REPUBLIC OF SUDAN

WORLD HEALTH ORGANIZATION

Sudan Health Assistance and Response to Emergencies (SHARE)
(P504629)

ENVIRONMENTAL AND SOCIAL MANAGEMENT FRAMEWORK (ESMF)

April 2025

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Abbreviations and Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
CBD	Convention on Biological Diversity
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CERC	Contingency Emergency Response Component
CoC	Code of Conduct
E&S	Environmental and Social
EWARS	Early Warning, Alerting and Response System
EHS	Environmental Health and Safety
EHSGS	World Bank Group Environmental, Health and Safety Guidelines
EIA	Environmental Impact Assessment
EOCs	Emergency Operating Centres
EPL	Environment Protection law
ESCP	Environmental and Social Commitment Plan
ESF	World Bank Environmental and Social Framework
ESS	World Bank Environmental and Social Standards
ESHS	Environmental, Social, Health and Safety
ESIA	Environmental and Social Impact Assessment
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
EWARS	Early Warning Alert and Response System
FCV	Fragility, conflict, and violence
GBV	Gender Based Violence
GIIP	Good International Industry Practice
GM	Grievance Mechanism
GRM	Grievance Readiness Mechanism
HCWs	Health Care Workers
IDPs	Internally Displaced Persons
IDRS	Integrated Disease Surveillance and Response
HIV	Human Immunodeficiency Virus
HF	Healthcare Facility
HIV	Human Immunodeficiency Virus
ICU	Intensive Care Unit
IDP	Internally Displaced Persons
INSS	Integrated Nutrition Surveillance System
IOM	International Organization for Migration
IP	Implementing Partner
IPC	Infection Prevention and Control
LMP	Labor Management Procedures
MAM	Moderate Acute Malnutrition
FMOH	Federal Ministry of Health
MOFNE	Ministry of Finance and National Economy

MSP	Minimum Service Package
MWMP	Medical Waste Management Plan
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organization
OHS	Occupational Health and Safety
PHC	Primary Health Care
PMU	Project Management Unit
PPE	Personal Protective Equipment
PRSEAH	Preventing & Responding to Sexual Exploitation, Abuse and Harassment
PSEA	Protection from Sexual Exploitation and Abuse
RCCE	Risk Communication and Community Engagement
RRT	Rapid Response Team
SAM	Severe Acute Malnutrition
SDG	Standard Developmental Goal
SEA/SH	Sexual Exploitation and Abuse / Sexual Harassment
SHARE	Sudan Health Assistance and Response to Emergencies
SEP	Stakeholder Engagement Plan
SMP	Security Management Plan
SRA/MP	Security Risk Assessment and Management Plan
SA/SRMF	Social Assessment and Social Risk Management Framework
SSHUTLC	Sub-Saharan African Historically Underserved Traditional Local Communities
TPM	Third Party Monitoring
UN	United Nations
UNCCD	United Nations Convention to Combat Desertification
UNFCCC	United Nations Framework Convention on Climate Change
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNMAS	United Nations Agency for Mine Action Services
UXO	Unexploded Ordnances
WASH	Water, Sanitation and Hygiene
WB	World Bank
WHO	World Health Organization
WSS	Water Supply and Sanitation

Executive Summary

The World Bank will be supporting WHO in implementing the SHARE project. The objective of the project is to restore access to a basic package of health and nutrition services and preserve the main elements of essential public health functions. The project will support the following activities: improving access to basic health and nutrition services at the first level referral centers and hospitals, reducing the impacts of climate change on health and the health services delivery, preserving the main elements of the health system to prepare for and respond to health emergencies and control diseases. The SHARE Project will be implemented nationwide, covering all states in Sudan. While some hospital-based interventions will target 10 selected states (Dongola, Kassala, Atbara, Osman Degna, Alsororab, Damazin, Sinnar, Algeneina, Alobid, and Nyala), the project's broader public health interventions—including emergency preparedness, surveillance, laboratory support, blood banking, and rapid response teams—will be implemented across all states where funds are feasible and available. Additionally, climate adaptation initiatives and national data management efforts will contribute to strengthening the overall health system.

This Environmental and Social Management Framework (ESMF) has been prepared to identify the potential environmental and social risks, and the impacts of proposed project activities, and suitable mitigation measures to manage these risks and impacts. It maps out the Sudan laws and regulations and the World Bank policies applicable to the Project, and describes the principles, approaches, implementation arrangements, and environmental and social mitigation measures to be followed. The potential environmental and social risks for project activities are identified as: The main potential environmental, health, and safety (EHS) risks, and impacts are associated with Components 1 and 2. The potential EHS risks and impacts related with the rehabilitation or building and operation phases of health facilities (Component 1) and Emergencies Operations Centre (EOCs) and blood banking services (Component 2) include noise and dust pollution, the generation of hazardous and non-hazardous waste and improper waste disposal. The procurement, use, and/or maintenance of medical and non-medical equipment and supplies, essential drugs, vaccines, consumables, reagents, and test kits (Components 1 and 2), along with the delivery of prioritized packages of health services (Component 1), could lead to waste generation. If not managed properly, this waste could cause environmental contamination and pollution. There is also e-waste issues associated with the financing of the (a) integration of digital innovations that will facilitate service provision and enhance staff communication and training allowing for improved quality of service delivery (Components 1 and 3) and (b) solar power for health facilities (Component 1). Project-related potentially hazardous waste, resulting from Components 1 and 2, include infectious materials, sharps, pharmaceuticals, chemicals, and so on. Air pollution could arise from medical storage sites, medical waste incineration, and isolation wards, among others, if health facility wastes are not properly managed. The use of mobile health service teams and outreach rounds (Component 1) may also increase fuel consumption and vehicle emissions, further contributing to air pollution. Potential air pollution sources also include medical waste storage and incineration, isolation wards, and ventilation systems. Further, contaminated wastewater could be discharged from health facilities including medical wards, laboratories, pharmaceutical and chemical stores, and disposal of medical and lab equipment. All this poses occupational and community health risks. Project management (Component 3) activities, such as monitoring, evaluation, and knowledge management, can be resource-intensive, leading to increased carbon emissions and electronic waste. Overall, these potential EHS risks are generally site-specific, temporary, and reversible and can be managed by applying World Bank Environmental and Social Framework (ESF) standards, World Bank Group General EHS Guidelines, and Good International Industry Practice.

The potential social risks and impacts of the project are also associated with Component 1: Improving Access to Basic Health and Nutrition Services and Component 2: Preserving the Main Elements of the Health System. The project will have the following social benefits: improved access to the health system; reduced maternal and child mortality; improved WASH facilities; better nutrition services for the vulnerable groups, IDPs, persons with disabilities, refugees, children, and children; and all other populations at risk. Despite these positive contributions of the project, the following potential social risks and impacts are anticipated: (a) leaving behind some of the populations at risks, exclusion of vulnerable groups; (b)

security risks and illegal activities, such as violence, extortion, theft, armed assault, looting, and vandalism of project materials and properties; (c) risks associated with sexual misconduct-sexual exploitation and abuse, and sexual harassments (SEA/SH); (d) weak and gender insensitive community participation and engagement during implementation; (e) social tensions between the IDPs and host communities over project benefits and rejection of targeting criteria; (f) a possible increase in IDPs mobility to the project areas to benefit from the project, (g) social norms and gender norms, beliefs and practices, (h) and limited attention addressing the entire project from a human rights, and results-based management approaches.

These risks will be managed and mitigated through the application of the World Bank's ESF and implementation of the required environmental and social (E&S) management instruments. These instruments include the Environmental and Social Management Framework (ESMF), including as annexes, Labor management Procedures (LMP), Social Assessment and Social Risk Management Framework (SA/SRMF), Security Risk Assessment and Management Plan (SRA/MP) that guide the preparation of site-specific Security Management Plans (SMP), Sexual and Abuse and Sexual Harassment (SEA/SH) Risk Assessment and well-resourced risk mitigation and response plan and generic Environmental, social and Waste Management plans (WMPs). The relevant site-specific Plans will be developed before the implementation of the rehabilitation activities where applicable. The budget to implement these plans is estimated to be 524,000 USD including different training, printing materials, WASH and IPC supplies and transportation of medical waste for final disposal area by responsible health authority as detailed in section 5.6 table 8.The project will be implemented by WHO where a Project Management Unit (PMU) will be established and maintained to support management of ESHS risks and impacts. The PMU will provide support, oversight, and quality control to field staff working on E&S risk management, review and provide quality assurance and approval to screening forms and ESMPs as relevant, provide training for central and field staff and contractors who will be responsible for implementing the ESMF. Additionally, the PMU will ensure that all bidding and contract documents include all relevant E&S management provisions and provide the necessary support and logistics to the partners to ensure compliance with all requirements. The implementing partners (see Table 7 under subsection 5.2 for details) will be responsible for the implementation and regular monitoring through the lifetime of the project. They must to the extent possible, apply required mitigation measures for subprojects/project activities as stated in this ESMF or other relevant instruments, inform WHO on any deviations or further requirements, ensure project activities do not fall under the exclusion list, fill out screening forms for relevant subproject activities, prepare and implement site-specific ESMPs and other pertinent ESRM instrument for subproject activities and submit forms to the WHO PMU for review and PMU will send to the world bank for final review and clearance before the implementation, and provide training to local contractors and communities on relevant environmental and social mitigation measures, roles, and responsibilities.
During implementation, the WHO will conduct regular monitoring visits oversite the implementation of the E&S mitigation measures which will be regularly implemented and monitored by the implementing partners. The WHO will also track grievances/beneficiary feedback (in line with the Stakeholder Engagement Plan SEP) during project implementation to use as a monitoring tool for implementation of project activities and environmental and social mitigation measures.

The implementing partners will submit regular reports to WHO at national level and accordingly a quarterly progress report will be submitted from WHO to the World Bank. WHO will notify the world bank when become aware of serious incident of accident within 48 hours

Third Party Monitoring Agency (contracted by UNICEF on behalf of the project) will be involved and every three months will assess the status and performance of project implementation phases, compliance status, or emerging issues through a specialized party and to provide an unbiased reflection on the issue and status, and to make recommendations for improvement, where relevant.

A **Stakeholder Engagement Plan** (SEP) has been prepared for the Project, based on the World Bank's Environmental and Social Standard 10 on Stakeholder Engagement. The SEP can be found here: https://www.emro.who.int/sdn/information-resources/stakeholder-engagement-plan.html

1. Introduction

This Environmental and Social Management Framework (ESMF) is developed to support the environmental and social due diligence provisions for activities financed by the World Bank in the SHARE project. The project will support restoring access to a basic package of health and nutrition services and preserve the main elements of essential public health functions in 10 states. The WHO and its implementing partners (Alight; Addition for Disasters assistance and Development; Sudan Family Planning Association; Intersos; Sudanese American Physician Association (SAPA); Pan Care; and Building Foundation for Development) will be implementing the Project activities.

This ESMF follows the World Bank Environmental and Social Framework (ESF) as well as the national laws and regulations of Sudan. The objective of the ESMF is to assess and mitigate potential negative environmental; and social risks and impacts of the Project consistent with the Environmental and Social Standards (ESSs) of the World Bank ESF and national requirements. More specifically, the ESMF aims to (a) assess the potential environmental and social risks and impacts of the proposed Project and propose mitigation measures; (b) establish procedures for the environmental and social screening, review, approval, and implementation of activities; (c) specify appropriate roles and responsibilities, and outline the necessary reporting procedures, for managing and monitoring environmental and social issues related to the activities; (d) identify the staffing requirements, as well as the training and capacity building needed to successfully implement the provisions of the ESMF; (e) address mechanisms for public consultation and disclosure of project documents as well as redress of possible grievances; (f) establish the budget requirements for implementation of the ESMF; and (g) provide adequate information on the states in which the subprojects are expected to be sited including any potential environmental and social vulnerabilities.

This ESMF should be read together with other plans prepared for the project, including the Stakeholder Engagement Plan (SEP), the Environmental and Social Commitment Plan (ESCP).

Project Description

The SHARE project will contribute to efforts by the international community to maintain and enhance health and nutrition services, providing a Minimum Service Package (MSP) and responding to health and nutrition crises. SHARE project has three components; two of them have relevant environmental and social risks and impact as follows:

Component 1: Improving Access to Basic Health and Nutrition Services:

This component aims to enhance access to basic health and nutrition services in Sudan through low-cost, high-impact interventions using a Primary Health Care (PHC) approach. It targets both displaced and host communities. A minimum service package that includes the following services: Expanded Program on Immunization, integrated management of childhood illnesses, maternal, newborn, and paediatric health, nutrition, and noncommunicable diseases (NCDs), including mental health, as well as prevention and response to outbreaks and health emergencies will be supported under this component at different levels of service delivery.

- Subcomponent 1.1: Strengthening the Integration of Primary Health Care Model (implemented by UNICEF)

- Subcomponent 1.2. Supporting Health and Nutrition Services at the First Level Referral Centers and Hospitals (**implemented by WHO**)

Subcomponent 1.2 will complement the Primary Health Care (PHC) model by ensuring the continuum of care at referral centers and hospitals through the provision of a basic package of health and nutrition services, including: (a) management of severe acute malnutrition (SAM) cases with complications and for patients who failed an Outpatient Therapeutic Program at Therapeutic Feeding Centers and/or Stabilization Centers; (b) support to human resources through incentives (excluding the formal employment or payment of salaries of civil servants), training, and capacity building; (c) provision of Basic Emergency Obstetric and Neonatal Care (BEmONC) and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) services in targeted referral centers; (d) provision of basic health diagnostic and pharmacy services in the areas of maternal and child health, communicable diseases, NCDs, including mental health and rehabilitation, public health, infection prevention and control (IPC), WASH, and improving quality of care; (e) procurement and maintenance of equipment, as well as, procurement of medical and non-medical supplies, essential medicines including oxygen supply, routine vaccines, training, and operating costs for the first level referral centers and hospitals; (f) support to vaccination campaigns to reach under-vaccinated populations and raise awareness about its benefits; and (g) implementation of telemedicine where possible.

The WHO will be responsible for: (a) oversight and coordination of health services and information systems including reactivation and rollout of DHIS2 at selected hospitals/first level referral centers; (b) supervision and quality assurance of hospitals/first level referral centers in line with relevant plans and guidelines; (c) coordination and provision of in-service training; (d) in coordination with UNICEF, capacity development of LHMTs to plan, supervise, and oversee service delivery and the DHIS2 system; (e) integrated pharmaceutical procurement, quantification, and forecasting; and (f) support for the implementation and rollout of digital health technology to address service delivery and human resources challenges at selected hospitals.

- Subcomponent 1.3: Climate Change Adaptive Health Service Delivery (implemented by WHO)

Sudan is extremely climate vulnerable, particularly to floods and high heat, as well as to climate-sensitive diseases, primarily malaria and diarrheal diseases such as cholera with significant impacts on health and health service delivery. Climate change has exacerbated the impacts of the conflict on the population. This subcomponent aims to reduce the impacts of climate change on health and the health system and will finance: (a) technical assistance to support the development of contingency plans for climate change health service delivery at referral health facilities; (b) flood and high heat risk assessments at health facilities; (c) development of pre-positioning plans for vector control and water treatment supplies to limit outbreaks of vector-borne and waterborne diseases; (d) training of CHWs on climate

emergency preparedness and response; (e) basic interventions to make referral facilities more climate resilient including minor rehabilitation, solar power, IPC, and WASH; (f) climate change risk communication activities to highly climate vulnerable communities; and (g) integration of meteorologic data into the Early Warning, Alert, and Response System (EWARS) to better understand the relationship between outbreak prone infectious diseases and climate change.

- Subcomponent 1.4: Climate Change Resilient Health Facilities (implemented by UNICEF)
- Subcomponent 1.5: Integrating Digital Solutions to Service Delivery (implemented by UNICEF)

Component 2: Preserving the Main Elements of the Health System (implemented by WHO):

This component will focus on strengthening health systems and public health programs and improving the main elements of the health system to prepare for and respond to health emergencies and control diseases by strengthening emergency preparedness, laboratories, and disease control systems. Specific activities will include essential preparedness functions such as: (a) training and operating cost for Integrated Disease Surveillance and Response (IDSR) including Early Warning, Alerting and Response System (EWARS); (b) operating costs and rehabilitation for selected Emergency Operations Centers (EOCs) with a primary focus on response to climate shocks; (c) supporting health information systems and the Health Resources and Services Availability Monitoring System; (d) developing, disseminating, and training of trainers on subnational emergency preparedness and response plans, primarily focusing on climate shock emergency preparedness and response along with response to conflict; (e) updating and disseminating laboratory guidelines and providing laboratory operating costs; and (f) training and deploying Rapid Response Teams(RRTs). The component will also support strengthening the country's blood bank and transfusion systems, which currently have limited reach, impairing access to Comprehensive Emergency Obstetric and Newborn Care (CEmONC), and safe surgical services. This includes: (a) developing guidelines for the proper collection, storage, transport, and use of blood for transfusions; (b) building or strengthening existing blood banking services; and (c) developing systems and protocols for the transfer of blood products for transfusions.

Component 3: Monitoring and Evaluation and Project Management:

This component will finance costs related to monitoring and evaluation (M&E) and management of project activities. The project will ensure that independent and credible data on health service delivery and coverage and commodities are generated, and that the data are usable and will enable the World Bank and development partners to verify that resources are reaching the intended beneficiaries. The third-party monitoring (TPM) agency's role will include working with UNICEF, WHO, the World Bank, and implementing partners (IPs) to explain results, providing guidance on improved methods, proposing context-appropriate solutions, and conducting ex post facto verification of results provided by project reporting mechanisms.

- Subcomponent 3.1: Third Party Monitoring implemented by UNICEF)

This subcomponent will finance TPM to ensure accountability and transparency of project-supported activities. Under the project, a TPM agency will monitor and verify the delivery of project-supported inputs (for example, medications, supplies, and fuel) to the end users (for example, health facilities and public health campaigns, if needed), as well as monitor the service delivery activities conducted at supported facilities (including, but not limited to, collecting data on monthly utilization of supported health services). UNICEF will receive the financing to contract a TPM agency, and both organizations will agree: (a) to a schedule for regular, periodic monitoring of all supported health facilities and (b) on procedures and protocols for data collection, data transmission, and raw data reporting by the TPM agency to the World Bank, WHO, and UNICEF.

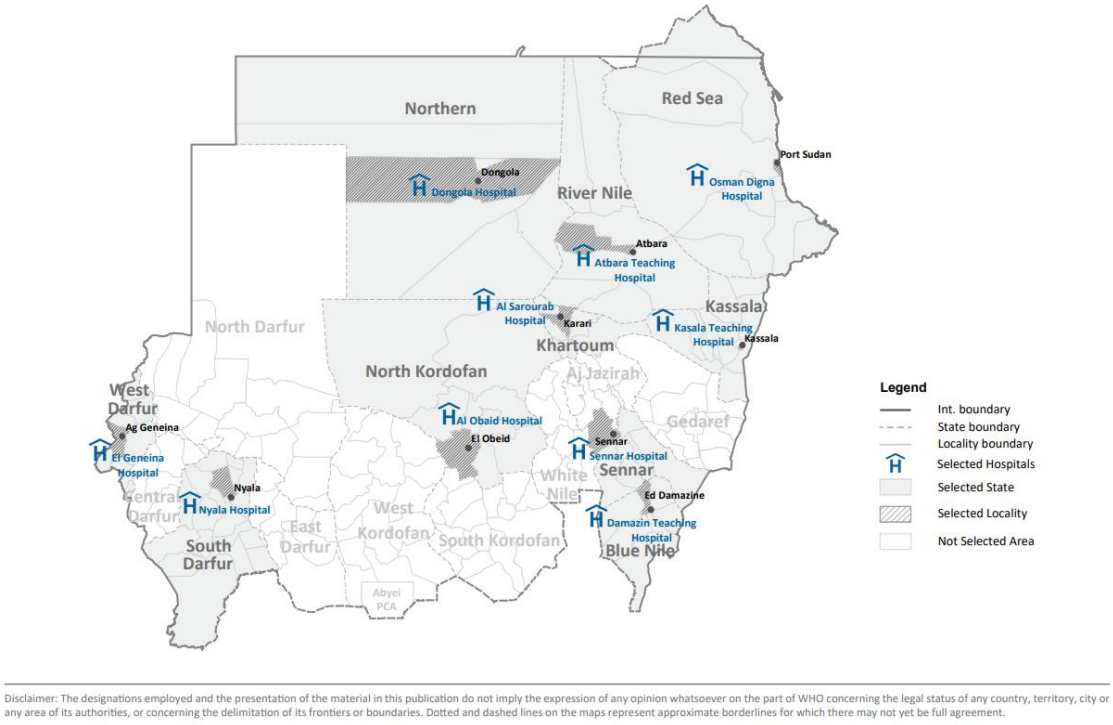
- Subcomponent 3.2: Data Analysis and Knowledge Management (implemented by WHO and UNICEF)

This subcomponent will support the analysis and utilization of data to improve the documentation of project activities, analyze implementation effectiveness, and report findings to internal and external audiences. The project expects that the World Bank, UNICEF, and WHO will collaborate to produce high-value data analysis products, focusing on prioritized topics that contribute to knowledge sharing and global learning. Under this subcomponent, UNICEF and WHO will appoint knowledge management focal points and agree to share relevant data among the organizations to support the described activities. The three organizations will jointly develop knowledge management products (for example, journal articles, briefs, and dashboards) and will also work closely with the TPM agency to ensure high-quality data collection that will inform data analysis. Key focus areas will include service availability, outbreak response, routine vaccination coverage, maternal health, SAM, and others, aligned with project-supported activities. The organizations will collect and analyze data from relevant sources, including EWARS, DHIS2, Health Resources and Service Availability Monitoring System, TPM, and other data sets. Analyses will focus on understanding the impact of project activities and exploring the mechanisms by which impacts were achieved.

- Subcomponent 3.3: Project Management (implemented by WHO and UNICEF)

This subcomponent will finance Project Management Units (PMUs) for both UNICEF and WHO. Both agencies will perform project core management and implementation support activities through their multidisciplinary teams. Specifically, the two organizations will: (a) monitor the project targets and results in coordination with the existing local health workforce; (b) handle procurement, financial management (FM), and disbursement management, including the preparation of withdrawal applications under the project; (c) ensure that independent audits of IPs carrying out project activities are undertaken; and (d) ensure that all reporting requirements for IDA are met according to the Project Financing Agreements. This component will support the M&E activities undertaken by the two organizations under the project. The project M&E arrangements emphasize not only measuring the results but also extracting lessons and recommendations for future interventions.

The project will target the whole country to sustain the main public health functions, with some interventions focused on selected hospitals in 10 states and localities as per priorities and needs.
All the proposed actions highlighted in components 1 and 2 above will fully integrate cross cutting issues such as; positioning SEA/SH risk mitigations and victims/survivors assistance; have gender disaggregated indicators (highlighting the specificity of males, females amongst the different groups targeted and reached); and ensuring the inclusion of vulnerable population and meeting ESS7 requirements in all the phases of planning, implementation and reporting of the project.



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WHO will coordinate project activities, including day-to-day implementation, coordination, supervision, and overall management of project activities. The Project will be implemented with the support of multiple implementing partners with specific roles and responsibilities, see section

3. Environmental and Social Baseline Context

Sudan, located in northeast Africa, is the third-largest country on the continent, covering 1.88 million km². The country has five major ecological zones:

- Desert
- Semi-desert
- Low-rainfall savanna
- High-rainfall savanna
- Mountain vegetation

Sudan is rich in natural resources, including forests, rangelands, arable land, water resources, wildlife, and biodiversity. Approximately 35.6% of Sudan's land area is covered by forests and rangelands, providing essential ecosystem services and livelihoods. Additionally, Sudan has substantial freshwater resources, with nearly half of the Nile River Basin within its borders.

Environmental Challenges:

Despite its rich natural resources, Sudan faces several critical environmental challenges, including:

- Deforestation, land degradation, and desertification—driven by unsustainable land use, agriculture, and urban expansion.
- Climate change impacts, such as rising temperatures, increased droughts, and shifting rainfall patterns, which have exacerbated environmental vulnerabilities.
- Frequent natural disasters, including flooding, droughts, and dust storms, which disrupt agriculture, infrastructure, and public health.
- Air and water pollution, worsened by inadequate waste management, including improper disposal of medical and hazardous waste.

The project's implementation must consider these environmental risks, particularly regarding waste disposal, water resource management, and climate resilience.

Social Context

Sudan has a diverse population with over 500 ethnic groups speaking more than 400 languages. Among these, pastoralists and agro-pastoralists, who constitute about 13% of the population, face historical marginalization and are at risk of exclusion from basic health services.

Socioeconomic Challenges:

- Poverty and Economic Decline:
  - Extreme poverty increased from 20.4% in 2018 to 35% in 2023.
  - The economic downturn resulted in an 11.3% GDP contraction from 2018-2023.
  - The combined impact of conflict, inflation, and natural disasters has worsened living conditions.
- Internally Displaced Persons (IDPs) and Vulnerable Populations:
  - Millions of IDPs are concentrated in conflict-affected states, particularly Darfur, Kordofan, and Blue Nile.
  - Tensions exist between IDPs and host communities due to competition over resources and access to services.
- Health System Challenges:
  - Only 40-50% of the population has access to basic health services.
  - The Universal Health Coverage (UHC) Index for Sudan is at 44% (2021), well below global targets.
  - Key health indicators:

- Maternal Mortality Ratio: 270 per 100,000 live births.
- Under-Five Mortality Rate: 55 per 1,000 live births.
- Neonatal Mortality Rate: 27 per 1,000 live births.
- Prevalence of Stunting: 36.4% of children under five suffer from malnutrition.

- Impact of Conflict on Health Services:
  - Since April 2023, ongoing conflict has severely disrupted Sudan's health system, leading to:
    - 70% of health facilities in conflict areas becoming non-functional.
    - Overwhelming of remaining operational health facilities due to an influx of patients.
    - Severe shortages of medical personnel, equipment, and essential medicines.
    - Increased risk of epidemics due to disrupted vaccination and disease surveillance systems.
    - Destruction and looting of health infrastructure.

Impacts and Enhancement Measures

The Sudan Health Assistance and Response to Emergencies (SHARE) Project will have significant positive environmental and social benefits. These benefits will extend beyond immediate service provision and contribute to long-term improvements in Sudan's health system and resilience.

Positive Environmental Impacts

Improved Medical Waste Management:

- The project introduces structured waste management protocols, reducing the risk of hazardous medical waste disposal.
- Facilities will adopt best practices for infection prevention and control (IPC), reducing biohazard risks.

Climate Resilience in Healthcare Facilities:

- The project supports solar energy installation in selected health facilities, promoting renewable energy use.
- Implementation of flood and heat mitigation measures will strengthen climate adaptation strategies.

Water and Sanitation Improvements (WASH):

- Investments in safe water supply, sanitation, and hygiene infrastructure will reduce the incidence of waterborne diseases.
- Health facilities will receive sanitation upgrades, ensuring clean and safe environments for patients and staff.

Positive Social Impacts

Expanded Healthcare Access for Vulnerable Populations:

- The project targets Internally Displaced Persons (IDPs), host communities, and rural populations, ensuring equal access to health services.
- Special emphasis is placed on maternal and child healthcare, reducing maternal and infant mortality rates.

Strengthening of Emergency Response & Surveillance Systems:

- The project supports nationwide disease surveillance (EWARS), improving early detection of outbreaks.
- Emergency Operations Centers (EOCs) will be upgraded to enhance crisis response capabilities.

Increased Employment and Capacity Building:

- The project will create jobs for healthcare workers, construction teams, and logistics personnel.
- Training programs for healthcare workers will enhance technical expertise and public health preparedness.

Reduction in Gender-Based Violence (GBV) Risks:

a. The project includes GBV risk mitigation measures, including safe reporting mechanisms and survivor support services.

b. Special training on Preventing Sexual Exploitation and Abuse (PSEA) will be provided to all project personnel.

4. Environmental and Social Policies, Regulations, and Laws

4.1 Sudan Legal Framework

Table 1 Sudan Relevant Legal Framework

Law	Description and Relevance to Project Activities
Labor Law 1997	Applies to all workers except civil servants, members of the armed forces, domestic servants, agricultural workers, family members of an employer, and casual workers. **Chapter 4** covers the employment of women and young persons. Prohibits the employment of women during night hours (except in administrative or health-care jobs) and in hazardous or arduous working conditions. Forbids the employment of children (defined as a person under 12 years of age) and the employment of young people (persons under 16 years of age) in specified tasks (no infants shall be required to work at night between 8 p.m. and 6 a.m. and the commissioner may, where he deems it fit, exempt any infant between fifteen and sixteen years of age from the application of the provision of sub-section (1) Juveniles under twelve years of age shall not be employed with the exception of:- (a) the vocational schools of the State; (b) training workshops not for the purposes of profit; (c) members of the employer's family who work under his supervision in an enterprise in which no other person is employed; (d) workers under apprenticeship contract, a juvenile under fifteen years of age shall not be employed unless he has a guardian who resides with him in the place of work. And the contract with the juvenile shall not be binding on him unless his guardian has approved his employment and presented to the employer what proof of his guardianship over the juvenile, and his address. Juveniles shall not be employed for additional hours and shall not be employed in the weekly or official holiday or waive their right to annual leave or postpone or break the same (s. 21). The hours of work for young people should be seven hours per day and one hour of paid rest. **Chapter 5:** providers for employment contracts. **Chapter 6** covers wages; wages shall be paid in cash, except for allowances for food, fuel, housing, transportation, and clothing, which may be paid in kind (s. 35), as well it mentioned that the employer doesn't have to assign the worker to perform work that is substantially different from the work agreed upon in the employment contract without their consent, unless necessity arises to prevent an accident or to repair the consequences of such an accident, and in cases of force majeure. The assignment must be temporary, and its duration should not exceed two weeks (s.32). **Chapter 7** regards matters related to hours of work and leave, including overtime, paid leave, and annual leave. Women workers shall be granted maternity leave of eight weeks (four weeks before and after confinement) for each year of service. Also provides for Hadj leave and Idda leave (mourning leave for a Moslem widow). **Chapter 8** provides for matters regarding termination of employment and redundancy. **Chapter 9** provides severance pay, including for seasonal workers. **Chapter 10** contains general provisions regarding penalties, validity of contracts with successor employers, and labor inspection. Establishes a National and District Council for Labor Relations. **Chapter 11** regards occupational safety matters, including registration of factories, safety inspectors,

	notification of accidents, and the establishment of safety committees in factories employing 500 or more workers. Labor disputes are covered in **Chapter 12**. S. 101 provides that court cases related to people planning an action in relation to a labor dispute shall be rejected, unless such actions were a "crime" as defined by law. **Chapter 13** covers the settlement of labor disputes through negotiation and arbitration. S. 124 prohibits the partial or full stoppage of work. Final provisions are contained in **Chapter 14**.
Compensation Act 1981	Applies to the compensation paid for work injuries to any worker in Sudan, if the worker becomes disabled or dies as a result of the accident and this worker or his family members are entitled to a special or exceptional pension under the provisions of the Sudan Government Pension Act of 1919 or the Public Service Pension Act of 1975 or any other pension law, they shall be paid that pension or their entitlement under the provisions of this law, whichever is better. **Chapter 2:** covers the work injuries, responsibility of reporting, Wage during a period of absence from work due to a work-related injury and medical examination and treatment. **Chapter 3:** covers work injury compensation, claims compensation and entitlements.
The Social Insurance Law 1990 and its amendments 2008	Applies to the compensation paid for work injuries to any worker in Sudan, if the worker becomes disabled or dies as a result of the accident and this worker or his family members are entitled to a special or exceptional pension under the provisions of the Sudan Government Pension Act of 1919 or the Public Service Pension Act of 1975 or any other pension law, they shall be paid that pension or their entitlement under the provisions of this law, whichever is better. **Chapter 2:** covers the work injuries, responsibility of reporting, Wage during a period of absence from work due to a work-related injury and medical examination and treatment. **Chapter 3:** covers work injury compensation, claims compensation and entitlements.
The Social Insurance Law 1990 and its amendments 2016	Applies to all the employees of the Federal and the state's governments except civil servants, members of the armed forces, domestic servants, agricultural workers, family members of an employer, and casual workers. **Chapter 4:** Work Injuries Pension Insurance. **Chapter 5:** Old age, Disability and Death Insurance, **chapter 6:** covers Entitlement to Pension Persons entitled and condition of their entitlement,
The Minimum Wage Law 1974	Applies to all workers except civil servants, members of the armed forces, domestic servants, agricultural workers, family members of an employer, and casual workers. Article **4**; requires payment of minimum wages to all adult workers who work in any establishment within the regions specified in various timeframes by the Minister.
Environmental Protection and Water Management 2001	The fourth constitutional decree of 1991 established Sudan as a federal country and this was reinforced by the Interim National Constitution of 2005 and later by the 2015 amendment to the constitution. Environmental policies and laws in Sudan include inter alia: • The **2020 Sudan Water Resources - Act** is a significant legislation that aims to reform the management and use of water resources in Sudan. • The country is currently in a 25-Year Development Strategy (2007–2031), which will conclude a year after the end date of the SDGs. • 2005 Comprehensive Peace Agreement and the Interim National Constitution. The constitution is clear on the need to provide a clean environment, protect biodiversity and better manage land resources.

	• The act applies to the assessment and mitigation of risk, **Chapter 3**: on Policies and General Directives for Environment Protection Evaluation and environmental follow-up, every person desirous entering into any project as may probably negatively affect the environment and natural resources, shall present environmental feasibility study, signed by the evaluation and follow-up committee constituted by the Council includes (a) the expected environmental effect, (b)the negative effects of the project which can be evaded, upon execution, (c) the available alternatives project, (d) sufficient clarification that short term utilization of the natural resources and environment, does not affect the offering of these resources in the long term, (e) where the project connected with the utilization of nonrenewable natural resources, the said feasibility study shall include the continuity of utilization of these resources, (f) precautions adopted for containing the negative effects of the project and limit the same. Accordingly, the competent authority shall give due regard to policies and directives for the protection and promotion of the environment Environmental Protection Law, 2001.
Health Care Waste Management	• FMoH, Hazardous Waste Regulation, 2014. • FMoH, Health Care Waste Regulation, 2005. • Environmental Health Act No. 1 of 2009 • National Environmental Health (EH) Strategic Plan, 2015–2019 • National Guidelines for Solid Waste Management. • FMoH, Hazardous Waste Regulation, 2014 • FMoH, Health Care Waste Regulation, 2015 • National EH Strategic Plan, 2015–2019 • Sudan National Sanitation and Hygiene Strategic Framework 2016 Sudan is also committed to the below international conventions and multilateral agreements: • Stockholm Convention; Basel Convention; Rotterdam Convention; and Minamata Convention. • The United Nations Framework Convention on Climate Change (UNFCCC), • The Convention on Biological Diversity (CBD), The United Nations Convention to Combat Desertification (UNCCD),

Sudan National Public Health Act of 2008	As per the Act, this consists of 35 articles and aims at protecting the health of the human being in Sudan. It establishes the Public Health Co-ordination National Council with different tasks including: (i) lay down the systems and standards of the national health system; (ii) approve the national health policies and strategies; (iii) propose health legislation in co-operation with the competent bodies; (iv) supervise medical research conducted on human beings and verify their compatibility with profession ethics, values, traditions and heritages; (v) lay-down the bases and control of monitoring epidemic diseases, and strive to prevent the spreading thereof, combat and eradicate the same, and organize procedure of quarantine; and (vi) organize the international relations in the field of health. The Act deals also with (i) communicable and epidemic diseases and their reporting; (ii) prohibition to travel or enter an intended destination for a patient of a communicable diseases or suspected of being infected with such diseases, save upon the approval of the competent health authorities; (iii) practice of a profession suspended; (iv) public places closed; (v) closure, or demolishing of buildings, and destruction of luggage and clothes; (vi) children vaccinations; (vii) medical service in emergent cases; (viii) right to free treatment (in emergent cases, children up to the age of five, pregnant women, and service of the basic health care); and (ix) prohibition of blood-transfusion, abortion and exhumation of tombs without following the procedures specified in arts. 31-33. The Act also establishes the National Health Research Council with different tasks.
'Sudan's Constitution of 2019 Subsequently amended'	The rape and sexual harassment amendments were reportedly signed into law, together with a raft of other amendments to the Criminal Act, on 22 February 2015.Also, according to UNFPA ''Sexual harassment Article 151 of the Criminal Act was amended in 2015 to criminalize acts of sexual harassment' Sudan-EN-2pager1. The provision in the amended acted is reported to be: "A person who commits sexual harassment is anyone who carries out an act, a speech or behavior that is a temptation or an invitation for someone else to practice illegitimate sex or conducts horrendous or inappropriate behavior of sexual nature that harms a person, psychologically, or makes them feel unsafe. This person will be sentenced to a period of no more than three years and lashing."

4.2 World Bank Standards

The project will follow the World Bank Environmental and Social Standards (ESSs), follow the guidance in the IFC document use the security forces as well as the World Bank Group Environmental, Health and Safety Guidelines, assess and manage the risks and impact where relevant. Based on these policies, the environmental risk of the project is classified as substantial considering the potential EHS risks and impacts mainly associated with Components 1 and 2, occupational and community health and safety (OCHS) risks across all components, and the Fragility, conflict and violence (FCV) context along with the ongoing conflicts across the country, impending natural disaster and capacity constraint. The social risk rating for the project is High at appraisal. The project is expected to generate important social benefits, including improved access to the health system, reduced maternal and child mortality, improved WASH facilities, and better nutrition services for vulnerable groups, IDPs, and children. Despite these positive contributions of the project, the following social risks and potential adverse impacts are anticipated: (i) exclusion of vulnerable groups and historically underserved people, particularly pastoralists; (ii) security risks; (iii) risks associated with Gender Based Violence (GBV), SEA, and SH; (iv) weak community participation and engagement during implementation; (v) social tensions between IDPs and host communities due to competition over resources and project benefits; and (vi) a possible increase in IDP mobility to the project areas to access health services. The project will be implemented in conflict-affected areas and IDPs hosting states, which are

volatile and highly prone to instability and insecurity. As a result, project staff, implementing partners, and contractors will face security risks. The social risk is thus considered high mainly because of the conflict in the project implementation areas which could exacerbate social risks and affect the implementation and achievement of project outcomes if not properly managed.
The World Bank's environmental and social standards applicable to project activities are summarized below.

