

THE REPUBLIC OF FIJI

Ministry of Health & Medical Services

**Fiji COVID-19 Emergency Response Project
World Bank: P173903**

ENVIRONMENTAL AND SOCIAL MANAGEMENT FRAMEWORK

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1 Background

The Government of Fiji (GoF) has secured US\$7.35 million in project financing of which US\$6.4 million is IDA credits allocated from the World Bank through the Fast Track Covid-19 Response Program for the Fiji COVID-19 Emergency Responses Project (the Project). The Project reflects the emergency response under the COVID-19 Strategic Preparedness and Response Program (SPRP). The Project aims to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health in Fiji by improving emergency preparedness and response, strengthening health systems, and managing implementation and monitoring and evaluation.

This Environmental and Social Management Framework (ESMF) sets out the principles, policies and procedures for environmental and social protection that the GoF will employ in the context of the Project. The ESMF template for COVID-19 Response was used to guide the development of this ESMF. The rationale of using an ESMF instead of project-specific environmental and social assessment and management plans, is that the exact locations of project activities, as well as the type and magnitude of the environmental and social impacts will not be known until the project is at an advanced stage of implementation.

The purpose of the ESMF is to guide the Ministry of Health and Medical Services (MHMS) and any Sub-component project Proponents on the environmental and social screening processes and subsequent assessment during implementation, including activity-specific plans in accordance with the World Bank Environmental and Social Framework (ESF).

The scope of this ESMF includes procedures relevant to the development of all activities, including how to conduct screening of project activities to assess the environmental and social risks and impacts and identify mitigation measures, as part of activity-specific assessment and plans. This ESMF is supported by the Infection Prevention Control and Waste Management Plan (IPC&WMP), Labour Management Procedure (LMP), Stakeholder Engagement Plan (SEP), Project Operational Manual (POM) and other specific plans that have been or will be prepared for the Project. This ESMF will allow the GoF to clarify, to the extent possible and based on existing information, the approach that should be taken at the activity level, in accordance with the World Bank ESF.

2 Project Description

2.1 Project Summary

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

The PDO will be monitored through the following PDO level outcome indicators:

- Proportion of identified at-risk population investigated with laboratory testing for COVID-19
- Proportion of suspected and diagnosed cases treated as per approved protocol

The intermediate results indicators are:

- Number of health workers responding to surge receiving overtime and per diem payments
- Number of health facilities with improved connectivity for case reporting and public health surveillance
- Number of health facilities with access to improved health care waste management systems and facilities

- Monitoring and evaluation system established to monitor COVID-19 preparedness and response

The Project objectives are aligned to the results chain of the COVID-19 SPRP. This project is prepared under the global framework of the World Bank COVID-19 Response financed under the Fast Track COVID-19 Facility.

2.2 Project Subcomponents

The proposed project components and sub-components are:

Component 1: Emergency COVID-19 Response (IDA: US\$ 3.90 million equivalent; PEF Grant: US\$0.95 million)

The aim of this component is to strengthen Fiji's capacity to respond to COVID-19. This component will provide immediate support to implement prevention, preparedness, and emergency response activities for COVID-19. Specifically this component will: (a) address the COVID-19 emergency by enhancing disease detection capacities, case confirmation, and contact tracing; (b) strengthen the capacity of the health system to minimize the risk of spread of the disease and provide clinical care for patients with COVID-19; and (c) implement effective risk communication campaigns for mass awareness and education of the population to tackle the COVID-19 emergency, and enhance internet connectivity across health facilities.

Sub-Component 1.1: Enhance case detection, confirmation, and contact tracing (US\$1.05 million equivalent)

This sub-component will focus on strengthening Fiji's capacity for early detection, case confirmation, and contact tracing for COVID-19 by equipping laboratories with relevant supplies and consumables. Equipment to be procured under this component for laboratories include biosafety cabinets, GeneXpert cartridges, analyzers, and swabs.

Sub-Component 1.2: Enhance health service delivery (US\$ 2.50 million equivalent)

This sub-component will support enhancing clinical care capacity to manage COVID-19 cases and infection prevention and control capacity, including: (a) providing PPE and essential medical equipment for case treatment; and (b) mobilizing existing MHMS personnel, and personnel of other agencies seconded to the MHMS through an approved written agency circular, to respond to a surge in demand for health care services and associated COVID-19 response work. The support related to mobilization of those personnel will specifically be for certain recurrent operational expenses, i.e. overtime, per diem and accommodation costs required for those personnel to respond to a surge in demand for health care services and associated COVID-19 response work.

Sub-Component 1.3: Communication Preparedness and Response (US\$1.30 million equivalent)

This sub-component will provide support to strengthen COVID-19 community awareness and communication, to increase knowledge and understanding among the general population about the risk and potential impact of the pandemic. The activities under this sub-component are aligned with the GoF's own risk communication strategy under its COVID-19 Preparedness and Response Plan. As other DPs such as UNICEF and WHO are providing risk communications support, this sub-component will primarily focus on supporting the dissemination of messages to the general public to increase understanding about the risks and impacts of the pandemic, including those aimed at increasing awareness to the ways of

preventing infectious diseases. This will be through various communication channels, including posters and billboards, and will be integrated into ongoing outreach activities of the MHMS.

In addition, this sub-component will support the enhancement of telecommunication connectivity for 35 health facilities in priority areas, as identified by the MHMS, to improve communication and data reporting between the MHMS and front-line health workers. Given that the identified priority areas are well-served by existing telecommunications infrastructure, it is expected that the market will respond to the needs of the MHMS and provide packaged deals that could be utilized by the MHMS to boost telecommunications connectivity at the identified sites. The cost of increased bandwidth, antenna system, routers and operating costs related to these activities, will be financed under this sub-component. This sub-component will also finance annual licenses for software used in the health sector, such as ArcGIS, as may be needed.

Component 2: Health System Strengthening (Total US\$ 1.40 million equivalent)

This component will focus on medium- and long-term health care system strengthening focusing on three main priorities: (a) enhancing health care waste management including procurement and installation of a medical waste treatment facility at the Naboro landfill to serve the central division health facilities, any incidental works associated with it, and technical assistance to support such activities; b) training for health care workers on health care waste management; and (c) construction of a warehouse to supplement storage facilities at the Fiji Pharmaceutical and Biomedical Services (FPBS) center in Suva. This warehouse located directly behind the FPBS building will be constructed on land that is owned under lease by Government. The warehouse will be used to store goods and medical supplies that are awaiting clearance and distribution to health facilities. MHMS currently pays substantial fees to freight companies, as well as high rental fees for hired buildings and space to store goods once they have arrived in the country. The planned warehouse would reduce this financial burden.

This component will also support improving Fiji's pandemic preparedness and response capacity for emerging infectious diseases through the development of a pandemic preparedness plan.

Component 3: Implementation Management, Monitoring and Evaluation (Total US\$1.10 million equivalent)

This component will provide technical and operational assistance on project management, including supporting M&E, supervision and reporting, financial management, procurement and environmental and social risk mitigation activities; and sharing lessons learnt from response exercises and joint learning domestically and internationally. Key activities include: (a) recruitment of a project manager and environmental and social risk management experts; (b) operating expenses for project management, reporting and supervision; (c) support for procurement, financial management (FM), environmental and social risk management; and (d) M&E.

Table 1 - Components and Key Activities Cost Estimates

Project Component and Key Activities	Budget (US\$ millions equivalent)
Component 1: Emergency COVID-19 Response	4.85
Component 2: Health System Strengthening	1.40
Component 3: Implementation Management, Monitoring & Evaluation	1.10
Total	7.35

2.3 Summary of Key Project Activities

Project activities for this emergency operation will include the provision of goods and services and technical assistance investments. The main project activities will include enhancing disease detection capacities, case confirmation, and contact tracing; risk communication and awareness campaigns; strengthening health infrastructure including laboratory and intensive care equipment; and enhancing health care waste management including the procurement and installation of a medical waste treatment facility and construction of a pharmaceutical warehouse.

Civil works associated with the installation of the medical waste treatment facility at Naboro is expected. However minimum civil works for the construction of the warehouse will be required as the land is already prepared and ready to build. Project activities are not expected to involve land acquisition, physical or economic displacement, or restriction of access to natural resources. The medical waste treatment facility is anticipated to occupy an area of approximately 5m³ and will require approximately another 1000m² for storage, unloading and ancillary facilities. It is anticipated to burn up to approximately 200 kg/hour of waste. It is expected to be built on the footprint of an existing engineered-landfill site, the Naboro Landfill, where land is already disturbed, and upgraded to accommodate solid waste management process. Meetings were conducted between MOHMS, PMU and Department of Environment followed by joint site visit at Naboro landfill. MOHMS has identified its preferred location at Naboro land fill and has officially notified the Permanent Secretary of Environment on its interest to the site. Further to that a task force has been initiated by Ministry of Economy (MoE) to fast track Medical waste treatment facility at Naboro land fill. In this regard a joint meeting was held between MOHMS, Project management Unit (PMU), Dept. of Environment and MOE. As of now a screening application has been lodged with Dept. of Environment for the preferred sites. As soon as a written confirmation is received from the Permanent Secretary Environment, a Cabinet paper which has been drafted, will be presented to cabinet for endorsement to secure the land and support from other Departments for the project. This will fast track the project implementation with relevant stakeholders. The MOHMS has engaged its consultant to procure appropriate technology for its health care waste management and treatment. The Naboro Landfill site covers an area of approximately seven hectares and is located 24 kilometres from central Suva. It is owned by the Government of Fiji and operated by a private company.

The FPBS site is also owned by GoF and the land preparation for the construction had been upgraded during its inception and construction of the existing FPBS building. The pharmaceutical warehouse will supplement storage facilities at the Fiji Pharmaceutical and Biomedical Services (FPBS) center in Suva. It will be located on previously disturbed, government leased land, within the grounds of the FPBS center in an industrial zone in Suva. Dimensions of the warehouse will be approximately 20m by 30m with all its functional details that will be specified in the detail drawings.

The general types of project activities can be summarized into the following general activities which will be assessed and screened for their environmental and social risks:

Table 2 – Summary of Proposed Project Activities

Project Activity	Description
Risk communication and awareness campaigns	Dissemination of messages to the general public to increase understanding about the risks and impacts of the pandemic. This will be through various communication channels, including posters and billboards as part of ongoing Covid-19 outreach activities of the MHMS.
Enhancement of telecommunication connectivity	Enhancement of telecommunication connectivity for 35 health facilities in priority areas to improve communication and data reporting between the MHMS and front-line health workers.
Provision of goods and supplies.	Includes PPE, test kits, reagents and swabs.
Provision of laboratory and medical equipment	Includes medical equipment (ventilators, bedside monitoring equipment, biosafety cabinets, beds, thermal scanners).
Enhancing health-care waste management	Procurement, installation, and operation of a medical waste treatment facility and any ancillary works associated with it such as construction of ancillary buildings/sheds, procurement of bins, waste trolleys, internal storage facilities, signage and utility services.
	Technical assistance including a feasibility study on the planned medical waste treatment facility and an assessment of other incinerators that might be required to manage medical waste across Fiji.
	Training for health care workers on health care waste management.
	Construction of a pharmaceutical warehouse at the FPBS center in Suva.

2.4 Project Area and Beneficiaries

The expected project beneficiaries will be the population at large given the nature of the disease, including infected people, at-risk populations, particularly the elderly and people with chronic conditions, as well as medical and emergency personnel, medical and testing facilities, and public health agencies engaged in the response in Fiji. The medical waste treatment facility will serve other health centres and nursing stations in close proximity to the Naboro landfill site. The exact locations of the 35 health facilities in priority areas for telecommunication connectivity have been determined by MOHMS attached as Annex XI.

Policy, Legal and Regulatory Framework

2.5 Country Context

2.5.1 Environmental Assessment, Review and Permitting

Environmental management in Fiji is administered through the requirements of the Environment Management Act (EMA) 2005 and the accompanying regulatory instruments, the Environment Management (EIA Process) Regulations 2007 and the Environment Management (Waste Disposal and Recycling) Regulations 2007. All are administered by the Department of Environment (DOE) within the Ministry of Environment and Waterways.

The Project activities that this approval process relate to, are the installation and operation of the health care waste treatment facility and the pharmaceutical warehouse. The health care waste treatment facility is defined as a Part 1 development activity by the Schedule 2 [1(k) and (w) of the EMA 2005 . This will be determined during project implementation after completion of the EIA Screening process for the site. The warehouse is projected to be a Part 2 activity as defined by the EMA 2005. The MHMS will engage an EIA registered consultant to undertake the EIA study for the medical waste treatment facility at Naboro and submit the findings to the MoE for approvals. The warehouse facility is highly not likely to involve an EIA however an ESIA has been conducted which is under review in compliance with the project Environment and Social Commitment Plan (ESCP) and World Bank Environmental and Social Framework (ESF) .

Environment Management Act (EMA) 2005

The Environment Management Act (EMA) 2005 provides for an integrated system of development control, environmental assessment, and pollution control. Section 3(2) of the EMA 2005 states the purpose of the Act which is to (a) apply the principles of sustainable use and development of natural resources and (b) identify matters of national importance for the Fiji Islands. Matters of national importance are identified in subsection (3) as:

- (a) The preservation of the coastal environment, margins of wetlands, lakes and rivers;
- (b) The protection of outstanding natural landscapes and natural features;
- (c) The protection of areas of significant indigenous vegetation and significant habitat of indigenous
- (d) The relationship of indigenous Fijians with their ancestral lands, waters, sites, sacred areas and other treasures;
- (e) The protection of human life and health.

Part 2 of the EMA 2005, Administration, establishes a National Environmental Council and outlines the functions, duties and powers of the Council and the Department.

Part 4 of the Act EMA 2005, Environment Impact Assessment, requires that any proposed development activity that is likely to cause significant impact on the environment must undergo an environmental impact assessment (EIA) process which includes screening, scoping, preparation of an assessment EIA report, reviewing of the report and decision on the report. EIA is a formal study used to predict the environmental consequences of the proposed development. In this context, “environment” is taken to include all aspects of the natural and human environment. Section 32(1) of the EMA 2005, A proponent must prepare and implement any environment or resource management plan, monitoring programme, protection plan or mitigation measure that is required as a condition of any approved EIA , 32(2) The EIA Administrator or an approving authority, may conduct any inspection to determine compliance with subsection (1). A condition for approved EIA report will require the proponent to prepare and implement any environmental or resource management plan, monitoring program, protection plan or mitigation measure, which may be subject to inspection by the EIA Administrator, or an approving authority. When the preparation of an EIA assessment is completed, a public hearing must be conducted by the proponent within the vicinity of the area of the proposed development.

The EIA process is provided in Figure 1, outlining the different stages in the EIA process and the timeline associated to each stage. This includes and is not limited to EIA Screening, Scoping, Terms of References (TOR), EIA Study, Review and Decision of the EIA Study. The Review process takes a total of 21 days in

which a decision on the EIA study is made by the EIA Administrator or an extra 14 days for EIA report clarification and editions.

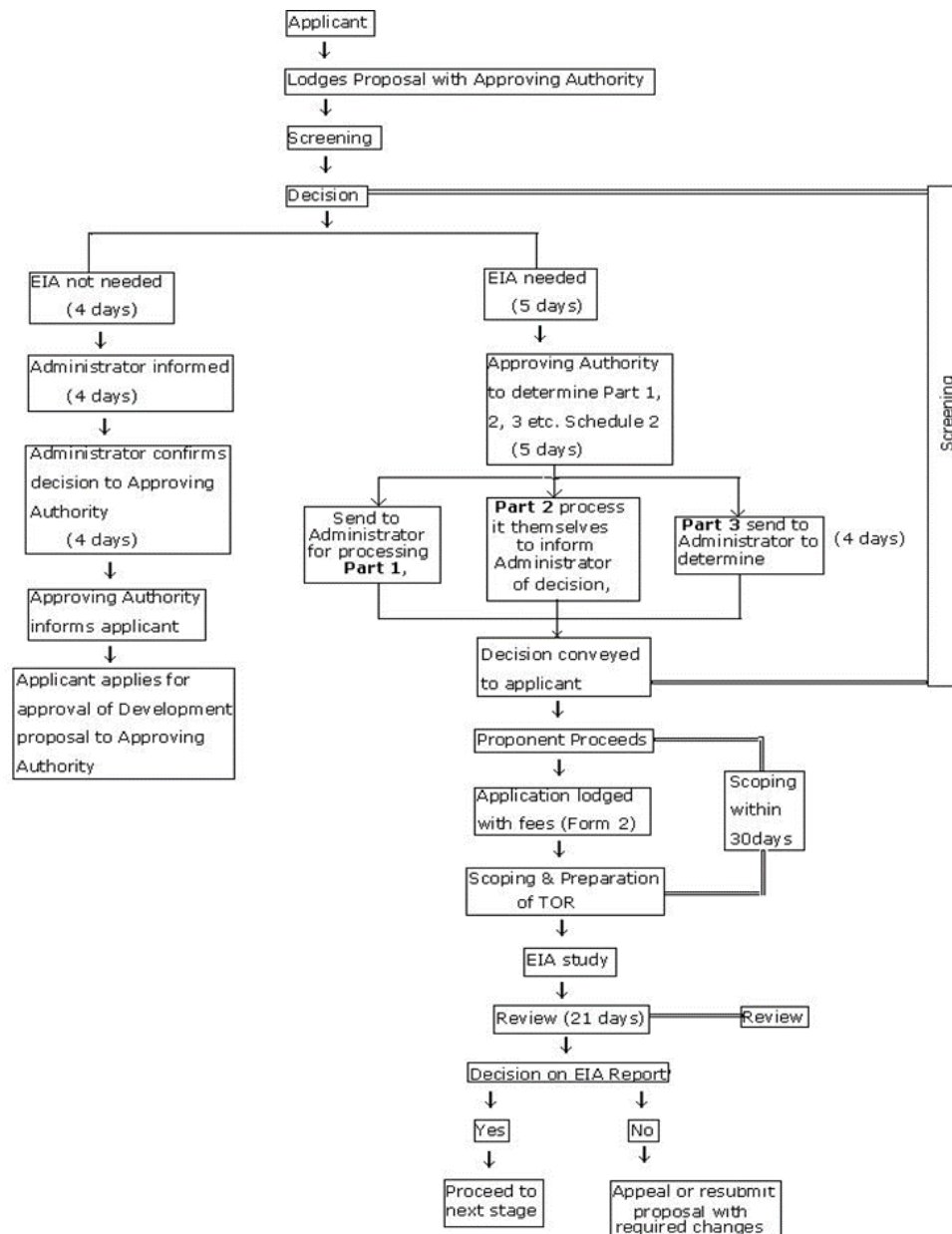


Figure 1 – Flow Diagram on EIA Procedure in accordance with the Environment Management Act (2005) and Environment Management (EIA Process) Regulations (2007)¹.

¹ Department of the Environment (2008). *Environmental Impact Assessment (EIA) Guidelines*. Government of Fiji

After an EIA application is approved, the proponent is required to submit a Construction Environment Management Plan (CEMP) that must be approved by the Department of Environment before any construction (including earthworks) can commence².

Most classes of activities which impact key environmental components, such as erosion of land, degradation of waters or the loss of species, for example, are to be assessed by the EIA Administrator³. Relevant examples of development proposals under the Schedule 2 of the EMA 2005 are:

Part 1 – Approved by the administrator	Part 2- Approved by the Approving Authority	Part 3 - development proposals that may not require the EIA Process or an EIA report
<p>(k) A proposal that would introduce pollutants or properties to the air that are disagreeable or potentially harmful to people and wildlife.</p> <p>(q) a proposal for the construction of a landfill facility, composting plant, marine outfall or wastewater treatment plant.</p> <p>(w) a proposal financed by an international or local development finance institution and which requires an EIA as a condition of the finance</p>	<p>(a) a proposal that requires processing only because it could endanger or degrade public health or sanitation.</p> <p>(e) a proposal for general commercial development.</p> <p>(f) a proposal for general industrial development.</p>	<p>(d) subject to paragraph 2 and 3, a proposal for emergency action.</p>

Environment Management (EIA Process) Regulations 2007

Part 4 of the Environment Management Act 2005 sets out the framework for the Environmental Impact Assessment process which must be applied to most proposals for development activities or undertakings before they can be approved. The Environment Management (EIA Process) Regulations 2007, defines Part 4 (EIA) of the EMA 2005 in details, as shown in Section 61 of the Act, provide the details.

The EIA Process Regulations 2007 states:

- a) what information must be contained in the application form when a development proposal is submitted for screening;
- b) how the approving authority is to screen proposals to decide whether they need an EIA report;
- c) how development proposals are to be submitted to the approving authority for EIA processing;

² Department of the Environment (2008). *Environmental Impact Assessment (EIA) Guidelines*. Government of Fiji

³ Evans, N. (2006). *Natural resources and the environment in Fiji: A review of existing and proposed legislation*.

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- d) if a report is needed, how the terms of reference for the report are drawn up, and what needs to go into the report;
- e) how the EIA report is published and reviewed; and
- f) how approval of the report is granted or refused.

Schedule 1 of the Regulations contains a number of forms: Form 1 - EIA Screening application; Form 2 - EIA processing application; and Form 3 - Application for registration/renewal EIA/review consultants. Schedule 2 contains the schedule of fees. A proponent who wishes to apply for screening of a proposal must apply to the approving authority on Form 1 in Schedule 1 to these Regulations and pay the prescribed fee. EIA forms are available for download from the DOE website:

<https://doefiji.wordpress.com/>

Environment Management (Waste Disposal and Recycling) Regulations 2007

The Environment Management (Waste Disposal and Recycling) Regulations 2007 allows the Waste and Pollution Control Administrator power to issue permits for solid and liquid waste discharge and air discharges. The regulations include national air quality standards and criteria for the discharge of liquid and solid waste.

Section 8 (1) of the regulation's states:

"8. – (1) A solid or liquid waste permit may relate to either construction or operation of a facility or any premises.

(2) A construction waste permit –

(a) relates to solid or liquid waste and pollutants generated during construction or demolition of premises of a facility; and

(b) lapses upon completion of the construction or demolition work"

Section 14 (1) of the regulation states:

"14. – (1) Subject to this regulation, every commercial or industrial facility that emits exhaust gases, smoke, steam or dust from any of its premises, must hold an air pollution permit in respect of the emission."

Project activities, for example the construction of the warehouse and installation of the incinerator housing, may generate waste, and so a solid waste permit may be required to dispose of any remaining construction materials. The operation of the incinerator will emit smoke and gasses and will likely need an air pollution permit.

The MHMS will follow the Fiji waste permit application process to determine what permits, if any, will be needed for the installation and operation of the incinerator and for the construction of the pharmaceutical warehouse.

Public Health (Building) Regulations

Building Permits are issued by Local Authorities (LA) under the Public Health Act Building Sections & Regulations. The purpose of building permits is to certify - for public health and safety - that construction methods are sound. When an application for Development Permission for building or rebuilding is lodged, applicants can also lodge an Application for Permission to Erect, Alter, Re-Build, Add to or Repair a Building, which can be considered simultaneously with the Application for Development Permission.

Information (fees and requirements) and forms relating to Building Permits can be obtained at the offices of the respective LA's. A LA cannot issue a Building Permit until the Director of Town & Country Planning (DTCP) provides consent to the Application for Development Permission within the Town Planning zone or scheme. However outside Town Planning scheme/zones Local Authorities have powers to approve without the consent of Director Town & Country Planning (DTCP). This permit process is relevant to both the construction of any ancillary buildings for the health medical waste treatment facility, such as the incinerator housing, and the construction of the warehouse.

2.5.1.1 DOE Capacity

The DOE have overall accountability for environmental and waste management in Fiji. MHMS have been consulting with the DOE regarding the procurement of the health medical waste treatment facility and also the incinerator technical advisory work. The DOE have some existing World Bank safeguard experience and capacity from working on previous World Bank funded projects such as the Fiji Transport Infrastructure and Investment Project (P150028). The Project will not fund complex sub-projects which have the potential to create significant social and environmental impacts and therefore, the capacity and resources of the DOE to process the required permits in a timely manner is considered to be adequate.

2.5.2 Health-care Regulatory and Policy Framework

Fiji has a well-established regulatory and policy framework that provides measures to improving health services. The Ministry of Health and Medical Services (MHMS) is responsible for managing Fiji's overall health care system. The MHMS administers a number of Acts, including the Public Health Act (2002), as delegated by Parliament and, since the suspension of Parliament in December 2006, by Decree. The MHMS sets standards through powers delegated to the Minister of Health, and these are enforced and monitored by the various regulatory bodies appointed under the relevant legislation⁴.

Other relevant plans and policies include:

- **National Development Plan (2017).** The Ministry of Economy's (MoE) National Development Plan (NDP) outlines a 20-year development plan (2017-36) that emphasises inclusive socio-economic development to improve the social well-being of all Fijians, with no one being left behind 'regardless of geographical location, gender, ethnicity, physical and intellectual capability and social and economic status'. The NDP vision is for a high-quality health system, where medical services will be raised to international standards. According to the NDP, investments will be made to reduce patient waiting time; improve hospital services; increase the number of beds; improve ambulance services; and raise the doctor-to-patient ratio to one doctor per 1,000 people. The government will continue with its free medicine scheme to assist low-income households⁵.
- **MHMS Strategic Plan (2020-2025).** This Strategic Plan sets the strategic direction for the next five years (2020-2025), based on a one system approach. It sets out MHMS's vision, mission, values and strategic priorities. The three strategic policies are: Reform public health services to provide a population-based approach for diseases and the climate crisis; Increase access to quality, safe and patient-focused clinical services; and Drive efficient and effective management of the health system. The plan is closely aligned to the National Development Plan (NDP) that emphasises inclusive socio-economic development to improve the social well-being of all Fijians, with no one being left behind⁶.

⁴ World Health Organization. Regional Office for the Western Pacific (2011) *The Fiji Islands health system review*.

⁵ MHMS, (2020). *Strategic Plan 2020-2025*

⁶ MHMS, (2020). *Strategic Plan 2020-2025*

- **Health Emergency and Disaster Management Plan (HEADMAP) (2013).** The primary objective of HEADMAP is to serve as a guide for the health sector in the management of public health emergencies and disasters. HEADMAP applies to all health programmes and activities within the National, Divisional and Sub divisional Health Services that are related to Health Emergencies and Disaster Management. These include mitigation, preparedness, emergency responses, relief and rehabilitation.
- **Gender Policy and Rights of Persons with Disabilities Act (2018).** The National Gender Policy promotes gender equality, including improved male health-seeking behaviour. The Rights of a Person with Disabilities Act states that people with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.
- **2007 National Policy on Sexual Harassment in the Workplace.** The GoF considers sexual harassment in the workplace an important and priority issue that Fiji has to address in order to ensure a quality work environment free of intimidation and sexual harassment, and to enhance productivity. The Government believes that every working person should be able to enjoy a working environment free from all forms of harassment and discrimination, whether on the basis of ethnicity, national or social origin, religion, political affiliation, gender, or any other form of personal identity. Therefore, behaviour and attitudes respecting the dignity and human rights of a worker will be actively promoted.

2.5.3 Health & Government Infrastructure Approvals Process

Public Health Act Building Section and Regulations clearly spells that “Any person who intends to build/Construct, alter or add to a building must obtain a permit in writing first from the LA”. The approval processes are clearly stated in the Building section and Regulations. Whilst there is not a detailed written description of internal Government process pertaining to development, infrastructure and construction of Government Facilities, there is a systematic legal approval process that needs to be followed in Fiji.

The MHMS has a well-established Asset Management Unit (AMU) that has the responsibility of planning, asset surveys and management, understating minor and major projects, maintenance and development works and to oversee MHMS facilities.

Any development application before being submitted for building approvals or legislative approvals undergoes an internal vetting process. A working force is formed consisting of recipient division/sub-division and the AMU team. This working work is expected to research and make the recommendations to PSHMS for approvals.

Upon approvals from the Permanent Secretary MHMS, the development project seeks the support and assistance of the Ministry of Infrastructure and Transport (MoIT) and the application may undergo a vetting process with the Construction Implementation Unit (CIU) based at the Ministry of Economy.

These processes though not well-documented are necessary and mandatory to ensure that there is a sustainable approach to development projects in Fiji. The timelines for vetting under the CIU may vary from a few weeks to a months.

After the internal process is complete, plans are lodged with respective LA’s for approval and issuance of a building permit.

These processes will therefore be required to be adhered to when undertaking development, construction under this project.

2.5.4 COVID-19 Preparedness and Response

- **COVID-19 Preparedness and Response Plan** – The MHMS developed a COVID-19 Preparedness and Response Plan in early March. The objectives of the Plan are to: (a) facilitate preparedness of health services and other relevant agencies for a potential case of COVID-19; (b) support a coordinated system-wide response to a potential case of COVID-19; (c) provide guidance to health services and related agencies for the management of potential case of COVID-19; and (d) outline key activities and responsible units and individuals. The Plan is a living document that will be regularly updated based on the evolving situation and as more information is generated about the outbreak. It is being implemented with the oversight of the IMT) or Incident Management Team
- **Risk Communication Strategy** – The risk communication strategy was prepared under the COVID-19 Preparedness and Response Plan. It sets out the strategies for undertaking COVID-19 community awareness and communication to increase knowledge and understanding among the general population about the risk and potential impact of the pandemic. The Project SEP was developed with the risk communication strategy as a reference and in terms of messaging is consistent with the Preparedness and Response Plan. However, the SEP is specifically focused on activities supporting the Project, while the National strategy also deals with broader social issues and stakeholders.

2.5.5 Infection Prevention Control and Health Care Waste Management

The health-care waste management sector relies on legislative and regulatory documents that contain general waste provisions. The laws, policies and guidelines summarized in Table 3 should be used as the guidance for proper management of health-care wastes in Fiji. An IPC&WMP has been developed for the project (Annex VIII) and contains procedures, based on WHO guidance, for the safe operation of health facilities and protection of the public from exposure to the virus as a result of project activities.

Table 3 – Fiji Health-Care Waste Management Legislation Summary⁷

Legislation	Type	Summary	Regulator/ Agency
Environmental Management Act 2005	Act	Part 5 of the EMA 2005 sets out the framework for Waste Management and Pollution Control in the Fiji Islands. It establishes a waste and pollution permitting system that aims to protect the environment by controlling the release of solid and liquid wastes, the emission of polluting gases, smoke and dust, and the handling, storage and disposal of waste and hazardous substances.	Department of Environment
Environmental Management (Waste Disposal and Recycling) (Amendment) Regulations 2011	Reg.	The purpose is to prevent environmental pollution by controlling the discharge and disposal of solid wastes, air emissions, and hazardous substances. It also prescribes permitting conditions for landfills, waste dumps, waste transport, waste recycling facilities, importing/manufacturing plastic bottles, and lead acid battery handling	Department of Environment

⁷ SPREP, (2014). *Baseline Study for the Pacific Hazardous Waste Management Project – Healthcare Waste, Fiji*.

Environmental Management (Container Deposit) Regulation 2011	Reg.	Provides the legal framework for the establishment of the Container Deposit and Refund Recycling System.	Department of Environment
National Solid Waste Management Strategy 2011 – 2014 (under review)	Strategy	Key objectives of this strategy: <ul style="list-style-type: none"> • reduces the amount of waste that each community generates. • make best use of the waste that is generated, • develop and implement economic and social incentive mechanisms to change wasteful behavior. • improve and upgrade existing waste management and disposal systems. • encourage /provide waste management practices, which minimise the environmental risk and harm to human health. • provide a guideline template for rural or community level solid waste management practices. 	Department of Environment
Public Health Act 2005	Act	Requires persons engaged in carrying or removing garbage to apply for a permit from the local authority <ul style="list-style-type: none"> • Allows local authorities to formulate bylaws in respect of the storage, collection and disposal of garbage, and prescribing the fees to be paid for removal of garbage. • Regulates (i.e., garbage dumps, and incineration of garbage or refuse). • Health Care management Policy and Guidelines. 	MHMS
Draft Health-care Waste Management Policy 2011 (Under review)	Policy	Reference from National Solid Waste Management Strategy 2011 – 2014 indicates that all health care waste (including from small clinics) must be incinerated in Fiji.	MHMS
Revised draft IPC Plan for MOHMS		The 2011 IPC manual has been revised with the assistance from SPC which includes infectious disease such as Ebola and COVID19.	MHMS

2.5.6 Labour Legislation

Labour legislation relevant to the project is summarized in the Labour Management Procedure (LMP) (Annex IX).

2.5.7 Summary

In summary, there are clear linkages between the requirements of the country's legal framework and the Project activities. The main conclusions are:

- The installation and operation of the health care waste treatment facility will require an EIA report as per EMA approved by the EIA Administrator or by the Director of Environment. The WB

will also require an ESIA and a “No objection” has to be obtained before the commencement of the project. The EIA process will be followed by MHMSs’ compliance to the conditions of the EIA report approval (if any) for the installation and operation of the health care waste treatment facility and the warehouse.

- The construction of the warehouse and installation of the health care waste treatment facility will generate waste, and so a solid waste permit may be required to dispose of any remaining construction materials. Waste generated during construction of the warehouse and medical waste treatment facility will be the responsibility of the contractor for its safe disposal to the satisfaction of the LA. This will be in-built in the scope and tender documents. The operation of the incinerator will emit smoke and gasses and will likely need an air pollution permit. MHMS will follow the Fiji waste permit application process to determine what permits, if any, will be needed for the installation and operation of the incinerator and for the construction of the pharmaceutical warehouse.
- The Building Permits process is relevant to both the construction of any ancillary buildings for the incinerator, such as the incinerator housing, and to the construction of the warehouse.
- The Project will not fund complex sub-projects which have the potential to create significant social and environmental impacts and therefore, the capacity and resources of the DOE to process the required permits in a timely manner is considered to be adequate.
- There is a Building Permit and Government Infrastructure approvals process. These processes, are necessary and mandatory to ensure that there is a sustainable approach to development projects in Fiji. These projects will not be undertaken by CIU, however MOHMS will work closely with CIU for the tender process, scope of work, bidding documents and agreements. The COVID-19 Preparedness and Response Plan will be regularly updated based on the evolving situation and as more information is generated about the outbreak. It is being implemented with the oversight of the CRU formerly known as Incident Management Team (IMT)

2.6 World Bank Environmental and Social Standards

2.6.1 ESF Standards Relevant to the Project

The Environmental and Social risk is classified as ‘Substantial’ for the Project. Five of the ten Environmental and Social Standards (ESSs) of the World Bank’s (WB’s) Environmental and Social Framework (ESF) have been screened as relevant. They are assessed in Table 4 below.

The other five are considered not relevant, namely: ESS5 Land Acquisition, Restrictions on Land Use and Involuntary Resettlement, ESS6 Biodiversity Conservation and Sustainable Management of Living Natural Resources, ESS7 Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities, ESS8 on Cultural Heritage, and ESS9 on Financial Intermediaries. Detailed information on the Bank’s ESF are available at: <https://www.worldbank.org/en/projects-operations/environmental-and-social-framework>.

The ESS that apply to the Project and the required measures and actions that apply, as contained in the Environmental and Social Commitment Plan (ESCP)⁸, are listed in Table 4.

Table 4 - Required Project Environmental and Social Standard Actions

⁸ Disclosed version of the ESCP is available at: <http://www.health.gov.fj/media-center/novel-coronavirus-covid-19/world-bank-project/>

Environmental & Social Standard	Required Measures and Actions
ESS1 Assessment and Management of Environmental and Social Risks and Impacts	<p>The Ministry of Health and Medical Services (MHMS) appointed a project manager supported by qualified staff, Finance officer, Procurement officer and a Health Risk Communication officer including a local environmental, social, health, safety and community engagement (ESHSC) specialist and an international environment, social and health and safety (ESHS) specialist (part time) with resources to support management of ESHS risks and impacts of the Project.</p> <p>The MHMS has developed an Environmental and Social Management Framework (ESMF) which had been disclosed and adopted. The ESMF is currently under review to reflect its validity and face value. The MHMS has assessed the environmental and social risks and impacts of proposed Project activities, in accordance with the ESMF, to ensure that individuals or groups are not disadvantaged to access the development benefits resulting from the Project. Assessments have been conducted for the warehouse and will be carried out for medical waste treatment facility as soon as a site is agreed and confirmed at Naboro Land fill and the lockdowns are lifted to move safely in the community. This will be done prior to the carrying out of the relevant Project activities.</p> <p>The MHMS shall prepare, disclose, adopt, and implement any Environmental and Social Impact Assessment and Environmental and Social Management Plans (ESIAs and ESMPs), including the health care waste treatment facility and the construction of the warehouse, and other instruments required for the respective Project activities based on the assessment process, in accordance with the ESSs, the ESMF, the ESHGs, and other relevant Good International Industry Practice (GIIP) including relevant WHO guidelines on COVID-19. The ESIA for the warehouse has been prepared and is under review while MOHMS awaits agreement/confirmation of a site at Naboro landfill before ESIA and ESMP could be prepared, disclosed and adopted prior to the procurement of the incinerator and commencement of construction of the warehouse.</p>
ESS2 Labour and Working Conditions	<p>The MHMS has adopted the Labour Management Procedures (LMP) incorporating the relevant requirements of ESS2. The LMP will be updated disclosed and adopted as part of the ESMF.</p>
ESS3 Resource Efficiency and Pollution Prevention and Management	<p>The MHMS has reviewed the IPC manual for Fiji and drafted a Waste Management Plan (IPC&WMP). The IPC&WMP will be prepared, disclosed and adopted as part of the ESMF, no later than 30 days after Effective Date.</p> <p>The MHMS has developed an ESMF which is currently under review which will be, disclosed and adopted no later than 30 days after Effective Date and prior to commencement of relevant Project activities. The ESMF includes measures to manage health care wastes and other types of hazardous and non-hazardous wastes associated with proposed Project activities.</p>
ESS4 Community Health and Safety	<p>The revised IPC has incorporated precautions measures in line with the ESMF, IPC&WMP and WHO guidelines on COVID- to prevent or minimize the spread of the infectious disease/COVID-19 from laboratories and medical facilities to the community.</p>
ESS7 Indigenous Peoples/Sub-Saharan African Historically	<p>While this standard is not considered relevant, the Project's ESCP and SEP commit the project to raising awareness and conducting stakeholder engagement with disadvantaged or vulnerable individuals and groups across the</p>

Environmental & Social Standard	Required Measures and Actions
Underserved Traditional Local Communities	Fijian population, including across diverse ethnic groups. Awareness raising and stakeholder engagement will be adapted to account for such groups or individuals' particular sensitivities, concerns and cultural sensitivities.
ESS10 Stakeholder Engagement and Information Disclosure	The SEP has been updated, and it will be disclosed and adopted with this revised ESMF. The MHMS has adopted, implemented and updated the Grievance Mechanism (GM). It will be continuously be updated. Refer Annex IX.

2.6.2 World Bank Group Environmental, Health and Safety Guidelines (EHS Guidelines) relevant to the project

The following EHS guidelines are relevant to the project and have been used to guide the development of the Code of Environmental Practice (CoESP), IPC&WMP, and LMP:

- General EHS Guidelines: Community Health and Safety. Section 3.6 - Disease Prevention.
- General EHS Guidelines: Occupational Health and Safety.
- General EHS Guidelines: Waste Management.
- Environmental, Health, And Safety Guidelines Health Care Facilities.

2.6.3 World Bank Response to COVID-19.

The World Bank Group (WBG) has developed the following guidance material in response to COVID-19 outbreak:

- Guideline for the preparation of a Contingency Plan for Project Sites
- Technical Note: Public Consultations and Stakeholder Engagement to be applied to projects under implementation and those under preparation.
- Technical Note: Use of Military Forces to Assist in Covid-19 Operations Suggestions on how to Mitigate Risks.
- Technical Note on SEA/H for HNP COVID Response Operations

For ESS1, the WBG also identifies risks and mitigations measures for the transactions involving specific project finance activities (i.e. works, goods and services, and technical assistance). The guidance has been considered during the preparation of this ESMF and supporting documents.

