**MONGOLIA**

**MONGOLIA SUPPORT FOR COVID-19 PROJECT (P173799), PEF SUPPORT FOR COVID-19 PROJECT (P174571) and COVID-19 VACCINATION ADDITIONAL FINANCING (P175730)**

**ENVIRONMENTAL and SOCIAL**

**MANAGEMENT FRAMEWORK (ESMF)**

Draft of 06 January 2021

# Abbreviations and Acronyms

|  |  |
| --- | --- |
| ADB | Asian Development Bank  |
| BFP | Bank-facilitated Procurement  |
| CVD | Cardiovascular system disease  |
| COVID-19 | Coronavirus Disease 2019  |
| CoC | Codes of Conduct  |
| CERC | Contingent Emergency Response Component  |
| CHD | Center for Health Department  |
| ESMF | Environmental and Social Management Framework  |
| ESS | Environmental and Social Standard  |
| ESCOP | Environmental and Social Code of Practice  |
| ESF | Environmental and Social Framework  |
| EHS | Environment, Health and Safety  |
| EBRD | European Bank for Reconstruction and Development |
| FCTF | Fast Track COVID-19 Facility  |
| GABP | General Authority for Border Protection  |
| GASI | General Agency for Specialized Inspection |
| GRM | Grievance Redress Mechanism  |
| GIZ | German Society for International Cooperation |
| GRS | Grievance Redress Service  |
| GBV | Gender-Based Violence  |
| HAI | Health impact assessment  |
| HSSMP | Health Sector Strategic Master Plan  |
| ICWMP | Infection Control Waste Management Plan  |
| HCF | healthcare facility  |
| HTH | High-test hypochlorite  |
| IPIU | Integrated project unit  |
| ICC | Inter-agency Coordination Committee  |
| IBRD | International Bank for Reconstruction and Development |
| PEF | Pandemic Emergency Financing Facility  |
| LMP | Labor Management Procedures  |
| M&E | Monitoring and Evaluation  |
| MOH | Ministry of Health  |
| MNS | Mongolian National Standard  |
| MoFAL | Ministry of Food, Agriculture, and Light Industry |
| MP | Member of parliament  |
| NCCD | National Center for Communicable Diseases  |
| NCZD | National Center for Zoonotic Diseases  |
| NCPH | National Center for Public Health  |
| NEMA  | National Emergency Management Agency  |
| NGOs | Non-governmental organization  |
| PSCN | Pandemic Supply Chain Network  |
| PA | Police Agency  |
| SEP | Stakeholder Engagement Plan  |
| SEC | State Emergency Committee  |
| SEA | Sexual Exploitation and Abuse  |
| SHCs | Soum health center  |
| RDTC | Regional Diagnostic and Treatment Center  |
| RSD | Respiratory system disease  |
| RCCE | Risk Communication and Community Engagement Plan |
| UB | Ulaanbaatar  |
| UNICEF | United Nations Children’s Fund  |
| UNDP | United Nations Development Program  |
| VAC | Violence Against Children |
| WBG | World Bank Group  |
| WHO | World Health Organization  |
| WSP | Water Safety Plan  |
| WASH | Water and Sanitation, Hygiene  |
| WG | Technical Working Group |

# Contents

[Abbreviations and Acronyms 2](#_Toc60843595)

[Contents 4](#_Toc60843596)

[Executive summary 5](#_Toc60843597)

[1. Introduction and Background 13](#_Toc60843598)

[2. Project Description 15](#_Toc60843599)

[Project Components 17](#_Toc60843600)

[Project Components and Estimated Budget 23](#_Toc60843601)

[Project Area and Beneficiaries 24](#_Toc60843602)

[3. Policy, Legal and Regulatory Framework 25](#_Toc60843603)

[Applicable World Bank Environmental and Social Standards 29](#_Toc60843604)

[4. Environmental and Social Baseline 32](#_Toc60843605)

[5. Potential Environment and Social Risks and Impacts and their Mitigation Measures 36](#_Toc60843606)

[6. Procedures to Address Environmental and Social Issues 50](#_Toc60843607)

[7. Monitoring, Supervision and Reporting 51](#_Toc60843608)

[8. Implementation Arrangements and Responsibilities 51](#_Toc60843609)

[9. Capacity Building 54](#_Toc60843610)

[10. Consultation and Stakeholder Engagement 55](#_Toc60843611)

[11. Grievance Redress Mechanism 59](#_Toc60843612)

[12. Monitoring and Reporting 62](#_Toc60843613)

[13. Budget 63](#_Toc60843614)

[14. Appendices 64](#_Toc60843615)

[Annex 1. Screening form of potential risk of E&R issues 64](#_Toc60843616)

[Annex 2. Infection Control and Waste Management Plan (ICWMP) Template 74](#_Toc60843617)

[Annex 3. Labor management plan 125](#_Toc60843627)

[Annex 4. Stakeholder engagement plan 148](#_Toc60843628)

[Annex 5. Report on Stakeholder Consultation on ESMF 161](#_Toc60843629)

[Annex 6. Additional information 163](#_Toc60843630)

# Executive summary

This Environmental and Social Management Framework (EMSF) is developed to support the environment and social due diligence provisions for activities financed by the World Bank Group *Mongolia PEF support for COVID-19 Project* (P174571) (the Project) and by the Pandemic Emergency Financing Facility (PEF) as additional financing of the Project with the involvement of the Ministry of Health (MoH). The International Bank for Reconstruction and Development and the International Development Association (hereinafter the Bank/the Association) have agreed to provide financing for the Project.

The objective of the ESMF is to assess and mitigate potential negative environment and social (E&S) risks and impacts of the Project consistently with the Environmental and Social Standards (ESSs) of the World Bank Environmental and Social Framework (ESF). Specific objectives of the ESMF are to: (a) assess the potential E&S risks and impacts of the proposed Project and propose their mitigation measures; (b) establish procedures for the E&S screening, review, approval, and implementation of activities; (c) specify appropriate roles and responsibilities, and outline the necessary reporting procedures, for managing and monitoring E&S issues/ concerns related to the activities; (d) identify the training and capacity building needed to successfully implement the provisions of the ESMF; (e) address mechanisms for public consultation and disclosure of project documents as well as redress of possible grievances; and (f) establish the budget requirements for implementation of the ESMF. The ESMF also provides principles and specific process to ensure that disadvantaged, vulnerable individuals or groups have access to the project’s benefits.

As agreed by the Bank/the Association and the Borrower/Recipient, this ESMF may be revised from time to time during Project implementation, to reflect adaptive management of Project changes and unforeseen circumstances or in response to assessment of Project performance conducted under the ESCP itself. In such circumstances, the Borrower/Recipient, through its MoH, will agree to the changes with the Bank/the Association and will update the ESCP to reflect such changes. Agreement on changes to the ESCP will be documented through the exchange of letters signed between the Bank/the Association and the Borrower/Recipient, through its MoH. The Borrower/Recipient, through its MoH, will promptly disclose the updated ESMF.

Where Project changes, unforeseen circumstances, or Project performance result in changes to the risks and impacts during Project implementation, the Borrower/Recipient shall provide additional funds, if needed, to implement actions and measures to address such risks and impacts.

Project Description

**This Project was selected for COVID-19 financing because Mongolia faces an elevated risk for COVID-19 outbreak spread.** The scope and the components of this Project are fully aligned with the COVID-19 Fast Track Facility, using standard components as described in Annex 2 of the COVID-19 Board paper. This Project complements the longer-term development work in the Health Sector, including the Mongolia’s E Health Project (P131290)which seeks to improve integration and utilization of health information and e-health solutions for better health service delivery in selected pilot sites

**A phased response through the COVID-19 Fast Track Facility is proposed.** While support will surely be needed to respond to the economic impact of COVID-19 on households, businesses and government budgets, the World Bank’s approach is to lead with the health response. As a first step, the majority of operations processed through the Fast Track Facility will be health sector operations to respond to urgent preparedness and response needs related to the COVID-19 outbreak. One of the challenges with the response to COVID-19 is the availability (and price) of medical equipment and supplies. The global PSCN (Pandemic Supply Chain Network), of which the World Bank is a co-convener, has identified a list of medical products critical to the response. The task team will work with MOH to customize this list further to develop a positive list of goods to be procured with World Bank financing. Further the health system has been weak, with years of underinvestment and neglect. Rapid investments to build capacity, including through procurement of equipment, will be necessary to ensure the system is able to meet the increased demand from complicated COVID-19 cases. Indeed, there will likely be growing disruption to economic activities, businesses and livelihoods. Options for support through other financing instruments are being explored as the facility is established and through country consultations.

**While addressing the COVID-19 is an immediate priority for the Government of Mongolia the Project will in tandem strengthen health system preparedness for similar future public health emergencies**. The Project will therefore address some of the immediate needs for responding to COVID-19 including risk communication, strengthening response capacity and investing in the building blocks for a coordinated multi-sectoral approach. It will further address health system gaps in the availability of drugs, medical supplies and equipment in key hospitals and aimag centers to meet the surge of expected patients and enhance the quality of patient care.

**The need for additional resources to expand the** **Coronavirus Disease 2019 (COVID-19) response was formally conveyed by the Government of Mongolia** (GOM) in a letter from the Minister of Finance dated September 23rd, 2020, requesting the use of International Development Association (IDA) Crises Response Window resources for the purchase of COVID-19 vaccine. The proposed AF will form part of an expanded health response to the pandemic. As of December 31, 2020, 25.9 percent of the total funding of the parent project has been disbursed. The needs for additional resources in Mongolia are significant given the fact that since the parent project was approved (April 2, 2020), a great deal of progress has been made in COVID-19 response, including vaccine development. The Government of Mongolia is leading the donor coordination in close consultation with United Nations Children’s Fund (UNICEF), World Health Organization (WHO) and the World Bank. The World Bank is currently the only confirmed external donor to the COVID-19 response. Therefore, continuing the World Bank engagement is essential to enable a sustained and comprehensive pandemic response in Mongolia.

The Additional Financing will expand the scope of the parent project in its efforts to support Mongolia government's efforts in strengthening the preparedness and response to COVID-19 pandemic while simultaneously preparing the health system for future public health emergencies. The primary objectives of the AF are to enable affordable and equitable access to COVID vaccines and help ensure effective vaccine deployment in Mongolia through enhanced vaccination system strengthening and to further strengthen preparedness and response activities under the parent project.

Project Components

**Component 1: Emergency COVID-19 Prevention and Response (Total US$2.5 million COVID19 FTF):** The aim of this component is to slow down and limit the spread of COVID-19 in the country and improve preparedness for future public health emergencies. This will be achieved through providing immediate support for a comprehensive communication and behavior change intervention, strengthening capacity for active case detection and response, building an enabling platform for One Health and strengthening capacity of the health work force to manage the current and future public health emergencies. It has four sub-components:

1.1: Risk Communication and Community Engagement

1.2: Response support

1.3: Human resource development

1.4: Creating an enabling environment for One Health

**Component 2: Strengthening Health Care Delivery Capacity (Total US$ 23.75 million including US$9.95 million from COVID19 FTF, US$13.8 million IBRD)** The aim of this component is to strengthen essential health care service delivery to be able to provide the best care possible in the event of a surge in demand. It will also provide ongoing support for people falling ill in the community to minimize the overall impact of the disease. Assistance will be provided to the health care system for preparedness planning to provide optimal medical care, maintain essential lifesaving services, and minimize risks for patients and health personnel. Strengthened clinical care capacity will be achieved by establishing specialized units in selected hospitals; publishing treatment guidelines, and hospital infection control interventions; strengthening waste management systems; and procurement of essential additional inputs for treatment such as oxygen delivery systems and medicines. Local containment will be supported through the establishment of local isolation units in hospitals. Widespread infection control training and measures will be instituted across health facilities.

**As COVID-19 will place a substantial burden on inpatient and outpatient health care services**, **support will be provided to rehabilitate and equip selected health facilities for the delivery of critical medical services and to cope with increased demand**. Health system strengthening efforts will therefore focus on provision of medical and laboratory equipment, PPE, medical supplies and laboratory tests to selected hospitals and health facilities. The Government of Mongolia has several health facilities as additional designated hospitals where COVID-19 patients will be admitted for treatment. These include i) Medical University Teaching Hospital; ii) Perinatology Center of Ulaanbaatar City; iii) the Third State Central Hospital known Shastin Central Hospital; and iv) all provincial and district general hospitals.

**Component 3: Implementation Management and Monitoring and Evaluation (US$0.65 million COVID19 FTF):** The Project will use currently existing PIU staff of the ongoing E-Health Project and include additional capacity and expertise as required. This component would also support monitoring and evaluation of prevention and preparedness, building capacity for clinical and public health research, and joint-learning across and within countries. As may be needed, this component will also support third-party monitoring of progress and efficient utilization of project investments.

**Component 4: Contingent Emergency Response Component (CERC) (US$0 million):** In the event of an Eligible Crisis or Emergency, the project will contribute to providing immediate and effective response to said crisis or emergency. A zero-value component has been included to ensure funds can be deployed through the project depending on the specific needs that may arise.

Under the AF activities will be expanded to include 1) risk communication and community outreach around the nation-wide covid-19 vaccination to increase awareness and “vaccine literacy”, build trust, and reduce stigma around any COVID-19 vaccine for a larger target population; 2) the preparation of detailed vaccine deployment plan based on WHO Fair Allocation Framework and development of a monitoring and evaluation (M&E) system to record the details of the recipients of vaccine as well as vaccine adverse effects; 3) engaging local community-based organizations design, adapt, and scale up innovative service delivery and community mobilization plans; 4) human resource deployment and training for effectively delivering a COVID-19 vaccination program; 5) procurement COVID-19 vaccines; 6) construction of required storage facility and cold chain upgrade as well as minor civil works for WASH and environmental health. Each of expended activities were described in the table 2.1 of this ESMF.

Applicable World Bank Environmental and Social Standards

The Environmental and Social risk associated with the Project, together with the activities under the project’s additional financing, is classified as ‘Substantial’. Six of the ten Environmental and Social Standards (ESSs) of the WB’s Environmental and Social Framework (ESF) have been screened as relevant: ESS1 Assessment and Management of Environmental and Social Risks and Impacts, ESS2 Labor and Working Conditions, ESS3 Resource Efficiency and Pollution Prevention and Management; ESS4 Community Health and Safety, ESS7 Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities and ESS10 Stakeholder Engagement and Information Disclosure. The ESMF also takes into account the national requirements as well as the application of an international protocols for infectious disease control and medical waste management.

WBG Environment, Health and Safety (EHS) Guidelines will apply to the extent relevant as well as appropriate current WHO Guidance on COVID-19 (see resources appendix) including those on “healthcare facilities”, “waste management”, “hazardous materials management”, and “construction and decommissioning”.

In addition to World Bank ESSs, the project shall comply with the national program on Environmental health, Good International Industry Practice guidance, including as a minimum WHO guidance notes on COVID-19 management and other related regulatory framework on Environmental protections. Applicable laws and regulations include, but not limit to, the Law on Mongolian Law on Hygiene, Law on Immunization, Law on Solid Waste, Law on Occupation safety and Hygiene, Labour Law, Disaster Protection Law and relevant decree on Health Care Waste Management, Law on Immunization and National guidelines for IPC in health facilities, vaccine deployment plan etc.

Environmental and Social Risks and Impacts

The project will be national in coverage and scope. No major civil works are expected in this project. But only small-scale civil work will be done such as building WASH facilities at the soum health centers, and expansion of the Cold storage at the NCCD. This COVID-19 financing will support the rehabilitation of existing buildings within the state land only, no land acquisition or involuntary resettlement impacts are expected. As a result, there is no impact or risks critical natural habitats, protected areas or cultural sites. However, the COVID-19 Preparedness and Response operations of laboratories (equipment, reagents /chemicals) may have considerable environmental and social impacts, such as those related to medical and general waste disposal, and the potential for transmission of the COVID-19 virus if prevention protocols are not followed.

Medical wastes and chemical wastes (including water, reagents, infected materials, etc.) from the labs, quarantine, and screening posts to be supported (drugs, supplies and medical equipment) can have a significant impact on the environment and human health, in particular the potential for transmission of COVID-19. Each beneficiary medical facility/lab, will need to follow the requirements of the ESMF and the mitigation measures outlined, in-line with WHO COVID-19 guidance documents and National Guidelines for Infection Prevention and Control in healthcare facilities, and other best international practices, and prepare and follow an Infection Control Waste Management Plan (ICWMP) to prevent or minimize such adverse impacts.