Table 2. Relevant World Bank ESS

E&S Standard	Relevance
1. Assessment and Management of Environmental and Social Risks and Impacts	ESS1 Relevant for the project because project activities are expected to pose substantial environmental risks and high social risks such as; - Air & water pollution, dust, and noise due to minor rehabilitation activities. -Escalation of conflict or violence. -Social exclusion toward individuals or groups. -Impacts on the health, safety and well-being of workers and project-affected communities.
2. Labor and Working Conditions	ESS2 Relevant for the project because there are certain labor risks for project workers. Labor-related risks include: -Inappropriate work conditions and occupational health and safety risks -Child and force labor. -Discrimination toward individuals or groups. -SEA/SH risks
3.Resource Efficiency and Pollution Prevention and Management:	ESS3 Relevant for the project because there are certain resource pollution risks from the project such as; -Air & water pollution, dust and noise from minor rehabilitation and maintenance equipment. -Generation of various waste including chemical, infectious and pharmaceutical waste.
4.Community Health and Safety:	ESS4 Relevant for the project as the host community and residence are the primary beneficiary of provided health services, some risks are anticipated from the project includes; -Disturbance from rehabilitation activities, noise, dust and waste. -Emergency hazard, arising from both natural and man-made hazards (conflict, floods, leaks or spills, fire, etc.). -SEA/SH risks
7. Sub-Saharan African Historically Underserved Traditional Local Communities	ESS 7 Relevant for all project activities as there are Historically Underserved People (HUP) and vulnerable groups who meet ESS7 criteria and identify key groups. The primary beneficiaries include resident / host community (which include different ethnic groups and languages) and IDPs and the marginalization of the IDPs groups are increased with expansion of conflict (according to Sudan Mobility Update_014_v3.pdfthe number of IPDs reached around 573,974 in Northern State, 1,046,629 in River Nile State, 373,152 in Kassala State, 269,885 in Red Sea State, 96,627 in Khartoum State, 145,651 in Sinnar State, 356,477 in Blue Nile State, 201,500 in West Darfur State, 933,109 in South Darfur State, and 1,162,978 in North Kordofan State) and some sort of risks could be identified such as discrimination during planning design and implementation of activities of activities,

8.Cultural Heritage	ESS 8 Relevant for the project, Sudan is rich in tangible cultural heritage, particularly in the form of both natural and human-made, religious sites as well as archeological sites. The project will finance minor rehabilitation health facilities which could have an impact on cultural heritage in terms of potential damage
10. Stakeholder Engagement and Information Disclosure	ESS10 is relevant for all projects, given the need to engage with beneficiaries and stakeholders on development activities that affect their lives.

4.3. WHO ESS frameworks and its principles:

The WHO framework for ESS aims to promote universal access to health care, a better quality of care, social fairness and equality while also enhancing resilience to social and environmental shocks and achieving the Sustainable Development Goals (SDGs). It also is intended to avoid, mitigate and minimize any adverse environmental and social impacts from WHO activities. The ESSF establishes nine fundamental principles and environmental and social safeguard standards aligned with the UN Sustainable Development Group's (UNSDG) guidelines for Cooperation Framework that shape the design and implementation of the UN's programs and policies; 1) Accessing universal health care, 2) Leaving no one behind, 3) Promoting sustainability and resilience, 4) Preserving human rights, 5) Fostering disability inclusion, 6) Enhancing gender equality, 7) Mandating zero-tolerance of sexual exploitation, abuse, and harassment, 8) Reducing disaster risk, 9) Ensuring accountability, transparency, and integrity.

The ESSF has eight environmental and social safeguard standards; 1) Gauging social and health impacts: assessing and limiting the potential social and health impacts of WHO-supported projects. 2) Mitigating climate change: building climate resilient health systems and reducing WHO's own environmental footprint. 3) Evaluating resource efficiency: promoting resource efficiency sustainable and safe waste management in the health care sector. 4) Incorporating biodiversity conservation: integrating biodiversity conservation into WHO's efforts to strengthen health resilience. 5) Backing labour rights: promoting ILO labour standards and ensuring safe working conditions for all workers involved in WHO supported projects. 6) Addressing displacement: understanding the needs of migrants and displaced people and promoting their health and well-being. 7) Recognizing Indigenous Peoples' rights: supporting the rights of Indigenous Peoples to land, resources, and cultural heritage. 8) Understanding cultural heritage: preserving and promoting cultural heritage as a means of promoting social cohesion and well-being.

WHO ESSF are focused on public health and environmental health and the related WB standards (to health projects) are fully aligned. However, WHO has a separate standard for health climate change which is addressed by WB's ESS3 which covers **resource efficiency** and **climate change mitigation and adaptation** in the context of projects. In addition, the WB has a separate standard for Stakeholder Engagement and Information Disclosure (ESS 10) which is considered a comprehensive and inclusive process. This process is an ongoing requirement throughout the project cycle, and the WHO framework also emphasizes engagement with stakeholders in a similar manner. The process is designed to ensure that communities, including those affected by the project, are informed and consulted at every stage of the project.

5. Potential Environmental and Social Risk Impacts and Standard Mitigation Measures

Risks and Mitigation Measures Specific to Disadvantaged and Vulnerable Groups

The following section outlines the risks and mitigation measures that WHO and its Implementing Partner (IPs) /Contractors will implement to manage the potential risks and adverse impacts on the disadvantage and vulnerable group and on the environment and to improve the overall environmental and social performance of the project. The proposed mitigation measures are expected to be operationalized before the start of activities and will be integrated at the agreements and contracts with, respectively, WHO IPs/contractors. IPs/Contractors are required to comply and cause subcontractors and primary suppliers to comply with the ESHS requirements of their respective contracts.

Targeted Risks and Mitigation Measures for Disadvantaged and Vulnerable Groups

The **SHARE Project** is committed to ensuring that **disadvantaged and vulnerable groups**, including **Internally Displaced Persons (IDPs), persons with disabilities, indigenous groups, refugees, and other marginalized populations**, have equitable access to project benefits. However, these groups face **specific environmental and social risks** that require targeted mitigation measures.

A. Risks Related to Exclusion from Health Services
Risk: Disadvantaged groups may face barriers to accessing project benefits, including lack of information, logistical constraints, financial limitations, and social discrimination.
Affected Groups: IDPs, pastoralists, rural communities, refugees, women, and persons with disabilities.

- **Mitigation Measures:**
  - Conduct targeted programs to ensure awareness of project services, particularly for IDPs and remote populations.
  - Provide free or subsidized healthcare services for those facing financial barriers.
  - Ensure inclusive communication strategies, such as multilingual information campaigns and visual-based materials for illiterate populations.
  - Strengthen grievance redress mechanisms (GRM)

B. Risks Related to Gender and Health Disparities
Risk: Women and girls, especially in rural and conflict-affected areas, may face barriers in accessing maternal and reproductive health services due to **cultural norms, safety concerns, and lack of female healthcare workers**.
Affected Groups: Women, adolescent girls, female-headed households.

- **Mitigation Measures:**
  - Increase the recruitment and training of female healthcare workers to improve gender-sensitive service provision.
  - Expand maternal health services, including antenatal care, postnatal care, and emergency obstetric care.
  - Ensure health facilities have safe and private spaces for women's healthcare needs.
  - Strengthen referral pathways for women requiring specialized maternal health services.
  - Strengthen grievance redress mechanisms (GRM)

Table 3: **Risks and mitigation measures**

RISK DESCRIPTION	MITIGATION MEASURE
ESS 1: Assessment and Management of Environmental and Social Risks and Impacts	
1. Assessment of subproject risks	1.1 Conduct an environmental and social assessment of the proposed project.
	1.2 Undertake stakeholder engagement and disclose appropriate information in accordance with ESS10.

RISK DESCRIPTION	MITIGATION MEASURE
	1.3 Develop an ESMP, and implement all measures and actions set out in the legal agreement including the ESCP.
	1.4 Conduct monitoring and reporting on the environmental and social performance of the project against the ESSs.
ESS 2: Labor and Working Conditions	
1. Child and forced labor	1.1 adopt and implement LMP
	1.2 Ensure the existence of contractual requirements on prevention of child labor with a minimum age of 18
	1.3 Provide workers with contracts in accordance with national labor laws and procedures
	1.4 Train and sensitize IPs/Contractors and raise the communities' awareness on the content of Standard of Conduct, including a focus on child labor and forced labor
	1.5 Ensure project workers, including subcontracted ones, are trained, and sensitized on the Standard of Conduct, including a focus on child labor and forced labor
	1.5 Submit to WHO the signed CoCs, including for subcontracted workers
2. Discrimination	2.1 Require fair treatment of workers, non- discrimination, and equal opportunities and ensure all stakeholders are treated with respect and dignity
	2.2 Train and sensitize IPs/Contractors, project workers, Front Line Workers, and raise the community's awareness on the content of Code of Conduct, including a focus on prevention of discrimination
	2.3 Ensure project workers, including subcontracted ones, Front Line Workers, are trained and sensitized in the Code of Conduct, including a focus on prevention of discrimination
	2.4 Submit to WHO the signed CoCs, including for subcontracted workers and Front Line Workers.
3. Labor influx	3.1 Prioritize workers from local communities, including IDPs and other vulnerable groups; if not possible, provide non-local workers with suitable accommodation in a specific site, well defined to minimize contact with the local community after sensitization of the non-local workers about the community practices and social norms.
	3.2 Train and sensitize IPs/Contractors and raise the communities' awareness on the content of Code of Conduct, with a focus on labor influx
	3.3 Ensure project workers, including subcontracted ones, are trained and sensitized on the Standard of Conduct, with a focus on labor influx
	3.4 Submit to WHO the signed CoCs, including for subcontracted workers
4. SEA/SH related risks	4.1 Adopt SEA/SH Risk mitigation and response Action Plan
	4.2 Prioritize the recruitment of women for activities with women and girls
	4.3 Maintain and, if not available, put in place safe and accessible reporting mechanisms in consultation with women and girls
	4.4 Include a PSEA requirement in partnerships and contractual agreements

RISK DESCRIPTION	MITIGATION MEASURE
	4.5 Train and sensitize IPs/Contractors, Front Line Workers, and raise the communities awareness on the content of the Code of Conduct, with a focus on PSEA, GBV risk mitigation, and how to safely handle incidents reporting and management
	4.6 Conduct community sensitization on GBV/SEA/SH risks, ensure it is well publicized and availability of accessible GRM for securely handling SEA/SH complaints.
	4.6 Ensure project workers, including the subcontracted ones, Front Line Workers, are trained and sensitized on the Standard of Conduct, with a focus on PSEA, GBV risk mitigation, and how to safely handle incident reporting and management
	4.7 Submit to WHO the signed CoCs, including subcontracted workers and Front-Line Workers.
	4.8 Ensure that the minor rehabilitation work does not disturb the communities' access to the available services (e.g., safe spaces, health care services, schools, etc.); if not possible, avoid proximity between workers and community members. Whenever possible, avoid working during night hours. And wherein women are part of, or participating in the rehabilitation work, ensure they are aware of their rights to protection and available reporting channels.
	4.9 Ensure laborers are aware and have access to grievance redress mechanisms to highlight any feedback.
	4.10 timely reporting of SEA cases to WHO focal person to handle the complaints.
5. Inappropriate working conditions and Occupational Health and Safety (OHS)	5.1 Provide workers with contracts in accordance with national labor laws and procedures
	5.2 Ensure adequate provision of hygiene facilities (toilets, hand-washing basins), resting areas, etc. separated by gender, as needed
	5.3 Put in place warning signs, ensure safe storage of equipment, and allow only authorized people access to working area
	5.4 Ensure construction/rehabilitation sites have protective measures (barriers, fencing), as appropriate
	5.5 Provide Personal Protective Equipment (PPE) as suitable to the tasks and hazards of each worker, without cost to the worker
	5.6 Provide first aid equipment and facilities in accordance with the national labor laws and procedures
	5.7 Ensure working hours are in line with local labor laws and regulations. Where possible, avoid working during night hours
	5.8 Require all workplace health and safety incidents to be properly recorded in a register and reported to WHO
	5.9 Ensure the work areas are properly arranged/organized with assigned safe routes for workers and that all rehabilitation materials and equipment are stored in safe and appropriate location
	5.10 Provide training on OHS, including all the above
	5.11 Ensure labors are aware and have access to grievance redress mechanisms to highlight any feedback.
6.Exposure to emergency hazards: - Armed conflict - Unexploded Ordnances (UXO) - Epidemic/pandemic	6.1 Adopt the SMP
	6.2 Ensure IPs/Contractors are timely informed of any conflict related or natural disaster related event in the project areas
	6.3 Regularly conduct consultations with relevant authorities
	6.4 Establish/maintain security protocols (communication material, early warning systems, emergency cells, business continuity/contingency plans, etc.) and train

RISK DESCRIPTION	MITIGATION MEASURE
- Floods	workers on their content and adjust activity implementation accordingly
	6.5 Undertake hazard risk assessment and develop preparedness and response emergency plan
	6.5 Adjust activity implementation modalities based on natural hazards (e.g., epidemic, floods, etc.)
	6.6 Whenever necessary, liaise with the United Nations Agency for Mine Action Services (UNMAS) to assess and confirm that no unexploded ordnances (UXO) are present prior to commencing the works and inform IPs/Contractors accordingly
	6.7 Ensure Labors are aware and have access to grievance redress mechanisms to highlight any feedback.
7. Road accidents and incidents	7.1 Adopt the SMP
	7.2 Ensure workers, Front Line Workers are trained in road safety measures (including in CoC)
	7.5 Require all vehicle drivers to have appropriate licenses
	7.6 Use well maintained vehicles and equipment
	7.7 Require WHO personnel to comply with WHO vehicle fleet and road safety/management policies, procedures, and guidelines
	7.8 Work with the local authorities, when needed, to manage traffic near Project sites where activities include rehabilitation works.
	7.9 ESMPs to include traffic management
ESS3: Resource efficiency and Pollution Prevention and Management	
1. Air pollution Dust and noise:	1.1 Ensure adequate transportation of rehabilitation materials
	1.2 Use dust control methods, such as covers, water suppression, or increased moisture content for open materials storage piles, installation of ventilation system that prevent scape of possibly hazardous substance whenever possible
	1.3 Install exhaust silencing equipment on construction machinery, where possible, shut them down when not in use, and keep them in good conditions
	1.4 Where possible, ensure that rehabilitation works happen outside of the working hours of the schools (from 08:00 to 14:00) or health facilities (from 08:00 to 15:00) and avoid work during night hours, where feasible. Ensure a notice is shared with the community in case of service reduction or suspension ensuring a nearby service can be provided.
2. Water pollution	2.1 Train IPs and communities on water testing
3. Health care waste	3.1 Adopt the Medical Waste Management Plan(MWMP) (see summary in Annex 7.6
	3.2 Obtain written approval of relevant authorities about the designated waste disposal areas, including for hazardous waste
	3.3 Safe collection, segregation and disposing off the wastes in the designated land fill areas.
	3.4 Follow the national safety guidelines for the storage, transport, and distribution of hazardous materials including waste to minimize the potential for misuse, spills, and accidental human exposure in coordination with local authorities
	3.5 Train the relevant workers on how to: - Collect and properly manage all medical waste in a timely manner

RISK DESCRIPTION	MITIGATION MEASURE
	- Deposit or discharge toxic liquids into adequate containers for salvage or subsequent removal to off-site locations - Label waste using easily understandable symbols
4. Inefficient use of solar power and raw material	4.1 Ensure adequate use of solar energy and raw material
	4.2 Adopt environmentally friendly solution e.g., prioritize solar energy whenever feasible through Bills of Quantities
ESS 4: Community Health and Safety	
1.Exposure to disturbances linked to rehabilitation works: - Noise - Dust - Waste - And water pollution - Lack of access to - Services	1.1 Ref. ESS3 (risks from #1 to #4)
	1.2 Where possible, ensure that construction and rehabilitation work happen outside of the working hours (from 08:00 to 14:00) of the schools or (from 08:00 to 15:00) health facilities. and avoid working during night hours, where feasible. Ensure a notice is shared with the community in case of service reduction or suspension ensuring a nearby service can be provided.
	1.3 Ensure communities are aware and have access to grievance redress mechanisms to highlight any feedback.
2.Exposure to an unsafe environment linked to rehabilitation works	2.1 Put in place warning signs, ensure safe storage of machinery and equipment, and allow only authorized people access to working area.
	2.2 Ensure rehabilitation sites have protective measures (barriers, fencing).
	2.3 Ensure communities are aware and have access to grievance redress mechanisms to highlight any feedback.
3. Exposure to Emergency hazards: - Armed conflict - Crime - UXO - Epidemic/pandemic - Floods	3.1 Adopt the SMP
	3.2 Ensure IPs/Contractors are timely informed of any conflict related or natural disaster related event in the project areas.
	3.3 Regularly conduct consultations with relevant authorities.
	3.4 Establish/maintain security protocols (communication material, early warning systems, emergency cells, business continuity/contingency plans, etc.) and train workers on their content and adjust activity implementation accordingly.
	3.5 Undertake hazard risk assessment and develop preparedness and response plans to address risks posed by flooding.
	3.6 Adjust activity implementation modalities based on natural hazards (e.g., epidemic, heatwaves, etc.).
	3.7 Ensure communities are aware and have access to grievance redress mechanisms to highlight any feedback.
	3.8 Whenever necessary, liaise with the United Nations Agency for Mine Action Services (UNMAS) to assess and confirm that no unexploded ordnances (UXO) are present in place prior to commencing the work and inform IPs/Contractors accordingly.
4. SEA/ SH risks	4.1 Ref. ESS2 (risk #4) In consultations with communities (especially with women, girls and boys including those with disabilities and at risk), regular risk analysis will be conducted, and appropriate risk mitigation actions will be taken (see SEA/SH action plan).
5.Risks of conflict/tensions between beneficiaries (conflict	5.1 Ensure community representation in stakeholder groups such as youth, women, IDP, indigenous groups and others
	5.2 Ensure the targeting criteria are transparently disseminated among the communities and accepted.

RISK DESCRIPTION	MITIGATION MEASURE
between hosting community and IDPs)	5.3 Raise awareness within the communities on inclusive participation and social cohesion (see Social Assessment and Social Risk Management Framework).
	5.4 Ensure communities are aware and have access to grievance redress mechanisms to highlight any feedback.
6.Health risks specific to the proximity between project workers and targeted communities – transmission of communicable diseases	6.1 Ensure social distancing in crowded areas (e.g., gathering, distributions ,..etc).
	6.2 Ensure the utilization of PPEs, as appropriate, and raise awareness on how to prevent/reduce the spread of any infections and communicable disease outbreaks including AIDS and Sexually Transmitted Infections.
	6.3 Ensure communities are aware and have access to grievance redress mechanisms to highlight any feedback.
7. Risks related security personnel or military forces	7.1 develop clear protocols on the role of security personnel within the healthcare facility, ensuring they do not interfere with patient care or the operations of the facility unless absolutely necessary.
	7.2 adopt and implement SMP
ESS 7: Indigenous Peoples / Sub-Saharan African Historically underserved traditional Local Communities	
1. Marginalization/ discrimination during the planning, design and implementation of activities of some of the following vulnerable communities: - Indigenous population such as Nubians, Copts, Arabaised Sheikha, Beja Tribe and its sub-tribes - IDPs, Mine workers, Refugees	1.1 Prepare and implement a social assessment and implement the social risk mitigation framework to guide the preparation and implementation of Social Risk Mitigation Plans
	1.2 Consult Historically Underserved People (HUP) and disadvantaged group in the social assessment and ensure that they are inclusively informed using appropriate manner consider their culture.
	1.3 Ensure representation of vulnerable groups in community discussions
	1.4 Ensure meaningful and culturally appropriate participation of and separate consultations with vulnerable groups
ESS 8: Cultural Heritage	
1. Risk of damage to the cultural heritage because of the rehabilitation of infrastructures	1.1 Ensure no damage to cultural heritage is performed.
	1.2 Coordinate with national/local related authority on historical and cultural chance finding.
	1.3 Ensure project workers, including subcontracted ones, are trained and sensitized in the Code of Conduct, including a focus on above listed risks.
	1.4 Submit to WHO the signed CoCs, including for subcontracted workers. 1.5 Apply the chance finds procedure, please refer Annex 8.5
ESS10 Stakeholder Engagement and Information Disclosure:	
1. lack/limited awareness of the Grievance Readiness Mechanism (GRM) and project	1.1 Adopt Stakeholder Engagement Plan (link provided in section 10 on consultation and disclosure requirements and the community feedback mechanism are detailed in the Stakeholder-Engagement-Plan Dec 2024.pdf)

RISK DESCRIPTION	MITIGATION MEASURE
acceptance, ownership, sustainability, and accountability.	
2. Difficult access to CFM	2.1 Establish Multiple Feedback Channels as part of the existing CFM including Free hotlines, Chatbot, Email, Community help desks (social workers at community level) and community focal points.
3. Weak community engagement and participation or exclusion of specific group	3.1. Increase the awareness of the community on the existing CFM adopting the local language and culturally sensitive approach

Planning and Design Considerations for Avoidance of Environmental and Social Risks and Impacts

Table 4: potential risks and Mitigation measures

Subproject Activities	Project Phase	Potential Risks and Impacts	Risk Response and Mitigation Measures	Responsibilities
Identify the type, location, and scale of supported healthcare facilities and type of support provision including the recruitment and engagement of workers and beneficiaries	Planning	Exclusion of vulnerable people or areas in need. Inequity and discrimination during the selection process. Inadequate supplies provision. Shortage and delay in providing in the necessary and urgent supplies. Lengthy procurement process. Lengthy process of administrating approving the distribution plans.	Determination of needs and requirements will be performed by the WHO in cooperation with the relevant health authorities with transparent criteria and public communication of the project services, benefits, supported facilities, and any other benefits. Planning, identifying and distribution of needs to be performed based on adequate assessment following WHO guidelines Selection and procured equipment and supply as per the WHO guidelines and standards. The distribution of benefits will cover all governates and the Project will work with the relevant authorities towards ensuring all beneficiaries will have equal opportunities in getting the project benefits including the recruitment chances. Strengthen communication with project stakeholders, at all levels, during the various Project stages.	WHO in coordination with responsible authorities

Subproject Activities	Project Phase	Potential Risks and Impacts	Risk Response and Mitigation Measures	Responsibilities
			Transparent/fair selection and engagement process of workers according to WHO regulation. Widely disseminating the Grievance Mechanism (GM) channels that enable affected community members or beneficiaries to send his/her grievance.	
Storage / transportation of medical and medical equipment or supplies.	Implementation	Equipment damage. Pollution from the hazardous substances. Road incidents and accidents. Supplies expiry during warehousing periods. Fire and other emergencies.	Regular inspections of supplies and warehouses and will keep a log of inventories for monitoring purposes. Appropriate warehousing and logistics management as per the WHO guidelines and procedures. Supplied goods will be temporarily stored in WHO warehouses in accordance with WHO guidelines and procedures. WHO and its contractors will follow WHO guidelines on transport of medicines, pharmacy and bio-hazardous material and will train their personnel on relevant risks. Strengthening communication and consultation with authorities for quick and effective distribution. Provision of the necessary firefighting means and equipment with adequate design of warehouses following the applicable standards and procedures. Involvement of qualified contractors and trained personnel in the logistics and supply chain process. Effective management of emergencies and tracking of corrective and preventive actions.	WHO / Contractors
Strengthening emergency preparedness and response systems	Implementation	Inadequate response to outbreaks; Lack of trained personnel	Provide capacity-building training; Establish emergency response protocols	WHO
Deployment of Early Warning and Response System (EWARS)	Implementation	Limited coverage in conflict areas; Data reporting challenges	Expand EWARS network; Provide mobile data collection tools	WHO and the MoH

Subproject Activities	Project Phase	Potential Risks and Impacts	Risk Response and Mitigation Measures	Responsibilities
Engagement of contractors/suppliers in the Project implementation.	Planning and Implementation	Child labor / Forced labor GBV - SEA/SH Contractor workers exposure to workplace hazards/diseases Occupational incidents and diseases Discrimination or elite capture	Contractual obligations through CoC and legal requirements enforcement so all contractors and suppliers involved in Project implementation are addressing fully the legal requirements. Transparent bidding and selection criteria based on competency and professionalism. Monitoring the LMP and legal requirements implementation including staff training. Functional GM that can be used as a reporting channel of any deviation where such grievances shall be treated with high priority. Contractors shall undertake the primary responsibility for their staff grievances and appropriate mechanisms shall be provided. Workplace grievances should be addressed by each contractor in a timely manner and a list of grievances should be maintained.	WHO / Contractors
General Healthcare Facilities operation – Environment.	Implementation & Completion	Improper handling and disposal medical waste and hazardous substances.	Each supported healthcare facility should implement appropriate measures following the local regulations as well as Project MWMP, in addition to the applicable WHO guidance documents and other best international practices to prevent or minimize such adverse impacts. Monitoring of the implementation of adequate waste management practices (including regular collection for off-site disposal) during the various project stages and the necessary corrective/preventive actions will be determined and tracked. Enforcement of appropriate and close supervision by trained and qualified staff. Effective management of emergencies and tracking of corrective and preventive actions.	WHO / IP / Responsible authorities
			Training on Infection Prevention and Control (IPC) and waste management requirements will be provided under the Project to HCWs involved in the supported healthcare facilities or activities.	WHO

Subproject Activities	Project Phase	Potential Risks and Impacts	Risk Response and Mitigation Measures	Responsibilities
			Under the Project and to the extent possible, supported healthcare facilities will be provided with waste management supplies and PPE for appropriate protection from any adverse impacts. Monitoring of the implementation of adequate waste management practices during the various project stages and the necessary corrective/preventive actions will be determined and tracked. Functional GM that can be used as a reporting channel of any deviation where such grievances shall be treated accordingly. Effective consultation and engagement with the authorities and beneficiaries.	
Healthcare Facilities operation– Labor issues.	Implementation & Completion	Child labor / Forced labor GBV - SEA/SH Worker's exposure to workplace hazards/diseases Occupational incidents	All workers in the supported facilities are civil servants under the MOH authority and they are subjected to applicable laws. Enforcement of appropriate and close supervision by trained and qualified staff. Appropriate coordination with WHO on the implementation of necessary requirements and correct deviations, if any. All supported facilities exist healthcare facilities under the authority of MOH where appropriate working conditions as well as rules and regulations should be maintained.	Responsible authorities
			Training and capacity building to the workers involved in the supported healthcare facilities or activities. Under the Project scope, supported healthcare facilities will be provided with supplies and PPE for appropriate protection from any adverse impacts. Functional GM that can be used as a reporting channel of any deviation where such grievances shall be treated accordingly.	WHO

Subproject Activities	Project Phase	Potential Risks and Impacts	Risk Response and Mitigation Measures	Responsibilities
			Effective consultation and engagement with the authorities and beneficiaries at facilities level. Monitoring of the implementation of workplace conditions during the various project stages and the necessary corrective/preventive actions will be determined and tracked.	
Healthcare Facilities operation– Community Health and Safety.	Implementation & Completion	GBV, SEA/SH Exclusion of vulnerable groups and people in need Transmission of disease and exposure to hazardous environment	Appropriate coordination with WHO on the implementation of necessary requirements and correct deviations, if any. All supported facilities are existing healthcare facilities under the authority of MOH where appropriate community protection as well as rules and regulations should be maintained. Distribution of project supported activities to all citizens without any discrimination.	Responsible authorities
			Functional GM that can be used as a reporting channel of any deviation where such grievances shall be treated accordingly. Effective consultation and engagement with the authorities and beneficiaries at facilities level. Monitoring of the implementation of workplace conditions during the various project stages and the necessary corrective/preventive actions will be determined and tracked.	WHO
Project implementation with volatile security conditions.	Implementation	Security risks that include kidnapping, road incidents, working in conflict condition and workers injuries.	Implementation and update of the Project security management plan requirements and risk mitigations. Coordination with authorities to assess the security risks and avoid operating in high-risk areas or environment. When security personnel are engaged, the selection and screening of security personnel verify that they have not engaged in past unlawful or abusive behavior.	WHO

Subproject Activities	Project Phase	Potential Risks and Impacts	Risk Response and Mitigation Measures	Responsibilities
			Including the security issues, risks, and mitigations during the Project stakeholders' engagement activities. Any concerns or grievances about the security issues will be received, monitored, documented, and addressed through the Project's grievance mechanism.	
Minor civil works activities (if implemented under the project).	Implementation & Completion	Child labor / Forced labor GBV, SEA/SH Contractor workers exposure to workplace hazards Occupational incident Community disturbance Noise/dust/falling objects.	Screening the activity as per the provision of annex 8.1 Environmental risks and impacts associated with resource efficiency and material supply; related solid waste, wastewater, noise, dust, and emission management; hazardous materials management. Institutional arrangements of the contractors and monitoring requirements to be assessed. Project Environmental and Social Team shall prepare the subproject ESMP. Enforcement of CoC as well as the applicable rules and regulations. Functional GM that can be used as a reporting channel of any deviation where such grievances shall be treated accordingly. Effective consultation and engagement with the authorities and beneficiaries. The contractors to develop their own ESMP and to deliver regular reporting on the work progress and status of the E&S requirements implementation.	WHO / Contractors
Monitoring and Evaluation (M&E) implementation	Implementation & Completion	Inaccurate data reporting; Lack of accountability	Third-party monitoring; Digital reporting tools	WHO, TPM agency

Site Selection Criteria for Subprojects

To ensure fair and transparent selection of project-supported sites, the following site selection criteria will be applied:

1. Health Needs Assessment:
    a. Facilities must be located in high-need areas, prioritizing conflict-affected, underserved, and disaster-prone regions.
    b. Selection is based on disease burden, service gaps, and population health indicators.
2. Alignment with Project Objectives:
    a. Facilities should align with WHO's mandate under the SHARE Project, focusing on emergency preparedness, disease surveillance, and system resilience.
3. Infrastructure Readiness and Feasibility:
    a. Preference is given to facilities requiring minimal rehabilitation for rapid delivery service.
    b. Sites should have basic infrastructure, access to power and water, and security feasibility.
4. Stakeholder Consultation and Coordination:
    a. Decisions will involve local health authorities, humanitarian organizations, and community representatives.
    b. Facilities must demonstrate commitment to project sustainability post-implementation.

Indirect and Cumulative Impacts

The SHARE Project will have both indirect and cumulative environmental and social impacts that must be assessed and managed appropriately.

Indirect Impacts

- Increased Demand for Healthcare Services:
    - As access to healthcare improves, demand for medications, medical equipment, and trained personnel will rise.
    - This could strain supply chains and existing healthcare staff, requiring capacity-building interventions.
- Migration and Population Movements:
    - Improved healthcare services may attract IDPs and migrants to project areas, increasing demand for services and social tensions.
    - Project planning should include provisions for equitable service distribution.
- Economic Growth in Project Areas:
    - The project will create employment opportunities in healthcare, construction, and logistics, contributing to local economic stimulation.
    - Improved health outcomes will lead to higher workforce productivity.

Cumulative Impacts

- Pressure on Natural Resources:
    - Increased water use in healthcare facilities could strain local water sources, particularly in arid regions.
    - Sustainable water management strategies and rainwater harvesting solutions should be explored.
- Increased Waste Generation:
    - Expanded healthcare services will increase medical and non-medical waste.
    - A comprehensive waste management plan is needed to mitigate long-term environmental risks.
- Climate Change Adaptation Needs:
    - Facilities in flood-prone or heat-exposed areas may require further climate adaptation investments.
    - The project should integrate weather data into early warning and disease prediction systems.
- Urbanization and Infrastructure Demands:
    - Health facility upgrades may trigger local infrastructure developments, such as roads, utilities, and housing.

6. Procedures and Implementation Arrangements

6.1 Environmental and Social Risk Management Procedures

The environmental and social risk management procedures will be implemented through the Project's lifecycle. In summary, the procedures aim to do the following:

Table 5. Project Cycle and E&S Management Procedures

Project Stage	E&S Stage	E&S Management Procedures
a. Assessment and Analysis: Subproject identification	Screening	- During subproject identification, ensure subproject eligibility by referring to the ***Exclusion List in table 6*** below. - For all activities, use the ***Screening Form in Annex8.1*** to identify and assess potential environmental and social risks and impacts, and identify the appropriate mitigation measures for the subproject. - Identify the documentation, permits, and clearances required under the government's Environmental Regulation.
b. Formulation and Planning: Planning for subproject activities, including human and budgetary resources and monitoring measures	Planning	- Based on ***Screening Form*** adopt and/or prepare relevant environmental and social procedures and plans. - For activities requiring Environmental and Social Management Plans (ESMPs), submit the first 5 ESMPs for prior review and no objection by the World Bank prior to initiating bidding processes (for subprojects involving bidding processes) and/or launching activities (for subproject activities not subject to bidding). - For activities requiring Environmental and Social Impact Assessments (ESIAs), conduct the assessments in accordance with World Bank Environmental and Social Standards (ESS) and Sudan's national regulations. ESIAs should inform the development of Environmental and Social Management Plans (ESMPs), ensuring that mitigation measures are robust and evidence-based. - Ensure that the contents of the ESMPs and ESIAs are shared with relevant stakeholders in an accessible manner and consultations are held with the affected communities in accordance with the SEP. - Complete all documentation, permits, and clearances required under the government's Environmental Regulation. - Train staff responsible for implementation and monitoring plans. - Incorporate relevant environmental and social procedures and plans into contractor bidding documents; train contractors on relevant procedures and plans.
c. Implementation and Monitoring: Implementation support and continuous	Implementation	- Ensure implementation of plans through site visits, regular reporting from the field, and other planned monitoring. - Track grievances/beneficiary feedback. - Continue awareness raising and/or training for relevant staff, volunteers, contractors, communities.

Project Stage	E&S Stage	E&S Management Procedures
monitoring for projects		
d. Review and Evaluation: Qualitative, quantitative, or participatory data collection on a sample basis	Completion	- Assess whether plans have been effectively implemented.

More details for each stage are provided below.

a. Subproject Assessment and Analysis – E&S Screening

In line with ESS1: "WHO, in consultation with the Bank, will identify and use appropriate methods and tools, including scoping, environ- mental and social analyses, investigations, audits, surveys and studies, to identify and assess the potential environmental and social risks and impacts of the proposed project. These methods and tools will reflect the nature and scale of the project, and will include, as appropriate, a combination (or elements of) the following: environmental and social impact assessment (ESIA); environmental audit; hazard or risk assessment; social and conflict analysis; environmental and social management plan (ESMP); environmental and social management framework (ESMF); regional or sectoral EIA; strategic environmental and social assessment (SESA)

Hence, all proposed activities will be screened to ensure that they are within the boundaries of the Project's eligible activities, and they are not considered as activities listed on the E&S Exclusion List in the table below.

Table 6. Exclusion List

- Weapons, including but not limited to mines, guns, ammunition, and explosives (in the case of the presence of such items at a project site as these pose a risk to workers and community)
- Support of production of any hazardous goods, including alcohol, tobacco, and controlled substances (as this is against WHO rules and regulations)
- Any construction in protected areas or priority areas for biodiversity conservation, as defined in national law, to prevent potentially harm to environmentally sensitive areas.
- Activities that have the potential to cause any significant loss or degradation of critical natural habitats, whether directly or indirectly, or which would lead to adverse impacts on natural habitats and ecosystem integrity.
- to protect land from deforestation and degradation. Purchase or use of banned/restricted pesticides, insecticides, herbicides, and other dangerous chemicals (banned under national law and World Health Organization (WHO) category 1A and 1B pesticides) to prevent exposure to toxic substances.
- (not relevant to this project). Any activity affecting physical cultural heritage such as graves, temples, churches, historical relics, archeological sites, or other cultural structures
- Activities that may cause or lead to forced labor or child abuse, child labor exploitation or human trafficking, or subprojects that employ or engage children, over the minimum age of 14 and under the age of 18, in connection with the project in a manner that is likely to be hazardous or interfere with the child's education or be harmful to the child's health or physical, mental, spiritual, moral, or social development
- Any activity on land that has disputed ownership or tenure rights
- Any activity with significant environmental and social risks and impacts that require an Environmental and Social Impact Assessment (Environmental and Social Impact Assessment (ESIA))

- Any activity that requires Free, Prior and Informed Consent (FPIC) as defined in ESS7.
- Any activity that will cause degradation/encroachment to and affect important natural habitats (e.g., wildlife reserves, parks or sanctuaries, protected areas, etc.).
- Any activity that may have significant adverse impacts on physical cultural resources, including archaeological sites, religious monuments or structures, cemeteries, graveyards, graves, and other important locations, unless identification, assessment, and protection of these cultural resources are feasible.
- Subprojects that will be in protected and ecologically sensitive areas.
- Any activity that would disadvantage or not give an advantage to community members. No member of the community will be deliberately excluded based on sex, sexual preference or similar factors.
- Any activity that will contravene international conventions and regional agreements on environmental and social issues.
- Any activity that can cause large-scale physical disturbance of the site or the surroundings unless the adverse impacts on the physical environment are manageable with appropriate mitigation strategies.
- Any activity that may undertake construction/rehabilitation of healthcare facilities in high-risk areas due to natural hazards such as floods, landslides, etc.
- Any activity that will block the access to natural resources, including water points etc. used by others.
- Any activity requiring land acquisition to avoid displacement or forced resettlement.

WHO will use the ***E&S Screening Form in Annex 8.1*** to identify and assess relevant environmental and social risks specific to the activities and identify the appropriate mitigation measures. The *Screening Form* lists the various mitigation measures and plans that may be relevant for the specific activities (such as the Codes of Practice, the Environmental and Social Management Plan, the Labor Management Procedures, …., etc.). The need for an ESIA will be determined in relation to the E&S category for the prospective sub-project.

The WHO will also identify the documentation, permits, and clearances required under the government's Environmental Regulation.

b. Subproject Formulation and Planning – E&S Planning

Based on the process above and the Screening Form, the implementing partners will adopt the necessary environmental and social management measures already included in the Annexes of this ESMF (such as the LMP, MWMP, the general ESMP etc.) or develop relevant site-specific environmental and social management plans, as required.

If site-specific ESMPs are necessary, the implementing partners will prepare these ESMPs, screening forms and other applicable documents as needed and submit for review and approvals to WHO PMU. Sample ESMPs will be shared with the world bank for final review and clearance before implementation. The contents of the ESMPs will be shared with relevant stakeholders in an accessible manner, and consultations will be held with the affected communities on the environmental and social risks and mitigation measures. If certain subprojects or contracts are being initiated at the same time or within a certain location, an overall ESMP covering multiple subprojects or contracts can be prepared. Some moderate risk subprojects may also benefit from the preparation of a site-specific environmental and social assessment prior to the preparation of an ESMP. As mentioned above, the need for an ESIA will be determined based on the screening process and the E&S category for the prospective sub-project.

