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PRESCRIPTIONS FOR INCLUSION IN CONSTRUCTION/WORKSITE ESMPS TO STRENGTHEN COVID-19 HEALTH CONTROL

PRESCRIPTIONS POUR RENFORCER LE CONTROLE SANITAIRE DANS LES PGES TRAVAUX/CHANTIERS

#MondeEnCommun

AFD
AGENCE FRANÇAISE
DE DÉVELOPPEMENT

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ACRONYMS AND ABBREVIATIONS

AFD	French Agency for Development - *Agence Française de Développement*
E&S	Environment and Social
ESMP	Environmental and Social Management Plan
IFC	International Finance Corporation
PPE	Personal Protective Equipment
WHO	World Health Organization

A. Introduction

1. This document provides prescriptions that are recommended for integration into the health and safety components of environmental and social management plans and systems of projects financed by the French Agency for Development (AFD) and that are currently in a construction (or pre-construction) phase.

2. The prescriptions are intended to strengthen the control of COVID-19 risk at, and in the vicinity of, project construction sites and worker accommodation camps. There are also prescriptions for the management of COVID-19 risks for situations where project activities and project organisation may influence community health in the vicinity of projects.

3. The prescriptions have been gathered from guidance documents available in the public domain and from non-published working papers prepared by various International Financial Institutions. The prescriptions are not exhaustive and reflect the understanding of the characteristics of COVID-19 and its control at the time of writing. However, it is worthy of note that currently there are many unknowns about the disease and approaches for the control of risks may change as knowledge about the disease improves.

4. It is recommended that the Project Owner selects the necessary prescriptions for its project and integrates them into the project's E&S Requirements so that they are developed into specific tangible actions to be implemented by the Owners' Engineer and Contractors as appropriate.

5. The document is organised as follows:

   i. Prescriptions related to project organisation, coordination with stakeholders (including authorities) and decision-making processes for continuation of works are provided in sections [A], [B], [C], and [D].

   ii. Prescriptions related to the prevention of transmission of COVID-19 on project sites and within worker accommodation camps are provided in section [E].

   iii. Prescriptions related to the management of cases of COVID-19 amongst project workers are provided in section [F].

   iv. Prescriptions for the management of community health risks are provided in [G].

   v. Prescriptions related to project plans, procedures and processes are provided in [H].

   vi. Prescriptions related to monitoring and reporting are provided in [I].

B. Actors, Roles, Responsibilities and Resources

6. The key plans for management of COVID-19 by a project are (i) the Project Continuity Plan, prepared by the Project Owner, and (ii) the COVID-19 Response Plan, prepared by the Contractor(s). The prescriptions in this document make frequent reference to these plans, and description of the requirements regarding these plans is provided in section [H].

B.1 PROJECT OWNER ROLE, RESPONSIBILITIES AND RESOURCES

7. The Project Owner should have a leadership role and be responsible for ensuring that effective and appropriate measures to manage COVID-19 are developed and implemented at its project sites. The project site(s) comprise worksites, worker accommodation camps (if any), and any other temporary or permanent project facilities.

8. The Project Owner, assisted as necessary by the Owners' Engineer, should prepare a Project Continuity Plan of which the depth and breadth is commensurate with the scale of the project and the context and project risks (see Section [H.1]) and set out the resources, responsibilities and decision-making processes for the project continuation (or stopping). Detailed guidance for the continuity plan is provided in a guidance note for the Project Owner (provided as a separate document).

9. If not already covered by existing agreements, the Project Owner may delegate the responsibility of instructing and supervising contractors to undertake the actions as per the continuity plan, including the preparation and implementation of a COVID-19 Response Plan to the Owners' Engineer and ensure that sufficient resources are mobilised.

10. The Project Owner should keep records of the development of the COVID-19 situation at its project site(s) through review of updates and reports provided by the Owners' Engineer and/or Contractors.

11. The Project Owner should, in coordination with local/national authorities, the Owners' Engineer and Contractors, take appropriate informed decisions regarding the continuation of project works, (progressive) scaling down of works, stopping of works and (progressive) restarting of any works that have been stopped. The decision-making process should include assessment of the context and project risks (see section [D]).

12. The Project Owner should put in place an appropriate COVID-19 governance structure that is commensurate with the scale of the project. As a minimum, a designated person should be assigned the responsibility of managing the control of the project's COVID-19 risks and coordinating with the Owners' Engineer counterpart and with local/national authorities.

B.2 OWNERS' ENGINEER ROLE, RESPONSIBILITIES AND RESOURCES

13. Depending on the agreement with the Project Owner, the Owners' Engineer may assist the Project Owner, as necessary, in the preparation and implementation of the Project Continuity Plan (see item [8] above).

14. The Owners' Engineer should implement instructions from the Project Owner, and integrate the prescriptions provided in Project Continuity Plan and this document into the Owners E&S Requirements for Contractors. This may be in the form of an addendum or similar. The Owners' Engineer should coordinate with the Contractor(s) to ensure that the prescriptions are integrated into the Contractors' E&S management, that a COVID-19 Response Plan (see Section [H.2]) is prepared and implemented .

15. As necessary, the Owners' Engineer should prepare plans that are applicable to its activities as indicated in the prescriptions included in this document. In addition, the Owners' Engineer should implement appropriate measures with regard to its staff that are present at the project site(s).

16. The Owners' Engineer should designate a COVID-19 manager assisted by a suitably sized team to manage the following:

i. Coordination with the Project Owner, local/national authorities and Contractor(s).

ii. Integration of the prescriptions provided in this document into the Owners' E&S Requirements for Contractors and establishment of an agreement on contractual arrangements with the Contractor(s).

iii. Supervision of implementation of COVID-19 risk management by Contractors.

iv. Development and implementation of plans, procedure and process that are relevant to the activities of the Owners' Engineer staff present at the project site.

v. Recruitment of additional staff, as necessary, to assist in the implementation of the Owners' Engineers COVID-19 risk management.

vi. Reporting of the Contractor(s) COVID-19 risk management performance to the Project Owner.

B.3 CONTRACTOR(S) ROLE, RESPONSIBILITIES AND RESOURCES

17. The Contractor(s) should translate the COVID-19 prescriptions included in the Project Continuity Plan and the Owners' E&S Requirements for Contractor(s) into a COVID-19 Response Plan which will be applicable to, and implemented by, the Contractors' staff and their subcontractors in a time scale agreed with the Owners' Engineer and Project Owner.

18. Each Contractor should designate a COVID-19 manager and establish a suitably sized team to coordinate with counterparts from the Owners' Engineer team and implement the contractor's COVID-19 Response Plan. As necessary, the Contractor will recruit additional staff and procure material resources necessary to effectively implement the COVID-19 Response Plan.

