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FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA

MINISTRY OF HEALTH

Ethiopia Health Emergency Preparedness, Response and Resilience Project

Rapid Social Assessment
Final Report

JUNE 29, 2023 ADDIS ABABA, ETHIOPIA

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Acronyms/Abbreviations

AF	Additional Financing
AFE	AFRITAC (*Africa Regional Technical Assistance Center*) East
AGP	Agricultural Growth Program
CBO	Community-based organization
CDC	Centre for Disease Control
CEBS	Community and Event Based Surveillance Services
CEDAW	Convention on Elimination of All Forms of Discrimination Against Women
CERC	Contingent Emergency Response Component
cVDPV	**circulating vaccine-derived polioviruses**
DEVAW	Declaration on the Elimination of Violence against Women
DPO	Disabled Peoples Organization
DRS	Developing Regional States
ECA	Ethiopian Communications Authority
ECSA-HC	East, Central, and Southern Africa – Health Community
EFDA	Ethiopian Food and Drug Administration
ELEAP	ETHIOPIA ELECTRIFICATION PROGRAM
EOC	Emergency Operation Centre
EPHF	Essential Public Health Functions
EPHI	Ethiopian Public Health Institute
EPSA	Ethiopian Pharmaceutical Supply Agency
ERM	Emergency Response Manual
ERSNP	Ethiopia Rural Safety Net Program
ESMF	Environmental and Social Management Framework
ESIA	Environmental and Social Impact Assessment
ESPES	Enhancing Shared Prosperity through Equitable Services
ESS	Environmental and Social Standards
ESSA	Environmental and Social systems assessment
FDRE	Federal Democratic Republic of Ethiopia
FEAPD	Federation of Ethiopian Associations of Persons with Disabilities
GBV	Gender Based Violence

GDP	Gross Domestic Product
GoE	Government of Ethiopia
GMU	Grant Management Unit
GRM	Grievance Redress Mechanism
GQs	Guiding Questions
GTP	Growth and Transformation Plan
HEs	Health Emergenccies
HEPRR	Health Emergency Preparedness, Response and Resilience
HIV/AIDS	Human Immuno-Virus/Acquired Immunodeficiency Syndrome
HoF	House of Federation
HPR	House of Peoples' Representative
HSS	Health Systems Strengthening
ICT	Information Communication Technology
IGAD	Intergovernmental Authority on Development
LLRP	Lowland Livelihood Resilience Project
LMP	Labour Management Procedure
M & E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MoFED	Ministry of Finance and Economic Development
MoH	Ministry of Health
MoWCYA	Ministry of Women, Children and Youth Affairs
MPA	Multiphase Programmatic Approaches
NGO	Non-governmental Organization
PAD	Project Appraisal Document
PCD	Partnership and Cooperation Directorate (of the Ethiopian MoH)
PCDP/ILLRP	Pastoralist Development Program/Integrated Lowland Livelihood Resilience Project
PDO	Project Development Objective
PHEs	Public Health Emergencies
PHEM	Public health emergency management
PIM	Project Implementation Manual

PIU	Project Implementation Unit
PoEs	Port of entries
PPR	Pandemic Preparedness and Response
PrDO	Program Development Objective
PSNP	Productive Safety Net Program
RAP	Resettlement Action Plans
RLLP	Resilient Livelihood and Landscape Program
RPF	Resettlement Policy Framework
RPLRP	Regional Pastoral Livelihood Resilience Program
RSA	Rapid Social assessment
SDG	Sustainable Development Goals
SEA/SH	Sexual Exploitation and Abuse/Sexual Harassment
SE	Sexual Harassment
SLMP	Sustainable Land Management Program
SMP	Social Management Plan
SNNPR	Southern Nations, Nationalities and Peoples Region
STIs	Sexually Transmitted Infections
TA	Technical Assistance
ToR	Terms of Reference
UN	United Nations
WB	World Bank

Executive Summary

Background and Context

Ethiopia is Africa's second-most populous country with a population of more than 115 million in 2021. The country has made important development gains over the past two decades and has registered commendable achievements on Millennium Development Goals (MDGs) mainly in reducing poverty head count, achieving universal primary education, narrowing gender disparities in primary education, reducing child and neonatal mortality, and combating HIV, TB, and malaria. The demand for equitable access and quality healthcare services is increasing because of a rapidly growing population, epidemiological transition of diseases, rapid urbanisation, and broader social and economic changes occurring in the country and the geopolitical context in the eastern Africa region.

The COVID-19 pandemic, civil conflict and climate shocks including drought have severely impacted the wellbeing of Ethiopia's people. Ethiopia has had the second largest number of COVID-19 cases and fatalities in Sub-Saharan Africa with almost half a million cases and 8,000 deaths since March 2020[1]. Severe repeating droughts and flooding in 2021 further impacted the livelihoods and food security of over 12 million people.[2] There are (Ibid.) over 2 million people currently displaced due to drought, conflict, seasonal and flash floods. These shocks have had dire economic consequences across the country and poverty rates are expected to increase. In Fiscal Year (FY) 20, the pandemic contributed to a three percent decrease of Gross Domestic Product (GDP) and foreign direct investment declined by 20 percent. The report of for FY22, GDP is again expected to be significantly reduced due to the conflict and ongoing COVID-19 pandemic, while inflation has been steadily rising reaching over 33.6 percent in January 2023.[3] If not addressed urgently, Ethiopia risks to erode the human capital gains achieved through decades of investments.

Starting from the last quarter of 2022, Ethiopia is experiencing a prolonged drought after five (5) consecutive failed rainy seasons since late 2020 affecting 24 million people: Somali (11 zones), Oromia (8 zones), Southwest (3 zones) and Southern Nations, Nationalities, and Peoples, SNNP (7 zones). The number of severe acute malnutrition cases has increased in 2022 by 21 per cent in drought affected woredas of Afar, Oromia, Somali and SNNPR, comparing with 2021. Cholera and measles cases have been reported in January 2023 in drought affected regions in the country and are expanding to other areas[4]. The overlap of COVID-19 outbreaks, and protracted conflict have disrupted the delivery of essential maternal and child health services negatively impacted the linear progress observed in key health outcomes in the past two decades. Prior to the conflict, COVID-19 outbreak has reduced, averaging from 10% to 26%, utilization of out-patient services, skilled birth attendant at health facilities, child immunization and vitamin A supplementation and nutrition screening. The conflict has directly affected primary health care infrastructures including 1,350 health posts, 750 health centers and 76 hospitals throughout the country and whereby pre-conflict health and nutrition service delivery indicators to be dropped

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[1] Ministry of Health (MOH), "COVID-19 report," April 26, 2022.

[2] Reliefweb, 2021: https://reliefweb.int/disaster/dr-2015-000109-eth; and https://reliefweb.int/sites/reliefweb.int/files/resources/ethiopia_drought_update_january_2022.pdf

[3] Ethiopia: Monthly Economic Update – February 2023

[4] Ethiopia Ministry of Health ^ Month Drought Response Plan

in the immediate aftermath of the conflict. The risk of outbreaks from vaccine preventable diseases and other water borne sources is high implying the increased disease burden and mortality therein and the need to invest on health system resilience in the country.

By way of responding to these challenges and augmenting its national development financing, Ethiopia has partnered in multilateral and bilateral development projects with several development financing institutions such as the World Bank (WB), Africa Development Bank (AfDB) and others. As its continued development partnership, WB is financing this **Health Emergency Preparedness, Response, and Resilience** (**HEPRR**) project, a regional capacity building project in which Ethiopia is one of the implementing countries. The **HEPRR** project will be implemented by the Ministry of Health (**MoH**), with the Ethiopian Public Health Institute (EPHI) as the key technical entity for the implementation of the project activities. This *rapid social assessment* (**RSA**) is prepared as part of the risk management instruments and focuses primarily on the Health Sector.

This rapid **RSA** assessed the broad project risks and impacts on vulnerable (underserved peoples, women, children, aged people, persons with disability, poor and other deprived segments) and other communities and recommends risk mitigation measures that will be used at both the project design and implementation phases to ensure all beneficiaries can receive the project benefits..

Development Objective

Project Development Objective: The Program Development Objective (PrDO) of the Health Emergency Preparedness, Response and Resilience (HEPRR) Program is to strengthen health system resilience and multisectoral preparedness and response to health emergencies in Ethiopia.

Building on ongoing World Bank and other development partners effort, and working cross sector and cross border, HEPRR will strengthen two inter-connected pillars–Preparedness/Response and Resilience—of health systems, enabling the rapid detection of and response to health emergencies while ensuring the availability of essential pharmaceuticals and health services continue to be delivered optimally even during emergencies. In addition, the proposed project engages with regional integration institutions such as IGAD and HECSA to support the cross border public health emergencies preparation and response through health emergency information/data sharing, advancing the learning agenda and to strengthen capacity building across countries. Furthermore, efforts will be made to leverage the academic and public and private sector capacities in manufacturing diagnostic and preventive pharmaceuticals to satisfy the requirements in Ethiopia and neighbouring countries and provide assistance to enhance regulatory activities through strengthening collaboration with Africa Medical Agency and expand market networking for sustainability.

Project Components

The proposed Project has four components.

***Component 1: Strengthening the Preparedness and Resilience of the Health System to manage PHEs* (US$80M).**

This component would support institutional capacity building and resilience health systems strengthening across the health system building pillars to cope with public health emergencies while ensuring the continuity of essential health service delivery during public health emergencies. Based on the lesson from the COVID-19 pandemic, Ebola outbreak in western and eastern Africa and other health emergencies of communicable and non-communicable infectious and non-infectious diseases in the country, effective emergency preparedness requires connecting and working together across all building blocks of the health system including health workforce, pharmaceutical supply and value chain, regulatory and governance capacity, and quality data and evidence informed decision making, adequate and sustainable financing, and integrated service delivery.

Component 2: Improving the detection of and response to public health emergencies (USD $145M):

This component will support the national detection and response pillars which aim to strengthen early warning system, revise the list of reportable diseases, strengthen risk screening at port of entries (PoEs) including border areas, enhance digital information management of multi-hazards (infectious disease outbreaks, biological, chemical, radiological and environmental), surveillance data analysis and interpretation, community level information collection and verification, provide feed-back to facilities and regions, finally, risk communication will be held alongside information management.

Component 3: Program Management:

***Sub-component 3.1: will support monitoring and evaluation and engagement of academia and think tank groups*.** This component will provide financing for i) Coaching and technical support for data analysis, interpretation and lesson sharing and support for decision-making; ii) Third party implementation and monitoring to support implementation of the project activities in conflict and security constrained areas and assure the validity of Results Framework indicator data reported by governments; and (iv) Data-based cross-border learning initiatives, which will share proven strategies to effectively collect and use data to enhance health emergency response.

Sub-component 3.2: will focus on all other aspects of program management. Implementing the proposed project will require administrative and human resources that exceed the current capacity of the implementing institutions, in addition to those mobilized through the other bank projects including COVID19 emergency response project and Africa CDC Project. Specific activities include: i) support for procurement, FM, environmental and social safeguards, monitoring and evaluation, and reporting; ii) recruitment and Training of Grants Management Unit and EPHI staff and technical consultants; iii) operating costs and iv) support for cross border related administrative activities and collaboration with IGAD.

Component 4: Contingent Emergency Response Component (CERC): TBD

Scope of the Rapid Social Assessment (RSA)

This R**SA** is a risk mitigation tool covering risks, challenges and recommendations that will inform the implementation of '*Health Emergency Preparedness, Response and Resilience*'.[5] As clearly stated in the PAD, this is a capacity building project with a focus on Technical Assistance (TA): "Building on ongoing World Bank and other development partners effort, and working cross sector and cross border, HEPRR will strengthen two inter-connected pillars– Preparedness/Response and Resilience—of health systems, enabling the rapid detection of and response to health emergencies while ensuring the availability of essential pharmaceuticals and health services continue to be delivered optimally even during emergencies". The PAD adds "The project will undertake interventions that are at policy and strategy level but still focusing on creating the public health preparedness, response, and resilient health system capacity at the district level".

The project is implemented at national and sub-regional levels and this includes communities that are underserved and vulnerable. RSA looks at (consistent with ESS7) how underserved communities who are often disadvantaged in development projects can equitably access project benefits in a culturally appropriate and inclusive manner. It, therefore, helps make the project responsive to social development concerns, including seeking to enhance benefits for the poor and vulnerable peoples and underserved groups, while minimizing or mitigating risk and adverse impacts. It analyzes distributional impacts of intended project benefits on different stakeholder groups, and identifies differences in assets and capabilities to access the Project benefits.

Objectives of the Social Assessment

The study aims to assess the social characteristics of local communities, including determining the nature and characteristics of underserved groups in the **HEPRR** project intervention areas, with special emphasis on their cultural characteristics, social institutions and organization and establish that the project will not negatively impact the way of life of these people. RSA is a systemic assessment of positive and adverse social impacts associated with the project and proposes appropriate risk mitigation measures to ensure equitable project benefits.

Methodology

The **HEPRR** project is one among many development projects financed by Development Partners, among which the WB is one. During these several years of financing development projects[6], many documents, e.g., PADs, ESMF, ESIA, RPF, RSA reports, etc. have been

[5] The '*Health Emergency Preparedness, Response and Resilience*' Concept Note.

[6] For instance, recently the following projects were financed by the WB, and safeguards documents produced for these were consulted: the *Africa CDC Regional Investment Financing Project*; *Ethiopia COVID-19 Emergency Response Project* (parent project and AF); *Sustainable Development Goal Program for Results*; *Ethiopia Program for Results (Hybrid) for Strengthening Primary Health Care Services*; *Digital Ethiopia;* and *Response-Recovery-Resilience for Conflict-Affected Communities in Ethiopia Project (3R-4CACE),* 2022.

produced to inform project design, implementation and monitoring and evaluation processes of projects in the country. These documents have amply documented information on various issues about the beneficiary communities differentially located in the socio-economic structure of the Ethiopian society, and serve as vital secondary sources of information for this RSA study.

The RSA for **HEPRR** project has used both primary and secondary sources of data. The data from the existing works were used because most of the communities intended to be covered in this project have already been studied in the past. Relevant published works were also consulted, in addition to the review of the national laws, regulations, and relevant international conventions.

As much primary data as possible was generated to understand the views and document the concerns of different social groups such as the vulnerable people in the underserved and emerging regions. Consultations have been conducted with the Project design team members, the federal, and regional public health officers and experts, as well as some potential beneficiaries on the project as they related to the context of the RSA document. Health experts working for NGOs among the underserved and vulnerable groups were the other major source of primary data as they contributed to the RSA, some by responding in writing to the GQs and others through telephonic interview.

Key RSA Findings

One key finding of the RSA is that there is a strong support for the project as it is believed to address the systemic marginalization of the vulnerable people. The **HEPRR** project will build on what has already been started and further enhances HE response capacity of the country, which over the last few years was challenged by '***drought*,** and ***IDP***

Health infrastructures or facilities meant to serve permanently settled communities and the modalities of their services rarely take into account the mobility-based (following the availability of pasture and water) livelihood strategies of pastoralist communities. In light of this, pastoralist communities are not benefitting from static health services often designed to serve settled communities. Moreover, pastoralist communities are exposed to health problems such as cholera and meningitis, which are aggravated during drought.

In the past couple of years, Ethiopia has been experiencing serious humanitarian challenges largely attributable to conflict, drought and floods, each of these with its own devastating health impacts. The first and most consequential impact of these are the displacement of millions of people from their homes and belongings. Internal Displaced Persons affected by the internal conflicts in the past years are facing several challenges, including food insecurity, shelter, water shortage/unavailability for consumption and hygiene, personal security (risk of being attacked) and risk of exposure to ***GBV and sexual exploitation and abuse/harassment***. Women IDPs also experience several maternal health problems, either as lactating mothers or pregnant women. IDPS are among the ***most vulnerable in the context of Ethiopia today.***

Other most *vulnerable and underserved groups* in the Project context include women, *the poorest of the poor,* persons with disability, the elderly, unemployed youth, low-income households, people with low literacy status; IDPs; people living in border and remote areas; minority groups; people with chronic illness like HIV/AIDS; widows; female-headed as well child headed households; children, especially of pastoralist communities, because they are always on a move.

Institutional capacity **problems** that limit/constrain program implementation is caused by knowledge gap, low salary, understanding of project objectives, and low incentive mechanism.

GRM – Project implementing health institutions have existing government structure, namely Ethics and Anti-corruption Office and Women, Child and Youth office which are working with existing legal and justice structures to address GBV related complaints.

GBV and SEA/H: The project might not bring additional GBV and sexual exploitation risks. But consultation participants emphasized these problems are already common, whether the project is implemented or not and the project need to put in place effective and accessible GBV GRM. There is a need for continuous community engagement on these and similar issues.

Consultation participants and all who contributed to this RSA emphasized that **traditional/indigenous organizations and leaders** can play significant roles in health messaging by clarifying misconceptions and serving as role models in health campaign.

Proposed Mitigation Measures

The following key mitigation measures were developed based on Consultations.

- Conduct participatory research on the pastoralists' livelihoods, movement patterns, etc. to make the project fit into the pastoralists' contexts.
- To address barriers such as lack of access to health information, infrastructures that are suitable to their special needs, awareness of the existence and affordability of the services for the vulnerable and underserved communities: provide and disseminate information through different means/platforms, put in place health infrastructure/facilities that are accessible and services that are affordable.
- Support institutional capacity building; strengthen leadership commitment; training; introduce employment benefit packages; clear and transparent institutional arrangement.
- Introduce competitive salary and other benefit schemes (e.g., health insurance, housing allowance, etc.).
- Conduct capacity assessment study to understand the facts on the ground in specific project implementation area, specifically among the pastoral and underserved communities.
- Modernize organizational structure and project prioritization process; and introduce state of the art technologies.

- Strengthen anti-corruption and complaints handling mechanisms to solve any conflict of interest that might arise among the firms or companies and individuals involved in the Project.
- Reinforce a robust, accessible and functioning **GRM** as an integral part of the project, which also serves as GBV GRM.
- The vulnerable people should be consulted and take part in the project and their views solicited.
- Enhance the status of women through access to digital technologies and information that alleviate their burden and allow them greater time and freedom to engage in a wide range of activities with reduced hardship and pressure.
- Develop and implement clear and transparent guidelines to mitigate the risks of corruption, nepotism, and other unethical behaviour and practices.
- To address the challenges of urban poor and low-income households:
    1. provide support to the urban poor and other low-income households in the short-term (including subsidized health services by availing drugs and medical supplies and equipment in accessible health facilities); and
    2. building community resilience by investing in health, communication (including digital) and other essential infrastructures such as roads and transportation in the long-term.

Synthesized Recommendations

The **HEPRR** project should learn from the challenges of past or current development projects financed by the Bank and devise mechanisms in targeting project beneficiaries to ensure both *exclusion* and *inclusion errors* are unlikely to occur due to the influence of traditional structures (social and economic), corruption, clientelism and lack of awareness, livelihood strategies (e.g., pastoralism) especially at the grassroots levels. Adequate community consultation and transparent and accountable institutional arrangements are the key antidotes of *exclusion* and *inclusion errors* likely to take place due to the aforementioned reasons. Moreover, as repeatedly discussed in the foregoing sections, participatory project identification, priority setting, beneficiary targeting, design, planning, implementation, and M&E are the key successful project implementation. Institutions closer to the vulnerable population and vulnerable community groups should be consulted and take part in the project and their views solicited" from day one.

The need to build sustainable institutions at grassroots level can never be overemphasized, since they are crucial for the delivery of services and the attainment of project objectives. Lessons learned from various development programs/projects financed by the WB (e.g., AGP, PSNP, SLMP, PCDP/RLLP, etc.) show that the quality of project implementation and outcomes registered were good where local implementation structures were better organized and manned with the requisite number and right combination of experts. The implementation structure, especially at the grassroots levels, need to be well organized, resourced, nurtured, and sustained

through targeted capacity building work, and proper reward and incentive schemes put in place for the staff.

The best way to address the adverse impacts or promote equitable access to Project benefits is, according to an expert, ***health and resource distribution equity*** that should be anchored in ***a strategic partnership with community organizations.***

Programs such as **HEPRR**, which are implemented not only in diverse agro-ecological settings, but also in areas where government implementation structures are not the strongest (e.g., under-resourced remote and pastoralist areas) makes it critically important to put in place effective and efficient monitoring and evaluation system.