Most activities supported by the project will be conducted by health- laboratory workers, i.e. civil servants employed by the Government of Mongolia, including non-medical hospital staff (such as clerks and drivers), and professional consultants and contractors. The key risk for these workers is contamination with COVID-19 (or other contagious illnesses). Labor Management Procedures (LMP, see annex 3) in the ESMF cover these risks for entry into health care facilities; procedures for protection of workers in relation to infection control precautions; provision of immediate and ongoing training on the procedures to all categories of workers; training on use of Personal Protection Equipment (PPE), and overall ensuring adequate Occupational Health and Safety (OHS) protections are in place. Also, the project will regularly integrate the latest guidance by WHO as it develops over time addressing COVID-19.

The Stakeholder Engagement Plan (SEP, see annex 4) will also ensure widespread engagement with communities in order to disseminate information related to community health and safety, particularly around social distancing, high risk demographics, self-quarantine, and mandatory quarantine. The project will strive to ensure communication materials are created in a way that can reach all groups of people, in particularly the most vulnerable, and that are in a format and manner that is applicable to them.

Other risks from the project include Sexual Exploitation and Abuse (SEA), Gender-Based Violence (GBV) and Violence Against Children (VAC), which are addressed in the ESMF mitigation measures, the LMP and Codes of Conduct (CoC). Gender considerations are also part of all project components, in particular since the brunt of health workers in the country are women.

Vaccine quality and selection of individuals or groups for vaccinated, risk that project-related impacts fall disproportionately on individuals or groups who, because of their particular circumstances, may be disadvantaged or vulnerable; and risk of prejudice or discrimination toward individuals or groups in providing access to development resources and project benefits, particularly in the case of those who may be disadvantaged or vulnerable which are addressed in the ESMF mitigation measures. Health facilities shall ensure the provision of safe water, sanitation, and hygienic conditions, which is essential to protecting human health during all infectious disease outbreaks, including the COVID-19 outbreak.

MOH may need to develop specific mitigation measures for this, outside the scope of this ESMF. Mitigation measures for these and other risks are detailed in the ESMF.

Environmental and Social Screening

The purpose of screening is to: (i) determine whether activities are likely to have potential negative environmental and social risks and impacts; and (ii) identify appropriate mitigation measures. For activities with adverse risks or impacts, the mitigation measures are then incorporated into the activity implementation, e.g. through appropriate environmental and social management plans the implementation of which is monitored and reported.

Monitoring, Supervision and Reporting

The Project Implementation Unit (PIU) will prepare and submit to the World Bank regular monitoring reports on the environmental, social, health and safety (ESHS) performance of the Project, including but not limited to, stakeholder engagement activities, accidents and grievances log.

The working group at the MOH will be responsible for day to day supervision on implementation of mitigation measures.

Department of Public Health of the Ministry of health will be responsible for monitoring implementation of ESMF/ESMP provisions and report implementation progress in the project quarterly progress reports.

Implementation Arrangements and Responsibilities

Mongolian arrangement of COVID-19 pandemic. State emergency committee (SEC), NEMA MOH, and others. SEC will be led the intersectoral coordination of activities combating with the COB+VID-19 pandemic at the national level. Ministry of health will be coordinate and manage all activities related with the COVID-19 outbreak in Mongolia which of health sector human resource, capacity building, establishing a surveillance, treating, diagnosing and disseminating an IEC material for general public, and ect.

The Disaster Protection Law (in place since 2017) authorizes the National Emergency Management Agency and SEC to direct emergency policies and measures via the Government of Mongolia and regional emergency committees. The legal enforcement of SEC-led precautionary measures enabled a unified and focused administration of COVID-19 disaster management.

Capacity Building

The health sector has experience in infection prevention and control, healthcare waste management, communication and risk management and community engagement during emergency situations. As found across most countries, the capacity to manage risks associated with COVID-19 is a monumental challenge as the healthcare professionals may not have the detailed know-how on the infectious risk management in the labs to be used for COVID-19 diagnostic testing, quarantine and isolation centers for COVID-19 treatment, in particular waste management. Additionally, the communication process with the public handling social concerns around COVID19 as well as related measures, including quarantine is a catch-up process globally. The project will provide considerable funding, training and capacity building to support these critical initiatives and build upon international expertise to achieve international best practices on these matters in line with WHO guidelines. This will also include further identification of capacity gaps and detailed measures in line with the project proposal.

Consultation and Stakeholder Engagement

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

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

WHO and UNICEF have been instrumental in preparing Mongolia’s COVAX[[1]](#footnote-1) application, as well as their vaccination deployment plan. They will continue to play an integral role in supporting implementation and building capacity. Through their fully established offices, skilled manpower and longstanding relations with the MOH, especially in the areas of health system development and health service delivery, where they are in an unique position to provide this support.

Grievance Redress Mechanism

A grievance redress mechanism (GRM) is part of the project ESMF and SEP and will be established to resolve complaints and grievances in a timely, effective and efficient manner. Project related grievances can be submitted for detrimental impact on the community, the environment, or on their quality of life. Stakeholders may also submit comments and suggestions. The GRM provides complaint or resolving measures for any dispute, appropriate redress actions and avoids the need to resort to judicial proceedings. Grievances will be handled at each municipal/provincial referral hospitals and at the national level by a Grievance Redress Committee to be established by MOH, including via dedicated hotline to be established.

Budget

ESMF implementation costs are allocated to include training, development of E&S due diligence measures and other to be determined tools. Funds are needed to hire consultant(s) to prepare ESS site specific EMPs and all associated E&S due diligence reports. Costs for undertaking travel to conduct monitoring and trainings are also identified. The anticipated cost for all these initiatives is estimated at $230,000.

It is worth noting that there is a significant overlap in project activities to achieve its objectives, and the risk management measures prescribed by the ESMF (infection control is an illustrative example). A good part of the Project budget will be used for very similar activities as those outlined in the ESMF, e.g. for training, laboratory safety, and information dissemination. It is also noted that the World Bank activated COVID-19 CERC is also undertaking parallel actions and the projected costs estimates here need to be rectified with the on-going MOH actions to ensure costs savings.

# Introduction and Background

This Environmental and Social Management Framework (EMSF) is developed to support the environment and social due diligence provisions for activities financed by the World Bank Group Fast Track COVID-19 Facility (FCTF) to COVID-19 Fast Track Facility, using standard components as described in Annex 2 of the COVID-19 Board paper.

This Project complements the longer-term development work in the Health Sector, including the Mongolia’s E Health Project (P131290)which seeks to improve integration and utilization of health information and e-health solutions for better health service delivery in selected pilot sites. The Project was approved by the World Bank Board on 9 April, 2020 and was effective on 9 April 2020. This Project was selected for COVID-19 financing because Mongolia faces an elevated risk for COVID-19 outbreak spread. The scope and the components of this Project are fully aligned with the COVID-19 Fast Track Facility, using standard components. This Project complements the longer-term development work in the Health Sector, including the Mongolia’s E Health Project (P131290)which seeks to improve integration and utilization of health information and e-health solutions for better health service delivery in selected pilot sites.

**A phased response through the COVID-19 Fast Track Facility is proposed.** While support will surely be needed to respond to the economic impact of COVID-19 on households, businesses and government budgets, the World Bank’s approach is to lead with the health response. As a first step, the majority of operations processed through the Fast Track Facility will be health sector operations to respond to urgent preparedness and response needs related to the COVID-19 outbreak. One of the challenges with the response to COVID-19 is the availability (and price) of medical equipment and supplies. The global PSCN (Pandemic Supply Chain Network), of which the World Bank is a co-convener, has identified a list of medical products critical to the response. The task team will work with MOH to customize this list further to develop a positive list of goods to be procured with World Bank financing. Further the health system has been weak, with years of underinvestment and neglect. Rapid investments to build capacity, including through procurement of equipment, will be necessary to ensure the system is able to meet the increased demand from complicated COVID-19 cases. Indeed, there will likely be growing disruption to economic activities, businesses and livelihoods. Options for support through other financing instruments are being explored as the facility is established and through country consultations.

**While addressing the COVID-19 is an immediate priority for the Government of Mongolia the Project will in tandem strengthen health system preparedness for similar future public health emergencies**. The Project will therefore address some of the immediate needs for responding to COVID-19 including risk communication, strengthening response capacity and investing in the building blocks for a coordinated multi-sectoral approach. It will further address health system gaps in the availability of drugs, medical supplies and equipment in key hospitals and aimag centers to meet the surge of expected patients and enhance the quality of patient care.

This Mongolian COVID-19 updated ESMF follows World Bank Environmental and Social Framework. Summary (ESRS)[[2]](#footnote-2), updated Environmental and Social Commitment Plan (ESCP)[[3]](#footnote-3), and the updated Stakeholder Engagement Plan (SEP)[[4]](#footnote-4). As part of the World Bank support, the Ministry of Health is required to develop this EMSF. The following sections describe the environmental and social due diligence across all the anticipated project activities.

**1.2 Objective, Rationale and Application of the ESMF**

The objective of the ESMF is to assess and mitigate potential negative environment and social (E&S) risks and impacts of the Project consistently with the Environmental and Social Standards (ESSs) of the World Bank Environmental and Social Framework (ESF).

Specific objectives of the ESMF are to: (a) assess the potential E&S risks and impacts of the proposed Project and propose their mitigation measures; (b) establish procedures for the E&S screening, review, approval, and implementation of activities; (c) specify appropriate roles and responsibilities, and outline the necessary reporting procedures, for managing and monitoring E&S issues/concerns related to the activities; (d) identify the training and capacity building needed to successfully implement the provisions of the ESMF; (e) address mechanisms for public consultation and disclosure of project documents as well as redress of possible grievances; and (f) establish the budget requirements for implementation of the ESMF.

The ESMF provides principles and specific process and technical guidance to the Project implementing agencies and their consultants to assess the E&S risks and impacts of the Project activities, including ensuring that individuals or groups who, because of their particular circumstances, may be disadvantaged or vulnerable, have access to the development benefits resulting from the Project.

This ESMF is included to the Stakeholder Engagement Plan (SEP) and other specific plans (such as ESCP, and LMP) that have prepared for the Project after 30 days of AF contract signed.

This ESMF will be applied to all activities (works, good/services, technical assistance and research activities to be financed by the Project and/or its subprojects.

**1.3 Scope of the ESMF**

This ESMF includes guidelines for development and implementation of (i) an Infectious Control and Waste Management Plan (ICWMP) which will help strengthening the function of the existing health-care infectious control and waste management system including facilities and human capacity, and establish the system for new provinces; (ii) Community Health and Safety measures; (iii) Labor Management Procedures (LMP); (iv) Environmental and Social Code of Practice (ESCOP) for minor civil works; and (iv) an E&S risk management Capacity Building Plan. The ESMF also includes an environmental and social baseline and an analysis of key environmental and social risks of the project, including the risk of the most vulnerable not being able to access project benefits.

# Project Description

**This Project was selected for COVID-19 financing because Mongolia faces an elevated risk for COVID-19 outbreak spread.** The scope and the components of this Project are fully aligned with the COVID-19 Fast Track Facility, using standard components as described in Annex 2 of the COVID-19 Board paper. This Project complements the longer-term development work in the Health Sector, including the Mongolia’s E Health Project (P131290)which seeks to improve integration and utilization of health information and e-health solutions for better health service delivery in selected pilot sites

The Project will be address some of the immediate needs for responding to COVID-19 including risk communication, strengthening response capacity and investing in the building blocks for a coordinated multi-sectoral approach. It will further address health system gaps in the availability of drugs, medical supplies and equipment in key hospitals and aimag centers to meet the surge of expected patients and enhance the quality of patient care and vaccine service delivery.

The Covid-19 project consists of four components. Component 1 will address emergency COVID-19 Prevention and Response and aimed to slow down and limit the spread of COVID-19 in the country and improve preparedness for future public health emergencies. Component 2 will strengthening Health Care Delivery Capacity and aimed to strengthen essential health care service delivery to be able to provide the best care possible in the event of a surge in demand. Component 3 will support monitoring and evaluation of prevention and preparedness, building capacity for clinical and public health research, and joint-learning across and within countries. Component 4 will contribute to providing immediate and effective response to said crisis or emergency. A zero-value component has been included to ensure funds can be deployed through the project depending on the specific needs that may arise.

**A phased response through the COVID-19 Fast Track Facility is proposed.** While support will surely be needed to respond to the economic impact of COVID-19 on households, businesses and government budgets, the World Bank’s approach is to lead with the health response. As a first step, the majority of operations processed through the Fast Track Facility will be health sector operations to respond to urgent preparedness and response needs related to the COVID-19 outbreak. One of the challenges with the response to COVID-19 is the availability (and price) of medical equipment and supplies. The global PSCN (Pandemic Supply Chain Network), of which the World Bank is a co-convener, has identified a list of medical products critical to the response. The task team will work with MOH to customize this list further to develop a positive list of goods to be procured with World Bank financing. Further the health system has been weak, with years of underinvestment and neglect. Rapid investments to build capacity, including through procurement of equipment, will be necessary to ensure the system is able to meet the increased demand from complicated COVID-19 cases. Indeed, there will likely be growing disruption to economic activities, businesses and livelihoods. Options for support through other financing instruments are being explored as the facility is established and through country consultations.

**While addressing the COVID-19 is an immediate priority for the Government of Mongolia the Project will in tandem strengthen health system preparedness for similar future public health emergencies**. The Project will therefore address some of the immediate needs for responding to COVID-19 including risk communication, strengthening response capacity and investing in the building blocks for a coordinated multi-sectoral approach. It will further address health system gaps in the availability of drugs, medical supplies and equipment in key hospitals and aimag centers to meet the surge of expected patients and enhance the quality of patient care.

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Under the AF activities will be expanded to include 1) risk communication and community outreach around the nation-wide covid-19 vaccination to increase awareness and “vaccine literacy”, build trust, and reduce stigma around any COVID-19 vaccine for a larger target population; 2) the preparation of detailed vaccine deployment plan based on WHO Fair Allocation Framework and development of a monitoring and evaluation (M&E) system to record the details of the recipients of vaccine as well as vaccine adverse effects; 3) engaging local community-based organizations design, adapt, and scale up innovative service delivery and community mobilization plans; 4) human resource deployment and training for effectively delivering a COVID-19 vaccination program; 5) procurement COVID-19 vaccines; 6) construction of required storage facility and cold chain upgrade as well as minor civil works for WASH and environmental health. Each of expended activities were described in the table 2.1 of this ESMF.

The proposed project development objective is to strengthen the Government of Mongolia’s capacity to prevent and to respond to the COVID-19 outbreak and strengthen national systems for public health preparedness.

The primary objectives of the AF are to further strengthen preparedness and response activities under the parent project and to help ensure equitable and effective vaccine deployment in Mongolia through enhanced vaccination system strengthening. The PDO of the parent project will remain the same, as will the parent project component structure. An increase in scope and cost will be required to support: (i) vaccine and drug purchase; (ii) systems strengthening and service delivery efforts to ensure effective vaccine deployment; and (iii) monitoring, tracking of vaccines use and recording of any adverse reactions to vaccination.

**The need for additional resources to expand the** **Coronavirus Disease 2019 (COVID-19) response was formally conveyed by the Government of Mongolia** (GOM) in a letter from the Minister of Finance dated September 23rd, 2020, requesting the use of International Development Association (IDA) Crises Response Window resources for the purchase of COVID-19 vaccine. The proposed AF will form part of an expanded health response to the pandemic. As of December 31, 2020, 25.9 percent of the total funding of the parent project has been disbursed. The needs for additional resources in Mongolia are significant given the fact that since the parent project was approved (April 2, 2020), a great deal of progress has been made in COVID-19 response, including vaccine development. The Government of Mongolia is leading the donor coordination in close consultation with United Nations Children’s Fund (UNICEF), World Health Organization (WHO) and the World Bank. The World Bank is currently the only confirmed external donor to the COVID-19 response. Therefore, continuing the World Bank engagement is essential to enable a sustained and comprehensive pandemic response in Mongolia.