B.4 DECISIONS & GUIDANCE FROM AUTHORITIES AND INTERNATIONAL ORGANISATIONS

19. The Project Owner should monitor guidance updates and decisions made by local/national authorities and international organisations (such as the World Health Organization – WHO) regarding COVID-19 response (see section [I.1]) . The project will liaise with the authorities to ensure there is a coordinated approach to the management of COVID-19 risk at the project site(s) and in the neighboring communities.

C. Coordination with Stakeholders

20. The Project Owner has the responsibility of identifying stakeholders and establishing procedures/channels of communication to be used for each stakeholder. This task can be delegated to the Owners' Engineer; therefore, reference to "the project" in the prescriptions below can refer to either the Project Owner or the Owners' Engineer.

21. The existing project Stakeholder Engagement Plan should be updated to include stakeholders involved in the COVID-19 response (see section [H.1]).

C.1 STAKEHOLDERS

22. Stakeholders identified should comprise project stakeholders and stakeholders that have a role or an interest in the management of the COVID-19.

23. Project stakeholders considered should include as a minimum the AFD, other lenders (if any), Project Owner, Owners' Engineer, Contractor(s) and their subcontractors, project employees and workers' collective bargaining organisations.

24. A stakeholder contact should be established, with the names, position/function and contact details of (focal points for) each stakeholder. If appropriate, the project's Stakeholder Engagement Plan can be used as a basis and developed as necessary.

25. Stakeholders that have a role in the management of COVID-19 risks should include as a minimum the following:

i. Local and national authorities – including health authorities, police, security forces, etc.
ii. Local health clinics and hospitals.
iii. Local waste management facilities (specialist contractors, municipal facilities).
iv. Suppliers of goods and services.
v. Suppliers of specialist equipment such as masks, gowns, gloves, disinfectant, etc.
vi. Transport services – including emergency evacuation services.

26. Stakeholders that have an interest in project management of COVID-19 and whose support may be needed for the implementation of community health measures should include:

i. Local community leaders.
ii. Religious leaders.
iii. Associations (including youth and women's associations).
iv. Local people, including those benefiting from direct and indirect employment linked to the project.
v. Project workers.

C.2 PROCEDURES AND CHANNELS OF COMMUNICATION

27. The Project should establish the procedures/channels of communication for communicating with each stakeholder.

28. The Project should establish procedures or processes for communicating and coordinating with local and national authorities, including health authorities, and which cover – but not limited to - the following situations:

i. Inform authorities of COVID-19 cases / deaths amongst the project workers.
ii. Request information on local or national COVID-19 situation.
iii. Receive information on actions to be taken required by the government.
iv. Mobilisation of local or regional health resources to assist the Project (see [C.3] below).

29. The Project should establish processes for communicating and coordinating with local police and security forces and which cover – but not limited to – the following situations:

i. Notify police and/or security forces of security issues within the project sites or in the areas around the project sites.

ii. Request information on actions taken in the environs of project sites by police and/or security.

iii. Request information on the security situation at local, regional and national levels.

iv. Request for mobilisation of police or security forces to assist the project (see [C.4] below).

C.3 MOBILISATION OF LOCAL/REGIONAL/NATIONAL HEALTH RESOURCES

30. The Project should make contingency plans for situations when mobilisation of local, regional or national or health resources may be required, such as – but not limited to – the following:

i. When project resources are insufficient to manage a COVID-19 outbreak amongst workers accommodated/quarantined in worker accommodation camps.

ii. When there is concern that (potential) COVID-19 prevalence within the neighboring communities, such as informal settlements around the project sites/facilities, are a risk for workers' health.

iii. When COVID-19 prevalence amongst project workers, such as local workers who are accommodated at their homes in surrounding villages, is considered to represent a risk for community health.

C.4 MOBILISATION OF GOVERNMENT SECURITY FORCES

31. The Project should make contingency plans for situations when mobilisation of government security forces may be required, such as – but not limited to – the following:

i. Workers quarantined in worker accommodation camps become violent and/or wish to break out.

ii. The works are scaled down or stopped and there is social unrest amongst local workers who wish to continue working.

iii. There is a need to prevent the site's facilities from being occupied illegally following the stopping of works and demobilisation of project workers and management.

iv. There is social unrest in the surrounding communities with project workers from other regions and overseas stigmatised by local communities who perceive them as bringing the COVID-19 virus to their communities.

D. Decision Processes for Project Continuity

D.1 DECISION-MAKING FRAMEWORK

32. The Project Owner should adhere to decisions taken by, and instructions from, authorities and will stop or scale-down works and isolate workers if required.

33. The Project Owner assisted by the Owners' Engineer and the Contractor(s) should (i) assess the project's management capacity for COVID-19 response (including its own capacity and that of the Owner' Engineer and Contractor(s) capacities), (ii) assess the context risk and project risk, and (iii) determine the project's risk profile. Based on the findings of the assessments, the Project Owner should decide on the best way forward and advise the Owners' Engineer and Contractor(s) and which may be the continuation, partial stopping or stopping of works and restarting of any works that have been stopped when COVID-19 situation is brought under control. The Project Owner may delegate certain tasks in the decision-making process to the Owners' Engineer. The decision-making process will be undertaken in coordination with the Owners' Engineer and the Contractor(s).

34. The decision-making framework should be document in the Project Continuity Plan (see section [H.1]).

D.2 CONTINUATION OF WORKS

35. The Project Owner may decide to continue with project works as planned before the COVID-19 outbreak. This way forward will be adopted in the following situations:

i. Local and national authorities allow the continuation of the works, and

ii. The project's management capacity for COVID-19 response is judged by the Project Owner to be sufficient to manage the context and project risks, or that it can be strengthened in a time frame compatible with the expected development of the pandemic.

36. The Contractor should strengthen its management capacity for COVID-19 response if required by the Project Owner, and this may include actions such as preparing a COVID-19 response plan (see [H.1]) and implementing prescriptions provided in this document.

37. During the continuation of works the Project Owner, assisted by the Owners' Engineer and Contractor(s) will monitor the COVID-19 situation at national, region and project level, and re-evaluate the project's management capacity for COVID-19 response. If necessary, the Project Owner should advise to scale down or stop works.

D.3 SCALE DOWN OF WORKS

38. The Project Owner may decide to scale down works. This way forward will be adopted in the following situations:

i. Local and national authorities allow the continuation of the scaled down works, and

ii. The project's management capacity for COVID-19 response is judged by the Project Owner to be sufficient to manage the risk for scaled-down works (but not for full works), or that it can be strengthened for scaled-down works in a time frame compatible with the expected development of the pandemic on a local scale.