Monitoring and Evaluation (M&E) should serve the intended purpose, and help the program implementers to learn from their weaknesses and further boost their strengths, and for the higher-level program structures to monitor performances and evaluate the impact of the program on the program beneficiary and institutional capacity building at all levels of the program implementation structures. M&E is not a routine activity reporting exercise meant to meet the reporting requirement, which has been the major problem of some of these projects. Rather it is an integral component of the program in which the information generated through the M&E system is used to guide management decisions at both the local and higher levels of the program implementation structure.

As a new initiative with its own unique characteristics, being regional and national at the same time, the **HEPRR** project should learn from the past projects by not repeating their mistakes (where M & E is seen as routine activity reporting exercise) and build on their strengths where M&E becomes not only an integral part of the project implementation plans, but also an ***inbuilt system*** of the Project implementing institutions.

Conclusion

The RSA findings showed a very strong support for the **HEPRR** project across the wide spectrum of the potential project beneficiaries and experts with deep knowledge of the sector and the livelihoods of the vulnerable and historically underserved groups. Though conducting actual field visit was not possible due, largely, to time constraint and other challenges (security), enough data needed for this R**SA** were generated from both secondary and primary sources (see Methodology section).

Generally, there is a strong support for the project as it is believed to enhance the HE preparedness, response and resilience of Ethiopian health sector building on what has already been achieved in the last few years, including the capacity building accomplishments of the federal and regional health institutions in the past few years including through the support obtained from *Ethiopia COVID-19 Emergency Response Project*. Moreover, there is a huge potential for the project to benefit people, especially the vulnerable population groups among the underserved communities in the emerging regions. The commitment to realize the project

objectives is very high among all implementing agencies, especially the key implementing federal institutions MoH and EPHI, and their partners in the regional states.

It is also worth noting the importance of taking into ~~serious~~ consideration during the remaining phases of the Project the potential risks identified in this RSA and the proposed mitigation measures which are the key to the successful implementation of the **HEPRR** project.

1. Introduction

1.1. Background and Context

Ethiopia is Africa's second-most populous country with a population of more than 115 million in 2021. The country has made important development gains over the past two decades and has registered commendable achievements on Millennium Development Goals (MDGs) mainly in reducing poverty head count, achieving universal primary education, narrowing gender disparities in primary education, reducing child and neonatal mortality, and combating HIV, TB, and malaria. The demand for equitable access and quality healthcare services is increasing because of a rapidly growing population, epidemiological transition of diseases, rapid urbanisation, and broader social and economic changes occurring in the country and the geopolitical context in the eastern Africa region.

The COVID-19 pandemic, civil conflict and climate shocks including drought have severely impacted the wellbeing of Ethiopia's people. Ethiopia has had the second largest number of COVID-19 cases and fatalities in Sub-Saharan Africa with almost half a million cases and 8,000 deaths since March 2020[7]. Severe repeating droughts and flooding in 2021 further impacted the livelihoods and food security of over 12 million people.[8] There are over 2 million people currently displaced due to drought, conflict, seasonal and flash floods (add reference). These shocks have had dire economic consequences across the country and poverty rates are expected to increase. In Fiscal Year (FY) 20, the pandemic contributed to a three percent decrease of Gross Domestic Product (GDP) and foreign direct investment declined by 20 percent. According to the official statistics for FY22, GDP is again expected to be significantly reduced due to the conflict and ongoing COVID-19 pandemic, while inflation has been steadily rising reaching over 33.6 percent in January 2023.[9] If not addressed urgently, Ethiopia risks to erode the human capital gains achieved through decades of investments.

Starting from the last quarter of 2022, Ethiopia is experiencing a prolonged drought after five (5) consecutive failed rainy seasons since late 2020 affecting 24 million people: Somali (11 zones), Oromia (8 zones), Southwest (3 zones) and Southern Nations, Nationalities, and Peoples, SNNP (7 zones). The number of severe acute malnutrition cases has increased in 2022 by 21 per cent in drought affected woredas of Afar, Oromia, Somali and SNNPR, comparing with 2021. Cholera and measles cases have been reported in January 2023 in drought affected regions in the country and are expanding to other areas[10]. The overlap of COVID-19 outbreaks, and protracted conflict have disrupted the delivery of essential maternal and child health services negatively impacted the linear progress observed in key health outcomes in the past two decades. Prior to the conflict, COVID-19 outbreak has reduced, averaging from 10% to 26%, utilization of out-patient services, skilled birth attendant at health facilities, child immunization and vitamin A supplementation and nutrition screening. The conflict has directly affected primary health care infrastructures including 1,350 health posts, 750 health centers and 76 hospitals throughout the country and whereby pre-conflict health and nutrition service delivery indicators to be dropped

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[7] Ministry of Health (MOH), "COVID-19 report," April 26, 2022.

[8] Reliefweb, 2021: https://reliefweb.int/disaster/dr-2015-000109-eth; and https://reliefweb.int/sites/reliefweb.int/files/resources/ethiopia_drought_update_january_2022.pdf

[9] Ethiopia: Monthly Economic Update – February 2023

[10] Ethiopia Ministry of Health ^ Month Drought Response Plan

to zero in the immediate aftermath of the conflict. The risk of outbreaks from vaccine preventable diseases and other water borne sources is high implying the increased disease burden and mortality therein and the need to invest in health system resilience in the country.

By way of responding to these challenges and augmenting its national development financing, Ethiopia has partnered in multilateral and bilateral development projects with several development financing institutions such as the World Bank (WB), Africa Development Bank (AfDB) and others. As its continued development partnership, WB is financing this **Health Emergency Preparedness, Response, and Resilience** (**HEPRR**) project, a regional capacity building project in which Ethiopia is one of the implementing countries. The **HEPRR** project will be implemented by the Ministry of Health (**MoH**), with the Ethiopian Public Health Institute (EPHI) as the key technical entity for the implementation of the project activities. This *rapid social assessment* (**RSA**) is prepared as part of the safeguard instruments.

This rapid **RSA** is, therefore, initiated to assess broad project risks and impacts on vulnerable (underserved peoples, women, children, aged people, persons with disability, poor and other deprived segments) and other communities and recommend risk mitigation measures that will be used at both the project design and implementation phases.

1.2. Scope of the Rapid Social Assessment

This Rapid **SA** is a risk mitigation tool covering risks, challenges and recommendations that will impact the implementation of '*Health Emergency Preparedness, Response and Resilience*'.[11] As clearly stated the PAD, this is a capacity building project with a focus of Technical Assistance (TA): "Building on ongoing World Bank and other development partners effort, and working cross sector and cross border, HEPRR will strengthen two inter-connected pillars– Preparedness/Response and Resilience—of health systems, enabling the rapid detection of and response to health emergencies while ensuring the availability of essential pharmaceuticals and health services continue to be delivered optimally even during emergencies". The PAD adds "The project will undertake interventions that are at policy and strategy level but still focusing on creating the public health preparedness, response, and resilient health system capacity at the district level".

The project is implemented at national and sub-regional levels and this includes communities that are underserved and vulnerable. RSA looks at (consistent with ESS7 and the World Bank Directive on Addressing Risks and Impacts on Disadvantaged or Vulnerable Individuals or Groups[12]) how underserved communities who are often disadvantaged in development projects can equitably access project benefits in a culturally appropriate and inclusive manner. It, therefore, helps make the project responsive to social development concerns, including seeking to enhance

[11] The '*Health Emergency Preparedness, Response and Resilience*' Concept Note.
[12] https://documents1.worldbank.org/curated/en/573841530208492785/Environment-and-Social-Framework-ESF-Good-Practice-Note-on-Disability-English.pdf

benefits for the poor and vulnerable peoples and underserved groups, while minimizing or mitigating risk and adverse impacts. It analyzes distributional impacts of intended project benefits on different stakeholder groups, and identifies differences in assets and capabilities to access the Project benefits.

The **RSA** consists of the analysis of context and social issues with a participatory process of stakeholder consultations and involvement, to provide operational guidance on, project implementation, and a monitoring and evaluation (M&E) framework. It also complements other risk management relevant in this project, with the aim to prevent and mitigate undue harm to people and their environment in the development process. These standards provide guidelines for the World Bank and borrower in the identification, preparation, and implementation of programs and projects; and more importantly, these standards provided a platform for the participation of stakeholders in this project design, and have been an important instrument for building ownership among local populations.

Different project sub-components will have varying levels of impacts on different community groups. Some will have marginal direct impact on the grassroot level communities (*e.g., Component 3: Program Management*), while others (e.g., *Component 1: Strengthening the Preparedness and Resilience of Regional and National Health Systems to manage HEs*) have more direct impacts, both positive and negative. This means, this rapid **RSA** needs to explore the potential risks and impacts of the project, with more emphasis on some components (e.g., sub-comp.1.3, 1.4, 1.5 and 2.1)[13] and their impacts on the vulnerable segment of the population. This, by no means, should imply other project components and their impacts on the larger society will be less emphasized. To reiterate what was stated in the ToR, the RSA is "intended to help the Project to understand key social issues and risks, and to determine social impacts on different stakeholders. It needs to include needs and priorities of key stakeholders, outline their views on proposed implementation mechanisms of the project, and build capacity and involvement". It will also outline "requirements for the design of an appropriate institutional arrangement to implement, monitor, and evaluate the project on the achievement of social outcomes".

1.3. Objectives of the Rapid Social Assessment

The study aims to assess the social characteristics of local communities, including determining the nature and characteristics of underserved groups in the **HEPRR** project intervention areas, with special emphasis on their cultural characteristics, social institutions and organization and establish that the project will not negatively impact the way of life of these people. RSA is a systemic assessment of positive and adverse social impacts associated with project and propose appropriate risk mitigation measures.

[13] Subcomponent 1.3: supports the readiness of healthcare systems and essential services continuity; subcomponent 1.4: supports information systems for HEs and the digitalization of the health sector; subcomponent 1.5: supports climate resilient health systems; and subcomponent 2.1: supports collaborative surveillance and laboratory diagnostics.

This rapid **RSA** is intended to help the Project to understand key social issues and risks, and to determine social impacts on different stakeholders, specifically looking at historically underserved communities and other vulnerable groups. It also assesses the needs and priorities of key stakeholders, outlines their views on the design and proposed implementation mechanisms of the project, and build capacity and involvement. It will also provide requirements for the design of an appropriate institutional arrangement to implement, monitor, and evaluate the project on the achievement of social outcomes.

The **RSA** is the basis for the preparation of the Social Management Plan (SMP) in which all the mitigation measures are provided as actions and if those actions require budget, an indicative budget and the timeline for the implementation will be included in the SMP.

1.4. Study Approach

1.4.1. Methodology

The development of the social assessment involved a participatory process led by the MoH. The **HEPRR** project is one among the hundreds of development projects financed by Development Partners in Ethiopia, among which WB is one. During these several years of financing development projects[14], many documents, e.g., PADs, ESMF, ESIA, RPF, SA reports, etc. have been produced to inform project design, implementation and monitoring and evaluation processes. These documents have amply documented information on various issues about the beneficiary communities differentially located in the socio-economic structure of the Ethiopian society, and serve as important secondary sources of information for this RSA study.

The RSA for **HEPRR** project has used both primary and secondary sources of data. The data from the existing works were used because most of the communities intended to be covered in this project have already been studied in the past. Relevant published works were also consulted, in addition to the review of the national laws, regulations, and relevant international conventions.

As much primary data as possible was generated to understand the views and document the concerns of different social groups such as the vulnerable people in the underserved and emerging regions. Consultations have been conducted with the Project design team members, the federal, and regional public health officers and experts. Health experts working for NGOs among the underserved and vulnerable groups were the other major source of primary data as they contributed to the RSA, some by responding in writing to the GQs and others through telephonic interview.

[14] For instance, recently the following projects were financed by the WB, and safeguards documents produced for these were consulted: the *Africa CDC Regional Investment Financing Project*; *Ethiopia COVID-19 Emergency Response Project* (parent project and AF); *Sustainable Development Goal Program for Results*; *Ethiopia Program for Results (Hybrid) for Strengthening Primary Health Care Services*; *Digital Ethiopia;* and *Response-Recovery-Resilience for Conflict-Affected Communities in Ethiopia Project (3R-4CACE),* 2022.

As the project has a national coverage with primarily TA related activities and no specific project sites are identified, this RSA relied on gathering of primary data from underserved communities accessible within the constraints of communication, logistics and other accessibility issues. Information was also gathered from key implementing Federal institutions, i.e., MoH and EPHI, a few regional Health Bureaus for the collection of primary data. Moreover, a handful of written comments on key social issues were also received from both the federal and regional health institutions, and experts working among the local communities in the underserved areas.

1.4.2. Methods

As mentioned in the forgoing sections, both primary and secondary data sources were used for this RSA. The secondary data sources included, reports of the previous and current Bank financed projects[15]. Moreover, primary data sources were also used for which open-ended Guiding Questions (GQs) were prepared for different categories of respondents, i.e., officials and experts from key implementing Federal institutions, officials and experts of the regional health Bureaus and experts from beneficiary institutions. Consultations with potential beneficiaries and public health experts, themselves from the emerging regional states and working among the underserved communities, and health experts working with local communities for NGOs, were consulted and their views included (see Key RSA findings section below).

1.5. Project Development Objectives and Components

1.5.1. Development Objective

Project Development Objective: The Program Development Objective (PrDO) of the Health Emergency Preparedness, Response and Resilience (HEPRR) Program is to strengthen health system resilience and multisectoral preparedness and response to health emergencies in Ethiopia.

Building on ongoing World Bank and other development partners effort, and working cross sector and cross border, HEPRR will strengthen two inter-connected pillars– Preparedness/Response and Resilience—of health systems, enabling the rapid detection of and response to health emergencies while ensuring the availability of essential pharmaceuticals and health services continue to be delivered optimally even during emergencies. In addition, the proposed project engages with regional integration institutions such as IGAD and HECSA to support the cross border public health emergencies preparation and response through health emergency information/data sharing, advancing the learning agenda and to strengthen capacity building across countries. Furthermore, efforts will be made to leverage the academic and public and private sector capacities in manufacturing diagnostic and preventive pharmaceuticals to satisfy the requirements in Ethiopia and neighbouring countries and provide assistance to enhance regulatory activities through strengthening collaboration with Africa Medical Agency

[15] For instance, RLLP, 2020; SEAN-Enhanced SA and Consultation, 2020; ERSNP, Enhanced SA and Consultation, 2017; AGP-II, 2015; PSNP-IV, 2014; SLMP-II, 2013; Enhancing Shared Prosperity through Equitable Services (ESPES) Additional Financing (AF) Incremental Environment and Social Systems Assessment (ESSA), 2017; ESSA for ELEAP, 2018), Ethiopia Digital Foundation, COVID-19 Emergency Response Project (2021), and Response-Recovery-Resilience for Conflict-Affected Communities in Ethiopia Project (3R-4CACE), 2022).

and expand market networking for sustainability.

1.5.2. **Project Components**

The proposed Project will have four components.

***Component 1: Strengthening the Preparedness and Resilience of the Health System to manage PHEs* (US$80M).**

This component would support institutional capacity building and resilience health systems strengthening across the health system building pillars to cope with public health emergencies while ensuring the continuity of essential health service delivery during public health emergencies. Based on the lesson from the COVID-19 pandemic, Ebola outbreak in western and eastern Africa and other health emergencies of communicable and non-communicable infectious and non-infectious in the country, effective emergency preparedness requires connecting and working together across all building blocks of the health system including health workforce, pharmaceutical supply and value chain, regulatory and governance capacity, and quality data and evidence informed decision making, adequate and sustainable financing, and integrated service delivery.

Subcomponent 1.1: Strengthen cross- sectoral and cross-border public health emergency preparedness and response and develop necessary legal frameworks and directives emphasizing essential public health functions. The support under this subcomponent goes beyond the conventional health sector and encompass both human and animal aspects of public health emergency while still focusing on integration of such efforts within the wider health systems building pillars and reflecting the roles and contribution of other sectors. Human and animal health are administered separately by different intuitions in Ethiopia with limited functional coordination and surveillance and event information sharing when it comes to public health emergency preparedness. Endemic and epidemic infectious diseases, emergence of newly discovered pathogens, drug resistance, and outbreaks of emerging and re-emerging zoonotic diseases are causing substantial personal and economic loss in the human, livestock, and environment sub-sectors of the country. In Ethiopia, the human and animal sectors have their own surveillance systems at all levels that help to anticipate prevention, preparation for, early detection and response for health emergencies in their respective sectors.

Specifically, this subcomponent supports: i) establishment of national public health security council to serve as a mechanism for collaboration among the relevant ministries and create accountability and political commitment; ii) Enhance the linkage between the surveillance system, information communication, and diagnostic laboratory system within the public health sector and between the public and animal health sector; iii) under the umbrella of IGAD, establish/strengthen framework of agreement between neighboring countries to enhance cross boarder collaboration and coordination mechanism with neighboring countries including human and animal health; iv) revise and codify the existing one-health and multi-sectorial public health emergency response legal frameworks and guidelines; v) expand the capacity of national Emergency Operating Center (EOC) in Ethiopia to be fit for non-traditional health sector related emergencies in terms of its preparedness level as well as ability to respond, both at national and sub-national level; and vi) as an important element of the PHEM preparedness, establish a public

health emergency response contingency and equity fund with matching from government, private sector, and other partners will be established.

Subcomponent 1.2: Support health workforce skill development and resilient engagement during public health emergency. Ethiopia's health workforce is characterized by a shortage and substantial imbalance of health professionals across rural and urban areas. Staff shortages will be amplified by population growth, a changing disease burden, urbanization, and public health emergencies due to outbreaks and conflict. Early detection, response, and recovery in times of public health emergencies requires the availability of a multidisciplinary health workforce with the right knowledge, number and skill mix, clear risk compensation and incentive package. The public health emergency management (PHEM). Preparedness and Resilience PHEMs is heavily reliant on availability and capacity of a multidisciplinary health workforce with a strong surge capacity to mobilize experts from various institutions in times of PHEs. It is, therefore, important to strengthen PHEM leadership and the PHEs health workforce by rostering/preparing surge capacity, training public health cadres, and capacity building in PHEM staffs and stakeholders, as well as the development of emergency management, to strengthen, respond to, and lead public health emergencies. This subcomponent supports, specifically, i) strengthen the pre-service education and capacity to mainstream public health emergency detection and response in to the existing health science training curriculums for both undergraduate and graduate studies through curriculum revisions to reflect the emerging, re-emerging, and endemic causes of public health emergencies ii) training of additional field epidemiologists, genomics, data scientists, and health informatics, and laboratory professionals in a way that links different sectors that will involve in the preparedness and response of the emergencies both at national and sub-national level; v) Establish Ethiopia Multisectoral Emergency Response Team at national, regional, district level and cross border areas with a clear training curriculum, SOPs, reporting and accountability framework and equipped with necessary tools, medical equipment's and incentive package. This is on-call response team organized based on existing civil servants working in government institutions.

Subcomponent 1.3: Support health systems readiness for continuity of essential health service delivery during public health emergencies. Another critical challenge in times of public health emergencies is to ensure continuity of essential health programmes and services delivery. During the COVID-19 pandemic, for example, delivery of essential primary health care services has been significantly affected in Ethiopia, as in other settings. An average of 10 – 23 percent reduction is observed in utilization of essential health services including child immunization, skilled birth attendance, out-patient services, antenatal care and treatment of chronic diseases such as TB, Diabetes Mellitus and HIV/AIDS. This is mainly derived by a shift in leadership focus, resources, clear plans/strategies on how to manage the continuity of essential health service delivery while managing public health emergencies. Beyond COVID19 pandemic, the health system is also tested to cope with the fast-evolving and unprecedented manmade crisis such as conflict and insecurity which led to a major disruption of essential health services to a point of zero.

