

PHILIPPINES COVID-19 EMERGENCY RESPONSE PROJECT

ENVIRONMENTAL AND SOCIAL MANAGEMENT FRAMEWORK

DRAFT

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Executive Summary

The Project Development Objective of the COVID-19 Emergency Response Project is to strengthen the Philippines' capacity to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness.

The Environmental and Social Management Framework (ESMF). The Project consists of a number of different activities and/or investments (sometimes referred to as subprojects) for which the risks and impacts cannot be determined until implementation. The ESMF describes principles, processes and technical guidance to the Project implementing agencies and their consultants to assess the E&S risks and impacts of the Project activities.

The ESMF is applicable to all investments under the Project. It aims to (a) assess the potential environmental and social (E&S) risks and impacts of the Project and propose mitigation measures which will effectively address these risks/impacts; (b) establish clear 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 related to eligible 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 requirement for implementation of the ESMF.

Eligible Project Activities. The Project will be national in coverage and scope, and would finance a number of activities that focus on (i) procurement of goods such as equipment for ICUs (in existing hospitals at national, provincial and local government level), ambulances and PPE; (ii) provisions to address capacity building needs of the medical service providers and supporting staff training related to COVID-19 emergency preparedness, infection control and medical waste management; (iii) civil works that involve retrofitting existing hospital buildings to include isolation/negative pressure wards; (iv) establishment of point-of-entry quarantine and decontamination facilities; and (v) strengthening laboratory capacity at national and sub-national level.

Potential Environmental Impacts and Risks. Overall, the environmental risk is expected to be moderate due to the nature of associated works and duration of construction period (less than 12 months). Civil works are expected to be minor and may generate limited adverse environmental impacts such as dust, noise, wastewater, solid wastes and hazardous wastes. These impacts are site specific, temporary and can be mitigated with standard mitigation measures.

Potential Social Impacts and Risks. There are substantial risks related to the direct and indirect social impacts of the eligible activities. These risks can be mainly classified in (i) occupational health and safety risks, (ii) risks of exclusion and (iii) stigma:

- *Occupational Health and Safety.* There is a risk that health personnel and other hospital workers and/or hospital visitors/non-COVID-19 patients, are exposed to COVID-19 when in hospital, or workers when establishing or upgrading health facilities.
- *Risks of Exclusion.* There is a risk of social exclusion in particular of the most vulnerable and marginalized groups (ethnic groups in remote areas, the elderly, those with underlying medical conditions, people living with a disability). COVID-19 information materials developed could

exclude the most vulnerable or be developed in a way that is not sensitive to the needs and access of these different groups.

- *Stigma and discrimination.* Fear or stigma associated with COVID-19 may make people hide symptoms, avoid getting tested and even reject hygiene measures, which could lead to spread of the virus. Health workers may face discrimination and harassment when going back to their communities due to people's fear in contracting the virus, frustrations over medical care or misinformation.

Procedures to Address Environmental and Social Issues. The ESMF provides a screening tool for potential project activities to allow determination of potential environmental and social issues. The screening process identifies possible instruments to be applied during Project implementation, based on subproject typology (e.g. Environmental and Social Management Plan (ESMP)).

Institutional Arrangement for ESMF implementation. The Department of Health (DOH) will be responsible for the coordination, management, and implementation of the project at the national and sub-national levels including financial management, procurement and environmental and social management. The project will be implemented through mainstream DOH processes and will not involve a parallel project implementation unit or secretariat. This will be strengthened by the recruitment of additional staff/consultants responsible for environmental and social management.

1 Introduction and Background

1.1 Purpose of this Document

This Environmental and Social Management Framework (ESMF) has been prepared to assess and manage environmental and social risks and impacts of the Philippine COVID-19 Emergency Response Project. A framework approach is chosen as the specific locations and details of the sub-projects will not be known until implementation. This ESMF will allow the Borrower to clarify, to the extent possible and based on existing information, the environmental and social management approach that should be taken at the subproject level, in accordance with the World Bank Environmental and Social Framework (ESF).

The purpose of the ESMF is to guide MOH and other proponents on environmental and social screening, assessment and management of specific project activities during implementation. The document also provides guidance on preparation of location specific Environmental and Social Management Plans (ESMPs), when needed, in accordance with the ESF.

1.2 COVID-19 World Bank Program

An outbreak of the coronavirus disease (COVID-19) caused by the 2019 novel coronavirus (SARS-CoV-2) has been spreading rapidly across the world since December 2019, following the diagnosis of the initial cases in Wuhan, Hubei Province, China. Since the beginning of March 2020, the number of cases outside China has increased thirteenfold and the number of affected countries has tripled. On March 11, 2020, the World Health Organization (WHO) declared a global pandemic as the coronavirus rapidly spreads across the world. As of March 26, 2020, the outbreak has resulted in an estimated 416,686 cases and 18,589 deaths in 197 countries and territories.¹

COVID-19 is one of several emerging infectious disease (EID) outbreaks in recent decades that have emerged from animals in contact with humans, resulting in major outbreaks with significant public health and economic impacts. The last moderately severe influenza pandemics were in 1957 and 1968; each killed more than a million people around the world. Although countries are now far more prepared than in the past, the world is also far more interconnected, and many more people today have behavior risk factors such as tobacco use² and pre-existing chronic health problems that make viral respiratory infections particularly dangerous³.

With COVID-19, scientists are still trying to understand the full picture of the disease symptoms and severity. Reported symptoms in patients have varied from mild to severe, and can include fever, cough and shortness of breath. In general, studies of hospitalized patients have found that about 83% to 98% of patients develop a fever, 76% to 82% develop a dry cough and 11% to 44% develop fatigue or muscle aches⁴. Other symptoms, including headache, sore throat, abdominal pain, and diarrhea, have been

¹ <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>

² Marquez, PV. 2020. "Does Tobacco Smoking Increases the Risk of Coronavirus Disease (Covid-19) Severity? The Case of China." <http://www.pvmarquez.com/Covid-19>

³ Fauci, AS, Lane, C, and Redfield, RR. 2020. "Covid-19 — Navigating the Uncharted." *New Eng J of Medicine*, DOI: 10.1056/NEJMe2002387

⁴ Del Rio, C. and Malani, PN. 2020. "COVID-19—New Insights on a Rapidly Changing Epidemic." *JAMA*, doi:10.1001/jama.2020.3072

reported, but are less common. While 3.7% of the people worldwide confirmed as having been infected have died, WHO has been careful not to describe that as a mortality rate or death rate. This is because in an unfolding epidemic it can be misleading to look simply at the estimate of deaths divided by known cases so far. Hence, given that the actual prevalence of COVID-19 infection remains unknown in most countries, it poses unparalleled challenges with respect to global containment and mitigation. These issues reinforce the need to strengthen the response to COVID-19 across all IDA/IBRD countries to minimize the national and global risks and impacts posed by this disease.

This project is prepared under the global framework of the World Bank COVID-19 Response financed under the Fast Track COVID-19 Facility, which provided up to US\$14 billion in immediate support to assist countries coping with the impact of the global outbreak.

1.3 World Bank Programming in the Country Health Sector

The project is aligned with World Bank Group strategic priorities, particularly the WBG's mission to end extreme poverty and boost shared prosperity. The Program is focused on preparedness which is also critical to achieving Universal Health Coverage. It is also aligned with the World Bank's support for national plans and global commitments to strengthen pandemic preparedness through three key actions under Preparedness: (i) improving national preparedness plans including organizational structure of the government; promoting adherence to the International Health Regulations (IHR); and utilizing international framework for monitoring and evaluation of IHR.

The economic rationale for investing in the MPA interventions is strong, given that success can reduce the economic burden suffered both by individuals and countries. The project complements both WBG and development partner investments in health systems strengthening, disease control and surveillance, attention to changing individual and institutional behavior, and citizen engagement. The project contributes to the implementation of IHR (2005), Integrated Disease Surveillance and Response (IDSR), and the World Organisation for Animal Health (OIE) international standards, the Global Health Security Agenda, the Paris Climate Agreement, the attainment of Universal Health Coverage and of the Sustainable Development Goals (SDG), and the promotion of a One Health approach.

The Project supports Specific Objective #4 in the Philippines' *National Objectives for Health 2017-2022* that strives to increase access to quality essential health products and services. This includes working toward a resilient health system that has the capacity to absorb, adapt and transform when exposed to a shock such as pandemics, natural disasters or armed conflict and still retain the same control on its structure and functions. The objective is to enable local government units (LGUs) to mobilise communities to implement Disaster Risk Reduction and Management in Health (DRRM-H), which will be institutionalized in all levels of governance by: (1) developing and implementing DRRM-H plans, (2) organizing trained and equipped health emergency response teams, (3) ensuring availability and accessibility of health emergency commodities, and (4) ensuring functionality of Operation Centers (OPCEN).

2 Project Description

2.1 Development Objectives

The Project objectives are aligned to the results chain of the COVID-19 Strategic Preparedness and Response Program (SPRP). The project development objective (PDO) is to strengthen the Philippines' capacity to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness. Three PDO level indicators are proposed:

- Percentage of hospitals with personal protective equipment and infection control products and supplies according to DOH requirements, without stock-outs in preceding one month;
- Percentage of designated laboratories with COVID-19 diagnostic equipment, test kits, and reagents, without stock-outs in preceding one month; and
- Number of acute healthcare facilities with isolation capacity according to DOH established standards (Number).

2.2 COVID-19 Project Components and Activities

The Project will finance a broad range of both immediate and near-term priority health sector activities, medical facilities refurbishment, health care equipment and ambulances, personal protective equipment (PPE) and medical consumables that constitute priorities of the Government of the Philippines (GoP) national response to the COVID-19 pandemic.

In particular, this will include establishing testing and quarantine facilities at six major international airports in Luzon, Visayas and Mindanao administrations, 21 first-line decontamination facilities at international airports, strengthening the national reference laboratories as well as sub-national and public health laboratories for COVID-19 analysis, refurbishing and establishing negative pressure isolation rooms in about 70 DoH and 85 Provincial public hospitals, setting up 450 isolation tents, extensive provision and training on use of PPE, about 150 land and 10 sea ambulances, COVID-19 test kits, array of diagnostic and life support equipment (ventilators, oxygen machines, cardiac monitors, infusion pumps, portable x-ray machines, PCR equipment, dialysis machines).

The Project will be national in scope, supporting the existing network of the health care facilities and services in the Philippines, and providing support to immediate response, e.g. testing, quarantine, decontamination and treatment, as well as mid-term activities such as completion of construction of the national reference laboratory complex. The Project will include the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) and areas with indigenous peoples. Approximately ten percent of the population in the Philippines is considered indigenous peoples. They live in several regions but are particularly concentrated in the mountains of Northern and Central Luzon as well as in the island of Mindanao.

Refurbishment and civil works activities are expected to be of small scale, distributed throughout the health care network providing COVID-19 response, and will take place within the existing compounds of the health care facilities.

2.3 Subcomponent Typology

The project involves two distinct phases: a COVID-19 emergency response (Component 1); and a mid-term initiative to strengthen laboratory capacity to support emerging infectious diseases (EIDs) (Component 2). In addition, the project includes a Management/Monitoring and Evaluation component (Component 3) and Contingent Emergency Response Component or CERC (Component 4).

The environmental and social management approaches to Component 1 and 2 will be governed by the urgency of the interventions. Activities under Component 1 will be undertaken in an unpredictable environment determined by the extent of the COVID-19 outbreak in the Philippines, the capacity of the health system and the duration of the pandemic. Environmental and social management measures for Component 1 will need to be adaptable to the circumstances, with the priority necessarily being the public health risks of the virus. Component 2 activities will be undertaken in orderly and predictable manner allowing environmental and social management measures to be better calibrated.

Component 1: Strengthening Emergency COVID-19 Health Care Response (Total US\$ 82,500,000): The aim of this component is to strengthen essential health care service delivery system to be able to respond to a surge in demand as a result of anticipated rise in the number of COVID-19 cases in the coming months. As COVID-19 will place a substantial burden on inpatient and outpatient health care services, support will be provided to equip selected health facilities prioritized by DOH 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 as well as essential inputs for treatment such as oxygen delivery systems and medicines to selected hospitals and health facilities. Local containment will be supported through the establishment of local temporary isolation units. The component will also finance requirements of infrastructure of quarantine facilities. It is anticipated that any construction involved under this component will be conducted at existing facilities; activities requiring land acquisition or involuntary resettlement are not eligible. This component also supports the Department of Health in preparing a guidance note on standard design for hospital isolation and treatment centers to manage Severe Acute Respiratory Infections (SARI) patients that will be used in health facilities across the country to ensure standard and quality of COVID-19 health care services. The component has three sub-components.

- (a) **Sub-component 1.1. Provision of medical and laboratory equipment and reagents⁵ (US\$ 43,200,000):** This sub-component will support selected DOH hospitals and provincial hospitals with laboratory equipment (e.g. Polymerase Chain Reaction machines), test kits, reagents, as well as to upgrade diagnostics and treatment of COVID-19 infection capacity through procurement of such intensive care unit equipment and devices as mechanical ventilators, cardiac monitors, portable x-ray, Extracorporeal membrane oxygenation (ECMO) machine; Portable Oxygen Generator machine, Continuous Positive Airway Pressure (CPAP). The sub-component will also support provision of oxygen, 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, and to support the necessary logistics and supply chain to ensure that the equipment will reach frontline health facilities without delays.

⁵ Laboratory support under Sub-Component 1.1 is short-term and includes PCR machines and test kits for selected DOH hospitals and provincial hospitals. Component 2 supports strengthening of reference laboratories at both national and sub-national levels to address EIDs in the short and medium term.

- (b) **Sub-component 1.2. Provision of medical supplies, including Personal Protective Equipment (PPE), medicines, and ambulance (US\$ 16,300,000):** This subcomponent will support the health system with supplies including PPE such as 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 co-morbidity and complications such as CVDs and diabetes. This subcomponent will also support short trainings on use of medical supplies for health providers and technicians as needed, and to support the necessary logistics and supply chain to ensure that the medical supplies and PPE will reach frontline health facilities without delays. Small part of this sub-component may also support ambulance vehicles to address COVID-19 response, as needed.
- (c) **Sub-component 1.3. Enhancing isolation/quarantine facilities (US\$ 23,000,000):** This sub-component will support the establishment, construction, retrofitting/refurbishment of quarantine facilities in major points of entry, increase number of regular isolation rooms in DOH and provincial hospitals as well as establishment of negative pressure isolation rooms in DOH and provincial hospitals. It will also support setting up of first line decontamination facilities in international airports (holding areas) as well as establishing isolation tents for triaging in health facilities.

Component 2: Strengthening laboratory capacity at national and sub-national level to support Emerging Infectious Diseases (EIDs) Prevention, Preparedness, and Response (Total US\$ 16,500,000):

The component will support the establishment of national reference laboratories as well as selected subnational and public health laboratories. It will include improving, retrofitting and refurbishing national reference laboratory – Research Institute for Tropical Medicine (RITM) as well as six sub-national and public health laboratories in Baguio, Cebu, Davao, Surigao City, and Manila.⁶ The sub-component may also support constructing and expanding laboratory capacity in priority regions that currently do not have necessary laboratory capacity. The sub-component will also support necessary laboratory equipment, laboratory supplies, reagents, as well as capacity building for relevant laboratory staff. It is anticipated that any construction involved under this component will be conducted at existing facilities, and that no new land acquisition or involuntary resettlement are expected.

Component 3: Implementation Management and Monitoring and Evaluation (Total US\$ 1,000,000):

Project Management. The component will support the Department of Health (DOH) as the implementing agency of the project. DOH will be responsible for the coordination, management, and implementation of the project at the national and sub-national levels, financial management and procurement. The project will be implemented through mainstream DOH processes and will not involve a parallel project implementation unit or secretariat. This will be strengthened by the recruitment of additional staff/consultants responsible for overall administration, procurement, and financial management under country specific projects. To this end, the Project would support costs associated with project coordination, management, and implementation. This component will also support costs

⁶ Subnational and public health laboratories include (i) Lung Center of the Philippines (QC); (ii) San Lazaro Hospital (Manila); (iii) Baguio General Hospital (Baguio); (iv) Vicente Sotto Memorial Medical Center (Cebu); (v) Caraga Regional Hospital (Surigao City); (vi) Southern Philippines Medical Center (Davao).

related to the management of environmental and social risks under the Bank’s ESF, including the implementation of this ESMF and Stakeholder Engagement Plan (SEP).

Monitoring and Evaluation (M&E). This component would also support monitoring and evaluation of project implementation, 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):

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. List of Goods, Services and Works.

Project Activities: Table 1 lists the goods, services and works that will be financed under the project which will be deployed variously to Department of Health (DoH) hospitals, provincial hospitals and local government unit (LGU) hospitals as specified.

Table 1 List of Goods, Services and Works

Goods*
Intensive Care Unit (ICU) equipment - mechanical ventilator, cardiac monitor, closed-circuit apparatus, suction pump, portable x-ray, dialysis machine (70 DOH hospitals)
Polymerase Chain Reaction (PCR) Machines (70 DOH hospitals; 85 Provincial Hospitals)
Real Time (RT-PCR) Nucleic Acid Detection Kits
Continuous Positive Airway Pressure (CPAP), Extracorporeal Membrane Oxygenation (ECMO), Portable Oxygen Generator machine (70 DOH hospitals)
Personal protective equipment (300,000 sets)
Ambulances (approximately 180 vehicles plus 10 water ambulances)
Isolation tents x 452 units (70 DOH Hospitals; 85 Provincial Hospitals; 297 Level 1 LGU Hospitals)
Services**
Community outreach
Training and capacity building
Support to project implementation and monitoring
Works*
Strengthen capacity of sub-national and public health laboratories (6 facilities)
Research Institute for Tropical Medicine (RITM) Biosafety Level (BSL) 3 Lab and National Reference Laboratory (NRL) Complex
Point-of-Entry Quarantine Facilities (Luzon (1), Visayas (2) and Mindanao (3))
First line decontamination facilities International Airports (Manila (Pasay), Clark, Bicol, Cebu, Kalibo, Cagayan de Oro, Davao)
Regular isolation rooms in DOH and Provincial hospitals (35 DOH and 45 Provincial hospitals)
Negative pressure isolation rooms in DOH and Provincial hospitals (70 DOH and 85 Provincial hospitals)

Source: *Philippines COVID-19 Emergency Response Project Procurement Plan (May, 2020)

**Project Appraisal Document (April 23, 2020)

2.4 Prohibited/Negative List

The Project has a list of prohibited activities that will not be eligible for financing as follows:

- Activities that have potential to cause any significant loss or degradation of critical natural habitats whether directly or indirectly.
- Activities that could adversely affect forest and forest health.
- Activities that could affect sites with archaeological, paleontological, historical, religious, or unique natural values.
- Activities that will result in the involuntary taking of land, relocation of households, loss of assets or access to assets that leads to loss of income sources or other means of livelihoods, and interference with households' use of land and livelihoods.
- Use of goods and equipment on lands abandoned due to social tension / conflict, or the ownership of the land is disputed or cannot be ascertained.
- Use of goods and equipment to demolish or remove assets, unless the ownership of the assets can be ascertained, and the owners are consulted.
- Use of goods and equipment involving forced labor, child labor, or other harmful or exploitative forms of labor.
- Use of goods and equipment for activities that would affect indigenous peoples, unless due consultation and broad support has been documented and confirmed prior to the commencement of the activities.
- Use of goods and equipment for military or paramilitary purposes.

3 Policy, Legal and Regulatory Framework

3.1 Philippines Legal Framework relevant to the ESF

3.1.1 Philippine Environmental Impact Assessment System of 1978

The ***Philippine Environmental Impact Assessment System of 1978 (Presidential Decree 1586)*** is the primary law that establishes the Philippine Environmental Impact Statement (EIS) System. This is one of the series of degrees promulgated in the late 1970s to address emerging environmental issues and concerns. The other related laws are PD 1151 (the Philippine Environmental Policy) and PD 1152 (The Philippine Environment Code). The Philippine EIS system introduce the concept of environmentally critical area (ECA) and environmentally critical project (ECP) and provides that "no person, partnership or corporation shall undertake or operate any such declared ECP or project within an ECA without first securing an Environmental Compliance Certificate (ECC)" which require the submission of an Environmental Impact Statement. The latest implementing rules for this law is the DENR Administrative Order 30-2003 (DAO 30-2003) which provides criteria for and detailed lists of ECAs and ECPs. Based on these rules and criteria, the Covid-19 emergency response project is covered by the EIS System and therefore initiatives that fall under the purview of the law are required to undergo the Environmental Impact Assessment process. The law states:

LGU facilities are required to secure Environmental Compliance Certificate (ECC) from DENR-Environmental Management Bureau (EMB) which requires to have a waste facility in place.