The Additional Financing will expand the scope of the parent project in its efforts to support Mongolia government's efforts in strengthening the preparedness and response to COVID-19 pandemic while simultaneously preparing the health system for future public health emergencies. The primary objectives of the AF are to enable affordable and equitable access to COVID vaccines and help ensure effective vaccine deployment in Mongolia through enhanced vaccination system strengthening and to further strengthen preparedness and response activities under the parent project.

### Project Components

The Covid-19 project consists of four components. Component 1 will address emergency COVID-19 Prevention and Response and aimed to slow down and limit the spread of COVID-19 in the country and improve preparedness for future public health emergencies. Component 2 will be strengthening Health Care Delivery Capacity and aimed to strengthen essential health care service delivery to be able to provide the best care possible in the event of a surge in demand. Component 3 will support monitoring and evaluation of prevention and preparedness, building capacity for clinical and public health research, and joint-learning across and within countries. Component 4 will contribute to providing immediate and effective response to said crisis or emergency. A zero-value component has been included to ensure funds can be deployed through the project depending on the specific needs that may arise.

Under the AF activities will be expanded to include 1) risk communication and community outreach around the nation-wide covid-19 vaccination to increase awareness and “vaccine literacy”, build trust, and reduce stigma around any COVID-19 vaccine for a larger target population; 2) the preparation of detailed vaccine deployment plan based on WHO Fair Allocation Framework and development of a monitoring and evaluation (M&E) system to record the details of the recipients of vaccine as well as vaccine adverse effects; 3) engaging local community-based organizations design, adapt, and scale up innovative service delivery and community mobilization plans; 4) human resource deployment and training for effectively delivering a COVID-19 vaccination program; 5) procurement COVID-19 vaccines; 6) construction of required storage facility and cold chain upgrade as well as minor civil works for WASH and environmental health. Each of expended activities were described in the table below 2.1.

**Component 1: Emergency COVID-19 Prevention and Response (Total US$2.5 million COVID19 FTF):** The aim of this component is to slow down and limit the spread of COVID-19 in the country and improve preparedness for future public health emergencies. This will be achieved through providing immediate support for a comprehensive communication and behavior change intervention, strengthening capacity for active case detection and response, building an enabling platform for One Health and strengthening capacity of the health work force to manage the current and future public health emergencies. It will have four sub-components:

1. **Sub-Component 1.1: Risk Communication and Community Engagement** (**US$1.1 million COVID19 FTF**): There will be a comprehensive communication and behavior change intervention to support key prevention behaviors (hand washing, social distancing etc.), including i) developing and testing messages and materials; and ii) further enhancing infrastructure to disseminate information from national to aimag and soum levels, and between the public and private sectors. Community mobilization will take place through existing Government and community institutions such as Aimag/city and Soum/district Governor’s offices, health and education sector social workers, local CSOs, and bagh/khoroo (lowest administrative unit) Governors and doctors. A community engagement, risk communication, and social distancing program for the highly populated capital city will also be mobilized. Communication campaigns will include messages regarding appropriate care for sick family members, to decrease health risks to caregivers (often female) and provide information on to minimize psychosocial impacts. These modes for communication will include TV, radio, social media and printed materials as well as outreach through the community health workers who will need to be trained and compensated for this activity.

1. **Sub-Component 1.2: Response support (US$0.65million COVID19 FTF):** This sub-component would help strengthen disease surveillance systems, and epidemiological capacity for early detection and confirmation of cases; combine detection of new cases with active contact tracing; support epidemiological investigation; strengthen risk assessment; and provide on-time data and information for guiding decision making and response and mitigation activities. It will improve public health emergency preparedness including the health facility preparedness. Aimag/district hospitals will prepare pandemic preparedness and response plans that are grounded in sound gender analyses and needs of other vulnerable populations. Health care workers will have access to all populations in need, and any movement restrictions relating to COVID-19, will account for the needs of different vulnerable groups especially the elderly and women. Support under this sub-component will: i) improve management of public health events and emergencies; ii) place incident management systems within the health sector and across other sectors, including at local levels; iii) develop M&E system to measure performance of health security systems; iv) improve coordination on public health emergencies and disaster management within the health sector and beyond at national and local levels; v) continue to strengthen system readiness to implement emergency plans, and vi) conduct strategic risk assessment and health risk and resource mapping.

1. **Sub-Component 1.3: Human resource development** (**US$0.45 million COVID19 FTF**): This component will finance activities related to preparedness, capacity building and trainings. It will enhance human resource capacity in diagnosing and treating the COVID-19 and conduct epidemiological and clinical research. Key areas will include support for i) training for emergency care doctors, nurses and paramedical staff in diagnosing, triage and providing first aid care; ii) training for health care staff on infection control; iii) building diagnostic capacity for COVID-19 at the national; district and aimag level; iv) providing psychosocial support to frontline responders v) translating, adapting and disseminating guidance to triage, treat, manage and follow up people with mild suspected symptoms in primary care settings, non-health facilities, community settings and at home; v) epidemiological and clinical research studies to take stock of the COVID-19 detection and treatment.
2. **Sub-Component 1.4: Creating an enabling environment for One Health (US$0.3 million COVID19 FTF):** This subcomponent will strengthen capacities for multi-sectoral response operations to emerging and new infectious diseases. Working with the General Authority for Veterinary Services (GAVS), Ministry of Food, Agriculture, and Light Industry (MOFALI) and National Emergency Management Agency (NEMA) it will support capacity for joint response for new and emerging infectious diseases. This subcomponent will i) organize National Bridging Workshops (NBW) to analyze and improve the collaboration between the MOH, GAVS, MOFALI for the prevention, detection and response to zoonotic diseases and other health events at the animal-human interface ii) enhance institutional policies, plans, procedures and linkages to facilitate improved multi-sectoral communication, coordination and collaboration; iii) strengthen public health law enforcement and review to address inconsistencies; iii) conduct joint surveillance and risk assessments by MOH and GAVS; and iv) create joint data sharing platform between MOH and GAVS, both for early warning systems and joint control of disease outbreaks.

**Component 2: Strengthening Health Care Delivery Capacity (Total US$ 23.75 million including US$9.95 million from COVID19 FTF, US$13.8 million IBRD)** The aim of this component is to strengthen essential health care service delivery to be able to provide the best care possible in the event of a surge in demand. It will also provide ongoing support for people falling ill in the community to minimize the overall impact of the disease. Assistance will be provided to the health care system for preparedness planning to provide optimal medical care, maintain essential lifesaving services, and minimize risks for patients and health personnel. Strengthened clinical care capacity will be achieved by establishing specialized units in selected hospitals; publishing treatment guidelines, and hospital infection control interventions; strengthening waste management systems; and procurement of essential additional inputs for treatment such as oxygen delivery systems and medicines. Local containment will be supported through the establishment of local isolation units in hospitals. Widespread infection control training and measures will be instituted across health facilities.

**As COVID-19 will place a substantial burden on inpatient and outpatient health care services**, **support will be provided to rehabilitate and equip selected health facilities for the delivery of critical medical services and to cope with increased demand**. Health system strengthening efforts will therefore focus on provision of medical and laboratory equipment, PPE, medical supplies and laboratory tests to selected hospitals and health facilities. The Government of Mongolia has several health facilities as additional designated hospitals where COVID-19 patients will be admitted for treatment. These include i) Medical University Teaching Hospital; ii) Perinatology Center of Ulaanbaatar City; iii) the Third State Central Hospital known Shastin Central Hospital; and iv) all provincial and district general hospitals.

1. **Sub-component 2.1. Provision of medical and laboratory equipment and reagents (Total US$22.38 million, including US$8.58 million from COVID-19 FTF and US$13.8 million IBRD) :** This sub-component will upgrade health facilities in 21 provinces and 9 districts of Ulaanbaatar city and selected hospitals for diagnostics and treatment of COVID-19 infection capacity through procurement of intensive care unit equipment and devices including Extracorporeal membrane oxygenation (ECMO) machine; establishment of oxygen mini-factory; provision of oxygen balloons, emergency beds, laboratory reagents and waste management facilities. This subcomponent will also support short trainings on use of equipment, devices, and tests for health providers and technicians.

1. **Sub-component 2.2. Provision of medical supplies, including PPE and medicines (US$1.37 million COVID19 FTF):** This subcomponent will support the health system with supplies including Personal Protective Equipment like N95 respirators, medical masks, goggles, gloves, gowns etc. It will also support medical counter measures and medical supplies for case management and infection prevention, as well as procurement of drugs such as antivirals, antibiotics and essential medicines for patients with comorbidity and complications such as CVDs and diabetes.

**Component 3: Implementation Management and Monitoring and Evaluation (US$0.65 million COVID19 FTF):** The Project will use currently existing PIU staff of the ongoing E-Health Project and include additional capacity and expertise as required. This component would also support monitoring and evaluation of prevention and preparedness, building capacity for clinical and public health research, and joint-learning across and within countries. As may be needed, this component will also support third-party monitoring of progress and efficient utilization of project investments.

**Component 4: Contingent Emergency Response Component (CERC) (US$0 million):** In the event of an Eligible Crisis or Emergency, the project will contribute to providing immediate and effective response to said crisis or emergency. A zero-value component has been included to ensure funds can be deployed through the project depending on the specific needs that may arise.

**Project management arrangements will be adapted under the ongoing e-health Project (P131290), currently functioning satisfactorily, to utilize existing capacity in Ministry of Health (MOH) and coordinate with all stakeholders.** Through its central departments and provincial offices, the MOH will be responsible for implementation of the project, including overall coordination, results monitoring and communicating with the World Bank on the implementation of the project. The COVID-19 project IPIU will consist of 9 staffs. Potential safety and health risks for direct workers are considered to be low.

**Current E-Health Project Steering Committee (PSC), chaired by the Minister of Health will be used for oversight and to provide strategic policy advice and guidance to the Project.** Membership of the PSC will be extended to include additional members from MOH, National Center for Communicable Disease, Center for Zoonosis Disease and Public Health Institute. The Project Steering Committee will also be responsible for ensuring synergies between the project activities and the State emergency preparedness plan. The Project Steering Committee will meet on a regular schedule to review progress of the project, ensure coordinated efforts by all stakeholders and conduct annual reviews of the project. The multisectoral aspects of the COVID-19 response will be guided by National Emergency Commission chaired by Deputy Prime Minister.

**Table 2. 1: Original Activities and Activities under AF**

|  |  |
| --- | --- |
| Original components and activities | Changes or Additionalities under AF |
| Component 1: Emergency COVID-19 Prevention and Response |  |
| Sub-component 1.1 will support comprehensive communication and behavior change intervention to support key prevention behaviors (hand washing, social distancing etc.), including i) developing and testing messages and materials; and ii) further enhancing infrastructure to disseminate information from national to aimag and soum levels, and between the public and private sectors. | Activities will be expanded to include information to the public of the rationale for vaccinating selected target populations; vaccine safety; the process for vaccine deployment; registration and possible side-effects of the vaccine to foster confidence in a new vaccine. Effective communication and outreach will be imperative to increase awareness and “vaccine literacy”, build trust, and reduce stigma around any COVID-19 vaccine for a larger target population. |
| Sub-component 1.2 will support i) improved management of public health events and emergencies; ii) place incident management systems within the health sector and across other sectors, including at local levels; iii) develop M&E system to measure performance of health security systems; iv) improve coordination on public health emergencies and disaster management within the health sector and beyond at national and local levels; v) continue to strengthen system readiness to implement emergency plans, and vi) conduct strategic risk assessment and health risk and resource mapping. | Activities will be expanded to include the preparation of i) a detailed vaccine deployment plan, and, based on the WHO Fair Allocation Framework to identify priority population groups to receive vaccination; ii) development of a monitoring and evaluation (M&E) system to record the details of the recipients of vaccine as well as vaccine adverse effects; iii) districts/aimags to design, adapt, and scale innovative service delivery and community mobilization plans; local community-based organizations will be contracted to perform such actions where relevant. |
| Sub-component 1.3. will support i) training for emergency care doctors, nurses and paramedical staff in diagnosing, triage and providing first aid care; ii) training for health care staff on infection control; iii) building diagnostic capacity for COVID-19 at the national; district and aimag level; iv) providing psychosocial support to frontline responders v) translating, adapting and disseminating guidance to triage, treat, manage and follow up people with mild suspected symptoms in primary care settings, non-health facilities, community settings and at home; v) epidemiological and clinical research studies to take stock of the COVID-19 detection and treatment | Activities will be expanded to include a human resource deployment and training plan for effectively delivering a vaccine program. This would need to be rolled out across the country in the shortest possible time to existing staff and additional vaccinators (retired health staff, Red Cross members, pharmacists etc.) on provision of the vaccine, infection control, pharmacovigilance and environmental safety measures as well as interpersonal communication tools to counter any resistance to the vaccine.  |
| Subcomponent 1.4. will strengthen capacities for multi-sectoral response operations to emerging and new infectious diseases | No additional activities |
| Component 2: Strengthen Health Care Delivery Capacity |  |
| Sub-component 2.1. will upgrade health facilities in 21 provinces and 9 districts of Ulaanbaatar city and selected hospitals for diagnostics and treatment of COVID-19 | No additional activities |
| Sub-component 2.2. will support the health system with supplies including Personal Protective Equipment and medical supplies for case management and infection prevention, as well as drugs for patients with co-morbidity and complications. | Activities will be expanded to include the procurement of the required storage facility and cold chain upgrade as well as the vaccines and supplies require for vaccine deployment. Minor civil works for WASH and environmental health may also be supported. will be supported.  |
| Component 3: Implementation Management and Monitoring and Evaluation |  |
| This component supports the existing PIU staff of the ongoing E-Health Project along with additional capacity and expertise as required. It also supports monitoring and evaluation and third-party monitoring of progress and efficient utilization of project investments. | Activities will support any additional technical staff required for management and monitoring with regard to vaccine procurement, cold chain strengthening and vaccination delivery support. This may include engaging partner organizations, especially UNICEF and WHO, in various roles. In addition to routine immunization recording, daily records documenting the bar code of the vaccine provided to each individual and records of any adverse vaccination effects will be maintained. |
| Component 4: Contingent Emergency Response Component  | No additional activity |
| In the event of an Eligible Crisis or Emergency, the project will contribute to providing immediate and effective response to said crisis or emergency.  | No additional activity |

**Current E-Health Project Steering Committee (PSC), chaired by the Minister of Health will be used for oversight and to provide strategic policy advice and guidance to the Project.** Membership of the PSC will be extended to include additional members from MOH, National Center for Communicable Disease, Center for Zoonosis Disease and Public Health Institute. The Project Steering Committee will also be responsible for ensuring synergies between the project activities and the State emergency preparedness plan. The Project Steering Committee will meet on a regular schedule to review progress of the project, ensure coordinated efforts by all stakeholders and conduct annual reviews of the project. The multisectoral aspects of the COVID-19 response will be guided by National Emergency Commission chaired by Deputy Prime Minister.

### Project Components and Estimated Budget

The primary activities in the COVID-19 Master Plan to be supported by the Project, in line with the RGC’s request, are presented in Table 1.

**Table 2. 2: Cost Distribution (in USD Million)**

|  |  |  |
| --- | --- | --- |
| Parent project | AF | Grant total |
|  | **Total** | **COVID19 FTF** | **IBRD** | **IDA** |
| Component 1: Emergency COVID-19 Prevention and Response | **2.5** | 2.5 |  |  | 2.5 |
| Sub-component 1.1 Risk Communication and Community Engagement  | 1.1 | 1.1 |  | 2.5 | 3.6 |
| Sub-component 1.2 Response support  | 0.65 | 0.65 |  | 2.1 | 2.75 |
| Sub-Component 1.3 Human resource development | 0.45 | 0.45 |  | 3.0 | 3.45 |
| Sub-component 1.4 Creating an enabling environment for One Health | 0.3 | 0.3 |  |  | 0.3 |
| Component 2: Strengthening Health Care Delivery Capacity | **23.75** |  |  |  | 23.75 |
| Sub-component 2.1 Provision of medical and laboratory equipment and reagents  | 22.38 | 8.58 | 13.8 | 5.0 | 27.38 |
| Sub-component 2.2 Provision of medical supplies, including PPE and medicines | 1.37 | 1.37 |  | 36.1 | 37.47 |
| Component 3: Implementation Management and Monitoring and Evaluation  | **0.65** | 0.65 |  | 2.0 | 2.65 |
| Component 4: Contingent Emergency Response Component (CERC)  | 0 |  |  |  |  |
| Total  | **26.9** | **13.1** | **13.8** | **50.7** | **77.6** |

 It is important to note that given project focus on immediate priority activities, the project should avoid activities or subprojects with complex environmental and social aspects. To ensure that adverse impacts will not occur given the nature of emergency, the items and activities identified below are ineligible. The following type of activities shall not be eligible for finance under the Project:

**Ineligible Activities to be financed by the Project**

* Any new construction
* Activities that may cause long term, permanent and/or irreversible (e.g. loss of major natural habitat) adverse impacts
* Activities that have high probability of causing serious adverse effects to human health and/or the environment other than during treatment of COVID-19 cases
* Activities that may have significant adverse social impacts and may give rise to significant social conflict
* Activities that may affect lands or rights of indigenous people or other vulnerable minorities,
* Activities that may involve permanent resettlement or land acquisition or adverse impacts on cultural heritage.