39. The Contractor will strengthen its management capacity for COVID-19 response as required by the Project Owner, and this may include actions such as preparing a COVID-19 response plan (see [H.1] and implementing prescriptions provided in this document.

D.4 TEMPORARY STOPPING OF WORKS WITHOUT DEMOBILISATION OF WORKFORCE

40. The Project Owner may decide to temporarily stop works but without worker demobilisation. This way forward will be adopted in the following situations:

i. Local or national authorities have instructed the Project Owner to stop works, or new national legislation is in force that requires works to stop, and there are travel restrictions that prevent the workers from outside the region (or from overseas) returning to their homes.

ii. The project's management capacity for COVID-19 response is judged by the Project Owner to be insufficient to manage the context and project risks – thus requiring works to be stopped, but that the management capacity can be strengthened allowing works to restart in a suitable time frame that avoids the need to demobilise the workforce.

41. The Contractor should stop works and instruct local workers to stay at home. Workers from outside the region or from overseas that are accommodated at worker accommodation camps will remain at the worker camp(s). The remuneration of workers "furloughed" in this manner should be maintained as described in Section [G.3].

42. If required by the Project Owner, the Contractor should strengthen its management capacity for COVID-19 response, and this may include actions such as preparing a COVID-19 response plan (see [H.1]) and implementing prescriptions provided in this document.

43. The Project Owner, assisted by the Owners' Engineer and Contractor(s) will monitor the COVID-19 situation at national, region and project level, and re-evaluate the project's strengthened management capacity for COVID-19 response.

44. When authorities/legislation allows works to restart and/or the management capacity for response is judged to be sufficient, the Project Owner may instruct the Contactor to restart works.

D.5 STOPPING OF WORKS WITH DEMOBILISATION OF WORKFORCE

45. The Project Owner may decide to stop works and demobilise workers. This way forward will be adopted in the following situations:

i. Local or national authorities have instructed the Project Owner to stop works, or new national legislation is in force that requires works to stop, and there are no travel restrictions that prevent the workers from outside the region (or from overseas) returning to their homes.

ii. The project's management capacity for COVID-19 response is judged by the Project Owner to be insufficient to manage the context and project risks – thus requiring works to be stopped, and that the management capacity cannot be strengthened in a suitable time frame that avoids the need to demobilise the workforce.

46. The Contractor should stop works and instruct local workers to stay at home. Workers from outside the region or from overseas that are accommodated at worker accommodation camps will return to their home regions/countries. The remuneration of workers "furloughed" or whose contracts are terminated should align with prescriptions provide in Section [G.3].

47. If required by the Project Owner, the Contractor should strengthen its management capacity for COVID-19 response, and this may include actions such as preparing a COVID-19 response plan (see [H.1]) and implementing prescriptions provided in this document.

48. The Project Owner, assisted by the Owners' Engineer and Contractor(s) will monitor the COVID-19 situation at national, region and project level, and re-evaluate the project's strengthened management capacity for COVID-19 response.

49. When authorities/legislation allows works to restart and/or the management capacity for response is judged to be sufficient, the Project Owner may instruct the Contactor to remobilise workers and restart works.

D.6 RESTARTING OF WORKS

50. After a period of scaled-down or stopped works, the Project Owner in coordination with the Owners' Engineer and Contactor(s) may decide to restart works. This decision will be taken in the following situations:

i. Local or national authorities, or new national legislation, allow works to restart, and the Project can implement any measures required by the authorities/legislation.

ii. The project's management capacity for COVID-19 response is judged by the Project Owner to be sufficient to manage the context and project risks.

51. The Contractor should mobilise any workers that were demobilised and restart works in a time frame that will be agreed with the Project Owner.

E. Prevention of Transmission of COVID-19 at the Project Site(s)

52. The Contractor(s) should document in the COVID-19 Response Plan (see section [H.2]) the processes for implementing the adopted prescriptions from sections [E.1] to [E.11] below.

E.1 PROVIDE EMPLOYEES WITH INFORMATION ON COVID-19

53. The Project Owner and Owners' Engineer should seek regular updates on COVID-19 management from national health authorities and the WHO and advise the Contractor(s) on good practices for preventing COVID-19 transmission. The Contractor should develop and provide information to project workers on these good practices, particularly observing recommendations on social distancing, and for training workers to recognize the symptoms of COVID-19 and understand their required response. Information about COVID-19 used by the project should always originate from the World Health Organization (www.who.int) and from national health authority websites.

54. The Contractor should ensure there is no discrimination against, or stigmatization of workers affected by COVID-19 or their families (see section [G.5]).

55. The Contractor should ensure that the COVID-19 transmission prevention measures do not cause additional or incremental increase in existing worker and community health and safety risks or impair existing health and safety measures.

56. The Contractor should inform its workers of the contact details of the company's on-site COVID-19 focal point and communication channels for workers to raise concerns on an ongoing basis; and ensure that such channels are operational.

57. The Owners' Engineer and the Contractor(s) should be able address the Frequently Asked Questions provided in [K] (Annex – Template for FAQ for Workers), and ensure that updated information is available and understandable to all the project staff.

58. The Contractor should organise regular awareness and tool-box sessions with workers on COVID-19 risk management at the worksite(s) and include COVID-19 risk on the agenda of general (daily or weekly) EHS meetings. At the beginning of each working shift, the incoming team should participle to a short COVID-19 awareness meeting to:

i. Remind the workers of the potential presence of the virus on surfaces and the risk of transmission within the team and with third parties.

ii. Monitor the evolution of the team's physical, mental, moral state, family, relatives.

iii. Remind the workers of the general precautions: social distancing, use of PPE (see section [E.9]) and ensure that sufficient PPE is available.

iv. Organize the management of waste (masks, gloves, handkerchiefs, rubbish bins).

v. Remind workers on the specific health precautions to be taken.

E.2 MINIMISE TRAVEL AND SELF-ISOLATION ON ARRIVAL AT SITE

59. The Contractor should reduce national and international travel to only the absolute minimum during the Pandemic. The Contractor should consider mobilising only those workers that are necessary for the continuation of the project. Where travel is essential, relevant travel restrictions should be observed. Unless travel is medical evacuation, persons who travel should not have any COVID-19 symptoms and have not been in contact with COVID-19 patients within the period recommended by relevant authorities (WHO recommends 14 days).

