
- b. Preliminary judgment on the sub-project environmental and social category per the country context,
- c. Decision on the environmental and social risks and impacts rating (High, Substantial, Moderate or Low) in line with the Bank's ESS1 standard, and
- d. Process, timeframe and responsibilities for securing the requisite clearances and permissions per Government of Eswatini and World Bank guidelines.

It is critical at this stage to review the list of applicable legislations, standards, policies and regulations with the MOH and the World Bank to first diffuse inconsistencies in understanding, and to mobilize assistance both at the national and local levels to facilitate applications process.

Based on the screening results, a decision can be made as to whether the sub-projects would require further field assessments and studies. The Guidance note also gives an outline for presenting data with necessary explanation for recording likely environmental and social impacts.

The screening process enhances implementation by screening out or enhancing acceptability of sub-project proposals on the basis of environmental criteria. Apart from the screening of sub-project for proposed inclusion in the project, the results/findings from this exercise would be used to determine the scope of Environmental and Social Impact Assessment (ESIA) requirements.

Step 3: Environmental and Social Impact Assessment (ESIA)

An ESIA consists of a comprehensive study that involves thorough documentation of existing conditions, and identification of impacts with a comparison of alternative project design options, including “without the project” option. If implemented early, the ESIA can be an excellent preventative tool. Usually, ESIA has three principal objectives: (a) assist decision makers in getting a clear picture of the potential impacts on the overall environmental and social quality; (b) provision of impact prevention and enhancement of benefits and minimization of impacts in the long term, and (c) provide a forum that allows direct input from stakeholders in the design of the project.

An ESIA should have:

- An executive summary concisely discussing significant findings and recommended actions;
- Analysis of legal and institutional framework for the project, within which the environmental and social assessment is carried out, including comparison of Eswatini’s existing environmental and social framework and the ESSs and identification of gaps between them;
- A general information on the MOH Health Strengthening Systems project, requisite environmental clearance processes and a list of the project components;
- The locations of the subprojects with maps and topographical sheets, including the potential benefits and need for the project, description of options, implementation schedule and the projected costs for the project;
- Characterize the relevant features of the current (“baseline”) state of the receiving environment biological, physical and socio-economic description of the subproject areas and the region, including description of the potential interactions between the intervention and the baseline environment;
- The project/subproject environmental and social risks and impacts as identified in the Bank’s ESS2-8 and 10, particularly impacts and risks both direct and indirect to stakeholders, including any other risks and impacts arising as a consequence of specific nature and context of the project;
- Measures to avoid, mitigate, compensate and monitor any potentially significant adverse impacts and cost of management measures in an Environmental and Social Management Plan;
- Analysis of alternatives with particular reference to location of project and the applicable engineering technologies;
- Summarize significant concerns and recommend needed actions to address such concerns;
- Design measures, which sets out the basis for selecting the particular project design proposed and the applicable EHSs. Where EHSs are inapplicable, justification for recommended emission levels and approaches to pollution prevention and abatement that are consistent with GIIP;
- Summary of key measures and actions and the timeframe required for the project to meet the requirements of the ESSs. This will be used in finalizing the Environmental and Social Commitment Plan (ESCP);
- Conclusion – stating that either (a) the ESIA/ESMP is the completed environmental assessment for the intervention or (b) further assessment work is required and will be incorporated in a revised ESIA. For example, a subproject that would need a follow-up biodiversity assessment to track changes will be stated in the ESIA;
- Disclosure of the ESIA in line with Eswatini and the World Bank’s requirements.

The following is the recommended table of contents of an ESIA:

- Executive summary
- Policy, legal and institutional framework

- Project description
- Status of the environment (baseline data)
- Environmental and social risks and impacts
- Analysis of cumulative E&S impacts
- Analysis of alternatives
- Additional studies (if applicable)
- Project Benefits
- Mitigation measures
- Environmental and Social Management Plan
- Stakeholder consultations
- Summary and recommendations
- Annexes

The above model outline does not explicitly provide section/subsection headings for many of ESIA activities. Therefore, the ESIA consultants will create their own customized outline from this model that provides sections/subsections for ESIA activity undertaken for the sub-project under consideration.

Step 4: Preparation of Environmental and Social Management Plan (ESMP)

ESMP is the next step in the Environmental and Social Assessment (ESA) process after identifying potential impacts. It involves the identification and development of measures aimed at avoiding, mitigating, offsetting and/or reducing impacts to levels that are environmentally and socially acceptable during implementation and operation of the proposed COVID-19 Emergency project. ESMPs provide an essential link between the impacts predicted and mitigation measures specified within the ESIA and implementation and operation activities.

Certain activities/interventions will have an impact on the natural and socio-economic environment, the scale of which would depend on the existing baseline conditions along the project zones of impacts and thus would require a specific plan to institute and monitor mitigation measures and take desired actions in a timely manner. An ESMP must be sub-project specific, clearly describing adverse impacts and mitigation actions to be taken. The magnitude and temporal scale of the various subprojects will determine the contents/coverage of the ESMP. Depending on extent of issues that are to be avoided, minimized and/or mitigated, the ESMP will have concrete/specific mitigation actions, timelines and responsible persons.

For each subproject activity, an ESMP should address the following:

- Mitigation, enhancement, protection and compensation measures for each phase including design pre-construction, construction, operation and maintenance;
- Mitigation performance monitoring (i.e., monitoring the operation and maintenance of mitigation measures and their targeted impacts);
- Project Affected People (PAP) participation arrangements by project development phase;
- Disaster management contingency plan where applicable especially in areas with potential flooding, earthquake zones;
- Capacity development and training requirements, including institutional arrangements for implementation, monitoring and reporting;
- Cost estimates for all ESMP activities;
- Integration of the ESMP with the project's overall planning, designing, budget and implementation, and

- Standard construction environmental and social safeguards clauses for engineering and civil works.

In developing the ESMP, the consultant will consider findings from the stakeholder/public consultation process, including suggestions from MOH, PAP (to include vulnerable people). For Substantial Risk subproject, the Bank's ESF guidelines require the development of a detailed standalone ESMP.

Below are the proposed elements of an ESMP:

Identification of Impacts and Description of Mitigation Measures: Under this sub-heading, the ESMP will describe the identified environmental and social impacts that may result from the project interventions. With reference to each impact, it will describe feasible and cost-effective measures to minimize impacts to acceptable levels. This section will also provide details on the conditions under which the mitigation measures will be implemented whether as a routine or in the event of contingencies. The ESMP will also distinguish between type of solution proposed and the phase in which it should become operable.

Enhancement Plans: Positive impacts or opportunities arising out of the project will be identified during the ESIA process. Some of these opportunities can be further developed to draw environmental and social benefits to local communities within the project zone of impact. The ESMP will identify such opportunities and develop a plan to systematically harness any such benefit.

Monitoring Plan: In order to ensure that the proposed mitigation measures have the intended results and comply with national and World Bank requirements, an environmental and social performance monitoring program will be included in the ESMP with the following suggested details:

- Monitoring indicators to be measured for evaluating the performance of each mitigation measure.
- Monitoring mechanisms and methodologies
- Monitoring frequency
- Monitoring locations
- Expected cost of monitoring
- Responsibility

Institutional Arrangements: Institutions/parties responsible for implementing mitigation measures and for monitoring their performances will be clearly identified along with any legal instruments that define their obligations. Where necessary, mechanisms for institutional co-ordination will be identified as monitoring tends to involve more than one institution.

Implementation Schedules: Timing, frequency and duration of mitigation measures with links to overall implementation schedule of the project will be specified.

Reporting Procedures: Feedback mechanisms to inform the relevant parties on the progress and effectiveness of the mitigation measures and monitoring will be specified. Guidelines on the type of information wanted and the presentation of feedback information will also be highlighted.

Cost Estimation: Implementation of mitigation measures presented in the ESMP will involve an initial investment cost as well as recurrent costs. The ESMP should include costs estimates for each measure and also identify sources of funding.

Step 5: Consultation of prepared ESMP

The Infection Control and Waste Management Plan (ICWMP) and ESMP will be consulted with health facility staff, particularly nurses and female health professionals, and with local communities.

Step 6: Review and approval of ESMP

The ICWMP and ESMP will be reviewed by E&S specialists in the PIU and the Department of Preventive Medicine under the MOH and approved by the Project director. The World Bank will review ICWMPs and ESMPs as well.

Step 7: Implementation and monitoring of ESMP

The implementing agency will also assign the construction supervision consultant or field engineer to be responsible for day-to-day monitoring of the renovation civil works and maintain close consultation with local community as necessary. If appropriate, Provincial DOH and other local authorities may also monitor the implementation of the E&S measure during implementation of the physical renovation works, as well as ensuring there is equitable access to services. Monitoring and reporting to the MOH and the World Bank, will also be required.

6.2 Key Principles for Subproject Engineering Design

In order to avoid and minimize adverse environmental and social impacts at sub-project level, key findings from the environmental and social screening report should provide the basis for developing sub-project engineering designs for air conditioning, plumbing, incinerator installation and waste storage centres. In situations where results from the field assessments are not duly factored into the sub-project design, environmental and social footprints that could result from such proposed engineering designs could be found to be significant. To eliminate such complexities, project contractors will work hand in hand with the respective environmental and social experts to ensure that the proposed designs are environmentally, socially and economically viable and sustainable. Until the ESIA/ESMPs are publicly disclosed and approved, engineering drawings would undergo a series of changes to incorporate all recommendations from the environmental and social standpoint.

6.3 Consultation and Disclosure Requirements

Consultation with project affected people, subject-matter experts and NGOs in preparing the ESIA/ESMPs is critical for Substantial Risk project/subproject. For all such project/sub-projects, MoH is expected to consult project-affected groups and local nongovernmental organizations (NGOs) about the project's environmental and social aspects and take their views into consideration. Their views and concern expressed during consultations will be used to improve project design and implementation and mechanism shall be devised to ensure that their views are adequately incorporated. The disclosure of documents shall be as per requirements of Eswatini national and World Bank procedures.

6.4 Integration of ESMP into Bidding Documents

Relevant sections of the construction stage of the project/subproject will be integrated into the Bid Documents and the ESCP (See Annex 4). Site-specific ESMPs for civil works including air conditioning, plumbing, incinerator installation and construction of waste storage centers will be added to bidding documents and contracts. Contract documents will need to be incorporated with clauses directly linked to the implementation of environmental and social risks and impacts management measures. Mechanisms such as incorporating ESSs requirements into the contractor's contract and linking the

payment schedules to implementation to contractor's contract clauses need to be explored and implemented, as appropriate.

Chapter 7: CONSULTATION AND PUBLIC DISCLOSURE

This section describes the consultation process and how project-specific information will be disclosed in relation to this ESMF and each individual subproject. The section describes how to achieve communication between the Project Implementation Unit (PIU) and the affected communities and stakeholders. Consultation with project affected people, subject-matter experts and NGOs in preparing the ESIA/ESMPs is critical for Substantial Risk project/subproject. For all such project/sub-projects, MOH is expected to consult project-affected groups and local nongovernmental organizations (NGOs) about the project's environmental and social aspects and take their views into consideration. Their views and concern expressed during consultations will be used to improve project design and implementation and mechanism shall be devised to ensure that their views are adequately incorporated. The disclosure of documents shall be as per requirements of Eswatini and World Bank procedures. The right to access information held by public authorities, or the right to information, is recognised under international law as a fundamental human right. Access to information is important in its own right, and as a means to protect other rights, including democracy, and to support sustainable development. The section describes how to achieve communication between the Project Implementation Unit (PIU) and the affected communities and stakeholders.

One of the major challenges for COVID-19 prevention and control is finding effective ways to encourage new behaviours and achieve behavioural results. An approach known as COMBI (Communication-for-Behavioural-Impact) will be used in the design and implementation of Advocacy, Communication and Social mobilization plans for the adoption of healthy behaviours.

The key in planning COMBI programmes is to strive for an integrated approach with a judicious blending and selection of communication actions appropriate to the behavioural outcome desired, and not to believe that one single kind of communication intervention is all-powerful. COMBI uses the five communication actions:

Public Relations/Advocacy/Administrative Mobilization

This focuses on putting the COVID-19 prevention and control behaviours on the public and administrative/programme management agenda.

This involves the use of both mass and social media presence to share timely, relevant public health information

- Mass media
 - Print
 - Contribute weekly COVID-19 Feature articles in both newspapers
 - Share daily updates with the newspapers
 - Produce weekly newsletter with special topic on COVID-19 delivered to health facilities and stakeholders
 - Electronic
 - Radio Share weekly updates with Programme Producers
 - Use radio and television talk shows focusing on COVID-19 and the behavioural messages
 - Production of short 8-minute video in collaboration with Eswatini TV
- Social media
 - Facebook, Twitter, Instagram

- Upload posts on Facebook, Twitter, Instagram about the emergency response and comprising mostly photos and text

Community Mobilization

This involves sustained community based social marketing to remind communities of COVID-19 pandemic, information provision to individuals through face to face engagement, communication with high risk groups including elderly and people with pre-existing medical conditions as well as integrate the issue of COVID-19 prevention into community meetings, churches and other social groupings.

- Use of mobile TV truck driving through COVID-19 hot spots areas stopping in places and explaining to people why the behavioural message.
- Regional COVID-19 community engagement teams visiting prayer service at whatever church and mosque they arrive at, and after prayer mingle with people and explain the COVID-19 behavioural message.

Sustained Appropriate Advertising,

This is done in MRIP fashion – Massive, Repetitive, Intense, Persistent, via radio, television, newspapers and other available media, engaging people in reviewing the merits of the recommended behaviour vis-à-vis the “cost” of carrying it out.

- Radio, television and newspaper advertising—Two 2-week flights, 6-8 radio spots per day and 2-3 TV spots per evening, five days per week in each flight, full page or half-page ads in first week of each flight in newspapers;

Personal Selling/Interpersonal Communication/Counseling,

This is done at the community level, in homes and particularly at service points, with appropriate informational literature and additional incentives, and allowing for careful listening to people’s concerns and addressing them.

- Health workers
 - for patient who visit health facilities Provide advice about prevention and control of COVID-19 and give instructions to visit the health facility for diagnosis and treatment
- Community Volunteers
 - Selection of community volunteers to form teams with badges and COVID-19 worksheets for door-to-door home visits
- School children
 - School children taking home paper pin-wheels with COVID-19 behavioural message and information worksheets (private sector co-sponsored)
 - About 50 000 school children taking home paper pin-wheels with the COVID-19 behavioural message and information worksheets

- School children to influence their homes and their circle of friends. Teachers distribute worksheet to children in form 5 and grade 7

Point-of-Service Promotion

This emphasizes easily accessible and readily available solutions to health problems.

- Branding of public transport travelling to COVID-19 hot spot areas
- Placing signage directing people where to get COVID-19 services

7.1 THE ESWATINI COVID 19 VACCINATION COMMUNICATION PLAN

INTRODUCTION

The communication strategy that supports the COVID-19 vaccines rollout in Eswatini seeks to disseminate timely, accurate and transparent information about the vaccine(s) to alleviate apprehensions about the vaccine, ensure its acceptance and encourage uptake. The strategy will also serve to guide national, state and district level communication activities, so that the information on the COVID-19 vaccines and vaccination process reaches all people, across all states in the country.

COVID-19 has disproportionately impacted communities, the elderly, and individuals with underlying health conditions since its arrival in the Kingdom of Eswatini. By working collaboratively with partners, the MoH is intent on ensuring thoughtful and thorough communications processes are put into place to help these stakeholders access the vaccine, and to help the broader public understand the importance of prioritizing these groups in vaccine distribution.

This communication plan incorporates both internal and external communication methods to ensure MoH staff employees and the public understand the process used to develop the vaccination plan, how to access vaccines, and who to contact with questions or concerns.

The Covid vaccine communication plan recommended is at country level to promote awareness of vaccine risks and benefits, understand perceptions of risk, and prepare for managing any adverse events and concerns about vaccine safety promptly.

Communicating about Covid 19 vaccine safety is important. It is essential in at least three situations, namely:

- Explaining properly the benefits and risks of the recommended Covid 19 vaccine;
- Addressing public concerns and upcoming or persistent rumours about vaccine safety;
- Preparing to address vaccine safety crises if and when they occur.

The effective communication is an ongoing process that involves all stakeholders for the Covid 19 vaccine. The MoH will promote the development and strengthening of continuing communication about important Covid 19 vaccine safety issues between local communities, health-care workers and decision-makers.

AIM

The MOH supports and encourage appropriate uptake of the Covid 19 vaccine by:

- Managing and mitigating any potential disappointment expressed by unmet demand for the vaccine or 'eagerness' amongst people.
- Addressing vaccine 'hesitancy' that could arise because of apprehensions around vaccine safety, efficacy; and any other myths and misconceptions.
- Provide information on potential risks and mitigate unintended crisis (e.g., AEFI clusters, delay in vaccine rollout for certain population categories) during the introduction and rollout

The strategy also seeks to build trust and enable greater confidence in the COVID-19 vaccine amongst all people by employing transparency in communication, while also managing any mis/disinformation and rumours around it.

HOW WILL IT BE DONE

This will be achieved by: Using the social influence or endorsements from experts and official voices to:

- Involving community mobilizers and frontline workers to engage with the community at various levels:
- Establishment of a National Media Rapid Response Cell at MoH
- Spell out the process of immunization (where, how, who, when - date and time) Through community consultations, faith leaders and religious meetings
- Ensure preparedness through media monitoring and social listening and respond in real time
- Emphasize on the safety and efficacy of vaccines
- Engaging youth, civil society organizations, self-help groups
- Unfold media and public discourse, through extensive monitoring of print, electronic and digital media
- Explain the decision to conduct the drive in a phased manner the rural health programme and other community-based platforms

KEY AREAS OF FOCUS

There are Four Key Areas that will be addressed as part of interventions under the strategy

By using an integrated advocacy, communication and social mobilization strategy nationwide, four key areas will be addressed as shown below:

- **Information on the new COVID-19 vaccine:** Provide prompt, simple and focused communication on the COVID-19 vaccine(s) and vaccination processes

- **Vaccine Eagerness:** Ensure understanding and acceptance of the phased and prioritized approach to overcome concerns of the population waiting for vaccination
- **Vaccine Hesitancy:** Build public confidence on the safety and efficacy of the new vaccine
- **COVID Appropriate Behaviours:** Maintain and sustain key preventive behaviours: wearing masks, maintaining physical distance and hand washing with soap

OBJECTIVES OF THE COVID-19 VACCINE COMMUNICATION STRATEGY

- Ensure that all eligible groups receive the vaccine with confidence
- All people get correct information and are not influenced by mis/disinformation, myths or misconceptions
- Hesitancy of public is addressed on the COVID-19 vaccination process
- Provide correct, consistent and timely information on the new COVID-19 vaccine(s) (availability, safety, and timelines) and vaccination processes
- Generate awareness and understanding of the phased approach of prioritizing target groups
- Address low-risk perception of the infection amongst people and build an enabling environment to adopt and maintain COVID appropriate behaviours to reduce any risks of infection

TARGET AUDIENCE

All citizens; vaccine eager and vaccine hesitant groups; with a focus on priority for people to be vaccinated in the first phase

- health care workers,
- frontline functionaries,
- people over 50 years of age and people under 50 years with co-morbidities.
- National media including traditional and digital media, which will disseminate correct/factual information by proactively addressing any mis/disinformation or incorrect messaging.

INFORMATION ON COVID – 19 VACCINES

Information on vaccines will clarify:

- Eligibility criteria and vaccination process
- The vaccine has gone through various trials and is safe
- Where to access the vaccine Process of registration and pre-conditions for vaccination
- Post vaccination care and support

Vaccine Eagerness (VE)

There is significant keenness amongst the public as people have been waiting for the COVID-19 vaccine so that they are able to get back to their normal life. It is therefore important to:

- Acknowledge that there might be a degree of vaccine eagerness but people will have to wait to get vaccine access, based on the defined prioritization criteria
- Refer to key messages (shared as annexures with this document) and communication package addressing the potential for vaccine eagerness and engaging people to support the vaccination rollout
- Share accurate information, consistently with general public and those waiting for the vaccine to address any knowledge gaps
- Advocate for and refer to reliable sources of information (MoH website and official social media handles), and proactively manage any mis/ disinformation or fake news

Vaccine Hesitancy (VH)

Suggested actions to tackle and address any concerns of vaccine hesitant and resistant groups:

- Community engagement with credible communication approaches for each target group to build trust in vaccines
- Identify traditionally known vaccine-hesitant and resistant areas/groups/communities, based on prior experience. Orient credible influencers from local communities to build their trust and acceptance
- Develop articles with support from influencers about the safety and efficacy of the COVID-19 vaccine in national, state and regional media
- Use articles and research in support of the vaccine, scientific explanations and clips of credible influencers during interaction with the hesitant groups
- Create a pool of editors who will write and share opinion editorials in national, state and regional media
- Ensure real-time, round the-clock monitoring of digital media to facilitate appropriate and timely action to address hesitancy

COVID Appropriate Behaviours (CAB)

While the vaccine is an important part of COVID-19 protection, it is important to emphasize the continued practice of COVID Appropriate Behaviours or CAB (frequent and thorough hand washing using soap and water, wearing a mask/face cover and physical distancing of 2 metre (6 feet)) for personal safety and prevention of community transmission. The continuation and reinforcement of CAB will be achieved through the following actions:

- Disseminating key messages explaining rationale to continue CAB to reduce risk of infection even after vaccination and also after recovering from COVID-19.

- Leverage existing official WhatsApp groups, Telegram platform, mass (including local cable radio and community radio networks) and social media handles
- Leveraging NGOs, Community Based Organizations (CBOs), FBO's
- Mask use
- Handwashing with Soap and water/
- Use Hand Sanitizer
- Social Distancing(2m)
- Prompt Testing
- Prompt Self Isolation
- Promoting CAB messaging at state and regional levels using local / vernacular language
- Engaging influencers at various levels to reinforce CAB

KEY ELEMENTS OF THE COMMUNICATION STRATEGY

Based on the learnings of previous national immunization campaigns, five key elements of the strategy have been developed in order to support the rollout and introduction of the COVID-19 vaccine at the national and state level:

1. Advocacy
2. Capacity Building
3. Media engagement and social media
4. Social mobilisation and community engagement
5. Crisis communication
6. Covid 19 vaccine eagerness, trust and confidence

PLATFORMS

1.INDIVIDUALS/INFLUENCERS

Celebrity

- Entertainment Industry,
- Sport, Politics

Influencers

- Local Leaders,
- Faith Leaders, Social-cultural Leaders,
- Tinkhundla Leaders,
- Teachers

Frontline workers

- Nurses
- Doctors
- Indvuna yeNkhundla
- Bucopho beNkhundla

•	Rural health motivators
2. COMMUNITY GROUPS	
•	School Management Committee,
•	Schools Inspectors 'Committees;
•	Children's School Committees,
•	Headmasters' associations
•	Scouts & Guides, '
•	Cooperatives
3. MEDIA	
•	Twitter,
•	Facebook,
•	WhatsApp,
•	Telegram,
•	Youtube
3.1. Community Media	
•	Folk Songs,
•	Drama,
•	Dance,
•	Story-telling,
•	Leaflets
3.2 Mass Media	
•	Cable TV Networks,
•	Television,
•	Radio,
•	Mobile,
•	Print
3.3 Outdoor Media	
•	Wall Paintings, Hoardings,
•	Bus Panels,
•	LED Scroll,
•	Poster,
•	Banners

TOOLS/MATERIALS FOR EACH TYPE OF PLATFORM

To achieve a wide reach for the messages and in order to get a greater degree of engagement from all target audiences, a wide variety of trusted sources and communication channels and platforms will be leveraged in both urban and rural areas. Each platform will have specific communication tools and materials for activation, mobilization and broadcast from the inventory below:

Games, Songs, Prayers, Pledge, Posters, Flipbooks, Dialogue Cards/Interpersonal Communication Videos, Interactive Radio Programmes Tweets, Videos, Messages, Scripts, Folk Song Lyrics, Stories, Community

Radio Programmes, TV Programmes, Radio Programmes, TV commercials, Radio spots, Ringtone, Mobile Games, Prototype Designs of Wall Painting, Bus Panels, LED Scrolls

KEY COMPONENTS OF THE ADVOCACY STRATEGY

Advocacy efforts will aim to engage the maximum number of people by promoting the benefits of COVID-19 vaccine and support in building an enabling environment. Various stakeholders and experts will lead the advocacy campaigns at national, state and district level. These include (but are not limited to):

1. Honourable Prime Minister
2. Parliamentarians
3. Ministry of Health, Ministries in the Central Government and their field-level networks
4. Professional bodies IMA, doctors and health workers, alternate medicine practitioners, Rotary and Lions Club
5. National and local media representatives
6. Public and private sector companies
7. Development partners, Civil Society, Community Based Organizations & Religious/faith-based leaders

At the national level, the following advocacy actions will be implemented:

- Development of advocacy package- FAQs, leaflets, factsheet, multimedia material, along with their language versions
- Adequate preparation for the launch of the vaccine, by holding pre-launch sensitization events with journalists; develop media kits
- Organizing inter-ministerial meeting/ briefing on the COVID-19 Vaccine Communication Strategy and vaccination process to ensure that all political and bureaucratic leadership is reinforcing the same messaging
- Sharing communication materials and messages for efficient use of platforms owned by the above-mentioned influential voices
- Leveraging national and state-owned media agencies for organizing advocacy activities
- Publishing opinion pieces, organizing interviews and discussions with scientists, experts and other credible voices
- Implement Standard Operating Procedures (SOPs) for MOH management, spokespersons' training, preparedness, rumour management, planning for press releases and conferences National and local media representatives
- Public and private sector companies
- Development partners, Civil Society, Community Based Organizations
- Religious/faith-based leaders

KEY ACTIONS AT DISTRICT AND LOCAL LEVEL

- Utilise platforms of district and block task force, district specific communication plan (annexed) including implementation and monitoring mechanisms
- Organizing advocacy events with religious leaders and faith-based institutions - written appeal, audio/ video bytes – amplified through electronic, print, WhatsApp, and social media
- Identifying and leveraging support of professional bodies, youth organisations and panchayat bodies to support implementation of communications actions
- Disseminating messages through local champions and influencers

CAPACITY BUILDING OF KEY STAKEHOLDERS

Since the vaccine for COVID-19 is new, it will be important to orient and train all those stakeholders who will be responsible for the implementation of communications actions, in both urban and rural areas. Communications training will be carried out in line with the training modules that will be developed to plan and implement communications actions at all levels. Districts will be required to identify training mechanisms to reach the extensive network of frontline workers, health care providers, community-based volunteers, influencers and other stakeholders in remote areas to ensure outreach to the last mile, while also ensuring an equal focus on the urban areas.

The following cadres will be trained to support the implementation of the communications plan:

- Rural Health Motivators
- Development partners
- Key Officials from Ministries of Tinkhundla,
- Ministry of Housing, Youth, Women & Child Development, Railways, Labour among others
- CBOs, Influencers, Youth Networks and Volunteers
- Staff of COVID- Helpline Call Centres

STRENGTHENING MASS MEDIA, SOCIAL MEDIA, ENGAGING INTERNATIONAL MEDIA, SOCIAL MOBILIZATION AND COMMUNITY ENGAGEMENT

For the COVID-19 Vaccination rollout, media and social media will play a critical role in creating and influencing perceptions across the wider public. Media engagement will involve activities at the national, state and district levels; customized for different audience segments in the three phases – pre-vaccine introduction, during vaccine rollout and post vaccine introduction.

Key Stakeholders

The MOH stakeholders are Media houses at the national level News channels at national, state and regional levels Senior editors and health, education and business journalists Media from regional dailies and local dailies.

National Media Rapid Response

The Health Promotion Unit will be responsible for national media rapid response. This has been set up at MoH to enable both proactive engagement as well as rapid response to news in traditional media and social media, especially during crisis.

The Health Promotion Unit (HPU) will enable real-time monitoring and tracking of the large volume of conversations on the theme of COVID-19 vaccination. It will capture the pulse of the discussion across the country by extensive and constant monitoring of topics related to vaccine eagerness, vaccine hesitancy and any misreporting or false information regarding COVID-19 vaccine. Print, electronic and digital media platforms will be monitored, including national media as well as nationally representative state and language media to enable coordination in rapid response across messages, media and channels for appropriate response management.

The HPU will do fact-checking, draft rejoinders, collate, advise and share key messages which will be disseminated by PIB/designated media unit of MoH. A real-time digital media dashboard, and overall social media monitoring will also be managed by the PIU. The PMU will have live data feeds and digital media visualizations that will provide a clear view of the real-time conversations and themes that are emerging from the public discourse. It will also have linkages with the designated field staff to get updated information from the states and any on-ground information that might not otherwise be captured through its monitoring tools.

MANAGING DIGITAL MEDIA

Digital media platforms, especially social media channels, can reach and engage large audiences quickly. The results are in real-time and the channels are cost-effective. To maximize the reach of COVID-19 communications and ensure visibility and amplification, consistent, simple, precise messaging with a consistent branding will be disseminated through the use of multiple social media channels, including WhatsApp. Ensuring content is branded officially can help build trust among many audiences. A social media plan will be developed, to include content and marketing through official channels, and to ensure engagement with key influencers through their channels. The MOH will be required to utilize their existing official channels as those will have established credibility and organic reach. All official content will need to be adapted to the local context and state audiences.

ENGAGING INTERNATIONAL MEDIA ON COVID

While the UK and USA have emerged as the first two countries in the world to launch the COVID vaccine, Eswatini too is gearing to launch one of the world's largest COVID vaccination drive. There is interest in the global community on how Eswatini is going to go-ahead with the vaccination programme. This is an opportunity to highlight Eswatini's preparedness and plans in the global arena. Therefore, along with national media engagement, international media would need to be engaged to ensure correct and transparent information about the vaccine programme is conveyed in a sustained manner.

PRE-VACCINE LAUNCH: PREPAREDNESS PHASE

The Ministry of Foreign Affairs will be approached to reach out to Eswatini's Missions abroad with all relevant information on the vaccination campaign. The following initiatives are planned at the national level to engage the international media.

1. Conduct a series of briefings with select international media, press clubs
2. Prepare key messages both for recurrent questions as well as to handle crisis responses
3. Keep a multimedia feed of videos and a B-roll of pictures ready for sharing.
4. Evaluate international media coverage and response and take corrective decisions on-courtesy negative news and showcase the country's role in the launch and roll out of the vaccine and its successful delivery.

DURING THE CAMPAIGN

1. Arrange interviews of COVID warriors, health workers, police personnel, sanitation workers who will be inoculated first in India and pitch them in popular slots, front-pages
2. Organize virtual/ in-person field visits of international media (following CAB guidelines) to storage units, vaccination centres to showcase preparedness and systems put in place. [Similar engagement done during MR Drive was widely picked].

POST-VACCINE

1. Pitch positive stories of the success of the campaign
2. Arrange interviews with on ground workers involved in the success of the campaign
3. Pitch human interest stories of people inoculated

SOCIAL MOBILISATION AND COMMUNITY ENGAGEMENT

Social mobilization actions will focus on risk communications and community engagement. It will respond to perceptions of communities and health service providers on the COVID-19 vaccines and ensure that all people perceive and understand the vaccination process correctly and act accordingly. The social mobilization plan will focus on:

- (i) the phased vaccination plans
- (ii) addressing vaccine eagerness on one end and vaccine hesitancy on the other. The social mobilization plan will be contextualized to state and community requirements, and address state-specific variations and vulnerabilities such as urban-rural, tribal – nontribal, and hard to reach pockets. While social mobilization actions will reach public across all categories, it will specifically focus on motivating the

priority groups for COVID-19 vaccination and their family members through community consultations and inter-personal

Chapter 8 - Stakeholder Consultation

8.1 Stakeholder Consultation

The Eswatini COVID-19 Emergency Response Project is being prepared under the World Bank's Environment and Social Framework (ESF). As per the Environmental and Social Standard (ESS) 10 on Stakeholders Engagement and Information Disclosure, the implementing agencies should provide stakeholders with timely, relevant, understandable and accessible information, and consult with them in a culturally appropriate manner, which is free of manipulation, interference, coercion, discrimination and intimidation.

The overall objective of this SEP is to define a program for stakeholder engagement, including public information disclosure and consultation, throughout the entire project cycle. The SEP outlines the ways in which the project team will engage with stakeholders and includes a mechanism by which people can raise concerns, provide feedback, or make complaints about the project and any activities related to the project. The involvement of the local population is essential to the success of the project in order to ensure smooth collaboration between project staff and local communities and to minimize and mitigate environmental and social risks related to the proposed project activities. In the context of infectious diseases, broad, culturally appropriate and adapted awareness raising activities are particularly important to properly sensitize the communities to the risks related to infectious diseases. This SEP is a living document that will be updated during project implementation as more details on the stakeholders' groups and measures are identified.

8.1.1 SEP UPDATE

On March 17, 2020, Eswatini declared a State of Emergency and as of April 12, (less than a month later) there were 14 confirmed cases of COVID-19. Since April 12, and as of September 2, 2020, COVID 19 confirmed cases in Eswatini have increased by 329 folds with 4,618 confirmed cases, 3,652 recoveries, 962 active cases, and 94 deaths.

In addition to the above data on prevalence of COVID-19 in Eswatini, the SEP that was prepared and disclosed on April 20th, 2020. needed updating due to the reasons stated below:

- Consultations were limited during the development of the SEP, so further meaningful engagements had to be done to inform the document;
- The project has commenced, and stakeholder engagement is ongoing; and
- Eswatini was responding to the COVID-19 emergency prior to the project.

In view of the above shortcomings, a comprehensive review to update and align the SEP was therefore necessary. Structured engagements with key stakeholders, the review of relevant documentation from the World Bank, MoH and Communication strategy for COVID-19 response activities and a formal review of strengths, weaknesses, opportunities and threats (SWOT) to stakeholder engagement was done to inform the SEP.

Interviews with key stakeholders (High Influence, Low Interest and High Interest and Low Influence) were arranged and conducted. Eight stakeholders have been consulted and revealed their concerns and flagged issues about the virus as well as their needs and expectations in relation to the Eswatini COVID-19 Emergency Response Project.

The list of stakeholders engaged in the SEP include the following:

- Recovered COVID-19 Patient
- COVID-19 Affected person under quarantine
- Rapid Response Teams (RRTs) from the Hhohho, Shiselweni and Lubombo regions
- Manager of National Laboratory
- CSO – World Vision (advocates for vulnerable persons in rural areas)
- CSO – Save the Children
- SOE - NERCHA Executive Director
- Local Authorities – Mbabane and Siteki Municipalities
- Deputy's Prime Minister's Office

Representatives of the stakeholders were selected from each category and a consultation schedule and an interview guide were prepared and administered to the respondents. The engagement channels used were guided by the *Technical Note: Public Consultations and Stakeholder Engagement in World Bank-supported operations when there are constraints on conducting public meetings*. The channels included small groups for face-to-face meetings, conference telephone calls, virtual meeting rooms and emails. The following aspects were central to the engagement:

- Awareness of the project and COVID-19;
- Fears and experiences with COVID-19;
- Needs and expectations;
- Engagement initiatives and channels;
- Issues, challenges and grievances; and
- Proposed improvements.

8.1.1.1 Findings from Consultations

Below are brief summaries of interviews with various selected representatives of the stakeholders. Details of interviews are presented in Annex I.

➤ Recovered COVID-19 Patient

One COVID-19 recovered patient was engaged and was asked to share their experiences. It was observed that i) they experience dehumanization in the process of receiving care, ii) there is no psychosocial support for patients, iii) social needs for patients receiving COVID-19 care are not attended to, iv) patients are disconnected from their family members because treatment facilities do not have means to enhance communication between patients and family members, v) grievances response is lengthy and cumbersome (grievances should be received by the nurse manager and reported to the Matron who consequently forward them to the SMO), vi) ethical principle of Confidentiality was not observed.

➤ COVID-19 Affected person under quarantine

The process also involved engagement with affected people housed in quarantine facilities. The people include those arriving from lengthy periods out of the country and they often tested negative for COVID-19 on assumption of duty. The needs, experiences and concerns they presented indicate that i) they needed to communicate with their families as they were homesick and did not have access to WIFI and other means of communication to attend to outside personal matters; ii) wanted time to do physical training as part their routine; iii) PPEs to limit exposure to the virus; iv) prefer to communicate COVID-19 matters through face-to-face and not the toll-free line is often subjected to abuse and COVID-19 results must be conveyed through face-to-face means and avoid others means to prevent adverse reactions in cases where results are positive to COVID-19. They recommended the COVID-19 response be improved through: intensification of public awareness and education on behavioral change; proper counseling of clients when receiving their results and disclosure of results through face-to-face meetings whether the results are positive or negative.

➤ Rapid Response Teams (RRTs) from the Hhohho, Shiselweni and Lubombo regions

Members of the RRTs from all the regions were also engaged on a variety of COVID-19 response issues. Their experiences over the last three months indicate that i) they suffer emotional, social and physical

challenges mainly being stigmatization, breakup of their families and fatigue; ii) subjected to un-conducive working conditions where they work for long hours (double shifts), crowded temporary accommodation, arrogance of the laboratory staff, lack of PPEs, lack equipment including vehicles and fuel as well as lack of transport to report for duty; iii) lack of motivation and support from the Ministry and iv) lack of coordination among the players involved in COVID-19 response i.e. case tracing, case management and evacuation; v) slow response to grievances lodged (grievances meeting is convened once a week) and vi) lack of psychosocial support. Suggestions raised for improvement in COVID-19 include: i) improvement of working conditions of the RRTs staff through provision of adequate and permanent accommodation and payment of hardship allowances; ii) maintain a regular supply of PPEs; iii) provision of vehicles and fuels to RRTs; improvement of coordination and links among all departments involved in COVID-19 response and iv) return to drawing boards using the three months experience the country has in responding to COVID-19 pandemic.

➤ **Manager of National Laboratory**

The engagement of laboratory personnel revealed that testing laboratories have been affected by the COVID-19 pandemic in a number of ways including i) increase in workload as a result of the increase test cases as for some time there was one COVID-19 testing laboratory; ii) anxiety and safety concerns among staff as a result of lack of knowledge about COVID-19; iii) increase in labour issues such as staff relocations; iv) increase in generation of special (medical) waste with a reduced waste management capacity; iv) problems of coordination and communication among institutions involved in COVID-19 response i.e. lack of clarity on roles and responsibilities and v) irregular supply of relevant PPEs. Laboratory management periodically receives grievances from staff yet there is no GRM in place. Suggestions for improvement presented include hiring of more laboratory staff; supply of more testing kits and relevant PPEs; provision of incinerators in Mbabane Government Hospital; training of laboratory staff in COVID-19; strengthening of communication and coordination among institutions tasked with COVID-19 response.

➤ **CSO – World Vision (advocates for vulnerable persons in rural areas)**

World Vision is an NGO that advocates for vulnerable people in rural areas. Impacts of the COVID-19 pandemic include disruption of services and programs supporting vulnerable people such the delivery health services as a result of diversion of resources support people's livelihoods; increasing number of malnourished children; increase in domestic violence, GBV incidents and sexual abuse women and girl child. The World Vision raised a number of concerns brought about by the COVID-19 pandemic which include increase in fear and anxiety among people due mainly to job losses; fear of stigmatization and discrimination against those taken in for COVID-19 testing and treatment; and escalation of infections due to lack of adherence to COVID-19 procedures. This is all against the backdrop of lack of facilities and proper measures for self-isolation in rural homesteads; long turn around testing time for COVID-19 and weak GRM that result only on collection of complaints through a toll-free number transfer of complaints to relevant departments elsewhere. Suggestions for improvement include strengthening of WASH programme in public places; Intensification of behavioral change campaigns; building capacity of and equipping RHMs to deal COVID-19 cases (e.g., supply RHMs with equipment for basic screening); improve

COVID-19 information dissemination and strengthening communication and coordination of COVID 19 response agencies.