### Project Area and Beneficiaries

The project will be implemented countrywide. The expected project beneficiaries will be all Mongolian people, but in particular people with COVID-19, at-risk populations, medical and emergency personnel, laboratories of National Center for Communicable Diseases of Ministry of Health and 21 aimags and 9 district hospitals, emergency operation centers (EOCs) and health agencies including National Center for Public Health. The proposed Project will make specific efforts to reach the most vulnerable communities, including poor households, remote communities, ethnic minorities, female-headed households, adult with chronic disease, people with a disability and other populations that are at high risk of epidemic disease. Also, 60 percent of general population will be vaccinated anti-COVOD-19 vaccine.

# Policy, Legal and Regulatory Framework

The Disaster Protection Law (in place since 2017) authorizes the National Emergency Management Agency and State Emergency Committee (SEC) to direct emergency policies and measures via the Government of Mongolia and regional emergency committees. The legal enforcement of SEC-led precautionary measures enabled a unified and focused administration of COVID-19 disaster management.

On 20 April, 2020, The Parliament of Mongolia endorsed a temporary law on the coronavirus infection prevention, combating, reducing the social and economic impact. The multisectoral aspects of the COVID-19 response will be guided by the National Emergency Commission chaired by the Deputy Prime Minister.

Law on Health and related regulations by MOH and Law on Social Welfare and related regulations by MLSW, by the law on Preschool education and related regulations and national programmes activities and objectives included to FHCs and SHCs. It is included in bilateral agreement between FHCs and SHCs with the City and aimag governor’s office or Health departments. All national programs health indicators included in SHC and FHCs monthly, quarterly and annual report forms, by which MOH is trying reinforce the implementation of programs and conduct ongoing monitoring and evaluation of the programs.

**Law on Hygiene, 2016,** The Parliament of Mongolia nullified the Law on Sanitation adopted on May 07, 1998 and passed the Law on Hygiene on Feb 04, 2016. The laws warrant the Constitutional right of a citizen to live in healthy and safe environment. Based on this law the environmental surveillance system stated to implement at the National center for Public Health since 2018.

**The Law on Air** regulates protection of air in the environment, prevention of air pollution, monitoring and reduction of air pollutants (2012). The Law on Air specifies the powers and duties of central government bodies, local self-governing entities, economic entities, organizations and citizens in relation to air protection.

**The Law on Air** (2012) and **Law on Air Pollution Fees** (2010) regulates relations concerning the imposition and payment of air pollution fees on air pollutants and sets four types of fees – from coal burning, automobiles, organic substances and other sources to be collected by the state budget. The law was revised in January 2018; accordingly, air pollution fees must be collected by the Anti-Air Pollution Fund from January 2019.

**The Law on Energy** (2001) regulates energy use, generation, transmission and distribution activities and supports the construction of efficient, reliable and sustainable energy resources. The law supports the creation of subsidized energy tariffs for households in ger districts to encourage the use of affordable electric energy sources for heating and cooking rather than the traditional burning of raw coal and woody biomass. The Law on Renewable Energy (2007) regulates the generation and distribution of electricity created by renewable energy sources and gives special priority to wind and solar energy. The law sets the government guaranteed feed-in tariffs for renewable energy power sources and sets up a renewable energy fund.

 “**Law on Air Pollution Fees**”, June 24, 2010 (the law was amended on May 17, 2012). It regulates the protection of the atmosphere to provide environmental balance for the sake of present and future generations, allows government to set standard limits on emissions from all sources and provides for the regular monitoring of ambient air pollution, hazardous impacts and changes in small air components such as ozone and hydrogen.

**Law on waste**, 2012. This law regulates the decrease, sorting, collection, transport, storage, reuse, recycle, use by restoration, and disposal of ordinary solid wastes; and collection, transport, storage, reuse, recycle, use by restoration, and disposal of gaseous, liquid and solid wastes other than radioactive waste. According to this law open burning of all kind of waste is prohibited in all stage.

**Health care waste management**

Healthcare waste is considered to be hazardous. Hence, laws regulate the collection, transportation and disposal of such waste. The current legal framework for the management of healthcare wastes (HCW) in Mongolia consists of relevant international conventions ratified by Mongolia, the Law on Waste and other specific national laws, strategies, Ministerial Orders, and legal documents related to its enforcement.

The Government started to pay special attention to waste management in 1999 after approval of the Waste Management program. In May 2012, the Parliament of Mongolia endorsed the “Law on Waste” and it is the primary document that regulates waste management in Mongolia and updated in 2017. The purpose of this law is to regulate various aspects related to storage, collection, transport, landfilling, recycling, final disposal, export, import and trade of waste and to eliminate hazardous impacts of household and hazardous wastes on public health and the environment. In relation to the approval of this law, the “Law on Importing, Exporting and Transporting Hazardous Waste Across Borders and its Prohibition” was abolished.

Clause 3.1.3 of the Law on Waste defines hazardous waste as, “any waste that damages, infects and harms people, animals, plants, and their descendants; and that has detrimental effects on the environment, having the attributes of being contaminative, corrosive, oxidizing, flammable, explosive, radioactive and infectious”

Moreover, while this legislation does contain the term “medical waste” it does not contain the term “special medical waste”. Additionally, the Law on Waste gives the government the right to approve the procedures for issuing licenses related to the collection, packaging, temporary storage, disposal, recycling and long-term storage of waste to citizens, businesses and organizations.

In the Clause 8 of the **Law on Waste** states that:

8.3. The central administrative body in charge of health care will have the following rights:

8.3.1. To supervise and control the waste management of its affiliated units and organizations, to provide them with professional and methodological guidance and to provide financial support;

8.3.2. To approve and supervise he methods for collecting, storing, transporting and disposing of waste for each specific case;

8.3.3. To approve of the fees and norms for waste management services in relation to the methods;

8.3.4. Determine norms for health facilities in accordance with the procedures specified in 8.1.10 of this law (Approve the methodology for determining municipal waste normative)

8.3.5. Provide professional, methodological, and financial support to the classification, collection, transport, recycling, recycling and disposal of hazardous waste from the health organizations.

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The purpose of this law is to regulate various aspects related to storage, collection, transport, landfilling, recycling, final disposal, export, import and trade of waste and to eliminate hazardous impacts of household and hazardous wastes on public health and the environment. In relation to the approval of this law, the “Law on Importing, Exporting and Transporting Hazardous Waste Across Borders and its Prohibition” was abolished.

In 2017, Health ministerial order #A/505 on classifying, collecting, transporting, storing, treating and eliminating of health care waste was approved and implementing till now. According to the order, all health care service provider in all level should follow the order in terms of the health care waste management issues. Medical and chemical wastes (including water, reagents, infected materials, etc.) from the labs, quarantine, and screening posts to be supported (drugs, supplies and medical equipment) can have significant impact on environment and human health. Wastes that may be generated from medical facilities/ labs could include liquid contaminated waste, chemicals and other hazardous materials, and other waste from labs and quarantine and isolation centers including sharps, used in diagnosis and treatment. The AF component adds additional waste types including syringes and vaccine vials, as well as expired or wasted vaccines.

Healthcare waste management is undergoing a transformation, which is well advanced in Ulaanbaatar but lags behind in other parts of Mongolia. In Ulaanbaatar, a central healthcare waste treatment facility has been in operation since 2011 by the company Element LLC, which operates under a public–private partnership agreement between Ulaanbaatar City, the Ministry of Health and Element LLC. Element LLC collects medical waste from all public and private healthcare facilities in Ulaanbaatar City on a routine basis and, after autoclave disinfection, disposes of this waste in the Narangiin Enger disposal site. The facility consists of two autoclave units for biological waste and one unit for needles and sharps, with a total capacity of 2,800 kg/d.

**Law on Chemical and Toxic Substances**

The “Law on Chemical and Toxic Substances” which was endorsed in 2006, is used in regulating the use, transportation and disposal of expired or unused medicines, chemical reagents and substances used in radiation therapy, radiology and other diagnosis. Chemical and toxic substances are disposed of at specific points based upon the decisions of professional inspection agencies. The points for disposal are determined by the local governor and a committee consisting of environmental and health inspectors. The local emergency workers prepare acts to report about the disposal.

**Law on Immunization**

This law been endorsed in 2000 and the latest amendment was done in 2015. It was used to regulate relations pertaining to the prevention of the Mongolian population from and the immunization against infectious diseases. All the steps such as selecting of the vaccine, transportation, storing, delivering medical service to the client and etc. which of stated in the Vaccination deployment plan will be undergone by this law.

In the Clause 12 states:

12.1 Immunization agent may be voluntary taken according to the relevant regulation by the citizen who are traveling to a region or country that has high endemicity of contagious diseases and/or by persons who are involved in certain types of jobs and services. In such cases the expenses of vaccination shall be born by the persons involved.

12.2 The list of jobs and services that require vaccination, shall be adopted by the Government.

**Brief overview of labor and OSH legislations**

#

Mongolian Labor Law (1999), Law on Trade Unions (1991), Law on Promotion of Gender Equality (2011), Law on Occupational Safety and Hygiene (amended in 2015) and related regulations adopted by the Government and tripartite bodies provide the legal framework for protecting the legitimate rights and interests of workers of Mongolia.

The Law on Occupational Safety and Hygiene (amended 2015) determines the state policy and principles on occupational safety and hygiene and provides the requirements as regards to the OHS management and monitoring system.

**Water, sanitation and hygiene**

In the Mongolian standards of the different level hospitals are included with water and sanitation criteria. In 2017 Nov approved the structure and activity MNS50952017 standard for General hospitals and states that: Sanitation shall to connect to centralised system; in hospital departments and units toilet should have warm and cold water for wash hand, supply by antibacterial soap, disposal hand towel and hand disinfection solutions.

**Infection prevention control**

The legal framework for infection prevention and control (IPC) is Order 165 which was issued in 2010, consisting of both administrative and technical frameworks. It was intended to provide comprehensive administrative and technical guidelines that includes essential aspects related to IPC, among others, organization, roles and responsibilities of IPC committee/subcommittee; infection control precautions; disinfection and sterilization instructions; diagnostic criteria for hospital acquired infection (HAI); list of single-use disposable items; surveillance reporting forms for HAI.

Order 165 is complemented by a number of orders and standards that are relevant to IPC, including waste management orders; blood safety orders; Order 397 on care of tuberculosis patients; standard of HAIs surveillance (MNS 59856-2003); standard of resistant pathogens (MNS 5948-57-2003).

The General Agency for Specialized Inspection is responsible for external evaluation of the hospitals’ quality of services, in which the scope of inspection encompasses the hygiene and infection control of health care facilities. The current inspection checklist audits on the availability of organization and plan for IPC activities; hand hygiene commodity, guideline and training; medical waste management; essential facilities and sterilization equipment; surveillance of resistant microorganisms; staff vaccination coverage and infection prevention plan for health care workers (HCW), etc[[5]](#footnote-5).

The existing national regulatory policy documents shall applicable to the implementation of the project.

### Applicable World Bank Environmental and Social Standards

The Project’s environmental and social risk is classified as ‘Substantial’. Seven of the ten Environmental and Social Standards (ESSs) of the WB’s Environmental and Social Framework (ESF) have been screened as relevant. Those are i) **ESS1 Assessment and Management of Environmental and Social Risks** and Impacts sets out the Borrower’s responsibilities for assessing, managing and monitoring environmental and social risks and impacts associated with each stage of a project supported by the Bank through Investment Project Financing (IPF). ii) **ESS2 Labor and Working Conditions** recognizes the importance of employment creation and income generation in the pursuit of poverty reduction and inclusive economic growth. iii) **ESS3 Resource Efficiency and Pollution Prevention and Management** recognizes that economic activity and urbanization often generate pollution to air, water, and land, and consume finite resources that may threaten people, ecosystem services and the environment at the local, regional, and global levels. iv) **ESS4: Community Health and Safety** addresses the health, safety, and security risks and impacts on project-affected communities. v) **ESS5: Land Acquisition, Restrictions on Land Use and Involuntary Resettlement** - involuntary resettlement should be avoided. vii) **ESS8: Cultural Heritage** recognizes that cultural heritage provides continuity in tangible and intangible forms between the past, present and future. vi) **ESS9**: **Financial Intermediaries** (FIs) recognizes that strong domestic capital and financial markets and access to finance are important for economic development, growth and poverty reduction. vii) **ESS10: Stakeholder Engagement and Information Disclosure recognizes** the importance of open and transparent engagement between the Borrower and project stakeholders as an essential element of good international practice.

The screening of social risks and impacts is based on discussion with the task team and consultations with MOH. The ESMF has also taken into account the national requirements as well as the application of an international protocols for infectious disease control and medical waste management. The Project is not expected to impact natural habitats or cultural sites. In addition, all activities financed through the project are subject to the World Bank Group Environmental, Health and Safety (EHS) Guidelines (see Annex 4 Resources) including those on “healthcare facilities”, “waste management”, “hazardous materials management”, and “construction and decommissioning”.

An Environmental and Social Commitment Plan (ESCP) has been prepared, consulted on, and updated, which takes into account the need to ensure adequate budget, staffing and operational arrangements for Project E&S risk management.

A Stakeholder Engagement Plan (SEP) has also been prepared and consulted on, and updated, describing a program for stakeholder engagement, including public information disclosure and consultation, throughout the entire project cycle recognizing the need for an effective and inclusive engagement with all of the relevant stakeholders and the population at large. Considering the serious challenges associated with COVID-19, dissemination of clear messages around social distancing, high risk demographics, self-quarantine, and, when necessary, mandatory quarantine is critical. The project will also strive to address other communication messages that may be needed, such as around mental health, support to parents and Gender-Based Violence, particularly if social isolation restrictions and school closures continue.

With support from UNICEF and WHO, the MOH is appraising the country’s readiness for deployment of the COVID-19 vaccine using the Vaccine Introduction Readiness Assessment Tool (VIRAT) and the Vaccine Readiness Assessment Framework (VRAF). These tools assess institutional, operational and financial capacity, gaps and need and the full assessment is expected to be completed by early 2021 . The AF will engage these partner organizations in various roles such as procurement agents and suppliers and as providers of specialized technical assistance such as vaccine registration and risk communication.

Project preparation has included a mapping of the stakeholders. Individuals and groups likely to be affected (direct beneficiaries) have been identified. Mapping of other interested parties such as government agencies/authorities, NGOs and CSOs, and other international agencies have also been completed. The SEP was prepared by the client and publicly disclosed[[6]](#footnote-6). The SEP will be updated during project implementation.