Hence, this component strengthens the ability of all actors and functions related to health to collectively mitigate, prepare, respond and recover from disruptive events with public health implications, while maintaining the provision of essential functions and services. Specifically, i) establishing regulatory, governance and management mechanisms to health facilities and health

bureaus at different level to mobilize rapidly in times of crisis: not only to respond to threats, but also to sustain essential service provision during shock events; ii) review the budgeting, public financial management and supply chain systems to reflect contingency resource commitments, fiscal flexibilities and autonomy to quickly respond to public health emergencies at all levels; iii) revise the essential health service package and medicines and equipment list to include supplies needed to deal with public health emergencies and review the system of forecasting, procurement, and distribution of medical supplies and equipment's to be accommodative of emergency operations, iv) Establish risk communication and community engagement strategies and mechanism for assessing and maintaining public trust in health services and public health measures to ensure routine health service utilization during public health emergencies; and v) Develop capacities for quickly reorganizing and utilizing alternative service-delivery platforms to prevent service disruption during emergencies (e.g. digital and virtual services) and institutionalize simulation exercises that test health systems resilience regularly and at all levels.

Subcomponent 1.4: Support digitalization of health sector processes and PHE information systems. The COVID19 pandemic, conflict and associated displacement and refugee crisis, drought induced measles and cholera outbreaks, and other crisis's has s showed that well-functioning digital services and data interoperability are crucial components during a public health crisis as essential as rapid response and management strategies including contact tracing, case surveillance, diagnostic testing, case treatment and vaccination efforts. There are various digitization efforts at point of care and institution levels that presented opportunities for unprecedented impact on the foundation of Ethiopia's public health system. The ministry of health has established electronic health information management system that tracks health service delivery, public health emergency information and community-based activities that generate information from community level and aggregate at health facility and different health care administration level to track service delivery and decision making. However, there is poor interoperability among the different health information systems, limited and variable geographic coverage (example, eCHIS 18% and DHIS-2 65%) no clear mechanism for data sharing (interface mechanism) with agricultural, veterinary, and environmental disease surveillance systems. There is a lack of a real-time surveillance system for health emergency preparedness and response due to inadequate data collection, analysis, and mechanisms for data-sharing.

This subcomponent specifically supports, i) establish integrated and interoperable health information systems to monitor health risks, public health events and their impacts on health systems and services: (iii) Establish/strengthen structures and resources for dissemination/communicating of information related to public health emergency and strengthen the platforms to engage with populations/communities; (iv) Invest in cutting-edge, cost-effective technologies for risk registering and profiling at all levels of healthcare provision for the populations served; (v) Engage private health service providers (institutional and individual) in the integration and alignment of health information systems to build health systems resilience, responding to and recovering from disruptive events; (vi) Develop functional Information systems to improve the integration of critical public health, health care services, environment, port health, and veterinary surveillance data; and (viii) Establish real-time monitoring systems to assess the disruptions to essential health services, incorporating specific thresholds to trigger support and ameliorative action from the onset of emergencies and throughout an evolving response;

Component 2: Improving the detection of and response to public health emergencies (USD $145M):

This component will support the national detection and response pillars which aims to strengthen early warning system, revise the list of reportable diseases, strengthen risk screening at port of entries (PoEs) including border areas, enhance digital information management of multi-hazards (infectious disease outbreaks, biological, chemical, radiological and environmental), surveillance data analysis and interpretation, community level information collection and verification, provide feed-back to facilities and regions, finally, risk communication will be held alongside information management.

***Subcomponent 2.1: Support the Collaborative Surveillance and Laboratory diagnostics* (US$5M):** This sub-component focuses on the integration of surveillance information, laboratory investigation and feedback mechanisms and decision making at the cross-border areas considering the geopolitical situation of Ethiopia in part of the east Africa region which are characterized by frequent conflict and fragile health systems, high number of refugees and internally displaced peoples (IDPs), unregulated movement of peoples and cattle across border and commercial movements. The most recent available joint external evaluation (JEE) and state party annual reporting tool (SPAR) assessments have documented that the minimum IHR-2005 capacities at points of entry was documented to be low, and it was clearly stipulated that enhancing the detection and response capacities at cross border areas is critical. Poor integration among animal and human sectors in data sharing, joint analysis and interpretation of findings and joint action are missing or ad-hoc based. Hence, tis component also entails the need to strengthen the one health approach in cross-border area through a focus on multi-sectorial approach and enhanced engagement of regional institutions such as IGAD and HECSA.

Specifically, the support will include: i) strengthening the capacity of selected points of entries for screening, isolation, and quarantine as well as expanding the capacities of those existing centers to integrate one-health approach; ii) strengthen the linkages between field level bio-safety level (BSL-2) laboratories constructed by the Africa CDC project to the cross border detection and response activities and enhance the information exchanges practice using state of the art digital health technologies; iii) develop the legal frameworks, institutional structures with clear accountability for multisectoral and cross border engagement with neighboring countries through the support and leadership of IGAD; and iv) Engage with academic institutions and think-tank groups to develop a research priority list and conduct evidence generation on prioritized zoonotic diseases and other health threats at the animal-human-environment interface.

***Subcomponent 2.2: Support the Emergency Management and Coordination*.** Investments from the world bank COVID19 emergency response project and Africa CDC investment financing project have focused on. As demonstrated through different outbreak and other public health emergency responses including COVID-19, Ethiopia has not reached its optimum capacity in terms of rapid and effective emergency management and disease outbreak controls. To improve the capacity of the country to effectively respond integrated with regional public health agencies such as AU-CDC and others, to any public health hazard, improving human resource capacity/subject matter experts, coordination centers and platforms, conduct operational research/outbreak investigations and equipping the response team with necessary logistics are critically important. Specifically, this component involves i) Strengthening readiness and

response coordination mechanism at national and sub-national level including strengthening the public health emergency operation centers (PHEOC) towards effective coordination of public health emergencies (PHEs) preparedness and response activities to COVID-19 pandemic, IDP health Intervention, Cholera and cVDPV outbreak response and Monkey pox and EVD preparedness activities; ii) capacitate and strengthen the rapid response team through identifying, training, and rostering subject matter experts at national and sub-national levels.

Subcomponent 2.3: Support accelerated access to and deployment of R&D, legal, and regulatory countermeasures in a PHE, leveraging public and private sector resources. The major causes of disarray in health outcome between low income and developed countries is the inequitable access to essential diagnostic and treatment pharmaceutical supplies. Despite hosting 17% of the global population and untapped natural resources, Africa produce only 1% of the continental vaccine needs; many countries including Ethiopia fully rely on import for essential vaccines. In 2020, Ethiopia's pharmaceutical market averaged nearly US$ 1 billion and is estimated to reach more than US$ 3.6 billion by 2030. The market for pharmaceuticals and medical devices in Ethiopia is met through import (purchase and donation) and local production. With local production contributing less than 10% of the total market for pharmaceutical products and medical devices, the Ethiopian Pharmaceutical Supply Service Agency (EPSSA), private importers, donors, and international organizations are involved in the import and distribution of pharmaceutical products and medical devices.

For Ethiopia, with growing population, increasing disease burden and unmet needs for pharmaceutical supplies such as medicines, diagnostic supplies, and vaccines, investing in local production is very strategic and an issue of national security as demonstrated by the COVID19 pandemic. It is worth noticing that vaccine manufacturing is technology and capital intensive with stringent regulatory requirements. The ongoing government commitment in infrastructure development and policy reform; the growing local and regional market to be facilitated by regional institutions such as IGAD; the implementation of attractive incentive schemes for local manufacturers can be enabling factors to invest in vaccine manufacturing in the country. Pharmaceutical manufacturing (pharmaceuticals, vaccine, medical supplies, and diagnostics) is identified as a major focus area of the ten-year manufacturing industry development plan (2021-2030), highlighting significant opportunities to strengthen the sector to promote import substitution and satisfy domestic demand, improve access to essential medicines, and supply the export market by producing competitive products. Despite the market dominance of pharmaceutical manufacturers based in high and middle-income countries, there are many reasons why Ethiopia wants to establish its own pharmaceutical supply, such as the need for supply security, control over production scheduling and sustainability, control of costs, better control over the quality of vaccines, socio-economic development, rapid response to local epidemics including emerging infectious diseases, and dealing efficiently with endemic and pandemic disease.

This component supports the local pharmaceutical manufacturing initiative of the government and other sector actors along the value chain of pharmaceutical manufacturing**.** Specifically, i) support to strengthen the national enabling environment including medicine regulatory system; ii) develop human resources through relevant education and training; iii) encourage cluster development and production of active pharmaceutical ingredients; iv) create a research and development platform; and procure medical equipment's, supplies and other inputs to furnish

and make functional the already existing industrial park dedicated to local pharmaceutical production. This initiative needs to be complemented by the overall government investment strategies that focuses on attracting more foreign direct investment in the pharmaceutical sector and create incentives designed to move companies along the value chain in sustainable pharmaceutical production that satisfies the local diagnostic and treatment needs.

Component 3: Program Management:

Sub-component 3.1: will support monitoring and evaluation and engagement of academia and think tank groups. This component will provide financing for i) Coaching and technical support for data analysis, interpretation and lesson sharing and support for decision-making; ii) Third party implementation and monitoring to support implementation of the project activities in conflict and security constrained areas and assure the validity of Results Framework indicator data reported by governments; and (iv) Data-based cross-border learning initiatives, which will share proven strategies to effectively collect and use data to enhance health emergency response.

Sub-component 3.2: will focus on all other aspects of program management. Implementing the proposed project will require administrative and human resources that exceed the current capacity of the implementing institutions, in addition to those mobilized through the other bank projects including COVID19 emergency response project and Africa CDC Project. Specific activities include: i) support for procurement, FM, environmental and social safeguards, monitoring and evaluation, and reporting; ii) recruitment and Training of Grants Management Unit and EPHI staff and technical consultants; iii) operating costs and iv) support for cross border related administrative activities and collaboration with IGAD.

Component 4: Contingent Emergency Response Component (CERC): TBD

1.5.3. Institutional and Implementation Arrangements

The Ministry of Health (MoH) of the Government of Ethiopia will be the implementing agency for the project and oversee the overall implementation of the project. The state minister for Programs will be responsible for the execution of project activities and oversee the overall implementation of the project. The Grant management unit of the Ethiopia MoH's Partnership and Cooperation Directorate (PCD) will be responsible for the day-to-day management of activities supported under the project as well as the preparation of a consolidated annual workplan and a consolidated activity and financial report for the above-mentioned project components. The PCD already manages and coordinates several World Bank funded projects in the health sector, including the Africa Centre for Disease Control (CDC) and Prevention regional investment financing project (P167916); Ethiopia COVID19 Emergency Response Project (P173750); Sustainable Development Goal Program for Results (P123531); and Ethiopia Program for Results (Hybrid) for Strengthening Primary Health Care Services (P175167).

The Ethiopian Public Health Institute (EPHI)[16] will serve as the key technical entity for the implementation of the project activities. It will both support the PCD and directly implement

[16] EPHI is under the Ethiopian Ministry of Health and is responsible for implementation of several WBG supported projects (e.g., the COVID-19 and Africa CDC projects in Ethiopia), while the MoH is the primary recipient of WBG funding.

certain technical activities. The EPHI will report directly to the state minister, and it will share the project's technical and financial updates with the grant management unit. If necessary, the EPHI will also reinforce the GMU with additional staff, including accountants and procurement officers, to manage project activities under its purview. The Ethiopia MoH will also deploy the staff needed for proper implementation of the environmental and social management plan as specified in the project's Environmental and Social Impact Assessment (ESIA). In addition to MOH and the Ethiopia Public Health Institute (EPHI), the Ethiopia Pharmaceutical Supply Agency (EPSA), Ethiopian Food and Drug Administration (EFDA), Regional Health Bureaus, technical directorates at the MoH and other key agencies will be involved in project activities based on their functional capacities and institutional mandates.

The implementation of the ongoing World Bank Funded projects has provided several insights in key implementation capacity gaps that this new operation needs to address to ensure enhanced implementation capacity and achieve intended results through efficiency in the use of project resources. The three key aspects that are important lessons learned incorporated into the design of this operations are: i) Cross border collaborations, multi-sectorial coordination, and limited project implementation capacity in emerging regions are key factors affecting project implementation and achievement of the intended result of the project. Establishment of cross-border coordination task force, strengthening multi-sectorial platforms and capacity building on quality data collection and utilization for decision making are key project components; ii) Access and implementation of project activities in areas of affected by conflict and insecurity, especially in the border areas. The team has explored all options and is incorporating the possibility of using the contracting of a third party for the implementation of project activities in the areas affected by the conflict and insecurity. Based progressive assessment of the situation, activities being implemented by third party will be transferred to ministry of health on a phased based approach; and iii) capacity gaps in project management and technical gaps in preparedness, response and building resilient health systems. It is critical to build the capacity of grant management unit in sequencing of project activities that are in alignment with the results framework and government's budget cycles and other guidelines and rules that affect planning, disbursements, and procurement processes.

Strengthening the capacity of the GMU has already been agreed within the framework of the ongoing bank projects, and further expansion of the unit will be supported under this project. A hands-on approach to supervision of key fiduciary aspects will support Ethiopia Ministry of Health and the GMU in exploring all the options to help tackle the key barriers for accelerated implementation of procurement processes and budgeting. For this effect a technical assistance fund will be established as part of component 3 (project management) and finance key capacity gaps and technical assistance needs based on annual work plans. The GMU may also recruit specialized technical staff as needed, and some activities may be outsourced to third parties through contract agreements acceptable to the World Bank.

The resources of this project are designed to leverage resources provided by government and other development partners. The project is also designed to ensure the desired outcomes can be accomplished with ownership of the regional and subregional entities that are also engaged in supporting key public health interventions. Using the existing country's policy dialogue platforms, the World Bank will work closely with development partners and other regional institutions (TBD) to engage in relevant activities and have an ongoing discussion that

can foster complementarities and exchange of information.

Table 1: Project Components and Implementing Agencies

Component	Sub-component	Implementing Agency
Component 1: *Strengthening the Preparedness and Resilience of the Health System to manage PHEs*	*Subcomponent 1.1:* **Strengthen cross-sectoral and cross-border public health emergency preparedness and response and develop necessary legal frameworks and directives emphasizing essential public health functions.**	MoH/EPHI/RHB /MoA
	Subcomponent 1.2: **Support health workforce skill development and resilient engagement during public health emergency.**	MoH/EPHI/RHB
	Subcomponent 1.3: **Support health systems readiness for continuity of essential health service delivery during public health emergencies**	MoH/EPHI/RHB
	Subcomponent 1.4: **Support digitalization of health sector processes and PHE information systems**	MoH/EPHI/RHB
Component 2: *Improving the detection of and response to public health emergencies*	*Subcomponent 2.1:* **Support the Collaborative Surveillance and Laboratory diagnostics**	MoH/ AHRI/ EPHI/RHB
	Subcomponent 2.2: **Support the Emergency Management and Coordination**	MoH/EPHI/RHB
	Subcomponent 2.3: **Support accelerated access to and deployment of R&D, legal, and regulatory countermeasures in a PHE, leveraging public and private sector resources**	MoH/EPHI/RHB
Component 3: *Program Management*	*Sub-component 3.1*: **support monitoring and evaluation and engagement of academia and think tank groups**	MoH
	Sub-component 3.2: **will focus on all other aspects of program management**	MoH

Component 4: *Contingent Emergency Response Component (CERC***)**		MoH

1.5.4. Project Intervention Areas

This is a national project covering all the eleven regional governments and two city administrations, but the bulk of the project interventions will likely be carried out in "high-potential" climate crisis prone low land areas and border areas due to the cross-border nature of the project. The project will undertake interventions that are at policy and strategy level but still focusing on creating the public health preparedness, response, and resilient health system capacity at the district level. Due to the multisectoral nature of the project, the project will engage with regional governments within Ethiopia to ensure their buy-in, support coordination with sectors other than health and able to reflect their unique context in the design of the project interventions.

Already in its design that this is a regional integration project, Intergovernmental agency for Development (IGAD) and Africa Center of Disease Control (Africa CDC) will be involved in the project implementation. In addition to working on broader public health emergency preparedness, response and resilient health system building at national and sub-national level, the project will work with regional integration institutions such as Intergovernmental agency for Development (IGAD) and Africa Center of Disease Control (Africa CDC). The selection of IGAD as regional institution is based on the comparative advantage and leveraging power of IGAD in engaging political leaders in the east Africa to work together in cross border public health emergency, cross country information and data sharing among member countries that border with Ethiopia.

1.5.5. Project Beneficiaries

The project will benefit communities in Ethiopia, especially poor households, communities bordering other countries, refugees, and other populations that are at high risk of epidemic disease. Key beneficiaries include populations in Ethiopia (115 million), as well as communities in countries directly bordering Ethiopia: Sudan (46.6 million), South Sudan (11.5 million), Djibouti (1.01 million), and Eritrea (3.7 million). Projects indirect beneficiaries extends to other IGAD member countries through knowledge and information/data sharing on public health emergency management. In addition, due to the "one health" focus of the project, the project beneficiaries extend to Animal health and increase productivity in the rural sector by reducing animal deaths, increasing animal fertility, and boosting the marginal output of animal products. The project will improve the overall social and economic benefits of improved health indicators and lower mortality rates, finally, through working with regional integration institutions such as IGAD and Africa CDC, the project will strengthen domestic, regional, and continental institutions and build the capacity of their staff, reinforcing the framework for an integrated Africa.

2. Legal Frameworks: Basis for Social Assessment

This section discusses the national legislations and World Bank environmental and social safeguard policies relevant to historically underserved communities.

2.1. National Legal and Institutional Framework for Underserved and Vulnerable Groups

Various national legislations have been used during the implementation of projects. These emanate from the 1995 Constitution of the Federal Democratic Republic of Ethiopia (FDRE) and various policies, strategies, proclamations and regulations. This will be discussed in the following sections.

The **1995 Constitution** of the federal Republic of Ethiopia recognizes the presence of different socio-cultural groups, including historically disadvantaged and underserved communities, pastoralists, agro-pastoralists, and minorities, as well as their rights to socioeconomic equity and justice.

Article 39 of the Ethiopian Constitution recognizes the rights of groups identified as "Nations, Nationalities and Peoples". They are defined as "a group of people who have or share a large measure of common culture or similar customs, mutual intelligibility of language, belief in a common or related identity, a common psychological make-up, and who inhabit an identifiable, predominantly contiguous territory." This represents some 75 out of the 80 groups[17] who are members of the House of Federation (HoF), which is the second chamber of the Ethiopian legislature (Van der Beken, 2007). The HoF is the representative organ of the diverse Ethiopian ethnic groups in the federation because Article 61(1-3) of the federal constitution stipulates that all nations, nationalities and peoples, including those with less than 100,000 population and who cannot elect their representatives to the lower house, the legislative House of Peoples' Representative (HPR), are entitled to at least one representative, elected either by the regional parliaments or within the framework of direct elections organised by these parliaments.

The *Constitution recognizes the rights of these Nations, Nationalities and Peoples to: self-determination, including the right to secession; speak, write and develop their own languages; express, develop and promote their cultures; preserve their history; and, self-government, which includes the right to establish institutions of government in the territory that they inhabit and equitable representation* in state and Federal governments.

The Constitution also recognizes the rights of pastoral groups inhabiting the lowland areas of the country. The constitution under article 40(4) stipulates '*Ethiopian pastoralists have a right to free land for grazing and cultivation as well as a right not to be displaced from their own lands'*. Article 41(8) affirms that "*Ethiopian pastoralists have the right to receive fair prices for their products, that would lead to improvement in their conditions of life and to enable them to obtain an equitable share of the national wealth commensurate with their contribution. This objective shall guide the State in the formulation of economic, social and development policies.'*

[17] The national minorities constituted 8.8% of the total population of Ethiopia, which was 73,918,505 according to the 2007 Population and Housing Census.

Pastoralist regions/areas recognized by the government are: Afar; Somali; Borena Zone and Fentale *Woreda* (Oromia); South Omo Zone, Bench-Maji Zone, and parts of Decha *Wereda* in Keffa Zone (SNNPR); and Nuer Zone (Gambella).

The pastoralists comprise approximately 12-15 million people that belong to 29 groups of Nations, Nationalities and Peoples.[18] Whilst government policies have strengthened and resource allocations increased over the last decade,[19] pastoralist areas are still amongst the least served in terms of basic services. Education indicators for pastoralist areas are among the lowest in the country: lowest literacy rates, highest dropout rates and greatest distance from schools (Jennings et al., 2011). Some pastoral households view formal education as a threat to the contributions that children make to the household and the pastoralist way of life and girls' access to education is also constrained by the perceptions of parents that schooling compromises girls' reputation, makes them less compliant which, in turn, reduces their worth as marriage partners (Brocklesby et al. 2011).