➤ **CSO – Save the Children**

The organization noted the following impacts of COVID-19; i) Increase in child exploitation and domestic abuse; ii) increase difficulties experienced by people with disabilities to access health facilities and people living with albinism having to cope with sanitizers that harmful to their sensitive skin; iii) increase in the number of households experiencing shortage of food; and decline in the organization's capacity deliver services to vulnerable people. Among concerns related to the pandemic raised by the organization include difficulties to access health facilities due to lockdown, absence of transport and distance; fear and anxiety engulfing the people; communication and coordination challenges among agencies involved (especially duplication of efforts); fear of increase of infection cases due to crowded living conditions specially among those sharing the one-room accommodation facilities. The organization currently receives support from the EU, NDMA, National Response Team and Food Security Consortium. Suggestions for improvement of COVID-19 response include the provision of psychosocial support to COVID-19 patients and their families as well as medical personnel; training of communities on WASH and COVID-19; strengthen coordination of agencies involved in COVID-19 response and provision of basic household needs especially food and sanitation.

➤ **SOE - NERCHA Executive Director**

The pandemic has resulted in the scaling down of NERCHA's HIV and AIDS responses to give attention to COVID-19. This affected services such as distribution of medication as well interpersonal communication and counselling. The tightening of resources has also resulted in fears of discontinuations among those on ARVs treatment. Other fears include overburdening of local system; potential increase in new infections especially among the youth; malnourishment among children that are no longer benefiting from the school feeding schemes; reduction in supply of ARVs due to COVID-19 impacts on operation of manufactures and increase in general failure among people to access health facilities for medication due to lockdown and lack of transport. Suggestions for improvement of COVID-19 response include development of clear framework to address COVID-19 and HIV and AIDS. Development of clear monitoring plans for provision of food to communities and NCPs; conducting periodical testing to people with underlying diseases including HIV and AIDS; recruitment of more health staff to reduce the workload of current staff and mount more vigilance or surveillance on households for timeous detection of domestic violence and GBV cases.

➤ **Local Authorities – Mbabane and Siteki Municipalities**

The main impact of COVID-19 was the reduction of service delivery to urban inhabitants due to diversion of resources to combat the pandemic. During lockdown almost all the operations of the local governments were shut down as well social and commercial activities within the urban areas. Concerns emanating from the pandemic included continued crowding of the urban areas despite the rising infection rates; dealing with fears of COVID-19 infection among urban residents neighboring health facilities such as the Lubombo Referral Hospital; complete shutdown of service delivery; reduction of

government financial support as focus is now on combating the pandemic; decline in revenue collection; increase in poverty levels due loss of jobs and sources of income and a massive increase in generation of special waste from both health facilities and affected homesteads. The local authorities have to deal with complaints arising from closure of businesses, marketing facilities and recreation facilities. There are also challenges of weak institutional coordination. Grievances from municipal staff include complaints about exposure to the virus during waste collections from households and frequency of waste collection. Grievances from the residents revolve around the reduced service delivery especially waste collection. Suggestions for improvement of the COVID-19 response include strengthening of information sharing mechanisms; prioritization of municipal issues in the COVID-19 response activities; frequent engagement of local authorities on health issues.

➤ **Deputy's Prime Minister's Office**

The COVID-19 pandemic has interrupted the DPMO's schedule of service delivery especially distribution of social grants and food to NCPs. Concerns raised by the DMPO include increasing infections among the youth and rural communities as they seem not to heed the COVID-19 regulations and procedures; loss of jobs and means of livelihood; difficulties to avail services to the vulnerable people; failure to ascertain and monitor vulnerability levels in the country since there will be no Vulnerability Assessment for 2020; lack of capacity and limited support from the MoH to implement infection control interventions for the old people. The main grievance reported to the DPMO is lack of and late arrival services to outlying rural areas. Suggestions for improvement of COVID-19 response include provision of psychosocial support to affected people and their families; implement strategies to respond to family needs; identify and close gaps among response COVID-19 priorities and interventions; strengthen coordination of all institutions involved in COVID-19 response to avoid waste of resources and duplication of efforts; strengthen preventative capacity of the public sector unit in the MoH; review of the disaster management policy; development of COVID-19 guidelines specific for the vulnerable people and consider the development or region-specific COVID-19 guidelines as experience has showed that infection rates and patterns differ among the regions (i.e. regions that are classified as epicenters may be treated differently from those that are not).

The findings summarized above and presented in annexure 1 indicate the following:

1. Fear of Stigmatization and discrimination

The stakeholders expressed varying fears and experiences including fear of stigmatization and discrimination, dehumanization, neglect and isolation. The issue of ill-treatment of patients was also raised. The absence of means of communication (WIFI etc.) with their families is another constraint noted by patients in quarantine.

2. Lack of psychosocial support

No counseling and psychosocial support to patients and their families, this has been raised as a need by several stakeholders.

3. Needs of Health Personal

A consistent and adequate supply of relevant PPEs has been singled out as the important need for all personnel involved. The staff also need access to transport as well as permanent and adequate accommodation when reporting for duty. There is a need to hire adequate personnel to relieve the staff workloads.

4. Lack of a GRM

Patients have reported being subjected to lengthy and cumbersome process when making complaints through the toll-free line. Health personnel were also unhappy with the slow and ineffective GM within the health sector. While the toll-free line is being used as the primary means of communication with citizens around COVID-19, they did not favor these especially for test results, where they prefer face-to-face meetings.

5. Lack of Measures to Ensure Confidentiality

While all the stakeholders are entrusted with sensitive information there are no strict guidelines enforced to ensure confidentiality.

6. Lack of coordination, communication and unclear division of roles and responsibilities between key agencies in COVID-19 response

Stakeholders were critical of the current situation where there seems to be poor coordination of efforts and lines of communication among institutions and departments involved in the COVID-19 response. Cases of duplication of efforts have been noted while responsibilities and mandates appeared unclear in some cases.

Appropriate measures to address the above challenges are being considered by the Project implementation team.

8.1.1.2 Findings of Desktop Review and Consultations with Communications Department and Case Management Team

A desktop review of relevant documents including the Eswatini National Contingency Plan for COVID was done. Consultation sessions were also organized with the Communication Department and the Case Management for clarification of findings from consultations and alignment plans. The outcome of the sessions is summarized below:

- The latest revised draft (21 June 2020) of the Eswatini National Contingency for Novel Corona Virus (COVID-19) has two pillars on coordination, planning and monitoring and Risk Communication and Community Engagement with supporting structure activities and monitoring and review regimes;
- Coordination, engagement and communication has had significant challenges since commencement and means to rectify these challenges include:
 - o Urgently re-organization of the Operational leadership and coordination of Public Health Response in line with the WHO Incident Management System;
 - o Formerly appoint an Incident Management Team led by a senior MOH official as Incident Manager; and
 - o An inclusion strategy for all role players involved in the fight against COVID-19.
- The Communication Department is already engaging a variety of stakeholders at the national and regional level and through social media and the government website.

A SWOT analysis to assist in building on what is done well, address what is lacking, minimize risks, and to take the greatest possible advantage of chances for success was done. Table 2 below is a summary of the SWOT analysis:

Table 2: Summary of SWOT Analysis Results

Strengths	Weaknesses	Way forward
- COVID declared a national emergency (prioritized); - Emergency response plan with resources; - Motivated and willing role players; - Support from international and national institutions; - The size of the	- Coordination amongst teams involved needs improvement; - Limited resolution of issues and grievances; - Psycho-social support needed for clients who tested positive for COVID-19 and their families; - Awareness of COVID-19 and of the Project	- Advocate for coordination meetings of teams involved in the response - Capacity building for health workers on psychological care for COVID-19 affected clients - Engagement of all stakeholders including

population and having a universal language; - Pre-existing structures and institutions with established rules and resources	activities needs improvement; - Communication and information disclosure need improvement; - Recognition and use of pre-existing structures and institutions needs improvement; - Strained staff due to division of labor.	vulnerable groups on the project - Training health workers and community health volunteers on COVID-19
Opportunities - Improved coordination, engagement and communication; - Use of already existing structures and institutions to reduce waste and improve productivity; - Education and capacity building on COVID-19 and WASH practices; - Effective engagement and knowledge on vulnerable group needs.	Threats - Disinformation and misinformation on COVID-19; - Stigmatization due to mismanagement of confidential information; - Politicizing of COVID-19 response activities leading to duplication of resources; - Wastage of resources due to miscommunication and lack of coordination.	Strengthen education of members of public on COVID-19 through various channels (radio, TV, newspaper, interpersonal communication through health workers and volunteers)

8.2 . Stakeholder Engagement Overview

The Stakeholder Engagement processes will be free of manipulation, interference, coercion, and intimidation, and conducted on the basis of timely, relevant, understandable and accessible format and location, in a culturally appropriate manner.

8.2.1 Principles for Effective Stakeholder Engagement

For best practice, the project will apply the following principles for stakeholder engagement:

- **Commitment** is demonstrated when the need to understand, engage and identify the community is recognized and acted upon early in the process;
- **Integrity** occurs when engagement is conducted in a manner that fosters mutual respect and trust;
- **Respect** is created when the rights, cultural beliefs, values and interests of stakeholders and affected communities are recognized;
- **Transparency** is demonstrated when community concerns are responded to in a timely, open and effective manner;
- **Inclusiveness** is achieved when broad participation is encouraged and supported by appropriate participation opportunities; and
- **Trust** is achieved through open and meaningful dialogue that respects and upholds a community's beliefs, values and opinions.

8.2.2 Overall Objectives

The overall objectives of SEP as informed by ESS-10 are to:

- To identify the roles and responsibility of all stakeholders and ensure their participation in the complete project cycle;
- Establish a systematic approach to stakeholder engagements that will help the project identify stakeholders and build and maintain a constructive relationship with them, in particular project-affected parties;
- Assess the level of stakeholder interest and support for the project and to enable stakeholders' views to be taken into account in project design and environmental and social performance.
- Promote and provide means for effective and inclusive engagement with project affected parties throughout the project life-cycle on issues that could potentially affect them;
- Ensure that appropriate project information on environmental and social risks and impacts is disclosed to stakeholders in a timely, understandable, accessible and appropriate manner and format taking special consideration for the disadvantaged or vulnerable groups;
- Provide project-affected parties with accessible and inclusive means to raise issues and grievances and allow the project to respond to and manage such grievances;
- To devise a plan of action that clearly identifies the means and frequency of engagement with each stakeholder;
- To allocate budgetary and other resources in the project design, project implementation, and Monitoring and Evaluation (M&E) for stakeholder engagement and participation.

8.3 Stakeholder Identification

The Project Implementation Unit (PIU) identified project stakeholders who will be engaged on a regular basis to ascertain their concerns in relation to the project implementation, needs and expectation for engagement, priorities and objectives in relation to the project and this will continue to be used to tailor engagements with these stakeholders. During the process it has been critical to identify vulnerable and disadvantaged groups such as women, people living with disabilities etc.

For the purposes of effective and tailored engagement, stakeholders of the project will be divided into the following three (3) core categories:

Project 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 Groups – persons who may be disproportionately impacted or further disadvantaged by the project(s) as compared with any other groups due to their vulnerable status⁴⁵, and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project.

8.3.1 Project Affected Parties

Project Affected Parties include individuals, organizations, communities and other parties that may be subject to direct impacts from the Project Activities specifically.

The following individuals and groups may fall within this category:

- COVID-19 infected people in the project-impacted facilities;
- People under COVID-19 quarantine, including workers in the quarantine facilities;
- Patients at health care facilities;
- Staff at selected hospitals, including janitorial staff, workers in quarantine/isolation facilities, diagnostic laboratories, Environmental Health Department, etc.;
- Workers involved in storage and transportation of samples;
- Neighboring communities to laboratories, quarantine centers, and screening posts, and the selected hospitals;
- Public Health Workers;
- Medical and testing facilities staff;
- Public health agencies engaged in the response;
- People affected by or otherwise involved in project-supported activities;
- Migrants returning from South Africa and other neighboring countries;
- Community Health Volunteers (Rural Health Motivators (RHMs) and other lay health workers)

⁴⁵ 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.

- People eligible for vaccination (Frontline workers, elderly, people with comorbidities, vulnerable and marginalized and those above 18 years old).

8.3.2 Other Interested Parties

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

- Government Ministries;
- Traditional and opinion leaders in the Kingdom of Eswatini;
- Media and other interest groups, including social media and the Government Information Department;
- Other national health organizations, CSOs, CBO, FBOs and UN agencies;
- Businesses with sub-regional and international links;
- Local business community;
- The public at large;

8.3.3 Disadvantaged / Vulnerable Individuals or Groups

It is particularly important to understand whether project impacts may disproportionately fall on disadvantaged or vulnerable individuals or groups, who often do not have a voice to express their concerns or understand the impacts of a project and to ensure that awareness raising and stakeholder engagement with disadvantaged or vulnerable individuals or groups [on infectious diseases and medical treatments in particular] be adapted to take into account such groups or individuals particular sensitivities, concerns and cultural sensitivities and to ensure a full understanding of project activities and benefits. The vulnerability may stem from person's origin, gender, age, health condition, economic deficiency and financial insecurity, disadvantaged status in the community (e.g., minorities or fringe groups), dependence on other individuals or natural resources, etc. Engagement with the vulnerable groups and individuals often requires the application of specific measures and assistance aimed at the facilitation of their participation in the project-related decision making so that their awareness of and input to the overall process are commensurate to those of the other stakeholders.

Within the Project, the vulnerable or disadvantaged groups include and are not limited to the following:

- Elderly;
- Individuals with chronic diseases and pre-existing medical conditions; Diabetes, Hypertension, HIV, etc.;
- People with disabilities;
- Pregnant women;
- Women, girls and female headed households;
- Children;
- Those living below poverty line;
- Communities in remote and inaccessible areas;
- Key populations (sex workers, etc.).

8.4 Stakeholder Analysis

The stakeholders were analyzed according to their role in the project, influence and interest.

Table 1 below summarizes the analyses.

Table 2: Project Stakeholder Analysis

Stakeholder Group	Influence	Interest
Project Affected Parties		
COVID-19 infected people in the project-impacted facilities;	Low	High
People under COVID-19 quarantine, including workers in the quarantine facilities;	Low	High
Patients at health care facilities;	Low	High
Staff at selected hospitals, including janitorial staff, workers in quarantine/isolation facilities, diagnostic laboratories, Environmental Health Department, etc.;	Low	High
Workers involved in storage and transportation of samples;	Low	High
Neighboring communities to laboratories, quarantine centers, and screening posts, and the selected hospitals;	Low	High
Public Health Workers;	High	High
Medical and testing facilities staff;	High	High
Public health agencies engaged in the	High	High

response;		
People affected by or otherwise involved in project-supported activities;	Low	High
Migrants returning from South Africa and other neighboring countries;	Low	High
Community Health Volunteers (Rural Health Motivators and other lay health workers)	Low	High
People eligible for vaccination	Low	High
Other Interested Parties		
Government Ministries;	Low	High
Traditional and opinion leaders in the Kingdom of Eswatini;	Low	High
Media and other interest groups, including social media and the Government Information Department	Low	High
Other national health organizations, CSOs, CBO, Faith Health Initiatives and UN agencies	Low	High
Businesses with sub-regional and international links	Low	High
Local business community	Low	High
The public at large;	Low	High
Vulnerable Groups		
Elderly;	Low	High
Individuals with chronic diseases and pre-existing medical conditions; Diabetes, Hypertension, HIV, etc.;	Low	High
People with disabilities;	Low	High

Pregnant women;	Low	High
Women, girls and female headed households;	Low	High
Children;	Low	High
Those living below poverty line;	Low	High
Communities in remote and inaccessible areas;	Low	High
Key populations (sex workers, etc.).	Low	High

8.5 Stakeholder Engagement

8.5.1 Stakeholder Engagement

Comprehensive community engagement is a precondition for the effectiveness of the project. Stakeholder engagement under the project will be carried out on two fronts: (i) consultations with stakeholders throughout the entire project cycle to inform them about the project, including gathering their concerns, feedback and complaints about the project and feeding back this information to improve the design and implementation of the project, and (ii) awareness-raising activities to sensitize communities on the risks of COVID-19, and the introduction of COVID-19 Vaccine. Additionally, the revised SEP must facilitate the resolution of issues and grievances identified during the consultations, enhance strengths, manage weaknesses, take advantage of opportunities and mitigate threats.

Effective ways will be adopted to engage stakeholders amidst COVID-19 and related restrictions. The engagements will be done in accordance with Government's regulation on COVID-19 response, the local laws, policies and new social norms in effect to prevent virus transmission. These approaches will include: having consultations in small groups of not more than 20 people, bilateral meetings, virtual meetings (e.g., WebEx, Zoom, Skype, etc.), emails, social media and mobile apps for instant messaging and employing traditional channels of communications such as TV, radio, conference telephone calls, SMS broadcasting, and public announcements when stakeholders do not have access to online channels or do not use them frequently. Continuous stakeholders' consultations and engagement as well as review and adjustment of approach and methodologies will be implemented to avoid the risk of virus spread. Stakeholder engagement will be carried out for (i) consultations with stakeholders throughout the entire project cycle to inform them about the project, including their concerns, feedback and complaints, (ii) awareness-raising activities to sensitize communities on risks of COVID-19, and the introduction and rollout of COVID-19 Vaccine.

The WB's ESS10 and the relevant national policy or strategy for health communication and WHO's "COVID-19 Strategic Preparedness and Response Plan -- Operational Planning Guidelines to Support Country Preparedness and Response" (2020) will be the basis for the project's stakeholder engagement. In particular, Pillar 2 on *WHO Risk Communication and Community Engagement* outlines the following approach:

"It is critical to proactively 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."

Due to the issues and challenges reviewed, the updated SEP will be divided into two parts i.e., an SEP for stakeholders within the emergency response component of the project and another for the rest of the affected, interested and vulnerable groups.

8.5.1.1 STRATEGY TO INCORPORATE THE VIEWS OF VULNERABLE GROUPS

Consultations were made with CSOs, SOEs and government departments that work with vulnerable groups. These included the World Vision, Save the Children, NERCHA and Deputy Prime Ministers Office (DPMO). Their concerns were as follows:

- Appropriate communication channels and messages for the deaf and dumb;
- Inadequate information on how to react to the pandemic;
- Improved provision of WASH facilities and material for the elderly and child headed households;
- No source of living for incapacitated, self-employed, elderly and child-headed households;
- Special attention needed for those with pre-existing medical conditions;
- Impractical social distancing or isolation measures for those living in crowded and small spaces;
- No access to health centres or support when sick; and
- Increase in domestic violence and gender-based violence cases due to financial strains.

CSOs and Government are already supporting some of these groups with WASH facilities and material, cash and food distribution and home-based care but there remains a huge gap in engagement, provisions and support.

8.5.2 Implementation of Social Distancing Measures and Strengthening Communication Preparedness

In addition to on-going consultations required during project implementation, for the awareness-raising activities under *Sub-component 1.3 on improving implementation of social distancing measures and*

strengthening communication preparedness, the project activities support implementation of a well-designed communication plan targeting all affected, interested and vulnerable groups. The project provides technical and financial assistance for communication activities that supports cost effective and sustainable methods such as promoting “handwashing” through various communication channels via mass media, counselling, schools, workplaces, and integrated into specific interventions as well as on-going outreach activities of ministries and sectors, especially ministries of health, education, agriculture, and transport. Guidelines have been developed to support implementation of response activities in the various sectors: home care for suspected and confirmed COVID-19 clients, standard operating procedures for preparedness, detection of and response to the coronavirus (COVID-19) outbreak in Eswatini learning institutions.

8.5.3 VACCINE ACCEPTANCE AND UPTAKE (DEMAND)

Through the project additional financing, support for activities towards introduction and roll out of COVID-19 Vaccine as well as building the public confidence will be implemented. This will take into account the different public views and a number of influencers making up the environment. Proactive, credible and consistent health communication messaging is very critical during this time to ensure acceptance and uptake of the COVID – 19 Vaccines by the population.

In addition, MOH will conduct capacity building of all stakeholders involved in the development and dissemination of COVID -19 information materials to support uptake of the COVID-19 Vaccine. Policy makers and the Media will be critical in the rollout plan for the vaccine hence the need for them to be prioritized with the training to enable their buy in into the whole process.

The guide below informed the development of the SEP for awareness raising:

Step	Actions to be taken
1	☐ Implement national risk-communication and community engagement plan for COVID-19, including details of anticipated public health measures (use the existing procedures for pandemic influenza if available) ☐ Conduct rapid behaviour assessment to understand key target audience, perceptions, concerns, influencers and preferred communication channels ☐ Prepare local messages and pre-test through a participatory process, specifically targeting key stakeholders and at-risk groups ☐ Identify trusted community groups (local influencers such as community leaders, religious leaders, health workers, community volunteers) and local networks (women's groups, youth groups, business groups, traditional healers, etc.)
2	☐ Establish and utilize clearance processes for timely dissemination of messages and materials in local languages and adopt relevant communication channels ☐ Engage with existing public health and community-based networks, media, local NGOs, schools, local governments and other sectors such as healthcare service providers, education sector, business, travel and food/agriculture sectors using a consistent mechanism of communication ☐ Utilize two-way 'channels' for community and public information sharing such as hotlines (text and talk), responsive social media such as U-Report where available, and radio shows, with systems to detect and rapidly respond to and counter misinformation ☐ Establish large scale community engagement for social and behaviour change approaches to ensure preventive community and individual health and hygiene practices in line with the national public health containment recommendations
3	☐ Systematically establish community information and feedback mechanisms including through: social media monitoring; community perceptions, knowledge, attitude and practice surveys; and direct dialogues and consultations ☐ Ensure changes to community engagement approaches are based on evidence and needs, and ensure all engagement is culturally appropriate and empathetic. ☐ Document lessons learned to inform future preparedness and response activities

TABLE 3: Summary of On-going Stakeholder Engagement During Project Implementation, Including Awareness Raising, Communication Around COVID-19 and the introduction of COVID-19 Vaccine

Project Activity/ Consultation topics	Target Audience	Communication method/Engagement Channel	Frequency of Engagement	Responsibility	Status
Project activities, E&S principles and obligations, E&S documents i.e., ESMF, SEP, GRM and ESCP Update on project development	Government Ministries and agencies, CSOs; Local traditional authorities Tinkhundla centers and other groups that represent all PAPs, Other Interested, parties, parties, business community, Vulnerable groups: Women, elderly, children, key populations, poor people, pregnant women. This will be done through smaller meetings.	Dissemination of information via dedicated MOH website, one on one meetings, virtual formal meetings, including hard copies at designated public locations; Information leaflets and brochures; and separate focus group meetings with vulnerable groups, while making appropriate adjustments to consultation formats in order to take into account the need for social distancing (e.g., use of mobile technology such as telephone calls, SMS,	September-October 2020 Monthly for regular project updates	Social Officer	Awaiting endorsement of SEP and ESMF

		etc.)			
Technical designs of the isolation units and quarantine facilities, SEP, relevant E&S, GRM procedure, regular updates on Project development	Selected hospitals including the RFMH and the Lubombo Referral Hospital: People under COVID-19 quarantine, including workers in the facilities; Relatives of patients/affected people; neighboring communities; public health workers; other public authorities, civil society organizations, quarantine centers, workers at construction sites of quarantine centers, public health workers, MoH, border control	Public notices; Electronic publications and press releases on the MoH web-site & via social media; Dissemination of hard copies at designated public locations; Press releases in the local media; Consultation meetings, separate focus group meetings with vulnerable groups, while making appropriate adjustments to consultation formats in order to take into account the need for social distancing (e.g., use of mobile technology such as telephone calls, SMS, etc.).	October – November 2020	Social officer	Awaiting endorsement of SEP

The development and distribution of basic communication materials (such as question and answer sheets and fact sheets in Siswati on COVID-19, and (ii) general preventive measures such as “dos” and “don’ts” for the general public; (iii) information and guidelines for health care providers: (iv) training modules (web-based, printed, and video); (v) presentations, slide sets, videos, and documentaries; and (vi) symposia on surveillance, treatment and prophylaxis.	Vulnerable groups: Women, elderly, children, key populations, poor people, pregnant women CSOs Rural Health Motivators Local traditional authorities Tinkhundla centres	SMS broadcast channel National Radio National Television Social media- websites, and social media platforms such as WhatsApp, Facebook, Twitter etc.	Every 3 months	Social Officer	Developed information on Do and Don’t for general public, Siswati COVID-19 fact sheets and guidelines for IPC, Home Care, Case management guidelines have been developed including conferences for health care workers have been conducted.
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COVID 19 information: government guidelines/restrictions; new information on numbers/virus detection, testing and treatment	Include PAPs and OIPs as well Vulnerable groups: Women, elderly, children, key populations, poor people, pregnant women. CSOs Rural Health Motivators Local traditional authorities Tinkhundla centres	SMS broadcast channel National Radio National Television Social media- websites, and social media platforms such as WhatsApp, Facebook, Twitter etc.	Within a month after new guidelines have been released and then on a weekly basis with information on numbers/virus detection, testing and treatment	Social Officer	Press release of information on COVID-19 including number of confirmed cases and fatalities on daily basis by Honourable Minister for Health
To create demand for the COVID -19 Vaccines.	Health care workers, Policy makers, Politicians, Line Ministries and Government Agencies, Civil Society Organisations, Bilateral Organisations,	• Virtual platforms (Zoom, Werbex) • Social media (Facebook, WhatsApp, • Editorials from state/local health officials and other earned media, such as	Before introduction, during rollout of COVID-19 Vaccine and post implementation	Social Officer	Development of COVID-19 Vaccine communication plan and messages

	International Organizations, FBOs, Media, Traditional leaders, Local Government and organisations of people living with comorbidities.	press releases and interviews • Radio, TV Spot and Print media • emails, telephone calls • Texting (SMSs) • Face to face meetings			
Training and Communication on COVID-19 Vaccine key messages.	Parliamentarians, Health workers including community health volunteers, Regulators, Religious and Traditional Leaders, General Public	• Social media (Facebook, WhatsApp, • Editorials from state/local health officials and other earned media, such as press releases and interviews • Social media graphics/messaging • Public Service Announcements (jingles and videos) through the national radio and television	Before introduction, during rollout of COVID-19 Vaccine	Social Officer	Development of training and communication plans

		stations • Media (Radio, TV Spots, Print Media) • IEC Materials: - Brochures, - Pamphlets, Flyers, - Posters, Postcards, - Job Aids • Digital advertising • Billboards • Place messages on public transportation, intersections, and other high traveled areas • Texting (SMSs and notification) • Interpersonal Selling			
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8.5.4 Information Disclosure

The initial SEP was disclosed on April 20th, 2020. In terms of information disclosure methodology moving forward, it will be important that the different activities are inclusive and culturally sensitive, thereby ensuring that the vulnerable groups outlined above will have the chance to participate in the Project benefits. This can include household-outreach and focus-group discussions in addition to community consultations, the usage of different languages, the use of verbal communication or pictures instead of text, etc.

The project will thereby have to adapt to different requirements. While country-wide awareness campaigns will be established, specific communication around borders and international airports as well as quarantine centres and laboratories will have to be timed according to need and be adjusted to the specific local circumstance.

8.5.5 Resources and Responsibilities for Implementing Stakeholder Engagement Activities

The PIU E&S staff in the Ministry of Health will oversee stakeholder engagement activities. The budget for the SEP is included in Component 1 of the project and through additional financing.

8.6 Management functions and responsibilities

The project implementation arrangements are as follows:

The Ministry of Health (MOH) is the lead technical agency for project implementation. The MOH Senior Management Team (SMT), chaired by the Principal Secretary, provides overall strategic guidance of the COVID-19 sector response. The National Public Health Emergency Committee (NPHEMC), chaired by the MOH (Public Health Lead), comprised of MOH technical leads and experts critical for response to public health emergencies, is supporting the project implementation along with the 'Core Implementation Team'. The core implementation team is an agile implementation team that will support project effectiveness. The core implementation team/PIU has hired an Environmental Risk Management Specialist and a Social Risk Management Specialist. The PIU will be responsible for carrying out stakeholder engagement activities, while working closely together with established Emergency coordination structures implementing the COVID-19 Emergency Plan and the communication and community engagement committee for COVID -19 Vaccine introduction and rollout, other entities, such as local government units, media outlets, health workers, UN agencies etc. The stakeholder engagement activities and outcomes including updates on all social activities outlined under ESMF will be documented through quarterly progress reports, to be shared with the World Bank.

8.7 Grievance Mechanism

The main objective of a Grievance Redress Mechanism (GRM) is to assist to resolve complaints and grievances in a timely, effective and efficient manner that satisfies all parties involved. Specifically, it provides a transparent and credible process for fair, effective and lasting outcomes. It also builds trust

and cooperation as an integral component of broader community consultation that facilitates corrective actions. Specifically, the GRM:

- Provides affected people with avenues for making a complaint or resolving any dispute that may arise during the course of the implementation of projects;
- Ensures that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants; and
- Avoids the need to resort to judicial proceedings.

The GM will be based on the following principles:

- **Fairness.** Grievances are treated confidentially, assessed impartially, and handled transparently.
- **Objectiveness and independence.** The GM operates independently of all interested parties in order to guarantee fair, objective, and impartial treatment to each case. GM officials have adequate means and powers to investigate grievances (e.g., interview witnesses, access records).
- **Simplicity and accessibility.** Procedures to file grievances and seek action are simple enough that project beneficiaries can easily understand them. Project beneficiaries have a range of contact options including, at a minimum, a telephone number (preferably toll-free), an e-mail address, and a postal address. The GM is accessible to all stakeholders, irrespective of the remoteness of the area they live in, the language they speak, and their level of education or income. The GM does not use complex processes that create confusion or anxiety (such as only accepting grievances on official-looking standard forms or through grievance boxes in government offices).
- **Responsiveness and efficiency.** The GM is designed to be responsive to the needs of all complainants. Accordingly, officials handling grievances are trained to take effective action upon, and respond quickly to, grievances and suggestions.
- **Speed and proportionality.** All grievances, simple or complex, are addressed and resolved as quickly as possible. The action taken on the grievance or suggestion is swift, decisive, and constructive.
- **Participatory and social inclusion.** A wide range of project-affected people— community members, members of vulnerable groups, project implementers, civil society, and the media— are encouraged to bring grievances and comments to the attention of project authorities. Special attention is given to ensure that poor people and marginalized groups, including those with special needs, are able to access the GM.

8.7.1 Structure of Grievance Mechanism (GM)

Grievances will be handled by the Grievance Office at MoH national level through the dedicated COVID-19 help desk Hotline. This national Hotline to address COVID-19 issues is already active and successfully

connected with the PIU. Other avenues for receiving grievances include emails, social media, formal letter and during stakeholder engagement sessions.

The GM will include the following steps:

Stage 1: Grievance raised with the PIU GM.

1. Grievances can be raised directly with the PIU through the MoH toll free line, 977, emails, social media, formal letter and during stakeholder engagement sessions;
2. The Hotline should pass the complaints to the PIU GM focal point within 24 hours from time of receipt.
3. The GM focal point logs the grievance and acknowledges receipt to the complainant within two working days including the timeline within which resolution is expected, i.e., 14 days or 30 days in case additional investigation/research is needed.
4. The GM focal point then refers the same to the Grievance Committee (GC) within 24 hours for resolution within 14 working days, i.e., not more than 3 weeks from when the complaint was originally made to the hotline.
5. If the GC determines additional research/investigation is needed, it will inform the complainant that additional time will be required, not more than 6 weeks from when the complaint was first made to the hotline.
6. In exceptional circumstances, if more than 6 weeks is required, this will be recorded in detail for review by the Project Coordinator and World Bank team and will be reflected in the PIU's Bi-annual reports and M&E reporting.
7. The complainant will be informed of the outcome immediately and at the latest within 5 days of the decision.

Timelines:

The timeline for complaint resolution will be not more than 21 working days (3 weeks) upon receipt of the complaint by the Hotline.

For complaints that require additional study and research, the timeline for complaint resolution will be not more than working days (6 weeks) upon receipt of the complaint by the Hotline.

The PIU GM and the GC are required to follow the steps and timelines for resolution of grievances as set out below.

- The GC shall convene as per necessity (but at least once a month) and shall include at a minimum 4 members. Special provisions will be made for any complaints of a confidential nature and in the case of complaints related to sexual exploitation and abuse (SEA) and sexual harassment (SH), procedures as laid out in the SEA/SH action plan to be prepared will be followed.

- The composition of the GC is as follows: The GC will be composed of the four officers - Social Officer, Case management Chairperson, Emergency Operation Centre chairperson and Human Resources Officer. Based on the classification, some complaints can then be prioritized and assigned to the relevant department for follow up. Investigation/follow-up can include site visits, document review, and meetings with parties who can solve the problem. The results of the investigation and response will be submitted for consideration to the Project Coordinator, who will decide what action to take.

Stage 2: Appeal to the Director of Health Services

Unsolved grievances, with the complainant's consent, will be sent to the next level in written form. PIU Social officer/GM Focal point will review the written complaints of PAPs, which were not satisfied at Stage 1 and send them internally to the appropriate departments (legal, technical, contracts etc.) for redress or the Director of Health Services. The timeframe for referral is 7 days. The complainant shall be informed of the decision within a maximum of 30 days.

Timeline: Timeline for appeals that go to the Director of Health services is thus a maximum of 7 weeks from the time the complaint was first logged by the Hotline and 10 weeks in the case of complaints that required additional research/investigation.

Once all possible redress has been proposed and if the complainant is still not satisfied then they should be advised of their right to legal recourse.

8.7.2 Process to be Followed by all Grievance Mechanism Structures

The two-stage grievance resolution process involves the following main steps at each level:

- Receipt of grievances and acknowledgement
- Screening for standing and/or acceptance or rejection
- Processing of complaint
- Grievance resolution approach
- Closure of grievances;
- Handling of grievance records and documentation. For handling grievances relating to sexual exploitation and abuse (SEA) and sexual harassment (SH), please refer to SEA/SH action plan to be prepared.

Step 1: Receipt of Grievances

Any PAPs, OIPs or others believing they are affected by the Project can submit a grievance. Grievances can be raised using the toll-free number, submitting in person or in writing to the GM Focal point in the PIU, or by email as per the below contact details:

Dedicated Toll-free Line COVID-19 Help desk operating 24 hours: 977

Office address: Cooper Centre, Mbabane Kingdom of Eswatini

Email: ruralhealth@swazi.net.

COVID-19 help desk staff will classify the complaints based on the typology of complaints in order to provide a more efficient response and will provide the initial response within 24 hours.

Classification of typology is based on the characteristics of the complainant and the nature of the complaint (e.g., disruptions in the vicinity of quarantine facilities and isolation units, inability to access the information provided on COVID 19 transmission; inability to receive adequate medical care/attention, etc.). SEA/SH grievances will not be documented in the publicly accessible book. However, a SEA/SH action Plan will be prepared to manage related risks, and a specialized NGO will be engaged for awareness and will develop a system that will capture GBV related issues.

The GM Focal point shall acknowledge receipt of any written grievance within two days from the date of submission and shall inform the complainant about the timeframe in which a response can be expected. In cases where a grievance is raised in person, verbal acknowledgement will be provided. In cases where a complex grievance is raised, the complainant will receive an update explaining the actions required to resolve the complaint and the likely timeline. The complaint shall be filed and labelled with an identification code, communicated immediately to the complainant.

As a minimum the following information shall be recorded:

1. Case number
2. Complainant's name and contact details
3. Date and time of complaint
4. Description/statement of the grievance including where it happened, date and the Contractor staff complained against if applicable
5. Date complaint is referred to the PIU by Hotline

Step 2: The process by which a complaint will be accepted or rejected

The acceptance/rejection of a complaint shall go through a discussion stage where the complainant and the GM staff interact on the grounds and motives of the complaint, after which the plaintiff should clearly and transparently be told whether or not the complaint is eligible and will be processed. The acceptance/rejection of the complaint is based on an established objective criterion.

The following broad criteria will be used and publicly disclosed by the GM, including a written copy displayed in the public access areas of the GM in an appropriate language as well as at the Health Facilities and other project sites.

- All concerns raised in relation to the implementation of any projects and programs coordinated by the PIU;
- All concerns raised in relation to community health and safety risks in project areas
- Adverse environmental and social impacts in relation to Project funded activities and programs.

Step 3: Processing of the complaint (if accepted)

Grievances will be categorized based on project significant impacts and the type of issue(s) raised and the effect on the environment/claimant if the impact raised by the complainant were to occur. Based on the categorization, the complaints can then be prioritized and assigned to the relevant department for follow up. In the case of complaints that relate to governance issues, i.e., the client or World Bank staff, those should normally be addressed at a higher level, through MoH Director of Health Services.

Step 4: Grievance resolution approach

The GM Committee or MoH Director of Health Services will aim to resolve any grievances as per timelines set out in Stage 1 and Stage 2 above. The following steps shall be performed in a timely manner to avoid delaying resolution of a grievance:

- Obtain and document as much information as possible from the person who received the complaint, as well as from the complainant to gain a first-hand understanding of the grievance (For handling grievances relating to SEA and SH, please refer to SEA/SH action plan to be prepared).
- Undertake a site visit, if required, to clarify the parties and issues involved. Gather the views of other stakeholders.
- Determine whether the grievance is legitimate/sound. Inform the complainant of the expected time frame for resolution of the grievance.
- Enter the findings of the investigation in the grievance database.

If the grievance continues to be unresolved at Stage 2, it will be presented to Director of Health Services at the Ministry of Health, who will review and decide upon the grievance. The complainant shall be informed in writing of the MoH's decision. If MoH's decision fails to satisfy the aggrieved affected persons, they can pursue further action by submitting their case to the appropriate court of law. Appeals may be referred to national courts or through other suitable processes such as mediation or arbitration. The final decision will be taken by the arbitrator or courts based on compliance with laws, policies, standards, rules, regulations, procedures, past agreements or common practice. The results of the investigation of non-sensitive complaints should be publicized.

If wider consultation is necessary or in cases where the type of complaint necessitates that it be addressed by a credible third party, grievances will be forwarded to such a third party. For example, if the complaint relates to governance issues regarding the client or the World Bank and it is a conflict of interest or claims regarding issues where specialized credible institutions may already exist as is often the case in disputes over land, a credible third party should be identified. This third party should be neutral, well-respected, and agreed upon by both MoH and the affected parties. These may include public defenders, legal advisors, local or international NGOs, or technical experts.

Step 5: Closure of Grievance

A grievance will be considered "resolved" or "closed" when a resolution satisfactory to both parties has been reached, and after corrective measures have been successfully implemented. When a proposed solution is agreed between the Project and the complainant, the time needed to implement it will depend

on the nature of the solution. However, the actions to implement this solution will be undertaken within one month of the grievance being logged and will be tracked until completion. Once the solution is under implementation or has been implemented to the satisfaction of the complainant, a complaint closes out form will be signed by both parties (PIU Coordinator or its representative and the complainant), stating that the complainant considers that his/her grievance is closed. The grievance then, will be archived in the Project Grievance database. In certain situations, however, the Project may "close" a grievance even if the complainant is not satisfied with the outcome. This could be the case, for example, if the complainant is unable to substantiate a grievance, or it is obviously speculative or fraudulent. In such situations, the Project's efforts to investigate the grievance and to arrive at a conclusion will be well documented and the complainant advised of the situation. MoH will not dismiss grievances based on a cursory review and close them unless the complainant has been notified and had the opportunity to provide supplementary information or evidence.

Step 6: Grievance Records and Documentation.

MoH PIU GM Focal Point will manage a grievance log to keep a record of all grievances received. PIU will use a simple Word or Excel based file to log, document and track all grievances received. The complainant will be informed immediately once the grievance has been received and they will be provided with a case number. Grievances shall be assigned a case number and records of communication/consultation shall all be attached with the relevant entry and filed. The database will contain the name of the individual or organization lodging a grievance; the date and nature of the grievance; any follow-up actions taken; the solutions and corrective actions implemented by the Contractor or other relevant party; the final result; and how and when this decision was communicated to the complainant.

The database shall be monitored regularly tracking the grievances throughout the processing cycle to reflect the status and important details. Recurring grievances will be monitored to ensure that appropriate mitigation measures are put in place for improvement. Supervisor and construction companies in their monthly monitoring reports will provide information on grievance management. Grievance monitoring and reporting will occur in MoH's six-monthly and annual public reports.