3.1.2 Republic Act (RA) 6969 - Toxic Substances and Hazardous and Nuclear Wastes Control Act of 1990;

The **Philippine Toxic Substances and Hazardous and Nuclear Wastes Control Act of 1990** was enacted to regulate, restrict or prohibit the importation, manufacture, processing, sale, distribution, use and disposal of chemical substances and mixtures that present unreasonable risk and/or injury to health or the environment; to prohibit the entry, even in transit, of hazardous and nuclear wastes and their disposal into the Philippine territorial limits for whatever purpose; and to provide advancement and facilitate research and studies on toxic chemicals.

DENR Administrative Order (DAO) 2000-02 established the Implementing Rules and Regulations (IRR) of Republic Act 6969 or Toxic Substances and Hazardous and Nuclear Waste Management Act

- Requires hazardous waste generator to register with the DENR-EMB, properly manage and dispose of hazardous wastes generated in its facility
- Hazardous wastes must be segregated, labeled, kept in proper storage facility, transported, treated/recycled and disposed of through DENR-accredited firms

3.1.3 Joint DOH-DENR DAO Order No. 2005-02 dated August 24, 2005 defines health care wastes

Defines the classification of health care wastes according to the following: general waste, infectious waste, pathological waste, sharps, pharmaceutical wastes, genotoxic waste, chemical waste, waste with high heavy metals content, pressurized containers, radioactive waste.

3.1.4 DAO 2014-02 issued February 3, 2014

Required industrial, commercial and manufacturing establishments and private entities whose activities are potential and actual sources of pollution to designate a Pollution Control Officer (PCO). The PCO shall secure accreditation from the DENR in accordance with this DAO.

Memorandum Circular (MC) 2020 -20 or the Provisional Guidelines on the Hazardous Wastes Management dated April 30, 2020

DENR MC 2020-20 provides the guidelines that health facilities need to comply with during the extended enhanced community quarantine. It upholds the policy of the government to continuously monitor the transport, treatment, storage and disposal of hazardous wastes in order to prevent or avoid the likelihood of environmental disaster and contamination and provide temporary protocols for waste handlers, transporters, treaters, local government units, law enforcement authorities, and other stakeholders in the smooth implementation of proper hazardous waste management. It describes the coverage and simplification of existing procedures for the issuance of the permit to transport to registered transporters and registered TSD facilities to haul, treat and dispose health care wastes and related hazardous wastes.

3.1.5 Philippine Clean Air Act of 1999

The *Philippine Clean Air Act of 1999 (Republic Act (RA) 8749)* provided for a comprehensive air pollution control policy and recognizes the rights of Philippine citizens to breathe clean air. RA 8749 applies to the project due to the potential for emissions from health-care waste incineration. Section 20 of RA 8749 states:

Ban on Incineration - Incineration, hereby defined as the burning of municipal, bio-medical and hazardous wastes, which process emits poisonous and toxic fumes, is hereby prohibited: Provided, however, that the prohibition shall not apply to traditional small-scale method of community/neighborhood sanitation "siga", traditional, agricultural, cultural, health, and food preparation and crematoria: Provided, further, That existing incinerators dealing with bio-medical wastes shall be phased out within three (3) years after the effectivity of this Act: Provided, finally, That in the interim, such units shall be limited to the burning of pathological and infectious wastes, and subject to close monitoring by the Department.

With due concern on the effects of climate change, the Department shall promote the use of state-of-the-art, environmentally-sound and safe non-burn technologies for the handling,

treatment, thermal destruction, utilization, and disposal of sorted, unrecycled, uncomposted municipal, bio-medical and hazardous wastes.

These provisions of RA 8749 were clarified by a Department of Environment and Natural Resources Memorandum Circular (DMC-2002-05), which:

- states that RA 8749 does not prohibit incineration of wastes except those burning processes which emit poisonous and toxic fumes;
- recognises that appropriate disposal techniques for medical and bio-medical wastes are limited; and
- incineration of these wastes is only permitted in state-of-the-art facilities which are proven to emit minimal air pollutants with concentrations meeting RA 8749 criteria.

The phasing out of bio-medical incinerators contemplated under RA 8749 was deemed impracticable due to lack of affordable best available technology (BAT)

3.1.6 RA 9003 – Ecological Waste Management Act; and DENR AO 2001-34 (Implementing rules and regulations);

This law seeks to ensure the protection of public health and the environment through the utilization of environmentally sound methods for treating, handling and disposing of solid wastes and encourages waste minimization and segregation at source.

3.1.7 DOH Administrative Order – Hospitals and Other Health Facilities

Joint DOH-DENR Administrative Order No. 2005-02 dated August 24, 2005 defines health care wastes as all wastes generated as a result of the following: 1) diagnosis, treatment, management, and immunization of humans or animals, 2) research pertaining to the above activities, 3) producing or testing of biological products, 4) wastes originating from minor or scattered sources (e.g. dental clinics, alternative medicine clinics, etc.). The DAO also identifies its hazards to people and the strategies to manage these wastes.

DOH Administrative Order No. 2005-0029 dated December 12, 2005 “Amendment to Administrative Order No. 147 s. 2004: Amending Administrative Order No. 70-A series 2002 re: Revised Rules and Regulations Governing the Registration, Licensure and Operation of Hospitals and Other Health Facilities in the Philippines.”

The AO amends specific provisions of preceding issuances. Amendment includes the requirement for hospitals and other health facilities applying for initial License to Operate to accomplish/submit a Waste Management Plan, among other documents.

3.1.8 DOH Administrative Order – Clinical Laboratories

Department of Health Administrative Order (AO) No. 2007-0027 “*Revised Rules and Regulations Governing the Licensure and Regulation of Clinical Laboratories in the Philippines*” prescribes “...a revised minimum standard for clinical laboratories [to]...ensure accuracy and precision of laboratory examinations in order to safeguard public health and safety.” The AO requires all clinical laboratories,

government or private, to have written policies and procedures for the provision of laboratory services and for the operation and maintenance of the laboratory, including proper disposal of waste and hazardous substances, as well as biosafety and biosecurity. This AO applies directly to activities under the project, most specifically under Component 2.

3.1.9 DoH Manual on Health Care Waste Management 2020

The 4th Edition of the Manual on Health Care Waste Management is intended to serve as the most comprehensive set of guidelines on the safe management of waste generated from health care activities in the country. It incorporates the requirements of all Philippines laws and regulations governing HCWM and considers the recommendations of the World Health Organization (WHO) and stakeholders, including end-users.

This edition is intended and designed for the use of individuals, establishments, and other entities involved in the segregation, collection, handling, storage, treatment, and disposal of waste generated.

3.1.10 Department of Health COVID-19 Interim Guidelines

DoH has developed a series of Interim Guidelines specifically targeted at COVID-19 response (<https://www.doh.gov.ph/2019-nCov/interim-guidelines?page=1>). Relevant guidelines include:

- Department Memorandum No. 2020-0188 - Interim Guidelines on the Zoning of COVID-19 Laboratories (<https://www.doh.gov.ph/sites/default/files/health-update/dm2020-0188.pdf>)
- Department Memorandum No. 2020-0151 - *Guidelines on Cleaning and Disinfection in Various Settings as an Infection Prevention and Control Measure Against COVID-19* (<https://www.doh.gov.ph/sites/default/files/health-update/dm2020-0157.pdf>)
- Department Memorandum No. 2020-0151 – *Interim Guidelines on Expanded Testing for COVID-19* (<https://www.doh.gov.ph/sites/default/files/health-update/dc2020-0174.pdf>)
- Administrative Order No. 2020-2014 – *Guidelines in Securing a License to Operate a COVID-19 testing Laboratory in the Philippines* (<https://www.doh.gov.ph/sites/default/files/health-update/ao2020-0014.pdf>)
- Department Memorandum No. 2020-0170 – *Interim Guidelines on the Management of Health Care Waste in Health Facilities, Community Quarantine Units and Temporary Treatment and Monitoring Facilities with cases of Coronavirus Disease 2019 (COVID-19)* (<https://www.doh.gov.ph/sites/default/files/health-update/dm2020-0170.pdf>)
- Department Memorandum No. 2020-0153 - Interim Guidelines for Emergency Hiring of Health Personnel in Select Hospitals and Other Health Facilities in Response to COVID-19 Health Emergency (<https://www.doh.gov.ph/sites/default/files/health-update/dm2020-0153.pdf>)
- Department Memorandum No. 2020-0142 - *Interim Guidelines on COVID-19 Referral Hospitals* (<https://www.doh.gov.ph/sites/default/files/health-update/dm2020-0142.pdf>)
- Department Memorandum No. 2020-0123 - *Interim Guidelines on Management of Surge Capacity through the Conversion of Public Spaces to Operate as Temporary Treatment and Monitoring Facilities for the Management of Persons Under Investigation and Mild Cases of Coronavirus Disease 2019 (COVID-19)* (<https://www.doh.gov.ph/sites/default/files/health-update/dm2020-0123.pdf>)

- Department Memorandum No. 2020-0072 - *Interim Guidelines on the Activation of 5 DOH Subnational Laboratories for the 2019-nCoV*
(<https://www.doh.gov.ph/sites/default/files/health-update/DM2020-0071-Interim-Guidelines-on-the-Activation-of-Five-DOH-Subnational-Laboratories-for-the-2019-nCoV-ARD-Response.pdf>)
- Department Memorandum No. 2020-0072 - *Interim Guidelines For 2019 Novel Coronavirus Acute Respiratory Disease Response In Hospitals And Other Health Facilities*
https://drive.google.com/file/d/1zmXeJt_3kmlOzyJyt9laVXTfk6JKJsbT/preview

The application of these Guidelines should be considered in comparison with evolving WHO guidance to ensure that contemporary good practice is adopted.

3.1.11 Labor Legislation

Labor Code of the Philippines

Presidential Decree No. 44, as amended by RA 6715, known as the “Labor Code of the Philippines”, governs all employment practices and relations in the country. Provisions of the code are aligned with international good practice on decent work and shall be strictly implemented. These provisions include:

Wage and Welfare

1. Employees shall receive their wages by means of legal tender, at least once every two weeks or twice a month at intervals not exceeding sixteen (16) days.
2. In a contracted work, employees of the contractor and of the latter’s subcontractor, shall also be paid in accordance with the labor code.
3. The wage paid by the employers to the workers shall not be lower than the prescribed minimum wage set by the Regional Tripartite Wages and Productivity Boards.

Working time, Rest Days and Holidays

1. The normal work hours for every employee shall not exceed eight (8) hours a day. If all or any part of the employee’s working hours falls on 10:00 PM to 6:00 AM, he/she shall be entitled to a night shift pay in addition to the regular wage. If the worked performed exceeds the normal working hours, he/she shall be given overtime pay.
2. It is the right of every employee for a rest period not less than twenty-four (24) consecutive hours after every six (6) consecutive normal workdays.
3. Compensation shall be given for work performed during holidays and Sundays.

Equal Rights

1. Workers shall have the right to self-organization and to form, join, or assist labor organizations of their own choosing for purposes of collective bargaining.
2. Minimum employable age is 18 years old. Persons of age 15 to 18 can be employed given that they work in non-hazardous environment.

3. Gender discrimination in employment and labor relations shall be prohibited. Male and female employees are entitled to equal compensation for work of equal value and access to promotion and training opportunities.

International Labour Organisation

The Philippines became a member of the International Labor Organization (ILO) on 15 June 1948. It was the first country in Asia to participate in a pilot programme on decent work in 2002. The Philippines has ratified thirty-eight (38) ILO Conventions including all of the eight (8) Fundamental Conventions, as follows:

- C.29 Forced Labour Convention, 1930
- C.87 Freedom of Association and Protection of the Right to Organise Convention, 1948
- C.98 Right to Organise and Collective Bargaining Convention, 1949
- C.100 Equal Remuneration Convention, 1951
- C.105 Abolition of Forced Labour Convention, 1957
- C.111 Discrimination (Employment and Occupation) Convention, 1958
- C.138 Minimum Age Convention, 1973
- C.182 Worst Forms of Child Labour Convention, 1999

The 1987 Constitution of the Republic of the Philippines provide the following relevant provisions as legislative framework for labor concerns:

- Sec. 3, Art. XIII – The State shall afford full protection to labor, local and overseas, organized and unorganized, and promote full employment and equality of employment opportunities for all. It shall guarantee the right of all workers to self-organization, collective bargaining and negotiations, and peaceful concerted activities, including the right to strike in accordance with the law. They shall be entitled to security of tenure, humane conditions of work, and a living wage. They shall also participate in policy and decision-making processes affecting their rights and benefits as may be provided by law. The State shall promote the principle of shared responsibility between workers and employers and the preferential use of voluntary modes in settling disputes, including conciliation, and shall enforce their mutual compliance therewith to foster industrial peace. The State shall regulate the relations between workers and employers, recognizing the right of labor to its just share in the fruits of production and the right of enterprises to reasonable returns to investments, and to expansion and growth.
- Sec. 11, Art. II – The State values the dignity of every human person and guarantees full respect for human rights.
- Sec 13, Art. II – The State recognizes the vital role of the youth in nation-building and shall promote and protect their physical, moral, spiritual, intellectual, and social well-being. It shall inculcate in the youth patriotism and nationalism, and encourage their involvement in public and civic affairs.
- Sec. 14, Art. II – The State recognizes the role of women in nation-building, and shall ensure the fundamental equality before the law of women and men.
- Sec. 1, Art III – No person shall be deprived of life, liberty, or property without due process of law, nor shall any person be denied equal protection of the laws.

- Sec. 4, Art. III – No law shall be passed abridging the freedom of speech, of expression, or of the press, or the right of the people to peaceably assemble and petition the government for redress of grievances.
- Sec. 14, Art. XIII – The State shall protect working women by providing safe and healthful working conditions, taking into account their maternal functions, and such facilities and opportunities that will enhance their welfare and enable them to realize their full potential in the service of the nation.

Occupational Health and Safety

The protection against OHS risk to the workers embodied in various international laws, national laws and administrative issuances governing the public sector, shall be observed.

Republic Act 11058 – The Occupational Safety and Health Standards Act

This law strengthens the compliance with Occupational Safety and Health Standards to ensure a safe and healthful workplace for all working people by affording them full protection against all hazards in their work environment. To ensure that the provisions of the Labor Code of the Philippines, all domestic laws, and internationally recognized standards on occupational safety and health are being fully enforced and complied with by the employers. And to protect every worker against injury, sickness or death through safe and healthful working conditions thereby assuring the conservation of valuable manpower resources and prevention of loss or damage to lives and properties. DOLE Department Order No. 198-2018 sets out the implementing rules and regulations of this act.

ILO Technical Convention: C187 – Promotional Framework for Occupational Safety and Health Convention

This convention will enter into force for Philippines on 17 June 2020 which is well within the period of implementation of the Project. The following are National Policy under Section 3:

1. Each Member shall promote a safe and healthy working environment by formulating a national policy;
2. Each Member shall promote and advance, at all relevant levels, the right of workers to a safe and healthy working environment;
3. In formulating its national policy, each Member, in light of national conditions and practice and in consultation with the most representative organizations of employers and workers, shall promote basic principles such as assessing occupational risks or hazards; combating occupational risks or hazards at source; and developing a national preventative safety and health culture that includes information, consultation and training.

1987 Constitution of the Republic of the Philippines

The relevant provisions of the Constitution as regards OHS are as follows:

- Sec. 3, Art. XIII – The State shall afford full protection to labor, local and overseas, organized and unorganized, and promote full employment and equality of employment opportunities for all. It shall guarantee the right of all workers to self-organization, collective bargaining and negotiations, and peaceful concerted activities, including the right to strike in accordance with

the law. They shall be entitled to security of tenure, humane conditions of work, and a living wage. They shall also participate in policy and decision-making processes affecting their rights and benefits as may be provided by law.

- Sec 13, Art. II – The State recognizes the vital role of the youth in nation-building and shall promote and protect their physical, moral, spiritual, intellectual, and social well-being. It shall inculcate in the youth patriotism and nationalism, and encourage their involvement in public and civic affairs
- Sec. 14, Art. XIII – The State shall protect working women by providing safe and healthful working conditions, taking into account their maternal functions, and such facilities and opportunities that will enhance their welfare and enable them to realize their full potential in the service of the nation.
- Sec. 11, Art. II – The State values the dignity of every human person and guarantees full respect for human rights.

Civil Service Commission Administrative Issuances

- Memorandum Circular No. 33, Series of 1997 (Policy on Working Conditions at the Workplace) – all government offices shall provide adequate office ventilation and lighting, clean and adequate comfort room facilities, potable drinking water, First Aid Kit facilities, and all government offices should be non-smoking areas.
- Memorandum Circular No. 08, Series of 2011 (Reiteration of the Physical Fitness Program “Great Filipino Workout”) – requiring all agencies to adopt “The Great Filipino Workout” in order to develop a healthy and alert workforce.
- Memorandum Circular No. 04, Series of 2003 (Promotion of Good Nutrition in the Bureaucracy) – promotion of good nutrition of workers as an effective strategy to achieve and sustain increased organizational productivity.

3.1.12 Indigenous Peoples

The *Indigenous Peoples’ Rights Act of 1997* (IPRA) is a landmark legislation that recognizes and respects the rights of indigenous communities in the Philippines, including rights of control of their ancestral lands and right to self-determination. The law requires, among others, that development undertakings within the declared ancestral domains of the ICC/IPs shall be subject to their free, prior informed consent (FPIC) following different procedures depending on the character of activities. The IPRA, inter alia, declares that the State shall recognize and promote the rights of ICCs/IPs to government’s basic health services. The National Commission for Indigenous Peoples (NCIP) is responsible for implementing the IPRA. Likewise, the Joint Memorandum Circular 2013-01 entitled “Guidelines on the Delivery of Basic Health Services for Indigenous Cultural Communities / Indigenous Peoples” will also be considered.

3.2 World Bank Environmental and Social Policies

3.2.1 ESS1 Assessment and Management of Environmental and Social Risks and Impacts

ESS1 is relevant given the environmental and social risks to assess and manage. The main environmental risks associated are: (i) occupational health and safety risks resulting from the operation of medical

facilities and laboratories involved in COVID-19 response which inherently expose staff to infection risk; (ii) health care waste management and disposal and community health and safety issues related to the handling, transportation and disposal of healthcare wastes; and (iii) environmental and safety risks associated with small scale civil works for medical facilities refurbishment or completion of ongoing construction. Occupational health and safety and medical waste management are of particular concern.

Healthcare-associated infections due to inadequate adherence to occupational health and safety standards can lead to illness and death among healthcare and laboratory workers and exposed communities. The laboratories and relevant healthcare facilities which will be used for COVID-19 diagnostic testing and isolation of patients can generate biological waste, chemical waste, and other hazardous waste. Effective management and controls measures will have to be in place to avoid and minimize these risks; these measures, minimizing the risk of occupational health and safety, proper management and disposal of hazardous waste and other sharps, use of appropriate disinfectants, proper quarantine procedure for COVID-19, appropriate chemical and infectious substance handling and transportation procedures, etc., as documented in this ESMF and in line with WHO Interim Guidance (February 12,2020) on “Laboratory Biosafety Guidance related to the novel coronavirus (2019-nCoV)” as well as applicable GoP regulations. The ESMF includes guidelines for assessing adequacy of the existing Health Care Waste Management system for handling increased quantities of waste and identifying measures for strengthening its capacity if needed.

Social risks include exclusion of marginalized and vulnerable social groups, exclusion of, and engagement with, indigenous peoples, risk of panic/conflicts resulting from false rumors and social unrest, the social stigma associated with COVID-19, and Sexual Exploitation and Abuse (SEA) and Sexual Harassment (SH), Gender-Based Violence (GBV) and/or Violence Against Children (VAC).

The Project’s ESMF also provides environmental and social risk management for the Contingent Emergency Response Component (CERC) should it be activated during project implementation for another health related emergency with similar needs and eligible activities. For other eligible emergencies that could lead to the CERC’s activation (e.g. earthquakes, typhoons, and volcanic eruptions), where the measures included in this ESMF do not fit the activities of the activated CERC, an Addendum to the ESMF would be prepared with the situation-specific environmental and social risk assessment and management measures. In all circumstances, the ESMF provisions will be reflected in the CERC Operations Manual that will be prepared to guide CERC implementation, including a description of the type of activities eligible for support in response to the emergency and their environmental and social risks and management measures as well as a negative list of activities categorically excluded from support under the activated CERC.