**Table 3.1 Required Project Environmental and Social Standards Measures and Actions**

|  |  |
| --- | --- |
| **Relevant Environmental & Social Standard**  | **Required Measures and Actions**  |
| ESS1 Assessment and Management of Environmental and Social Risks and Impacts  | **Ministry of Health (MOH) shall establish and maintain** assigned departments/institutes with qualified staff and resources to support the management of ESHS risks and impacts of the Project including environmental and social risk management specialists. **The Environmental and Social Management Framework (ESMF)** shall be prepared within 30 days after the project effectiveness.  |
| ESS2 Labor and Working Conditions  | **Occupational Health and Safety (OHS) measures** in line with the ESMF, LMP, IPC&WMP and WHO guidelines on COVID19 shall be established and complied in all facilities, including laboratories, quarantine and isolation centers, and screening posts. **A Grievance Hotline and assignment** of focal points to address these grievances shall be established within MOH and PIUProvisions to prevent SEA, GBV and/or VAC, including CoC for PIU’s staff for contracted workers in line with relevant national laws and legislation shall be included at the project’s LMP, adopted and applied under the project.  |
| ESS3 Resource Efficiency and Pollution Prevention and Management  | IPC&WMP acceptable to the Association will be prepared before beginning the relevant Project activities  |
| ESS4 Community Health and Safety  | **Precautions measures** in line with the ESMF, IPC&WMP and WHO guidelines on COVID19 shall be put in place to prevent or minimize the spread of the infectious disease/COVID-19 from laboratories, quarantine and isolation centers to the community  |
| ESS7 Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities  | The project’s SEP will be adapted in a manner acceptable for the Bank to make sure that EM community members are fully consulted in a culturally-appropriated manner about and have opportunities to benefit from the project activities.  |
| ESS10 Stakeholder Engagement and Information Disclosure  | **A draft Stakeholder Engagement Plan (SEP)** including a Grievance Mechanism shall be prepared, consulted and disclosed. The SEP shall be updated and disclosed within 30 days after the Effective Date. Grievance Mechanism shall be made publicly available to receive and facilitate resolution of concerns and grievances in relation to the Project, consistent with ESS10, in a manner acceptable to the Association.  |

The project has prepared an SEP, which has been updated. The SEP serves the following purposes: (i) stakeholder identification and analysis; (ii) methods for stakeholder engagement, including effective communication tools for consultations and disclosure; (iii) defining roles and responsibilities of different actors in implementing the Plan; and (iv) a grievance redress mechanism (GRM). Provisions have been included to reach and meaningfully engage vulnerable and disadvantaged groups (elderly, children who are high risk – such as those who are malnourished --, poor households, ethnic minorities, resident in rural areas, people living with a disability, female-headed households and those with chronic illnesses).

WBG EHS Guidelines will apply to the extent relevant as well as appropriate current WHO Guidance (see Resources appendix). Beyond this immediate concern, project implementation needs also to be responsive to the needs of marginalized and vulnerable social groups who may be unable to access facilities and services designed to combat the disease. To mitigate this risk MOH, in the ESCP, is committed to the provision of services and supplies based on the urgency of the need, in line with the latest data related to the prevalence of the cases.

# Environmental and Social Baseline

**Mongolia’s health system reflects the country’s rapid economic and political change**. Mongolia has made important gains in declining infant, child and maternal mortality, and achieved a high level of health insurance coverage. However, health disparities persist, largely due to geographical (urban versus rural), income-related and demographic (nomads versus settled population) variations. The burden of disease in Mongolia is evolving:

* Mongolia is seeing a shift in the burden of disease, moving from communicable to noncommunicable diseases (NCDs). Leading causes of mortality are now circulatory system disorders and cancers.
* Although overall, communicable diseases have decreased over the years, they still account for a high proportion of overall disability-adjusted life years (DALYs) and, outbreaks and health emergencies can lead to significant socioeconomic losses. Mongolia also faces emerging diseases, environmental threats such as toxic chemical hazards, dzud (summer droughts followed by severe winters) and flooding.
* The large herder population in Mongolia, increases the chances for zoonotic diseases. In recent years zoonotic diseases have expanded and outbreaks of transboundary disease have emerged in animals and humans. Brucellosis, anthrax, tick borne disease and rabies still constitute a threat to human health and welfare.

The health sector preparedness is **guided by the government’s Health Sector Strategic Master Plan (HSSMP) for 2019-2024**. Led by the Ministry of Health, surveillance and emergency response coordination systems – including regional emergency operations centers and a laboratory network in aimags (administrative districts) near national borders – have been established. Mongolia has also endorsed the International Health Regulations, or IHR (2005), and the Asia Pacific Strategy for Emerging Diseases (APSED), which has been used to build core capacity for surveillance and response including pandemic influenza.

**Yet there are substantial challenges.** The bulk of health services are provided at three types of facilities (primary, secondary and tertiary) and over two administrative divisions (the capital and the provinces or the aimags). This hospital-oriented system inherited from the socialist period has hindered improving the efficiency of the health system. Service delivery is challenging given the extremely low population density in a vast country. The health system needs to be able to adapt to the changing needs of the population as NCDs become more pervasive and more problematic. Risk assessments are carried out when outbreaks occur, but there is no comprehensive systematic disease surveillance system. Laboratory capacities are weak in both human and animal health domains. Evidence-based decision making and response, and utilization of risk assessment finding need to be further improved.

**Building the policy, technical, institutional and operational framework for a strengthened disease control system will require more sustained effort.** Public health events regularly occur in Mongolia. On average, the national surveillance system detects over 260 public health events a year. The 2016 APSED review concluded that Mongolia remains vulnerable to emerging diseases and public health emergencies, and that challenges exist in national system readiness to respond to large-scale and complex events in an effective and coordinated way. Further, the lack of an effective Incident Management has resulted in a fragmented and disorganized process, leading to life, financial and reputational losses. In the absence of standardized system for emergency management, daily routine activities of the Ministry of Health or organizations under MoH are disrupted. Everyone responds to the emergency, creating a duplicate or parallel system, reporting burden for overburdened staff, and forcing each to work with incomplete or incorrect information. The main lessons learned from the 2009 H1N1 and PanStop exercises were that the current pandemic plan almost entirely focused on health issues and health-related problems. The plan lacks preparedness, contingency planning and integration into national and local disaster management planning. Government Resolution No. 416 in 2015 mandates that individuals, organizations, enterprises, soums, districts, provinces and cities should annually revise their disaster protection plans, including making provisions for resource allocation and stockpiling of emergency supplies for natural disasters and human health emergencies. However, these plans are largely unfunded.

**Finally, Mongolia’s health spending is low.** At just over 4%, the share of total health spending in GDP is lower today than in 2003 (6.7%), and lower than in most other middle-income countries. Since 2010, government health spending has remained consistently low, fluctuating between 6-8% of total government spending. Most of the public spending is on recurrent expenditures, with the wage bill as the fastest growing and largest component. Allocations to maintenance and repairs are extremely low. Poor sector planning that is not based on clear medium-and long-term strategies affects the quality and efficiency of investments and recurrent expenditures. There has been a phenomenal expansion of the private sector in provision of both inpatient and outpatient services.

The project will provide funding, training and capacity building to manage risks associated with COVID-19 including 3 hospitals for COVID-19 treatment.

The health facilities system of Mongolia consists of state-owned, private and mixed-owned health facilities that are in charge of public health, medical care service, pharmaceuticals supply, health education, research and training. Medical care service is controlled by the integrated regulations of the state and is dedicated to be mutually beneficial with state, citizens and legal entities fair respectful for clients, equitable and accessible. Family health centers, soum and village health centers, inter-soum hospitals, clinics, maternity hospitals, public health centers, general hospitals, sanatoriums, ambulances service centers, regional diagnostic and treatment centers (RDTCs), central hospitals and specialized medical centers are currently serving a medical care services.

As of 2020, a total of 4 343 health facilities were operating and delivering health care services around the country, including 13 central and specialized hospitals, 5 RDTCs, 16 aimag general hospitals, 12 district general hospitals and public health centers (PHCs), 6 rural general hospitals, 39 inter-soum hospitals, 219 family health centers (FHCs), 273 soums health centers (SHCs), 243 private hospitals and 1 340 private clinics.

Environmental factors such as air pollution, poor access to clean water and sanitation and chemical safety are significant public health concerns, especially in urban centers. These issues were a key part of Mongolia’s unfinished Millennium Development Goals (MDG) agenda.

**Water, sanitation and hygiene**

By this standard all health facilities shall meet sanitation and water criteria. For health care facilities, centralized water supply 14.1%, decentralized water supply 85.9%. Since 2005 numbers of project related to the WASH were successfully implemented. Those are ‘Pilot project for improvement of WASH in rural hospital”, “Essential ENH standards for HCFs “and WSP Initiative. In terms of legislation the Law on Hygiene is staring to implement since 2015. Assessment of the implementation conducted by MOH and GASI with WHO financial and technical support in 2014-2016. The sampling area was the Health Facility Environmental Hygiene Standard (MNS 6392:2013) in general hospitals of 21 provinces, Regional Diagnostic and Treatment Centers in Khovd, Dornod, Uvurkhangai, Orkhon and Umnugobi provinces, Health Centers of 8 districts and general hospitals of 4 districts of the capital city, State Central Hospital No. 1, 2 & 3, and 7 specialized centers.

According to the implementation about 70% of institutions were met with the standard level. Based on the evaluation result every health institutions are developing improvement plan of sanitation settings at the own organization. Future challenges are evaluating environmental condition including WASH in 329 soum health centers, tight follow-up of implementation of improvement plans in all HCFs, 2017-2018. As well as designing and construction of water and sanitation facilities in cold climate context at local level. Moreover, WASH especially sanitation still remains a low priority among government and donors and a great need for IEC campaign to raise the benefits of WASH.



**Figure 1. Percentage of soum health centers which connected to the central water supply and sewage system, nationwide, 2017**

**Current COVID-19 update**

As of 06 January, 2021, the number of new coronavirus infections reached 1349 in Mongolia. Of those, 408 of them confirmed as transported cases and 941 as confirmed as an in-country transmission. The cluster infection was been registered in Ulaanbaatar city (capital), Selenge, Darkhan-Uul, Gobisumber, Orkhon, Dornogobi and Arkhangai provinces. The cluster infection was been registered in Ulaanbaatar city (capital), Selenge, Darkhan-Uul, Gobisumber, Orkhon, Dornogobi and Arkhangai provinces. Since after the internal conformed case reported, in 5-40 cases were confirmed a day. In total 90 or 22.1% of total internal confirmed cases are HCWs. In last 24 hours, 41 new cases were confirmed in Ulaanbaatar from general population, 14 HWCs and 6 transported cases were confirmed and 16377 lab analysis (PCR) had done.

**Table 4.1. General update of the coronavirus outbreak in Mongolia**

|  |  |  |  |
| --- | --- | --- | --- |
| Indicators  | In last 24 hours  | Total  | By percentage  |
| Total conformed cases  | 41 | 1,349  | 100%  |
| Recovered  | 3 | 887  | 65.75%  |
| Undertreatment  | 20  | 451 | 33.43%  |
| Returned to back home country  | 0  | 9  | 0.7%  |
| Death  | 0  | 2 | 0.15%  |

From 06 January, 2021 until 11 January 2021 a strict lockdown will be implemented in Ulaanbaatar with some exceptions. Authorities urged the public to stay at home and restrict their movement only to essential necessities, such as to buy groceries and medicines.  Supermarkets, grocery stores, and markets will remain open. Public transportation will continue operating at normal hours, without restrictions.

# Potential Environment and Social Risks and Impacts and their Mitigation Measures

Implementation of the project activities will be positive and urgently needed. As this project will finance procurement of drugs, supplies and medical equipment – which has limited, if any, impacts – the environmental risks result from the operation of the labs, the quarantine and isolation centers, and screening posts at land crossings, as well as with the appropriateness of the medical waste management system to be put in place by the client. Given that Mongolia has limited experience in managing highly infectious medical wastes such as those associated with COVID-19, the project can be judged to have a substantial environmental risk and will require that appropriate precautionary measures are planned and implemented.

From a social perspective, there are also substantial risks related to the direct and indirect social impacts of the activities proposed by the project, those these are expected to be mostly temporary, predictable, and avoidable. The major areas of social and occupational risks are expected to be: (i) Occupational, Health, and Safety (OHS) risks for project workers associated with the upgrading activities; (ii) OHS risks related to the spread of the virus among health care workers; (iii) risks related to the spread of COVID-19 among the population at large and, especially for the most disadvantaged and vulnerable populations such as (elderly, children who are high risk – such as those who are malnourished-, poor households, etc.), due to poor training, communication and public awareness related to the readiness and response to the new COVID-19; and (iv) risk of panic/conflicts resulting from false rumors and social unrest, the social stigma associated with COVID-19 or potential unrest with respect to access to tested and other services related to public health services, including inability of accessing services by the most disadvantaged. Under component II will be engage small-scale civil for extension for central vaccine storage at the NCCD, building WASH facility, and building oxygen mini plant installment under Component 2 and no land acquisition or involuntary resettlement impacts are expected. It should be noted that it may be difficult to draw a clear line between existing, manifested risks managing which is the project objective, and the risks and impacts that could additionally be created by the project. For example, spread of COVID-19 among the population at large is a pre-existing condition the project is tackling, but could also be a risk from potentially poorly implemented project activities.

**Table 5.1. Environmental and Social Risks and Mitigation Measures during Designing and Planning Stage**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **№** | **Key activities** | **Potential risk and impacts** | **Proposed mitigating measures** | **Responsible parties** |
|  | Development of technical specifications for PPEs | Incorrect standard or quality of PPE leads to spread of infection to healthcare workers and cleaners. | The healthcare workers shall be provided with medical personal protective equipment (PPE) includes: Medical mask, Gown, Apron, Eye protection (goggles or face shield), Respirator (N95 or FFP2 standard), Boots/closed work shoes WHO interim guidance on rational use of PPE for coronavirus disease 2019 provided further details on the types of PPE that are required for different functions. | Ministry of Health (NCCD, NCZD) and 21 aimags and 9 district hospitals |
|  | Extension of storage for cold chain and building indoor WASH facility and building for oxygen mini plant  | Dust, noise and vibration generated from construction, rehabilitation or minor civil works | * The contractor(s) is responsible for compliance with relevant national legislation with respect to ambient air quality, noise and vibration - The contractor(s) undertaking works shall ensure that the generation of dust is minimized and implement a dust control plan to maintain a safe working environment and minimize disturbances for patients, staff and surrounding community
* The contractor(s) undertaking works shall implement dust suppression measures (e.g. water paths, covering of material stockpiles, etc.) as required. Materials used shall be covered and secured properly during transportation to prevent scattering of soil, sand, materials, or generating dust. Exposed soil and material stockpiles shall be protected against wind erosion
* The contractor(s) shall ensure onsite latrine be properly operated and maintained to collect and dispose wastewater from those who do the works
* The contractor(s) should not carry out construction activities generating high level of noise during healthcare activities, especially when services are being delivered to the clients
* The contractor (s) shall ensure fire safety issues of the mini plant building.
 | Contractor(s) |
| Solid waste generated from construction, rehabilitation or minor civil works | * The contractor(s) shall develop and follow a brief site-specific solid waste control procedure (storage, provision of bins, site clean-up, bin clean-out schedule, etc.) before commencement of any financed rehabilitation works;
* The contractor(s) shall use litter bins, containers and waste collection facilities at all places during works. - The contractor(s) may store solid waste temporarily on site in a designated place prior to off-site transportation and disposal through a licensed waste collector. Transport management plan in line with WBG good practice should be developed.
* The contractor(s) shall dispose of waste at designated place identified and approved by local authority. Open burning or burial of solid waste at the hospital premises shall not be allowed. It is prohibited for the contractor(s) to dispose of any debris or construction material/paint in environmentally sensitive areas (including watercourse).
* Recyclable materials such as wooden plates for trench works, steel, scaffolding material, site holding, packaging material, etc. shall be segregated and collected on-site from other waste sources for reuse or recycle (sale).
 | Contractor(s) |
| Asbestos containing materials (ACM) generated from construction, renovation or minor civil works  | The asbestos audit will be undertaken as required prior to/at the beginning of refurbishment. * Safe removal of any asbestos-containing materials or other toxic substances shall be performed and disposed of by specially trained workers in line with the WBG guidelines on asbestos management.
* If ACM at a given hospital is to be removed or repaired, the MOH will stipulate required removal and repair procedures in the contractor's contract.
* Contractors will remove or repair ACM strictly in accordance with their contract. Removal personnel will have proper training prior to removal or repair of ACM.
* All asbestos waste and products containing asbestos is to be buried at an appropriate landfill and not to be tampered or broken down to ensure no fibers are airborne. Disposal of waste containing asbestos should be agreed with MOH.
* No ACM will be used for renovation works.
 | Contractor(s) |
|  | Safety risks during works | * The contractor(s) shall comply with all national and good practice regulations regarding workers’ safety.
* The contractor(s) shall prepare and implement a simple action plan to cope with risk and emergency (e.g., fire, earthquake, floods, COVID-19 outbreak)
* The contractor(s) shall have or receive minimum required training on occupational safety regulations and use of personal protective equipment
* The contractor(s) shall provide safety measures as appropriate during works such as installation of fences, fire extinguishers, first aid kits, restricted access zones, warning signs, overhead protection against falling debris, lighting system to protect hospital staff and patients against construction risks
 | Contractor(s) |
|  | Vaccine procurement and  | Vaccine quality and selection of individuals or groups for vaccinated  | * According to the Law on Immunization of Mongolia, only certified vaccines from the WHO shall be used for Mongolian people. As well as development of vaccination strategy and community engagement to ensure support for the vaccine.
* Risk that project-related impacts fall disproportionately on individuals or groups who, because of their particular circumstances, may be disadvantaged or vulnerable; and risk of prejudice or discrimination toward individuals or groups in providing access to development resources and project benefits, particularly in the case of those who may be disadvantaged or vulnerable. Prioritization and selection of population groups to be vaccinated first will be conducted in accordance with emerging WHO guidance including the Values Framework for the allocation and prioritization of COVID-19 vaccination, the Roadmap for Prioritizing Population Groups for Vaccines against COVID-19 and the Fair Allocation Framework. Examples of target priority groups include frontline health and care workers at high risk of infection, older adults, and those people at high risk of death because of underlying conditions like heart disease and diabetes.
 | MOH, NITAG, WHO, UNICEF,  |