Article 54(1) of the FDRE Constitution also recognizes another group called "national minorities", i.e., Nationalities and Peoples whose total population is "less than 100,000 members and most [of them] live in the 'Developing Regional States'".

Owing to their limited access to socioeconomic development and underserved status over decades, the GoE has designated four regions, i.e., *Afar, Somali, Benishangul-Gumuz, and Gambella as* ***Developing Regional States (DRS)***. In this respect, Article 89(2) of the 1995 Constitution stipulates: 'The Government has the obligation to ensure that all Ethiopians get equal opportunity to improve their economic situations and to promote equitable distribution of wealth among them'. Article 89(4) in particular states: 'Nations, Nationalities and Peoples least advantaged in economic and social development shall receive special assistance'.

In connection with the institutional framework designed to ensure equity between regions, the government has set up the Ministry of Federal Affairs (MoFA)[20]. The responsibilities of this Ministry include promoting equitable development, with emphasis on delivering special support to the developing regions. The main purpose of the special support is to address the inequalities that have existed between the regions over the decades, thereby hastening equitable growth and development. Federal Special Support Board, which consists of relevant sector ministries including the MoA, was reorganized in March 2011. The MoFA acts as Vice Chair and secretariat of the Board. A Technical Committee (TC) composed of sector ministries constituting the Board was also set up under the MoFA to monitor and report the implementation of special

[18]Pastoralist Forum Ethiopia, http://www.pfe-ethiopia.org/about.html

[19]PASDEP (2005 -2010), the previous five-year poverty reduction plan to GTP promoted more targeted assistance to marginalized areas – the emerging regions and pastoralist/agro-pastoralist areas (MoFED 2010).

[20] Now a defunct Ministry, but most of its mandates such as Federal and Pastoralist Development Affairs, inter-regional affairs and issues related to peace were put under the Ministry of Peace. A new department tasked with Low-land irrigation was established under the Ministry of Agriculture.

support plans. As its main aim, the Board coordinates the affirmative support provided to the developing regions by the different organs of the federal government, and ensures the effectiveness of the implementation process.

In addition, *Equitable Development Directorate General* has been set up within the MoFA, with Directorates put in place to operate under it for the respective developing regions. Among many other activities, the Directorate General coordinates and directs case teams to collect, organize and analyze data in relation to the gaps in capacity building, social and economic development, good governance, gender and environmental development in the regions in need of special support.

With the announcement of *the National Policy of Women* in 1993 and the promulgation of the new Constitution in 1995, the Ethiopian Government declared its commitment to the equitable socio-economic development of women. The National Policy on Ethiopian Women aims to institutionalize the political, economic, and social rights of women by creating appropriate structures in government offices and institutions so that public policies and interventions become gender-responsive in order to ensure equitable development for all Ethiopians.

Labour Proclamation (Proc. No. 377/2003) provided women with a special attention. This proclamation is aware of the fact that women are marginalized historically, and hence genuine equality will not be maintained only by the principle of non-discrimination on the basis of sex rather women should also be given with a special treatment, affirmative action.

After long discussions, the Government recently announced revision of its 15-year-old Labour Law. The revised Labour Proclamation ***(Proc. No. 1156/2019)*** is one of the key pieces of legislation that the Government has adopted in order to move forward in alignment with the Country's fast economic growth and evolving employment relations, and to comply with multiple International Labour Organization's ("ILO") Treaties and Commentaries.[21] The new Proclamation No. 1156/2019 which repeals the previous proclamation No. 377/2003 and Labour (Amendment) Proclamation No. 466/2005. One of the major additions in the revised Labour proclamation relates to Sexual violence and Harassment in the work place. The new Proclamation defines sexual harassment as "means to persuade or convince another through utterances, signs or any other manner, to submit for sexual favor without his/her consent" (Art.2(11)). Sexual violence is defined as "means sexual harassment accompanied by force or an attempt thereof" (Art.2(12)). Moreover, the hitherto thirty days pre-natal and sixty days post-natal leave has been changed to thirty consecutive days pre-natal and ninety consecutive days post-natal leave (88(3)). Additionally, the revised Proclamation has introduced paternity leave of three working days with full pay (Art.81(3)), which was not recognized under the previous proclamation.

In 2005, the Women 's Affairs Ministry was established to coordinate women's activities and translate the policy objectives. In 2006, the Ministry of Women's Affairs issued the *National Plan of Action for Gender Equality (NAPGE)* for the period 2006 – 2010. Its goal is "*to*

[21] https://mehrteableul.com/images/Legal_Update_Employment.pdf

contribute to the attainment of equality between men and women in social, political and economic development".

Recently, the GoE has put in place a strong policy foundation for the social protection sector, with the approval of the *National Social Protection Policy* (**NSPP**) 2014 and *National Social Protection Strategy* 2016. This policy envisions "to see all Ethiopians enjoy social and economic wellbeing, security and social justice "and recognizes the contribution of social protection to the development goals of the country. It further indicates that the Government will commit human and financial resources to reducing poverty and provide social protection to its ***poorest and most vulnerable citizens***. The **NSPP** has a broad objective of providing an overall Social Protection system and creating an enabling environment in which Ethiopian citizens have equitable access to **Social Protection** services that will enhance inclusive growth and development. Overall, the policy commits the government to move beyond the partial, and fragmented, provision of Social Protection to establish a *comprehensive Social Protection system* (MoLSA 2014).

The policy has five integrated focus areas, which includes: (1) *Promote Productive safety nets*; (2) *Promote employment opportunities and improve livelihood*: (3) *Promote social Insurance:* (4) *Enhancing equitable access to and use of basic services*; and (5) *Providing legal protection and support services for those vulnerable to violence and abuse*. Across these areas, both the Policy and the Strategy seek to bring together a variety of existing programs into a national social protection system for supporting ***vulnerable*** Ethiopians. The fourth area of focus that aimed to enhance access to health, education and other social services introduced specific strategies among others: '*health fee waivers and health insurance subsidies, services for the elderly and labour-constrained, establishing a social work system and school feeding*' (MoLSA 2014; 2016). The policy serves as a framework for collaboration and coordination system of social protection in order to provide different services by different organization at all level.

Moreover, Ethiopia's 'Growth and Transformation Plan' (GTP I 2010/11-2014/15 & GTP II 2015/16-2019/20) is a national five-year plan initiated and developed by the Ethiopian Federal Government to improve the country's economy by achieving a projected gross domestic product (GDP) growth of 11-15 percent per year from 2015/2016 to 2019/2020. Among others, GTP II envisages strengthening the empowerment of women so as to ensure their active participation in the political, social and economic processes that are taking place in the country. All public development programs will be designed in such a way that they engage women and ensure their equity in the outcomes of such programs. During GTP II, the political empowerment of women will be realized by establishing mechanisms for women's equal participation and equitable representation at all levels of the political process and public life in society. A critical element in this endeavour is promoting women organizations that articulate and advance women's concerns, needs and priority agendas, and that influence public policies and actions" (p.3)[22].

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[22] Enhancing Shared Prosperity through Equitable Services (ESPES) Additional Financing (AF) Incremental Environment and Social Systems Assessment (ESSA).

Following the end of GPT II, the ***Ten Years Development Plan: A Path to Prosperity*** (2021–2030)[23] was launched. The ten-year development plan lays a long-term vision of making Ethiopia an "***African Beacon of Prosperity***" by creating the necessary and sufficient conditions. It states "prosperity should be defined in terms of the overall human and institutional capability we create over the long-term whose development outcomes can be expressed as follows" (p.19).

1. Improvement in income levels and wealth accumulations so that every citizen would be able to satisfy their basic needs and aspirations.
2. Basic economic and social services such as food, clean water, shelter, health, education, and other basic services should be accessible to every citizen regardless of their economic status.
3. Creating an enabling and just environment where citizens would be able to utilize their potentials and resources so that they lead quality life.
4. Improvement in social dignity, equality, and freedom where citizens can freely participate in every social, economic, and political affairs of their country regardless of their social background.

One of the six key development objectives of the Plan is no. 6 says "*Building strong and inclusive institutions that would ensure peaceful society, access to justice and upholding the rule of law and human rights*." (p.20) Among the eight key strategic pillars identified to realize the development objectives, number 8 is pertinent here: "***Gender and Social Inclusion***" (p.21)/

The key priority areas are: (p.21)

1. Multi-sectoral and Diversified Sources of Growth and Job Opportunities,
2. Sustainable and Inclusive Financial Sector Development,
3. Harnessing the Demographic Dividend,
4. Quality and Efficient Infrastructure Development,
5. Sustainable Urban Development, and
6. Peace, Justice, and Inclusive Institutions

The whole **Chapter 8** of the **Ten Years Development Plan** is dedicated to ***Gender and Social Inclusion*** pillar, while health was treated under chapter 7, i.e., Demography and Human Resource Development.

2.2. The Nexus between Ethiopian Policies and Laws and the World Bank Environment and Social Framework

The Federal Democratic Republic of Ethiopia has formulated several development policies, strategies, proclamations, regulation, programs and projects to improve the livelihood and to promote sustainable development of Ethiopian people in general and the pastoral as well as agro-pastoral communities in particular. The government has also made certain shift in the thinking of pastoral development from its predecessors by bringing pastoralists themselves to participate in the policy making processes that affect their livelihoods.

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http://documents1.worldbank.org/curated/en/280901496649106913/pdf/115609-EA-P161373-Box402912B-PUBLIC-Disclosed-6-2-2017.pdf

[23] file:///C:/Users/soria/Downloads/ten_year_plan_popular_version.pdf

Detail review of Ethiopia's relevant policies, strategies and proclamations on Social and Environmental issues along with the pertinent social and environmental safeguard framework of the World Bank is covered under the ESMF/ESIA. Here suffice it to say, pastoralists and agro-pastoralists as well as disadvantaged communities are adequately considered in the Ethiopian constitution and this concurs with the World Bank's Environmental and Social Standards (ESS) (ESS 1, 5, 7 and 8)[24]. This will help '*Health Emergency Preparedness, Response and Resilience*' (**HEPRR**)' project to give due attention to the vulnerable and underserved communities during implementation that in turn enables it to meet the intents of World Bank's ESF in socially and culturally appropriate ways. The WB's ESS7 recognizes that ***Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities*** have identities and aspirations that are distinct from mainstream groups in national societies and often are disadvantaged by traditional models of development. In many instances, they are among the most economically marginalized and vulnerable segments of the population. This is clearly shown in its ***6 points objectives***.

1. To ensure that the development process 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.
2. To **avoid adverse impacts** of projects on Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities, or when avoidance is not possible, to minimize, mitigate, and/or compensate for such impacts.
3. To **promote sustainable development benefits and opportunities** for Indigenous Peoples/ Sub-Saharan African Historically Underserved Traditional Local Communities in a manner that is accessible, culturally appropriate, and inclusive.
4. To improve project design and promote local support by establishing and maintaining an ongoing relationship based on **meaningful consultation** with the Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities affected by a project throughout the project's life cycle.
5. To obtain the Free, Prior, and Informed Consent (**FPIC**) of affected Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities in the three circumstances described in this ESS.
6. To **recognize, respect, and preserve** the culture, knowledge, and practices of Indigenous Peoples/ Sub-Saharan African Historically Underserved Traditional Local Communities, and to provide them with an opportunity to adapt to changing conditions in a manner and in a time frame acceptable to them.

A key purpose of **ESS 7** is to ensure that *Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities* present in or with collective attachment to the

[24] ESS1 – Assessment and Management of Environmental and Social Risks and Impacts; ESS5 – Land Acquisitions, Restrictions on Land Use and Involuntary Resettlement; ESS7 - Sub-Saharan African Historically Underserved Traditional Local Communities; and ESS8 – Cultural Heritage.

project area are fully **consulted** about, and **have opportunities to actively participate in**, project design and the determination of project implementation arrangements. The scope and scale of consultation, as well as subsequent project planning and documentation processes, will be proportionate to the scope and scale of potential project risks and impacts as they may affect Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities. As amply demonstrated in the analyses of Ethiopian legal and policy frameworks crafted to address the problems of the underserved and vulnerable groups of the Ethiopian population, they all duly recognize the peculiar characteristics of the underserved and vulnerable groups of the nations in the pastoral and agropastoral areas and this meets the expectations of ESS 7 despite the fact that they are, as the first paragraph of ESS 7 clearly stipulates, "referred to in different countries by different terms".

3. Social Assessment Findings

3.1.Characteristics of Vulnerability and Underserved Target Communities

The Ethiopian Constitution recognizes the presence of different socio-cultural groups, including historically disadvantaged and underserved communities.

According to the National Social Protection Policy (NSPP), 2014 of Ethiopia, in the Ethiopian context, vulnerability is associated with low agricultural growth, natural calamities, economic shocks, health and nutrition risks, and population explosion. It is also connected with environmental degradation and dependence on rain-fed agriculture, which are the contributory factors of chronic food insecurity, one of the major challenges in Ethiopia today[25], as well as with unemployment and underemployment. Broadly defined, the term vulnerability applies to all social groups that find themselves disadvantaged because of the deprivation of access to socioeconomic benefits, or the adverse consequences suffered as a result of mainstream development interventions and exacerbated by lack of access to information.

Vulnerability describes the factors which expose people to the negative impacts of their living circumstances, and render them less resilient to cope with these impacts. Economic poverty is obviously a vulnerability factor; other factors include sudden shocks such as economic collapse or natural disasters (price hikes, sudden conflict, desert locus invasion as observed in the horn of Africa in 2020, and prolonged drought as observed in the lowland areas of Oromia, Somali, and SNNR in 2021 and 2022). Further vulnerability factors are:

- ❖ Lack of adequate understanding and awareness resulting from insufficient or inappropriate communication of information and ideas (which '*Digital Ethiopia*' project, currently operational and also funded by the WB, aims to address); [One of the key activities of component 2 of the HEPRR project is exactly this, i.e., ***enhance digital information management of multi-hazards (infectious disease outbreaks, biological, chemical, radiological and environmental***.]
- ❖ Embedded social and cultural attitudes and practices which discriminate against or give precedence to certain people on certain grounds (gender, age, ethnicity, religion, and occupation) also sustained by lack of information about the national and international standards on human rights and respect for human dignity;
- ❖ Attitudes towards people manifesting certain behaviour, or reactions to people with certain conditions (persons with disability, people living with HIV/AIDS and other chronic health problems such as people with leprosy).

Vulnerability can also be seen in terms of biophysical environment such as people who live in semi-arid lowland areas, where poverty, gender-based inequalities, forms of agricultural

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[25] "Overall, an estimated 12.9 million people are expected to be facing high levels of acute food insecurity (IPC Phase 3 or above) in the presence of currently planned and funded humanitarian response interventions from January to June 2021." Ethiopia: IPC Acute Food Insecurity Analysis October 2020 – September 2021, Issued December 2020 - Ethiopia | ReliefWeb

livelihood, customary practices, and spatial disparities in resource potential are the key factors affecting people's abilities to access services that would enhance their means of livelihoods. Irrespective of their vulnerability, no community members in the project implementation areas will be intended to be excluded from the '*Health Emergency Preparedness, Response and Resilience*' (**HEPRR**)' Project.

The socioeconomic and cultural profile of the population groups described as vulnerable and underserved and considered as potential beneficiaries of the **HEPRR** Project are presented below.

3.1.1. Women

The **HEPRR** Project Concept Note (parag. 20) acknowledges the risk of exclusion from project benefits of vulnerable groups including women. Gender-based social exclusion, discrimination and differential treatment constitute key risks and addressing those should be an important entry point to the design and implementation of development programs such as **HEPRR**. Women become vulnerable because of lack of education, gender bias, traditional and cultural norms, and their reproductive and productive roles and more importantly lack of access to up to date and reliable information.

More specifically, socially constructed determinants mainly societal attitudes towards women, women's socioeconomic status, their levels of education, and the awareness of their rights define women's roles and position in society. In relation to this, specific issues for deeper examination are: societal attitudes placing the burden of domestic responsibilities on women, their low economic status evidenced by their limited property rights (land and livestock), little or no access to education and unaffordability of ICT services with its ramifications of rights conscious deficiency at all levels, and their vulnerable status emanating from the difficulty to balance their triple roles competing for their equal attention in male-headed households and single-handedly running the households in female-headed households.

3.1.2. Women's time poverty

Document review of the SA studies of various development projects (e.g., RLLP, 2020; SEAN-Enhanced SA and Consultation, 2020; ERSNP, Enhanced SA and Consultation, 2017; AGP-II, 2015; PSNP-IV, 2014; SLMP-II, 2013; *Digital Ethiopia SA 2021*) show women play a significant role in farm activities, domestic chores, and off-farm tasks in addition to their reproductive roles and maternal responsibilities towards their children. There were also cases in which women found it difficult to balance their triple roles competing for their equal attention: bearing and rearing children, maintenance of household members and domestic work, community managing role and productive role such as harvesting, weeding, threshing the harvest, etc. The difficulty of balancing these equally important responsibilities resulted in the risk of losing project benefits in varying degrees (*e.g., SLMP-2*).

Besides, women are responsible for much of the buying and selling at the local markets to earn additional sources of income for the household. Despite the embeddedness of gender-based division of labor in many communities, women often perform the jobs assigned to men. For instance, among the Gumz and Majanger women normally perform all the tasks considered to be in the domain of men such as forest clearing, hoeing farm plots, planting, weeding, and threshing (AGP-II SA report, 2015:31). Women's multiple roles in productive, reproductive and community-related activities which all compete for their effort and attention result in what is often called ***time poverty***. With their time and attention divided among these commitments, they find it difficult to balance their responsibilities including participation in development programs which would, at the end of the day, benefit them and their families (AGP-II SA report, 2015:31-2).

Women's vulnerability is further aggravated by out-migration of male adults and youths among some of the communities (e.g., Enmor ena Ener *Woreda* of SNNPR). This deprives households of male labor for agricultural engagements, forcing women to carry the entire burden of farm and domestic work. Being labor intensive and the exclusive domain of women, the chore of *enset* (*enset edulis*, also called "false banana") processing is another taxing duty that adds pressure to women and causing them ***time poverty*** in Enmor ena Ener *Woreda*, as in other *enset* growing areas of the country. *Enset* is a staple in Ethiopia, where around 20 million people rely on it for food.

Women's drudgery is exacerbated by economic hardships, exposing them to even higher vulnerability. Hence, the worse off women are, the greater their burden of work, with the consequence of increased time poverty. Moreover, as stated in the **HEPRR** project Concept Note (Parag. 1, last sentence), Health Emergencies (HEs) "affect vulnerable populations unevenly, with forcibly displaced communities and their hosts, **women**, and children often bearing the brunt of the adverse impacts". Therefore, **HEPRR** project will further enhance the status of women and other vulnerable populations through improved health with more investment in HE preparedness.

3.1.3. Female-Headed Households

It is a common to see female-headed households struggling to sustain their families in both rural and urban settings of Ethiopia. However, data on the number of female-headed households are not easy to come by. Female-headed households are challenged not only because of absence of adult male to shoulder the responsibility assigned to him, but also by access to only small farmland (often 0.25 hectare in in some parts of the country such as Tigray and Amhara) with large household size.

A significant proportion of the female household heads are widows in childbearing age with small family size. Due to the shortage of manpower in the household, these widows mostly depend on external labor, which they find through land rent or share-cropping. Having to share the produce with others in both cases, they are left with reduced benefit, not being able to get the

full amount of what their land can offer them. Female-headed households with small farmland and shortage of draft power (e.g., Kafta Humera *Woreda*) are more vulnerable groups, e.g., they lease out the land because of lack of money to hire draft oxen or machinery, which means forfeiting the income they would otherwise be able to earn. When dispute arises between the female leaser and male leaser in the traditional dispute settlement mechanisms, disputes are mostly handled in favor of the better offs, i.e., male leaser. Because of lack of resources, time and money, the leaser female household heads do not pursue the disputes through the formal legal channels, which are often time consuming and expensive.

The fact that gender inequality is embedded in the societal fabric in Ethiopia, i.e., women experience higher rate of unemployment, far less participating in seasonal (37%) and temporary (13%) employment, poorer women and girls especially facing multiple disadvantages, 58 percent of women being illiterate, and less than 12 percent of women access internet, the risk of women and girls being left out from the project beneficiary is very high.