PIU Grievance Log: The PIU Grievance log at a minimum will record the following information

1. Individual case number
2. Complainant's name and contact details (unless the complaint has been submitted anonymously)
3. Date and time of complaint
4. Date complaint was sent by Hotline to PIU (standard is within 2 working days of complaint being received by Hotline)
5. Date complaint was logged by PIU
6. Date acknowledgement was sent to complainant by PIU
7. Time estimated to address (3 weeks or 6 weeks)
8. Description/statement of the grievance including where it happened, date and the Contractor staff complained against if applicable

9. Details of proposed resolution, including person(s) who will be responsible for authorizing and implementing any corrective actions that are part of the proposed resolution OR Details of it being sent to Stage 2 (Director of Health Services for resolution)
10. Date when proposed resolution was communicated to the complainant (unless anonymous) Or Date of when it was referred to Stage 2 (Director of Health Services)
11. Details of whether the complainant was satisfied with the resolution, whether the complaint can be closed out
12. Date of when the complaint is closed
13. Date when the resolution is implemented (if any).

8.7.3 Sexual exploitation and abuse and Sexual Harassment:

Other measures to handle sensitive and confidential complaints, including those related to Sexual Exploitation and Abuse/Harassment (SEA/SH), will be identified in the SEA/SH Action Plan. With respect to SEA/SH related complaints, special procedures will be adopted in order to ensure anonymity and referral procedures to associated NGOs who are experienced in handling GBV cases will be set up.

If the matter remains unresolved, or complainant is not satisfied with the outcome at the project level, the head of the GM, will then refer the matter to the MOH for a resolution. Project Affected Parties (PAPs) have the option to take their respective case/s directly to the established legal system as provided by Eswatini law

8.7.4 World Bank Grievance Redress System:

If the project GM failed to resolve disputes in amicable fashion, PAPs and individuals who believe that they are adversely affected by a project supported by the World Bank may also send complaints directly to the Bank through the Bank's Grievance Redress Service (GRS). A complaint can be submitted to the Bank GRS through the following channels:

- Email: grievances@worldbank.org
- Fax: +1.202.614.7313
- Mail: The World Bank, Grievance Redress Service, MSN MC10-1018, 1818 H Street,
- Northwest, Washington, DC 20433, USA.

8.7.5 Awareness raising and disclosure of the GM

Awareness raising and disclosure of the GM will be provided in an accessible format. Communities and potentially affected persons will be advised of the GM in the early stages of engagement on the project, and be made aware of:

- The potential impacts of the project and how these impacts are to be minimized;
- How they can access the GM (i.e., key people and complaint forms);
- Who to speak to and how to make a complaint;
- The timeframes for each stage of the process;
- The GM being confidential, responsive and transparent; and
- Alternative avenues of dispute resolution where conflicts of interest exist.

8.7.6 Roles and Responsibilities

Social Officer

Will be responsible for managing the GM including updating the grievance database to track the progress of formal grievances for the duration of projects. This involves coordinating between key agencies on a regular basis. The Social Officer is responsible for final oversight of community consultation and grievance management.

Project Implementation Team (PIT)

The PIU is responsible for the management of the entire GM. The PIU Coordinator will direct the PIU to deal with all grievances in an appropriate manner through the grievances committee, and if necessary, delegate members or others to assist or intervene directly in resolution activities.

Role Player	Responsibilities
PIU	• Collection, investigation and resolution of project related grievances • Management of the entire GM system
Grievances committee	• Notification to complainants about receipts and deadlines for reviewing complaints • Observing the entire problems, including the causal relationship between project activities and suspected damage/danger/disturbance • Decision making based on the observation • Processing appeals or ongoing communication to complainants with the aim of resolving the issue peacefully • Publishing the responses to a complaint (need to be confirmed by the complainant)
Social Officer	• Organizing and applying information delivery and awareness raising campaigns • Reporting and handling GM results.
COVID-19 Help Desk	• Receiving and recording and routing of grievances and issues

	• Sorting / categorizing complaints
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8.8 Monitoring and Reporting

8.8.1 Reporting back to stakeholder groups

Monitoring and evaluation of the stakeholder engagement plan is important to respond to identified issues and alter the schedule and nature of engagement activities to make them more effective. Monthly summaries and internal reports on public grievances, enquiries and related incidents, together with the status of implementation of associated corrective/preventative actions will be collated by social officer and shared with the senior management of the project. 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 public engagement activities undertaken by the Project during the year will be conveyed to the stakeholders in two possible ways:

- Publication of a standalone annual report on project's interaction with the stakeholders.
- A number of Key Performance Indicators (KPIs) will also be monitored by the project on a regular basis

8.8.2 Monitoring and Evaluation Plan

The below summarizes the monitoring and evaluation plan for the SEP.

Table 4: Monitoring and Evaluation Plan for the SEP

Project Activity	Indicators	Monitoring Frequency	Monitoring Method	Responsibility	Status
Stakeholder Engagement	Number and types of stakeholders engaged Number and type of engagement channels applied Impact of	Weekly monitoring Monthly reviews	Review of daily records Review of monthly reports	PIU	On going

	engagement on emergency response Effectiveness of the SEP				
Awareness Raising	Number and type of messages communicated Number of articles and information Impact of communicated messages Effectiveness of the awareness raising initiatives	Weekly monitoring Monthly reviews	Review of records Review of reports	PIU	On going
Grievance Redress Mechanism	Number and types of grievances received Number of grievances investigated Number of grievances resolved and communicated Effectiveness of the GRM	Weekly monitoring Monthly reviews	Review of records Review of reports	PIU	On going

Chapter 9 - INSTITUTIONAL ARRANGEMENTS

9.1 Implementation Arrangements

As it was the case with the Parent Project, the existing PIU will continue to be used for the AF. The MOH is also working closely with other DPs located in-country, especially UNICEF and WHO, who are providing technical assistance on aspects that include procurement, vaccine registration and risk communication. A Project Operational Manual (POM) was also issued and shared with the Bank on June 21, 2020. These documents will be further updated and finalized incorporating modifications introduced through the proposed AF and finalized by January 15, 2021. A PIU induction was conducted between August 28 and September 7, followed by trainings on Environmental and Social Standards. Additional trainings to support fiduciary control functions are scheduled for January 2021. The PIU now has in place both a Social Development Specialist, an Environmental Specialist, and is in the process of engaging an Assistant Social Specialist and Communications Specialist. The Task team held a PIU training workshop on Grievance Redress Mechanisms in November 2020, resulting in an Action Plan that has been developed by the PIU on steps being taken to further strengthen awareness raising and the GRM effectiveness. The Action Plan is being used for the ongoing monitoring of the project.

The Core Implementation Team (CIT) or Project Implementation Unit (PIU), an agile implementation team, will be established to support project effectiveness. The core team is to be comprised primarily of MOH staff (civil servants). The implementation team will be led by a Coordinator. For effective and timely decision making the Coordinator will report to the Principal Secretary of the MOH, who serves as a member of the NETT. With oversight by the Coordinator, the implementation team will be comprised of specialists for fiduciary controls (fiduciary management and procurement), M&E, and environmental and social risk management. Due to the AF, capacity of the PIU will be enhanced to include technical expertise in logistics, procurement and vaccine implementation. The MOH is also working closely with other DPs located in-country, especially UNICEF and WHO, who are providing technical assistance on aspects that include procurement, vaccine registration and risk communication. For critical functions where the MOH technical capacity or knowledge of World Bank procedures and standards is limited, the project will provide surge capacity for a specified duration through specialist consultants. For operational efficiency, it is proposed that some technical roles (fiduciary, environmental and social) are shared between this emergency project implementation team and the project implementation unit (PIU) proposed for the health sector project under preparation (P168564). Sharing technical staff is expected to reduce overhead costs across the two projects, and by tapping into retroactive financing, it can provide surge capacity early on to accelerate effectiveness. The Coordinators for the two projects (P173883 and P168564) will ensure that the project implementation responsibilities are organized in a way to harness operational benefits and reduce operating costs.

For effective management of environmental aspects, the Environmental Specialist will support the

Environmental Health Department in identifying gaps, planning and execution of environmental and waste management related aspects. The support will be accorded to the national focal office, regional Environmental Health Offices and Incinerator Operators in each facility. The structure and personnel is already existent and functional. Training on COVID-19 related environmental and waste management aspects will be done. Improvements to reporting, waste minimization, storage and treatment will also be necessary for the health care waste management system to cope with additional volumes. The Specialist will also support the Quality Management Office responsible for Infection Prevention and Control. The support will be accorded to the national focal office, regional and health facility focal persons. These structures are already in place and are functioning, support needed will be in the form of training on the ICWMP, reporting improvements and supply of PPE will have to be done.

The Social Specialist will work closely with the Rural Health Manager, Health Promotion and Deputy Prime Minister's GBV Unit. To effectively execute the Stakeholder Engagement Plan with the GRMs, the Specialist together with the Assistant Social Specialist will be working close with the Rural Health Manager. Training and capacity on GRMs will be necessary for the Rural Health Manager. For Risk Communication, the Health Promotion Unit will be supported by the Social Specialist together with the Communications Specialist. The Health Promotion Unit is well capacitated and already has a Risk Communication plan to be supported. The GBV Unit is well capacitated and already has a plan for support that the Social Specialist will assist on.

MoH, working together with the social and environmental experts, will:

- Ensure integration of the ESIA/ESMP into the project design and implementation plans (contract documents);
- Monitor implementation of the mitigation measures by the contractors;
- Assist contractors by providing appropriate environmental advice, and developing/revising environmental mitigation measures for the sub-projects;
- Assist the PIU to carry out participatory consultation during planning, design and implementation of sub-project;
- Document experiences associated with and lessons learned from environmental mitigation and prepare useful training materials for both internal and external capacity building; and
- Prepare regular or periodic progress reports on the implementation of the ESMPs throughout project implementation process.

M&E activities will be the responsibility of the MOH Epidemiology and Disease Control unit within the Strategic Information Department. Because the project focuses on COVID-19 preparedness and response, the Epidemiology and Disease Control Unit (EDCU) is mandated to coordinate efforts and strengthen public health surveillance through implementing IDSR to fulfill requirements of the 2005 IHRs and the GHSA. Since the COVID-19 outbreak, the unit has coordinated closely with WHO and the MOH COVID-19 Task Team to mount an effective response and set up the surveillance systems in the country. To this end, the unit will provide the routine monitoring support for COVID-19 and will receive backstopping from the MOH M&E unit once the pandemic has been contained. Tools for surveillance and reporting are already in place and shall be used as the data sources for the Results Framework indicators in this project.

Actual construction work will be carried out by the consultants/contractors under the direct supervision of supervision consultants/supervising firms. The environmental and social experts on both the Contractor and MoH teams will ensure strict compliance with the environmental and contractual clauses in the Bid documents and the ESCP and will report on progress.

For operational efficiency, the Core Implementation Team’s technical roles (fiduciary, M&E, environmental and social) are shared between this project and the project implementation unit for the Eswatini Strengthening the Health System and Nutrition for Human Capital Development in Eswatini Project (P168564). Sharing MOH staff and technical consultants will improve the strategic scope while reducing the overhead costs across the two projects. Tapping into technical surge capacity early on will accelerate effectiveness. The Coordinators for the two projects (P173883; P168564) will ensure that the project implementation responsibilities are organized in a way to harness operational benefits and reduce operating costs.

Training Requirements

The table below summarizes training requirements for the effective implementation of the project.

Training Aspect	Target Audience
1. COVID-19 Testing	National Laboratory Staff
2. COVID-19 Case Management	Regional Response Teams
3. Vaccine Immunization	Health Care Workers and temporary volunteers
4. ESMF and ESMP	All key stakeholders
5. ICWMP	IPC and Waste Management Focal Persons, contractors
6. Infectious Waste Collection and Treatment	Incinerator Operators and Health Care Waste Drivers
7. Stakeholder Engagement Plans	All key stakeholders
8. Project-specific Grievance Redress Mechanisms	All role players and stakeholders
9. Labor Management Procedures	Health Care Workers and Contractors
10. Good Practices in Responding to GBV Cases	Health Care Workers and Rural Health Motivators

The National Contingency Response Plan structure is as follows:

Cabinet-level inter-sectoral coordination and steering oversight will be provided by the *National Emergency Management Committee* (NEMC, Cabinet sub-committee), chaired by the Deputy Prime Minister. To support the NEMC, the *National Emergency Task Team* (NETT) was formed, which is

comprised of members of different sectors, and representation from the National Disaster Management Agency NDMA.⁴⁶ The NETT is tasked to implement the National and Regional Emergency Plans and Procedures and coordinate the preparedness and response activities. As the primary crisis is health, the lead technical agency for project implementation will be the MOH. To ensure robust technical oversight and agility, the following two bodies will support project implementation:

The MOH Senior Management Team (SMT), chaired by the Principal Secretary, provides overall strategic implementation of the COVID-19 sector response. They are responsible for providing the necessary resources, strategic guidance and facilitating the feedback loop between the Cabinet-level inter-sectoral coordination and steering committee and the National Public Health Emergency Committee (NPHEMC) tasked with the technical response for the sector. The NPHEMC is chaired by the MOH (Senior Medical Officer, Public Health Lead). The committee is comprised of MOH technical leads and experts critical for response to public health emergencies and representatives from Development Partners (UN agencies and the World Bank). To support regional preparedness and response, the NPHEMC has regional response committees that are chaired by the emergency response and preparedness officers in each region and comprise of regional nurse managers and designated allied workers responsible for the evacuations, isolation of patients and contact tracing. The regional chairpersons are members of the regional health management teams thus provide feedback to the regional health administrators on the response while being members of the NPHEMC.

Covid-19 Status Quo

Eswatini recorded the first case of COVID-19 on 13th March 2020. Subsequently, His Majesty King Mswati III invoked section 29 of the Disaster Management Act 2006 and declared the COVID-19 pandemic a National Emergency in the Kingdom of Eswatini from the 17th of March 2020. Even though the country is implementing comprehensive public health measures – such as rapid case identification, rapid testing and isolation of cases, comprehensive contact tracing and quarantine of contacts – the country has not managed to suppress the spread of COVID-19. The country recorded a sharp increase during the December holidays which triggered the re-instating of a partial lockdown by Government in January 2021 (Figure 4.9). By February, 18 2021 the country reported a cumulative total of 16773 cases, 637 have fatalities, 12487 recoveries and 3482 are active cases.

⁴⁶ NDMA is a standing body with a mandate to provides coordination across relevant sectors and actors to implement a response to emergencies, including public health emergencies of international concern (PHEIC) and pandemics.

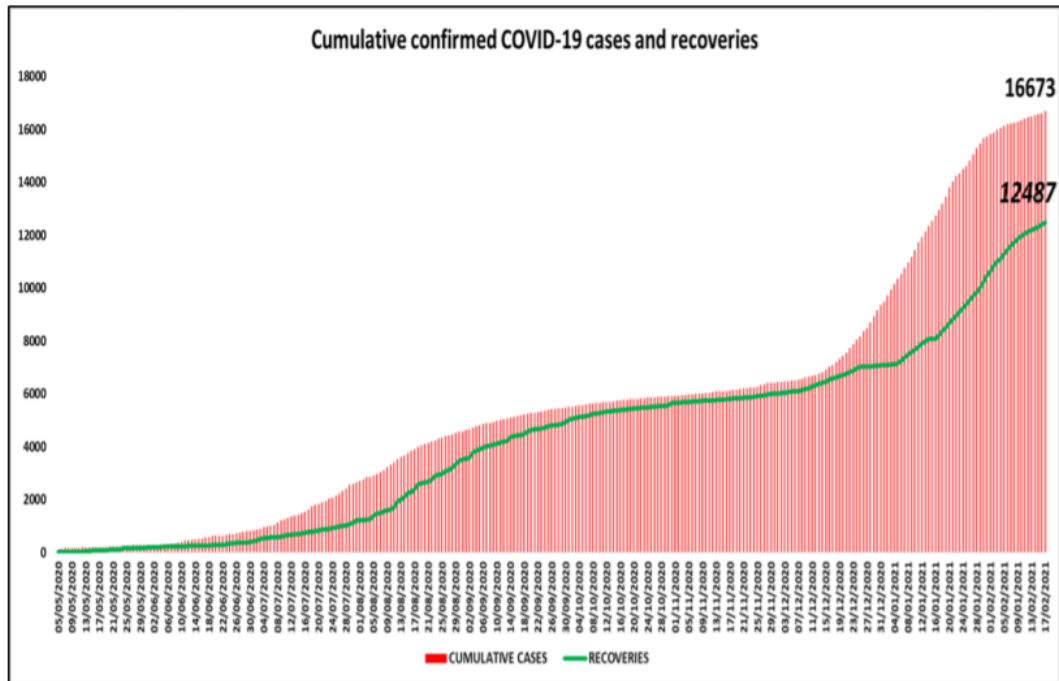


Figure 4.9: Cumulative graph of daily confirmed cases and recoveries

Figure 4.10 below shows the distribution of COVID's impact by region. Hhhohho has the highest number of cases whilst Shiselweni has the least number of cases. Hhhohho and Manzini cases have more than tripled cases in Shiselweni and Lubombo. This could be due to the high number of daily movements especially in the two major cities (Mbabane and Manzini) within the two regions.

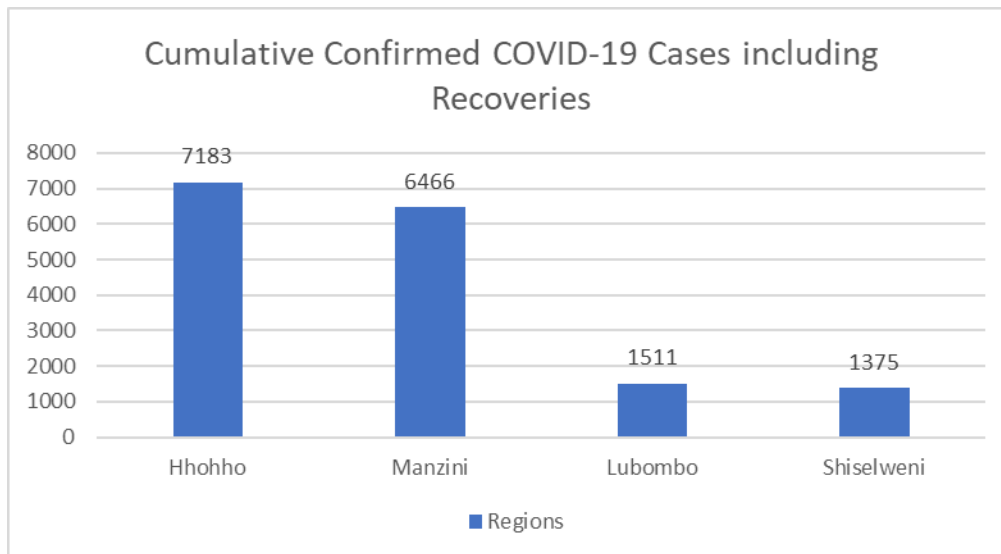


Figure 4.10: Confirmed COVID-19 Cases including Recoveries Per Region

Age-sex distribution of COVID-19 cases (Cumulative)

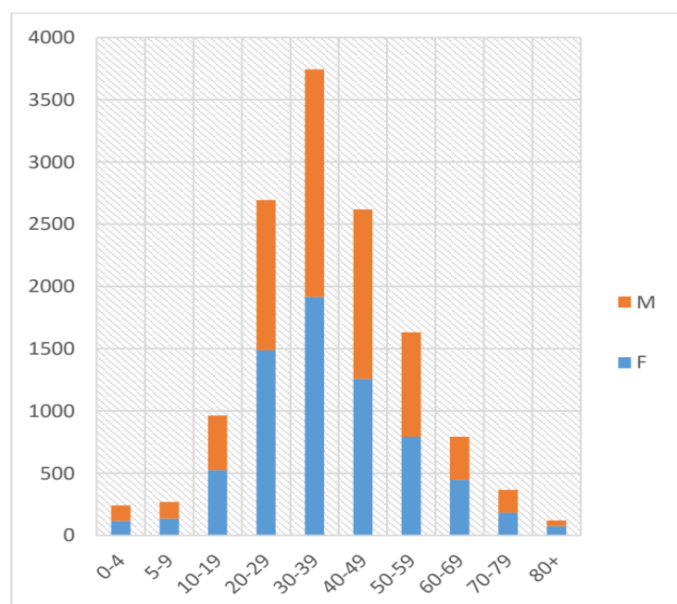


Figure 4.11: Age-Sex Distribution of COVID-19 Cases (Cumulative)

The age 30-39 Years has the highest infection rate which is the highly mobile age group and Fifty-two Percent (52%) of the cases are female and 48% are male. The sharp increase in confirmed cases overly stretched the health system and this resulted in a sharp increase in the case fatality rate. The increase in cases prompted the re-instating of partial lockdown restrictions which exerted further pressure on the socio-economic environment. Travelling, schools, religious gatherings and liquor outlets were restricted. An increase in GBV cases was noted.

The following progress was observed within the context of the National Contingency Response Plan have been actualized:

COORDINATION, PLANNING AND MONITORING

- The country has adopted an incident management approach for responding to emergencies that established the Incident Management Team (IMT) that meets on a daily basis at the PHEOC.
- The national Incident Action Plan (IAP) has been finalized for period 20th January to 20th February 2021.
- The pillars review and reports on implementation progress of the Incident Action Plan (IAP) every two weeks.
- The IMT Managers reports progress on the COVID-19 response to Senior Staff of MoH every Monday and to Cabinet every Tuesday.
- RHMTs and regional PHEMCs provide feedback to IMT every week.
- Development partners participate in IMT meetings virtually during the thematic presentation.
- The country has received technical experts for critical care from WHO to assist the country in management of COVID-19 critical patients.

RISK COMMUNICATION, COMMUNITY ENGAGEMENT & SOCIAL MOBILISATION

- The national campaign "Umgcini Wesive" for COVID-19 prevention was launched by His Excellency the Right Honorable Prime Minister of the Kingdom of Eswatini and implementation is ongoing.

- Risk communication messages continue to be aired in all media houses and the Risk Communication Team is working on reviewing and updating messages to address emerging issues

SURVEILLANCE AND RESPONSE

- COVID -19 screening is ongoing in all health facilities to identify suspect cases.
- EFTTIT teams are continuing with the door-to-door screening and testing for COVID-19 in identified hotspots as well as congregate settings.
- The RRTs continue to do case investigation, contact tracing and screening of suspected cases in all regions.
- There have been some efforts to step up contact tracing through establishment of contact tracing stations “kiosks” in selected areas in the Hhohho region. Index cases are called, screened and referred for testing and such strategies will be rolled out to other regions as per the need.

POINTS OF ENTRY

- Screening of travelers is ongoing in all presently opened Formal 7 Points of Entry (PoE) by Port Health Officers (PHOs).

LABORATORY

- Antigen testing of inbound travelers at Ngwenya Boarder Gate is ongoing.
- Antigen testing has been adopted as one of the testing strategies in the country and has been introduced in all hospital and health centres (private and public).

INFECTION PREVENTION AND CONTROL

- The IPC team continue to conduct supportive supervision in health facilities and IPC training of health care workers is ongoing.
- The E&S Team met with the Quality Management Team (IPC National Focal Person and Client Care) to identify gaps and offer support planned activities;
- A Monitoring and Evaluation Framework has been prepared by the IPC National Focal for monitoring purposes and it will be rolled out to the rest of the team.

CASE MANAGEMENT

- The Hhohho and Manzini Regional Health Management Teams are working with Regional Hospitals and Health Centre to decentralize management of confirmed COVID-19 cases. The teams were oriented on updated case management guidelines.
- The ministry has established a site for initiation of care at the EPR site in Malagwane and Zakhele Hall for COVID-19 positive patients registered under home care.
- The case management team is conducting supportive supervision on COVID-19 case management to health facilities.
- A weekly platform (Wednesdays) has been formulated to discuss COVID-19 issues and share clinical experience with a focus.

A National Deployment and Vaccination Structure has been established for the roll out of the COVID-19 vaccination. The structure is detailed below:

In preparation for the COVID-19 vaccine introduction the country the Ministry of Health appointed a National Coordination Committee which is chaired by Deputy Director Pharmaceutical Services. This committee has a multisectoral representation composed of senior-level officials from relevant ministries (Deputy Prime Minister, development partners, representatives from private sector and NGOs. In addition, the COVID-19 vaccine technical working group (TWG) to support the implementation of the pre, intra and post introduction of the vaccine was established. The NTWG report to the National Coordinating Committee. The TWG is responsible for collecting data on sero-epidemiology of Covid-19, hospitalization and deaths associated with Covid-19 by age, sex, underlying conditions, ethnicity and deprivation and proportion of immune; analyze this data and advise the coordinating committee on priority groups to be vaccinated based on the evidence collected. The TWG will also update the National Coordinating Committee on new information on characteristics of vaccine candidates under development, safety and immunogenicity data for Covid-19 vaccines, effectiveness of the vaccine in identified priority groups, doses available, co administration with other vaccines on market and programs, side effects, public acceptance. They will also guide the National Coordinating Committee on the communication strategies regarding Covid-19 vaccine introduction.

Eswatini national immunization technical advisory groups (NITAG) will provide evidence-based recommendations and policy guidance specifically related to COVID-19 vaccines, to facilitate fully informed decision-making by the government. The chair, or core members, of the NITAG have been invited to participate in the national coordination mechanism to ensure adequate information flow between the planning, policy and implementation levels. The NITAG will refine, revise and update their recommendations to national policy-makers regularly as new evidence becomes available and it was set up to make recommendations for childhood vaccinations. In its evidence-based, independent, advisory role, will provide transparency and credibility to the decision-making process and contribute to building public confidence in the vaccination programme. Furthermore regional (RHMT) level meetings will be convened to discuss and operationalize the implementation plan for COVID-19 vaccine introduction. The EEPI programme will lead and be convener of the various committee meetings. To ensure optimal participation notification of meetings and an agenda will be distributed to members at least 10 working days prior to the meeting. Subcommittee leads will be identified to oversee key components of the vaccination program including provider outreach and enrolment, data systems, vaccine management, and vaccine communications. The lead technical agency for project implementation will be the MOH. To ensure robust technical oversight and agility, the following two bodies will support project implementation:

The Eswatini Environment Authority (EEA). The Eswatini Environment Authority is the legal body entrusted with ensuring that the project meets the environmental obligations contained within this document. The EEA will approve all ESMPs developed under this project and will be responsible for overall compliance monitoring with periodic inspections to sites under the project. The EEA will also review and comment on all environmental reports from the project and advise accordingly on related matters.

The PIU supports the implementation of the National Contingency Response Plan and National Vaccine Deployment Plan. Members of the PIU are strategically placed within decision-making and working groups within the organizational structures of the two plans to contribute to decisions made and technically support implementation. They will work in close liaison with the Eswatini Environment Authority.

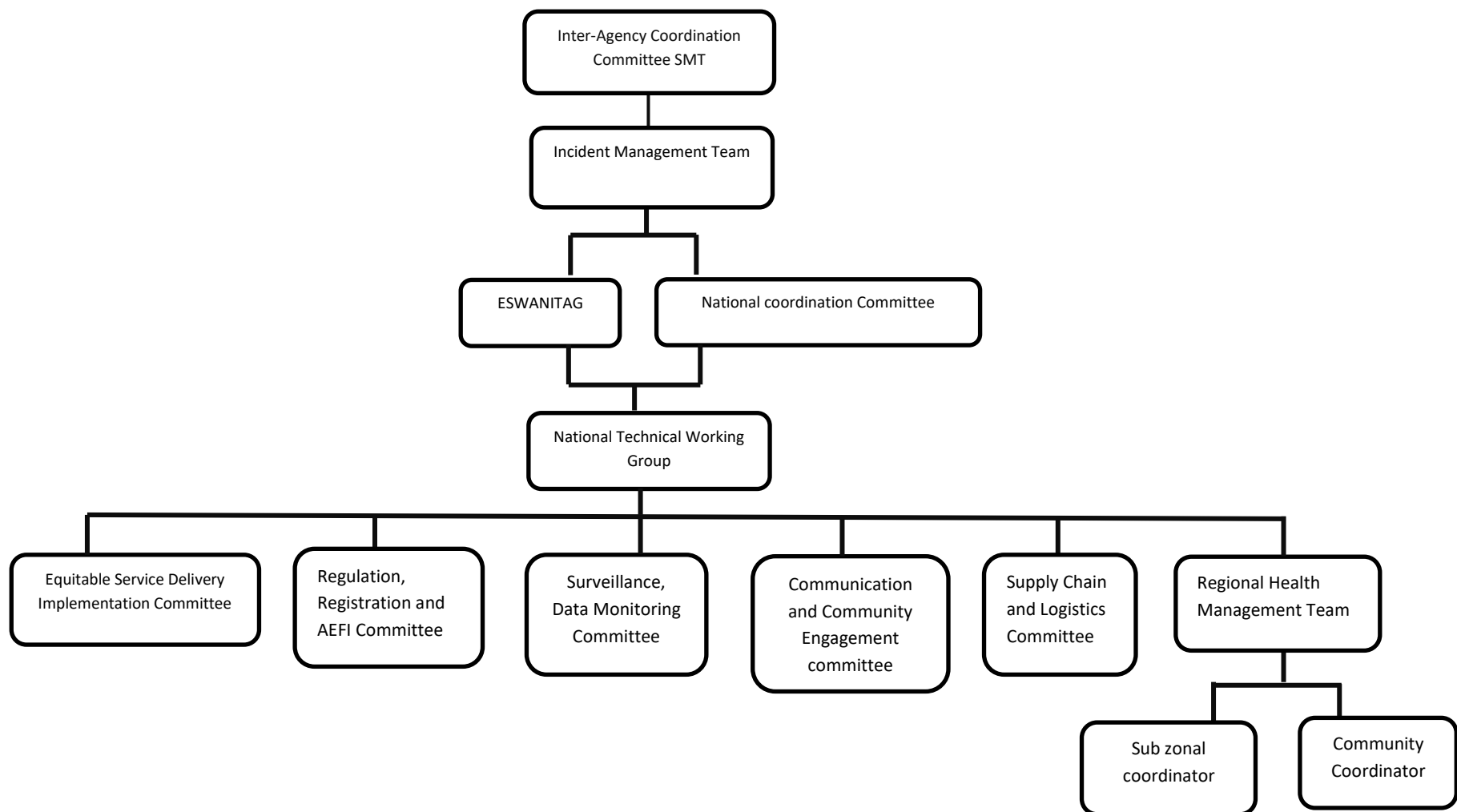


Figure 9.1: National Vaccination Deployment Structure

9.2 Monitoring Arrangements for Effective Environmental and Social Management

M&E activities will be the responsibility of the MOH Epidemiology and Disease Control unit within the Strategic Information Department. Because the project focuses on COVID-19 preparedness and response, the Epidemiology and Disease Control Unit (EDCU) is mandated to coordinate efforts and strengthen public health surveillance through implementing IDSR to fulfill requirements of the 2005 IHRs and the GHSA. Since the COVID-19 outbreak, the unit has coordinated closely with WHO and the MOH COVID-19 Task Team to mount an effective response and set up the surveillance systems in the country. To this end, the unit will provide the routine monitoring support for COVID-19 and will receive backstopping from the MOH M&E unit once the pandemic has been contained. Tools for surveillance and reporting are already in place and shall be used as the data sources for the Results Framework indicators in this project.

9.3 Measures to Strengthen Institutional Capacity

The MOH demonstrates strong stewardship of the COVID-19 response through the National Task Team, which has representation from diverse stakeholders within the sector. Additionally, the MOH has previous experience managing World Bank projects effectively. However, this being an emergency project, there is a risk that the capacity to process transactions and implement activities based on an evolving response may be limited within the MOH.

EHD is currently staffed with officers that have experience in implementing World Bank projects under the Bank's safeguards policies. However, they have no experience in applying the Environmental and Social Framework, and they will therefore need training in the World Bank Environmental and Social Standards (ESSs). The EHD officers will require training to be able to implement the ESCP; similarly, the facility management will also have to be sensitized to appreciate the need for complying with the ESCP, and supporting actions proposed for preventing or mitigating any adverse environmental, social and health and safety occurrences.

The project will require substantial support from the World Bank's task team. The World Bank will work with the MOH and the CIT to ensure that effective coordination is established. The World Bank team will work with the MOH and the CIT and agree on regular reporting formats. The reports will include updates on technical and financial progress and on monitoring indicators. The World Bank team will also advise the MOH and CIT on environmental due diligence to ensure that the Environmental and Social Framework tools, prepared for the project, are adhered to. The World Bank task team will work with the Borrower to identify underperforming areas (if any) and address any constraints. Additional implementation support will include monitoring changes in risks and compliance with legal covenants.

The World Bank's implementation support will broadly consist of:

- Institutional capacity-building activities, covering technical, fiduciary, and social and environmental dimensions;
- Provision of technical advice and implementation support geared to the attainment of the PDOs, including support to the MOH to support prevention, detection, response to COVID-19 and strengthen national systems for public health preparedness;
- Ongoing monitoring of implementation progress, including regularly reviewing key outcome and intermediate indicators;
- Review of financial and progress reports prepared by the Borrower and audit reports prepared by internal and external auditors.
- Monitoring risks and identifying the corresponding mitigation measures; and

- Close coordination with other development partners to leverage resources to ensure coordination of efforts and avoid duplication.

Table 9.1. Implementation Support Plan

Time	Focus	Skills Needed	Resource Estimate
First six months	Technical advice to support project implementation (procurement, M&E, FM)	Technical, fiduciary, operational, environment, and social	At least one implementation support visit (virtual) by technical specialists focused on planning, capacity building, technical assistance, and monitoring. One implementation support visit (virtual) by environment and social specialists focused on capacity building and reviewing/strengthening effectiveness of redress mechanism.
6–12 months	Continued technical support for project implementation Implementation Monitoring	Technical, fiduciary, environment, and social	One implementation support visit (virtual) by technical and fiduciary specialists focused on fiduciary and implementation support. One implementation support visit (virtual) by social/environmental specialists focused on strengthening local capacity, and implementation support.
midterm	Implementation progress review and identification of necessary midcourse adjustments	Technical, fiduciary, environment, social, and operational	One implementation support visit including technical, fiduciary, social, environment, M&E, and operational specialists.
12–24 months	Implementation M&E Technical advice to support program implementation & closing	Technical and fiduciary	One implementation support visit by technical and fiduciary specialists focused on implementation and fiduciary support. One implementation support visit by social/environmental specialist focused on strengthening local capacity, and implementation support.

9.4 ESMP Implementation Cost/Budget

In view of the environmental management measures suggested above and factoring in the limited implementation capacity of the MoH, necessary budgetary provisions should be made for project. Accordingly, for all three aspects (mitigation, monitoring, and capacity development), the ESMP shall provide (a) an implementation schedule for measures that must be carried out as part of the project, showing phasing and coordination with overall project implementation plans; and (b) the capital and recurrent cost estimates and sources of funds for implementing the ESMP. These figures should be integrated into the total project cost tables.

ANNEX 1 – Additional Resources

Given the COVID-19 situation is rapidly evolving, a version of this resource list will be regularly updated and made available on the World Bank COVID-19 operations intranet page (<http://covidoperations/>).

WHO Guidance

Advice for the public

- WHO advice for the public, including on social distancing, respiratory hygiene, self-quarantine, and seeking medical advice, can be consulted on this WHO website: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>
- [Considerations for quarantine of individuals in the context of containment for coronavirus disease \(COVID-19\)](#)
- [Key considerations for repatriation and quarantine of travelers in relation to the outbreak of novel coronavirus 2019-nCoV](#)
- [Preparedness, prevention and control of coronavirus disease \(COVID-19\) for refugees and migrants in non-camp settings](#)

Technical guidance

- [Infection prevention and control during health care when novel coronavirus \(nCoV\) infection is suspected](#), issued on March 19, 2020
- [Recommendations to Member States to Improve Hygiene Practices](#), issued on April 1, 2020
- [Severe Acute Respiratory Infections Treatment Center](#), issued on March 28, 2020
- [Infection prevention and control at health care facilities \(with a focus on settings with limited resources\)](#), issued in 2018
- [Laboratory biosafety guidance related to coronavirus disease 2019 \(COVID-19\)](#), issued on March 18, 2020
- [Laboratory Biosafety Manual, 3rd edition](#), issued in 2014
- [Laboratory testing for COVID-19, including specimen collection and shipment](#), issued on March 19, 2020
- [Covid-19 Technical Guidance: Laboratory testing for 2019-nCoV in humans](#), issued on March 2, 2020
- [Prioritized Laboratory Testing Strategy According to 4Cs Transmission Scenarios](#), issued on March 21, 2020
- [Infection Prevention and Control for the safe management of a dead body in the context of COVID-19](#), issued on March 24, 2020
- [Key considerations for repatriation and quarantine of travelers in relation to the outbreak COVID-19](#), issued on February 11, 2020
- [Preparedness, prevention and control of COVID-19 for refugees and migrants in non-camp settings](#), issued on April 17, 2020
- [Coronavirus disease \(COVID-19\) outbreak: rights, roles and responsibilities of health workers, including key considerations for occupational safety and health](#), issued on March 18, 2020
- [Oxygen sources and distribution for COVID-19 treatment centers](#), issued on April 4, 2020
- [Risk Communication and Community Engagement \(RCCE\) Action Plan Guidance COVID-19 Preparedness and Response](#), issued on March 16, 2020
- [Considerations for quarantine of individuals in the context of containment for coronavirus disease \(COVID-19\)](#), issued on March 19, 2020

- [Operational considerations for case management of COVID-19 in health facility and community](#), issued on March 19, 2020
- [Rational use of personal protective equipment for coronavirus disease 2019 \(COVID-19\)](#), issued on February 27, 2020
- [Getting your workplace ready for COVID-19](#), issued on March 19, 2020
- [Water, sanitation, hygiene and waste management for COVID-19](#), issued on March 19, 2020
- [Safe management of wastes from health-care activities](#), issued in 2014
- [Advice on the use of masks in the community, during home care and in healthcare settings in the context of the novel coronavirus \(COVID-19\) outbreak](#), issued on March 19, 2020
- [Disability Considerations during the COVID-19 outbreak](#), issued on March 26, 2020

WORLD BANK GROUP GUIDANCE

- [Technical Note: Public Consultations and Stakeholder Engagement in WB-supported operations when there are constraints on conducting public meetings](#), issued on March 20, 2020
- [Technical Note: Use of Military Forces to Assist in COVID-19 Operations](#), issued on March 25, 2020
- [ESF/Safeguards Interim Note: COVID-19 Considerations in Construction/Civil Works Projects](#), issued on April 7, 2020
- [Technical Note on SEA/H for HNP COVID Response Operations](#), issued in March 2020
- [Interim Advice for IFC Clients on Preventing and Managing Health Risks of COVID-19 in the Workplace](#), issued on April 6, 2020
- [Interim Advice for IFC Clients on Supporting Workers in the Context of COVID-19](#), issued on April 6, 2020
- [IFC Tip Sheet for Company Leadership on Crisis Response: Facing the COVID-19 Pandemic](#), issued on April 6, 2020
- [WBG EHS Guidelines for Healthcare Facilities](#), issued on April 30, 2007

ILO GUIDANCE

- [ILO Standards and COVID-19 FAQ](#), issued on March 23, 2020 (provides a compilation of answers to most frequently asked questions related to international labor standards and COVID-19)

MFI GUIDANCE

- [ADB Managing Infectious Medical Waste during the COVID-19 Pandemic](#)
- [IDB Invest Guidance for Infrastructure Projects on COVID-19: A Rapid Risk Profile and Decision Framework](#)
- [KfW DEG COVID-19 Guidance for employers](#), issued on March 31, 2020
- [CDC Group COVID-19 Guidance for Employers](#), issued on March 23, 2020
- [USCDC, EPA, DOT, et al; Managing Solid Waste Contaminated with a Category A Infectious Substance](#)

ANNEX 2 -- Generic Terms of Reference for Conducting an ESIA/ESMP

Environment and Social Impact Assessment (ESIA) is a decision support mechanism to ensure that the project design and implementation are environmentally and socially sound and sustainable. During the preparation phase, the objective of the ESIA is to provide inputs to the selection of sub-projects, feasibility study; preliminary and detailed design as well as assist development of a holistic development of the project package. During the implementation phase, environmental and social management plans (developed as a part of the EA during the preparation phase) are to be used for executing the environmental mitigation, enhancement and monitoring measures.

Objectives of ESIA

In the preparation phase, the ESIA shall achieve the following objectives:

1. Establish the environmental and social baseline in the study area;
2. Identify and analyze environmental and social issues that may affect the project and the sector;
3. Identify any potential environmental and social issues (direct/indirect/induced/cumulative) caused from the project activities;
4. Assess impacts of the project and provide for measures to address the adverse impacts by the provision of avoidance, mitigation and compensation measures;
5. Integrate environmental and social issues in the project planning and design, and
6. Develop appropriate management plans for implementing, monitoring and reporting of the suggested environmental and social mitigation and enhancement measures.