* 1. **Environmental and Social Risks and Mitigation Measures during operation stage**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **№** | **Key activities** | **Potential risk and impacts** | **Proposed mitigating measures** | **Responsible parties** |
|  | COVID-19 testing and diagnosis  | Improper collection of samples and testing for COVID19 and appropriate laboratory biosafety could result in spread of disease to medical workers or laboratory workers, or population during the transport of potentially affected samples. | Collection of samples, transport of samples and testing of the clinical specimens from patients meeting the suspect case definition should be performed in accordance with WHO interim guidance Laboratory testing for coronavirus disease 2019 (COVID-19) in suspected human cases. Tests should be performed in appropriately equipped laboratories (specimen handling for molecular testing requires BSL-2 or equivalent facilities) by staff trained in the relevant technical and safety procedures. National guidelines on laboratory biosafety should be followed. For more information related to COVID-19 risk assessment, see specific interim guidance document: WHO interim guidance for laboratory biosafety related to 2019- SARnCoV. Samples that are potentially infectious materials (PIM) need to be handled and stored as described in WHO document Guidance to minimize risks for facilities collecting, handling or storing materials potentially infectious for polioviruses (PIM Guidance).For general laboratory biosafety guidelines, see the WHO Laboratory Biosafety Manual, 3rd edition. | Laboratories in NCCD, NCZD and aimag hospitals |
|  | Isolation, care and treatment of COVID19 patients in healthcare facilities | Weak compliance with the precaution measures for infection prevention and control in isolation and treatment of infected cases spreads COVID-19 infections in healthcare facilities. | Health facilities should establish and apply Standard Precautions including: * Hand Hygiene (HH);
* Respiratory hygiene/cough etiquette.
* Use of personal protective equipment (PPE);
* Handling of patient care equipment, and soiled linen;
* Environmental cleaning;
* Prevention of needle-stick/sharp injuries;
* appropriate Health Care Waste Management;

In addition, health facilities should establish and apply Transmission based precautions (contact, droplet, and airborne precautions) as well as specific procedures for managing patients in isolation room/unit. Establishment of Standard precautions and Transmission based precautions should be in line with National guidelines for IPC in healthcare facilities and take into account guidance from WHO and/or CDC on COVID19 infection control: * WHO interim guidance on Infection prevention and control during health care when COVID-19 infection is suspected;
* WHO guidance on infection prevention and control at health care facilities (with a focus on settings with limited resources);
* CDC Guidelines for isolation precautions: preventing transmissions of infectious agents in healthcare settings; and
* CDC guidelines for environmental infection control in healthcare facilities. Special considerations need to be made to vulnerable groups in delivering these services
 | All treatment settings  |
| Medical waste is contaminated with COVID-19 virus. Improper collection, transport, treatment and disposal of infectious waste becomes a vector for the spread of the virus. | All hospitals and laboratories should prepare waste management procedures in accordance with the national requirements that outline waste segregation procedures, on site handling, collection, transport, treatment and disposal, and training of staff. Wastes should be segregated at the point of generation by risk, including segregation of organic, recyclables, biological infectious and hazardous health care wastes which are temporary stored for pickup of contracted waste management company on site. Transport routes including elevators should also be defined and marked for infected wastes and other types of wastes. Instructions related how to handle medical waste safely should be made to relevant people handling medical waste including health and waste workers. The treatment of healthcare waste produced during the care of COVID-19 patients should be collected safely in designated containers and bags, treated and then safely disposed. The good practices as follow:* Waste reduction and segregation to minimize quantities of waste to be incinerated;
* Siting incinerators away from patient wards, residential areas or where food is grown;
* A clearly described method of operation to achieve the desired combustion conditions and emissions; for example, appropriate start-up and cool-down procedures, achievement and maintenance of a minimum temperature before waste is burned, use of appropriate loading/charging rates (both fuel and waste) to maintain appropriate temperatures, proper disposal of ash and equipment to safeguard workers;
* Periodic maintenance to replace or repair defective components;
* Improved training for operators and improved management including the availability of an operating and maintenance manual, visible management oversight, and regular maintenance schedules. Alternative treatments should be designed into longer term projects, such as steam treatment methods. Steam treatment should preferably be on site, although once treated, sterile/non-infectious waste may be shredded and disposed of in suitable waste facilities.
* The project health facilities should establish and apply procedures for healthcare waste management. HCWM procedures should be in line with National guidelines for Infection Prevention and Control in healthcare facilities and take into account WHO guidelines for Safe management of wastes from health-care activities and WHO technical brief water, sanitation, hygiene and waste management for COVID-19;
 | All treatment settings |
|  |  | Poor sanitation and improper management of wastewater related to COVID-19 diagnosis and treatment services transmit diseases to communities and pollute environment. | Health facilities shall ensure the provision of safe water, sanitation, and hygienic conditions, which is essential to protecting human health during all infectious disease outbreaks, including the COVID-19 outbreak. Health facilities shall establish and apply good practices line with WHO guidance on water, sanitation and waste management for COVID-19 and National guidelines for Infection Prevention and Control healthcare facilities | All treatment settings |
| Hazardous materials used and generated during the provision of COVID-19 diagnosis, care and treatment services Hazardous chemicals in the hospitals and health care centers are limited to small volumes of laboratory reagents, chemicals, solvents, medicinal gases etc. | The hospitals and laboratories should develop a hazardous material management procedure that defines: inventory of hazardous materials in the health care facilities, proper labeling of hazardous materials, safe handling, storage and use of hazardous materials, use of protective equipment procedure for managing spill, exposures and other incidents, procedure for reporting of incidents.Hazardous materials should be handled in accordance with the accepted practices. Only trained personnel should handle the materials and precautions taken when handling materials by using required protection equipment such as ventilation hoods and personal protective equipment.  | All treatment settings |
|  | Labor management | Health workers (especially nurses), cleaners, ambulance drivers and caterers may be asked to work overtime to respond to the COVID-19 pandemic. It is important that these personnel are able to access overtime pay as needed. Health care and other staff, including cleaners, or workers in upgrade/rehabilitation may need medical care if they contract COVID-19 Health workers, a big proportion who are female (and who may also bear additional responsibilities in terms of child and eldercare), may face mental health issues or burnout as result of an outbreak. Health workers, cleaners or workers involved in upgrades experiencing respiratory symptoms may fear not getting paid and continue to show up at work. | All workers must be paid for overtime as per Labor Law. All workers must be provided with security of medical care, in particular ensuring they can access free medical care if they contract COVID-19.Ensure that the staff with lower qualification or less experienced working in the health sector (e.g., cleaners, caterers, part-time workers, etc.), often female workers, also have access to the required Personnel Protection Equipment (PPE) – including gloves, gowns, masks and eye protection if exposed to patients with COVID-19, their waste, clothes or linen – and training to make sure they work in a safe environment. Most vulnerable workers should be identified, such as female single heads of household, who may need additional support in order for them to do their job (for instance, female nurses who are single heads of household may need additional support if they have to work overtime). Additional support to consider may include cash grants, access to food support or provision of child care services. Health care workers must be actively supported by their employers and commended for their work, as well as offered psychological, emotional or mental support if possible. This may mean bringing in monks to a hospital for a ceremony, or ensuring health workers have regular breaks and proper food throughout the day. In case quarantine and isolation and/or vaccination centers are to be protected by security personnel, it will be ensured that the security personnel follow a strict code of conduct and avoid any escalation of situation. All workers involved in upgrading facilities, health workers, cleaners, etc., must be reassured that they will continue to get paid if they need to self-isolate if they are showing with COVID-19/respiratory symptoms. These provisions must be made including for contracted staff and are included in the Labor Management Plan (LMP). | All treatment settings |
|  | Access to COVID-19 healthcare services | Planning and design of measures to screen people for COVID-19 and information materials developed could exclude the most vulnerable, including the poor, elderly, indigenous peoples, people living with a disability and households headed by single women, who are also less likely to have access or be active on social media. IPs and people in the rural areas are at heightened risk if they contract COVID-19 due to their remoteness in accessing treatment (though their remoteness may protect them from contracting the virus). Their location may also make the diagnosing and treatment of the virus more difficult. | Planning of containment measures and social restrictions need to take into account the livelihood impact it will have for the population, in particular the most vulnerable (the poor, elderly, women single heads of household, IPs, those with disabilities). MOH may need to develop specific mitigation measures for this, outside the scope of this ESMF. This may include social safety nets with cash transfers to specific population groups, ensuring that it does not exclude informal workers, the poor, home-based workers, etc. May also include food grants, essential basket of goods, child care support for women, etc. SEC/MOH should consider having a dedicated hotline for people to call for questions and recommendations on what to do if they suspect they may have COVID-19. Communication materials must also be clear about (i) how to avoid contracting COVID-19 (good hygiene measures); (ii) symptoms of COVID19; (iii) what to do if suspect have COVID-19. Information on how to protect oneself from COVID-19, the symptoms of COVID-19, where and how to get tested should be made available to everyone and ensure they are accessible to marginalized groups, those with disabilities, other vulnerable groups and the elderly by using different languages (including sign language, graphics and illustrations or other forms of visual communication), and in a manner that is culturally appropriate to the respective groups and specific needs. Communication materials and outreach to people, must make clear that all treatment for COVID-19 at NCCD and aimag hospitals is free and accessible for all population. People must also be told about the GRM process to denounce any instance where they are asked to pay to access needed medical services at hospital). | MOH, NCCD, NCZD, NCPH, and aimag health department, City health department  |
|  | Access to other healthcare services | Focus on COVID-19 may redirect staff and resources at health facilities and negatively impact other areas, such as maternal health check-ups, vaccinations for children and treatment of chronic diseases. This may particularly impact women, young children and the elderly. People, in particular women with young children, pregnant women, the elderly, those with disabilities, chronic illness and other vulnerable populations, may be fearful of going to the hospital/health center for fear of contracting the virus. This may cause children to miss out on needed vaccinations, women not seeking support during pregnancy, etc. | Hospitals and other health facilities must ensure they still have adequate staff to deal with ongoing medical needs. While non-urgent cases may be deferred, it is important that childhood vaccinations continue, that women have prenatal and antenatal visits, that sexual and reproductive health services are available and that those with chronic conditions and/or disabilities continue to receive necessary treatments (with adequate measures to separate from patients with COVID-19, as detailed in other sections in this Table). Communication materials must stress that these normal services are still being provided, and explain measures taken in health centers to avoid COVID-19 risks (for instance, that COVID-19 patients are treated in a different area from where mothers deliver babies) as there may be apprehension from community members to go to health facilities. This may include radio messages, Facebook, loudspeaker announcements, signage in hospitals, etc. | MOH, NCCD and aimag hospitals  |
|  | Information, communication, capacity building and stakeholder engagement | Appropriate information and communication increase social stigma with those who expose or are infected by virus. Risk of fear and/or stigma towards the virus, which may make people hide symptoms, avoid getting tested and even reject hygiene measures or wearing PPE equipment (or masks if recommended) Health workers may suffer stigma, in particular when coming back to their communities, as they may be seen as potential “carriers” Some groups may be particularly vulnerable to stigma, such as Cham minorities who are already being prejudiced again due to high number of cases in their communities | When developing communication messages about COVID-19, it is important to have social stigma issues in mind and choose language that does not exacerbate stigma. It is best to not refer to people with the disease as “COVID-19 cases”, “victims” “COVID-19 families” or “the diseased”. It is better to refer as “people who have COVID-19”, “people who are being treated for COVID-19”, or “people who are recovering from COVID-19”. It is important to separate a person from having an identity defined by COVID-19, in order to reduce stigma. This language should be used throughout all communication materials. Ensure accurate information about the virus is widely disseminated, and that there is also a focus on people recovered. When developing communication materials, refer to WHO information on social stigma: https://www.who.int/docs/default-source/coronaviruse/covid19-stigmaguide.pdf Engage social influencers, such as religious leaders, who can help communicate accurate messages and help to reduce social stigma as well as support those who may be stigmatized. Correct misconceptions and provide accurate information. One way to do this could be through District health officials and/or commune leaders/officials. They could be trained on the basics of COVID-19 prevention (good hygiene, frequent hand washing, avoid touching face, social isolation measures) and be provided with simple materials in Khmer language. These officials can use this information to inform others in their communities, including correcting false rumors. Focus should be on prevention as well as on identifying symptoms and how to seek treatment. The SEP should include outreach to NGOs and other stakeholders to ensure it captures their views and suggestions on best methods to develop RCCE materials. Communication materials must reinforce the positive contribution of health care workers and other essential workers and their need to be supported by community members.Communication materials should make clear the steps health workers and others are taking to protect themselves against the virus and their use of PPE and also about safety vaccination.  | MOH, NCCD, NCPH, NCZD, CHD, aimag and city health department  |
|  | Communication materials may not reach the most vulnerable, including the elderly, IPs and workers from the informal sector, a lot of whom are women, who tend to have lower levels of education, lower incomes and may lack access to reliable information materials. | When developing communication materials, it is important to ensure that they are clear, concise and sound scientifically based, and that they are in a format/language that is understandable to all people, in particular the most vulnerable. Messages should be clear and concise, focusing on hygiene measures (hand washing, coughing), what to do if suspect have COVID-19, as well as restrictions if applicable (for instance specific guidelines on social-distancing). When developing communication materials, refer to WHO information on social stigma: <https://www.who.int/docs/default-source/coronaviruse/covid19-stigmaguide.pdf> This may mean that different media needs to be used (social media, radio, tv) plus engaging existing formal and informal public health and community-based networks (schools, healthcare service providers at local level, etc). Ensure that information is accessible in sign language, illustrations/pictorial and relevant languages of EM groups (in particular in Western Mongolia where there are more Kazak speaking population. Ensure messages relating to COVID-19 reach all groups of people, in particular the most vulnerable (the poor, elderly, women single heads of household, those with a disability, EM groups, any marginalized group). This may include having a multi-faceted approach to consultations and disclosure of information and information sharing, such as by loudspeaker (by commune authorities or district health authorities), Facebook, SMS, You Tube videos, social influencers/religious leaders, etc.A focus of information materials should be on women, as they tend to be the best venue of communication for children and the elderly in the household. | MOH, NCCD, NCPH, NCZD |
| If stakeholders are not properly consulted, information is not disclosed and people are not informed about their rights, options for grievance redress or project timelines, there could be misunderstandings, conflict, stigma, gender-based violence, false rumors or loss of confidence in the community regarding the project. | Stakeholder Engagement Plan (SEP) must use different communication methods. Stakeholder Engagement Plan (SEP) should ensure consultations with NGOs and other stakeholders that can provide recommendations on how to communicate information and develop. Ensure consultations on SEP and this ESMF include relevant government agencies, NGOs and other organizations working on health and gender, including GBV, as well as EM groups. Ensure women, and women’s groups, are targeted during consultations on the SEP and ESMF, as well as information campaigns and IEC materials as described above. Identify trusted community groups (local influencers such as community leaders, religious leaders, health workers, community volunteers, celebrities) and local networks (such as women’s groups, youth groups, business groups, and khoroo unit) that can help to disseminate messages. Define clear and easy mechanisms to disseminate messages and materials based on community questions and concerns.Ensure communication materials not only focus on COVID-19 symptoms and hygiene, but also on coping strategies if there is social isolation, avenues (materials, organizations, hotline) available for mental health, GBV, etc. that may be available. | MOH, NCCD and other relevant health facility  |
|  | COVID-19 vaccination delivery  | Vaccine delivery to the client, measures to screen people for COVID-19 and information materials developed could exclude the most vulnerable, including the poor, elderly, ethnic minority, people living with a disability and households headed by single women, who are also less likely to have access or be active on social media. The poor literacy and miss information could lead anti-vaccination campaign among general public. The registration may also make the vaccination delivery more difficult.HCWs who are engaging vaccination service delivery could get infected.  | The HCWs who are delivering the vaccination shall have vaccinated with 2 full doses of COVID-19 vaccination in prior to engage this service. Also, all health and non-health staff need to have proper training on vaccination deployment plan in Mongolia. Mobilized vaccinators and newly trained vaccinators shall have attended special training from the MOH/NCCD. Planning of vaccination measures need to take into account the living location and work station and in particular the most vulnerable (HCWs, inspection agency workers, border workers, costume workers, the poor, elderly, adults with chronic diseases, women single heads of household, those with disabilities). MOH may need to develop specific mitigation measures for this, outside the scope of this ESMF. Communication materials must also be clear about (i) safety measures of vaccination; (ii) possible side effects of COVID19 vaccine; (iii) what to do if client had tested as COVID-19 positive in the vaccination unit. iv) information on vaccination units, v) selection of person who should have vaccinated. Based on WHO guidance, the overall purpose of the stakeholder engagement and consultation process is to build trust in the prevention and response of misinformation that may interfere with decision-making in the population for Coronavirus disease (COVID-19) and to adhere to public health advice. This will include scientifically sound information on relevant vaccines. This would be based on WHO guidance (WHO Guidance - Risk Communication and Community Engagement) and would seek to provide proper awareness raising and timely information dissemination to (i) avoid conflicts resulting from false rumors; (ii) ensure equitable access to services for all who need it; and (iii) address issues resulting from people being kept in quarantine.Message should be developed in different languages (including sign language, graphics and illustrations or other forms of visual communication), and in a manner that is culturally appropriate to the respective groups and specific needs. People must also be told about the GRM process to denounce any instance where they are asked to pay to access needed medical services at hospital). | MOH, NCCD, NCPH, and aimag health department, City health department, all immunization units, FGP, Soum health centers , Police department  |
|  | Life and fire safety risk for building an oxygen mini plant  | Emergency response procedures for participating health facilities updated before oxygen delivery systems are installed. | * Relevant regulation and operating manual of service shall be provieded. Tose need to take into account the measurement to prevent or mitigate life and fire safety risks from the building an oxygen mini plant and delivery of the oxygen.
* Recipient health facilities of the oxygen mini plant need to develop and implement life and fire safety systems, update their emergency response procedures and ensure these are communicated to staff, and undertake regular drills.
 | Contractor, MOH, aimag health department  |