The first three to five ESMPs in each category of subproject will be submitted to the World Bank for prior review and no objection. After this, the World Bank and the WHO will reassess whether prior review is needed for further ESMPs or a certain category of ESMPs. The implementing partners will draft the screening forms and will follow actions as per annex 8.1 and send it to WHO- PMU for review and then to be shared with the world bank for final review and clearance before any project activities begin.

At this stage, personnel/staff who will be working on the various subproject activities should be trained in the environmental and social management plans relevant to the activities they work on. WHO will provide such training to field staff.

The WHO should also ensure that all selected contractors, subcontractors, and vendors understand and incorporate environmental and social mitigation measures relevant to them as standard operating procedures for civil works. The WHO should provide training to selected contractors to ensure that they understand and incorporate environmental and social mitigation measures; and plan for cascading training to be delivered by contractors to subcontractors and vendors. The WHO should further ensure that the entities or communities responsible for ongoing operation and maintenance of the investment have received training in operational stage environmental and social management measures as applicable.

c. Implementation and Monitoring – E&S Implementation

During implementation, the WHO will conduct regular monitoring visits. Describe the mechanisms, responsible parties, and the frequency for project supervision. The contractors will be responsible for implementing the mitigation measures in the E&S risk management documents, with WHO oversight.

The implementing partners working to implement the project will ensure that monitoring practices include the environmental and social risks identified in the ESMF and will monitor the implementation of E&S risk management mitigation plans as part of regular project monitoring.

At a minimum, the reporting will include (i) the overall implementation of E&S risk management instruments and measures, (ii) any environmental or social issues arising as a result of project activities and how these issues will be remedied or mitigated, including timelines, (iii) Occupational Health and Safety performance (including incidents and accidents), (iv) community health and safety, (v) stakeholder engagement updates, in line with the SEP, (vi) public notification and communications, (vii) progress on the implementation and completion of project works, and (viii) summary of grievances/beneficiary feedback received, actions taken, and complaints closed out, in line with the SEP. Reports from the local levels will be submitted to the WHO at the national level, where they will be aggregated and submitted to the World Bank on a quarterly basis.

Throughout the Project implementation stage, the implementing partners will continue to provide training and raise awareness to relevant stakeholders, such as staff, selected contractors, and communities, to support the implementation of the environmental and social risk management mitigation measures. Where applicable, the training topics during Project implementation will include:

ESMF and Approach:

- Identification and assessment of E&S risks (E&S Screening, ESMP preparation ….)
- Selection and application of relevant E&S risk management measures
- E&S monitoring and reporting
- Incident and accident reporting
- Application of LMP and procedures, including Code of Conduct, incident reporting, SEA/SH,
- Implementation of SEP and the grievance/beneficiary feedback mechanism
- Grievance mechanisms for workers and communities.
- GBV, including Code of conduct to prevent GBV and SEA/SH.
- Occupational Health and Safety.

- Community health and safety (including emergency prevention and preparedness, response arrangements to emergency).

Target groups include the following:

- Stakeholders including Contractor.
- Support Consultants (Labor Management Procedures; OHS guidelines; community health and safety).
- Project workers (OHS guidelines, provisions relating to LMP, GBV Risk).
- Staff responsible for overall implementation of ESMF

The WHO will also track grievances/beneficiary feedback (in line with the SEP) during project implementation to use as a monitoring tool for implementation of project activities and environmental and social mitigation measures.

The monitoring of environmental and social requirements compliance will be performed by the Third Party Monitoring Agency (contracted by UNICEF on behalf of the project) , in accordance with the relevant World Bank Good Practice Note and relevant E&S Standards. Third Party Monitoring (TPM) will assess the status and performance of project implementation phases, compliance status, or emerging issues through a specialized party and to provide an unbiased reflection on the issue and status, and to make recommendations for improvement, where relevant. Each monitoring report prepared by the TPM shall cover a period of three (3) months.

Last, if the WHO becomes aware of a serious incident in connection with the project, which may have significant adverse effects on the environment, the affected communities, the public, or workers, it should notify the World Bank within 48 hours of becoming aware of such incident. Fatality is automatically classified as a serious incident, as are incidents of forced or child labor, abuses of community members by project workers (including gender-based violence incidents), violent community protests, or kidnappings.

As per the ESCP, the follow-up reporting shall be shared with the WB's Grievance Redress Service (GRS) within 10 days of notification. For other incidents or accidents, the report will be submitted to the WB's task team within 30 days of the notification. In addition, WHO will report alleged incidents of SH involving WHO Staff and Non-Staff Personnel through the annual reports of the Recipient's integrity office to the Recipient's executive board, which are made publicly available.

d. Review and Evaluation – E&S Completion

Upon completion of Project activities, the WHO will review and evaluate progress and completion of project activities, and all required environmental and social mitigation measures. Especially for civil works, the WHO will ensure that the activities with regard to cultural heritage in the targeted facilities are done to an appropriate and acceptable standard before closing the contracts, in accordance with measures identified in the ESMPs and other plans. Any pending issues must be resolved before a subproject is considered fully completed. The WHO will prepare the completion report describing the final status of compliance with the E&S risk management measures and submit it to the World Bank.

6.2 Implementation Arrangements

The table below summarizes the roles and responsibilities regarding the implementation arrangements for **environmental and social management.**

Table 7. Implementation Arrangements

Level/ Responsible Party	Roles and Responsibilities
WHO	-The WHO will establish and maintain the existing Project Management Unit with qualified staff and resources to support management of ESHS risks and impacts of the Project including specialists on environmental, OHS, gender and social and PRSEAH focal person. Such specialists will prepare and submit E&S performance reports to the Bank as part of the semiannual progress report, reports on ESHS performance of the project, including but not limited to, stakeholder engagement activities and grievances log, as set out within the ESCP. - The central and field E&S staff will conduct E&S screening. They will also prepare site specific ESMPs based on the E&S screening recommendations, Provide support, oversight, and quality control to field staff working on environmental and social risk management. - Collect, review, and provide quality assurance and approval to Screening Forms and ESMPs as relevant. Keep documentation of all progress. - Oversee overall implementation and monitoring of environmental and social mitigation and management activities, compile progress reports from local levels/subjects, and report to the World Bank on a quarterly basis. - Train central and field staff and contractors who will be responsible for implementing the ESMF. - Ensure that all bidding and contract documents include all relevant E&S management provisions per screening forms, ESMPs, and ESCOPs.
Implementing partner	- The project will support the Healthcare facilities included in the current healthcare system structures in some states, WHO will work closely with the implementing partners to address the associated risks and implement the applicable mitigation measure, WHO will provide the necessary supports / logistics / capacity building the partners to ensure all requirements are implemented accordingly. Therefore, the level of responsibilities and implementation activities will be monitored through the lifetime of the project. WHO's implementing partners, Local Authorities, and supported Healthcare Facilities Managements have the sole responsibility for applying onsite the required mitigation measures as stated in this ESMF or other relevant instruments and informing WHO on any deviations or further requirements. - Ensure project activities do not fall under the exclusion list Fill out Screening Forms for relevant subproject activities. - If relevant, complete site-specific ESMPs for subproject activities and, the IP will submit forms to the WHO PMU for review and PMU will send it to the world bank for final review and clearance before the implementation - Oversee daily implementation and monitoring of environmental and social mitigation measures. - Provide training to local contractors and communities on relevant environmental and social mitigation measures, roles, and responsibilities. All implementing partners will go through a mandatory SEA capacity assessment/verification, and capacity building using the UN Partners Portal, and IP protocols
TPM	- The monitoring of compliance at the supported facilities will be performed by WHO monitoring and evaluation team as well as the project TPM, regular reports shall be issued, and the necessary corrective or preventive needs be implemented and tracked.

6.3 Proposed Training and Capacity Building

Table 8. Proposed Training and Capacity Building Approach

Level	Responsible Party	Audience	Topics/Themes that May Be Covered
National Level	World Bank	National staff responsible for overall implementation of ESMF	ESMF and approach: - Identification and assessment of E&S risks including health care waste management and security management. - Selection and application of relevant E&S risk management measures/instruments - E&S monitoring and reporting - Incident and accident reporting - Application of LMP, including Code of Conduct, incident reporting, SEA/SH. - Application of SEP and the grievance/beneficiary feedback mechanism
National level	WHO	National staff Contractors	ESMF and approach: - Identification and assessment of E&S risks - Selection and application of relevant E&S risk management measures - E&S monitoring and reporting - Incident and accident reporting - Application of LMP, including Code of Conduct, incident reporting, SEA/SH measures. - Application of SEP and the grievance/beneficiary feedback mechanism
Local/site level	implementing partners	Local staff Local contractors	- Application of SEP and the grievance/beneficiary feedback mechanism - Application of LMP, including Code of Conduct, incident reporting, SEA/SH. - Application of ESCOPs or ESMPs, as relevant

6.4. Lessons Learned from WHO experience in managing the E&S risks and impacts of similar WB projects :

Drawing from the Yemen Emergency Health and Nutrition Project (EHNP, P161809), the Sudan Health Assistance and Response to Emergencies (SHARE) Project has incorporated key lessons learned into its Environmental and Social Management Framework (ESMF). These insights will help strengthen risk mitigation, compliance with environmental and social safeguards, and overall project efficiency.

Strengthening Institutional Capacity and Accountability

1. Third-Party Monitoring (TPM) for Transparency and Oversight
    a. The EHNP in Yemen demonstrated that independent Third-Party Monitoring (TPM) was essential in ensuring transparency and holding health facilities accountable for environmental and social compliance.
    b. Lesson Applied in SHARE: Regular TPM assessments will be conducted to monitor environmental and social safeguards (ESSs) implementation.
    c. Action Plan: TPM reports will be shared with hospital administrators and the Federal Ministry of Health (FMOH) to ensure corrective actions are taken in case of non-compliance.

2. Institutionalizing E&S Capacity-Building for Health Facilities
    a. In Yemen, it was observed that many healthcare staff and administrators were unfamiliar with World Bank E&S requirements, leading to inconsistent compliance with safeguards.
    b. Lesson Applied in SHARE: WHO will establish a structured training program on E&S risk management, medical waste handling, and social safeguards.
    c. Action Plan:
        i. Conduct mandatory training sessions for WHO field staff, health facility managers, and implementing partners include E&S compliance responsibilities in all contracts with health facilities.
        ii. Ensuring Compliance with Environmental and Social Safeguards
3. Improving Medical Waste Management and Disposal Practices
    a. A major challenge in Yemen was the lack of proper medical waste disposal at health facilities, leading to environmental and public health risks. WHO will implement a comprehensive medical waste management system in Sudan, ensuring proper segregation, disposal, and incineration of hazardous waste in compliance with WHO and World Bank guidelines. Additionally, health facilities will receive capacity-building support to manage infectious waste effectively. The project will integrate waste disposal monitoring indicators into facility reporting and conduct regular inspections to assess compliance.

6.5. Estimated Budget

The following table lists estimated cost items for the implementation for the ESMF, which have been included in the overall project budget:

Table 9 ESMF Implementation Budget

Activity/Cost Item	Potential Cost (USD)	Comment
Training for staff and contractors (venue, travel, refreshments etc.)	150,000	Covers capacity-building on ESMF, OHS, and risk mitigation for WHO staff, health workers, and implementing partners.
Stakeholder engagement, consultations, and grievance redress activities	100,000	Ensures community participation, transparency, and feedback integration, including costs for engagement meetings and consultations.
Procurement of Personal Protective Equipment (PPE) and waste management supplies	120,000	Covers bins, safety boxes, incinerators, and protective gear for healthcare waste workers.
Medical waste transportation for offsite disposal	151,200	Supports safe transport of hazardous waste to ensure compliance with environmental regulations.
Preparation of site-specific ESMPs and other site-specific plans	30,000	Covers preparation, review, and updates of ESMPs for health facility sites.
Preparation of site-specific Security Management Plans (SMPs)	20,000	Ensures project activities in volatile areas meet security risk mitigation requirements.
Preparation of site-specific Waste Management Plans (WMPs)	20,000	Supports the development of site-specific waste handling and disposal protocols.
Supervision and accommodation budget for environmental and social staff site visits	35,000	Covers monitoring field visits by WHO E&S specialists to assess compliance and performance.
TOTAL	626,200	

7. Stakeholder Engagement, Disclosure, and Consultations

A separate Stakeholder Engagement Plan (SEP) has been prepared for the Project, based on the World Bank's Environmental and Social Standard 10 on Stakeholder Engagement. The SEP can be found here: https://www.emro.who.int/sdn/information-resources/stakeholder-engagement-plan.html

This includes:

- **Identification of the Key Stakeholders:** This includes national and local health authorities, WHO implementing partners, local health authorities, community representatives, healthcare facility staff, NGOs, and affected communities, including vulnerable groups.
- **Consultation Activities Conducted for the ESMF Preparation:** The ESMF was informed by stakeholder consultations conducted in target project areas, involving discussions with healthcare providers, community members, and implementing agencies (a list of the stakeholders is provided in the table below). The key findings highlighted concerns about healthcare access, medical waste management, and occupational health risks.
- **Overview of Stakeholder Engagement and Information Disclosure:** The project follows a proactive engagement approach that includes regular consultations, public disclosure of key documents (including the SEP), and capacity-building activities to strengthen stakeholder participation.
- **Project Grievance Redress Mechanism (GRM):** The project GRM ensures that grievances and feedback from stakeholders and community members are systematically recorded, addressed, and monitored. The mechanism includes multiple entry points for grievances, confidentiality for sensitive complaints (such as SEA/SH-related cases), and timely resolution procedures. WHO has already signed up to the complaints and feedback mechanism in Sudan (managed by UNICEF).

Below is a table 10 with WHO stakeholder engagement summary during the preparatory period:

Event/ Topic of consultation	With Whom	Channels of Engagement	Venue	Responsible Agency	Frequency	Purpose
Project design, preparation, consultations and negotiation.	● WHO team from RO, Sudan CO and Yemen CO, UNICEF team from RO, Sudan CO and Yemen CO, WB team and FMOH representatives	● In person. ● Virtual ● Emails	WHO EMRO	WHO SHARE team from the Ro and country office		● To prepare all project requirements including: key documents, selection of the facilities, service packages,etc.

Event/ Topic of consultation	With Whom	Channels of Engagement	Venue	Responsible Agency	Frequency	Purpose
Project Kickoff, implementation and monitoring.	● Federal Ministry of Health ● Ministry of Finance and International cooperation ● Local Authorities	● Official communications ● Progress reports ● Meetings, virtual or in-person ● Press conferences ● Emails	MOH MOFA	WHO/PMU	Regularly	● Sharing of information, reviews, clearance and seeking support
Project implementation and monitoring.	● State Ministry of Health ●	● Official communications ● Progress reports ● In person or virtual meetings ● Emails	SMOH Premises	WHO/PMU	Regularly	● Coordination of Project activities
Project implementation and monitoring.	● Local Health Management Team	● Operational meetings ● Trainings ● Monitoring, progress reports ● Face-to-face meetings ● Emails	Locality Health Team Office	WHO/PMU	Regularly	● Implementation of Project activities
Project implementation and monitoring.	● Health and Nutrition actors working in the targeted areas	● Cluster meetings ● Flyers ● Emails	Virtual meetings Meetings at agency premises	WHO/PMU	Regularly	● Coordination or awareness raising to avoid duplications of efforts among actors or cluster members ● Consultations to have inputs form technical specialists
During the project	● Humanitarian and	● Cluster meetings ● Flyers	Virtual meetings	WHO/PMU	Regularly	● Coordination or awareness raising to avoid

Event/ Topic of consultation	With Whom	Channels of Engagement	Venue	Responsible Agency	Frequency	Purpose
implementation, supervision and monitoring.	Development actors working in the targeted areas (e.g., NGOs, CSOs and others)	● Emails	Meetings at agency premises			duplications of efforts among actors or cluster members ● Consultations to have inputs form technical specialists
Beneficiaries' orientation, awareness activities and feedback	● Community leaders/members and decision-makers ● WASH, health and nutrition services receivers in the targeted areas	● Community meetings in person or over the phone ● Workshops	Project offices Community premises	WHO/PMU	Ad hoc meetings based on the community level intervention whin it's needed	● Sharing information ● Sharing feedback
Provision of community level interventions during the implementation stage.	● Vulnerable groups ● Households	● In person consultations and outreach campaigns ● Social media, leaflets, posters, brochures, and hand-outs ● GM hotlines	Mainly at facility level and if need at community premises	WHO/PMU	Regularly	● To ensure their participation in consultations ● To increase awareness, provide consultations and collect feedback ● To assess their needs and priorities ● Prevention of sexual exploitation and abuse

This ESMF, as well as the SEP and the Environmental and Social Commitment Plan (ESCP) that have been prepared for this project, have been disclosed in draft for stakeholder consultations on the following website https://www.emro.who.int/sdn/information-resources/stakeholder-engagement-plan.html on 1 May 2024. Key feedback, if any, on the disclosed ESMF is listed here [summary of feedback].

8. Annexes:

Annex 8.1 Environmental and Social Potential Risks Screening Template

This form is to be used by the Project Management Unit (PMU) to screen for the potential environmental and social risks and impacts of a proposed subproject. It will help the PMU 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 PMU to form an initial view of the potential risks and impacts of a subproject***. It is not a substitute for project-specific E&S assessments or specific mitigation plans.***

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

General information	
Date of screening	
Subproject Name	
Subproject Location	
Subproject activities	
Estimated Investment	
Estimated Start and Completion Dates	
Subproject Proponent/implementing partner	
Was the site visited beforehand	
Observations/Comments based on a visited site	
Name and signature of environmental/social specialist	
Name and signature of PMU coordinator	

Questions	**Answer**		**Relevant ESSs relevance**	**Due diligence / Actions: If these risks (yes) are present, refer to:**	**Comments**
	Yes	**No**			
Does the subproject involve civil works including new construction, expansion, upgrading or maintenance of healthcare facilities and/or waste management facilities?			ESS1	ESIA/ESMP, 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?			ESS1/ESS3	ESIA/ESMP, SEP	
Is there a sound regulatory framework and institutional capacity in place for healthcare facility infection control and healthcare waste management?			ESS1	ESIA/ESMP, SEP	
Does the subproject have an adequate system in place (capacity, processes and management) to address health care waste?			ESS1/ESS3	MWMP	
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)?			ESS1/ESS2	ESIA/ESMP	
Does the subproject have a GM in place, to which all workers have access, designed to respond quickly and effectively?			ESS2	LMP	
Does the subproject involve use of security or military personnel during construction and/or operation of healthcare facilities and related activities in accordance with *Security Risk Assessment and Management Plan (SRA/MP) that guide the preparation of site-specific Security Management Plans (SMP)*?			ESS4/ESS1	ESIA/ESMP, SEP; SRA/MP, SMP	
Does the project involve transboundary transportation of specimens, samples and hazardous infectious materials?			ESS 4	ESMF	
Do people who meet the definition of ESS7 live within the subproject areas?			ESS 7	Social Assessment, ESMF. SEP	
Is the subproject located within or in the vicinity of any known cultural heritage sites?			ESS8	ESIA/ESMP, SEP	
Does the project area present considerable Gender-Based Violence (GBV) and Sexual Exploitation and Abuse (SEA) risk?			ESS4/ESS2 /ESS1	ESIA/ESMP, SEP	
Does the subproject carry the risk that disadvantaged and vulnerable groups may have unequitable access to project benefits?			ESS1/ESS10	ESIA/ESMP, SEP	

Conclusions:

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

2. **Proposed E&S Management Plans/ Instruments to be further developed'**

   Name and title of person who conducted screening:
   Date of screening:

Annex 8.2. Environmental and Social Codes of Practice (ESCOP)

To manage and mitigate potential negative environmental impacts, the project applies Environmental Codes of Practice (ESCOPs); The ESCOPs contain specific, detailed and tangible measures that would mitigate the potential impacts of each type of eligible subproject activity under the project.

ESCOPs for Infrastructure Subprojects

General ESCOP for Infrastructure Subprojects

Issue	Environmental Prevention/Mitigation Measures	Project Phase and Responsible Party
1. Noise during construction	a) Plan activities in consultation with communities so that noisiest activities are undertaken during periods that will result in least disturbance. (Planning phase) b) Use when needed and feasible noise-control methods such as fences, barriers or deflectors (such as muffling devices for combustion engines or planting of fast-growing trees). (Implementation phase) c) Minimize project transportation through community areas. Maintain a buffer zone (such as open spaces, row of trees or vegetated areas) between the project site and residential areas to lessen the impact of noise to the living quarters. (Implementation phase) d) Conduct pre-construction baseline noise monitoring at locations near sensitive receptors (e.g., hospitals, schools, residential areas). e) Compare noise levels to WHO or national noise limits and develop a noise minimization strategy accordingly f) Use noise barriers, mufflers, or temporary enclosures where feasible. g) Restrict noisy construction activities to daytime hours and avoid work during night hours in residential areas. h) Implement regular noise monitoring during construction to assess compliance and adjust mitigation measures as necessary.	Rehabilitation WHO & Contractors
2. Soil erosion	a) Schedule construction during dry season. (Planning phase) b) Contour and minimize length and steepness of slopes. (Implementation phase) c) Use mulch, grasses or compacted soil to stabilize exposed areas. (Implementation phase) d) Cover with topsoil and re-vegetate (plant grass, fast-growing plants/bushes/trees) construction areas quickly once work is completed. (Post-Implementation phase) e) Design channels and ditches for post-construction flows and line steep channels/slopes (e.g., with palm frowns, jute mats, etc.). (Post-Implementation phase)	Rehabilitation WHO & Contractors
3. Air quality	a) Minimize dust from exposed work sites by applying water on the ground regularly during dry season. (Implementation phase) b) Avoid burn site clearance debris (trees, undergrowth) or construction waste materials. (Implementation phase) c) Keep stockpile of aggregate materials covered to avoid suspension or dispersal of fine soil particles during windy days or disturbance from stray animals. . (Implementation phase) d) Reduce the operation hours of generators /machines /equipment /vehicles. (Implementation phase)	Operation WHO, facility operators, contractors

	e) Control vehicle speed when driving through community areas is unavoidable so that dust dispersion from vehicle transport is minimized. (Implementation phase) f) Ensure medical waste incinerators are operated at recommended temperatures (minimum 850-1200°C) to reduce toxic emissions (dioxins and furans). g) Maintain incinerators with functional wet scrubbers to control emissions and prevent air pollution. h) Conduct air emissions monitoring at incineration sites to assess compliance with WHO air quality standards. i) Require periodic maintenance and inspection of fossil-fuel-powered equipment (generators, heavy vehicles) to ensure minimum emissions. j) Promote alternative energy sources, such as solar power, to reduce dependence on diesel generators where feasible.	
4. Water quality and availability	a) Activities should not affect the availability of water for drinking and hygienic purposes. (Implementation phase) b) No soiled materials, solid wastes, toxic or hazardous materials should be stored in, poured into or thrown into water bodies for dilution or disposal. (Implementation phase) c) Avoid the use of wastewater pools particularly without impermeable liners. d) Provision of toilets with temporary septic tank. (Implementation phase) e) The flow of natural waters should not be obstructed or diverted to another direction, which may lead to drying up of riverbeds or flooding of settlements. (Implementation phase) f) Separate concrete works in waterways and keep concrete mixing separate from drainage leading to waterways. (Implementation phase) g) Conduct **water quality assessments** before using any source for drinking or medical purposes. h) Ensure **all healthcare facilities have reliable water supply systems** with contingency plans for shortages. i) Install **water purification systems** (e.g., chlorination, filtration) for facilities in areas with high contamination risks.	Operation WHO and facility operators
5. Solid and hazardous waste	a) Segregate construction waste as recyclable, hazardous and non-hazardous waste. (Implementation phase) b) Collect, store and transport construction waste to appropriately designated/ controlled dump sites. (Implementation phase) c) On-site storage of wastes prior to final disposal (including earth dug for foundations) should be at least 300 metres from rivers, streams, lakes and wetlands. (Implementation phase) d) Use secured area for refuelling and transfer of other toxic fluids distant from settlement area (and at least 50 metres from drainage structures and 100 metres from important water bodies); ideally on a hard/non-porous surface. (Implementation phase) e) Train workers on correct transfer and handling of fuels and other substances and require the use of gloves, boots, aprons, eyewear and other protective equipment for protection in handling highly hazardous materials. (Implementation phase)	Rehabilitation and operation WHO, contractors and facility operators

	f) Collect and properly dispose of small amount of maintenance materials such as oily rags, oil filters, used oil, etc. Never dispose spent oils on the ground and in water courses as it can contaminate soil and groundwater (including drinking water aquifer). (Implementation phase) g) After each construction site is decommissioned, all debris and waste shall be cleared. (Post-Implementation phase) h) Designate a **secured, hard-surfaced area for fuel storage and refueling** at least **50 meters from drainage systems and water sources**. i) Maintain **spill kits** (absorbent materials, containment booms) at all **fuel storage and handling areas**. j) Establish **emergency response procedures** in case of spills, including: k) Immediate **containment of leaked fuel** using absorbent materials. l) Proper disposal of contaminated soil/materials. m) Notification of relevant authorities and environmental response teams n) Conduct **periodic leak inspections** of fuel storage tanks and transport vehicles.	
6. Asbestos	a) If asbestos or asbestos containing materials (ACM) are found at a construction site, they should be clearly marked as hazardous waste. (Implementation phase) b) The asbestos should be appropriately contained and sealed to minimize exposure. (Implementation phase) c) Prior to removal, if removal is necessary, ACM should be treated with a wetting agent to minimize asbestos dust. (Implementation phase) d) If ACM is to be stored temporarily, it should be securely placed inside closed containers and clearly labeled. (Implementation phase) e) Removed ACM must not be reused. (Implementation and post-implementation phase)	Rehabilitation WHO and contractors
7. Health and Safety	a) When planning activities of each subproject, discuss steps to avoid people getting hurt. (Planning phase) It is useful to consider: • Construction place: Are there any hazards that could be removed or should warn people about? • The people who will be taking part in construction: Do the participants have adequate skill and physical fitness to perform their works safely? • The equipment: Are there checks you could do to make sure that the equipment is in good working order? Do people need any particular skills or knowledge to enable them to use it safely? • Electricity Safety: Do any electricity good practices such as use of safe extension cords, voltage regulators and circuit breakers, labels on electrical wiring for safety measure, aware on identifying burning smell from wires, etc. apply at site? Is the worksite stocked with voltage detectors, clamp meters and receptacle testers? b) Mandate the use of personal protective equipment for workers as necessary (gloves, dust masks, hard hats, boots, goggles). (Implementation phase)	Rehabilitation and operation WHO, contractors and health facility manager

c) Follow the below measures for construction involve work at height (e.g. 2 meters above ground (Implementation phase):
   - Do as much work as possible from the ground.
   - Do not allow people with the following personal risks to perform work at height tasks: eyesight/balance problem; certain chronic diseases – such as osteoporosis, diabetes, arthritis or Parkinson's disease; certain medications – sleeping pills, tranquillisers, blood pressure medication or antidepressants; recent history of falls – having had a fall within the last 12 months, etc.
   - Only allow people with sufficient skills, knowledge and experience to perform the task.
   - Check that the place (eg a roof) where work at height is to be undertaken is safe.
   - Take precautions when working on or near fragile surfaces.
   - Clean up oil, grease, paint, and dirt immediately to prevent slipping; and
   - Provide fall protection measures e.g. safety hardness, simple scaffolding/guard rail for works over 4 meters from ground.

d) Keep worksite clean and free of debris on daily basis. (Implementation phase)

e) Provision of first aid kit with bandages, antibiotic cream, etc. or health care facilities and enough drinking water. (Implementation phase)

f) Keep corrosive fluids and other toxic materials in properly sealed containers for collection and disposal in properly secured areas. (Implementation phase)

g) Ensure adequate toilet facilities for workers from outside of the community. (Implementation phase)

h) Rope off construction area and secure materials stockpiles/ storage areas from the public and display warning signs including at unsafe locations. Do not allow children to play in construction areas. (Implementation phase)

i) Ensure structural openings are covered/protected adequately. (Implementation phase)

j) Secure loose or light material that is stored on roofs or open floors. (Implementation phase)

k) Keep hoses, power cords, welding leads, etc. from laying in heavily travelled walkways or areas. (Implementation phase)

l) If school children are in the vicinity, include traffic safety personnel to direct traffic during school hours, if needed. (Implementation phase)

m) Control driving speed of vehicles particularly when passing through community or nearby school, health center or other sensitive areas. (Implementation phase)

n) During heavy rains or emergencies of any kind, suspend all work. (Implementation phase)

	o) Fill in all earth borrow-pits once construction is completed to avoid standing water, water-borne diseases and possible drowning. (Post-Implementation phase)	
8. Other	a) No cutting of trees or destruction of vegetation other than on construction site. [Implementing agency] will procure locally sourced materials consistent with traditional construction practices in the communities. (Planning phase) b) No use of unapproved toxic materials including lead-based paints, un-bonded asbestos, etc. (Implementation phase) c) No disturbance of cultural or historic sites. (Planning and implementation phases) d) Conduct **regular environmental and social impact assessments** for project activities. e) Establish **community feedback and grievance redress mechanisms (GRM)** to address concerns transparently. f) Promote **energy-efficient technologies** (solar power, LED lighting) in healthcare facilities. g) Ensure **waste segregation at source** to improve waste management efficiency. h) Strengthen **climate adaptation measures**, including flood-resistant infrastructure and heat-resilient buildings.	All Phases (Planning, Implementation, Operation, and Completion) WHO, Local Authorities, Facility Operators

Specific ESCOPs for Infrastructure Subprojects

Subproject Type	Environmental Prevention/Mitigation Measures	Responsible Party
Buildings		
In general	a) Provide adequate drainage in the building's immediate surroundings to avoid standing water, insect related diseases (malaria, etc.) and unsanitary conditions. (Implementation phase) b) Include sanitary facilities such as toilets and basins for hand-washing. (Implementation phase) c) Restrict use of asbestos cement tiles as roofing. (Implementation phase) d) Tiled floors are preferred for easier cleaning and more hygienic. (Planning and implementation phases)	
Electrification		
Solar power supply	a) Tidy wiring for easy maintenance and reduces the risk of accidents. (Implementation phase) b) Need to raise community awareness on electrical hazards and health and safety concerns, as well as proper maintenance of solar panels (Implementation and post-implementation phases) c) Need to raise community awareness on proper disposal of solar panels, specifically avoiding disposal of panels near water bodies (post-implementation phase)	
Wastewater Systems		
Wastewater sewerage and treatment	a) Septic tanks must have a vent pipe to prevent the build-up of gas inside the chamber and shall have a 'manhole' that provides access inside the tank if needed. (Implementation phase) b) Ensure that the septic tanks have two chambers: first chamber is for settling of sludge, and the second chamber is for aerobic treatment. These chambers will	

Subproject Type	Environmental Prevention/Mitigation Measures	Responsible Party
	generally treat wastewater better. Partially treated septic tank effluent can pollute groundwater and surface water. (Implementation phase) c) Do not discharge septic tank effluent to an open drain or other surface water. The effluents need to be treated before final disposal. This may be achieved through: (i) an underground leach field, (ii) a vegetated leach field, or (iii) a pit for soaking away. (Implementation phase) d) Community awareness should be raised so that the community inspects the septic tanks periodically and ensures that the septic tanks are emptied every few years for the tank to continue to function properly. (Implementation and post-implementation phases)	
Solid Waste Management	a) Solid waste depots/disposal need to be located on hard-standing areas that prevent waste entering surface or groundwater. (Implementation phase) b) Waste depots/storage/disposal should be contained, sealed and/or roofed/covered to prevent storm water contamination. Wastes need to be emptied regularly. (Implementation phase)	

Annex 8.3. Environmental and Social Management Plan (ESMP) Template

Environmental and social risks and impacts are strongly linked to subproject location and scope of activities. This ESMP should be customized for each specific subproject location and activities.

1. Subproject Information

Subproject Title:	
Estimated Cost:	
Start/Completion Date:	

2. Site/Location Description

3. Subproject Description and Activities

4. ESMP Matrix: Risk and Impacts, Mitigation, Monitoring

Anticipated E&S Risks and Impacts	**Risk Mitigation and Management Measures**	**Impact Mitigation**		**Impact/Mitigation Monitoring**		
		Location/Timing/Frequency	**Responsibility**	**Parameter to be monitored**	**Methodology, including Location and Frequency**	**Responsibility**

5. Capacity Development & Training

6. Implementation Schedule and Cost Estimates

7. Attachments

ESCOPs, site specific SEP etc.

IV. Review & Approval

Prepared By: ……(Signature) Position: …… Date ……	
Reviewed By: ……(Signature) Position: ……Date ……	**Approved By**: ……(Signature) Position: …… Date ……

Annex 8.4 Labor management Procedures:

In accordance with the requirements of World Bank's Environmental and Social Standard 2 (ESS2) on Labor and Working Conditions, a LMP has been developed for the project. The LMP sets out the ways in which WHO will manage all project workers in relation to the associated risks and impacts. The objectives of the LMP are to: Identify the different types of project workers that are likely to be involved in the project; identify, analyze and evaluate the labor-related risks and impacts for project activities; provide procedures to meet the requirements of ESS 2 on Labor and Working Conditions, ESS 4 on Community Health and Safety, and applicable national legislation.

The Labor Management Procedures apply to all project workers, irrespective of contracts being full-time, part-time, temporary or casual. The types of workers that will be included in the project are listed below:

Direct workers:

1. **Project Management Unit (PMU):**

Direct workers include the Project Management Unit staff. The estimated number of direct workers in the WHO/PMU would be around 8 workers of various disciplines. In addition, several other WHO staff will contribute to project implementation. The direct workers under WHO/PMU are:

No	Title	International/National	Qty
1	Project Manager	International	1
2	Health & Knowledge Management	International	1
3	Environmental Safeguards Officer	National	1
4	Social Safeguards Officer	National	1
5	Team Assistant	National	1
6	Technical Officer (Hospital Services)	National	1
7	Monitoring and Evaluation	National	1
8	Procurement	National	1

2. **Civil servants:**

Civil servants engaged in the project supported facilities, such as medical and non- medical workers, will remain subject to the terms and conditions of their existing public sector employment agreement following the Labor Act 1997. ESS2 requirements will not apply to such government civil servants, except for the provisions of ESS2 paragraphs 17 to 20 (Protecting the Work Force) and ESS2 paragraphs 24 to 30 (Occupational Health and Safety). The use of forced and child labor is strictly prohibited within the public sector and the project supported facilities. The health and safety of the civil servant workers will be prioritized to the greatest possible extent, and measures adopted by the Project for addressing Occupational Health and Safety (OHS) issues will be considered such as providing Personal Protective Equipment (PPEs) and training where needed.

The civil servants include:

- **Health Care Workers (HCWs)**

The Health Care Workers (medical and non- medical workers) under the project are exclusively civil servants, they are already working in the health system and will carry out a range of activities. Their number is yet to be determined.

- **Waste Management Workers**

The Waste Management Workers (non-medical workers) under this project will be mainly those with responsibility for waste collection and transportation. Their number is yet to be determined.

- **Contracted workers**

Contractors must ensure that all requirements are communicated to their employees, parent companies, subsidiaries, affiliated entities, and subcontractors in the local language and in a manner that is clear and understood by all. These include those workers who will be contracted to provide services for the project.

- **Consultancy workers**

The project activities include the provision of translation services, conducting assessments or training programs. Training might cover a range of topics and might involve the procurement of service providers to perform these activities. Nevertheless, the expected number of consultants (firms and individuals) and potentially their collaborators (staff and sub-consultants) is yet to be determined.

- **Third Party Monitoring (TPM) workers**

The project activities include Third-Party Monitoring (TPM), who will be responsible for monitoring the project activities and provide feedback to the project to set proper mitigation measures. The TPM for the project will be used and potentially its collaborators (staff and sub-consultants). The Number of workers is not known yet. No child or forced labor will be involved.

- **Contracted supply workers**

The project will hire contractors to deliver the needed supplies to the targeted Health Facilities. This might include medicines and consumable supplies (PPE, etc.). The LMP will be updated to reflect any requirements related to supply workers, if applicable. The estimated number of workers is not known yet.

- **Community workers**

WHO will not engage community workers in this project

- **Primary supply workers**

These include those providing services such as medical supplies and equipment. The Number of workers is yet to be determined. No child or forced labor will be involved.

Labor Risks

The following potential labor risks are identified under the project:

- Violation of worker's rights: Terms and conditions of employment of workers may not be consistent with national legislation or World Bank standards
- Violation of worker's rights: Non-discrimination and equal opportunity of workers may not be consistent with national legislation or World Bank standards
- Use of child labor or forced labor
- Unsafe work environment and poor working conditions (Risk of oxygen explosion or fire, Risk of road accidents)
- Workplace injuries and accidents, particularly when operating construction equipment, when working at height on building construction, and when handling heavy equipment and materials
- Risks from exposure to hazardous substances (dust, cement, chemicals used in construction etc.)
- Sexual exploitation and abuse/sexual harassment (SEA/SH) risks for workers
- SEA/SH risks for community members, from workers from outside the project areas
- Conflicts between workers and communities
- Risks of exposure to health risks while providing health care, handling medical specimens, including inadequate measures and understanding of OHS such as risks for medical personnel and waste management personnel.
- Risk of trauma, mental distress, burn-out for project workers and contractors

- Security risks that could affect the safety of project personnel and stakeholders include lack of security arrangement, working and operating in high risk/ conflict areas, untrained security personnel

Relevant National Labor Legislation

- **National Laws and Regulations:**

Sudan has established institutions and responsibilities for labor management, joined international conventions and developed sector legislation and procedures. These include:

- Labor Act 1997
- Labor Compensation Act 1982
- The pension and Social Insurance Law 1990 and its amendments 2008 Social Insurance Act 1990 - Sudan.pdf
- The Minimum Wage Law 1974

Rest:

In the labor Act 1997, the official hours of work are 48 hours per week or 8 hours per day, broken by a paid period of rest of not less than half an hour per day for eating or resting. Workers are entitled to a weekly rest period consisting of not less than twenty-four non-interrupted hours during each period of seven days. The weekly rest period shall be calculated as to include the period from 6 a.m. to the next 6 a.m. Where the nature of the work or the service performed by the employee is such that the weekly rest cannot fall on a Sunday, another day maybe made a weekly rest day as a substitute. Working hours shall be reduced by one hour during the month of Ramadan for workers who fast and for breastfeeding mothers for two years as from the date of birth of their child, provided that this hour is paid.