3.2.2 ESS2 Labor and Working Conditions

Most activities supported by the Project will be conducted by health and laboratory workers, i.e. civil servants employed by the Government of the Philippines and professional consultants and contractors (hired as contracted workers). Activities encompass treatment of patients and small-scale civil works for medical facilities refurbishment or completion of ongoing construction. The key risk is contamination with COVID-19 (or other contagious illnesses as patients taken seriously ill with COVID-19 are likely to suffer from illnesses which compromise the immune system), which can lead to illness and death of workers. The project will ensure the application of OHS measures as outlined in the ESMF’s Labor

Management Procedures (LMP) (Annex B) and WHO guidelines. This encompasses procedures for entry into health care facilities, including minimizing visitors and undergoing strict checks before entering; procedures for the protection of workers in relation to infection control precautions; provision of immediate and ongoing training on the procedures to all categories of workers, and post signage in all public spaces mandating hand hygiene and PPE; ensuring adequate supplies of PPE (particularly facemask, gowns, gloves, handwashing soap, and sanitizer); and overall ensuring adequate OHS protections in accordance with General EHSs and industry-specific EHSs and follow evolving international best practice in relation to protection from COVID-19. Also, the project will regularly integrate the latest guidance by WHO as it develops over time and experience addressing COVID-19 globally.

The project's LMP incorporates issues for the DOH staff and contracted workers: working conditions and management of worker relationships, protecting the workforce and ensuring proper OHS, and a grievance mechanism for project workers whether direct or contracted workers hired for the small-scale civil works. Child labor is forbidden in accordance with ESS2 and Philippines law, and due to the hazardous work situation no person under the age of 18 will be hired by the Project. To prevent risks of Sexual Exploitation and Abuse (SEA) and Sexual Harassment (SH), Gender-Based Violence (GBV) and/or Violence Against Children (VAC) from interactions within work forces and between workers and patients and other community members, the LMP includes provisions for training on community interaction and SEA/SH/GBV/SEA to all teams, staff (civil servants and outsources staff/contractors) to ensure the teams respect local communities and their culture and will not engage in misconduct, including Codes of Conduct (CoC). Other relevant documents, such as letter of DOH's staff appointment and contracts for contracted workers in line with relevant national laws and legislation to be adopted and applied under the project, will also include the CoC. The LMP includes similar provisions for security personnel that will be involved in project activities, for instance in providing security at health facilities.

3.2.3 ESS3 Resource Efficiency and Pollution Prevention and Management

Healthcare wastes, medical wastes and other chemical wastes (including water, reagents, infected materials, etc.) from the labs testing, operation of quarantine and isolation centers, and screening posts (drugs, supplies and medical equipment) can have substantial impact on the environment and human health. Wastes that may be generated from medical facilities and national reference labs and DoH and provincial hospitals may include liquid contaminated waste, chemicals and other hazardous materials, and other waste such as sharps used in diagnosis and treatment. All facilities will follow the requirements of the ESMF and the national standards and regulations in place such as the Healthcare Waste Management Regulations.

The ESMF includes criteria to ensure that disposal of medical waste will not be permitted at sites which threaten human or environmental health including natural habitats. It similarly includes measures to ensure that standards relevant to the provision and protection of water resources and the effective management of wastewater from the facilities are observed.

The ESMF includes measures related to transportation and management of samples and medical goods or expired medications and chemicals. The project, as documented in the ESMF, will ensure the use of resources (water, air, etc.) in quarantine facilities and labs will follow standards and measures consistent with the US- Center for Disease Control (CDC), and the WHO environmental infection control guidelines

for medical facilities. As indicated, no major physical works are permitted until the ESMF and its measures are in place.

3.2.4 ESS4 Community Health and Safety

Medical wastes and general waste from labs, health centers, and quarantine and isolation centers have a potential of carrying micro-organisms that can infect the community at large if they are not properly disposed of. There is a possibility for the infectious microorganism to be introduced into the environment if not well contained within the laboratory or due to accidents or emergencies, such as a fire response or natural phenomena event (e.g., seismic). Laboratories, quarantine and isolation centers, and screening posts will have to follow certain procedures. The operation of quarantine and isolation centers needs to be implemented in a way that staff, patients, and the wider public follow and are treated in line with international good practices as outlined in the WHO guidance for COVID-19 response.

The Stakeholder Engagement Plan also ensures widespread engagement with communities in order to disseminate information related to project activities, particularly with communities in the vicinity of health facilities, such as screening and quarantine facilities.

The project will need to mitigate potential risks of Sexual Exploitation and Abuse by applying the WHO Code of Ethics and Professional Conduct for all workers in the quarantine facilities as well as the provision of gender-sensitive infrastructures, such as segregated toilets and enough lighting in quarantine and isolation centers. As noted under ESS2, the LMP includes provisions to prevent SEA/GBV/SEA through training and Codes of Conduct (CoC) to ensure workers respect local communities and their culture and will not involve in misconduct.

Health facilities supported by the project is expected to use some security personnel. Normally a security agency is contracted on a long-term basis by health care facilities to ensure safety of employees and the facility, including the equipment and supplies. In relation to security of the equipment during delivery, DOH's freight service provider ensures that all equipment is delivered intact and safe onsite. DOH reports that security has not been an issue in the delivery of equipment in different areas nationwide. However, as COVID-19 may develop in unpredictable ways and due to potential concerns among the public, the use of additional government security personnel from the local or national police, or in some instances possibly the military, may be directed to implement measures to ensure peace and order in affected areas, including at quarantine, isolation, decontamination and other health facilities.

The potential scope of such security measures, and potential risks surrounding them, have been assessed as part of preparing the ESMF to manage environmental and social risks concerning project activities and monitored during project implementation. In cases where project activities are supported by private or government security personnel, it will be ensured that the security personnel follow a strict code of conduct and avoid any escalation, taking into consideration protocols consistent with ESS4 and international guidance (e.g. IFC *Good Practice Handbook on the Use of Security Forces: Assessing and Managing Risks and Impacts*).

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

The Bank's ESS 7 on Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities (IPs or ICC/IPs in the Philippines context) aims to:

- ensure that the development process fosters full respect for the human rights, dignity, aspirations, identity, culture, and natural resource-based livelihoods of IPs;
- avoid adverse impacts of projects on IPs, or when avoidance is not possible, to minimize, mitigate and/or compensate for such impacts;
- promote sustainable development benefits and opportunities for IPs in a manner that is accessible, culturally appropriate and inclusive;
- improve project design and promote local support by establishing and maintaining an ongoing relationship based on meaningful consultation with IPs affected by a project throughout the project's life cycle;
- obtain the FPIC of affected IPs in the three circumstances described in this ESS; and
- recognize, respect and preserve the culture, knowledge, and practices of IPs, and to provide them with an opportunity to adapt to changing conditions in a manner and in a timeframe acceptable to them.

When indigenous peoples are present in, or have collective attachment to, a project area ESS7 requires that:

- The IPs should be fully consulted about, and have opportunities to actively participate in, the project design and the determination of project implementation arrangements.
- There should be an assessment of the nature and degree of the expected direct and indirect economic, social, cultural (including cultural heritage), and environmental impacts on them.
- The borrower should develop a consultation strategy and means by which affected IPs will participate in project design and implementation and adopt measures and actions in consultation with the affected IPs to be contained in a time-bound plan (IP Plan) which will be proportionate to the potential risks and impacts of the project.
- Adverse impacts on the IPs should be avoided by exploring alternatives to the project and where adverse impacts are unavoidable, the Borrower will minimize, mitigate and/or compensate for these impacts in a culturally appropriate manner. The mitigation and compensation measures shall include culturally appropriate and sustainable development benefits whether delivered through the community or individually.

The standard requires free, prior and informed consent (FPIC) when a project may have adverse impacts on the land and natural resources, cause relocation or have significant impacts on IPs' cultural heritage. None of these circumstances are present in this project.

There are a few differences between the national framework and ESS7. These concern the requirements for FPIC, the scope of undertaking a social assessment, preparing an Indigenous Peoples Plans (IPP), and disclosure and monitoring of such plans. However, given the nature of the project's activities, these differences do not have material effects and the project would not require free, prior and informed consent under ESS7 or IPRA, nor require the preparation of IPPs (see sections 4.2 and 6.2).

3.2.6 ESS10 Stakeholder Engagement and Information Disclosure

The project recognizes the need for effective and inclusive engagement with all relevant stakeholders and the population at large. Considering the serious challenges associated with COVID-19, dissemination of clear messages around physical distancing, high-risk demographics, self-quarantine, and, when necessary, mandatory quarantine is critical. Meaningful consultation, particularly when public meetings are counter to local and national advisories on physical distancing, means that meaningful disclosure of appropriate information and innovative and virtual stakeholder engagement assume huge significance for ensuring public health and safety from all perspectives social, environmental, economic, and medical/ health.

To address these challenges a Stakeholder Engagement Plan (SEP) has been prepared. The SEP defines a program for stakeholder engagement, including public information disclosure and consultation, throughout the entire project cycle. It outlines the ways in which the DoH and partners will communicate with stakeholders and includes a grievance redress mechanism by which people can raise concerns, provide feedback, or make complaints about the project and any activities related to the project. Provisions have been included to reach and meaningfully engage vulnerable and disadvantaged groups (e.g. elderly, children, poor households, vulnerable groups, people with disabilities and indigenous peoples), including in rural areas with little access to the internet.

Project preparation has included a preliminary mapping of 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 done. The draft SEP has been disclosed publicly by DOH and will be disclosed at the World Bank's external website before World Bank Board approval. The SEP will be updated during implementation and publicly re-disclosed.

3.3 International and Regional Regulations and Guidance

3.3.1 World Health Organisation

Laboratory Assessment Tool for laboratories implementing COVID-19 testing

This tool has been designed to assess the capacity of laboratories that have implemented or intend to implement testing for SARS-CoV-2, the virus that causes novel coronavirus disease 2019 (COVID-19). The tool is a shortened version of the 2012 Laboratory assessment tool that is widely used to assess national laboratory systems and the capacity of laboratories.

Laboratory biosafety guidance related to coronavirus disease (COVID-19)

The purpose of this document is to provide interim guidance on laboratory biosafety related to the testing of clinical specimens of patients that meet the case definition of the novel pathogen identified in Wuhan, China, that is, coronavirus disease 2019 COVID-19.

[https://www.who.int/publications-detail/laboratory-biosafety-guidance-related-to-coronavirus-disease-2019-\(covid-19\)](https://www.who.int/publications-detail/laboratory-biosafety-guidance-related-to-coronavirus-disease-2019-(covid-19))

Rational use of personal protective equipment (PPE) for coronavirus disease (COVID-19)

This document summarizes WHO's recommendations for the rational use of personal protective equipment (PPE) in health care and community settings, as well as during the handling of cargo; in this context, PPE includes gloves, medical masks, goggles or a face shield, and gowns, as well as for specific procedures, respirators (i.e. N95 or FFP2 standard or equivalent) and aprons.

The document includes guidance on PPE in various settings including points of entry.

3.3.2 Stockholm Convention

The *Stockholm Convention on Persistent Organic Pollutants* is a global treaty to protect human health and the environment from chemicals that remain intact in the environment for long periods, become widely distributed geographically, accumulate in the fatty tissue of humans and wildlife, and have harmful impacts on human health or on the environment. Exposure to Persistent Organic Pollutants (POPs) can lead to serious health effects including certain cancers, birth defects, dysfunctional immune and reproductive systems, greater susceptibility to disease and damages to the central and peripheral nervous systems.

The Philippine government ratified the Convention in 2004 and is therefore required (under Article 5) to take measures to reduce or eliminate releases from unintentional POPs production. The Convention requires the promotion of best available techniques and best environmental practices to reduce these releases. Medical waste incineration is a significant source of POPs in the form of dioxins and furans which can be released in the form of emissions from the burning process and in ash remaining after combustion.

4 Environmental and Social Baseline

The Philippine Development Plan 2017-2022 outlines an aspiring reform agenda with the focus on equitable tax reforms, boosting market competition, and easing of doing business, as well as scaling up public investments to infrastructure and social services. This Plan has four areas for strategic action: (a) building a prosperous, predominantly middle-class society where no one is poor; (b) promoting a long and healthy life through quality and affordable universal health care and social protection; (c) becoming smarter and more innovative through expansion of skill sets in order to adapt to rapidly changing technology and work requirements; and (d) building a high-trust society, through people-centered, effective, and accountable government. This medium-term plan is anchored on Ambisyon Natin 2040, a 25-year long-term vision adopted by the current administration. Approved in October 2016 by President Rodrigo Roa Duterte, the Ambisyon Natin vision targets a three-fold increase in per capita income by 2040 and envisages the end of poverty in the Philippines.

Despite remarkable progress, the Philippines faces challenges to this development vision. Income inequality, although declining, remains stubbornly high in the Philippines, one of the highest in the region. Despite the rapid economic growth, the average real wage has been stagnant since 2000, partly driven by a lack of market competition. Geographic and demographic diversity are reflected in inequitable income and access to social services across and within the islands. The geography of poverty reflects the strong nexus between poverty and vulnerability, both to conflict and to the impacts of natural hazards and climate change. The latest Global Terrorism Index ranked the Philippines as one of the top 10 countries affected by fatal terrorist attacks. Poverty rates increase with distance from Metro Manila. While under 5 percent of the population in Metro Manila falls below the national poverty line, the highest poverty rates—exceeding 50 percent of the population—are in two areas: (i) conflict-affected areas of western Mindanao and islands of the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) and (ii) disaster-prone provinces in the Eastern Visayas region. The largest share of the poor live in Mindanao, home to roughly 25 percent of the country's population but 39 percent of the poor.

Due to its geographical location, the Philippine archipelago is at high risk from a range of natural disasters. The Philippines has been identified as the third most vulnerable country in the world to weather-related extreme events and sea-level rise. The main hazards in the Philippines include typhoons, floods, earthquakes, and volcano eruptions. Typhoon Yolanda (Haiyan), which was the strongest typhoon ever recorded, hit the Philippines in 2013 and reportedly cost about Php571.1 billion in total damage (US\$ 12.9 billion) and had a devastating impact on public infrastructure, including roads, hospitals and school buildings.

The Philippine population is expected to reach nearly 140 million by 2040, with the working age population (15-64 years) set to increase to 66 percent of the population compared to 8 percent over age 65 by that time. However, current trends reveal mixed human capital outcomes that undermine the wellbeing and productivity of current and future generations. The Philippines ranked 84th out of 157 countries in the WBG Human Capital Index (HCI), which captures the impact of human capital on future growth prospects. The national HCI for the Philippines (0.55) indicates that the future productivity of a child born today in the Philippines will be 45 percent below what could have been achieved with complete education and full health.

The Philippines moved aggressively to mitigate the COVID-19 epidemic at an early stage when confirmed cases were still at a very low level. The President declared the whole Philippines under a State of Calamity for a period of six months from March 16 and imposed an Enhanced Community Quarantine (ECQ) throughout the island of Luzon (which includes Metro Manila) from March 17 to 13 April, which is extended until 30 April.

On March 24, 2020, the Congress passed the Bayanihan To Heal As One Act (Republic Act No. 11469) which declares a national emergency due to COVID-19, and grants the President expanded powers to adopt measure to prevent and suppress the spread of COVID-19 for three months. The Act also authorizes the Executive branch to reallocate and realign savings from the national budget as well as from government corporations. The number of confirmed COVID-19 cases has continued to increase rapidly. After ramping up testing capabilities, current testing capacity is approximately 1,000 per day. As of April 19, 2020, there have been 6,259 confirmed cases and 409 deaths. Confirmed cases stretch across the age distribution, with a larger share among those age 50 and above, and 57% are male (Figures 1 and 2). The epicenter of COVID-19 is Metro Manila, which accounts for 72.6% of confirmed cases. In the COVID-19 Situation Report for the Philippines, the WHO notes that hospitals have faced shortages of Personal Protective Equipment and ventilators.

4.1 Air Quality and Healthcare Waste Incineration

Air quality in the Philippines (and Manila in particular) has improved substantially in the 20 year-period since the enactment of the *Clean Air Act of 1999* (CAA). A Japan International Cooperation Agency (JICA, 1997) study cited waste incineration as a major source of air pollution in Manila leading to a ban on incineration in 1999 under the CAA. The incineration ban was subsequently appealed with the Supreme Court ruling that only incinerators that emit poisonous and toxic emissions were banned. Hence, thermal waste treatment is permitted provided that emissions meet standards specified in the CAA. A phase-out of medical waste incinerators under the CAA was also deemed impractical due to the lack of affordable best available technologies (BAT). Incinerator operators are required to self-regulate emissions and report to the Department of Environment and Natural Resources Environmental Management Bureau (DENR-EMB).

The default thermal treatment method for health-care waste (HCW) in the Philippines is incineration. WHO (2019) describes the following HCW management hierarchy:

- The preferred approach is to avoid generating waste and thus minimise the quantity entering the waste stream.
- Where practicable and safe, those waste items that can be recovered for secondary use is the next most preferable method.
- Waste that cannot be recovered must then be dealt with by the least harmful options, such as treatment or land disposal to reduce their health and environmental impacts.

Under COVID-19 conditions the HCW quantities are expected to increase substantially potentially overwhelming thermal treatment capacity with associated OH&S and environmental pollution implications.

The Stockholm Convention recommends that priority consideration should be given to alternative processes, techniques or practices that have similar usefulness, but which avoid the formation and

release of dioxins and furans. Non-incineration waste treatment technologies should always be implemented wherever possible. WHO has called on all stakeholders to uphold the Stockholm Convention and work towards incrementally improving safe health care waste management practices to protect health and reduce harm to the environment.

4.2 Indigenous Peoples

The project is likely to take place in areas with indigenous peoples, particularly for some regional health facilities and local health centers. No direct adverse impacts on indigenous peoples are expected from project activities, although as generally a marginalized group they may be more affected by the virus should it spread in their communities. Civil works are expected to be confined to existing premises of health facilities and would not require any land acquisition. Some health facilities in areas with indigenous peoples may be directly supported with equipment, supplies and critical medical services. Stakeholder engagement and information sharing at these sites would be key to ensure that indigenous communities and Covid-19 affected persons are able to avail themselves of health services supported by the Project.

The term “indigenous cultural communities/indigenous peoples” (ICC/IP) is used in the Indigenous Peoples Rights Act (IPRA) of 1997 (Republic Act No. 8371) and includes a wide variety of groups that share certain conditions which set them apart from mainstream society in the Philippines. The IPRA defines ICCs/IPs as a group of people or homogenous societies identified by self-ascription and ascription by others, who have continuously lived as organized community on communally bounded and defined territory, and who have, under claims of ownership since time immemorial, occupied, possessed and utilized such territories, sharing common bonds of language, customs, traditions and other distinctive cultural traits, or who have, through resistance to political, social and cultural inroads of colonization, non-indigenous religions and cultures, became historically differentiated from the majority of Filipinos.

The IPRA definition has been found to be consistent with the identifying characteristics for social groups covered by the Bank’s previous Operational Policy (OP 4.10) on indigenous peoples and is also considered consistent with the new E&S Standard 7 (ESS7) on indigenous peoples. ESS7 identifies social groups covered by the standard as a distinct social and cultural group possessing the following characteristics in varying degrees: (a) Self-identification as members of a distinct indigenous social and cultural group and recognition of this identity by others; and (b) Collective attachment to geographically distinct habitats, ancestral territories, or areas of seasonal use or occupation, as well as to the natural resources in these areas; and (c) Customary cultural, economic, social, or political institutions that are distinct or separate from those of the mainstream society or culture; and (d) A distinct language or dialect, often different from the official language or languages of the country or region in which they reside.

Indigenous peoples live in most areas of the Philippines, but the majority resides in Mindanao (about 60 percent) and North-Central Luzon (about 30 percent). There are no accurate census data regarding the number of indigenous peoples, but it is estimated to be between 10-15 million people. The National Commission on Indigenous Peoples (NCIP) officially recognizes the existence of 110 ethno-linguistic groups in the country. In Luzon, most of the indigenous peoples are concentrated in the northern mountain ranges of the Cordilleras (e.g. the Kalinga, Ifugao, Ibaloy, and Ilongot) and in the Sierra Madre

mountain ranges (e.g. the Agta, Dumagat, and Itawis). They are also found in Zambales, Pampanga, Tarlac, Quezon Province, Pollilo Island and the Bicol Peninsula (e.g. the Pinatubo, Baluga and Agta).

The Western Islands Region and Central Philippine Islands Region are home to the Mangyan, Tagbanua, Batak, Tau't Bato, Keney, Sulod, Magahat, Ata and Ati, mainly in Mindoro, Palawan, Panay and Negros. In the island of Mindanao, there are about fifteen major indigenous groups and several subgroups living in the interior rainforest, hills, plateaus, narrow valleys and marginal plains, which include the Mandaya, Manobo, Bilaan, T'boli, Tiruray, Subanun, Higaonon, Tasaday, Bagobo, Manuvu, Matigsalug, Ata, and others; collectively they are called Lumads. The majority Muslim population in Mindanao, called Moro, is not considered to meet the identifying criteria as indigenous peoples and ESS7 is not applicable to them. The Bangsamoro Autonomous Region in Muslim Mindanao or BARMM is inhabited by indigenous peoples, including some marginalized Muslim groups such as the Badjao.