# Procedures to Address Environmental and Social Issues

This section sets out the procedures for identifying, preparing and implementing the project components, environmental and social screening, preparation of required E&S plans, consultation on such plans, review and approval and implementation.

**Screening:**

The purpose of screening is to (i) determine whether activities are eligible to be financed, and likely to have potential negative environmental and social risks and impacts; and (ii) identify appropriate mitigation measures for activities with adverse risks or impacts. The MOH PIU will use the E&S screening form and Indicative Screening Guidance.

Based on the screening, the MOH PIU will (a) ensure that the activities on the “ineligible list” will not be financed by the Project; (b) sign the E&S screening form; and (c) prepare and implement the specific E&S instrument/plan as needed.

**Preparation of E&S plan:**

To facilitate preparation of E&S plan, beneficiary health facilities fall broadly into 2 groups:

Group 1 – health facility without civil works and

Group 2 – health facility with civil works (those soum health centers building a WASH facility). Each health facility without and with civil works shall prepare an ICWMP using Template in the Annex 2.

The ESMP will include three parts: an ICWMP in line with the Template presented in the Annex 2; COPs to mitigate impacts related to repair/rehabilitation as proposed in the section 5.1 and 5.2; and LMPs as presented in the Annex 3. The ECOPs will then be incorporated into the bidding and contract documents, and the implementing agency will ensure that the contractor is aware and committed to comply with the E&S obligations in the ECOPs. MOH PIU will support beneficiary health facilities to prepare the ICWMP and ESMP.

**Consultation of prepared E&S plan**: The ICWMP and ESMP will be consulted with health facility staff, particularly nurses and female health professionals, and with local communities.

**Review and approval of E&S plan:** The ICWMP and ESMF will be reviewed by E&S specialists in PIU and the Department of Preventive Medicine under MOH, and approved by the Project director. The World Bank will review ICWMs and ESMFs as well.

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

# Monitoring, Supervision and Reporting

The PIU will prepare and submit to the World Bank regular monitoring reports on the environmental, social, health and safety (ESHS) performance of the Project, including but not limited to, stakeholder engagement activities and grievances log.

The Ministry of Health will be responsible for monitoring implementation of ESMF/ESMP provisions and report implementation progress in the project **Semi-Annually** progress reports.

# Implementation Arrangements and Responsibilities

Mongolian arrangement of COVID-19 pandemic. State emergency committee, NEMA MOH, and others.

The Disaster Protection Law (in place since 2017) authorises the National Emergency Management Agency and SEC to direct emergency policies and measures via the Government of Mongolia and regional emergency committees. The legal enforcement of SEC-led precautionary measures enabled a unified and focused administration of COVID-19 disaster management.

**Responsibilities of state health agency for COVID-19 prevention and treatment related agencies are:**

**Ministry of health**

* Develop and implement an action plan to combat and prevent coronavirus infection;
* Establish a working group, a professional advisory team and a rapid response team to provide integrated coordination of measures to combat and prevent coronavirus infection (COVID -19), and work as an emergency operating unit;
* Develop and approve procedures and guidelines for coronavirus infection (COVID -19) prevention, surveillance, early detection, preparedness, response, and implementation;
* To provide information on the spread of coronavirus infection (COVID -19) and the measures being taken to the Parliament, the Government, the National Security Council, the State Emergency Commission and other relevant organizations;
* Assess preparedness resources for coronavirus infection (COVID-19) and submit to the Government for decision;
* To ensure the availability of emergency medicine, medical equipment, tools, personal protective equipment, masks, diagnostics, reagents and disinfectants;
* Provide human resource planning, general instructions, methodologies;
* To give official instructions and recommendations to health organizations to ensure regular and sustainable human resource activities;
* Provide the population with integrated information on coronavirus infection (coVID-19);
* Orient a risk communication activity, and providing the public with official information on coronavirus infection (COVID-19);
* Introduce, maintain and update coronavirus infection control panels (COVID -19), websites, conferences, chat bots, call-pro services;

**National Center for Infectious Diseases, National Center for Zoonotic disease, National Center for public health, Center for health development, Ulaanbaatar city and Aimag health authorities and other health agencies**

* Develop and implement a preparedness plan to prevent coronavirus infection (COVID-19);
* Conduct risk assessments in collaboration with cross-sectoral organizations in the context of coronavirus infection (COVID -19), organize response depending on the level of risk and emergency activation code, and operate as an emergency operating unit;
* Develop procedures and guidelines for the fight against coronavirus infection (COVID-19), prevention, surveillance, preparedness, and rapid response in accordance with WHO Interim Guidelines,
* Provide professional and methodological guidance in the fight against coronavirus infection (COVID-19) at the national level, prevention, surveillance, preparedness, and implementation of response procedures and guidelines;
* Provide professional and methodological guidance and support to health care providers to ensure preparedness for coronavirus infection (COVID-10) and intensify rapid response;
* Investigate suspicious and probable cases, determine the source of the confirmed case, the extent of close contact, and take action;
* Collection and laboratory confirmation of suspected cases of coronavirus infection (COVID-19);
* Ensure the readiness of new and re-emerging infectious and special wards, arrange hospital beds, provide additional beds, and provide medical care in suspected and confirmed cases;
* Assign an emergency response team to the site of a coronavirus infection (COVID-19) and provide continuous training and protective clothing and equipment;
* Regularly analyze the incidence of coronavirus infection (COVID-19), plan response, and provide information to decision makers;
* To mobilize human resources and organize training in case of coronavirus infection (coVID-19) outbreak;
* To provide professional and methodological advice on the infection control regime of isolation and observation facilities;
* To provide professional and methodological support to state inspectors and employees of aimag, capital city and border specialized inspection services and divisions on infection prevention regimes and response measures;
* When a suspected case of infection is detected at an air border crossing, international railway or customs control zone, send a professional team to respond promptly and, if necessary, send a professional team to the local area;
* Organize training on surveillance, diagnosis and treatment of coronavirus infection COVID-19), including health, professional inspection and relevant organizations,
* analyze the information provided by citizens, correct misinformation, and study public attitudes;
* Expand and stabilize information and publicity for the population;
* 24-hour hotline number to inform the public about coronavirus infection (COVID-19);
* Investigate public perceptions and attitudes toward coronavirus infection and respond promptly; -Expand and stabilize information and publicity for the population.
* To provide decision-makers with information on the health of citizens under observation
* To conduct research on medicines, medical devices and equipment of health organizations;
* Appoint, train, and provide protective clothing and equipment for emergency response and care teams at the site of coronavirus infection (COVID-19);
* To mobilize human resources and organize training in case of coronavirus infection (COVID-19) outbreak;
* Establish a stockpile of antiviral disinfectants, ensure their readiness, and develop guidelines for their use;
* Capacity building and training for mobilized human resources in the event of an outbreak of coronavirus infection (COVID-19);
* Ensure virology laboratory readiness and laboratory testing;
* Public awareness and prevention of coronavirus infection (COVID-19).

**Vaccine related project Institutional arrangements are as under:**

**At the National level:**

Following the recently concluded restructuring of the MOH, the current Integrated Project Steering Committee (IPSC) responsible for all WB-funded projects in health sector chaired by the Minister of Health will be reconstituted in February 2021 and a new Project Director for the COVID ERP will be appointed by the Minister of Health. The reconstituted IPSC will provide oversight and management of the project and provide strategic policy advice and guidance to the Project implementation.

Inter-agency Coordination Committee (ICC) consists of representatives of National Emergency Management Agency (NEMA), General Agency for Specialized Inspection (GASI, other relevant government agencies and integrated PIU. Representatives of relevant International organizations will join with advisory and observer roles. The ICC is chaired by the Minister/or Deputy Minister of Health and the Director of the Public Health department of the MOH acts as the Secretary of the ICC. The ICC will be responsible for overall management of COVID vaccine deployment at the national level. The ICC will discuss and approve all regulations, guidance and national plans as relevant to the COVID vaccination and vaccine deployment.

 For the COVID vaccine deployment and management the following temporary Technical Working Groups (WG) will also be established under the MOH to provide technical advice and guidance:

1. Technical WG on Planning and Management of COVID vaccine will be established with representatives from relevant government agencies, CSOs, IPIU and technical advisors from WHO and UNICEF. The Public health department of the MOH will chair the WG. The WG will be responsible for coordination, management and implementation of the COVID vaccine deployment plan, including identification of target groups, mapping of vaccination points, developing a suitable formula for financial resource allocation for vaccination points and M&E of vaccination processes, and other delivery related issues.
2. Technical Working Group (WG) on Vaccine Supply and Delivery will be established with representatives from relevant government agencies, CSOs and technical advisors from WHO and UNICEF. The WG will be chaired by Director of Health sector economic policy and implementation department of the ministry. The WG will be responsible for ensuring readiness of cold chain equipment and facilities, defining local demand and supply of vaccine, vaccine ordering, safety of vaccine delivery to the vaccination points, registration of received vaccines at the vaccination points.



1. Technical WG on Vaccine Program Support will be established with representatives from relevant government and UN agencies, international and local CSOs, and will be chaired by Director of Public health response, communicable disease control and prevention division. This WG will provide guidance and support on management of the risk communication and community engagement, vaccine hesitancy response, capacity building and training of health workers and stakeholders, data collection and analysis on COVID vaccination, registration of complications, health care waste management.
2. Technical WG on Support system and Infrastructure will be established with representatives from relevant government agencies and will be chaired by Director of Monitoring and evaluation department. This WG will be responsible for monitoring and assessment of surveillance of vaccine safety, logistics and transportation safety.

# Capacity Building

The health sector has experience in infection prevention and control, healthcare waste management, communication and risk management and community engagement during emergency situations. As found across most countries, the capacity to manage risks associated with COVID-19 is a monumental challenge as the healthcare professionals may not have the detailed know-how on the infectious risk management in the labs to be used for COVID-19 diagnostic testing, quarantine and isolation centers for COVID-19 treatment, in particular waste management. Additionally, the communication process with the public or in and in handling social concerns around COVID-19 as well as related measures, including quarantine is a catch-up process globally. The project will provide considerable funding, training and capacity building to support these critical initiatives and build upon international expertise to achieve international best practices on these matters in line with WHO guidelines. This will also include further identification of capacity gaps and detailed measures in line with the project proposal.

The vaccine delivery process is needed highly professional skill. To becoming vaccinators is needed special postgraduate train which lasts more than 6 months. However, under this pandemic circumstances MOH/NCCD had planned to organize short term training for nurses and retired health personnel for vaccine delivery. Also, non-health personnel who shall be attend to the vaccine deployment plan need to have trained.

# Consultation and Stakeholder Engagement

**Stakeholder Engagement Plan (SEP)**

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

The SEP outlines the ways in which the project team will communicate with stakeholders and includes a mechanism by which people can raise concerns, provide feedback, or make complaints about project and any activities related to the project. The involvement of the local population is essential to the success of the project in order to ensure smooth collaboration between project staff and local communities and to minimize and mitigate environmental and social risks related to the proposed project activities. Broad ranging culturally appropriate, and adapted awareness raising activities are particularly important to properly sensitize the communities to the risks related to infectious diseases (Annex 4).

The SEP will enable the Project to:

* Provide ongoing information on the Project to government agencies, public health agencies, international development partners, national non-government organizations, private sector partners, rural population and the general community.
* Provide timely and appropriate information prior to and during Project implementation to enable informed participation in the Project and definition of appropriate mitigation measures.
* Encourage equal participation of all affected groups in the consultation process.
* Disclose any environmental or social impacts of the Project and proposed mitigation measures.
* Obtain stakeholder input on the design and implementation of any mitigation measures.
* Facilitate open and continuous communication and consultation between the Project’s many stakeholders and communities.
* Address any stakeholder concerns and provide feedback to issues raised by stakeholders.
* Establish a Grievance Redress Mechanism (GRM) to satisfactorily redress any Project-related grievances.

**Stakeholder identification and analysis**

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

1. are affected or likely to be affected directly or indirectly, positively or negatively, by the Project (also known as ‘affected parties’); and
2. may have an interest in the Project (‘interested parties’). They include individuals or groups whose interests may be affected by the Project and who have the potential to influence the Project outcomes in any way.

Cooperation and negotiation with the stakeholders throughout the Project development often also require the identification of persons within the groups who act as legitimate representatives of their respective stakeholder group, i.e. the individuals who have been entrusted by their fellow group members with advocating the groups’ interests in the process of engagement with the Project. Community representatives may provide helpful insight into the local settings and act as main conduits for dissemination of the Project-related information and as a primary communication/liaison link between the Project and targeted communities and their established networks. Verification of stakeholder representatives (i.e. the process of confirming that they are legitimate and genuine advocates of the community they represent) remains an important task in establishing contact with the community stakeholders. Legitimacy of the community representatives can be verified by talking informally to a random sample of community members and heeding their views on who can be representing their interests in the most effective way.

**The Government including:** State Emergency Committee, MoH, MoFALI, hospital administration (UB, Aimag level), urban and rural level local administration;

**General public including:** elders, single parent headed households; mining and other large infrastructure project workers; patients staying in hospitals, people who are in the facilities were temporary isolated or quarantined; large food market and its vendors and customers; school children est.

Rural population including herders and herder households in rural areas; ethnic minorities;

International Organizations such as WHO, UNICEF, ADB, UNDP, EBRD, GIZ est.