Wages:

In the Labor Act 1997, unless the context otherwise requires, wage means the aggregate of the basic pay and all other remunerations payable to the worker by an employer and includes the value of any food, fuel or residence and any overtime, payments or other special remunerations for any work done and any other increments, provided, or gift or traveling allowance or privilege or any subscription paid by the employer for the worker in any social insurance project, such as provident fund or pension or life insurance, or special expenses paid by the employer to the workers;

- Article 28: any contract that exceeds three months in duration shall be made in writing by the employer. Such a contract shall be written in three copies and signed by the two parties. Each party shall keep one copy, and the third copy shall be deposited with the Labor Office.
- Article 30: gives the content of the contract which should include among others "the agreed wage and the time of payment". Note: It is important to mention here that the minimum wage is determined by the national tripartite committee.
- Article 13: the worker wage is determined by the initial value of his position.
- Article 15: employment conditions specify the age of employment as not greater than the age of retirement (65) and not less than 18.

Leave:

Leave will be granted following current legislation (annual leave: Articles 44 and 86; maternity leave: Article 38; sick leave: article 39 and 105) as per the labor act 1997.

Responsible staff:

The body responsible for workers management varies depending on the type of worker. The direct workers will be managed by UN/WHO internal Staff Rules, Policies, Procedures and Guidelines and do not follow local legislation. The management of government civil servants working on the project will be subjected to the national labour laws.

Age of employment:

In the labor act 1997, the minimum age for employment is 16 years. The minimum Age for Hazardous Work is set as 18 years. Workers between the ages of 14 to 18 years are classified as young workers. It is prohibited to employ young workers to carry out work which, on account of its nature or due to the condition in which it is carried out, endangers the life or health of the young workers performing it. Normal working hours for young people may not exceed seven hours per day. It is prohibited to employ young workers on night work between 10 p.m. and 6 a.m.; overtime work; weekly rest

days; and public holidays. The law also defined that normal hours of work for young workers should not exceed seven hours a day. The project will not involve young workers as specified in the relevant laws.

OHS measures:

The project activities such as rehabilitation and maintenance which involve occupational health risks, the project, in collaboration with implementing partners, will develop and conduct an occupational health session for data collectors, supervisors and other key players. This should be in line with the Sudan Labor Laws and the requirements of ESS2 and other relevant ESSs.

OHS measures include the following provisions where applicable:

Ensuring workplace health and safety standards in full compliance with labor act 1997 at a minimum, and including (1) basic safety awareness training to be provided to all persons as well as on IPC measures; (2) safe management of the area around operating equipment inside or outside hospitals/ laboratories; (3) workers to be equipped with hard helmets, safety boots and protective gloves and/or PPE equipment as needed (particularly facemask, gowns, gloves, handwashing soap, and sanitizer) to from hazardous or medical wastes from the work place; and (6) First aid equipment and facilities to be provided in accordance with the Labor Law; (7) all implementing partners ensure that all project workers are covered by social insurance against occupational hazards, including ability to access medical care and take paid leave if they need.

Sexual Harassment

The rape and sexual harassment amendments were reportedly signed into law, together with a raft of other amendments to the Criminal Act, on 22 February 2015.Also, according to UNFPA ''Sexual harassment Article 151 of the Criminal Act was amended in 2015 to criminalize acts of sexual harassment' (Source:Sudan-EN-2pager1). Moreover, the national labor law gives the employer the right to terminate the employment contract without prior notice when the worker commits a morally offensive act. Specific measures to prevent harassment, intimidation and exploitation during the implementation of project activities considering the separate SEA/SH action plan and application of GBV-SEA/SH Code of conduct for all project workers to uphold ethical standards and relevant E&S obligations and national legislation.

- **World Bank and International regulations:**
  - World Bank Environmental and Social Standards ESS relevant to the project
  - World Bank Group Environmental, Health and Safety Guidelines (EHS Guidelines) relevant to the project.
  - Technical Note: Public Consultations and Stakeholder Engagement in WB-supported operations when there are constraints on conducting public meetings, issued on March 20, 2020.
  - WBG EHS Guidelines for Healthcare Facilities, issued on April 30, 2007.

General Applicable Procedures

WHO and contractors will apply the following guidelines when dealing with workers:

- There will be no discrimination with respect to any aspects of the employment relationship, such as: Recruitment and hiring; compensation (including wages and benefits; working conditions and terms of employment; access to training; job assignment; promotion; termination of employment or retirement; or disciplinary practices.
- Harassment, intimidation and/or exploitation will be prevented or addressed appropriately.
- Special measures of protection and assistance to remedy discrimination or selection for a particular job will not be deemed as discrimination.
- Vulnerable project workers will be provided with special protection.
- WHO and contractors will provide job / employment contracts with clear terms and conditions including rights related to hours of work, wages, overtime, compensation and benefits, annual holiday and sick leave, maternity leave and family leave. Code of Conduct included in this LMP will be applicable for all project workers.
- WHO will ensure compliance with the Code of Conduct including providing briefings/awareness raising on the Code.
- WHO and contractors will ensure compliance with occupational health and safety procedures including that the workers are properly trained in the application of the standards that are relevant to the work.
- WHO and retained contractors will ensure no person under the age of 18 shall be employed. Age verification of all workers will be conducted by the contractors.

- WHO will recruit contractors and labor locally to the extent that they are available.
- Workers shall be recruited voluntarily, and no worker is forced or coerced into work.
- WHO will supervise and monitor to ensure compliance with the above requirements.
- All workers will be made aware of the Worker's Grievance Mechanism (see below) to raise work related grievances, including any sensitive and serious grievances on SEA/SH.

Below table A explain mitigation measures per risk and monitoring mechanism.

Risk title	Mitigation measure	Monitoring measures
Risks associated with GBV and SEA/SH and risk of trauma, mental distress, burn-out for project workers and contractors in the project.	-Please see separate GBV/SEA/SH Action Plan -Conduct regular or periodic Safety Audits in the project sites and service facilities with inputs from women and girls. Wherein safety gaps are identified through safety audits, take appropriate actions to address them -Prioritize the recruitment of women for activities with women and girls -Maintain and, if not available, put in place safe and accessible reporting mechanisms in consultation with women and girls -Prioritize the recruitment of women for activities with women and girls -Maintain and, if not available, put in place safe and accessible reporting mechanisms in consultation with women and girls -Include a PSEA requirement in partnerships and contractual agreements -Train and sensitize IPs/Contractors, Front Line Workers, and raise the community awareness on the content of the Code of Conduct, with a focus on PSEA, GBV risk mitigation, and how to safely handle incidents reporting and management -Ensure project workers, including the subcontracted ones, Front Line Workers, are trained and sensitized in the Standard of Conduct, with a focus on PSEA, GBV risk mitigation, and how to safely handle incident reporting and management -Submit to WHO the signed CoCs, including subcontracted workers and Front-Line Workers. -\ -Whenever possible, avoid working during night hours. And wherein women are part of, or participating in the rehabilitation work, ensure they are aware of their rights to protection and available reporting channels.	-Number of Sensitization or training done about GBV, SEA/SH -Access to psychosocial support based on the needs and availability of such services

	-Ensure labors are aware and have access to grievance redress mechanisms to highlight any feedback.	
Child and forced labor	-Ensure the existence of contractual requirements on prevention of child labor with a minimum age of 18. -Provide workers with contracts in accordance with national labor laws and procedures -Train and sensitize IPs/Contractors and raise the community's awareness on the content of Standard of Conduct, including a focus on child labor and forced labor -Ensure project workers, including subcontracted ones, are trained and sensitized on the Standard of Conduct, including a focus on child labor and forced labor -Submit to WHO the signed CoCs, including for subcontracted workers	-Regular supervision of selected health care facilities ensured compliance with national labor law 1997 and CoC
-Exposure to health risks while providing health care, handling specimens and dealing with biological waste, chemical waste, and other hazardous by-products generated by health care facilitates.	-Reduction, sorting and disposal of medical waste will be duly carried out taking into consideration workers' health and safety in line with the Medical Waste Management Plan (MWMP) of the project and sensitize workers -Staff revived IPC training to control transmission of infections and following IPC measures -Provision of personal protective equipment (PPE) and WASH supplies with adequate provision of hygiene facilities (toilets, hand-washing basins, resting areas etc. separated by gender as needed and with distancing guidelines in place	-Supervision on the equipment needed and PPEs are in place. Ensuring that all OHS incidents are recorded and reported on the project.
Risk of road accidents and workplace injuries particularly when operating and handling rehabilitation equipment	-See the separate SMP -Ensure workers, Front Line Workers are trained in road safety measures (including in CoC) -Require all vehicle drivers to have appropriate licenses -Use well maintained vehicles and equipment -Require WHO personnel to comply with WHO vehicle fleet and road safety/management policies, procedures, and guidelines -Work with the local authorities, when needed, to manage traffic near Project sites where activities include rehabilitation works.	-Proper vehicle inspection, -Training drivers on defensive driving and putting speed limit devices on the project cars.
Discrimination in relation to recruitment, hiring including labor influx, compensation,	-Require fair treatment of workers, non-discrimination, and equal opportunities and ensure all stakeholders are treated with respect and dignity	-Regular supervision to selected health care facilities ensured that all workers (medical and

working conditions, terms of employment, etc.	-Contractors will provide job / employment contracts with clear terms and conditions including rights related to hours of work, wages, overtime, compensation and benefits, annual holiday and sick leave, maternity leave and family leave. -Train and sensitize IPs/Contractors, project workers, Front Line Workers, and raise the communities awareness on the content of Code of Conduct, including a focus on prevention of discrimination -Ensure project workers, including subcontracted ones, Front Line Workers, are trained and sensitized in the Code of Conduct, including a focus on prevention of discrimination. -Submit to WHO the signed CoCs, including for subcontracted workers and Front-Line Workers. -Revise recruitment process and selection criteria and ensure alignment with national labor act and ESS2.	non-medical) are receiving equal opportunities
Inappropriate working conditions and OHS	-Provide workers with contracts in accordance with national labor laws and procedures -Ensure adequate provision of hygiene facilities (toilets, hand-washing basins), resting areas, etc. separated by gender, as needed -Put in place warning signs, ensure safe storage of equipment, and allow only authorized people access to the working area -Ensure construction/rehabilitation sites have protective measures (barriers, fencing), as appropriate -Provide PPE as suitable to the tasks and hazards of each worker, without cost to the worker -Provide first aid equipment and facilities in accordance with the national labor laws and procedures -Ensure working hours are in line with local labor laws and regulations. Where possible, avoid working during night hours -Require all workplace health and safety incidents to be properly recorded in a register and reported to WHO -Ensure the work areas are properly arranged/organized with assigned safe routes for workers and that all rehabilitation	-Regular supervision to selected health care facilities to ensure appropriate working condition

	materials and equipment are stored in safe and appropriate locations -Provide training on OHS, including all the above -Ensure labors are aware and have access to grievance redress mechanisms to highlight any feedback. - The contractor will develop a contractor-ESMP, including, as deemed necessary, a Traffic Management Plan, Waste Management Plan, OCHS Plan, Emergency Preparedness and Response Plan, and CoC and enforce their implementation	
Security risks that could affect the safety of project personnel and stakeholders include: - lack of security arrangement at conflict areas. - working and operating in high risk such as fire and oxygen explosion. Risk of shooting, kidnapping and rape especially in conflict areas.	-Adopt the separated SMP -Ensure IPs/Contractors are timely informed of any conflict related or natural disaster related event in the project areas -Regularly conduct consultations with relevant authorities -Establish/maintain security protocols (communication material, early warning systems, emergency cells, business continuity/contingency plans, etc.) and train workers on their content and adjust activity implementation accordingly -Undertake hazard risk assessment and develop preparedness and response emergency plan -Adjust activity implementation modalities based on natural hazards (e.g., epidemic, floods, etc.) -Whenever necessary, liaise with the United Nations Agency for Mine Action Services (UNMAS) to assess and confirm that no unexploded ordnances (UXO) are present prior to commencing the work and inform IPs/Contractors accordingly -Ensure Labors are aware and have access to grievance redress mechanisms to highlight any feedback.	-UNDSS threat monitoring, Security Community of Practice convened for this project provide ongoing monitoring through bi-weekly meetings. -Convoy security for transportation of medical supplies where needed.
Risk of conflicts between workers and the community	Ensure that the minor rehabilitation work does not disturb the communities' access to the available services (e.g., safe spaces, health care services, schools, etc.); if not possible, avoid proximity between workers and community members. Prioritize workers from local communities, including IDPs and other vulnerable groups; if not possible, provide non-local workers with	

	suitable accommodation in a specific site, well defined to minimize contact with the local community after sensitization of the non-local workers about the community practices and social norms.	

Occupational Health and Safety (OHS) Procedures

The objective of the procedure is to achieve and maintain a healthy and safe work environment for all project workers (contracted workers and community workers) and the host community.

- On procurement for contractors, WHO will avail the ESMF to the aspiring contractors so that contractors include the budgetary requirements for OHS measures in their respective bids.
- The contractor will develop and maintain an OHS management system that is consistent with the scope of work, which must include measures and procedures to address all the following topics listed below and in accordance with local legislation and GIIP (as defined by World Bank Group EHSGs). The management system must be consistent with the duration of the contract and this LMP.
- Contractor will conduct workplace hazards identification and adopt all applicable E&S risk mitigation measures in accordance with local legislation requirements and WBG EHSGs.
- The contractor designates a responsible person to oversee OHS related issues at the project site and define OHS roles and responsibilities for task leaders and contract managers.
- Contractors should put in place processes for workers to report work situations that they believe are not safe or healthy, and to remove themselves from a work situation in which they have reasonable justification to believe presents an imminent and serious danger to their life or health, without fear of retaliation.
- Contractor provides preventive and protective measures, including modification, substitution, or elimination of hazardous conditions or substances informed by assessment and plan. Whenever PPEs are required for the work, it must be provided at no cost for the workers.
- Contractors should assess workers' exposure to hazardous agents (noise, vibration, heat, cold, vapors, chemicals, airborne contaminants etc.) and adopt adequate control measures in accordance with local regulations and WB EHSGs.
- Contractors provide facilities appropriate to the circumstances of the work, including access to canteens, hygiene facilities, and appropriate areas for rest. Where accommodation services are provided to project workers, policies will be put in place and implemented on the management and quality of accommodation to protect and promote the health, safety, and well-being of the project workers, and to provide access to or provision of services that accommodate their physical, social and cultural needs.
- Contractor provides appropriate training/induction of project workers and maintenance of training records on OHS subjects.
- Contractor documents and reports on occupational incidents, diseases and incidents as per ESMF guidance.
- Contractor provides emergency prevention and preparedness and response arrangements to emergency situations including and not limited to workplace accidents, workplace illnesses, flooding, fire outbreak, disease outbreak, labor unrest and security.
- Contractor provides remedies for adverse impacts such as occupational injuries, deaths, disability and disease in accordance with local regulatory requirements and Good International Industry Practices.
- The contractor shall maintain all such records for activities related to safety, health and environmental management for inspection by WHO or the World Bank.

Contractor Management Procedures

The objective of this procedure is to ensure that WHO has contractual power to administer oversight and action against contractors for non-compliance with the LMP.

- WHO will make available relevant documentation to inform the contractor about requirements for effective implementation of the LMP.
- WHO will include the provisions of the ESMF, LMP and other relevant documents into the specification section of the bidding documents. The contractors will be required to comply with these specifications.
- Contractor will raise worker awareness on the Code and Conduct.
- The contractor will show evidence of OHS and Emergency Preparedness procedures.
- WHO will monitor contract's E&S performance during its regular site visits utilizing contractor reporting or external monitoring/supervision consultants where available. Where appropriate, WHO may withhold contractor's payment or apply other contractual remedies as appropriate until corrective action(s) is/are implemented on significant non-compliance with the LMP, such as failure to notify WHO of incidents and accidents.

Procedures for Primary Suppliers

The objective of the procedure is to ensure that labor-related risks, especially child and forced labor as well as serious safety issues to the project from primary supply workers are managed. WHO and all contractors will undertake the following measures:

- Procure supplies from legally constituted suppliers.
- To the extent feasible, conduct due diligence to ensure that primary suppliers conduct age verifications, employ workers without any force or coercion, and maintain basic OHS systems.

Worker Accommodation

*If accommodations are provided for workers, contractors will ensure that they are provided in good hygiene s*tandards, with fresh drinking water, clean beds, restrooms and showers, clean bedrooms, good illumination, lockers, proper ventilation, safe electrical installation, fire and lightening protection, separate cooking and eating areas. There will be separate facilities provided for men and women. The contractors will be liable to comply with "Workers' Accommodation: Processes and Standards: A guidance Note" by IFC and the EBRD.

Institutional Arrangement for Implementation of the LMP

WHO will monitor the implementation of the LMP. The contractor/ implementing partner will identify subproject activities, prepare subproject designs and bidding documents, as well as procure contractors. The contractor/ implementing partner will be responsible for the contractor and site supervision, technical quality assurance, certification, and payment of works. The contractor/ implementing partner will ensure that labor management procedures are integrated into the specification section of the bidding documents and the procurement contracts.

The Third-Party Monitoring Agent will be hired (based on ToR agreed with the Bank) to provide an independent biannual review of Project implementation and verification of Project results and adherence to all E&S requirements addressed in the ESCP and all ESHS instruments, including through, inter alia: periodic site visits, assessment of local context and conditions, interviews, awareness raising.

Grievance Mechanism

A grievance mechanism will be established jointly with UNICEF a "complaints and feedback mechanism (CFM)" – Marhab center to handle the concerns of direct, contracted workers and the beneficiaries. Processes for documenting complaints and concerns have been specified, including time commitments to resolve issues. Stakeholders and beneficiaries will be informed about the relevant CFM upon the effectiveness of the project.

Routine Grievances

The process for the CFM is as follows:

- Any worker or beneficiary may report their grievance by phone, text message, mail or email (including anonymously if required) to the Complaints and Feedback mechanism- CFM (Marhab Center). The CFM focal person will work to address and resolve all the complaints received and inform the beneficiary as promptly as possible, in particular if the complaint is related to something urgent that may cause harm or exposure to the person, such as lack of PPE needed to prevent communicable disease transmission. For non-urgent complaints, the CFM focal person will aim to resolve complaints withing 3 weeks. For complaints that were satisfactorily resolved by the CFM focal person, the

incident and resultant resolution will be logged by CFM focal person and reported monthly to CFM focal person at WHO as part of regular reporting. Where the complaint has not been resolved, the CFM focal person will refer to CFM focal person at WHO for further action or resolution.

The workers will preserve all rights to refer matters to relevant judicial proceedings as provided under national labor law.

At CFM – Marhab Center level, each grievance record will follow complaint logging. Complaint records (letter, email, record of conversation) should be stored together, electronically or in hard copy. The WHO will appoint CFM Focal Person, who will be responsible for undertaking a monthly review of all grievances to analyze and respond to any common issues arising. The Focal Person will also be responsible for oversight, monitoring and reporting on the Worker CFM.

Serious Grievances

In case of an experience serious mistreatment such as harassment, intimidation, abuse, violence, discrimination or injustice at the workplace, the worker may raise the case, verbally or in writing directly to the CFM focal person at WHO. The CFM focal person at WHO will report the case for investigate team at WHO- HQ respecting confidentiality and anonymity of the worker. As well workers can raise the complaints to the WB's GRS.

Upon project effectiveness, the WHO will designate a Focal Person or Persons for Serious Grievances. These Focal Persons will receive training on serious cases reporting, relevant laws and regulations, and World Bank standards including the rights of people who file a grievance.

All complaints received will be filed and kept confidential. For statistical purposes, cases will be anonymized and bundled to avoid identification of persons involved.

Code of Conduct

WHO has a Policy on Preventing and Addressing Sexual Misconduct, harassment and other types of abusive conduct which is also incorporated into WHO Purchase Order General Conditions WORLD HEALTH ORGANIZATION PURCHASE ORDER - PO rev as all well as all bidding/solicitation documentations; RFPs, ITBs http://www.who.int/about/ethics/en/ WHO Policy on Preventing and Addressing Abusive Conduct and WHO code of conduct **WHO Code of Conduct.pdf** will be used in the Project.

Annex 8.5 Chance Find Procedures

Cultural heritage encompasses tangible and intangible heritage which may be recognized and valued at a local, regional, national or global level. *Tangible cultural heritage*, which includes movable or immovable objects, sites, structures, groups of structures, and natural features and landscapes that have archaeological, paleontological, historical, architectural, religious, aesthetic, or other cultural significance. Tangible cultural heritage may be located in urban or rural settings and may be above or below land or under the water. *Intangible cultural heritage*, which includes practices, representations, expressions, knowledge, skills as well as the instruments, objects, artefacts and cultural spaces associated therewith that communities and groups recognize as part of their cultural heritage, as transmitted from generation to generation and constantly recreated by them in response to their environment, their interaction with nature and their history.
In the event that during construction, sites, resources or artifacts of cultural value are found, the following procedures for identification, protection from theft, and treatment of discovered artefacts should be followed and included in standard bidding documents. These procedures take into account requirements related to Chance Finding under national legislation including the Antiquities Protection Law of 1911.

- Stop the construction activities in the area of chance find temporarily.
- Secure the site to prevent any damage or loss of removable objects. In cases of removable antiquities or sensitive remains, a guard shall be arranged until the responsible local authorities take over. These authorities are the National Authority for Antiquities and Museums.
- Notify the relevant contractor and the relevant National Authority for Antiquities and Museums immediately. contractors will inform the [implementing partner.
- The relevant the National Authority for Antiquities and Museums shall promptly carry out the necessities and inform the Ministry of Culture and Information immediately from the date on which the information is received.
- The Ministry of Culture and Information would be in charge of evaluation /inspection of the significance or importance of the chance finds and advise on appropriate subsequent procedures.
- If the Ministry of Culture and Information determines that chance find is a non-cultural heritage chance find, the construction process can resume.
- If the Ministry of Culture and Information determines chance find is an isolated chance find, Ministry of Culture and Information would provide technical support/advice on chance find treatment with related expenditure on the treatment provided by the entity report the chance find.

Introduction

Medical waste refers to the entirety of waste generated by healthcare and medical research facilities and laboratories. Though only 10-25% of medical waste is considered hazardous, posing various health and environmental risks, it is essential that a comprehensive plan be developed to prevent and mitigate these risks. The safe and sustainable management of medical waste is a public health imperative and a responsibility of partners working in the health sector. Improper management of medical waste poses a significant risk to patients, health-care workers, the community, and the environment. This problem can be solved by the right investment of resources and commitment and will result in a substantive reduction in the disease burden and corresponding savings in health expenditures.

The main objectives of this plan are to provide guidance on medical waste management, reflect the distribution of responsibility between partners, analyses the expected environmental and social risks and identify mitigation measures to avoid where possible, minimize and mitigate these risks.

1. Existing Medical Waste Management System/Practices

At present there is limited capacity in appropriate management of hospital or healthcare waste across the country. Although some good basic groundwork has been carried out in an attempt to bring about improvements, the situation remains deplorable and represents a serious health risk, not only to medical staff but also to the general public. Mixing most of the hospital waste with municipal solid waste worsens the problem. Most healthcare facilities have no common standards for source separation, collection bins, collection equipment for the disposal of medical waste. Disposable syringes, body organs, plastic bottles lay astray in the open dumps of the hospital waste. Some hospitals and municipalities burn their waste, which results in the production of large amounts of high toxic gases. Therefore, the risk of injury and infection resulting from the improper management of the waste is high.

Within the supported facilities under this project, WHO will support the capacity building of healthcare workers through regular training on medical waste management and infection prevention and control principles. In addition, the supported healthcare facilities will be provided with waste management and infection prevention and control supplies on a regular basis, including disinfectants, bins, bags, safety boxes and Personal Protective Equipment (PPE). Monitoring of adherence and the level of implementation of waste management requirements in the supported healthcare facilities will be performed by Third Party Monitoring agencies and WHO's monitoring and evaluation team. Corrective actions and preventive measures will be regularly determined based on the monitoring outcomes and addressed in a timely manner with the relevant authorities to avoid any deviation.

The supported facilities will implement this Medical Waste Management Plan (MWMP) which includes the related environmental and health risks, mitigation measures, arrangements and requirements for safe management of medical waste as well, WHO guidance and recommendations included in the safe management of wastes from health-care activities will be followed during the operation phase.

2. Guidelines on Medical Waste Management

Effective management of medical waste is an integral part of a national health-care system, and as such needs to be integrated in this project. A holistic approach to medical waste management should include a clear delineation of responsibilities, occupational health and safety programs, waste minimization, adequate storage conditions for the medical supplies and segregation, and capacity building. Best practices for safely managing health-care waste should be followed in healthcare facilities, which includes assigning responsibility and sufficient human and material resources to segregate and dispose of waste safely.

As highlighted by WHO recommendations[1], the first step in medical waste management is to minimize waste. A standardized assessment tool should be developed to identify gaps in the management process, including occupational health and safety issues. Though all staff are responsible for managing waste, to ensure optimal waste management, it is

[1] http://apps.who.int/iris/bitstream/10665/85349/1/9789241548564_eng.pdf

recommended to establish a facility-based Waste Management Committee and designate a single waste management project lead. The project lead should coordinate the medical waste management system and be supported by the health facility management. In addition, the roles and responsibilities of key personnel engaged in waste management activities should be defined during all phases (i.e., generation, segregation, transportation, and final disposal) and a waste-management committee should be established.
Annex 3 details the segregation, treatment and disposal principals for healthcare waste categories in accordance with the World Bank Environmental, Health, and Safety Guidelines for Health Care Facilities.

☐ **Waste Handling Safety Measures**

- All personnel handling infectious medical waste shall wear gloves and additional protective medical clothing and personal protective equipment (PPE) appropriate to the level of risk they encounter and shall remove any protective medical clothing used prior to leaving the work area and to place it in a designated area or container. When performing procedures where splashing is not expected, gloves are the minimum PPE that may be worn.
- Protective medical clothing and PPE should not be sent for laundering unless sterilized.
- Where splashing may occur or when infectious medical waste bags or containers may contact more than the worker's hands and wrists, the following is required in addition to gloves:
  - Appropriate protective medical clothing should be of material that does not permit infectious medical waste from penetrating and reaching workers' clothes or skin.
  - Eye protection, surgical face masks, and face shields when personnel may reasonably anticipate facial exposure to infectious medical waste.
  - Implement immunization for staff members, as necessary (e.g. vaccination for hepatitis virus, tetanus immunization).

☐ **Waste Segregation Strategies**

At the point of generation, waste should be identified and segregated. Non-hazardous waste, such as paper and cardboard, glass, aluminum and plastic, should be collected separately and recycled. Food waste should be segregated and composted. Infectious and / or hazardous wastes should be identified and segregated according to its category using a colour-coded system. If different types of waste are mixed accidentally, waste should be treated as hazardous. Other segregation considerations include the following:

- Avoid mixing general health care waste with hazardous health care waste to reduce disposal costs.
- Segregate waste containing mercury for special disposal.
- Management of mercury containing products and associated waste should be conducted as part of a plan involving specific personnel training in segregation and clean up procedures.
- Segregate waste with a high content of heavy metals (e.g. cadmium, thallium, arsenic, lead) to avoid entry into wastewater streams.
- Separate residual chemicals from containers and remove them to proper disposal containers to reduce generation of contaminated wastewater. Different types of hazardous chemicals should not be mixed.
- Establish procedures and mechanisms to provide for separate collection of urine, feces, blood, vomits, and other wastes from patients treated with genotoxic drugs. Such waste is hazardous and should be treated accordingly.
- Aerosol cans and other gas containers should be segregated to avoid disposal via incineration and related explosion hazard.
- Segregate health care products containing Polyvinyl Chloride (PVC) to avoid disposal via incineration or in landfills.

☐ **On-site Handling, Collection, Transport and Storage**

- Seal and replace waste bags and containers when they are approximately three quarters
- Full bags and containers should be replaced immediately.

- Identify and label waste bags and containers properly prior to removal.
- Transport waste to storage areas on designated trolleys / carts, which should be cleaned and disinfected regularly.
- Waste storage areas should be located within the facility and sized to the quantities of waste generated, with the following design considerations:
  - Hard, impermeable floor with drainage, and designed for cleaning / disinfection with available water supply
  - Secured by locks with restricted access
  - Designed for access and regular cleaning by authorized cleaning staff and vehicles
  - Segregated from food supplies and preparation areas
  - Equipped with supplies of protective clothing, and spare bags / containers
- The storage times between generation and treatment of waste should not exceed the following 48 hours Store mercury containing wastes separately in sealed and impermeable containers in a secure location.
- Store cytotoxic waste (its pharmaceutical waste such as azathioprine and cyclophosphamide) separately from other waste in a secure location.
- Store radioactive waste (produced from x-rays services) in containers to limit dispersion, and secure behind lead shields.

☐ **Transport to External Facilities**

- Transport waste destined for off-site facilities according to the guidelines for transport of hazardous wastes / dangerous goods in the General EHS Guidelines (World Bank Document)
- Transport packaging for infectious waste should include an inner, watertight layer of metal or plastic with a leak-proof seal. Outer packaging should be of adequate strength and capacity for the specific type and volume of waste.
- Packaging containers for sharps should be puncture-proof.
- Waste should be labeled appropriately, noting the substance class, packaging symbol (e.g. infectious waste, radioactive waste), waste category, mass / volume, place of origin within hospital, and final destination.
- Transport vehicles should be dedicated to waste and the vehicle compartments carrying waste sealed.

☐ **Disposal of Contaminated Waste**

In facilities that have a waste zone, this is the final disposal site of medical waste. A fully functional waste zone should have the following components:

- A dual- Chamber incinerator or burner for treatment of soft waste with temperature range Min. 850-1100 °C, Max. 1050-1200
- An ash pit for disposal of residues from the incinerator or burner and a covered pit with a hatch lid as per the guideline IETC_Compendium_Technologies_Treatment_Destruction_Healthcare_Waste.pdf
- A sharps pit for disposal of sharps containers. A sealed, covered pit with a 1m length of pipe incorporated in the top to prevent access to the contents.
- An organics pit for disposal of human tissue and other biological waste.

An infiltration facility or sewer for the disposal of liquids.
categories of medical waste are detailed in annex 1 and non-exhaustive list is outlined in the table below.

Common medical waste and disposal methods

Waste Item*	Waste Collection	Storage	Treatment/Disposal
Needles, ampoules, scalpels, broken glass and vials	Closed sharps container	No	Sharps pit
Needle caps, syringes (w/o needles), masks, gloves, paper and dressings	Soft bucket	Temporary	Incinerator/ash Pit

Human body tissue, blood and fluids	Organics bucket	No	Organics Pit
Wastewater	Bucket	No	Sewer/Infiltration facility
Domestic waste	Bin in communal area	No	Domestic waste pit

☐ **Best Practices for the Disposal of Liquid Contaminated Wastes**

Liquid contaminated waste (e.g. human tissue, blood, feces, urine and other body fluids) requires special handling, as it may pose an infectious risk to healthcare workers with contact or handle the waste. Steps for the disposal of liquid contaminated waste are the following:

- Wear PPE (utility gloves, protective eyewear and plastic apron)
- Carefully pour waste down a utility sink drain or into a flushable toilet and rinse the toilet or sink carefully and thoroughly with water to remove residual waste. Avoid splashing.
- If a sewage system doesn't exist, dispose of liquids in a deep, covered hole, not into open drains. This should be located at a safe distance from water sources.
- Decontaminate specimen containers by placing them in a 0.5% chlorine solution for 10 minutes before washing them.
- Remove utility gloves (wash daily or when visibly soiled and dry).
- Wash and dry hands or use an antiseptic hand rub as described above.
- Acids and alkalis should be diluted; pH neutralized and disposed of to the sewer with water. Neutralization can be done with lime, which is cheap and effective.

Some of the facilities are directly connected with the sewage system and other facilities are using the septic tank as primary treatment unit and regularly sucked.

☐ **Best Practice for the Disposal of Solid Contaminated Wastes**

Solid contaminated waste (e.g. surgical specimens, used dressings and other items contaminated with blood and organic materials) may carry microorganisms. Remember:

- Never use hands to compress waste into containers
- Hold plastic bags at the top
- Keep bags from touching or brushing against the body while lifting or during transport

Steps for the disposal of solid contaminated waste are:

- Wear heavy-duty or utility gloves when handling and transporting solid waste.
- Wearing glasses if you are working with material that may splash into your face or eyes
- Dispose of solid waste by placing it in a plastic or galvanized metal container with a tight-fitting cover. Never recap needles after use.
- Collect the waste containers on a regular basis and transport the burnable ones to the incinerator or area for burning.

If incineration is not available or waste is non burnable, bury it. Remove utility gloves (wash daily or when visibly soiled and dry).

- Wash and dry hands or use an antiseptic hand rub as described above.
- Disposing of waste into designated containers as soon as it is generated
- Wearing boots, coveralls, glasses and gloves when disposing of waste
- Using adequate tools to avoid contact with waste (brush, shovel)

2. Guidelines on Emergency Preparedness and Response

Emergency events occurring in a healthcare facility (HF) may include occupational exposure to infectious materials, accidental releases of infectious or hazardous substances to the environment, medical equipment failure, failure of solid waste and wastewater treatment facilities and fire. These emergency events are likely to seriously affect medical workers, communities, the HF's operation, and the environment.

One person needs to be designated as responsible for the handling of emergencies, including coordination of actions, reporting to managers and regulators, and liaising with emergency services, and a deputy will be appointed to act in case of absence. In health-care establishments, spillage is probably the most common type of emergency involving infectious or other hazardous material or waste. Response procedures are essentially the same regardless of whether the events involve waste or material in use, and should ensure that:

- The waste management plan is respected.
- Contaminated areas are cleaned and, if necessary, disinfected.
- Exposure of workers is limited as much as possible during the clearing up operation.
- The impact on patients, medical and other personnel, and the environment is as limited as possible.
- Health-care personnel are being trained for emergency response, and the necessary equipment will be provided to ensure that all required measures can be implemented safely and rapidly.
- Written procedures for the different types of emergencies were drawn up. For dangerous spills, the clean-up operation will be carried out by designated personnel specially trained for the purpose.

In case of a needle stick injury, bleeding of the wound should be encouraged, and the area should be washed under clean running water. The remaining elements of the accident response plan should then be followed. The feasibility of provision Hep-B protection for all healthcare workers and administering post-exposure prophylaxis (PEP) in case of needle-stick injuries to be assessed and evaluated by the healthcare authorities.
The purpose of incident reporting should not be seen as punitive and active support by managers should encourage prompt and accurate reporting.

General procedures in case of spillages

The actions listed below provide an example of typical measures that could/should be taken in case of accidental spillages of healthcare waste.

- Evacuate the contaminated area.
- Decontaminate the eyes and skin of exposed personnel immediately.
- Inform the designated person who should coordinate the necessary actions.
- Determine the nature of the spill.
- Evacuate all the people not involved in cleaning up.
- Provide first aid and medical care for injured individuals.
- Secure the area to prevent exposure of additional individuals.
- Provide adequate protective clothing for personnel involved in cleaning up.
- Limit the spread of the spill.
- Neutralize or disinfect the spilled or contaminated material if indicated.
- Collect all spilled and contaminated material. [Sharps should never be picked up by hand. brushes and pans or other suitable tools should be used]. Spilled material and disposable contaminated items used for cleaning should be placed in the appropriate waste bags or containers.
- Decontaminate or disinfect the area, wiping up with absorbent cloth. The cloth (or other absorbent material) should never be turned during this process, because this will spread the contamination. The decontamination should be carried out by working from the least to the most contaminated part, with a change of cloth at each stage. Dry clothes should be used in case of liquid spillage. for spillages of solids, cloth impregnated with water (acidic, basic, or neutral as appropriate) should be used.
- Rinse the area and wipe dry with absorbent cloths.

- Decontaminate or disinfect any tools that were used.
- Remove protective clothing and decontaminate or disinfect it if necessary.
- Seek medical attention if exposure to hazardous material has occurred during the operation.

Medical Waste Management Procedure

Guidelines and standards that are included in sections 3 and 4 are the best practices according to international guidance and WHO recommendations. Additionally, the healthcare waste (HCW) management guidelines should apply to all individuals who are exposed to hazardous HCW and therefore potentially at risk of being injured or infected, including:

- Medical staff: doctors, nurses, sanitary staff and hospital maintenance personnel.
- In- and outpatients receiving treatment in health-care facilities as well as their visitors.
- Workers support services linked to health-care facilities such as laundries, waste handling and transportation services.
- Workers in waste disposal facilities, including scavengers.
- The general public and more specifically the children playing with the items they can find in the waste outside the health-care facilities when it is directly accessible to them.

During handling of waste, the medical and ancillary staff as well as the sanitary laborers can be injured if the waste has not been packed safely. In that respect, sharps are considered as one of the most dangerous categories of waste. Many injuries occur because syringe needles or other sharps have not been collected in safety boxes or because these have been overfilled. On dumpsites, scavengers during their recycling activities may also come in contact with infectious waste if it has not been properly treated or disposed of.

The general public can be infected by HCW either directly or indirectly through several routes of contamination. Dumping HCW in open areas is a practice that can have major adverse effects on the population. The “recycling” practices that have been reported, particularly, the reuse of syringes is considered by WHO to be the most serious problem in some of the developing countries. The WHO estimates that over 20 million infections of hepatitis B, C and HIV occur yearly due to unsafe injection practices (reuse of syringes and needles in the absence of sterilization). There is a risk for public health as regards the sale of recovered drugs in the informal sector and the lack of controls.

Dumping HCW in uncontrolled areas can have a direct environmental effect by contaminating soil and groundwaters. During incineration, if no proper emissions control is applied, air can be polluted, causing illnesses to the nearby populations. This has to be taken into consideration when choosing a treatment or a disposal method by carrying out a rapid environmental impact assessment.

Construction waste management:

Construction waste materials treated as solid waste and the Contractor shall at all times during the rehabilitation and keep the construction area, including storage areas used free from accumulation of waste material or rubbish, as well prior to the completion of the work, the Contractor shall remove from the vicinity of the work all facilities, buildings, rubbish, unused materials, concrete forms and other like material, belonging to him or used under his directions during construction. All work areas shall be graded and left in a neat manner conforming to the natural appearance of the landscape as it was before rehabilitation works and shall be disposed of by the Contractor and removed from the construction area.