4.3 Disadvantaged and Vulnerable Groups

4.4 Persons with Disabilities

As COVID-19 continues to have wide-reaching impacts across the globe, it is important to note how persons with disabilities are uniquely impacted by the pandemic and may have constraints in accessing services. This section serves as a brief overview of emerging impacts and sets out some preliminary steps to mitigate the impact within the Bank's unfolding operations on COVID-19.

4.4.1 Situation Overview in Key Areas

Health

- Many persons with disabilities have additional underlying health needs that make them particularly vulnerable to severe symptoms of COVID-19, if they contract it.
- Persons with disabilities may be at increased risk of contracting COVID-19 because information about the spread of the disease, the symptoms associated with it, and how to prevent getting it are not provided in accessible formats, such as print materials in Braille or large print, sign language interpretation, captions, audio provision, and graphics.
- Persons with disabilities may be at increased risk of contracting COVID-19, as they may not have the same access to handwashing facilities/alternatives or may have trouble social distancing because they require in-person assistance in various ways.
- Some persons with disabilities who require personal protective gear or other medical supplies, such as ventilators, for their regular health needs may have more difficulty accessing them due to an increased demand for those particular items.
- In addition, in economies where persons with disabilities have personal assistants for essential home-based care social distancing mandates may jeopardize support received, and the burden of care heightened.
- Existing physical and communication barriers that limit the accessibility of health systems still exist and might prevent persons with disabilities from seeking appropriate care for COVID-19 and other needs.
- Reduced access to personal aides and support is likely to have harmful effects on health. In particular, there may be long-term impacts on sexual and reproductive health because of lack of access to clean water, contraceptives, and menstrual hygiene products.

Education

- As schools close nation-wide in over 160 countries and many more at localized levels, over 87% of the world's student population is out-of-school, interrupting educational progress and risking that children with disabilities have difficulty returning to school.
- Interruption of schooling can also interrupt access to basic services like meal programs; assistive technologies; access to resource personnel; recreation programs; extracurricular activities; and water, sanitation, and hygiene programs, all of which have benefits for children with disabilities.
- In settings where online learning is possible and provided to ensure instructional continuity, children with disabilities may have difficulty accessing the online platforms and content if accessibility features are not considered. They may miss out on important therapies, services, or accommodations they typically receive to support their learning if alternative options are not offered.

Economic and Employment Impacts

- Persons with disabilities already experience higher poverty rates and lower levels of employment. The current economic situation is expected to exacerbate economic and employment instability for persons with disabilities, especially those who are freelance workers or self-employed.
- Persons with disabilities represent a high proportion of informal sector employment, including the gig economy which is particularly adversely affected by the current economic environment and pandemic.
- Workplace accommodations, including physical accommodations or assistive technologies, may be workplace bound and employees with disabilities may face delays in receiving similar setups at home to continue their job tasks.

Transport and Travel

- As public transport systems reduce or stop services, persons with disabilities who rely on these methods for accessible transport may not be able to travel, even for basic necessities or critical medical appointments.
- With rapidly changing guidance and travel restrictions, persons with disabilities might not be able to return to their homes or to places that are more accessible to them.

Social Protection and Safety Nets

- There are concerns and reports that existing barriers, isolation, stigma, and discrimination are intensifying amid the outbreak.
- Social protection systems are weak in many countries and do not always cater to the needs of persons with disabilities.
- Safety nets may need to cover caregiving and other expenses particularly those emerging from ruptures in services for persons with disabilities.
- With increased stress, family confinement, and isolation, there is also an increased risk of gender-based violence. Since evidence shows that persons with disabilities, particularly women and girls, experience greater rates of violence and abuse, they are at a heightened risk during this period.

4.4.2 Disability-Inclusion in the World Bank's COVID-19 Response

With the robust funding commitments to help clients fight COVID-19, there are opportunities to address persons with disabilities and limit the impacts delineated above. Potential responses include:

Immediate, as part of the COVID-19 Support Package:

- Ensure existing health needs of persons with disabilities are met, and not superseded, by additional health system needs.
- Contract health facilities and temporary testing and treatment facilities that comply with universal access standards.
- Provide health information and government guidance in accessible formats. This includes explanations of what is happening during the time of care for deaf, blind and people with cognitive disabilities. Accessible formats may include print materials in Braille or large print, sign language interpretation, captions, audio provision, and graphics.
- Disaggregated monitoring and evaluating for prevention, preparedness, and community-based disease surveillance by disability status and type to understand how persons with disabilities are impacted in pandemic situations. This should include data on differentiated rates of infection, economic impacts, and regarding the burden of care, barriers of access to care for people with disabilities.
- Integrate accessibility and disability considerations into all technical assistance the World Bank provides on supporting the outbreak. Considerations may need to balance disability-related and social distancing needs, including exemptions for personal caregivers during lockdowns/shelter-in-place procedures and access to personal protective equipment (PPE).
- Employ universal design principles in expanding clinical care capacities, including refurbishing ICUs or inpatient hospital facilities.

Long-term actions to ensure the needs of persons with disabilities are met in the coming months and future outbreak situations:

- Train health workers, including community health workers or volunteers in rural communities; government officials; emergency planners; and other stakeholders on interacting with persons with disabilities and how to support their needs.
- Strengthen disability-disaggregated data collection to address and mitigate risks to persons with disabilities during outbreak situations.
- Contract health facilities and temporary testing and treatment facilities that comply with universal access standards.
- Engage persons with disabilities in future public health emergency preparedness planning.
- Strengthen social security networks, particularly for people in the informal sector.
- Ensure that children with disabilities are supported in returning to school.
- Implement universal design standards in the development and use of online and virtual platforms, tools, and applications used to support government services, educational, employment, public awareness, emergency communications, and recreational activities.

4.5 Gender and Gender-based Violence

The Project will benefit both men and women by reducing the risks of Covid 19 to their personal health. The Department of Health generates sex and age-disaggregated data and it is expected that slight variations in project benefits will accrue by gender depending on the subgroup of the population being analyzed. Based on trends of DOH information of Covid-19 patients, men constitute around 60 percent of those afflicted with the disease with women comprising the remaining 40 percent. Although health care has shifted much from being a predominantly female profession and there is no gender-disaggregated data on Covid-19 frontline workers yet, anecdotal evidence and inference shows that there will be likely more women nurses, medical technologists, etc. who are involved in taking care of Covid-19 patients. As the Project addresses the effects of the pandemic across populations, it does not have a component dedicated exclusively for promoting women's welfare in the communities and will not have a conscious preference over women beneficiaries while being implemented in various localities. However, the Project will ensure that both men and women are informed and consulted, and that gender-sensitive public information will be disseminated. When appropriate, goods and facilities procured under the Project need to take into consideration the differential needs of men and women. It will also be sensitive to the needs of poor and vulnerable women who may not have access to information and health care.

In the time of Covid-19, gender-based violence can occur in three major areas: in health facilities, at home by spouses or other members of the family, and in the streets by enforcers of community quarantine including the military, police, security personnel, and barangay patrollers. In hospitals and health clinics/centers, women health workers are exposed to sexual harassment by colleagues, patients, or relatives and friends of patients. The added stress of dealing with the pandemic could also result in other forms of workplace harassment including verbal abuse. Women patients are also prone to sexual harassment especially when unaccompanied in quarantine facilities. The medical profession has a code of ethics and it is expected that health facilities will be able to ensure that these are followed including their respective codes of conduct for their employees.

With families under quarantine, the incidence of domestic violence within a household can be expected to increase. This means that households experiencing domestic violence are more likely to experience it more and that domestic violence is not likely to spread across the community. Women are faced with the risk of abuse as they stay at home and the risk of getting infected with the disease when they go out to seek help. However, with service-providers not in operation or overwhelmed with other tasks, women survivors are not able to receive the full support they need. At the very least, hotlines and online psychosocial support needs to be available to survivors.

With enforcers of community quarantine seemingly having more power, violence against women may also increase. In many households particularly in rural areas, women are tasked to go to the market which is the only allowed form of social mobility during quarantine. As they perform this role, women are exposed to formal and informal security forces stationed in their communities. Provided that maximum tolerance will be enforced and there will be no abuse of power, women should be generally safe from gender-based violence when they go outside their homes.

Further, aside from gender-based violence, access to sexual and reproductive care services have become limited due to exhaustion of resources addressing COVID-19. There are alleged reported cases of

women who died due to birth-related complications caused by untimely maternal care by certain hospitals. With this, there is a risk of increase in maternal and infant mortality rate.

5 Potential Environmental and Social Impacts and Mitigation Measures

5.1 Methodology for Assessing Risk and Impacts

The ESMF is prepared based on an assessment of direct and indirect risks and impacts of the specific project activities. A direct impact is defined under the ESF as “...an impact which is caused by the project, and occurs contemporaneously in the location of the project.” An indirect impact is one “...which is caused by the project and is later in time or farther removed in distance than a direct impact, but is still reasonably foreseeable, and will not include induced impacts”. Induced impacts are those that are unknown, speculative, uncertain or remote. Induced impacts are not considered further in this document as they cannot be reasonably assessed or mitigated at this time. Induced impacts emerging during project implementation will be managed responsively and the ESMF amended accordingly.

The project will apply the World Bank’s Environment and Social Framework (ESF), procedures for IPF operations designed to respond to COVID-19 and processed as an emergency operation under paragraph 12 of the IPF Policy. The Project will have positive social and environmental impacts as it should improve COVID-19 surveillance, monitoring, and containment. However, the project could also cause substantial environment and social risks.

5.2 Risk Summary

5.2.1 Environmental Risks

The main environmental risks are: (i) occupational health and safety resulted from the operation of laboratory related to COVID-19 process that may cause unsafe to the health of technicians and medical staff who work in the laboratory and hospitals throughout the country and (ii) medical and other chemical waste management and community health and safety issues related to the handling, transportation and disposal of healthcare wastes. Hazardous, infectious, and toxic (HIT) wastes that may be generated from labs, quarantine facilities, detection and controlling centers, isolation centers and hospitals could include liquid contaminated waste (e.g. blood, other body fluids and contaminated fluid) and infected materials (water used; lab solutions and reagents, syringes, bed sheets, majority of waste from labs and quarantine and isolation centers, etc.) which requires special capacity to manage and dispose. Without proper handling, these infectious wastes may pose risk to the healthcare workers and communities who are in contact or handle the waste and live near its disposal area. Potential health risks due to sharp waste disposal is high.

5.2.2 Social Risks

The social risks are considered Substantial, although the direct and indirect social impacts and risks associated with the activities proposed by this project are expected to be mostly temporary, predictable, and avoidable. No major construction works will be financed under this project.

The major areas of social risks are expected to concern: (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, poor households, persons with disabilities including physical and mental health disabilities indigenous peoples 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. There may also be risks concerning sexual exploitation and abuse (SEA) and violence against women and girls (VAC), especially related to healthcare workers and people in quarantine. Civil works envisaged in the project mainly refer to repair and rehabilitation of existing buildings. New facilities will be on existing premises and activities that would require land acquisition or involuntary resettlement are not eligible for project financing.

The potential social risks and impacts will be addressed through the implementation of a Stakeholder Engagement Plan (SEP), including a Grievance Mechanism, and this Environmental and Social Management Framework (ESMF), including Labor Management Procedures (LMP), prepared based on an assessment of social risks and impacts in line with the applicable WB ESSs of the WB's ESF, the WHO COVID-19 guidance on risk communication and community engagement, and national laws and regulations.

Women, the elderly, adolescents, youth, and children, persons with disabilities, indigenous populations and minorities generally experience the highest degree of socio-economic marginalization. Marginalized people often become even more vulnerable in emergencies due to poor, or lack of, access to health services, information, and lack of effective monitoring and early-warning systems. The Project aims to provide health services to all COVID-19 affected persons, however, in some instances additional measures may be needed to ensure inclusion and outreach to vulnerable and marginalized people.

5.3 Construction Stage

5.3.1 Environmental Risks

Environmental risks at the construction stage are not expected to be significant. Construction works will mainly involve fit-out type activities in existing premises. Minor quantities of construction waste will be generated; however, none is expected to be hazardous and all will be disposed in accordance with local regulations.

Construction activities within health facilities will need to comply with relevant regulations for the specific circumstances to ensure that the integrity of the facility is not compromised.

5.3.2 Occupational Health and Safety

Risks

Occupational health and safety hazards during construction activities include potential exposure to COVID-19 and regular hazards associated with construction activities. COVID-19 transmission hazards can be considered in terms of work location in accordance with **Error! Reference source not found.**, with works in health facilities carrying the potential for nosocomial transmission (infection contracted because of an infection or toxin that exists in a certain location, such as a hospital). Works undertaken

for isolation tent establishment will be on health facility premises but separate to the main building. Hence, there is a slightly elevated risk of COVID-19 transmission due to proximity to patients and health workers. Works to establish quarantine facilities and decontamination stations carry similar hazards to normal community activities under COVID-19 restrictions. Depending on location and scope there may be some impacts to local communities near the site, e.g. in terms of dust, noise, traffic, workers. There may also be fear, mistrust and resistance among the local community. Information disclosure and stakeholder engagement is therefore required in these circumstances following the provisions of the SEP.

Mitigation Measures

All workers involved with construction activities must follow basic hygiene procedures at all times to prevent the transmission of COVID-19:

1. performing hand hygiene frequently with an alcohol-based hand rub if your hands are not visibly dirty or with soap and water if hands are dirty;
2. avoiding touching your eyes, nose, and mouth;
3. practicing respiratory hygiene by coughing or sneezing into a bent elbow or tissue and then immediately disposing of the tissue;
4. workers exhibiting respiratory symptoms must not attend the workplace and should seek immediate medical advice;
5. maintaining social distance (a minimum of 1 meter) from other persons, particularly if they are showing respiratory symptoms.

Construction works required under the project are low hazard activities; hence standard construction OH&S principles should be followed as described in Department of Labor and Employment (DOLE) (2020) *Occupational Safety and Health Standards*.

As an overarching philosophy the OHS hierarchy of controls should be adopted to mitigate OHS risks as shown in Figure 1.

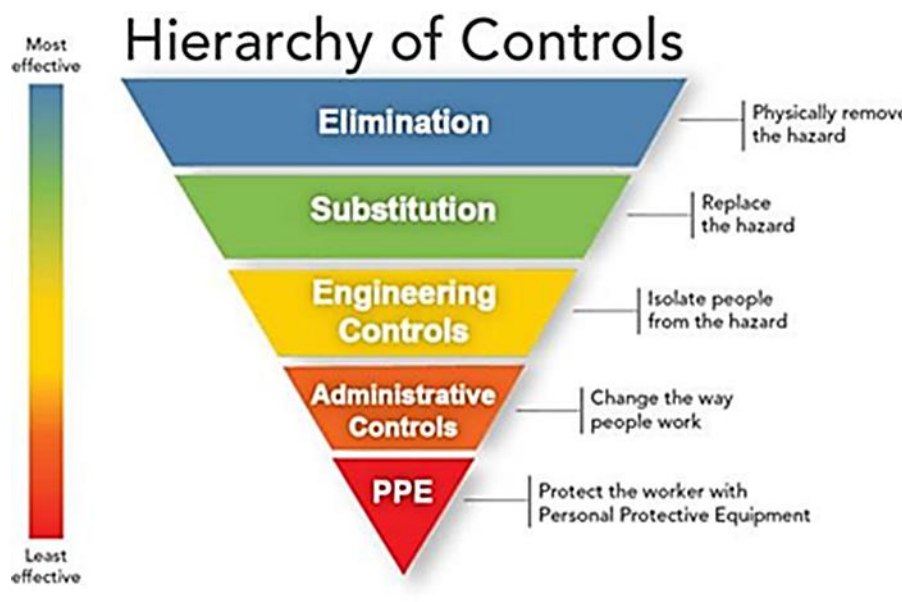


Figure 1 OHS Hierarchy of Controls

The provisions of Department Order No. 198 (DO 198-18) (Implementing Rules of Republic Act No. 11058) must be complied with by all construction contractors. Specifically, the following provisions must be adhered to:

- All employers must develop an Occupational Health and Safety Program in accordance with Section 12;
- All workers must undertake the Mandatory 8-hour Safety and Health Seminar for Workers (Section 3); and
- Each workforce must have a qualified Safety Officer in accordance with DO 198 Section 14

5.4 Operational Stage

5.4.1 Occupational Health and Safety

Occupational health and safety (OH&S) risks in the operational stage are predominantly associated with COVID-19 transmission risk. The hazard will vary according to the location of the activities and the exposure to the main modes of COVID-19 transmission. WHO⁷ notes *“COVID-19 virus is primarily transmitted between people through respiratory droplets and contact routes.”* Contact routes involve viral particles emitted from the respiratory tract of an infected individual landing on a surface. Then another person touches that object then touches their nose, mouth or eyes and the virus enters the body via the mucous membranes, infecting the second person. These are the predominant modes of COVID-19 transmission.

A secondary transmission mode is airborne. Airborne transmission is different from droplet transmission as it refers to the presence of microbes within droplet nuclei, which are generally considered to be particles less than 5 microns (μm) in diameter which can remain in the air for long periods of time and be transmitted to others over distances greater than one metre. This transmission mode *“...may be possible in specific circumstances and settings in which procedures or support treatments that generate aerosols are performed; i.e., endotracheal intubation, bronchoscopy, open suctioning...”* etc.⁷

Noting the above *“WHO continues to recommend droplet and contact precautions for those people caring for COVID-19 patients. WHO continues to recommend airborne precautions for circumstances and settings in which aerosol generating procedures and support treatment are performed, according to risk assessment”*

Rational use of Personal Protective Equipment (PPE)

WHO⁸ (March 19 2020) noted *“The current global stockpile of PPE is insufficient, particularly for medical masks and respirators; the supply of gowns and goggles is soon expected to be insufficient also. Surging global demand – driven not only by the number of COVID-19 cases but also by misinformation, panic*

⁷ WHO (2020) *Modes of Transmission of virus causing COVID-19: implications for IPC precaution recommendations*. Scientific Brief. March 27, 2020.

⁸ WHO (2020) *Rational use of personal protective equipment (PPE) for coronavirus disease (COVID-19) Interim guidance*. 19 March 2020

buying, and stockpiling – will result in further shortages of PPE globally". The European Centre for Disease Prevention and Control (ECDC)⁹ (May 2020) noted:

"...countries worldwide affected by COVID-19 have been experiencing difficulties in accessing personal protective equipment (PPE) and hand hygiene materials. Coordinated supply chains for PPE should ensure distribution of such materials to healthcare systems in order to reduce the potential of healthcare-associated transmission to vulnerable groups and healthcare workers."

In these circumstances it is important that PPE is allocated in a rational way to ensure that those at highest risk of disease transmission are protected from infection. Judgements on the rational use of PPE should be guided by WHO⁸ (Table 1) reproduced in part in Table 2.

Cargo Handling

To date, there is no epidemiological information to suggest that contact with goods or products shipped from countries affected by the COVID-19 outbreak have been the source of COVID-19 disease in humans⁸.

Training

WHO has developed a free course - *Infection Prevention and Control (IPC) for Novel Coronavirus (COVID-19)* (<https://openwho.org/courses/COVID-19-IPC-EN>) – targeted at healthcare workers and public health professionals. The course includes information on what facilities should be doing to be prepared to respond to a case of an emerging respiratory virus such as COVID-19, how to identify a case once it occurs, and how to properly implement IPC measures to ensure there is no further transmission to HCW or to other patients and others in the healthcare facility.

⁹ European Centre for Disease Prevention and Control. Infection prevention and control for COVID-19 in healthcare settings – Third update. 13 May 2020. ECDC: Stockholm; 2020.