60. Workers coming from or passing through countries/regions with cases of the virus should not return if displaying symptoms and should self-isolate for 14 days following their return. The Contractor will make provisions to manage self-isolation as follows:

i. Workers should be provided with a single room that is well-ventilated (i.e., with open windows and an open door). If a single room is not available for each worker, adequate space should be provided to maintain a distance of at least 2 m and a curtain to separate workers sharing a room. Men and women should not share a room. A dedicated bathroom should be provided for the isolation facilities and there should be separate bathroom facilities for men and women.

ii. Workers in self-isolation should limit their movements in areas which are also used by unaffected workers (shared areas) and avoid using these areas when unaffected workers are present. Where workers in isolation need to use shared spaces (such as kitchens/canteens), arrangements should be made for cleaning prior to and after their use of the facilities. The number of staff involved in caring for those in isolation, including providing food and water, should be kept to a minimum and appropriate PPE should be used by those staff.

iii. At a minimum, isolation areas should be cleaned daily and healthcare professionals should visit workers in the isolation areas daily. Cleaners and healthcare professionals should wear appropriate PPE and ensure good hygiene when visiting workers in isolation.

iv. Visitors should not be allowed until the worker has shown no signs and symptoms for 14 days.

E.3 UNDERTAKE HEALTH CHECKS AND POTENTIALLY INFECTED WORKERS TO STOP WORK

61. The Contractor should put in place processes to prevent potentially infected employees who are accommodated at their homes outside the project site boundary from entering the project site(s) and infecting co-workers. The Contractor should require that workers stay away from work in cases where they exhibit any COVID-19 symptoms or have been in close contact with a confirmed COVID-19 patient during the previous 14 days. Workers who do not feel well should seek immediate medical advice.

62. The Contractor should put in place (any necessary) processes , which may be temporary, to ensure that potentially sick staff continue to be remunerated (see section [G.3]) and do not feel pressured to attend work, thereby risking transmitting the virus to the rest of the workforce.

63. The Contractor should develop a short workers' health questionnaire using guidance from the WHO (if and when available) and guidance (if available) from national health authorities and to address country specific context and risks. Workers should only report to work if they answer "no" to all the questions. The following is an example of the types of questions and is not exhaustive:

i. Have you, in the last two weeks, been in close contact with a person who has COVID-19?

ii. Have you, in the last two weeks, been in a country/region with a high number of cases of COVID-19?

iii. Do you have a fever?

iv. Have you used medications such as paracetamol or aspirin to suppress fever in the last 24 hours?

v. Are you coughing (even mildly)?

vi. Do you currently experience shortness of breath?

64. The Contractor should follow WHO recommendations and not take the temperature of workers at the entrance to the project site(s) as equipment may be unreliable, body temperature is not an accurate indicator of the presence of the virus, and taking body temperature may be a source of transmission of the virus.

65. The Contractor should ensure, where possible, that staff have adequate access to medical consultation, in case they encounter symptoms and keep records (see section [I.2]).

66. The Contractor should respect the workers' privacy and put in place a system with numbers instead names to identify the workers and guaranty the confidentiality in all aspects, especially for medical data, tracking of persons met in the last 48 hours.

E.4 COUGH HYGIENE

67. The Contractor will put in place hygiene practices to prevent the spread of the virus by infected persons coughing and sneezing. Workers should be instructed to follow the cough etiquette outlined below to reduce these risks:

i. Mouth and nose are to be covered with a tissue when coughing or sneezing and the tissue disposed of in a wastebasket equipped (if possible) with a (pedal operated) lid.

ii. When no tissue is available, workers are to cough or sneeze into the upper sleeve or elbow, not into their hands.

iii. Clean hands after coughing or sneezing, preferably by thorough water-soap handwashing, following the recommendations of health organizations. If soap and water are not available, use a hand sanitizing gel.

68. The Contractor should ensure that workers are well informed on the risks related to coughing and sneezing and cough hygiene measures. It should provide enough water-soap handwashing facilities in all workplaces and provide disposable tissues and rubbish bins. It should encourage people to speak up if they encounter nonconforming behaviour.

E.5 SOCIAL DISTANCING

69. To prevent person-to-person infection, the Contractor should put in place processes to minimize direct contact as much as possible. Where people are regularly working or meeting, a safe distance of 1 metre between people should be observed.

70. The Contractor should identify all places where people normally work closer than 1 metre from each other. Adjust workplace design and work processes to minimize this likelihood as much as possible, and PPE is to be used as described section [E.9]. Examples to be considered include:

i. For stationary workplaces, such as offices, meeting rooms, etc., indicate safe distances by, for example, placement of chairs or markings on the floor.

ii. Place markers on the floor, indicating safe distances, where people commonly wait, for example site entrance control areas, canteens, and so forth.

iii. Inform people about the hazards of close contacts, including with direct co-workers, and promote alternative behaviours, such as maintaining safe distances and using alternatives for handshakes.

iv. Postpone nonessential social events, especially for groups larger than 10 persons or as indicated by relevant authorities.

v. Consider establishing alternating workdays or adding extra shifts to reduce the total number of employees in a facility at a given time, allowing them to maintain the recommended distance from each other, while maintaining a full onsite work week.

71. The Contractor should put in place processes to manage situations where it is not possible or safe for workers to distance themselves from each other by 1 metre by adopting the following general principles where they can be applied without compromising existing health and safety practices:

i. Non-essential physical work that requires close contact between workers should not be carried out.

ii. Work requiring skin to skin contact should not be carried out.

iii. Plan all other work to minimise contact between workers.

iv. PPE should be used as described in section [E.9].

v. Re-usable PPE should be thoroughly cleaned after use and not shared between workers.

vi. Single use PPE should be disposed of so that it cannot be reused.

vii. Stairs should be used in preference to lifts or hoists.

viii. Where lifts or hoists must be used: (a) lower their capacity to reduce congestion and contact at all time, and (b) regularly clean touchpoints, doors, buttons etc.

ix. Increase ventilation in enclosed spaces.

x. Regularly clean the inside of vehicle cabs and between uses by different operators.

72. The Contractor will put in place process for social distancing during site meetings, such as the following:

i. Only participants that are absolutely necessary should attend meetings.

ii. Attendees should be 2 metres apart from each other.

iii. Rooms should be well ventilated / windows opened to allow fresh air circulation

iv. Consider holding meetings in open areas where possible.

73. The Contractor should ensure the minimum distance of 1 m between people in project vehicles, i.e. 1 person per row maximum and staggered if several rows. If this is impossible workers may travel together when wearing protection masks and limiting the number of people in the vehicle:

i. For a 3-seater vehicle: 2 employees.

ii. For a 5-seater vehicle: 4 employees.

iii. For a 6-seater vehicle: 4 employees.

iv. For a 9-seater vehicle: 6 employees.