The environmental and social assessment studies and reporting requirements to be undertaken under this TOR must conform to Eswatini regulations and the Bank's Environmental and Social Standards and guidelines.

Description of the Project

(Include description of the project; covering geographical location, type of development envisaged, including a description of project activities. Also include current status of the project. Provide brief information on any other study already completed/on-GOKE or proposed) ... to be added by Client.

Scope of Work

The ESIA comprises the following three components: (i) environmental and social screening for the entire project; (ii) Environmental and Social Impact Assessment (ESIA) for the individual project/sub-projects, as may be required; and (c) Environmental and Social Management Plans (ESMPs) for the individual project and sub-projects. The following paragraphs give the detailed scope of work in each of these stages.

Inception

The Consultants shall use the inception period to familiarize themselves with the project details. The Consultants shall recognize that the remaining aspects of the project, such as engineering and social, would be studied in parallel, and it is important that all these aspects be integrated into the final project design to facilitate their successful project implementation. The Consultants should also recognize that due care and diligence planned during the inception stage helps in improving the timing and quality of the ESIA reports.

During the inception period, the Consultants shall: (a) study the project information to appreciate the context within which the ESIA has to be carried-out; (b) identify the sources of secondary information on

the project, on similar projects and on the project area; (c) carry out a reconnaissance survey; and (d) undertake preliminary consultations with selected stakeholders.

Following the site visits and stakeholder consultations, as well as a review of the conditions of contract with the Client, the consultant shall analyze the adequacy of the allocated manpower, time and budget and shall clearly identify any deviations, if any. The Consultant shall study the various available surveys, techniques, models and software in order to determine what would be the most appropriate in the context of this project.

The Consultant shall interact with the engineering and E&S consultants to determine how the ESIA work fits into the over-all project preparation cycle, how overlapping areas are to be jointly addressed, and to appropriately plan the timing of the deliverables of the ESIA process. These shall be succinctly documented in the Inception Report.

Environmental and Social Screening

Consultants shall summarize the known sub-projects' environmental and social risks and impacts consistent with the Bank's ESS1 requirements. During such determination, consideration shall be paid to: (i) location of sub-project with respect to environmentally and socially sensitive areas; and (ii) volume, nature and technology of construction. The screening parameters should be such that their identification and measurement is easy and does not involve detailed studies. The screening criteria shall also contain exclusion criteria, for sub-projects, which should not be taken up due to potential significant environmental and social impacts that cannot be mitigated (including, but not limited to, permanent obstruction to wildlife corridors, or opening up increased access to threatened biodiversity resource hotspots, or construction on top of eroded and vulnerable flood embankments).

Environmental and Social Scoping

Based on result of the environmental and social screening exercise, consultants shall suggest the scope of Environmental and Social Impact Assessment to be undertaken. It shall include a listing of other environment and social issues that do not deserve a detailed examination in the project ESIA (covering, for example, induced impacts that may be outside the purview of the client) along with a justification. The scoping needs to identify and describe the specific deviations or inclusions vis-à-vis the ESIA ToR provided, if any, along with a justification; modify this ToR for the sub-project ESIA, if required; and recommend studies that need to be conducted in parallel but are outside the ESIA process.

Baseline

All regionally or nationally recognized environmental and social resources and features within the project's influence area shall be clearly identified and studied in relation to activities proposed under the project. These will include all protected areas (such as national parks, wildlife sanctuaries, reserved forests, RAMSAR sites, biosphere reserves, wilderness zones), unprotected and community forests and forest patches, wetlands of local/regional importance not yet notified, rivers, rivulets and other surface water bodies and sensitive environmental features such as wildlife corridors, biodiversity hotspots, flood prone areas, areas of severe river erosion, flood embankments (some of which are also used as roads). Consultants shall consolidate all this information in a map of adequate scale.

Stakeholder Identification and Consultation

Consultation with the stakeholders shall be used to improve the plan and design of the project rather than merely having project information dissemination sessions. The consultants shall carry out consultations with experts, NGOs, concerned government agencies and other stakeholders to: (a) collect baseline information; (b) obtain a better understanding of the potential impacts; (c) appreciate the

perspectives/concerns of the stakeholders; and (d) secure their active involvement during subsequent stages of the project.

Consultations shall be preceded by a systematic stakeholder analysis, which would: (a) identify the individual or stakeholder groups relevant to the project and to environmental and social issues; (b) include expert opinion and inputs; (c) determine the nature and scope of consultation with each type of stakeholders; and (d) determine the tools to be used in contacting and consulting each type of stakeholder group. A systematic consultation plan with attendant schedules will be prepared for subsequent stages of project preparation as well as implementation and operation, as required.

Identification of Relevant Macro/Regional Level Environmental and Social Issues

Consultants shall determine the Valued Environment and Social Components (VESC) considering the baseline information (from both secondary and primary sources), the preliminary understanding of the activities proposed in the project and, most importantly, the stakeholder (and expert) consultations, which would need to be carefully documented. Use of iterative Delphi techniques is recommended. Based on the identification of VESCs, consultants shall identify information gaps to be filled, and conduct additional baseline surveys, including primary surveys. The consultants shall conduct a preliminary analysis of the nature, scale and magnitude of the impacts that the project is likely to cause on the environment, especially on the identified VESCs, and classify the same using established methods. For the negative impacts identified, alternative mitigation/management options shall be examined, and the most appropriate strategy/technique should be suggested. The preliminary assessment should clearly identify aspects where the consultants shall also analyze indirect and cumulative impacts during all phases and activities of the project. For the positive measures identified, alternative and preferred enhancement measures shall be proposed.

Analysis for the Environmental and Social Impact Assessment

The Consultants shall undertake necessary impact analysis on the basis of primary and secondary information and outputs from the stakeholder consultation process. In the cases of very significant environmental losses or benefits, the consultants shall estimate the economic/financial costs of environment damage and the economic/financial benefits the project is likely to cause. In the cases, the impacts or benefits are not too significant, qualitative methods could be used. In addition, wherever economic and financial costs of the environmental impacts cannot be satisfactorily estimated, or in the cases of significant irreversible environmental and social impacts, the consultants shall make recommendations to avoid generating such impacts.

Environmental and Social Management Plan

The consultants shall prepare an ESMP to address identified planning, design, construction and operation stage issues. For each issue, the consultants shall prepare a menu of alternative avoidance, mitigation, compensation, enhancement and/or mitigation measures, as required/necessary. Consultants shall provide robust estimates of costs for environmental and social management measures. These costs shall be verified for common works items in line with the rate analysis for other works. The consultants shall organize consultations with line departments and will finalize the ESMP.

Environmental and Social Inputs to Feasibility Study and Preliminary Project Design

The ESA consultants shall make design recommendations, related to alignment, cross-sections, construction material use, and mitigation and enhancement measures. The ESA consultants shall interact regularly with MoH and familiarize themselves with the Project's over-all feasibility analyses models, so that the ESA inputs are in conformity to the needs of the over-all feasibility study.

Capacity Building and Training Plan

Based on the preliminary findings of the environmental screening, stakeholder consultations and institutional analysis of the implementing agency's capacity to manage environmental and social issues, the consultants shall prepare a Capacity Building Plan to mainstream environmental and social management in the implementing agency's activities by the end of project implementation period. Earmarking staff for environmental and social management and improving their skill sets would be simultaneously pursued during project preparation and implementation. In addition, recommendations should be made concerning any changes to guidelines, standards and regulations, which would improve medium- and long-term environmental and social management in the line departments works.

A detailed training plan shall be prepared to develop and strengthen environmental and social capacities of the client and other associated agencies/departments. The strategy should include a mix of hands-on training for key staff involved in project preparation, site visits to similar projects, and whenever required, full-fledged academic programs on environmental and social management at well-recognized institutions.

The consultants shall conduct orientation training for the key client, early in the assignment. Periodic training at various levels should continue during project preparation to ensure that the knowledge, skills and perspectives gained during the ESA assignment are transferred to the Client and are utilized effectively during project implementation.

Mechanisms for improved co-ordination between Client and Line departments

The consultants shall examine the various options available for improved and timely coordination between various state government departments. These could take the form of written MoUs for specific activities, apex co-ordination committee of top bureaucrats, or any such mechanism that can be effective in reducing delays in ancillary activities such as, but not limited to, shifting of utilities and obtaining required regulatory permissions.

Co-ordination among Engineering, Social, Environment and Other Studies

The consultants, with assistance from the Client, shall establish a strong co-ordination with the other project-preparation studies – engineering, social and/or institutional development. The consultants shall keep in mind the specific requirements of the project in general, and the engineering/design studies in particular, and shall plan their outputs accordingly. It is recommended that some of the consultation sessions may be organized in co-ordination with the social and engineering consultants, as feasible, and when the stakeholders consulted are the same.

The consultant shall review the contract documents – technical specifications, and rate analysis, to ensure that there are minimal conflicts between the ESMP stipulations and specifications governing the execution of works under the project.

Public Disclosure

The consultants shall prepare a non-technical ESIA summary report for public disclosure and will provide support to the client in meeting the disclosure requirements, which at the minimum shall meet the World Bank's standard on public disclosure. The consultants will prepare a plan for in-country disclosure, specifying the timing and locations; translate the key documents (including executive summary of ESIA/ESMPs) in the local language, draft the newspaper announcements for disclosure, and help the client to place all the ESIA reports on the client's website.

Consultant's Inputs

The Consultants are free to employ resources as they see fit. Additional expertise shall be provided as demanded by the context of the project. The consultants are encouraged to visit the project area and familiarize themselves, at their own cost, before submitting the proposal; and propose an adequate number and skill set for the senior specialists and technical support staff for the ESA assignment. Further, the consultant will allocate adequate number of field surveyors, distinct from the technical support staff, to complete the study in time. Timing is an important essence for any ESA study, which shall be closely coordinated with the works of the engineering and social teams, simultaneously involved in preparation of the project.

The consultants shall provide for all tools, models, software, hardware and supplies, as required to complete the assignment satisfactorily. These should be widely recognized or accepted. Any new model or tool or software employed should be field-tested before use or the purpose of this ESA.

The consultants shall make formal presentations, coordinated by the client, at key milestones on the (a) proposed work plan after submitting the Inception Report; (b) recommendations from the environmental screening; and (c) ESA findings, design and ESMP recommendations. All supporting information gathered by the consultant in undertaking these terms of reference would be made available to the client.

ANNEX 3 – Detailed Environment and Social Screening Guidance Note

A. Purpose/Objectives of Environment and Social Screening

Environmental and social screening is undertaken to determine the key environmental and social issues/concerns and the nature and magnitude of the potential environmental and social risks and impacts that are likely to arise on account of proposed project/sub-project interventions. The key environmental and social issues to be identified will be determined by the type, location, sensitivity and scale of the project/sub-project. The results/findings from this exercise are/will be used to determine:

- The extent and type of ESIA/ESMPs required
- The environmental and social risks and impacts rating of the project/sub-project

The screening result will also be an important input for analyzing the ‘feasibility’ of the project/sub-project along with engineering/economics and social criteria.

B. Environmental and Social Screening - Report Structure

The table of contents/presentation structure of the Environment and Social Screening Report has been mentioned below:

1. Table of Contents
2. Executive Summary
3. Introduction
 - 3.1. Project Description
 - 3.2. Project Proponent
 - 3.3. Description of the sub-project (including its location, proposed start and end points, regional setting, scale and size)
 - 3.4. Over-view of major key sub-project activities
 - 3.5. Need for the sub-project
 - 3.6. Expected benefits from the sub-project
 - 3.7. Various studies/reports being prepared for the project and how the environment and social screening study relates to/feeds into the over-all project preparation
4. Methodology Adopted for Environment and Social Screening Exercise
 - 4.1. Purpose/Objectives of the Environment and Social Screening Exercise
 - 4.2. Methodology (step-by-step process) adopted for Environmental and Social Screening Exercise
 - 4.2.1. Project Influence Area (mention the direct and indirect spatial zone considered for the environment screening study)
 - 4.2.2. Types and sources of data collection
 - 4.2.3. Weightage/ranking system used
 - 4.2.4. Data gaps/constraints, if any
5. Regulatory and Institutional Regime
 - 5.1. Environmental and social policies and their implications/application in the sub-project context
 - 5.2. Environmental and Social Acts and their implications/application in the sub-project context
 - 5.2.1. Environmental and Social Risks and Impact Rating
 - 5.3. International conventions and their implications/application in the subproject context
 - 5.4. Environmental and social permits/approvals that will be required for the sub-project (include specific local requirements, if any)

5.5. Existing institutional arrangements/set-up (both in terms of environmental and social regulatory agencies and project proponent set-up)

6. Baseline Environmental and Social Conditions

6.1. Natural Environment

- 6.1.1. Over-all environmental setting of the project (including topography)
- 6.1.2. Natural resource availability
- 6.1.3. Natural hazards and vulnerability of the sub-project area
- 6.1.4. Air Quality
- 6.1.5. Water availability and quality (include both surface and ground water sources)
- 6.1.6. Drainage conditions/issues
- 6.1.7. Slope stability (soil type/s; erosion; landslide/landslip problems, if any)
- 6.1.8. Visual resources (if any)

6.2. Biological Environment

- 6.2.1. Protected Natural Habitats (Biosphere Reserves; National Parks and Sanctuaries)
- 6.2.2. Wildlife Habitats (outside designated protected areas) (including bird habitats, aquatic habitats, as relevant)
- 6.2.3. Presence of Forest (Reserved, Protected or of any other category)
- 6.2.4. Flora/vegetation (general) (include a broad estimate of trees (no.) that may get affected)
- 6.2.5. Presence of vulnerable, threatened and/or endangered species of flora and fauna, if any

6.3. Physical and Socio-economic Environment

- 6.3.1. Land-use
- 6.3.2. Socio-economic characteristics of the project influence area (including transportation network; existing economic/ employment base)
- 6.3.3. Cultural resources (archeological heritage; religious structures; local built heritage and art forms)
- 6.3.4. Safety
- 6.3.5. Presence of sensitive receptors such as schools/colleges/health centers/hospitals
- 6.3.6. Local level features and issues (features such as presence of markets or pastures and issues like noise, vibration, congestion, waste dumping along the road, presence of contaminated sites)

7. Assessment of Key Environmental and Social Impacts

- 7.1. Link-up existing environmental and social conditions with proposed project intervention/s and identify/assess the potential environmental risks and impacts on natural, biological and physical environmental attributes that may result in this process.
- 7.2. Look at the key issues that may result purely on account of proposed project intervention/s (such as safety issues; drainage alterations)
- 7.3. Analysis of cumulative E&S impacts
- 7.4. Analyze/propose alternative options that can avoid and/or reduce the identified potential impacts
- 7.5. Mitigation of impacts.

8. Stakeholder Consultation

- 8.1. Definition of stakeholder
- 8.2. Types/categories of stakeholders consulted for the Feasibility/Screening studies
- 8.3. Details about the consultations conducted
 - 8.3.1. Provide summary in the chapter and supporting details in the annex.
 - 8.3.2. In the summary, kindly mention when, where, how many people attended, key topics discussed, and information shared.

8.3.3. Clearly list out findings including areas/issues that are of concern to the stakeholders and need attention.

9. Findings/Recommendations of Environmental and Social Screening Exercise

- 9.1. Summary of results (weighted) from the environment and social screening exercise
- 9.2. Key issues/concerns identified
- 9.3. Summary of key benefits from the sub-project/project intervention
- 9.4. Key recommendations from the stakeholder consultation exercise
- 9.5. Summary - opportunities and constraints at the sub-project level
- 9.6. Scoping (focus) of the ESA (mention specific areas/aspects that need to be studied in detail)
- 9.7. Recommendation(s)/conclusion

10. References

11. Annexes

- 11.1. Names and contact details of key staff involved in the Feasibility (including Environment and Social Screening exercise)
- 11.2. Stakeholder consultation details
- 11.3. Details of the data collected

Note

This is a typical or generic reporting structure, kindly do include any specific environmental and social feature/issue that is unique to the sub-project and has not been mentioned here. This can/should also include any specific local regulatory requirement.

Use 'weighted matrix' for presenting results. This will help in making a more objective comparison between various sub-projects. The environmental sensitivity or ranking will clearly emerge through this and will influence decision-making at the project level. However, for meaningful and factual analysis, consultants must ensure that the information is clearly captured/presented in the Environmental and Social Screening Report, including a clear mention about data gaps/constraints, if any. Not doing so can otherwise lead to erroneous decisions and affect project planning and delivery at a later date, requiring mid-course correction. An objective screening process is an attempt to avoid/minimize such unwarranted situation/s.

Ensure that any map/cross-section/photographs provided in the report are legible and correctly labeled.

Screening Form for Potential Environmental and Social Issues

This form is to be used by the Project Implementation Unit (PIU) to screen for the potential environmental and social risks and impacts of a proposed subproject. It will help the PIU in identifying the relevant Environmental and Social Standards (ESS), establishing an appropriate E&S risk rating for these subprojects and specifying the type of environmental and social assessment required, including specific instruments/plans. Use of this form will allow the PIU to form an initial view of the potential risks and impacts of a subproject. *It is not a substitute for project-specific E&S assessments or specific mitigation plans.*

Subproject Name				
Subproject Location				
Subproject Proponent				
Estimated Investment				
Start/Completion Date				
Questions	Answer		Relevant ESS/OP	Due diligence, Actions
	Yes	No		

Does the subproject involve civil works including new construction, expansion, upgrading or rehabilitation of healthcare facilities and/or waste management facilities?			ESS1	ESIA/ESMP, ICWMP, SEP
Does the subproject involve land acquisition and/or restrictions on land use?			ESS5	RAP/ARAP, SEP
Does the subproject involve acquisition of assets for quarantine, isolation or medical treatment purposes?			ESS5	RAP/ARAP, SEP
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, ICWMP, SEP
Is there a sound regulatory framework and institutional capacity in place for healthcare facility infection control and healthcare waste management?			ESS1	ESIA/ESMP, ICWMP, SEP
Does the subproject have an adequate system in place (capacity, processes and management) to address waste?			ESS3	ESIA/ESMP, ICWMP, SEP
Does the subproject involve recruitment of workers including direct, contracted, primary supply, and/or community workers?			ESS2	LMP, SEP
Does the subproject have appropriate OHS procedures in place, and an adequate supply of PPE (where necessary)?			ESS2	ESMP, LMP, SEP
Does the subproject have a GRM in place, to which all workers have access, designed to respond quickly and effectively?			ESS10	SEP
Does the subproject involve transboundary transportation (including Potentially infected specimens may be transported from healthcare facilities to testing laboratories, and transboundary) of specimen, samples, infectious and hazardous materials?			ESS3	ESIA/ESMP, ICWMP, SEP
Does the subproject involve use of security or military personnel during construction and/or operation of healthcare facilities and related activities?			ESS4	ESIA/ESMP, SEP
Is the subproject located within or in the vicinity of any ecologically sensitive areas?			ESS6	ESIA/ESMP, SEP
Are there any indigenous groups (meeting specified ESS7 criteria) present in the subproject area and are they likely to be affected by the proposed subproject negatively or positively?			ESS7	IPP or similar plan
Is the subproject located within or in the vicinity of any known cultural heritage sites?			ESS8	ESIA/ESMP, SEP
Does the project area present considerable Gender-Based Violence (GBV) and Sexual Exploitation and Abuse (SEA) risk?			ESS1	ESIA/ESMP, SEP
Does the subproject carry risk that disadvantaged and vulnerable groups may have unequitable access to project benefits?			ESS1	ESIA/ESMP, SEP
Is there any territorial dispute between two or more countries in the subproject and its ancillary aspects and related activities?			OP7.60	Governments concerned agree
Will the subproject and related activities involve the use or potential pollution of, or be located in international waterways?			OP7.50	Notification (or exceptions)

Conclusions:

1. Proposed Environmental and Social Risk Ratings (High, Substantial, Moderate or Low). Provide Justifications.
2. Proposed E&S Management Plans/ Instruments.

Screening E&S Risks of Medical laboratories

Many COVID-19 projects include capacity building and operational support to existing medical laboratories. It is important that such laboratories have in place procedures relevant to appropriate biosafety practices. WHO advises that non-propagative diagnostic work can be conducted in a Biosafety Level 2 (BSL-2) laboratory, while propagative work should be conducted at a BSL-3 laboratory. Patient specimens should be transported as Category B infectious substance (UN3373), while viral cultures or isolates should be transported as Category A “Infectious substance, affecting humans” (UN2814). The process for assessing the biosafety level of a medical laboratory (including management of the laboratory operations and the transportation of specimens) should consider both biosafety and general safety risks. OHS of workers in the laboratory and potential community exposure to the virus should be considered.

The following documents provide further guidance on screening of the E&S risks associated with a medical laboratory. They also provide information for assessing and managing the risks.

- [WHO; Prioritized Laboratory Testing Strategy According to 4Cs Transmission Scenarios](#)
- [WHO Covid-19 Technical Guidance: Laboratory testing for 2019-nCoV in humans:](#)
- [WHO Laboratory Biosafety Manual, 3rd edition](#)
- [USCDC, EPA, DOT, *et al*; Managing Solid Waste Contaminated with a Category A Infectious Substance](#) (August 2019)

Screening E&S Risks of Quarantine and Isolation Centers

According to WHO:

- **Quarantine** is the restriction of activities of or the separation of persons *who are not ill but who may have been exposed to* an infectious agent or disease, with the objective of monitoring their symptoms and ensuring the early detection of cases
- **Isolation** is the separation of *ill or infected persons* from others to prevent the spread of infection or contamination.

Many COVID-19 projects include construction, renovation and equipping of quarantine and isolation centers at Point of Entry (POE), in urban and in remote areas. There may also be circumstances where tents are used for quarantine or isolation. Public or private facilities such as a stadium or hotel may also be acquired for this purpose.

In screening for E&S risks associated with quarantine and isolation, the following may be considered:

- contextual risks such as conflicts and presence or influx of refugees
- construction and decommissioning related risks
- land or asset acquisition
- use of security personnel or military forces
- availability of minimum requirements of food, fuel, water, hygiene
- whether infection prevention and control, and monitoring of quarantined persons can be carried out effectively
- whether adequate systems are in place for waste and wastewater management

The following documents provide further guidance regarding quarantine of persons.

- [WHO; Considerations for quarantine of individuals in the context of containment for coronavirus disease \(COVID-19\)](#)

- [WHO; Key considerations for repatriation and quarantine of travelers in relation to the outbreak of novel coronavirus 2019-nCoV](#)
- [WHO; Preparedness, prevention and control of coronavirus disease \(COVID-19\) for refugees and migrants in non-camp settings](#)

SCREENING E&S RISKS OF TREATMENT CENTERS

WHO has published a manual that provides recommendations, technical guidance, standards and minimum requirements for setting up and operating severe acute respiratory infection (SARI) treatment centers in low- and middle-income countries and limited-resource settings, including the standards needed to repurpose an existing building into a SARI treatment center, and specifically for acute respiratory infections that have the potential for rapid spread and may cause epidemics or pandemics.

- [WHO Severe Acute Respiratory Infections Treatment Centre](#)
- [WHO Covid-19 Technical Guidance: Infection prevention and control / WASH](#)
- [WBG EHS Guidelines for Healthcare Facilities](#)

SCREENING E&S RISKS RELATING TO LABOR AND WORKING CONDITIONS

A COVID-19 project may include different types of workers. In addition to regular medical workers and laboratory workers who would normally be classified as direct workers, the project may include contracted workers to carry out construction and community workers (such as community health volunteers) to provide clinical support, contact tracing, and data collection, etc. The size of the workforce engaged could be considerable. Risks for such a workforce will range from occupational health and safety to types of contracts and terms and conditions of employment. Further details relevant to labor and working conditions for COVID-19 projects are discussed in the [LMP template for COVID-19](#).

ANNEX 4 – Guidance Note for Incorporation of the ESMP into Contract Documents

The purpose of the annex is to provide guidance on the integration of the ESMPs into the contract documents of the Project/Subproject.

Environment and Social requirements in the Pre-bid Documents

1. The PIU (MoH) issues the pre-bid documents to shortlist a few contractors, based on their expression of interest and capability. While details on environmental and social requirements may not be required in the pre-bid stage, it is useful to mention that the contractor is expected to have good environmental and social management capability or experience.

Incorporating the ESMP in the Bid Document

2. The PIU (MoH) issues the bid documents to the pre-qualified contractors. There are two kinds of bid documents: International Competitive Bids (ICB) and National Competitive Bids (NCB). In World Bank projects, these documents are prepared based on templates (separate for ICB and NCB) provided by the Bank. The ICB documents are based on the FIDIC (International Institute of Consulting Engineers) guidelines, while the NCB is closer to the national contracting procedures. The bid documents contain separate volumes. For instance, a typical ICB document contains: (i) General Conditions of Contract, which is based on the FIDIC; (ii) Technical Specifications, which is based on the applicable specifications in Eswatini for similar related works; (iii) Bill of Quantities and (iv) Drawings.
3. The ESMP parts/sections should be included in the relevant locations of the bid documents in the following way:
 - a. *Mitigation/enhancement measures & monitoring requirements tables* - The cross-reference to these tables should be included in the “conditions of particular application (COPA)”, which is a part of the General Conditions of Contract. As a standard practice, there is an over-all reference to the laws that have to be followed in this section/item. The relevant laws need to be mentioned here. In addition, the adherence to the mitigation/enhancement measures and table on monitoring requirements should be included. The two tables will have to be added as Annexes or the entire ESMP (without cost and drawings) as a whole should be attached. Either the Annexes or the appropriate section in the ESMP should be cross-referred in the description of this item.
 - b. *Modifications/additions to the technical specifications* - Due to the mitigation/enhancement measures included in the ESMP, there may be (a) additions/alterations required to the applicable specifications and/or (b) there may be a need to add new specification/s. These are to be referred in the section on “Supplementary Specifications” in the Technical Specifications Volume of the bid document. However, changes and additions to these specifications may be made through the inclusion of a section “Supplementary Specifications.” This section should also include additional technical specifications related to the ESMP or should provide a cross-reference to the specific section of the ESMP.
 - c. *Cost table* - All the items in the ESMP cost table relevant to the contractor have to be referred in the Bill of Quantities (BoQ) table, which is a separate volume of the bid documents. It is to be noted that the BoQ table in the bid document includes the various tasks to be done by the contractor under difference environmental and social risks and impacts rating. Against each task, the contractor will have to indicate a unit rate while completing the bid documents.

- d. *Drawings* - All ESMP drawings are to be reflected in the “Drawings” volume of the Bid document. If the drawings are included in the ESMP, then a cross-reference should be provided in the Drawings Volume.

Developing the ESMP to suit the bid/contract document

- 4. As one of the intentions is to integrate the ESMP requirements into the bid documents/contract Agreement, the ESMP should be developed keeping the following in mind:
 - a. *Mitigation/enhancement measures:* In the Mitigation/Enhancement Measure table, the text describing each measure should not include/repeat what is already covered under the technical specification/s, and this should only be cross-referenced. The text should be short, clear and succinct. The description should focus on ‘what’ and ‘where’ of the mitigation / enhancement measure as the ‘how’ of the measure is covered under the specification.
 - b. *Monitoring requirements table:* There are certain monitoring requirements for the contractor. While developing the Monitoring Requirement table, those that pertain to the contractor should be clearly mentioned.
 - c. *Technical specifications:* The modifications to the specifications and the additional specifications should be separately listed. These should be included as an Annex in the ESMP. The (added or modified) technical specifications should be adequately detailed to avoid problems (including that of interpretations) at site.
 - d. *Drawings:* The modifications to the drawings and the additional drawings should be included as an Annex in the ESMP. It is important to note that all drawings included/ added should be ‘execution drawings’ detailed as per requirement of the particular item so as to execute at site with adequate quality control and workmanship. Also, it is important to note that the quality of BoQ [or cost estimate] and technical specifications part of the contract document depends on the degree of detailing in the drawings.
 - e. *Cost table:* The items pertaining to the contractor should be clearly separated from the expenditures that are to be incurred by the MoH, supervision consultant and/or any other agency/organization.
 - f. *Timing for finalizing ESMP:* It is best to finalize the ESMP before the finalizing the bid documents. This is required to fully reflect the sections of the ESMP relevant to the contractor in the bid document and to ensure its proper integration.

Other Notes

Once the completed bids have been received from prospective contractors, the MoH makes a decision based on the costs and the technical merit of the bids. Following the decision, the implementing agency and the chosen contractor sign and countersign the completed bid documents. It becomes the contract agreement thereafter. If issues have been missed in the bid documents, it cannot be amended at the time of signing the contract agreement stage unless there is a really strong justification for the same. If there is an ESMP cost item that is not reflected in the BoQ of the signed contract agreement, the supervision consultant/engineer may issue a variation order, if such case has merit. Contractor will quote a rate and the task gets done. This issue of variation orders is a standard practice and can be used, if found necessary. However, the intent of the good contracting practices should be to minimize variation orders and therefore ESMP should be carefully prepared and integrated in the bid document.

ANNEX 5 – Archaeological Chance Finds Procedure

1.0 INTRODUCTION

The purpose of the Archaeological Chance Finds Procedure is to address the possibility of archaeological deposits, finds and features becoming exposed during earthmoving and ground altering activities that will be associated with the Project and to provide procedures to follow in the event of a chance archaeological find.

The objectives of these procedures are to identify and promote the preservation and recording of any archaeological material that may be discovered and notify the relevant authority and the EEA to resolve any archaeological issue that may arise.

2.0 ARCHAEOLOGICAL CHANCE FINDS PROCEDURE

During the project induction meeting/training, all contractors/construction teams will be made aware of the need to be on the lookout for objects of archaeological interest as they carry out their earthmoving and excavation activities.

Generally, the following procedure is to be executed in the event that archaeological material is discovered:

- All construction activity in the vicinity of the find/feature/site will cease immediately.
- The discovered find/ feature/ site will be delineated immediately.
- Record the find location, and make sure all remains are left in place.
- Secure the area to prevent any damage or loss of removable objects.
- Contact, inform and notify the EEA immediately.
- The Authorities so notified will use an archaeologist.
- The archaeologist will assess record and photograph the find/feature/ site.
- The archaeologist will undertake the inspection process in accordance with all project health and safety protocols under direction of the EEA.
- In consultation with the EEA authorities, the Archaeologist will determine the appropriate course of action to take.
- Finds retrieval strategy: All investigation of archaeological soils will be undertaken by hand, all finds, osteological remains and samples will be kept and submitted to the National Museum as required. In the event that any artefacts need to be conserved, the relevant license will be sought from the EEA.
- An on-site office and finds storage area will be provided, allowing storage of any artefacts or other archaeological material recovered during the monitoring process.
- In the case of human remains, in addition to the above, the Local Leadership will be contacted and the guidelines for the treatment of human remains will be adhered to. If skeletal remains are identified, an osteoarchaeologist will be available to examine the remains.
- Conservation: A conservator should be made available to the project, if required.
- The on-site archaeologist will complete a report on the findings as part of the licensing agreement in place with the EEA.
- Once authorization has been given by the responsible statutory authorities, the client will be informed when works can resume.

ANNEX 6 – Labor Management Procedures

List of Abbreviations

CoC	Code of Conduct
CMAC	Conciliation, Mediation and Arbitration Commission
EHO	Environmental Health Office
ESMF	Environmental and Social Management Framework
GBV	Gender Based Violence
GOs	Eswatini Government General Orders
GRM	Grievance Redress Mechanism
HCWM	Healthcare Waste Management
HIRA	Hazard Identification and Risk Assessment
ICWMP	Infection Control and Medical Waste Management Plan
ILO	The International Labour Organization
LMP	Labour Management Procedures
MCH	Maternal Child Health
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
NCDs	Non-Communicable Diseases
OH&S	Occupational Health and Safety
PIU	Project Implementation Unit
PMT	Project Management Unit
SEA	Sexual Exploitation and Assault
SHE	Safety, Health and Environment
SHEQ	Safety, Health, Environment and Quality
SODV	Sexual Offences and Domestic Violence

INTRODUCTION

This Labour Management Procedures (LMP) was developed by the Eswatini Ministry of Health to manage risks under the *Health System Strengthening for Human Capital Development in Eswatini Project* (P168564) funded by the World Bank. The same LMP will be used for the COVID-19 Emergency Response Project as both projects are implemented by the Ministry of Health and share many of the same institutional arrangements. The two projects share many of the same staff and the LMPs should be consistent between the two projects.

Overview of Labour Use in the Project

The project supports: (i) strengthening COVID-19 case detection, confirmation, case tracing, recording and reporting; (ii) health systems strengthening for COVID-19 preparedness planning; and (iii) improving the implementation of social distancing measures and strengthening communication preparedness. The project is expected to use direct workers and contracted workers. Most activities supported by the project will be conducted by direct workers of the Project, such as health and laboratory technicians, i.e., civil servants employed by the Ministry of Health. The project may outsource minor civil works to contractors for activities such as constructing minor civils works. While the number of workers cannot be estimated at the current stage, no significant labor influx is expected.

The LMP applies to all Project workers whether full-time, part-time, or temporary. The LMP is applicable, as per ESS2, to the Project in the following manner:⁴⁷

- People employed or engaged directly by Eswatini Ministry of Health to work specifically on the Project, including healthcare workers within hospitals and healthcare facilities supported under the project;⁴⁸
- People employed or engaged by contractors to perform work related to core function of the project, regardless of location;
- People employed or engaged by the Eswatini Ministry of Health's primary suppliers.

In terms of labor requirements, the MoH and/or contractors engaged by MoH, will identify relevant staff needs as per the components of the project as specific activities are identified and clarified. This LMP will be updated accordingly. Currently, the following labor needs are identified as reflected below.

Labour Requirements: Operation of Health Facilities and Clinics

The project includes support for the operation of health facilities through the deployment and operation of biomedical equipment and supplies for hygiene and sanitation to supplement COVID-19 healthcare readiness in hospitals and health facilities, including patient monitors, ICU beds, oxygen concentrators, waste skips, and disinfectants. Healthcare services to deploy this biomedical equipment and supplies will be conducted by healthcare workers at hospitals and healthcare facilities.

The hospitals and facilities where this equipment will be deployed include: Lubombo referral hospital designated for the treatment of covid-19 patients, RFM hospital to increase ICU capacity, as well as other

⁴⁷ The project will not engage community labor or security forces. Government civil servants, who may provide support to the Project, will remain subject to the terms and conditions of their existing public sector employment agreement or arrangement.

⁴⁸ Eswatini Ministry of Health staff, including Project staff and consultants, will remain subject to the terms and conditions of currently in place laws of Eswatini. These conditions are outlined in the LMP.

selected sites as deemed necessary for the delivery of critical medical services and to cope with increased demand of services posed by the outbreak.

Assessment of Key Potential Labour Risks

The main labor risks associated with the project are assessed to be related to worker health and safety and the potentially hazardous work environment and the associated risk of accidents for construction works. Even though labor influx is not anticipated, social impacts such as GBV, sexual exploitation and communicable diseases for local communities cannot be ruled out. Based on current conditions in the sector, it is assessed that the risk of child or forced labor is negligible, and already managed through national legislation and Eswatini Government General Orders (GOs).

The ESMP will include labor related clauses, GBV risk management measures and preventive health measures. The contractors' contracts will include specific clauses prioritizing recruitment of unskilled local labor and will take into account social and environmental mitigation measures (making reference to the ESMPs and the WBG EHSOs). Any civil works contracts will include the EHSOs, good international practice, and industry standard Codes of Conduct that address OHS risks and include measures to prevent GBV/SEA. The LMP also includes guidance on the worker specific GRM (for direct and contract workers).

Community Health and Safety: While the anticipated construction works (rehabilitation of wastewater facilities, sanitation) has a small footprint, the MOH will consider the incremental risks of the public's health and safety and potential exposure to operational accidents. As there might be minimal construction works, labor influx is not anticipated, the Project ESMP as well as the LMP includes clauses to avoid, minimize, manage and mitigate any SEA and GBV risks. Additionally, the MOH recognizes its responsibility to monitor GBV/SEA risk throughout the project cycle.

Should there be any rehabilitation of waste management and sanitation facilities, these may expose neighboring communities to noise and dust pollution, increased traffic and road accidents (if there is unusual movement of transport of materials). However, the ESMP and its associated ESMP, will provide guidance on how impacts on the community will be managed. While the construction works will take place in an existing footprint, the MOH will pursue preventative safety measures through risk assessment and strive to reduce occupational accidents on a continual basis.

Labour Influx: The Project footprint is relatively small and not likely to engage a significant amount of labor. The majority of labor will be already existing health workers in health facilities. The Eswatini Ministry of Health's existing operational procedure is to mandate and localize the economic benefits and only allow for outside, including expatriate labor where there is a requirement for special skills. External workers, which will be few in number, will be accommodated at existing housing in the area which has been prior practice by the Eswatini Ministry of Health in similar projects.

Overview of Labour Legislation: Terms and Conditions

There are three main pieces of legislation in Eswatini which regulate the terms and conditions of employment, namely: The Employment Act 5, 1980; The Industrial Relations Act 2000 (as amended); and the Wages Act 16, 1964. For all civil servants, the code of conduct is enshrined in the Eswatini General Orders of April 1973, the Civil Service regulations Act, Occupational Health and Safety Act of 2001, Public Service Act 1963 and the Public Health Act of 1969.

The Employment Act provides for the basic conditions of employment with a view of improving the status of employees in Eswatini. The Act makes it mandatory for employers to furnish employees with written particulars of employment stating hours of work, wages, leave entitlements, job description, grievance procedure, benefits if any, etc. It further mandates the Ministry responsible to issue Wage Regulations on a regular basis which deal with worker's terms and conditions for each particular industry. It is in this

legislation where you will find provisions regulating contracts of employment, leave entitlements, protection of wages (prohibition against unlawful deductions), retrenchment procedures, and fair and unfair reasons for termination of employment

The Industrial Relations Act 2000 (as amended) is the main Act which provides for the collective negotiation of terms and conditions of employment in the workplace (i.e., negotiations between employers and trade unions, and the dispute resolution mechanism). There are three specialized forums for dealing specifically with labor issues in Eswatini: The Conciliation Mediation and Arbitration Commission (CMAC), The Industrial Court and the Industrial Court of Appeal.

The Wages Act 16, 1980, deals specifically with the minimum wages and basic terms and conditions of employment in virtually all sections of economic activity in Eswatini, be it in retail, manufacturing, agriculture or building and construction industry. The Eswatini Ministry of Health requires Contractors to comply with the most current Wages Regulations Order for Building and Construction as issued by the Minister from time to time.

The Public Service Act of 1963 (part V) deals with all disciplinary control and proceedings for Civil Servants. The Public Health Act, 1969 provides for the establishment of processes to ensure public health at all phases of a project. It also provides for steps to take should there be any incident from the project affecting the public and lays out responsibilities for actions to be taken.

The Occupational Health and Safety Act 2001, is an Act to provide for the safety and health of persons at work and at the workplace and for the protection of persons other than persons at the workplace against hazards to safety and health arising out of or in connection with the activities of persons in the workplace and to provide for other matters incidental thereto.

[Overview of Labor Legislation: Occupational Health and Safety](#)

The Occupational Health and Safety Act 9, 2001 provides for the safety and health of persons at work and at the workplace and for the protection of persons other than persons at the workplace against hazards to safety and health arising out of, or in connection with, the activities of persons in the workplace and to provide for other matters incidental thereto. This Act obligates the employer to ensure the safety and health of all its employees, and also to mitigate risks of exposure to any hazards in the workplace. The legislation makes it mandatory for employers to provide personal protective clothing or equipment to employees exposed to wet, dusty, noisy or any conditions that might expose the employees to harsh or dangerous conditions. Employees are to be trained to perform their work in order to avoid exposure to danger or injury and to be informed of any known hazards or diseases. The Eswatini Ministry of Health is committed to:

- Complying with legislation and other applicable requirements which relate to the company's occupational health and safety hazards.
- Enabling active participation in OH&S risks elimination through promotion of appropriate skills, knowledge and attitudes towards hazards.
- Continually improving the OH&S management system and performance.
- Communicating this policy statement to all persons working under the control of Eswatini Ministry of Health with emphasis on individual OH&S responsibilities.
- Availing this policy statement to all interested parties at all MoH facilities and sites.⁴⁹

⁴⁹ Eswatini Ministry of Health's S-S-SH-D-01_Occupational Health and Safety Policy Statement (1)

- Under current Occupational Health and Safety Act (2001), any contractor is required to have at least one Safety, Health and Environmental Representative for the workplace or a section of the workplace for an agreed period in accordance with Section 14 of the Eswatini Occupational Safety and Health Act (2001). At a minimum, the Representative must:
- Identify potential hazards;
- In collaboration with the employer, investigate the cause of accidents at the workplace;
- Inspect the workplace including plant, machinery, substance, with a view to ascertaining the safety and health of employees provided that the employer is informed about the purpose of the inspection;
- Accompany an inspector whilst that inspector is carrying out the inspector's duties in the workplace;
- Attend meetings of the safety and health committee to which that safety and health representative is a member;
- Make recommendations to the employer in respect of safety and health matters affecting employees, through a safety and health committee; and
- Where there is no safety and health committee, the safety and health representatives shall make recommendations directly to the employer in respect of any safety and health matters affecting the employees.