2.7 Relevant International and Regional Agreements and Conventions

Fiji is a party to the following relevant regional and international agreements:

- **Natural Resources & Environment of South Pacific Region (1986) (SPREP or Noumea Convention).** This Convention is the major multilateral umbrella agreement in the Pacific Region for the protection of natural resources and the environment. This Convention was ratified by Fiji in 1989 and entered into force in 1990.
- **Pacific Regional Solid Waste Management Strategy 2010-2015.** Fiji was one of several Pacific island countries to adopt the Pacific Regional Solid Waste Management Strategy, initiated by SPREP, and adopted by member countries in 2009.
- **Stockholm Convention for Persistent Organic Pollutants.** The Stockholm Convention on Persistent Organic Pollutants is an international environmental treaty, signed in 2001 and

- effective from May 2004, that aims to eliminate or restrict the production and use of persistent organic pollutants (POPs). This convention entered into force in Fiji in May 2004.
- **Waigani Convention on Hazardous Waste.** The 1995 Waigani Convention is a treaty that bans the exporting of hazardous or radioactive waste to Pacific Islands Forum countries and prohibits Forum island countries from importing such waste. The convention has been ratified by Fiji and entered into force in 1996.

2.8 Relevant Good International Industry Practice (GIIP)

Relevant Good International Industry Practice (GIIP) such as WHO technical guidance have been developed for addressing COVID-19. These technical guidance documents are evolving, and they are being updated as new information becomes available. The guidance has been considered during the preparation of this ESMF and supporting documents.

WHO resources include technical guidance on: (i) [laboratory biosafety](#), (ii) [infection prevention and control](#), (iii) [rights, roles and responsibilities of health workers, including key considerations for occupational safety and health](#), (iv) [water, sanitation, hygiene and waste management](#), (v) [quarantine of individuals](#), (vi) [rational use of PPE](#), (vii) [oxygen sources and distribution for COVID-19 treatment centres](#), (viii) [Surveillance and case definitions](#) (ix) [Risk communication and community engagement](#)

WHO Guidelines for COVID-19 are summarized in Table 5. Additional guidance is also listed in Annex X.

Table 5 – WHO Guidelines for COVID-19

WHO Guideline	Content
Covid-19 guidance environmental on cleaning for healthcare facilities 17 April 2020	Guidance on the cleaning and disinfection of rooms and wards or areas in healthcare facilities occupied with suspected and confirmed COVID-19 patients.
Covid19-stigma-guide	Methods to address risk of social stigma and discriminatory behaviours against people of certain ethnic backgrounds as well as anyone perceived to have been in contact with the virus.
Critical preparedness readiness and response actions COVID-10 2020-03-22_FINAL-eng	Update to the interim guidance document. This version provides updated links to WHO guidance materials and provides the full list of WHO technical guidance available for COVID-19 and provides updated recommendations in the table.
WHO-2019-nCoV-essential_health_services-2020.1-eng	Countries will need to make difficult decisions to balance the demands of responding directly to COVID-19, while simultaneously engaging in strategic planning and coordinated action to maintain essential health service delivery, mitigating the risk of system collapse. ... Establishing effective patient flow (including screening, triage, and targeted referral of COVID-19 and non-COVID-19 cases) is essential at all levels.
WHO-2019-nCoV-Hand_Hygiene_Stations-2020.1-eng	Hand hygiene is the most effective single measure to reduce the spread of infections through multimodal strategies.

WHO Guideline	Content
WHO-2019-nCoV-HCF_operations-2020.1 – eng	To guide the care of COVID-19 patients as the response capacity of health systems is challenged; to ensure that COVID-19 patients can access life-saving treatment, without compromising public health objectives and safety of health workers.
WHO-2019-nCoV-HCW_risk_assessment-2020.2-eng	This data collection form and risk assessment tool can be used to identify infection prevention and control breaches and define policies that will mitigate health care worker's exposure and nosocomial infection (infection originating in a hospital).
WHO-2019-nCoV-HCW advice-2020.2-eng	This document highlights the rights and responsibilities of health workers, including the specific measures needed to protect occupational safety and health.
WHO-2019-nCoV-IPC_Masks-2020.3-eng	It is possible that people infected with COVID-19 could transmit the virus before symptoms develop. It is important to recognize that pre-symptomatic transmission still requires the virus to be spread via infectious droplets or through touching contaminated surfaces.
WHO-2019-nCoV-IPC_WASH-2020.2-eng	Frequent and proper hand hygiene is one of the most important measures that can be used to prevent infection with the COVID-19 virus. WASH practitioners should work to enable more frequent and regular hand hygiene by improving facilities and using proven behaviour-change techniques.
WHO-2019-nCoV-IPC-2020.3-eng	Guidance on infection prevention and control (IPC) strategies for use when COVID-19 is suspected.
WHO-2019-nCoV-IPC PPE_use-2020.2-eng	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.
WHO-2019-nCoV-Leveraging_GISRS-2020.1– eng	Several countries have demonstrated that COVID-19 transmission from one person to another can be slowed or stopped. The key actions to stop transmission include active case finding, care and isolation, contact tracing, and quarantine.
WHO-COVID-19-lab_testing-2020.1-eng	Laboratory testing guidance for COVID-19 in suspected human cases.
WHO-COVID-19-IPC_DBMgmt-2020.1-eng	Interim guidance for all those, including managers of health care facilities and mortuaries, religious and public health authorities, and families, who tend to the bodies of persons who have died of suspected or confirmed COVID-19.
WHO-WPE-GIH-2020.2-eng	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.

WHO Guideline	Content
WHO 2019 Overview of the Technologies for the Treatment of Infectious and Sharp Waste from Health Care Facilities?	The purpose of this document is to provide 1) criteria for selecting technologies to facilitate decision making for improved health care waste management in health care facilities and 2) an overview of specific health care waste technologies for the treatment of solid infectious and sharp waste for health care facility administrators and planners, WASH and infection prevention control staff, national planners, donors and partners.

3 Environmental and Social Baselines

3.1 Socio-Economic Baseline

Fiji is classified as an upper middle-income country and, although it shares the constraints of a small population, remoteness, and vulnerability to natural disasters, it is relatively more developed and larger than most other Pacific island countries. Fiji is an economic, political, and social leader across the South Pacific and, given its geographical location, an important hub for transport and many other services in the region.

Fiji has a population of about 885,000 people distributed over a total area of 18,273km². The population is concentrated on the islands of Viti Levu (about 80% of the total population) and Vanua Levu (about 15% of the total population), which together account for about 87% of the total land area. Fiji achieved nine consecutive years of growth, averaging 3.1% per annum, between 2010 and 2018. However, the economic base is narrow and remains heavily reliant on the tourism sector; the closest major markets are New Zealand and Australia, some 2,000–3,000km away; and Fiji is vulnerable to natural disasters (it is estimated, for example, that Tropical Cyclone Winston in 2016 caused damage and losses equivalent to 29.2% of GDP). Major challenges for sustained and inclusive growth include low levels of private investment and reliance on public investment to drive economic growth; limited access to quality services and economic opportunities caused in part by infrastructure deficits; and vulnerability to climate and disaster risks and other external shocks that erode fiscal buffers and cause economic volatility.

3.1.1 Vulnerable Groups

Fiji has one of the lowest rates of extreme poverty and inequality in the Pacific. Fiji in 2018 was ranked 98 out of 189 countries on the UNDP Human Development Index, putting it in the High Human Development category⁹. The period 1990 to 2018 witnessed significant increases across the range of HDI indicators: life expectancy at birth increased by 2.0 years (to 73.1 years for women and 67.1 years for men); mean years of schooling increased by 2.5 years and expected years of schooling increased by 2.3 years; and GNI per capita increased by about 60.3%. In 2013, just 1.4% of people in Fiji lived in extreme poverty, or under the US\$1.90 per day (2011 purchasing power parity) poverty line. Inequality in Fiji is also among the lowest in the East Asia and Pacific region: the Gini Index, a measure of inequality, stood at 36.4 in 2013. However, the incidence of poverty in Fiji at 48.6% remains higher than that of most other upper middle-income countries.

⁹ United Nations Development Program (2019). *Human Development Report 2019, Inequalities in Human Development in the 21st Century: Briefing note for countries on the 2019 Human Development Report, Fiji*.

3.1.2 Indigenous People and Culture

The Indigenous Peoples of Fiji, the iTaukei, represent the mainstream society in Fiji. The iTaukei represent the majority, or 57 percent of the population according to the 2007 census. As iTaukei customary cultural, economic, social and political institutions are the mainstream culture of Fijian society, ESS7 is not considered relevant. While ESS7 is not deemed relevant to the project, the project will still ensure that all stakeholder engagement with local people through the project activities are maintained. Consultations will be done in the preferred language of the community keeping cultural sensitive issues and protocols in mind. In light of the iTaukei protocols especially SE in villages, traditional protocols through Ministry of iTaukei Affairs and Provincial Office will be coordinated.

The remaining population in Fiji are comprised of Indo-Fijians, whose ancestors migrated to the Fijian Islands in the late 19th and early 20th centuries, make up 38 percent of the population. The remaining 5 percent consist of other minority communities, including people from various Pacific Island countries, Australia, New Zealand, the People's Republic of China, and Europe.

3.1.3 Economy

Fiji's economy has outperformed most other Pacific island countries, enjoying steady growth since 2010—longer than any other period since it gained independence in 1970. Average growth during 2010–2018 was 3.1%, and average annual inflation during 2010–2018 was 3.4%, just above the government target of 3.0% per year. Per capita income increased from \$3,684 in 2010 to \$5,678 in 2018. The period saw a significant increase in the importance of the services sector, in particular tourism, in Fiji's economy: the service sector's share of GDP increased from 68.6% in 2010 (constant prices) to 71.2% of GDP in 2018, while the agriculture and manufacturing sectors' share decreased. Overall growth was driven by public investments and tourism, while private investment outside of the tourism industry remained low. The trade deficit is largely offset by remittances and tourism earnings.

Tourism is the largest foreign exchange earner for Fiji and contributes significantly, both directly and indirectly, to the country's economy. Further, Fiji is a regional transit hub, with many flights to other Pacific Island countries passing through Nadi International Airport. The tourism sector has been impacted adversely by the restrictions on travel imposed during the Covid-19 pandemic, including closure of the airport and other ports of entry.

3.1.3.1 *Economic impacts resulting from the COVID-19 crisis*

It is expected that the economic impact of COVID-19 on the Fiji economy will be significant. The most direct impact would be through the increased illness and mortality on the size and productivity of the labour force. The major economic impact is attributable to international travel restrictions on tourism, which is an important source of employment and income. Other expected disruptions to economic activity include the closure of workplaces, workplace absenteeism, disruption of production processes and 'physical/social distancing' practices which reduce demand for retail sales, leisure and entertainment and mass transportation, and negatively impact local business development.

Government policy efforts to prevent the epidemic, contain it, and mitigate its harmful effects on the population will directly impact the national economy. The imposition of travel restrictions and lockdowns which require citizens to stay at home and only essential businesses to remain open will have economic effects in Fiji which are difficult to quantify but are expected to be significant. Unemployment will rise due to shrinking demand for goods and services. The downturn in the economy will be most significantly felt by the most vulnerable and relief measures will need to be targeted to ensure basic needs such as food and health services remain available. To reduce the economic impact from COVID-19, Fiji like many countries, has introduced an economic stimulus package to support its citizens through this economic

hardship. A supplementary budget (FJD1 billion) was announced on March 26, 2020 in response to the COVID-19 pandemic. Supplemental expenditures have been approved for public health, lump sum payments through the Fiji National Provident Fund, tax and tariff reductions, and loan repayment holidays aimed at protecting public health, supporting the economy and ensuring food security.

3.1.4 Health and Health-care Services

Since Independence in 1970, Fiji has made considerable progress in improving its key health indicators, however, significant health challenges remain. While life expectancy has increased steadily up until 2018, improvements in maternal mortality have stagnated in recent years. Infant mortality and under five mortality continuously decreased until 2002, reaching minimum values of 19 and 22.4 per 1,000 live births, respectively. Since 2002, these trends experienced a slight reversal, increasing to 21.6 and 25.6 per 1,000 live births, respectively in 2018.

In addition, in line with Fiji's demographic transition, non-communicable diseases now represent the leading cause of morbidity and mortality, accounting for 76% of the loss of Disability Adjusted Life Years. These diseases increase vulnerability to severe COVID-19 (and other infections), therefore putting the population of Fiji at high risk of COVID-19 complications.

Health services in Fiji are tax funded, provided mainly at public facilities and primarily free of charge. The Ministry of Health operates via a system of four decentralised divisional offices, geographically based:

- Central and Eastern (often combined) in Suva
- Western in Lautoka, and
- Northern in Labasa¹⁰.

The divisional offices are responsible for provision of public health services, operation of the sub-divisional hospitals, health centres and nursing stations, and are led by a Divisional Medical Officer, reporting to the Deputy Secretary Public Health. Fiji faces challenges in health service delivery, with many public health facilities in deteriorating condition and shortages of pharmaceutical and medical supplies a regular occurrence¹¹.

Government budget allocations for health have remained relatively constant, despite the increasing demand and cost for health care. Health sector budgets have decreased in real terms, with current and public expenditure on health in Fiji relatively low compared to the country's income level. Government health expenditure as a proportion of total government expenditure has averaged 7.4% for the last 5 years. Over that same period, health expenditure as a proportion of gross domestic product has hovered around 2.5%. Compared to most other low- and middle-income countries in the Pacific, Fiji is at the lower end of the spectrum on this indicator. Since 2011, out-of-pocket expenditure as a proportion of total health expenditure has been declining. In terms of resource input, salaries and administration account for the bulk of the health budget. In terms of service outputs, clinical services at hospitals absorb most of the health expenditure. This leaves little for health promotion, prevention and/or broader public health initiatives at the lower level health facilities and to the communities they serve.

The delivery of healthcare is challenging in a country that comprises 332 islands spread over 1.3 million square kilometres of the South Pacific Ocean. Health services are provided through a range of offices and

¹⁰ SPREP (2014). *Baseline Study for the Pacific Hazardous Waste Management Project Healthcare Waste - Fiji*.

¹¹ SPREP (2014). *Baseline Study for the Pacific Hazardous Waste Management Project Healthcare Waste - Fiji*.

health facilities, including the Ministry of Health & Medical Services (MHMS) head office, three divisional offices with administrative and clinical facilities, 25 hospitals, 19 sub-divisional offices, 80 health canter, 6 specialized centres, and 107 nursing stations. Fiji has a national ratio of 2.05 hospital beds per 1,000 population (this excludes holding beds available at isolated health canter for short-term observation of general patients and those requiring emergency births or awaiting transfers), but there is considerable variation across the country. Overall, the efficiency and quality of the health system could be improved by increased and adequate investment in upgrading and maintenance of health infrastructure. This includes adequate provision of hand basins in good working order and related sanitation measures which are essential components of basic infection prevention and control interventions.

3.1.4.1 Population health

Average life expectancy in Fiji rose from 65.5 years in 1990 to 70.4 years in 2017. The country has a young population: 54% of the population in 2017 were under 30 years old. The population is also rapidly becoming more urban, especially in the Greater Suva area, increasing demand for services.

Non-communicable diseases are responsible for an estimated 78% of premature deaths, the majority of recorded in groups aged between 45 and 59 years. Cardiovascular diseases, cancers, diabetes and chronic respiratory diseases are the main contributors to the deaths and are often linked to other health problems. There is evidence of an increasing trend in obesity in younger generations.

Mental health is increasingly recognised as an area where additional support is needed throughout the health system for children, adolescents and adults. As an indication of the burden, adult suicides increased from 29 people in 2015 to 61 people in 2017 across all age groups.

Fiji has made significant improvements in the capability of its health systems to deal with infectious diseases, and also with community health promotion and messaging on communicable diseases, in particular, dengue, typhoid and leptospirosis. Acute respiratory infections are reported as the most common communicable diseases through the National Notifiable Disease Surveillance System. Tuberculosis cases have risen steadily over the past 20 years. From 2010 to 2016 there were 50-70 new cases of HIV per year; at February 2017, Fiji had a cumulative total of 747 confirmed HIV cases. 31 Major outbreaks in recent years have included dengue in 2013-14 and meningococcal C, which was new to Fiji in 2018. A measles outbreak was declared in November 2019, in response to 28 cases in the Central Division. The MHMS aims to vaccinate at least 95% of people in the target group and has to date immunised more than 300,000 people in the target group against measles.

Around 96% of Fiji's population has access to improved drinking water sources, with the unserved 4 per cent living in rural areas. Some 87% of the population have access to improved sanitation facilities. However, the data have not been updated for several years and expansion of peri-urban areas may affect the countrywide access figures. Rapid urbanisation is leading to increased demand for services, especially in the Greater Suva area. Of particular concern from the perspective of environmental risks and human rights are urban sprawl, inadequate sewage collection and treatment infrastructure, and poor solid waste management. Inadequate sanitation facilities and poor waste management threaten human and ecosystem health by contaminating soil, food, air, fresh water and the ocean. There are roughly 200 informal settlements in Fiji, home to around 15% of the population.¹²

¹² Ministry of Health and Medical Services (2019). *Strategic Plan: 2020-2025*

3.1.5 Current COVID-19 Status

Fiji is one of the many Pacific Island countries that had or still has active COVID-19 cases. Currently Fiji is going through the second wave of COVID19 and as of 26th May 2021 Fiji had 272 cases since first case was detected in March 2020, 121 active cases in isolation with 147 recoveries and 4 deaths Gender Equality

Occupational discrimination and gender segregation in education and the labour market are persistent challenges in Fiji. Women's share of employment is significantly lower than that of men, and there is a gender wage gap. According to the 2017 census, the labour force participation rate for women was 37.4% compared to 76.4% for men, and the unemployment rate for women was 7.8% compared to 2.9% for men.

Many women work in the informal sector. Fiji has higher financial inclusion rates for women than other Pacific island countries but more women than men are excluded from financial services. On the United Nations Gender Inequality Index, Fiji had an index value of 0.352 in 2017, ranking it at 79th out of 160 countries. In 2018, a World Economic Forum (WEF) report on gender gaps ranked Fiji 106th out of 149 countries. The migration of men to urban areas has increased the number of female-headed households in rural areas, which has increased pressures on women but may lead to changes in traditional gender roles. The WEF report identified economic participation and opportunity, and political empowerment as key issues, though Fiji ranked better for health and survival and educational attainment. Nevertheless, challenges remain in areas such as sexual and reproductive health and rights, and gender-based violence.

3.1.6 Gender Based Violence

Violence against women in Fiji is recognised to be pervasive, widespread and a serious national issue. The Fiji Women's Crisis Centre reports that overall, 72% of women experienced one or more types of violence in their lifetime from their husbands or partners – physical, sexual or emotional. This is particularly prevalent in the Eastern Division. The percentage of women who have been subjected to domestic violence by their husband or partner during their lifetime in the Eastern Division is one of the very highest recorded to date in the world – 79% of women in the Eastern Division experienced physical violence compared with 61% for Fiji as a whole, and 53% experienced sexual violence compared with 34% for the whole country¹³.

The rates of violence against women and girls are generally lower than the national average for Indo-Fijian women, and significantly higher for i-Taukei women, as well as for all other ethnic groups combined. This is closely related to the higher prevalence in the Eastern Division, which has a much higher proportion of i-Taukei communities, compared with other Divisions¹⁴.

The stress, disruption of social and protective networks, and reduced access to services associated with the Covid-19 pandemic, are all likely to exacerbate the risk of gender-based violence in Fiji. As distancing measures are put in place and people are encouraged to stay at home, the risk of intimate partner violence is likely to increase. For example:

- The likelihood that women in an abusive relationship and their children will be exposed to violence is dramatically increased, as family members spend more time in close contact and families cope with additional stress and potential economic or job losses.

¹³ Fiji Women's Crisis Centre (2013). *Somebody's Life, Everybody's Business!*. Fiji Women's Crisis Centre (FWCC)

¹⁴ Fiji Women's Crisis Centre (2013). *Somebody's Life, Everybody's Business!*. Fiji Women's Crisis Centre (FWCC)

- Women may have less contact with family and friends who might provide support and protection from violence.
- Women bear the brunt of increased care work during this pandemic. School closures further exacerbate this burden and place more stress on them.
- The disruption of livelihoods and ability to earn a living, including for women (many of whom are informal wage workers), may reduce access to basic needs and services, increasing stress on families, with the potential to exacerbate conflicts and violence. As resources become scarcer, women may be at greater risk for experiencing economic abuse.

3.2 Environmental Baseline

3.2.1 Solid Waste Management

Waste legislation, strategies, resources and facilities are generally available and implemented in Fiji. There are 12 urban sanitary districts (two city and 10 town councils) and 16 rural sanitary districts in Fiji. Under the Local Government Act, city and town councils are responsible for the management of solid waste. Health Inspectors, who report to the Ministry of Health, are given powers under the Public Health Act to monitor the disposal of garbage. The DOE is responsible for ensuring that waste management acts and regulations, and the development of policies on waste management are in place to safeguard the Environment¹⁵.

Fiji is particularly concerned with solid waste management (SWM) as it has the potential to cause negative impacts on the fragile environment, tourism, trade, food supplies, public health and severely place constraint on the existing limited resources¹⁶. However, most solid waste is still currently being thrown in open dumpsites, illegally disposed of in the sea, on unused land, or in the streets¹⁷. In parts of Fiji, illegal dumping and burning of waste are still common due to inadequate enforcement¹⁸. Finding suitable new landfill sites is often quite difficult due to land issues like customary rights over the use of land and reluctance by landowners to lease land for use as disposal sites due to fear of negative environmental, social and economic impacts¹⁹.

However, despite these challenges Fiji, Suva City in particular, has achieved important improvements in SWM in recent years. In Suva, the wastes collected by Suva City Council are now disposed of at the sanitary landfill at Naboro. The landfill, located 24 kilometres from central Suva, also serves Lami; Nasinu; and Nausori towns, as well as Navua and Korovou. The nearest built environment to the existing Naboro landfill is the Naboro prison which is on an elevated landscape approximately 500 m away on the same side of the Queens high way. A small informal settlement is also located opposite Queens's highway and approximately 1km away from the preferred site at Naboro landfill. There are other small scattered settlements (Google Ariel map) far away from landfill. All residential and industrial wastes can be deposited at the landfill if it meets the acceptance criteria established by DOE. The anaerobic landfill was developed at a cost of about F\$14 million (around US\$7.56 million) with funding from the European Union

¹⁵ GOF (2011). *Fiji National Solid Waste Management Strategy (2011-2014)*.

¹⁶ Kumar, P. (2013). *Country Analysis Paper – Fiji*. 3Rs in the Context of Rio+20 Outcomes – The Future We Want” Ha Noi, Viet Nam, 18-20 March 2013.

¹⁷ GOF (2011). *Fiji National Solid Waste Management Strategy (2011-2014)*

¹⁸ ADB (2014). *Solid Waste Management in the Pacific: Fiji Country Snapshot*.

¹⁹ Kumar, P. (2013). *Country Analysis Paper – Fiji*. 3Rs in the Context of Rio+20 Outcomes – The Future We Want” Ha Noi, Viet Nam, 18-20 March 2013.

and began operations in October 2005 after the closure of the Lami dump. The landfill has a life of at least 70 years. It covers an area of 7 hectares in the current first stage and will cover 38.2 hectares in another four stages. The landfill receives 184 tons of waste per day, of which councils account for about 70% and waste management companies for 30%. The landfill is owned by the Government of Fiji, and its operation falls under the responsibility of DOE, which contracts out landfill management to the private sector. The operator monitors leachate and water quality in an upstream creek and wetland and three wells downstream on a daily basis, and reports once a month to DOE. The opening of the landfill in Naboro has significantly reduced environmental and public health risks in recent years²⁰.

Under the JICA-funded Waste Minimization and Recycling Promotion Project, some improvements have also been made to the Vunato Waste Disposal Site, which services Nadi Town and Lautoka City. These improvements include the establishment of a composting operation, the installation of a weigh bridge and data collection systems, the procurement of heavy equipment, compaction and placement of waste, and development of a site operational plan²¹. Improvements to the Labasa Landfill on Vanua Levu have also been implemented by the Secretariat of the Pacific Regional Environment Programme (SPREP) with the technical expertise of the Japanese Technical Cooperation Project for Promotion of Regional Initiative on Solid Waste Management in Pacific Island Countries (J-PRISM). Improvements include installing accessible roads, a proper drainage system, a pond to capture and reduce leachate spillage, reduced fire risks with regulated gas flow from the landfill vents, and controlled dumping of waste now being better enforced²².

Many other areas are still serviced by uncontrolled dumpsites which pollute air, water, and land. There have been on-going discussions and trainings with provincial councils and local authorities on implementing low-cost solid waste dump improvements, with a focus on moving towards environmentally sound operations and meeting the requirements under the Environment Management (Waste Disposal and Recycling) Regulations 2007. A key issue is the need to improve the efficiency of waste transportation and disposal, perhaps through developing a system of strategically located transfer stations such that waste is bulked-up for transporting to centralized waste disposal facilities, thereby reducing the unit cost for transport²³.

3.2.2 Health-care Waste Management and Infection Control

Fiji's approach to healthcare waste management and infection control procedures are higher than most in the region. There are good waste management systems and procedures in place and staff in infection control roles that are generally more aware of the risk posed by healthcare waste than before. All 3 divisional hospitals have a dedicated IPC officers and all sub divisional hospitals have the IPC link nurse who coordinate IPC issues with divisional IPC officer and the National IPC coordinator based at MHMS/HQ. Some hospitals have more than 1 dedicated staffs for infection control, such as CWMH which has three infection control staff members and four dedicated waste management officers (two for internal management and two for treatment operation)²⁴. Implementation of waste management and infection

²⁰ ADB (2014). *Solid Waste Management in the Pacific: Fiji Country Snapshot*.

²¹ GOF (2011). *Fiji National Solid Waste Management Strategy (2011-2014)*.

²² <https://www.sprep.org/news/climate-proof-landfill-now-operational-fiji>. Accessed 8th June 2020.

²³ GOF (2011). *Fiji National Solid Waste Management Strategy (2011-2014)*

²⁴ SPREP (2014). *Baseline Study for the Pacific Hazardous Waste Management Project Healthcare Waste - Fiji*.

control systems is therefore variable and appears to be working in some cases only because of the commitment of a small group of individuals²⁵.

Medical wastes from the main hospitals and quarantine wastes from airports and ports are incinerated. The Central Board of Health (CBH), under the Ministry of Health, is responsible to oversee protocols, procedures and process for collection, treatment, and disposal of biomedical waste from sub divisional hospitals to divisional hospital where medical waste incinerators are based. Sub divisions are responsible to collect and transport their medical wastes from sub divisions to divisional incinerators as is the current practice. The incinerator at the CWM hospital has a single chamber with a loading capacity of 260 kg a day. The ash from the incinerator is disposed in designated cells at the Naboro Landfill. Since the CWM incinerator is old and inefficient, MHMS are in the process of sourcing a new medical waste incinerator for Suva and other locations as required²⁶.

Waste incinerators for infectious wastes have been installed in various locations, often as a result of donor funding. However, because of maintenance and operational costs, and insufficient operational budget, all of these incinerators are broken down and not in operation. The incinerator in Lautoka Hospital is generally in good condition and treats infectious medical waste (80kg/3 hours capacity) which caters for all the sub divisional hospitals in the division including some private health care facilities. It is operated appropriately, but the exhaust gas is emitted without treatment and the ash is disposed at the Vunato disposal site. Sharp objects generated in the western region are treated in Suva separately from the other infectious medical waste²⁷.

Infectious medical wastes from smaller clinics needs to be collected as required from each clinic for incineration. However, once a medical incinerator is installed at Naboro Landfill, the intention is to have a regular collection using a designated vehicle to collect infections waste for treatment²⁸. Private health facilities will also be able to utilise on user-pay basis.

In terms of medical waste disposal at the Naboro Landfill, collection is done by private operators; the waste collected is generally incinerator ash and infectious waste (Yellow bags). The councils sanitary services only collects garbage, trade, commercial and general waste. The private collect uses skip bins properly covered to avoid overspill while councils use standard municipal compactor vehicles or similar and the collection is either twice weekly or as requested when containers are full²⁹.

Information regarding the waste management process occurring, from ward-level waste generation, separation of wastes, through to ultimate treatment and disposal as assessed by SPREP in 2014, is described for five Fiji hospitals in Table 6. There is no updated records available so far. However segregation and different color bags are used from wards currently under the close watch of the IPV officers.

²⁵ SPREP (2014). *Baseline Study for the Pacific Hazardous Waste Management Project Healthcare Waste - Fiji*.

²⁶ GOF (2011). *Fiji National Solid Waste Management Strategy (2011-2014)*

²⁷ Kumar, P. (2013). *Country Analysis Paper – Fiji. 3Rs in the Context of Rio+20 Outcomes – The Future We Want*. Ha Noi, Viet Nam, 18-20 March 2013.

²⁸ GOF, (2011). *Fiji National Solid Waste Management Strategy (2011-2014)*

²⁹ GOF, (2011). *Fiji National Solid Waste Management Strategy (2011-2014)*

Table 6 – Waste Management Processes Observed at Five Fiji Hospitals³⁰

	Hospital Name	CWMH Suva		Lautoka		Labasa		Nadi		Sigatoka	
Generation & Segregation	Dedicated Containers/ Bags	Y		Y		Y		Y		Y	
	Colour Coding	Y		Y		Y		Y		Y	
	Sharps segregated & secure	Y		Y		Y		Y		Y	
	Signage Present	Y		Y		Y		N		Y	
Internal Handling	Degree of manual handling of bags	Low		Low		Low		High		Medium	
	Internal Transport Mode	Trolley		Trolley		Trolley		Wheelie Bin		Trolley	
	Spill Kit Present	Y		Y		N		N		N	
Storage	Dedicated & Appropriate Area	N		N		N		N		N	
	Loading/unloading acceptable	N		Y		Y		N		Y	
	Spill Kits Present	N		N		N		N		N	
	Monitoring & record keeping occurs	Y		Y		Y		N		N	
Treatment	Treatment per Waste Stream		Tech. Type		Tech. Type		Tech. Type		Tech. Type		Tech. Type
	Healthcare Waste	✓	Incinerate (int.)	✓	Incinerate (int.)	✓	Incinerate (int.)	✓	Incinerate (ext.)	✓	Incinerate (ext.)
	Sharps	✓	Incinerate (int.)	✓	Incinerate (int.)	✓	Incinerate (int.)	✓	Incinerate (ext.)	✓	Incinerate (ext.)
	Pharmaceutical	✓	Incinerate (int.)	✓	Incinerate (int.)	✓	Incinerate (int.)	✓	Incinerate (ext.)	✓	Incinerate (ext.)
	Cytotoxic	✓	Incinerate (int.)	✓	Incinerate (int.)	×	Incinerate (int.)	×	NA	×	NA
	General	✓	Landfill (w/o treat)	✓	Landfill (w/o treat)	✓	Landfill (w/o treat)	✓	Landfill (w/o treat)	✓	Landfill (w/o treat)
	If incinerator present	Yes		Two incinerators – main larger older unit		Two incinerators present – original unit and new incinerator (yet to be commissioned)		Yes, but not used. HCW sent to Lautoka		Yes, but not used. HCW sent to Lautoka	

³⁰ SPREP (2014). *Baseline Study for the Pacific Hazardous Waste Management Project Healthcare Waste - Fiji*

3.3 National COVID-19 Response

The GoF has been quick to respond to the COVID-19 outbreak, and authorities have been proactive in their efforts to contain the spread of the virus in Fiji by imposing international travel restrictions and a broad set of measures, including: social distancing, closure of schools and non-essential businesses in affected areas (Lautoka and Suva), a nationwide curfew, and a 14 day lockdown and restrictions on movement in Suva (between April 3 – April 17). In addition, health authorities continue to invest in contact tracing, community surveillance, reinforced detection measures by setting up a total of 32 fever clinics around the country, quarantine and isolation units, and carrying out risk communication activities.

The second wave of COVID19 pandemic cases was first detected in Fiji on March 19 2021 from boarder quarantine workers which led to containment of areas of Lautoka, Nadi, Suva and Nausori. As of 26th August 2021 Fiji had over 44,188 cases since first case was detected in March 2020, 121 active cases in isolation with 24,425 recoveries and 444 deaths. A Cumulative total of 49,362 COVID-19 laboratory tests have been conducted, with a daily average of 839 tests per day over the last 7 days, and a weekly average of 3,485 tests per week over the last 2 weeks. As at 29/4, Fiji CDC has conducted 49,362 lab tests (RT PCR) including GeneXpert conducted at Divisional Hospital Laboratories.

The GoF appointed a Coronavirus Taskforce in late January 2020 to oversee the MHMS response to the global COVID-19 outbreak. To further progress preparedness, a COVID-19 Response Unit (CRU) formally known as Incident Management Team (IMT) was also formed on March 1, 2020 and MHMS developed a COVID-19 Preparedness and Response Plan in early March (before any cases were confirmed). The objectives of the Plan are to: (a) facilitate preparedness of health services and other relevant agencies for a potential case of COVID-19; (b) support a coordinated system-wide response to a potential case of COVID-19; (c) provide guidance to health services and related agencies for the management of potential case of COVID-19; and (d) outline key activities and responsible units and individuals. The cost of the Plan for six months was estimated at FJD83.4 million (~US\$36.7 million). To support its Plan, an additional FJD40 million (~US\$17.2 million) was provided by the GoF to the health sector for procurement of medical equipment.

In addition to the domestic support for activities related to COVID-19, Fiji is also receiving assistance from several development partners (DPs). These include the United Nations (UN – mainly WHO and UNICEF) who are providing personal protective equipment (PPE) along with other medical and laboratory supplies, tents for isolation, risk communication and community engagement support, and a broad range of technical assistance (as is the Pacific Community (SPC)). The Australian Department of Foreign Affairs and Trade (DFAT) is providing a broad range of ongoing technical assistance as well as funding (including PPE and medical equipment, isolation infrastructure and information technology support for contact tracing), as is the New Zealand Ministry of Foreign Affairs and Trade. The World Bank investment support will fill critical gaps in the preparedness and response efforts and complement activities committed by other DPs.

3.3.1 Testing for COVID-19

Fiji is one of four Pacific Island countries with existing broader reverse transcription polymerase chain reaction (PCR) laboratory capacity, which enables it to test for COVID-19. Since March 2020, Fiji has been able to use this PCR capacity to test for COVID-19 at Mataika House, the level 2 reference laboratory in Tamavua, Suva. However, testing sites across the country need to be expanded. With the

recently available GeneXpert COVID-19 test cartridges, it is possible to expand Fiji's testing sites across the country, including at the sub-divisional level, pending adequate provision of PCR testing facilities either through broader PCR set up, or further provision of GeneXpert Analyzers and testing kits.

Environment and Social Risks, Potential Impacts and Mitigation

The project will have long term positive environmental and social impacts, insofar as it should improve COVID-19 surveillance, monitoring, treatment and containment. Nevertheless, in the short-term the environmental and social risks are considered to be Substantial.

3.4 Summary of Main Environmental Risks

The environmental risks are considered substantial. The main environmental risks identified include:

- The provision of laboratory and medical equipment and PPE: (i) occupational health and safety (OHS) issues related to the use of equipment financed by the Project; (ii) the OHS issues for medical staff and employees related to the treatment of COVID-19 patients; and (iii) medical waste management and community health and safety issues related to the handling, transportation and disposal of hazardous and infectious healthcare waste with respect to both disease transmission and contamination of the receiving environment such as soil or water.
- The incinerator: (i) community health and safety impacts from reduced air quality due to the incorrect positioning or operation of the incinerator; (ii) OHS impacts to staff operating the incinerator (contact with contaminated medical waste, reduced air quality and use of combustible fuel etc.); (iii) other environmental impacts associated with the operation of the incinerator such as minor fuel spills and waste ash disposal; (iv) minor civil works during incinerator installation (land clearance, noise and dust); and (v) transport and storage of HCW. The identified risks should be easily managed through an environmental and social management plan (ESMP).
- The warehouse: the warehouse will be a simple structure, located in an industrial zone on previously disturbed land and, as such, construction is not expected to pose a risk to biodiversity or the abiotic environment. The warehouse will be a simple structure and the usual environmental (dust, noise, hydrocarbon spill, erosion and sediment control etc.) and occupational health and safety risks should be easily managed through an ESMP.

It is not expected that there will be any environmental impacts associated with the information technology and communications aspects of the project as no civil or earthworks will be required. Therefore, no further risk screening of this activity is required.

3.5 Summary of Main Social Risks

The social risks are considered substantial. Whilst social risks and impacts are present, they are considered temporary, predictable, and readily managed through project design features and mitigation measures. MHMS's capacity and systems, while limited in overall social management, can be addressed through the recruitment of experienced E&S specialists and development and implementation of project procedures and systems. Management of social risk will be further strengthened by the contracting of UNICEF which has considerable experience in implementing health initiatives in Fiji.

No land acquisition or involuntary physical or economic displacement impacts are expected. All Project activities will be conducted within existing government facilities/grounds and no new land will be acquired. Any activity involving permanent land acquisition or resettlement, or any involuntary taking of land (even temporary), is not eligible for project support and is included in Table 10- Ineligible Activity List in Chapter 6.

A key social risk is the potential for inequitable access to Project supported facilities and services particularly for vulnerable and high-risk social groups (poor, disabled, elderly, isolated groups, ethnic groups). To mitigate this risk MHMS has committed in the ESCP to the provision of services and supplies to all people, regardless of their social status, based on the urgency of the need, in line with the latest data related to the prevalence of the cases, and the implementation of WHO guidance tools for COVID-19 risk communication and engagement.

While protecting the health of communities from infection with COVID-19 is a central part of the project, without adequate controls and procedures, project activities ranging from medical facility operation through to on-ground public engagement exercises have the potential to contribute to virus transmission and other community health and safety issues. This section outlines procedures for each project activity commensurate to the risk. The IPC&WMP (Annex VIII) contains procedures, based on WHO guidance, for the safe operation of health facilities and protection of the public from exposure to the virus as a result of these operations. In addition, the project's Stakeholder Engagement Plan (SEP) ensures widespread engagement with communities – including its more vulnerable groups – to disseminate information related to community health and safety, particularly about social distancing, high-risk demographics, self-quarantine, and mandatory quarantine through media communication team at IMT and at the Divisional Offices. The IEC information's and materials are multi-lingual (English/Hindi/Itaukei) to suite the different ethnic groups. Though Fiji's literacy rate is high according to 2017 census, the face value and validity of information is better gauged in the vernacular languages.

Some project activities also present increased health and safety risks for project workers, particularly those working in medical and laboratory facilities. The project workforce – both those directly employed or engaged to work on the project and those engaged by third party contractors – may be at risk of sexual exploitation and abuse (SEA) and sexual harassment (SH). SEA and SH risks will be assessed and addressed during implementation, including screening and adopting appropriate measures to prevent and mitigate the SEA/SH risks. To mitigate these risks, the MHMS, has adopted Fijis-2017 Sexual Harassment at Work Place Policy. **Preliminary Risk Analysis**

The following tables provide a preliminary analysis of the type of project activities identified, potential social and environmental impacts that may result from the project activities, key mitigation methods for residual impacts, and environmental and social risk management tools that are required.