Each contractor will develop a plan for construction waste management including the risks and mitigation measure and the collection of the construction waste will be done regularly and in collaboration with local authority. The plan will be revised by WHO-PMU and regularly monitor to ensure the implementation.

It is not expected that all of these measures are applicable and realistic within the context of Sudan, however the project's responsibility to identify the risks and most practical mitigation measures as applicable in the operating environment to mitigate the medical waste management risks that are inherent in the activities supported through the project.

4.1 Project Implementation and Institutional Arrangements

Under SHARE project, WHO will be the grant recipients and will be the managing and implementing agency, where the organization is responsible for the respective activities based on the project design and the implementation experience under the Emergency Health program. WHO managed to set implementation mechanisms in place for the subprojects, through the existing local public system structures, to deliver various results on the ground during the ongoing conflict in Sudan.

Environmental Health and Food Control Directorate is the responsible technical body for health care waste management at federal level and the operational responsibility is shared between the health care facility, local authority and private sector at state level. WHO will coordinate with all parties to facilitate the implementation of the provisions of this plan and further ensure medical waste management sustainability beyond the scope and duration of the project.

Ideally and at facility level, it is recommended that waste management / infection control team needs to be assigned by the in charge of the hospital. Generally, this will comprise of:

1. Director of the hospital.
2. Infection control nurse.
3. Nursing Supervisor.
4. Senior Pharmacist.
5. Lab technician.
6. Ward master.
7. Public health officer/ Water Sanitation and Hygiene (WASH) focal person.
8. Registrar Medicine / Surgery / Radiology / Gynecology and Obstetrics.

WHO has included specialists in Environmental health as part of its Project Management Unit (PMU) for the project. The Specialist will be responsible for providing training and raising awareness for relevant staff involved in the oversight and management of the MWMP and will work closely with WHO personnel at central and field levels. WHO field staff will be closely involved in the management, monitoring, and reporting of environmental and social risk management aspects throughout project implementation.

The Third-Party Monitoring (TPM) agent that will be hired to monitor implementation activities under the project, will include in their monitoring process indicators to measure and report on implementation of the MWMP provisions.

4.2 **Requirements for Medical Waste Management**

To ensure the best practice of medical waste management specific requirements need to be in place and regularly monitored Monitoring to control the expected environmental effects through specific mitigation measures include the segregation of medical waste, appropriate storage bins and bags, inside disinfection/decontamination, regular removal for inside and offsite disposal. Also, maintain records to monitor the volume of medical waste generated, collected and disposed.

4.3 Awareness Raising and Capacity Building

Healthcare staff will need to be trained and aware of good practices and procedures of waste management and infection control under this plan. Such practices and procedures should be disseminated to the healthcare facilities to be considered as part of the project activities through the following options:

- Designating members of the teams to train other healthcare staff, waste management workers and cleaners on the management of generated waste.
- Installation of signs and instructions of good practices/procedures for waste management within the healthcare facilities as well as during the other campaigns supported by the Project.

- Conducting regular training and awareness sessions for the healthcare workers on the appropriate waste management practices.
- Where applicable, third-party waste management service providers are provided with the relevant training.

The Project Stakeholders Engagement Plan (SEP) covers the engagement strategy and approach to the necessary infection prevention and waste management topics and relevant stakeholders. Awareness raising among patients and families could be achieved through the deployment of posters and leaflets on infection prevention and waste management best practices.

4.4 Waste Management Supplies and Equipment

For appropriate management of the generated medical waste, supported healthcare facilities should be equipped with proper equipment and materials. Such supplies are very important to facilitate implementation of the provisions of this management plan and the Project (based on the available budget) will cover the costs of procurement and distribution of mentioned supplies to the supported healthcare facilities. These could be among others:

- Color-coding containers and safety boxes. Waste bins, bags, drums or other containers, including liquid waste containers.
- Personal Protective Equipment.
- Cleaning and disinfection supplies.
- Others as required.

3. Monitoring Plan

Monitoring is required to follow-up on decisions made to intervene in various activities of medical waste management in order to protect human health and the environment. This can be achieved through periodic internal and external processes of monitoring and evaluation on a continuous basis, at all institutional levels and through regular reporting and documentation by the contractor/ implementing partner which will be validated during the supervision by different bodies.

To achieve the MWMP objectives, the implementation of the plan must be monitored by both internal and external bodies including the WHO, State Ministries of Health as well as Third Party Monitoring agencies. These bodies will use existing institutional arrangements as mentioned in section 4 for proper waste management at health units and facilities.6.1 Monitoring Objectives

The aim of the monitoring is to establish appropriate criteria to address potential negative impacts of Medical Waste (MW) and the unforeseen impacts are detected, and the mitigation measures implemented at an early stage. Specific objectives of the monitoring plan are to:

- Address any additional impacts appropriately.
- Check the effectiveness of the recommended mitigation measures.
- Ensure that the proposed mitigation measures are appropriate.
- Demonstrate that medical waste management is being implemented according to plan and existing regulatory procedures.
- Provide feedback to implementing partners to make modifications to the operational activities where necessary.

5.1 Monitoring Arrangements

The medical waste management plan will be monitored both internally and externally. Internally, the plan will be part of the project's overall monitoring and reporting. WHO will work with the relevant health authorities towards ensuring that the staff hired at the unit/facility level will be monitoring the implementation of the Medical Waste Management Plan. Externally, the project will use third party monitoring service for intervention and activities under each component of the project. To this end, a Term of Reference (TOR) has been drafted for the TPM service, including tasks on monitoring the implementation of the medical waste management. The cost of implementing the monitoring plan is included as part of the project's cost.

5.2 Monitoring Indicators

Considering the type of interventions implemented by this project which are expected to have limited, site-specific impacts, the following will be used to monitor progress in implementing the medical waste management plan:

- The existence of human resource capacity in healthcare facilities with basic knowledge to deal with medical waste.
- Development of mechanisms for proper and safe medical waste management and disposal.

Monitoring environmental effects is necessary so that the predicted impacts are addressed effectively and efficiently through the mitigation measures indicated. Specific monitoring indicators for consideration include the following:

Internal Packaging and Storage

- Segregation of waste (at point of origin)
- Storage bins / bags
- Frequency of removal

External Packaging and Storage

- Segregation of waste
- Storage area
- Frequency of waste removal
- Amount of waste generated

Treatment and Disposal

- Chemical disinfection and decontamination

Administration

- For effective record keeping, each health institution shall keep records on:
  - The type and volume or weight of waste generated
  - The means of transportation, type and volume transported
  - responsible health authority of waste transportation for out-site disposal.

Annex 2 includes a questionnaire for monitoring medical waste management in the supported facilities. The questionnaire will be filled by the project focal points in the State Ministries of health in coordination with the facilities representatives periodically and if any modification or expansion occurred. The survey will be used by the project team as a reference to determine the needs and to prepare the required plans.

Reporting of Related Incident and accident:

As per the ESCP, immediate notification by the contractor/ implementing partner to be received by WHO for all incidents and accidents including the events related to medical waste management practices (day to day work) which has, or is likely to have, a significant adverse effect on the environment, the affected communities, the public or worker and detailed report to be shared within 3o days of accordance with sufficient detail regarding the scope, severity, and possible causes of the incident or accident, indicating immediate measures taken or that are planned to be taken to address it.

1. Medical waste management risk and mitigation measures:

The Identification of associated risks with medical waste and measures needed to control the impact on social and environmental health is one of the objectives of this plan. Although higher percentage of medical waste (75 – 90 %) is non -hazardous and poses no risks. The smaller percentage of hazardous waste needs to be properly managed so that the health and environmental risks from exposure to known hazards can be minimized. Protection of the health of staff, patients and the general public is the fundamental reason for implementing a medical waste management plan.

Area	Risks	Gaps	Mitigation Measures
Point of care (health care provider, patients, co-patients, worker/cleaner)	• Risk of disease infection from available pathogen (HIV, HBV, HCV,..ect) from the unproperly managed medical waste. • Cancer risk from lack of measures when dealing with genotoxic waste. • Injuries and cuts from sharp objects. • Exposure to chemicals substance which could be toxic, allergenic, ,..ect.	• 5.6% of health care facilities were segregating waste in 3 labelled bines • 17.6 % of health care providers are trained on medical waste management.	• Implement medical waste management guideline (provided in section 3). • Provide colour-coded system to support proper segregation of medical waste. • Train of health care provider to segregate the medical waste at point of care using the colour-coded system. • Provision of PPES for medical providers • Increase the awareness of patients and their co-patients on related risk of medical waste at health care points. • Ensure that GM is accessible and publicized to receive all feedback.
Collection (health care provider, patients, co-patients, worker/cleaner)	• Spillages of medical waste during the collection. • Injuries and cuts from sharp objects • Risk of infection from available pathogen (HIV, HBV, HCV,..ect) from the unproperly managed medical waste. • Exposure to chemicals substance which could be toxic, allergenic, ,..ect.	• 6.9% of waste handler are trained on associated risk with medical waste handling	• Implement medical waste management guideline (provided in section 3). • Provide medical waste collection tools to support proper collection inside the facility. • Ensuring that waste bags are not opened or punctured during collection (disinfection of the trolleys /area to be carried out in case of leakage from bags). • Training of cleaners/ workers with responsibility of collecting the produced medical waste from storage area inside the facility. • Provision of PPES for medical providers • Increase the awareness of patients and their co-patients on related risk of medical waste at health care points.

			• Ensure that GM is accessible and publicized to receive all feedback.
Storage area (worker/cleaner, community)	• Injuries and cuts from sharp objects • Risk of infection from available pathogen (HIV, HBV, HCV,..ect) from the unproperly managed medical waste. • Forming breeding sites for vectors due to poor or delay of collection for final disposal.	• 19.1 % of health care facilities have an access restricted area for medical waste storage.	• Implement medical waste management guideline (provided in section 3). • Control access to the storage area. • Ensuring that waste bags are not opened or punctured at the storage area (disinfection of the trolleys / area to be carried out in case of leakage from bags). • Ensure that GM is accessible and publicized to receive all feedback. • Documentation of waste volume. • Ensure availability of MWM tools and consumables.
Treatment (worker/ cleaner)	• Exposure to chemicals substance which could be toxic, allergenic, ,..ect. • Spillages of chemical substance during the application which could leads to skin burring and injuries. •	• 9.3 % od worker handling water have appropriate PPEs	• Implement medical waste management guideline (provided in section 3). • Ensure provision of PPEs • Train the workers/cleaners on precautions and measures to be taken. • Ensure that GM is accessible and publicized to receive all feedback. • Ensure availability of MWM tools and consumables.
Inside disposal (health care provider, patients, co-patients, worker/cleaner, community)	• Respiratory infection from inhalation of toxic fumes and dust from incinerators where available. • Ground water pollution and soil contamination from improper dumping of ash where incinerators are available. • Air pollution from improperly functioning incinerator where available.	• 3.6% of health care facilities have a functional incinerator.	• Implement medical waste management guideline (provided in section 3). • properly used the available double chamber incinerators with wet scrubbers ensuring that incineration is carried out at 1200 °C. • Properly operate and maintain incinerators particularly to avoid leakage of gases from the first chamber.

			• Capacity building of operators • Provision of PPEs and ensure the usage. • Ensure that GM is accessible and publicized to receive all feedback.
Transportation	• Injuries and cuts from sharp objects • Risk of infection from available pathogen (HIV, HBV, HCV,..ect) from the unproperly managed medical waste. • Forming breeding sites for vectors due to poor or delay of collection for final disposal.	• 12% of health care facilities were regularly collect the medical waste for offsite disposal	• Implement medical waste management guideline (provided in section 3). • Ensure regular transportation for offsite disposal. • Ensure that GM is accessible and publicized to receive all feedback.
Liquid contaminated water	• Contamination of drinking water supplies if any leakage. • Annoying Oder • Form breeding sites from mosquito and flies. • Imped the access to some section • Possibility of accident (sliding) when crossing	• 15.4% of health care facilities were regularly check drinking water quality	• Implement medical waste management guideline (provided in section 3). • Ensure that the treatment system (eg, septic tank) is properly working. • Daily monitor the quality of drinking water supplies and keep records. • Ensure that GM is accessible and publicized to receive all feedback.

1. Action plan and time frame

Risks	**Action**	**Action by/ Responsible Body**	**Time Frame**	**Budget**
Risk of disease infections due to occupational hazards	• Train health care provides, workers/ cleaners on associated disease infection risks. • Awareness rising of patients and co-patens on related infection diseases using Information, education and communication materials such as posters.	Contractor/ IP	• Regularly throughout the project lifetime	100,000

Risks	Action	Action by/ Responsible Body	Time Frame	Budget
Risk of disease infections due to lack of supplies	• Provision of medical waste management tools and equipment. • Provision of PPEs.	Contractor/ IP	• Regularly throughout the project lifetime	123,444
Incident and accident	• Train health care provider and workers on reporting of related incident and accident using GM mechanism.	Contractor/ IP	Immediate notification for WHO and detailed report within 30 days	0
Vector breeding sites	• Implement regular breading side inspection and treatment.	SMoH, Contractor/ IPs	weekly	20,000
Drinking water contamination	• Implement regular quality monitoring of drinking water supplies inside health facility using rapid testing devices (colour change indicators)	Contractor/ IP	Daily	0,000
Accumulation of medical waste inside the health facility	• Regular collection of produced medical waste through health authority to final disposal area	Contractor/IP, Local authority	Regular (every 48 H)	51,200
Contamination of facility, drinking water, poor functioning of WASH facilities, ground water & air pollution and soil contamination	• Implement the provided guidance for onsite disposal (where incinerators are functioning). • Rehabilitate WASH and IPC facilities.	IP	Regularly throughout the project lifetime	5,000
Validation of reports	• Monitoring and supervisory visits	FMoH / WHO	Quarterly	0,236

2. Cost of Implementing the Medical Waste Management Plan

The estimated budget for implementation of the medical waste management within the supported facilities includes the cost of training, waste management supplies provision, and deployment of awareness messages as well as monitoring and visits. Project activities, including the trainings and workshops, will involve participants from all states ministries of health and supported facilities based on the need and in coordination with the relevant authorities. The estimated budget is as below:

MWMP Implementation Costs	USD
Training and Monitoring 1. Training on Infection Prevention and Control including Medical Waste Management to the workers in supported facilities. 2. Visits, Monitoring, and reporting.	180,236
Supplies Procurement 1. Procurement of supplies such as: waste bins, bags, safety boxes. 2. Procurement of PPE to the waste management workers.	123,444
Waste transportation costs: 3. provide Transportation cost for local health authority	151,200
Minor refurbishment works. 4. Provide minor rehabilitation for WASH/ Infection Prevention Control (IPC) services	15,000
TOTAL USD	**469,880**

Annex 1: Major Categories of Medical Waste

Waste type	Description
1. Infectious waste	Infectious wastes are susceptible to containing pathogens (or their toxins) in sufficient concentration to cause diseases to a potential host. Examples include discarded materials or equipment, used for the diagnosis, treatment and prevention of disease that has been in contact with body fluids (dressings, swabs, nappies, blood bags etc). It also includes liquid waste such as faeces, urine, blood or other body secretions.
2. Pathological and anatomical waste	Pathological waste consists of organs, tissues, body parts or fluids such as blood. Anatomical waste consists in recognizable human body parts, whether they may be infected or not.
3. Hazardous pharmaceutical waste	Pharmaceutical waste includes expired, unused and contaminated pharmaceutical products, drugs and vaccines. This category also includes discarded items used in the handling of pharmaceuticals like bottles, vials and connecting tubing.
4. Hazardous chemical waste	Chemical waste consists of discarded chemicals (solid, liquid or gaseous) that are generated during disinfecting procedures. They may be hazardous (toxic, corrosive, flammable or reactive) and must be used and disposed of according to the specification formulated on each container.
5. Waste with a high content of heavy metals	Waste with high contents of heavy metals and derivatives are highly toxic (e.g. cadmium or mercury from thermometers or manometers).
6. Pressurized containers	Pressurized containers consist of full or emptied containers or aerosol cans with pressurized liquids, gas or powdered materials
7. Sharps	Sharps are items that can cause cuts or puncture wounds (e.g. needle stick injuries). They are highly dangerous and potentially infectious waste. They must be segregated, packed and handled specifically within the Health Care Facility (HCF) to ensure the safety of the medical and ancillary staff.
8. Highly infectious waste	This includes microbial cultures and stocks of highly infectious agents from medical laboratories. They also include body fluids of patients with highly infectious diseases.
9. Genotoxic/cytotoxic waste	Genotoxic waste includes all the drugs and equipment used for mixing and administration of cytotoxic drugs. Cytotoxic drugs or genotoxic drugs are drugs that have the ability to reduce the growth of certain living cells and are used in chemotherapy for cancer.
10. Radioactive waste	Radioactive waste includes liquids, gas and solids contaminated with radio nuclides whose ionizing radiation has genotoxic effects. These include x- and g-rays as well as a- and b- particles.

Source: Safe Management of Wastes from Health-Care Activities, WHO 1999

Annex 2: Medical Waste Management Monitoring Questionnaire

Health Facility (name, locality): _____

_____

_____

No. of inpatients: _____ /day
No. of outpatients: _____ /day
No. of beds (total): _____ /day

Type/Category of Health Facility (tick one):

☐	Tertiary: Specialist, National, Teaching Hospitals
☐	Secondary: Governorate Gen. Hospitals, Sub-HCF Hospital, Private Hospitals
☐	Primary; Health Centre, Dispensary
☐	Mobile healthcare unit

Type of solid waste produced and estimated quantity
(Consult classification and mark X where waste is produced)

Type	Estimated Quantity (kg/day)
Sharps	
Pathological waste	
Infectious waste	
Pharmaceutical waste	
Pressurized containers	

Waste segregation, collection, storage, and handling
Describe briefly what happens between segregation (if any) and final disposal of:

Sharps _____
Pathological waste _____
Infectious waste _____
Pharmaceutical waste _____
Pressurized containers _____

Waste segregation, collection, labelling, transport, and disposal

1. Handling of segregated waste	Sharps	Pathological waste	Infectious waste	Pharmaceutical waste	Pressurized containers
Indicate by X the type of waste (if any) that is segregated from general waste stream.					
Where is the segregation taking place (i.e. operating room, laboratory, among others)?					
What type of containers/bags (primary containment vessels) are used to segregate waste (bags, cardboard boxes, plastic containers, metal containers, among others)? describe accurately.					
What type of labelling, colour-coding (if any) is used for marking segregated waste? Describe					
i. Who handles (removes) the segregated waste (designation of the hospital staff member)? ii. Is the waste handler using any protective clothing (gloves, among others) during waste handling? Yes/No.					
What type of containers (plastic bins, bags, cardboard boxes, trolleys, wheelbarrows, safe boxes, metal containers, among others) are used for collection and internal transport of the waste? Describe.					
Where is the segregated waste stored while awaiting removal from the hospital for disposal? Describe.					
Describe briefly the final disposal of segregated waste (taken to municipal landfill, buried on hospital grounds, incinerated (external incinerator, own incinerator), open burned, removed from premises, among others)					
If removed from premises; who is responsible for removal? Health facility/self, private collector, state health authority					
If removed from premises, what form of transport is used? Enclosed waste track, open waste track, open pick-up, among others					
How often is the waste removed from site?					
Daily					
3 – 4 times per week					
1 – 2 times per week					
Once a week					
Every two weeks					
Once a month					
Less often					

Is safety clothing issued to staff involved in medical waste collection, i.e. gloves, aprons, among others?

Yes ☐ No ☐

If yes, please list the safety clothing/items issued to medical waste collectors and the frequency of issue:

Items issued	Daily	Weekly	Monthly	As Needed
Aprons				
Gloves				
Safety shoes				
Overhauls				
Others (specify)				

Which of these waste collection, handling, transport and disposal activities are undertaken by Health-care staff and which are outsourced? List the party responsible for that activity, where the activity is outsourced, and the start and end dates of the contract entered into:

ACTIVITY	RESPONSIBLE PARTY (self/facility, state health authority, Private collector, among others)	NAME OF THE RESPONSIBLE PARTY/PRIVATE COLLECTOR
Collection		
Handling		
Transport		
Incineration		
Disposal		

Personnel involved in the management of Health-care waste

1. (a) Designation of person(s) responsible for organization and management of waste collection, handling, storage, and disposal at the hospital administration level.

_____

_____

(c) Has he/she received any training in hospital waste management? Yes ☐ No ☐

If yes, what type of training and at what duration?

_____

Annex 3: Treatment and Disposal Methods for Healthcare Waste Categories

Type of waste	Summary of treatment and disposal options/notes
Infectious waste: Includes waste suspected to contain pathogens (e.g., bacteria, viruses, parasites, or fungi) in sufficient concentration or quantity to cause disease in susceptible hosts. Includes pathological and anatomical material (e.g., tissues, organs, body parts, human fetuses, animal carcasses, blood, and other body fluids), clothes, dressings, equipment / instruments, and other items that may have come into contact with infectious materials.	**Waste Segregation Strategy**: Yellow or red coloured bag/container, marked "infectious" with international infectious symbol. Strong, leak proof plastic bag, or container capable of being autoclaved. **Treatment**: Chemical disinfection; Wet thermal treatment; Microwave irradiation; Safe burial on hospital premises; Sanitary landfill; Incineration (Rotary kiln; pyrolytic incinerator; single-chamber incinerator; drum or brick incinerator) [e] • Highly infectious waste, such as cultures from lab work, should be sterilized using wet thermal treatment, such as autoclaving. • **Anatomical waste** should be treated using Incineration (Rotary kiln; pyrolytic incinerator; single-chamber incinerator; drum or brick incinerator).
Sharps: Includes needles, scalpels, blades, knives, infusion sets, saws, broken glass, and nails etc.	**Waste Segregation Strategy**: Yellow or red colour code, marked "Sharps". Rigid, impermeable, puncture-proof container (e.g., steel or hard plastic) with cover. Sharp's containers should be placed in a sealed, yellow bag labeled "infectious waste". **Treatment**: Chemical disinfection; Wet thermal treatment; Microwave irradiation; Encapsulation; Safe burial on hospital premises; Incineration (Rotary kiln; pyrolytic incinerator; single-chamber incinerator; drum or brick incinerator) [e] • Following incinerators, residues should be landfilled • Sharps disinfected with chlorinated solutions should not be incinerated due to risk of generating Persistent Organic Pollutants POPs • Needles and syringes should undergo mechanical mutilation (e.g., milling or crushing) prior to wet thermal treatment
Pharmaceutical waste: Includes expired, unused, spoiled, and contaminated pharmaceutical products, drugs, vaccines, and sera that are no longer needed, including containers and other potentially contaminated materials (e.g. drug bottles vials, tubing etc.).	**Waste Segregation Strategy**: Brown bag / container. Leak-proof plastic bag or container. **Treatment**: Sanitary landfill[a]; Encapsulation[a]; Discharge to sewer [a]; Return expired drugs to supplier; Incineration (Rotary kiln; pyrolytic incinerator [a]); Safe burial on hospital premises[a] as a last resort. • Small quantities: Landfill disposal acceptable, however cytotoxic and narcotic drugs should not be landfilled. Discharge to sewer only for mild, liquid pharmaceuticals, not antibiotics or cytotoxic drugs, and into a large water flow. Incineration acceptable in pyrolytic or rotary kiln incinerators, provided pharmaceuticals do not exceed 1 percent of total waste to avoid hazardous air emissions. Intravenous fluids (e.g., salts, amino acids) should be landfilled or discharged to sewer. Ampoules should be crushed and disposed of with sharps. • Large quantities: Incineration at temperatures exceeding 1200 °C. Encapsulation in metal drums. Landfilling is not recommended unless encapsulated in metal drums and groundwater contamination risk is minimal.

Type of waste	Summary of treatment and disposal options/notes
Genotoxic / cytotoxic waste: Genotoxic waste may have mutagenic, teratogenic, or carcinogenic properties, and typically arises from the feces, urine, and vomit of patients receiving cytostatic drugs, and from treatment with chemicals and radioactive materials. Cytotoxic drugs are commonly used in oncology and radiology departments as part of cancer treatments.	**Waste Segregation Strategy:** See above for "infectious waste". Cytotoxic waste should be labeled "Cytotoxic waste". **Treatment**: Return expired drugs to supplier; Chemical degradation; Encapsulation[a]; Inertization; Incineration (Rotary kiln, pyrolytic incinerator): • Cytotoxic waste should not be landfilled or discharged to sewer systems. • Incineration is the preferred disposal option. Waste should be returned to suppliers where incineration is not an option. Incineration should be undertaken at specific temperatures and time specifications for particular drugs. Most municipal or single chamber incinerators are not adequate for cytotoxic waste disposal. Open burning of waste is not acceptable. • Chemical degradation may be used for certain cytotoxic drugs – See Pruss et al. (1999) Annex 2 for details. • Encapsulation and inertization should be a last resort waste disposal option.
Chemical waste: Waste may be hazardous depending on the toxic, corrosive, flammable, reactive, and genotoxic properties. Chemical waste may be in solid, liquid, or gaseous form and is generated through use of chemicals during diagnostic / experimental work, cleaning, housekeeping, and disinfection. Chemicals typically include formaldehyde, photographic chemicals, halogenated and nonhalogenated solvents [d], organic chemicals for cleaning / disinfecting, and various inorganic chemicals (e.g., acids and alkalis).	**Waste Segregation Strategy**: Brown bag / container. Leak-proof plastic bags or container resistant to chemical corrosion effects. **Treatment:** Return unused chemicals to supplier; Encapsulation[a]; Safe burial on hospital premises[a]; Incineration (Pyrolytic incinerator • Facilities should have permits for disposal of general chemical waste (e.g. sugars, amino acids, alts) to sewer systems. • Small hazardous quantities: Pyrolytic incineration, encapsulation, or landfilling. • Large hazardous quantities: Transported to appropriate facilities for disposal or returned to the original supplier using shipping arrangements that abide by the Basel Convention. Large quantities of chemical waste should not be encapsulated or landfilled
Radioactive waste: Includes solid, liquid, and gaseous materials that have been contaminated with radionuclides. Radioactive waste originates from activities such as organ imaging, tumor localization, radiotherapy, and research / clinical laboratory procedures, among others, and may include glassware, syringes, solutions, and excreta from treated patients.	**Waste Segregation Strategy**: Lead box, labeled with the radioactive symbol. **Treatment:** Radioactive waste should be managed according to national requirements and current guidelines from the International Atomic Energy Agency. IAEA (2003). Management of Waste from the Use of Radioactive Materials in Medicine, Industry and Research. IAEA Draft Safety Guide DS 160, 7 February 2003.
Waste with high content of heavy metals: Batteries, broken thermometers, blood pressure gauges, (e.g., mercury and cadmium content).	**Waste Segregation Strategy**: Waste containing heavy metals should be separated from general health care waste. **Treatment:** Safe storage site designed for final disposal of hazardous waste.

Type of waste	Summary of treatment and disposal options/notes
	• Waste should not be burned, incinerated, or landfilled. Transport to specialized facilities for metal recovery
Pressurized containers: Includes containers / cartridges / cylinders for nitrous oxide, ethylene oxide, oxygen, nitrogen, carbon dioxide, compressed air and other gases.	**Waste Segregation Strategy:** Pressurized containers should be separated from general health care waste. **Treatment:** Recycling and reuse; Crushing followed by landfill • Incineration is not an option due to explosion risk • Halogenated agents in liquid form should be disposed of as chemical waste, as above
General health care waste (including food waste and paper, plastics, cardboard.	**Waste Segregation Strategy**: Black bag / container. Halogenated plastics such as PVC should be separated from general health care facility waste to avoid disposal through incineration and associated hazardous air emissions from exhaust gases (e.g. hydrochloric acids and dioxins). **Treatment**: Disposal as part of domestic waste. Food waste should be segregated and composted. Component waste (e.g., paper, cardboard, recyclable plastics [PET, PE, PP], glass) should be segregated and sent for recycling.

Source: Safe Management of Wastes from Health-Care Activities. International Labor Organization (ILO), Eds. Pruss, A. Giroult, and P. Rushbrook (1999)

Notes:

a. Small quantities only
b. Low-level infectious waste only
c. Low-level liquid waste only
d. Halogenated and nonhalogenated solvents (e.g., chloroform, TCE, acetone, methanol) are usually a laboratory-related waste stream for fixation and preservation of specimens in histology /pathology and for extractions in labs.

Annex 8.7 SEA/SH Prevention and Response and Accountability Action Plan

Key Messages

- Gender-based violence (GBV) is widespread in any humanitarian context and more likely in the context of Sudan. Many GBV and sexual exploitation and abuse and sexual harassment (SEA/SH) cases go unreported due to social stigma and taboos around GBV and SEA/SH.
- The Action plan will focus on a specific type of GBV, notably SEA/SH, occurring in the framework of the project implementation and will develop and implement mitigation activities and adapt intervention models to achieve a safer impact on the project components. The scope of the SEA/SH Action plan will be implemented and monitored throughout the life of the project and will be adjusted as needed.
- More efforts will be needed to ensure buy-in of these activities of SEA/SH actions by bringing more stakeholders to the table and demonstrating the social value of investing in interventions to address risks of SEA/SH.

Introduction

1 in 3 women face gender-based violence (GBV) in their lifetime. In the Eastern Mediterranean Region (EMR), WHO estimates that 37% of ever-partnered women have experienced physical and/or sexual intimate partner violence (IPV) at some point in their lives this is the second highest prevalence at a global level after South-East Asian Region (37.7%).

According to the GBV sub-cluster, since 15 April 2023, when the armed conflict started in Sudan between the Sudanese army and the Rapid Support Forces (RSF), the number of people in need of GBV services has increased from over 1 million to 4.2 million. The number of individuals targeted for GBV services has increased to 1.3 million, with an increase of over 90% of targeted individuals in states heavily impacted but still accessible. https://reliefweb.int/report/sudan/crisis-sudan-gbv-aor-sub-sector-sudan-situation-brief-23-may-2023.

In Sudan there are no concrete estimates on the actual numbers of GBV survivors or Rape survivors in Sudan. However, the National Unit on Combating Violence against Women is showing numbers of more than 60+ cases of Rape and 70 + cases of sexual assault in Sudan during the first year of the ongoing conflict on the 15th of April. Surging reports of cases of GBV, including sexual violence, have been reported by the GBV sub-sector in Sudan and health services providers in hospitals and health centres. Most at risk groups are internally displaced persons (IDPs) fleeing from one state to another, residents when homes are being looted, as well as an increased number of domestic violence cases. Displaced women and girls are at very high risk of sexual violence and exploitation when displaced, in transit, in temporary shelters, and while awaiting visas at border crossings, as well as at risk of transactional sex trying to get basic goods – including food, water, and fuel, considering that prices skyrocketing, and cash is almost impossible to obtain. An increased number of domestic violence cases has also been observed.

The Sudan Health Assistance and Response to Emergency Project (SHARE) is a joint project in the Republic of Sudan between World Health Organization (WHO) and United Nations Children's Fund (UNICEF) with the support of the World Bank. The project development objective is to address immediate emergency health needs in Sudan through delivery of essential health care at primary and secondary service level and sustaining core public health functions. Unless specified, the term “project” hereinafter is referring to SHARE.

As part of the environmental and social risk management, the project was screened at high risk for SEA/SH and as such, proportional mitigation measures need to be designed and implemented. This Action plan summarizes the key SEA/SH risk factors associated with the project implementation and outlines the key mitigation measures the project unit will put in place.

Definitions

Gender-Based Violence is an umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed gender differences. GBV and SEA/SH include acts that inflict physical, mental, sexual harm or suffering; threats of such acts; and coercion and other deprivations of liberty, whether occurring in public or in private life.

Sexual Exploitation: Any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially, or politically from the sexual exploitation of another.

Sexual Abuse: Actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.
Sexual Harassment: Any unwelcome sexual advance, request for sexual favour, verbal or physical conduct or gesture of a sexual nature, or any other behaviour of a sexual nature.[2]
Project Components
The SHARE Project has three components as follows:
This component aims to enhance access to basic health and nutrition services in Sudan through low-cost, high-impact interventions using a PHC approach. It targets both displaced and host communities. A minimum service package that includes the following services**: Expanded Program on Immunization**, integrated management of **childhood illnesses**, **maternal, newborn and paediatric** health, **nutrition**, and **noncommunicable diseases (NCDs**), including mental health, as well as prevention and **response to outbreaks** and health emergencies will be supported under this component at different levels of service delivery.

Subcomponent 1.1: Strengthening the Integration of Primary Health Care Model (implemented by UNICEF)
Subcomponent 1.2. Supporting Health and Nutrition Services at the First Level Referral Centers and Hospitals (, implemented by WHO)
Subcomponent 1.3: Climate Change Adaptive Health Service Delivery (implemented by WHO)
Subcomponent 1.4: Climate Change Resilient Health Facilities (implemented by UNICEF)
Subcomponent 1.5: Integrating Digital Solutions to Service Delivery (implemented by UNICEF)

Component 2: Preserving the Main Elements of the Health System (implemented by WHO):

This component will focus on strengthening health systems and public health programs and improving the main elements of the health system to prepare for and respond to health emergencies and control diseases by strengthening emergency preparedness, laboratories, and disease control systems. Specific activities will include essential preparedness functions such as: (a) training and operating cost for integrated disease surveillance and response (IDSR) including EWARS; (b) operating costs and rehabilitation for selected Emergency Operations Centers (EOCs) with a primary focus on response to climate shocks; (c) supporting health information systems and the Health Resources and Services Availability Monitoring System; (d) developing, disseminating, and training of trainers on subnational emergency preparedness and response plans, primarily focusing on climate shock emergency preparedness and response along with response to conflict; (e) updating and disseminating laboratory guidelines and providing laboratory operating costs; and (f) training and deploying Rapid Response Teams. The component will also support strengthening the country's blood bank and transfusion systems, which currently have limited reach, impairing access to CEmONC and safe surgical services. This includes: (a) developing guidelines for the proper collection, storage, transport, and use of blood for transfusions; (b) building or strengthening existing blood banking services; and (c) developing systems and protocols for the transfer of blood products for transfusions.

Component 3: Monitoring and Evaluation and Project management, includes:

- Subcomponent 3.1: Third Party Monitoring (implemented by UNICEF): The third-party monitoring (TPM) agency's role will include working with UNICEF, WHO, the World Bank, and implementing partners (IPs) to explain results, providing guidance on improved methods, proposing context-appropriate solutions, and conducting ex post facto verification of results provided by project reporting mechanisms.
- Subcomponent 3.2: Data Analysis and Knowledge Management (implemented by WHO and UNICEF]): The project will ensure that independent and credible data on health service delivery and coverage and commodities are generated, and that the data are usable and will enable the World Bank and development partners to verify that resources are reaching the intended beneficiaries.
- Subcomponent *3.3: Project Management (implemented by WHO and UNICEF)* includes the finance costs related to monitoring and evaluation (M&E) and management of project activities.

[2] Good Practice Note. Addressing Sexual Exploitation and Abuse and Sexual Harassment (SEA/SH) in Investment Project Financing involving Major Civil Works. The World Bank Second Edition February 2020

Health Needs

Sudan is projected to face a critical health crisis in 2025, with around 20.3 million people, including approximately 7.4 million internally displaced persons (IDPs), in need of humanitarian assistance including health interventions. An estimated 8,619,054 individuals have been displaced internally since April 15, 2023. IDPs originated from all 18 states in Sudan and were displaced to 9,750 locations in 184 localities across all 18 states in Sudan. Khartoum represents the top state of origin for IDPs: an estimated 33 per cent of all IDPs in Sudan reportedly originated from Khartoum, followed by South Darfur (18 per cent) and North Darfur (14 per cent) states.

The conflict in Sudan has left 70-80 per cent of health facilities non-operational or overwhelmed, compounded by violence, economic instability, and climate challenges. Vulnerable groups, particularly women, children, the elderly, and individuals with disabilities, are disproportionately affected. Women needing medical and reproductive health services constitute 35 per cent of the overall affected population, while 55 per cent are children facing increased risks from disease outbreaks, poor GBV response services and the lack of paediatric care. Around 65 per cent of the population lacks access to adequate healthcare, and attacks on healthcare facilities, with 145 incidents reported by WHO, have caused over 80 deaths and significant disruptions to services. Non-communicable diseases (NCDs) account for over 54 per cent of deaths, and around 15 per cent of the population lives with disabilities and requires rehabilitative services.

Disease outbreaks, including measles, polio, cholera, malaria, and dengue, are exacerbated by low vaccination rates (over 30 per cent of children are unvaccinated), poor sanitation, and environmental changes, heightening the public health crisis.
Access to services is a key challenge, especially in conflict-affected states, where only 10% of service providers are operational. Services are severely curtailed by ongoing fighting, as well as destruction of goods and properties, and looting of medical supplies and facilities, including health centres and hospitals. However, in states where access is feasible, 90% of GBV actors are currently operational
https://reliefweb.int/report/sudan/crisis-sudan-gbv-aor-sub-sector-sudan-situation-brief-23-may-2023
According to the WHO, health care was identified among the highest priority needs for the population. Within this context, the World Bank SHARE will be responding to the humanitarian crisis in Sudan through an integrated response approach that includes Health and nutrition services.

Country Contexts of GBV and SEA/SH:
Concerns about human rights violations, including sexual misconduct, and the departure of healthcare professionals in rural areas, active conflict areas and stable areas with huge number of IDPs, have further strained healthcare delivery. The displaced people are at high risk of disease outbreaks and face severe limitations in their ability to access healthcare and other basic services including SHARE focus states. This adds to heightened risks of abuse, particularly sexual exploitation and abuse (SEA), that these populations are facing. Such risks stem from severe food insecurity and water scarcity; vulnerability and pre-existing social norms, gender disparities and inequalities; the emergence of survival or transactional sex between the beneficiaries, the humanitarian workers and host communities, as mentioned by some of the health senior managers in the field; a breakdown in the rule of law and the involvement of military personnel in the provision of humanitarian assistance or at border points. Compounding these risks are also the limited accessibility of safe services that could provide SEA and GBV victims/survivors assistance, low SEA reporting, non-functional complaint mechanisms, and a low level of awareness on the issue by both the affected population and some of the service providers.

Gender Equality, GBV and SEA/SH Risk Analysis
Findings from referenced assessments:

- Voices from Sudan 2020 highlighted significant barriers to women accessing SRH services, including stigma and lack of awareness.
- GBV Qualitative Assessment showed limited safe spaces and inadequate mental health support.