Table 2 Recommended PPE during the outbreak of COVID-19 outbreak, according to the setting, personnel, and type of activity

Setting	Target personnel or patients	Activity	Type of PPE or procedure
Inpatient facilities			
Patient room	Health care workers	Providing direct care to COVID-19 patients	Medical mask; Gown; Gloves; Eye protection (goggles or face shield)
		Aerosol-generating procedures performed on COVID-19 patients	Respirator N95 or FFP2 standard, or equivalent; Gown; Gloves; Eye protection; Apron
	Cleaners	Entering the room of COVID-19 patients	Medical mask; Gown; Heavy duty gloves; Eye protection (if risk of splash from organic material or chemicals); Boots or closed work shoes
	Visitors	Entering the room of COVID-19 patients	Medical mask; Gown; Gloves
Other areas of patient transit (e.g. corridors).	All staff, including health care workers.	Any activity that does not involve contact with COVID-19 patients	No PPE required
Triage	Health care workers	Preliminary screening not involving direct contact.	Maintain spatial distance of at least 1 metre. No PPE required
	Patients with respiratory symptoms	Any	Maintain spatial distance of at least 1 metre. Provide medical mask if tolerated by patient
	Patients without respiratory symptoms	Any	No PPE required
Laboratory	Lab technician	Manipulation of respiratory samples	Medical mask; Gown; Gloves; Eye protection (if risk of splash)
Administrative areas	All staff, including health care workers.	Administrative tasks that do not involve contact with COVID-19 patients.	No PPE required
Outpatient facilities			
Consultation room	Health care workers	Physical examination of patient with respiratory symptom	Medical mask; Gown; Gloves; Eye protection
		Physical examination of patient without respiratory symptom	PPE according to standard precautions and risk assessment.
	Patients with respiratory symptoms	Any	Provide medical mask if tolerated.
	Patients without respiratory symptoms	Any	No PPE required
	Cleaners	After and between consultations with patients with respiratory symptoms.	Medical mask; Gown; Heavy duty gloves; Eye protection (if risk of splash from organic material or chemicals); Boots or closed work shoes

Setting	Target personnel or patients	Activity	Type of PPE or procedure
Waiting room	Patients with respiratory symptoms	Any	Provide medical mask if tolerated. Immediately move the patient to an isolation room or separate area away from others; if this is not feasible, ensure spatial distance of at least 1 metre from other patients.
	Patients without respiratory symptoms	Any	No PPE required
Triage	Health care workers	Preliminary screening not involving direct contact.	Maintain spatial distance of at least 1 metre. No PPE required
	Patients with respiratory symptoms	Any	Maintain spatial distance of at least 1 metre. Provide medical mask if tolerated.
	Patients without respiratory symptoms	Any	No PPE required
Points of entry			
Administrative areas	All staff	Any	No PPE required
Screening area	Staff	First screening (temperature measurement) not involving direct contact.	Maintain spatial distance of at least 1 metre. No PPE required
		Second screening (i.e. interviewing passengers with fever for clinical symptoms suggestive of COVID-19 disease and travel history)	Medical mask
	Cleaners	Cleaning the area where passengers with fever are being screened	Medical mask; Gown; Heavy duty gloves; Eye protection (if risk of splash from organic material or chemicals); Boots or closed work shoes
Temporary isolation area	Staff	Entering the isolation area, but not providing direct assistance	Maintain spatial distance of at least 1 metre; medical mask; gloves
	Staff, health care workers	Assisting passenger being transported to a health care facility	Medical mask; gown; gloves; eye protection
	Cleaners	Cleaning isolation area	Medical mask; Gown; Heavy duty gloves; Eye protection (if risk of splash from organic material or chemicals); Boots or closed work shoes

5.4.2 Waste Management

Natural disasters and conflicts, by their nature, are highly disruptive and dangerous events. Their consequences are unpredictable, and it is inevitable that many essential public services will be interrupted. HCFs, public health and municipal services, such as waste management, may totally or partially cease due to destroyed buildings, damaged equipment, dislocation of staff and blocked roads.

In such situations, all forms of wastes including hazardous HCW remains uncollected and untreated. It is inevitable that wastes will accumulate, and serious environment and health hazards (e.g. hepatitis B and C) may affect communities. Therefore, measures need to be taken to remove wastes as soon as possible after an emergency. The purpose is to reduce the proximity of people to accumulated wastes and so reduce the potential for disease transmission.

The purpose of HCWM in an emergency is to avoid wastes from being scattered indiscriminately around medical buildings and their grounds and reduce the likelihood of secondary infections. As a basic starting point and to avoid sharps injuries, HCW generated by emergency medical care activities (in tents, field hospitals, mobile hospitals) should be segregated using a “two-bin solution” that is, sorting waste into used sharps and non-sharps wastes (including general wastes and infectious, pathological and pharmaceutical residues). The two bins should be kept segregated until final disposal. Basic considerations in emergency response in HCWM:

- All non-sharps wastes, without exception, should be collected in medical areas in rigid containers, such as plastic buckets with a cover, to prevent waste items from being exposed to disease transmission by contact by hand, airborne particles and flying insects.
- Containers and covers should be washed and disinfected daily after being emptied.
- Reuse of rigid waste containers after disinfection with a chlorine (0.2%) solution may be the most practical option to introduce quickly in an emergency situation and is low cost at a time when resources for better forms of waste segregation and storage may be scarce.
- Sharps wastes should be stored safely in puncture-proof and leak-proof containers.
- Burial of non-sharps and sharps wastes in pits or trenches may be considered as a pragmatic option in emergency situations. Burning of HCW is less desirable, but if it is genuinely the only realistic option in an emergency it should be undertaken in a confined area (burning within a dugout pit, followed by covering with a layer of soil).

Hazards and Risks

Actual cases of non-sharps waste being demonstrated to cause an infection in health care personnel and waste workers are rarely documented. HCW handlers are at greatest risk from infectious hazards which include chemical exposures such as chemotherapeutic drugs, disinfectants and sterilants; physical hazards such as ionizing radiation; and ergonomic hazards.

Mitigation Measures

The following preventive measures can also be implemented during an emergency response phase to reduce public and occupational health risks:

- Provide hepatitis B vaccination to all health care personnel and waste handlers.
- Encourage hand hygiene (washing, preferably followed by disinfection).
- Use gloves for handling HCW.
- Raise the awareness of staff about simple post exposure prophylaxis in the event of an occupational injury (e.g., needle-stick injury).
- Contain and promptly clean up spillages of infectious materials and disinfect quickly to avoid pathogen transmission.
- Disinfect body fluids before their discharge.
- Conduct on-site awareness-raising activities (whenever possible) to remind health care personnel about occupational exposures and the safe practices for managing HCW.

Table: HCWM practice in emergencies

Segregation and packaging	<p>All containers and bags should be filled to three quarters of their capacities to avoid spillage and kept covered to prevent casual access by people or disease vectors.</p> <p>Should colour coding of plastic bags and containers not be possible, signs or marks can be put on containers to differentiate between hazardous health-care waste and general waste.</p> <p>Segregated waste should be regularly removed and safely stored to reduce the risk of transmission of pathogens and improve general standards of cleanliness and hygiene in medical areas.</p> <p>If plastic bags are not available, containers for non-sharps wastes should be washed and disinfected after being emptied.</p> <p>Body parts should be safely stored and disposed of according to local culture and customs.</p>
Collection	<p>Exclusively allocated carts or trolleys with lids should be used to collect and transport health-care waste. Carts should be regularly cleaned and disinfected.</p> <p>Highly infectious wastes (e.g. laboratory wastes and wastes from persons with contagious diseases) should be collected quickly and carried to a single, secure central storage area; on no account should collected waste be left anywhere other than at a central storage point.</p>
Storage	<p>Segregated waste should preferably be stored in specific restricted areas. The storage area should be a locked room or guarded enclosure.</p>

	<p>If this is not available, large containers with lids may be used for temporary storage of segregated waste and should be placed in restricted areas to minimize contact with people and animals.</p> <p>Mark the storage area with the biohazard symbol, or put a sign or mark that is understood locally to differentiate between hazardous and non-risk wastes.</p>
<p>Treatment and Disposal</p>	<p>Should resources not be available, minimal treatment and disposal practices should continue to be used as follows:</p> <ul style="list-style-type: none"> • onsite burial in pits or trenches; • disposal in special cells in municipal dumping sites; • burning in pits and then covering with soil; • incineration in low-cost double-chamber incinerators; • encapsulation of sharps waste or small quantities of pharmaceuticals followed by onsite burial or burial in special cells in municipal dumping sites; • incineration in high-temperature industrial incinerators (provided that there is a safe means of transportation); • disinfection of infectious and sharps wastes with a small autoclave (when resources are available); non-sharps disinfected wastes should join the general waste stream.

5.4.3 Labor Rights and Gender

Risks

The following potential risks need to be considered at each facility:

- Workers, in particular health personnel (especially nurses) and cleaners, 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;
- Women may in particular need to be provided with extra support if they are single heads of household and also have child-care duties;
- 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, may face mental issues or burnout as result of an outbreak; and
- Health workers, cleaners or workers involved in upgrades experiencing respiratory symptoms may fear not getting paid and continue to show up at work.

There is a minor risk of underage workers working as cleaners in medical facilities or transporting medical supplies or equipment. Labor law prohibits anyone under 18 years being involved in hazardous work.

Mitigation Measures

The following mitigation measures are applicable to labor rights and gender:

- All workers must be paid for overtime in accordance with Government labor laws;
- 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 staff with lower qualification or less experienced working in the health sector (e.g., cleaners, 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;
- 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 childcare 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;
- All workers 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);
- Child labor or indentured labor is absolutely prohibited in the project. All medical staff, cleaners, and all others handling equipment, tests, wastes, etc. or involved in the transportation of medical equipment and supplies related to the project must be over 18 years.

5.4.4 Community Health and Safety

Risks

Potential community health and safety risks associated with the sub-projects include:

- Transport of wastes, transport of lab tests, transport of people who have tested positive with COVID-19 and movement of health workers and other staff in contact with patients with COVID-19, has the potential to spread the virus in the community. (Note transport of medical supplies and equipment is not expected to result in virus transmission.);
- Health workers may face discrimination and harassment when going back to their communities due to people's fear in contracting the virus, frustrations over medical care or misinformation;
- Screening of people entering the country, in particular land borders with migrants coming back into Philippines, as well as checks and/or enforcement of any community movement restrictions or quarantine/lockdown or social restriction measures, could lead to abuse of power by law enforcement, fear from community members (especially the elderly), a potential for discrimination of marginalized groups, GBV, Sexual Exploitation and Abuse (SEA) and/or VAC;

Mitigation Measures

The following community health and safety measures are proposed:

- transport of all COVID-19 wastes and lab tests, blood samples, etc., should be collected safely in designated containers and bags, treated and then safely disposed;
- 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 biosafety measures and WHO guidelines on Laboratory testing for coronavirus disease 2019 (COVID-19) in suspected human cases;
- transport of medical equipment/supplies is not expected to be a vector in transmitting the virus, however, workers transporting materials should be reminded to wash hands appropriately and to avoid touching their face;
- training must be provided to medical and other staff (doctors, nurses, cleaners, lab technicians, etc.) in contact with patients with COVID-19 and/or their wastes, clothes, linen or tests, on disinfection procedures when going back to their homes/communities. In extreme cases, this may involve isolating medical and other personnel involved with COVID-19 patients.
- any medical or other hospital staff (including cleaners) experiencing symptoms of COVID-19 or a respiratory illness (fever + cold or cough) must remain at home/isolated and report symptoms immediately to supervisors.
- 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 other staff are taking to protect themselves against the virus and their use of PPE.
- ensure widespread engagement with communities in order to disseminate information related to community health and safety, particularly around social distancing, hand washing, high-risk demographics, self-quarantine, and mandatory quarantine.
- law enforcement personnel must adhere to Code of Conduct (CoC), including fair treatment and non-discrimination when carrying out their duties. Key points in CoC must be publicly available as part of disclosure and law enforcement personnel must be made aware and trained in key items (especially non-discrimination, OHS and issues relating to GBV).

5.4.5 Social Exclusion

Risks

The following potential risks of social exclusion should be considered for each sub-project:

- 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.
- Limited access to COVID-19 testing and other public health services, especially in rural areas.

- Restrictions on travel, general movement, etc. have the potential to enhance negative impacts to the vulnerable groups, who may have lower incomes, lack social support, lose jobs, have childcare duties, and may also be the most vulnerable to contracting COVID-19.
- Communication materials may not reach the most vulnerable, in particular 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 have lower literacy.

Mitigation Measures

The following mitigation measures should be considered for social exclusion impacts:

- planning of quarantine measures and social distancing 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);
- communication materials must be clear and concise and 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). This may require different media (social media, radio, tv) plus engaging existing formal and informal public health and community-based networks (schools, healthcare service providers at local level, etc).
- Communication materials must also be clear about (i) how to avoid contracting COVID-19 (good hygiene measures); (ii) symptoms of COVID-19; (iii) what to do if suspect have COVID-19.
- Workplaces should be encouraged to post and provide communication materials, in particular workplaces which may face a higher risk of COVID-19 spread, such as construction sites and factories.
- 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 IPs, marginalized groups, those with disabilities, other vulnerable groups and the elderly.
- 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 traditional healers) that can help to disseminate messages.
- Stakeholder Engagement Plan (SEP) should ensure consultations with NGOs and other stakeholders that can provide recommendations on how to communicate information.
- Information dissemination should 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.

5.4.6 Gender-Based Violence (GBV) and/or Violence Against Children (VAC)

Risks

GBV and VAC risks may include the following:

- Quarantine measures, together with fears over COVID-19, livelihood impacts as a result of any restrictions in movement, social isolation and increased economic pressures and loss of jobs

(informal or formal sector) may exacerbate household tensions and lead to an increase in GBV and VAC.

- School closures mean children are at home and this could increase risk of VAC and GBV, in particular if family members are stressed, drinking or violent. Young females may be in particular risk.
- Project staff (civil servants and outsourced staff/contractors) may be involved in misconduct behaviours impacting women and children at local level.

Mitigation Measures

The following measures should be considered in mitigating GBV and VAC risks:

- Communication materials should include advice to cope with psychological aspects of the COVID-19 pandemic, including loss of jobs and quarantine measures. For instance, there should be information on how to cope with stress and anxiety, recommendations on how to talk to children, etc. Information materials should provide links to resources/organizations that can provide support.
- Ensure that GBV-resolution mechanisms and GBV and other mental health services continue to be well resourced as there may be increased demand for their services. NGOs or other organizations working on GBV or mental health may need to be supported to increase their services (or, for instance, enhancing support to a hotline to report cases or to women's shelters).
- Apply the WHO Code of Ethics and Professional Conduct -Code of Conduct (CoC) for all workers in the quarantine facilities as well as the provision of gender-sensitive infrastructure, such as segregated toilets and enough light in quarantine and isolation centers.
- Codes of Conduct (CoC) included in the letter of PIU's staff appointment and contracts (for contracted workers) in line with relevant national laws and legislations and the project's Labor Management Procedures (LMP).
- Training on community interaction and GBV/VAC to be provided for all teams, staff (civil servants and outsourced staff/contractors) to ensure the teams respect local communities and their culture and not engage in misconduct.

5.4.7 Social Stigma

Risks

Social stigma could be precipitated by COVID-19 both to and from sufferers as follows:

- 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".

Mitigation Measures

Mitigation of social stigma should include the following measures:

- 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”.
- Ensure accurate information about the virus is widely disseminated, and that there is also a focus on people who have recovered.
- 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.
- 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.

6 Procedures to Address Environmental and Social Issues

6.1 Screening Process

Annex C comprises a screening form that should be used by the Project Implementation Unit (PIU) in DoH to screen for the potential environmental and social risks and impacts of specific sub-projects. Screening will allow the PIU to identify the relevant Environmental and Social Standards (ESS), establish an appropriate environmental and social risk rating for each subproject and specify the type of environmental and social risk management measures required, including specific instruments, if needed.

6.2 Environmental and Social Management Plans

For sub-projects involving civil works or construction activities an Environmental and Social Management Plan (ESMP) will be required. The ESMP shall be site-specific, and proportionate and relevant to the hazards and risks associated with the particular sub-project. For example, activities such as establishment of isolation tents and first line decontamination facilities are simple construction activities and the ESMP may just comprise a Labor Management Plan (LMP). Establishment of quarantine facilities involving new building construction will require a more comprehensive ESMP.

An ESMP will comprise a simple matrix in the format shown on the following page. When designing mitigation measures the ESMP should draw on the Environmental Codes of Practice (ECOP) included in Annex D and relevant, up-to-date guidance from WHO and DOH on COVID-19 specific advice.

The site specific ESMP will include (as attachments): ECOPs, ICWMP, SEP, and LMP. For each identified environmental and social risk, the format shows (1) proposed risk mitigation measures, including measures to be implemented by the construction contractor; (2) responsibility for each risk mitigation measure, (3) Timeline (e.g. pre-construction, during construction, etc.); and (4) Budget. For mitigation measures that are the responsibility of the construction contractor, the supervising engineer will verify that measure have been properly implemented. Implementation of E&S risk mitigation measures will be reported and will be a condition for approval of payments.

ENVIRONMENTAL AND SOCIAL MANAGEMENT PLAN TEMPLATE

I. Subproject Information

Subproject Name	
Subproject Location	
Subproject Proponent	
Estimated Investment	
Start/Completion Date	

II. Site/Location Description

Concisely describes the proposed location and its geographic, ecological, social and temporal context including any offsite investments that may be required (e.g. access roads, water supply, etc.). Normally includes a map showing the location and project areas of influence.

III. ESMP Matrix

Potential E&S Risks and Impacts	Proposed Risk Mitigation Measures	Responsibility	Timeline	Budget

IV. Attachments

ECOPs, ICWMP, SEP, and LMP

V. Review & Approval

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

6.3 Health-care Waste Management

The project will engage a consultant to provide technical assistance and capacity building to DOH on health-care waste management. HCWM is well-regulated in the Philippines through the *Manual on Health Care Waste Management* (November 2019); however, capacity gaps in implementation are widespread.

The technical assistance program will involve provision of real-time capacity building support to DOH on immediate priorities for safely managing COVID-19 HCW. Initially, a pilot is proposed for a small number of facilities to establish a compliance baseline. Using this baseline a video training package will be developed for distribution across all health-care facilities. Annex E contains an Infection Control and Waste Management Plan (ICWMP) template which can be used as a checklist during the capacity

building exercise and cross-referenced with the DOH Manual to determine any gaps or opportunities for improvement.

6.4 Indigenous Peoples

Despite the strong rights provided by the IPRA and the historic recognition of indigenous peoples in the Philippines, conflicts over their identities and access to land and natural resources continue. And despite being relatively well organized, including the existence of numerous local and national indigenous peoples' organizations, they still face social and political marginalization. They are among the poorest population groups in the Philippines, fare worse in terms of health and education indicators and are affected by civil conflicts (e.g. in Mindanao).

Given these vulnerabilities, the COVID-19 pandemic poses particular risks to indigenous peoples. The United Nations' Department of Economic and Social Affairs has noted that indigenous peoples often "experience poor access to healthcare, higher rates of communicable and non-communicable diseases, lack of access to essential services, sanitation, and other key preventive measures, such as clean water, soap, disinfectant, etc. Likewise, most nearby local medical facilities, if and when there are any, are often under-equipped and under-staffed. Even when indigenous peoples are able to access healthcare services, they can face stigma and discrimination. A key factor is to ensure these services and facilities are provided in indigenous languages, and as appropriate to the specific situation." It is also noted, that indigenous peoples' traditional lifestyles are a source of their resilience, but can also pose a threat to spreading of the virus; e.g. through traditional gatherings to mark special events and living in multi-generational housing. Many communities in relative isolation and remote areas may be less exposed to the virus, but if it does reach such communities the risks would be heightened due to their lack of access to adequate health and social services and effective monitoring and early-warning systems.

Indigenous peoples may also be particularly vulnerable in relation to project-financed construction and operation of health facilities (screening, quarantine and treatment) in their communities. However, it is expected that most such health facilities would be in urban areas and not directly within indigenous communities, although they may provide health services to near-by IPs. Moreover, most new facilities are expected to be within existing premises of health facilities or government premises.

It has been found that providing health care to indigenous peoples can be more effective when integrating Western medicine with traditional knowledge, systems, and practices of healing, which may include herbal medicines, acupressure, acupuncture, and *hilot*, an ancient Filipino art of healing derived from shamanic traditions that uses different techniques of manipulation and massage to achieve the treatment outcome. A study of health perceptions and practices of the *Lumads* of Mindanao finds that they recognize the benefits of Western medicine provided through the government's health services. However, they continue to combine such health care with their indigenous health and treatment beliefs, practices and rituals provided by the *bayian* or traditional healer when confronted with health problems. The active participation of IPs, their organizations and health practitioners, is critical in providing efficient and culturally appropriate health services in indigenous communities. Such an approach is recognized by DoH in the "Guidelines on the Delivery of Basic Health Services for Indigenous Peoples/Indigenous Cultural Communities" or Joint Memorandum Circular No. 2013-01 agreed to between DOH, NCIP, the Department of Interior and Local Government (DILG) on April 19, 2013, which will guide the project's approach to supporting health services in areas with indigenous peoples.

The project will not develop a stand-alone indigenous peoples instrument (e.g. an Indigenous Peoples Plan). Instead the requirements of ESS7 will be addressed through a targeted engagement strategy, included in the Project's and sub-project's Stakeholder Engagement Plan. This is appropriate given the project activities to support hospitals and local health facilities to combat Covid-19, through procuring equipment and PPEs for health workers and enhancing testing, quarantine and treatment capabilities. It is consistent with ESS7's emphasis on developing plans that are proportionate to the potential risks and impacts of the project (paragraphs 13 and 17). No civil works outside of existing health premises are expected to be financed by the project and no activities that would require any land acquisition will be financed. Therefore, no circumstances requiring free, prior and informed consent under ESS7 are present in project activities.