Table 7 – Assessment of Key Project Risks/Impacts and Proposed Mitigation Methods – Planning and Design Stage

Activity	Significant Potential Risks /Impacts	Key Mitigation Methods	E&S Risk Management Tools
Planning and Design Stage			
Procurement of goods e.g. PPE (sub-components 1.1 & 1.2).	<p>Failures in the procurement process e.g. incorrect standard or quality of PPE leads to spread of infection to health-care workers.</p> <p>Procurement and use of goods will not be sustainable.</p>	<p>Due diligence and assessments is undertaken by MHMS to ensure fit for purpose equipment is procured.</p> <p>The MHMS purchases has complied the WHO interim guidance on rational use of PPE for coronavirus disease 2019 which describes the types of PPE that are required for different functions/personnel.</p> <p>Sustainable use of goods and materials are encouraged through capacity building and training of health service personnel.</p>	N/A
Procurement of laboratory and medical equipment e.g. biosafety cabinets (sub-components 1.1 & 1.2)	<p>Failures in procurement process e.g. equipment that is inappropriate and could lead to:</p> <ul style="list-style-type: none"> • Incorrect results and diagnosis. • spread of infection to health-care workers and/or cleaners. • health & safety risks to workers. • adverse environmental harm. 	<p>Due diligence and assessments is undertaken by MHMS regarding purchase of equipment to ensure correct specifications and fit for purpose equipment is procured to Fijian standards.</p>	N/A
Procurement and location of the incinerator (sub-component 2.)	<p>Failures in procurement process e.g. incinerator is not fit for the purpose and could lead to:</p> <ul style="list-style-type: none"> • incinerator unable to operate at a high enough temperature to kill the virus (and denature other pathogens in waste materials). • incinerator does not have measures to reduce air quality issues e.g. scrubbers. • Increase in fuel consumption. • Breakdowns and increases in maintenance and repairs. 	<p>A detail evaluation will be conducted for the planned incinerator to (i) ensure that an incinerator is the correct waste management solution for the situation; (ii) determine the specifications for the incinerator; and (iii) confirm where the incinerator should be located. The feasibility study terms of reference (TOR) and final report will be reviewed by the MHMS E&S Specialist/s and World Bank E&S specialists prior to procurement of the incinerator to ensure compliance with the ESF and EHSs.</p>	<p>ESIA (WB) incorporating EIA (Fiji) (if required)</p> <p>SEP</p>

	<p>Incorrect siting of the incinerator which affects the dispersion of the plume from the chimney causing reduced air quality and/or community and OHS issues.</p>	<p>The proper design of the incinerator should achieve desired temperatures, residence times, and other conditions necessary to destroy pathogens with pollution control equipment suited for the types and volumes of waste processed.</p> <p>An ESIA will be prepared to assess the environmental and social impacts associated with the incinerator installation and operation prior to the commencement of procurement. The ESIA will confirm that no physical or economic displacement will occur, including to non-title holders such as waste pickers and that emissions are compliant with the EHSs. If an EIA permit is determined during project implementation to be required by Fiji, the EIA can be incorporated into the ESIA prepared in accordance with the ESF.</p> <p>Public consultation shall be undertaken to ensure the proposed site can be utilized for the incinerator.</p>	
<p>Design and location of pharmaceutical warehouse (sub-component 2).</p>	<p>Location of warehouse requires temporary or permanent land acquisition.</p> <p>Location of the warehouse poses a risk to biodiversity or the abiotic environment (eg., water quality).</p> <p>Warehouse facilities that are not covered by adequate life and fire safety (L&FS) risk assessment and mitigation measures.</p> <p>Warehouse design is inadequate to achieve structural integrity or cannot be constructed safely.</p>	<p>The warehouse will be located on existing government leased facilities/grounds and no new land will be acquired or accessed. Due diligence and screening will ensure that appropriate sites are utilized for project infrastructure activities. Any activity involving permanent land acquisition or resettlement, or any involuntary taking of land (even temporary) is not eligible for project support and is included in Table 10 - Ineligible Activity List in Chapter 6. The temporary use of private land e.g. for staging, could be considered if there is a written, voluntary agreement between landowner and the project</p> <p>An ESIA has been prepared to assess environmental and social impacts associated with the warehouse installation. If an EIA permit is determined during project implementation to be required by Fiji, the</p>	<p>ESIA (WB) incorporating EIA (Fiji) (if required)</p> <p>SEP</p>

		<p>EIA can be incorporated into the ESIA prepared in accordance with the ESF.</p> <p>The warehouse will be located in an industrial zone in previously disturbed land and, as such, construction is not expected to pose a risk to biodiversity. Public consultation shall be undertaken to ensure the proposed site can be utilized for the warehouse.</p> <p>L&FS master planning will be included in the design of the new facilities in line with GIIP and national legal requirements. MHMS will ensure that all national legal L&FS requirements are met, upon completion of the installation. The warehouse should be provided with Fire Detection and Alarm; Means of Egress; Fire Control and Suppression; Smoke Control.</p> <p>The warehouse design was prepared by MOIT. The layout design has been agreed upon and the detail drawings are in progress by qualified architects.</p>	
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Table 8 – Assessment of Key Project Risks/Impacts and Proposed Mitigation Methods – Construction Stage

Activity	Significant Potential Risks / Impacts	Key Mitigation Methods	E&S Risk Management Tools
Construction Stage			
Construction and installation activities e.g.: <ul style="list-style-type: none"> • Incinerator and/or incinerator housings (sub-component 2). • Pharmaceutical warehouse (sub-component 2) 	<p>Civil works may generate limited adverse environmental impacts such as land clearance, dust, noise, vibration, waste, solid waste, hydrocarbon spills, erosion and sediment control, traffic obstruction and occupational and/or community health and safety.</p> <p>Increase in sexual exploitation and abuse/harassment (SEA/H) related to project workforce</p> <p>Issues related to inappropriate worker accommodations which further spread COVID-19.</p> <p>Cultural heritage impacts.</p> <p>Social impacts to nearby stakeholders (eg.residents and schools), such as from excessive noise and increased traffic</p>	<p>Comply with the requirements of the EMA 2005 (Fiji EIA and Waste Permit process). The exact approvals needed will be determined during project implementation and prior to installation of the incinerator and warehouse. The MHMS E&S Specialist/s will comply the EMA 2005 (Fiji EIA and waste permit process) to identify the level of approvals and which waste permits are required.</p> <p>Construction impacts addressed in a Construction Environmental and Social Management Plan (CESMP) / Construction Environmental and Social Code of Practice (CESCOP) (as determined through screening process) prepared by the E&S specialists prior to the commencement of installation / construction activities per World Bank requirements.</p> <p>Sustainability, waste minimization and management measures detailed in the Construction Waste Management Plan(s) to be developed during project by the contractor and submitted to the E&S Specialists for approval prior to any physical works commencing.</p> <p>Construction Health and Safety (H&S) management plan(s) to be developed during project by the contractor, and submitted to the E&S Specialists for approval prior to any physical works commencing and construction works completed accordingly.</p> <p>SEA and SH risks will be assessed during implementation through the ESMF, including screening and adopting appropriate measures to prevent and mitigate the SEA/SH risks. MHMS, in the ESCP, committed to the implementation of the WHO Code of Ethics and</p>	<p><u>Construction</u> Follow EIA process/waste permit process (Fiji)</p> <p>CESMP/CESCOP (WB) as defined through the screening process.</p> <p>Construction Waste Management Plan(s)</p> <p>Construction H&S Management Plan(s)</p> <p>LMP</p> <p>SEP/GM</p> <p>CFP</p>

		<p>Professional Conduct which includes provisions for SEA/SH prevention.</p> <p>Labour issues including working conditions, OHS, SEA/S addressed in Project's LMP. Implementation of Code of Conduct. Provide separate facilities for female and male workers.</p> <p>Project Grievance Mechanism (GM) available to enable communities to raise project related concerns and grievances.</p> <p>Chance Finds Procedure (CFP) in place prior to any physical works commencing (Annex VII).</p>	ERA/ESCP
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Table 9 – Assessment of Key Project Risks/Impacts and Proposed Mitigation Methods – Operational Stage

Activity	Significant Potential Risks / Impacts	Key Mitigation Methods	E&S Risk Management Tools
Operational Stage			
Use of goods including PPE (sub-components 1.1 & 1.2).	<p>Incorrect use of PPE leads to spread of infection to health-care workers and cleaners.</p> <p>Inequitable distribution of goods. Negative reaction to perceived unfairness of resource distribution.</p>	<p>Infection Prevention Control and Health Care Waste Management Plan (IPC&WMP) developed and implemented.</p> <p>Clear communication of risks and prevention measures will be included in training and stakeholder engagement activities.</p> <p>MHMS has committed to the provision of services and supplies to all people in the project ESCP.</p>	<p>IPC&WMP</p> <p>SEP</p>
Use of medical and laboratory equipment (sub-components 1.1 & 1.2).	<p>Occupational health and safety risks related to exposure to infections / diseases e.g. from testing, laboratory and health care waste, treatment of COVID-19 patients etc.</p> <p>Surfaces of imported materials maybe contaminated during handling and transportation which may result in the spread of infection.</p> <p>Occupational health and safety risks related to the delivery and storage of goods, including samples, pharmaceuticals, reagents and other hazardous materials. This also includes inappropriate management of wastes.</p> <p>Occupational health and safety risks related to the use of X-ray machines such as exposure to high radiation levels.</p> <p>General occupational health and safety risks from working in a medical facility /laboratory e.g. manual handling injuries, such as sprains and strains from</p>	<p>A Labour Management Procedure (LMP) developed and implemented to protect project direct workers and contracted staff who may be at risk of exposure to infected patients, hazardous waste etc.</p> <p>Infection Prevention Control and Health Care Waste Management Plan (IPC&WMP) developed and implemented.</p> <p>If concerned about contaminated imported materials (for example when dealing with goods that have come from countries with high numbers of infected people) equipment may be decontaminated using disinfectant. After disinfecting, workers should wash hands with soap and water or use alcohol -based hand rub.</p> <p>Follow GIIP for safe operation of x-ray machines such as the Radiological Hazards section in the <u>IFC EHS Guidelines – 2.0 Occupational Health and Safety</u>.</p> <p>Worker H&S Management plans developed by MHMS and submitted to the E&S specialist for approval prior to</p>	<p>LMP</p> <p>IPC&WMP</p> <p>Worker H&S plans</p> <p>SEP</p>

	<p>lifting and carrying patients; falls, trips, and slips; injuries caused by moving objects; and mental stress fatigue, psychological distress, stigma.</p>	<p>activities commencing. Development of H&S plans will refer to <u>IFC EHS Guidelines – 2.0 Occupational Health and Safety</u>.</p> <p>Clear communication of risks and prevention measures will be included in training and stakeholder engagement activities. Training and awareness raising should incorporate the WHO guidance tools for COVID-19 preparedness and response including the <u>COVID-19 Risk Communication Package for Healthcare Facilities</u> which provides healthcare workers and healthcare facility management with the information, procedures, and tools required to safely and effectively work.</p>	
<p>COVID-19 testing and diagnosis (sub-components 1.1 & 1.2).</p>	<p>Improper collection of samples and testing for COVID-19 and appropriate laboratory biosafety could result in spread of disease to medical workers or laboratory workers, or population during the transport of potentially affected samples and from waste management.</p>	<p>Collection of samples, transport of samples and testing of the clinical specimens from patients meeting the suspect case definition will be performed in accordance with WHO interim guidance <u>laboratory testing for coronavirus disease 2019 (COVID-19) in suspected human cases</u>. Tests will be performed in appropriately equipped laboratories (specimen handling for molecular testing requires BSL-2 or equivalent facilities) by staff trained in the relevant technical and safety procedures.</p> <p>National guidelines on laboratory biosafety will be followed. There is still limited information on the risk posed by COVID-19, but all procedures will be undertaken based on a risk assessment. For more information related to COVID-19 risk assessment, see specific interim guidance document: WHO interim guidance for <u>laboratory biosafety related to 2019-nCoV</u>.</p> <p>Samples that are potentially infectious materials (PIM) will be handled and stored as described in WHO <u>guidance to minimize risks for facilities collecting, handling or storing materials potentially infectious for polioviruses (PIM Guidance)</u>.</p>	<p>LMP</p> <p>IPC&WMP</p>

		<p>For general laboratory biosafety guidelines, see the WHO <u>Laboratory Biosafety Manual, 3rd edition</u>.</p> <p>Infection Prevention Control and Health Care Waste Management Plan (IPC&WMP) developed and implemented.</p>	
<p>Treatment of COVID-19 patients in healthcare facilities (sub-components 1.1 & 1.2).</p>	<p>Weak compliance with the precaution measures for infection prevention and control in isolation and treatment of infected cases spreads COVID-19 infections in healthcare facilities.</p>	<p>Health facilities will follow the IPC&WMP and establish and apply Standard Precautions including:</p> <ul style="list-style-type: none"> • Hand Hygiene (HH); • Respiratory hygiene/cough etiquette. • Use of personal protective equipment (PPE); • Handling of patient care equipment, and soiled linen; • Environmental cleaning; • Prevention of needle-stick/sharp injuries; and • Appropriate Health Care Waste Management. <p>In addition, health facilities will establish and apply transmission-based precautions (contact, droplet, and airborne precautions) as well as specific procedures for managing patients in isolation room/unit.</p> <p>Establishment of standard precautions and transmission-based precautions will be in line with National guidelines for IPC in healthcare facilities and take into account guidance from WHO and/or CDC on COVID-19 infection control:</p> <ul style="list-style-type: none"> ✓ WHO interim guidance on <u>Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected</u>; ✓ WHO guidance on <u>infection prevention and control at health care facilities (with a focus on settings with limited resources)</u>; ✓ CDC Guidelines for <u>isolation precautions: preventing transmissions of infectious agents in healthcare settings</u>; and ✓ CDC <u>guidelines for environmental infection control in healthcare facilities</u>. 	<p>IPC&WMP</p>

		<p>Special considerations will be made to address the particular needs of vulnerable groups in delivering these services.</p> <p>Infection Prevention Control and Health Care Waste Management Plan (IPC&WMP) developed and implemented.</p>	
Generation of health care wastes (sub-components 1.1 & 1.2).	<p>Medical waste management and community health and safety issues related to the generation, handling, transportation, treatment and disposal of hazardous and infectious health-care wastes with respect to both disease transmission and contamination of the receiving environment such as soil or water.</p> <p>Offsite disposal facilities (if used) do not comply with standards required by transport and disposal regulations and for licensing of transport vehicles.</p>	<p>Project IPC&WMP developed and implemented to ensure the correct separation, storage, transport and disposal of health care wastes (both infectious, hazardous and non-infectious wastes).</p> <p>The Project will invest in the procurement of a high temperature incinerator for disposing of health-care waste at the Naboro landfill.</p> <p>Training of medical, laboratory and waste management personnel financed under sub-component 2 to ensure compliance with the IPC&WMP, National Infection Prevention and Control Policy 2018, WHO guidance and GIIP.</p>	IPC&WMP
Poor sanitation and improper management of wastewater (sub-components 1.1 & 1.2).	<p>Poor sanitation and improper management of wastewater related to COVID-19 diagnosis and treatment services transmitting diseases to communities and polluting environment.</p>	<p>Health facilities will ensure the provision of safe water, sanitation, and hygienic conditions, which is essential to protecting human health during all infectious disease outbreaks, including the COVID-19 outbreak.</p> <p>Health facilities will establish and apply good practices in line with WHO <u>guidance on water, sanitation and waste management for COVID-19</u>, the National Infection Prevention and Control Policy 2018, and the IPC&WMP.</p>	IPC&WMP

<p>Community impacts (sub-components 1.1 & 1.2).</p>	<p>Risk of transmission in the community from project activities e.g. operation of the incinerator, etc. if they are not properly managed and controlled.</p> <p>Wider public and patients are not treated with respect for their dignity, human rights and fundamental freedoms.</p>	<p>The IPC&WMP contains detailed procedures, based on WHO guidance, for the safe operation of health facilities and protection of the public from exposure to the virus as a result of these operations.</p> <p>The project's Stakeholder Engagement Plan (SEP) will ensure widespread engagement with communities – including its more vulnerable groups – to disseminate information related to community health and safety, particularly about social distancing, high-risk demographics, self-quarantine, and mandatory quarantine.</p> <p>Project grievance mechanism (GM) enables communities to raise project related concerns and grievances.</p> <p>The operation of medical centres will be implemented in a way that both the wider public, as well as the patients are treated in line with international best practice as outlined in WHO guidelines. Patients will be treated with respect for their dignity, human rights and fundamental freedoms and minimize any discomfort or distress associated with such measures taking into consideration their gender, sociocultural, ethnic or religious needs.</p> <p>MHMS has committed to the implementation of the WHO Code of Ethics and Professional Conduct which includes provisions for SEA/SH prevention in the project ESCP.</p>	<p>IPC&WMP</p> <p>SEP/GM</p> <p>Code of Ethics and Professional Conduct</p>
<p>Vulnerable Groups Access to Project Services (sub-components 1.1 & 1.2).</p>	<p>Marginalized, high-risk and vulnerable social groups (poor, disabled, elderly, isolated groups or ethnic groups) are unable to access facilities and services designed to combat the disease, in a way that undermines the central objectives of the project</p>	<p>MHMS, in the ESCP, committed to the provision of services and supplies to all people and ensure that individuals or groups who, because of their particular circumstances, may be disadvantaged or vulnerable, have access to the development benefits. This will be communicated to all beneficiaries through MOHMS Web sites, Risk and social media communication platforms.</p>	<p>SEP</p> <p>Code of Ethics and Professional Conduct</p>

		The MHMS is implementing WHO guidance tools for COVID-19 risk communication and engagement, including with respect to social stigma (https://www.who.int/docs/default-source/coronaviruse/covid19-stigma-guide.pdf).	
Community awareness and communication (Sub-component 1.3)	<p>Presence of project workers working in rural communities and non-adherence to acceptable cultural norms.</p> <p>On-ground public engagement exercises have the potential to contribute to virus transmission.</p> <p>Increase in sexual exploitation and abuse/harassment (SEA/SH) related to project workforce</p> <p>Outreach campaigns do not meet the needs of the public e.g. inappropriate information and communication increases social stigma with those who expose or are infected by virus.</p>	<p>Labour issues addressed in LMP.</p> <p>Workers must wear correct PPE and follow hand hygiene (HH) and respiratory hygiene/cough etiquette as detailed in the Project IPC&WMP.</p> <p>SEP implementation will ensure community awareness and communication activities address potential issues.</p> <p>Clear communication of SEA/SH risks and prevention measures will be included within stakeholder engagement activities and the project's Labour Management Procedure (LMP). The project will focus on embedding messages on healthy conflict resolution, healthy parenting, stress and anger management in community and other awareness campaigns. Communications will also include information on how to seek GBV-related services during periods of social distancing, such as the Fiji Women's Crisis Center (http://www.fijiwomen.com/). MHMS, in the ESCP, also committed to implementation of WHO Code of Ethics and Professional Conduct, including provisions for SEA/SH prevention.</p> <p>Project grievance mechanism (GM) available to enable communities to raise project related concerns and grievances.</p>	<p>LMP</p> <p>IPC&WMP</p> <p>SEP/GM</p> <p>Code of Ethics and Professional Conduct</p>
Operation of the incinerator (sub-component 2).	Air quality negatively impacted by incinerators e.g. Persistent Organic Pollutants (POP) emissions when not operated at the correct temperatures or incorrectly operated. Incinerators can generate	The incinerators will likely need an EIA and/or an air pollution permit for operation under Fiji law to be prepared prior to the commencement of the project. The exact approvals needed will be determined during project implementation and prior to installation of the	Follow EIA/air pollution permit process (Fiji)

	<p>particulates, heavy metals, dioxins and furans, which may be present in the waste gases, water or ash.</p> <p>Incorrect disposal of ash causing adverse environmental and social impacts e.g. soil contamination.</p> <p>Other minor environmental impacts associated with the operation of the incinerator such as minor fuel spills.</p> <p>Community health and safety impacts from reduced air quality due to the incorrect positioning or operation of the incinerator.</p> <p>OHS impacts to staff operating the incinerator (contact with contaminated medical waste, reduced air quality and use of combustible fuel etc.)</p> <p>Lack of ongoing maintenance causing incinerators to no longer operate or operate inefficiently.</p>	<p>incinerator. The MHMS E&S Specialists will follow the Fiji EIA/air pollution permit process to identify what level of approvals and what permits are required and then apply the identified conditions for the incinerators, including installation of scrubbers on the stacks to mitigate air emissions.</p> <p>The MHMS E&S Specialist/s will develop an ESMP for the incinerator to meet World Bank requirements. If an EIA study or other permit is required by Fiji, to be determined during project implementation, the EIA can be incorporated into the ESMP prepared in accordance with the ESF.</p> <p>Waste Management and Health and Safety plans for incinerator operation will be prepared by the MHMS and submitted to the E&S Specialists for approval prior to commencement of operations.</p> <p>Training for operators on operation in accordance with GIIP including the method to achieve the desired combustion conditions and emissions will be provided for example, appropriate start-up and cool-down procedures, achievement and maintenance of a minimum temperature before waste is burned, use of appropriate loading/charging rates (both fuel and waste) to maintain appropriate temperatures, proper disposal of ash and equipment to safeguard workers. Operator training plans will be prepared by the MHMS and submitted to the E&S Specialists for approval prior to commencement of operations.</p> <p>Logs of incinerator operation (e.g., loads by weight, temperatures achieved, time for processing etc), will be recorded by the operators and reviewed by MHMS.</p> <p>Project will further develop and implement existing maintenance plans that specify the responsibilities for</p>	<p>ESMP (WB) incorporating EIA (Fiji) (if required)</p> <p>Waste Management Plan</p> <p>EHS Plan</p> <p>Operator Training Plan</p> <p>Maintenance Plan</p> <p>LMP/ Code of Ethics and Professional Conduct</p>
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		regular maintenance schedules to replace or repair defective components. Maintenance plans will be prepared by the MHMS and submitted to the E&S Specialists for approval prior to commencement of operations.	
Training for health care workers on health-care waste management (Sub-component 2).	<p>Outcomes that are contrary to health-care workers' well-being and/or activities have adverse environmental impacts.</p> <p>Negative reaction to perceived unfairness of health-care workers' access to training.</p>	<p>Infection Prevention Control and Health Care Waste Management Plan (IPC&WMP) developed and implemented.</p> <p>Environmental, social, and health and safety best practices incorporated into training programs including stigma issues. Training programs for healthcare waste management training will be developed.</p> <p>MHMS E&S specialists will review any interim and progress reports to ensure that environmental and social mitigation measures are in place.</p> <p>Project objectives and operational strategies clearly communicated through SEP to address any perception of inequitable access to training. GM to address concerns regarding distribution of project benefits.</p>	<p>IPC&WMP</p> <p>SEP/GM</p> <p>LMP/ Code of Ethics and Professional Conduct</p>
Operation of the Warehouse (sub-component 2).	<p>Incorrect pharmaceutical storage and disposal potentially leads to community and/or worker health and safety impacts, waste generation and/or water/soil pollution.</p> <p>General occupational health and safety risks for warehouse staff.</p>	<p>The warehouse will likely need an EIA permit for operation under Fiji law to be prepared prior to the commencement of the project. The exact approvals needed will be determined during project implementation and prior to construction of the warehouse. The MHMS E&S Specialist/s will follow the Fiji EIA permit process to identify what level of approvals and what permits are required.</p> <p>The MHMS E&S Specialist/s will develop an ESMP for the warehouse to meet World Bank requirements. If an EIA permit is required by Fiji, to be determined during project</p>	<p>Follow EIA permit process (Fiji)</p> <p>ESMP (WB) incorporating EIA (Fiji) (if required)</p> <p>Waste Management Plan.</p> <p>EHS Plan.</p>

		<p>implementation, the EIA can be incorporated into the ESMP prepared in accordance with the ESF.</p> <p>Waste management plan that addresses correct disposal of chemical and other solid wastes will be prepared by the MHMS and submitted to the E&S specialists for approval prior to commencement of operations. This plan will focus on management options such as waste avoidance and recycling before disposal options.</p> <p>Health and Safety management plan for warehouse operation will be prepared by the MHMS and submitted to the E&S specialists for approval prior to commencement of operations.</p>	LMP/Code of Ethics and Professional Conduct
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4 Procedures to Address Environmental and Social Issues

4.1 Overview of the Screening Process

The screening process will be used to screen all project activities for risks and then identify the environmental and social risk management tools that need to be prepared or followed. The purpose of the screening is to: (i) determine whether activities are likely to have potential negative environmental and social risks and impacts; (ii) identify appropriate mitigation measures for activities with adverse risks or impacts; (iii) incorporate mitigation measures into implementation of the activity; (iv) review and approve the management plan/s and (v) monitor application of management plan/s for those activities requiring E&S due diligence.

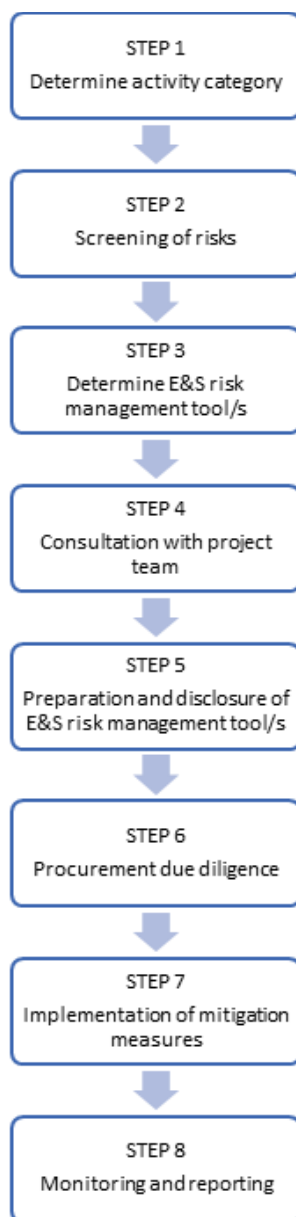
The project typologies identified as requiring environmental and social screening and management during implementation of the Project include: risk communication and awareness campaigns; procurement and use of goods and supplies; provision and use of laboratory and medical equipment; procurement, installation and operation of the Health care waste treatment facility; construction and operation of the pharmaceutical warehouse; and any technical assistance activities such as training and/or feasibility studies.

The local ESHSCE Specialist, supported by the International ESHS Specialist (E&S Specialists), to be employed in the MHMS, will undertake the environmental screening, preparation and disclosure of site-specific instruments and DOE EIA and permit applications, and consultation and information dissemination activities with relevant stakeholders. Responsibilities for implementing these procedures are outlined in further detail in Chapter 8. The screening process should be reviewed after six months of project implementation by the MHMS E&S Specialist/s to ensure that the process is appropriate.

4.2 Screening of Project Activities

The following provides the steps that will be undertaken in the assessment of project activities. The screening of activities will take place either during the annual work plan or on ad hoc basis as activities are defined by the Project Team/s. The screening process will follow the key steps in Figure 2:

Figure 2 – Key Activity Screening Steps



Step 1 – Determine Activity Category

The first step of screening is to determine what type of activity is being proposed and determine the immediate next step. To determine the project activity category, refer to Figure 3 – Activity Screening Process. This will determine whether a screening checklist needs to be completed and/or which project E&S risk management plan/s must be followed.

Step 2- Screening of Risks

The next step is to complete the activity screening checklist/s, as determined in Step 1. The checklist/s will determine what activity E&S risk management tool/s are required to be developed and/or followed (if any).

Note: If the Screening Form for Potential Environmental and Social Issues in Annex III is completed, also check Table 10 – Ineligible Activity to determine the activities eligibility for project funding.

Step 3 – Determine E&S Risk Management Tool/s

The third step is to determine what specific E&S risk management tool/s are required or apply, if any, under World Bank and Fiji E&S risk management requirements. The project activity screening process (Figure 3 – Activity Screening Process) will assist in determining the E&S risk management tool/s that need to be prepared or followed.

Step 4: Consultation with Project Team

If required, the screening outcomes will be discussed with the project team and design personnel to identify ways to reduce or avoid any adverse impacts. Any adjustments to the design, categorization or E&S risk management tool/s can be refined following this process.

Step 5: Preparation and Disclosure of E&S Risk Management Tool/s

If required, the next step is to prepare the relevant E&S risk management tool/s, both for Fiji and the WB processes. This process may include site visits and data gathering, consultation, and public disclosure of the documents in accordance with the Chapter 7 – Consultation and Stakeholder Engagement.

Step 6 – Procurement Due Diligence

Determine if procurement is required for the activity. If yes then ESHS provisions will be incorporated into bidding documents, in accordance with the new World Bank Procurement Framework.

Step 7: Implementation of Mitigation Measures

The implementation of the E&S risk management tool/s and conditions of any environmental approvals will need to be implemented, monitored and enforced. Training of implementing staff may be needed to ensure that conditions of the E&S risk management tool/s are met. For contractors, monitoring and supervision will be needed to ensure that conditions of the E&S risk management tool/s are met.

Step 8: Monitoring and Reporting

Monitoring is required to gather information to determine the effectiveness of implemented mitigation and management measures and to ensure compliance with the approved E&S risk management tool/s. Monitoring methods must provide assurance that E&S risk management tool/s measures are undertaken effectively.

Six-monthly reports will need to be prepared and provided to the WB. The semi-annual E&S monitoring reports to the Bank will include: (i) the status of the implementation of mitigation measures; and (ii) the findings of monitoring programs (iii) stakeholder engagement activities (iv) grievances log (v) any incidents/accidents with adverse impacts and the actions taken to address it and prevent reoccurrence.

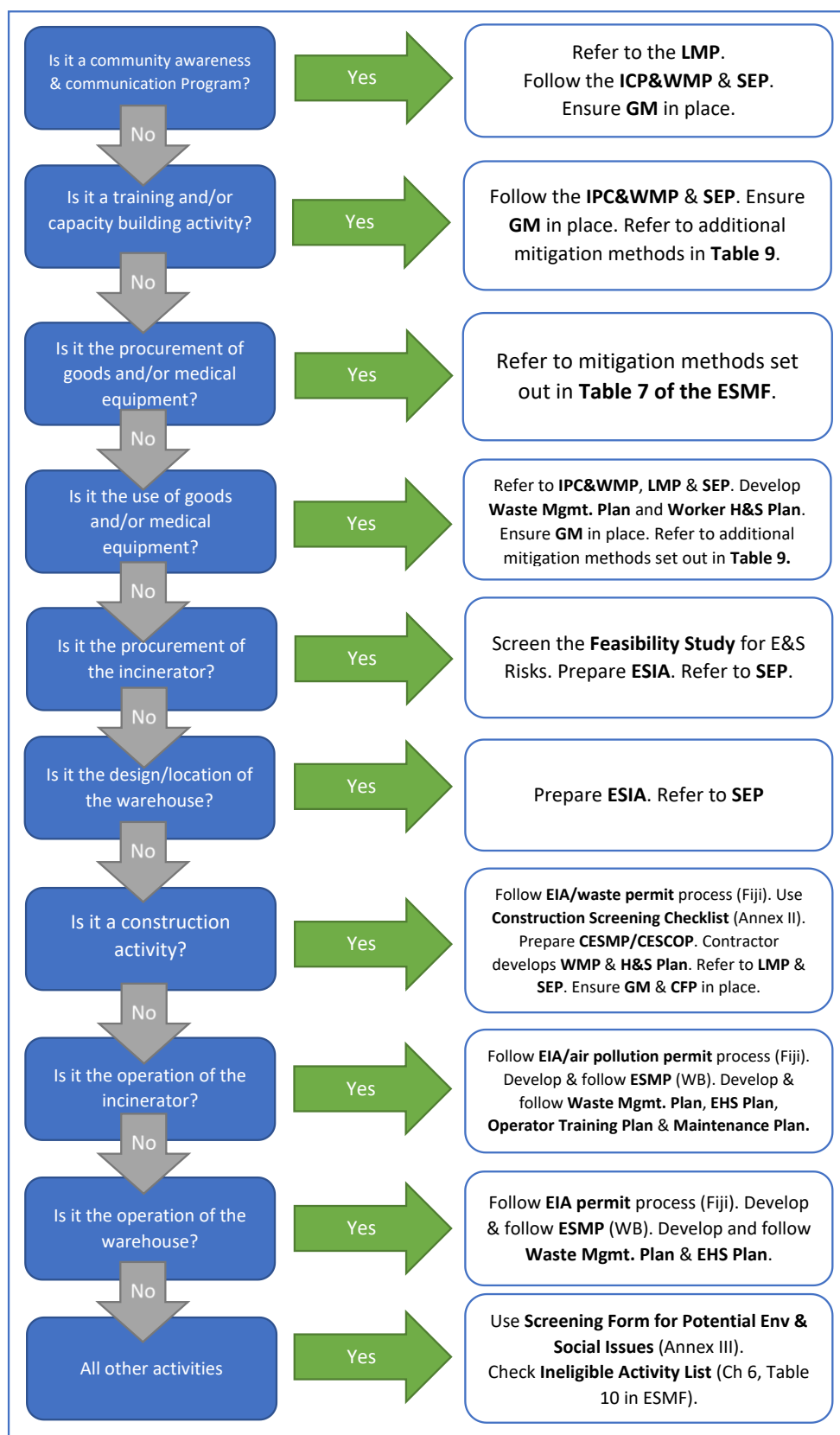


Figure 3 –Activity Screening Process

Table 10 – Ineligible Activity List

The following type of activities shall not be eligible for financing under the Project:

- Activities of any type classifiable as “High” risk pursuant to the World Bank’s Environment and Social Standard 1 (ESS1) of the Environment and Social Framework (ESF). The following activities are illustrative examples of “High” risk activities:
 - Activities that may cause long term, permanent and/or irreversible (e.g. loss of major natural habitat) adverse impacts;
 - Activities that have high probability of causing serious adverse effects to human health and/or the environment not related treatment of COVID-19 cases;
 - Activities that may have significant adverse social impacts and may give rise to significant social conflict;
 - Activities that may affect lands or rights of indigenous people or other vulnerable minorities;
 - Activities that may involve permanent resettlement or land acquisition or any involuntary taking of land (even temporary) or adverse impacts on cultural heritage;
 - Activities that are considered by the World Bank (a) to have potential to cause significant loss or degradation of critical natural habitats whether directly or indirectly or those that could adversely affect forest and forest health; (b) that could affect sites with archaeological, paleontological, historical, religious, or unique natural values; and (c) that will result in adverse impacts on 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; and
 - Use of goods and equipment as considered by the World Bank to meet the following conditions: (a) lands abandoned due to social tension/conflict, or the ownership of the land is disputed or cannot be ascertained; (b) to demolish or remove assets, unless the ownership of the assets can be ascertained, and the owners are consulted; (c) involving forced/conscripted labour, child labour (under the age of 18), or other harmful or exploitative forms of labour; (d) activities that would affect indigenous peoples, unless due consultation and broad support has been documented and confirmed prior to the commencement of the activities; and/or other paramilitary purposes.

5 Consultation and Stakeholder Engagement

A stand-alone Stakeholder Engagement Plan (SEP) has been developed to describe the Project's program for stakeholder engagement, public information disclosure and consultation³¹. The SEP outlines the ways in which the Project team will communicate with stakeholders and provides a mechanism through which people can raise concerns, provide feedback, or make complaints about the Project or any activities related to the Project including SEA and SH. The participation of the local population is essential to ensure collaboration between Project staff and local communities and to minimize and mitigate environmental and social risks related to the proposed Project activities. Broad-ranging, culturally appropriate and adapted awareness raising activities are particularly important to sensitize the communities to the risks related to infectious diseases.

Stakeholder engagement will continue throughout the life of the Project and will include formal scheduled consultations and meetings as well other means of communication. The stakeholder engagement process has two components:

- Early and ongoing engagements with key stakeholders at national, sub national and community to provide information on the Project and obtain feedback on experiences and outcomes of the Project and its activities.
- A Grievances Mechanism to address any public complaints during the implementation of the Project

5.1 Project Stakeholders

To ensure effective and targeted engagement, the Project identifies three core stakeholder categories: affected parties; other interested parties; and vulnerable groups.

5.1.1 Affected Parties

Affected Parties comprise persons, groups and other entities within the Project Area of Influence (PAI) that are directly influenced (actually or potentially) by the Project and/or have been identified as most susceptible to change associated with the Project, and who need to be closely engaged in identifying impacts and their significance, as well as in decision-making on mitigation and management measures.

The following are considered affected parties in the context of this Project:

- COVID-19 infected people
- Communities (i.e. religions, race, gender) of COVID-19 infected people
- People under COVID-19 isolation
- Family members of COVID-19 infected people
- Family members of people under COVID-19 isolation
- Neighbouring communities to laboratories, health facilities, isolation centres, and screening posts
- Workers at construction sites of laboratories, health facilities, isolation centres and screening posts
- People at COVID-19 risks (travellers, inhabitants of areas where cases have been identified, etc.)

³¹ The disclosed version of the SEP is available at: <http://www.health.gov.fj/media-center/novel-coronavirus-covid-19/world-bank-project/>

- Public Health Workers
- Municipal waste collection and disposal workers
- National Department of Health
- Other public authorities

5.1.2 Other Interested Parties

Other interested parties include individuals, groups and other entities that may not experience direct impacts from the Project but who consider or perceive their interests as being affected by the Project and/or who could affect the Project and its implementation in some way. Other interested parties may include:

- Traditional media
- Participants of social media
- Politicians
- Other national and international health organizations
- Local and international non-governmental organizations (NGOs)
- Local businesses
- Businesses with international links
- The public at large

5.1.3 Vulnerable Groups

The Project identifies vulnerable groups as any persons or groups who may be disproportionately impacted or further disadvantaged by the Project due to their vulnerable status, and who may require special engagement efforts to ensure their equal representation in Project consultation and decision-making processes. The Project will conduct targeted engagement with vulnerable groups to ensure they are fully informed of the Project and to understand their concerns and needs in accessing information, medical facilities and services and other challenges they face at home, at workplaces and in their communities including social stigma, SEA and SH.

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

- Elderly
- Illiterate people
- Vulnerable groups working in informal economy
- People with disabilities
- Female-headed households

Vulnerable groups within the communities affected by the Project will be further confirmed and consulted through dedicated means, as appropriate.

5.2 Consultation and Information Disclosure

5.2.1 Stakeholder Engagement during Project Preparation

Given the emergency nature of the Project and the transmission dynamics of COVID-19, consultations during the Project preparation phase and during the development of the ESMF were limited to relevant government officials, health experts, hospital administrators and others from institutions working in health sector. The ESMF and SEP will be consulted on and disclosed as it is continuously updated throughout the Project implementation period.

5.2.2 Consultation and Disclosure during Project Implementation

Two-way mechanisms for ongoing consultation will operate throughout the life of the Project, to disclose information and seek feedback. Dedicated channels for information dissemination will be established to ensure consistent communication at national and local levels throughout the Project. Project stakeholder engagement will be carried out on two fronts:

- I. Awareness-raising activities to sensitize communities on risks of COVID-19.
- II. Consultations with stakeholders throughout the entire Project cycle to inform them of the Project and to solicit their concerns, feedback and complaints about any activities related to the Project and consultations to improve Project design and implementation.

Stakeholders will be kept informed as the Project develops, including reporting on Project environmental and social performance and implementation of the SEP and the grievance mechanism. This will be important for the wider public, but more particularly for suspected and/or identified COVID-19 cases and their families.

The Project consultation and disclosure programme is summarized in Table 11 below.

Table 11 – Project Consultation and Disclosure

Project Component	Methods	Target Stakeholders	Information to be disclosed
Component 1.1: Enhance case detection, confirmation, and contact tracing	<ul style="list-style-type: none"> Information and communication materials developed and sent to provinces and health facilities. These materials include guidance on early detection, case confirmation, contact tracing and appropriate use of supplies and consumables. 	<ul style="list-style-type: none"> Public health authorities Laboratory management Health workers 	<ul style="list-style-type: none"> Early Covid-19 detection Case confirmation Contact tracing Appropriate use of supplies and consumables.
Sub-Component 1.2: Enhance health service delivery	<ul style="list-style-type: none"> Conducting training to improve oversight, coordination, surveillance and data analysis to guide the Covid-19 response Advice and training on use of infection prevention and control materials and equipment to protect frontline health workers including items for PPE, environmental and waste management materials. Capacity building activities and training in relation to interpersonal communication by health workers related to Covid-19, infection prevention and control, testing, waste management and clinical management of patients in primary care settings. 	<ul style="list-style-type: none"> Public health authorities Laboratory management Health workers 	<ul style="list-style-type: none"> Public health oversight, coordination, and surveillance Data analysis to guide the Covid-19 response Use of infection prevention and control materials and equipment to protect frontline health workers Use of environmental and waste management materials. Health communications Infection prevention and control Testing Waste management Clinical management of patients in primary care settings.