To provide equitable benefits and opportunities, the project will ensure active participation of women in the project implementation units (PIU) and various committees including the Project Steering and Technical Committees. The project will also engage women groups to ensure that men and women have access to information on project related business opportunities. Gender-disaggregated data will be collected as part of the routine tracking and monitoring system of the project.

3.1.4. Youth

Ethiopia is a country of youthful population and the issue of youth has received greater attention in Ethiopia over the last one and half decades. Ethiopia's ***National Youth Policy*** (2004) marks a major step in recognizing and promoting the rights of young people in the country. The policy "aims to bring about the active participation of youth in the building of a democratic system and good governance as well as in the economic, social and cultural activities and to enable them to fairly benefit from the results". It envisions "a young generation with democratic outlook and ideals, equipped with knowledge and professional skills." Ethiopia's youth have the potential to play a significant role in the country's socio-economic and political development and its participation is increasingly recognized by the public authorities, following the government's strategy to involve youth in decision-making processes.[26]

Currently the youth are facing various challenges to be involved in economic activities. Some of these challenges include acquiring productive farmland in rural areas (Schmidt and Bekele, 2016), work place in the towns, start-up capital, skills and smart ICT. Unemployment and underemployment, compounded with other challenges, are the main drivers of youth vulnerability. Unemployed youth in who have, for various reasons, dropped out of school at primary, secondary or preparatory levels. Others are young men and women who have returned to live in their natal villages, not being able to find work in the towns/cities after completing

[26] http://www.oecd.org/dev/inclusivesocietiesanddevelopment/youth-issues-in-ethiopia.htm.

technical and vocational training or college education. The underemployed are by and large rural youths who have not had access to school and continue to live with their parents assisting them with farm work or it includes those who have married and survive on small portions of farm plots transferred to them by their parents. Both groups are underemployed because the small farm plots on which they work can hardly fully engage them and support themselves. These problems are pronounced among the pastoral and agro-pastoral communities due to natural and man-made challenges such as recurrent drought, flood, inter-and intra-group conflict, cattle raids, low schooling and lack of access to affordable ICT services, and high risk of community wide impoverishment.

As reflected in the findings of this RSA, "The educated and urban residents are more likely to benefit from any project due to access and affordability advantage they have over others". Likewise, the **HEPRR** project might involve this selectivity bias in favour of the educated, the resourced/financed, the urbanites, people with strong connection to the politically and economically privileged, etc., the risk that the unemployed/underemployed youth (women and men), the rural youth, and youth from the low-income households, particularly girls might be left out in beneficiary targeting process is high. Moreover, corruption/nepotism and elite capture risks are also high, including political corruption where affiliation to the ruling party might make one a stronger candidate for selection (e.g., PSNP-IV SA report). The SA for *Digital Ethiopia* concurred with previous studies and similar concerns were raised in this RSA. As a way forward, it is recommended to involve the youth from all the differentially positioned groups in the committees that might be established as part of project implementation organs.

3.1.5. Chronically ill and people living with HIV/AIDS

Chronic illness and HIV/AIDS cause labour shortages in resource-poor households, preventing them from diversifying income activities. These people endure extended periods of pain and suffering and face high costs for treatment and medication, which may erode savings and make them dependent on family and friends. The chronic illness leads to the loss of their ability to earn a livelihood and support themselves. Although development programs such as the **HEPRR** project are meant to address the major health, information and mobility challenges of the chronically ill persons of the project target communities, their chance of being excluded from the actual beneficiary groups is high due to the financial, information and may be literacy constraints they have. That is why, beneficiary selection needs to be carefully planned and executed in a participatory way, namely involving direct project beneficiaries and the existing traditional/indigenous institutions renowned for their integrity in their respective communities.

3.1.6. Elderly

According to the UN definition, older people are those people whose age is 60 years and above. This also corresponds with Ethiopia's official retirement age.[27] Although gradually being eroded/diminishing due to urbanisation and "modernisation" "older people in Ethiopia used to be treated with respect and love, and they received support from their families, relatives and the community" (ibid.). Their accumulated knowledge and experience are recognized.

However, when families or communities themselves face problems, it is difficult for older persons to get the support and assistance they need. Some elderly persons who lack a social support network and cannot find work may turn to begging. It is also recognized that the Ethiopians' long-standing culture of intergenerational solidarity and mutual support may be declining due to urbanization, "modernization", and economic stress on the younger generation, in turn caused by unemployment and underemployment, resulting in increasing vulnerability, particularly among older persons. The interaction of several factors exacerbates the vulnerability of the elderly people.

> Poverty has become more acute among older people and it is much more difficult for them to come out of it. Ill health, unsuitable residential areas, diminishing family and community support, limited social security services, lack of education and training opportunities, limited employment and income generating opportunities, and lack of balanced diet and shelter are some of the factors contributing to the poverty of older people. (ibid.)

Access to affordable health services and improved HE responses will definitely benefit the elderly people, which in turn will benefit the community (e.g., healthier and productive senior citizens). The big question, however, is what is the likelihood of their inclusion in the project given all the aforementioned challenges that exacerbate their vulnerability? Therefore, there is a need for an honest community consultation to assess the scale of this challenge and in consultation with the respective local community devise a workable and inclusive project implementation plan.

3.1.7. Persons with disability

Disability of one sort or the other is one of the major challenges in Ethiopia. According to UNICEF: "Using survey data from 2015/16, nearly 7.8 million people in Ethiopia are estimated to live with some form of disability, or 9.3 percent of the country's total population. Of these, up to 2.2 million people (2.4 percent) have very profound difficulties. The estimated number of people with severe disabilities in Addis Ababa is around 47,000, and 324,000 in other urban areas of the country."[28]

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[27] Vulnerability of Older People in Ethiopia The Case of Oromia, Amhara and SNNP Regional States | Humanitarian Library

[28] 3.Situation and access to services of persons with disabilities in Addis Ababa Briefing Note.pdf (unicef.org)

The underlying causes of physical disability are often misunderstood in rural Ethiopia, often thought of as 'a curse from God.' As a result, disabled people's access to education is a challenge and rejection by family and society is common. Health care challenges also mean that mobility aids are not widely available; those who are unable to walk unassisted have no choice but to crawl.

The recent SA conducted for the '*Digital Ethiopia*' project (2021) benefitted from the thoughtful and enlightening responses of the *Federation of Ethiopian Associations of Persons with Disabilities (*FEAPD*)*. According to FEAPD***:***

> A lack of accessible communication and information affects the life of many disabled people. Individuals with communication difficulties, such as hearing impairment or speech impairment, are at a significant social disadvantage, in both developing and developed countries. This disadvantage is particularly experienced in sectors where effective communication is critical – such as those of health care, education, local government, and justice.

FEAPD, based on a survey conducted in different countries on access to and the use of digital media, argues "disabled people are half as likely as non-disabled people to have a computer at home, and even less likely to have Internet access at home. The concept of the digital divide refers not only to physical access to computers, connectivity, and infrastructure but also to the geographical, economic, cultural and social factors – such as illiteracy – that create barriers to social inclusion." The positive impact of affordable access to digital technologies and ICT for the persons with disabilities is too obvious to tell, as FEAPD argues:

> Once they are able to access the web, they value the ***health information*** and other services provided on it. Online communities can be particularly empowering for those with hearing or visual impairments or autistic spectrum conditions because they overcome barriers experienced in face-to-face contact. People with disabilities who are isolated value the Internet in enabling them to interact with others and potentially to conceal their difference.

According to FEAPD the risk of exclusion is there, at least based on past experiences and proposes the mechanism to address the problem: "Persons with disabilities should have the same choice in everyday telecommunications as other people – ***in access, quality, and price***. **Subcomponent 1.4** of *HEPRR* project that supports '***information systems for HEs and the digitalization of the health sector'*** will build on the project activities currently being supported by the '*Digital Ethiopia'* project in availing accessible and affordable ***health information*** for persons with disabilities, who, as FEAPD noted, "have significantly lower rates of ICT use than non-disabled people. In some cases, they may be unable to access even basic products and services such as telephones, television and the Internet. Hence the project will help them in availing accessible and affordable information."

3.1.8. Occupational Minorities

Occupational minorities constitute potters, smiths, weavers, tanners and carpenters, who have been historically despised and marginalized because of their occupation. In the PSNP *woreda*s of Amhara and SNNPR regional states, occupational minorities used to be excluded for generations from mainstream social and economic activities including access to land. Although there are improvements in attitudes and practices that facilitated the integration of the occupational minorities into the mainstream society, there are still challenges.

The Manja, who live in the Konta and Decha *woredas* SNNPR, are a largely despised and vulnerable occupational minority. They are associated with a number of stereotypes related to their eating habits and personal hygiene. It is said that they eat the meat of religiously prohibited animals and that they do not keep themselves and their clothes clean. Such views and attitudes have led to the treatment of the Manja as social outcasts, resulting in their exclusion from all forms of interaction in the community including engaging in agricultural activities. A recent PhD study at Addis Ababa University (Samuel, 2015:168) showed unimaginable level of discrimination towards the Manja/Mana, even among the recently converted Evangelical Christians. They are segregated in the church premises, sit in a separate corner of the church hall and "were not allowed to be buried at the same cemetery with the converted Malla" [the politically powerful upper 'caste'] being members of the same Evangelical Church. The reason given, Samuel explains, is "based on the credence that the cemetery of Malla would be polluted if the Manja were buried there" (ibid.).

Sub-components 1.3, 1.4 and 1.5 of the **HEPRR** project will contribute to the social and cultural integration of occupational minorities, and enhance their standing in the socio-cultural and economic life of the so-called "mainstream" society. Occupational minorities are diverse and live distributed in different parts of the country, hence one-model-fits-all approach might not work to ensure they all benefit from this project. Detail implementation plans should be informed by locally specific information, but providing and disseminating information through different means, including traditional mechanisms available in those respective communities, putting in place health infrastructure/facilities that are accessible and affordable, including drugs, medical supplies and equipment in the health facilities, are key.

3.1.9. Ethnic Minorities and Shifting Cultivators

The other vulnerable groups include 'ethnic minorities' and 'shifting cultivators. The former is either indigenous to the area where they currently live (e.g., Tsemai, Nyangatom, Dassanech, Benna in SNNPR) or recent immigrants (i.e., the Irob, Saho and Kunama in Tahtay Adiabo and Kafta Humera *woredas* of Tigray, and the Gumz and Shinasha in Guangua *Woreda* of Awi Zone of Amhara region). The latter are the people who occupy the western borderlands of Ethiopia, stretching from western Tigray and running through the frontier districts of the regions of Benishangul-Gumz and Gambella is spoken an interrelated set of languages belonging to the Nilo-Saharan. The Ethiopian Nilo-Saharan language speakers consist, among others, of the

Kunama, Gumz, Berta, Anuak, Majanger and Mao-Komo. Most of the shifting cultivators occupy the hot lowlands from the slopes of the western edges of the Ethiopian plateau and penetrating deep into the inhospitable gorges and valleys of the Dinder, the Abay River, and the Anger-Diddessa rivers and many of their tributaries.

They practice a system of shifting hoe cultivation and in times of food shortages, they also resort to the more ancient practices of hunting and gathering, as well as fishing and honey collection[29]. Historically, shifting cultivators have been the most underserved communities in Ethiopia, much like nomadic pastoralists. Mainly as a result of certain 'myths' about the way of life of shifting cultivators, previous governments in Ethiopia used to favor the mainstream iron-tipped ox–drawn plow settled agriculture over shifting cultivation. Largely due to this, there was a tendency in those times for the expansion of the mainstream agriculture, leading to the undermining of slash and burn cultivation.

Dating back to past centuries, the shifting cultivators have been the objects of discrimination and stereotyping in the society. As they have always done, the horticulturalists produce their subsistence crops using simple agricultural tools such as hoes and digging sticks. By contrast, their neighbors have had a long tradition of using draft animals. In the course of time, this led to social attitudes and perceptions that resulted in viewing sedentary plough culture as superior, which become the basis of discrimination against slash-and-burn cultivators. The situation of shifting cultivators/horticulturalists was further compounded by lack of due policy attention by successive previous Ethiopian governments.

These communities are exposed to all sorts of risks (i.e., conflict, drought, flood, communicable diseases, etc.) due to the fragile natural environment which they inhabit and their minority status among the majority ethnic groups, and projects such as the **HEPRR** need to take their vulnerability into account and ensure they benefit from the project as the most vulnerable historically underserved traditional communities[30].

3.1.10. Pastoralists and Agro-pastoralists

Although they only form 6% of the country's rural population, pastoralists inhabit a great part of the east and far south of the country. This is because only they can make a living out of the otherwise unpromising semi-arid environments where the rainfall will not support any crops. Although pastoralists consume far more milk than the cropping population, even than their agro-pastoral neighbors, only the better off minority of herders manages to live *primarily* on milk and meat. For the rest, the household economy centers on getting the cash to buy the grain that makes up the better part of their diet. In the main, it is the sale of animals and their products, destined chiefly for distant urban consumption that brings in the money. But poorer pastoralists with

[29] Wolde-Selassie Abbute (1997) "The Dynamics of Socio-Economic Differentiation and Change in the Beles-Valley /Pawe/ Resettlement Area, North Western Ethiopia". Department of Social Anthropology, Addis Ababa University, MA Thesis.

[30] For specific recommendations, see Table 2.

fewer animals to sell must usually supplement this by selling firewood or gums or bush products, or by paid work for others. Seasonal change means great fluctuations in milk availability and in animal condition and therefore sale prices. The annual hunger season is keenly felt by most pastoralists, and they are particularly at risk if the rains that bring this period to an end fail.

Experts with long experience working among the pastoralist communities underscore the peculiar vulnerability risks related to mobility and low literacy status of some sections of the society such as girls, boys, women and the elderly people among the pastoralists. The major challenges identified among the pastoralist communities include: lack of IT infrastructure, power interruption, unreliable networks (both telephone and internet), low literacy level, low economic status, lack of digital skills and mobile livelihood strategies. They recommend tailored participatory research on the pastoralists' livelihoods, movement patterns, etc. to contextualize the design and implementation plan and ensure **HEPRR** project is inclusive enough of the youth, women and girls, the elderly, people with low economic status, and persons with disability among the pastoralist and other underserved communities.

According to a study conducted by ***Ethiopian Health and Nutrition Research Institute, Food Science and Nutrition Research Directorate*** in collaboration with FMoH and WB, the major challenges in the endeavor to provide adequate healthcare service to Ethiopian pastoralists are summarized as follows:[31]

i. The food insecurity and consequently the widespread acute and chronic malnutrition is directly or indirectly associated with chronic poverty, poor infrastructure, ecological constraints, limited arable land, absence of irrigation, disease, poor water and sanitation, inadequate nutritional and health knowledge and ethnic conflicts.
ii. The reasons behind the low performance of healthcare service are associated mainly with pastoralist lifestyles that include dispersed settlement pattern, seasonal mobility, pervasive prevalence of harmful traditional practices, which, among other things, perpetuate underutilization of services even when and where the health services are available.
iii. Health facilities in pastoralist communities are limited in number, are under-staffed and service delivery is poorly organized. Most facilities operate at a level far below their potential capacity. Those which give service did not meet the need of pastoralists as they only provide preventive care rather than curative care.
iv. Recruiting, training and retaining female HEWs is most difficult. In some areas, female who completed their secondary school are scarce. In few places the recruitment was conducted not based on merit and performance but just to benefit clan members and family. As a result, it became difficult for woreda health offices to take disciplinary measures when those HEWs underperform due to fear of conflict. In all the studied areas staff turn-over are among the major problems.
v. Absence of commitment of frontline staff (HEWs & WoHO), very low salary, absence of means of transportation together with dispersed settlement of pastoral community and absence of incentives despite the livelihood hardships (Hardship (temperature, Water, Housing, food items, ...)

[31] https://ephi.gov.et/images/nutrition/adaptation%20pastoralto.pdf

vi. Prevalence of endemic diseases, such as malaria, trachoma, and zoonotic diseases (e.g., bovine TB) and infectious diseases associated with poverty (poor housing, poor environmental and personal hygiene, lack of potable water, etc.) are common.

As indicated above, health facilities in developing regional states, where majority of the underserved communities live, are limited in number and most often under-staffed. One NGO expert with work experience in Benishangul-Gumuz observed "many Gumuz women still give birth alone in a forest". The reasons are, as one recently published work indicated, "provision of free maternal initiative alone is not sufficient to increase utilization of delivery services to the desired level".[32] Among others, the **key barriers** to utilization of delivery services in low-income settings are **distance and awareness.** Therefore, "Strengthening efforts to bring delivery services closer to home and enhancing birth preparedness and complication readiness (BPCR) are necessary to increase institutional delivery service utilization". The study clearly shows that health facilities are still not closer enough for people to seek those services and awareness about BPCR arrangement are so low that they do not opt to give birth in health facilities. It is, therefore, important, as one Jigjiga based public health expert advised: (a) improve access to health care; and (b) create awareness of health and health related practices.[33]

Broader contextual challenges such as climate change induced drought and flooding (causing outbreaks such as malaria, diarrheal diseases, Acute Respiratory Infections (ARIs), meningitis and cholera), conflict and overall fragility, which Ethiopia is facing at the time, further compound this reality and heighten the threat of infectious diseases, access to essential health services, and food insecurity of the already vulnerable and historically underserved communities. The pastoralist regions, where people are highly dependent on animal husbandry and farming, are particularly vulnerable to worsening floods and drought compromising food security and human nutrition for instance, eastern and southern parts of the country.

For the pastoralist communities, livestock are the key livelihood strategies and human health and welfare are inseparable from the health and wellbeing of their herds. In good years, there is abundant rain, which means abundant water and pasture resources, which in turn means enough food and cash in the hands of the pastoralist communities. In the years when rain fails, lack/absence of water and pasture means, such as what was unfortunately the case in the Horn of Africa, including large areas of eastern and southern parts of Ethiopia this year, deprivation and catastrophic humanitarian crisis, with millions of livestock perished. According to OCHA *"Over 9.5 million livestock—which pastoralist families rely upon for sustenance and livelihoods—have already died across the region, including 4 million in Ethiopia, 2.5 million in Kenya and over 3 million in Somalia, and many more are at risk"*.[34] That is why, as one expert working among the

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[32] Predictors of facility-based delivery utilization in central Ethiopia: A case-control study. https://doi.org/10.1371%2Fjournal.pone.0261360

[33] For specific recommendations such as mobile human and veterinary clinics, see Table 2.

[34] *Horn of Africa Drought: Regional Humanitarian Overview & Call to Action (Revised 28 November 2022).* https://reliefweb.int/report/ethiopia/horn-africa-drought-regional-humanitarian-overview-call-action-revised-28-november-2022#:~:text=The%20severity%20and%20duration%20of,at%20risk%20in%20Ethiopia%20alone.

local communities with an NGO commented "***They strongly need veterinary clinic, medicine, and vaccination more than their own health needs***". It is, therefore, critically important to take into account this intertwinement and rethink the project components and activities, i.e., by way of integrating veterinary services with human health. This perfectly fits into **One Health** approach that 'recognizes the health of people is closely connected to the health of animals and our shared environment'.

3.1.11. Urban Poor

According to the 2016 report of Ministry of Urban Development and Housing (MoUDH), though there is low level of urbanization, there is high rate of urban growth in the big and small cities of Ethiopia.[35] Urbanization is considered as an essential element to make Ethiopia a middle-income status by 2025. However, following rapid urbanization, poverty has significantly risen in urban centers, i.e., 11% of Ethiopia's poor lived in cities in 2000, but this rose to 14 percent in 2011. Poverty rates in the two largest cities of Addis Ababa and Dire Dawa are much higher than this trend would predict (World Bank, 2015).

The rate of urbanization increased at a 4.63 percent rate due to the high rate of rural to urban migration and the number of urban centers has also been increasing (Hagos, 2019). The root causes of food insecurity in urban Ethiopia are disorganized rural-urban migration, inadequate employment opportunities, poor market exchange system, poor service delivery, poor working environment, absence of organized social protection for deprived people, among others. Consequently, a large number of urban people are vulnerable to food price inflation, food insecurity, unemployed and underemployed, which significantly affects their health seeking behaviour. As discussed earlier, the recent uptake in the IDP number in Ethiopia in general and in the towns and cities in particular, believed to be relatively safer, exacerbated the problems of urban poverty and the overall vulnerability of urban poor and millions of low-income households who are already struggling to make means meet ends due to inflation. As discussed under the foregoing sub-sections, the impact of broader contextual challenges such as climate change induced drought and flooding (causing outbreaks such as malaria, diarrheal diseases, ARIs, meningitis and cholera), conflict (resulting in damages to health infrastructures) and over all fragility (i.e., inflation causing unavailability/shortage of drugs and medical supplies, and rising cost of health services), worsen the livelihood challenges of urban poor.