Stakeholder engagement and public consultations with representatives of indigenous peoples and their organizations are provided for in the SEP. These organizations and representatives will be consulted during project implementation. The NCIP at national, regional and local levels will also be consulted, particular for any project activities taking place within the ancestral domain of indigenous communities, and indigenous peoples in areas of site-specific project activities will be engaged and consulted consistent with the IPRA, the Joint Memorandum Circular No. 2013-01 and ESS7. It is noted that overall awareness raising concerning Covid-19 is not included in the World Bank-financed project.

For site-specific project support to regional and local health facilities in areas with indigenous communities DoH and local partners (e.g. LGUs) will consult with indigenous peoples, their representatives and NCIP; local NGOs or CSOs may also be consulted.

Project activities in areas with indigenous communities will be informed by the Joint Memorandum Circular, which provides guidelines around five key principles for delivering health services to indigenous peoples:

1) *Making basic health services available and culture-sensitive.*

'Culture-sensitive' health care, means policymakers and health workers acknowledge and respect cultural diversity among the populace since this effects values, learning, behaviour, health practices and outcomes. Health care providers will recognize existing beliefs and practices to the extent that these are not a hindrance to effective measures against the Covid-19 pandemic, and 'culture-sensitive' orientation and training to health workers, managers and other stakeholders is provided as appropriate.

Indigenous health care practitioners in communities should be informed about Covid-19 symptoms and local outbreaks, and should be involved in engagements with indigenous communities and patients, as appropriate (indigenous practitioners are likely to be the first point of contact for indigenous peoples seeking medical services).

2) *Providing equitable distribution of needed health resources.*

At project-supported health facilities in areas with indigenous peoples, they and their support organizations will be informed of the services provided and efforts will be made to ensure the indigenous peoples affected by Covid-19 will receive the same treatment as non-indigenous patients.

Indigenous health care providers/staff at DoH and LGU facilities, when available, are provided with the same resources, including PPEs and information about Covid-19. These may also be provided to indigenous health practitioners.

3) *Ensuring non-discrimination of ICCs/IPs in the delivery of health services.*

'Culture-sensitive' orientation and training to health workers, managers and other stakeholders is provided as appropriate.

Indigenous health care providers at DoH and LGU facilities, when available, and indigenous health practitioners are involved in providing health care services to indigenous communities and patients, as appropriate.

4) *Managing geographical, financial and socio-cultural barriers so that IPs can access basic health services.*

As the project is financing emergency responses to Covid-19 this principle is not applicable. However, once the emergency subsides additional measures to enhance IPs' access to health services may be considered.

5) *Strengthening recognition, promotion, and respect of safe and beneficial traditional health practices.*

Efforts to hire indigenous health care workers should be made to the extent possible. Existing indigenous health care workers at DoH and LGU facilities will be involved in providing services to indigenous communities. An IP health care worker or an IP-oriented health care worker at health facilities should be designated to care for, or oversee care for, indigenous patients. Indigenous health practitioners are involved in providing health care services to indigenous communities and patients, as appropriate.

Measures to enhance benefits and avoid adverse impacts will be developed in consultation with representatives of the indigenous peoples as appropriate in the local context and in a manner proportional to the project activities' risks and potential impacts or benefits. Physical distancing and other Covid-19 restrictions will be respected.

7 Consultation and Disclosure

SUMMARY OF CONSULTATIONS ON THE ESMF AND SEP TO BE FINALIZED AFTER CONSULTATIONS

The ESMF is prepared together with the Project's SEP and Environmental and Social Commitment Plan (ESCP). The ESCP and the first draft of the SEP were disclosed on April 20, 2020 through the website of DOH: www.doh.gov.ph. They were disclosed on April 8, 2020 at the World Bank's external website ([www. http://documents.worldbank.org/curated/en/home](http://documents.worldbank.org/curated/en/home)). The draft ESMF was disclosed on DoH website on **XXX**, 2020 and will be disclosed at the World Bank's website.

Consultations with affected and interested stakeholder on the three documents were conducted in the period... Due to the physical distancing restrictions, the engagement process was conducted virtually through the following tools....:

Key feedback received include....

The SEP provides further details on the consultations on the draft documents and the plan for continued stakeholder engagement during project implementation.

8 Stakeholder Engagement

The Stakeholder Engagement Plan (SEP) has been developed to ensure that stakeholders are informed about project risks and mitigation measures, information is disclosed properly, communities and local government units are engaged, and social preparation for areas that will host isolation and quarantine facilities will be conducted. The SEP will be implemented in a way that takes into consideration specific circumstances for indigenous peoples, other vulnerable groups, and the locality's ways of information dissemination and conducting consultations while communities or households may be in quarantine or physical distancing restrictions. The SEP includes a grievance redress mechanism by which people can raise concerns, provide feedback, or make complaints about project related activities.

8.1 Vulnerable Groups

Women, the elderly, adolescents, youth, and children, persons with disabilities, indigenous populations, refugees, migrants, and minorities experience the highest degree of socio-economic marginalization. Marginalized people become even more vulnerable in emergencies. This is due to factors such as their lack of access to effective surveillance and early-warning systems, and health services. The COVID-19 outbreak is predicted to have significant impacts on various sectors.

The populations most at risk are those that:

- depend heavily on the informal economy;
- occupy areas prone to shocks;
- have inadequate access to social services or political influence;
- have limited capacities and opportunities to cope and adapt; and
- limited or no access to technologies.

By understanding these issues, we can support the capacity of vulnerable populations in emergencies. We can give them priority assistance, and engage them in decision-making processes for response, recovery, preparedness, and risk reduction.

Previous epidemics illustrate the value of engaging with women when communicating about risks:

- Women are a disproportionate part of the health workforce;
- As primary caregivers to children, the elderly, and the ill, we must recognize and engage women in risk communication and community engagement;
- When we don't recognize gendered dynamics during outbreaks, we limit the effectiveness of risk communication efforts;
- Women's access to information on outbreaks and available services are severely constrained when community engagement teams are dominated by men; and
- Tailoring community engagement interventions for gender, language, and local culture improves communities' uptake with interventions.

9 Project Implementation Arrangements, Responsibilities and Capacity Building

9.1 Implementation Arrangements

Department of Health (DOH) will be the implementing agency for the Project. The DOH has appointed a Project Director (Undersecretary level), and a Project Manager (Director level). The Project Director and Project Manager will be acting through DOH's technical departments and national programs, as well as the regional health units, LGUs, referral hospitals, and health centers. Within the DOH, the Project will be implemented through the Bureau of International Health Cooperation (BIHC), Health Facility Enhancement Program Management Office (HFEPMO), Disease Prevention and Control Bureau (DPCB), Health Emergency Management Bureau (HEMB), Procurement Service (PS), Finance Management Service (FMS), and relevant units, with BIHC as the main project focal point. The project implementation will use mainstream DOH processes and will not involve a parallel project implementation unit or secretariat. However, the DOH has assigned officials who will be in charge of project implementation. The project will have a provision to strengthen DOH units' capacity and skills through additional consultants or advisors. Additional consultants or advisors will be recruited with an aim to strengthen the overall fiduciary, ESF functions as well as to support implementation of project activities. DOH will also ensure effective implementation at the sub-national levels and close coordination with relevant LGUs.

The guiding documents for the Project will be an updated Project Operational Manual, including standard project fiduciary, environmental and social risk management (a summary of the ESMF and SEP provisions and arrangements, including for GRM), implementation, and M&E requirements, as well as relevant official documents to be developed. In addition, Annual Work Plan and Budget (AWPB) will be submitted for no-objection to the World Bank no later than October 30 of each year, detailing the project work program and budget for each government fiscal year and specifying the allocation and sources of funding for all project components.

While the DOH had limited experiences working on Bank operations in recent years, lessons learned from previous projects could guide DOH to avoid past challenges in future projects. The last two health projects in the Philippines were National Sector Support for Health Reform (2006-2012) and Women's Health and Safe Motherhood Project (2005-2013). The support from the first project led to an increase in the coverage of PhilHealth, from 13.6 million poor receiving subsidized coverage in 2007 to 31.4 million in 2013. This, in turn, contributed to the increased use of health services by the poor. The second project led to a large increase in the number of facility-based deliveries. However, there were key implementation challenges faced by both projects, including slow implementation by DOH, delays in delivery of key reports, limited support to LGUs. The implementation of the second project was so slow that only 18 percent of funds were disbursed in the first five years of the project. At project closing, 35 percent of project funds were not used and had to be cancelled. These provide important lessons learned for DOH to avoid similar challenges in future projects.

DoH does not have recent experience or dedicated capacity implementing World Bank financed projects and is not familiar with the Bank's safeguards or Environmental and Social Framework (ESF)

requirements. It is, however, familiar with the Philippines' relatively well-developed regulatory framework for environmental and social management as it pertains to the health sector.

In 2005, DOH has instituted a number of policies and guidelines on healthcare waste management (HCWM) including the DENR-DOH Joint Administrative Order No. 02-2005 entitled Policies and Guidelines on Effective and Proper Handling, Collection, Transport, Treatment, Storage and Disposal of Healthcare Waste. The implementation and enforcement of relevant rules and regulations are still lacking in practice. DAO 2013-22 provides for its Procedural Manual Healthcare Wastes Management Manual and serves as a guidebook for the healthcare workers and other professionals involved in the health sector. It provides options for a safe, efficient, environment-friendly waste management options.

However, assessment is needed to evaluate the existing health care waste management system in the facilities that will be covered by the project to ensure that it will be able to handle the anticipated increase in HCW load, fulfills international standards, and to propose mitigating measures if found otherwise in the project's environmental and social risk management instruments.

DoH has a designate team of DOH's civil service officials, led by a project director and project manager, and with one Environmental and one Social Risk Management Focal Points to coordinate ESF implementation. DoH designated the Focal Points already during project preparation.

The implementation of ESF instruments will be supported and monitored by World Bank staff throughout project implementation to assist the implementing agencies to undertake the planned environmental and social risk management measures, including stakeholder engagement and preparation of required management plans to be applied under the Project and provide training to the assigned staff.

9.2 Capacity Building

The Philippines, together with almost all countries, has capacity issues in responding to the unprecedented COVID-19 pandemic including infection control, testing and laboratory analysis, establishment and operation of quarantine and isolation facilities and waste management. Additionally, the citizen and stakeholder engagement process is continually evolving in response to the unpredictable disease outbreak. The Project will provide funding, training and capacity building to support these critical initiatives, building on international expertise to achieve international best practices in line with WHO guidelines as follows:

- supporting DOH in preparing a guidance note on standard design for hospital isolation and treatment centers to manage Severe Acute Respiratory Infections (SARI) patients;
- training on use of medical and laboratory equipment, devices, and testing kits for health providers and technicians; and supporting the necessary logistics arrangements to deploy goods and equipment to health facilities without delay;
- training on the appropriate use of PPE, guided by the WHO (2020) interim guidance *Rational use of personal protective equipment (PPE) for coronavirus disease (COVID-19)*, 19 March 2020;
- capacity building for laboratory staff and technicians on COVID-19 testing;

9.3 Estimated Budget

The costs of implementing the ESMF relate to activities and costs beyond the costs of the dedicated E&S personnel involved in various measures and actions of the ESMF. The main costs of implementing this ESMF relate to (i) training and workshops, (ii) development of E&S due diligence as well as measures and other tools, (iii) information and communication, and (iv) supervision, monitoring, and reporting. A budget estimate for these costs is provided in Table 3.

Table 3 ESMF Implementation Costs

ESMF Activities	Description of Activities	Estimated Cost (USD)
Training and capacity building	Training on good practice environmental and social management at national, provincial and local government level.	150,000
Development of E&S Due Diligence,	Recruitment of consultants for preparation/adaption of ECOPs, ESMPs, etc.	120,000
Information and Communication	Production and dissemination of communication materials targeting vulnerable groups and indigenous peoples	50,000
Supervision, monitoring, and reporting	Travel to provinces for training and conducting monitoring and reporting	60,000
TOTAL		\$380,000

ANNEXES

A. Abbreviations and Acronyms

COVID-19	Coronavirus Disease 2019
CERC	Contingent Emergency Response Component
DBF	Department of Budget and Finance
DA	Designated Account
EOC	Emergency Operation Center
ESMF	Environmental and Social Management Framework
EVD-WA	West African Ebola Virus Disease
FMM	Financial Management Manual
FM	Financial Management
GRS	Grievance Redress Service
H-EQIP	Health Equity and Quality Improvement Project
IDA	International Development Association
IBRD	International Bank for Reconstruction and Development
IHR	International Health Regulations
IPF	Investment Project Financing
IMF	International Monetary Fund
JEE	Joint External Evaluation
M&E	Monitoring and Evaluation
DOH	Department of Health
PDO	Project Development Objective
PPSD	Project Procurement Strategy for Development
SEP	Stakeholder Engagement Plan
SOP	Standard Operational Procedures
SPRP	Strategic Preparedness and Response Program
STEP	Systematic tracking of Exchanges in Procurement
UNICEF	United Nations Children's Fund
WBG	World Bank Group
WHO	World Health Organization

B. Labor Management Procedures

Under ESS2 on Labor and Working Conditions, Borrowers are required to develop labor management procedures (LMP). The purpose of the LMP is to facilitate planning and implementation of the project. The LMP identify the main labor requirements and risks associated with the project, and help the Borrower to determine the resources necessary to address project labor issues. The LMP is a living document, which is initiated early in project preparation, and is reviewed and updated throughout development and implementation of the project.

B.1 Labor and Working Conditions

Labor Use

The Project will employ about a hundred contracted workers to refurbish existing or construct new quarantine facilities or isolation rooms in various parts of the Philippines. The Project will benefit thousands of health workers including medical technicians mostly in major cities in the country including Baguio City, Cebu, Metro Manila, and Surigao City. Waste management personnel who are expected to be part of the labor force of health facilities will also benefit from the protection and safety equipment to be provided by the Project.

Security personnel in hospitals are usually contracted out. Civil servants of the Department of Health and local government units will be involved as part of the project implementation team. Community workers will not be employed.

Characteristics of Project Workers

The minimum legal working age in the Philippines is 18 years old. All workers must meet this requirement. Contracted workers will most likely be male. Health workers will most likely be female. Health workers will consist of medical professionals directly employed by the health facilities as organic staff or contracted on a temporary basis. There may also be some volunteers.

A small number of civil servants from the Department of Health at the national and local levels and LGUs will be involved in project implementation. Construction workers will be hired in time for the refurbishment or construction of the isolation facilities.

Health workers are expected to already be working in the hospitals and laboratories. Provision of laboratory equipment may entail the need to hire additional technicians. Contracted workers are expected only for the construction of quarantine facilities which will not constitute major civil works. These will most likely be small, temporary buildings scattered in various areas of the country with local hospitals in partnership with LGUs in charge of procuring these small contracts.

Health workers will be at the forefront in the fight against Covid 19. As such, they are at the most risk of infection but with the provision of PPEs, reagents, and technology against the virus, they are also the main beneficiaries.

Civil servants from the Department of Health and LGUs will be involved in project management and are expected to abide by social distancing measures and proper hygiene as they carry out their tasks.

Waste management workers are expected to be part of the labor force of health facilities including the quarantine facilities to be constructed. Like the health workers, they are highly at risk and will benefit from the PPEs and other safety measures to be provided by the Project.

Security personnel including the military who will be involved in the Project are expected to receive the appropriate PPEs from the project. They will abide by a Code of Conduct and DoH will ensure that they are informed about the CoC and receive appropriate training, as needed.

Migrant workers are not expected to be involved.

B.2 Assessment of Potential Labor Risks

Health workers, waste management and security personnel will be more at risk of infection without the provision of PPE and the use of disinfectants that will be provided by the project. With physical mobility being restricted and given the nature of construction activities, labor influx is not expected. However, the movement of laborers from the worksite to the community may increase the risk of infection in both areas.

COVID-19 specific risks relate to the activities being carried out by the workers, in the context in which the project is being conducted. Potential risks could include workers mobilized from adjoining provinces or regions, or local workers returning from abroad, become vectors for transmission of COVID-19 to other workers in construction project sites and nearby communities.

These risks may be minimized and addressed through:

- conducting pre-employment health checks
- controlling entry and exit from site/workplace
- reviewing accommodation arrangements, to see if they are adequate and designed to reduce contact with the community
- reviewing contract durations, to reduce the frequency of workers entering/exiting the site
- rearranging work tasks or reducing numbers on the worksite to allow social/physical distancing, or rotating workers through a 24-hour schedule
- providing appropriate forms of personal protective equipment (PPE)
- putting in place alternatives to direct contact, like tele-medicine appointments and live stream of instructions.

Another example of potential risk is where the project activity is the treatment by health care workers of COVID-19 patients. In this case the risks could include pathogen exposure, infection and associated illness, death, illegal and untenable overtime, psychological distress, fatigue, occupational burnout, stigma and passing on infections to family and community.

B.3 Labor Legislation

Presidential Decree No. 44, as amended by RA 6715, known as the “Labor Code of the Philippines”, governs all employment practices and relations in the country. Provisions of the code are aligned with international good practice on decent work and shall be strictly implemented. These provisions include:

Wage and Welfare

1. Employees shall receive their wages by means of legal tender, at least once every two weeks or twice a month at intervals not exceeding sixteen (16) days.
2. In a contracted work, employees of the contractor and of the latter's subcontractor, shall also be paid in accordance with the labor code.
3. The wage paid by the employers to the workers shall not be lower than the prescribed minimum wage set by the Regional Tripartite Wages and Productivity Boards.

Working time, Rest Days and Holidays

1. The normal work hours for every employee shall not exceed eight (8) hours a day. If all or any part of the employee's working hours falls on 10:00 PM to 6:00 AM, he/she shall be entitled to a night shift pay in addition to the regular wage. If the worked performed exceeds the normal working hours, he/she shall be given overtime pay.
2. It is the right of every employee for a rest period not less than twenty-four (24) consecutive hours after every six (6) consecutive normal workdays.
3. Compensation shall be given for work performed during holidays and Sundays.

Equal Rights

1. Workers shall have the right to self-organization and to form, join, or assist labor organizations of their own choosing for purposes of collective bargaining.
2. Minimum employable age is 18 years old. Persons of age 15 to 18 can be employed given that they work in non-hazardous environment.
3. Gender discrimination in employment and labor relations shall be prohibited. Male and female employees are entitled to equal compensation for work of equal value and access to promotion and training opportunities.

Occupational Health and Safety

According to Chapter III of Republic Act No. 11058 (the OSH Law), the following are the duties of every employer, contractor or subcontractor, and any person who manages, controls or supervises the work:

1. Equip a place of employment for workers free from hazardous conditions that are causing or are likely to cause death, illness or physical harm to the workers
2. Provide complete job safety instructions and proper orientation to all workers including, but not limited to, those entering the job for the first time and to those relating to familiarization with their work environment
3. Inform the workers of the hazards associated with their work, health risks involved or to which they are exposed to, preventive measures to eliminate or minimize the risks, and steps to be taken in case of emergency
4. Use only approved specific industry set of standards of devices and equipment for the workplace as applicable
5. Comply with OSH standards including training, medical examination, and when necessary, provisions on protective and safety devices such as PPE and machine guards. Training for workers shall include health promotion, hazards associated with their work, health risks involved or to

which they are exposed to, preventive measures to eliminate or minimize risks, steps to be taken in case of emergency, and safety instructions for the jobs, activities and tasks to be handled by workers

6. Make arrangements for workers and their representatives to have the time and resource to participate actively in the processes of organizing, planning and implementation, monitoring, evaluation and action for improvement of the OSH management system
7. Provide, when necessary, for measures identifying trainings and drills, evacuation plans, etc., o deal with emergencies, fires and accidents including first-aid arrangements

To comply with the OSH standards, every employee/worker shall:

1. Participate in the capacity building activities on safety and health and other OSH related topics and programs
2. Proper use of all safeguards and safety devices furnished for workers' protection and that of others
3. Comply with instructions to prevent accidents or imminent danger situations in the workplace
4. Observe prescribed steps to be taken in cases of emergency including participation in the conduct of national or local disaster drills
5. Report to their immediate supervisor or any other responsible safety and health personnel any work hazard that may be discovered in the workplace

Employed citizens, employees shall have the following common rights:

1. To refuse to work without threat or reprisal from the employer if an imminent danger situation exists.
2. To report accidents, dangerous occurrences, and hazards to the employer, to DOLE, and to other concerned competent government agencies.
3. To receive personal protective equipment, to be provided by their employer, contractor or subcontractor, free of charge, for any part of the body that may be exposed to hazards, and other lifeline
4. To receive information on workplace conditions, risks that can impose danger to health, industrial dangerous and poisonous factors

The Occupational Safety and Health Standards, in compliance with Article 162 of the Labor Code of the Philippines, was formulated to protect every working man against the dangers of injury, sickness or death through safe and healthful working conditions. For this project, chapters discussing standards for personal protective equipment and devices, construction safety, and hazardous materials are necessary and should be complied.