<p>Sub-Component 1.3: Communication Preparedness and Response</p>	<ul style="list-style-type: none"> • Providing provinces and risk communication focal points with guidance on community engagement and materials to promote health awareness and behavioural change in community messaging, including through: <ul style="list-style-type: none"> - One-on-one meetings with community leaders - Outreach activities – including community and small group meetings – that are safe and culturally appropriate - Dissemination of IEC materials (posters, leaflets, brochures, video screening, social media content) with approved, tested messages - Information materials for travelers at airports, seaports and border crossing - Infographics on prevention messages for Covid-2019 - Fact sheets and Q&As - Press releases (for key events and major announcements) 	<ul style="list-style-type: none"> • Infected individuals and their families • Local communities • Vulnerable groups (e.g. older people, people with pre-existing medical conditions, people with disability and people with limited access to health services) • Special groups (e.g. pregnant and breastfeeding women) • Local and religious leaders • School and educational institutions • Local businesses • Travelers 	<ul style="list-style-type: none"> • Project objectives and implementation • Risk communication materials to reduce risk of Covid-19 and other infectious diseases • Health awareness messages: importance of hand hygiene, cough etiquette, physical distancing and staying home if unwell etc. • Project Environment and social risk and impact management/ESMF • Grievance mechanisms • SEA and SH <p>The MHMS will implement WHO guidance tools for COVID-19 risk communication and engagement, including with respect to social stigma (https://www.who.int/docs/default-source/coronaviruse/covid19-stigma-guide.pdf).</p>
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	<ul style="list-style-type: none"> - Public service announcements (for radio and TV) - Newspaper advertisements and insets - Information desks in Provincial government offices and health facilities - Posters and leaflets (e-copy) for sharing in schools and educational institutions - Social media update (prevention messages) - TV and radio shows and guesting (free airtime for public health programs) - Linking with schools for community messaging - Use existing education platforms for messaging on Covid-19 - Linking with church groups for community messaging, both in church gatherings and in online platforms • Training in use of enhanced telecommunication connectivity for health facilities to improve communication and data reporting between the MHMS and front-line health workers 		
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Component 2: Health System Strengthening	<ul style="list-style-type: none"> • Providing information materials and training for health care workers on health care waste management. • Training in procurement, installation and operation of medical waste incinerator to serve central division health facilities. • Capacity building and support to improving Fiji's pandemic preparedness and response capacity for emerging infectious diseases through the development of a pandemic preparedness plan. 	<ul style="list-style-type: none"> • MHMS • Health facility management • Waste incinerator management and staff • Health workers 	<ul style="list-style-type: none"> • Health care waste management. • Procurement, installation and operation of medical waste incinerator • Development of a pandemic preparedness plan
Component 3: Implementation Management, Monitoring and Evaluation	<ul style="list-style-type: none"> • Training to improve oversight, coordination, surveillance and data analysis to support implementation management, monitoring and evaluation. • Support to Project monitoring and evaluation framework development, implementation, and reporting. • Support to integration of Project monitoring and evaluation results into the existing national surveillance and reporting systems. 	<ul style="list-style-type: none"> • MHMS 	<ul style="list-style-type: none"> • Public health oversight, coordination and surveillance • Data analysis to support implementation management, monitoring and evaluation. • Project monitoring and evaluation framework development, implementation, and reporting. • Integration of Project monitoring and evaluation results into national surveillance and reporting systems.

5.3 Grievance Procedures

5.3.1 Grievance Mechanism

The Project Grievance Mechanism (GM) will seek to resolve complaints and grievances in a timely, effective and efficient manner that satisfies all parties involved. It will provide a transparent and credible process for fair, effective and lasting outcomes. It will also build trust and cooperation as an integral component of broader community consultation that facilitates corrective actions. The GM will:

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

5.3.2 GM for Fiji.

MHMS will follow the ERA to handle all its grievances regarding workers who may have been discriminated within the terms of Part 9 of the ERA or has been sexually harassed in the worker's employment within the terms of section 76 of the ERA or any other issues such as unfair treatment or termination. The Employment Relations Tribunal determines all such cases as mandated in the ERA. However, MHMS is open to accept any complaints through PSHMS that may need internal investigation through Civil Service Disciplinary procedures and guidelines.

5.3.3 World Bank Grievance Redress

Communities and individuals who believe that they are adversely affected by a World Bank-supported Project may submit complaints to existing Project-level GM or to the World Bank's Grievance Redress Service (GRS). Once the concerns have been brought directly to the World Bank's attention, and Bank management has been given an opportunity to respond, complaints may be submitted to the World Bank's independent Inspection Panel which determines whether harm occurred, or could occur, because of World Bank non-compliance with its policies and procedures. Information on the World Bank's corporate Grievance Redress Service is provided at: www.worldbank.org/en/Projects-operations/products-and-services/grievance-redress-service. Information on how to submit complaints to the World Bank's Inspection Panel is provided at: www.inspectionpanel.org.

5.4 Monitoring and Reporting

The SEP will be periodically revised and updated as necessary in the course of Project implementation in order to ensure that the information presented is consistent and reflects the evolving nature of information required at different stages of the Project, and that the identified methods of engagement remain appropriate and effective in relation to the Project context and specific phases of the development. Any major changes to Project related activities or schedule will be reflected in the SEP. Quarterly summaries and internal reports on public grievances, enquiries and related incidents, together with the status of implementation of associated corrective/preventative actions, will be collated by the designated GM officer, and referred to the Project Director, Manager and Project Steering Committee. The quarterly summaries will provide a mechanism for assessing both the number and the nature of complaints and requests for information, along with the Project's ability to address those in a timely and effective manner.

6 Implementation Arrangements, Responsibilities and Capacity Building

6.1 Implementing Agency

The MHMS will be the Project's implementing agency. MHMS will have overall responsibility for carrying out the day-to-day management and implementation of the Project as well as coordination with other government ministries and stakeholders on all aspects of project implementation as required.

Procurement will also be carried out by MHMS. The MHMS has no previous experience with World Bank financed projects and will require significant support. To address this, the MHMS will hire a Project Manager to lead the day-to-day project management and implementation and coordinate between ministries. The MHMS will ensure the Project Manager is contracted within two months after the effective date of the Financing Agreement.

A Project Operational Manual (POM) will be developed no later than three months after the effective date of the Financing Agreement (approximately by mid-September 2020) to support the MHMS to meet its responsibilities for management and implementation of the Project. The POM will describe detailed arrangement and procedures for the implementation of the project, such as operational systems and procedures, project organizational structure, office operations and procedures, finance and accounting procedures (including funds flow and disbursement arrangements, and details relating to MHMS Staff Costs), procurement procedures, the process for selection of health facilities in priority areas for telecommunication connectivity, personal data collection and processing in accordance with good international practice, Project monitoring, reporting, evaluation and communication arrangements, and implementation arrangements for the Environmental and Social Commitment Plan (ESCP) as well as the preparation and/or implementation of instruments referred to in the ESCP such as Environmental and Social Management Plans (ESMPs) per WB ESF guidance.

The ESMF and associated documents will be reviewed and updated by the incoming MHMS E&S Specialists continuously. Updated documents will be re-disclosed.

MHMS will prepare and submit regular (six-monthly) monitoring reports on the environmental, social, health and safety (ESHS) performance of the Project, including but not limited to, the implementation of the ESCP, status of preparation and implementation of the Project's environmental and social documents, stakeholder engagement activities and grievances log, Labour Management Procedures, contractor's ESHS implementation (when required), ESHS incidents, and the functioning of the grievance mechanism.

Environmental and Social Risk Management Support

The Project Manager will be supported by two specialists: one part-time international Environment, Social and Health and Safety (ESHS) Specialist, who will collaborate closely with one full-time local Environmental, Social, Health, Safety and Community Engagement (ESHSCE) Specialist. The ESHS and ESHSCE specialists (E&S Specialists) will develop and support the implementation of the Project's environmental, social, health and safety, and community engagement instruments in compliance with local legislation, good international industry practice (GIIP), including WHO Guidance on COVID-19 and the WB ESF. The E&S specialists will be recruited not later than two months after the effective date of the Financing Agreement and before the carrying out of the relevant Project activities.

ESHSCE Specialist

The full-time ESHSCE Specialist, reporting to the Project Manager and collaborating closely with the International ESHS Specialist, will ensure that environmental, social, and health and safety risks are managed in accordance with the requirements of the World Bank's ESF, WHO Guidance on COVID-19, and GoF Law.

Specifically, the ESHSCE Specialist will:

- Support the International ESHS Specialist in the preparation of the ESIA, = CESMP/CESCOP, and ESMP for the procurement, installation and operation of the incinerator;
- Lead the implementation of the project's ESMF and associated instruments in accordance with the World Bank ESF, project ESCP and GoF legal requirements including:
 - Develop and deliver ESHS training for relevant stakeholders.
 - Environmental screening (outlined in Chapter 6), preparation and disclosure of site-specific instruments, consultation and information dissemination activities with relevant stakeholders.
 - Site-based environmental, safety and social monitoring. Address non-compliances and develop and confirm the implementation of corrective actions. Assist with the implementation of project investment opportunities that would improve performance.
 - Preparation of monthly and six-monthly monitoring reports on the environmental, social, health and safety (ESHS) performance of the Project
 - Notification, reporting and management of incidents or accidents related to the Project which have, or are likely to have, a significant adverse effect on the environment, the affected communities, the public or workers.
- Managing the oversight of project consultants and contractors including Civil Works Contractors;
- Provide support and training for Civil Works Contractors to prepare construction waste management and health and safety plans;
- Managing environmental and social risks in procurement e.g. for the medical waste incinerator and the pharmaceutical warehouse construction materials;
- Oversee the implementation of the project's Stakeholder Engagement Plan in close collaboration with the Project Risk Communication and Community Engagement team (likely comprised of members from the MHMS and Ministry of Communications);
- Coordinate the implementation of the project's GM ensuring timely resolution of project related grievances;
- Participate in semi-annual Project Supervision missions, representing MHMS on environmental, safety and social aspects;
- Preparation of the monthly and six-monthly monitoring reports on the environmental, social, health and safety (ESHS) performance of the Project; and
- Conduct other ESHS and CE related activities as required by the Project Manager.

International ESHS Specialist

The International ESHS Specialist, reporting to the Project Manager and collaborating closely with the ESHSCE Specialist, will develop and support the implementation of environmental and occupational health and safety instruments that are compliant with local legislation, good international industry practice (GIIP), including WHO Guidance on COVID-19 and the World Bank ESF.

Especially the International ESHS Specialist will:

- Review the consultant’s feasibility report relating to the incinerator needs assessment work.
- Develop the ESIA, CESMP/CESCOP, and ESMP for the procurement, installation and operation of the incinerator. Follow the Fiji EIA/waste permit/air pollution permit process to identify what level of approvals and what permits are required and then apply the identified conditions. If required, the EIA or other permits can be incorporated into the ESIA prepared in accordance with the ESF;
- Develop the ESIA, CESMP/CESCOP, and ESMP for the design, construction and operation of the pharmaceutical warehouse. Follow the Fiji EIA/waste permit process to identify what level of approvals and what permits are required and then apply the identified conditions. If required, the EIA or other permits can be incorporated into the ESIA prepared in accordance with the ESF;
- Develop/review ESHS procedures and co-ordinate training for the operation and maintenance of the incinerator; and
- Provide technical support to the ESHSCE Specialist to implement the project's ESMF and associated instruments in accordance with the World Bank ESF, ESCP and GoF legal requirements including:
 - Support the ESHS&CE to develop and deliver ESHS training for relevant stakeholders.
 - Support environmental screening, preparation and disclosure of site-specific instruments, and consultation and information dissemination activities with relevant stakeholders.
 - Support site-based environmental, safety and social monitoring. Advise on suitable corrective actions/opportunities for improving performance.
 - Support/review monthly and six-monthly monitoring reports on the environmental, social, health and safety (ESHS) performance of the Project.
 - Support notification, reporting and management of incidents or accidents related to the Project which have, or are likely to have, a significant adverse effect on the environment, the affected communities, the public or workers.
 - Participate (remotely) in semi-annual Project Supervision missions, representing MHMS on environmental, safety and social aspects.

6.2 Activity Level Environmental and Social Risk Management Responsibilities

UN Agencies

The MHMS may contract one or more of the United Nations (UN) agencies, e.g. UNICEF, to support project activities e.g. to procure and provide medical supplies and equipment. The list of equipment and supplies to be procured shall be approved by MHMS in accordance with the Project’s environmental and social requirements. All UN agency contracted activities, including procurement, are expected to comply with the Project’s environmental and social E&S risk management documents³² and this would be specified in the contractor’s agreement.

Construction Contractors

Construction contractors may be used for activities such as the installation of the incinerator and any ancillary activities, and the construction of the warehouse. Contractor(s) are expected to comply with the projects E&S risk management documents, including the ESMP/ESIA’s, CESMP/CESCOPs, and LMP as well as local legislations and this will be specified in the contractor’s agreements. Contractor(s) will be expected to disseminate and create awareness within their workforce of environmental and social E&S

³² ESMF, LMP, SEP, IPC&WMP

risk management compliance, and undertake any staff training necessary for their effective implementation. Where contractors do not have existing environmental staff, the MHMS E&S Specialists, supported by the World Bank Environmental and Social team, will make arrangements for adequate capacity building within the contractor's workforce.

Contractor(s) will also be required to prepare and comply with waste management plans and construction health and safety plans, submit those plans to the E&S specialist for approval prior to physical works commencing, and to take all necessary precautions to maintain the health and safety of their personnel. The contractor(s) will appoint a health and safety officer at site, who will have the authority to issue directives for the purpose of maintaining the health and safety of all personnel authorized to enter and or work on the site, to take protective measures to prevent accidents, to ensure suitable arrangements are made for all necessary welfare and hygiene requirements, to undertake worker training, and be a focal point to deal with COVID-19 issues. Contractor(s) will be briefed on the GM and required to refer any grievances to the E&S specialists who will coordinate the GM.

Health-care Facilities

At the health-care facility level, the head of the health-care facility will have overall responsibility for infection prevention control (IPC) and health-care waste management. During project implementation, the head of the health-care facility should assess the following:

- whether adequate and qualified staff are in place, including those in charge of IPC and health-care waste management;
- whether additional staff are required: if so, how many, and with what qualifications and training;
- How relevant departments in the healthcare facility will work together to create an intra-departmental team to manage, coordinate and regularly review the issues and performance of the facility.

The head of a health-care facility should formally appoint or identify a person or team to be responsible for implementing the procedures and mitigation measures that have been adopted to avoid or minimize the spread of COVID-19. This would be the person/team with overall responsibility for infection prevention control and health-care waste management and would ensure that IPC and health-care waste management activities are carried out in accordance with the IPC&WMP. This person/team would also manage, coordinate and regularly review and report to the head of the health-care facility as to the performance of the facility in terms of how the waste streams in the health-care facilities are managed (ie., by at source separation, transport, storage, treatment and disposal). In addition, in regards to COVID-19 samples to manage, coordinate and regularly review how they are tracked, and recorded, and to oversee the procedures for the safe transportation of potentially infected samples to testing facilities.

Currently, some health care facilities have a dedicated person/s who champions IPC and health-care waste management who could also be identified for IPC and health-care waste management oversight for this Project. This will be decided during project implementation.

6.3 World Bank Environmental and Social Team

The Bank's Environmental and Social team will provide regular E&S risk management compliance support for the duration of the project, remote and during missions, and to build capacity for ESMF

implementation and stakeholder engagement. As international travel may be slow to resume, supervision and missions may continue to be conducted remotely for some time.

6.4 Capacity Building

The incoming MHMS E&S Specialist/s may have differing level of familiarity with the WB Environmental and Social Standards and Procedures and may need ongoing support, training, and technical assistance to implement the Project E&S documents and prepare project activity instruments, such as ESIA/ESMPs, during project implementation. It is expected that enhanced oversight from the Bank E&S team will be required and a capacity assessment will identify where training and further capacity building will be needed. Implementation support will include: (a) capacity building for MHMS staff on WB implementation and requirements; (b) an implementation support mission every six months, once international travel has resumed to Fiji; (c) interim technical discussions and site visits by the WB; (d) monitoring and reporting by the implementation team on implementation progress and achievement of results; (e) annual internal and external financial audits and FM reporting; and (f) periodic procurement post review. In the event of the inability of relevant staff to travel to Fiji to undertake implementation support, the use of audio/video conferencing, as has been the case during the preparation, will continue in order to ensure “just in time” support to the MHMS. The WB will also maintain a close dialogue with the MHMS E&S Specialist/s and ensure implementation support for environmental and social risk management and stakeholder engagement when needed. Further capacity assessments during project implementation will identify where training and further capacity building will be needed.

The Fiji health sector has some experience in IPC, health-care waste management, and communication and public awareness for emergency situations through other national health projects. Effective implementation of the environmental and social risk management will require capacity development for those responsible for implementing project activities at grass-root levels.

Training and capacity support of hospital medical, laboratory and waste management personnel, community outreach officers are built into to the project design (component 2) and will be primarily delivered by WHO (contracted by UNICEF). E&S related training topics/themes will include (as required):

- Interpersonal communication by health workers related to COVID-19;
- Infection prevention and control, testing;
- Health-care waste management; and
- Clinical management of patients with mild symptoms in primary care settings.

Training topics/themes delivered by the E&S Specialists will likely cover the following topics:

- The relevant requirements of the ESMF, LMP, SEP, IPC&WMP, provisions to prevent SEA/SH, and WHO guidelines on COVID-19.
- The roles and responsibilities of different key agencies in the E&S risk management implementation.
- Managing COVID-19 related waste, and general medical health care waste.
- Labour management procedures.
- Grievance mechanisms.
- Consultations, communications and feedback.
- Ensuring all peoples are given equal access and rights (vulnerable groups, ethnic groups).
- Understanding concerns with gender-based violence, violence against children, social stigma with COVID 19.

- Awareness on SEAH
- Monitoring and reporting at all levels.

6.5 E&S Risk Management Budget

ESMF implementation costs are allocated according to the budget line items in Table 12. Such costs include the E&S Specialists, training, and other costs to be determined during project implementation. Costs for undertaking travel to conduct monitoring and trainings as well as participation with World Bank supervision missions are also identified. The anticipated cost for all these initiatives is estimated at \$225,000 USD.

The national E&S specialists, once on board, will be maintained throughout project implementation. The E&S Specialist/s in MHMS will not have a stand-alone, earmarked budget to complete E&S risk management activities such as the preparation of activity level E&S risk management instruments. Instead the cost is embedded in the E&S Specialist/s budgets. It is worth noting that there is a significant overlap in project activities to achieve its objectives, and the risk management measures prescribed by the ESMF (e.g. risk communication and awareness activities). A good part of the Project budget will be used for activities outlined in the ESMF e.g. for health-care worker training and information dissemination. Therefore, significantly more money will be spent on E&S risk management, than is reflected in Table 12.

Table 12 - ESMF Implementation Costs

E&S risk management resource	USD
ESHSCE Specialist (Local)	\$75,000
<ul style="list-style-type: none"> • Screening of activities. • Preparation and disclosure of activity level instruments. • Supervision, monitoring, and reporting. • Information and communication • Monitoring including preparation of six-monthly monitoring reports on the environmental, social, health and safety (ESHS) performance of the Project. • Training and workshops • Coordinating the Project's GM 	
ESHS Specialist (International)	\$100,000
<ul style="list-style-type: none"> • Support screening of activities. • Support preparation and disclosure of activity level instruments. • Support supervision, monitoring, and reporting. • Support monitoring including preparation of six-monthly monitoring reports on the environmental, social, health and safety (ESHS) performance of the Project. • Support notification, reporting and management of incidents or accidents. • Training and Workshops. • Capacity Building. • Support the coordination of the Project's GM. 	
Training and Communications	\$25,000
<ul style="list-style-type: none"> • MHMS E&S specialist/s to travel to provide ESHS training at national and provincial level. • Consultation activities in accordance with the SEP. 	
Supervision, monitoring, and reporting	\$25,000
<ul style="list-style-type: none"> • MHMS E&S specialist/s to travel to provinces semi-annually for conducting project supervision, monitoring and reporting. 	
TOTAL	\$225,000

7 Annexes

Annex I. Abbreviations and Acronyms

BSL	Biosafety Level
CDC	Centre for Disease Control and Prevention
CEMP	Construction Environment Management Plan
CESCOP	Construction Environmental and Social Code of Practice
CESMP	Construction Environmental and Social Management Plan
COVID-19	Coronavirus Disease 2019
DOE	Department of Environment
EHS	Environmental, Health and Safety
EIA	Environmental Impact Assessment
ERP	Emergency Response Plan
ESCP	Environmental and Social Commitment Plan
ESF	Environmental and Social Framework
ESHS	Environmental, Social, Health and Safety
ESHSCE	Environmental, Social, Health, Safety and Community Engagement
ESIA	Environmental and Social Impact Assessment
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
ESS	Environmental and Social Standard
GBV	Gender Based Violence
GIIP	Good International Industry Practice
GM	Grievance Mechanism
GoF	Government of Fiji
HCF	Health-care Facility
HCW	Health-care Waste
HCWM	Health-care Waste Management
HEPA	High Efficiency Particulate Air filter
IPC	Infection and Prevention Control
IPC&WMP	Infection Prevention Control and Waste Management Plan
MoE	Ministry of Economy
MHMS	Ministry of Health & Medical Services
OHS	Occupational Health and Safety
PDO	Project Development Objectives
POM	Project Operational Manual
PPE	Personal Protective Equipment
SEA	Sexual Exploitation and Abuse
SEP	Stakeholder Engagement Plan
SH	Sexual Harassment
SOP	Standard Operating Procedures
SPRP	COVID-19 Strategic Preparedness and Response Program
SWM	Solid Waste Management
TA	Technical Assistance
UN	United Nations
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization
WMP	Waste Management Plan
WWTP	Wastewater Treatment Plant

Annex II. Construction Screening Checklist

Name of the activity: _____ Screening Date: _____

Locality: _____ Description of the area: _____

Step 1: Land Acquisition

1. Is the land required government land, government leased land or private land?

☐ **Government land or Government leased land.** Proceed to Step 2.

☐ **Private land.** Ineligible for project funding.

Step 2: Environmental Risks

1. Will this activity require any clearance of trees or other vegetation?

☐ Yes

☐ No

2. Will there be any negative impacts on sensitive or non-critical habitats i.e. those not defined as 'critical habitat' in World Bank ESS6³³?

☐ Yes

☐ No

3. Will construction be located near rivers, waterways or water bodies/ponds?

☐ Yes

☐ No

4. Will this activity require any land reclamation?

☐ Yes

☐ No

5. Will this activity result in any significant increase in pollution e.g. generation of waste etc.?

☐ Yes

☐ No

6. Will this activity result in the occurrence, or increase the chances of occurrence, of natural hazards such as soil erosion, flooding, tidal inundation or hazardous substances?

☐ Yes

☐ No

7. Are utility services unavailable and/or inadequate for the activity?

☐ Yes

☐ No

³³ Activities in Critical Habitats are ineligible for project funding

Step 3: Social Risks

1. Will this activity require compensation for loss of assets or access to assets that leads to loss of income sources or other means of livelihoods?

- ☐ Yes
☐ No

2. Will this activity impact areas, landscapes and structures of aesthetic, archeological, cultural, historical, recreational, scenic or scientific value?

- ☐ Yes – ineligible for project funding.
☐ No – ensure chance find procedures in place (Annex VII).

Step 4. Categorization and E&S risk management instruments required

If yes to any of the questions in Step 2 or Step 3, Construction Environmental and Social Management Plan (CESMP) to be developed by E&S Specialists and followed by Contractors. Recommend further scoping to determine actual scale of risk and identify opportunities to reduce risks. Contractor required to prepare and follow Construction Waste Management Plan and Construction Health and Safety Plan with GBV requirements included.

If no's to all questions in Step 2 and Step 3. Minor risks. E&S Specialists prepare Construction Environmental and Social Code of Practice (CESCOP). Contractor prepares Construction Waste Management Plan and Construction Health and Safety Plan with GBV requirements included.

Step 5: Preparation of E&S risk management instruments

Before developing E&S risk management instruments, discuss design with Project Team (Step 4 of Screening of Subprojects Process, see Chapter 6 of the ESMF).

The activity _____ located _____
 has been assessed and the following E&S risk management documents / instruments will be prepared:

- | | |
|--|----------------------|
| <input type="checkbox"/> CESMP | Date Complete: _____ |
| <input type="checkbox"/> CESCOP | Date Complete: _____ |
| <input type="checkbox"/> Waste Management Plan (Contractor) | Date Complete: _____ |
| <input type="checkbox"/> Health and Safety Plan (Contractor) | Date Complete: _____ |

Annex III. Screening Form for Potential Environmental and Social Issues

This form is to be used by the MHMS to for screen potential environmental and social risks and impacts of a proposed project activity not pre-screened in Chapter 5 of the ESMF e.g. for additional financing activities. The purpose of screening is to (i) determine whether activities are eligible to be financed, and likely to have potential negative environmental and social risks and impacts; and (ii) identify appropriate mitigation measures for activities with adverse risks or impacts. The screening will help the E&S Specialists 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, including specific instruments/plans.

This form is for all 'other' activities not already pre-screened in Chapter 5 the ESMF. Before screening, also check that the activity is not listed in Ineligible Activity List (Chapter 6, Table 10 in the ESMF).

Use of this form will allow the MHMS E&S Specialists to form an initial view of the potential risks and impacts of a project activity. ***It is not a substitute for project-specific E&S assessments or specific mitigation plans.***

The completed forms will be signed and kept in the Project ESF file and included in the ESF implementation progress report to be submitted to World Bank (WB) per the schedule as agreed with WB.

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

Questions	Answer		ESS relevance	Due diligence / Actions
	Yes	no		
Does the activity involve civil works including new construction, expansion, upgrading or rehabilitation of health-care facilities and/or waste management facilities?			ESS1	ESIA/ESMP, Construction/Renovation H&S and WMP, LMP, SEP, GM
Does the activity involve land acquisition and/or restrictions on land use?			ESS5	If yes, this activity is ineligible for project financing
Does the activity involve acquisition of assets for quarantine, isolation or medical treatment purposes?			ESS5	If yes, this activity is ineligible for project financing
Does the subproject involve 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?			ESS5	If yes, this activity is ineligible for project financing
Does the subproject involve 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?			ESS5	If yes, this activity is ineligible for project financing
Does the subproject involve uses of goods and equipment involving forced labour, child labour, or other harmful or exploitative forms of labour?			ESS2	If yes, this activity is ineligible for project financing
Is the activity associated with any external waste management facilities such as a sanitary landfill, incinerator, or wastewater treatment plant for health-care waste disposal?			ESS3	IPC&WMP, LMP, SEP
Is there a sound regulatory framework and institutional capacity in place for health-care facility infection control and health-care waste management?			ESS1	IPC&WMP, SEP
Does the activity have an adequate system in place (capacity, processes and management) to address waste such as incorporating recycling systems?				IPC&WMP or activity WMP, SEP
Does the activity involve recruitment of workers including direct, contracted, primary supply, and/or community workers?			ESS2	LMP, SEP
Has a construction safety management plan been prepared?				Activity ESMP, LMP

Does the activity have appropriate OHS procedures in place, and an adequate supply of PPE (where necessary)?				Activity ESMP, LMP
Does the activity have a GM in place, to which all workers have access, designed to respond quickly and effectively?				Project GM
Does the activity involve transboundary transportation (including Potentially infected specimens may be transported from health-care facilities to testing laboratories, and transboundary) of specimen, samples, infectious and hazardous materials?			ESS3	IPC&WMP, SEP. Transport should be performed in accordance with WHO interim guidelines on specimen collection and shipment
Does the activity involve use of security or military personnel during construction and/or operation of health-care facilities and related activities?			ESS4	Follow WB Technical Note: Use of Military Forces to Assist in Covid-19 Operations Suggestions on how to Mitigate Risks, SEP
Is the activity located within or in the vicinity of any ecologically sensitive areas?			ESS6	If yes, this activity is ineligible for project financing
Are there any indigenous groups (meeting specified ESS7 criteria) present in the activity area and are they likely to be affected by the proposed activity negatively or positively?			ESS7	SEP incorporating provisions for IPs
Is the activity located within or in the vicinity of any known cultural heritage sites?			ESS8	If yes, this activity is ineligible for project financing
Does the activity area present considerable Gender-Based Violence (GBV) and Sexual Exploitation and Abuse (SEA) risk?			ESS1	LMP, SEP
Is there any territorial dispute between two or more countries in the activity and its ancillary aspects and related activities?			<i>OP7.60 Projects in Disputed Areas</i>	If yes, this activity is ineligible for project financing
Will the activity and any related activities involve the use or potential pollution of, or be located in international waterways ³⁴ ?			<i>OP7.50 Projects on International Waterways</i>	If yes, this activity is ineligible for project financing

³⁴ International waterways include any river, canal, lake or similar body of water that forms a boundary between, or any river or surface water that flows through two or more states.

Conclusions:

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

- 2. E&S Management Plans/ Instruments to follow.**

Remarks.....

Sign by: Activities owner:

Position:Date

Sign by:

Position:Date:.....

Annex IV. Environmental and Social Impact Assessment (ESIA) Outline

An Environmental and social impact assessment (ESIA) is an instrument to identify and assess the potential environmental and social impacts of a proposed activity, evaluate alternatives, and design appropriate mitigation, management, and monitoring measures.

Any ESIA prepared for Project activities, such as the incinerator and the pharmaceutical warehouse, should be prepared with regards to the following project documents:

- Environmental and Social Management Framework (ESMF)
- Infection Prevention Control and Waste Management Plan (IPC&WMP)
- Labour Management Procedure (LMP)
- Stakeholder Engagement Plan (SEP)
- Project Operational Manual (POM)

If an EIA permit or other permits are determined during project implementation to be required by Fiji, the requirements of the Fiji EIA can be incorporated into the ESIA to be prepared in accordance with the ESF.

Where an ESIA is prepared as part of the environmental and social assessment for Project activities the following outline can be used for guidance on what should be included :

- (a) Executive summary
 - Concisely discusses significant findings and recommended actions.
- (b) Project description
 - Concisely describes the proposed project and its geographic, environmental, social, and temporal context, including any offsite investments that may be required (e.g., access roads, power supply, water supply, and raw material and product storage facilities), as well as the project's primary suppliers.
 - Includes a map of sufficient detail, showing the project site and the area that may be affected by the project's direct, indirect, and cumulative impacts.
- (c) Baseline information
 - Based on current information, describes relevant physical, biological, and socioeconomic conditions, including any changes anticipated before the project commences.
 - Takes into account current and proposed development activities within the project area not directly connected to the project.
- (d) Environmental and social risks and impacts
 - Takes into account all relevant environmental and social risks and impacts of the project. This will include the environmental and social risks and impacts specifically identified in WB ESF standards, and any other environmental and social risks and impacts arising as a consequence of the specific nature and context of the project. Refer to chapter 5 of the ESMF for an assessment of the environmental and social risks identified during the preliminary screening of the project activities.
- (e) Mitigation measures
 - Identifies avoidance and mitigation measures and significant residual negative impacts that cannot be mitigated and, to the extent possible, assess the acceptability of those residual negative impacts.
 - Identifies differentiated measures so that adverse impacts do not fall disproportionately on the disadvantaged or vulnerable.

- Assesses the feasibility of mitigating the environmental and social impacts; the capital and recurrent costs of proposed mitigation measures, and their suitability under local conditions; the institutional, training, and monitoring requirements for the proposed mitigation measures.
 - Specifies issues that do not require further attention, providing the basis for this determination.
- (f) Analysis of alternatives
- Systematically compares feasible alternatives to the proposed project site, technology, design, and operation—including the "without project" situation—in terms of their potential environmental and social impacts;
 - Assesses the alternatives' feasibility of mitigating the environmental and social impacts; the capital and recurrent costs of alternative mitigation measures, and their suitability under local conditions; the institutional, training, and monitoring requirements for the alternative mitigation measures.
 - For each of the alternatives, quantifies the environmental and social impacts to the extent possible, and attaches economic values (where feasible).
- (g) Design measures
- Sets out the basis for selecting the particular project design proposed and specifies the applicable ESHGs, or if the ESHGs are determined to be inapplicable, justifies recommended emission levels and approaches to pollution prevention and abatement that are consistent with GIIP.
- (h) Key measures and actions
- Summarizes key measures and actions and the time frame required for the project to meet the requirements of the WB ESF standards.
- (i) Appendices
- References—set out the written materials, both published and unpublished, that have been used.
 - Record of meetings, consultations, and surveys with stakeholders, including those with affected people and other interested parties. The record specifies the means of such stakeholder engagement that were used to obtain the views of affected people and other interested parties.
 - Tables presenting the relevant data referred to or summarized in the main text.
 - List of associated reports or plans.

Annex V. Environmental and Social Management Plan (ESMP/CESMP) Template

An Environmental and social management plan (ESMP) is an instrument that details (i) the measures to be taken during the implementation and operation of an activity to eliminate or offset adverse environmental and social impacts, or to reduce them to acceptable levels; and (ii) the actions needed to implement these measures.

The MHMS E&S specialists may need to develop an Environmental and Social Management Plan (ESMP) or a Construction Environmental and Social Management Plan (CESMP) for project activities, such as the installation and operation of the incinerator and warehouse or for additional financing activities, setting out how the environmental and social risks and impacts will be identified and managed through the project lifecycle.

Any ESMP/CESMP prepared for Project activities should be prepared with regards to the following project documents:

- Environmental and Social Management Framework (ESMF)
- Infection Prevention Control and Waste Management Plan (IPC&WMP)
- Labor Management Procedure (LMP)
- Stakeholder Engagement Plan (SEP)
- Project Operational Manual (POM)

This ESMP template, adapted from the World Bank ESMF template for COVID-19 response, includes several matrices identifying key risks and setting out suggested E&S mitigation measures. If required, the MHMS E&S Specialists can use these matrices to assist in identifying risks and possible mitigations. This template can be used for both the ESMP and CESMP (if required) to be prepared by the E&S specialist during project implementation. If an EIA permit or other permits are determined during project implementation to be required by Fiji, the EIA can be incorporated into the ESMP prepared in accordance with the ESF.

The ESMP/CESMP should also include other key elements relevant to delivery of the project, such as institutional arrangements, plans for capacity building and training plan, and background information. The MHMS may incorporate relevant sections of the ESMF and supporting documents into the ESMP/CESMP, with necessary updates.

The matrices illustrate the importance of considering lifecycle management of E&S risks, including during the different phases of the project identified in the ESMF: planning and design, construction, operations and decommissioning.

The issues and risks identified in the matrix are based on current COVID-19 knowledge, management responses and experience of other World Bank financed healthcare sector projects. The MHMS E&S specialists should review and add to them during the environmental and social assessment of a project activity.

The WBG EHS Guidelines, WHO technical guidance documents and other GIIPs set out in detail many mitigation measures and good practices, and can be used by the MHMS E&S specialists to develop the ESMP/CESMP. Proper stakeholder engagement should be conducted in determining the mitigation measures, including close involvement of medical and healthcare waste management professionals.

The ESMP/CESMP should be incorporated into the contractors bidding document and/or contract.