Eswatini Ministry of Health further has specific requirements related to first aid provisions. In accordance with these provisions, and to avoid work related accidents and injuries, the contractor will:

- Provide occupational health and safety training to all employees involved in works. Provide protective masks, helmet, overall and safety shoes, and safety goggles, as appropriate.
- Provide workers in high noise areas with earplugs or earmuffs.
- Ensure availability of first aid box.
- Provide employees with access to toilets and potable drinking water.
- Provide safety and occupational safety measures to workers with Personal Protection Equipment PPE when installing pumps to prevent accidents during replacement and installation and follow safety measures in installing submersible pump and cleaning the raiser pipes.

Further to enforcing the compliance of environmental management, contractors are responsible and liable of safety of site equipment, labors and daily workers attending to the construction site and safety of citizens for each subproject with the work they do.

[Responsible Staff and Procedures](#)

The overview of responsible staff and oversight mechanisms will be described in further detail in the Project ESMP which is currently being drafted.

The Eswatini Ministry of Health's Project Management Unit has the overall responsibility to oversee all aspects of the implementation of the LMP, in particular to ensure contractor compliance. The Eswatini Ministry of Health will address all LMP aspects as part of procurement for works as well as during contractor induction. The contractor is subsequently responsible for management of labor issues in accordance with contract specific Labor Management Plans, implementation of which will be supervised by the Eswatini Ministry of Health's Project Management Unit on a monthly basis or at shorter intervals as defined by specific Plans. The detailed approach is described in the following sections.

Healthcare Worker Occupational Health and Safety. The Ministry must deploy one Environmental Health Officer in each regional hospital. Among his/her responsibilities will be to ensure the implementation and compliance to occupational health and safety requirements. The healthcare facilities must formulate

comprehensive OHS programs, establish safety representatives for day-to-day monitoring of safety requirements, recording and reporting all incidents accordingly to the Ministry.

Healthcare Worker Labor and Working Conditions. Government civil servants, who may provide support to the Project, will remain subject to the terms and conditions of their existing public sector employment agreement or arrangement (General Orders). In addition to these the Coronavirus (COVID-19) regulations 2020 will also apply. This is detailed in the Overview of Labour Legislation above.

Contractors Occupational Health and Safety. Contractors must engage a minimum of one safety representative. Smaller contracts may permit for the safety representative to carry out other assignments as well. The safety representative ensures the day-to-day compliance with specified safety measures and records of any incidents. Minor incidents are reported to the Eswatini Ministry of Health on a monthly basis; serious incidents are reported immediately. Minor incidents are reflected in the quarterly reports to the World Bank; major issues are flagged to the World Bank immediately.

Contractor Labor and Working Conditions. Contractors will keep records in accordance with specifications set out in this LMP. The Eswatini Ministry of Health may at any time require records to ensure that labor conditions are met. The Project Management Unit will review records against actuals at a minimum on a monthly basis and can require immediate remedial actions if warranted. A summary of issues and remedial actions will be included in quarterly reports to the World Bank.

Worker Grievances. The Eswatini Ministry of Health's procedures currently in place will remain for Project staff. Contractors will be required to present a worker grievance redress mechanism which responds to the minimum requirements in this LMP. The Project Management Unit's Social Officer will review records on a monthly basis. Where worker concerns are not resolved, the national system will be used as set out in the section, but the Project Management Unit will keep abreast of resolutions and reflect them in quarterly reports to the World Bank.

Additional Training. Contractors are required to, at all times, have a qualified safety officer on board. If training is required, this will be the contractor's responsibility. The safety officer will provide instructions to contractor staff. Eswatini Ministry of Health will procure for training to address risks associated with labor influx and will provide a schedule for trainings required. The contractor will be obligated to make staff available for this training, as well as any additional mandatory trainings required by Eswatini Ministry of Health, as specified by the contract.

[Policies and Procedures](#)

Most environmental and social impacts of subprojects resulting from activities directly under the control of contractors will be mitigated directly by those same contractors. As a consequence, ensuring that contractors effectively mitigate project activities related impacts is the core of the Project's approach. The Eswatini Ministry of Health will incorporate standardized environmental and social clauses in the tender and contract documents in order for potential bidders to be aware of environmental and social performance requirements that will be expected of them and are able to reflect that in their bids and required to implement the clauses for the duration of the contract. The Eswatini Ministry of Health will enforce compliance by contractors.

As a core contractual requirement, the contractor is required to ensure all documentation related to environmental and social management, including the LMP, is available for inspection at any time by the Eswatini Ministry of Health or Eswatini Ministry of Health appointed agents. The contractual arrangements with each project worker must be clearly defined in accordance with Eswatini law. A full set of contractual requirements related to environmental and social risk and impact management will be provided in the Projects' Environmental and Social Impact Assessment. All environmental and social

requirements will be included in the bidding documents and contracts in addition to any additional clauses, which are contained, in the Projects environmental and social instruments.

Under no circumstances will the Ministry, Contractors, suppliers or sub-contractors engage forced labor. Forced labor includes bonded labor (working against an impossible debt), excessive limitations of freedom of movement, excessive notice periods, retaining the worker's identity or other government-issued documents or personal belonging, imposition of recruitment or employment fees payable at the commencement of employment, loss or delay of wages that impede the workers' right to end employment within their legal rights, substantial or inappropriate fines, physical punishment, use of security or other personnel to force or extract work from project workers, or other restrictions that compel a project worker to work on a non-voluntary basis.

Labor Influx and Gender Based Violence

Contractors will need to maintain labor relations with local communities through a code of conduct (CoC). The CoC commits all persons engaged by the contractor, including sub-contractors and suppliers, to acceptable standards of behavior. The CoC must include sanctions for non-compliance, including non-compliance with specific policies related to gender-based violence, sexual exploitation and sexual harassment (e.g., termination). The CoC should be written in plain language and signed by each worker to indicate that they have:

- Received a copy of the CoC as part of their contract;
- Had the CoC explained to them as part of induction process;
- Acknowledged that adherence to this CoC is a mandatory condition of employment;
- Understood that violations of the CoC can result in serious consequences, up to and including dismissal, or referral to legal authorities.
- A copy of the CoC shall be displayed in a location easily accessible to the community and project affected people. It shall be provided in English and SiSwati.
- Contractors must address the risk of gender-based violence, through:
 - Mandatory training and awareness raising for the workforce about refraining from unacceptable conduct toward local community members, specifically women. Training may be repeated;
 - Informing workers about national laws that make sexual harassment and gender-based violence a punishable offence which is prosecuted;
 - Adopting a policy to cooperate with law enforcement agencies in investigating complaints about gender-based violence;
 - Developing a system to capture gender-based violence, sexual exploitation and workplace sexual harassment related complaints/issues.

This process will be under the portfolio of the Social Standards Officer to be recruited in the PIU and shall identify and engage the relevant stakeholders on GBV and HIV/AIDS related issues.

Age of Employment

Eswatini ratified both the ILO Minimum of Age Convention (C138) and the ILO Worst Forms of Child Labour Convention (C182) in 2002. It also signed the African Charter on the Rights and Welfare of the Child in 1992 but has not yet ratified it. Section 97 of the Employment Act applies minimum age protections to children working in industrial undertakings, but it does not cover children working in domestic and agricultural work. Similarly, Section 246 of the Children's Protection and Welfare Act 6, 2012 prohibits hazardous work for children under the age of 18 in industrial undertakings, including in mining, manufacturing, and electrical work.

The minimum age of employment for this project shall be 18 years and to ensure compliance, all employees will be required to produce National Identification Cards (which is the national identification document required for employment) as proof of their identity and age.

If any contractor employs a person under the age of 18 years, that contractor's will not only be terminated by Eswatini Ministry of Health but also be reported to the authorities. Section 248 of the Children's Protection and Welfare Act states that any person who employs underage children will be liable on conviction to a minimum fine of E100,000.00 or 5 years' imprisonment or both for a first offender. For a second offender, it is imprisonment of not less than 10 years.

Terms and Conditions

As stated in section 3 of this LMP the terms and conditions of employment in Eswatini are governed by the provisions of The Employment Act 5, 1980. Section 22 of the Act makes it mandatory for employers to give its employees a copy of the written particulars of employment (Appendix 2), signed by both parties within six weeks of employment. This requirement however is not applicable to employees engaged for a fixed period of less than six weeks or anyone expected to work less than 21 hours per week. For this project, contractors will be required to provide all its employees with written particular of employment, including those excluded by the provision of S.22 and casual employees.

Contractors will also be required to comply with the most current Regulation of Wages Order for the Building and Construction Industry which is issued by the Government and reviewed on a regular basis. The Wages Order specifies the minimum wages, hours of work, overtime pay, leave entitlements, travelling and subsistence allowances, and the issue of protective clothing.

Section 136 of the Act states that before a contractor is awarded a public contract, that contractor is required to certify in writing that the wages, hour and conditions of work or persons to be employed by him on the contract are not less favorable than those contained in the most current wages regulation issued by the Labour Commissioner. Where a contractor fails to comply with this requirement, Section 143 states that the contract with the contractor may be withdrawn as an approved contractor upon recommendations of the Labour Commissioner. In ensuring full compliance with the law in this regard, contractors will be required to furnish the Eswatini Ministry of Health with copies of the Written Particulars of Employment or copies of the contract of all its workforce. Contractors will not be allowed to deploy any employee to work in the project if such copy of employment of that employee has not been given to the Eswatini Ministry of Health.

As a monitoring mechanism, Section 139 of the Act provides that a contractor shall not be entitled to any payment unless he has filed, together with his claim for payment, a certificate: a) stating whether any wages due to employees are in arrears; b) stating that all employment conditions of the contract are being complied with. Section 141 authorizes the office of the Labour Commissioner to intervene if the contractor defaults in the payment of wages due to any of its employees by arranging for the payment of the wages to the employee out of the sum payable to the contractor. However, for this project, it will be a material term of the contract to allow the Eswatini Ministry of Health to withhold payment from the contractor should the contractor not fulfill their payment obligation to their workers.

Worker's Organization

The country has ratified the numerous ILO Conventions aimed at ensuring that member states protect the notion of collective bargaining. These Conventions include ILO Convention 87 on Freedom of Association and Protection of the Right to Organize and ILO Convention 98 on the Right to Organize and Collective Bargaining. Section 32 (2) of The Constitution of Swaziland, 2005 on the Rights of Workers, guarantees all workers of their right to freely form, join or not join a trade union for the promotion and

protection of the economic interest of that worker; and collective bargaining and representation. The Industrial Relations Act 2000 (as amended) was enacted to give effect to the collective bargaining, amongst other purposes. Section 4 (c) to (e) of the act allows for the collective negotiation of terms and conditions of employment.

The Eswatini Ministry of Health provides employees with the right to join and form an organization for purpose of labor representation. Presently the Eswatini Ministry of Health has signed Recognition Agreements with the National Public Services and Allied Workers Union (NAPSAWU) and the Eswatini Nursing Association (ENA).

Disciplinary Procedures and Grievance Mechanism

In any working environment it is essential for both employers and employees to be fully conversant with all aspects of disciplinary processes, the grievance handling procedures and the legal requirements and rights involved. In implementing an effective dispute management system consideration must be given to the disputes resulting from the following:

- Disciplinary action
- Individual grievances
- Collective grievances and negotiation of collective grievances
- Gender-based violence, sexual exploitation and workplace sexual harassment

Disciplinary Procedure

The starting point for all disciplinary action is rules. These rules may be implied or explicit and will vary from workplace to workplace. Some rules are implied in the contract of employment (e.g. rule against stealing from the employer), however it is advisable that even implied rules be included in the disciplinary code or schedule of offences. In an organized workplace these rules ideally are negotiated with the trade union and are often included in the Recognition Agreements signed by the employer and trade union.

In terms of Clause 6 of the Code of Good Practice: Termination of Employment, these workplace rules must be:

- Valid or reasonable;
- Clear and unambiguous;
- The employee is aware, or could reasonably be aware of the rule or standard; and
- The procedure to be applied in the event the employee contravenes any of these rules
- The Code of Good Practice: Resolution of Disputes at the Workplace which, in terms of S.109 of The Industrial Relations Act 2000 (as amended) at Clause 4.2, requires employers to establish a fair and effective disciplinary procedure in the workplace, which should be in line with Clause 11
- (Fair Procedure). The procedure is as follows: -
- Conduct an investigation to determine whether there are grounds for a hearing to be held;
- If a hearing is to be held, the employer is to notify the employee of the allegations using a form and language that the employee can understand;
- The employee is to be given reasonable time to prepare for the hearing and to be represented by a fellow employee or a union representative;
- The employee must be given an opportunity to respond to the allegations, question the witnesses of the employer and to lead witnesses;
- If an employee fails to attend the hearing the employer may proceed with the hearing in the absence of the employee;

- The hearing must be held and concluded within a reasonable time and is to be chaired by an impartial representative;

If an employee is dismissed, he/she must be given the reasons for dismissal and the right to refer the dispute concerning the fairness of the dismissal to the Conciliation, Mediation and Arbitration Commission (CMAC).

Therefore, it is incumbent upon the Contractors to ensure that they have a disciplinary procedure and Code and standards which the employees are aware of. Each contractor will be required to produce this procedure to ensure that employees are not treated unfairly.

Individual Grievance Procedure

Clause 4.3 of the Code of Good Practice: Termination of Employment requires every employer, including contractors, to have a Formal Grievance Procedure which should be known and explained to the employee.

The Code recommends that such procedure should at least:

- Specify to whom the employee should lodge the grievance;
- Refer to time frames to allow the grievance to be dealt with expeditiously;
- Allow the person to refer the grievance to a more senior level within the organization, if it is not resolved at the lowest level;
- If a grievance is not resolved the employee has the right to lodge a dispute with CMAC.

All the contractors who will be engaged for the project will be required to produce their grievance procedure as a requirement for tender which at a minimum comply with these requirements. In addition, good international practice recommends that the procedures be transparent, is confidential, adheres to non-retribution practices and includes the right to representation. After they are engaged, they will be required to produce proof that each employee has been inducted and signed that they have been inducted on the procedure.

Collective Grievances and Disputes Resulting from the Negotiations of Collective Agreements

Where a trade union is recognized, it is entitled to negotiate on a regular basis with the employer over terms and conditions existing at the workplace and the employer is obliged to negotiate with it. The procedures followed in such instances is usually contained in the Recognition Agreement, which states how the issues are raised, the procedure for negotiations, the composition of the parties involved in the negotiation and the procedure to deal with issues that are not resolved through consensus. Clauses 4.4 and 4.5 of the Code deals with the handling of collective grievances as raised by the employees.

In the type of disputes, if the dispute is not resolved at the workplace, the parties to the dispute can utilize the dispute resolutions mechanisms provided for in the labor legislation.

For civil servants, the Public Service Act of 1963 (Part V (B)) which deals with disciplinary proceedings is also included.

Gender-based Violence, Sexual Exploitation and Workplace Sexual Harassment

Violence and harassment in the work world deprives people of their dignity, is incompatible with decent work, and a threat to equal opportunities and to safe, healthy, and productive working environments. It remains a widespread phenomenon, present in all countries and disregarding sectors, occupations and workplace arrangements. Convention No. 190 and Recommendation No. 206 recognizes the right of everyone to a world of work free from violence and harassment, including gender-based violence and harassment.

Contractor Management

The Eswatini Ministry of Health requires that contractors monitor, keep records and report on terms and conditions related to labor management. The contractor must provide workers with evidence of all payments made, including social security benefits, pension contributions or other entitlements regardless of the worker being engaged on a fixed term contract, full-time, part-time or temporarily. The application of this requirement will be proportionate to the activities and to the size of the contract, in a manner acceptable to the Eswatini Ministry of Health and the World Bank.

Labor conditions: records of workers engaged under the Project, including contracts (see Appendix 2 for Eswatini requirements), registry of induction of workers including CoC (see section 6.2), hours worked, remuneration and deductions (including overtime), collective bargaining agreements.

Safety: recordable incidents and corresponding Root Cause Analysis (lost time incidents, medical treatment cases), first aid cases, high potential near misses, and remedial and preventive activities required (for example, revised job safety analysis, new or different equipment, skills training, and so forth).

Workers: number of workers, indication of origin (expatriate, local, nonlocal nationals), gender, age with evidence that no child labor is involved, and skill level (unskilled, skilled, supervisory, professional, management).

Training/induction: dates, number of trainees, and topics.

Details of any security risks: details of risks the contractor may be exposed to while performing its work—the threats may come from third parties external to the project.

Worker grievances: details including occurrence date, grievance, and date submitted; actions taken and dates; resolution (if any) and date; and follow-up yet to be taken—grievances listed should include those received since the preceding report and those that were unresolved at the time of that report.

Every Safety File is 'site-specific'. It will be compiled following the client's and the site's safety specifications. The overall information requirements remain the same, and the site-specific documents will be added. When Health and Safety File is set up, it will consist of the following Documents:

- Contractor appointment letter. (Construction Regulation 5(3)(f) of the OHS A) 37(2) Agreement between client and contractor
- Notification of Construction Work
- Copy of the OHS Act
- Occupational Health and Safety Management Plan
- Company Occupational Health and Safety Policy
- Letter of Good Standing
- Material Safety Data Sheets for hazardous materials used (if required)
- Tax Clearance Certificate
- Risk Assessments
- Safe work procedures (Site Specific)
- Fall Protection Plan (if required)
- Legal appointment with proof of training (Ex. Chief Executive Officer, Risk Assessor, First Aider, etc.)
- Incident Reporting Procedures
- Incident Reports (General Administrative Regulation 9 (3) – Annexure 1)

- Incident Registers
- Reports of Accidents
- Emergency Preparedness Documents
- First Aid Documents
- Induction Records
- Medical Surveillance Records
- Safety Communication (e.g. Toolbox talks)
- Minutes of Safety Meetings
- Inspection Registers

Community Workers

The project will not engage community workers. Community workers are not currently used by the Eswatini Ministry of Health in any projects due to the specialized labor needs required.

Primary Supply Workers

This section addresses labor management risk associated with people employed or engaged by Eswatini Ministry of Health's primary suppliers. Primary suppliers are suppliers who, on an onGOKEng basis, provide goods or materials directly to the Project.

The project will require procurement of a substantial amount of materials, include protection and control equipment, power-poles, steel products, etc. The risk associated with primary supply associated with the Project is assessed below. All primary suppliers are formal businesses who are required to procure and produce materials subject to high standards.

Manager's Code of Conduct

Instructions: This Code of Conduct should be included in bidding documents for the civil works contractor(s) and in their contracts once hired.

The contractor is committed to ensuring that the project is implemented in such a way which minimizes any negative impacts on the local environment, communities, and its workers. This will be done by respecting the environmental, social, health and safety (ESHS) standards, and ensuring appropriate occupational health and safety (OHS) standards are met. The contractor is also committed to creating and maintaining an environment where children under the age of 18 will be protected, and where sexual abuse and sexual harassment have no place. Improper actions towards children, Violence Against Children (VAC), sexual abuse/harassment, and/or acts of Gender Based Violence (GBV) will not be tolerated by any employee, sub-contractors, supplier, associate, or representative of the company.

Staff at all levels have a responsibility to uphold the contractor's commitment. Contractors need to support and promote the implementation of the Code of Conduct. To that end, staff must adhere to this Code of Conduct and also to sign the Individual Code of Conduct.

Implementation

1. To ensure maximum effectiveness of the Code of Conduct:
 - 1.1. Prominently displaying the Code of Conduct in clear view at workers' camps, offices, and in public areas of the workspace. Examples of areas include waiting, rest and lobby areas of sites, canteen areas and health clinics.
 - 1.2. Ensuring all posted and distributed copies of the Code of Conduct are translated into the appropriate language of use in the work site areas as well as for any international staff in their native language.

2. Verbally and in writing explain the Code of Conduct to all staff, including in an initial training session.
3. Ensure that:
 - 3.1. All staff sign the 'Individual Code of Conduct', including acknowledgment that they have read and agree with the Code of Conduct.
 - 3.2. Staff lists and signed copies of the Individual Code of Conduct are provided to the OHS Manager and the MOH Focal Point.
 - 3.3. Participate in training and ensure that staff also participate as outlined below.
 - 3.4. Put in place a mechanism for staff to:
 - 3.5. report concerns on ESHS or OHS compliance; and,
 - 3.6. confidentially report GBV incidents through the Grievance Redress Mechanism
 - 3.7. Staff are encouraged to report suspected or actual ESHS, OHS, GBV, VAC issues, emphasizing the staff's responsibility in compliance with applicable laws and to the best of your abilities, prevent perpetrators of sexual exploitation and abuse from being hired, re-hired or deployed. Use background and criminal reference checks for all employees nor ordinarily resident in the country where the works are taking place.
4. Ensure that when engaging in partnership, sub-contractor, supplier or similar agreements, these agreements:
 - 4.1. Incorporate the ESHS, OHS, GBV, VAC Codes of Conduct as an attachment.
 - 4.2. Include the appropriate language requiring such contracting entities and individuals, and their employees and volunteers, to comply with the Individual Codes of Conduct.
 - 4.3. Expressly state that the failure of those entities or individuals, as appropriate, to ensure compliance with the ESHS and OHS standards, take preventive measures against GBV and VAC, to investigate allegations thereof, or to take corrective actions when GBV or VAC has occurred, shall not only constitute grounds for sanctions and penalties in accordance with the Individual Codes of Conduct but also termination of agreements to work on or supply the project.
5. Provide support and resources to create and disseminate staff training and awareness-raising strategy on GBV, VAC and other issues highlighted in the ESMF.
6. Ensure that any GBV or VAC complaint warranting Police action is reported to the Police, MOH and the World Bank immediately.
7. Report and act in accordance with the agreed response protocol any suspected or actual acts of GBV or VAC.
8. Ensure that any major ESHS or OHS incidents are reported to MOH and the supervision engineer immediately, non-major issues in accordance with the agreed reporting protocol.
9. Ensure that children under the age of 18 are not present at the construction site, engaged in any hazardous activities or otherwise employed.
10. Training
11. The managers are responsible to:
 - 11.1. Ensure that staff have a suitable understanding of the ESMF, in particular OHS aspects and COVID-19 prevention, as well as GBV and VAC and are trained as appropriate.
12. Response
13. Managers will be required to take appropriate actions to address any ESHS or OHS incidents.
14. Regarding GBV:
 - 14.1. Maintain the confidentiality of all employees who report or (allegedly) perpetrate incidences of GBV (unless a breach of confidentiality is required to protect persons or property from serious harm or where required by law).
 - 14.2. If a manager develops concerns or suspicions regarding any form of GBV by one of his/her direct reports, or by an employee working for another contractor on the same work site, s/he is required to report the case using the GRM.

- 14.3. Once a sanction has been determined by the GRM, the relevant manager(s) is/are expected to be personally responsible for ensuring that the measure is effectively enforced, within a maximum timeframe of 14 days from the date on which the decision to sanction was made by the GRM.
- 14.4. If a Manager has a conflict of interest due to personal or familial relationships with the survivor and/or perpetrator, he/she must notify the Company and the GRM. The Company will be required to appoint another manager without a conflict of interest to respond to complaints.
- 14.5. Ensure that any GBV issue warranting Police action is reported to the Police, MOH and the World Bank immediately.
15. Managers failing address ESHS or OHS incidents or failing to report or comply with the GBV provisions may be subject to disciplinary measures, to be determined and enacted by the Company. Those measures may include:
 - 15.1. Informal warning;
 - 15.2. Formal warning;
 - 15.3. Additional Training;
 - 15.4. Loss of up to one week's salary;
 - 15.5. Suspension of employment (without payment of salary), for a minimum period of 1 month up to a maximum of 6 months;
 - 15.6. Termination of employment.
16. Ultimately, failure to effectively respond to ESHS, OHS, VAC and GBV cases on the work site by the company's managers may provide grounds for legal actions by authorities.

I do hereby acknowledge that I have read the Code of Conduct, do agree to comply with the standards contained therein and understand my roles and responsibilities to prevent and respond to ESHS, OHS, VAC and GBV requirements. I understand that any action inconsistent with this Code of Conduct or failure to act mandated by this Code of Conduct may result in disciplinary action.

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Individual Code of Conduct

Instructions: This Code of Conduct should be included in bidding documents for the civil works contractor(s) and in their contracts once hired.

I, _____, acknowledge that adhering to environmental, social, health and safety (ESHS) standards, following the project's occupational health and safety (OHS) requirements, and preventing Violence Against Children (VAC) and Gender Based Violence (GBV) is important.

The Contractor considers that failure to follow ESHS and OHS standards, or to partake in activities constituting VAC or GBV—be it on the work site, the work site surroundings, at workers' camps, or the surrounding communities—constitute acts of gross misconduct and are therefore grounds for sanctions, penalties or potential termination of employment. Prosecution by the Police of those who commit GBV or VAC may be pursued if appropriate.

I agree that while working on the project I will:

1. Consent to a background check in any place I have worked for more than six months.
2. Attend and actively partake in training courses related to ESHS, OHS, COVID-19 prevention, VAC and GBV as requested by my employer.
3. Will wear my personal protective equipment (PPE) at all times when at the work site or engaged in project related activities, in particular if related to exposure to COVID-19.
4. Will follow all prevention measures relating to COVID-19, including (i) washing hands with water and soap before and after eating, when entering my work area, after sneezing/coughing, etc.; (ii) sneeze or cough on elbow and/or wash hands after sneezing/coughing; (iii) if feeling unwell or have symptoms of a cold, flu or any respiratory illness, inform manager immediately, stay at home and do not come to work.
5. Take all practical steps to implement the environmental and social management framework (ESMF).
6. Implement OHS measures.
7. Adhere to a zero-alcohol policy during work activities, and refrain from the use of narcotics or other substances which can impair faculties at all times.
8. Treat women, children (persons under the age of 18), and men with respect regardless of ethnicity, color, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.
9. Not use language or behavior towards women, children or men that is inappropriate, harassing, abusive, sexually provocative, demeaning or culturally inappropriate.
10. Not sexually exploit or abuse project beneficiaries and members of the surrounding communities.
11. Not engage in sexual harassment of work personnel and staff — for instance, making unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature is prohibited: i.e. looking somebody up and down; kissing, howling or smacking sounds; hanging around somebody; whistling and catcalls; in some instances, giving personal gifts.
12. Not engage in sexual favors —for instance, making promises of favorable treatment (i.e. promotion), threats of unfavorable treatment (i.e. loss of job) or payments in kind or in cash, dependent on sexual acts—or other forms of humiliating, degrading or exploitative behavior.
13. Not use prostitution in any form at any time.
14. Not participate in sexual contact or activity with children under the age of 18—including grooming or contact through digital media. Mistaken belief regarding the age of a child is not a defense. Consent from the child is also not a defense or excuse.
15. Unless there is the full consent by all parties involved, I will not have sexual interactions with members of the surrounding communities. This includes relationships involving the withholding or promise of actual provision of benefit (monetary or non-monetary) to community members in exchange for sex (including prostitution). Such sexual activity is considered “non-consensual” within the scope of this Code.
16. Consider reporting through the GRM or to my manager any suspected or actual GBV by a fellow worker, whether employed by my company or not, or any breaches of this Code of Conduct.

With respect to children under the age of 18:

1. Bring to the attention of my manager the presence of any children on the construction site or engaged in hazardous activities.
2. Wherever possible, ensure that another adult is present when working in the proximity of children.

3. Not invite unaccompanied children unrelated to my family into my home, unless they are at immediate risk of injury or in physical danger.
4. Not use any computers, mobile phones, video and digital cameras or any other medium to exploit or harass children or to access child pornography
5. Refrain from physical punishment or discipline of children.
6. No hiring of children for any project activity (no persons under the age of 18).

Sanctions

I understand that if I breach this Individual Code of Conduct, my employer will take disciplinary action which could include:

1. Informal warning;
1. Formal warning;
2. Additional Training;
3. Loss of up to one week's salary;
4. Suspension of employment (without payment of salary), for a minimum period of 1 month up to a maximum of 6 months;
5. Termination of employment;
6. Report to the Police if warranted.

I understand that it is my responsibility to ensure that the environmental, social, health and safety standards are met. That I will adhere to the occupational health and safety management plan. That I will avoid actions or behaviors that could be construed as VAC or GBV. Any such actions will be a breach this Individual Code of Conduct. I do hereby acknowledge that I have read the Individual Code of Conduct, do agree to comply with the standards contained therein and understand my roles and responsibilities to prevent and respond to ESHS, OHS, VAC and GBV issues. I understand that any action inconsistent with this Individual Code of Conduct or failure to act mandated by this Individual Code of Conduct may result in disciplinary action and may affect my ongoing employment.

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Appendix 1: Comparative Table of ESF and National Objectives and Requirements (General orders)

ESF Objectives	National Requirements	Recommended Actions
ESS 2 Labor and Working Conditions		
To provide every employee with written particulars of employment	The Employment Act 5, 1980 S.22 – makes it mandatory for the employer to give each of its employees a copy of the written particulars of employment, signed by both parties within six weeks of commencement of employment. This requirement is not applicable to employees engaged for a fixed period of less than six weeks or anyone expected to work less than 21 hours per week. S.30 – makes it an offence to provide an employee with such form with fine of not more than E3, 000.00 or imprisonment of not more than 1 year or both. S.136 – requires that before a contractor is awarded a public contract, that contractor is required to certify in writing that the wages, hour and conditions of work or persons to be employed by him on the contract are not less favorable than those contained in the most current wages regulation issued by the Labour Commissioner. S.143 - states that the contract with the contractor may be withdrawn as an approved contractor upon recommendations of the Labour Commissioner.	Post award, the contractors will be required to furnish MoH PIU with copies of the Written Particulars of all its employees or Contracts of employment including those who work below 21 hours a week and casual employees. The contract employment shall at least have the information contained in the prescribed template of the Form Contained in the Second Schedule as can be seen in Appendix 1 Each contractor will be required to provide MoH PIU with such information as required in terms of S.136 as part of the tendering process.
To promote safety and health at work.	The Occupational Safety and Health Act 9, 2001 - This Act provide for the safety and health of persons at work and at the workplace and for the protection of persons other than persons at the workplace against hazards to safety and health arising out of or in connection with the activities of persons in the workplace and to provide for other matters incidental thereto. S.9 – entrusts the employer to ensure the safety and health of all its employees, and also to; Mitigate risks of exposure to danger of its workforce; Provide personal protective clothing or equipment to employees exposed to wet, dusty, noisy or any conditions that might expose the employees to harsh or dangerous conditions; To train its workers to perform their work in order to avoid exposure to danger or injury; and to inform employees of any known hazards or disease associated with the work. The Factories, Machinery and Construction Works Act 17, 1972	Each contractor will be required to have a SHEQ Officer and First Aider Contractors required to keep logs of incidents and should be reported and investigated timeously.

ESF Objectives	National Requirements	Recommended Actions
	This legislation provides for the registration of factories and the regulations of working conditions and the use of machinery at factories, construction works and other premises and for matters incidental thereto The Act mandates the office of the Labour Commissioner to monitor and inspect any working environment or structure to determine its suitability. The office of the Labour Commissioner is also required to investigate incident or accident involving any person injured in connection with the activities of the employer.	
The contractor will conduct induction talks to workers and contractors weekly	The Workman's Compensation Act 7, 1983 it provides for the compensation and medical treatment of workmen who suffer injury or contract diseases in the course of their employment. The scope of its application extends to not an injury or accident that occurs within the workplace but also while the employee is travelling by reasonable means and within any reasonable route between the workplace and his place of residence In terms of the Act, Workman is any person who has entered into the works under the contract of service or of apprenticeship or of traineeship whether the contract is express or implied, is oral or in writing whether the remuneration is calculated by time or work done.	
To promote the fair treatment, nondiscrimination and equal opportunity of project workers.	The Employment Act 5, 1980 S.29 – prohibits employers from discriminating against any person on grounds of race, color, religion, marital status, sex, national origin, tribal or clan extraction, political affiliation or social status S.30 – makes it an offence to discriminate against any person as envisaged in S.29. Such employer if found guilty shall be liable on conviction to a fine not exceeding E3,000.00 or imprisonment not exceeding 1 year or both. S.96 – mandates employers to accord female employees the same treatment as their male counterparts in the workplace and also pay them 'equal pay for equal work'.	Contractors will be required to comply with national legislation when recruiting
To prevent the use of all forms of forced labor	The Employment Act 5, 1980 (Part XIV) – Forced Labour S.144 – prohibits all works or service which is extracted from any person under the threat of any penalty and for which the said person has not offered himself voluntarily. S.147 – states that, if any person acting in an official capacity coerces any person under his charge, that person shall be held personally liable and shall be liable to a fine not exceeding E3,000.00, or imprisonment not exceeding one year or both.	Contractors will be required to comply with national legislation and as precautionary measure the contractor will conduct an induction Random inspection will be done on a regular basis to ensure compliance
To prevent the use of all	The Country ratified both the ILO Minimum of Age Convention (C138) and the ILO	Contractor will be prohibited from

ESF Objectives	National Requirements	Recommended Actions
forms of child labor	Worst Forms of Child Labour Convention (C182) in 2002. It also signed the African Charter on the Rights and Welfare of the Child in 1992 but has not yet ratified it. The Employment Act 5, 1980 S.97 – Prohibits the employment of children below the age of 15. The Children’s Protection and welfare Act 6, 2012 S.234 – Minimum age of engagement for children is 15 S.236 – children below the age of 18 cannot be engaged in any form of hazardous employment S.248 – any person who employs underage children liable on conviction to a minimum fine of E100,000.00 or 5 years’ imprisonment or both for a first offender. For a second offender, it is imprisonment of not less than 10 years.	employing anyone under the age of 18 years. Monitoring will be done through the National ID system which every employee is required to produce on employment. If a contractor is found to have engaged underage kids for the project, a formal case will be reported to the police and the contract will be terminated.
To support the principles of freedom of association and collective bargaining of project workers in a manner consistent with national law.	The country has ratified the numerous ILO Conventions aimed at ensuring that member states do protect the notion of collective bargaining. These Conventions include; ILO Convention 87 on Freedom of Association and Protection of the Right to Organize and the ILO Convention 98 on the Right to Organize and Collective Bargaining. Section 32 (2) of The Constitution of Eswatini, 2005 on the Rights of Workers, guarantees all workers of their right to freely form, join or not join a trade union for the promotion and protection of the economic interest of that worker; and collective bargaining and representation. The Industrial Relations Act 2000 (as amended) was enacted to give effect to the collective bargaining, amongst other purposes. Section 4 (c) to (e) of the Act allows for the collective negotiation of terms and conditions of employment. Part 4 of The Industrial Relations Act 2000 (as amended) deals with the registration and/or formation of Employee, Staff and Employer Organizations, Federations and International Organizations. In terms of S. 26 (3) of the Act a minimum of six employees can form a trade union by obtaining a Certificate of Registration through the office of the Labour Commissioner (S.27). Once registered, a trade union can recruit any employees who falls within its bargaining unit with that particular employer. S.42 (9) states that once the union has recruited more than fifty percent of the employees in respect of which it seeks recognition, the union can then apply for recognition with the employer. The employer is obliged to recognize the trade union if it meets the required threshold. If, however the union membership is below the threshold the employer is not obliged to recognize the union but can exercise its discretion. Once a union is recognized, it has the right to bargain or negotiate for and on behalf of its members and also to represent them at the workplace.	The constructors have recognized unions, i.e., NESMASA and SESMAWU Contractors need to inform their workers of their right to organize. The Written Particulars of Employment as prescribed by S.22 of the Employment Act 1980 allows employee to state the trade union they are affiliated to on employment.
To protect project workers,	S.20 of the Constitution guarantees citizens the right to equality before the law in all	Allow the person to refer the

ESF Objectives	National Requirements	Recommended Actions
including vulnerable workers such as women, persons with disabilities, children (of working age, in accordance with this ESS) and migrant workers, contracted workers, community workers and primary supply workers, as appropriate.	spheres and it further affirms that a person shall not be discriminated against on the grounds of gender, race, color, ethnic origin, tribe, birth, creed or religion, or social or economic standing, political opinion, age or disability. S.29 of The Employment Act 1980 states that, no employer shall discriminate against any person or between employees on grounds of race, color, religion marital status, sex national origin, tribal or clan extraction, political affiliation or social status. Community Workers are not used by MoH and will not be used for this project. Rights of woman – S28(1) of The Constitution guarantees the rights of woman to equal treatment with men including equal opportunities in political economic and social activities. S.96(1) of The Employment Act 1980 also requires employers not to discriminate between male and female employees by failing to pay equal pay for equal work. SODV ACT of 20. For protection of women against any gender based violence, exploitation and harassment in places of employment Primary Supply Workers - Registered suppliers are subject to regular review in accordance with the Procurement Act. S.2 read with S.16 (7) of The Industrial Relations Act 2000 states that where it is found that the reason for the termination of an employee's services is that the employer discriminated against an employee directly or indirectly, that employee shall be awarded compensation of not more than 24 months' remuneration calculated at the rate of the employee's rate of remuneration at the time of dismissal. This compensation serves as a deterrent as is it double the amount of compensation awarded to any other form of compensation.	grievance to a more senior level within the organization, if it is not resolved at the lowest level. If a grievance is not resolved the employee has the right to lodge a dispute with CMAC.
ESS 4 Community Health and Safety		
To anticipate and avoid adverse impacts on the health and safety of project-affected communities during the project lifecycle from both routine and non-routine circumstances. To promote quality and safety, and considerations relating to climate change, in the design and construction of infrastructure, including dams. To avoid or minimize community	The Public Health Act, 1969 This Act provides for the establishment of processes to ensure public health at all phases of a project. It also provides for steps to take should there be any incident from the project affecting the public and lays out responsibilities for actions to be taken. The Occupational Health and Safety Act, 2001: This Act provides for the safety and health of both employees and the public, especially during the construction phase of proposed projects, and specifies processes to be undertaken in order to ensure that safe and health practices are adhered to and implemented at work. The Road Traffic Act, 2007: This Act provides for the compliance of all roads users and for those organizations such as EEC conducting works on and/or along public roads.	National requirements and ESF objectives are aligned. No significant gaps are noted. It is recommended that both World Bank ESF objectives and National Requirements apply to the project.

ESF Objectives	National Requirements	Recommended Actions
exposure to project-related traffic and road safety risks, diseases and hazardous materials. To have in place effective measures to address emergency events. To ensure that the safeguarding of Personnel and property is carried out in a manner that avoids or minimizes risks to the project-affected communities.	Eswatini Electric Company (EEC) Hazard Identification, Risk Assessment and Determining Control Procedure (S-S-SHP-01, REV 3): This procedure ensures that EEC has an on-GOKEng hazard identification, risk assessment and management process, necessary for all its operations.	
	Emergency Preparedness Response Plan (SS-SH-M-01, REV 1): This document provides processes for when there are emergency situations at EEC and surrounding areas. It details procedures, and responsibilities. EEC Occupational Health and Safety Implementation Plan (S-S-SH-D-04, REV 1): This document provides for the management and control of EEC's significant health and safety hazards, with an overall objective to ensure the effective implementation and management of health and safety issues. EEC Occupational Health and Safety Policy Statement (S-S-SH-D-01, REV 5): This document underlines EEC's commitment to the prevention of work-related injury and ill-health associated with the company's activities.	