**Methodology**

In order to meet best practice approaches, the project will apply the following principles for stakeholder engagement:

* *Openness and life-cycle approach*: public consultations for the project(s) will be arranged during the whole life-cycle, carried out in an open manner, free of external manipulation, interference, coercion or intimidation;
* *Informed participation and feedback*: information will be provided to and widely distributed among all stakeholders in an appropriate format; opportunities are provided for communicating stakeholders’ feedback, for analyzing and addressing comments and concerns; and
* *Inclusiveness and sensitivity*: stakeholder identification is undertaken to support better communications and build effective relationships. The participation process for the projects is inclusive. All stakeholders at all times encouraged to be involved in the consultation process. Equal access to information is provided to all stakeholders. Sensitivity to stakeholders’ needs is the key principle underlying the selection of engagement methods. Special attention is given to vulnerable groups, in particular women, elders, herder families live in remote rural areas, persons with disabilities, youth and ethnic groups live in west part of country and speak/read local language different than Mongolian.

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

* **Affected Parties** – persons, groups and other entities within the Project Area of Influence (PAI) that are directly influenced (actually or potentially) by the project and/or have been identified as most susceptible to change associated with the project, and who need to be closely engaged in identifying impacts and their significance, as well as in decision-making on mitigation and management measures;
* **Other Interested Parties** – individuals/groups/entities that may not experience direct impacts from the Project but who consider or perceive their interests as being affected by the project and/or who could affect the project and the process of its implementation in some way; and
* **Disadvantaged / vulnerable individuals or groups –** persons who may be disproportionately impacted or further disadvantaged by the project(s) as compared with any other groups due to their vulnerable status[[7]](#footnote-7), and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project.

 **Affected parties**

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

* **The Government including:**
	+ State Emergency Committee,
	+ MoH, MoFALI,
	+ Hospital administration (UB, Aimag, Soum level), urban and rural level local administration;
	+ Health workers nursing and treating infected people in the National center for communicable disease, or in the hospitals and the quarantine facilities
	+ Thematic WG of vaccine deployment plan at MoH
	+ The national committees on immunization (NITAG, AEFI, VCC, NEPC)
	+ All staff and customers at the hospitals, health centers and household health center
	+ Security guard and inspectors around quarantine center
	+ Other public authorities including border and checking points’ control staff including custom, inspection authority and traffic and public police.
* **General public including:**
	+ COVID19 infected people
	+ Relatives of COVID19 infected people
	+ First and secondary contacted people to the conformed cases
	+ Neighboring communities to laboratories, quarantine centers, and screening posts
	+ Patients staying at National center for communicable disease or hospitals
	+ Customers at hospitals for testing and seeking temporary treatment
	+ People under COVID-19 quarantine, including workers in the quarantine facilities
	+ Relatives of people under COVID19 quarantine
	+ People at COVID-19 risks, who are travelers, Mongolian living in abroad and inhabitants of areas where cases have been identified, etc.
	+ Airlines and other international transport business
	+ Drivers of public transportation, tracks and inter -city public transportation,
	+ Workers, customers, vendors and travelers at the public places such as schools, hospitals, shops, restaurants, pubs, training centers, sport and fitness centers ...etc.
	+ Media persons working at quarantine facilities
	+ Municipal waste collection and disposal workers
	+ People affected by or otherwise involved in project-supported activities
	+ Volunteers who will be engage to the vaccination and COVID-19 treatment activity
	+ Community residing in or around border towns.
	+ Workers of inspection agency, border unit, police department, teachers of universities

**Other interested parties**

Other interested parties include individuals/groups/entities that may not experience direct impacts from the Project but who consider or perceive their interests as being affected by the project and/or who could affect the project and the process of its implementation in some way. Specifically, the following individuals and groups may fall within this category:

* + Political decision makers including MPs, cabinet members
	+ National and international health organizations
	+ Donors, international organizations and embassies in Mongolia
	+ Mongolian consuls and embassies in abroad
	+ The national and local government related authorities
	+ Partners such as recognized public figures, influencers, particularly social media influencers
	+ Traditional media
	+ Mongolian, living and traveling in abroad where cases have been identified
	+ Other national & International NGOs
	+ Private sector-Businesses with domestic and international links
	+ The public at large

**Disadvantaged/vulnerable individuals or groups**

It is particularly important to understand whether project impacts may disproportionately fall on disadvantaged or vulnerable individuals or groups, who often do not have a voice to express their concerns or understand the impacts of a project and to ensure that awareness raising and stakeholder engagement with disadvantaged or vulnerable individuals or groups [on infectious diseases and medical treatments in particular,] be adapted to take into account such groups or individuals particular sensitivities, concerns and cultural sensitivities and to ensure a full understanding of project activities and benefits.

The vulnerability may stem from person’s origin, gender, age, health condition, economic deficiency and financial insecurity, disadvantaged status in the community (e.g. minorities or fringe groups), dependence on other individuals or natural resources, especially those living in remote, insecure or inaccessible areas, etc.

Engagement with the vulnerable groups and individuals often requires the application of specific measures and assistance aimed at the facilitation of their participation in the project-related decision making so that their awareness of and input to the overall process are commensurate to those of the other stakeholders.

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

* + Elderly at age pensioners who stay home or in nursing facilities
	+ Patient with chronic diseases (RSD, CVD, diabetes, and others)
	+ People with disabilities or nursing facilities
	+ People who are in the facilities were temporary isolated or quarantined;
	+ Herder household and children live in remote rural area
	+ Ethnic minorities /Kazakh/
	+ Single parent headed households
	+ Returnees
	+ Front line health workers, police, border, inspection agency workers
	+ Volunteers who will be engage to the vaccination activity
	+ Citizens of border soums.

Vulnerable groups within the communities affected by the project should be updated throughout project implementation the and consulted through dedicated means, as appropriate. Description of the methods of engagement that will be undertaken by the project is provided in the following sections.

# Grievance Redress Mechanism

Accessible grievance arrangements shall be made publicly available to receive and facilitate resolution of concerns and grievances in relation to the Project, consistent with ESS10, in a manner acceptable to the Bank/Association.

A grievance redress mechanism (GRM) is part of the project ESMF and SEP and will be established to resolve complaints and grievances in a timely, effective and efficient manner. Project related grievances can be submitted for detrimental impact on the community, the environment, or on their quality of life. Stakeholders may also submit comments and suggestions. The GRM provides complaint or resolving measures for any dispute, appropriate redress actions and avoids the need to resort to judicial proceedings. Grievances will be handled at each municipal/provincial referral hospitals and at the national level by a Grievance Redress Committee to be established by MOH, including via dedicated hotline to be established.

The main objective of a Grievance Redress Mechanism (GRM) is to assist to resolve complaints and grievances in a timely, effective and efficient manner that satisfies all parties involved. Specifically, it provides a transparent and credible process for fair, effective and lasting outcomes. It also builds trust and cooperation as an integral component of broader community consultation that facilitates corrective actions. Specifically, the GRM:

* Provides affected people with avenues for making a complaint or resolving any dispute that may arise during the course of the implementation of projects;
* Ensures that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants;
* Ensure that project level GRM should be also culturally appropriate and accessible for IPs; and
* Avoids the need to resort to judicial proceedings.
* Anti Covid -19 vaccine related compliance will be not taken in this management system.

**Description of GRM**

Grievances will be handled at the national level by MoH and E-Health PIU. Currently there are some dedicated platforms and channels have been launched by MoH to disseminate COVID 19 related information, take feedback and grievance redress from audiences and stakeholders. E-Health PIU is to launch platform and channel such as webpage and chat-box, hotline for handling grievances linked to the project implementation aiming at project GRM implementation and reporting.

The GRM will include the following steps:

Step 1: Submission of grievances either orally or in writing to E-Health PIU via call, project websites, email..etc:

Step 2: Recording of grievance and providing the initial response within 48 hours

Step 3: Investigating the grievance and Communication of the Response within 7 days

Step 4: Complainant Response: either grievance closure or taking further steps if the grievance remains open. If grievance remains open, complainant will be given opportunity to appeal to MoH via email or calling to +976 – 264923 and 119, and mobile application [shuurhai 119](https://play.google.com/store/apps/details?id=mn.callpro.shuurkhai). The grievance redress will be handled in accordance with the rules written on the [MoH website](https://www.mohs.mn/app)  .

Once all possible redress has been proposed and if the complainant is still not satisfied then they should be advised of their right to legal recourse including process stated in the Law on Resolving Citizens’ Complaint/Petition Addressed to Public Organization or Servant (1995). According to law, the public organization who has accepted grievance expected to respond within 30 days with possible extension another 30 days.

In the instance of the COVID 19 emergency, existing grievance procedures should be used to encourage reporting of co-workers if they show outward symptoms, such as ongoing and severe coughing with fever, and do not voluntarily submit to testing. Once all possible redress has been proposed and if the complainant is still not satisfied then they should be advised of their right to legal recourse.

**Venues to register Grievances - Uptake Channels**

A complaint can be registered directly at COVID 19 (GRCs) through any of the following modes and, if necessary, anonymously or through third parties.

* By telephone at +976 – 264923 and 119. The list of the contact for services related to COVED-19, the people can contact respective local hospital by visiting <https://covid19.mohs.mn/p/cat/post/52/>
* By e-mail to info@moh.gov.mn or  piu@ehp.mn
* By-mobile application to shuurhai 119
* By letter directly at provincial health authority/ and provincial contracted NGOs for healthcare services.
* By complaint form to be lodged at any of the address listed above- this form will be made available in the relevant healthcare facilities to be used by the complainants and can be filled.
* Walk-ins and registering a complaint on grievance logbook at healthcare facility or suggestion box at clinic/hospitals

 Once a complaint has been received, it should be recorded in the complaints logbook or grievance excel-sheet- grievance database.

**GRM Unit for COVID 19**

MoH established a dedicated webpage that contains series of information designed for public use as well as list of hospital and clinic and their contact number. The project will help to strengthen this webpage to ensure that it can be also used for COVID-19 project and launch dedicated part for grievance redress at COVID 19 project webpage under E-health project.

**Grievance for Gender-Based Violence (GBV) issues**

There will be specific procedures for addressing GBV including confidential reporting with safe and ethical documenting of GBV cases. Multiple channels will be in place for a complainant to lodge a complaint in connection to GBV issue. Specific GRM considerations for addressing GBV under COVID-19 are:

* a separate GBV GRM system, potentially run by a GBV Services Provider with feedback to the project GRM, similar to that for parallel GRMs will be established. The GRM operators are to be trained on how to collect GBV cases confidentially and empathetically (with no judgment).
* COVID 19 will establish multiple complaint channels, and these must be trusted by those who need to use them.
* No identifiable information on the survivor should be stored in the GRM logbook or GRM database.
* The GRM should not ask for, or record, information on more than three aspects related to the GBV incident:
	+ The nature of the complaint (what the complainant says in her/his own words without direct questioning);
	+ If, to the best of complainant’s knowledge, the perpetrator was associated with the project; and
	+ If possible, the age and sex of the survivor.
* The GRM should assist GBV survivors by referring them to GBV Services Provider(s) for support immediately after receiving a complaint directly from a survivor. This will be possible because a list of service providers will already be available before project work commences as part of the mapping exercise.
* The information in the GRM must be confidential—especially when related to the identity of the complainant. For GBV, the GRM should primarily serve to: (i) refer complainants to the GBV Services Provider; and (ii) record resolution of the complaint.

Data Sharing: The GBV Services Provider will have its own case management process which will be used to gather the necessary detailed data to support the complainant and facilitate resolution of the case referred by the GRM operator. The GBV Services Provider should enter into an information sharing protocol with the GRM Operator to close the case. This information should not go beyond the resolution of the incident, the date the incident was resolved, and that the case is closed. Service providers are under no obligation to provide case data to anyone without the survivor’s consent. If the survivor consents to case data being shared the service provider can share information when and if doing so is safe, meaning the sharing of data will not put the survivor or service provider at risk for experiencing more violence. For more information on GBV data sharing see: <http://www.gbvims.com/gbvims-tools/isp/>.

The GRM should have in place processes to immediately notify both the ministry and the World Bank of any GBV complaints with the consent of the survivor. For World Bank reporting protocol refer to the Safeguards Incident Response Toolkit.

# Monitoring and Reporting

**Involvement of stakeholders in monitoring activities [if applicable]**

**Reporting back to stakeholder groups**

The SEP will be periodically revised and updated as necessary in the course of project implementation in order to ensure that the information presented herein is consistent and is the most recent, and that the identified methods of engagement remain appropriate and effective in relation to the project context and specific phases of the development. Any major changes to the project related activities and to its schedule will be duly reflected in the SEP. Quarterly summaries and internal reports on public grievances, enquiries and related incidents, together with the status of implementation of associated corrective/preventative actions will be collated by responsible staff and referred to the senior management of the project. The quarterly summaries will provide a mechanism for assessing both the number and the nature of complaints and requests for information, along with the Project’s ability to address those in a timely and effective manner. PIU is to prepare GRM report twice a year, send it to the Bank and disclosure the report to project stakeholders by appropriate methods via channels and platforms identified above. Information on public engagement activities undertaken by the Project during the year may be conveyed to the stakeholders in two possible ways:

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

Further details will be outlined in the Updated SEP, to be prepared within one month of effectiveness.

#  Budget

ESMF implementation costs are allocated to include training, development of E&S due diligence measures and other to be determined tools. Funds are needed to hire consultant(s) to prepare ESS site specific EMPs and all associated E&S due diligence reports. Costs for undertaking travel to conduct monitoring and trainings are also identified. The anticipated cost for all these initiatives is estimated at $230,000 USD.

Training topics for personnel involved in the implementation of Project activities will among others include:

* COVID-19 Infection Prevention and Control Recommendations Laboratory biosafety guidance related to the COVID-19
* Specimen collection and shipment
* Standard precautions for COVID-19 patients
* Risk communication and community engagement
* Medical and hazardous waste management
* Vaccine storage, transportation, distribution and administration
* Labor management procedures
* Grievance redress mechanisms
* Consultations, communications and feedback
* Ensuring all peoples are given equal access and rights (vulnerable groups, ethnic groups)
* Understanding concerns with gender-based violence, violence against children, social stigma with COVID 19
* Monitoring and reporting at all levels

**Table 13.1 ESMF implementation costs**

|  |  |  |
| --- | --- | --- |
| № | Activities  | Budget USD |
|  | Training and workshops  | 55,000 |
|  | Development of necessary tools  | 40,000 |
|  | IEC material development and disseminating  | 55,000 |
|  | Supervision, monitoring, and reporting | 80,000 |
| Total  | $230,000 |

1. COVAX is the vaccines pillar of the Access to COVID-19 Tools (ACT) Accelerator and is co-led by Gavi, the Coalition for Epidemic Preparedness Innovations (CEPI) and WHO. Its aim is to accelerate the development and manufacture of COVID-19 vaccines, and to guarantee fair and equitable access for every country. <https://www.gavi.org/covax-facility> [↑](#footnote-ref-1)
2. https://documents.worldbank.org/en/publication/documents-reports/documentdetail/352661585718919785/project-information-document-mongolia-covid-19-emergency-response-and-health-system-preparedness-project-p173799 [↑](#footnote-ref-2)
3. https://documents.worldbank.org/en/publication/documents-reports/documentdetail/957021585174181217/environmental-and-social-commitment-plan-escp-mongolia-covid-19-emergency-response-and-health-system-preparedness-project-p173799 [↑](#footnote-ref-3)
4. https://documents.worldbank.org/en/publication/documents-reports/documentdetail/773991585914437112/stakeholder-engagement-plan-sep-mongolia-covid-19-emergency-response-and-health-system-preparedness-project-p173799 [↑](#footnote-ref-4)
5. ADB, Subsector Analysis (Summary): Hospital Hygiene and Infection Prevention and Control Project Number: 45009, Mongolia: Fifth Health Sector Development Project,

https://www.adb.org/sites/default/files/linked-documents/45009-002-mon-oth-03.pdf [↑](#footnote-ref-5)
6. https://documents.worldbank.org/en/publication/documents-reports/documentdetail/773991585914437112/stakeholder-engagement-plan-sep-mongolia-covid-19-emergency-response-and-health-system-preparedness-project-p173799 [↑](#footnote-ref-6)
7. Vulnerable status may stem from an individual’s or group’s race, national, ethnic or social origin, color, gender, language, religion, political or other opinion, property, age, culture, literacy, sickness, physical or mental disability, poverty or economic disadvantage, and dependence on unique natural resources. [↑](#footnote-ref-7)