- Rapid Assessment of the Health Structure and Functions During Armed Conflict, 2023 revealed closure of facilities, shortages of supplies, funds, and human resources. Moreover, health system governance was also affected as a result of the instability of security situation in multiple states.

Even before the recent conflict, Sudan ranked at the bottom of many indicators for women's rights. For instance, on the Women, Peace and Security Index, Sudan ranks 162 out of 170 countries. This is due to factors including (but not limited to): very high rates of organized violence and Intimate Partner Violence (IPV); poor women's financial inclusion, education, employment, and cell phone use; and most notably, Sudan has the worst rate of laws and regulations that limit women's ability to participate in society and the economy (Georgetown Institute for Women, Peace, and Security, 2021). On the UNDP's Gender Equality Index (GII), which assesses reproductive health, empowerment, and the labor market, Sudan's value is 0.553 – indicating very high inequality between women and men (UNDP, 2022). The recent conflict has exacerbated all types of gender-based violence against women especially sexual violence in conflict-affected areas. This calls for a greater focus on strengthening SRH services, protection services and women empowerment.

On a positive note, prior to the conflict Sudan was making noticeable progress towards gender equality for women and men, girls, and boys, and to protect women and girls from harmful social norms. The Government had endorsed national pledges to end Female Genital Mutilation (FGM) and Child Marriage and prevent and combat gender-based violence (GBV). This current momentum calls for action to capitalize on a potential shift to an enabling environment. It presents an opportunity to work on SRHR policies, capacity strengthening, and community empowerment.

As part of the overall response plan, WHO SRMNCAH/GBV team has conducted some consultations with healthcare providers, health managers, academic institutions, women-led groups and MoH officials, as well as with beneficiaries at facility and community levels, including those in refugees and IDPs gathering points to inform the SRMNCAH including GBV plan under the essential service pillar in the national response plan. The consultations aimed to capture the barriers to accessing essential health and nutrition services, particularly gender-specific and social norm-related barriers on both the demand and supply side. On the supply side, consultations with partners raised concerns about the availability of appropriate skills to provide gender responsive sexual and reproductive health services, and addressing the needs of adolescent girls and women with disabilities, fragmented services that do not provide comprehensive SRH support, including mental health, the design of facilities without safe, private spaces (i.e. safe corners for the management of Sexual Violence) and the lack of sufficient and up-to-date data and evidence on the dynamic and changing gender and social norms that hinder access and uptake of SRH services along with the sever impact of the current emergency on the accessibility of the services. In order to identify the GBV priorities to respond to the current emergency and to improve the provision of the services, WHO relied mainly on administrative program data, different previous consultations as well as assessments which provided insight into gender and social norm variables. These included extensive consultations that have been conducted for the update of the National SRH policy in 2021, Voices from Sudan 2020 in addition to a qualitative assessment of gender-based violence in Sudan along with another Health Facilities Quality Assessment, which was conducted in 2021 to assess the readiness of the health facilities to provide quality services to GBV/ SEA/SH survivors. This assessment has also been followed by a rapid facility assessment conducted in May 2023 to assess the availability of the essential and lifesaving health services including SRH and health services for the GBV survivors to inform the development of the national health response plan.

All these available information and evidence have shown that gender inequality in access to education between males and females was documented, and it was more evident in rural and fragile settings. For instance, more than 50% of schools are co-educational (primarily due to a limited number of students, teachers, or space). Co-education is not culturally acceptable for many communities and will likely limit girls' enrollment or lead to dropout, especially if aggravated by inadequate WASH facilities[1]. Access to the improved drinking water source ranges from 58.7% and 48.3% of the population in the country; the percentage of open defecation in the country is 33%. The referral system has significantly been affected by the crisis, especially in the hot zones with active conflict areas with high risk of GBV. Shortage of the post rape treatments and medications along with the lack of trained healthcare providers on GBV including clinical management of rape, has been reported in 56% of the assessed health facilities in three states.

[1] Federal Ministry of General Education & UNICEF, 2014: Out of School Children Initiative, Sudan

To this end and to respond to these challenges the project will take into consideration the current context in order to implementation of the project especially for vulnerable groups, women and children. The SEA/SH Prevention and Response and Accountability Action Plan is in accordance with ESS4 and relevant World Bank (WB) good practice notes on addressing SEA/SH, and in line with existing inter-agency frameworks and agreements to assess and manage, as well as prevent and respond to SEA/SH risks related to the project.

The plan requires each site-specific Environmental and Social Management Plan (ESMP) to include actions to prevent and mitigate risks of SEA/SH in line with the Environmental and Social Management Framework (ESMF) and enforce their implementation; Preparation and adherence to Code of Conduct (CoC); SEA/SH-sensitized grievance mechanisms; and awareness-raising of project workers and community members on SEA/SH risks and mitigation measures.

Project SEA/SH Risks

SHARE project will be supporting provision of minimum essential and lifesaving health services targeting vulnerable population including IDPs. The objective of this project is contributing to the ultimate goal of reducing the inequalities and inequities in accessing the essential services as women's, young girls and children's health is becoming increasingly recognized as public health issue in Sudan especially during emergencies. Under this project WHO will be focusing on the minimum services package at hospital level which includes maternal, obstetric care and pediatric care along with other services to address the needs of the most vulnerable population and reduce the gender gap as well.

SHARE WHO targeted hospitals are distributed in different geographical locations and states with various number of IDPs and economic status, serving diverse beneficiaries from multiple ethnic groups and tripes with several gender and social norms. These disparities among the project target population are also affected by some underlying factors that include, the educational level of the mothers at the households along with the other socio-economic status of the families in the catchment areas of these hospital, considering the number of IDPs, demographics movement and proportion of women to men in these targeted areas.

All these gender specific factors are increasing the gender related risks of the project. These risks vary in their magnitude, possibility, and impact, These risks are grouped under different categories including social barriers and stigma, fear of GBV disclosure and retaliation, abusive conduct towards female health care workers, sexual exchange for health care services, harassment on women health workers, vulnerability barriers, quality and accessibility of the health services and the capacity of the health care providers and the project partners to provide survivors-centered services. Based on the identified SHARE risks, WHO has come with a set of mitigation measures that aim to limit the impact of these risks by putting more emphasis on the capacities of the project related personnel, orienting them on the concepts of how to prevent and respond to SEA/SH and to ensure provision of quality health services for the survivors/victims. This investment of project human resources will also be augmented by holding them accountable to all relevant WHO policies, values and principles along with other mitigation measures that are related to the hardware of ensuring availability of safe space, essential medicines and supplies, improving reporting channels form all levels and working closely with all project stakeholders.

The following risks are identified as a result of the analysis of different types.

Area	Risks	Mitigation Measures
Social barriers	• Survivor of SEA/SH may face stigma and rejection from her community and family. • Fear of disclosure and retaliation that prevent SEA/SH survivor from seeking service. • Social barriers that prevent women from being the decision maker to access health services and GBV services and relying on male guardian decision. • Barriers to conduct awareness-raising and general consultations such as focus	• Communicate that all complaints will be dealt with in a confidential manner during SEA/SH training for health care workers, contractors, and other stakeholders. • Ensure and enhance confidentiality and safety processes for SEA/SH survivors. • The project will ensure consultations with female health care workers through various means such as phone calls, online surveys, and other means as appropriate. The aim of the consultations is to have a

	group discussion at the community level on SEA/SH.	general understanding of issues such as service access, challenges, and barriers, and not to identify/investigate any SEA/SH cases.
Health care services	• Limited and insufficient number of trained health providers to identify and provide safe health care to SEA/SH survivors, as well as inadequate health infrastructures. • Women are often at risk of experiencing sexual harassment and other forms of gender-based violence when seeking health services. Risk of SEA/SH in project area (e.g. requests for sexual favours to receive health services). • Abusive conduct towards female health care workers (HCWs) resulting from gender inequalities. • Exclusion of the poor and vulnerable groups such as elderly people, and women. • Lack of meaningful representation and engagement of women in the health care sector structure.	• Address any SEA/SH that are reported through the Grievance Mechanism (GM). • Project workers and contractors sign a Code of Conduct. Sensitization is carried out on the CoC and penalties for misconduct. • Follow up through different channels of the project process such as via Third-Party Monitoring (TPM) that may identify any SEA/SH risks. The TPMA shall collect data based on the project TPM tools that include questions for the beneficiaries and health care workers for feedback on service accessibility and appropriateness from gender perspective. • Ensure that GMs are publicized to the affected population. Involve specialized service providers and ensure a survivor-centred approach. • Hold consultations with female health care workers with the aim to learn of their experience with the project and any barriers faced by women and girls in accessing specialized services, and not to collect information on SEA/SH-related cases and incidents in the project area.

Government and local actors	Lack of buy-in to SEA/SH issues from local actors and weak-prioritization of SEA/SH issues within the Sudan humanitarian crisis which result in:
	• challenges to conduct SEA/SH training and awareness-raising activities for the health care workers, contractors and suppliers, which will impact negatively on the SEA/SH activities.
	• challenges to conduct needs assessment and SEA/SH consultation with HCWs especially in the northern areas of the country.
		• Engage with local actors where possible to sensitize them about the social safeguards' requirements such as:
		  • Adaptation of SEA/SH training material to address the cultural sensitivity.
		  • Adaptation of TPM tools to fit the cultural sensitivity.

GBV SEA/SH services	• Inadequate GBV SEA/SH service provision to respond to SEA/SH cases especially at the district level due to deteriorating health care services. • The lack of supportive legal system on SEA/SH issues and non-supportive social system towards issues of SEA/SH.	• *Carry out GBV service mapping in collaboration with the national GBV Area of Responsibility (AoR) GBV Sub-Sector and develop location-specific referral pathways.* Work on identifying reliable GBV response service providers by means of engaging and networking with other SEA/SH actors.

	• Illiterate women may not know how to report SEA/SH and face language barriers.	• Distribute posters with icons that have a clear message about communication channels and ways to lodge grievances.
Vulnerability factors	• *Women and girls represent a high proportion of direct beneficiaries of the project, and specific groups at risk of women and girls are direct beneficiaries of the project.* • *The project does not have clear mechanisms to actively involve women and girls and ensure their safe involvement in the whole project cycle in order to include their insights and monitor their safety and well-being avoiding any backlashes.* • *The project does not have any clear protocols to provide women and girls with the necessary assistance if they are put in danger or hurt by their involvement in the project activities.* • *The project does not foresee measures to promote gender equality throughout its cycle.*	• *Work to advocate for gender equality with MOH and key partners including* Sudan family Planning Association, Alight, Save the Children, SAPA, Addition, OGSS, Midwives Association, Nursing Federation, Medical Student Network (MedSIN Sudan) and MFS. *Conduct awareness-raising on concepts of gender mainstreaming and gender-responsive services in health interventions especially for the activities require engagement with women and girls to address inequalities in the project and to reach the most vulnerable people in communities.* • *Ensure 50% female participation in training activities.* • *Conduct consultations on a regular basis to increase stakeholder engagement, including female HCWs.* • *Promote GM to submit complaints and concerns.*
SEA/SH risks in the project	• *Women and girls are sexually exploited in exchange of accessing health care and services.* • *Women and girls are sexually exploited in exchange of accessing medical drugs and treatment.* • *Female health workers are harassed in the workplace or abused while performing home visits.* • *Female health workers are harassed and sexually assaulted by patients' family members.*	• *Establish and activate grievance redress mechanisms to report any case related to SEA/SH. At national level through joining UNICEF complaints feedback mechanism.* • *Disseminate GM channels in all HFs and during training activities and consultation sessions. Share GM channels with all project trainees, governmental health directors and SHARE health facilities' directors.* • *Regularly post GM information on social media pages.* • *Share GM information with stakeholders and the health cluster.* • *Include project GM information on project boards.* *Conduct training for HCWs on SEA/SH measures and response to survivors of SEA/SH by building the capacity of health workers to provide survivor-centred care, identify signs of violence, deliver clinical care and psychosocial support, and provide referrals to specialized services.* *The project maintains consultation with female HCWs.*

Progress of Action Plan and Time Frame

No.	Action	Action by/ Responsible Body	Time Frame	Budget	Indicator & Target
1	Sensitize the Project Stakeholders on SEA/SH risks in the project and the needed prevention and mitigation measures	SHARE Social Safeguard Officer jointly with WHO GBV and PRSAEH officers	• Throughout the project lifetime (woth sensitization of the new stakeholders as needed)	3000$	Stakeholders are sensitized about SEA/SH definitions, policies, procedures, responsibilities, and reporting mechanism
2	Gather additional information on: • Country/sector-specific SEA/SH Risk Assessment • GBV/SEA Service providers in project areas and identify local level SEA/SH actors to prepare for service mapping. This step involves engagement with GBV SEA/SH actors (such as the GBV sub-cluster), to gather information on any existing mapping of GBV services and their level of quality, and existing reports/ materials with details of country/context specific SEA/SH scope and risks to supplement the limited information in the screening tool. Ensure engagement with GBV sub-cluster to get updates on SEA/SH issues such as challenges, opportunities, and other aspects.	SHARE Social Safeguard Officer jointly with WHO GBV and PRSAEH officers	• Initial mapping during the 1st quarter of the project implementation list of service providers updated quarterly during project lifetime	3,000$	Updated GBV service mapping is in place Services are provided and evaluated positively
3	Revise/develop the following: • GM to include SEA/SH-sensitive approaches, including: o SEA/SH reporting and allegation procedures: The GM process for receiving employees' and community members' disclosure of SEA/SH breaches of CoC. This also	SHARE Social Safeguard Officer jointly with WHO GBV and PRSAEH officers This will also be done jointly with UNICEF	• Training for the GM to be conducted in collaboration with UNICEF as needed	4,000$	Effective GM is in place Allegations are received confidentially and with due process

No.	Action	Action by/ Responsible Body	Time Frame	Budget	Indicator & Target
	implies the identification of several adequate and safe reporting channels and the dissemination of the GM information to communities and other actors. ○ Accountability and response protocol that describes the steps to be taken when a case of SEA/SH is reported, such as referrals to service providers, whom to notify internally for case accountability procedures, confidentiality requirements for dealing with cases etc. ○ Mechanisms to hold accountable alleged perpetrators associated with the project, including disciplinary action for violation of the CoC by workers that is consistent with local labour legislation and applicable industrial agreements.	safeguard team when required.			
4	Capacity-building for: • GM focal point and operators to implement the GM in an empathetic, non-judgmental listening and information gathering manner that helps strengthen response mechanisms through survivor-centred mitigation measures and GMs to effectively handle SEA/SH complaints. • Health service providers to provide care to survivors of SEA/SH, including referral	SHARE Social Safeguard Officer jointly with WHO GBV and PRSAEH officers	• Refresher GM training to be conducted in collaboration with UNICEF targeting the relevant staff from the IPs and call centre operators as needed. This will be directly implemented by social safeguard • Awareness to HCWs involved	19,000$	GM focal point(s) trained on SEA/SH response 120 health care providers trained on SEA/SH response Training activities will be conducted on a quarterly basis and target the remaining health facilities that were not

No.	Action	Action by/ Responsible Body	Time Frame	Budget	Indicator & Target
	protocol as part of the management of SEA/SH response. • As needed, training to other sectoral services or local organizations can be foreseen. • General induction and orientation to project staff.		in the project implementation during the lifetime of the project and will be led by the IP		included in the previous trainings
5	**Project's stakeholder consultations:** with women or groups representing women, children and other vulnerable groups accessing health services, to get their feedback on their experience with the project. Feedback is collected and well-integrated in the SEA/SH action plan. The consultations should also focus on female health care workers' experience with the project, listening to their experience rather than collecting SEA/SH cases. Community awareness-raising to inform on project-related SEA/SH risks, mitigation measures and reporting mechanisms (e.g. Codes of Conduct, etc. in the work site, labour camps, surrounding communities)	SHARE Social Safeguard Officer jointly with WHO GBV and PRSAEH officers. The consultations and community awareness will be implemented and led by the IPs with technical support from the project social safeguard.	• Quarterly throughout the project implementation (through different modalities) visits to targeted health facilities, phone calls and ad hoc meetings as needed • Quarterly throughout the project lifetime	8,000$	Consultations conducted with 50 female health care workers and 15 NGOs 500 awareness-raising materials distributed Further consultations will be conducted on quarterly basis

6	Ensure that:
	• Project Code of Conduct for specific SEA/SH language is applied in bidding documents for contractors at all the locations under all activities.
	  • Appropriate SEA/SH mitigation measures are included in the safeguards instruments (ESMP)
	  • Appropriate SEA/SH mitigation measures as stipulated in the safeguards instruments
		HR/ procurement with follow-up from social safeguards officer and PRSEAH FP
		
		Social safeguards team
			• Included in all project approval contractual arrangements	0	All contractors sign COC and are trained on SEA/SH mitigation measures upon being contracted

No.	Action	Action by/ Responsible Body	Time Frame	Budget	Indicator & Target
	(ESMP) are reflected in contractors' bidding documents				
7	Ensure availability of TPM tools to monitor SEA/SH issues during the operations in the field and ensure they are culturally sensitive and updated as appropriate.	TPM and M&E Officer	• updated and implemented as needed	0	Issues received through the TPM
8	WHO to report on the application of the Action plan progress reports that are sent to the Bank as well as during supervision missions. The Action plan will be revised y	SHARE Social Safeguard Officer jointly with WHO GBV and PRSAEH officers	• Quarterly	0	Progress reported regularly
9	Collaboration meetings with UNFPA and UNICEF / subcluster	SHARE Social Safeguard Officer jointly with WHO GBV and PRSAEH officers	• Quarterly throughout the project lifetime	1,000$	Progress reported regularly
10	**Monitoring visits**	SHARE Social Safeguard Officer jointly with WHO GBV and PRSAEH officers	• Biannually throughout the project lifetime	7,000	Progress reported regularly

Budget is only indicative and will be updated.

Institutional Arrangements for the Implementation of SEA/SH/GBV Action Plan

Based on its technical and normative mandate, WHO is working closely with all partners to ensure provision of GBV and SEAH survivors/victims centred health services as an essential part of the health services in all settings. It's also leading on strengthening health system response to GBV adopting comprehensive protection, prevention, and care approach.

It contributes to different aspects of strengthening the health system, improving the quality of health services, and scaling the response during emergencies system, in full alignment with the other agencies and partners mandates. This contribution includes:

1. Supporting coordination mechanisms withing the health sectors if needed and being a member in the GBV sub-sector, which is led by UNFPA.
2. leading adoption of all evidence-based guidelines and protocols related to health services for the GBV survivors.
3. Enhancing capacities of the health care providers to ensure provision of quality health care on CMR MHPSS.
4. Strengthening reporting and information system focusing on integration of GBV related indicators in the HIS.

5. Ensure the availability of medicines and supplies to complement the role of UNFPA on provision of SRH supplies and commodities.
6. Strengthening services delivery approaches and adopting different possible modalities to ensure accessibility of the services.
7. Strengthening the referral pathways specially facility-based referral as UNFPA is leading on the community-based ones.

These collective efforts are usually addressed as part of the national strategies, policies and priorities in the stable situations, while are also always addressed as part of the overall national health response plans for emergencies.
For the PRSEAH, WHO is a member in the global Inter-Agency Standing Committee (IASC) as well as the inter-country PSEA Network and PSEA Network's Strategic Advisory Group (SAG) which is a sub-group under the country network.
This PSEA Network is supported by regular Resident Coordinator/Humanitarian Coordinator oversight and has system-wide responsibility for developing collective PSEA strategies and ensuring action plans are implemented. The RC/HC with support of the Inter-Agency PSEA Coordinator engages in monitoring, discussion, and feedback on overall PSEA Network activities and implementation of PSEA Network's Action Plan. The RC/HC bears the final responsibility for ensuring that victims/survivors have access to appropriate, immediate, and long-term assistance, the development of complaints and feedback mechanisms (CFM), ensuring coordinating the Inter-Agency referrals and reporting regularly to the HCT and UNCT as well as to the Emergency Relief Coordinator on PSEA in relation to humanitarian operations. Moreover, under the auspices of the RC/HC, the PSEA Network shall be overseen by the HCT and UNCT. All agencies have representation in the inter-country network who is usually the PRSEAH coordinator/FP at the national level.
WHO PRSEAH coordinator/FP is leading on the integration of PRSEAH in all WHO programs at all levels towards zero-tolerance of any sexual misconduct working closely with all WHO staff, contractors, suppliers, and partners. This FP is also leading on assessing the SEAH related risks and identifying the mitigation measures according to each risk.

Roles and Responsibilities

- **Project Manager PMU:** is the overall custodian managing requirements of the ESCP. It has dedicated staff for this purpose including a social safeguards officer and an environmental safeguards officer. Holds overall accountability for any SEA/SH cases such as overseeing the investigation process and will oversee the implementation of the ESCP throughout project implementation and responsible for reporting regularly on the application of the Action plan in regular progress reports that are sent to the Bank as well as during supervision missions.
- **Project contractors:** Will be sensitized on SEA/SH prevention and response requirements, requested to sign the Code of Conduct, and informed of the application of SEA/SH mitigation measures.
- **HR focal point**: The social safeguards team may seek support at any point from the HR where appropriate to coordinate the response to any case of SEA/SH.
- **Procurement focal point**: Will be responsible for integrating SEA/SH responsibilities as per the ESCP into the contract documents with suppliers, implementing partners, etc. and ensure that procurement documents reflect SEA/SH requirements.
- **Social Safeguards officer:** Will respond to SEA/SH reports and provide support to implementing the SEA/SH Action plan, preventing and responding to SEA/SH in the project and promoting best practices. Will also be responsible for following up with the concerned WHO staff to support the survivors in accessing the needed health services, referring them to the specialized services, in addition to leading implementation of the GBV related interventions under the SHARE SEA/SH Action plan. This includes enhancing the capacities of the health care providers in the project supported facilities on GBV related training packages, monitoring the quality of the health services for the survivors and improving reporting of GBV from the supported facilities. As well as sharing updates on the availability of health GBV related services as part of the referral system. Social Safeguard officer will work closely with WHO PRSEAH coordinator/ FP to ensure that all staff and related personnel receive regular SEA/SH training, assessing the capacities of the partners in preventing and responding to SEAH, raising

awareness, and ensuring Code of Conduct is signed by staff and contractors. The PRSEAH coordinator/FP will provide support to the social safeguards team and will decide upon proportionate course of action pursuant to WHO regulations and in line with the local legislation

- **All project staff**: Required to report SEA/SH cases via relevant channels, subject to the consent of the survivor and following all due processes. Staff shall work with respect to the core principles of SEA/SH. Staff shall be engaged in training and awareness-raising activities on SEA/SH that will enable them to understand their roles. All project staff are to provide support to the overall implementation of the SEA/SH Action plan by:
    - Facilitating activities with the local authorities.
    - Ensuring continuous engagement with MOH on the SEA/SH prevention and response requirements and the implementation mechanism.
    - Integrating SEA/SH awareness-raising activities with other training activities that are conducted within the project.
    - Ensuring availability of TPM tools to monitor SEA/SH issues during the operations in the field.

TPMA Roles and Responsibilities

The TPMA role is not to identify SEA/SH cases: the focus of TPM activities in the project is non-sensitive interventions pertaining to:

- Evaluating women's access to health care services.
- Identifying social barriers and challenges such as privacy concerns within the project-supported activities.
- Identifying availability of female health care workers in the supported facilities.
- Evaluating the overall service satisfaction (e.g. satisfaction level with the services or activities supported by the project).
- Reporting any findings related to the above-mentioned points within the regular TPM reports of the project.

GBV Response Service Providers

WHO is a member of the Gender-Based Violence sub-Sector led by UNFPA which coordinates the humanitarian response for prevention, risk mitigation and response to all forms of GBV in Sudan with its engagement in the health cluster to ensure availability of health services for the GBV/SH survivors. The Gender-Based Violence sub-cluster conducts regular mapping of GBV response service providers across the country and at the district level, identifies response gaps and strengthens survivors' referral to appropriate services. The GBV service mapping (2023) is in place and is updated frequently by the cluster and shared with its members – it is accessible through the link Crisis in Sudan - GBV AoR Sub-Sector Sudan: Situation Brief (23 May 2023) – Sudan. The service mapping includes a comprehensive list of GBV response service providers such as INGOs, local NGOs, CSOs that work across Sudan. Communication is done at the project level with several GBV response service providers to ensure coordination and established common ground of SEA/SH referral pathways. The Sudan Women Union is identified as one of the main GBV response service providers that provides comprehensive services for survivors across Sudan.

A monthly meeting is coordinated by the sub-sector at national and sub-national level that supports effective and smooth collaboration among the multiple GBV SEA/SH actors at various levels, including on relevant training and -capacity building activities and technical aspects necessary for the establishment and management of a comprehensive referral mechanism to support women survivors of SEA/SH.

Under the mandate to address SEA/SH in both development and humanitarian settings, the project is committed to ensuring that the needs of SEA/SH survivors are met through adequate health responses, psychosocial support, comprehensive case management, legal support, safety and security mechanisms, safe shelters, social and economic empowerment, and other services, in line with -survivor centred approach guidelines. The GBV officer is responsible for making sure that survivors are informed of all the options available to them and that issues and problems a survivor faces are identified and followed up throughout the process.

Grievance Mechanism (GM)

SHARE Project will utilize a joint Grievance Redress Mechanism (GRM) as part of its project-related activities to ensure that the affected populations and stakeholders have access to a unified mechanism for grievances and feedback. Averaging from the Inter-agency feedback mechanism recently supported by the Central GRM systems, the project will specifically adopt the Complaints and Inter-agency Feedback Mechanism (CFM) established, and currently run the AAP Working group, and UNICEF in Sudan, which provides safe, accessible, accountable, equitable, and inclusive two-way/multiple dialogue and communication channels. UNICEF has built informed channels following needs, preferences, context analysis and lessons learned followed by community consultations executed. These include:

- **Nationwide toll-free hotline "6664"** run by physical call center in Port Sudan covering all Sudan, well equipped to receive, handle and support the diversity of typology of grievances from diverse local dialect. This will allow cross-country and uniform access regardless of internet availability.
- **WhatsApp on 0900747913**; where the complainant-feedback/project worker submits a submits their feedback and is responded to.
- **Email** on sudan.feedback@unicef.org as above. For data protection and confidentiality, an autoreply indicating the additional channels;

Overall, feedback/complaints are checked to follow-up on most urgent sensitive flagged cases through reaching out to the complainant for better case management, processing and response.

UNICEF CFM allows not only the submission of grievances, but also queries, suggestions, consultations, listening, positive feedback, and any concerns of project-affected parties related to the environmental and social performance of a project to be submitted. Complaints are responded to within 3 weeks and actively monitored and verified, including a satisfaction record.

Furthermore, additional channels may be established throughout the course of the implementation following needs assessments and community consultations if required, feasible and needed by the community, health facilities and by Project workers.

The CFM process will involve:

- Receipt of grievances (written, verbal, text message, telephone through all available channels).
- Registration/logging/analysis of grievances by a dedicated GRM team for each channel using a digitized system with three levels of categorization.
- Referral to assigned focal points at WHO to resolve the complaint and provide feedback to the GRM team.
- Feedback provision to the complainant using the GRM channels will be provided.
- Closure of all resolved grievance.
- Reporting trend analysis for quality programming, response adjustment and quality assurance, satisfaction, and monitoring will be done monthly from GRM team to the assigned focal person at WHO.

While the project will use the CFM, SEA/SH cases will be managed by specific WHO focal points.

SEA/SH and allegation cases can be received in person or by phone using the different CFM channels. Once reported, the CFM has in place processes to immediately notify focal person at WHO of any SEA/SH complaints, which will be channelled through the system to the focal person at WHO, with the consent of the survivors. The CFM operator records the survivor's account of the incident; this shall be conducted in a private setting, ensuring that any specific vulnerabilities are taken into consideration. After a complaint is received and recorded, it is registered in the project's GM. Confidential reporting with safe and ethical documenting of SEA/SH cases is implemented, ensuring limited access to the data, with the focal person at WHO being the only one able to access the data system. The survivor must give explicit consent via a specialized form to data sharing and know what data will be shared, with whom and for what purposes fully aligned with WHO policies towards zero tolerance of any sexual misconduct.

The focal person at WHO will facilitate timely referral of the SEA/SH survivor to the service providers immediately after receiving a complaint directly from a survivor and subject to consent of the survivor. This should be possible because a list of service providers would already be available and updated as part of the mapping exercise. The focal person at WHO will comply with disclosure procedures when receiving information of a SEA/SH incident from a survivor and will provide the survivor with:

- Psychosocial first aid and Firstline Support.
- Information on services that may be able to assist the survivor.
- Details on how to access these services; and
- Appropriate support to help the survivor access these services.

The SEA/SH FP will notify the World Bank of any SEA/SH complaints within 48 hours, and an Incident report is to be prepared with details upon request of the Bank based on all the collected and available information, with due respect to the privacy and confidentiality principles. Elements to be reported should only include: (i) the age and sex of survivor; (ii) the type of alleged incident (as reported); (iii) whether the alleged perpetrator is employed by the project; and (iv) whether the survivor was referred to a service provider.

In addition, WHO will inform the World Bank that a referral has been made to internal investigation mechanism led by Internal Oversight Services (IOS) at WHO-HQ and provide any information on existing risk mitigation measures that are in place, as well as those that will be put in place, if relevant. All reports and information shared by WHO shall be subject to the same standards and requirements of confidentiality and information-sharing described in Grant Arrangement.

To consider a case closed, based on the feedback provided to the primary accountability officer, the SEA/SH FP will use the appropriate WB ESIRT template to report to WB on whether an investigation was carried out, outcomes of that investigation, and implementation of the corrective actions based on the underlying causes.

WHO will provide training for CFM operators on the WHO components of the SHARE project and the system categorization in addition to a session on SEA/SH and how to collect SEA/SH cases confidentially and empathetically. The GM operator does not and will not ask for, or record, information on more than the following basic details related to the SEA/SH allegation:

- The nature of the complaint (what the complainant says in her/his own words without direct questioning);
- If, to the best of the survivor's knowledge, the perpetrator was associated with the project.
- If possible, the age and sex of the survivor; and
- If possible, information on whether the survivor was referred to support services.

The project's social safeguards team reviews the GM's reception and processing of complaints to ensure that due protocols are being followed in a timely manner.
The key guiding principles for the review process of the complaints received through the GM are ensuring complete confidentiality of the survivor's case information, a survivor-centred approach, a fair assessment and due process for all those involved, measures against perpetrators, and a speedy resolution. The social safeguards team will be continuously engaged in capacity building to enable them to implement and advance the Action plan. All processes applied uphold the guiding principles and ethical requirements for dealing with survivors of SEA/SH.
All contracted partners undergo rigorous vetting process as part of the Organization's due diligence, in which they are informed on the standards of conduct and zero tolerance to all forms of misconduct including sexual misconduct. All partners are required to be registered on the UN partner portal (https://www.unpartnerportal.org), which provides all information on partners' obligation to deal with any reported cases of sexual misconduct as per the IASC minimum standards. Partners have to conduct a self-assessment and provide proof of meeting the core standards before being contracted. Contractual provisions include measures to ensure that the conduct of the employees and any other persons engaged by external partners/suppliers to perform any activities in direct contact with local communities and/or to provide any

services on behalf of WHO should abide by the code of conduct. Whenever a complaint is lodged involving a contracted partner and/or any third party sub-contracted by the implementing partner, their contract with the Organization will be subject to inquiry and will necessitate corrective actions that might lead to suspending the funding and a breach of contract in case of inaction to any form of misconduct, inaction to prevent and respond to reported cases, or retaliation is found and documented.

SEA/SH Mitigation Measures: Estimated costs

GBV estimated costs	USD
1. Training, consultations, and raising awareness activities	38,000
2. Monitoring visits	7,000
TOTAL USD	**45,000**

Annex 1: Sample code of conduct for Contractors/Sub-contractors

(Sample - Code of Conduct)

The Code of Conduct should be written in plain language and signed by each worker to indicate that they have:

- *received a copy of the code;*
- *had the code explained to them;*
- *acknowledged that adherence to this Code of Conduct is a condition of employment; and*
- *understood that violations of the Code can result in serious consequences, up to and including dismissal, or referral to legal authorities.*

To Be Signed by All Employees, Sub-contractors, Engineer, and Any Personnel thereof.

I, _____ agree that in the course of my association with the Employer, I must:

- ✓ treat children and women with respect regardless of race, color, gender, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status;
- ✓ not use language or behavior towards children and women that is inappropriate, harassing, abusive, sexually provocative, demeaning or culturally inappropriate;
- ✓ not engage children under the age of 18 in any form of sexual intercourse or sexual activity (other than in the context of legal unions that took place between parties under the laws of the country), including paying for sexual services or acts;
- ✓ Not engage sexually with any woman, in a situation, without mutual consent
- ✓ Wherever possible, ensure that another adult is present when working in the proximity of children;
- ✓ Not invite unaccompanied children into my place of residence, unless they are at immediate risk of injury or in physical danger;
- ✓ Not invite women into my place of residence if this is not acceptable by the code of ethics of the company;
- ✓ Not sleep close to unsupervised children unless absolutely necessary, in which case I must obtain my supervisor's permission, and ensure that another adult is present if possible;
- ✓ Use any computers, mobile phones, video cameras, cameras or social media appropriately, and never to exploit or harass children or access child exploitation material through any media;
- ✓ Not use physical punishment on children and women;
- ✓ Not hire children for domestic or other labor, which is inappropriate given their age or developmental stage, which interferes with their time available for education and recreational activities, or which places them at significant risk of injury;
- ✓ Comply with code of ethics of the company and all relevant local legislation, including labor laws in relation to child labor and behavior;
- ✓ Immediately report concerns or allegations of child and women exploitation and abuse and policy non-compliance in accordance with appropriate procedures;
- ✓ Immediately disclose all charges, convictions and other outcomes of an offence, which occurred before or occurred during my association with the Employer that relate to child exploitation and abuse.

When photographing or filming a child or using children's images for work-related purposes, I must:

- ✓ Assess and endeavor to comply with local traditions or restrictions for reproducing personal images before photographing or filming a child;
- ✓ Obtain informed consent from the child and parent or guardian of the child before photographing or filming a child. As part of this I must explain how the photograph or film will be used;
- ✓ Ensure photographs, films, videos and DVDs present children in a dignified and respectful manner and not in a vulnerable or submissive manner. Children should be adequately clothed and not in poses that could be seen as sexually suggestive;
- ✓ Ensure images are honest representations of the context and the facts;
- ✓ Ensure file labels, meta data or text descriptions do not reveal identifying information about a child when sending images electronically or publishing images in any form;

I understand that the onus is on me, as a person associated with the Employer, to use common sense and avoid actions or behaviors that could be construed as child exploitation and abuse.

Signed: Date:

Annex 8.8 Social Assessment and Social Risk Management Plan

Executive summary:

The desk review aims to identify, assess and mitigate potential risks of the SHARE project on IP/SSHUTLCs and other vulnerable groups consistent with ESS7 and to ensure their equal access to project benefits. It was conducted against the World Bank Environmental and Social Standards (ESSs) and the SHARE disclosed Environmental and Social Commitment Plan (ESCP). It addresses the relevant standards that might have potential social risk with focus on the ESS1. This standard sets out the Borrower's responsibilities for assessing, managing, and monitoring environmental and social risks and impact associated with each stage of a project supported by the Bank through Investment Project Financing, in order to achieve environmental and social outcomes consistent with the Environmental and Social Standards (ESSs)[3]. It also addresses another relevant social standard (ESS7) which focus on the indigenous people/Sub-Saharan African Historically Underserved Traditional Local Communities (SSHUTLC) to ensure that SHARE project will be carried out in accordance with the Sudan context and its relevant environmental and social possible risks.

This rapid review has assessed wide range of available studies and assessments for better understanding of the current situation in Sudan including the health situation in Sudan in General and specifically in the project targeted states, tribal and ethnic mapping and social context and vulnerable population.

As a result of this rapid disk review, several risks related to the SHARE project targeted communities have been identified including the different tripes and ethnic groups in the targeted locations, their social and demographical characteristics, economic situation, potential social barriers in accessing the provided health services under the SHARE project and the cultural practices, traditions, and beliefs of indigenous communities that will support in addressing the needs of vulnerable groups. The SRMF provides guidance for the preparation of site-specific SA/SRMPs as necessary.

Background and Context:

Sudan lies at the crossroads of Sub-Saharan Africa and the Middle East, facing the Red Sea. It shares its border with seven countries: the Central African Republic, Chad, Egypt, Eritrea, Ethiopia, Libya, and South Sudan. The White and Blue Niles meet in Khartoum, its capital, merging to become the Nile River, which flows all the way to the Mediterranean via Egypt. Sudan has a Sahelian belt with desert in the far north, fertile land in the Nile valleys and the Gezira region, with land used for farming and livestock across the rest of the country, from Darfur to Kassala, via the states of Blue Nile and Kordofan[4].

After years of protracted crisis, Sudan plunged into a conflict of alarming scale in mid-April 2023 when fighting between the Sudan Armed Forces (SAF) and the Rapid Support Forces (RSF), a paramilitary group, broke out initially in the capital Khartoum, and quickly expanded to other areas across the country. The current bout of insecurity has resulted in human casualties, with more than 12,000 fatalities. This conflict has affected majority of the 18 states either directly or indirectly with different scale of effects which varies from heavy shooting to high influx of displaced people. Khartoum has been the site of heavy fighting, while severe violent clashes and heavy bombardments have also been reported in the greater Darfur and Kordofan regions. The escalating hostilities have resulted in extensive damage to critical infrastructure and facilities, including water and healthcare, the collapse of banking and financial services, frequent interruptions to electricity supply and telecommunication services and widespread looting[5].

This emergency has severely impacted the health system in Sudan and has resulted in a huge gap in the availability and accessibility to lifesaving ad basic health services. As part of the response to the emergency and the high need for the basic lifesaving services, different donors' programs and projects are introduced responding to the health needs of Sudanese people with focus on the vulnerable population.

SHARE project was developed and introduced with support from the WB to be implemented by WHO and UNICEF with different components that aim to address immediate emergency health needs in Sudan through the delivery of essential health care at primary and secondary service level and sustaining core public health functions in the country. SHARE is designed to complement the current humanitarian aid to Sudan by laying a

[3] The World Bank Environmental and Social Framework

[4] Sudan Overview: Development news, research, data. World Bank

[5] HNRP_2024_SDN_EN.pdf

foundation for medium- and longer-term development support, especially in underserved areas with high concentration of Internal Displaced Persons (IDPs), building critical clinical skills to address existing and emerging needs, restoring access to basic health services, protecting human capital, and enhancing communities' resilience. This will be achieved through the provision of a basic health and nutrition packages at primary and secondary level, population-based interventions, enhancing water, sanitation and hygiene (WASH), climate adaptation in health facilities (HF), and response to emergencies, including health response to gender-based violence (GBV), strengthening health systems, use of innovations, and state and local capacities on health service delivery[6].