DPWH Department Order 56 series of 2005: Guidelines for the Implementation of Department of Labor and Employment (DOLE) No.13 series of 1998, Guidelines in the Governing Occupational Safety and Health in the Construction Industry, it is expected that the contractors should follow the said guidelines to eliminate or reduce occupational safety and health hazards in all work places, and institute new, and update existing programs to ensure safe and healthful working conditions in all places of employment.

The following international conventions, and directives may also support measures for addressing health and safety issues relevant to COVID-19:

- ILO Occupational Safety and Health Convention, 1981 (No. 155)
- ILO Occupational Health Services Convention, 1985 (No. 161)
- ILO Safety and Health in Construction Convention, 1988 (No. 167)
- WHO International Health Regulations, 2005
- WHO Emergency Response Framework, 2017

B.4 Grievance Redress Mechanism

DOH Workers

Management of DOH personnel is governed by the Civil Service Commission which requires the establishment of a Grievance Redress Committee in charge of preventing and addressing grievances as stipulated in the following provisions:

- The Grievance Committee shall develop and implement pro-active measures or activities to prevent grievance such as employee assembly which shall be conducted at least once every quarter, “talakayan” counseling and other HRD interventions;
- Conduct continuing information drive on Grievance machinery among officials and employees in collaboration with the Personnel Administration Division;
- Conduct dialogue between and among the parties involved;
- Conduct investigation and hearing within ten (10) days from receipt of the grievance and render decision within five (5) working days after the investigation. Provided, however where the object of the grievance is the grievance committee, the aggrieved party may submit the grievance to top management;
- Direct the documentation of the grievance management process including the preparation and signing of written agreements reached by the parties involved;
- Issue Certification on the Final Action on the Grievance (CFAG) which shall contain, among other things, the information, history and final action taken by the agency on the grievance, and;
- Submit a quarterly report of its accomplishments and status of unresolved grievance to the Civil Service Commission Regional Office concerned.

Contractors

Contractors are expected to hire much of their laborers upon assuming the civil works contract. At the time of recruitment, workers will be informed of the grievance mechanism and the measures put in place to protect them against any reprisal for its use. The grievance mechanism shall be made easily accessible to all project workers. Regular meetings with the project workers to discuss any work-related issues and concerns will be conducted. Every grievance raised by a worker will be documented with the actions undertaken by the office to address such grievance. The aggrieved worker may raise any issue anonymously through a letter which shall be submitted to his/her immediate supervisor’s office. All non-anonymous grievances relative to adequate working conditions, standard occupational safety and health and other concerns from the workers shall be addressed following the procedures outlined below:

- The grievance shall be filed by the workers to the Contractor who shall follow the DOLE procedures in handling the complaints. The Contractor shall act within 15 days upon receipt thereof;
- If no understanding or amicable solution can be reached, or if the complainant does not receive a response from the Contractor within 15 days of registry of the complaint, he/she can appeal to the project grievance focal person within DOH, which should act on the complaint/grievance within 15 days from the day of its filing. If the PIU does not see itself fit to address the complaint it will immediately bring the matter to the concerned DOLE office.
- If the complainant is not satisfied with the resolution offered by the PIU, he/she can appeal to the concerned DOLE office, which should act on the complaint/grievance within 15 days from the day of its filing.

B.5 Considerations in Construction/Civil Works Projects

Responsibilities of the Project Proponent

1. The Project Proponent should request details in writing from the main Contractor of the measures being taken to address the risks. The construction contract should include health and safety requirements, and these can be used as the basis for identification of, and requirements to implement, COVID-19 specific measures. The measures may be presented as a contingency plan, as an extension of the existing project emergency and preparedness plan or as standalone procedures. The measures may be reflected in revisions to the project's health and safety manual.
2. The Project Proponent should require the Contractor to convene regular meetings with the project health and safety specialists and medical staff (and where appropriate the local health authorities), and to take their advice in designing and implementing the agreed measures.
3. Where possible, a senior person should be identified as a focal point to deal with COVID-19 issues. This can be a work supervisor or a health and safety specialist. This person can be responsible for coordinating preparation of the site and making sure that the measures taken are communicated to the workers, those entering the site and the local community. It is also advisable to designate at least one back-up person, in case the focal point becomes ill; that person should be aware of the arrangements that are in place.
4. On sites where there are a number of contractors and therefore (in effect) different work forces, the request should emphasize the importance of coordination and communication between the different parties. Where necessary, the Project Proponent should request the main contractor to put in place a protocol for regular meetings of the different contractors, requiring each to appoint a designated staff member (with back up) to attend such meetings. If meetings cannot be held in person, they should be conducted using whatever IT is available. The effectiveness of mitigation measures will depend on the weakest implementation, and therefore it is important that all contractors and sub-contractors understand the risks and the procedure to be followed.
5. The Project Proponent may provide support to projects in identifying appropriate mitigation measures, particularly where these will involve interface with local services, in particular health and emergency services. In many cases, the Project Proponent can play a valuable role in connecting project representatives with local Government agencies, and helping coordinate a

strategic response, which takes into account the availability of resources. To be most effective, projects should consult and coordinate with relevant Government agencies and other projects in the vicinity.

6. Workers should be encouraged to use the existing project grievance mechanism to report concerns relating to COVID-19, preparations being made by the project to address COVID-19 related issues, how procedures are being implemented, and concerns about the health of their co-workers and other staff.
7. The head of the concerned Implementing Office (IO) shall issue construction quarantine pass (QP) to the individual qualified personnel of the concessionaires, contractors, subcontractors, and suppliers, clearly stating the identification, designation, nature of work, validity and destination. It is understood that the QP shall cover transit of personnel from (a) GCQ area to ECQ area, and vice versa and (b) an area not under community quarantine to a GCQ or ECQ area, and vice versa.

Responsibilities of the Contractor

Prior to Deployment

1. Only persons from Twenty-One (21) to Fifty-Nine (59) years of age, without pre-existing health conditions, such as, but not limited to, immunodeficiency, comorbidities, or other health risks, including any person who resides with the aforementioned; and who did not come into contact with someone with COVID-19 shall be allowed to be included in the workforce. Employees or consultants who are 60 years of age or above may be part of the workforce for construction projects as may be allowed under GCQ and ECQ guidelines under Omnibus Guidelines on the Implementation of Community Quarantine in the Philippines (“OG”) dated 29 April 2020.
2. Construction personnel shall be required to undergo any available COVID-19 test, as may be prescribed by DOH, and retested as the need arises. In this regard, consultation with medical doctors (duly accredited by DOH, if possible) prior to the conduct of COVID-19 test shall be made.
3. The concessionaires, contractors, subcontractors, and suppliers shall provide for their personnel/workers the necessary welfare facilities and amenities, such as employees’ quarters for board and lodging, ensuring compliance to social distancing, proper hygiene, etc. Contractors shall submit the design for the said welfare facilities and amenities, for monitoring, to the District Engineering Offices or Regional Offices.
4. Contractors shall ensure that their projects are in compliance with DOLE D.O. NO. 13 series of 1998. Contractors shall provide their personnel and workers continuous supply of vitamins, particularly vitamin C, other over-the-counter medicines, quarantine facilities, and oxygen tanks for emergency purposes.
5. Contractors shall provide disinfection facilities in their respective project sites in compliance with pertinent DOH and IATF Guidelines, to be placed at strategic locations to ensure the safety and welfare of all personnel.
6. Proper information dissemination regarding COVID-19 construction protocols on top of existing construction safety practices shall be conducted by Safety Officers to all personnel.

7. For Government construction projects, personal records of all personnel necessary for contact tracing shall be submitted by the concessionaires, contractors, subcontractors, and suppliers to the DPWH IO and shall be resubmitted and updated monthly, or as the need arises.

During Deployment

1. Conduct an inventory of works for the construction sequencing to be followed and undertaken to uphold the required social distancing. Break times shall be conducted in a staggered manner.
2. Employees shall be housed in their respective quarters for the entire duration of the project covered by the ECQ and GCQ. Otherwise, "Prior to Deployment" procedures shall be conducted at every instance of re-entry.
3. Errands to be conducted outside the construction site premises shall be kept to a minimum. Number of personnel running errands shall be limited and shall be properly disinfected and closely monitored for symptoms within fourteen (14) days upon re-entry.
4. Field offices, employees' quarters, and other common areas shall be regularly maintained including the daily disinfection of such facilities.
5. Adequate food, safe/potable drinking water, disinfectants, and hand soaps shall be made available by the concessionaires, contractors, subcontractors, and suppliers to its in – house personnel.
6. Daily monitoring of the pre and post work health conditions of workers shall be undertaken by the concessionaires, contractors, subcontractors, and suppliers including, but not limited to, temperature, health, and exposure monitoring, as preventive measures. Personnel with manifestations or symptoms relative to COVID-19 shall be immediately isolated and quarantined for fourteen (14) days and if necessary, brought to the nearest DOH COVID-19 treatment facility under strict confidentiality and privacy. Proper protocols in accordance with the DTI and DOLE Interim Guidelines on Work Place Prevention and Control of COVID-19 shall likewise be strictly observed. For Government construction projects, a daily health monitoring report to be prepared by the Safety Officer shall be submitted to the DPWH IO.
7. Work activities shall be under daily strict monitoring by the Safety Officer at site to ensure compliance to safety standards and quarantine protocols.
8. For government construction projects, the DPWH Engineers assigned at the site shall ensure strict compliance to DOLE D.O. 13, series of 1998, and implementation of wearing additional Personal Protective Equipment (PPE) required such as, but not limited to, face masks, safety glasses/goggles, face shields, and long sleeve T-shirts, to contain the spread of COVID-19 in the workplace. On the other hand, contractors for essential private construction projects under GCQ shall assign a full time safety officer devoted to ensure compliance with D.O. 13, series of 1998 and implementation of social distancing measures provided herein.
9. For off-site employees' quarters, transport service, duly disinfected before and after use, shall be provided, with social distancing observed.

10. Sharing of construction and office equipment is discouraged. However, if necessary, the shared equipment must be disinfected in between transfers amongst personnel.
11. All material and equipment delivery and disposal shall be conducted by a specific team of personnel on an isolated loading/unloading zone while limiting contact with the delivery/disposal personnel. All material and/or equipment entering the construction site shall be duly disinfected, as possible.
12. Non-essential personnel, visitors, and the general public shall be restricted to enter the construction site, employees' quarters, and field offices. Otherwise, all personnel entering the construction site premises on a temporary basis (e.g. Delivery truck drivers, inspectors, etc.) shall be properly logged and checked for symptoms. Gatherings, Liquors, and/or merry – making are strictly prohibited within the construction site premises.
13. Proper waste disposal shall be provided for infectious waste such as PPEs and other waste products coming from outside the construction premises.
14. Requirements on general hygiene should be communicated and monitored, to include:
 - Training workers and staff on site on the signs and symptoms of COVID-19, how it is spread, how to protect themselves (including regular handwashing and social distancing) and what to do if they or other people have symptoms.
 - Placing posters and signs around the site, with images and text in local languages.
 - Ensuring handwashing facilities supplied with soap, disposable paper towels and closed waste bins exist at key places throughout site, including at entrances/exits to work areas; where there is a toilet, canteen or food distribution, or provision of drinking water; in worker accommodation; at waste stations; at stores; and in common spaces. Where handwashing facilities do not exist or are not adequate, arrangements should be made to set them up. Alcohol based sanitizer (if available, 60-95% alcohol) can also be used.
 - Setting aside part of worker accommodation for precautionary self-quarantine as well as more formal isolation of staff who may be infected.
 - Conducting regular and thorough cleaning of all site facilities, including offices, accommodation, canteens, common spaces. Review cleaning protocols for key construction equipment (particularly if it is being operated by different workers).
 - Providing cleaning staff with adequate cleaning equipment, materials and disinfectant.
 - Reviewing general cleaning systems, training cleaning staff on appropriate cleaning procedures and appropriate frequency in high use or high-risk areas.
 - Where it is anticipated that cleaners will be required to clean areas that have been or are suspected to have been contaminated with COVID-19, providing them with appropriate PPE:

gowns or aprons, gloves, eye protection (masks, goggles or face screens) and boots or closed work shoes. If appropriate PPE is not available, cleaners should be provided with best available alternatives.

- Training cleaners in proper hygiene (including handwashing) prior to, during and after conducting cleaning activities; how to safely use PPE (where required); in waste control (including for used PPE and cleaning materials).
- Any medical waste produced during the care of ill workers should be collected safely in designated containers or bags and treated and disposed of following relevant requirements (e.g., national, WHO). If open burning and incineration of medical wastes is necessary, this should be for as limited a duration as possible. Waste should be reduced and segregated, so that only the smallest amount of waste is incinerated.

15. Consider whether existing project medical services are adequate, taking into account existing infrastructure (size of clinic/medical post, number of beds, isolation facilities), medical staff, equipment and supplies, procedures and training. Where these are not adequate, consider upgrading services where possible, including:

- Training medical staff, which should include current WHO advice on COVID-19 and recommendations on the specifics of COVID-19. Where COVID-19 infection is suspected, medical providers on site should follow WHO interim guidance on infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected.
- Assessing the current stock of equipment, supplies and medicines on site, and obtaining additional stock, where required and possible. This could include medical PPE, such as gowns, aprons, medical masks, gloves, and eye protection. Refer to WHO guidance as to what is advised.
- If PPE items are unavailable due to world-wide shortages, medical staff on the project should agree on alternatives and try to procure them. Alternatives that may commonly be found on construction sites include dust masks, construction gloves and eye goggles. While these items are not recommended, they should be used as a last resort if no medical PPE is available.
- Ventilators will not normally be available on work sites, and in any event, intubation should only be conducted by experienced medical staff. If a worker is extremely ill and unable to breathe properly on his or her own, they should be referred immediately to the local hospital.
- Review existing methods for dealing with medical waste, including systems for storage and disposal.

16. Given the limited scope of project medical services, the project may need to refer sick workers to local medical services. Preparation for this includes:

- Obtaining information as to the resources and capacity of local medical services (e.g. number of beds, availability of trained staff and essential supplies).

- Conducting preliminary discussions with specific medical facilities, to agree what should be done in the event of ill workers needing to be referred.
- Considering ways in which the project may be able to support local medical services in preparing for members of the community becoming ill, recognizing that the elderly or those with pre-existing medical conditions require additional support to access appropriate treatment if they become ill.
- Clarifying the way in which an ill worker will be transported to the medical facility, and checking availability of such transportation.
- Establishing an agreed protocol for communications with local emergency/medical services.
- Agreeing with the local medical services/specific medical facilities the scope of services to be provided, the procedure for in-take of patients and (where relevant) any costs or payments that may be involved.

B.6 Use of security personnel

Health facilities supported by the project is expected to use some security personnel. Normally a security agency is contracted on a long-term basis by health care facilities to ensure safety of employees and the facility, including the equipment and supplies. In relation to security of the equipment during delivery, DOH's freight service provider ensures that all equipment is delivered intact and safe onsite. DOH reports that security has not been an issue in the delivery of equipment in different areas nationwide. The Project is not expected to use government security personnel in construction of facilities financed by the Project. However, as COVID-19 may develop in unpredictable ways and due to potential concerns among the public, the use of additional government security personnel from the local or national police, or in some instances possibly the military, may be directed to implement measures to ensure peace and order in affected areas, including at quarantine, isolation, decontamination and other health facilities. The potential scope of such security measures, and potential risks surrounding them, will be assessed and monitored during implementation and this LMP may be revised accordingly to manage environmental and social risks concerning project activities. The World Bank's ESS4 on Community Health and Safety encourages disclosure of government security arrangements and ensure that government personnel act in a manner consistent with the provisions of the standard. As actions of security personnel can pose a significant reputational risk and can increase tensions with the local population. Thus, security decorum must be clearly defined.

In case project activities are supported by private or government security personnel, it will be ensured that the security personnel follow a strict code of conduct and avoid any escalation consistent with the ESF and IFC guidance on the use of security personnel (*IFC Good Practice Handbook on the Use of Security Forces: Assessing and Managing Risks and Impacts*). In these cases, DOH will assess risks posed by these security arrangements to project workers and the local community. Security personnel will provide security services in a manner consistent with the applicable laws and code of practices and consistent with the Bank's ESS4. DOH will ensure that the workers and local community is informed about the arrangements and the project's GRM. DOH will review any allegations of unlawful or abusive

acts of security personnel, take action (or urge appropriate parties to take action) to prevent recurrence and, where necessary, report unlawful abusive acts to the relevant authorities.

C. Screening Form for Potential Environmental and Social Risk

This form is to be used by DoH to screen for the potential environmental and social risks and impacts of specific project activities. It will help the PIU in identifying the relevant Environmental and Social Standards (ESS), establishing an appropriate E&S risk rating for these activities and specifying the type of environmental and social assessment required (if any), E&S risk management measures and specific instruments if required (e.g. ESMP, SEP, LMP), ECOP. Use of this form will allow DoH to form an initial view of the potential risks and impacts of a subproject. ***It is not a substitute for project-specific E&S assessments or specific mitigation plans, if needed.***

Section 6.2 provides a template for an ESMP that will be prepared for project activities including civil works. Annex D provides standards Environmental and Social Codes of Practice for various project activities.

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

Activity	
Location	
Proponent	
Estimated Investment	
Start/Completion Date	

Questions	Answer		ESS relevance	Due diligence / Actions
	Yes	no		
Does the project activity involve civil works including new construction, expansion, upgrading or rehabilitation of healthcare facilities and/or waste management facilities?			ESS1	ESMP, ECOP
Does the project activity involve land acquisition and/or restrictions on land use?			ESS5	Not eligible
Does the project activity involve acquisition of assets for quarantine, isolation or medical treatment purposes?			ESS5	Not eligible
Is the local health facility associated with any external waste management facilities such as a sanitary landfill, incinerator, or wastewater treatment plant for healthcare waste disposal?			ESS3	ESMP, ECOP

Is there a sound regulatory framework and institutional capacity in place for healthcare facility infection control and healthcare waste management?			ESS1	ESMP, ECOP
Does the local health facility have an adequate system in place (capacity, processes and management) to address waste?			ESS3	ESMP, ECOP
Does the project activity involve recruitment of workers including direct, contracted, primary supply, and/or community workers?			ESS2	LMP, SEP
Does the local health facility have appropriate OHS procedures in place, and an adequate supply of PPE (where necessary)?			ESS2	LMP, ESMP
Does the subproject involve transboundary transportation (including Potentially infected specimens may be transported from healthcare facilities to testing laboratories, and transboundary) of specimen, samples, infectious and hazardous materials?			ESS3	LMP, ESMP
Does the subproject involve use of security or military personnel during construction and/or operation of healthcare facilities and related activities?			ESS2, ESS4	Assessment of risks, Code of Conduct, Training
Is the subproject located within or in the vicinity of any ecologically sensitive areas?			ESS6	Not eligible
Are there any indigenous groups (meeting specified ESS7 criteria) present in the subproject area and are they likely to be affected by the proposed subproject negatively or positively?			ESS7	SEP. Meaningful consultations with IP community and traditional health practitioners, coordination with traditional health practitioners
Is the subproject located within or in the vicinity of any known cultural heritage sites?			ESS8	Not eligible

Does the project area present considerable Gender-Based Violence (GBV) and Sexual Exploitation and Abuse (SEA) risk?			ESS1, ESS2, ESS4	Code of Conduct, Training
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INFECTION CONTROL: CONSIDERATIONS AND TOOLS TO ASSIST IN E&S SCREENING AND RISK RATING:

In the context of global COVID-19 outbreak, many countries have adopted a containment strategy that includes extensive testing, quarantine, isolation and treatment either in a medical facility or at home.

A COVID-19 response project may include the following activities:

- construction of and/or operational support to medical laboratories, quarantine and isolation centers at multiple locations and in different forms, and infection treatment centers in existing healthcare facilities
- procurement and delivery of medical supplies, equipment and materials, such as reagents, chemicals, and Personal Protective Equipment (PPEs)
- transportation of potentially infected specimens from healthcare facilities to testing laboratories
- construction, expansion or enhancing healthcare waste and wastewater facilities
- training of medical workers and volunteers
- community engagement and communication

1. Screening E&S Risks of Medical laboratories

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

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

- [WHO; Prioritized Laboratory Testing Strategy According to 4Cs Transmission Scenarios](#)
- [WHO Covid-19 Technical Guidance: Laboratory testing for 2019-nCoV in humans:](#)

- [WHO Laboratory Biosafety Manual, 3rd edition](#)
- [USCDC, EPA, DOT, *et al*; Managing Solid Waste Contaminated with a Category A Infectious Substance](#) (August 2019)

2. Screening E&S Risks of Quarantine and Isolation Centers

According to WHO:

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

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

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

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

The following documents provide further guidance regarding quarantine of persons.