Table 1 - Environmental and Social Risks and Mitigation Measures during Planning and Designing Stage

Key Activities	Potential E&S Risks and Impacts	Proposed Mitigation Measures	Responsibilities	Timeline	Budget
Identify the type, location and scale of the facilities and technology.	Selection of an inappropriate technology and/or capacity to treat the types and volumes of waste generated.	A review of available and relevant technologies undertaken in tandem with an understanding of the types and volumes and sources of waste needed to be managed by the facility.	MOHMS	June 2021	USD900,000
Identify the need for new construction, expansion, upgrading and/or rehabilitation	Environmental & Social Risks	Review of all relevant options to mitigate identified adverse impacts	PMU/MHMS	August 2021	
Identify the needs for ancillary works and associated facilities, such as access roads, construction materials, supplies of water and power, sewage system	ESHS Risk	Review of all relevant options to mitigate the adverse impacts	MHMS	October 2021	
Identify the needs for acquisition of land and assets (e.g. acquiring existing assets such as hostel, stadium to hold potential patients)	Risk of exposure to Community and health care workers, security if facility is not well equipped.	Strengthen COVID19 protocol to mitigate	MHMS	October 2021	
Identify onsite and offsite waste management facilities, and waste transportation routes and service providers	Inadequate facilities and processes for treatment of waste	<ul style="list-style-type: none"> ➤ Estimate potential waste streams ➤ Consider the capacity of existing facilities, and plan to increase capacity, if necessary, through construction, expansion etc. ➤ Specify that the design of the facility considers the collection, segregation, transport and treatment of the anticipated volumes and types of healthcare wastes along with disposal of residues. ➤ Require that receptacles for waste should be sized appropriately for the waste volumes generated, and color coded and labeled according to the types of waste to be deposited. Develop appropriate protocols for the collection of waste and transportation to storage/disposal areas in accordance with WHO guidance. Design and implement training for staff in the segregation of wastes at the time of use as well 	MHMS	October 2021	

		as management from point of generation to final treatment/disposal.			
Identify needs for transboundary movement of samples, specimen, reagent, and other hazardous materials	Materials not transported in accord with legislative requirements and not safely	Protocols and procedures for transporting materials be developed and implemented.	MHMS		
Identify needs for workforce and type of project workers	Workers not qualified or overworked resulting in OHS issues	<ul style="list-style-type: none"> ➤ Identify numbers and types of workers ➤ Consider accommodation and measures to minimize cross infection ➤ Refer to the Project LMP to identify possible mitigation measures 	MHMS		
Identify needs for using security personnel during construction and/or operation of facility	Loss of equipment and supplies, or unauthorized person entering the site	Follow WB Technical Note: Use of Military Forces to Assist in Covid-19 Operations Suggestions on how to Mitigate Risks, SEP	MHMS		
Facility design – general	<ul style="list-style-type: none"> - Structural safety risk; - Functional layout and engineering control for nosocomial infection (if applicable) 	Design to comply with Building code and structural stability and safety.	MHMS		
Facility design - considerations for differentiated treatment for groups of higher sensitivity or vulnerable (the elderly, those with preexisting conditions, or the very young) and those with disabilities (if applicable)	Some groups may have difficulty accessing health facilities	Make provisions for disabled, senior citizens and special challenged patients.	MHMS		
Design of facility should reflect specific treatment requirements, including triage, isolation or quarantine (if applicable)	Facility not fit for purpose	<ul style="list-style-type: none"> ➤ The design, set up and management of will take into account the advice provided by WHO guidance for Severe Acute Respiratory Infections Treatment Center. ➤ Hand washing facilities should be provided at the entrances to health care facilities in line with WHO Recommendations to Member States to Improve Hygiene Practices. ➤ Isolation rooms should be provided and used at medical facilities for patients with possible or confirmed COVID-19. ➤ Isolation rooms should: 	MHMS		

		<ul style="list-style-type: none"> ✓ be single rooms with attached bathrooms (or with a dedicated commode); ✓ ideally be under negative pressure (neutral pressure may be used, but positive pressure rooms should be avoided) ✓ be sited away from busy areas or close to vulnerable or high-risk patients, to minimize chances of infection spread; ✓ have dedicated equipment (for example blood pressure machine, peak flow meter and stethoscope) ✓ have signs on doors to control entry to the room, with the door kept closed; <p>have an ante-room for staff to put on and take off PPE and to wash/decontaminate before and after providing treatment.</p>			
Design to consider mortuary arrangements (if applicable)	Insufficient capacity Spread of infection	<ul style="list-style-type: none"> ➤ Include adequate mortuary arrangements in the design ➤ See WHO Infection Prevention and Control for the safe management of a dead body in the context of COVID-19 	MHMS		

Table 2 - Environmental and Social Risks and Mitigation Measures during Construction Stage

Activities	Potential E&S Risks and Impacts	Proposed Mitigation Measures	Responsibilities	Timeline	Budget
Clearing of vegetation and trees; construction activities near ecologically sensitive areas/spots	- Impacts on natural habitats, ecological resources and biodiversity	Implement EIA/ESIA recommendations	MHMS		
General construction activities - foundation excavation; borehole digging	- Impacts on soils and groundwater; - Geological risks	Minimize extensive and unnecessary excavations Alternative designs	MHMS		
General construction activities – materials supply	- Resource efficiency issues, including raw materials, water and energy use; - Materials supply	Minimum standards will be implemented as required under the Building Laws. Site engineers and architects to monitor. Utility services will be arranged prior to start of the project.	MHMS		
General construction activities - general pollution management	- Construction solid waste; - Construction wastewater; - Noise; - Vibration; - Dust; - Air emissions from construction equipment	Implementation of the ESIA and CESMP with monitoring by MHMS	MHMS		
General construction activities – hazardous waste management	- Fuel, oils, lubricant spills and incorrect management of wastes resulting in environmental and human health impacts	Implementation of the ESIA and CESMP with monitoring by MHMS	MHMS		
General construction activities – Labour issues	- Workers coming from infected areas - Co-workers becoming infected - Workers introducing infection into community/general public	- Refer to Project LMP - Ensure all workers are aware of and comply with COVID-19 management protocols. - Implement procedures to minimize/control movement in and out of construction areas/site. - If workers are accommodated on site require them to minimize contact with people outside the construction area/site or prohibit them from leaving the area/site for the duration of their contract - Implement procedures to confirm workers are fit for work before they start work, paying	MHMS		

		<p>special attention to workers with underlying health issues or who may be otherwise at risk</p> <ul style="list-style-type: none"> - Check and record temperatures of workers and other people entering the construction area/site or require self-reporting prior to or on entering - Provide daily briefings to workers prior to commencing work, focusing on COVID-19 specific considerations including cough etiquette, hand hygiene and distancing measures. - Require workers to self-monitor for possible symptoms (fever, cough) and to report to their supervisor if they have symptoms or are feeling unwell - Prevent a worker from an affected area or who has been in contact with an infected person from entering the construction area/site for 14 days - Preventing a sick worker from entering the construction area/site, referring them to local health facilities if necessary or requiring them to isolate at home for 14 days - Determine eligibility for COVID_19 vaccinations for personnel. 			
General construction activities – Occupational Health and Safety (OHS)	Construction activities result in adverse environmental and human health impacts	Construction Health and Safety Plan	MHMS		
General construction activities – traffic and road safety	Damage to infrastructure, vehicles and injuries to personnel	Apply ESIA/EIA recommendations	MHMS		
General construction activities – security personnel	N/A	N/A	N/A		
General construction activities – land and asset	Acquisition of land and assets	N/A	N/A		
General construction activities	GBV/SEA/SH issues	Addressed by ERA and disciplinary procedures.	MHMS		
General construction activities – cultural heritage	Cultural heritage	Chance-finds procedure (Annex VII) to be adhered to.	MHMS		

General construction activities – emergency preparedness and response	Impacts to the environment, health impacts to personnel and loss of building supplies.	Emergency Response Plan	MHMS		
Construction activities related to <i>onsite</i> waste management facilities, including temporary storage, incinerator, sewerage system and wastewater treatment works	Inappropriate management of wastes resulting in non-adherence to legislative and Policy requirements and environmental impacts.	Existing waste management services sewerage systems to be utilized and a project specific waste management plan developed and implemented.	MHMS		
Construction activities related to demolition of existing structures or facilities (if needed)	N/A	N/A	N/A		

Table 3 - Environmental and Social Risks and Mitigation Measures during Operational Stage

Activities	Potential E&S Risks and Impacts	Proposed Mitigation Measures	Responsibilities	Timeline	Budget
General facility operation – Environment	Waste and wastewater generation, energy consumption and air emissions	Development and implementation of operational procedures, training of operators on correct operation of the facility and management of contingencies such as spills.	MHMS		
General facility operation – OHS issues	Exposure to hazards such as: - Physical hazards; - Electrical hazards; - Fire; - Chemical use; - Ergonomic hazard; -	OHS Plan developed and implementation along with training of facility staff on correct operational procedures.	MHMS		
Facility operation – Labour issue		Refer to the Project LMP			
	Nil				
Facility operation – cleaning		<ul style="list-style-type: none"> • Provide cleaning staff with adequate cleaning equipment, materials and disinfectant. • Implement general cleaning systems, training cleaning staff on appropriate cleaning procedures and appropriate frequency in high use or high-risk areas. • Where cleaners will be required to clean areas that have been or are suspected to have been contaminated with COVID-19, provide 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, provide best available alternatives. • Train 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). 	MHMS		

Facility operation - Infection control and waste management plan	Refer to Project IPC&WMP	Refer to Project IPC&WMP	MHMS		
Waste management	<p>Incorrect waste segregation leading to inappropriate management pathways for wastes types and potential spread of COVID-19.</p> <p>Incorrect operation of waste treatment technologies results in reduction in air quality, water and land contamination and health impacts to operators and/or the community, use of fuel, OHS risks from operation etc.</p> <p>Refer to Project IPC&WMP</p>	<ul style="list-style-type: none"> ➤ Refer to Project IPC&WMP ➤ Healthcare waste treatment systems designed to reduce potential for off-site impacts such as dedining air quality and water pollution, resource consumption (eg., fuel use), as well as safe for facility staff, patients, and the wider community. ➤ 	MHMS		
Delivery and storage of specimen, samples, reagents, pharmaceuticals and medical supplies	All such supplies and samples are damaged and not able to be used or processed.	Infrastructure provided that will ensure the integrity of supplies and samples along with training in correct management. Monitoring and corrective action procedures developed, implemented and regular auditing undertaken to ensure compliance with the required standard(s).	MHMS		
Storage and handling of specimen, samples, reagents, and infectious materials	All such supplies, samples and materials are incorrectly handled and stored leading in OHS issues and damage to these items.	Infrastructure provided that will ensure the integrity of supplies and samples along with training in correct management. Monitoring and corrective action procedures developed, implemented and regular auditing undertaken to ensure compliance with the required standard(s).	MHMS		
Waste segregation, packaging, color coding and labeling	Incorrect segregation of wastes reuling in incorrect waste management (ie., treatment and/or disposal), OHS impacts to healthcare and waste management personnel.	Provision of dedicated containers such as bins colour coded Operators trained in management of waste, appropriate storage facility and bins provided	MHMS		
On site collection and transport	OHS impacts and environment contamination from spills.	IPC&WMP	MHMS		
Waste storage	OHS impacts and environment contamination from spills.	IPC&WMP and provision of storage facility	MHMS		

		Construction of a dedicated waste storage facility that is secure and will contain all waste types.			
Onsite waste treatment and disposal	Risk of contaminating land, water and air emissions. Potential for infection risks to staff, patients and the wider community.	No on-site treatment at healthcare facilities	MHMS		
Waste transportation to and disposal in offsite treatment and disposal facilities	OHS impacts and environment contamination from spills.	IPC&WMP	MHMS		
Transportation and disposal at offsite waste management facilities	OHS impacts and environment contamination from spills. Contamination of soil and waterways.	IPC&WMP	MHMS		
HCF operation – transboundary movement of specimen, samples, reagents, medical equipment, and infectious materials	All such supplies, samples and materials are incorrectly handled and stored leading in OHS issues and damage to these items.	IPC&WMP, SEP. Transport should be performed in accordance with WHO interim guidelines on specimen collection and shipment	MHMS		
Emergency events	<ul style="list-style-type: none"> - Spillage; - Occupational exposure to infectious disease; - Accidental releases of infectious or hazardous substances to the environment; - Medical equipment failure; - Failure of solid waste and wastewater treatment facilities - Fire; - Other emergency events 	<ul style="list-style-type: none"> ➤ Emergency Response Plan developed and implemented. ➤ All reported incidents investigated and corrective actions implemented. 	MHMS		
Mortuary arrangements (if applicable)	<ul style="list-style-type: none"> - Arrangements are insufficient - Processes are insufficient 	<ul style="list-style-type: none"> ➤ Implement good infection control practices (see <u>WHO Infection Prevention and Control for the safe management of a dead body in the context of COVID-19</u>) ➤ Use mortuaries and body bags, together with appropriate safeguards during funerals (see WHO <u>Practical considerations and recommendations</u>) 	MHMS		

		<u>for religious leaders and faith-based communities in the context of COVID-19)</u>			
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Table 4 - Environmental and Social Risks and Mitigation Measures during Decommissioning (if required)

Key Activities	Potential E&S Risks and Impacts	Proposed Mitigation Measures	Responsibilities	Timeline	Budget
Decommissioning of interim Facility (if applicable)	N/A	N/A	MHMS		
Decommissioning of medical equipment (if applicable)	N/A	N/A	MHMS		
Regular decommissioning (if applicable)	N/A	N/A	MHMS		

Annex VI. Construction Environmental and Social Code of Practice (CESCOP) Outline

The Construction Environmental and Social Code of Practice (CESCOP) outline provides guidance for the environmental and social management of minor construction activities during the implementation of the Project. The ESCOPs should use the following structure as an example of the components to include in a construction ESCOP, as appropriate.

Any ESCOP prepared for Project activities should be prepared with regards to the following project documents:

- Environmental and Social Management Framework (ESMF)
- Infection Prevention Control and Waste Management Plan (IPC&WMP)
- Labour Management Procedure (LMP)
- Stakeholder Engagement Plan (SEP)
- Project Operational Manual (POM)

The CESCOP should be prepared by the E&S specialists, prior to construction commencing and should be incorporated into the contractors bidding document and/or contract.

CESCOP Outline

1.0 Introduction

- 1.1 Project Description
- 1.2 Rationale of the CESCOP
- 1.3 Monitoring and Compliance Requirements
- 1.4 Reporting Requirements

2.0 Environmental and Social Risks and Impacts

3.0 Mitigation Measures

- 5.1 Management of Construction Sites
 - 5.1.1 Prohibitions
 - 5.1.2 Working Hours
 - 5.1.3 Good Housekeeping/General Site Management
 - 5.1.4 Public Information and Site Access
 - 5.1.5 Site Layout and Facilities³⁵
 - 5.1.6 Gender Based Violence and SEA/SH requirements
 - 5.1.7 Emergency Procedures
 - 5.1.8 Fire Prevention and Control
 - 5.1.9 Operation of Equipment
 - 5.1.10 Clearance of the Construction Site after Completion
- 5.2 Management of Environment and Sanitation
 - 5.2.1 Nuisance, Dust, Vibration and Noise Control
 - 5.2.2 Disposal of Construction and Worker Waste
 - 5.2.3 Erosion and sediment control
 - 5.2.4 Resource efficiency issues, including materials supply
 - 5.2.5 Management of Chemicals and/or Hazardous Wastes
 - 5.2.6 Workforce and Workers Sanitation

³⁵ Include provisions for separate facilities for men and women

- 5.2.7 Workforce Occupational Health and Safety during Construction
- 5.2.8 Community Occupational Health and Safety during Construction
- 5.2.9 Social Disturbance/Disruption to Existing Services (including traffic disruption)
- 5.2.10 Community Relations
- 5.2.11 Cultural Heritage Chance-finds Procedures

4.0 Monitoring Verification and Frequency

5.0 Responsibilities for CESCOP Implementation and Oversight

Annex VII. Chance Finds Procedure

Cultural heritage encompasses tangible and intangible heritage which may be recognized and valued at a local, regional, national or global level. *Tangible cultural heritage*, which includes movable or immovable objects, sites, structures, groups of structures, and natural features and landscapes that have archaeological, paleontological, historical, architectural, religious, aesthetic, or other cultural significance. Tangible cultural heritage may be located in urban or rural settings, and may be above or below land or under the water. *Intangible cultural heritage*, which includes practices, representations, expressions, knowledge, skills—as well as the instruments, objects, artefacts and cultural spaces associated therewith—that communities and groups recognize as part of their cultural heritage, as transmitted from generation to generation and constantly recreated by them in response to their environment, their interaction with nature and their history.

The list of negative activity attributes which would make an activity ineligible for support includes any activity that would adversely impact cultural heritage assets. In the event that during reconstruction or construction sites of cultural value are found, the following procedures for identification, protection from theft, and treatment of discovered artefacts should be followed and included in standard bidding documents.

Chance find procedures will be used as follows:

- (a) Stop the earthworks, construction or land clearing activities in the area of the chance find;
- (b) Delineate the discovered site or area;
- (c) Secure the site to prevent any damage or loss of removable objects. In cases of removable antiquities or sensitive remains, a night guard shall be present until the responsible local authorities and the relevant Ministry take over;
- (d) Notify the supervisory Engineer who in turn will notify the responsible local authorities and the relevant Ministry immediately;
- (e) Responsible local authorities and the relevant Ministry would be in charge of protecting and preserving the site before deciding on subsequent appropriate procedures;
- (f) Decisions on how to handle the finding shall be taken by the responsible authorities and the relevant Ministry;
- (g) Implementation for the authority decision concerning the management of the finding shall be communicated in writing by the relevant Ministry; and
- (h) Construction work could resume only after permission is given from the responsible local authorities and the relevant Ministry concerning safeguard of the heritage.

These procedures must be referred to as standard provisions in construction contracts. During project supervision, the Site Engineer shall monitor the above regulations relating to the treatment of any chance find encountered are observed.

Relevant findings will be recorded in World Bank Supervision Reports and Implementation Completion Reports will assess the overall effectiveness of the project's cultural heritage mitigation, management, and activities.

Annex VIII. Infection Prevention Control and Waste Management Plan (IPC&WMP)

1 Introduction

Infection control and waste management have been identified as key risks associated with the Project. While protecting the health of communities from infection with COVID-19 is a central part of the project, without adequate controls and procedures, project activities ranging from medical facility operation through to on-ground public engagement exercises have the potential to contribute to virus transmission.

Some project activities present increased health and safety risks for project workers, particularly those working in medical and laboratory facilities. Workers in health care facilities are particularly vulnerable to contagions like COVID-19. Healthcare-associated infections due to inadequate adherence to occupational health and safety standards can lead to illness and death among health and laboratory workers as well as having the potential to spread infections to the wider community. All project activities ranging from the use of testing equipment to community engagement activities also present a risk of transmission in the community. The completion of testing activities have a high potential of carrying micro-organisms that can infect the community at large if they are not properly managed and controlled.

Wastes that may be generated from the use of materials financed by the COVID-19 readiness and response project could include liquid contaminated waste (e.g. blood, other body and contaminated fluids) and infected materials (lab solutions and reagents, syringes, used PPE and swabs etc.) that require special handling and awareness as they may pose an infectious risk to healthcare workers and waste management personnel in contact with the waste. Incorrect treatment and disposal may lead to contamination of soil and groundwater, air pollution, but more importantly, to further spreading of the virus to nearby communities.

In order to mitigate these risks, this Infection Prevention Control and Waste Management Plan (IPC&WMP) has been prepared and the Project will also invest in the procurement of personal protective equipment (PPE), procurement and installation of a high-temperature medical waste incinerator at the Naboro landfill, and training for health care workers on health care waste management to ensure compliance with this IPC&WMP, WHO guidance, and GIIP.

The IPC manual for Fiji has been reviewed incorporating the COVID19 protocols contained within this IPC&WMP. Clinical and nursing personnel in health facilities are vested to oversee safe implementations of the IPC/WMP. The IPC links nurses from Sub divisions to coordinate with the IPC officer at Divisional Hospitals and is supported by the National IPC officer from MHMS/HQ. Currently medical waste from Vanualevu is incinerated at Labasa Hospital, For West Fiji, all medical waste is incinerated at Lautoka Hospital Incinerator. For the Central division, all medical waste is currently being incinerated at the Ports Authority incinerator at Walu Bay.

1.1 Scope of the IPC&WMP

This IPC&WMP contains detailed procedures, based on World Health Organization (WHO) guidance, for protocols necessary for effective infection control, treating patients and handling medical waste, as well as environmental health and safety guidelines for health-care staff, including the necessary PPE. Proper storage and disposal of medical wastes, including sharps, and disposal/treatment protocols are also

included. The IPC&WMP applies to all items, activities and associated facilities, such as laboratories, funded under the Project as well as any community outreach programmes.

However, waste management and Infection Prevention Control (IPC) for construction activities and the operation of the Naboro incinerator are not included in this IPC&WMP. Construction activity labour issues, including working conditions and occupational health and safety (OHS), are addressed in the Project's Labour Management Procedures (LMP) and by Construction Health and Safety (H&S) management plans to be developed during Project by the construction contractor. Construction waste management will be managed through the Construction Waste Management Plans developed by the construction contractor prior to the implementation of the Project. The correct operation of the incinerator will be managed by an Environmental and Social Management Plan (ESMP) developed by the MHMS E&S Specialists. Waste Management and EHS plans for incinerator operation will be developed prior to commencing operation to manage OHS impacts to staff from operating the incinerator, including IPC and correct disposal practices for ash to minimize spreading the virus.

2 Infection Prevention and Control

2.1 Introduction

Infection Prevention and Control (IPC) is a practical, evidence-based approach preventing patients and health-care workers (HCWs) from being harmed by avoidable infections and hospital outbreaks. IPC measures apply to all stages of patient care whether in-patients, out-patients, at health stations and in outreach programmes. IPC is also used to protect workers involved in waste management, transporting laboratory specimens, and other personnel such as ambulance workers. This section describes the IPC strategies that should be undertaken by HCWs in the context of the Project.

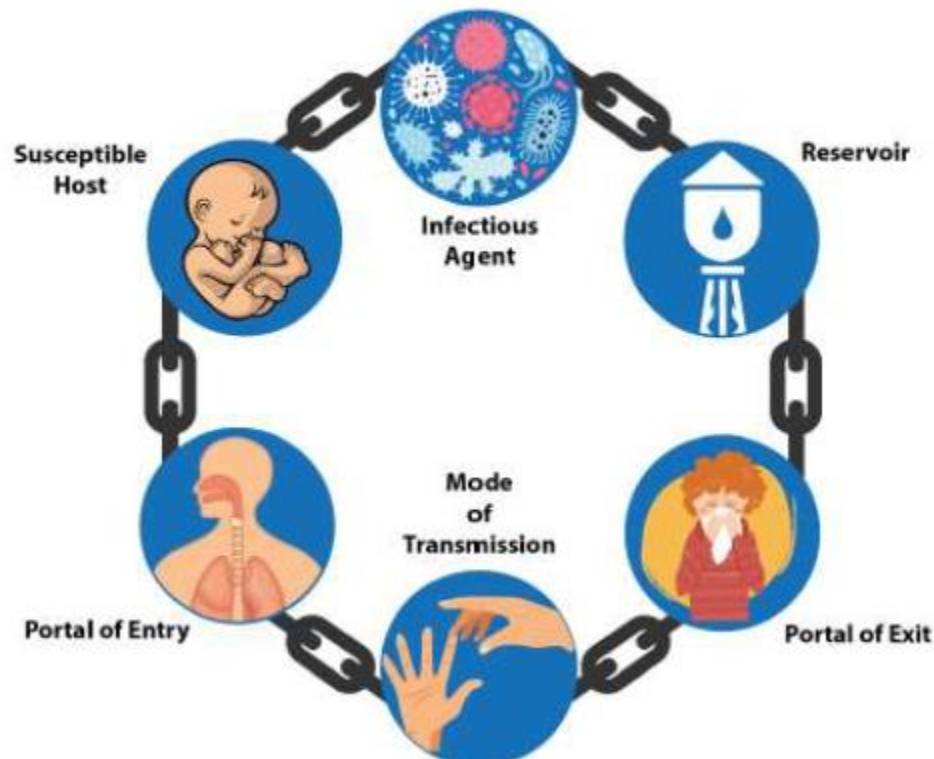
This IPC section has taken into consideration and incorporated requirements that are contained in the Fiji Government MHMS, Draft Infection Prevention and Control Guidelines 2021. A key statement in regards to the importance of IPC in regards to management of COVID-19 from the Guideline is: *IPC continues to play a crucial role in containing outbreaks as demonstrated in the preparedness and response phases of the 2020 COVID-19 pandemic. It highlighted the critical importance of having IPC focal points supported by senior management to implement immediate IPC strategies to limit or prevent the transmission of COVID-19*

2.3 IPC Strategies

IPC Strategies to prevent or limit transmission in health-care settings include the following:

1. Ensuring triage, early recognition, and source control (isolating patients with suspected COVID-19);
2. Vaccination of healthcare staff (and other essential workers);
3. Applying standard precautions for all patients;
4. Implementing empiric additional precautions (droplet and contact and, whenever applicable, airborne precautions) for suspected cases of COVID-19;
5. Implementing administrative controls; and
6. Using environmental and engineering controls.

As per the Fiji Government MHMS, Draft Infection Prevention and Control Guidelines 2021 IPC strategies are designed to break the chain of infection as illustrated below. Strategies focus on one or more links in this chain (e.g., from vaccinations, isolation, use of PPE, disinfection programs, correct waste management etc.), so that infection risks from COVID-19 are avoided.



2.2 COVID-19 Transmission Routes

The main routes of transmission of COVID-19 are respiratory droplets and direct contact. Any person who is in close contact with an infected individual is at risk of being exposed to potentially infective respiratory droplets (i.e. aerosols). Droplets may also land on surfaces where the virus could remain viable; thus, the immediate environment of an infected individual can serve as a source of transmission.ⁱ

According to the Centers for Disease Control, exposure to the COVID-19 virus occurs in three principal ways³⁶:

1. inhalation of very fine respiratory droplets and aerosol particles,
2. deposition of respiratory droplets and particles on exposed mucous membranes in the mouth, nose, or eye by direct splashes and sprays, and

³⁶ <https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html>

3. Touching mucous membranes with hands that have been soiled either directly by virus-containing respiratory fluids or indirectly by touching surfaces with virus on them.

Based on the available evidence, WHO recommends 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.ⁱⁱ

2.3.1 Ensuring Triage, Early Recognition, and Source Control

Clinical triage includes a system for assessing all patients at admission, allowing for early recognition of possible COVID-19 and immediate isolation of patients with suspected disease in an area separate from other patients (source control).

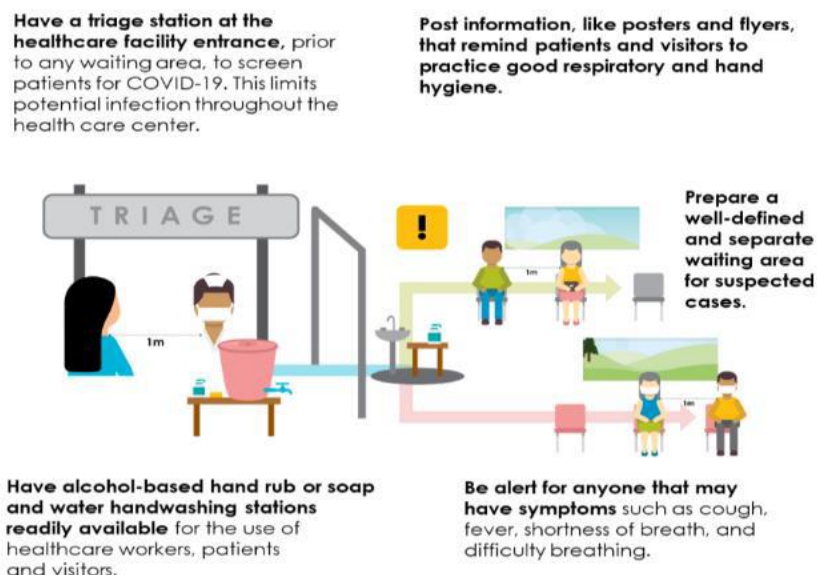
To facilitate the early identification of cases of suspected COVID-19, health care facilities should:

- Encourage health care workers to have a high level of clinical suspicion;
- Establish a well-equipped triage station (i.e., PPE, hand sanitizer, waste bins), at the entrance to the facility, supported by trained staff;
- Institute the use of screening questionnaires according to the updated case definition³⁷; and
- Post signs in public areas reminding symptomatic patients to alert HCWs.

Figure 1 illustrates a typical “set-up” for a triage station that would be located at entrances to a health care facility.

Figure 1: Triage stationⁱⁱⁱ

³⁷ Refer to the WHO Global Surveillance for human infection with coronavirus disease (COVID-19)³⁷ for case definitions



2.3.2 Applying Standard Precautions for all Patients

Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered.

Standard precautions include hand and respiratory hygiene, the use of appropriate personal protective equipment (PPE) according to a risk assessment, injection safety practices, safe waste management, proper linens, environmental cleaning, and sterilization of patient-care equipment.

Respiratory hygiene

Ensure that the following respiratory hygiene measures are used:

- Ensure that all patients cover their nose and mouth with a tissue or elbow when coughing or sneezing;
- Offer a medical mask to patients with suspected COVID-19 while they are in waiting/public areas or in consulting rooms; and
- Perform hand hygiene after contact with respiratory secretions.

2.3.3 Implementing Empiric Additional Precautions

Contact and droplet precautions

The following precautions should be followed to protect against infections transmission:

- in addition to using standard precautions, all individuals, including HCW's, family members, visitors and HCWs, should use contact and droplet precautions before entering the room of suspected or confirmed COVID-19 patients;
- patients should be placed in adequately ventilated single rooms. For general ward rooms with natural ventilation, adequate ventilation is considered to be 60 L/s per patient;

- when single rooms are not available, patients suspected of having COVID-19 should be grouped together;
- all patients' beds should be placed at least 1 to 2 meters apart regardless of whether they are suspected to have COVID-19;
- dedicated waste containers located in appropriate areas for the collection of all wastes and also to allow for correct segregation of wastes;
- where possible, a team of HCWs should be designated to care exclusively for suspected or confirmed cases to reduce the risk of transmission;
- HCWs should use a medical mask (for specifications, see reference World Health Organization.^{iv} WHO Infection prevention and control of epidemic- and pandemic-prone acute respiratory diseases in health care);
- HCWs should wear eye protection (goggles) or facial protection (face shield) to avoid contamination of mucous membranes;
- HCWs should wear a clean, non-sterile, long-sleeved gown;
- HCWs should also use gloves;
- the use of boots, coverall, and apron is not required during routine care;
- after patient care, appropriate doffing (refer to³⁸) and disposal of all PPE and hand hygiene should be carried out;
- A new set of PPE is needed when care is given to a different patient (for alternatives in case of restricted PPE supplies see above strategies to optimize the availability of PPE);
- Equipment should be either single-use or disposable or dedicated equipment (e.g. stethoscopes, blood pressure cuffs and thermometers). If equipment needs to be shared among patients, clean and disinfect it between use for each individual patient (e.g. by using ethyl alcohol 70%)^v (<https://www.who.int/infectionprevention/publications/decontamination/en/>); and
- HCWs should refrain from touching eyes, nose, or mouth with potentially contaminated gloved or bare hands.
- Avoid moving and transporting patients out of their room or area unless medically necessary. Use designated portable X-ray equipment or other designated diagnostic equipment. If transport is required, use predetermined transport routes to minimize exposure for staff, other patients and visitors, and have the patient wear a medical mask;
- ensure that HCWs who are transporting patients perform hand hygiene and wear appropriate PPE as described in this section;
- notify the area receiving the patient of any necessary precautions as early as possible before the patient's arrival;
- routinely clean and disinfect surfaces with which the patient is in contact;
- limit the number of HCWs, family members, and visitors who are in contact with suspected or confirmed COVID-19 patients; and
- Maintain a record of all persons entering a patient's room, including all staff and visitors.

Additional airborne precautions are required for aerosol-generating procedures

³⁸ <https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf>

Some aerosol-generating procedures, such as tracheal intubation, non-invasive ventilation, tracheotomy, cardiopulmonary resuscitation, manual ventilation before intubation, and bronchoscopy, have been associated with an increased risk of transmission of coronaviruses.

Ensure that HCWs performing aerosol-generating procedures:

- perform procedures in an adequately ventilated room – that is, natural ventilation with air flow of at least 160 L/s per patient or in negative - pressure rooms with at least 12 air changes per hour and controlled direction of air flow when using mechanical ventilation;
- Use a particulate respirator at least as protective as US NIOSH-certified N95, European Union (EU) standard FFP2, or equivalent. When Health Care Workers put on a disposable particulate respirator, they must always perform the seal check. Note that facial hair (e.g. a beard) may prevent a proper respirator fit;
- use eye protection (i.e. goggles or a face shield);
- Wear a clean, non-sterile, long-sleeved gown and gloves. If gowns are not fluid resistant, HCWs should use a waterproof apron for procedures expected to create high volumes of fluid that might penetrate the gown; and
- Limit the number of persons present in the room to the absolute minimum required for the patient's care and support.^{vi}

Hand hygiene

Hand hygiene is extremely important to prevent the spread of the COVID-19 virus. All health-care facilities should establish hand hygiene programmes, if they do not have them already, or strengthen existing ones. In addition, rapid activities to prevent the spread of the COVID-19 virus are needed, such as procurement of adequate quantities of hand hygiene supplies; hand hygiene refresher courses and communications campaigns. Cleaning hands using an alcohol-based hand rub or with water and soap should be done according to the instructions known as “My 5 moments for hand hygiene”^{vii}. These are:

1. Before touching a patient;
2. Before clean/aseptic procedures;
3. After body fluid exposure/risk;
4. After touching a patient; and
5. After touching patient surroundings.

If hands are not visibly dirty, the preferred method is using an alcohol-based hand rub for 20–30 seconds using the appropriate technique. When hands are visibly dirty, they should be washed with soap and water for 40–60 seconds using the appropriate technique. If soap or alcohol-based hand rub is not available using chlorinated water (0.05%) for handwashing is an option but requires care to avoid causing dermatitis (See Annex 1 for WHO hand cleaning and hand rub posters).

In addition to performing hand hygiene at all five moments, it should be performed in the following situations:

- Before putting on PPE and after removing it;
- When changing gloves; after any contact with a patient with suspected or confirmed COVID-19 infection, their waste or the environment in that patient's immediate surroundings; and

- After contact with any respiratory secretions; before food preparation and eating; and after using the toilet.

Functional hand hygiene facilities should be present for all HCWs at all points of care, in areas where PPE is put on or taken off, and where health-care waste is handled. In addition, functional hand hygiene facilities should be available for all patients, family members and visitors, and should be available within 5m of toilets, as well as at the entry/exit of the facility, in waiting rooms and other public areas.

An effective alcohol-based hand rub product should contain between 60% and 80% of alcohol and its efficacy should be proven according to the European Norm 1500 or the standards of the ASTM International (formerly, the American Society for Testing and Materials) known as ASTM E-1174. These products can be purchased on the market, but can also be produced locally in pharmacies using the formula and instructions provided by WHO^{viii}.

Use of signage promoting good infection control practices such as the following for hand hygiene should be posted in all patient and staff areas and other areas where visitors may enter.



Hand hygiene Stations

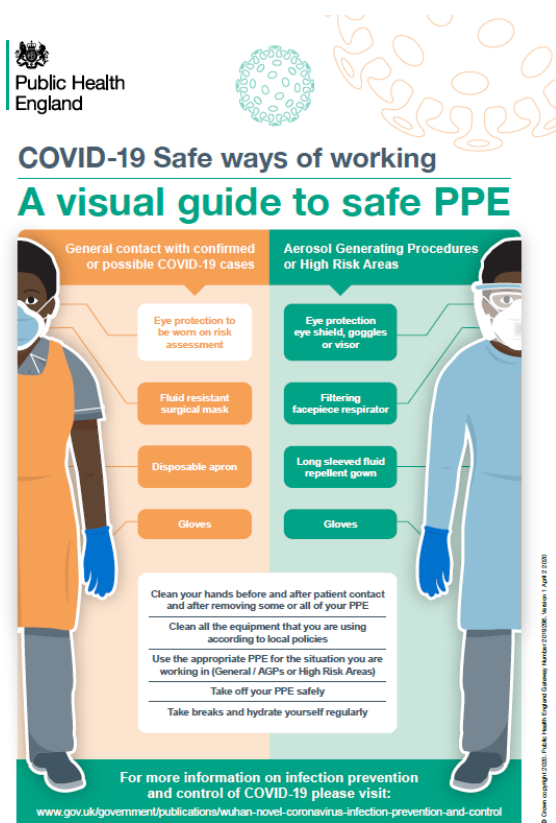
All facilities should provide hand hygiene stations. Hand hygiene stations can consist of either water, such as sinks attached to a piped-water supply, refillable water reservoir or clean, covered buckets with taps equipped with plain soap or alcohol-based hand rub dispensers where running water is not available. Where alcohol-based hand rub or bar soap is not feasible, a liquid soap solution, mixing detergent with water can be used. The ratio of detergent to water will depend on types and strengths of locally available product. Soap does not need to be antibacterial and evidence indicates that normal soap is effective in inactivating enveloped viruses, such as coronaviruses. Alcohol-based hand rub should contain at least 60% alcohol. Such products should be certified and, where supplies are limited or prohibitively expensive, can be produced locally according to WHO-recommended formulations.

Drying of hands is important so disposable towels and waste bins need to be provided.

Personal Protective Equipment (PPE)

Personal Protective Equipment or PPE consists of equipment and clothing to protect health care workers and patients from infected droplets, surfaces and from aerosol generating procedures. In the context of COVID-19 this includes medical gowns, masks, gloves, goggles and or face shields. The diagram below shows a visual guide to safe PPE^{ix}.

Figure 3: A visual guide to safe PPE



It is essential that HCWs are trained on the correct use, wear, doffing and disposal of PPE including gloves, gowns, facemasks, eye protection and respirators (if available) and check they understand.

How to Put On (Don) PPE Gear

More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is an example of donning.

1. Identify and gather the proper PPE to don. Ensure choice of gown size is correct (based on training).
2. Perform hand hygiene using either soap/water, alcohol hand rub or a hand sanitizer.
3. Put on isolation gown. Tie all of the ties on the gown. Assistance may be needed by other healthcare personnel.

4. Put on the approved type of facemask for the procedure you are undertaking (eg., NIOSH-approved N95 filtering face piece respirator or higher for aerosol generating procedures, using a facemask if a respirator is not available). If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in pocket.
 - Respirator: Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
 - Facemask: Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.
5. Put on face shield or goggles. When wearing an N95 respirator or half face piece elastomeric respirator, select the proper eye protection to ensure that the respirator does not interfere with the correct positioning of the eye protection, and the eye protection does not affect the fit or seal of the respirator. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
6. Put on gloves. Gloves should cover the cuff (wrist) of gown.

How to Take Off (Doff) PPE Gear

More than one doffing method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is an example of doffing.

1. Remove gloves. Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
2. Remove gown. Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in waste bin.
3. Perform hand hygiene.
4. Remove face shield or goggles. Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
5. Remove and discard respirator (or facemask if used instead of respirator). Do not touch the front of the respirator or facemask.
 - Respirator: Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
 - Facemask: Carefully untie (or unhook from the ears) and pull away from face without touching the front.

6. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing reuse.

Annex 2 provides pictorial instructions for the correct steps for donning (putting on) and doffing (safe removal) of PPE for health-care settings.



The type of PPE used when caring for people with COVID-19 will vary according to the setting, type of personnel and activity. HCWs involved in the direct care of patients should use gowns, gloves, medical masks and eye protection (goggles, face shields). Table 1 is provided below outlining appropriate PPE for different health care settings.

Table 1: Recommended personal protective equipment (PPE) for use in the context of COVID-19, according to the setting, personnel and type of activity^x

Setting	Target staff or patient	Activity	Type of PPE or procedure
Health-care facilities			
Inpatient facilities			
Patient's room	Health-care workers	Providing direct care to patients with SARI	Medical mask, gown, gloves, eye protection (goggles or face shield)
		Aerosol-generating procedures performed on patients with SARI	Respirator N95 or FFP2 standard or equivalent, gown, gloves, eye protection, apron
	Cleaners	Entering patient's room	Medical mask, gown, heavy-duty gloves, eye protection (if risk of splash from organic material or chemicals), boots or closed work shoes
	Visitors	Entering patient's room	Medical mask, gown, gloves
Other areas of patient transit (e.g. wards, corridors)	All staff, including health-care workers	Any activity that does not involve contact with patients	No PPE required
Triage	Health-care workers	Any	Maintain distance of at least 2 m
	Patients with respiratory symptoms	Any	Provide medical mask if tolerated by patient
Laboratory	Laboratory technicians	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 patients	No PPE required
Outpatient facilities			
Consultation room	Health-care workers	Physical examination of patients with respiratory symptoms	Medical mask, gown, gloves, eye protection
	Health-care workers	Physical examination of patients without respiratory symptoms	PPE according to standard precautions and risk assessment
	Patients with respiratory symptoms	Any	Provide medical mask if tolerated
	Patients without respiratory symptoms	Any	Provide medical mask if tolerated
	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
Waiting room	Patients with respiratory symptoms	Any	Provide medical mask if tolerated; immediately move patient to isolation room or separate area away from others; if this is not feasible, ensure distance of at least 2 m from other patients
	Patients without respiratory symptoms	Any	Provide medical mask if tolerated
Administrative areas	All staff, including health-care workers	Administrative tasks	No PPE required
Triage	Health-care workers	Preliminary screening not involving direct contact	Maintain distance of at least 1 m; no PPE required
	Patients with respiratory symptoms	Any	Maintain distance of at least 1 m; provide medical mask if tolerated
	Patients without respiratory symptoms	Any	No PPE required

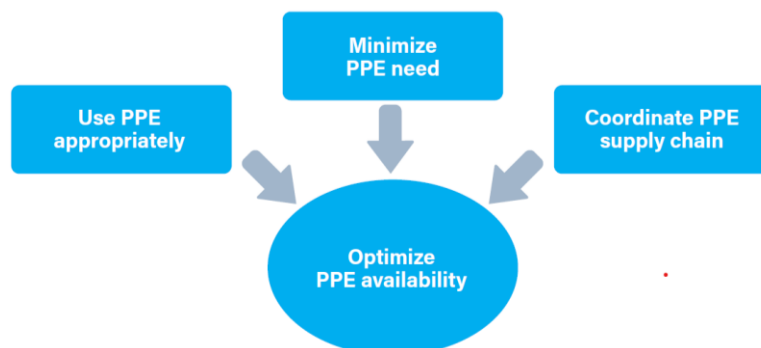
SARI, severe acute respiratory infection.

^x The number of visitors should be restricted. If visitors must enter a patient's room, they should be provided with clear instructions about how to put on and remove PPE and about performing hand hygiene before putting on and after removing PPE; this should be supervised by a health-care worker.

Strategies to optimize the availability of PPE

The protection of frontline health workers is paramount and PPE, including medical masks, respirators, gloves, gowns, and eye protection, must be prioritized for HCWs and others caring for COVID-19 patients. In view of the global PPE shortage, strategies that can facilitate optimal PPE availability include minimizing the need for PPE in health care settings, ensuring rational and appropriate use of PPE, and coordinating PPE supply chain management mechanisms (Figure 4).

Figure 4: Strategies to optimize the availability of personal protective equipment (PPE)



Source: Rational use of personal protective equipment for coronavirus disease 2019 (COVID-19). Geneva: World Health Organization; 2020.

The following interventions can minimize the need for PPE while protecting HCWs and other people from exposure to the infection in health-care settings:

- Use physical barriers to reduce exposure to the virus, such as glass or plastic windows. This approach can be implemented in areas where patients first present, such as triage areas or the registration desk at the emergency department.
- Restrict HCWs from entering the rooms of patients with COVID-19 if they are not involved in direct care. Consider bundling activities to minimize the number of times a room is entered (e.g. check vital signs during medication administration; have food delivered by HCWs while they perform other care), and plan which activities will be performed at the bedside.
- Ideally visitors should not be allowed. If this is not possible, restrict the number of visitors to areas where patients with COVID-19 are being isolated; restrict the amount of time visitors are allowed to spend in the area; and provide clear instructions about how to put on and remove PPE and perform hand hygiene to ensure visitors avoid self-contamination).
- PPE should be based on the risk of exposure (e.g. type of activity) and the transmission dynamics of the pathogen (e.g. contact, droplet, aerosol). The overuse of PPE has a further impact on supply shortages, as well as increasing waste. Observing the following recommendations will ensure the use of PPE is rationalized.
- Respirators (N95, FFP2 or equivalent standard) have been used for an extended time during previous public health emergencies involving acute respiratory illness when PPE was in short supply. This refers to wearing the same respirator while caring for multiple patients with the same diagnosis without removing the respirator. Evidence indicates that respirators maintain their protection when used for extended periods. However, using the same respirator for more than four hours can lead to discomfort and should be avoided.^{xi}

In some areas access to PPE may be limited or delayed, CDC has suggested measures, described below, that may be adopted in these circumstances. *However, in some cases they cannot be considered PPE as their capability to protect HCW is unknown or has not been evaluated.*

Strategies to optimize the supply of PPE and equipment^{xiii}

1. Strategies for Extended Use of Eye Protection.

Extended use of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with several different patients, without removing eye protection between patient encounters. Extended use of eye protection can be applied to disposable and reusable devices.

- Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through.
- If a disposable face shield is reprocessed, it should be dedicated to one HCW and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on. See protocol for removing and reprocessing eye protection below.
- Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility).
- HCW should take care not to touch their eye protection. If they touch or adjust their eye protection, they must immediately perform hand hygiene.
- HCW should leave patient care area if they need to remove their eye protection. See protocol for removing and reprocessing eye protection below.

Use eye protection devices beyond the manufacturer-designated shelf life during patient care activities.

- If there is no date available on the eye protection device label or packaging, facilities should contact the manufacturer. The user should visually inspect the product prior to use and, if there are concerns (such as degraded materials), discard the product.

Prioritize eye protection for selected activities such as:

- During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures.
- During activities where prolonged face-to-face or close contact with a potentially infectious patient is unavoidable.

Selected Options for Reprocessing Eye Protection:

Adhere to recommended manufacturer instructions for cleaning and disinfection.

When manufacturer instructions for cleaning and disinfection are unavailable, such as for single use disposable face shields, consider protocol as follows:

- While wearing gloves, carefully wipe the *inside, followed by the outside* of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe.
- Carefully wipe the *outside* of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution.
- Wipe the outside of face shield or goggles with clean water or alcohol to remove residue.
- Fully dry (air dry or use clean absorbent towels).
- Remove gloves and perform hand hygiene.

2. Strategies for Optimizing the Supply of Isolation Gowns:

Implementing extended use of isolation gowns^{xiii}.

- Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCW when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious diagnoses transmitted by contact among patients. If the gown becomes visibly soiled, it must be removed and discarded as per usual practices.
- Re-use of cloth isolation gowns.
- Disposable gowns are not typically amenable to being doffed and re-used because the ties and fasteners typically break during doffing. Cloth isolation gowns could potentially be untied and retied and could be considered for re-use without laundering in between.
- In a situation where the gown is being used as part of standard precautions to protect HCW from a splash, the risk of re-using a non-visibly soiled cloth isolation gown may be lower. However, for care of patients with suspected or confirmed COVID-19, HCW risk from re-use of cloth isolation gowns without laundering among (1) single HCW caring for multiple patients using one gown or (2) among multiple HCW sharing one gown is unclear. The goal of this strategy is to minimize exposures to HCW and not necessarily prevent transmission between patients. Any gown that becomes visibly soiled during patient care should be disposed of and cleaned.

When No Gowns Are Available

In the situation of severely limited or no available isolation gowns, the following pieces of clothing can be considered as a last resort for care of COVID-19 patients as single use. However, **none of these options can be considered PPE, since their capability to protect HCW is unknown**. Preferable features include long sleeves and closures (snaps, buttons) that can be fastened and secured.

- Disposable laboratory coats.
- Reusable (washable) patient gowns.
- Reusable (washable) laboratory coats.
- Disposable aprons.
- Combinations of clothing: Combinations of pieces of clothing can be considered for activities that may involve body fluids and when there are no gowns available.
- Long sleeve aprons in combination with long sleeve patient gowns or laboratory coats.
- Open back gowns with long sleeve patient gowns or laboratory coats.
- Sleeve covers in combination with aprons and long sleeve patient gowns or laboratory coats.
- Reusable patient gowns and lab coats can be safely laundered according to routine procedures.

Laundry operations and personnel may need to be augmented to facilitate additional washing loads and cycles

Systems are established to routinely inspect, maintain (e.g., mend a small hole in a gown, replace missing fastening ties) and replace reusable gowns when needed (e.g., when they are thin or ripped)

Implement limited re-use of facemasks^{xiv}.

Limited re-use of facemasks is the practice of using the same facemask by one HCW for multiple encounters with different patients but removing it after each encounter. As it is unknown what the potential contribution of contact transmission is for SARS-CoV-2, care should be taken to ensure that HCW **do not** touch outer surfaces of the mask during care, and that mask removal and replacement be done in a careful and deliberate manner.

- The facemask should be removed and discarded into the designated waste bin, if soiled, damaged, or hard to breathe through.
- Not all facemasks can be re-used.
- Facemasks that fasten to the provider via ties may not be able to be undone without tearing and should be considered only for extended use, rather than re-use.
- Facemasks with elastic ear hooks may be more suitable for re-use.
- HCW should leave patient care area if they need to remove the facemask. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container.

Prioritize facemasks for selected activities such as:

For provision of essential surgeries and procedures

- During care activities where splashes and sprays are anticipated.
- During activities where prolonged face-to-face or close contact with a potentially infectious patient is unavoidable.
- For performing aerosol generating procedures if respirators are no longer available.

When No Facemasks Are Available, Options Include:

- Use a face shield that covers the entire front (that extends to the chin or below) and sides of the face with no facemask.
- Consider use of expedient patient isolation rooms for risk reduction: Portable fan devices with high-efficiency particulate air (HEPA) filtration that are carefully placed can increase the effective air changes per hour of clean air to the patient room, reducing risk to individuals entering the room without respiratory protection. US National Institute for Occupational Safety and Health (NIOSH) has developed guidance for using portable HEPA filtration systems to create expedient patient isolation rooms. The expedient patient isolation room approach involves establishing a high-ventilation-rate, negative pressure, inner isolation zone that sits within a “clean” larger ventilated zone.
- Consider use of ventilated headboards: NIOSH has developed the ventilated headboard that draws exhaled air from a patient in bed into a HEPA filter, decreasing risk of HCW exposure to patient-generated aerosol. This technology consists of lightweight, sturdy, and adjustable aluminum framing with a retractable plastic canopy. The ventilated headboard can be deployed in combination with HEPA fan/filter units to provide surge isolation capacity within a variety of environments, from traditional patient rooms to triage stations, and emergency medical shelters.
- HCW use of homemade masks: In settings where facemasks are not available, HCW might use homemade masks (e.g., bandana, scarf) for care of patients with COVID-19 as a last resort.

However, homemade masks are not considered PPE since their capability to protect HCW is unknown. Caution should be exercised when considering this option. Homemade masks should ideally be used in combination with a face shield that covers the entire front (that extends to the chin or below) and sides of the face.

Precautions to be implemented by HCWs caring for people with suspected or actual COVID-19 include using PPE appropriately. The rational, correct, and consistent use of PPE also helps reduce the spread of pathogens. PPE effectiveness depends strongly on adequate and regular supplies, adequate staff training, appropriate hand hygiene, and appropriate human behavior^{xv}.

2.3.4 Implementing Administrative Controls

Administrative controls and policies for the prevention and control of transmission of COVID-19 within the health-care setting include, but may not be limited to: establishing sustainable IPC infrastructures and activities; educating patients' caregivers; developing policies on the early recognition of acute respiratory infection potentially caused by COVID-19 virus; ensuring access to prompt laboratory testing for identification of the etiologic agent; preventing overcrowding, especially in emergency departments; providing dedicated waiting areas for symptomatic patients; appropriately isolating hospitalized patients; ensuring adequate supplies of PPE; and ensuring adherence to IPC policies and procedures for all aspects of health care.^{xvi}

Administrative measures related to HCWs include:

- provision of adequate training for HCWs;
- ensuring an adequate patient-to-staff ratio;
- establishing a surveillance process for acute respiratory infections potentially caused by COVID-19 virus among HCWs;
- ensuring that HCWs and the public understand the importance of promptly seeking medical care; and
- Monitoring HCW compliance with standard precautions and providing mechanisms for improvement as needed.

2.3.5 Using Environmental and Engineering Controls

These controls address the basic infrastructure of the health-care facility and aim to ensure adequate ventilation in all areas in the health-care facility, as well as adequate environmental cleaning. Additionally, separation of at least 1 to 2 meters should be maintained between all patients. Both spatial separation and adequate ventilation can help reduce the spread of many pathogens in the health-care setting. Ensure that cleaning and disinfection procedures are followed consistently and correctly.⁹ Cleaning environmental surfaces with water and detergent and applying commonly used hospital disinfectants (such as sodium hypochlorite) is effective and sufficient. Manage laundry, food service utensils and medical waste in accordance with safe routine procedures.

2.4.2 Preparation of isolation

Room / unit

The isolation room should be prepared as follows:

- Isolate infectious patient in a single room
- If there is no single room, isolate in the cohort room. In cohort room, always keep suspected cases separate from confirmed cases
- If single and cohort room, keep the single room for suspected cases and the cohort room for confirmed cases
- Avoid movement of infectious suspected and confirmed patients (only if crucial)
- Limit number of visitor (ideally only one)
- Staff help the visitor select PPE base on route of transmission, visitor must be trained for wearing PPE
- Put a clear sign of restrictive area and fence around isolation room/unit
- Set up isolation room/ unit as per standard
- Prepare the isolation room and ensure refurbishment of PPE/ material.

PPE should be kept on the trolley at all times so that it is always available for healthcare workers.

The PPE to wear will depends on the type of isolation precautions; therefore several PPE procedures are possible. Keep in mind the steps of removing the PPE (from more contaminated to less), this will guide the step of putting on the PPE.

2.4.3 HCWs/staff in the isolation room /unit

Apply IPC standard and adequate additional precaution(s) based on route of transmission.

Exclusively assigned trained staff (medical and non-medical)

- If HCW is not trained, they must not wear PPE and enter in the isolation room

Prior entering to the room:

- HCW must record their name and contact details
- Perform hand hygiene and wear PPE for identify route of transmission (following PPE procedure)

After contact with isolated patient:

- HCW must safely take off PPE, and thoroughly wash hands precautions (following PPE procedure)

2.5 Collecting and handling laboratory specimens from patients with suspected COVID-19.

All specimens collected for laboratory investigations should be regarded as potentially infectious. HCWs who collect, handle, or transport clinical specimens should adhere rigorously to the following standard precaution measures and biosafety practices to minimize the possibility of exposure to pathogens:

- Ensure that HCWs who collect specimens use appropriate PPE (i.e. eye protection, a medical mask, a long-sleeved gown, and gloves). If the specimen is collected during an aerosol-generating procedure, personnel should wear a particulate respirator at least as protective as a US NIOSH-certified N95, an EU standard FFP2, or the equivalent;
- Ensure that all personnel who transport specimens are trained in safe handling practices, waste management and spill decontamination procedures;
- Place specimens for transport in leak-proof specimen bags (secondary containers) that have a separate sealable pocket for the specimen (a plastic biohazard specimen bag), with the patient's label on the specimen container (the primary container), and a clearly written laboratory request form;
- Ensure that laboratories in health care facilities adhere to appropriate biosafety practices and transport requirements, according to the type of organism being handled;
- Deliver all specimens by hand whenever possible. DO NOT use pneumatic-tube systems to transport specimens;
- Document clearly each patient's full name, date of birth and "suspected COVID-19" on the laboratory request form. Notify the laboratory as soon as possible that the specimen is being transported.
- Ensure all discarded specimens are disposed of in accord with waste management procedures.

xvii

2.7 IPC in Laboratories

All specimens collected for laboratory investigations should be regarded as potentially infectious. HCWs who collect, handle, or transport clinical specimens should adhere rigorously to the following standard precaution measures and biosafety practices to minimize the possibility of exposure to pathogens.

- Ensure that HCWs who collect specimens use appropriate PPE (i.e. eye protection, a medical mask, a long-sleeved gown, and gloves). If the specimen is collected during an aerosol-generating procedure, personnel should wear a particulate respirator at least as protective as a US NIOSH-certified N95, an EU standard FFP2, or the equivalent;
- ensure that all personnel who transport specimens are trained in safe handling practices and spill decontamination procedures;
- place specimens for transport in leak-proof specimen bags (secondary containers) that have a separate sealable pocket for the specimen (a plastic biohazard specimen bag), with the patient's label on the specimen container (the primary container), and a clearly written laboratory request form;
- ensure that laboratories in health care facilities adhere to appropriate biosafety practices and transport requirements, according to the type of organism being handled;
- deliver all specimens by hand whenever possible. DO NOT use pneumatic-tube systems to transport specimens; and

- document clearly each patient’s full name, date of birth and “suspected COVID-19” on the laboratory request form. Notify the laboratory as soon as possible that the specimen is being transported.^{xviii}

2.6 Management of Dead Bodies

While the risk of transmission of COVID-19 from handling the body of a deceased person is low, health care workers and others handling dead bodies should apply standard precautions at all times. Health care workers or mortuary staff preparing the body should wear: scrub suit, impermeable disposable gown (or disposable gown with impermeable apron), gloves, mask, face shield (preferably) or goggles, and boots. After use, PPE should be carefully removed and decontaminated or disposed as infectious waste as soon as practicable and hand hygiene should be performed. The body of a deceased person confirmed or suspected to have COVID-19 should be wrapped in cloth or fabric and transferred as soon as possible to the mortuary area. Body bags are not necessary for COVID-19 virus although they may be used for other reasons (e.g. excessive body fluid leakage).

The responsible authority within the health-care facility should organize and prepare a team for dead body management. This team should have received appropriate training. They should have the necessary materials and PPE to prepare the body for burial.^{xix}

Cleaning and disinfection of biomedical devices

Sterilization or decontamination of items, equipment and medical devices is a complex and highly specialized subject. All patient care surfaces, medical devices and equipment used in health care have the potential to become contaminated with microorganisms. Once contaminated, these items can pose a risk to patients, staff and visitors. As an essential component of IPC strategies, all health-care facilities should implement a standardized operating procedure for the safe and effective decontamination of high-touch patient care areas and all reusable items and equipment to prevent cross-infection. It is essential that facilities have a dedicated area for the decontamination of reusable items and equipment.

The WHO manual ‘Decontamination and Reprocessing of Medical Devices for Health-care Facilities’ outlines the decontamination lifecycle, including specific cleaning, disinfection and sterilization methods applied to medical devices. Always follow the device manufacturer’s instructions for decontamination so as to not cause any damage and ensure proper decontamination.^{xx}

Patient-care equipment cleaning and disinfection procedures

All medical devices are either single-use or reusable. Single-use equipment must be discarded into the correct waste bin, while all reusable equipment must be properly processed (sterilized or disinfected)

between use and between patients, to prevent infections. For proper reprocessing of equipment, all items need to be cleaned with detergent (liquid soap) and water before disinfection and/or sterilization, to remove all organic matter (e.g. blood and mucus), that may neutralize chemical disinfectant and affecting the efficiency of the disinfectant.

Figure 2: Equipment cleaning classification

Category	Application	Type of processing	Example of items
Critical	Sterile tissues or the blood system	Sterilization (by heat or chemicals)	Dressing and suture instruments, surgical instruments, delivery sets, diagnostic catheters, dental instruments, bronchoscopes, cystoscopes, etc.
Semi-critical	Mucous membranes or non-intact skin	High-level disinfection (HLD) & intermediate level disinfection	Laryngoscope blades, vaginal specula, instruments for MVA, respiratory therapy and anaesthesia equipment, dental impressions, endoscopes, gastroscopes, etc.
Non-critical	Intact skin	Cleaning, low level Disinfection (depending on contact with the type of patient)	bedpans, toilets, urinals, blood pressure cuffs, ECG leads, thermometers, stethoscopes, beds, bedside tables

The following summarizes the procedures for ensuring that patient care equipment is correctly disinfected or sterilized.

Patient-care equipment cleaning procedure

- Prepare all cleaning and disinfecting equipment and solution
- Cleaner wear PPE: rubber gloves and boots, impermeable apron. when there is a risk of splash in the face, staff must wear eyes protection and surgical mask.
- Take off any gross soiling on the instrument by rinsing in clean water
- Take instrument apart – fully and immerse all parts in detergent solution, and clean all channels and bores of the instrument
- Ensure all visible soil is take off from the instrument – follow manufacturers' instructions,
- Rinse thoroughly with clean water
- Dry the instrument (let it dry to – on a clean rack or hang if tubing or items with lumens, away from other dirty items)
- Inspect to ensure the instrument is cleaned

Patient-care equipment disinfecting procedure

- Prepare disinfectant solution according to the volume of medical instruments (and suppliers instructions), with the cleaner to wear appropriate PPE.
- Immerse the cleaned equipment completely in the disinfectant solution. Soak in the solution, duration will depend on the disinfectant suppliers recommendations and dilutions. For example: Sodium hypochlorite 0.05%: soak for 30 minutes
- Rinse thoroughly with clear or sterile water (depending on the required level of disinfection and the use of the equipment)
- Sterile water for semi-critical instrument (HLD)
- Clean water for non-critical instrument (low level of disinfectant)
- Let it dry (on a rack)
- Wrap the disinfected equipment in appropriate materials or place into containers and store in a clean area

Prevention of needle-stick/sharp injuries

In healthcare settings, injuries from needles or other sharp instruments are the number-one cause of occupational exposure to blood-borne infections. All staff that come in contact with sharps - from doctors and nurses to those who manage waste - are at risk of infections. Improper disposal of sharps also poses a great threat to members of the community.

The term sharps refers to any sharp instrument or object used in the delivery of healthcare services - including hypodermic needles, suture needles, scalpel blades, sharp instruments, intravenous (IV) catheters, and razor blades – this includes items that have the potential to become sharp during the disposal process such as glass pipettes that become sharps when broken. Needle stick/sharp injury means the skin is accidentally punctured by a used needle/ sharp (e.g. scalpel). The injury is a port of entry for blood-borne diseases, such as hepatitis B (HBV) and hepatitis C (HCV), HIV or other pathogens. Exposure to patient's body fluid also put HCWs at risk of infection. Therefore, they are encouraged to strictly comply with IPC precautions related to body fluid.

The main causes of needle stick/sharp injury include:

- Recapping of needles (identified as the most common cause)
- Unsafe handling of sharp waste (identified as the second most common cause)
- Reuse of safety box
- Manipulation of used sharps (bending, breaking, or cutting needles).
- Unnecessary injections
- Lack of supplies: disposable syringes, sharps-disposal container/safety box
- Failure to place needles in sharps containers immediately after injection
- Passing sharps from hand to hand (e.g. during surgery)
- Lack of management of sharp wastes
- Lack of awareness of the problem
- Lack of training for staff

Principle of the disposal of used needles/sharps:

- Never recap needle/sharp
- Dispose of needles and syringes immediately after use in the safety box.

- Close the sharps container, whenever the containers become $\frac{3}{4}$ full.
- Safely dispose the sharps container (e.g. via incinerator with temperature at least of 800o Celsius or other approved method)
- When it is not immediately disposed, keep sharps container in an appropriate storage area such as for infectious waste.

Environmental cleaning, laundry and disinfection procedures

Recommended cleaning and disinfection procedures for health care facilities should be followed consistently and correctly. Cleaning environmental surfaces with water and detergent and applying commonly used hospital disinfectants (such as sodium hypochlorite) is effective and sufficient. Also manage laundry, food service utensils and medical waste in accordance with safe routine procedures.

Laundry should be done and surfaces in all environments in which COVID-19 patients receive care (treatment units, community care centers) should be cleaned at least once a day and when a patient is discharged.^{xxi}

Many disinfectants are active against enveloped viruses, such as the COVID-19 virus, including commonly used hospital disinfectants. Currently, WHO recommends using:

- 70% ethyl alcohol to disinfect small areas between uses, such as reusable dedicated equipment (for example, thermometers); and
- Sodium hypochlorite at 0.1% (1000 ppm) for disinfecting surfaces and 0.5% (5000 ppm) for disinfection of blood or bodily fluids spills in health-care facilities.

All individuals dealing with soiled bedding, towels, and clothes from patients with COVID-19 infection should wear appropriate PPE before touching soiled items, including heavy duty gloves, a mask, eye protection (goggles or a face shield), a long-sleeved gown, an apron if the gown is not fluid resistant, and boots or closed shoes. They should perform hand hygiene after exposure to blood or body fluids and after removing PPE. Soiled linen should be placed in clearly labelled, leak-proof bags or containers, after carefully removing any solid excrement and putting it in a covered bucket to be disposed of in a toilet or latrine. Machine washing with warm water at 60–90°C (140–194°F) with laundry detergent is recommended. The laundry can then be dried according to routine procedures. If machine washing is not possible, linens can be soaked in hot water and soap in a large drum using a stick to stir and being careful to avoid splashing. The drum should then be emptied, and the linens soaked in 0.05% chlorine for approximately 30 minutes. Finally, the laundry should be rinsed with clean water and the linens allowed to dry fully in the sunlight.^{xxii}

For detailed information regarding cleaning methods, disinfectants and cleaning monitoring and evaluation tools please see CDC and ICAN. Best Practices for Environmental Cleaning in Healthcare Facilities in Resource-Limited Settings. Atlanta, GA: US Department of Health and Human Services, CDC; Cape Town, South Africa: Infection Control Africa Network; 2019.^{xxiii} Available at: <https://www.cdc.gov/hai/pdfs/resourcelimited/environmental-cleaning-508.pdf> <http://www.icanetwork.co.za/icanguideline2019/>

2.4 Isolation Rooms

2.4.1 Isolation Room Requirements

Isolation rooms should be designed as follows:

- be single rooms with attached bathrooms (or with a dedicated commode);
- ideally be under negative pressure (neutral pressure may be used, but positive pressure rooms should be avoided)
- be sited away from busy areas or close to vulnerable or high-risk patients, to minimize chances of infection spread;
- have dedicated equipment (for example blood pressure machine, peak flow meter and stethoscope
- have signs on doors to control entry to the room, with the door kept closed; and
- Have an ante-room for staff to put on and take off PPE and to wash/decontaminate before and after providing treatment.

2.8 IPC for PMU Staff

PMU staff may be required to conduct stakeholder consultations and travel for supervision/monitoring of Project activities. Stakeholder consultations and other group meetings have the potential to contribute to virus transmission. When planning consultations and supervision/monitoring activities, PMU staff should do the following to minimise the potential to spread the virus:

- Review the current advisories and restrictions put in place by the GOF to contain virus spread;
- Review the Stakeholder Engagement Plan (SEP), particularly the approach, methods and forms of engagement proposed, and assess the associated potential risks of virus transmission in conducting various engagement activities;
- Avoid mass gatherings. Social gatherings must be limited to 20 people or fewer in accordance with current GOF advisories;
- If small group meetings are permitted in the location, conduct consultations in small-group sessions, such as focus group meetings. If small group meetings are not permitted in the area, make all reasonable efforts to conduct meetings through online channels, including webex, zoom and skype.
- Social distancing shall be adhered to during the meetings with at least 1 to 2 metres of separation between participants, in accordance with current GOF advisories.
- PMU staff and physical attendees must follow standard precautions such as hand hygiene and respiratory hygiene.
- PMU staff to ensure that all physical attendees articulate and express their understandings on social distancing behaviour and good hygiene practices, and that any consultation/stakeholder engagement events be preceded with the procedure of articulating such hygienic practices.
- All physical attendees must register their name and contact details for contact tracing purposes.
- Meeting rooms/areas should be disinfected upon the attendees departing and prior to any other meetings occurring in that room/area.

WASH in healthcare settings

Existing recommendations for water, sanitation and hygiene measures in health care settings are important for providing adequate care for patients and protecting patients, staff, and caregivers from infection risks. The following actions are particularly important: (i) managing excreta (feces and urine) safely, including ensuring that no one comes into contact with it and that it is treated and disposed of correctly; (ii) engaging in frequent hand hygiene using appropriate techniques; (iii) implementing regular cleaning and disinfection practices; and (iv) safely (and correctly) managing health care.

Waste produced by COVID-19 cases. Other important measures include providing sufficient safe drinking-water to staff, caregivers, and patients; ensuring that personal hygiene can be maintained, including hand hygiene, for patients, staff and caregivers; regularly laundering bedsheets and patients' clothing; providing adequate and accessible toilets (including separate facilities for confirmed and suspected cases of COVID-19 infection); and segregating and safely disposing of health-care waste (refer to Section 3 for waste management procedures).^{xxiv}

Keeping water supplies safe

The COVID-19 virus has not been detected in drinking water supplies and based on current evidence, the risk to water supplies is low^{xxv}. A number of measures can be taken to improve water safety, starting with protecting the source water; treating water at the point of distribution, collection, or consumption; and ensuring that treated water is safely stored at home in regularly cleaned and covered containers.

Water used in health-care facilities should use potable water or a centralized disinfection system where possible. Conventional, centralized water treatment methods that use filtration and disinfection should deactivate the COVID-19 virus. The COVID-19 virus is likely to be more sensitive to chlorine and other oxidant disinfection processes than many other viruses. For effective centralized disinfection, there should be a residual concentration of free chlorine of ≥ 0.5 mg/L after at least 30 minutes of contact time at pH < 8.0 .¹² A chlorine residual should be maintained throughout the distribution system.

Sanitation and plumbing

People with suspected or confirmed COVID-19 disease should be provided with their own flush toilet or latrine that has a door that closes to separate it from the patient's room. Flush toilets should operate properly and have functioning drain traps. When possible, the toilet should be flushed with the lid down to prevent droplet splatter and aerosol clouds. If it is not possible to provide separate toilets, the toilet should be cleaned and disinfected at least twice daily by a trained cleaner wearing PPE (gown, gloves, boots, mask, and a face shield or goggles). Further, and consistent with existing guidance, staff and health care workers should have toilet facilities that are separate from those used by all patients.

WHO recommends the use of standard, well-maintained plumbing, such as sealed bathroom drains, and backflow valves on sprayers and faucets to prevent aerosolized fecal matter from entering the plumbing or ventilation system, together with standard wastewater treatment. If facilities are connected to sewers, a risk assessment should be conducted to confirm that wastewater is contained within the system (that is, the system does not leak) before its arrival at a functioning treatment or disposal site, or both. Risks pertaining to the adequacy of the collection system or to treatment and disposal methods

should be assessed following a safety planning approach, with critical control points prioritized for mitigation^{xxvi}

Toilets and the handling of faces

It is critical to conduct hand hygiene when there is suspected or direct contact with faces (if hands are dirty, then soap and water are preferred to the use of an alcohol-based hand rub). If the patient is unable to use a latrine, excreta should be collected in either a diaper/continence pad or a clean bedpan and immediately and carefully disposed of into a separate toilet or latrine used only by suspected or confirmed cases of COVID-19. In all health care settings, including those with suspected or confirmed COVID-19 cases, faces must be treated as a biohazard and handled as little as possible.

After disposing of excreta, bedpans should be cleaned with a neutral detergent and water, disinfected with a 0.5% chlorine solution, and then rinsed with clean water. The rinse water should be disposed of in a drain, toilet or latrine. Other effective disinfectants include commercially available quaternary ammonium compounds, such as cetylpyridinium chloride, used according to manufacturer's instructions, and peracetic or peroxyacetic acid at concentrations of 500–2000 mg/L.

Anyone handling faces should follow WHO contact and droplet precautions^{xxvii} and use PPE to prevent exposure, including long-sleeved gowns, gloves, boots, masks, and goggles or a face shield. If diapers/incontinence pads are used, they should be disposed of as infectious waste as they would be in all situations. Workers should be trained in how to put on, use, and remove PPE so that these protective barriers are not breached. If PPE is not available or the supply is limited, hand hygiene should be regularly practiced, and workers should keep at least 1 m distance from any suspected or confirmed cases.^{xxviii}

Emptying latrines and holding tanks and transporting excreta off-site.

There is no reason to empty latrines and holding tanks of excreta from suspected or confirmed COVID-19 cases unless they are at capacity. In general, the best practices for safely managing excreta should be followed. Latrines or holding tanks should be designed to meet patient demand, considering potential sudden increases in cases, and there should be a regular schedule for emptying them based on the wastewater volumes generated. PPE (long-sleeved gown, gloves, boots, masks, and goggles or a face shield) should be worn at all times when handling or transporting excreta off site, and great care should be taken to avoid splashing. For crews, this includes pumping out tanks or unloading pumper trucks. After handling the waste and once there is no risk of further exposure, individuals should safely remove their PPE and perform hand hygiene before entering the transport vehicle. Soiled PPE should be put in a sealed bag for later safe laundering.

Safely disposing of grey water or water from washing PPE, surfaces and floors.

Current WHO recommendations are to clean utility gloves or heavy duty, reusable plastic aprons with soap and water and then decontaminate them with 0.5% sodium hypochlorite solution after each use. Single-use gloves (nitrile or latex) and gowns should be discarded after each use and not reused; hand hygiene should be performed after PPE is removed. If greywater includes disinfectant used in prior cleaning, it does not need to be chlorinated or treated again. However, it is important that such water is disposed of in drains connected to a septic system or sewer or in a soak away pit. If greywater is

disposed of in a soak away pit, the pit should be fenced off within the health facility grounds to prevent tampering and to avoid possible exposure in the case of overflow.

2.9 Household IPC and Household Overcrowding

When there are suspected or confirmed cases of COVID-19 in the home setting, immediate action must be taken to protect caregivers and other family members from the risk of contact with respiratory secretions and excreta that may contain the COVID-19 virus. Patients and household members should be educated about personal hygiene, basic IPC measures, and how to care as safely as possible for the person suspected of having COVID-19 to prevent the infection from spreading to household contacts. The patient and household members should be provided with ongoing support and education, and monitoring should continue for the duration of home care. Household members should adhere to the following recommendations:^{xxx}

Instructions in writing (in appropriate languages), must be provided to the patient and/or care giver outlining the correct procedures for managing all aspects of care of the patient – including hand hygiene, use of masks and other PPE, disinfection procedures and waste management.

Home care for patients with suspected COVID-19 who present with mild symptoms	
Household	IPC Action
Accommodation and care	<ul style="list-style-type: none"> Place the patient in a well-ventilated single room (i.e. with open windows and an open door). Limit the movement of the patient in the house and minimize shared space. Ensure that shared spaces (e.g. kitchen, bathroom) are well ventilated (keep windows open). Household members should stay in a different room or, if that is not possible, maintain a distance of at least 1 to 2 metres from the ill person (e.g. sleep in a separate bed). Limit the number of caregivers. Ideally, assign one person who is in good health and has no underlying chronic or immuno-compromising conditions. Visitors should not be allowed until the patient has completely recovered and has no signs or symptoms of COVID-19.
Hand hygiene	<ul style="list-style-type: none"> Perform hand hygiene after any type of contact with patients or their immediate environment. Hand hygiene should also be performed before and after preparing food, before eating, after using the toilet, and whenever hands look dirty. If hands are not visibly dirty, an alcohol-based hand rub can be used. For visibly dirty hands, use soap and water. When soap or alcohol-based hand rub are not available, the use of ash or soil can be considered and has shown to be effective in some cases. Ash, in particular, may inactivate pathogens by raising the pH. However, in communities with limited sanitation services, soil may be faecal contaminated, and thus it is important to weigh the benefits against the risk of contaminating hands. Finally, washing with water alone, although not as effective as using soap or alcohol-based rub can result in reductions in faecal contamination on hands and in diarrhoea.^{xxx}

	<ul style="list-style-type: none"> When washing hands with soap and water, it is preferable to use disposable paper towels to dry hands. If these are not available, use clean towels and replace them frequently or allow hands to air-dry.
Respiratory hygiene – masks and gloves	<ul style="list-style-type: none"> To contain respiratory secretions, a medical mask (or cloth face covering such as a bandana or scarf when no medical mask is available) should be provided to the patient and worn as much as possible and changed daily. They should not be used on children under age 2, anyone who has trouble breathing or anyone who is not able to remove the covering without help)^{xxxi} Individuals who cannot tolerate a medical mask should use rigorous respiratory hygiene; that is, the mouth and nose should be covered with a disposable paper tissue when coughing or sneezing. Materials used to cover the mouth and nose should be discarded or cleaned appropriately after use (e.g. wash handkerchiefs using regular soap or detergent and water). Perform hand hygiene after any type of contact with patients or their immediate environment. Hand hygiene should also be performed before and after preparing food, before eating, after using the toilet, and whenever hands look dirty. If hands are not visibly dirty, an alcohol-based hand rub can be used. For visibly dirty hands, use soap and water. When washing hands with soap and water, it is preferable to use disposable paper towels to dry hands. If these are not available, use clean cloth towels and replace them frequently or, allow hands to air-dry for a few seconds. Caregivers should wear a medical mask or cloth alternative that covers their mouth and nose when in the same room as the patient. Masks should not be touched or handled during use. If the mask gets wet or dirty from secretions, it must be replaced immediately with a new clean, dry mask. Remove the mask using the appropriate technique – that is, do not touch the front, but instead untie it. Discard the mask/place in laundry (see below washing advice) immediately after use and perform hand hygiene. Avoid direct contact with body fluids, particularly oral or respiratory secretions, and stool. Use disposable gloves and a mask when providing oral or respiratory care and when handling stool, urine, and other waste. Perform hand hygiene before and after removing gloves and the mask. Do not reuse masks or gloves.
Cleaning	<ul style="list-style-type: none"> Use dedicated linen and eating utensils for the patient; these items should be cleaned with soap and water after use and may be re-used instead of being discarded. Daily clean and disinfect surfaces that are frequently touched in the room where the patient is being cared for, such as bedside

	<p>tables, bedframes, and other bedroom furniture. Regular household soap or detergent should be used first for cleaning, and then, after rinsing, regular household disinfectant containing 0.1% sodium hypochlorite (i.e. equivalent to 1000 ppm) should be applied.</p> <ul style="list-style-type: none"> • Clean and disinfect bathroom and toilet surfaces at least once daily. Regular household soap or detergent should be used first for cleaning, and then, after rinsing, regular household disinfectant containing 0.1% sodium hypochlorite should be applied. • Clean the patient's clothes, bed linen, and bath and hand towels using regular laundry soap and water or machine wash at 60–90 °C (140–194 °F) with common household detergent, and dry thoroughly. Place contaminated linen into a laundry bag. Do not shake soiled laundry and avoid contaminated materials coming into contact with skin and clothes. • If machine washing is not possible, linens can be soaked in hot water and soap in a large drum using a stick to stir and being careful to avoid splashing. The drum should then be emptied, and the linens soaked in 0.05% chlorine for approximately 30 minutes. Finally, the laundry should be rinsed with clean water and the linens allowed to dry fully in the sunlight. • Gloves and protective clothing (e.g. plastic aprons) should be used when cleaning surfaces or handling clothing or linen soiled with body fluids. Depending on the context, either utility or single-use gloves can be used. After use, utility gloves should be cleaned with soap and water and decontaminated with 0.1% sodium hypochlorite solution. Single-use gloves (e.g. nitrile or latex) should be discarded after each use. Perform hand hygiene before putting on and after removing gloves.
Domestic waste management	<ul style="list-style-type: none"> • Gloves, masks, and other waste generated during home care should be placed into a liner such as a plastic bag and then in to the waste bin with a lid in the patient's room before disposing of it as infectious waste. The onus of disposal of infectious waste resides with the local sanitary authority.
<p>For detailed guidance for larger or extended families living in the same household Please refer to: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/living-in-close-quarters.html also WHO Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts. Interim guidance 17 March 2020 https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and-management-of-contacts^{xxxii}</p>	

3 Health-Care Waste Management

3.1 Introduction

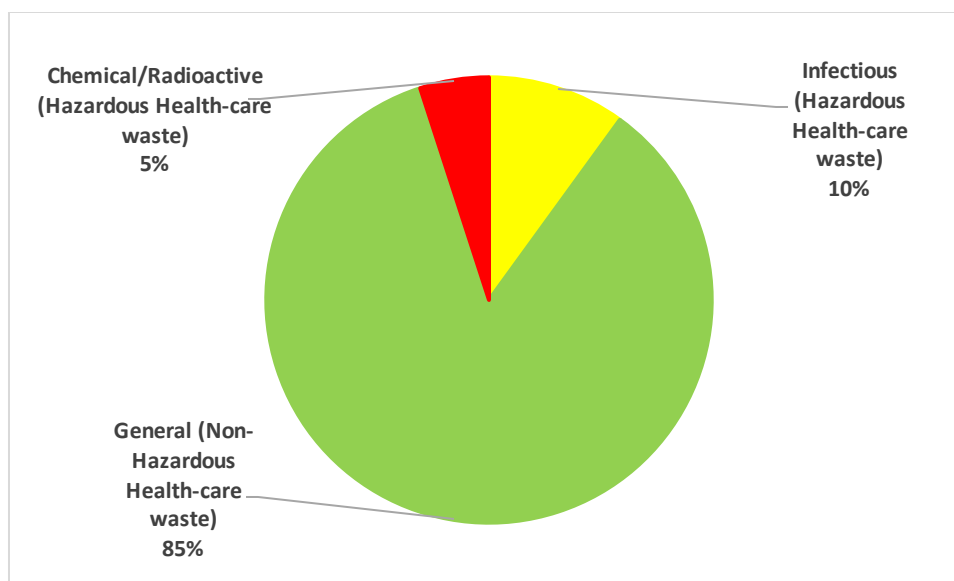
The term health-care waste includes all the waste generated within health-care facilities (including hospitals, clinics, GP practices and similar), research centres and laboratories related to medical procedures. This also includes COVID-19 testing and vaccinations centres. The guiding principle for health-care waste is to apply cradle-to-grave management to avoid cross-infection in these facilities, and community exposure. While COVID-19 is a challenging situation, dealing with it in all aspects requires the most efficient application of existing resources to the extent they are available. This includes avoiding/minimizing the amount of waste generated where possible and ensuring that cross contamination of waste is avoided to the greatest extent possible (ie., by correct identification, segregation, transport, storage and treatment). This section describes the waste management strategies that should be implemented and followed in the context of the Project.

The key components of a healthcare waste management program are:

- Policies/Procedures
- Waste Management Plans
- Definitions
- Waste categorization
- Education/Training
- Containers/Receptacles
- Internal transport and storage
- External transport and treatment/disposal
- Health & Safety Including PPE
- Contingency management including spills
- Compliance Monitoring and Reporting

3.2 Types of Health-Care Waste and Relative Amounts

In general, between 75% and 90% of the waste produced in a HCF is comparable to domestic waste and usually called “non-hazardous” or “general health-care waste”. It comes mostly from the administrative, kitchen and housekeeping functions at health-care facilities and may also include packaging waste and waste generated during maintenance of health-care buildings. The remaining 10–25% of health-care waste can be regarded as “hazardous” and may pose a variety of environmental and health risks (Figure 5)^{xxxiii}

Figure 5: Typical waste compositions in health-care facilities³⁹

These numbers suggest that overall, the volume of material classified as hazardous is relatively small. However, should general (non-hazardous) waste come into contact with hazardous waste, the entire volume becomes hazardous and must be treated as such. Failing to separate such wastes, increases the total volume and complexity of waste to be disposed of, putting stress and cost on infrastructure and systems. Separation of waste is therefore a key component of effective waste management. Also, given the infectious nature of the novel coronavirus, some wastes that are traditionally classified as non-hazardous may be considered hazardous and requires special handling and awareness, as they may pose an infectious risk to healthcare workers and/or the wider community that may come into contact with the waste.

Wastes from health facilities typically fall into the following categories^{xxxiv}:

Table 2 – Categories of Healthcare Wastes⁴⁰

³⁹ Safe management of wastes from health-care activities. Geneva; World Health Organisation; 2014. P3

⁴⁰ Safe management of wastes from health-care activities. Geneva; World Health Organisation; 2014

Waste categories	Descriptions and examples
Hazardous health-care waste	
Infectious waste	Waste known or suspected to contain pathogens and pose a risk of disease transmission, e.g. waste and waste water contaminated with blood and other body fluids, including highly infectious waste such as laboratory cultures and microbiological stocks; and waste including excreta and other materials that have been in contact with patients infected with highly infectious diseases in isolation wards.
Sharps waste	Used or unused sharps, e.g. hypodermic, intravenous or other needles; auto-disable syringes; syringes with attached needles; infusion sets; scalpels; pipettes; knives; blades; broken glass.
Pathological waste	Human tissues, organs or fluids; body parts; foetuses; unused blood products.
Pharmaceutical waste, cytotoxic waste	Pharmaceuticals that are expired or no longer needed; items contaminated by, or containing, pharmaceuticals. Cytotoxic waste containing substances with genotoxic properties, e.g. waste containing cytostatic drugs (often used in cancer therapy); genotoxic chemicals.
Chemical waste	Waste containing chemical substances, e.g. laboratory reagents; film developer; disinfectants that are expired or no longer needed; solvents; waste with high content of heavy metals, e.g. batteries, broken thermometers and blood pressure gauges.
Radioactive waste	Waste containing radioactive substances, e.g. unused liquids from radiotherapy or laboratory research; contaminated glassware, packages or absorbent paper; urine and excreta from patients treated or tested with unsealed radionuclides; sealed sources.
Non-hazardous or general health-care waste	
	Waste that does not pose any specific biological, chemical, radioactive or physical hazard.