E.6 HAND SANITATION

74. The Contractor should promote frequent water-soap handwashing amongst workers to prevent spread of the infection. WHO recommends rinsing and washing hands with soap for at least 20 seconds, rinsing again, and then using paper, such as a paper towel, when turning off taps. Only disposable (paper) towels or air dryers are to be used. Shared hand towels should not be used.

75. The Contactors should provide enough places for employees to wash their hands. If soap and running water are not immediately available, alcohol-based hand rubs containing at least 60% alcohol should be provided. The Contractor should ensure that these facilities are sufficient in number and are available close to work area.

E.7 CLEANING AND DISINFECTING WORK AND COMMUNAL AREAS

76. The Contractor, should procure the following to carry out cleaning and disinfecting:

i. Bleach disinfectant diluted to 5%, alcohol at 70 ° (e.g. Anios Oxy'floor®).

ii. Disinfectant wipes (for door handles, computer keyboard, toilet seats, vehicles, machines, tools, etc.…).

iii. Soap.

iv. Disposable hand towels.

v. Pedal bins with lids for disposing of hygiene consumables after use.

vi. Garbage bags.

vii. Usual work gloves.

viii. Disposable gloves for handling rubbish bins and for cleaning/disinfection.

ix. In the absence of a water point at the workplace, water containers clearly marked "hand wash water".

x. Gel or hydroalcoholic solution (in addition, if available).

77. Using suitable cleaning/disinfecting agents, the Contractor should put in place processes and resources to clean and disinfect touched surfaces, at least daily, to prevent the spread of the virus. Examples of touched surfaces include tables, doorknobs, handrails, light switches, appliances, countertops, handles, desks, phones, keyboards, toilets, taps, sinks, and so forth.

78. The Contractor should ensure that enough cleaning staff is available and should check that the cleaning/disinfecting is carried out correctly.

79. The Contractor should instruct workers to clean where possible touched surfaces at their work areas at the end of each shift and provide equipment and instructions on how to do this.

80. The Contractor should provide disposable wipes so that commonly used surfaces (for example, doorknobs, keyboards, remote controls, and desks) can be wiped down by workers before and after each use.

81. The Contractor should provide suitable personal protective equipment (PPE) to personnel performing the cleaning activities and instruct them to follow the manufacturers' instructions.

E.8 FOOD PREPARATION

82. The project should put in place processes to manage kitchen and canteen staff and the risk of COVID-19, including (but not limited to) the following:

i. In case of COVID-19 cases in the project area, the use of the canteen and kitchen should be avoided (local workers should bring their own meals, bottles of water) if not possible, the use of the canteen should be reduced to a minimum number of persons. However, this does not apply to the project's worker accommodation camp.

ii. Staff should not report to work if they have COVID-19 symptoms or have been in close contact with a confirmed COVID-19 patient, and any food he/she has been in contact with should be thrown away.

iii. Staff should be trained in common food safety practices including changing clothes and washing hands each time before entering the kitchen area.

iv. Staff should be trained in how to safely put on and use PPE by medical staff, and necessary hygiene (including hand washing) prior to, during and after handling food and kitchen material.

v. Kitchen clothes should not be used outside the kitchen. A changing room with a handwashing facility and lockers (gender separated when possible) should be available. Work clothes should be washed at a minimum of 72°C daily.

vi. Staff should not be involved in any cleaning or disinfection activities outside the food preparation and dining areas.

vii. Cross contamination caused by people sharing the same serving spoons should be avoided. This can be achieved by avoiding buffet-style food presentation and serving food by the kitchen staff or present food on individual serving plates.

viii. Workers should wash their hands with soap prior to entering the canteen area.

E.9 PERSONAL PROTECTIVE EQUIPMENT

83. The Contractor should procure Personal Protective Equipment (PPE) by its employees:

i. Type 1 non-sanitary mask (filtration ≥90%, type FFP1 or similar).

ii. Type II surgical mask.

iii. Helmet face shields, descending at least 3 cm below the chin.

iv. Gloves, goggles, aprons.

v. Body temperature monitoring devices.

84. The Contractor should put in place process to ensure that workers and health care staff are trained to use PPE correctly and how to clean/disinfect reusable PPE and dispose of single-use PPE.

85. The Contractor should put in place processes regarding the mandatory use of PPE by its employees (permanent staff and contracted staff) as follows:

i. When working within 1 metre of another person, workers should wear a type 1 non-sanitary mask or a mask with superior protection.

ii. When in contact with a person potentially with COVID-19, workers should wear a type II surgical mask and the potential/confirmed sick person (and his/her entourage) must also wear a type II surgical mask.

iii. When in contact with a potentially vulnerable person (older people, pregnant women, and those with underlying medical problems), workers should wear a type 1 non-sanitary mask or a mask with superior protection.

iv. In other cases, wearing a mask is not compulsory but this should be reviewed as the pandemic evolves.

v. Wearing standard work gloves and glasses is recommended.

E.10 WORKERS ACCOMMODATION

86. The Contractor should apply the prescriptions provided in [E4]-[E9] above to worker accommodation facilities and also endeavor to implement the following additional measures:

i. Prevent infected persons from entering workers' accommodations areas, and if applicable or necessary, quarantine these persons per local regulations and/or recommendations from relevant international organizations.

ii. Promote, respect, and enforce the occupancy density limits in workers' accommodations.

iii. In case new staff is arriving from countries or areas with a high risk of COVID-19, ensure that these persons are adequately quarantined per local regulations and/or recommendations from relevant international organizations.

iv. Wherever possible, the housing coordinator or the person(s) in charge of managing the accommodations should coordinate taking daily recordings of residents' temperatures. Note: Use a thermometer that prevents cross contamination, and that protects the person taking residents' temperatures from possible infection.

v. When accommodations contain people at high risk of developing fatal complications from COVID-19, consider providing them with separate housing. In this context persons aged 65 years or older, or those with high blood pressure, heart disease, lung disease, cancer, or diabetes, are considered at high risk.

vi. Ensure that all workers have access to medical professionals. Remove any language barriers.

vii. Handwashing soap should be made available for the workers in all bathrooms. Everyone should follow a strict cleaning and housekeeping routine daily.

viii. Doorknobs, taps, TV sets / media equipment, kitchen equipment, controls, buttons, and any other object in common areas that are regularly touched must be cleaned several times per day. Frequency is to be determined by each facility.

ix. Common surfaces, including ones in vehicles transporting workers from their accommodations to the workplace, counters, floors, and walls, should be treated as potentially contaminated and be cleaned regularly as described above.

x. Bed linen should be washed at 72°C at least once per week.

xi. Clean/replace Air Conditioning filters at least monthly.