The SHARE project targets the population of Sudan, particularly women of reproductive age, children under five, and IDPs to improve access to basic health services, where WHO is leading on providing these services by focusing on ten hospitals in ten states and strengthen the health system through supporting essential system elements such as blood bank, laboratories, and surveillance systems.

Project Description:

The SHARE Project has three components as follows:

This component aims to enhance access to basic health and nutrition services in Sudan through low-cost, high-impact interventions using a PHC approach. It targets both displaced and host communities. A minimum service package that includes the following services**: Expanded Program on Immunization**, integrated management of **childhood illnesses**, **maternal, newborn and paediatric** health, **nutrition**, and **noncommunicable diseases (NCDs**), including mental health, as well as prevention and **response to outbreaks** and health emergencies will be supported under this component at different levels of service delivery.

Component 1: Improving Access to Basic Health and Nutrition Services (implemented by UNICEF and WHO):

Subcomponent 1.1: Strengthening the Integration of Primary Health Care Model (implemented by UNICEF)
Subcomponent 1.2. Supporting Health and Nutrition Services at the First Level Referral Centers and Hospitals (, implemented by WHO)
Subcomponent 1.3: Climate Change Adaptive Health Service Delivery (implemented by WHO)
Subcomponent 1.4: Climate Change Resilient Health Facilities (implemented by UNICEF)
Subcomponent 1.5: Integrating Digital Solutions to Service Delivery (implemented by UNICEF)

Component 2: Preserving the Main Elements of the Health System (implemented by WHO):

This component will focus on strengthening health systems and public health programs and improving the main elements of the health system to prepare for and respond to health emergencies and control diseases by strengthening emergency preparedness, laboratories, and disease control systems. Specific activities will include essential preparedness functions such as: (a) training and operating cost for integrated disease surveillance and response (IDSR) including EWARS; (b) operating costs and rehabilitation for selected Emergency Operations Centers (EOCs) with a primary focus on response to climate shocks; (c) supporting health information systems and the Health Resources and Services Availability Monitoring System; (d) developing, disseminating, and training of trainers on subnational emergency preparedness and response plans, primarily focusing on climate shock emergency preparedness and response along with response to conflict; (e) updating and disseminating laboratory guidelines and providing laboratory operating costs; and (f) training and deploying Rapid Response Teams. The component will also support strengthening the country's blood bank and transfusion systems, which currently have limited reach, impairing access to CEmONC and safe surgical services. This includes: (a) developing guidelines for the proper collection, storage, transport, and use of blood for transfusions; (b) building or strengthening existing blood banking services; and (c) developing systems and protocols for the transfer of blood products for transfusions.

Component 3: Monitoring and Evaluation and Project management, includes:

- Subcomponent 3.1: Third Party Monitoring (implemented by UNICEF): The third-party monitoring (TPM) agency's role will include working with UNICEF, WHO, the World Bank, and implementing partners (IPs) to

[6] Sudan Health Assistance and Response to Emergency-Project Implementation Manual.

explain results, providing guidance on improved methods, proposing context-appropriate solutions, and conducting ex post facto verification of results provided by project reporting mechanisms.

- Subcomponent 3.2: Data Analysis and Knowledge Management (implemented by WHO and UNICEF]): The project will ensure that independent and credible data on health service delivery and coverage and commodities are generated, and that the data are usable and will enable the World Bank and development partners to verify that resources are reaching the intended beneficiaries.
  - Subcomponent *3.3: Project Management (implemented by WHO and UNICEF)* includes the finance costs related to monitoring and evaluation (M&E) and management of project activities.

Objectives:

1.General objective:

The goal of the Social Assessment and Social Risk Management Framework (SA/SRMF) is to identify, evaluate, and analyze potential risks that the SHARE Project may pose to IP/SSHUTLCs and other vulnerable groups, in alignment with ESS7. It also aims to ensure equitable access to project benefits by vulnerable groups and underserved communities of Sudan.

2. Specific objectives:

a. To ensure that the development process upholds full respect for human rights, dignity, aspirations, and identity.
b. To enhance project design and encourage local support by fostering a continuous, meaningful consultation process with Indigenous Peoples/Sub-Saharan African communities.
c. To guide local community health development interventions and provide direction for creating site-specific SA/SRMPs when necessary.
d. To explore indigenous and herbal medicine practices among IP/SSHUTLCs, including an analysis of barriers preventing traditional local communities from accessing health facilities.
e. To assess social dynamics and associated risks that may obstruct the effective implementation of the SHARE Project.

Methodology:

WHO has conducted this secondary data and information desk review to ensure that SHARE development process and design fosters full respect for the human rights, dignity, aspirations, identity, culture, and natural resource-based livelihoods of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities. Due to time constraints, effectiveness of the project and country emergency situation, this was done through a rapid literature review of the relevant information from different relevant studies and articles, along with the SHARE project disclosed documents that included the Sexual Exploitation and Abuse/ Sexual Harassment Action Plan (SEA/SH).

A detailed social assessment and site specific (project implementation areas) will be conducted throughout project implementation and the SRMF will be updated accordingly where accessible through implementing partners. This planned s social assessment will be carried out by adopting mixed method of focus group discission, consultations with the targeted communities and indigenous people and other vulnerable groups that reside at community level and implementing partners, key informants' interviews along with the observations during the planned project supportive supervisory visits, along with consultations with different project's stakeholders. WHO's SA/SRMF will be implemented in tandem with the SEP, the SEA/SH Action Plan, LMP and the SMF.

WHO emphasizes the need to respect the cultural practices, traditions, and beliefs of indigenous communities and addressing the needs of vulnerable groups. It encourages health interventions that are planned to be implemented in culturally appropriate manner and align with indigenous values through implementing partners, regular stakeholder engagement and regular WHO supervisory visits. In addition, the Indigenous peoples and vulnerable groups will be empowered and informed about the availability of different Community Feedback Mechanism (CFM) channels and how to access it to raise their feedback, complaint. WHO's SA/SRMF will be implemented in tandem with the SEP, the SEA/SH Action Plan, LMP and the SMF.

Legal and Institutional Framework:

There are over 500 ethnic groups, speaking numerous languages and dialects in Sudan. Sudanese formal law does not identify specific indigenous groups. The 2019 Constitution, developed under the Transitional Government, includes provision 66 on ethnic and cultural groups which states: *"All ethnic and cultural groups have the right to enjoy their own private culture and develop it freely. The members of such groups have the right to exercise their beliefs, use their languages, observe their religions or customs, and raise their children in the framework of such cultures and customs."*

According to World Bank ESS-7, IP/SSHUTLCs are groups with a strong connection to specific lands and natural resources, distinct cultural and social systems, and a shared identity as an indigenous community, often with their own language or dialect.

Under the Constitutional Declaration (2019) of the Transitional Government committed to combat discrimination under Article 48 (Equality before the Law) of the Bill of Rights which states that *'[p]eople are equal before the law and have the right to the protection of the law without discrimination between them on the basis of ethnicity, colour, gender, language, religious faith, political opinion, racial or ethnic origin, or any other reason'*. The Criminal Act of 1991, which discriminated against certain sects and groups, was also amended under the Transitional Government period. The Juba Peace Agreement of Oct 2020 committed to respect ethnic, religious and cultural diversity without discrimination and should be managed *"in accordance with the standards that reflect national unity"*

The Interim Constitution committed to social and economic programmes to empower marginalized groups, in particular women and youth, including the provision of healthcare, education housing and social security. Article 32 stated *"women and men have equal entitlement to all civil, political, economic, social, and cultural rights"* while Article 15 stated *"the State shall emancipate women from injustice, promote gender equality and encourage the role of women in family and public life".* However, despite these commitments Sudanese women continue to suffer from discrimination, exclusion and subordination at all levels, with many existing discriminatory laws failing to be revised to conform to the Interim Constitution.

The 2008 Sudanese National Elections Act takes no affirmative action for minorities: *"The act embodied no particular provisions or measures for minority representation, and no proportionate representation of minority groups was provided for. Thus, the long-lasting political exclusion of some minority groups was not addressed. This legislative shortcoming negatively affected, among other reasons, efforts to build peace and peaceful coexistence in Sudan."* Similarly, the 2003 Local Government Act provides no guidance on ethnic or religious groups: *"Sudanese. Article 27(1)(2) of the Local Government Act details the process for electing local assemblies but does not address the issue of diversity management, and article 27(2) on seat allocation mentions nothing about minorities; instead, it mentions only the system for the special and direct election of women."* In 2007, one renown political commentator described Government of Sudan (GoS) approach to 'indigenous' tribes thus: *"The Sudanese state has unwittingly maintained some colonial coercive institutions and brutally deployed them against its indigenous peoples (Salih 1999, p. 1) as part of its relentless endeavor aiming at building a socio-culturally homogeneous society".*

Article 6 of the 2005 Interim National Constitution provides for religious rights, and the Bill of Rights within that interim constitution re-affirms this under Freedom of Creed and Worship. However, the GoS has not been neutral towards different religious groups, and some have been stigmatized. Under Article 47 'Rights of ethnic and cultural communities' the Bill of Rights states: Ethnic and cultural communities shall have the right to freely enjoy and develop their particular culture: members of such communities shall have the right to practice their beliefs, use their languages, observe their religions and raise their children within the framework of their respective cultures and customs."

However customary mechanisms relating to tribal homelands and native administration do provide specific protection for access to land and governance to 'native' tribes, and significant obstacles to other 'settler' tribes, creating significant vulnerabilities for these 'settlers.' Customary tribal homeland provided the initial basis of rights and access to land in Sudan, providing security of tenure to settled communities and access to rangelands for specific pastoralists. These tribal homelands are synonymous with 'indigenous peoples' but are not formally recognized as such. These tribal homelands were accompanied by a Native Administration – formally recognized by the British colonial authorities in a three-tiered system of customary governance (Sheikh, Omda, Chief), playing a role in local justice and natural resource management. However, in 1970 the Unregistered Land Act effectively nationalized all unregistered land, denying legitimacy to customary property rights, and entitled the

GoS to use force to 'safeguard' its land. At the same time the Native Administration were abolished as part of an agenda to 'modernize' governance, replacing traditional authorities with administrative councils.
The Native Administrations were re-instated under the NCP but were significantly politicized, and the 2018-19 revolution highlighted the tensions between the Native Administration and other, youth-led initiatives such as Resistance Committees.
There are significant disparities in how indigenous peoples and historically underserved or marginalized tribal communities are protected and empowered. While Sudan's legal framework, particularly under the 2019 Constitution and the Juba Peace Agreement, recognizes ethnic, cultural, and religious diversity and commits to equality before the law, there are gaps in the implementation of these principles, especially concerning indigenous practices and the protection of indigenous knowledge. The absence of formal recognition for indigenous peoples and their rights to land, cultural practices, and herbal medicine, combined with the lack of affirmative action in electoral processes, undermines the meaningful representation and participation of indigenous groups in decision-making. Additionally, the 2008 National Elections Act and the 2003 Local Government Act fail to address the specific needs of indigenous and minority groups, limiting their ability to influence policies that affect their livelihoods and cultural practices. ESS7, which aims to protect the rights and dignity of indigenous peoples, calls for active involvement in the development process and the preservation of traditional knowledge, including indigenous health and herbal medicine practices. However, Sudan's existing institutional framework—marked by fragmented governance between the central state and Native Administrations—does not provide sufficient safeguards for such practices. The politicization of traditional governance structures and the historical marginalization of indigenous groups contribute to challenges in ensuring that these communities can fully exercise their rights.
To align with ESS7, the implementation process of SHARE project will ensure the respects to different identities, traditions, and health practices of indigenous communities and collaboration with indigenous representatives, and civil society as stakeholder and support the empowerment of indigenous peoples. The SA/SRMF, throughout the project implementation, will include and ensures measures to, inter-alia, provide stakeholders with timely, relevant, understandable, and accessible information, and reporting on project implementation performance.

Baseline data:

1.Key Health and Institutional Analysis

For a long time, Sudan's health system has been described as on the brink of collapse because of its consistently unsatisfactory health outcomes. Primary health care (PHC) coverage is very low, resulting in a high maternal mortality ratio of 270 per 100,000 live births. The under-five mortality rate is 55 per 1,000 live births, the neonatal mortality rate 27 per 1,000 live births, and the prevalence of stunting 36.4 percent. Additionally, only a little over half of pregnant women attend at least four antenatal care (ANC) visits. A Joint External Evaluation of the core capacities for pandemic preparedness conducted in 2016 showed weak to no capacity in 37 of the 48 areas evaluated, including critical components of the real-time surveillance system, national laboratory system, and health workforces.
Following the 2019 revolution, the country's health system had multiple challenges, including limited resources, high turnover of health workers, weak infrastructure, and poor service delivery. To address these issues, the National Health Sector Recovery and Reform Policy (2021–2024) and the Health Sector Strategic Plan (2022–2024) were developed. These plans provide a framework that reorients available resources and capacities toward improving health services through enhancing the coverage of the PHC service package, strengthening emergency care and emergency preparedness and response, and mobilizing additional resources for health.
After the eruption of war in April 2023, about two-thirds of the population lack access to health services. In conflict-affected areas, nearly 75 percent of health facilities are not functioning, while the remaining ones are inundated by the influx of people seeking care. Disrupted service delivery has resulted in the interruption of essential health services, including obstetric care and emergency services. The situation is further exacerbated by attacks on health facilities, the dire shortage of medical supplies and equipment and health and nutrition workers as well as insufficient funding for health services and salaries, especially for frontline workers. Financial losses to the health system are estimated at US$900 million, including life-saving drugs and vaccines and federal social support for free health care services, severely affecting an already underfunded sector.

The conflict has significantly increased the vulnerability of women and children in Sudan. Gender gaps, GBV, and detrimental social norms that disadvantage women and girls have long persisted, and the ongoing conflict is depleting human capital. In 2024, about 1.7 million children under the age of one are at risk of missing lifesaving vaccinations to protect them from preventable diseases, while 700,000 children with severe wasting are at an increased risk of dying without timely treatment, jeopardizing the future of a generation of children. Furthermore, out of 2.64 million women and girls of reproductive age, 105,000 are estimated to be currently pregnant. Lack of access to appropriate care for safe and clean deliveries for those women and their newborns is a major concern, especially for those with pregnancy complications, as more deliveries will have to take place at home.

Disease outbreaks such as cholera, malaria, measles, and dengue have escalated because of disruption to basic public health services, coupled with the start of the rainy season and the lack of access to water and sanitation systems. More than 10,700 suspected cholera cases, including 275 that resulted in death, were reported as of January 20, 2024, from 60 localities in 11 states. Moreover, the water, sanitation, and hygiene (WASH) sector reported that about 19 million people were in urgent need of assistance at the end of 2023.
The HIV epidemic in Sudan is classified as a low epidemic with adult (15-49 years) HIV prevalence of less than 0.3% according to the 2017 estimates and projections. However, there are remarkable variations in the distribution of the HIV burden between the different regions/ states of the country. The two rounds of IBBS in 2011 and 2015 reported higher prevalence rates among key populations (FSW and MSM) in the eastern zone of the country.

While humanitarian efforts have been addressing the immediate and urgent needs of IDPs and host communities, their medium-term development needs and resilience remain unaddressed, and the country's human capital remains jeopardized. The large scale and prolonged displacement have resulted in insufficient delivery of basic services in areas with high concentration of IDPs, such as water, sanitation, and hygiene (WASH), health, and education. Prior to the conflict, 40 percent of households in Sudan did not have access to basic water supply, two-thirds lacked access to basic sanitation, and three quarters did not have access to basic hygiene. Open defecation was practiced by 53 percent of the poorest quintile[7].
Despite tremendous advances in modern medicine, the utilization of plants as a cure in health care is still of high importance. In Sudan, medicinal plants still play an important role in the treatment of diseases, especially in rural areas. Sudanese folk medicine represents a unique blend of Islamic, Arabic, and African traditions. The intersection of diverse cultures and the unique geography holds great potential for Sudanese herbal medicine and its application in modern medicine.
In light of all these facts and current health situation WHO will support 10 hospitals under the SHARE project in ten states (Northern state, River Nile, Kassala, Red Sea, Khartoum, Blue Nile, Sinnar, West Drafur, North Kordufan and South Darfur) toward the overall objective of the project[8].

2.Social context focusing on vulnerable groups

From the reviewed literature, it has been observed that economic and social dimensions of human rights are equally critical in Sudan with its geographical and demographical diversities. High levels of poverty leading to food crises, limited access to education, and healthcare disparities persist, demanding a comprehensive analysis of economic policies and their implications on human rights.

In Sudan, there are 19 major ethnic groups and over 597 ethnic subgroups speaking more than 100 languages and dialects. These multifaceted ethnic divisions make Sudan a very diverse country, with each ethnic group having a unique culture of its own and lifestyle. The management of cultural and social diversity in the country is a source of concern for many social and civil movements, and it contributes to the inequal accessibility to the

6 Sudan Somoud. Enhancing Community Resilient Project.

8 Traditional Sudanese Medicine for Modern Drug Development

basic services including health services along with the series of political interference and security disturbances in the country[9].

In April 2023 war broke out in Sudan principally in the capital Khartoum between the Sudanese Armed Forces (SAF), led by General Abdel Fattah al-Burhan, and the paramilitary Rapid Support Forces (RSF), which had previously been part of the Sudanese security services, headed by Mohamed Hamden Dagalo (often referred to as 'Hemedti'). Fighting also erupted in other parts of Sudan, in particular in West Darfur, and in Kordofan. The fighting in Khartoum has caused widespread destruction in the capital and remains a protracted battleground between these two sides. Conversely in West Darfur the conflict shifted to ethnic-driven violence. The UN Panel of Experts on Sudan stated: "In West Darfur (El Geneina, Siraba, Murne and Masteri) RSF and allied militias targeted the Masalit community. The RSF and allied militias systematically violated international humanitarian law. Some of these violations may amount to war crimes and crimes against humanity. The RSF and allied militias targeted IDP gathering sites, civilian neighborhoods, medical facilities and committed sexual violence against women and girls. The Eastern Region, while not facing open violence, has its own set of conflict drivers related to tensions between different tribal groups, and a SAF recruitment drive in Eastern Sudan has fueled competition between tribes. As of June 2024, the majority of Darfur was in the control of the RSF, the East and North of the Sudan under control of SAF, and pockets of control by other groups, notably the SPLM-N (Al Hilu) having expanded the territory of the 'Two Areas' in South Kordofan / Blue Nile, and SLA-AW (Abdel Wahid) in Jebel Marra in Central Darfur. SLA-MM (Minni Minawi) and JEM (Gibril Ibrahim) also control territories in North Darfur. In early 2024 SAF made some inroads into RSF held areas, in Khartoum.

The disruption that has been happening now in Sudan is first of its kind for Sudanese people to face before, even on its worst times they faced before. The random killing of people, ethnic cleansing events recorded all over the country, from different tribes and ethnic backgrounds in Sudan, with disruption of the basic lifesaving services is increasing the vulnerability of certain groups including women, children, people of Darfur and Kordofan regions and other marginalized communities. These vulnerable people are experiencing specific health challenges during and after conflicts. Sexual violence is prevalent in many conflict zones in Khartoum and Darfurs which has led to physical and psychological trauma for survivors and is contributing to long-term health inequities

A. Tribal / ethnic mapping

In the context of Sudan, some of the tribes and ethnic groups are considered under the ESS7 based on their historical connection to land, culture, and natural resources, as well as their vulnerability and marginalization in development processes such as Nuba in western region, Beja and Rashaida in eastern region, Fur and Zaghawa in Darfur region in western Sudan, Hausa in eastern region.

The following table 1 sets out the main tribes across three out of 10 targeted states, drawn from key informant interviews and compiled specifically for, SMOUD project (another WB Bank financed and implemented by UNICEF). Mapping of the remaining States will be conducted throughout the course of implementation of the project. This will include the definition of available tribes/ ethnic groups that meet the requirements of ESS7, assessment of the vulnerability of the tribal groups and individuals which could affect their participation, access to health services including reproductive health, access to information and other social vulnerability factors. Mitigation measures will be planned accordingly during the implementation of sub-components.

Table 1: Tribal mapping on part of the project operation states/Localities:

State	**Main Sudanese Trible**	**Other Sudanese tribes**	Non-Sudanese tribes
Northern	**Shaigiya / Shawiga** – largest tribe in this state, and most of this tribe are found in this state. Many are settled with land growing dates and citrus fruits. Strongly	**Nubian tribes**: **Halfaween, Danagla, Mahas** – less conservative towards	

5 Cultural Diversity in Sudan: Promotion of Peace and Development. July 2021

State	**Main Sudanese Trible**	**Other Sudanese tribes**	Non-Sudanese tribes
	conservative towards women. Some inter-marriage with Nubians.	women compared to Shaigiya tribe	
	Shawiyahad– minor sub-branch	**Arab tribes.**	
River Nile State	**Jaalian** – largest tribe in this state. Very strongly conservative towards women.		**Berber** – historically settled from North Africa but are largely now perceived as Arab tribe.
	Shagigya – minority tribe in this state. Have land. Some intermarriage with Jaalian.		
	Robatap – A subtribe of Jaalian. Large tribe in this area. Also, very strongly conservative towards women		
	Manasir – Significantly affected by the Merowe dam		
	Hamdab – Also significantly affected by the Merowe dam		
	Amri		
	Bushareen – fully nomadic with camels, not settled anywhere but use land.		
	Haraween – fully nomadic with camels, not settled anywhere but use land.		
	Kebabish		
Kassala	**Beja** – considered 'indigenous' with several	**Nuba**	**Hausa** – settled from Nigeria
	important sub-tribes:	**Halfawiyyan** (Sub-tribe of Nuba) mainly based in Khasm al Girba / Half Al Jedidah	
	Hadendawa - This is the largest group, mainly in North Kassala in the Gash delta and pastoral land.	**Fur** – Darfuri farmers who settled since 1950s.	
	Bani Amer – there is some debate over whether they are a sub-tribe or not. They are derogatorily regarded as 'foreigners' from Eritrea. They received citizenship under Bashir's regime and are close to the NCP. They are spread from Eritrean border to Atbara River	**Zagawa** - Darfuri farmers who settled since 1950s.	
	Bisharin		
	Amarer		
	Halenga – small subtribe mainly in Kassala town		
	Badawit – from Northern state		
	Rashida – Bedouin nomads, settled from Saudi Arabia. Land was granted to Rashida.		
	Shagiyya – settled in 19th century, mainly in towns and in Gash basin		

State	**Main Sudanese Trible**	**Other Sudanese tribes**	Non-Sudanese tribes
	Jaalian – as for Shagiyya		
	Zebadiaya – nomads with camels and small ruminents **Habab** **Shukriyya**		

B) Settlers

All the states in Sudan had experienced waves of migrations going back over hundreds of years, mostly from within Sudan, but also a significant population from West Africa. The terms 'native' and 'settler' carry strong connotations, there are very significant differences between designation as 'native' or 'settler' in Sudan, and even migrants from other parts of Sudan are considered 'settlers' (or at least 'non-native') if they are from other tribes. Settlers face significant exclusions and vulnerabilities: there is a strong cultural code prohibiting sales of land to non 'natives' (particularly Northern and River Nile States) and settlers do not have representation within the Native Administration, they must instead defer to the host tribe 'native' structures. There is also some racism towards African farming tribes, who are perceived as former slaves, a legacy of a slave trade in the 1800s where African tribes were taken from the Nuba Mountains and Darfur by Arab traders to work in Sennar and River Nile States. The slave trade ended during the colonial period, and while some former slaves returned to their point of origin, others remained, and became agricultural workforce, without any land of their own. There is more trust towards these longer-term settlers, but there is no intermarriage, they are considered lower class. There is significant sensitivity around this issue. In some locations settlers are in satellite camps referred to as 'seasonal labour' – although these settlements are permanent and have often been present for over 40 years. In other locations they live within the 'native community. There were previously laws preventing settlers from building long-lasting materials, which left them not only disadvantaged and vulnerable, but also very distinguishable. Moreover, denied the opportunity to own land, these settlers sometimes work as agricultural labor or take on share cropping, and work within customary laws about the division of the crop – 1/3 to landowner, 1/3 to provider of the provider of the sapling, and 1/3 to the planter farmer.

C) Women in the workforce

There are extensive cultural controls on women, which have a major effect on women's ability to participate in the labor force. Women are confined to the home in many parts of Sudan and forbidden from accessing markets. There are variations between different states, and within states, and these have also evolved since the major displacements following the outbreak of war in April 2023. Eastern states are known as the most conservative states in Sudan, in which women's rights are severely constrained for Arab tribes in particular – in some areas women cannot even leave their home unaccompanied (Hameshkoreib) while among other Arab tribes women may be allowed to work in their own kitchen gardens or the family field but not as agricultural labor on the fields of others, while women from West Sudanese 'settler' communities can work as agricultural labor on the fields of others.

The weak involvement of women in the health workforce in some areas in Sudan including eastern states might negatively affect women and girls' access to health services as they are not allowed to seek health services that are provided by men. This includes some essential services like SRH services that should be provided by females at community and facility levels. The effect might also extend to include some child health services who should be accompanied by a care giver (Mainly mothers) when seeking services from facility level during daytime in absence of the fathers.

In Sudan, women are not only key beneficiaries of health services but also play significant roles as healthcare providers and advocates for reproductive health. This involvement is crucial as it addresses not only immediate health needs but also long-term societal stability.

Women's involvement in the health workforce:

- Midwives as health care workers: Women play a vital role as midwives and healthcare providers. Approximately 27,000 midwives operate across Sudan. These midwives are essential for providing care in both functioning health facilities and home settings, especially when hospitals are inaccessible.

- Community Health Initiatives: Trained midwives are establishing initiatives and safe spaces for women to receive GBV prevention and response services. These initiatives include providing FGM complication management, referral and mental health support for survivors of violence.
- Leadership in health services; Despite the challenges posed by the conflict, women have emerged as leaders in community health initiatives. For example, female staff from displaced communities are actively working in health facilities supported by numerous organizations. Their dedication has been recognized as critical to delivering life-saving healthcare services.

Some progress has been made in building buy-in among men to allow women in these conservative communities to engage in a small selection of income generating activities (perfume making, traditional handicrafts). Northern state is also particularly conservative. Nationally, workforce participation was 29.1% for women, and 68.1% for men in 2021.
Across Sudan as a whole, women are increasingly working outside the household to provide an income for their families since the outbreak of war, commonly in roles such as selling tea, cleaning houses, and doing laundry. Women remain responsible for domestic labor in the household, and this has increased since April since schools have been closed, and children are at home.

D) Children and Youth

A child is anyone under the age of 18 in Sudan. Children are widely expected to work on different types of work as paid labor, although it is not preferred as children require more supervision and do not work as efficiently as adults. Children and young people are particularly vulnerable in such situations of armed conflicts. These groups of people who are living in and fleeing from areas affected by war and armed conflicts face a myriad of challenges that can have profound and lasting effects on their development and overall well-being including mental disorders along with other risks related to communicable diseases, SRH GBV and injuries.
Youth in Sudan played a key role in the December 2018 revolution that led to end of the Bashir regime. Again in 2021 youth were at the forefront of protests at the coup that overthrew the Transitional Government. They have been key players in the ongoing revolutionary efforts within the Resistance Committees, and since April 2023 have been very active in establishing Emergency Response Rooms to provide humanitarian relief within Khartoum and across the country.
In Sudan, where protracted conflicts, disease outbreaks, and natural disasters have strained formal health systems, youth and medical students have emerged as vital frontline responders, employing innovative and integrated strategies to address this crisis.

Youth-led initiatives have provided critical support, assisting millions of civilians through innovative approaches such as addressing urgent healthcare needs, creating safe evacuation routes, and repairing infrastructure. Medical students have also leveraged digital platforms like Telegram to access emergency training programs, add to that during disease outbreaks, they leveraged online social media for real-time surveillance, vaccination campaigns, and public health education and advocacy to IDPs sites and host communities.

To combat natural disasters, geospatial mapping and crowdsourced platforms enabled rapid rescue operations and resource allocation. Their approaches blend low-tech solutions—such as SMS alerts for remote communities—with telemedicine and decentralized networks, ensuring care reaches underserved areas.

Their integrated approaches include collaborating with local and international organizations to ensure a comprehensive response that addresses immediate needs like healthcare, food, advocacy and shelter, while also focusing on long-term resilience and recovery.
The impact of these efforts is profound, with Medical Students Networks and Emergency rooms alone reaching millions of civilians, filling the void left by humanitarian agencies or governments, and fostering a sense of solidarity and hope among affected communities.

This dynamic involvement not only mitigates the immediate effects of the Sudanese crises but also builds a foundation for sustainable development and peace in Sudan. Despite risks like violence and resource shortages, their efforts have saved lives, strengthened local capacity, and advocated for systemic change, exemplifying

how grassroots innovation and cross-sector integration can redefine emergency response in general and health response in particular in fragile contexts.

E) Recently arrived IDPs since April 2023

The numbers of displaced people and the population movement is rapidly increasing as the war is still ongoing. According to the UN refugee and migrants' agencies UNHCR & IOM reports, 8,837,055 people internally displaced after the outbreak of the conflict on 15 April 2023.

Approximately 54 % of IDPs were female, while an estimated 46 % were male. Over half of IDPs (53%) were children under the age of 18-years-old, while approximately a quarter (26%) were children under five-years-old. Approximately 29 % of IDPs were female children under 18-years old.

Table 2 : Number of IDPs per targeted states: (Sudan Mobility Update_014 v3.pdf)

Northern State	573,974
River Nile State	1,046,629
Kassala State	373,152
Red Sea State	269,885
Khartoum State	96,627
Sinnar State	145,651
Blue Nile State	356,477
West Darfur State	201,500
South Darfur State	933,109
North Kordofan State	1,162,978

According to the recent update from Sudan FMOH, all the states of Sudan host IDP camps and gathering points which is expected, given that the country is home to the largest internal displacement crisis in the world. The results of the last SRMNCAH services' assessment have shown that White Nile State harbors the highest number of camps (521), followed by Kassala (273) and Gezira (173) and River Nile (172) and North Kordofan (171). It is worth noting that IDP camps in Gezira state primarily clustered in two localities: ALmanageel and Algorashi. Conversely, the lowest numbers of IDP camps and gathering points are reported in Kordofan and Darfur zones ranging between 5 to 56 with Central Darfur reporting the lowest number of 5 IDP camps. The rest of the states reported the number of IDP camps ranging between 93 and 16610. Drivers of conflict

F) People with disabilities:

It was evident that people with disabilities face several barriers when trying to access the health services they need and that users and health professionals have distinct and complementary views on difficulties. The main barriers from the service user side are communication failure between professionals and patient/caregiver; financial limitations; attitudinal/behavioral issues; scarce service provision; organizational and transport barriers. While the main barriers from service providers side are: lack of training to professionals; failure of the health system; physical barriers; lack of resources/technology; and language barriers.

As the SHRAE project will provide a well-defined minimum service package for free, all these services will be provided for all health seekers including people with disabilities. Health care provider in these targeted facilities will be trained and sensitized to provide quality services for the disabled people addressing there special needs to reduce the accessibility barriers.

3. Sexual Exploitation and Sexual Harassment

Sexual Exploitation and Sexual Harassment (SEA/SH) is extremely widespread in Sudan, although data is scarce, and reporting is limited since this usually triggers reprisals. This topic is discussed in the separate SEA/SH Action Plan.

Gender discrimination, negative social norms, and power dynamics continue to pose a huge setback to the development, and equal treatment for the vulnerable and affected populations in the world, including Sudan. This is even more concerning with the conservative norms and practices in Sudan, that permit gender inequality, human rights violations, and are manifested in a manner that embraces misconduct such as Sexual Exploitation (SE) or Sexual Abuse (SA).

Vertical occupational segregation (the clustering of women in lower status, lower paid roles) in the health sector by gender, with women being 70% of health workers and men holding 25% leadership roles, creates an enabling environment for SEAH. The risk of SEAH is increased by wider gender inequities in the health workforce where women are marginalized in leadership, earn less than men on average and are in less powerful roles. For women, children and persons with disability affected by humanitarian, emergency and conflict situations, the risk of SEA/SH has been proven to be high in such context considering the higher vulnerability of such population groups with power dynamics being one of the key drivers to SEA/SH.

4. Tribal Lands:

Competition for land has contributed to the strengthening of tribal identities, based around the concept of 'tribal lands'. This became bound up with alliances as different groups sought to become recognized, be allocated land and roles within the Native Administration governance structures.

There have been intermittent tribal conflicts over the past years, which have increased since April 2019. The Eastern track of the JPA heightened tribal tensions, and the Beja rejected it entirely stating it lacked inclusive and adequate representation. Key drivers of conflict are:

Identity and racial discrimination – The 2019 revolution triggered grievances among the Beja community, who perceived that newcomer tribes have been given equal if not more rights in their region. There is a narrative of 'citizen' and 'foreigner' with the Bani Amer portrayed as 'foreigners' from Eritrea. There has been much negative stereotyping between the Beja and the Bani Amer, and a prevailing belief that an individual is only as strong as their tribe, which feeds a competitive mindset.

Inadequate representation and inclusion – Local administrative structures are based on ethnic representation, which is also tied up with 'tribal lands'. The rejection of the Eastern Track by Hadendowa reflected that it was negotiated by the Bani Amer. The Hadendowa had previously held a close relationship with the NCP and have lost this patron since the 2019 revolution. By making alliances with political parties the Rashayda achieved tribal representation in local governance and became powerful. Conversely the Lahawiyyan, who settled at a similar time to the Rashayda, affiliated to the Shukkriyya rather than seek recognition as an autonomous entity. They were excluded from the development of mechanized agriculture and were not supported in the 1980s-90s drought.

Climate change – causing the loss of crops and water and increasing competition over water.

Weak and polarized conflict resolution mechanisms – peace mechanisms have been politicized and have lost much respect, particularly since the role of the Native Administration in 2021.

Traditional methods of conflict resolution are increasingly ineffective in addressing the evolving nature of conflicts, which have become more violent and politically charged. External interventions by State and international actors have further complicated local dynamics, often marginalizing traditional leaders and mechanisms along with other factors that include environmental degradation and population displacement, evolving socio-political dynamics. Therefore, traditional conflict resolution mechanisms in Sudan are no longer sustainable in their current form and calls for adapting and integrating modern approaches to better address the complex and multi-layered conflicts in the region.

A comprehensive approach that integrates modern conflict resolution practices with traditional methods, considering the unique socio-cultural context of Sudan, is essential. Without such adaptation, existing systems will remain inadequate, perpetuating the cycle of conflict and undermining long-term stability in the different regions of the country. It is therefore critical that policymakers, local leaders and international stakeholders collaborate in rethinking conflict resolution and reform strategies that can effectively address the multifaceted challenges facing Sudan.

Social risks and Development Plan

1.Social risks and mitigation measures

This rapid social review was done based on potential risks that are specific to indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities as per the bank environmental and social standards. The following table sets out identified risks, and proposed mitigation and monitoring measures

concerning indigenous peoples / SSAHUTLCs, vulnerable and disadvantaged groups. Some risks are handled elsewhere (SGBV / SEA risks are handled in the Prevention of Sexual Exploitation and Abuse Action Plan, and labor risks are handled in the Labor Management Plan) so are excluded here.

All these identified risks and mitigation measures will have positive impacts on the targeted communities. The SHARE project will provide the minimum essential service package to improve access to basic health and nutrition services, it will also contribute to building resilient health system by maintaining the basic and core public health functions with well identified monitoring system that has learning purposes as well.

Table 3: Potential social risks, mitigation measures and monitoring

Risks	Risk description	Mitigation measure
Lack of knowledge about free health care services	Vulnerable individuals often lack information, due to insufficient engagement of the community and improper disclosure of information as per the requirements (considering the language and the means of disclosure) will lead to delayed or denied care.	- Information disclosure through different means consider the local language and ensure regular stakeholder engagement consider the participation of the IP.
Exclusion of vulnerable groups from project benefits.	Vulnerable and Marginalized Populations do not have access to the health services in a similar way to other ethnic communities in the targeted facilities.	- lobbying and advocacy skills to understand and influence the health care services, use appropriate participatory approaches for improving health services uptake. - Regular and ad hoc supervisory visits will be conducted to observe the provision of the services. - The targeted communities will be sensitized to encourage the utilization of the provided services using clear messages. - GM will be accessible for communities in their local languages (the inter-agency CFM hosted by UNICEF).
Exclusion of vulnerable groups from project decision-making structures	Vulnerable and Marginalized Populations are not engaged in the planning project planning, implementation and monitoring processes.	- Meaningful consultation and screening and outreach must be carried out with vulnerable sub-groups to identify their needs and concerns, to establish a robust mechanism for better identification as members of a distinct tribal cultural group and recognition of this identity by others, customary cultural, economic, social, or political institutions that are separate from those of the dominant society and culture and any tribal language, often different from the official language of the country or region to be considered. -

Risks	Risk description	Mitigation measure
Project resources perceived to benefit specific groups over other, for example IDPs against host communities over project benefits which might create conflict between the IDPs and host communities.	The selection of location or beneficiaries could disproportionately direct resources to certain groups inadvertently. This becomes more likely and obvious when: - populations live in largely segregated communities - tribes traditionally engage in specific livelihoods which are away from the location of the selected facility. - Conflict situation and displacement.	Conduct social assessment and consultation with IP's tribe to: - Identify key stakeholders among tribal communities and establish an appropriate framework for their participation in the project lifecycle. - Assess the demographic, socioeconomic, cultural and other relevant characteristics of ethnic population on and near the project sites, establish social baseline and identify potential barriers to their full participation in benefiting from project activities. - Review relevant legal and institutional framework applicable to tribal community. - Based on assessment and free, prior, and informed consultation (in case of adverse impact) propose specific measures to ensure that affected tribal people will, meaningfully and in a culturally appropriate manner, participate in project activities and benefit from the project. - Develop institutional arrangements and implementation procedures to assist tribal beneficiaries and provide GRM to enable addressing their complaints and feedback.
- Vertical occupational segregation and lower paid role of women in the targeted facilities	- The women in the workforce at the supported facilities might not be paid in the same scale of the men (only one facility will receive incentives and salary top-ups under this project). This may also lead to experience SEA/SH.	- Reduce the provision of financial incentives among the health care providers in the targeted hospitals except one hospital. - Conduction of orientation session on prevention and response to SEA/SH. - Distribution of IEC materials and dissemination of the reporting tools.
- lack of access to culturally appropriate feedback and complaint mechanisms	- Vulnerable people will face communication barrier to share their complaints and feedback on the provided services or any project related feedback.	- The project adopted CFM is accessible for communities with different local languages and dialects. - Capacity building and orientation sessions will be conducted by the project team targeting the CFM operators and workers.
- For risks relating to SGBV / SEA please see separate GBV/SEA/SH Action Plan - For risks relating to women & children in the labor force, please see the Labor Management Plan - For the risks related to medical waste management, please see the MWM plan		

Risks	Risk description	Mitigation measure
- For risks related to security please refer to the SMF.		