During the implementation of HEPRR and beyond, the livelihood challenges that the urban poor face need to be taken into serious consideration as a distinct vulnerable group. As argued above, their inherent problems such as food insecurity, inadequate housing/homelessness, joblessness, severe overcrowding and underdeveloped infrastructure such as ill-equipped health facilities are aggravated by continued displacement and growing IDP population. Therefore, there is a need for wide-ranging national social protection programmes, specifically in the context of this project

[35] https://knoema.com/atlas/Ethiopia/Poverty-rate-at-national-poverty-line

support to the urban poor and other low-income households in the form of subsidized health services and by availing drugs and medical supplies in accessible health facilities, building community resilience by investing in health, communication (including digital) and essential infrastructures such as roads and transportation.

3.1.12. General comments on the vulnerable groups

As discussed in the forgoing sections, vulnerable groups are so diverse in terms of their livelihoods (e.g., from hunter-gatherers who live in the remotest corners of the country, pastoralists who live in the arid/semiarid areas to the urban poor who live in big cities), geographical location, access to basic services such as health and education, literacy level (from the unable to read and write to unemployed University/College graduates), from the chronically ill and those living with HIV/AIDS to the elderly and persons with disabilities, and to women, girls and female household heads trapped in complex socio-economic and cultural problems. As also discussed from the outset, this project is a capacity building one whose exact implementation site is yet to be identified. It is, therefore, recommended that site specific consultations are conducted and appropriate risk mitigation measures identified and implemented when specific project location are identified. Notwithstanding the above, potential risks and proposed mitigation measures are summarized in **Table 3** below.

Table 2: Summary of Potential Risks and Proposed Mitigation Measures

Vulnerable Groups	Potential Risks	Proposed Mitigation Measures
Women, girls and female-headed households	Risk being left out from the project beneficiary– due to embedded gender inequality, poverty, higher illiteracy	• Ensure they have access to information on project related business opportunities. • Gender-disaggregated data should be collected as part of the routine tracking and monitoring system of the project. • Ensure their active participation in the project implementation units (PIU) and various committees.
Youth	Unemployment & underemployment, compounded with other challenges[36]	Involve the youth from all the differentially positioned groups in the committees that might be established as part of project implementation organs
Chronically ill & people living with HIV/AIDS	Exclusion from the actual beneficiary groups is high due to the financial, information, and may be literacy constraints	Beneficiary selection needs to be carefully planned and executed in a participatory way, namely involving direct project beneficiaries and the existing traditional/indigenous institutions renowned for their integrity in their respective communities.
Elderly people	Poverty, lack of access to affordable health services	Conduct honest community consultations to assess the scale of this challenge and in consultation with the respective local community devise a workable and inclusive project implementation plan
Persons with	'*Digital divide*' – "disabled	Build on the project activities currently being

[36] Acquiring productive farmland in rural areas, work place in the towns, start-up capital, skills and smart ICT.

disabilities	people are half as likely as non-disabled people to have a computer at home, and even less likely to have Internet access at home”	supported by the ‘*Digital Ethiopia*’ project in availing accessible and affordable health information for persons with disabilities “have significantly lower rates of ICT use than non-disabled people. **See** *Subcomponent 1.4 of HEPRR project that supports **‘information systems for HEs and the digitalization of the health sector’***
Occupational Minorities	Risk of exclusion because of socio-culturally embedded segregation and historical margination	• Detail implementation plans should be informed by locally specific information, but providing and disseminating information through different means, including traditional mechanisms available in those respective communities. • Put in place health infrastructure/facilities that are accessible and affordable, including drugs, medical supplies and equipment in the health facilities.
Ethnic Minorities and Shifting Cultivators	Exposed to all sorts of risks (i.e., conflict, drought, flood, communicable diseases, etc.) due to the fragile natural environment which they inhabit and their minority status	
Pastoralists and Agro-pastoralists	Risk of exclusion due to mobility, poverty, low literacy, poor infrastructure	Take into account the intertwined nature of the challenges they face and rethink the project components and activities, i.e., by way of integrating *veterinary services* with human health. This perfectly fits into **One Health** approach that ‘recognizes the health of people is closely connected to the health of animals and our shared environment’.
Urban poor	Risk of exclusion due to poverty, low literacy, and poor infrastructure (e.g., ill-equipped health facilities) aggravated by continued displacement and growing IDP population	Support to the urban poor and other low-income households in the form of subsidized health services and by availing drugs and medical supplies in accessible health facilities, building community resilience by investing in health, communication (including digital) and essential infrastructures such as roads and transportation.

3.2.Community Institutions

Community institutions are mechanisms of social order that govern the behaviour of a set of individuals within a given community, which promote cultural, social, political and economic aspects of local communities. Local/informal community institutions rely on local communities’ cultures that have distinctive structures or forms. They play important roles in shaping the capacities of communities to respond to changes in natural and socio-economic systems of their respective communities. Thus, it is imperative to see how local community institutions facilitate or enable interaction between the local communities and external actors. Formal community institutions depend on written laws by government or other bodies. The two forms of local institutions were existent in the selected pastoral and agro-pastoral communities and are briefly discussed below.

Several SA studies documented among the pastoral and agro-pastoral communities of Ethiopia, both the formal and informal authority structure function side by side, in fact, in practice, with more power to enforce rules vested in the informal structure (e.g., LLRP, 2019[37]; PSNP-IV, 2014). For instance, the SA report for the LLRP (2019: vii) stated: "Participants in all of the *Woreda*s selected for the assessment indicated that in the Pastoral and Agro-pastoral (PAP) communities, concurrent with formal government structure, the community uses the traditional administration system. Besides government structure, there are several formal organizations such as community-based organization (CBO) in all regions."

Informal community institutions rely on local communities' cultures that have distinctive structures or forms. They play important role in shaping the capacities of communities to respond to changes in natural and social systems. Thus, it is imperative to see how local community institutions facilitate or enable interaction between the local communities and external actors. Pastoral and agro-pastoral communities have their own local institutions that are very strong and enable them ease their daily activities. The *Balabat* system is an informal institution found in many communities in South Omo, for example, in Hamar, Kara, Bashada and Benna ethnic groups where all members of the group are loyal to their respective *Bittas/balabat* and believe they perform all traditional rituals and religious practices for their members. There are also social positions in these communities such as *Donza*, *Zarsi*, and *Ayo* for communal political decisions or solution of problems of public concern.

Likewise, the Oromo people have the *Gadaa* system, which is based on an age-set system that cross-cuts kinship organization. The *Jaarsumma (*elders council) institution particularly plays significant role in mediating various problems encountering the community including solving intra- and inter-clan conflicts as well as conflicts with other ethnic groups (e.g., with the Somali, Konso). Similarly, among the Afar co-operation is based on the local community structure of clan, sub-clan, family, etc. and the higher units are clan (*Mela*) and the level below it is the local community (*Kaidoh*), and the next lower level is the extended family (*Dahla*), followed by the household (*Burra*). For that reason, the Sultanates are clan leaders, *Firma* or *Balabat* are community leaders, and household heads that reflect their daily socio-cultural aspects.

The Somali also have their own traditional institution called *Ugas* System for making decision and it is inevitably recognized by all members of the ethnic group. Every clan has their own representatives that take messages from the *Ugas* and pass down to their respective community members. *Gudi*/elders committee, composed of clan representatives, is another structure that plays the role of solving problems that encounter the community. In the event where the *Gudi* could not solve the problems, the cases are brought to the formal government structures. The Anyawa uses *Juatut* traditional conflict redress mechanism while the Nuer practices *Ruach*.

In short, in one way or the other, the significances/contributions of various traditional institutions, particularly the local informal institutions were emphasized as important factors to

[37] FDRE, Ministry of Peace, Final Social Assessment Report for Lowland Livelihood Resilience Project (LLRP) (P164336), March 15, 2019, Addis Ababa, Ethiopia.

be adequately involved in the project design (esp. sub-project design and implementation) in their respective communities. According to Oromia Health Bureau experts, ***Gadaa*** systems and the *Jaarsumma* institution can greatly contribute to make the project successful by creating a sense of ownership. The organized nature of these traditional institutions (including *Iddir* and *Equb*[38]) provide easy access to members in such a way that it makes it easier for awareness creation, beneficiary targeting, conflict resolution and other activities. One public health expert stressed the need to bring on board indigenous institutions such as *Iddir* and *Equb* saying: "*they have great impact on the integrity of the community for effective project implementation*". Participants in this RSA concur that indigenous/traditional institutions can help in creating a conducive environment for project implementation through their symbolic power in collaboration with local government structures.

3.3.Institutional Capacity

Strong institutions significantly encourage trust, promote property rights and avoid or at least reduce the exclusion risks of different sections of the population. Particularly grassroots level institutions play important roles in upholding the interest of the local people, safeguarding their physical cultural resources, facilitating development initiatives, as well as mitigating unexpected adverse effects. Currently, lower-level government structures are increasingly involved in community development efforts in Ethiopia. These structures include the different government and non-government organizations at *woreda* and *kebele* levels. The *woreda* level administration structure is more or less similar in all regional states (MCB, 2007). Almost all sector ministries and bureaus at federal and regional levels are represented at *woreda* level (AGP-I SA report, p. 44).

Notwithstanding their relevance and grassroot level presence, they have very serious capacity limitation which compromises effective implementation of development projects and the quality of services provided to the communities they serve. As one EPHI staff based in Amhara region said "***Low capacity and poor facility performance adversely affect sustainability of the project."***

The challenges are more pronounced in underserved/emerging regions and they include: (**1**) high illiteracy rate; (**2**) poor infrastructure, including ICT; (**3**) low salary and poor incentives; (**4**) lack of skilled human resources; and (**5**) low project management skill. Inadequate capacity will further widen the inequality gap among the differentially positioned project beneficiaries, such as urban and rural, women and men, poor and rich, illiterate and the educated, youth and elderly, persons with disability and others, etc. It means, **low capacity and poor facilities** will have adverse impact on the successful realization of any development project, exacerbating the further marginalization of the vulnerable groups and historically underserved communities.

[38] *Iqub* is an association established by a small group of people in order to provide substantial rotating funding for members in order to improve their lives and living conditions, while *Iddir* is an association established among neighbours or workers to raise funds that will be used during emergencies, such as death within these groups and their families.

3.4. Key Social Issues and Potential Challenges

Time constraint, in addition to overall security situation in many parts of the country, did not allow dedicated consultations beyond public authorities and health experts, both at the federal and some regional health bureau levels. As this is a regional capacity building project with regional (AFE) and national level institutional focus, it will build on the consultations and implementation experiences gained from the projects currently operational or recently phased out. Moreover, as discussed under the Methodology section of this report, recent community consultation results of other projects were used to inform both the design and implementation plan of this project. Additional consultations were conducted via virtual interview based on key Questions. The following summarizes the findings.

Consultation:

In all discussion sessions, stakeholders expressed strong interest to support the project implementation through their full cooperation.

For instance, Consultation participants from Oromia Health Bureau emphasized the importance of institutional capacity building projects such as this one based on their experiences of the implementation of *Ethiopia COVID-19 Emergency Response Project*, which helped them:

- ❖ Increased well-equipped fully functional laboratory from 2 to 15 in Oromia and, to the extent possible, evenly distributed in the vast and ecologically diverse region. One of these is located in Moyale, Borana zone, with the aim of serving the entire pastoral areas of the region currently experiencing immense HEs resulting from drought induced famine.
- ❖ Established 2 Emergency Operation Centres (EOC) located in Jimma and Bale.
- ❖ Established 10 well organized and resourced fully-functional ***One-Stop-Centre*** service provision facilities for GBV victims.
- ❖ Started Community and Event Based Surveillance Services (CEBS) which are still working very well in collaboration with community leaders such as *Abba Gada*, religious leaders and *Haadha Sinqe*.
- ❖ Free call centers established and people trained.
- ❖ Strengthened their data management and sharing system.
- ❖ Conducted several multi-disciplinary research, some of them already published, as part of technology and new knowledge transfer component of the project.

Therefore, they are very much eager to be part of the upcoming **HEPRR** project as this will build on what has already been started and further enhances HE response capacity of the Region,

which over the last few years was challenged by, what one Public Health expert at Oromia Health Bureau called, '***Triple Burden***', namely ***drought, cholera outbreak*** and ***IDP*** (caused by drought-induced famine and conflict). The data obtained from Oromia Health Bureau show that over the last three years: 870 health posts; 174 health centers; 11 hospitals; and 12 *woreda* health offices were damaged. Moreover, 78 ambulances, 9 vehicles, and 81 motorbikes were burned, looted and damaged.

The damage on health infrastructure is much worse in Tigray, Afar and Amhara regions that were directly affected by the recent conflict in northern Ethiopia and vulnerability to health-related risks has significantly increased. More than 22 million people were estimated to need humanitarian assistance in Ethiopia in 2022. Many faced the tragic consequences of conflict, particularly communities in the regions of Afar, Amhara, Tigray and Southern Nations (SNNPR). At the same time, natural disasters pushed people's coping mechanisms to their limits. Communities across the vastness of the Somali region experienced what is reported as the worst drought in 40 years, and when floods struck the Gambella region, more than 180,000 people were displaced from their homes, and health facilities suffered extensive damage.[39] Unfortunately, data showing the extent of the damage couldn't be obtained, at least at the time of working on this document.[40] In Afar, where malnutrition rates remain high, conflict, drought and floods have affected a total of 1,164,906 people as of 1 March 2023 according to data from the regional Disaster Risk Management and Food Security Commission (DRMFSC).[41]

In Benishangul-Gumuz region sporadic conflict has left thousands to flee for safety. According to the Regional Disaster Risk Management Commission (DRMC), 440,000 people were displaced across 16 *woredas* in Metekel, Kamashi and Assosa zones. In addition to the displacement, the conflict in the region has affected basic services provision. It was found out that 97 Health Posts and 6 Health Centers were partially damaged, 42 primary schools and five secondary schools were partially damaged, and 103 primary and 6 secondary schools were fully damaged in the 7 conflict affected *woredas* of the Metekel zone. According to an expert working for Ethiopian Red Cross Society (ERCS)[42], the security situation worsened an already bad situation, i.e., health facilities stressed by shortage/unavailability of drug and medical supplies, high staff turn-over and poor health infrastructure. Now with hundreds of thousands displaced, either sheltered in IDP camps or struggling on their own in a relatively safe environment of Assosa Zone, the available health facilities are overcrowded and drugs and medical supplies the greatest challenge for service providers. According to this expert, there were times when patients were asked to bring their own gloves when they go to a hospital, health centre or a clinic seeking health services. In situations like this it is the vulnerable groups such as the low-income families, urban poor, female-headed households, people with chronic health problems such as HIV/AIDS,

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[39] https://www.msf.org/treating-people-all-across-ethiopia

[40] But, one can imagine the gravity of the problem from this recent update of OCHA (20 March 2023): (i) 104 *woredas* in Amhara, hosting more than 600,000 IDPs, have been classified as hotspots; (ii) Children with global acute malnutrition exceeding the 15 per cent threshold identified in five *woredas* in Afar.

[41] https://reports.unocha.org/en/country/ethiopia/

[42] Telephone Interview, March 27,2023.

diabetes, etc. who suffer most. These only make maternal health seeking behaviours worse, forcing expectant Gumuz women to resort to customary child delivery practice, give birth 'alone and in the forest'.

Consultation participants and all who gave responded in writing to the guiding questions were unanimous on one key concern they have about projects financed by multilateral institutions for country level implementation through the federal government. Most projects financed by multilateral institutions such as the WB are identified, designed and approved for financing based on a general information about Ethiopia, despite the fact that there are huge differences within a given region let alone in Ethiopia at large. The gap in cultivating community sense of ownership of projects was underscored by other health experts at the federal level. One expert said "the project should be considered and designed to keep community beliefs, social structure and create mutual understanding with the group of people like women, local leaders like religious leaders, and the community should own the project in all its implementation stages". A written comment by a public health officer from Amhara region confirms the same: "*Majority of the development projects were donor driven and **community engagement was very low** so that when the project phases out no other activity is left for sustainability*". Another expert working with an NGO added "*several projects are designed with little or no involvement of the target population at grass root level and without any regard for population diversity in practical sense".*

- ✓ Therefore, there is a need for more coordinated and participatory project identification, prioritization, planning and implementation, including and up to M&E. As one expert noted, "*there is a need for practical community engagement not a theoretical one mentioned in reports*". This will create a strong sense of ownership of the project. An expert working on public health related projects in Amhara reiterated the need to improve community sense of '***ownership or participation for those institutions being in the surrounding areas of the project'*** and this could be realized through continuous engagement and consultation with the local level stakeholders, identify and address the concerns people have about the project and its implementation.

Focusing on health sector, which they know better, experts and consultation participants with work experience among the pastoralist communities said that most of the health infrastructures or facilities are meant to serve permanently settled communities and the modalities of services of these projects rarely take into account the livelihood strategies of pastoralist communities, such as regular mobility following the availability of pasture and water. In such circumstances, pastoralist communities who are moving from place to place depending on the seasonal availability of water and pasture will be left out. A public health expert based in Jigjiga, capital of Somali Regional State, added the vulnerability of pastoralist communities not only from the mobility necessitated by availability of pasture and water, but also from their "*susceptibility to*

shocks [such as drought], which are occurring more frequently now and has weakened the already fragile health system in these regions". Since communities are fleeing *as a result of these shocks, "health services are unable to meet the needs of such communities".*

What is becoming more evident is that mobility is both an adaptation strategy in the arid and semi-arid regions, and also a source of vulnerability in light of static nature of service providing institutions such as health and education. The latter gets worse in the context of shocks, natural (drought and flooding) or man-made such as conflict. Moreover, pastoralist communities are exposed to health problems such as cholera and meningitis, which are aggravated during drought.

- ✓ They recommended: (a) the need for mobile health services, which are equipped with health emergency facilities and technology, and projects such as **HEPRR** need to include mobile health services tailored to meet unique health needs of the pastoralist communities; and (b) System strengthening based on the context, because contexts vary even within one region.

In the past couple of years, Ethiopia has been experiencing serious humanitarian challenges largely attributable to conflict, drought and floods, each of these with its own devastating health impacts. The first and most consequential impact of these are the displacement of millions of people from their homes and belongings. There are different figures for the number of **IDPs in Ethiopia**, one because the figures change frequently (IDPs moving in and out of the camps/centres for various reasons, probably pursued by their attackers even in the camp), or, as UNCHR rightly argues, they "often move to areas where it is difficult" to trace them or "deliver humanitarian assistance". As a "result, these people are among the ***most vulnerable in the world***".[43] Nevertheless, some figures were obtained on this: "The DTM National Displacement report 14[44] indicates that, as of September 2022, an estimated total number of **2.73** million IDPs were identified across 11 regions of the country because of conflict and natural disaster…". [45]

Apart from the northern conflict, the western part of Oromia and some parts of the Benishangul Gumuz and the Somali regions have been vulnerable to violent attacks by armed groups that contributed to loss of lives, damaged properties, and livelihoods, disrupted essential social services, and **forced people into displacement** within and out of the region of origin. Similarly, some parts of the Southern Nations Nationalities and Peoples' region (SNNPR), such as Konso, also witnessed violent communal conflicts, which led to **displacement** and damages to

[43] https://www.unhcr.org/internally-displaced-people.html

[44] IOM, National Displacement Report 14, (August - September 2022) : Note-due to operational constraints, figures from Tigray region were not included in the total.
file:///C:/Users/soria/Downloads/UNHCR%20Response%20to%20Internal%20Diplacement%20in%20Ethiopia%20Report%20%234.pdf

[45] Ethiopia: Response to Internal Displacement, January - December 2022.
https://reliefweb.int/report/ethiopia/ethiopia-response-internal-displacement-january-december-2022

livelihoods and public infrastructures.[46]

Therefore, in light of the various challenges the country is facing at the moment and its direct impact on the people and their livelihoods, IDPs are among the most vulnerable, and constitute huge number (whatever the available data say about the figure) and they are available in almost all regions of the country. IDPs are facing several challenges including food insecurity, shelter, water shortage/unavailability for consumption and hygiene, personal security (risk of being attacked by their earlier attackers) and risk of exposure to ***GBV and sexual exploitation and abuse/harassment***. Women IDPs also experience several maternal health problems, either as lactating mothers or pregnant women. As IOM says, "When the number of displaced people in Ethiopia increased over the past few years due to several factors, the number of women needing support also increased. Despite their limited involvement in conflict and other man-made disasters, women and children are disproportionately the major victims."[47] These, for sure, constitutes some of the key **HE issues** this project aims to address.