xii. Minimize the number of people in a room and increase, as far as possible, the distance between beds to over 2 metres.

xiii. Maximise natural or forced ventilation within the limitations of comfort, security, and privacy. Consider changes in the facility to allow for ventilation during working hours.

xiv. Allow or prepare additional accommodations for workers who are stranded due to travel restrictions and who cannot be repatriated.

xv. Consider suspending or forgoing any rent or other charges which are paid by workers in case they have to increase the time spend in the life camp due to COVID-19 circumstances.

xvi. Determine whether workers can safely remain in the accommodation camp even if they are not currently at work due to long-term sickness, furloughing, or transfer to emergency response work.

xvii. Consider limiting access of non-essential staff and visitors depending on the level of risk in the specific country/area.

xviii. Restrictions, including a limitation of visitors and prohibition of going outside the project area, should be carefully explained in advance to the workers and alternative measures to provide contact with family/friends, e.g. phone or Skype calls, should be introduced.

xix. Depending on the level of risk in the specific country/area, access of non-essentials shared areas (i.e. sport room, TV room, spiritual room, e.g.) should be prohibited or restricted to a minimal number of persons.

xx. Consideration should be given to measures such as distributing food in rooms instead of a common canteen; or splitting out-of-room time, which could be divided by life camp zone/room to avoid concentration of workers even in open spaces.

xxi. The psychological impact of these measures needs to be considered and mitigated as much as possible, and basic emotional and practical support for affected people in life camp should be available.

E.11 PROJECT SITE ACCESS POINTS

87. The Contractor should put in place processes to carry out the following at the entrance to project site(s):

i. Stop all non-essential visitors.

ii. Introduce staggered start and finish times to reduce congestion and contact at all times.

iii. Monitor site access points to enable social distancing – you may need to change the number of access points, either increase to reduce congestion or decrease to enable monitoring.

iv. Remove or disable entry systems that require skin contact e.g. fingerprint scanners.

v. Require all workers to wash or clean their hands before entering or leaving the site.

vi. Allow plenty of space (two metres) between people waiting to enter site.

vii. Regularly clean common contact surfaces in reception, office, access control and delivery areas e.g. scanners, turnstiles, screens, telephone handsets, desks, particularly during peak flow times.

viii. Reduce the number of people in attendance at site inductions and consider holding them outdoors wherever possible.

ix. Drivers should remain in their vehicles if the load will allow it and must wash or clean their hands before unloading goods and materials.

x. If the project's health facilities are providing health care to potentially COVID-19 infected workers and/or their families a special way of access should be put in place to allow the access to the health facilities without direct contact with project's staff or infrastructures.

F. Management of COVID-19 Cases Amongst Project Workers

88. The Contractor(s) should document in the COVID-19 Response Plan (see section [H.2]) the processes for implementing the adopted prescriptions from sections [88] to [F.7] below.

F.1 PREPARATION

89. The Contractor should put in place processes to ensure that workers from local communities who are living at their homes nearby should stop work, stay at home and seek medical advice/assistance from local health services if they show signs of COVID-19 (or suspect they have been in contact with a person with COVID-19) (see [E.2]).

90. The Contractor should put in place processes to manage workers from other regions of the country (including migrant workers), overseas workers and international staff if they show signs of COVID-19 (or suspect they have been in contact with a person with COVID-19). This could entail the following:

i. Infected workers from other regions and overseas workers remain at the project's worker accommodation in self-isolation and receive health care provided by the project (see [F.2] below).

i. Infected workers from other regions and overseas workers are transferred to local/regional hospitals (see [F.5] below).

ii. Workers with confirmed or suspected COVID-19 should be checked-on to ensure they are meeting required timeframes for self-isolation, quarantine, and meeting return-to-work requirements after illness recovery.

iii. Infected international staff with prior medevac arrangements are transferred to in-country hospital facilities or medically evacuated to their home country as per their medivac arrangements if national/international travel is authorised (see [F.6] below).

iv. Establishing with national and international authorities any special situation when workers with COVID-19 can return to their home region or country and establish measures to be taken to prevent the transmission of the virus to others during the travel.

91. In coordination with the Project Owner and Owners' Engineer, the Contractor should prepare for the management of cases of infected workers from overseas or from other regions of the country that cannot return to their homes. This should include – but not be limited to – the following:

i. Prepare on-site health care facilities for checking the health of employees and providing health care of employees. If necessary, on-site health care should be strengthened, and contingency plans for the rapid recruitment of additional cleaning and health staff prepared.

ii. Prepare on-site accommodation to enable isolation of infected workers and prepare contingency plans for the rapid recruitment of additional staff to manage the accommodation facilities.

iii. Coordinate with local/regional health authorities to plan for transfer of workers showing severe signs of COVID-19 to local/regional hospitals (see [C.2]).

iv. Put in place processes to maintain the payment of salaries of the workers (see section [G.3]).

92. The Contractor should ensure that medical staff at the facilities are trained and kept up to date on WHO advice and recommendations on the specifics of COVID-19. They should take stock of the equipment and medicines that are present on site and ensure that there are good supplies of any necessary treatments, including paracetamol/acetaminophen. It should be ensured that medical facilities are stocked with adequate supplies of medical PPE, as a minimum: (i) gowns, aprons, (ii) medical masks (if possible) some respirators (N95 or FFP2), gloves, and eye protection (goggles or face screens).

93. The Contractor should ensure that cleaners are provided with PPE and disinfectant. Minimum PPE to be used when cleaning areas that have been or suspected to have been contaminated with COVID-19 is: (i) gowns, aprons, (ii) medical masks, (iii) gloves, (iv) eye protection (goggles or face screens), and (iv) boots or closed work shoes.

F.2 ON-SITE HEALTH CARE

94. The Contractor should make provisions for the accommodation and provision of health care for overseas workers and workers from other regions that are infected with COVID-19 and that cannot return to their homes. Workers from local communities should also be able to benefit from the health care facilities if local health services are inexistent or cannot provide care. Such patients should be provided with good care in an isolated area under medical supervision. The management of the health care facility should align with best practice, including the following:

i. Health care should always be provided by qualified medical professionals in accordance with local regulations.

ii. Patient should be placed in a well-ventilated single room.

iii. The number of health carers for each patient should be limited, ideally assign one person who is in a good health without risk conditions. There should be no visitors.

iv. The movement of patients should be limited and shared spaced minimised. Ensure that shared spaces (e.g. bathroom) are well ventilated (e.g. keep windows open).

v. Health carers should wear appropriate PPE and as a minimum, medical masks (see section [E.9]).

vi. Gloves, tissues, masks and other waste generated by ill persons or in the care of ill persons should be placed in a lined container (with a lid) in the ill person's room before disposal with other health care waste.

vii. Touched surfaces such as bedside tables, bedframes, and bedroom furniture should be cleaned and disinfected daily.

viii. Clean clothes, bedclothes, bath and hand towels, etc. of ill persons using regular laundry soap and water or machine wash at 70°C with detergent, and dry thoroughly. Place contaminated linen into a laundry bag. Do not shake soiled laundry and avoid direct contact of the skin and clothes with the contaminated materials.

ix. Persons with symptoms should remain in isolation until their symptoms are resolved based on either clinical and/or laboratory findings.

x. Prescriptions detailed in [F.3] and [F.4] regarding toilets, sanitary and domestic wastewater and healthcare waste.