ANNEX 7 – SEA/SH and GBV Action Plans

ACTIVITY 1: BUILD AND IMPROVE STAFF AND CLIENT CAPACITY TO ADDRESS RISKS OF SEA/SH AND GBV							
ACTIONS	Deadline	Risks / Constraints	Planned / proposed solutions	Responsible Persons (Name, email & Tel)	Actors involved	Additional human resources	Cost
Prior Action 1 Identify GBV service provider(s) to handle SEA/SH cases	30 March 2021	Low criteria for the selection of a partner NGO	Consult widely to develop a comprehensive criterion for the selection of a partner NGO	Social Specialist Bhekumusa Nxumalo bheki.rainmaker@gmail.com	- PIU - DSW		-----
Prior Action 2 Establish cooperation with GBV service provider	30 March 2021	Not partnering with the correct NGO	Selection of a GBV NGO provider that has a comprehensive offering of services and track record	Social Specialist Bhekumusa Nxumalo bheki.rainmaker@gmail.com	PIU		-----
Prior Action 3 Develop information sharing agreement with the GBV service provider(s)	30 March 2021	Delay in complaints resolutions	Monthly sharing of data and reporting	Social Specialist Bhekumusa Nxumalo bheki.rainmaker@gmail.com	- PIU - DSW		-----

ACTIVITY 1: BUILD AND IMPROVE STAFF AND CLIENT CAPACITY TO ADDRESS RISKS OF SEA/SH AND GBV							
ACTIONS	Deadline	Risks / Constraints	Planned / proposed solutions	Responsible Persons (Name, email & Tel)	Actors involved	Additional human resources	Cost
Prior Action 4 Develop a GBV training package for all stakeholders	30 April 2021	GBV training materials that do not address needs	Standardized training package for all stakeholders	Social Specialist Bhekumusa Nxumalo bheki.rainmaker@gmail.com	- PIU - DSW - UNICEF - Health Sector Response GBV Focal Person		-----
Prior Action 5 Conduct GBV awareness among stakeholders	On-going until April 2022	Poor analysis and recording of skills gaps	Actions to communicate GRM GBV procedures and to all stakeholders	Social Specialist Bhekumusa Nxumalo bheki.rainmaker@gmail.com	- DSW - UNICEF - Health Sector Response GBV Focal Person - PIU		200 000
Prior Action 6 Conduct an orientation of GBV service provider to the project GRM	31 March 2021	Poor NGO performance due to inadequate orientation on the GRM	Adherence to GRM orientation plan	Social Specialist Bhekumusa Nxumalo bheki.rainmaker@gmail.com	PIU		20 000

ACTIVITY 2: DEVELOP CLEAR INTERNAL REPORTING AND RESPONSE PROTOCOLS FOR CASES OF GBV/SEA INCIDENTS							
ACTIONS	Deadline	Risks / Constraints	Planned / proposed solutions	Responsible Persons (Name, email & Tel)	Actors involved	Additional human resources	Cost
Prior Action 1 Strengthen community awareness around SEA/GBV issues	On- going - April 2022	Low reporting of GBV cases	GBV/ awareness training and structures	Social Specialist Bhekumusa Nxumalo bheki.rainmaker@gmail.com	- PIU - Health Promotion Unit		200 000

ACTIVITY 2: DEVELOP CLEAR INTERNAL REPORTING AND RESPONSE PROTOCOLS FOR CASES OF GBV/SEA INCIDENTS							
ACTIONS	Deadline	Risks / Constraints	Planned / proposed solutions	Responsible Persons (Name, email & Tel)	Actors involved	Additional human resources	Cost
Prior Action 2 Itemization of GRM budget activities	28 February 2021	Leaving out key GRM budget items	Circulate widely within PIU and World bank structures	Social Specialist Bhekumusa Nxumalo bheki.rainmaker@gmail.com	• PIU		-----
Prior Action 3 Monitoring implementation of mitigation measures against project related risk of sexual exploitation and abuse	On-31 Jan going until April 2022	Lack of SEA/GBV Awareness prevention initiatives	Reduced number of reported SEA/GBV issues	Social Specialist Bhekumusa Nxumalo bheki.rainmaker@gmail.com	• PIU		-----

ACTIVITY 2: DEVELOP CLEAR INTERNAL REPORTING AND RESPONSE PROTOCOLS FOR CASES OF GBV/SEA INCIDENTS							
ACTIONS	Deadline	Risks / Constraints	Planned / proposed solutions	Responsible Persons (Name, email & Tel)	Actors involved	Additional human resources	Cost
Prior Action 4 Develop a separate Log for SEA/SH case.	30 th April 2021	Loss of confidentiality	Limiting user access to the GBV cases Log sheet through the allocation of user rights	Social Specialist Bhukumusa Nxumalo bheki.rainmaker@gmail.com	• PIU		-----
Prior Action 5 Report on GBV cases	Monthly	Loss of confidentiality	Limiting user access to the GBV cases Log sheet through the allocation of user rights	Social Specialist Bhukumusa Nxumalo bheki.rainmaker@gmail.com	• PIU		-----

ACTIVITY 2: DEVELOP CLEAR INTERNAL REPORTING AND RESPONSE PROTOCOLS FOR CASES OF GBV/SEA INCIDENTS

ACTIONS	Deadline	Risks / Constraints	Planned / proposed solutions	Responsible Persons <i>(Name, email & Tel)</i>	Actors involved	Additional human resources	Cost
Prior Action 6 Incorporate SEA/SH/GBV mitigation measures in sub projects plans- LMP, ESMP and GRM	July 2021	Poor implementation of plans due to insufficient budgets	- Ensure that the LMP has measures to facilitate validation and signing of sub- project worker's CoC prohibiting SEA/SH/GBV; - Ensure that the LMP had measures to address the discrimination of women in hiring processes; - Ensure all sub-project ESMPs include the management of GBV/SEA/SH cases - To ensure sensitivity to GBV/SEA/SH cases, the project GRM will be linked to mandated organizations such as the NGO GBV service provider appointed by MOH and has a separate GBV log for confidentiality and efficient redress - Ensure that the Project GRM outlines a clear process for linking of survivors with service providers, tracking and reporting the handling	Social Officer	- PIU - Construction Companies - Contractors	N/A	----- 232

Monitoring Indicators for GBV/SEA/SH

Monitoring Indicator	Monitoring Targets	Monitoring Frequency	Monitoring Method	Responsibility
Effective management of GBV and SEA/SH	100% of Health Workers and Rural Health Motivators trained on handling GBV/SEA/SH issues	Once off	Training registers	Social Officer/ M&E Officer/MoH
	80% coverage of national population made aware of GBV/ SEA/SH issues and management thereof	Monthly	Document review	Social Officer/ M&E Officer/MoH
	80% of GBV/SEA/SH cases reported are handled	Daily	Document review	Social Officer/ M&E Officer/MoH
	80% of reported cases on violence against children and child sexual abuse are handled	Daily	Document Review	Social Officer/ M&E Officer/MoH

Annex 8 – Infection Control and Waste Management Plan (ICWMP) for Covid-19 Outbreak

ABBREVIATIONS AND ACRONYMS

DHMT	District Health Management Team
EHD	Environmental Health Department
GDP	Gross Domestic Product
HAI	hospital associated infections
HCF	Health Care Facility.
HCGW	Health Care General Waste
HCRW	healthcare Risk Waste
HCW	Health Care Waste
HCWM	Health Care Waste Management
HCWMP	Health Care Waste Management Plan
HVAC	Heating, Ventilation and Air Conditioning systems
HEPA	High efficiency particulate air
ICWM	Infection Control and Waste Management
ICWMP	Infection Control and Waste Management Plan
MTEC	Ministry of Tourism, Environment, and Culture
MoH	Ministry of Health
NRL	National Reference Laboratory
RFMH	Raleigh Fitkin Memorial Hospital
SOPs	Standard Operating Procedures
SPRP	Strategic Preparedness and Response Program
UV	Ultraviolet
WASH	Water, Sanitation, and Health
WB	World Bank
WHO	World Health Organization

1. Introduction

1.1 Project context and components

The proposed emergency response project to the Kingdom of Eswatini is prepared under the COVID-19 Strategic Preparedness and Response Program (SPRP). This project will provide immediate support to prevent and limit the local transmission of the SARS-CoV-2 virus through detection, containment and treatment strategies, community engagement, relevant and cost-effective WASH measures not already covered by other sectors. It will enable mobilization of personal protective equipment, sterilization capacity and surge response capacity, and trained and well-equipped frontline health workers for surveillance and treatment. The project will support cross-border alignment with South Africa in preparedness and response. It will support enhancement of disease detection capacities through provision of technical expertise, additional human resources, and laboratory equipment to ensure prompt case finding and contact tracing, consistent with WHO guidelines in Strategic Response Plan and the country's National COVID-19 Integrated Response Plan, in close coordination and with strong support from United Nations (UN) agencies and other partners.

The proposed project has two components:

Component 1: Emergency COVID-19 Response

This component will provide support to Eswatini to minimize the risk of further imported cases and limit local transmission through containment strategies. It will support the implementation of Eswatini's COVID-19 National Contingency Plan in close coordination and with strong support from UN agencies and other partners. This component supports: (i) strengthening COVID-19 case detection, confirmation, case tracing, recording and reporting; (ii) health systems strengthening for COVID-19 preparedness planning; and (iii) improving the implementation of social distancing measures and strengthening communication preparedness.

(1) Strengthen COVID-19 Case Detection, Confirmation, Contact Tracing, Recording, and Reporting: The project will provide technical assistance and procure goods and equipment to (i) strengthen disease surveillance systems and the in-country testing capacity through scale up of rapid near patient molecular testing and other testing technology – including engaging the private sector – as appropriate and strengthening of health facilities and the National Reference Laboratory (NRL) (and other public health laboratories as deemed necessary) in specimen collection, packaging, storage, shipment and epidemiological capacity for early detection and confirmation of cases; (ii) combine detection of new cases with active contact tracing; (iii) support epidemiological investigation; (iv) strengthen risk assessment; (v) strengthen screening, isolation and follow up of travelers at point of entry; and (vi) provide on-time data and information for guiding decision-making and response and mitigation activities.

(2) Health System Strengthening for COVID-19 Preparedness Planning: Technical and financial assistance will be provided to the health care system for preparedness planning to provide optimal medical care, maintain essential community services and to minimize risks for patients and health personnel, including training health facilities' staff and front-line workers on risk mitigation measures and providing them with the appropriate protective equipment, as well as with water supply, sanitation and hygiene materials, and health care waste management services. Strengthened clinical care capacity will be achieved through financing plans for establishing specialized units in selected hospitals, treatment guidelines, clinical training of health workers and hospital infection control guidelines. Local containment will be supported through the establishment of local isolation units in hospitals. Widespread infection control training and measures will also be instituted across health facilities and ambulances. As COVID-19 would place a substantial burden on inpatient and outpatient health care services, support would be provided for temporary surge capacity for service delivery, reorganizing and repurposing/equipping the Lubombo referral hospital and the RFM hospital to

increase ICU capacity, as well as other selected sites as deemed necessary, for the delivery of critical medical services and to cope with increased demand of services posed by the outbreak, develop intra-hospital infection control measures, and procure ambulances fully equipped for highly infectious diseases.

(3) Improve Implementation of Social Distancing Measures and Strengthen Communication Preparedness: An effective measure to prevent contracting a respiratory virus such as COVID-19 is to limit, as much as possible, contact with the public. Therefore, the project will provide technical assistance to support improvements in the implementation of 'social distancing measures' already in place in country by developing a well-designed communication strategy targeting parents, traditional and religious leaders and the general public, guidelines for the management of at risk groups such as guidelines for elderly isolation and pension pick-up, and guidelines for alternative drug pick-up for people living with HIV and other chronic conditions. It is important to clarify that the Bank will not support the enforcement of social distancing measures when they involve actions by the police or the military, or otherwise that require the use of force. The project will also provide technical and financial assistance for behavior change communication activities that will support cost-effective and sustainable methods such as promotion of handwashing, food hygiene, and safe water practices through various communication channels via mass media, counseling, schools, workplace, and integrated into specific interventions as well as ongoing outreach activities of ministries and sectors, especially ministries of health, education, agriculture, and transport. In coordination with other development partners, complementary support will be provided for information and two-way communication activities to raise awareness, knowledge and understanding among the general population about the risk and potential impact of the pandemic. Community mobilization will take place through trained community health workers (Rural Health Motivators and Community Volunteers), religious leaders and traditional healers. In addition, support will be provided for: (i) the development and distribution of basic communication materials (such as question and answer sheets and fact sheets in Siswati on COVID-19, and (ii) general preventive measures such as "dos" and "don'ts" for the general public; (iii) information and guidelines for health care providers; (iv) training modules (web-based, printed, and video); (v) presentations, slide sets, videos, and documentaries; and (vi) symposia on surveillance, treatment and prophylaxis.

(4) COVID-19 Vaccine Deployment. The project will also support the deployment of a COVID-19 vaccine for Eswatini. This will include (i) vaccine and drug purchase; (ii) upgrading the cold chain for the vaccines; (iii) strengthening service delivery to ensure effective vaccine deployment; and (iv) monitoring, tracking of vaccines use and recording of any adverse reactions to vaccination. Eswatini's health system has established expertise and skills for childhood immunizations, which creates a strong foundation, but modifications will be required to vaccinate a large number of adults in a short time period. COVID-19 vaccines are aimed at a larger proportion of the total population and will need to be deployed within a short time period in order to have the public health impact required to reduce the burden on health and the economy. Even if implemented in a phased manner, an intense focus on expanding immunization capacity is necessary to ensure that the health system can effectively implement a comprehensive COVID-19 vaccine deployment strategy. This includes a critical assessment and actions to ensure functional, end-to-end supply chain and logistics management systems for effective vaccine deployment. The large number of staff and temporary volunteers required to perform the vaccination will need orientation and training. Likewise, large-scale communication and outreach campaigns, which will target household, community and national stakeholder including the political leadership, will be needed to ensure robust governance, accountability, and citizen engagement mechanisms. People-centered, innovative modes of communication will be required to counter any vaccine resistance and ensure the program can reach the hard to reach. National and local roll-out plans will be prepared which also include adequate monitoring as well as safe disposal of sharps and other biological wastes. This AF will support the GoKE's vaccine deployment up to 30 percent of the target population (.34 million), which represents 55 percent of the adult population (above 18 years of age), subject to availability of vaccines and

supplies for deployment.

As guided by WHO the Kingdom of Eswatini will follow Strategic Advisory Group of Expert (SAGE) policy as recommendation and use available doses for target groups defined by SAGE. The country is a participant in the COVAX Facility as an AMC Group Participant. Eswatini will follow the COVID-19 vaccine allocation on fair allocation planned in two phases.

Phase 1: Vaccines shall be allocated proportionally as follows:

i. Initially cover 3% of the national population.

It is anticipated that this initial allocation will be for frontline health workers who are at high risk (close contact with patients) both public and private. By choosing to set a 3% benchmark, as guided by WHO the MoH wants to ensure that volumes meet the needs of the target populations of health workers at risk. If health workers make up less than 3% of the national population, additional doses can be for the next priority group within Eswatini. According to CSO the projected population for 2021 is 1 145 4040.

Total population	3% of the population
1 145 404	34, 362

ii. Incremental shipments to reach a further 17% of a country's population will follow.

It is anticipated that this will likely be for elderly people and individuals with comorbidities on evidence-based information.

Total population	17% of the population
1 145 404	194,718

Phase 2: Increase coverage to 60% of the population

Eswatini will receive doses to vaccinate populations beyond the initial 20% included in the first phase. Consideration should be given to regions at risk in establishing the pace at which it would receive additional volume of vaccines.

The country is intending to cover an additional 60% of the total population which shall include vulnerable populations such as refugees and asylum seekers, and those dedicated to relieving suffering.

Total population	60% of the population
1 145 4040	687,242

The MoH will ensure that communities are engaged in a transparent manner and that the public is made aware of the identification criteria and how doses are administered. This will ensure that there is a clear communication strategy explaining the selection of the priority groups and why certain groups are not receiving the vaccine. Eswatini will use the WHO SAGE values framework which contain lists of over 20 subgroup populations that, if prioritized, would advance one or more of the principles and objectives identified within the framework. Eswatini will use the following six guiding principles: human well-being, global equity, reciprocity, equal respect, national equity and legitimacy,

to determine who should be given the vaccines, and when. Following guidance on the SAGE prioritization roadmap and with the Eswatini-specific nuances in epidemiological settings and different levels of vaccine availability, these priority groups will need to be further interpreted at all levels and the MoH will lead this process in wide consultation with key stakeholders.

In Phase 1, Eswatini defined its health workers, including in the private sector, who are at higher risk of COVID-19 infection than the general population due to the nature of their work, and more likely to be affected by COVID-19. In addition, health workers infected with COVID-19 may contribute to health care-associated infection transmission of infection to their patients and people they care for, including those at high risk for developing severe COVID-19 disease and complications. To ensure targeted use of COVID-19 vaccination of health workers in different settings of the kingdom of Eswatini (e.g. primary health care facilities, hospitals, long-term care facilities) and to address potential uptake issues, a National Health and Safety Policy and the EEPI: the classification of different health worker categories based on assessment of risk; the policy for vaccination for each category; and strategies for managing non-compliance of health workers.

In the latter part of Phase 1, Eswatini defines its elderly people by age-based risk specific to the Eswatini (60 years and above) and those with comorbidities who are at high risk of serious health outcomes and mortality due to COVID-19. According to STEPS (2014) the burden of hypertension and type 2 diabetes as comorbidities of COVID-19 is extremely high in the population. The majority people living with NCD in Eswatini (>80%) are undiagnosed resulting to complications such as Kidney disease.

Component 2: Additional Financing Component. Strengthen Capacity in Preparedness for Health Emergencies (additional financing of US\$3 million)

Supports the strengthening of Eswatini's capacity in preparedness for health emergencies, including: (i) strengthening the surveillance system and enhancing analytical capacity for real-time rapid reporting and analysis of surveillance data; (ii) supporting simulations to regularly evaluate and enhance health emergency preparedness; (iii) preparing and equipping the health system and facilities to respond to future health emergencies; and (iv) strengthening capacity for national health emergency rapid procurements.

To support the Government's vaccination planning, the AF will finance upfront technical assistance to support Eswatini to establish institutional frameworks for the safe and effective deployment of vaccines. These will include: (a) upgrading regulatory standards at the national level, including pharmacovigilance, and authorization mechanisms; (b) preparation of appropriate minimum standards for vaccine management including cold chain infrastructure (with financing for the investment to meet those standards as described below); and (c) creation of accountability, grievances, and citizen and community engagement mechanisms. Additional financing for Component 3 of the parent project would support the continued coordination and management of project activities. Further, this component will strengthen existing data and monitoring systems (immunization and public health) to accommodate the monitoring of COVID-19 vaccines deployment and therefore improve data collection, analysis, reporting and use of data for action and decision-making.

Financing from the Health Emergency Preparedness and Response Trust Fund (HEPRTF) of US\$3 million complements the IBRD Additional Financing and strengthens the project's likelihood of attaining the PDO by supporting:

- Strengthening surveillance: expanding and linking existing surveillance systems; piloting advanced geo-enabled surveillance platforms and early warning systems; strengthening

surveillance at ports of entry; community-based surveillance through development and use of social listening tools and the monitoring of information channels, to detect and rapidly respond to health emergencies; build institutional capacity at the health facility, regional and national levels for surveillance and advanced data analytics, interpretation and use; and institutionalizing traceability of medical countermeasures to improve: i) distribution to end-users; ii) prevent diversion; iii) identify false and sub-standard products; and (iv) monitor adverse events following immunization (AEFI) for all national vaccines under the expanded program for immunization (EPI).

- Health emergency simulations at national, regional and local levels to test operational readiness and build human resource capacity to strengthen preparedness to health emergencies.
- Health system and facility capacity for health emergency preparedness: strengthen health management and information systems to accommodate health emergency preparedness; digital solutions including use of GIS mapping; and collaboration mechanisms with the private sector.
- Expedited procurement of medical countermeasures in an emergency: quantification and forecasting of supply needs; national health emergency budgeting and budget tracking capacity; coordination between national health and finance authorities; streamlining of budget execution processes; and support flexible procurement processes, product registration, and streamlined customs procedures.

Component 3: Implementation Management and Monitoring and Evaluation

This component will support project management and monitoring and evaluation.

Project Management: Support for the strengthening of public structures for the coordination and management of the project will be provided, including central and local (decentralized) arrangements for coordination of activities, financial management and procurement. The MOH's implementation team will be strengthened through capacity building and recruitment of consultants responsible for overall administration, procurement, and financial management of the project. To this end, the project will support costs associated with project coordination.

Monitoring and Evaluation (M&E): This component will support the monitoring and evaluation of prevention and preparedness, building capacity for clinical and public health research, and joint-learning across and within countries. This component will support training in participatory monitoring and evaluation at all administrative levels, evaluation workshops, and development of an action plan for M&E and replication of successful models.

1.1.1 Categorization of HCW in Eswatini

Health Care Waste (HCW) is usually divided into the two main categories: Health Care General Waste (HCGW) and Health Care Risk Waste (HCRW). HCGW consists of the general household (domestic) waste and much of this waste can be recycled. Health Care Risk Waste (HCRW) is the more hazardous part of the waste generated from health care facilities and comprises: infectious waste; sharps; anatomical; pharmaceutical; chemical; and radioactive waste (GoKE, 2013).

The need for correct segregation is determined by the different treatment methodologies required for the safe and environmentally friendly treatment and disposal of the different waste streams.

In Eswatini, the National Health Care Waste Guidelines define HCRW as all waste that is generated as a result of any of the following activities:

- Diagnosis, treatment or immunization of human beings or animals;
- Research pertaining to the above activities;
- Production or testing of biologicals or pharmaceuticals;

- Wastes arising from home-based care and traditional and religious healing facilities and
- As also defined in the Waste Regulations of 2000.

It includes the following:

- (a) Infectious waste;
- (b) Pathological waste;
- (c) Sharps waste;
- (d) Pharmaceutical waste; and
- (e) Genotoxic waste.

In Health Care Facilities in the Kingdom of Eswatini, the following categories of waste are observed:

- a) **Healthcare general waste:** This comprises of the normal 'household' waste and is mainly waste coming out of a healthcare facility that has not come into contact with patients, such as plastic bags, boxes, paper, food waste etc. A large portion of this waste can be recycled.
- b) **Infectious waste:** All waste that is likely to contain pathogens (in sufficient concentration to cause diseases to a potential host). These include blood bags, urine, body secretions, etc.
- c) **Pathological (anatomical) waste** is waste that comprises of body parts and blood and includes placentas.
- d) **Pharmaceutical waste:** These include expired medication, unused pharmaceutical products, drugs, vaccines, etc.
- e) **Chemical waste:** These consist of chemicals that are generated during disinfecting procedures or cleaning processes.
- f) **Sharps:** These consist of all items that can cause puncture wounds such as needles, syringes, scalpel blades and slides.
- g) **Highly infectious waste:** This group consists of waste from laboratories, in microbial cultures, and stocks with viable biological agents, etc.
- h) **Radioactive waste:** Includes liquids, gases and solids that spontaneously emit radiation.

1.2 Healthcare Facility Design Requirements

A clean environment plays an important role in the prevention of hospital associated infections (HAI). Many factors, including the design of patient care areas, operating rooms, air quality, water supply and the laundry, can significantly influence the transmission of HAI.

1.2.1 General Design and Safety Requirements

In response to Covid-19 disease outbreak, the general requirements for design of Healthcare facilities for hospitalization of Covid-19 patients should ensure:

- Adequate safe water supply;
- Appropriate cleaning practices;
- Adequate floor space for beds (at least two meters apart);
- Adequate handwashing facilities;
- Adequate ventilation for isolation rooms and high-risk areas like operation theatres, transplant units, intensive care areas, etc.
- Adequate isolation facilities for airborne, droplet, contact isolation and protective environment;
- Regulation of traffic flow to minimize exposure of high-risk patients and facilitate patient transport;
- Measures to prevent exposure of patients to fungal spores during renovations;
- Precautions to control rodents, pests and other vectors; and
- Appropriate waste management facilities and practices.

1.2.2 Water Supply

The health care facility should provide safe water. Several measures can improve water safety, starting with protecting the source water; treating water at the point of distribution, collection or consumption; and ensuring that treated water is safely stored in regularly cleaned and covered containers.

Conventional, centralized water treatment methods that utilize filtration and disinfection should inactivate the COVID-19 virus. For effective centralized disinfection, there should be a residual concentration of free chlorine of ≥ 0.5 mg/L after at least 30 minutes of contact time at pH < 8.0. A chlorine residual should be maintained throughout the distribution system.

In situations where centralized water treatment and safe piped water supplies may not be available, a number of household water treatment technologies may be used to effectively remove and destroy viruses such as boiling or using high performing ultrafiltration or Nano membrane filters, solar irradiation and, in non-turbid waters, UV irradiation and appropriately dosed free chlorine. If the facility uses water storage tanks, they should be cleaned regularly, and the quality of water should be sampled periodically to check for bacterial contamination.

In addition to effective water treatment, water utility managers can adopt several other preventive measures, as part of a broader water-safety planning approach. These measures include:

- Ensuring adequate stocks of chemical additives and consumable reagents for water-quality testing,
- Ensuring that critical spare parts, fuel and contractors can still be accessed and that there are contingency plans for staff and training to maintain the required supply of safe drinking water.

1.2.3 Heating, ventilation and air conditioning (HVAC)

Ventilation systems should be designed and maintained to minimize microbial contamination. The air conditioning filters should be cleaned periodically and fans that can spread airborne pathogens should be avoided in high-risk areas. High-risk areas such as operating rooms, critical care units and transplant units require special ventilation systems. Filtration systems (air handling units) designed to provide clean air should have high efficiency particulate air (HEPA) filters in high-risk areas. Unidirectional laminar airflow systems should be available in appropriate areas in the hospital construction. Ultra clean air is valuable in some types of cardiac surgery/neurosurgery/implant surgery theatres and transplant units. For the operating room, the critical parameters for air quality include:

- Frequent maintenance/validation of efficacy of filters (in accordance with manufacturer's requirements);
- Pressure gradient across the filter bed and in the operation theatre;
- Air changes per hour (minimum 15 air changes per hour);
- General areas should be well ventilated if they are not air-conditioned.

2. Infection Prevention and Control Procedures

Health care workers and related personnel should follow infection prevention and control procedures for effective prevention and control of COVID-19.

2.1 Establishment of a COVID-19 management system and coordination mechanism

- Facilities should establish an implement action plans for COVID-19 preparedness and response, which include strategies on effective management of their employees, visitors, etc.
- Facilities should designate specific persons responsible for COVID-19 infection control to ensure accountability in disease prevention and mitigation efforts.

2.2 Hand hygiene procedure

HCFs staff and care givers should perform hand hygiene, when arriving at work/HCFs and before leaving work/HCFs, as well as before eating and after using the toilet/ latrine. Additionally, for anyone who is providing care to patients, the “Five moments for hand hygiene” must be respected.

Routine Hand Hygiene

Hand hygiene must be performed before and after every episode of patient contact.

- Before touching a patient
- Before a procedure
- After a procedure or body substance exposure risk
- After touching a patient
- After touching patient’s surroundings

Note: Hand hygiene MUST also be performed after taking off PPE.

2.3 Respiratory hygiene

Respiratory hygiene and cough etiquette is a standard precaution that should be applied by all patients, visitors and HCWs to contain respiratory secretions (e.g., when coughing or sneezing) to avoid spreading respiratory infections.

- Cover nose and mouth when coughing, sneezing with tissue or mask.
- If no tissues are available, cough or sneeze into the inner elbow rather than hand.
- Do not ‘spit’ in environment.
- Dispose used tissue and/or masks in the nearest bin after use.
- Avoid shaking hands when sick. Use traditional greetings instead.
- Perform hand hygiene after contact with respiratory secretions.

2.4 Education for effective prevention

- Facilities should provide their employees, visitors, and related personnel with information about COVID-19 and conduct training sessions on proper hand washing, social distancing, cough etiquette, etc.
- Notify facility users that their access to the facilities can be limited if they have a fever or respiratory symptoms with visual displays of such notification in common areas.
- Promote respiratory and cough etiquette by:
 - Educating HCF staff, patients, and visitors on the importance of containing respiratory droplet/aerosol and secretions to prevent the transmission of infectious disease.
 - Post visual signage informing that patients and family members with respiratory symptoms should use respiratory hygiene/cough etiquette.

2.5 Hygiene and environmental management

- Facilities should place hand wash, such as hand sanitizers and liquid soaps, in sufficient quantity in restrooms and other common areas within the facilities.
- Place trash bins at several locations in the facilities to allow the immediate disposal of waste used for coughing.
- Increase frequency of cleaning, sanitizing, and ventilation in common areas within facilities, related transportations, etc.
- Pay particular attention to disinfection for areas and objects that are frequently touched by related personnel such as doorknobs, handrails, desks, tables, telephones, keyboards, etc. Disinfect entrance doors, elevators, and similar public objects on a more frequent basis.

2.6 Patient-care equipment cleaning and disinfection procedures

All medical devices are either single-use or reusable ones. Single-use equipment must be discarded, while all reusable equipment must be properly processed between use and between patients, to prevent infections. For proper reprocessing of equipment, all items need to be cleaned with detergent (liquid soap) and water before disinfection and sterilization, to get rid of the organic matter

e.g. blood and mucus that may neutralize chemical disinfectant and affecting the efficiency of the disinfectant.

Instruments and other items may be classified based on the risk of transmitting infection into critical, semi-critical or non-critical, depending on the sites.

Category	Application	Type of Processing	Examples
Critical	Sterile issues of the blood system	Sterilization (by heat or chemicals)	Dressing and suture instruments, surgical instruments, delivery sets, diagnostic catheters, dental instruments, bronchoscopes, cystoscopes, etc.
Semi-critical	Mucous membranes or non-intact skin	High-level disinfection (HLD) & intermediate level disinfection	Laryngoscope blades, vaginal specula, instruments for MVA, respiratory therapy and anesthesia equipment, dental impressions, endoscopes, gastroscopes, etc.
Non-critical	Intact skin	Cleaning, low level disinfection	Bedpans, toilets, urinals, blood pressure cuffs, ECG leads, thermometers, stethoscopes, beds, bedside tables, etc.

Patient-care equipment cleaning procedure:

- Prepare all cleaning and disinfecting equipment and solution.
- Cleaner wear PPE: rubber gloves and boots, impermeable apron. Where there is a risk of splash in the face, staff must wear eyes protection and surgical mask.
- Take off any gross soiling on the instrument by rinsing in clean water.
- Take instrument apart, fully and immerse all parts in detergent solution, and clean all channels and bores of the instrument.
- Ensure all visible soil is taken off from the instrument – follow manufacturers' instructions.
- Rinse thoroughly with clean water.
- Dry the instrument (let it dry to– on a clean rack or hang if tubing or items with lumens, away from other dirty items).
- Inspect to ensure the instrument is cleaned.

Patient-care equipment disinfecting procedure

- Prepare disinfectant solution according to the volume of medical instruments, following notice of disinfectant, cleaner wearing PPE.
- Immerse the cleaned equipment completely in the disinfectant solution. Soak in the solution, duration will depend on the disinfectant recommendations and dilutions. For example: Sodium hypochlorite 0.05%: soak for 30 minutes.
- Rinse thoroughly with clear or sterile water (depending on the required level of disinfection and the use of the equipment).
- Sterile water for semi-critical instrument (HLD).
- Clean water for non-critical instrument (low level of disinfectant).
- Let it dry (on a rack).
- Pack the disinfected equipment and store in a clean area.

Environmental cleaning procedure

Most areas of HCFs are low risk zone (non-infectious zone). These areas should be cleaned daily, with detergent solution (soapy water) to remove dirt and organic material and dissolve or suspend grease, oil, and other matter so it can easily be removed by scrubbing. In high-risk areas where heavy contamination is expected and risk of cross-contamination by the staff and other patients, surfaces need to be cleaned with soapy water, rinsed, and let it dry, before being disinfected (e.g., sodium hypochlorite (chlorine) solution 0.05%). High risk areas are for instance, operating rooms, pre- and postoperative recovery areas, intensive care units (ICUs), isolation room, laboratory, toilets and latrines; or area with blood/ body fluid spills. When cleaning, cleaners are at risk and need to be properly trained. They also must wear appropriate PPE, at least rubber gloves, rubber boots, uniform or apron. When there is risk of splash in the face, wear surgical mask and eyes protection.

Principles of Environmental Cleaning

- Apply hand washing / hygiene and wear appropriate PPE (at least rubber gloves, rubber boots, uniform or apron. When risk of splash in the face, wear surgical mask and eyes protection).
- Prepare fresh cleaning and household solution once a day; and change solution whenever they appear to be dirty.
- Perform cleaning and disinfecting patient environment at least once a day.
- Clean first with detergent (soapy water), rinse with water, let it dry in non-patient area (e.g. including corridor, laundry room, etc.).
- In high risk area (patient care area), following cleaning procedure, disinfect surface by using household disinfectant (e.g., bleach 0.05% solution, alcohol 70% for small object, or follow manufacture recommendations).
- Every day clean all patients' rooms, units, cleaner's rooms.
- Cleaning with a moistened cloth helps to avoid contaminating the air and other surfaces.
- Clean from the less contaminated to the most contaminated area (e.g., start from corridor, then patient' room, and last finish to clean bathroom and toilet).
- After patient discharge, clean and disinfect patient room very well, including all equipment that has been in contact with patient (e.g. bed, bed table, etc.) as soon as possible.
- After use, all cleaning equipment (e.g., mop, brush, bucket, cloth, etc.) must be cleaned, disinfected and dried before storage, and be reused.
- In general, do not spray (i.e. fog) occupied or unoccupied clinical areas with disinfectant. This is a potentially dangerous practice that has no proven disease control benefit.

Cleaning up Spills

- Clean up spills of potentially infectious fluids immediately, to preventing the spread of the infection and also prevents accidents.
- Small spills of blood or other body fluids should be wiped with paper towel (staff using disposable gloves), then cleaned with soapy water, rinse and disinfect.

Appropriate handling of bedding

- Mattresses and pillows with plastic covers should be cleaned with detergent, after departure of each patient.
- In isolation unit and intensive care unit, as well as infectious wards (e.g. TB) disinfecting should follow cleaning procedure.

Trained staff is wearing PPE depending on route of transmission, adding rubber gloves, impermeable apron, rubber boots. In isolation room, all surfaces (floor, table...) need to be cleaned, then disinfected once per day. When heavy contamination (blood, vomit, feces) on surface and floor, take off spill, clean with detergent, disinfect with chlorine solution 0.5%.

Refer to the list of disinfectant to select those that will inactivate the pathogen. The most common hospital disinfectant includes:

- Sodium hypochlorite (household bleach);
- Ethyl alcohol 70%;
- Phenolic compounds;
- Quaternary ammonium compounds;
- Peroxygen compounds.

Some disinfectant solution, provide the two actions (detergent and disinfectant) in one product, follow instruction for that specific product.

2.7 Prevention of needle-stick/sharp injuries

In healthcare settings, injuries from needles or other sharp instruments are the number-one cause of occupational exposure to blood-borne infections. All staff that come in contact with sharps, from doctors and nurses to those who dispose of the trash, are at risk of infections. Improper disposal of sharps also poses a great threat to members of the community.

The term sharps refer to any sharp instrument or object used in the delivery of healthcare services - including hypodermic needles, suture needles, scalpel blades, sharp instruments, intravenous (IV) catheters, and razor blades. Needle stick/sharp injury means the skin is accidentally punctured by a used needle/ sharp (e.g. scalpel). The injury is a port of entry for blood-borne diseases, such as hepatitis B (HBV) and hepatitis C (HCV), HIV etc. Exposure to patient's body fluid also put HCWs at risk of infection. Therefore, they are encouraged to strictly comply with IPC precautions related to body fluid.

The main causes of needle stick/sharp injury include:

- Recapping of needles (identified as the most common cause)
- Unsafe handling of sharp waste (identified as the second most common cause)
- Manipulation of used sharps (bending, breaking, or cutting needles).
- Unnecessary injections
- Lack of supplies: disposable syringes, sharps-disposal container
- Failure to place needles in sharps containers immediately after injection
- Passing sharps from hand to hand (e.g. during surgery)
- Lack of management of sharp wastes
- Lack of awareness of the problem
- Lack of training for staff

Principle of the disposal of used needles/sharps

- Never recap needle/sharp
- Dispose of needles and syringes immediately after use in the sharps container.
- Close the sharps container, whenever the containers become $\frac{3}{4}$ full.
- Safely dispose the safety box (e.g. via incinerator with temperature at least of 800o Celsius)
- When it is not immediately disposed, keep sharps container in appropriate storage, for infectious waste.
- Refer to National Healthcare Waste Management Guidelines 2013 for more information.

Sharp disposal container

Sharps containers MUST be puncture and leak resistant. They should be conveniently located in any area where sharp objects are frequently used (such as injection rooms, treatment rooms, operating theatres, labor and delivery rooms, and laboratories).

2.8 Preparation of isolation room/unit

- Isolate infectious patient in a single room
- If there is no single room, isolate in the cohort room. In cohort room, always keep suspected cases separate from confirmed cases
- If single and cohort room, keep the single room for suspected cases and the cohort room for confirmed cases
- Avoid movement of infectious suspected and confirmed patients (only if crucial)
- Limit number of visitor (ideally only one)
- Staff help the visitor select PPE base on route of transmission, visitor must be trained for wearing PPE
- Put a clear sign of restrictive area and fence around isolation room/unit
- Set up isolation room/ unit as per standard
- Prepare the isolation room and ensure refurbishment of PPE/ material.

The following table should be kept on the trolley at all times so that PPE is always available for healthcare workers:

Equipment	Stock Present
Eye protection (visor or goggles)	
Face shield (provides eye, nose, and mouth protection)	
Gloves • Reusable vinyl or rubber gloves for environmental cleaning • Latex single-use gloves for clinical care	
Hair covers (optional)	
Particulate respirators (N95, FFP2, or equivalent)	
Medical (surgical or procedure) masks	
Gowns and aprons • Single-use long-sleeved fluid-resistant or reusable non-fluid-resistant gowns • Plastic aprons (for use over non-fluid-resistant gowns if splashing is anticipated and it fluid-resistant gowns are not available)	
Alcohol-based hand sanitizers	
Plain soap (liquid if possible, for washing hands in clean water)	
Clean single-use towels (e.g. paper towels)	
Sharps containers	
Appropriate detergent for environmental cleaning and disinfectant for disinfection of surfaces, instruments, or equipment	
Large plastic bags	
Appropriate clinical waste bags	
Linen bags	
Collection container for used equipment	

2.8.1 HCWs/staff in the isolation room/unit

Apply IPC standard and adequate additional precaution(s) based on route of transmission. For emerging infectious disease (EID), with unknown route of transmission, apply standard precautions and all additional precautions (contact+ droplet+ airborne), until the route of transmission has been identified (staff will wear FULL PPE, maximum protective personal equipment).

Exclusively assign trained staff (medical and non-medical). If HCW is not trained, he/she must not wear PPE and enter the isolation room. Prior entering to the room, HCW must record their name and

contact details. Perform hand hygiene and wear PPE for identify route of transmission (following PPE procedure). After contact with isolated patient, HCW must safely take off PPE, and thoroughly wash hands precautions (following PPE procedure).

2.8.2 Occupational health

Any staff and visitor who is entering in the isolation room/isolation unit (IU), or has any contact with contaminated equipment, linen, waste, dead body MUST:

- Register their name and contact details in the logbook of isolation room/unit, for contact tracing purpose.
- Follow up health status, fever and other symptoms (refer to suspect case definition/triage form)
- Take and record temperature twice daily, for the entire incubation period after the last contact
- Notify manager of unit, IPC team, and focal point if any symptoms
- Have good hygiene, drink plenty of safe drinking water, and rest to avoid mistakes due to severe fatigue.

Promote preventive medicine:

- No pregnant women should be working in isolation room/unit.
- Provide psychological support to the staff/team who work in isolation room/unit.
- Prevent heat illness/ dehydration (serious risk of heat illness while wearing PPE in tropical conditions).