Wastes that may be generated from activities to be supported by the Project could include non-infected solid waste (e.g. packaging waste), infected solid waste (e.g. PPE, COVID-19 samples and sampling equipment, syringes, bandages and other blood stained items), wastes designated as potentially or infected by infection control practitioners, liquid waste (e.g. blood and other body fluids), and air emissions (e.g. from incinerators).

To understand where and how much waste is generated, health-care facilities and laboratories should use a simple table as a starting point (Figure 6)^{xxxv}. This should be undertaken by a staff member who is fully aware of the different classifications of waste types. This review should also be undertaken several times to ensure that all information is correct.

Figure 6: Sample sheet for assessing waste generation⁴¹

Name of the health-care facility: Week:															
Waste-collection point: department/ location	Waste category ^a (specify)	Quantity of waste generated per day (weight and volume)													
		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		kg	litre	kg	litre	kg	litre	kg	litre	kg	litre	kg	litre	kg	litre

a Infectious waste, pathological waste, sharps, pharmaceutical waste, cytotoxic waste, waste with high heavy metal content, radioactive waste
Source: adapted from Christen [1996]

A waste survey undertaken by SPREP in 2014 estimated that the Colonial War Memorial hospital in Suva generates approximately 2,290 kg/week of health-care wastes, 250 kg/week of sharps, 315 kg/week of cytotoxic wastes⁴², and 1,000 kg/week of general wastes^{xxxvi}. The exact types and quantities (weight and volume) of waste generated by Project activities and associated facilities are not yet known and will be identified and confirmed during project implementation.

Note that wastes generated from the management of confirmed and suspected COVID-19 patients and diagnosis, treatment and vaccinations may be classified as Infectious Health-care waste to ensure there is minimal opportunity to inadvertently spread contaminated material to other personnel and the wider community.

3.3 Waste Management Measures

3.3.1 Waste Minimization

The health-care facilities should consider practices and procedures to avoid/minimize waste generation, where possible, without compromising patient and staff hygiene and safety considerations.

3.3.2 Waste Separation

⁴¹ Safe management of wastes from health-care activities. Geneva; World Health Organization; 2014, P62

⁴² Pharmaceutical waste was not measured

All HCFs supported by the Project shall ensure all wastes are correctly segregated at the source of generation. The various waste streams should be segregated and handled in accordance with the following WHO guidelines as close as practicable and safely at the point of generation^{xxxvii}.

The simplest and safest waste segregation system is to separate all hazardous waste from non-hazardous general waste at the point of generation. Infectious waste bins⁴³ should be located as close as possible to where waste is generated (e.g. nursing stations, procedure rooms or points of care). For COVID-19 related wards and departments where sampling and testing occurs, additional bins may be placed outside the ward/department to consolidate wastes and to ensure there is minimal traffic into these areas.

NB: Note though for wards/beds that are for COVID-19 patients, the waste bins are placed in cubicals, resuscitation room including the sluice room where collections are done regularly as per IPC protocols for COVID19. Placing sharps containers and segregation bins on treatment trolleys enables medical/nursing staff to segregate waste at the bedside or other treatment site. Placing the general waste container close to the sink or under a towel dispenser will encourage staff to place towels into the non-infectious receptacle.

⁴³ All bins MUST use appropriate bin liners for safe handling.

Table 3 – Handling of wastes at point of generation⁴⁴

Waste categories	Colour of container and markings	Type of container	Collection frequency
Infectious waste	Yellow with biohazard symbol (highly infectious waste should be additionally marked HIGHLY INFECTIOUS).	Leak-proof strong plastic bag placed in a container (bags for highly infectious waste should be capable of being autoclaved).	When three-quarters filled or at least once a day.
Sharp waste	Yellow, marked SHARPS with biohazard symbol.	Puncture-proof container.	When filled to the line or three-quarters filled.
Pathological waste	Yellow with biohazard symbol.	Leak-proof strong plastic bag placed in a container.	When three-quarters filled or at least once a day.
Chemical and pharmaceutical waste	Brown, labelled with appropriate hazard symbol.	Plastic bag or rigid container.	On demand.
Radioactive waste	Labelled with radiation symbol.	Lead box.	On demand.
General health-care waste	Black.	Plastic bag inside a container or container which is disinfected after use.	When three-quarters filled or at least once a day.

However, to ensure staff and patients are protected, the hazardous waste portion is very commonly separated into two parts: sharps and potentially infectious items. Consequently, the segregation into separate containers of general non-hazardous waste, potentially infectious waste and sharps is often referred to as the “three-bin system”^{xxxviii}. Where recycling is available as a separate stream, then bins for these materials would also be provided.

Figure 7: Three-Bin System⁴⁵

The key to an effective bin system is colour coding of the bins and/or bin liners as well as labelling bins as to what can be deposited into them and use of signage similarly to advise on correct segregation. Staff education is also essential.

⁴⁴ Safe management of wastes from health-care activities. Geneva; World Health Organisation; 2014

⁴⁵ Safe management of wastes from health-care activities. Geneva; World Health Organisation; 2014

This makes it easier to put waste items into the correct container and maintains the necessary segregation during transport, storage, treatment and disposal. Additional labelling of waste containers is used to identify the source, record the type and quantities of waste produced in each area. A simple approach is to attach a label to each filled bag with the details of the area where generated, date and time of closure of the bag and the name of the person filling out the label. This allows any problems with waste segregation to be traced back to the point of generation.

An international hazard symbol on each waste bag - such as the biohazard symbol below - should also be used.

Figure 8: Biohazard Symbol⁴⁶



The three divisional and two sub-divisional hospitals⁴⁷ in Fiji all operate a similar color-coded system for the collection, storage, and transfer of medical waste: clear or black (general waste), yellow bins or bags (infectious/pathological waste, non-sharps), purple (cytotoxic/pharmaceutical waste). Dedicated yellow sharps containers / pails are also provided for the segregation and safe disposal of sharps. Any facilities associated with Project activities should adopt a similar system to avoid confusion and ensure consistency with existing waste collection systems^{xxxix}.

3.3.3 Waste Handling and Collection

At all times the waste must be handled safely. Waste bags/bins and sharp containers should be filled to no more than three-quarters full (or to the fill line on sharps bins when marked). Once this level is reached, they should be sealed and double bagged (if possible), ready for collection. Plastic bags should never be stapled but may be tied in a knot or sealed with a plastic tag or tie. Plastic bags should also never be squeezed or compressed as this generates aerosols that could contain pathogens. Replacement bags or containers should be available at each waste generation area.

Collection times should be fixed and appropriate to the quantity of waste produced in each area of the health-care facility. Generally, pathological and infectious waste should be collected at least once per day. General waste should not be collected at the same time, or in the same trolley, as infectious or other hazardous wastes. The frequency of collection should be refined through experience to ensure that there are no overflowing waste containers at any time.

On-site transportation should take place whenever possible during less busy times (i.e. in the evenings or very early morning). Separate routes for transporting hazardous and non-hazardous waste should be

⁴⁶ Safe management of wastes from health-care activities. Geneva; World Health Organisation; 2014

⁴⁷ Colonial War Memorial Hospital (CWMH) Suva, Central Division, Lautoka Divisional Hospital, Western Division, Labasa Hospital, Northern Division, Nadi Sub-Divisional Hospital, Western Division, Sigatoka Sub-Divisional Hospital, Western Division.

planned and used. In general, a waste route should follow the principle from “clean to dirty”. Collection should start from the most hygienically sensitive medical areas (e.g. intensive care, dialysis, operating theatres) and follow a fixed route around other medical areas and interim storage locations.^{xi}. Transport staff should wear correct and appropriate PPE including gloves, eye protection, closed shoes, overalls and masks. Education and training must be provided to all waste management workers and include how to safely handle waste containers that leak or are broken.

Correct hand hygiene practices must be adhered to at all times when managing wastes.

Spill kits need to be provided in all areas where wastes are stored including on collection trolleys.

Health-care waste can be bulky and heavy and should be transported by using wheeled trolleys or carts that are not used for any other purpose. Waste, especially hazardous waste, should never be transported by hand due to the risk of accident or injury from infectious material or incorrectly disposed sharps that may protrude from a container. It is recommended that spare trolleys are available in the case of breakdowns and maintenance.

Waste workers are one of the most important sanitary barriers to keep communities safe. Current scientific research has not provided evidence that waste management is a vector for the transmission of COVID-19, but considering waste workers are essential workers, additional measures should be considered such as:^{xlii}:

- Strict adherence to enhanced hygiene norms, including frequent change and cleaning of PPE and professional clothing; replacing professional gloves in the event of breakage or any incident of potential contamination; sanitizing regularly facilities, vehicle cabins and other equipment. An important measure here is to make sure that where masks are usually worn, the workers are removing masks and gloves without getting in contact with them. This means using correct techniques for putting the mask on and taking it off (see Annex 2).
- Adaptation (as much as possible and considering the particularities of the waste collection systems) of the behavior in order to avoid contamination between workers in teams like strict respect of the distance between people (>1m), limiting as few as possible workers in the same area (control room, canteens, changing rooms) and all precautionary measures helping at preserving health of workers in safe occupational conditions.
- Direct contact (without gloves) with bins or bags should be avoided.
- Placing hands in soiled waste bags is to be avoided.
- Uniforms should be changed daily or cleaned - cleaning of work clothes and shoes minimizes the possibility of dispersing the virus and limiting its transmission.
- Work clothes should not be worn outside the healthcare facility (ie., travelling to and from the facility).
- If possible, put a disposable set of gloves, on a daily basis, in direct contact with workers' skin, before wearing usual work gloves.
- Make sure that there are disinfectants and alcohol hand rub hand available to waste collectors and workers.
- Ensure frequent hand-washing and increased cleaning in workers' facilities.
- Drivers and collectors should avoid contact with residents and employees from serviced business.

3.3.4 Aggregation and Temporary Storage

A storage location for health-care waste should be designated inside the health-care facility. These storage areas should be sized according to the quantities of waste generated and the frequency of collection. These areas must be totally enclosed and separate from supply rooms or food preparation areas. Only authorized staff should have access to the waste storage areas. Equipment for accidental spill/leakage should be available. Proper maintenance and disinfection of the storage areas should be carried out.

- **General non-hazardous waste storage:** General non-hazardous waste should be stored and kept for collection to the communal landfill/dumpsite or communal waste incinerator. It should be collected at least every week. The storage area should be enclosed, paved and connected to a public road. The gate should be big enough that the collection vehicles can enter.
- **Infectious and sharp waste storage:** The storage place must be identifiable as an infectious waste area by using the biohazard symbol. Floors and walls should be sealed or tiled to allow easy cleaning and disinfection. Storage times for infectious waste (e.g. the time gap between generation and treatment) should not exceed 24 hours.
- **Pathological waste storage:** Pathological waste is considered biologically active and gas formation during the storage should be expected. To minimize the possibility of this happening, storage places should have the same conditions as for infectious and sharps wastes. Where possible, waste should be stored under refrigerated conditions. The body of a deceased person confirmed or suspected to have COVID-19 should be wrapped in cloth or fabric and transferred as soon as possible to the mortuary area.

3.4 Waste Disposal

3.4.1 Solid Waste Disposal

Informal disposal may lead to contamination of soil and groundwater, but more importantly, to further spreading of the virus (or other pathogens) to nearby communities. Therefore, final disposal of healthcare wastes from facilities or activities financed by the Project must be either off-site to an approved/permited waste treatment/disposal facility or to a permitted on-site incinerator:

- For non-infectious solid waste, disposal at an approved/licensed landfill may be the most practical waste disposal option.
- For non-infectious hazardous waste (e.g. fly/bottom ash), disposal at a facility licensed to take hazardous wastes e.g. the Naboro sanitary landfill.
- For infectious waste, high temperature incineration or autoclaving solutions are preferable if available at the health-care facility. Currently, all health care-wastes in Fiji are incinerated. A high-temperature medical waste incinerator at the Naboro sanitary landfill may be funded by the project and should be permitted and equipped with air emission control systems, such as scrubbers. The following waste categories should not be incinerated:
 - mercury thermometers (preferably collect for mercury recovery);
 - pressurized containers (disposal in approved facility);
 - polyvinyl chloride (PVC) plastics such as intravenous sets, catheters and PVC containers for sharps (disposal in approved facility);
 - vials of vaccines (disposal in approved facility for incineration);
 - anatomical wastes or body parts (disposal in approved facility)
 - Radioactive/radiographic wastes (disposal in approved facility).

- For infectious waste at facilities that do not have operational on-site incinerators, and who cannot transport the waste to the Naboro sanitary landfill, burial may be the only option. This will be addressed during project implementation.

Prior to transport to any facility for disposal or treatment of the waste type, the generating site must ensure that the facility has the necessary permits to manage the specific waste types.

3.4.2 Transitional Arrangements for Infectious Waste (if required)

Some areas may lack the regional infrastructure to treat health-care and other infectious and hazardous waste. Even if the right treatment for infectious waste is available, in pandemics the amount of health-care waste generated is usually much more than usual, so sanitary landfills can provide an acceptable alternative route for safe disposal. Furthermore, fuel supply for the incinerators may be an issue. In those cases, and as an exceptional measure, the waste produced in health-care facilities during the COVID-19 Pandemics may have to be deposited in sanitary or engineered landfills in a secured and separated area, isolated from the regular waste, and with immediate cover once the waste load has been deposited. The main purpose of such measures is to ensure that health-care waste won't be exposed nor mixed with non-infectious waste; waste workers will not be at risk during disposal activities and once healthcare waste is deposited, no human or animal will be able to be in contact with it^{xlii}. As a general rule, double handling of healthcare waste is to be avoided.

The following options may be implemented during implementation of the Project, but should be considered transitional, interim solutions:

Pathological waste disposal: Placenta pits can be effective in low-resource settings. They need to be located at specific sites to avoid contamination of groundwater, locked and fenced for security. Natural degradation and draining of liquid into the subsoil greatly reduces the volume of waste in the pit and facilitates the inactivation of pathogens. Pathological waste may be disposed of at a landfill when no other treatment options are available. However, disposal should be in a pre-specified area to prevent recyclers or scavengers coming into contact with the waste. Waste should also be covered immediately.

Disposal of hazardous ash: Fly ash and bottom ash from incineration is generally considered to be hazardous, because of the possibility of heavy metal content and dioxins and furans. It should preferably be disposed in sites designed for hazardous wastes, e.g. designated cells at engineered landfills, encapsulated (ie. with a cement slurry as an example) and placed in specialized mono fill sites, or disposed in the ground in an ash pit.

Transportation of fly or bottom ash from incinerators will also be undertaken safely so that no ash escapes. All such ash would be placed into a container and sealed with a lid prior to transporting off-site. Where possible the ash should be dampened with a water mist prior to transport.

Sharp waste disposal: Even after decontamination, sharp waste may still pose physical risks. There may also be risk of reuse. Decontaminated sharp waste can be disposed of in safe sharp pits on the health-care facility premises and encapsulated by mixing waste with immobilizing material like cement before disposal. These procedures are only recommended where the waste is handled manually. However MOHMS is currently considering Private, Public Partnership (PPP) to outsource the medical waste

management under surveillance. If this project is implemented, all health facilities medical waste will be taken care irrespective of its location and remoteness.

Infectious and hazardous waste: Disposing of infectious/hazardous wastes without prior treatment into a general non-hazardous landfill greatly increases the risks to human health and the environment. If the waste is not properly covered, or disturbed by any means, further risks will arise. It is therefore poor practice to dispose of hazardous waste directly into a non-engineered landfill and should only be considered as a last resort when no other options are available. Use of techniques such as burning this waste in open pits is to be avoided.

3.4.3 Wastewater and Fecal Waste Disposal

There is no evidence to date that the COVID-19 virus has been transmitted via sewerage systems with or without wastewater treatment. However, as viral fragments have been found in excreta and because of other potential infectious disease risks from excreta, wastewater should be treated in well-designed and well-managed centralized wastewater treatment works. Health facilities shall ensure the provision of safe water, sanitation, and hygienic conditions, which is essential to protecting human health during all infectious disease outbreaks, including the COVID-19 outbreak. The health-care facilities should ensure that wastewater effluent complies with all applicable permits and standards, and the municipal wastewater treatment plant (WWTP) is capable of handling the type of effluent discharged.

Best practices for protecting the health of sanitation workers should be followed. Workers should wear appropriate PPE, which includes protective outerwear, heavy-duty gloves, boots, goggles or a face shield, and a mask; they should perform hand hygiene frequently; they should avoid touching their eyes, nose or mouth with unwashed hands, and they should practise social distancing while working.^{xliii}

3.5 Relevant International Disposal Issues

The 1995 Waigani Convention is a treaty that bans the exporting of hazardous or radioactive waste to Pacific Islands Forum countries, and prohibits Forum island countries from importing such waste. The provisions of this instrument do not apply to the Project if the transport and disposal of hazardous or radioactive waste remains within Fiji.

4 Emergency Preparedness and Response

Emergency incidents occurring in a health-care facility 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, power outages, 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 for the Project funded health-care facilities.

As defined in WB ESS 4 Community Health and Safety (para. 21) an ERP will include, as appropriate: (a) engineering controls (such as containment, automatic alarms, and shutoff systems) proportionate to the nature and scale of the hazard; (b) identification of and secure access to emergency equipment available on-site and nearby; (c) notification procedures for designated emergency responders; (d) diverse media channels for notification of the affected community and other stakeholders; (e) a training program for emergency responders including drills at regular intervals; (f) public evacuation procedures; (g) designated coordinator for ERP implementation; and (h) measures for restoration and cleanup of the environment following any major accident.

The following summarizes the management of the more likely incidents – that of service disruption and spillages of waste materials.

Service Disruption

The following indicates the course of action to be taken in the event of a disruption to normal services:

1. In the event of the contractor not conducting collection within the scheduled time, advice should be sought from the contractor as to when the collection service will occur.
2. Should the contractor advise that for any reason, they cannot collect wastes as per nominated schedules, advice should be sought as to when the collection will occur. If the delay will result in Point 3, then those arrangements must also be followed.
3. If deemed necessary by **the Waste Management Supervisor** (due to accumulation of material that could cause environmental or health effects), arrangements should be made with other contractors to transport the wastes to an appropriate facility.

Incident Reporting

All waste and environment incidents must be reporting to the manger or supervisor by the person involved immediately. Incident investigation and implementation of corrective actions must be completed in accordance with the procedures for the healthcare facility.

It is also essential to report needle stick injuries that may have occurred while handling wastes as soon as possible after the incident.

Spill Management

The following summarises the equipment and procedures for the management of spills of healthcare waste.

- i. Generator and treatment/disposal premises are required to have a spill kit located in all waste storage and/or loading/unloading areas.
- ii. A spill kit shall contain all items necessary to clean up spills of clinical and related waste. Typical contents include absorbents, disinfectant, bucket, shovel, gloves, disposable overalls, safety goggles / shield, tongs for sharps, sharps container, torch, disposable containers and plastic waste liners.
- iii. Records shall be maintained of all spills in regards to waste types, causes and corrective actions implemented.
- iv. Waste management staff trained in spill procedures and use of spill kit equipment.
- v. Spill kits shall be available in every vehicle transporting such waste, with staff trained in their correct use

The following summarises the equipment and procedures for the management of spills of healthcare waste.

- (a) Spill kits shall be located in each ward/department and waste storage areas.
- (b) A spill kit shall contain all items necessary to clean up spills of clinical and related waste. Typical contents include absorbents, disinfectant, bucket, shovel, gloves, disposable overalls, safety goggles / shield, tongs for sharps, sharps container, torch, disposable containers and plastic waste liners.

The following applies to the management of spills to ensure that any spill(s) from healthcare wastes or other containers located on-site are cleaned up in a manner to minimise impact to the environment and avoid injury to any staff member.

The following applies to the management of spills to ensure that any spill(s) from wastes or other containers located on-site are cleaned up in a manner to minimise impact to the environment and avoid injury to any staff member.

- a) If the spill has occurred in an area that does not have permanent bunding surrounding it, the staff member must obtain emergency bunding material from the nearest “Emergency Spill Kit” and place bunding to protect all drains and non-sealed (eg., cement), areas.
- b) The staff member observing the spilt material must immediately inform Environmental Services as to the location of the spill, type of material (if possible), type of container the spill is coming from and approximate quantity.
- c) Advise all staff working in the area to be aware of the spill and instruct any incoming vehicles to not proceed close to the area where the spill is located. Place emergency warning triangle signs around the spill area (ie., outside the bunded area).
- d) If instructed to clean up the spill by Environmental Services, obtain and put on correct personal protective equipment from the “Emergency Spill Kit” – gloves, masks, eye wear, overalls/disposable gowns and gumboots/shoe coverings.

- e) If the spilt material is liquid, apply the absorbent material from the “Emergency Spill Kit” onto all spilt waste. This should be conducted in a manner to prevent spilt clinical and related wastes splashing. Once the liquid material has been absorbed by the absorbent material, carefully, using the disposable broom and pan contained in the “Emergency Spill Kit”, collect the spilt material and deposit it into a yellow clinical waste plastic rigid container.
- f) If the spilt material is solid materials (e.g., a bag has broken), carefully using the disposable broom and pan (and tongs if necessary), contained in the “Emergency Spill Kit”, collect the spilt material and deposit it into a yellow clinical waste plastic rigid container.
- g) If any sharps have been spilt, these should be retrieved using the dedicated tongs located in the “Emergency Spill Kit”. All sharps must be deposited into a sharps container.
- h) When all material has been collected, deposit the disposable broom and pan (and tongs if required), into the yellow clinical waste rigid container.
- i) Once all the spilt material has been collected, spray the contaminated area with the disinfectant solution provided in the “Emergency Spill Kit” (i.e., Sodium Hypochlorite 5000 ppm).
- j) Place all disposable personal protective equipment into a yellow clinical waste container for disposal.
- k) Seal the container and transport the yellow clinical waste container to the ward/department storage area for disposal.
- l) Replace all items taken from the “Emergency Spill Kit” by obtaining supplies from the store – this includes the absorbent material and disinfectant solution. Wash hands with disinfectant supplied in washrooms.
- m) Remove bunding material from around all drains and non-sealed (e.g., cement), areas, inspect the area to ensure that all waste materials, absorbent materials and bunding materials have been collected and disposed of via a yellow clinical waste container for disposal.
- n) Inspect the area to ensure that all waste materials, absorbent materials and bunding materials have been collected and disposed of. Retrieve warning signs and return them to the storage area.
- o) Record all details of the incident including clean-up procedures in an incident report form.

5 Implementation Arrangements and Capacity Building

5.1 Implementation Arrangements

Department of the Environment (DOE)

The DOE is primarily responsible for the implementation, monitoring and enforcement of the environment and waste management acts and regulations, and the development of policies on waste management. The DOE has overall responsibility for ensuring that waste management acts and regulations, and the development of policies on waste management are in place to safeguard the environment. It is also the agency responsible for the management of the Naboro Sanitary Landfill, which it manages through a private contractor. The DOE are also responsible for issuing and monitoring compliance with any solid or liquid waste permits and/or air pollution permits that may be needed for Project activities in accordance with Environment Management (Waste Disposal and Recycling) Regulations 2007.

Ministry of Health and Medical Services (MHMS)

The MHMS is involved in solid waste management through the Public Health Act. The Central Board of Health (CBH), under the MHMS has overall responsibility for medical waste management including the collection, treatment, and disposal of medical wastes from the three main regional hospitals.

The MHMS is also the Implementing Agency for the Project and will have the overall responsibility for ensuring that environmental and social issues are adequately addressed within the Project.

MHMS E&S Specialists

The E&S Specialists in MHMS will manage the day-to-day implementation of the Project. The local ESHSCE Specialist, supported by the international ESHS Specialist, will oversee the implementation of and compliance with the ICP&WMP in accordance with the World Bank ESF.

Health-Care Facilities

At the health-care facility level, the head of the health-care facility will have overall responsibility for infection prevention control (IPC) and waste management. During project implementation, the head of the health-care facility should assess the following:

- whether adequate and qualified staff are in place, including those in charge of infection control and waste management;
- whether additional staff are required: if so, how many, and with what qualifications and training;
- how relevant departments in the healthcare facility will work together to create an intra-departmental team to manage, coordinate and regularly review the issues and performance of the facility; and
- ensuring that there is appropriate resources to enable infection control and waste management systems to operate.

The head of a health-care facility should formally appoint a person or team to be responsible for implementing the procedures and mitigation measures that have been adopted to avoid or minimize the spread of COVID-19. This would be the person/team with overall responsibility for infection prevention control and waste management and would ensure that IPC and health care waste management activities are carried out in accordance with the IPC&WMP. This person/team would also manage, coordinate and regularly review the performance of the facility in terms of how the waste streams in the health-care facilities are separated, tracked and recorded, and oversee the procedures for the safe transportation of potentially infected samples to testing facilities.

To be effective, waste management activities must be implemented within the framework of the facility IPC program, and not as a standalone intervention. Therefore, the officer or team should ideally be part of the infection prevention and control or WASH team of the health facility. Currently, some health care facilities have a dedicated person/s who champions IPC and health-care waste management who could also be identified for IPC and health-care waste management oversight for this Project. This will be decided during project implementation.

5.2 Capacity Building

Some hospitals in Fiji have formal training programs for IPC and health-care waste management. For example, CWMH in Suva has a formal training program in place that covers infection control, waste segregation, sharps management, spills management and use of PPE^{xliv}. However, other hospitals, such as Nadi Hospital, do not. To ensure consistency in IPC and health-care waste management approaches, the Project will invest in training of medical, laboratory and waste management personnel on health-care waste management, financed under sub-component 2 to ensure compliance with the IPC&WMP, WHO guidance, and GIIP. A formal training plan with recurring training programs should be developed and followed. The following aspects are recommended:

- Define roles and responsibilities along each link of the chain along the cradle-to-grave 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 head of a health-care facility takes overall responsibility for infection control and waste management;
- Involve all relevant departments in a health-care facility, 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 health-care facility;
- 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; and
- Consider the use of visual aids in communication materials to overcome language and literacy barriers.

6 Monitoring and Reporting

The health-care facility 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 health-care facility is encouraged to develop an IT based information management system should their technical and financial capacity allow.

Waste assessments may be undertaken on a minimum six-monthly basis to monitor compliance with the healthcare waste management strategy and to ensure that all types and volumes of wastes are understood. Data and information from the waste assessments would be included in the monitoring reports as described below.

As discussed above, the health-care facility head takes overall responsibility, leads an intra-departmental team and regularly reviews issues and performance of the infection control and waste management practices in the health-care facility. Internal reporting and filing systems should be in place and submitted to the MHMS for review on request.

The E&S Specialist/s in the MHMS will prepare six-monthly monitoring reports on the environmental, social, health and safety (ESHS) performance of the Project to submit to the World Bank per government and World Bank requirements.

Annex 1 - WHO hand cleaning and hand rub posters

1a – Hand Washing with Soap and Water



1b - Hand Hygiene with Alcohol-based Hand Rub (AHR)



Annex 2 - Correct steps for donning (putting on) and doffing (safe removal) of PPE for health care settings.

HCWs must select the appropriate PPE after having assessed the risk of contact with body fluid.

The following is not a sequence of PPE. It is procedure for each PPE item.

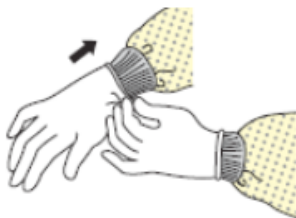
It is when the HCW remove the PPE that he/she may contaminate himself/ herself. Therefore wear PPE in a logical order, to be able to take off from the most contaminated item (higher risk) to the less contaminated item (lower risk).

Any PPE procedure must start by performing hand hygiene first.

When removing PPE, the last step is to thoroughly perform hand hygiene.

1. Gloves

Put On



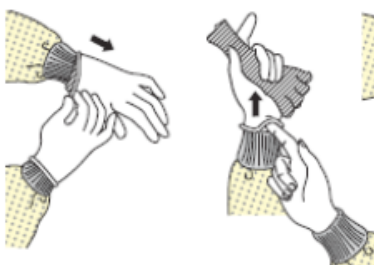
Putting on gloves

Put On

1. Carefully put on disposable gloves (to avoid breaking the gloves)

When wearing long sleeves gown, gloves cover the wrist of the gown

Take Off



Removing gloves

Take Off

! Outside part of gloves is con-taminated!

1. Grasp outside of glove with opposite gloved hand; peel off

2. Hold removed glove in gloved hand or discharge in waste container

3. Slide fingers of un-gloved hand under remaining glove at wrist

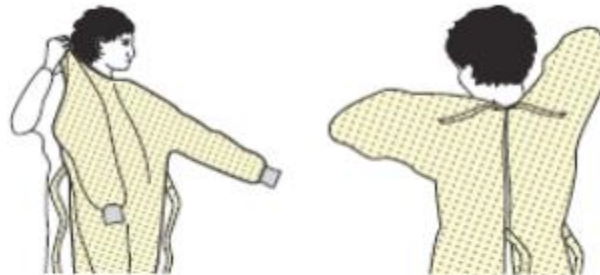
4. Peel glove off

5. Discard gloves in waste container

2. Gown

Put On

1. Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
2. Fasten in back of neck and waist



Take Off

1. Unfasten ties
2. Gown front and sleeves are contaminated!
3. Pull away from neck and shoulders, touching inside of gown (only if not wearing gloves)
4. Turn gown inside out
5. Fold or roll into a bundle and discard



Note: Reusable gown should be clean/ disinfected before being reuse

3. Surgical Mask

Put On

1. Secure ties or elastic bands at middle of head and neck
2. Fit flexible band to nose bridge
3. Fit snug to face and below chin



Put On



Take Off



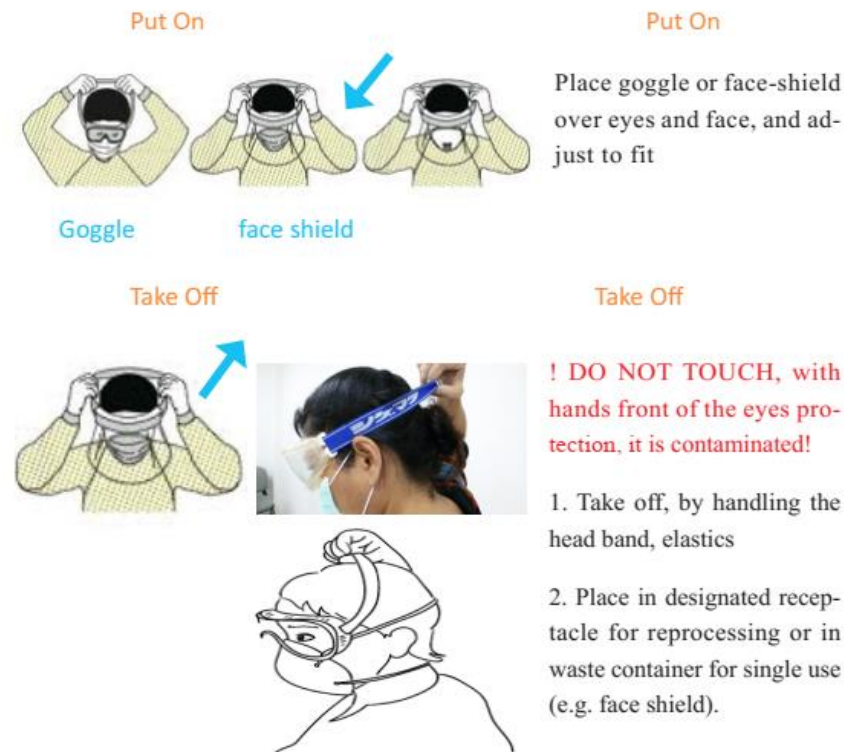
Take Off

! DO NOT TOUCH with hands the front of mask, it is contaminated!

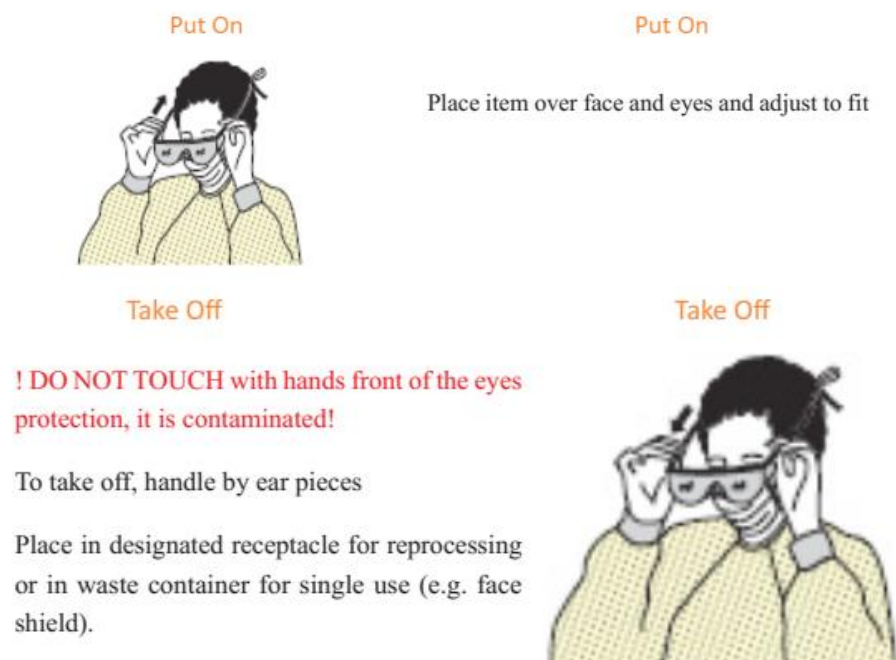
1. Grasp ties or elastics and take off
2. Discard in waste container

4. Eyes protection (safety glasses, goggles or face shield)

4.1 Procedure for goggle or face shield



4.2 Procedure for safety glasses



Annex 3 – The 5 moments for hand hygiene



Recommendation

Routine Hand Hygiene

Hand hygiene must be performed before and after every episode of patient contact.

- Before touching a patient
- Before a procedure
- After a procedure or body substance exposure risk
- After touching a patient
- After touching patient's surroundings

Note: Hand hygiene **MUST** also be performed after taking off PPE.

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Annex IX. Labour Management Procedure (LMP)

Abbreviations and Acronyms

CEDAW	Convention Against All Forms of Discrimination Against Women
ESCP	Environmental and Social Commitment Plan
ESHS	Environmental, Social, Health and Safety
ESHSCE	Environmental, Social, Health and Safety and Community Engagement
ESMF	Environmental and Social Management Framework
ESS	Environmental and Social Standards
FPBS	Fiji Pharmaceutical and Biomedical Services
FM	Financial Management
GBV	Gender-Based Violence
GoF	Government of Fiji
ILO	International Labour Organization
LMP	Labour Management Plan
MHMS	Ministry of Health and Medical Services
M&E	Monitoring and Evaluation
NOHSAB	National Occupational Health and Safety Advisory Board
OHS	Occupational Health and Safety
PPE	Personal protective equipment
POM	Project Operations Manual
SEA	Sexual Exploitation and Abuse
TIN	Tax Identification Number
WB	World Bank
WHO	World Health Organisation
WGM	Workers Grievance Mechanism

1. Introduction

The Fiji Covid-19 Emergency Response Project will assist the Government of Fiji (GoF) in its efforts to prevent, detect and respond to the threat posed by Covid-19 and to strengthen national systems for public health preparedness. The Project will support activities outlined in the GoF Ministry of Health and Medical Services (MHMS) COVID-19 Preparedness and Response Plan (March 2020).

The MHMS will be responsible for Project management, implementation and coordination with other government ministries and stakeholders. The MHMS will hire a Project Manager to lead day-to-day Project management and implementation, supported by one part-time international Environment, Social and Health and Safety (ESHS) Specialist and one part-time local Environmental, Social, Health, Safety and Community Engagement (ESHSCE) Specialist. This Labour Management Plan (LMP) aims to ensure proper working conditions, including occupational health and safety and protection from sexual exploitation, abuse and sexual harassment, for the Project Manager, ESHS and ESHSCE Specialists recruited by the Project. Government workers who participate in the Project as part of their broader responsibilities will be covered by Project occupational health and safety measures and by measures to protect the workforce in terms of child labour and forced labour. Health care workers in facilities that benefit from Project activities are outside the scope of this LMP.

1.1 Project Description

The Project will provide goods, services and technical assistance to enhance disease detection capacity, case confirmation, and contact tracing; risk communication and awareness campaigns; to strengthen health infrastructure including laboratory and intensive care facilities; and improve health care waste management including through procurement and installation of a medical waste incinerator and construction of a pharmaceutical warehouse. The Project will comprise the following components:

1. **Component 1: Emergency COVID-19 Response.** This component will strengthen Fiji's capacity to respond to COVID-19. It will provide immediate support to implement prevention, preparedness, and emergency response activities for COVID-19. Specifically, it will: (a) address the COVID-19 emergency by enhancing disease detection capacities, case confirmation, and contact tracing; (b) strengthen the capacity of the health system to minimize the risk of spread of the disease and provide clinical care for patients with COVID-19; and (c) implement effective risk communication campaigns for mass awareness and education of the population to tackle the COVID-19 emergency, and enhance internet connectivity across health facilities.
 - a. **Sub-Component 1.1: Enhance case detection, confirmation, and contact tracing.** This sub-component will focus on strengthening Fiji's capacity for early detection, case confirmation, and contact tracing for COVID-19 by equipping laboratories with relevant supplies and consumables. Equipment to be procured under this component for laboratories include biosafety cabinets, GeneXpert cartridges, analysers, and swabs.
 - b. **Sub-Component 1.2: Enhance health service delivery.** This sub-component will support enhanced clinical care capacity to manage COVID-19 cases and infection prevention and control capacity, including: (a) providing PPE and essential medical equipment for case treatment; and (b) mobilizing existing MHMS personnel, and personnel of other agencies seconded to the MHMS through an approved written agency circular, to

respond to a surge in demand for health care services and associated COVID-19 response work. The support related to mobilization of those personnel will specifically be for certain recurrent operational expenses, i.e. overtime, per diem and accommodation costs required for those personnel to respond to a surge in demand for health care services and associated COVID-19 response work.

- c. **Sub-Component 1.3: Communication Preparedness and Response.** This sub-component will provide support to strengthen COVID-19 community awareness and communication, to increase knowledge and understanding among the general population about the risk and potential impact of the pandemic. The activities under this sub-component are aligned with the GoF's own risk communication strategy under its COVID-19 Preparedness and Response Plan. As other DPs such as UNICEF and WHO are providing risk communications support, this sub-component will primarily focus on supporting the dissemination of messages to the general public to increase understanding about the risks and impacts of the pandemic, including those aimed at increasing awareness to the ways of preventing infectious diseases. This will be through various communication channels, including posters and billboards, and will be integrated into ongoing outreach activities of the MHMS. **Sub-Component 1.3** will also support the enhancement of telecommunication connectivity for 35 health facilities in priority areas, as identified by the MHMS, to improve communication and data reporting between the MHMS and front-line health workers. Given that the identified priority areas are well-served by existing telecommunications infrastructure, it is expected that the market will respond to the needs of the MHMS and provide packaged deals that could be utilized by the MHMS to boost telecommunications connectivity at the identified sites. The cost of increased bandwidth, antenna system, routers and operating costs related to these activities, will be financed under this sub-component. This sub-component will also finance annual licenses for software used in the health sector, such as ArcGIS, as may be needed.
2. **Component 2: Health System Strengthening.** This component will address medium- and long-term health care system strengthening, focusing on three main priorities: (a) enhancing health care waste management including procurement and installation of a medical waste incinerator at the Naboro landfill to serve the central division health facilities, any incidental works associated with it, and technical assistance to support such activities; b) training for health care workers on health care waste management; and (c) construction of a warehouse to supplement storage facilities at the Fiji Pharmaceutical and Biomedical Services (FPBS) centre in Suva. This warehouse located directly behind the FPBS building will be constructed on land that is owned under lease by Government. The warehouse will be used to store goods and medical supplies that are awaiting clearance and distribution to health facilities. MHMS currently pays substantial fees to freight companies, as well as high rental fees for hired buildings and space to store goods once they have arrived in the country. The planned warehouse would reduce this financial burden. This component will also support improving Fiji's pandemic preparedness and response capacity for emerging infectious diseases through the development of a pandemic preparedness plan.