F.3 HEALTH CARE FACILITY TOILETS AND SANITARY & DOMESTIC WASTEWATER

95. The Contractor should provide sufficient safe drinking-water to staff, caregivers, and patients for personal hygiene, laundering, toilets (including separate facilities for confirmed and suspected cases of COVID-19 infection).

96. The Contractor should provide toilet facilities as follows:

i. Workers with suspected or confirmed COVID-19 disease should be provided with their own properly functioning flush toilet or latrine with a lid and that has a door that closes to separate it from the patient's room. If it is not possible to provide separate toilets, the toilet should be cleaned and disinfected at least twice daily.

ii. Staff and health care workers should have toilet facilities that are separate from those used by all patients.

iii. Standard, well-maintained plumbing, such as sealed bathroom drains, and backflow valves on sprayers and faucets should be used to prevent aerosolized faecal matter from entering the plumbing or ventilation system, together with standard wastewater treatment.

iv. If health care toilet 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.

v. For smaller health care facilities in low-resource settings, if space and local conditions allow, pit latrines may be the preferred option. Precautions should be taken to prevent contamination of the environment by excreta: (a) Ensuring that at least 1.5 m exists between the bottom of the pit and the groundwater table (more space should be allowed in coarse sands, gravels, and fissured formations), (b) latrines are located at least 30 m horizontally from any groundwater source, (c) If there is a high groundwater table or a lack of space to dig pits, excreta should be retained in impermeable storage containers and left for as long as feasible to allow for a reduction in virus levels before moving it off-site for additional treatment or safe disposal, or both; (d) a two-tank system with parallel tanks would help facilitate inactivation by maximizing retention times, as one tank could be used until full, then allowed to sit while the next tank is being filled.

97. The Contractor should instruct health care workers on health practices for dealing with excreta from workers with COVID-19, including the following:

i. If the patient is unable to use a latrine, excreta should be collected in either a diaper 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. Faeces must be treated as a biohazard and handled as little as possible.

ii. Anyone handling faeces should use PPE to prevent exposure, including long-sleeved gowns, gloves, boots, masks, and goggles or a face shield.

iii. If diapers are used, they should be disposed of as infectious waste as they would be in all situations.

iv. 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.

v. If a bedpan is used, after disposing of excreta from it, the bedpan should be cleaned with a neutral detergent and water, disinfected, and then rinsed with clean water; the rinse water should be disposed of in a drain or a toilet or latrine.

vi. When handling or transporting excreta offsite, great care should be taken to avoid splashing.

vii. Where there is no off-site treatment, in-situ treatment can be done using lime. Such treatment involves using a 10% lime slurry added at 1-part lime slurry per 10 parts of waste.

98. The Contractor should establish cleaning and disinfection procedures for health care facilities, including the following:

i. Laundry should be done and surfaces in all environments in which COVID-19 patients receive care should be cleaned at least once a day and when a patient is discharged.

ii. 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.

iii. 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 70°C with laundry detergent is recommended. 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 sunlight.

iv. If excreta are on surfaces (such as linens or the floor), the excreta should be carefully removed with towels and immediately safely disposed of in a toilet or latrine. If the towels are single use, they should be treated as infectious waste; if they are reusable, they should be treated as soiled linens. The area should then be cleaned

and disinfected (with, for example, 0.5% free chlorine solution), following published guidance on cleaning and disinfection procedures for spilled body fluids.

v. Install a disinfectant shoe bath at the exit to the health care building or at the exit of areas where COVID-19 patients are accommodated.

99. The Contractor should establish processes for safely disposing of greywater or water from washing PPE, surfaces and floors, including the following:

i. Utility gloves or heavy duty, reusable plastic aprons are washed with soap and water and then decontaminated with 0.5% sodium hypochlorite solution after each use.

ii. Single-use gloves (nitrile or latex) and gowns should be discarded after each use and not reused.

iii. 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 soakaway pit. If greywater is disposed of in a soakaway 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.

F.4 HEALTH CARE WASTE

100. The Contractor should put in place processes to enforce good hygiene practices in relation health care waste; individuals should dispose of used handkerchiefs, masks and gloves in dedicated, resistant plastic bags with a functional closure system. This bag must be carefully closed and kept for 24 hours before being placed in the plastic rubbish bag. Used handkerchiefs, masks and gloves should not be disposed of with recyclable waste (packaging, paper, cardboard, plastics).

101. The Contractor should make provisions for segregating and safely disposing of health care waste in alignment with best practices such as the following:

i. Assign responsibility and sufficient human and material resources to dispose of such waste safely.

ii. All health care waste produced during the care of COVID 19 patients should be collected safely in designated containers and bags, treated, and then safely disposed of or treated, or both, preferably on-site.

iii. If waste is moved off-site, it is critical to understand where and how it will be treated and destroyed.

iv. All who handle health care waste should wear appropriate PPE (boots, apron, long-sleeved gown, thick gloves, mask, and goggles or a face shield) and perform hand hygiene after removing it.

F.5 TRANSFER OF INFECTED PROJECT WORKERS TO HOSPITALS

102. The Contractor should put in place processes for transferring workers from other regions (including migrant workers) and overseas workers with COVID-19 to local or regional hospitals. It can be expected that infected workers will need to be transferred in the following situations:

i. The infected worker is showing severe symptoms of COVID-19 requiring medical attention that cannot be provided by the project.

ii. The infected worker has underlying chronic conditions such as lung or heart disease, renal failure, or immunocompromising conditions that place him/her at increased risk of developing complications.

iii. The project health care facilities are saturated and cannot deal with new cases.

103. The Contractor will put in place processes to manage the transport of infected workers to hospitals, and covering the following aspects:

i. Admittance arrangements prior to transport of the infected worker to the hospital.

ii. Means of transporting the infected worker to the hospital.

iii. Protection and cleaning/disinfecting measures taken by the project health carers assisting the patient during the transfer.