For HCWs who are developing symptoms:

- Stop work immediately or do not report to work.
- Limit interactions with others.
- Exclude themselves from area.
- Notify the chief of unit or focal point if any fever > 38°C. and/ or other symptoms (refer to case definition).
- Exposed persons must receive follow-up care (e.g., antiviral therapy when available), counselling and psychological support.
- Inform supervisor, for contact tracing and follow-up of family, friends, co-workers and other patients, who may have been exposed to the disease through close contact with the infected HCW/staff.

2.9 PPE procedure

The PPE to wear will depends on the type of isolation precautions: therefore, several PPE procedures are possible. Keep in mind the steps of removing the PPE (from more contaminated to less), this will guide the step of putting on the PPE.

Personal Protective Equipment Procedures

- HCWs must select the appropriate PPE after having assessed the risk of contact with body fluid.
- Wear PPE in a logical order, to be able to take off from the most contaminated item to the least contaminated item.
 - **Gloves**
 - Putting on: Carefully put on disposable gloves. When wearing long sleeves gown, gloves cover the write of the gown.
 - Taking off: Outside part of gloves if contaminated.
 1. Grasp outside of glove with opposite gloved hand; peel off.

2. Hold removed glove in gloved hand or discharge in waste container.
 3. Slide fingers of un-gloved hand under remaining glove at wrist.
 4. Peel glove off.
 5. Discard gloves in waste container.
- **Gown**
 - Putting on:
 1. Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back.
 2. Fasten in back of neck and waist.
 - Taking off: Gown front and sleeves are contaminated.
 1. Unfasten ties.
 2. Pull away from neck and shoulders, touching inside of gown.
 3. Turn gown inside out.
 4. Fold or roll into a bundle and discard.
 - **Surgical Mask**
 - Putting on:
 1. Secure ties or elastic bands at middle of head and neck
 2. Fit flexible band to nose bridge
 3. Fit snug to face and below chin
 - Taking off: Front of the mask is contaminated.
 1. Grasp ties of elastics and take off
 2. Discard in waste container
 - **Eye protection (goggles, face shield, safety glasses)**
 - Putting on: Place item over eyes and face and adjust to fit.
 - Taking off: Front of the eyes protection is contaminated.
 1. Take off, by handling the head band, elastics.
 2. Place in designated receptacle for reprocessing or in waste container for single use.

2.10 Reprocessing reusable equipment

Clean with detergent, then soak into chlorine solution 0.05% for at least 30 minutes, rinse and let it dry in a clean area.

If using google or safety glasses, clean with detergent, then soak in chlorine solution 0.05% for 10 minutes (30 minutes can damage the goggle, glasses), thoroughly rinse (avoid irritation of eyes) and let it dry in a clean area, before reusing.

Contaminated equipment should be placed in clearly labelled, leak-proof bags or closed container.

Transport of equipment bag/container from the anteroom to the cleaning/ utility room

- The trained staff wears disposable gloves and mask to transport the bag to the cleaning room.
- Place the leak-proof bag into a new bag (double bag) or disinfect the outside part of the container with chlorine solution 0.05%
- Use a wheeled bin with a lid or trolley (covered trolley is preferred) to transport the bag. The staff must not carry the bag/container.
- Clean and disinfect all surfaces of the trollies or bins, after each use.

Cleaning staff, like other staff need to check and record their temperature twice a day, and notify to chief of unit or IPC team, if any symptoms.

2.11 Soiled linen:

Soiled linen must be proceeding by trained staff wearing PPE (depending on the pathogen route of transmission). At least wear rubber gloves, impermeable apron, and rubber boots. Soiled linen, from patients and HCWs, should be cleaned, and disinfected/sterilized when necessary in HCF laundry. To ensure a safe and sanitary environment for laundry staff, PPE should be available, as well as the supply of clean water, and hygienic laundry place. Soiled linen should be placed in clearly labelled, leak-proof bags or closed container.

If there is any solid excrement such as faeces or vomit:

- Remove carefully and flush it down the toilet (if proper sewage) or in the sluice before linen is placed in its bag or container.
- If not proper sewage, remove carefully, discharge in waste bag,
- or decontaminate with disinfectant solution (concentration depending on the pathogen)

The basic principles of linen management are as follows:

- In laundry room, the staff should be protected and wear at least: gloves, surgical mask, and impermeable apron, and close shoes or rubber boots. Where there is no laundry machine, and staff is washing by hands, the staff need to wear eyes protection (e.g., safety glasses).
- Place used linen in bag for linen at the point of generation. Do not rinse in patient care area.
- Any linens soiled with blood/bodily fluid are considered infectious.
- Separate infected linen from non-infected linen and put it in a bag for infectious linen (e.g. yellow impermeable bag). Keep it separated during transport.
- Handle all linen with minimum agitation to avoid aerosolization of pathogenic microorganisms.
- Mattresses and pillows should be covered with plastic and be wiped over with a neutral detergent (refer to environment cleaning). If there is no plastic cover, wash them by hand.

Principles for reprocessing soiled linen:

	Non-infectious linen	Infectious linen	Infectious drapes from operating room
Overview	Linen from non-infectious patient and without blood/ body fluid	All linens from infectious patients and/ or with blood/ body fluid.	All drapes from operating room are infectious.
PPE required when handling linen	Disposable gloves	Disposable gloves (Other PPE may be required depending on route of transmission).	Rubber gloves (Other PPE may be required depending on route of transmission)
Sorting used linen	Place in bag for linens. Separate linens soiled with bodily fluid and put in infectious linens bag.	Place all used linen in bag for infectious linen (e.g. yellow impermeable bag) at the point of generation.	Place all drapes in bag for infectious linen (e.g. yellow impermeable bag) at the point of generation.
PPE required in laundry room, when using laundry machine	Gloves Surgical mask; Impermeable apron; Close shoes or rubber boots	Rubber gloves; Surgical mask; Eye protection; Impermeable gown or non-impermeable gown with impermeable apron; Rubber boots	Rubber gloves; Surgical mask; Eye protection; Impermeable gown or non-impermeable gown with impermeable apron; Rubber boots
PPE required in laundry room, for hand washing	Rubber gloves, eyes protection, surgical mask, impermeable apron rubber boots,	MUST NOT be hand washed. If not laundry machine available, wash by hands with caution; Always wear eyes	MUST NOT be hand washed. If not laundry machine available, wash by hands with caution; Always wear eyes protection as

	Non-infectious linen	Infectious linen	Infectious drapes from operating room
		protection as using disinfectant.	using disinfectant
Washing process with hot water (at least 70oC)	Detergent (Laundry liquid or powder); Rinse; Dry (dryer or sun & iron)	Detergent (Laundry liquid or powder) Rinse; Dry (dryer or sun & iron)	Detergent (Laundry liquid or powder); Rinse; Dry (dryer or sun & iron); Bring clean and dried drapes to the central of sterilization
Washing process with warm or cold water (less than 70 C)	Wash with deter-gent (Laundry liquid or powder); Rinse; Dry (dryer or sun & iron)	Detergent (Laundry liquid or powder); Rinse; Soak in clean water with sodium hypochlorite 0.5% for 30 minutes; Wash again with detergent and water, and dry (dryer or sun & iron)	Detergent (Laundry liquid or powder); Rinse; Soak in clean water with sodium hypochlorite 0.5% for 30 minutes; Wash again with detergent and water, and dry (dryer or sun & iron); Bring dried drapes for packaging and sterilization.

Note: If there is no other option (no laundry machine), for infectious linen/ surgical drape, before being wash by hand, they need to be decontaminated at first (soak in disinfectant solution, e.g., bleach 0.05% or autoclaved), then they MUST be cleaned rinsed and disinfecting, and sterilization for sterile drapes, to avoid contamination of patient.

In the laundry room, trained staff wear PPE wearing PPE depending on the pathogen route of transmission, with rubber gloves, waterproof apron and rubber boots), wash infected linen with laundry machine:

- In hot water > 70°C: wash with detergent or disinfectant (30 minutes).
- In cold water < 70°C: wash with detergent, then disinfectant that are active in cold water. When using bleach, rinse in clean water, and dry before reuse.

Laundry staff, like other staff need to check and record their temperature twice a day, and notify to chief of unit or IPC team, if any symptoms

2.12 Handling of dead bodies

Discourage any local practices (touching/being in contact with the corpse) by HCW, family, friends, etc. Dead body remains should not be sprayed, washed or embalmed. The national guidelines on safe handling of covid-19 dead bodies should be applied accordingly in the burial process.

PPE to safely handle dead body. Refer to route of transmission, with at least:

- Disposable gown with long sleeves
- Waterproof apron
- Disposable, non-sterile gloves (over the cuffs of the gown)
- Surgical mask (wear particulate mask if autopsy)
- Eyes protection (preferable face-shield, or goggle)
- Rubber gloves
- Rubber boots

Put corpse in waterproof/ impermeable body bag immediately; and transfer to the mortuary as soon as possible after death. Bury or incinerate corpse without delay.

Surveillance of staff who handle dead body (need to check and record their temperature twice a day, and notify to manager of unit, IPC team if any symptoms).

2.13 Strengthening management of employees, visitors, and related personnel

- Facilities must conduct temperature checks at entry points and within the office.
 - It is recommended to conduct temperature checks and respiratory symptom screening of employees and related personnel twice a day.
 - Conduct temperature checks for facility users and visitors as they enter the facilities.
 - Maintain a record of visitors and users with their personal details, contact information, temperature check results, etc.
- Do not permit employees or visitors with fever or respiratory symptoms to work or use the HCF.
 - Workers with a fever or respiratory symptoms will remain at home and refrain from making contact with others, while monitoring their health for the next few days.
- Actively provide managerial notice that workers are required to stay home if they develop a fever or respiratory symptoms.
- If there is a suspected COVID-19 patient, provide an isolation area within the facilities with well-ventilated doors that can be closed and restrict access to this area to those who wear protective equipment such as medical facial masks.

2.13.1 Managing Blood/Body Fluid Exposure

- Persons including HCWs with percutaneous or muco-cutaneous exposure to blood, body fluids, secretions, or excretions from a patient with suspected or confirmed infectious disease, should immediately and safely stop any current tasks, and leave the patient care area.
- Safely take off PPE according to the steps in the procedure, in the anteroom
- Treat affected exposed area:
 - wash the affected skin surfaces or the percutaneous injury site with soap and water
 - Irrigate mucous membranes (e.g., conjunctiva) with copious amounts of water or an eyewash solution, and not with chlorine solutions or other disinfectants.
- Immediately report the incident to the chief of unit, IPC focal point (following hospital exposure procedure) as soon as the HCF staff exist the isolation room/ unit.
- Exposed persons should be medically evaluated for:
 - infectious disease (ID) (of isolated patient)
 - other potential exposures (e.g., HIV, HCV) if sharp/needle-stick injury
- Exposed persons must receive follow-up care, including:
 - fever monitoring, twice daily
 - period of recording symptoms will depend on the ID
 - Counselling and psychological support
- Immediately consult with an expert in infectious diseases for any exposed person who develops fever, symptoms after exposure.
- If fever appears and other symptoms, isolate HCF staff, and follow procedure for ID suspected until a negative diagnosis is confirmed.
- People suspected of having infected should be cared for/isolated, and the same recommendations outlined in this document must be applied until a negative diagnosis is confirmed.
- Conduct contact tracing and follow-up of family, friends, co-workers and other patients, who may have been exposed to Ebola virus through close contact with the infected HCW/ staff.

2.14 Social distancing

- Avoid physical contact including handshakes, etc. with other employees and visitors of the HCF.
- Improve the working environment by taking measures to keep an adequate distance between workers.

- Utilize alternative work and lunch hours to promote flexible work schedules and to prevent mass gathering of personnel.
- Temporarily suspend the operation of public spaces such as indoor lounges and rest areas.
- Postpone and/or cancel unnecessary mass gatherings, small-group events, etc.

2.15 Actions following detection of suspected patients

- Facilities managers should immediately report the local public health center/facilities if a suspected patient is identified.
- The suspected patient should wear a mask and stay in a separated space until the patient is transferred to a screening post. The suspected patient should be placed under self-quarantine until the test results are confirmed.
- After the suspected patient is transferred to the screening post, disinfect the area that the patient remained.

3. Waste Management Control and Healthcare Waste Management

3.1 Overview of healthcare waste management

3.1.1 Categorization of healthcare wastes

While approximately 80% of the wastes generated in a HCF are general waste, the remaining 20% comprise wastes that contain harmful microorganisms which can infect hospital patients, HCFs staff and the general public, as well as sharp objects and hazardous substances that can result in injuries, poisoning and pollution.

Healthcare waste is broadly categorized into two main groups, namely medical wastes and general wastes.

1. General wastes or household waste

- Any waste that are solid or semi-solids generated from HCFs that are non-toxic and non-hazardous and are not contaminated with medical wastes. These are the food wastes, paper, plastics, textiles, non-toxic metals, glass and garden wastes.
- In the event that general wastes are contaminated or mixed with any medical wastes, the general wastes shall be classified as medical wastes and managed accordingly.

2. Medical wastes

- Any waste which consists completely or partly of human or animal tissue, blood or other body fluids, excretions, drugs or other pharmaceutical products, swabs or dressings, syringes, needles or other sharps instruments, ... all wastes that are hazardous or can cause infection to any person coming into contact with it.
- Any other wastes generated from healthcare activities which may be hazardous or toxic.
- The categories of medical wastes are:
 - Infectious wastes
 - Pathological wastes
 - Sharps wastes
 - Pharmaceutical wastes
 - Genotoxic wastes
 - Chemical wastes
 - Wastes with high content of heavy metals
 - Pressurized containers
 - Radioactive wastes

3.1.2 Covid-19 Waste Categorization

In addition to categories of Health Care Waste (HCW), already described above; waste from all Covid-19 facilities, including self-quarantine individuals, here in after, referred to as Covid-19 Medical Waste can be categorized as follows:

a) Waste from Covid-19 Healthcare, Isolation and Quarantine Facilities

- All waste generated by confirmed patients admitted to all type of Covid-19 Facilities are treated as Covid-19 Medical Waste. They are disinfected and sealed; and then disinfected again and stored in a designated storage area to be processed on the same day.
- All general waste generated in all type of Covid-19 Facilities in no association with confirmed patients (e.g., wastes generated by administrative personnel, etc.) are treated as general medical waste. They are disinfected and sealed, then disinfected again and stored in a designated storage area to be processed on the same day.

b) Waste from Self Quarantine Individuals

- In case a confirmed patient is holding at home before being transported to Covid-19 Healthcare Facilities, the waste generated will be disposed as Covid-19 medical waste via a local Healthcare facility.
- In case a spike in confirmed cases forces a large number of confirmed patients to be quarantined at home and their waste cannot be processed via a local Healthcare Facilities, management of local Healthcare Facilities may form a separate emergency waste collection, transportation, and processing system to dispose of such waste materials (refer to Annex 2 for a detailed processing plan), in consultation with the Environmental Health Department (EHD) of MoH or Regional Health Management Team (RHMT).

3.1.3 General Healthcare Waste Management Procedures

Proper healthcare waste management includes (1) waste segregation, (2) collection and handling, (3) stock in a safe temporary storage, (4) safe treatment and disposal.

1. Waste segregation

All HCFs shall organize waste segregation at sources. Each type of waste should be contained in designated, color coded and labelled bags and containers.

2. Collection and handling

Workers should handle medical waste as little as possible before storage and disposal. The more waste is handled, the greater the chance for accidents.

Special care must be taken when handling used needles and other sharps, which pose the greatest risk of accidental injury and infection.

Emptying waste containers

Waste containers that are too full also present greater opportunities for accidents. Waste should be removed from operating theatres, procedure rooms, and sluice rooms before the containers become completely full. At the very least, these containers should be emptied once a day. Dispose of sharps containers when they are 3/4 full. (When sharps-disposal containers become too full, people may push sharps into the container, causing injury.)

Workers should wear utility gloves, heavy duty apron and boots when collecting waste.

Do not collect medical waste from patient-care areas by emptying it into open carts or wheelbarrows, as this may lead to spills and contamination of the surroundings, may encourage scavenging of waste,

and may increase the risk of injury to staff, patients, and visitors. Hand manipulation of waste inside a red plastic bag for infectious waste and/ or any other waste container is not allowed.

3. Stock in a safe temporary storage

Following segregation, medical wastes should be placed in a designated, safe (locked) and temporary storage at HCFs. Different health care waste should be streamed separately in standard storage equipment. Storage time of infectious waste should not exceed 48 hours. Anatomical waste should be buried or disposed daily. The central storage area must be:

- Located separately from the general waste storage areas.
- Should be clearly identifiable.
- Away from food preparation, public access and egress route.
- Arranged to store waste for landfill and waste for incineration waste separately.
- Well ventilated and well lit.
- Located on well drained, impervious hard-standing.
- Provided facilities for washing down and disinfection.

4. Treatment and disposal of medical waste

General wastes should be removed from the health facility by authorized agent (Municipality) to be disposed of in an authorized solid waste disposal facility. All Infectious waste generated from health facilities designated for management of covid-19 patients / cases should be treated and disposed of by the following methods:

Incineration. Two-chambered incinerators with proper temperature, required chimney heights should be used. The temperature must be at least of 800°C to ensure minimal emission of toxic gases at the primary chamber. Appropriate location and high chimney (higher than nearby roofs) are required. Pressured gas containers, halogenated plastics like PVC, mercury, cadmium and ampoules of heavy metals should never be incinerated. Health centers and regional hospitals are recommended to ensure that their residential incinerators operate efficiently for the treatment of the biohazard waste.

Single-chamber, drum and brick incinerators cannot meet the best available technology requirements of the Stockholm Convention on Persistent Organic Pollutants hence they are not recommended. Emissions of toxic and persistent organic pollutants (dioxin, furans, etc.) from these small-scale incinerators may result in human exposure at levels associated with adverse health risks. The project will not finance new small-scale onsite incinerator. If existing on-site incinerators are used, mitigation measures will be taken to control emissions to air in line with WBG EHS for healthcare facilities and WHO's guidelines for safe management of waste generated from healthcare activities. The good practices as follow:

- Waste reduction and segregation to minimize quantities of waste to be incinerated;
- Siting incinerators away from patient wards, residential areas or where food is grown;
- A clearly described method of operation to achieve the desired combustion conditions and emissions; for example, appropriate start-up and cool-down procedures, achievement and maintenance of a minimum temperature before waste is burned, use of appropriate loading/charging rates (both fuel and waste) to maintain appropriate temperatures, proper disposal of ash and equipment to safeguard workers;
- Periodic maintenance to replace or repair defective components;

- Improved training for operators and improved management including the availability of an operating and maintenance manual, visible management oversight, and regular maintenance schedules.

Autoclave. Autoclave used to decontaminate infectious waste is required for laboratory (Level BS2+ and BSL3). Infectious waste and waste materials resulting from the testing of covid-19 cases should be pretreated within the testing laboratory before transferred for final treatment and disposal (incineration). All laboratory equipment, materials and fluids must be decontaminated in the autoclave, before being discharged out of the laboratory.

Secured waste pits: *Infectious waste generated from a covid-19 confirmed cases in rural community where collection is impossible by the case management clinical team can be safely disposed in a secured waste pit and covered with reasonable amount of soil. Where there is no secured pit a pit-latrine can also be used as better option for disposal of the waste in remote areas*

5. Wastewater collection and treatment

Overall requirements

Health and environmental workers should always wear heavy utility gloves and shoes when handling or transporting liquid medical waste of any kind. When carrying or disposing of liquid medical waste, they should be careful to avoid splashing the waste on yourself, others, or on the floor and other surfaces.

Carefully pour liquid waste down a sink, drain, flushable toilet, or latrine. If this is not possible, bury it in a pit along with solid medical waste. Moderate quantities of mild liquid or semi-liquid pharmaceuticals such as solutions containing vitamins, cough syrups, intravenous solutions, eye drops (but not antibiotics or cytotoxic drugs), may be diluted in a large flow of water and discharged into municipal sewers. Pharmaceutical wastes shall not be disposed of into slow-moving or stagnant water. Pharmaceutical wastes shall not be disposed of into slow-moving or stagnant water.

All facilities should have appropriate drainage. If the facility does not link to a treated municipal water drainage system, then all drainage should be treated locally. This includes appropriate septic and filtration systems. Highly infectious waste should be disinfected by proper disinfectants or autoclaved before they are disposed of either by incineration or non-incineration processes. Unless there is an adequate waste-water treatment plant, blood should be disinfected before discharged to a sewer.

Management of fecal waste and wastewater in COVID-19 outbreak

There is no evidence that the COVID-19 virus has been transmitted via sewerage systems with or without wastewater treatment. Further, there is no evidence that sewage or wastewater treatment workers contracted the severe acute respiratory syndrome (SARS), which is caused by another type of coronavirus that caused a large outbreak of acute respiratory illness in 2003. 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 particularly well suited to destroying 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. Best practices for protecting the health of workers at sanitation treatment facilities should be followed. Workers should wear appropriate personal protective equipment (PPE), which includes protective outerwear, gloves, boots, goggles or a face shield, and a mask; they should perform hand hygiene frequently; and they should avoid touching eyes, nose, and mouth with unwashed hands.

- *Sanitation and plumbing*

People with suspected or confirmed COVID-19 disease should be provided with their own flush toilet or latrine that has a door that closes to separate it from the patient's room. Flush toilets should operate properly and have functioning drain traps. When possible, the toilet should be flushed with the lid down to prevent droplet splatter and aerosol clouds. If it is not possible to provide separate toilets, the toilet should be cleaned and disinfected at least twice daily by a trained cleaner wearing PPE (gown, gloves, boots, mask, and a face shield or goggles). Further, and consistent with existing guidance, staff and health care workers should have toilet facilities that are separate from those used by all patients.

WHO recommends the use of standard, well-maintained plumbing, such as sealed bathroom drains, and backflow valves on sprayers and faucets to prevent aerosolized fecal matter from entering the plumbing or ventilation system, together with standard wastewater treatment.²¹ Faulty plumbing and a poorly designed air ventilation system were implicated as contributing factors to the spread of the aerosolized SARS coronavirus in a high-rise apartment building in Hong Kong in 2003.²² Similar concerns have been raised about the spread of the COVID-19 virus from faulty toilets in high-rise apartment buildings.²³ If health care facilities are connected to sewers, a risk assessment should be conducted to confirm that wastewater is contained within the system (that is, the system does not leak) before its arrival at a functioning treatment or disposal site, or both. Risks pertaining to the adequacy of the collection system or to treatment and disposal methods should be assessed following a safety planning approach with critical control points prioritized for mitigation.

- *Toilets and the handling of feces*

It is critical to conduct hand hygiene when there is suspected or direct contact with feces (if hands are dirty, then soap and water are preferred to the use of an alcohol-based hand rub). If the patient is unable to use a latrine, excreta should be collected in either a diaper or a clean bedpan and immediately and carefully disposed of into a separate toilet or latrine used only by suspected or confirmed cases of COVID-19. In all health care settings, including those with suspected or confirmed COVID-19 cases, feces must be treated as a biohazard and handled as little as possible. Anyone handling feces should follow WHO contact and droplet precautions and use PPE to prevent exposure, including long-sleeved gowns, gloves, boots, masks, and goggles or a face shield. If diapers are used, they should be disposed of as infectious waste as they would be in all situations. Workers should be properly trained in how to put on, use, and remove PPE so that these protective barriers are not breached.²⁵ If PPE is not available or the supply is limited, hand hygiene should be regularly practiced, and workers should keep at least 1 m distance from any suspected or confirmed cases.

If a bedpan is used, after disposing of excreta from it, the bedpan should be cleaned with a neutral detergent and water, disinfected with a 0.5% chlorine solution, and then rinsed with clean water; the rinse water should be disposed of in a drain or a toilet or latrine. Other effective disinfectants include commercially available quaternary ammonium compounds, such as cetylpyridinium chloride, used according to manufacturer's instructions, and per acetic or peroxyacetic acid at concentrations of 500–2000 mg/L.

Chlorine is ineffective for disinfecting media containing large amounts of solid and dissolved organic matter. Therefore, there is limited benefit to adding chlorine solution to fresh excreta and it is possible that this may introduce risks associated with splashing.

- *Safely disposing of greywater or water from washing PPE, surfaces and floors.*

Current WHO recommendations are to clean utility gloves or heavy duty, reusable plastic aprons with soap and water and then decontaminate them with 0.5% sodium hypochlorite solution after each use. Single-use gloves (nitrile or latex) and gowns should be discarded after each use and not reused; hand hygiene should be performed after PPE is removed. If greywater includes disinfectant used in prior

cleaning, it does not need to be chlorinated or treated again. However, it is important that such water is disposed of in drains connected to a septic system or sewer or in a soaking pit. If greywater is disposed of in a soaking pit, the pit should be fenced off within the health facility grounds to prevent tampering and to avoid possible exposure in the case of overflow.

6. Other General Guidelines for Healthcare Waste Management Procedures

- Waste minimization, reuse and recycling: HCF should consider practices and procedures to minimize waste generation, without sacrificing patient hygiene and safety considerations.
- Delivery and storage of specimen, samples, reagents, pharmaceuticals and medical supplies: HCF should adopt practice and procedures to minimize risks associated with delivering, receiving and storage of hazardous medical goods.
- Waste segregation, packaging, color coding and labeling: HCF should strictly conduct waste segregation at the point of generation. Internationally adopted method for packaging, color coding and labeling the wastes should be followed.
- Onsite collection and transport: HCF should adopt practices and procedures to timely remove properly packaged and labelled wastes using designated trolleys/carts and routes. Disinfection of pertaining tools and spaces should be routinely conducted. Hygiene and safety of involved supporting medical workers such as cleaners should be ensured.
- Waste storage: A HCF should have multiple waste storage areas designed for different types of wastes. Their functions and sizes are determined at design stage. Proper maintenance and disinfection of the storage areas should be carried out. Existing reports suggest that during the COVID-19 outbreak, infectious wastes should be removed from HCF's storage area for disposal within 24 hours.
- Onsite waste treatment and disposal (e.g. an incinerator): Some HCFs may have their own waste incineration facilities installed onsite, or use local hospital incineration facility. 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 Environment and Social Impacts Assessment (ESIA) developed. Good design, operational practices and internationally adopted Generation standards for healthcare waste incinerators can be found in pertaining to Environment, Health and Safety (EHS) Guidelines and Good International Industrial Practice (GIIP).
- Transportation and disposal at offsite waste management facilities: Not all HCF has adequate or well-performed incinerator onsite, hence waste maybe exported from one Healthcare facility to another with incineration facility. Not all healthcare wastes are suitable for incineration. An onsite incinerator produces residuals after incineration. Hence offsite waste disposal facilities provided by Local government authority or the private sector may be needed. These offsite waste management facilities may include incinerators, hazardous wastes landfill. In the same vein, due diligence of such external waste management facilities should be conducted to examine its technical adequacy, process capacity, performance record, and operator's capacity. In case any gaps are discovered, corrective measures should be recommended and agreed with the government or the private sector operators.
- Wastewater treatment: HCF wastewater is related to hazardous waste management practices. Proper waste segregation and handling as discussed above should be conducted to minimize entry of solid waste into the wastewater stream. In case wastewater is discharged

into Local sewer sewerage system, the HCF should ensure that wastewater effluent comply with all applicable permits and standards, and the Local wastewater treatment plant (WWTP) is capable of handling the type of effluent discharged. In cases where Local sewage system is not in place, HCF should build and properly operate onsite primary and secondary wastewater treatment works, including disinfection. Residuals of the onsite wastewater treatment works, such as sludge, should be properly disposed of as well. There're also cases where HCF wastewater is transported by trucks to a Local wastewater treatment plant for treatment. Requirements on safe transportation, due diligence of WWTP in terms of its capacity and performance should be conducted.

- Only trained staff, wearing PPE depending on the pathogen route of trans-mission, with rubber gloves, impermeable apron and rubber boots, must handling infectious waste in the isolation room/ IU (see Appendix 2 Transmission based Precautions)
- Dispose needle/sharps in a sharp-proof container (as per standard precautions), and never re-cap needles and/or separate needle from syringe before disposing in the container.

Management of solid infectious waste

Transport of infectious waste bag from isolation room/ unit to incinerator or designated pit:

- Put the waste bag in another clean bag (double bagging) before exiting the isolation area or decontaminate container/bag with the infectious waste, with chlorine solution 0.05%.
- Outside the isolation area, staff who is helping for double bagging, trans-port the decontaminated bags/containers, should wear at least gloves and disposable mask if outside the isolation zone.

When storing bag/container with infected waste, before being properly manage:

- Do not store them more than 24 hours.
- The store place must be protected by a fence to prevent entry by animals, children, or untrained personnel

Management of waste bags with infected solid waste

- Incinerate bags with infectious wastes (high temperature > 800°C.)
- Disinfect infectious waste by autoclave
- Bury in a designated pit of appropriate depth (e.g., 2 meters)

Management of infected liquid waste (blood, feces, urine and vomit, grey water, etc.)

With adequate PPE, depending on the pathogen route of transmission, adding eyes protection and surgical mask (if not worn).

- Flush liquid waste (e.g., urine, liquid fecal waste) into the sewage system, if there is an adequate system in place.
- Avoid splashing when disposing of liquid infectious waste to avoid possible generation of aerosols.

When hospital does not have an adequate system:

- Select adequate disinfectant solution for the pathogen.
- In general, disinfect liquid waste with chlorine 0.05% or 0.5% depending on the pathogen before disposing (e.g., disinfect cholera with chlorine solution 0.5%)
- Avoid splashing when pouring disinfectant solution.

3.2 Plans for Covid-19 Waste Management

3.2.1 Plans for Safe Disposal of Covid-19 Medical Waste from Intensive Care Unit Facilities

a) Generation

- The waste is immediately inserted into a container designated for Covid-19 Medical Waste at the site of waste Generation (and minimize movement of the waste within the Healthcare facility). The Container is then sealed (double seal with designated bag plus designated container: Refer to Annex 7).
- The waste is disinfected before being put in the waste container and after sealing the container. In case supply of designated container made with synthetic resin is disrupted, designated container made with corrugated cardboard may be used to dispose of personal protective equipment (masks, protective suit, etc.) used by medical staff or waste disposal workers, as such equipment will not cause the designated bag to rip or leak.
- Food waste from confirmed patients are also treated as Covid-19 medical waste to be disposed of in a designated container. In case the entire Healthcare Facility is quarantined (cohort quarantined) and food waste cannot be disposed of in designated medical waste containers, such waste is disinfected and collectively incinerated (at public incinerators or commercial waste incinerators operated by the respective local governments or private facilities, where possible).
- Bed sheets, pillowcases, blankets, and other linens that can be washed are cleaned in washing machines with disinfectant or detergent in warm water cycle (as per the WHO guidelines) before reuse.

b) Storage

- In principle, waste is disposed from hospitals on the same day it was generated as to minimize the storage time in hospitals, however;
- When such waste is stored in hospitals, it is stored separately from other waste materials in a designated storage warehouse.
- Organic tissues must be stored in a designated refrigerated facility (4°C or colder), and quarantined waste that do not decay must be refrigerated in principle when possible.
- Storage warehouses must be disinfected every day. Warehouses must block the view of medical waste from outside, and entry must be controlled.

c) Collection Transportation

- Waste is sealed inside dedicated containers. In transportation, waste should not pass through temporary holding locations, and should be directly sent to medical waste incineration facilities to be incinerated.
- Only Special Waste carrier vehicle with valid permit should be used for the transportation of the infectious waste from one health facility to another for the treatment and disposal purposes.

d) Incineration

- Waste is put into incinerators as soon as they arrive at the incineration facility, while sealed inside designated container.
- Status of waste disposal and final processing are monitored on a regular basis by Environmental Health department.

3.2.2 Plans for Safe Disposal of Covid-19 Medical Waste from Confirmed Patients from Healthcare Facilities or Quarantine Facilities

All waste (including food waste) generated by confirmed patients are treated as Covid-19 medical waste. Such waste is (1) disinfected and sealed before generation, (2) regularly disinfected, and (3) all incinerated for disposal every day. All COVID-19 facilities providing living and medical support (i.e. isolation centers, quarantine centers or healthcare facilities, either private or government owned), are considered to be facilities generating Covid-19 medical waste.

a) Generation

- Waste is immediately inserted into a container designated for quarantined medical waste at the site of waste emission. Movement of waste is minimized within the hospital facility.
- Waste is disinfected and sealed inside designated medical waste bags, then put inside standard garbage bags to be stored.
- Individuals are advised to refrain from generating waste, with generations of waste taking place in extremely exceptional circumstances. Quarantined individuals must disinfect their own waste (including food waste), put it in designated medical waste bags and apply seal.
- Food waste from confirmed patients are also treated as quarantined medical waste to be disposed of in a designated container.
- Bed sheets, pillowcases, blankets, and other linen materials that can be washed and reused are cleaned in washing machines with disinfectant and/or detergent in a warm water cycle.
- Mattresses, beds, carpets, etc., used by the patients are appropriately disinfected.

b) Collection and Transportation

- Waste management workers collect the waste on a designated time every day. The waste is disinfected and stored in separately designated (temporary) storage locations. Such storage locations must block the view of medical waste from outside (in a separate space, temporary cargo container, etc.).
- Entry to such locations must be controlled and must be chemically disinfected at least once a day.

c) Transportation and Disposal

- Designated collection and transportation companies/State special waste carrier vehicles transport the stored waste to a designated disposal facility on the same day to be incinerated.
- Residential waste materials generated by the operation and support functions of Healthcare Facility, without coming into contact with confirmed patients, are strictly treated as general Covid-19 medical waste and are incinerated.
- As in the case with Covid-19 medical waste in Healthcare Facilities, materials treated as general medical waste are all disinfected, sealed and incinerated on the same day it was generated. However, they are contained in designated wheelie bins containers rather than designated synthetic resin containers.
- Healthcare Facility Management designate companies to exclusively collect and dispose of the Covid-19 medical waste. Such companies check the volume of generated and processed waste materials and report the figures to the Healthcare facilities and Department of Environment.

3.2.3 Plans for Safe Disposal of Covid-19 Medical Waste from Confirmed COVID-19 Patients Who Are Self Quarantined Due to Lack of Government Quarantine Facilities

a) Generation

- Self-quarantined patients disinfect ALL of their own waste, seal and put them inside designated medical waste bags, then put inside standard garbage bags until the patient is transported to a government quarantine facility.
- For individuals whose self-quarantine was released (tested negative), waste materials stored in designated medical waste bags are put into standard garbage bags and disposed as residential waste materials to be incinerated and /or in a secured risk waste pit in case of remote areas .

b) Collection and Disposal

- When the patient is transported to Covid-19 hospital, the waste is safely transported to a public clinic. Then, the public clinic contains the waste inside designated

synthetic resin containers sends process and transfer the waste the medical waste to be incinerated on the same day.

- In case of inevitable circumstances such as excessive waste volume and the waste cannot be disposed of on the same day, the waste is processed via local Health Centre.

c) Emergency Collection

- In case Healthcare facilities cannot dispose of the waste materials specified above, management of the Regional Healthcare facilities may configure and implement a separate emergency waste collection, transportation, and processing system (refer to Annex 2 for detailed processing plans).

3.2.4 Plans for Safe Disposal of Covid-19 Medical Waste Generated by Individuals Exhibiting COVID-19 Symptoms During Self Quarantine

a) Generation

- Until quarantine is lifted with negative diagnosis, store wastes in designated bags.
- All generated waste is disinfected and sealed inside designated medical waste bags, then put inside standard garbage bags to be stored in a secure place.

b) Collection and Disposal

- After safely transporting the waste to a local Healthcare facility, the Healthcare facility contains the waste inside designated synthetic resin containers and sends them to the company contracted to collect, transport, and process medical waste to be incinerated on the same day.
- In case of inevitable circumstances such as excessive waste volume and the waste cannot be disposed of on the same day, the waste is processed via district Healthcare facility.
- For individuals whose self-quarantine was released (tested negative), waste materials stored in designated medical waste bags are put into standard garbage bags and disposed as residential waste materials to be incinerated.

3.2.4.1 Generating Residential Waste When Asymptomatic of COVID-19

- Residential waste materials generated at home (including food waste) must be put into the provided designated bags. Use the disinfectant to sufficiently disinfect the top part of the waste and the outside of the bag before storing the waste. Disinfecting the waste bags at least once daily is recommended.
- Designated bags must be filled only to 75% of the capacity to enable complete seal when tied. Used bags should be sufficiently disinfected, tied up, and stored in a separate location. Stored Bags should be disinfected at least once a day.
- Patients should refrain from generating the waste materials contained inside the designated bags outside of their home. If waste contained in the designated bags must be disposed for inevitable reasons. Sufficiently disinfect the bags and put them inside standard garbage bags and call the local Healthcare facility to request collection and disposal of the waste.
- If patient have not received designated bags yet, standard garbage bags may be used in lieu. If waste needs to be disposed, bags should be put inside other standard garbage bags (double bagging).

3.2.4.2 Generating Residential Waste When Showing Symptoms of COVID-19

- If a patient is experiencing suspected novel coronavirus symptoms, patient should immediately call the health authorities, and store residential waste in sealed double standard garbage bags (double bagging). Waste will be collected free of charge by the health authorities and municipal and /or professional waste management companies to be safely disposed.

3.2.4.3 Generating Residential Waste When Self Quarantined as a Confirmed COVID-19 Patient

- Patient should store residential waste in designated bags in sealed double standard garbage bags (double bagging) and store the waste bags inside the provided synthetic resin containers before a patient is sent to a hospital. Patient's waste will be collected free of charge by the health authorities and municipal or professional waste management companies to be safely disposed.

3.2.5 Plans for Safe Disposal of Covid-19 Medical Waste from Locations Visited by Confirmed Patients

- Areas exposed to patients are appropriately disinfected as per WHO guidelines and blocked off until the next day.
- Generated waste materials are double sealed in standard garbage bags and disinfected before sending off for incineration in public Hospital incinerators.
- Protection suits, masks, etc. generated during disinfection process are treated as Covid-19 medical waste.
- Waste generated by preventive disinfection of public facilities are double sealed, disinfected, and incinerated in public Healthcare facility incinerators.

3.3 Healthcare Facility Covid-19 Waste Management and Disposal Manual

a) **Items Required for Waste Disposal:** For waste disposal, the following items are required: (1) waste disinfectant, (2) designated medical waste bag (red bag), (3) designated medical waste container (wheelie bin), and (4) designated medical waste container (stainless steel pedal bin).

b) Generation Method for Waste Generated by Patients in Healthcare Facilities – Covid-19 medical waste

- When disposing waste generated in quarantine rooms, first disinfect the inside of designated bags (orange bags) before putting the waste (without separating for recycle) in. When the waste is inside the bags, disinfect again and tie the bags so that the waste cannot be seen from outside.
- Then, put the designated bags (red plastic bags) inside the provided designated medical waste container (plastic). Disinfect before closing the lid of the designated container (pedal bin), and seal by completely closing the lid.
- Sealed designated medical waste containers should be disinfected on the outside before they are put outside in front of the quarantine room door.
- Waste materials can only be collected if they are disposed with the lids completely closed on the designated medical waste containers (plastic).
- Disposed waste must be collected by the center personnel every day and stored in a separate (temporary) storage location within the Healthcare facility.

c) Generation Method for Waste Generated by Healthcare Facility Staff, Etc.] - General Medical Waste

- Waste generated from staff work areas and lodging, as well as waste that were not directly in contact with confirmed patients (lunchbox, relief item box, etc.) are treated as general medical waste.
- Such waste is put into designated medical waste bags (red bags) without separating for recycling. Before sealing the bags, they must be disinfected.
- After disinfection, the designated bags (red bags) must be tied to prevent the contents from being seen outside. Then, the bags should be put inside designated medical waste containers (stainless steel pedal bin) and sealed.
- The sealed designated medical waste containers (stainless steel pedal bin) must be disinfected on the outside before they are collected.
- Disposed waste must be collected by the centre personnel every day and stored in a separate (temporary) storage location within the Community Health Centre (CHC).

d) Temporary Storage, Transportation, and Incineration Method for Waste from Healthcare Facilities

- Separate (temporary) storage locations must be disinfected once daily; if required, additional disinfection may take place.
- Medical waste stored in separate (temporary) storage locations must be transported and incinerated by medical waste disposal company (collection, transportation, and incineration) every day.

3.4 Guidelines for Patients Pending Hospitalization

3.4.1 Patients Pending Hospitalization

Patient should fill the provided designated bags with residential waste (including food waste) generated at home (fill less than 75% of the bag capacity). Sufficiently disinfect the top part of the waste and the outside of the bags and store the bags in a separate storage location. (Disinfecting the waste bags at least once daily is recommended.)