2. Social Development Action Plan

Table 4: Social Development Action Plan

Action	Responsible body	Time frame	Indicator & target
Awareness raising through disseminating the project information to all stakeholders through various means, such as community level meetings, mass media, project brochures/posters etc.	WHO, IP / contractor	Quarterly	Reports
Screening to be conducted to identify if tribal families or communities are present or have collective attachment in the area served by the selected facility,	WHO, IP / contractor	During the 1st 6 months of the implementation	Reports
Conduct Social Assessment (SA)	WHO, IP / contractor	SA is done as part of the pre-implementation phase.	Reports
Disclosure of information	WHO, IP / contractor	The SA information is shared with the implementing partners during the project launching workshop. And regular orientation will be carried out targeting the project stakeholders during the project implementation.	Reports
Establish functional, accessible, culturally accepted GRM	WHO	Has already been integrated in the interagency CFM hosted by UNICEF.	Effective GM is in place. The CFM is functioning in different local languages and dialects.
Monitoring and evaluation activities	WHO and IPs	During the implementation	Reports
Capacity building activities.	WHO and IPs	Targeting the implementing partners, health care providers	Reports

Action	Responsible body	Time frame	Indicator & target
		and the project stakeholders.	
Consultation with the vulnerable people when required	WHO and IPs	Will be dine during the project implementation based on need.	Reports

List of References:

1- The World Bank Environmental and Social Framework for SARE Project. 2024
2- Sudan Overview: Development news, research, data. World Bank. 2024
3- Humanitarian National Response Plan_2024_SDN_EN.pdf
4- Sudan Health Assistance and Response to Emergency-Project Implementation Manual. 2024.
5- Cultural Diversity in Sudan: Promotion of Peace and Development. July 2021
6- Sudan Somoud. Enhancing Community Resilient Project.
7- Traditional Sudanese Medicine for Modern Drug Development. 2020

Annex 8.9 Security Risk Assessment and Management Plan (SRA/MP)

Abbreviations and Glossary of Terms:

Abbreviation	**Definition**
ESCP	Environmental and Social Commitment Plan
ESMF	Environmental and Social Management Framework
ESS	Environmental and Social Standards
GBV	Gender Based Violence
GPN	Good Practice Note
IASMN	Inter-Agency Security Management Network
IED	Improvised Explosive Devices
LHMT	Local Health Management Teams
MOH	Ministry Of Health
MSP	Minimum Service Package
NGO	Non-Governmental Organization
OIC	Officer In Charge
PDO	Project Development Objective
PHC	Primary Health Care
PMU	Project Management Unit
SEA	Sexual Exploitation and Abuse
SH	Sexual Harassment
SHARE	Sudan Health Assistance and Response to Emergency
SLT	Saving Lives Together
SMOH	State Ministry of Health
SRA/MP	Security Risk Assessment/ Management Plan
SOP	Standard Operating Procedure
SRA	Security Risk Assessment
SRMM	Security Risk Mitigating Measures
TPM	Third-party monitoring
TTL	Task Team Leader
UN	United Nations
UNDSS	United Nations Department of Security and Safety
UNSMIN	United Nations Security Information Network
UNSMS	United Nations Security Management System
UXO	Unexploded ordnance
WB	World Bank
WHO	World Health Organization

Introduction
Project Description

This document outlines the Security Management Plan (SRA/MP) for the implementation of the Sudan Health Assistance and Response in Emergencies Project (SHARE). The Project Development Objective (PDO) is to restore access to essential health and nutrition services and maintain key public health functions. This SRA/MP applies to components implemented by WHO and its implementing partners and is one of the requirements of the WB ESMF.

WHO will implement the SHARE project in collaboration with the Ministry of Health (MOH), local authorities, UN agencies, NGOs, and other stakeholders. The project design leverages the World Bank's experience in fragile contexts, tailored for Sudan's unique challenges.

SRA/MPBefore 15th of April 2023, WHO operations were spread across all the 18 states of Sudan with some difference in the level of WHO presence in each state. In some of these states WHO has sub-offices that are usually led by OICs who are supported by other technical, administrative and financial staff, while in some other states the presence is limited to representation by public health officers that are providing the technical support to all health partners and coordinating with MOH. Implementing the interventions at the sub-national level in the entire 18 states takes place in coordination with the state ministry of health, local authorities, UN agencies, and non-governmental organizations, partners, communities, and any other relevant stakeholders. Health, nutrition, and other sectoral technical staff are deployed to support the continuity of essential health services. As it currently stands WHO is divided into 3 main zones: East, Center and West. Under each of the zones there are a number of states. There are sub-offices under the zones.
For this project, WHO will apply its implementation arrangements and will continue partnering with local implementing partners (SMOH, LHMT, Health Facilities, third-party service providers, implementing partners (INGOs, NGOs, CSOs), and contractors) to deliver results on the ground. Also, The Clusters are the main sectoral coordination mechanisms across UN agencies as well as international and national NGOs and civil society organizations.

Background
SHARE project is a World Bank-funded project which will contribute to efforts by the international community to maintain and enhance health and nutrition services providing a Minimum Service Package (MSP) and responding to health and nutrition crises. The project will target the whole country to sustain the main public health functions, with some interventions focused on selected hospitals in specific states and localities as per the priorities and needs. This SHARE project has three components as follows:

Component 1: Improving Access to Basic Health and Nutrition Services:

This component aims to enhance access to basic health and nutrition services in Sudan through low-cost, high-impact interventions using a PHC approach. It targets both displaced and host communities. A minimum service package that includes the following services**: Expanded Program on Immunization**, integrated management of **childhood illnesses**, **maternal, newborn and paediatric** health, **nutrition**, and **noncommunicable diseases (NCDs**), including mental health, as well as prevention and **response to outbreaks** and health emergencies will be supported under this component at different levels of service delivery.

1. Subcomponent 1.1: Strengthening the Integration of Primary Health Care Model (implemented by UNICEF)
2. Subcomponent 1.2. Supporting Health and Nutrition Services at the First Level Referral Centers and Hospitals (, implemented by WHO)
3. Subcomponent 1.3: Climate Change Adaptive Health Service Delivery (implemented by WHO)
4. Subcomponent 1.4: Climate Change Resilient Health Facilities (implemented by UNICEF)
5. Subcomponent 1.5: Integrating Digital Solutions to Service Delivery (implemented by UNICEF)

Component 2: Preserving the Main Elements of the Health System (implemented by WHO):

This component will focus on strengthening health systems and public health programs and improving the main elements of the health system to prepare for and respond to health emergencies and control diseases by strengthening emergency preparedness, laboratories, and disease control systems. Specific activities will include essential preparedness functions such as: (a) training and operating cost for integrated disease surveillance and response (IDSR) including EWARS; (b) operating costs and rehabilitation for selected Emergency Operations Centers (EOCs) with a primary focus on response to climate shocks; (c) supporting health information systems and the Health Resources and Services Availability Monitoring System; (d) developing, disseminating, and training of trainers on subnational emergency preparedness and response plans, primarily focusing on climate shock emergency preparedness and response along with response to conflict; (e) updating and disseminating laboratory guidelines and providing laboratory operating costs; and (f) training and deploying Rapid Response Teams. The component will also support strengthening the country's blood bank and transfusion systems, which currently have limited reach, impairing access to CEmONC and safe surgical services. This includes: (a) developing guidelines for the proper collection, storage, transport, and use of blood for transfusions; (b) building or strengthening existing blood banking services; and (c) developing systems and protocols for the transfer of blood products for transfusions.

Component 3: Monitoring and Evaluation and Project management, includes:

6. Subcomponent 3.1: Third Party Monitoring (implemented by UNICEF): The third-party monitoring (TPM) agency's role will include working with UNICEF, WHO, the World Bank, and implementing partners (IPs) to explain results, providing guidance on improved methods, proposing context-appropriate solutions, and conducting ex post facto verification of results provided by project reporting mechanisms.

7. Subcomponent 3.2: Data Analysis and Knowledge Management (implemented by WHO and UNICEF]): The project will ensure that independent and credible data on health service delivery and coverage and commodities are generated, and that the data are usable and will enable the World Bank and development partners to verify that resources are reaching the intended beneficiaries.

8. Subcomponent *3.3: Project Management (implemented by WHO and UNICEF)* includes the finance costs related to monitoring and evaluation (M&E) and management of project activities.

Rationale for the Security Management Plan

The SRA/MP aligns with the World Bank's Environmental and Social Standards (ESS1 and ESS4), emphasizing systematic risk management throughout the project's lifecycle (from the project design, planning, implementation, monitoring and final evaluation). Sudan's fragile and conflict-affected environment necessitates robust security measures to protect project workers, beneficiaries, and assets.

The World Bank's Environmental and Social Standards (ESSs) are designed to help borrowers/implementing agencies to manage the risks and impacts of a project. The recipients are expected to identify and manage the risks and impacts of a project throughout the project life cycle in a systematic manner. Given the fragile and conflict-affected environment in Sudan, the safety and security risks facing project workers and participants are of a significant consideration in implementation of the project. The project's Environmental and Social Commitment Plan (ESCP) stipulates that WHO hall prepare and implement a security Management Framework (SRA/MF) in accordance with the requirements of ESS1 and ESS4 and acceptable to the World Bank. ESS1:

Assessment and Management of Environmental and Social Risks and Impacts sets out the borrower's responsibilities throughout the project life cycle, while ESS 4: Community Health and Safety addresses the health, safety, and impacts security risks on project-affected communities and the corresponding responsibility of borrowers to avoid or minimize such impacts.

Objective of Project SRA/MP

The objective of this SRA/MP is to assess, manage and monitor security risks within the project and maintain a safe physical environment and manage staff activities to mitigate the risk of personal harm and property losses during the implementation of the project. SMP activities for WHO staff, and premises are governed by the United Nations Security Management System (UNSMS), which, through designated officials in collaboration with Heads of UN agencies and offices, ensure the security and safety of their staff, premises and operations. It also outlines the **requirements** and responsibilities of contracted third parties and other implementing partners not directly employed by WHO.

Security Risks within the Project

In summary, the ongoing war along with the protracted crisis in Sudan continues to pose a significant risk for the implementation of SHARE project.

The SHARE project faces diverse security risks and WHO have several mitigation strategies explained in table 1 below .

The table Key Security risks and mitigation measures

Expected security risks	Possible consequences	Project area	Mitigation measures	Responsible body	Time Frame
Armed Conflict	Airstrikes, crossfire, explosive hazards, Vandalism, and restrictions on movement.	**Areas with very high risks:** Khartoum. **Areas with high risks**: South Darfur, West Darfur, El Gezira, White Nile, Sennar Kassala, River Nile, Port-Sudan and Blue Nile	Induction briefings and mandatory training for WHO staff and contractors on safety and security protocols (and cascading this responsibility to implementing partners).	WHO	Before the implementation of the activities
			Collaboration with UNDSS and SLT working groups. Regular security risk assessments (SRAs). Evacuation plan to be prepared. Local relocation of the area. Prepared ad-hoc SRM process, focused on targeted programmatic activities.	Implementation partners (IP)	During the implementation of the project activities
Crime	Robberies, looting, aide diversion, sexual assault, and threats to SHARE project related workers.	**Areas with very high risks**: Khartoum. **Areas with high risks:** South Darfur, West Darfur, El Gezira, White Nile and Sennar. **Areas with medium to low risks:** Kassala, River Nile, Port-Sudan and Blue Nile.	Regular security advisories on measures to reduce risk of crime. Limit carriage of cash, attractive/valuable items. PEP kit protocols. Staff report all incidents via security team.	WHO	During implementation

Civil Unrest	Violent gatherings and disruptions in governance.	**Areas with high risks:** Khartoum. **Areas with medium risks:** South Darfur, West Dafur, El Gezira, White Nile and Sennar, River Nile, Port-Sudan, Kassala.	Use of measures to avoid risk. Working from home/personnel reductions. SRM measures at offices/guesthouses to mitigate risks. Timely security updates to advise presence in affected areas.		Before and during implementation
Site accessed by unauthorised person			Access control exercised by guard service at offices/guesthouses. ID to be displayed by authorised personnel at all times. 'Challenge culture' for all staff. External lights, CCTV, irregular patrols at all hours by guards,		Before and during implementation
Medical risks	9. Adapt the labor management plan		SUMAT clinics for WHO staff. Maintain list of local health providers able to assist in medical emergency IFAK and ETB, with training on each as appropriate CASEVAC/MEDEVAC plan PEP kit protocol Psychosocial support		Before, during, after implementation
Risks emanating from the use of security personnel (competency, trust)			No risk – security forces do **not** (currently) provide static security, escorts, etc.		N/A
Other risks: Detention of UN staff, Terrorism:	Hostage-taking, IEDs, and reconnaissance activities.	**Areas with high risks:** Khartoum. Areas with low risks; El Gazira, White Nile and Sennar	Security briefings UN Hostage Risk management protocols (UNSMS personnel only) Hostage Incident Management Plan, under UNDSS UNMAS briefings on explosive hazard	WHO staff.	Before and during implementation.

			awareness Liaison with host nation over detention Guards trained on hostile surveillance recognition and detection (HSRD) techniques		

Note: Regional-specific SRAs conducted by implementing partners will complement this framework to ensure localized risk management.

WHO and IPs will closely monitor and continuously assess the security risks that may influence the scaling up or scaling down of services provided under SHARE project and will inform the WB and include options of adjustment to programme activities through existing reporting mechanisms such as suspending project activities or removing a health facility from the project list where political and governance risks cannot be effectively managed after consultation with the WB on the wider and interrelated security risks as deemed necessary

Establishing communication and facilitation arrangements to secure the support of all relevant political and community actors at the national, governorate, and local levels to promote safe and politically neutral implementation of the project. To operationalize security risk management collaboration, as part of the contractual arrangements with IPs implementing activities in SHARE project, WHO Sudan will require IPs to join the United Nations Department for Safety and Security (UNDSS), SLT working group and all identified local security forums.

Security Coordination:

Under the SHARE project, WHO, in accordance with the UNSMS and the WB's ESSs, will coordinate the implementation of the SRA/MP by WHO security officer and existing security infrastructure. The Country office has a fully dedicated Security apparatus consisting of a security officer and one security assistant supporting WHO operations and personnel. The Security team covers the country, advises senior management and personnel on security related decisions, and supports capacity building for all WHO personnel, contractors, and partners.

WHO mitigates security risks by implementing the Security Risk Mitigating Measures (SRMMs). Close collaboration between WHO and United Nations Department of Security and Safety (UNDSS) is maintained for ensuring that security and safety of UN staff, premises and operations is achieved.

Establishing clear implementation arrangements which emphasize the independence of decision making by any political and/or public-sector entity. These arrangements are communicated to all parties and stakeholders on a regular basis. Neither the risks nor the mitigation measures mentioned above are exhaustive but aim to complete a specific Security Risk Assessment (SRA) by WHO when necessary, and IPs prior to/during implementation as required to identify the risks that the project may face and to determine appropriate measures to support project personnel.

The project specific SRA will be based on the existing UNSMS Area Security Risk Management (SRM) documentation that WHO, UN Agencies, and other organisations, such as the WB, are parties to. The Ips' own assessment(s) will identify the ways in which they shall manage security for their own personnel (staff and consultants). WHO will engage in regular assessments and re-evaluations of security situations in the areas within which the SHARE project implemented in appropriate time intervals or when a significant event occurs and adjust project activities as necessary in consultation with the WB.

This SRA/MP may be updated throughout the project implementation to address other safety and security risks as they arise.

Components of the SRA/MP

The SRA/MP is comprised of five components:

1. United Nations Security Management System (UNSMS).
2. Inter-Agency Security Management Network (IASMN) Saving Lives Together Framework (SLT).
3. Security Incident Reporting.
4. Service Providers/Contractors.
5. Road Safety.

Component 1 of this document considers WHO directly contracted staff and personnel for purposes of security management and Security Incident Reporting. This includes all Project Personnel who are defined to be WHO personnel (staff and consultants) as per the applicability of the UNSMS system, and whose salaries are supported by the project.

Components 2 and 4 considers the security provisions, risks and mitigating measures for service providers and contracted workers. The standards outlined in Component 4 of this SRA/MP will apply to TPM agencies, payments agencies, suppliers, distributors, and any other contractors hired to provide goods and/or services under the project. The third-party contracts are covered through legal agreements signed between WHO and service providers; however, the contractor will be fully responsible and liable for safety and security of their personnel and subcontractors. The Contractors will comply with all applicable international standards and national labor law, rules and regulations relating to the employment of national and international staff in connection with their work on the project. WHO will monitor contractors' compliance with the SRA/MP and work with contractors to take any corrective actions needed.

Component 5 outlines the Road Safety provisions for WHO staffs, contractors, and service providers/contracted workers.

United Nations Security Management System

The UNSMS forms the backbone of the SRA/MP, providing policies and guidelines for risk management (here is a link to access SRA conducted for the states in Sudan SRA Sudan.pdf). Mandatory security training, including BSAFE and field-specific protocols, ensures staff preparedness. Travel clearance processes, such as TRIP, ensure accountability and readiness.

The overall security management approach under the project will operate within the parameters identified by the United Nations Security Management System (UNSMS) to which both WHO and World Bank are parties. For example, the Saving Life Together framework (SLT) is a chapter of the UNSMS *Security Policy Manual*.[11]

The UNSMS comprises a variety of instruments, including policies, guidelines, manuals, handbooks, aide memoires and communiqués. All these documents are maintained on the United Nations Security Information Network (UNSMIN)[12]. This is complemented by enhancing staff security capacities by providing training.

staff training:

Specific objectives of security training are to develop and enhance the skills and knowledge of United Nations personnel to:

- Enhance the security preparedness and of managers with security responsibilities within the UNSMS.
- Upon recruitment of personnel all staff, both national and international, are inducted and taken through various mandatory courses, including security courses and security briefings. Some of the key courses that ensure that personnel are ready for deployment in high-risk duty stations is (BSAFE) which is mandatory for all staff while Safe and Secure Approaches in the field is a mandatory requirement for all international staff and field national staff.
- These trainings prepare the personnel to be able to respond or react to some of the security situations they may encounter during the course of their deployment.
- UN personnel are not allowed to travel to field locations without completing BSAFE training which are a requirement for TRIP Clearance (an online clearance system for travel).

-Implementing partner SMP will also consider training of its personnel, contractors, consultants and volunteers on security prevention and mitigation measures and procedures. This will include familiarization sessions relating to security, including but not limited to the need to follow local laws, International Humanitarian Law (IHL).

Saving Lives Together Framework (SLT)

The SLT is normally limited to international NGOs and does not extend to national NGOs or contractors. Within the context

[11] *Security Policy Manual*, Chapter II, Section F, "Saving Lives Together"

[12] See: https://unsmin.dss.un.org/

of the project, WHO will work mainly in partnership with local government counterparts and through third party contractors, however in the limited engagement of international NGOs that may arise, the SLT will be applied both for all IPs delivering services under the SHARE project, whether they are national or international NGOs, with local implementing partners being encouraged to join the SLT framework.
The SLT is a series of recommendations aimed at enhancing security collaboration between the United Nations (UN), and international NGOs and/or international organizations (known as "SLT partner organizations"). The objective of SLT *"is to enhance the ability of partner organizations to make informed decisions, manage risk and implement effective security arrangements to enable delivery of assistance and improve the safety and security of personnel and operations.*"

It is important to note that SLT partner organizations have different approaches to how they perceive and evaluate security risks and how they assess their vulnerabilities, accept different levels of security risks they face, and implement security arrangements which they consider suitable for their organization and operational conditions. With regards to accountability, SLT partners accept that they remain fully accountable for the security of their personnel in accordance with their 'duty of care' obligations as employing organizations. Accordingly, organizations that wish to cooperate under the SLT will be advised to maintain internal security risk management procedures, contingency planning, and adequate and reliable arrangements to respond to security incidents and crises.

All partners in the SLT are committed to establish security coordination arrangements, share relevant security information, cooperate on security trainings, cooperate on operational and logistical arrangements, identify resource requirements for enhancing security coordination and consult on common ground rules for humanitarian action.
SLT partner organizations remain fully accountable for the safety and security of their personnel in accordance with their 'duty of care' obligations as employing organizations. Organizations that wish to cooperate under the SLT framework are required to maintain internal security risk management procedures, contingency planning, and adequate arrangements to respond to emergencies. In summary, The SLT will be taken as an opportunity to foster security collaboration between the UN and partners, and it will emphasize:

- Information-sharing and coordination.
- Independent risk assessments by SLT partners.
- Accountability for partner organizations' personnel security.

Specifically, this project will follow the Saving Lives Together: A Framework for Improving Security Arrangements Among IGOs, NGOs and UN in the Field, (October 2015).

Security Incident Reporting
As per ESCP the WHO will promptly notify the World Bank Task Team Leader (TTL) via e-mail no later than 48 hours after being informed of the incident or accident by WHO staff or IP's (as applicable), once confirmed, and provide an initial report within 30 days of that notification indicating possible root causes and proposing possible corrective actions. This includes any security incident 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.

WHO will provide the World Bank with a description of a Security Incident and measures that are taken or planned to be taken to address the Incident "to the extent that the cause of Security Incident is within the scope of the Recipient's control" or their ability to identify and mitigate reasonably foreseeable security risks. WHO will provide as much information as is feasible and appropriate, considering that some information related to Security Incidents may be highly sensitive and/or confidential.

The Security Incident Reporting process is supported by WHO regular monitoring of the security situation on the ground, including monitoring of the security situation using data received from multiple sources, including UNDSS, media, etc.

Contractors and implementing partners will be responsible for reporting any security related incidents to WHO as outlined in the section below on contractors' security management, and WHO will in turn be responsible for reporting to the World Bank.

Security Incidents

Examples of Security Incidents include:

- Incidents related to the general context that cause insecurity and directly or indirectly affect the delivery of aid, WHO property or affect the staff. Any security categorized incident must be reported through proper channels describing the following:
- Any road traffic accidents involving staff members or WHO vehicles and other incidents that were not intentional, accidents, disasters.
- Direct or indirect actions taken by authorities or another actor that impede the project activities.
- Crimes: incidents that affect WHO or staff.
    1. Hostage taking or kidnapping.
    2. Illegal detention.
- Other security incidents that have negative impact on project activities.
    1. Violent unrest/disputes between any contractor and local authorities and communities[13];
    2. Looting of project supplies or supported facilities; and
- Any incident that results in death or serious, or multiple, injury of Project Personnel in the course of Official Business. A Security Incident may result in disruption of service provision to the beneficiaries. For purposes of this protocol, the following definitions related to disruption of services will be used:

a. Temporarily halted – When activities have had to immediately stop either at a static location (for example, fixed health facility) or while conducting outreach activities (e.g. community integrated outreach) to ensure the immediate safety of community members and/or health workers.

b. Suspension of activities – When agreement has been reached between World Bank and WHO to formally stop activities due to the prevailing security situation which has a direct negative impact to the project.

Security Incidents will be reported using the template in this **Annex A** (see table below). Using the same template, WHO will provide updates on a Security Incidents as information becomes available.

The following questions are a guide to the type of information to be gathered for the purposes of the initial Security Incident reporting. It is understood that not all information may yet be available and that not all questions may be relevant:

a. What safety and security measures were in place?

b. Recommend actions to be taken to rectify the failure(s) that led to the incident.

c. *What was the incident? What happened? To what or to whom?*

d. *What type of staff are involved (e.g., WHO, contractor/ service provider)?*

e. Where and when did the incident occur?

f. What is the information source? How did WHO find out about the incident?

g. Are the basic facts of the incident clear and uncontested, or are there conflicting versions?

h. What were the conditions or circumstances under which the incident occurred?

i. The sequence *of events and factual circumstances that led to the incident*

j. What failing(s) led to the incident?

k. Is the incident still ongoing or is it contained? Is loss of life or severe harm involved?

l. How serious was the incident? How is it being addressed? How is WHO responding?

m. *What is the negative impact on the project* activities?

[13] Grievances that community members have are to be reported as per the Grievances Redress Mechanism. It is recognized that grievances may results also in a Security Incident, if not addressed.

n. *What, if any, additional follow up action is required, and what are the associated timelines?*

World Bank Classification of Incidents

Upon receipt of a Significant Incident Report from WHO, the World Bank will classify the Significant Incident as Indicative, Serious or Severe[14]:

a. **Indicative,** such as the following contextualized examples:

i. Relatively minor and small-scale localized incident that negatively impacts a small geographical area or small number of people but predominantly not security related.

ii. Does not result in significant or irreparable harm.

iii. Failure to implement agreed environmental and social (E&S) measures with limited immediate impacts.

iv. Examples include minor job site injuries (related to Health and Safety; not Security); Individual and/or non-threatening social conflict relating to the project;[15]; and

v. A weather-related incident resulting in activities being temporarily halted.

b. Serious, such as the following contextualized examples:

i. An incident that caused or may potentially cause significant harm to project workers or project affected groups resulting in activities being temporarily halted.

ii. Failure to implement E&S measures with significant impacts or repeated non-compliance with E&S policies incidents.

iii. Failure to remedy indicative non-compliance that may potentially cause significant impacts which are complex and/or costly to reverse.

iv. May result in some level of lasting damage or injury; and

v. Examples include: injuries requiring off-site medical attention caused by both health & safety and security incidents; security incidents that indirectly impact the project, which may involve injury and / or activities being temporarily halted – this includes subnational conflict; cases of mistreatment of health workers, health services recipients or project affected groups by project staff/workers, or vice versa; instances of serious communicable diseases among workforce; non-violent community protests against the project; illegal detention of project staff for 48 hours or less without physical harm.

c. Severe, such as the following contextualized examples:

i. Any fatality among projects workers;

ii. Incidents that caused or may cause great harm to the health workers and project workers, resulting in activities being halted for an extended period of time with further consideration to cease activities.

iii. Failure to remedy serious non-compliance that may potentially cause significant impacts that cannot be reversed.

iv. Failure to remedy serious non-compliance that may potentially cause severe impacts which are complex and/or costly to reverse.

v. May result in high levels of lasting damage or injury; and

[14] The requirement to classify Significant Events stems from the World Bank's Safeguards Incidence Response Toolkit (SIRT) which is an internal World Bank tool that acts as a guide to report and manage incidents should they occur in a World Bank financed project.

[15] As a Significant Event may be comprised of more than one incident due to time of reporting, any incident of looting/damage will be reporting in one report. If additional looting/damage takes place at the same site prior to the Summary Report, then an update report on the original Significant Event will take place. If looting/damage occurs at the same site after a Summary Report has been provided, then it would be a new Significant Event.

vi. Examples include: abuses of health workers /community members by project staff, including but not limited to GBV, SEA, and/or SH; outbreaks of life-threatening communicable disease among workforce; criminal and/or political attacks directly targeting at worksites and/or involving project staff, including murder, kidnapping, manslaughter, or assault; violent community protests against the project; forced labour, child labour, and/or human trafficking; illegal detention of project staff for more than 48 hours and/or involving any amount of physical harm during the detention process.

If documented circumstances and relevant discussions between the PMU, contractors, supervisors and within the Bank team confirm that the incident is Indicative, Serious, or Severe, then a one to two-page Incident Report (IR) (see Annex-A) should be prepared and issued by the PMU, which shall be then forwarded to the WB Task Team (through Task Team Leader) within 48 hours of receipt of the information, with the support of the Project's E&S consultant/specialist(s), for internal communication.

The Security Incident Reporting Template to be used under this project is presented in **Annex A.**

Service Providers/Contractors

All WHO contractors, service providers and implementing partners are responsible for the security of their personnel, premises, equipment, activities. As per their contractual obligations, it will be their responsibility to understand and adhere to the SHARE project ESCP when implementing SHARE project supported programmes. These responsibilities are outlined in the clauses of the contracts entered between WHO and these contractors and derive from their fundamental duty of care as employers and as independent legal entities. WHO will ensure to the extent possible that service providers, contractors and implementing partners are informed of the need to adequately address security risks for their staff and affected communities and implement their SRM strategies.

The contractors will report to WHO on all matters related to program implementation including security incidents that negatively affect delivery or impact personnel according to the SOPs in place.

In summary, contractors will be responsible for:

- Ensuring personnel safety in compliance with the SRA/MP.
- Reporting incidents promptly.
- Including security management costs in project proposals.

On the other hand WHO will:

- Screen contractors' security capabilities during procurement.
- Monitor compliance and provide support during crises in line with UNSMS and SLT scheme.
- Ensure contractors are aware of the SHARE project ESCP and its requirements.

Contractors Screening and Agreements

Assessment of contractors' security capacity to manage security risks (by both security and procurement) will be included as part of the contract bidding process

Contractors working in the Sudan context are expected to have adequate understanding of the Sudan security context and to have provisions in place to operate within it as securely as possible, at their own cost.

Contractors may include their financial requirements for ensuring adequate security management systems are in place as embedded with their cost proposals and WHO understands that this is a necessary part of the cost of doing business in Sudan. However, security management costs will not be provided as a stand-alone budget separate to the contract, nor will additional resources for these requirements be financed by the World Bank or WHO outside of the budget allocated for the project.

Preparedness

WHO will require contractors to keep a listing of all Project Personnel and take primary responsibility for tracking the whereabouts of the Project Personnel, particularly during a Security Incident or crisis, and to provide this upon request.

Where possible, WHO will help the contractors in response to any security-related matter reported as a Security Incident. Any assistance provided by WHO will be considered on a case-by-case basis and upon request by any contractor.

Response to Security Incidents

If a Security Incident occurs, WHO will expect the contractors to take immediate measures based on their assessment of acceptable risk aligned with their security policies to support the security of staff and project assets. Based on the contractors' assessment of acceptable security risk, if it is envisaged that the security situation has deteriorated to the extent that it renders the contractor unable, wholly or in part, to perform its obligations and meet its responsibilities under the agreement, then WHO and the contractors may jointly agree, in consultation with the World Bank, to suspend further activities. If a cessation of activities is agreed, appropriate communication to communities and the wider international community operating in that area will be devised and promulgated to manage expectations on the return to programme delivery.

Use of Security Personnel

Where the service provider engages private security personnel, either directly or through third parties, the service provider will make reasonable enquiries to verify that individuals providing security are not implicated in past abuses and are adequately trained in the use of force and appropriate conduct toward workers and the community. The service provider will review all allegations of unlawful or abusive acts and where necessary report such acts to the relevant authorities; the service provider also acknowledges the right of WHO to do so, at its sole discretion. Service providers will be responsible for engagement and management of security personnel, ensuring compliance with project protocols and providing labour instructions on safety and security. Guidance for Code of Conduct for Private Security Personnel is presented in **Annex B.**

Road Safety and Convoy Procedures
WHO Personnel

Vehicles play a critical role in the implementation of programs including the project. All WHO personnel, irrespective of their type of contract, position, level and location, are responsible to familiarize themselves and comply with WHO vehicle fleet and road safety management policies, procedures and guidelines to conduct their regular monitoring visits to supported health sites.

Implementing Partners and Service Providers

Implementing Partners and service providers will be responsible for the engagement and management of personnel, ensuring compliance with road safety and convoy procedures. Implementing Partners and service providers will be responsible for the following:

- Ensure that all relevant activities are conducted in a way that manages road safety risks.
- Familiarize themselves and comply with road safety management mitigation measures.
- Attend and complete all road safety training and briefing relevant to their level and role.
- Ensure vehicles used for project activities are in good working condition.
- While travelling by road, exercise proper caution; and avoid taking unwarranted risks that endanger their safety and security or that of others.
- In the case that a convoy is used, comply with convoy procedures presented in **Annex C**; and,
- Report all road safety-related incidents in a timely manner and use prescribed forms.

All personnel must adhere to WHO's road safety protocols. Key measures include:

- Pre-departure briefings and trip planning.
- Emergency supplies and communication redundancies.
- Varying routes and avoiding travel during high-risk periods.
- Compliance with the United Nations' 2018 Road Safety Strategy.

Annex A: Security Incident Reporting Template

Security Incident Reporting			
Basic Information			
Incident number		**Project/ Intervention Name**	
Implementing Partner involved		**Funding source**	
Beginning Date and Time		**Submission Date**	
State		**Locality**	
Health Facility Name		**WHO sub-office**	
Reference/ The submitter		**Closing Date and Time**	
Details			
Subject of the incident			
Description of the incident (Kind of damage, value of damages, etc.)			
Reason for the incident			
Service suspension			
Other negative impacts			
Status & Subsequent actions			
Subsequent actions (Action taken, responsible staff or partner)			
Recommendations (If not action taken indicate any planned activity, funding source or explanation for not implementing remedial actions)			
Timeframe (Indicate expected date of completion or implementation of remedial actions)			
Estimated number of beneficiaries affected			

Annex B: Guidance for Code of Conduct for Private Security Personnel

In addition to general code of conduct applicable to project workers, the private security personnel engaged by the contractor shall abide by the following code of conduct, which is consistent with the World Bank's Environmental and Social Standards (ESSs) and its Good Practice Note (GPN) on the use of security personnel and relevant international good practice, such as "UN Basic Principles on the Use of Force" and the "International Code of Conduct for Private Security Providers":

1. **Background Screening**: The contractor will perform (and/or require its security firm to perform) valid background checks on potential security personnel to screen for any allegations of past abuses, inappropriate use of force, or other criminal activity and wrongdoing. No individual for whom there is credible negative information from these checks will serve on the project. These checks will be documented and maintained in individual personnel records, which are subject to review by the project and during project supervision.
2. **Prohibition of encroachment**: private security personnel have no law-enforcement authority and shall not encroach on the duties, responsibilities, and prerogatives reserved for public security forces. While they retain their inherent right to take action necessary to defend themselves (and persons and facilities as specified in their contract), they will not engage in offensive operations.
3. **Commitment to proportionate use of force**: Private security's role is limited to preventive and defensive services, protecting workers, facilities, equipment, and operations wherever they are located. In carrying out their duty, the security personnel will apply non-violent means before resorting to the use of force and firearms as far as possible. They may use force and firearms only if other means remain ineffective or without any promise of achieving the intended result. Officers will exhibit high levels of technical and professional proficiency and clearly understand the rules for the proportional use of force.
4. **Minimization of damage and injury**: Whenever the lawful use of force and firearms is unavoidable, the security personnel will: minimize damage and injury, and respect and preserve human life; ensure that assistance and medical aid are rendered to any injured or affected persons at the earliest possible moment; ensure that relatives or close friends of the injured or affected person are notified at the earliest possible moment.
5. **Provision and composition of the private security personnel**: the contract will describe the composition of the private security personnel with any provisions (such as uniforms and radios).
6. **Oversight of contractor performance and allegation of misconduct**: To ensure proper performance and review of allegation of misconduct, the project will undertake supervision, assist with training, and require the contractor to inquire into any credible allegations of abuse or wrongdoing, and monitor site performance on an ongoing basis.
7. **Security personnel training**:

- The training responsibilities of either the private security provider or the contractor will be clarified, as applicable. The project will review the effectiveness of training program.
- The project will ensure that private security personnel receive procedural or knowledge training in basic guarding skills, guard-post orders and procedures, proper conduct and ethics, rules of engagement, rules for the use of force, adequate weapons training (as applicable), health, safety, and environment mandatory training, and relevant public and worker grievance mechanisms.
- Training completion records will be kept. Training will be open to supervision/audit.

Annex C: Road Moves and Convoy Security Guidance

This document reflects industry standard for road move and convoy security, as well as the basic principles to follow when conducting overland operational travel in insecure environments.

Principles

Understanding the Context: Prior to departure, it is important to understand the threat environment along the proposed route. On a fundamental level, it is critical to **be aware of the threat actors** present in a given area and **whether your organization is particularly exposed to the threat, given the grievances or motivations** of those threat actors. Even if one is very familiar with the route and the surrounding environment, it is advisable to **get a situation report from local security forces**, as the threat dynamics can change over time.

Planning and Preparation: Be as prepared as possible for contingencies and **gather necessary information about the route**, road and weather conditions, health centers, security forces stations or patrols along the road, the destination, length of time needed for the journey, etc. Have **redundancies of communications equipment** and ensure the vehicles have **rudimentary repair equipment and a first aid kit**. Passengers should have the driver's cellphone number and the cellphone numbers of the other passengers. Passengers should also have a basic idea of the route to be used and the safety protocol in place.

Reasonableness: Not all of the following guidance needs to be implemented for every road journey. The farther the journey into unpopulated, higher-threat, or unfamiliar territory, the more of the guidance ought to be followed. If a journey is within a familiar city to a familiar destination, a minimum subset of the guidance can be followed, including the situation report of the threat context and the communication and basic trip plans.

Journey Guidance

1. Develop trip plan with primary and alternate routes, desired time of arrival at destination, etc. Its contents should be kept confidential.
2. Test all communication devices, review communication plan (waypoints and destination) with all individuals embarking on the journey.
3. Share full trip plan with someone in your organization not embarking on the journey, including regarding communication, expected time of arrival at destination, emergency procedures.
4. Visually inspect the vehicle.
5. Confirm personal and vehicle emergency supplies are in the vehicles.
6. Confirm emergency procedures.
7. Communicate any deviation from trip plan to the contact not embarking on the journey.
8. Conduct a pre-departure briefing so that journey members are aware of their roles in case of an emergency; and
9. Ensure all journey members have emergency contact information for local security forces/police (be mindful to have the contacts coded should the threat environment require it)

Security Risk Management Guidance

1. If trips to the same destination are undertaken on a regular basis, vary the routes taken and the time of day the journey is conducted but conduct travel only during daylight hours.
2. If the threat environment is elevated, utilize available escort options from local security forces.
3. Always observe surroundings and practice situational awareness, prior to and during the journey.
4. Considering postponing the trip should credibly reports or indicators inform in a particular period on a higher exposure to security threats.