Other most *vulnerable and underserved groups* in the Project context include women, *the poor,* persons with disabilities, the elderly, unemployed youth, low-income households, people with low literacy status; minority groups; people with chronic illness like HIV/AIDS; widows; IDPs; people living in cross border and remote area; female-headed as well child headed households; children, especially of pastoralist communities, because they are always on a move. A public health expert from Amhara region explains why they are the most vulnerable "***Because they lack the resources that might be needed to cope with the impact if adversely affected by the project***".

The major barriers for vulnerable people and underserved communities to equitably benefit from the project are lack of access to health information, infrastructures that are suitable to their special needs, awareness of the existence and affordability of the services.

- ❖ Hence, recommended providing and disseminating information through different means/platforms, put in place health infrastructures/facilities that are accessible and affordable.

As the main **capacity problems** that limit/constrain program implementation, experts identified knowledge gap, low salary, understanding of project objectives, and low incentive mechanism. These concerns are almost common issues raised during community/stakeholders' consultations of most of the WB financed projects (e.g., *Digital Ethiopia*, UPSNP).

Grievance Redress Mechanism (GRM): Federal health institutions have existing government

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[46] file:///C:/Users/soria/Downloads/UNHCR%20Response%20to%20Internal%20Diplacement%20in%20Ethiopia%20Report%20%234.pdf

[47] https://ethiopia.iom.int/stories/ethiopias-gondar-iom-providing-maternal-health-care-displaced-women

structure, namely Ethics and Anti-corruption Office and Women, Child and Youth office which are working with existing legal and justice structures to address GBV related complaints.

GBV and SEA/H: The responses on potential of **GBV/SEA/H** tend to concur that the project might not bring additional GBV and sexual exploitation risks. But they emphasized these problems are already common, whether the project is implemented or not and the project need to put in place effective and accessible GBV GRM. They also strongly recommend continuous community engagement on these and similar issues.

Traditional/indigenous organizations and leaders: Consultation with Oromia Health Bureau experts revealed that traditional/indigenous organizations and leaders can play significant roles in health messaging by clarifying misconceptions and serving as role models in health campaign. They pointed out the roles played by the *Abba Gadaa and* religious leaders during the *COVID-19 pandemic* by being vaccinated and showing those on the media and telling their followers that it is safe to get vaccinated, against the misconception surrounding COVID-19 vaccine (e.g., COVID-19 vaccines can lead to sterility and the inability to conceive, serious side effects like severe allergy). In fact, the role of *Abba Gadaa,* who are influential and recognized source of relevant information, goes way back to the era of HIV/AIDS where they served as important agents facilitating HIV awareness creation activities at community level.[48]

As was discussed under the '*Local Institutions*' section of this report, in Ethiopia there is a wealth of indigenous institutions serving their respective communities in many respects, i.e., resource management[49], grievance handling and conflict resolution mechanisms, communal political decisions or solution of problems of public concern. In fact, in some areas like the Somali, Afar, Oromia, and SNNPR regional states, traditional management systems are well established and acknowledged and often used by the government structure. For example, the, *odiyash deganka* in Somali*, jarsuma* in Oromia, *mebloo* in Afar, and *denb* in SNNPR were used though not always, by the government to solve interethnic conflict. Among the Somali and *Borana* pastoralists and agro-pastoralists, the *Ugas* and the *Gadaa*, respectively, are key for the maintain social order and mobilizing community resources for common good. The *Balabat* system is an informal institution found in all PAP communities in South Omo, for example, in Hamar, Kara, Bashada and Benna ethnic groups where all members of the group are loyal to their respective *Bittas/balabat* and believe they perform all traditional rituals and religious practices for their members. There are also social positions in these communities such as *Donza*, *Zarsi*, and *Ayo* for communal political decisions or solution of problems of public concern.

- ❖ Therefore, there is a need for these indigenous institutions and their leaders to be consulted during the design of the project [they are opinion makers among their respective communities]; help in project beneficiary targeting [esp. for the most

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[48] Mirgisa Kaba, 'Tapping local resources for HIV prevention among the Borana pastoral community. *Ethiop. J. Health Dev*. 2013, Vol.27(1), p.33-39.

[49] *Eela* – water wells are efficiently managed among the Borana under the leadership of *Abba Gadaa*.

vulnerable groups]; influence project participants to change the skill and use opportunities to be provided by the project; create conducive environment for project implementation through their symbolic power in collaboration with the local governments.

3.5. Proposed Mitigation Measures

The following key mitigation measures were developed based on Consultations.

- ❖ Adopt the principle of participatory project design, beneficiary targeting, planning, implementation, and M&E as *core principle* of the Project.
- ❖ Conduct participatory research on the pastoralists' livelihoods, movement patterns, etc. to make the project fit into the pastoralists' contexts.
- ❖ To address barriers such as lack of access to health information, infrastructures that are suitable to their special needs, awareness of the existence and affordability of the services for the vulnerable and underserved communities: provide and disseminate information through different means/platforms, put in place health infrastructure/facilities that are accessible and services that are affordable.
- ❖ Support institutional capacity building; strengthen leadership commitment; training; introduce employment benefit packages; clear and transparent institutional arrangement.
- ❖ Introduce competitive salary and other benefit packages (e.g., health insurance, housing allowance).[50]
- ❖ Conduct capacity assessment study to understand the facts on the ground in specific project implementation area, specifically among the pastoral and underserved communities.
- ❖ Modernize organizational structure and project prioritization process; and introduce state of the art technologies.
- ❖ Strengthen anti-corruption and complaints handling mechanisms to solve any conflict of interest that might arise among the firms or companies and individuals involved in the Project.
- ❖ Establish a robust, accessible and functioning **GRM** as an integral part of the project, which also serves as GBV GRM.
- ❖ The vulnerable people should be consulted and take part in the project and their views solicited.

[50] Among the key challenges of project implementation in the underserved areas are low salary and poor incentives resulting in high-staff turn-over.

- Enhance the status of women through access to digital technologies and information that alleviate their burden and allow them greater time and freedom to engage in a wide range of activities with reduced hardship and pressure.
- Develop and implement clear and transparent guidelines to mitigate the risks of corruption, nepotism, and other unethical behaviour and practices.
- To address the challenges of urban poor and low-income households:
  1. provide support to the urban poor and other low-income households (including subsidized health services by availing drugs and medical supplies and equipment in accessible health facilities); and
  2. building community resilience by investing in health, housing, water, employment, communication (including digital) and other essential infrastructures such as roads and transportation in the long-term.

3.6.Grievance Redress Mechanism

Effective grievance handling mechanisms constitute an important aspect of human relationship. For these arrangements to serve their purpose, they need to be developed and operated in such a way that they meet the needs of the target populations, being cost effective, accessible and working on the basis of a well-defined time schedule. Of course, such grievance handling arrangements do not replace the formal justice system, and so complainants who feel their grievance have not been fairly handled may seek justice in the court of law.

As was discussed under the '*Local Institutions*' section of this report, there is a wealth of indigenous grievance handling and conflict resolution mechanisms practiced by different communities of Ethiopia. In fact, in some areas like Somali, Afar, and Oromia regional states, traditional grievance management systems are well established and acknowledged and often used by the government structure. For example, the *denb* in SNNPR, *odiyash deganka* in Somali, *jaarssumma* in Oromia, and *mebloo* in Afar, were used though not always, by the government to solve interethnic conflict. Among the Somali and *Borana* pastoralists and agro-pastoralists, the type of penalty imposed on the offender is set in written form which varies in accordance with the type of offense and the extent of damage inflicted. Among the pastoralists and agro-pastoralists in SNNPR, the conflict resolution system is more traditional and well established. Though the *balabats* are the main agents in conflict resolution, they are less educated, highly traditional, and important in the day-to-day life of their ethnic group.

These well-established institutions can be mobilized both in project design, implementation and to support the formal GRM to be institutionalized as per the safeguards' requirements of the GoE and the WB, which will be discussed at length in the ESMF of the Project. In the institutions under the jurisdiction of MoH, notwithstanding their organization and capacity, there are grievance rules and procedures in the institutions, at the MoH, EPHI, and Regional Health Bureaus. Apart from official claims, none of the participants of this RSA said there was a strong functioning GRM in their respective institutions.

In view of this, it is worth noting here that the Project has to "ensure that the GRM is suitable to address more sensitive type of grievances such as Gender Based Violence (GBV) and Sexual Exploitation and Abuse related issues". The GRM committees that will be established at the various levels should address such complaints, including logging, tracking, and resolving grievances promptly during and after the implementation of the Project. The GRM need to have specific procedures for GBV including confidential reporting with safe and ethical documenting of GBV cases; and have project workers and local community undergo training on SEA and SH. The project needs to identify GBV service providers to effectively respond in case of incidents of SEA/SH and build this into the existing GRM.

4. Lessons Learned from Previous Projects

The SA for SLMP II (SLMP-II SA, 2013:25) revealed that the the implementation of the '*Rural Land Administration and Certification*' sub-component of the project, designed to ensure the tenure security of smallholder farmers, and thereby motivate them to adopt sustainable land management, ***unintentionally*** tended to exclude the section of the population who do not possess land (due to age, economic status, gender, etc.) where individual land possession by households was the norm, or pastoralist communities, hunting and gathering, and shifting cultivating groups where individual/family landholding system did not exist. Such unintended exclusionary practices need to be carefully studied and appropriate mitigation measures put in place. Commenting on the exclusion risk in the *Digital Ethiopia* project, Ethiopian Communication Authority (ECA) experts cautioned, people living in low-infrastructure, low-income and underserved parts of the country, the less educted, the unemployed, and people with information gap might experience exclusion, which could be aggravated by language barrier and non-localized technologies.

As discussed under the '*Key Social Assessment Findings*' section, despite good intentions, there are risks of some sections of the society being excluded (literacy and low-income affecting accessibility and affordability of certain services such as ICT, mobility compromising accessing services of permanent nature such as health and education). Therefore, depending on the nature of the project, certain categories of the communities such as the elderly, low-income households, unemployed youth (men and women), persons with disabilities, pastoralists, and people with low/no digital literacy face exclusion risks.

On the other hand, the PSNP IV Social Assessment (2014) documented problems of both ***targeting exclusion and inclusion errors*** both during community consultation and the discussion with the experts. These errors were attributed to nepotism, corruption and clientelism[51], which both the *kebele* leadership and some powerful (social, economic, or political) community

[51] Although there are different angles from which clientelism is understood, in this context PSNP-IV SA it was taken to describe the relationship between individuals with unequal economic and social status ("the economically powerful" and "the poor") that entails the reciprocal exchange of favours, goods and services based on a personal link that is generally perceived in terms of "moral" obligation. Although this information was based on field data gathered from two *kebeles*, experts observed that these problems are by no means limited to these *kebeles* alone

members practiced to benefit themselves (PSNP IV, 2014:36). For instance, the Meket *Woreda* FSTF members and PSNP staff at the *woreda* argue that targeting is susceptible to abuse in a situation where resources are scarce and wealth ranking, which the PSNP uses for beneficiary targeting, is not based on community level baseline information on households' wealth or food security status.[52] The *Woreda* FSTF members were unanimous that a few *kebele* chairmen used their power to favour their associates and some economically powerful members of the community organized their supporters to be included in the beneficiaries' list or used their established status to influence the targeted poor households from their villages to register their children as family members, since refusal to do so costs the latter a lot, e.g., helping hands when they are in need of cash, pack animals, seed to plant, etc. (ibid.:42)

Other observations from some of the projects, such as the Urban Productive Safety Net include risks such as "(ii) social exclusion and elite capture for targeting (Assessments conducted in the country indicate that young people and women are at a significant disadvantaged position in the urban labour market. These groups of people will face further exclusion in this project unless a careful targeting system is put in place.), (iii) insufficient community engagement". (p.6)[53]

The SA finding for the *Digital Ethiopia* project (2021) also indicates the risk of corruption and nepotism in the imeplementation of the project. Responding to whether targeting project beneficiaries could be influenced by informal networks (e.g., **nepotism, corruption, elite capture,** etc.], an official from one of the Federal implementing institutions warned "recruiting Digital businesses can be exposed to nepotism", which could result in unfit individuals taking advantage of the project implementation, in turn discouraging 'individuals with high potential' to work in the project. Many respondents also indicated the risk of "community members who have relatives in the government structure" unfairly benefiting from the project.

The **commitment of the local administration** in **supporting women's**, youth, persons with disability and other vulnerable groups participation in development is judged as **very low**. The **capacity and facilities** at the grassroots government structures to support the implementation of the Project is believed to be low, but still varies from region to region/place to place. This is pronounced in the developing regional states, largely attributable to overall structural problems, historically marginalized as communities. Therefore, it needs site specific focused assessment to get a clearer picture of the facts on the ground.

The **institutional capacity limitations** that might affect program implementation in underserved/emerging and other regions include: (i) high level illiteracy rate; (ii) poor infrastructure, including ICT; (iii) low salary and poor incentives resulting in high-staff turn-

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[52] It was stated in the targeting PIM that "Community targeting is a method of selecting safety net program beneficiaries by the community based on their own knowledge about the food security situation of their locality area and of each other on individual basis." The major points that need to be taken into account include, among others, asset ownership, access to asset, remittance, family size and food aid recipient for three consecutive years. (Food Security Coordination Bureau, *Safety Net Targeting Guideline*, p. 14-15.)

[53] http://documents1.worldbank.org/curated/en/687631598884711169/pdf/Environmental-and-Social-Review-Summary-Urban-Productive-Safety-Net-and-Jobs-Project-P169943.pdf

over. Inadequate capacity will further widen the inequality gap among the differentially positioned project beneficiaries, such as urban and rural, women and men, poor and rich, illiterate and the educated, youth and elderly, persons with disability and others, etc. As a public health expert from Benishangul-Gumuz observed "*low capacity and poor facilities highly contribute to marginalize and exacerbate challenges of the vulnerable groups. It affected the quality and access of health care services*".

Lack/Absence of community participation in the project from the beginning has an adverse impact on the sustainability of development projects. One EPHI expert asserted: "*Majority of the development projects were donor driven and community engagement was very low so that when the project becomes phase out no any other activity is left for sustainability".* It is recommended that participatory project design, beneficiary targeting, planning, implementation, and M&E need to be the *core principle* of the Project.

5. Synthesized Recommendations

The **HEPRR** project should learn from the challenges of past or current development projects financed by the Bank and devise mechanisms in targeting project beneficiaries to ensure both *exclusion* and *inclusion errors* are unlikely to occur due to the influence of traditional structures (social and economic), corruption, clientelism and lack of awareness, livelihood strategies (e.g., pastoralism) especially at the grassroots levels. Adequate community consultation and transparent and accountable institutional arrangements are the key antidotes of *exclusion* and *inclusion errors* likely to take place due to the aforementioned reasons. Moreover, as repeatedly discussed in the foregoing sections, participatory project identification, priority setting, beneficiary targeting, design, planning, implementation, and M&E are the key successful project implementation. Institutions closer to the vulnerable population and vulnerable community groups should be consulted and take part in the project and their views solicited" from day one.

The need to build sustainable institutions at grassroots level can never be overemphasized, since they are crucial for the delivery of services and the attainment of project objectives. Lessons learned from various development programs/projects financed by the WB (e.g., AGP, PSNP, SLMP, PCDP/RLLP, etc.) show that the quality of project implementation and outcomes registered were good where local implementation structures were better organized and manned with the requisite number and right combination of experts. The implementation structure, especially at the grassroots levels, need to be well organized, resourced, nurtured, and sustained through targeted capacity building work, and proper reward and incentive schemes put in place for the staff.

The best way to address the adverse impacts or promote equitable access to Project benefits is, according to an expert, ***health and resource distribution equity*** that should be anchored in ***a strategic partnership with community organizations.***

Programs such as **HEPRR**, which are implemented not only in diverse agro-ecological settings, but also in areas where government implementation structures are not the strongest (e.g., under-resourced remote and pastoralist areas) makes it critically important to put in place effective and efficient monitoring and evaluation system.

Monitoring and Evaluation (M&E) should serve the intended purpose, and help the program implementers to learn from their weaknesses and further boost their strengths, and for the higher-level program structures to monitor performances and evaluate the impact of the program on the program beneficiary and institutional capacity building at all levels of the program implementation structures. M&E is not a routine activity reporting exercise meant to meet the reporting requirement, which has been the major problem of some of these projects. Rather it is an integral component of the program in which the information generated through the M&E system is used to guide management decisions at both the local and higher levels of the program implementation structure.

As a new initiative with its own unique characteristics, being regional and national at the same time, the **HEPRR** project should learn from the past projects by not repeating their mistakes (where M & E is seen as routine activity reporting exercise) and build on their strengths where M&E becomes not only an integral part of the project implementation plans, but also an ***inbuilt system*** of the Project implementing institutions.

6. Potential Risks and Recommendations: Summarized

Based on the RSA findings, **Table 2** presents the key social issues, potential risks, and recommendations with a responsible body and timeframe as a *Social Management Plan* for the **HEPRR** project.

Table 3: HEPRR Project Input for Social Management Plan

Issues	***Potential risks and challenges***	***Mitigation measures***	***Responsibility***	***Time Frame***
Project identification and financing decision	Project identification and financing decisions do not take particular needs of different communities into account	Coordinated and participatory project identification, prioritization, planning and implementation, including and up to M&E. This will create a strong sense of ownership of the project.	GoE	Always
Health Infrastructures positioning:	• Mobility based livelihood strategies of pastoralist communities is a constraint for equally benefitting from static health facilities and services • Pastoralist communities exposed to health problems such as cholera and meningitis, which are aggravated during drought and flooding	Put in place mobile health services equipped with **HE** facilities and technology and that are tailored to meet the unique health needs of the pastoralist communities.	PIU	Throughout the project cycle
Vulnerable and historically underserved communities; Occupational minorities and	Risk of exclusion	• Provide and disseminate information through different means/platforms. • Put in place health infrastructure/facilities that are accessible and affordable. • Ensure availability of affordable	PIU In the long run the GoE	Throughout the project cycle

shifting cultivators; IDPs; people residing in border and remote areas		drugs and medical supplies and equipment in the health facilities.		
Urban poor	Inherent vulnerability challenges such as food insecurity, inadequate housing/homeless, joblessness, severe overcrowding, underdeveloped infrastructure (e.g., ill-equipped health facilities) are aggravated by continued displacement and growing IDP population.	• Provide support in the form of augmenting their income in the short-term (including subsidized health services by availing drugs and medical supplies and equipment in accessible health facilities); • Building community resilience by investing in health, housing, water, employment, communication (including digital) and other essential infrastructures such as roads and transportation in the long-term.	PIU GoE	
Gender	*Gender inequality*: Risk of women and girls being excluded	• Enhance the status of women through access to digital technologies and information that would alleviate their burden and allow them greater time and freedom to engage in a wide range of activities with reduced hardship and pressure. • Enhance the status of women through access to information and employment.	PIU GoE	Throughout the project cycle Always
GBV/SEA/H	Risks are high: (i) insecurity and	• Extra precaution needs to be taken to	PIU	Throughout the

	violence; (ii), project activities, including interactions between project workers and local communities, as well as sexual harassment among project workers.	mitigate any risk of GBV/SEA/H • Establish an effective GBV grievance redress mechanism (GRM) with multiple channels to initiate a complaint. • Provide community members the toll-free hotline information to report any incidents or concerns; • Train project workers and local communities on SEA and SH (e.g., specific procedures and confidential reporting) • Employ GBV service providers to effectively respond in case of incidents of GBV/SEA/H and build this into the existing GRM.		project cycle
	Women's weak bargaining power and the power difference may put them in a vulnerable position	• Enhance the status of women through access to information • Oversight and accountability	PIU The GoE	
Institutional capacity	• Weak institutional capacity • Poor leadership commitment • Low salary and lack of benefit schemes resulting in high staff turn-over.	• Training • Introduce employment benefit packages • Clear and transparent institutional arrangement • Introduce competitive salary and other benefit schemes (e.g., health insurance, housing allowance, etc.)	PIU	Throughout the project cycle

GRM	None of the institutions studied have strong, accessible and functioning GRM.	Establish a robust, accessible and functioning GRM as an integral part of the project, which also serves as GBV GRM.	PIU	Throughout the project cycle
M & E	M & E is seen as routine activity reporting exercise	• Establish an effective and participatory M&E system • Make it only an integral part of the project implementation plans, but also an ***inbuilt system of the Project implementing institutions.***	PIU	Throughout the project cycle
Corruption and other unethical behaviour	• Corruption • Nepotism • Elite capture risks	Strengthen anti-corruption and complaints handling mechanisms	PIU	Throughout the project cycle
		Develop and implement clear and transparent guidelines to mitigate the risks of corruption, nepotism, and other unethical behaviour and practices.	PIU	Throughout the project cycle

7. Concluding Remarks

The RSA findings showed a very strong support for the **HEPRR** project across the wide spectrum of the potential project beneficiaries and experts with deep knowledge of the sector and the livelihoods of the vulnerable and historically underserved groups. Though conducting actual field visit was not possible due, largely, to time constraint and other challenges (security), enough data needed for this **RSA** were generated from both secondary and primary sources (see Methodology section).