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

3. SCREENING E&S RISKS OF TREATMENT CENTERS

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

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

4. SCREENING E&S RISKS RELATING TO LABOR AND WORKING CONDITIONS

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

D. Environmental and Social Codes of Practice

CHECKLIST 1 Environmental and Social Codes of Practice – COVID 19 EXPOSURE AT HEALTH CARE FACILITY

Target: Health Care Workers/Health Care Facility Visitors/Construction Workers

General Infection Prevention and Control

- ✓ Procedures for entry into health care facilities, such as minimizing visitors and visitor hours, taking temperature checks and having separate area (including entry area) for patients presenting with COVID-19 symptoms/respiratory illness, who should be taken to a different area and given a face mask. All persons visiting hospitals should wash hands before entering and before leaving.
- ✓ Minimize contact between patients and other persons in the facility: health care professionals should be the only persons having contact with patients suspected of having COVID-19 and this should be restricted to essential personnel only (except in cases of young children or other persons requiring assistance, then a family member may be present but they must also be wearing PPE – at least gloves and mask – and adhering to protocols).
- ✓ Provide alcohol-based hand sanitizer (60-95% alcohol), tissues and facemasks in waiting rooms and patient rooms.

Isolation and Treatment

- ✓ Isolate patients as much as possible, separate from people presenting with COVID-19. People with COVID-19 should be separate from each other by curtains or in different rooms if possible. Only place together in the same room patients who are have all contracted COVID-19. People with COVID-19 must be separated at all times from other hospital patients and health and other staff. This means there must be dedicated toilet facilities (or bedpans), hand washing facilities, and medical equipment (stethoscope, blood pressure machine, etc.) for patients with COVID-19 only.
- ✓ Use of Personnel Protection Equipment (PPE) at all times for medical staff and cleaners as needed (particularly facemask, gowns, gloves, eye protection and potentially face shield) when in contact with someone who may have COVID-19.

Staff Occupational Health and Safety

- ✓ Immediate and ongoing training on the procedures to all categories of workers (lab technicians, doctors, nurses, cleaning staff, etc.) on use of PPE, personal hygiene and thorough disinfecting of surfaces on a regular basis (multiple times per day using a high-alcohol based cleaner to wipe down all surfaces and when COVID-19 patients are discharged; wash instruments with soap and water and then wipe down with high-alcohol based cleaner; dispose of rubbish by burning etc.) Put signage in hospital as a reminder.
- ✓ Make particular efforts to ensure that all staff (such as cleaners and those doing the washing) are able to understand these procedures and have access to the necessary PPE.
- ✓ Laboratories undertaking testing for COVID-19 virus should adhere strictly to appropriate biosafety practices and WHO guidelines on Laboratory testing for coronavirus disease 2019 (COVID-19) in suspected human cases.
- ✓ Labor personnel needs to be trained and acquainted with key provisions in Labor Management Plan (LMP), in particular Occupational Health and Safety (OHS) aspects.

Sanitation and Waste Management

- ✓ Ensure that the designs for medical facilities consider the collection, segregation and treatment of medical waste
- ✓ The treatment of healthcare wastes produced during the care of COVID-19 patients should be collected safely in designated containers and bags, treated and then safely dispose
- ✓ General cleaning strategies: (i) proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms; (ii) proceed from top areas to bottom areas to prevent dirt and microorganisms from dripping or falling down and contaminating already cleaned areas (for example clean mattress first, then clean bed legs); (iii) proceed in a methodical, systematic manner to avoid missing areas (for example, proceed from left to right or clockwise). Provide training to cleaning staff on these procedures, as well as on the use of PPE equipment, and put signage of reminders throughout health centers.
- ✓ Hospitals/health centers will also need to develop procedures and facilities for handling dirty linen and contaminated clothing, and preparing and handling food. For instance, social distancing measures (people 2m apart) should be implemented for those preparing and serving food in hospitals, ensuring thorough handwashing

as per above guidelines, with reminders in kitchen and eating areas, and cooks/servers should wear masks.

REFERENCES

- WHO interim guidance on [Infection prevention and control during health care when novel coronavirus \(nCoV\) infection is suspected](#);
- WHO technical brief [water, sanitation, hygiene and waste management for COVID-19](#);
- WHO guidance on [infection prevention and control at health care facilities \(with a focus on settings with limited resources\)](#);
- WHO interim practical manual for [improving infection prevention and control at the health facility](#);
- CDC Guidelines for [isolation precautions: preventing transmissions of infectious agents in healthcare settings](#);
- CDC [guidelines for environmental infection control in healthcare facilities](#)

CHECKLIST 2 Environmental and Social Codes of Practice – COVID 19 WASTE MANAGEMENT PROCEDURES

Target: Health Care Workers/Health Care Facilities/Laboratories

General Instructions

- ✓ All health care waste produced during the care of COVID-19 patients must be considered as infectious waste and should be collected safely in designated containers and bags, treated and then safely disposed (WHO).
- ✓ Train the staffs who are assigned in handling and disposal of waste management
- ✓ Train staffs on how to put and remove PPE.
- ✓ Ensure necessary PPE (Gown, gloves, face mask, goggles or face shield, gumboots) is provided to all staffs.
- ✓ Ensure staff wear PPE when handling and disposing waste according to HCW guideline.

General Waste - Food waste, paper, disposable cups, plates, spoons etc

- ✓ Collect in black bag
- ✓ Close and tie when 2/3rd full
- ✓ Transfer the waste to a temporary storage point for general waste along a specified route at a fixed time point and store the waste separately at a fixed location
- ✓ Transport to landfill away from facility

Infectious Waste - Gown, gloves, apron, shoe cover, disposable items, mask etc

- ✓ Collect in small biohazard red bags
- ✓ Close, seal the bag with cable ties and tie lose when 2/3 full
- ✓ Transfer the waste to a temporary storage point for medical waste along a specified route at a fixed time point and store the waste separately at a fixed location
- ✓ Securely transfer out for incinerating
- ✓ Transport outcome as general waste

Sharps Waste

- ✓ Put in puncture proof plastic container
- ✓ Close the lid and seal the container when 2/3 full
- ✓ Put in the red bag and tie lose
- ✓ Transfer the waste to a temporary storage point for medical waste along a specified route at a fixed time point and store the waste separately at a fixed location
- ✓ Securely transfer out for incinerating or appropriate disposal

REFERENCES

- WHO interim guidance on [Infection prevention and control during health care when novel coronavirus \(nCoV\) infection is suspected](#);
- WHO technical brief [water, sanitation, hygiene and waste management for COVID-19](#);
- WHO guidance on [infection prevention and control at health care facilities \(with a focus on settings with limited resources\)](#);
- WHO interim practical manual for [improving infection prevention and control at the health facility](#);
- CDC Guidelines for [isolation precautions: preventing transmissions of infectious agents in healthcare settings](#);
- CDC [guidelines for environmental infection control in healthcare facilities](#)

CHECKLIST 3 Environmental and Social Codes of Practice – COVID 19 COMMUNITY AND SOCIAL INCLUSION

Target: General Population/Vulnerable Groups/

General Communication

- ✓ When developing communication materials it is important to ensure that they are clear and concise, 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).
- ✓ Utilize appropriate 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).
- ✓ Communication materials must also be clear about (i) how to avoid contracting COVID-19 (good hygiene measures); (ii) symptoms of COVID-19; (iii) what to do if suspect have COVID-19.
- ✓ 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 traditional healers) that can help to disseminate messages. Define clear and easy mechanisms to disseminate messages and materials based on community questions and concerns
- ✓ 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.
- ✓ RGC/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.

Infection Prevention

- ✓ 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 IPs, marginalized groups, those with disabilities, other vulnerable groups and the elderly, and in a manner that is culturally appropriate to the respective groups and specific needs.
- ✓ Promote large scale social and behaviour change. Introduce preventive community and individual health and hygiene practices with a focus on handwashing. Could include gifting of soap bars, distributed by commune authorities or District health officials.
- ✓ Workplaces should be encouraged to post and provide communication materials, in particular workplaces which may face a higher risk of COVID-19 spread, such as construction sites and factories. This may include social isolation measures in workplaces, separating people from each other (2m), opening spaces to allow for natural ventilation, providing hand sanitation facilities (soap/water or hand sanitizer), etc.

Stakeholder Engagement

- ✓ 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 Risk Communication and Community Engagement Plan (RCCE).

REFERENCES

- WHO interim guidance on [Infection prevention and control during health care when novel coronavirus \(nCoV\) infection is suspected](#);
- WHO Risk Communication and Community Engagement (RCCE) Guidance, [https://www.who.int/publications-detail/risk-communication-and-community-engagement-\(rcce\)-action-plan-guidance](https://www.who.int/publications-detail/risk-communication-and-community-engagement-(rcce)-action-plan-guidance)
- IFRC, UNICEF, WHO Social Stigma associated with COVID-19: A guide to preventing and addressing social stigma, <https://www.unicef.org/documents/social-stigma-associated-coronavirus-disease-covid-19>
- Human Rights Watch COVID-19 A Human Rights Checklist: https://www.hrw.org/sites/default/files/supporting_resources/202004_northamerica_us_covid19_checklist2.pdf

CHECKLIST 4 Environmental and Social Codes of Practice – COVID 19 SMALL SCALE CONSTRUCTION, UPGRADES, REHAB, EXPANSION

Target: Construction Workers OHS/Project Supervisor/Facility Manager

Worker Safety

- ✓ The local construction and environment inspectorates and communities have been notified of upcoming activities
- ✓ The public has been notified of the works through appropriate notification in the media and/or at publicly accessible sites (including the site of the works)
- ✓ All legally required permits have been acquired for construction and/or rehabilitation
- ✓ The Contractor formally agrees that all work will be carried out in a safe and disciplined manner designed to minimize impacts on neighboring residents and environment.
- ✓ Workers' PPE will comply with international good practice (always hardhats, as needed masks and safety glasses, harnesses and safety boots)

General Rehabilitation and/or Construction

- ✓ During interior demolition debris-chutes shall be used above the first floor
- ✓ Demolition debris shall be kept in controlled area and sprayed with water mist to reduce debris dust
- ✓ During pneumatic drilling/wall destruction dust shall be suppressed by ongoing water spraying and/or installing dust screen enclosures at site
- ✓ The surrounding environment (sidewalks, roads) shall be kept free of debris to minimize dust
- ✓ There will be no open burning of construction / waste material at the site
- ✓ There will be no excessive idling of construction vehicles at sites
- ✓ Construction noise will be limited to restricted times agreed to in the permit
- ✓ During operations the engine covers of generators, air compressors and other powered mechanical equipment shall be closed, and equipment placed as far away from residential areas as possible
- ✓ The site will establish appropriate erosion and sediment control measures such as e.g. hay bales and / or silt fences to prevent sediment from moving off site and causing excessive turbidity in nearby streams and rivers.

Waste Management

- ✓ Waste collection and disposal pathways and sites will be identified for all major waste types expected from demolition and construction activities.
- ✓ Mineral construction and demolition wastes will be separated from general refuse, organic, liquid and chemical wastes by on-site sorting and stored in appropriate containers.
- ✓ Construction waste will be collected and disposed properly by licensed collectors

Wastewater Treatment

- ✓ The approach to handling sanitary wastes and wastewater from building sites (installation or reconstruction) must be approved by the local authorities
- ✓ Before being discharged into receiving waters, effluents from individual wastewater systems must be treated in order to meet the minimal quality criteria set out by national guidelines on effluent quality and wastewater treatment
- ✓ Monitoring of new wastewater systems (before/after) will be carried out
- ✓ Construction vehicles and machinery will be washed only in designated areas where runoff will not pollute natural surface water bodies.

REFERENCES

- WHO technical brief [water, sanitation, hygiene and waste management for COVID-19](#);
- WHO guidance on [infection prevention and control at health care facilities \(with a focus on settings with limited resources\)](#);

E. Infection Control and Waste Management Plan (ICWMP)

1. Introduction

1.1 Describe the project context and components

1.2 Describe the targeted healthcare facility (HCF):

- Type: E.g. general hospital, clinics, inpatient/outpatient facility, medical laboratory, quarantine or isolation centers;
- *Special type of HCF in response to COVID-19: E.g. existing assets may be acquired to hold yet-to-confirm cases for medical observation or isolation;*
- Functions and requirement for the level infection control, e.g. biosafety levels;
- Location and associated facilities, including access, water supply, power supply;
- Capacity: beds

1.3 Describe the design requirements of the HCF, which may include specifications for general design and safety, separation of wards, heating, ventilation and air conditioning (HVAC), autoclave, and waste management facilities.

2. Infection Control and Waste Management

2.1 Overview of infection control and waste management in the HCF

- Type, source and volume of healthcare waste (HCW) generated in the HCF, including solid, liquid and air emissions (if significant)
- Classify and quantify the HCW (infectious waste, pathological waste, sharps, liquid and non-hazardous) following WBG [EHS Guidelines](#) for Healthcare Facilities and pertaining GIIP.
- *Given the infectious nature of the novel coronavirus, some wastes that are traditionally classified as non-hazardous may be considered hazardous. It's likely the volume of waste will increase considerably given the number of admitted patients during COVID-19 outbreak. Special attention should be given to the identification, classification and quantification of the healthcare wastes.*
- Describe the healthcare waste management system in the HCF, including material delivery, waste generation, handling, disinfection and sterilization, collection, storage, transport, and disposal and treatment works
- Provide a flow chart of waste streams in the HCF if available
- Describe applicable performance levels and/or standards
- Describe institutional arrangement, roles and responsibilities in the HCF for infection control and waste management

2.2 Management Measures

- Waste minimization, reuse and recycling: HCF should consider practices and procedures to minimize waste generation, without sacrificing patient hygiene and safety considerations.
- Delivery and storage of specimen, samples, reagents, pharmaceuticals and medical supplies: HCF should adopt practice and procedures to minimize risks associated with delivering, receiving and storage of hazardous medical goods.
- Waste segregation, packaging, color coding and labeling: HCF should strictly conduct waste segregation at the point of generation. Internationally adopted method for packaging, color coding and labeling the wastes should be followed.
- Onsite collection and transport: HCF should adopt practices and procedures to timely remove properly packaged and labelled wastes using designated trolleys/carts and routes. Disinfection of pertaining tools and spaces should be routinely conducted. Hygiene and safety of involved supporting medical workers such as cleaners should be ensured.
- Waste storage: A HCF should have multiple waste storage areas designed for different types of wastes. Their functions and sizes are determined at design stage. Proper maintenance and disinfection of the storage areas should be carried out. Existing reports suggest that during the COVID-19 outbreak, infectious wastes should be removed from HCF's storage area for disposal within 24 hours.
- Onsite waste treatment and disposal (e.g. an incinerator): Many HCFs have their own waste incineration facilities installed onsite. Due diligence of an existing incinerator should be conducted to examine its technical adequacy, process capacity, performance record, and operator's capacity. In case any gaps are discovered, corrective measures should be recommended. For new HCF financed by the project, waste disposal facilities should be integrated into the overall design and ESIA developed. Good design, operational practices and internationally adopted emission standards for healthcare waste incinerators can be found in pertaining EHS Guidelines and GIIP.
- Transportation and disposal at offsite waste management facilities: Not all HCF has adequate or well-performed incinerator onsite. Not all healthcare wastes are suitable for incineration. An onsite incinerator produces residuals after incineration. Hence offsite waste disposal facilities provided by local government or the private sector are probably needed. These offsite waste management facilities may include incinerators, hazardous wastes landfill. In the same vein, due diligence of such external waste management facilities should be conducted to examine its technical adequacy, process capacity, performance record, and operator's capacity. In case any gaps are discovered, corrective measures should be recommended and agreed with the government or the private sector operators.
- Wastewater treatment: HCF wastewater is related to hazardous waste management practices. Proper waste segregation and handling as discussed above should be conducted to minimize entry of solid waste into the wastewater stream. In case wastewater is discharged into municipal sewer sewerage system, the HCF should ensure that wastewater effluent comply with all applicable permits and standards, and the municipal wastewater treatment plant (WWTP) is capable of handling the type of effluent discharged. In cases where municipal sewage system is not in place, HCF should build and properly operate onsite primary and secondary wastewater treatment works,

including disinfection. Residuals of the onsite wastewater treatment works, such as sludge, should be properly disposed of as well. There're also cases where HCF wastewater is transported by trucks to a municipal wastewater treatment plant for treatment. Requirements on safe transportation, due diligence of WWTP in terms of its capacity and performance should be conducted.

3. Emergency Preparedness and Response

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

Thus, an Emergency Response Plan (ERP) that is commensurate with the risk levels is recommended to be developed. The key elements of an ERP are defined in ESS 4 Community Health and Safety (para. 21).

4. Institutional Arrangement and Capacity Building

A clearly defined institutional arrangement, roles and responsibilities should be included. A training plan with recurring training programs should be developed. The following aspects are recommended:

- Define roles and responsibilities along each link of the chain along the cradle-to-crave infection control and waste management process;
- Ensure adequate and qualified staff are in place, including those in charge of infection control and biosafety and waste management facility operation.
- Stress the chief of a HCF takes overall responsibility for infection control and waste management;
- Involve all relevant departments in a HCF, and build an intra-departmental team to manage, coordinate and regularly review issues and performance;
- Establish an information management system to track and record the waste streams in HCF; and
- Capacity building and training should involve medical workers, waste management workers and cleaners. Third-party waste management service providers should be provided with relevant training as well.

5. Monitoring and Reporting

Many HCFs in developing countries face the challenge of inadequate monitoring and records of healthcare waste streams. HCF should establish an information management system to track and record the waste streams from the point of generation, segregation, packaging, temporary storage, transport carts/vehicles, to treatment facilities. The HCF is encouraged to develop an IT based information management system should their technical and financial capacity allow.

As discussed above, the HCF chief takes overall responsibility, leads an intra-departmental team and regularly reviews issues and performance of the infection control and waste management practices in the HCF. Internal reporting and filing systems should be in place.

Externally, reporting should be conducted per government and World Bank requirements.

Table ICWMP

Activities	Potential E&S Issues and Risks	Proposed Mitigation Measures	Responsibilities	Timeline	Budget
General HCF operation – Environment	General wastes, wastewater and air emissions				
General HCF operation – OHS issues	<ul style="list-style-type: none"> - Physical hazards; - Electrical and explosive hazards; - Fire; - Chemical use; - Ergonomic hazard; - Radioactive hazard. 				
HCF operation - Infection control and waste management plan					
Waste minimization, reuse and recycling					
Delivery and storage of specimen, samples, reagents, pharmaceuticals and medical supplies					
Storage and handling of specimen, samples, reagents, and infectious materials					

Waste segregation, packaging, color coding and labeling					
Onsite collection and transport					
Waste storage					
Onsite waste treatment and disposal					
Waste transportation to and disposal in offsite treatment and disposal facilities					
HCF operation – transboundary movement of specimen, samples, reagents, medical equipment, and infectious materials					
Emergency events	<ul style="list-style-type: none"> - Spillage; - Occupational exposure to infectious; - Exposure to radiation; - Accidental releases of infectious or hazardous substances to the environment; - Medical equipment failure; 	Emergency response plan			

	<ul style="list-style-type: none"> - Failure of solid waste and wastewater treatment facilities; - Fire; - Other emergent events 				
Operation of acquired assets for holding potential COVID-19 patients					
<i>To be expanded</i>					

F Resource List: COVID-19 Guidance

World Bank Environmental and Social Management Framework for COVID-19 Response, April 20, 2020

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

WHO Guidance

Advice for the Public

- WHO advice for the public, including on social distancing, respiratory hygiene, self-quarantine, and seeking medical advice, can be consulted on this WHO website: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>

Technical guidance

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

- [Risk Communication and Community Engagement \(RCCE\) Action Plan Guidance COVID-19 Preparedness and Response](#), issued on March 16, 2020
- [Considerations for quarantine of individuals in the context of containment for coronavirus disease \(COVID-19\)](#), issued on March 19, 2020
- [Operational considerations for case management of COVID-19 in health facility and community](#), issued on March 19, 2020
- [Rational use of personal protective equipment for coronavirus disease 2019 \(COVID-19\)](#), issued on February 27, 2020
- [Getting your workplace ready for COVID-19](#), issued on March 19, 2020
- [Water, sanitation, hygiene and waste management for COVID-19](#), issued on March 19, 2020
- [Safe management of wastes from health-care activities](#), issued in 2014
- [Advice on the use of masks in the community, during home care and in healthcare settings in the context of the novel coronavirus \(COVID-19\) outbreak](#), issued on March 19, 2020
- [Disability Considerations during the COVID-19 outbreak](#), issued on March 26, 2020

WORLD BANK GROUP GUIDANCE

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

ILO GUIDANCE

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

MFI GUIDANCE

- [ADB Managing Infectious Medical Waste during the COVID-19 Pandemic](#)
- [IDB Invest Guidance for Infrastructure Projects on COVID-19: A Rapid Risk Profile and Decision Framework](#)
- [KfW DEG COVID-19 Guidance for employers, issued on March 31, 2020](#)
- [CDC Group COVID-19 Guidance for Employers, issued on March 23, 2020](#)