3. **Component 3: Implementation Management, Monitoring and Evaluation.** This component will provide technical and operational assistance on project management, including supporting M&E, supervision and reporting, financial management, procurement and environmental and social risk mitigation activities; and sharing lessons learnt from response exercises and joint learning domestically and internationally. Key activities include: (a) recruitment of a project manager and environmental and social risk management experts; (b) operating expenses for project management, reporting and supervision; (c) support for procurement, financial management (FM), environmental and social risk management; and (d) M&E.

1.2 Project Management Overview

The MHMS will be responsible for Project management, implementation and coordination with other government ministries and stakeholders. The MHMS will hire a Project Manager to lead day-to-day Project management and implementation. The Project Manager will be supported by one part-time international ESHS Specialist and one part-time local ESHSCE Specialist. The ESHS and ESHSCE specialists will develop and support implementation of the Project's environmental, social, health and safety, and community engagement instruments in compliance with local legislation, good international industry practice (GIIP), including WHO Guidance on COVID-19 and the WB Environmental and Social Framework (ESF). The Project Manager, ESHS and ESHSCE Specialists will be recruited within 2 months of the effective date of the Financing Agreement.

The MHMS will use its existing institutional processes and procedures to carry out the Project's financial management and disbursement functions. The MHMS will submit a six-month interim unaudited financial report to the World Bank (WB) no later than 60 days after semester-end, starting from the first semester following the Project's first disbursement. MHMS will also submit an Annual Work Plan and Budget for the WB's no-objection no later than 90 days after the effective date of the Financing Agreement and by July 1 of each subsequent year during the implementation of the project (or such other interval or date as the WB may agree). The MHMS will develop a Project Operations Manual (POM) to describe detailed arrangements and procedures for Project implementation including operational systems and procedures, organizational structure, finance and accounting procedures (including funds flow and disbursement arrangements, and details relating to MHMS Staff Costs), procurement, the selection of priority areas for telecommunication connectivity, personal data collection and processing in accordance with good international practice, social and environmental management and Project monitoring, evaluation and reporting.

2. Labour Use on the Project

2.1 Categorization of the Workforce

ESS2 categorizes Project workers into four categories:

1. Direct workers: People employed or engaged directly to work specifically in relation to the Project.
2. Contracted workers: People employed or engaged by third party contractors to perform work related to core function of the Project, regardless of location.

3. **Primary supply workers:** People employed or engaged by the primary suppliers. (This category of workers is not expected to be engaged on the Covid-19 Emergency Response Project and is not discussed in the LMP.)
4. **Community workers:** People employed or engaged in providing community labour. (This category of workers is not expected to be engaged on the Covid-19 Emergency Response Project and is not discussed in this LMP.)

2.1.1 Direct Workers

Two types of direct workers will be employed by the Project: Direct Workers – Government and Direct Workers - other.

1. **Direct workers – Government** are public servants employed by the MHMS and health facilities in priority areas who will be involved in Project implementation. The number of government staff involved in Project implementation is not known yet. They will remain subject to the terms and conditions of their existing public sector employment agreement. They will, however, be covered by Project measures to address occupational health and safety issues (ESS2 paragraphs 24 to 30), including those specifically related to COVID-19, and measures to protect the workforce in terms of child labour and forced labour (ESS 2 paragraphs 17 to 20). Health care workers in facilities that benefit from Project activities (such as training, equipment etc) are considered project beneficiaries rather than Direct Workers – Government, and outside the scope of this LMP.
2. **Direct workers - Other** are those employed as full and part-time consultants by under the Project. This category will comprise the Project Manager, ESHS and ESHSCE Specialists recruited for the Project and maintained throughout Project implementation. Other experts/consultants will be hired on demand basis throughout the Project period.

2.1.2 Contracted workers

Contracted labour requirements are likely to be known when Project implementation commences. It is likely, however, that staff will be contracted to provide specialist expertise in areas such as health care waste management including procurement and installation of a medical waste incinerator; training in health care waste management; installation and training in improved telecommunications and systems upgrades; and construction and management of pharmaceutical storage facilities. Specialist support may also be contracted to provide diagnostic and social behavioural change communications training (including related logistics). Institutional capacity strengthening of MHMS and priority health facilities may also be required to support Project implementation.

Contracted staff will be subject to the LMP. Contractors will also be required to ensure that any subcontractors also adhere to the LMP.

2.1.3 Migrant workers

Migrant workers expected to work on the Project include international consultants. Those who will be working in Fiji will require a Short-Term Work Permit. Those who will be working in Fiji for longer periods will require a Work Permit for Non-Citizen Skilled Contracted Worker.

Under current Covid-19 restrictions, Fiji has closed its border to all nationals. All passenger flights have been stopped except for emergency medical evacuation. Travelers covered by this restriction are prevented from boarding Fiji-bound flights. Emergency travelers and special circumstances travel to Fiji are required to complete a health declaration form that will be examined by health officials and screened upon arrival in Fiji. They will be quarantined for 14 days at designated government quarantine facilities. They will be swabbed upon arrival and re-swabbed on day 14. Pax are only released if results are negative on second test and further home quarantine for 14 days at the discretion of local officials.

2.2 Project Labour Requirements

Project labour requirements are shown in **Table** below.

Table 1 Number, Characteristics and Timing of Workforce

Project Component	Estimated Number of Project Workers	Characteristics of Project Workers	Timing of Labour Requirements	Contracted Workers
1.1: Enhance case detection, confirmation, and contact tracing. Primarily equipping laboratories with relevant supplies and consumables	Unknown	<p>Project Manager</p> <p>MHMS Financial Management and Operations Management</p> <p>National workers in storage and distribution of laboratory supplies and equipment. May be hired directly or contracted by company providing the equipment.</p> <p>National workers for goods procured in-country, or workers in-country who procure goods internationally</p>	Operations	Contracted workers in procurement and distribution of laboratory supplies and consumables
1.2: Enhance health service delivery. Enhancing clinical care capacity by providing PPE and essential medical equipment; and mobilizing MHMS personnel and others seconded to the MHMS to respond to a surge in demand for health care services.	Unknown	<p>Project Manager</p> <p>MHMS Financial Management and Operations Management</p> <p>National workers in storage and distribution of medical equipment and PPE. May be hired directly or contracted by company providing the equipment.</p> <p>National workers for goods procured in-</p>	Operations	Contracted workers in procurement and distribution of medical equipment and PPE and support to mobilization of MHMS and other health care personnel.

Project Component	Estimated Number of Project Workers	Characteristics of Project Workers	Timing of Labour Requirements	Contracted Workers
		country, or workers in-country who procure goods internationally National workers engaged in recruitment and mobilization of health care staff		
1.3: Communication Preparedness and Response.	Unknown	Project Manager MHMS and health facilities health communications and promotion staff ESHSCE Specialist National workers engaged in production and distribution of Covid-19 information materials.	Operations	Contracted workers in development of communications and behavioural change strategies; production and distribution of information materials.
1.3: Enhancement of telecommunication connectivity for 35 health facilities in priority areas.	Unknown	Project Manager MHMS Financial Management and Operations Management National workers engaged in installation/ upgrading of telecommunications in health facilities.	Construction	Contracted workers in installation/ upgrading of telecommunications connectivity and training staff in use and maintenance of equipment.
2: Health System Strengthening. Three priorities: (a) procurement and installation of a medical waste incinerator; (b) training health care workers in waste management; and (c) construction of a warehouse to supplement pharmaceutical storage facilities.	Unknown	Project Manager ESHS and ESHSCE Specialists MHMS Financial Management and Operations Management National workers. As far as possible, workers should be hired locally to (i) avoid labour influx from other areas, (ii) mitigate risks to host communities, (iv) maintain support of local	Construction	Contracted workers employed in construction and installation of medical waste management facilities and pharmaceutical storage facilities; contracted staff training health care personnel in health care waste management.

Project Component	Estimated Number of Project Workers	Characteristics of Project Workers	Timing of Labour Requirements	Contracted Workers
		population, and (iv) reduce the need to set up labour camps		
3: Implementation Management, Monitoring and Evaluation: Supporting M&E, supervision and reporting, financial management, procurement, and environmental and social risk mitigation activities.	Unknown at this stage	Project Manager ESHS and ESHSCE Specialists MHMS Financial Management and Operations Management	Throughout the whole Project cycle	Contracted staff employed to support development of M&E frameworks, data collection and reporting

3. Potential Labour Risks

The Project management will demonstrate high standards of human resource management and adhere to Fiji's national labour and OSH legislation and international instruments including International Labour Office conventions ratified by Fiji.

On 16 April 2020, the GoF has declared the country's second State of Natural Disaster in a week, following the country's 17th confirmed case of Covid-19.⁴⁸ The possibility that the country's labour and OHS laws be amended to comply with the State of Natural Disaster has to be considered.

The most significant risks to worker health, safety and well-being are summarized in **Table** below.

Table 2 Key Labour Risks

Project Activity	Key Labour Risks
General project administration and implementation (hiring of consultants, monitoring and reporting, financial management, audits, E&S management, project coordination, conducting behaviour and communication campaigns, conducting trainings, M&E)	<ul style="list-style-type: none"> • Risk of traffic accidents in travel to remote and isolated areas. • Exposure to people who could have COVID-19 Project workers at risk of psychological distress, fatigue and stigma due to the nature of their work.
Minor civil works and/or construction works to upgrade hospitals and other medical facilities, including isolation units and labs, including supplying with medical equipment.	<ul style="list-style-type: none"> • Terms of employment (employment period, remuneration, tax and insurance payments etc.) are not secured by contractual agreements.

⁴⁸ A separate State of Natural Disaster was already in operation to deal with the destruction caused by Cyclone Harold.

Project Activity	Key Labour Risks
	<ul style="list-style-type: none"> Workers suffer discrimination and lack of equal opportunity in employment. Use of child labour contravenes national legislation and international conventions ratified by Fiji. Project workers at risk of psychological distress, fatigue, and stigma due to the nature of their work. Risks of workplace accidents, particularly when operating construction equipment, when working at height on building construction, and when handling heavy equipment and materials Risks from exposure to hazardous substances (dust, cement, chemicals used in construction etc.) Accidents or emergencies (OHS) Sexual Exploitation and Abuse (SEA), GBV and VAC to workers and community
Transportation of medical supplies, equipment	<ul style="list-style-type: none"> Road traffic accidents expose workers and local communities to hazardous materials (OHS) Risk of road accidents in travel to provinces (OHS) Risks of accidents when handling heavy equipment Infected transportation staff transmit COVID-19 to local populations
Transportation of medical waste	<ul style="list-style-type: none"> Road traffic accidents expose workers and local communities to hazardous materials (OHS) Risk of road accidents in travel to provinces (OHS) Risks from exposure to hazardous substances (medical waste, contaminated waste) Infected transportation staff transmit COVID-19 to local populations
Running laboratories, treatment facilities, isolation centres, etc. that deal directly with COVID-19 patients and/or their waste	<ul style="list-style-type: none"> Terms of employment (employment period, remuneration, tax and insurance payments etc.) are not secured by contractual agreements. Workers suffer discrimination and lack of equal opportunity in employment. Use of child labour contravenes national legislation and international conventions ratified by Fiji. Project workers at risk of psychological distress, fatigue and stigma due to the nature of their work.

Project Activity	Key Labour Risks
	<ul style="list-style-type: none"> • Risks from exposure to hazardous substances (medical waste, contaminated waste) • Risks from exposure with patients or their bodily fluids/waste, that have contracted COVID-19 • SEA, GBV and VAC to workers and community
Screening people entering the country	<ul style="list-style-type: none"> • Risks from exposure with people that may be positive for COVID-19 • People entering the country suffer abuse of power, discrimination, stigma during screening process
Conducting checks and screening on people in the community	<ul style="list-style-type: none"> • Risks from exposure with people that may be positive for COVID-19 • Community members suffer abuse of power, discrimination, stigma during screening process

4. Brief Overview of Labour Legislation

Fiji's labour legislation is comprehensive and covers most issues included in ESS2. The ***Constitution of the Republic of Fiji***, adopted in 2013, incorporates a Bill of Rights which contains some articles on labour and working conditions. Specifically, it guarantees protection for the following rights:

- To freedom from slavery, servitude, forced labour and human trafficking (Article 10).
- To freedom of assembly and association (Articles 18 and 19).
- To fair employment practices and the right to form or join a trade union and to engage in collective bargaining (Article 20).
- To equality and freedom from discrimination on the grounds of race, culture, ethnic or social origin, colour, place of origin, sex, gender, sexual orientation, gender identity and expression, birth, primary language, economic or social or health status, disability, age, religion, conscience, marital status or pregnancy (Article 26).
- To full and free economic participation (Article 32).
- To work and a just minimum wage (Article 33).

Attachment C sets out Fiji's key employment and occupational health and safety legislation and ratification of international conventions.

4.1 Employment and Working Conditions Legislation

The **Employment Relations Act 2007 (ERA)** is Fiji's main legislation covering labour and working conditions.⁴⁹ It sets out fundamental principles and rights at work including: the prohibition on forced labour and on the worst forms of child labour, the right to non-discrimination, freedom from harassment and equal opportunity in employment, equal pay for equal work, and freedom of association. It also establishes the Employment Relations Advisory Board (ERAB), an expert group comprising representatives of the Government, employers and workers, which advises the Minister on a range of matters related to employment policy and law.⁵⁰ The ERA regulates terms and conditions of employment including:

- The establishment and termination of employment.
- The payment of wages.
- Hours of work.
- Leave.
- Minimum age for employment and restrictions on the employment of children.
- Grievance procedures and dispute resolution mechanisms.
- Procedures governing industrial action.

In addition to the ERA, subsidiary legislation – including the Employment Relations (Administration) Regulations 2008, Hazardous Occupations Prohibited to Children under 18 Years of Age Order 2013, and Employment Relations (National Minimum Wage) Regulations 2015 – set out further details on these provisions.

The **Human Rights Commission Act 1999 (HRCA)** prohibits unfair discrimination and harassment in employment, including in recruitment and training. The HRCA provides that any person may make a complaint to the Human Rights Commission about unfair discrimination, harassment or another contravention of their human rights under the Act. The HRCA outlines the Commission's powers to investigate and conciliate a complaint. It also sets out judicial remedies for unfair discrimination or a contravention of Fiji's Bill of Rights. In addition to the HRCA, the **Rights of Persons with Disabilities Act 2018** sets out the rights to equal opportunity and non-discrimination in work and employment for people with a disability.

⁴⁹ The *Health and Safety at Work Act 1996* also operates in Fiji. However, it is not covered here as occupational health and safety is beyond the scope of this report.

⁵⁰ It is worth noting that the ILO's Committee of Experts on the Application of Conventions and Recommendations (CEACR), has reported two concerns relating to the ERAB: that it has not been regularly convened for some time; and that the Fiji Trades Union Congress has claimed that the Government has removed and/or replaced the tripartite representation on a number of bodies, including the ERAB.

4.2 Occupational Health and Safety Legislation

The Health and Safety at Work Act (HASAW), 1996 and amended in 2003, is the key legal instrument for safety and health at work. It is comprehensive, covering a wide range of key aspects of safe and healthy environment at work. The HASAW Act provides the following:

- The general inspection of safety and health at work.
- Duties of the persons assigned for the control of workplace.
- Duties of employers and workers to non-working people visiting the workplace.
- Duties of manufacturers, importers, suppliers, and installers.
- General obligations concerning non-interference of safety and health at work.
- Appointment and tasks, duties, rights and functions of the workers' Safety and Health Representative.
- Appointment and membership of the Safety and Health Committee.
- Provisions for prevention of discrimination of the Health and Safety Representative or an individual worker informing the OSH Inspector.
- Investigation of workers ceasing work under immediate threat to safety.
- Notification and registration of workplaces with twenty workers or more is stipulated, as well as the registration, notification and statistics of occupational accidents and diseases.

The HASAW Act mandates the Safety Inspection, Chief Inspectors, and the Inspectorate for enforcement of OHS regulations. The law stipulates the rights and powers of the Inspectorate; controls for notifications by employers; penalties; and appeal systems. The Act is supplemented by associated regulations on OHS administration, training, representatives and committees, general workplace conditions, and a number of specific substantive provisions such as diving, hazardous substances, and a Code of Practice on noise. In addition, the Code of Practice on HIV/AIDS in the Workplace (2008) and the National Policy on Sexual Harassment in the Workplace (2008) are important elements of the OHS regulatory environment.

The Act stipulates the establishment and operation of the National Occupational Health and Safety Advisory Board (NOHSAB) under the Ministry of Employment, Productivity and Industrial Relations. The role of the Board is advisory, providing support to the development of Ministry of Employment policies, follow-up of the development of OHS standards and responding to specific questions and requests set by the Minister. The Board is a tripartite and multi-sectoral body, chaired by the Permanent Secretary of the Ministry of Employment, Productivity and Industrial Relations, with Deputy Chairs from representative employers' and workers' organizations and members from the Ministries of Health, Mining, Agriculture, Transport and Civil Aviation, and the Environment. The Board may also include representatives from other relevant Ministries.

5. Roles and Responsibilities for Project Labour Management

5.1 Project Management

The MHMS will be responsible for Project management, implementation and coordination with other government ministries and stakeholders. The Project Manager to lead day-to-day Project management and implementation, supported by one part-time international ESHS Specialist and one part-time local ESHSCE Specialist. The Project Manager, with support of the ESHS and ESHSCE Specialists, will be responsible for the following within their responsibility area:

- Implementing this LMP;
- Ensuring that contractors comply with this LMP;
- Monitoring to verify that contractors are meeting labour and OHS obligations toward contracted workers as required by Fiji's legislation and ESS2;
- Monitoring contractors' implementation of this LMP;
- Monitoring compliance with occupational health and safety standards at all workplaces in line with the national occupational health and safety legislation;
- Monitoring compliance with COVID-19 related health and safety measures including making workplaces ready for COVID-19;
- Monitoring and implementing training on LMP, OHS and mitigating the spread of COVID-19 for Project workers as described in the Project ESMF;
- Ensuring that all direct workers – other are provided with health insurance that covers treatment for COVID-19 infections;
- Ensuring that the grievance mechanism for Project workers is established and implemented and that workers are informed of its purpose and operation.
- Have a system for regular monitoring and reporting on labour and occupational safety and health performance; and data collection, monitoring, and analysis of the LMP as part of the Project's M&E activity.

5.2 Contractors

Contractors are responsible for management of their workers or subcontracted workers in accordance with this LMP, which will be supervised by the MHMS and Project Manager.

Contractors will be responsible for the following:

- To obey requirements of the national legislation (including any emergency regulations) and this LMP;
- Maintain records of recruitment and employment process of contracted workers;
- Communicate clearly job description and employment conditions to contracted workers;

- Provide workers with evidence of all payments made, including benefits and any valid deductions;
- Provide all contracted workers with health insurance that covers treatment for COVID-19 infections;
- Maintain records regarding labour conditions and workers engaged under the Project, including contracts, registry of induction of workers including Code of Conduct, hours worked, remuneration and deductions (including overtime).
- Assign a designated safety officer, conducting training on and implementing OHS measures and measures to mitigate the spread of COVID-19, recording safety incidents and corresponding Root Cause Analysis (lost time incidents, medical treatment cases), first aid cases, high potential near misses, and remedial and preventive activities required (for example, revised job safety analysis, new or different equipment, skills training, etc.) in accordance with the project's ESMF
- Ensure no child or forced labour is involved in the Project.
- Maintain records of training/induction dates, number of trainees, and topics.
- Implement the grievance mechanism for workers, maintaining records of any worker grievances including occurrence date, grievance, and date submitted; actions taken and dates; resolution (if any) and date; and follow-up outstanding.
- Establish a system for regular review and reporting on labour, and occupational safety and health performance.

This LMP can be updated to include additional details about the hired workforce of contractors including, as necessary.

6. Project Labour Policies and Procedures

6.1 Terms and Conditions of Employment

Terms and conditions of direct workers are determined by their individual contracts. Permanent Project staff will have individual agreements (labour contract or service contract) with fixed monthly wage rates. All the recruiting procedures will be documented and filed in accordance to the requirements of Fiji's labour legislation and the ESS2. Forty hour per week employment should be practiced. Requirements and conditions of overtime and leave entitlements are agreed as part of individual contracts.

The Project Manager will ensure that contractors are aware of, and comply with, labour management and OSH policies and procedures outlined in this LMP. Each contractor will be required to submit an assessment of environmental and social risks (including labour risks) associated with their activities and risk mitigation measures in accordance with the Project's environmental and social requirements.

The Project's labour requirements are outlined in the sections below.

6.2 Age of Employment

Fiji has ratified both the ILO Minimum of Age Convention (C138) and the ILO Worst Forms of Child Labour Convention (C182). A study by the ILO based on five child labour surveys has reported that children in Fiji are engaged in child labour. Fiji recorded 173 cases of child labour from 2011 to 2014, including in street work, and in the worst forms of child labour such as commercial sexual exploitation. Children were also found to be involved in hazardous work such as collecting and handling scrap metals, chemicals, and carrying heavy loads. Poverty, parental or family neglect and other social problems, combined with the need for cash for personal requirements, remain the key factors that push children into child labour. The Employment Relations Act defines the minimum age and conditions of employment for children who are above 15 years. The Ministry of Employment, Productivity, and Industrial Relations has increased the number of labour inspections conducted throughout the year and was actively involved in the launch and implementation of the Tackling Child Labour Through Education Project.

The minimum age of employment for this Project will be 18 years due to the hazardous working conditions. To ensure compliance, all employees will be required to produce a Tax Identification Number (TIN) as proof of their identity and age. Contractors and subcontractors will be required to receive approval for the specific procedures they will use to verify the ages of job applicants.

6.3 Occupational Health and Safety

The OHS measures of the Project are based on the requirements of the relevant sections of ESS2 as well as WHO guidelines. These will particularly address the key identified risks, including infection of Project workers with Covid-19 and of psychological distress, fatigue and stigma due to the nature of their work.

The ESHS and ESHSCE Specialists will establish OSH guidelines for all Project workers, monitor and implement training on OHS for Project workers and establish a system for regular monitoring and reporting on OSH performance including documentation and reporting of occupational accidents, diseases and incidents.

The Project Manager will ensure effective methods are put in place for responding to identified hazards and risks, establishing priorities for taking action and evaluating outcomes. WHO's [guidance for health workers](#) details both the rights of health workers and expectations of employers and managers in health facilities, as well as the responsibilities of health workers. These guidelines include preventive and protective measures (such as the use of PPE), emergency prevention and preparedness and response arrangements to emergency situations, and remedies for adverse impacts as required under the ESS2.

The Project guidelines will require compliance with the following provisions:

- Ensure workplace health and safety standards in full compliance with Fiji law, ESS2 and WHO Guidelines and include:
 - Basic safety awareness training to be provided to all persons as well as on COVID-19 prevention and related measures.
 - All Project vehicle drivers to have appropriate licenses.

- Safe management of areas around operating equipment inside or outside hospitals/ laboratories/ treatment facilities/ isolation centres.
 - All workers to be equipped with all necessary PPE (particularly facemask, gowns, gloves, handwashing soap, and sanitizer) to protect from COVID-19.
 - Secure scaffolding and fixed ladders to be provided for work above ground level.
 - First aid equipment and facilities to be provided in accordance with labour legislation.
 - At least one supervisory staff trained in safety procedures to be present at all times when construction work is in progress.
 - Adequate provision of hygiene facilities (toilets, hand-washing basins) and resting areas etc.
- Compliance with Fiji legislation, WB's ESS2 requirements and other applicable requirements which relate to OHS hazards, including WHO specific COVID-19 guidelines.
 - All workplace health and safety incidents to be properly recorded in a register detailing the type of incident, injury, people affected, time/place and actions taken.
 - All workers (irrespective of contracts being full-time, part-time, temporary or casual) to be covered by insurance against occupational hazards and COVID-19, including ability to access medical care and take paid leave if they need to self-isolate as a result of contracting COVID-19.
 - All work sites to identify potential hazards and actions to be taken in case of emergency.
 - Any on-site accommodation to be safe and hygienic, including provision of an adequate supply of potable water, washing facilities, sanitation, accommodation and cooking facilities.
 - Workers residing at site accommodation to receive training in preventing prevention of infection through contaminated food and / or water, COVID-19 prevention and avoidance of sexually transmitted diseases.
 - Laminated signs of relevant safe working procedures to be placed in a visible area on work sites, in local language and English, including on hand hygiene and cough etiquette, as well as on symptoms of COVID-19 and steps to take if suspect have contracted the virus.
 - Fair and non-discriminatory employment practices.
 - Under no circumstances will contractors, suppliers or sub-contractors engage forced labour.
 - Construction materials to be procured only from suppliers able to certify that no forced labour or child labour (except as permitted by the Labour Law) has been used in production of the materials.
 - All employees to be aware of their rights under the Labour Law, including the right to organize.
 - All employees to be informed of their rights to submit a grievance through the Project Worker Grievance Mechanism. All employees to be provided training on appropriate behaviour with communities, gender-based violence and violence against children.

Project workers will receive OHS training at the start of their employment or engagement, and thereafter on a regular basis and when changes are made in the workplace, with records of the training kept on file. Training will cover the relevant aspects of OHS associated with daily work, including the ability to stop work without retaliation in situations of imminent danger (as set out in paragraph 27 of ESS2) and emergency arrangements.

All Project workers will also receive training on COVID-19 prevention, social distancing measures, hand hygiene, cough etiquette and relations with local community. Training programs will focus, as needed, on COVID-19 laboratory bio-safety, operation of quarantine and isolation centres and screening posts, communication and public-awareness strategies for health workers and the general public on emergency situations, as well as compliance monitoring and reporting requirements, including on waste management, the Project's labour-management procedures, stakeholder engagement and grievance mechanism.

All parties who employ or engage Project workers will actively collaborate and consult with Project workers in promoting understanding of, and methods for, implementation of OHS requirements, as well as in providing information to Project workers, training on occupational safety and health, and provision of personal protective equipment without expense to the Project workers.

6.3.1 Workers' Rights to Refuse Unsafe Work Environments

Workplace processes will be put in place for Project workers to report work situations that they believe are not safe or healthy. Project workers can remove themselves from a work situation which they have reasonable justification to believe presents an imminent and serious danger to their life or health. Project workers who remove themselves from such situations will not be required to return to work until necessary remedial action to correct the situation has been taken. Project workers will not be retaliated against or otherwise subject to reprisal or negative action for such reporting or removal.

6.3.2 Sexual Exploitation and Abuse and Sexual Harassment

Fiji ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1995. By ratifying CEDAW, it has made a commitment to ensure that the principles of equality are adhered to and that discriminatory practices including sexual exploitation and abuse and sexual harassment are abolished. Provisions to prevent sexual exploitation and abuse and sexual harassment will be included in the Code of Conduct for Project staff and for contracted workers in line with relevant national laws and legislation.

7. Workers' Grievance Management

MHMS and health staff working on the Project will have access to the grievance mechanisms established by the Project. For direct workers – other and contracted workers, a Project specific Workers' Grievance Mechanism (WGM) consistent with ESS2 will be established and maintained to raise workplace concerns.

Workers will be informed of the grievance mechanism at the time of recruitment. The WGM will be easily accessible and measures will be put in place to protect workers against reprisal for its use. The WGM can be used to raise workplace related concerns including about the terms of employment, rights at work, unsafe or unhealthy work situations and others. If the issue cannot be resolved at the

workplace level within seven days, it will be escalated to the Project Management level where the ESHSCE Specialist will serve as Grievance Focal Point to file the grievances and appeals. The Grievance Focal Point will coordinate with relevant departments/organizations and persons to address these grievances. The Project Manager will review the records on a monthly basis and report on the grievances, response time and resolution status in a quarterly report to the WB.

The WGM will operate as follows:

1. The complainant may report their grievance in person, by phone, text message, mail or email (including anonymously if required) to the contractor as the initial focal point for information and raising grievances. For complaints that are satisfactorily resolved at this stage, the incident and resultant resolution will be logged and reported to the Grievance Focal Point.
2. If the complainant is not satisfied, the contractor will refer the aggrieved party to the Grievance Focal Point. The Focal Point endeavours to address and resolve the complaint and inform the complainant in two weeks or less. For complaints that are satisfactorily resolved by the Focal Point, the incident and resultant resolution will be logged by the Focal Point. Where the complaint is not resolved, the Focal Point will refer to the Project Manager for further action or resolution.
3. As a third step, if the matter remains unresolved, or the complainant is not satisfied with the outcome, the Project Manager will refer the matter to the MHMS Permanent Secretary, which will aim to resolve the grievance in three weeks or less. The Grievance Focal Point will log details of issue and resultant resolution status.
4. If the complaint remains unresolved or the complainant is dissatisfied with the outcome proposed by the MHMS Permanent Secretary, the complainant may refer the matter to the appropriate legal or judicial authority, at the complainant's own expense. A decision of the Court will be final.

The grievance mechanism is not an alternative or substitute for the legal system for receiving and handling grievances and will not preclude access to other judicial or administrative remedies that might be available under the law or through existing arbitration procedures. While all employees always have the right to access the legal system, the purpose of establishing a grievance mechanism is to provide an accessible and practical means to mediate and seek appropriate solutions, wherever possible.

Attachment A: WHO Guidance on OHS and Covid-19 Outbreak

Coronavirus disease (COVID-19) outbreak: rights, roles and responsibilities of health workers, including key considerations for occupational safety and health

Interim guidance
19 March 2020



Background

Health workers are at the front line of the COVID-19 outbreak response and as such are exposed to hazards that put them at risk of infection. Hazards include pathogen exposure, long working hours, psychological distress, fatigue, occupational burnout, stigma, and physical and psychological violence. This document highlights the rights and responsibilities of health workers, including the specific measures needed to protect occupational safety and health.

Health work rights, roles and responsibilities

Health worker rights include the expectation that employers and managers in health facilities:

- assume overall responsibility to ensure that all necessary preventive and protective measures are taken to minimize occupational safety and health risks;¹
- provide information, instruction, and training on occupational safety and health, including;
- refresher training on infection prevention and control (IPC);
- use, putting on, taking off and disposal of personal protective equipment (PPE);
- provide adequate IPC and PPE supplies (masks, gloves, goggles, gowns, hand sanitizer, soap and water, cleaning supplies) in sufficient quantity to those caring for suspected or confirmed COVID-19 patients, such that workers do not incur expenses for occupational safety and health requirements;
- familiarize personnel with technical updates on COVID-19 and provide appropriate tools to assess, triage, test, and treat patients, and to share IPC information with patients and the public;
- provide appropriate security measures as needed for personal safety;
- provide a blame-free environment in which health workers can report on incidents, such as exposures to blood or bodily fluids from the respiratory system, or cases of violence, and adopt measures for immediate follow up, including support to victims;
- advise health workers on self-assessment, symptom reporting, and staying home when ill;

- maintain appropriate working hours with breaks;
- consult with health workers on occupational safety and health aspects of their work, and notify the labour inspectorate of cases of occupational diseases;
- allow health workers to exercise the right to remove themselves from a work situation that they have reasonable justification to believe presents an imminent and serious danger to their life or health, and protect health workers exercising this right from any undue consequences;
- not require health workers to return to a work situation where there has been a serious danger to life or health until any necessary remedial action has been taken;
- honour the right to compensation, rehabilitation, and curative services for health workers infected with COVID-19 following exposure in the workplace – considered as an occupational disease arising from occupational exposure;
- provide access to mental health and counselling resources; and
- enable cooperation between management and health workers and their representatives.

Health workers should:

- follow established occupational safety and health procedures, avoid exposing others to health and safety risks, and participate in employer-provided occupational safety and health training;
- use provided protocols to assess, triage, and treat patients;
- treat patients with respect, compassion, and dignity;
- maintain patient confidentiality;
- swiftly follow established public health reporting procedures of suspected and confirmed cases;
- provide or reinforce accurate IPC and public health information, including to concerned people who have neither symptoms nor risk;
- put on, use, take off, and dispose of PPE properly;
- self-monitor for signs of illness and self-isolate and report illness to managers, if it occurs;
- advise management if they are experiencing signs of undue stress or mental health challenges that require supportive interventions; and

¹ Including implementation of occupational safety and health management systems to identify hazards and assess

risks to health and safety; IPC measures; and zero-tolerance policies towards workplace violence and harassment.

Rights, roles and responsibilities of health workers, including key considerations for occupational safety and health: Interim guidance

- report to their immediate supervisor any situation which they have reasonable justification to believe presents an imminent and serious danger to life or health.

Additional resources

[Emerging respiratory viruses, including COVID-19: methods for detection, prevention, response and control.](#)

[WHO COVID-19 technical guidance](#)

WHO continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue a further update. Otherwise, this interim guidance document will expire 2 years after the date of publication.

Attachment B Code of Conduct for direct workers (other) and contracted workers

A satisfactory Code of Conduct will contain obligations on all direct workers (other) and contracted workers (including sub-contractors and day workers) that are suitable to address the following issues, as a minimum. Additional obligations may be added to respond to particular concerns of the region, the location and the project sector or to specific project requirements. The Code of Conduct shall contain a statement that the term 'child' / 'children' means any person(s) under the age of 18 years.

The issues to be addressed include:

1. Compliance with applicable laws, rules, and regulations
2. Compliance with applicable health and safety requirements to protect the local community (including vulnerable and disadvantaged groups), the Employer's and Project Manager's personnel, and the Contractor's personnel, including sub-contractors and day workers, (including wearing prescribed personal protective equipment, preventing avoidable accidents and a duty to report conditions or practices that pose a safety hazard or threaten the environment)
3. The use of illegal substances
4. Non-Discrimination in dealing with the local community (including vulnerable and disadvantaged groups), the Employer's and Project Manager's personnel, and the Contractor's personnel, including sub-contractors and day workers (for example on the basis of family status, ethnicity, race, gender, religion, language, marital status, age, disability (physical and mental), sexual orientation, gender identity, political conviction or social, civic, or health status)
5. Interactions with the local community(ies), members of the local community (ies), and any affected person(s) (for example to convey an attitude of respect, including to their culture and traditions)
6. Sexual harassment (for example to prohibit use of language or behavior, in particular towards women and/or children, that is inappropriate, harassing, abusive, sexually provocative, demeaning or culturally inappropriate)
7. Violence including sexual and/or gender-based violence (for example acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion, and deprivation of liberty)
8. Exploitation including sexual exploitation and abuse (for example the prohibition of the exchange of money, employment, goods, or services for sex, including sexual favors or other forms of humiliating, degrading behavior, exploitative behavior or abuse of power)
9. Protection of children (including prohibitions against sexual activity or abuse, or otherwise unacceptable behavior towards children, limiting interactions with children, and ensuring their safety in project areas)
10. Sanitation requirements (for example, to ensure workers use specified sanitary facilities provided by their employer and not open areas)
11. Avoidance of conflicts of interest (such that benefits, contracts, or employment, or any sort of preferential treatment or favors, are not provided to any person with whom there is a financial, family, or personal connection)

12. Respecting reasonable work instructions (including regarding environmental and social norms)
13. Protection and proper use of property (for example, to prohibit theft, carelessness or waste)
14. Duty to report violations of this Code
15. Non retaliation against workers who report violations of the Code, if that report is made in good faith.

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

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

A copy of the code shall be displayed in a location easily accessible to the community and project affected people. It shall be provided in languages comprehensible to the local community, Contractor's personnel (including sub-contractors and day workers), Employer's and Project Manager's personnel, and affected persons.

Attachment C: Relevant national legislation and international conventions ratified by Fiji

National legislation	Year adopted	Weblink
Constitution of the Republic of Fiji	2013	https://www.laws.gov.fj/ResourceFile/Get/?fileName=2013%20Constitution%20of%20Fiji%20(English).pdf
Employment Relations Act	2007	https://www.laws.gov.fj/Acts/DisplayAct/483
Employment Relations (Administration) Regulations	2008	https://laws.gov.fj/Acts/DisplayAct/483#
Employment Relations (National Minimum Wage) Regulations	2015	https://laws.gov.fj/Acts/DisplayAct/483#
Hazardous Occupations Prohibited to Children under 18 Years of Age Order	2013	https://laws.gov.fj/Acts/DisplayAct/483#
Human Rights Commission Act	1999	https://www.hurights.or.jp/archives/database/nhri-law-fiji.html#18
Rights of Persons with Disabilities Act	2018	https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/107420/132231/F-623634238/FJI107420.pdf
Maritime Transport Act	2013	https://www.laws.gov.fj/Acts/DisplayAct/570#
ILO Conventions - Fundamental		
C029 - Forced Labour Convention, 1930 (No. 29)		https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312174:NO
C087 - Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87)		https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312232:NO
C098 - Right to Organise and Collective Bargaining Convention, 1949 (No. 98)		https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312243:NO
C100 - Equal Remuneration Convention, 1951 (No. 100)		https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312245:NO
C105 - Abolition of Forced Labour Convention, 1957 (No. 105)		https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312250:NO
C111 - Discrimination (Employment and Occupation) Convention, 1958 (No. 111)		https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312256:NO
C138 - Minimum Age Convention, 1973 (No. 138)		https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312283:NO
C182 - Worst Forms of Child Labour Convention, 1999 (No. 182)		https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312327:NO
ILO Conventions - Governance		
C081 - Labour Inspection Convention, 1947 (No. 81)		https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312226:NO

C122 - Employment Policy Convention, 1964 (No. 122)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312267:NO
C129 - Labour Inspection (Agriculture) Convention, 1969 (No. 129)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312274:NO
C144 - Tripartite Consultation (International Labour Standards) Convention, 1976 (No. 144)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312289:NO
ILO Conventions - Technical	
C011 - Right of Association (Agriculture) Convention, 1921 (No. 11)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312156:NO
C012 - Workmen's Compensation (Agriculture) Convention, 1921 (No. 12)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312157:NO
C019 - Equality of Treatment (Accident Compensation) Convention, 1925 (No. 19)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312164:NO
C026 - Minimum Wage-Fixing Machinery Convention, 1928 (No. 26)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312171:NO
C045 - Underground Work (Women) Convention, 1935 (No. 45)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312190:NO
C084 - Right of Association (Non-Metropolitan Territories) Convention, 1947 (No. 84)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312229:NO
C085 - Labour Inspectorates (Non-Metropolitan Territories) Convention, 1947 (No. 85)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312230:NO
C108 - Seafarers' Identity Documents Convention, 1958 (No. 108)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312253:NO
C142 - Human Resources Development Convention, 1975 (No. 142)	https://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO:12100:P12100_INSTRUMENT_ID:312287
C149 - Nursing Personnel Convention, 1977 (No. 149)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312294:NO
C155 - Occupational Safety and Health Convention, 1981 (No. 155)⁵¹	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312300:NO
C159 - Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312304:NO
C169 - Indigenous and Tribal Peoples Convention, 1989 (No. 169)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312314:NO

⁵¹ I note that occupational safety and health is outside the scope of this report.

C172 - Working Conditions (Hotels and Restaurants) Convention, 1991 (No. 172)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312317:NO
C181 - Private Employment Agencies Convention, 1997 (No. 181)	https://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO:12100:P12100_INSTRUMENT_ID:312326
C184 - Safety and Health in Agriculture Convention, 2001 (No. 184)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312329:NO
MLC, 2006 - Maritime Labour Convention, 2006 (MLC, 2006)	https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:91:0::NO:91:P91_INSTRUMENT_ID:312331:NO
Other international conventions	
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)⁵²	https://www.ohchr.org/documents/professionalinterest/cedaw.pdf
Convention on the Rights of Persons with Disabilities (CRPD)⁵³	https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx
Convention on the Rights of the Child (CRC)⁵⁴	https://www.ohchr.org/en/professionalinterest/pages/crc.aspx
International Covenant on Economic, Social and Cultural Rights (ICESCR)⁵⁵	https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx

⁵² Article 11 deals with employment.

⁵³ Article 27 deals with work and employment.

⁵⁴ Article 32 deals with the right of a child to be protected from economic exploitation and from performing any work that is likely to be hazardous, harmful or to interfere with their education.

⁵⁵ Articles 6 and 7 deal with the right to work.

Annex X. Resource List: COVID-19 Guidance

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 Centre](#), 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 travellers 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 centres](#), 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 labour 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