Generally, there is a strong support for the project as it is believed to enhance the HE preparedness, response and resilience of Ethiopian health sector building on what has already been achieved in the last few years, including the capacity building accomplishments of the federal and regional health institutions in the past few years including through the support obtained from *Ethiopia COVID-19 Emergency Response Project*. Moreover, there is a huge potential for the project to benefit people, especially the vulnerable population groups among the underserved communities in the emerging regions. The commitment to realize the project objectives is very high among all implementing agencies, especially the key implementing federal institutions MoH and EPHI, and their partners in the regional states.

It is also worth noting the importance of taking into serious consideration during the remaining phases of the Project the potential risks identified in this RSA and the proposed mitigation measures which are the key to the successful implementation of the **HEPRR** project.

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Annexes

Terms of Reference

Terms of references for an Social Consultant for preparation of Social Assessment (SA) and Resettlement Framework for Ethiopia Component of AFE Health Emergency Preparedness, Response and Resilience MPA (P180127)

I. Project Background

Program Components: The proposed MPA will have four components, namely: (i) Strengthening the preparedness and resilience of regional and national health systems to manage PHEs; (ii) Improving the detection and response to public health emergincies (PHEs) at the regional and national levels; (iii) Program management; and (iv) Contingent Emergency Response Components (CERC). While regional institutional capacity building is proposed to be supported through component 3, a strong regional focus on issues such as equity and inclusion, effective governance/integration/coordination, information sharing, seamless knowledge creation, capacity building and exchange, cross-border surveillance, and robust technology transfer among all relevant public and private entities in the participating countries is cross-cutting across all components.

Component 1: Strengthening the Preparedness and Resilience of Regional & National Health Systems to manage PHEs

The widespread health and socioeconomic impact of the COVID-19 pandemic on all aspects of society is by now well-documented, but the impact of other PHEs is less well recognized. The disruption of essential health services has threatened the gains made in achieving the Sustainable Development Goal (SDG) 3 (Ensure healthy lives and promote well-being for all at all ages) and is clear evidence of the need to ensure the resilience of health systems worldwide in the face of health emergencies, going beyond simply preparedness and response. What has perhaps been less studied and documented–albeit just as important–are the impact of other acute and chronic health emergencies, such as climate change induced floods and drought, as well as non-communicable diseases, which are now the biggest contributors to the global burden of disease. This component will support the strengthening of essential institutions and activities that directly contribute to the resilience of the health systems to cope with PHEs and be complimentary to other HSS activities being conducted by other World Bank and partner investments. Operationalizing health systems resilience involves an array of system elements that must connect and work together, with contributions from all stakeholders within and outside the traditional health sector, as well as synergies between various efforts within and between all administrative and health-service-delivery levels.

Component 2: Improving the detection of and response to PHEs

The ability to detect and respond effectively to health emergencies at national, regional, and global levels depends on the operational readiness and capacities across the following critical

subsystems that will be supported under this component: Collaborative surveillance and laboratory diagnostics; Emergency management and coordination; Community engagement, empowerment, and protection; and Access to and deployment of countermeasures in a PHE context.

Component 3: Program Management

Sub-component 3.1 will support monitoring and evaluation. Accurate and timely data enable assessments of whether a project is on track to achieve its intended outcomes. This component will provide financing for the following activities: (i) Support for countries to ensure data collection related to program activities which is complete, accurate, and timely. This can include the development of monitoring frameworks, preparation of data collection tools, equipping data collectors with necessary skills and technology, data quality assurance, analysis and reporting of results, and integration of findings into managerial and strategic decision-making; (ii) Coaching and technical support for data collection, analysis, and use for decision-making. This support could be provided by national or international consulting firms, universities, or technical bodies; (iii) Third party monitoring to assure the validity of Results Framework indicator data reported by governments; and (iv) Data-based cross-border learning initiatives, which will share proven strategies to effectively collect and use data to enhance health emergency response.

Sub-component 3.2 will focus on all other aspects of program management, including equipment and materials, compliance with fiduciary, procurement, and safeguards (environmental and social) requirements. At the national level, these activities will be undertaken by the Program Implementation Units (PIUs).

Component 4: Contingent Emergency Response Component (CERC)

There is a possibility that, during the implementation of this MPA program, the participating countries may experience an outbreak of public health importance, or other health emergencies with the potential to cause major adverse economic and/or social impacts. In such an event, this component will finance the eligible expenditures. Activation of this component allows funds to be disbursed rapidly to reduce damage to infrastructure, ensure business continuity, and recover more rapidly from a disaster. Following a major health emergency, the affected participating country may request that the World Bank channel resources from other AFRE MPA HEPRR components into the CERC. As a condition for disbursement, an CERC Manual along with an Emergency Response Manual (ERM) and updated instruments (where applicable), will be developed for each country, stipulating the fiduciary, safeguards, monitoring, and reporting requirements related to invoking the CERC, as well as other coordination and implementation arrangements.

Experiences of the World Bank and those of Government of Ethiopia indicate that proper assessment/documentation and management of social risks and impacts add to the sustainability

of development works. Likewise, project risks and impacts on vulnerable (indigenous peoples, women, children, aged people, poor and other deprived segments) and other communities need to be properly documented and managed.

The MoH seeks to hire a lead consultant to review the social context within which the project will be implemented and conduct an analysis of social impacts on key stakeholders.

1. Objective

Rapid Social Assessment (RSA) is the process used by the Borrowers to assess the likely impacts of projects on key stakeholders. The rapid Social Assessment is intended to help the Project identify key social issues and risks, and to determine social impacts on different stakeholders. The RSA will focus on the health sector impacts with a focus on mitigating possible negative impacts and identifying opportunities for inclusion of vulnerable and marginalized groups. It needs to include needs and priorities of key stakeholders, outline their views on the design and proposed implementation mechanisms of the project, and build capacity and involvement. It will also provide requirements for the design of an appropriate institutional arrangement to implement, monitor, and evaluate the project on the achievement of social outcomes.

The RSA is the basis for the preparation of the Social Management Plan (SMP) in which all the mitigation measures are provided as actions and if those actions require budget, an indicative budget and the timeline for the implementation will be included in the SMP.

The Resettlement Framework clarifies the resettlement principles, organizational arrangements and design criteria to be applied to sub projects or project components to be prepared during project implementation. The RF will estimate displacement impacts, determine eligibility criteria, valuation methods for affected assets, procedures for compensation payments, description of grievance mechanism, cost estimates oof resettlement and arrangements for funding, consultation mechanisms and arrangements for monitoring.

The objective of this assignment is to provide assistance to the MoH (Ministry of Health) (MoH and other project beneficiaries in undertaking a targeted social assessment for the proposed project and identify potential list of indicators for monitoring and evaluation of project effectiveness as far as social impacts are concerned. Furthermore, assistance will be provided to develop a Resettlement Framework to mitigate risks of land acquisition, restriction on land use and involuntary resettlement as a result of implementation of project activities. The RPF will be an annex to the ESMF.

2. Methodological approach and process

3.1.Indicative Methodology

Development of the Social Assessment (SA) is a participatory process led by the MoH. The consultant is required to consult, next to the project design team members, also with federal, regional, and local public authorities as well as randomly selected beneficiaries on the project as they related to the context of the RSA document.

An inception report to be developed by the Consultant(s), and approved by the Client, will outline structure methodology, timeframe, and resources for conducting the assessment and development of the RF. The data for social assessment, is expected to be collected both from primary and secondary sources. The data collection process will be supported by the Client following the development of a user-friendly data collection template by the Consultant. The Consultant required coming up with data collection tool(s) that also allow producing analytical reports mainly on qualitative description. Other data collection tools as may deem necessary can be employed by the Consultant,

The primary data will be collected through conducting various consultations, interviews, Focus Group Discussion (FGD), field level observations, and others. As secondary data, relevant documents to be shared from implementing partners are considered, as well as any additional document, the consultant may be aware of.

3.2. Scope of the assessment

The assessments is country wide and will cover historically underserved communities in the regional states of Benishangul, Gambella, Southern Nations Nationalities and Peoples, South Western Ethiopia, Somali and pastoral and agro-pastoral communities in Oromia regional state. To delineate the data collection process, the Consultant will randomly select at least 2 woredas in each region, totaling 12 Woredas, being representative for the project implementation area. The inception report will furthermore outline any suggestion on data collection if necessary to achieve a balanced and comprehensive picture.

3.3 Tentative Outline of the Social Assessment document

The Report shall encompass the following structure:

- Introduction / SA team / data collection and research methods
- Background information / Project Description
- Description of the socio-cultural, institutional, historical and political context
- Legislative and regulatory considerations & institutional framework
- Key social issues including social diversity and gender; institutions, rules and behavior; stakeholders; participation; and social risks

- Stakeholder consultations and stakeholder management plan
- Strategy to achieve social development outcomes/Recommendations for project design and implementation arrangements
- Monitoring Plan
- Outputs, schedule, and reporting

Tentative Outline for Resettlement Framework:

- Overview of impact of project on land acquisition and involuntary resettlement
- Overview of legislation and regulatory framework,
- institutional arrangement for RPF
- Eligibility criteria, valuation methods and compensation process
- Grievance Mechanisms for project affected persons
- Stakeholder Consultation and disclosure
- Budget, workplan and monitoring

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3. Scope of Services, Tasks, and Expected Deliverables

The Consultant will be a team member of the Project Implementation Unit (PIU) supporting the implementation of the and will report to the PIU Director / PIU Coordinator. The scope of these ToR is to ensure a systemic assessment of positive and adverse social impacts associated with project and that the appropriate mitigation measures will be in place. Moreover, RF will be developed based on projects risks on land acquisition. . The drafts must be disclosed as soon as possible and before project appraisal and the Borrower will seek the views of stakeholders, including on the identification of stakeholders and the proposals for future engagement.

Specific tasks to be carried out by the individual consultant include but are not limited to the following components:

- Understand the ToR and better foundation of the project nature and issues;
- Review relevant information at federal and regional levels,
- Conduct an in-depth desk review of available reports from participating Government institutions and WB on earlier projects,
- Develop data collection tools, if need be and get the approval of the design team through MoH;
- Identify the most significant social and cultural features that differentiate social groups in the study area, and ensure proper capturing and consolidation of stakeholders' views and opinions;
- Examine social groups' characteristics, intra- group & inter-group relationships, and the relationships of those groups with public and private (e.g. Market) institutions (including

the norms, values and behavior that have been institutionalized through those relationships).

- Describe the institutional environment; consider both the presence and function of public, private and social institutions relevant to the operation,
- Identify the type of social impacts including gender-based violence and sexual exploitation that could be occurred due to the implementation of the new project in the area,
- Identify the stakeholder groups/people who may be affected negatively or positively due to the implementation of the sub projects in the area,
- Identify social inclusion and exclusion related risks and impacts
- Examine how people are organized into different social groups, and its implication for sub project implementation,
- Recommend mitigation measures for any adverse social impacts that could be occurred in the study area,
- Organize national project design team and other partner consultation workshops;
- Regional consultations, meetings conducted with key regional stakeholders;
- Deliver the above-described reports;
- Present the social assessment and potential recommendations; and
- Review and compile the final reports with all the deliverables and specific objectives met

For Resettlement Framework:

- Review project activities and the extent of potential impacts on land
- Define the type of adverse social impacts related to land including cultivable land, grazing land and water resources, structures, livelihoods and loss of crops and trees.
- Provide socio economic context of project affected areas
- Review the relevant land policies, laws and regulations both national and state levels
- Identify and consult with project affected communities and other key stakeholders at different levels
- Review institutional arrangements, assess implementation capacities
- Propose monitoring and evaluation plan for RF
- Provide grievance mechanism
- Propose budget for implementation of RF

Documents to be consulted include:

- Social assessments of other projects; including RPFs other projects
- World Bank Development Assistance Framework and Environmental and Social Framework
- The GoE environmental and social policy and legal documents;
- Any sectoral documents at federal and regional levels

4. **Duration of the Assignment**

The **Project Preparation stage** of this assignment is expected to be completed in about **45 days**

Prepare an inception report which includes information on stakeholders and groups that need to be consulted and involved as well as the methodology to be implemented for the assignment.

5. **Qualification and Experience**

The individual consultant should be able to offer all, or at least most, of the following qualifications and experience:

- An advanced degree (Master's degree or above) in sociology, Social anthropology, social policy, development economics, international development, or relevant field.
- Minimum of 10 years progressive experience in development related work.
- Strong analytical skills, a demonstrated ability to conduct interviews with a range of stakeholders, and experience in pulling together analysis and data into reports.
- Experience in reviewing and compiling multiple data sets and strong understanding of quantitative and qualitative analysis with Social Assessment.
- Work experience as a social specialist in/ with World Bank funded activities and knowledge of the World Bank safeguard policies and requirements will be a strong asset.
- Prior experience of working with complex national level social assessment or strategic plans involving multiple stakeholders.
- Ability to identify implementation issues and operational challenges and provide recommendations to remedy these issues to accelerate program delivery.
- Adequate understanding of human rights-based approach to development, gender equality, environmental sustainability, results-based management.
- Experience of carrying out similar assignment is an asset.
- Excellent proficiency in English is required.
- Strong writing abilities is required.

Guiding Questions:

Federal Democratic Republic of Ethiopia

Ministry of Health (**MoH**)

AFE HEALTH EMERGENCY PREPAREDNESS, RESPONSE AND RESILIENCE (HEPRR) MPA AND PROPOSED 3 PROJECTS UNDER PHASE 1

Social Assessment (SA)

Dear Participant,

Thank you for your generosity in taking a few minutes of your precious time to answer the questions outlined below. Your honest and critical reflection is invaluable not only for the timely completion of this study, but will also have an immense positive impact on the design and implementation of the '***HEPRR*' project** by bringing out key social issues, potential risks and recommending practical mitigation measures.

Project Goal and Objective of the SA

The overall aim of the proposed ***HEPRR*' project** is ***to ensure a sustained, comprehensive, and transformational impact on both health emergency preparedness/response and resilience, building on the many achievements of previous WBG supported projects***. This Social Assessment is intended to help the Project implementers understand key social issues and risks, and to determine social impacts on different stakeholders. The *objective of this assignment* is thus to provide assistance to the **MoH** and other project beneficiaries in undertaking a targeted Social Assessment for the proposed project and identify potential list of indicators for monitoring and evaluation of project effectiveness.

Guiding Questions for Experts from Implementing/Beneficiary Institutions:

1. What are the most significant social and cultural features that differentiate social groups in the Project area? [Ensure proper capturing and consolidation of stakeholders' views and opinions.]
2. Who are the most vulnerable and underserved groups in the Project context/*area*? [*Probe for* the poor; the poorest of the poor; women and children; the elderly; persons with disability; female-headed households; people living with HIV/AIDS (PLHIV); outcast and underserved occupational groups.]
3. What are the major needs and barriers for institutions (universities, government offices, businesses, etc.) located in underserved/emerging regions to equally access and benefit from this project?
    a. What are the specific recommendations to address the needs and barriers of such communities and institutions/offices based there?

4. **What** are the major needs and barriers for vulnerable people (persons with disability, the elderly, women, girls, youth etc.) to equally access and benefit from the project?
    a. What are the specific recommendations to address the needs and barriers?

5. Are there persons/community groups who will be adversely affected by or particularly benefiting from project activities?
    - ✓ If yes, who are:
        - adversely affected?
        - particularly benefiting?
    - ✓ In what ways are they:
        - adversely affected?
        - positively affected?
6. In your opinion, what are the best ways to address the adverse impacts or promote equitable access to Project benefits?
7. What traditional or indigenous social organizations exist in the Project area?
    a. How do you envisage their impacts on the Project?
8. In what ways do you think the Project might promote:
    - ✓ social capital [self-help groups, mutual assistance mechanisms, dispute settlement institutions, and indigenous natural resources use and conservation knowledge and practice];
    - ✓ social inclusion; and
    - ✓ existing power structures [i.e., the risk of further concentration of power due to beneficiary selectivity factors that tend to tilt towards certain sections of the population, e.g., the educated, the haves, able-bodied, the credit worthy better-offs, youths, male, etc. over the others.]
9. Do you think the project will be inclusive and equitably supportive of vulnerable and underserved populations?
    - ✓ If yes, how so?
    - ✓ If no, why so?
10. Is there a risk of exclusion of certain sections of the community?
    - ✓ If yes, what are the possible/likely basis of exclusion? [i.e., gender, economic status, education, employment, age, etc.]
    - ✓ If yes, what are the mechanisms to mitigate these risks?
11. Are there any known conflicts of interests arising among different groups in relation to the Project that may affect its implementation?
    a. If yes, what possible mechanisms can be used to address the problem?
12. In what ways are women likely to be involved in the Project?
13. In what particular ways are women benefiting from this Project?
14. Or, are women at a disadvantaged position as a result of the project?
    a. If yes, how?

15. How do you evaluate the commitment of the various structures of government in supporting women's participation in development?

16. What are the possible social impacts including gender-based violence (**GBV**), sexual exploitation and abuse/sexual harassment (**SEA/SH**) that could occur due to the implementation of the Project?

   a. What possible mechanisms can be used to address the impacts?

17. Do you recall any past development project in which targeting project beneficiaries was based on informal networks? [e.g., nepotism, corruption, elite capture, etc.]

   - How did it impact the implementation of the project?
   - What lessons can we learn from that project?

18. Do you envisage any potential constraint that might have differential impacts on beneficiaries? (economic status, urban vs. rural, literacy level, gender, age, livelihood strategies, etc.)

19. Who are the stakeholder groups/people that might be affected negatively due to the implementation of the Project/sub-projects?

   a. What do you recommend to mitigate the impacts?

20. What level of capacity and facilities exist in grassroots government structures to support the implementation of the Project?

21. In what ways can low capacity and poor facilities contribute to marginalize and exacerbate challenges of the vulnerable groups?

22. What are the main capacity problems that limit/constrain program implementation?

   a. For instance, lack of knowledge and skill, low salary and other benefit schemes resulting in high staff turn-over, etc.?

23. What grievance procedures exist for individuals/groups to express their complaints?

   a. Are these procedures/mechanisms effective?
   b. If yes, in what way?
   c. What are the strengths and constraints of the grievance procedures?
   d. What Grievance redress mechanism can be applied for the project to address environment & social issues including **GBV**/ **SEA/SH**?

24. What were the lessons learned from the implementation of the previous development projects financed by the World Bank that could be used here?

   a. ***Probe*** for adequate community consultation, capacity building, leadership commitment, inclusiveness, regular monitoring, etc.

THANK YOU!

Name: ___________________________________ Responsibility ______________________________

Email address: ______________________________

List of Consultation Participants

See Attached PDF files