Patient should refrain from generating waste as much as possible. If waste must be disposed for inevitable reasons, please sufficiently disinfect the waste bags and contact the local health authorities. (Also provide information about the approximate waste volume.)

When the waste collection request is submitted, local healthcare facility will notify you of the approximate collection time. A worker will come to patient door to collect the waste. Patient should store waste at the previously notified time of collection to waste disposal facilities.

3.4.2 Local Governments and Public Clinics

If patients pending hospitalization at home request collection of their residential waste, patient should do so by informing local healthcare facility. The local healthcare facility management should also arrange collection of medical waste generated by emergency responders and disease control personnel in relation to patients pending hospitalization.

3.5 Detailed Guidelines for Medical Waste Emergency Collection and Transportation System

As infectious disease risk warning level is raised and the number of confirmed cases rapidly increase, and there are many confirmed patients who are self-quarantined and not sent to hospitals, these guidelines will be used as systems for emergency collection, transportation, and disposal of waste generated by confirmed patients who are self-quarantined.

Waste disposed by confirmed patients who are self-quarantined is treated as Covid-19 medical waste. In case the self-quarantined confirmed patient is quarantined at home, etc. Local Environmental Department or the Local government authority coordinates medical waste collection and transportation companies to visit and collect the waste.

Waste generated by general (unconfirmed) self-quarantined individuals is treated as residential waste as specified in the "Special Waste Management Measures."

In case the self-quarantined confirmed patient is transferred to a hospital, the local Healthcare facility coordinates the Covid-19 Medical Waste to be collected and disposed by a medical waste disposal company.

3.5.1 Implementation Targets and Period

In regions where number of confirmed cases spiked to force confirmed patients to be self-quarantined instead of being admitted to a hospital, the Environmental Health Department may decide to implement an emergency collection, transportation, and disposal system for Covid-19 medical waste too difficult to process such individuals' waste. This guideline will be implemented on such regions.

This guideline will be in effect from when it is implemented until the aforementioned emergency waste collection and transportation system expires. Waste generated after this guideline is implemented will be processed in accordance with “Special Waste Management Measures for COVID-19 Outbreak.”

3.5.2 Plans for Collection and Disposal of Waste Generated by Self-Quarantined Individuals

Role Allocation

a) Local government authority, healthcare facilities

- Healthcare facilities Process requests for disposal of Covid-19 Medical Waste generated by self-quarantined confirmed patients.
- Receive phone requests for disposal of Covid-19 Medical Waste generated by self-quarantined confirmed patients.
- Transfer to the local Environmental department information about the received Covid-19 Medical Waste collection requests on a daily basis.

b) Local government authority

- Establish and operate a system for collection, transportation, and disposal of Covid-19 Medical Waste generated by self-quarantined confirmed patients.
- Provide overall management of requests for collection of Covid-19 Medical Waste that are submitted to Local governments and Healthcare facilities on a daily basis.
- Assign collection and transportation vehicles based on the daily requests for collection of quarantined medical waste.
- Manage the daily collection, transportation, and disposal status of collection and transportation vehicles.
- Establish a contact system with department of environment and local healthcare facilities to manage requests for collection of quarantined medical waste.

c) Healthcare facilities

- Promote methods of managing Covid-19 medical waste generated by self-quarantined confirmed patients.
- Provide information about making phone requests for collection of Covid-19 Medical Waste (phone number for agencies, etc.).
- Distribute designated medical waste containers (bags) to self-quarantined confirmed patients.

3.5.3 Collection and Disposal System

Receiving Requests to Collect Covid-19 Medical Waste Generated by Self Quarantined Confirmed Patients

- Requesting body: Local Healthcare facility
- Request Method: Use phone and other methods to provide information about the requested Covid-19 Medical Waste (emitter name, waste volume, contact information, etc.). Requests must be made according to Covid-19 Medical Waste Collection Request Form.
- Request Information Management: Healthcare facilities inform the daily Covid-19 medical waste collection request status to Environmental department via email (by 17:00, every day).

Allocation of Covid-19 Medical Waste Collection and Transportation Vehicle (Organizing Department)

- Collection and transportation vehicles are allocated based on the waste location and waste volume by local government authority.

- Collection and Disposal Volume Management: Provide management of information regarding waste location, actual collection volume and processing data assigned to waste collection and transportation vehicles by local government authority.

Collection, Transportation, and Disposal of Quarantined Medical Waste

- Supervision is done by Local Healthcare facility;
- Details of the waste is detailed in the Covid-19 Medical Waste Collection Request Form.
- Local Healthcare Facility or designated private collector secure and provide waste collection and transportation vehicles for emergency waste collection and transportation.
- Waste collection and transportation is conducted using medical waste collection and transported vehicles. However, under inevitable circumstances such as vehicle shortage, temporary vehicles (with refrigeration capabilities) may be used for waste collection and transportation.
- Medical waste collection and transportation vehicles must display appropriate identification forms on both sides and back of the truck.
- Employees of waste collection and transportation companies or healthcare facilities must submit personal information protection agreement before participating in waste collection and transportation jobs.
- Covid-19 Medical Waste collected and transported under emergency measure is transferred to medical waste disposal facilities on the same day of the collection.
- Data on daily collection and transportation of Covid-19 Medical Waste are sent to Department of Environmental Health (division responsible for Health Care Waste Management) by 1700HR. The MoH should then report to the Eswatini Environment Authority accordingly.
- Data on daily collection and transportation of Covid-19 Medical Waste must be sent according to Covid-19 Medical Waste Collection Request Form.

4. Institutional Arrangement and Responsibilities, Training and Capacity Building, Public Awareness, and Engagement of Private Sector (This section needs to be revised and confirmed by the Eswatini PIU)

This ICWMP is directly under the responsibility of the MoH. The Department will coordinate the implementation and apply a multi-stakeholder approach to embrace all the relevant stakeholders to include Ministry of Tourism, Environment, and Culture (MTEC), Local government Authorities, NGOs, and other private sector organizations.

4.1 Institutional Arrangement and Responsibilities

Part of improving ICWM involves clarifying who is responsible for what functions and identifying the fields of competencies of each institutional actor involved in this process. The following roles and responsibilities are suggested:

a) At the National level

The MoH is responsible for the national health policy and ensures the guardianship of the health facilities. The MOH will be heavily involved in overseeing the following ICWM activities:

- a) Procurement of consumables (sharp containers, color coded bin liners)
- b) Procurement of re-usable waste receptacles;
- c) Running maintenance of existing incinerators;
- d) Ensuring availability of land for new sites for installation of new waste treatment and disposal facilities;
- e) Organizing /facilitating capacity building on ICWM amongst Health Care Workers;

- f) Providing human resources (waste handlers, incinerator attendants, etc.)

The MOH will be responsible for monitoring of the implementation of the ICWMP. It has the overall responsibility of protecting the environment and thus ultimately the activities of the MoH must conform to the requirements of the Environmental Management regulations. It will watch over the whole chain of HCW from generation to final disposal.

The Ministry of Environment is also responsible for developing norms and standards for soil, water and air protection, mainly as they relate to the use of landfill sites that may be used for Covid-19 Medical Waste disposal after treatment by Healthcare Facilities. This function is very important as this assures an independent control and monitoring mechanism for the system to bring about safe handling of the Covid-19 Medical Waste throughout the system.

b) At the Regional / Local Authority level

The Regional and Local Authorities will need to put in place arrangements to make sure that HCW from Covid-19 facilities are not mixed with general wastes in their public landfills.

The Regional and Local Authorities must ensure, either by themselves or through partnerships, that facilities capable of handling all the Covid-19 Medical Waste generated in their areas of jurisdiction are in place. They should be responsible for a centralized ICWM regime within their areas of jurisdiction. They should also give their opinion about the ICWMP activities proposed for health facilities in their jurisdiction, in case some may have negative impacts on the local population's health. Coordination of the ICWM activities will be exercised by their respective

The Regional and Local Authorities should design their landfills according to government norms and standards, in order to avoid soil, water and air pollution in case of reception of Covid-19 Medical Waste. To accomplish safe disposal of Covid-19 Medical Waste, especially the ash from incinerators, specific areas should be reserved for that purpose. In addition, local governments should enact regulations to: (i) refuse to receive mixed HCW with non-infectious wastes at local landfills; and (ii) forbid uncontrolled HCW disposal; and (iii) set up strong waste management controls in their landfills (materials for covering, restriction for non-authorized public access, equipment protection, etc.).

c) At the health care facility level

The manager of each health care facility shall be responsible for ICWM for Covid-19 Disease outbreak in his/her establishment. The manager must ensure that the ICWM plan is prepared and then institute all the requirements of the national policy, regulations and standard operating procedures. S/he must designate the officers/teams charged with HCW segregation, collection, transportation and treatment and be overly responsible.

Table 4-1: Summary of key responsibilities for Management of waste from Covid-19 Facilities

Responsible Organization	Responsibilities
Environmental Health Department/ Quality Management (IPC)	• Develop ICWMP for Covid-19 Disease outbreak; • Connect emergency waste disposal companies to Healthcare Facilities; • Provide PPE and disinfectants to Healthcare Facilities;
Environmental Health Department/ Quality Management (IPC)	• Real-time sharing of Covid-19 infections statistics and healthcare facilities information; • Support designation of companies to dispose Covid-19 waste; • Develop and implement safety measures for waste collection, transportation, and disposal; • Provide designated waste bags and disinfectants to self-quarantined individuals;

Environmental Health Department/ Quality Management (IPC)	• Build safe waste management cooperation and support system; • Oversee COVID-19 waste disposal status from all Health Facilities; • Distribute manual for safe management of Covid-19 Medical Waste to all Health Facilities; • Develop plans for disinfecting self-quarantine locations (for positively diagnosed patients) as well as locations visited by Covid-19 patients;
Environmental Health Department/ Quality Management (IPC)	• Monitor Compliance for safe Disposal of All HCW;

4.2 Training and Capacity building

Training and capacity building activities should be led by the EHD of the MoH. The trainings should include among others, the World Health Organisation Guidelines on Covid-19 disease outbreak, more specifically the guidelines on Infection Control and Waste Management.

The specific training activities will be done in the first year of the program. The Senior Environmental Officer engaged through the project may be ideal for the preparation of the training courses and to train key staff as trainers in health facilities and other institutions like the Municipalities and local government authorities. The trained key staff should then train the other employees.

In each Regions, a training of trainer's workshop will be held and will be conducted by Training institutions or national consultants, under the supervision of the MoH or relevant local government teams. Regular reporting will be carried out on training and capacity building progress and outcomes.

In each health care facility, the supervising staff trained in the District workshops will ensure the training of all medical staff, orderlies, cleaners, etc., under their supervision. The heads of the health establishments must supervise this work and prepare periodic evaluation reports.

4.3 Public Awareness

The MoH will lead the activities intended to increase the awareness of the general public about the risks associated with HCW, more specifically with Covid-19 Medical Waste. At local level, RHMTs will do the supervision. These activities will cover the 2 years of the program, through Public animations, radio and television messages, posters, etc., and will be done as follows:

- The Health Education/Environmental Health Department of the MoH will elaborate the content of these messages, of posters and public animation;
- The televised messages will be diffused by the National Television Station;
- The radio messages will be diffused by the local radio stations, in English and Siswati, under the supervision of Ministry of Health, Environmental Health Department.
- Private companies (printing enterprises) will make posters to be used in the Healthcare Facilities.
- Public animation sessions will be led by NGOs acting in the health and the environmental field, under the supervision of Environmental Health Department within the Ministry of Health.

4.4 Strategy for private sector involvement and partnership

The elaboration of measures to involve private companies in ICWM, more specifically with the capacity to manage Waste from Covid-19 facilities will be coordinated by the MoH, in collaboration with other stakeholders.

5. Monitoring and Reporting

HCF should establish an information management system to track and record the waste streams from the point of generation, segregation, packaging, temporary storage, transport carts/vehicles, to treatment facilities. In addition to paper-based database system, the HCF is encouraged to develop an IT based information management system should their technical and financial capacity allow.

As discussed above, the HCF nurse in charge or Hospital Management takes overall responsibility, leads an intra-departmental team and regularly reviews issues and performance of the infection control and waste management practices in the HCF. Internal reporting and filing systems should be in place.

HCW monitoring in health facilities should be carried out regularly, in order to improve waste management and to ensure that good practices are performed after training. Measures should be adopted to ensure that problems and risks involved are identified to enhance safety and preventing the development of future problems. Supervision should be in the following areas: i. segregation, ii. Collection routines and labeling, iii. Internal treatment system, iv. Internal storage of HCW, v. transportation, vi. Worker safety measures, vii. Disposal at sanitary landfill, etc.

Appendix 1: Infection Control and Waste Management Plan template checklist and estimated budget

Activities	Potential E&S Issues and Risks	Proposed Mitigation Measures	Responsibilities	Timeline	Budget
General HCF operation – Environment	General wastes, wastewater and air Generations				
General HCF operation – OHS issues	• Physical hazards; • Electrical and explosive hazards; • Fire; • Chemical use; • Ergonomic hazard; • Radioactive hazard.				
HCF 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 infectious materials					
Emergency events	• Spillage; • Occupational exposure to infectious; • Exposure to radiation; • Accidental releases of infectious or hazardous substances to the	Emergency response plan			

Activities	Potential E&S Issues and Risks	Proposed Mitigation Measures	Responsibilities	Timeline	Budget
	environment; • Medical equipment failure; • Failure of solid waste and wastewater treatment facilities; • Fire; • Other emergent events				
Operation of acquired assets for holding potential COVID-19 patients					
<i>To be expanded...</i>					

Annex 9: Findings from Stakeholder Consultations

One-on-One Interview with stakeholders to understand how each stakeholder has been impacted by the COVID-19 pandemic, reveal their concerns and issues about the virus as well as their needs and expectations in relation to the Eswatini Covid-19 Emergency Response Project

Type of Stakeholder(s): Recovered COVID-19 Client

Location: Mbabane

Date: 24 June 2020

Consultation method(s): Telephonic interview

Question	Response
1. How aware are you of the following? COVID-19 Project	No
2. How has COVID-19 affected: - You - Staff - Operations	Experienced dehumanization in the process of receiving care
3. What are your concerns about COVID-19?	- No psychosocial support for patients - Admission was too soon after disclosure of results, there was no time provided to accept the positive results
4. Are you receiving enough attention and support in implementing the COVID-19 Response activities?	Social needs for patients receiving COVID-19 care are not attended to; Patients are disconnected from their family members because treatment facilities do not have means to enhance communication between patients and family members
5. What are your needs and expectations to support implementation of COVID -19 response?	- To continue to receive respect as a human - Appropriate way of disclosing results - Counselling following results disclosure - Give enough time to deal with the shock of receiving positive results
6. How has your experience dealing with COVID-19 been?	- As a patient you only follow instructions given by the health care team - No psychosocial support for patients - Delay in screening contacts among family members
7. Were you adequately engaged on issues that concern you?	Health care team is a bit harsh to the patients
8. What engagement channel suits you and your work?	N/A
9. Do you have or have you received any issues or grievances on the following: - Infections or exposure to infections - Operations - Engagement and communication - Labour related - Environmental	- Grievances concerning protocols for case detection; however, the medical officer disregarded the grievance because it did not come through the appropriate channel - Grievances should be received by the nurse manager and reported to the Matron who consequently forward them to the SMO
10. How were the above issues or grievances managed?	Was ordered to follow the right channels

11. How do you manage vital information?	Ethical principle of Confidentiality was not observed in handling his results
12. Are there any other issues and challenges faced?	No entertainment for patients besides TV which has recently been installed (no time allotted to go outside, exercise, no Wi-Fi to enhance communication with family members, no ways of buying airtime to connect to your family)
13. Where do you think improvements or changes must be made in COVID-19 response activities?	- Improve turnaround time for results to limit anxiety among clients - Add patients' transport to avoid patients arriving home very late - Documentation in the services needs to improve to limit errors - Provision of psychosocial support (individualized and groups) - Attend to welfare of staff working in the COVID-19 health facilities - Conduct research to understand the effects of COVID-19 on patients living with diabetes

Type of Stakeholder(s): COVID-19 Affected Client under Quarantine

Location: Ezulwini

Date: 24 June 2020

Consultation method(s): Face-to-face interview

Question	Response
How aware are you of the following? COVID-19 Project	No
How has COVID-19 affected: - You - Staff - Operations	Client was in Zimbabwe for 6 months course and could not come back home during course break, now that he is back in country, he hasn't been in his home, hence he is home sick. He has tested negative for COVID-19 and hopes to maintain negative status until discharge; however, client is worried if his family members will be tested too to avoid getting the virus.
What are your concerns about COVID-19?	COVID-19 has affected daily routine, as an army officer he was used to physical trainings, yet he has to be confined in the room.
Are you receiving enough attention and support in implementing the COVID-19 Response activities?	Yes, he is well taken care of in the quarantine centre. And regards the facility as "home away from home" with Wi-Fi enabling him to communicate with colleagues and friends. He appreciates the hospitality of the staff
What are your needs and expectations to support implementation of COVID -19 response?	More information to be given to the general public on COVID-19 and provision of PPE to help limit exposure
How has your experience dealing with COVID-19 been?	COVID- 19 has brought change in the way we do things, now we have to make face masks a part of our lives
Were you adequately engaged on issues that concern you?	Staff attending to clients are available all the time to attend to their needs
What engagement channel suits you and your work?	Face to face
Do you have or have you received any issues or	No issues currently

grievances on the following: • Infections or exposure to infections • Operations • Engagement and communication • Labour related • Environmental	
How were the above issues or grievances managed?	If there were issues, client preferred to use face to face channel when dealing with them as opposed to having a toll-free line because some people have a tendency to abuse toll free lines
How do you manage vital information?	Receiving positive COVID-19 results over the phone is not a good thing as some people may adversely react to the results.
Are there any other issues and challenges faced?	Nothing
Where do you think improvements or changes must be made in COVID-19 response activities?	- Intensify education on behaviour change to help limit the spread of COVID-19 - Proper counselling for clients who receive positive results - Disclose results face to face as opposed to over the telephone

Type of Stakeholder(s): Rapid Response Teams (RRTs) from the Hhohho, Shiselweni and Lubombo regions

Location: Mbabane

Date: 23 June 2020

Consultation method(s): Telephonic interview

Question	Topics	Response
How aware are you of the following? • COVID-19 Project		Mostly not aware of the project
How has COVID-19 affected: • You • Staff • Operations	Stigmatisation	- Healthcare workers are stigmatised as potential carriers of the virus, reception from the community is not pleasant
	Disruptions to Home Life	- Destabilised home life, separated from families and homes
	Work Pressure	- Double shifts (working COVID-19 assignments and the regular programme activities), hence no rest
	Other Challenges	- Colleagues are not cooperating with the teams as they assume MOH is giving the teams special allowances
What are your concerns about COVID-19?	Testing of Persons for COVID-19	- Limited number of sampling kits for contact tracing, supply not matching the demand - Limited number of samples can be taken to the lab at a time which makes the exercise of testing many people time and response consuming - Negative results tend not get as much priority as the positive ones which leads to persons spending more time unnecessarily in isolation, but this issue is improving - Results take too long to return from the lab, hence positive persons are not aware of their status for long periods of time and risk spreading the virus to others - Psychosocial support not given to persons who have tested positive nor to their families

	Adherence to Safety Precautions	- People only wear face masks when leaving the home and not within the home, even when there is a positive family member in the same house. - Low adherence to health and safety precautions by people, especially in the rural areas.
	Vulnerable/Disadvantages Persons	- Homes now being child-headed after parent(s) fall ill or die, there is a need to address the psychosocial needs of the remaining family member.
	Data Management	- Poor data management at treatment centres, no system in place, no data clerk
	Equipment	- Inconsistent supply of PPE
	Other Concerns	-Transport and fuel challenges
Are you receiving enough attention and support in implementing the COVID-19 Response activities?		No
What are your needs and expectations to support implementation of COVID - 19 response?	Communication	- Strengthen links between the teams - contact tracing, case management and the evacuation teams - Standard way for all teams to deal with COVID-19 positive persons
	Support	- Motivate RRT through special allowances i.e. hardship allowance - Psychosocial support - Provide long-term accommodation for healthcare workers for the duration of the contact tracing initiative so that they don't risk infecting their families
	Equipment	Promised trunks to store all necessary medical supplies - PPE
How has your experience dealing with COVID-19 been?		Very challenging; emotionally draining
Were you adequately engaged on issues that concern you?		Not really
What engagement channel suits you and your work?		- Regular documented communications - Clear reporting structures - Feedback forum for RRT and senior management - Registry - Notify RRTs when other teams attend to clients in their region
Do you have or have you received any issues or grievances on the following: • Infections or exposure to infections • Operations • Engagement and	Laboratory Services	- Laboratory staff display an arrogant attitude, poor management
	Response Time	- Response time of clinical management staff needs to improve
	Clinical Staff	- RRT not made aware of patients in home care – lack of communication between contact tracing, case management team and evacuation teams - Homecare guidelines should be distributed to

- communication - Labour related - Environmental	Communication Government Response Other issues and grievances from the Communities	RRTs - Communication: many parties communicating no coordination between teams - Promises made by government are not fulfilled, RRT now have to deal with people's anger - Government doesn't follow through on quarantining travellers that come into the country through borders - Government restricting the activities of RRTs in relation to contact tracing, deeming certain sectors as 'no go' areas - RRT concerns are not adequately addressed - Issues with public transport, no hand sanitizers on public transport - Too many people living in a house, no space for isolation for those potentially infected with the virus; social distancing within a home virtually impossible
How are above the issues or grievances managed?		Lubombo RRTs have meetings once a week where issues are raised
How do you manage vital information?		Maintain confidentiality at all cost
Are there any other issues and challenges faced?		N/A
Where do you think improvements or changes must be made in COVID-19 response activities?		There is need to go back to the drawing using the past 3 months experiences for improved future planning

Type of Stakeholder(s): Manager of National Laboratory

Location: Mbabane

Date: 23 June 2020

Consultation method(s): Face to face interview

Question	Response
Have you heard about the project before?	- Not necessarily aware of the project details, but aware that World Bank is supporting. Some aspects of the project are known
Would you like to receive more information on the project	- Yes
Do you receive enough information on COVID-19?	- Yes
What information and at what frequency would you like to receive the information?	- Information about the project - Funds available by the project for the lab at Lubombo
How has COVID-19 affected you or your sector?	- Backlog of tests since there was no lab, SA was flooded - No COVID-19 lab before, then it was created because of the Pandemic, no such tests had been done before - Molecular based tests are done in specialized labs, TB lab thus shares <u>space</u> since it does molecular based tests, but given the nature of the works, the TB staff don't get enough time to use the lab. Another space for TB was moved to Nhlengano, accommodated there. Support from Global Fund. BS level 3. - Backlog is increasing for COVID-19 due to positive tests received,

	more staff added now, shift system for morning and evening. Testing in SA - TB Staff had to relocate from their families - No blood available since people are positive, testing of donors for COVID-19 now done, thus additional work
What are your fears about COVID-19?	- Lack of knowledge on COVID-19
Are you receiving enough attention and support?	- Staff added - Lab space and material - People trained on COVID-19
What are your needs in as far as the project is concerned?	- Training on COVID-19 - Funds for testing
What are your expectations in as far as the project is concerned?	- Waste collection and treatment support
How has your experience been while affected?	N/A
What aspects of your experience have been acceptable?	N/A
What aspects of your experience have been unacceptable?	- No lab that focuses on emerging pandemics, emerging diseases shock the system due to lack of capacity and space for such. - Two labs at Lubombo to cater for such tests (requested through the project and Global Fund). Under estimation done.
How is the engagement/communication?	- Poor coordination and communication on waste collection and treatment - Clarity on roles for COVID-19 response and management as there is confusion on PPE wear - Coordinating Team for Lab, between 8-9 on Mondays to discuss issues, update management and highlight any issues, RRTs to feed information from community centres - Public Health Emergency Management Committee
1. Which communication/engagement channels are preferable to you?	- WhatsApp on Waste collection scheduling
2. What aspects need improvement?	- Need for communication and coordination on waste management to know available incinerators for management of waste - Communication forum for collection and disposal schedules for all involved e.g. WhatsApp
3. Do you have vital information to disclose?	- Testing results, in service training to remind people of information to divulge
4. How is this information disclosed?	N/A
5. Do you have or have you received any grievances?	- PPE for staff - Lab viewed as not working because of poor management of infectious waste (perception) - Project has not GRM in place
6. How are they managed?	- Met with them as management - Addressed the team, have a team for them for PPE allocation - PPE to be issued (CMS involved)
7. Are there any labour issues?	- Relocation of staff - Increased working hours due to COVID-19
8. How are labour issues managed?	N/A
9. What environmental issues are there?	- Challenges in terms of waste management - Increased waste generated – PPE, tests - Piles of waste generated (tripled) - All teams (wear three sets of PPEs a day)

	- More people and vehicles needed to collect waste - Mbabane incinerator stopped functioning for a while, waste taken to other incinerators because backlog is too much for Mbabane (Now it works); - Fuel is a challenge for transporting waste to other incinerators and personnel to incinerate - No control over incineration
10. How are they managed?	- Makeshift arrangements to collect and dispose waste (request available personnel and source fuel) - 2 big waste incinerators at Lubombo to cater for special waste from the Pandemic, a clear schedule will be availed - Safety programmes in the Lab with a focal person, to do risk assessments to inform PPE policy, waste etc. - WHO wants list of waste and samples for incineration, have them certified in line with COVID-19 - Waste holding areas supported by ICAP - Communication with EHS for supporting collection
11. Are there any other issues and challenges faced?	N/A

Type of Stakeholder(s): CSO – World Vision (advocates for vulnerable persons in rural areas)

Location: Mbabane

Date: 25 June 2020

Consultation method(s): Zoom Video Conferencing

Question	Topics	Response
How aware are you of the following? • COVID-19 Project • COVID-19	N/A	Project not known Adverts on newspaper (no details)
How has COVID-19 affected: • You • Staff • Operations	Disruption of Services and Programmes	• Some of the gains that they had achieved for their beneficiaries has been eroded • Regional Health Motivators (RHMs) are overloaded • Some RHMs are older and are at higher risk for infection, home visits have stopped, but just begun offering that services • Immunization of children has been disrupted • COVID-19 education interventions integrated with initiatives targeted at adolescent girls • Sexual reproductive health, MNC and family planning services have been disrupted • Due to limited food supplies, World Vision is now engaged in food distribution and cash transfer • Sessions/Teen clubs on HIV prevention, outreach services had to stop • Programmes targeted at vulnerable adolescent girls, adolescents living with HIV were interrupted
What are your fears concerning COVID-19?	Economic Ramifications	- Lockdowns have negatively affected small businesses (those run by vulnerable women) who are supported by World Vision - Farmers and informal traders who were selling in

		the urban areas have lost their market and thus livelihoods - Food security worse now (due to livelihoods affected)
	Social Ramifications	- Number of malnourished children has risen due to COVID-19 - Vulnerable households with OVCs cannot access services and food from schools, increases their vulnerability - GBV, neglect, sexual abuse, physical abuse cases have been increasing
Are you receiving enough attention and support?	N/A	N/A
What are your needs and expectations?	Behaviour Change	Behaviour change: though much has been done but there's a still gap, information must be translated into the actual change of habits
	WASH	- Hand washing and sanitation facilities needed where people meet – churches, schools - Hand washing facilities needed at strategic points – at the gate and closer to the classrooms at schools
	Capacity Strengthening	Build the capacity of RHMs, churches, communities, health facilities, and schools to do basic screening for COVID-19 where people meet. Relevant equipment must be provided for screening
	Vulnerable/Disadvantaged Groups	- Support vulnerable households with day to day needs for vulnerable families - Protection for child who are heading their homes
How has your experience dealing with COVID-19 been?		N/A
Were you adequately engaged on issues that concern you?		N/A
What engagement channel suits you and your work?		N/A
Do you have or have you received any issues or grievances on the following: • Infections or exposure to infections • Operations • Engagement and communication • Labour related • Environmental	WASH	- WASH: huge needs due to water shortage (123 tanks procured for increased access to water). Expensive to procure water. Demand is too huge. - Huge demand for hand washing facilities and material - Fear and confusion and anxiety due to job losses etc.
	Loss of Economic Opportunities	N/A
	Stigmatisation	Fear of stigmatisation and discrimination
	Adherence to Safety Precautions	Complacent people, not wearing protection
	Self-Isolation within a Household	No preparation on what to do if infection occurs within the household and a family has to self-isolate within the household, not enough adequate support for such persons

	Access	Communities can't access certain health services
	Testing COVID-19 Affected Persons	- Turnaround time is very slow (response and services), hotline call, persons advised to stay put but nothing happens thereafter - Tested but results not received (for more than 2 weeks)
How were the above issues or grievances managed?		- World Vision's cluster managers are part of the RRTs – regional level - World Vision representative is a member of the Infection Prevention and Control Team, liaises with the other leaders in the team, grievances are channelled accordingly to the right personnel – national level - Toll free number available for people to call on a 24-hour basis, issues are logged, directed to the relevant person and then resolved
How do you manage vital information?		N/A
Are there any other issues and challenges faced?		N/A
Where do you think improvements or changes must be made?		• Cross border screening especially around informal crossings • Temporal isolation rooms in clinics • Education on the disposal and risks associated with using masks and sanitizers (some are flammable) • EMS must collect COVID-19 affected persons, so that the client doesn't have to use public transport • Scaling up the testing for patients on the ground • Training on how to handle the body of person who had died from COVID-19 • Psychosocial support for families who have a family member that has COVID-19 • Support with day to day needs (food provision, protection, information, take risks because they fend for themselves).

Type of Stakeholder(s): CSO – Save the Children

Location: Mbabane

Date: 26 June 2020

Consultation method(s): Telephonic interview

Question	Response
How aware are you of the following? COVID-19 Project COVID-19	• Not heard of the project
How has COVID-19 affected: • You	• Slowed down operations, remote support • Resources

• Staff • Operations	• Beneficiaries have no access to food, no way of making money, food parcels needed • Movement limited • Where there are persons with disabilities, no care provided • Capacity to produce limited • Transport to get to clinics is a problem • Domestic violence due to tension created by lack of supplies • Backyard gardens encouraged
What are your fears concerning COVID-19?	N/A
Are you receiving enough attention and support?	• Funding from EU and other organizations • NDMA • National Response Team • Food security consortium
What are your needs and expectations?	• Coordination • Support on household needs • WASH material and equipment
How has your experience dealing with COVID-19 been?	N/A
Were you adequately engaged on issues that concern you?	N/A
What engagement channel suits you and your work?	• Food security consortium
Do you have or have you received any issues or grievances on the following: • Infections or exposure to infections • Operations • Engagement and communication • Labour related • Environmental	• Child exploitation • Violence • Elderly-headed or child-headed homes • Food • Health facilities very far • No gloves, sanitizers • Fears • Persons living with albinism left out (sanitizers not good for them) • Visually impaired can't read • Deaf and mute person cannot hear health messages • Politicizing the issue
How were above issues or grievances managed?	• Food parcels • Sanitizers from NDMA • Coordination is a real issue • Duplication of efforts use structures available
How do you manage vital information?	N/A
Are there any other issues and challenges faced?	• Clustered households (one room houses)
*****Where do you think improvements or changes must be made?	• Psychosocial support • Prevention (training on COVID-19 and WASH) • Coordination in the support • Focus even in urban areas • Needs of households

Type of Stakeholder(s): CSO - NERCHA Executive Director

Location: Mbabane

Date: 29 June 2020

Consultation method(s): Telephonic interview

Question	Topics	Response
How aware are you of the following? - COVID-19 Project - COVID-19		Aware that the ministry was writing a proposal for the loan to fund the pandemic
How has COVID-19 affected: - You - Staff - Operations	Responses	- COVID-19 came as a shock, as the organization was busy dealing with the HIV and AIDS pandemic - HIV response systems (health sector and the community HIV response systems) had to shrink to make room for the COVID-19 pandemic
	Services	- Transportation of the ARVs is getting more difficult because of restrictions on travel - Not able to continue interpersonal communication because of social distancing – counselling services impacted
What are your concerns and fears concerning COVID-19?	ARV and Drugs	- Production of ARVs by suppliers has been affected due to worldwide lockdowns - Resources for drug supply will be tight
	Local Healthcare Systems	Local healthcare systems are overly burdened by the pandemic – healthcare human resources are doubly burdened
	Persons Living with HIV and AIDS	- Ensure that HIV positive persons are still taking treatment - HIV not taken as a factor in decisions related to categorizing a person as vulnerable - Infection rate/new infections may increase as more people engage in unprotected sexual activities due to being unoccupied
	Socio-economic and Health Concerns	- Economic meltdown will disrupt the uptake of health services - Risk of girl-child being infected with HIV - Teen pregnancies - Increased GBV incidences - Safety of children returning to school - Children under 6 are no more benefitting from school feeding programmes
Are you receiving enough attention and support?		- PEPFAR/UN – made mobile vans available to bring services closer to the community - UNICEF assisting with facilitating virtual communication between counsellors and the community - Not enough guidance from the government and multi-lateral organizations on how to support those living with HIV and AIDS during the COVID-19 pandemic, no long term plan – response has been erratic
What are your needs and expectations?		N/A
How has your experience dealing with		N/A

COVID-19 been?		
Were you adequately engaged on issues that concern you?		N/A
What engagement channel suits you and your work?		N/A
Do you have or have you received any issues or grievances on the following: • Infections or exposure to infections • Operations • Engagement and communication • Labour related • Environmental		Transportation issues – community members can't access health care facilities; defaulter rates are growing
How were the above issues or grievances managed?		N/A
How do you manage vital information?		N/A
Are there any other issues and challenges faced?		N/A
Where do you think improvements or changes must be made?		• Look at HIV and AIDS within the context of COVID-19 for health and community response systems as these populations are still highly affected by the disease • HIV prevention and COVID-19 must be seen as related • HIV positive persons, those with TB must be included in the list for social grants • Bring health services closer to persons living HIV and AIDS so that they don't have to use pick-up points that they are not comfortable with • Reach communities that are hard to reach – reach every corner of the country with health services • Clear framework on how to respond to COVID-19 and HIV and AIDS • Clear plan on how to monitor the feeding of vulnerable children through NCPs • Ensure that everybody that has an underlying disease is able to test for COVID-19 • Look at the workload of service providers – consider task sharing and shifting • Government needs to be more vigilant in responding to cases of GBV

Type of Stakeholder(s): Local Authorities – Mbabane and Siteki Municipalities

Location: Mbabane

Date: 25 June 2020

Consultation method(s): Zoom Video Conference interview

Question	Response
How aware are you of the following? • COVID-19 Project • COVID-19	• Project unknown • Municipal has been working on COVID-19 so aware of the pandemic

How has COVID-19 affected: - You - Staff - Operations	- Affected both as an organisation and city - Some services had to be stopped, scaled down, change in working methods/shift systems - Staff divided into 3; essential, non-essential, non-critical - Safeguards to protect those working at the office and depots; sanitizers at all entry points, screening for temperature, providing face masks - Cut down numbers at markets, space vendors 2.5m apart, public facilities now have water tanks, soaps etc. - Responding to changing directives from Government - Trading controlled as per government regulations; inspectors deployed to check that people are adhering health precautions - Close sporting facilities and parks to limit activity in city centre - Command post; daily virtual meetings to review status of the city - Managing crowds is a problem - Law enforcement a problem at Siteki but now improved - Budget: Diverting of resources that were allocated to other things now has to go into dealing with the pandemic
What are your concerns and fears concerning COVID-19?	- Increased number of people in the city, despite infection rate still rising - Siteki - Residents and commercial community close to referral fear contact with virus - No time frame (for when the pandemic will end) so allocation of resources and plans are disrupted - Limited support from government in terms of resources - Waste: call from Lubombo Referral Hospital on waste. Household infectious waste from frontlines. How is this managed? No clear communication.
Are you receiving enough attention and support?	Not sufficient
What are your needs and expectations?	- Communication and coordination - Resources
How has your experience dealing with COVID-19 been?	N/A
Were you adequately engaged on issues that concern you?	There was engagement in the beginning, but it later seized
What engagement channel suits you and your work?	- Information sharing with the Public Health Unit - Residents and shops nearby
Do you have or have you received any issues or grievances on the following: - Infections or exposure to infections - Operations - Engagement and communication - Labour related - Environmental	- Difficult to keep people out of the parks especially now that the economy has opened up - Who is leading the COVID-19 response – communication and coordination a challenge with the various implementing stakeholders - Lack of collaboration between government structures created deal with COVID-19 and municipalities - Engagement in the beginning when planning contingency plans by Government is good, but when implementation started the resources and support were not available - Unpredictable nature of Government, changing statements makes it

	hard to manage constituents - Household waste now being collected as regularly - Businesses, vendors and traders complaining to Municipals due to loss of economic opportunities and reduced trading times, - Homeowners complain about reduced waste collection reduction - Payment of rates made more flexible, and fees and charges paid by business owners be reduced or halted for the time being - Siteki municipality not engaged when Lubombo Referral was designated the main treatment centre for the country, they have a right to information
How were the above issues or grievances managed?	- Participation and represented in regional forum headed by regional administrator (includes health and local council stakeholders and relevant structures) and WASH Committee - Inter-cluster meetings headed by NDMA and UN so grievances and concerns expressed there - Materials like sanitizers received but not enough. Networks used.
How do you manage vital information?	So far poor, government doesn't involve municipals. Therefore, disclosing information to rate payers becomes a challenge
Are there any other issues and challenges faced?	Municipality issues sometimes given less priority by the government
Where do you think improvements or changes must be made?	- Information sharing – local authorities sometimes left in the dark about certain issues - Municipalities should be engaged more for their input on health issues

Type of Stakeholder(s): Deputy's Prime Minister's Office

Location: Mbabane

Date: 29 June 2020

Consultation method(s): Telephonic interview

Question	Topics	Response
How aware are you of the following? - COVID-19 Project - COVID-19		Not aware of the project
How has COVID-19 affected: - You - Staff - Operations	Budget Strained	- Centres of OVCs (Residential Child Care Facilities) are in a bad condition – need to upgrade facilities (such as those for hygiene), issue of overcrowding, not able to adequately provide for their nutritional needs - Lack of funds to conduct this year's Vulnerability Assessment Study, the office managed to conduct the study but couldn't adequately reach urban populations - Not enough support to deliver food to NCPs - Money from donors diverted to dealing with COVID-19

What are your concerns and fears concerning COVID-19?	Adherence to Safety Precautions	Children socializing in groups, visiting other homes
	Women	- Increasing GBV incidence - Loss of work/livelihood means that women now turn to unhealthy coping strategies
	Reach	- No systems in place to reach vulnerable individuals due to social distancing and other restrictions - Issue of how to distribute social grants to vulnerable persons – govt had to use mobile service providers but this was also challenging
	Older Persons	Infection control interventions targeted at older persons dying from COVID-19
Are you receiving enough attention and support?		- UNDP gave money to conduct Vulnerable Assessment Study - MOH does provide clinical support but more support is needed to help vulnerable groups - Need more support for social protection
What are your needs and expectations?		N/A
How has your experience dealing with COVID-19 been?		N/A
Were you adequately engaged on issues that concern you?		N/A
What engagement channel suits you and your work?		N/A
Do you have or have you received any issues or grievances on the following: - Infections or exposure to infections - Operations - Engagement and communication		- Periphery communities not receiving much support – increased reach needed - Business as usual in some communities – lack of safety controls

• Labour related • Environmental		
How were the above issues or grievances managed?		N/A
How do you manage vital information?		N/A
Are there any other issues and challenges faced?		N/A
Where do you think improvements or changes must be made?		• Need to address family issues • Provide psychosocial to vulnerable persons in order to address their emotional wellbeing • Need to take stock of gaps and note priorities in relation to COVID-19 response - clarity on what interventions are needed, what resources are available • Review of Disaster Management Policy for the country • Coordinated system to respond to the COVID-19 pandemic – the countries' resources are being wasted, duplication of efforts. • Strengthening of prevention measures within Public Health/MOH • Focused implementation of guidelines for specific regions as some areas are regarded as epicenters • Directors within the DPMO's office that oversee the various vulnerable groups need to meet develop a strategy that collectively addresses issues that affect this group