F.6 EXPATRIATE STAFF WITH PRIOR MEDEVAC AGREEMENTS

104. The Contractor should liaise with medevac service providers to facilitate the medical evacuation.

F.7 MANAGEMENT OF DEATHS AT PROJECT SITE(S)

105. The Contractor should put in place processes for the management of any deaths from COVID-19 that may occur at the project site(s) and prepare processes so that the deceased is managed in an appropriate manner, such as the following:

i. Authorities should manage each situation on a case-by-case basis, balancing the rights of the family, and the risks of exposure to infection.

ii. The safety and well-being of everyone who tends to bodies should be the priority. Before attending to a body, people should ensure that the necessary hand hygiene and PPE supplies are available.

iii. The dignity of the dead, their cultural and religious traditions, and their families should be respected and protected throughout.

iv. Hasty disposal of a dead from COVID-19 should be avoided.

106. The Contractor should liaise as appropriate with local/regional/national and international authorities to best manage the burial (or cremation) of project workers who have died at the project site(s) and who are from outside the region or from another country.

107. The Contactor should take precautions when preparing and packing the body for transfer from a patient room to an autopsy unit, mortuary, crematorium, or burial site. Personnel who interact with the body should apply standard precautions including hand hygiene before and after interaction with the body, and the environment and use appropriate PPE, including a gown and gloves and if necessary facial protection such as face shield or goggles and medical mask. The body should be wrapped in cloth and transferred as soon as possible to the mortuary area. There is no need to disinfect the body before transfer to the mortuary area, and body bags are not usually necessary.

108. The Contractor should manage the personal items that belonged to the deceased person in alignment with any instructions from local authorities and in an appropriate manner. If the belongings are to be returned to the deceased family the following should be undertaken:

i. The belongings should be handled with gloves and cleaned with a detergent followed by disinfection with a solution of at least 70% ethanol or 0.1% (1000 ppm) bleach.

ii. Clothing and other fabric belonging should be machine washed with water at a minimum of 70°C and laundry detergent. 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 sunlight.

G. Management of Community Health Risks

109. The Project Owner should document in the Project Continuity Plan (see section [H.1]) the processes for implementing the adopted prescriptions from sections [109] to [G.11] below.

110. The Contractor(s) should document in the COVID-19 Response Plan (see section [H.2]) the processes for implementing the adopted prescriptions from sections [109] to [G.11] below.

G.1 GENERALITIES

111. The Project should operate in a responsible manner, coordinate with local and national authorities and implement preventive measures where possible for aspects where the project activities may be a source of community exposure to COVID-19. To this end, the project should put in place processes to ensure compliance with World Bank requirements regarding community exposure to health issues as set out in the Bank's Environmental and Social Framework - Community Health and Safety (ESS4):

i. Avoid or minimize the potential for community exposure to (...) communicable and non-communicable diseases that could result from project activities, taking into consideration differentiated exposure to and higher sensitivity of vulnerable groups.

ii. Avoid or minimize transmission of communicable diseases that may be associated with the influx of temporary or permanent project labour.

112. In this document, communities are considered "local communities" when the community:

i. Provides workers to the project.

ii. Provides services to the project (shops, markets, transport, bars, etc…).

iii. Shares services and resources with the project (water, waste storage or treatment, hospital).

iv. Has contact with project workers.

v. Includes people affected by the project, e.g. people affected by physical and economic resettlement.

G.2 PREVENTION OF PROJECT WORKERS PROPAGATING COVID-19 IN LOCAL COMMUNITIES

113. In this document "project workers" are considered to comprise the following worker categories as defined in the Word Bank Social and Environmental Framework (ESS2):

i. "Direct workers": People employed or engaged directly by the Project Owner to work specifically in relation to the project.

ii. "Contracted workers": People employed or engaged through third parties (Owners' Engineer and the Contractor(s)) to perform work related to core functions of the project, regardless of location. In this document "contracted workers" comprise "local workers" and "migrant workers". Local workers are mostly accommodated at their homes. Migrant workers are from other regions or from overseas are generally accommodated in the project worker accommodation camp(s), but there may be cases where migrant workers live in spontaneous informal settlements near the project site(s).

iii. "Primary supply workers": People employed or engaged by the project primary suppliers.

iv. "Community workers": People employed or engaged in providing community labour.

114. To prevent a project site becoming a centre for propagation of COVID-19 that can spread to the local communities, the Contractor (and Owners' Engineer as applicable) should put in place processes to ensure the following:

i. Prevent workers (of all categories - see above) who have, are suspected of having, or have been in contact with a person with COVID-19 from entering the project site(s) (see section [E.3]).

ii. Encourage contracted workers to be transparent about their eventual COVID-19 symptoms - and contact with others with symptoms - by continuing the remuneration of workers that are sick, quarantined, or furloughed (see section [G.3]) and preventing social stigma (see section [G.5]).

iii. Provide processes to manage contacted workers with COVID-19 at the project site(s), including isolation and health care for migrant workers that are accommodated in the project worker accommodation camp(s) (see section [F]).

iv. If possible, endeavor to provide isolation facilities and health care to migrant project workers who are living in spontaneous informal settlements around the project site(s).

115. The Contactor should put in place processes so that contracted workers can also protect their families from COVID-19 transmission, such as the following:

i. Inform contracted workers on early recognition of COVID-19 symptoms, basic precautions to be adopted, and which municipal/community health care facility the families of local contracted workers should go to.

ii. Provide soap, masks and hydroalcoholic solutions to families of local contracted workers.

iii. If there are suspected cases of COVID-19 at the project site(s) or in the surrounded communities, endeavor to test family members of contracted local workers for COVID-19.

iv. If local health services are lacking in capacity endeavor to give family members of local contracted workers access to project health care facilities and make access provisions to avoid contamination of project workers.

G.3 MAINTAINING SALARIES OF PROJECT WORKERS

116. The Contractor(s) (and Owners' Engineer as applicable) should put in place processes to "furlough" their permanent staff and contracted workers (including migrant workers) and continue paying their salary (or take advantage of any government schemes to pay salaries) when the person has been instructed by the project to stop work and is at home, in quarantine/isolation or in hospital because:

i. He/she has confirmed/suspected COVID-19 or has been in contact with a person with COVID-19.

ii. The Project Owner or authorities have decided to temporarily stop the project activities and put the workers in lockdown.

117. If the Project Owner decides to stop project activities and demobilise project workers, the Contractor(s) (and Owners' Engineer as applicable) should put in place processes to either transfer their permanent staff and contracted workers to other projects or to "furlough" them and continue paying their salary (or take advantage of any government schemes to pay salaries). Terminating the contracts of permanent staff and contracted workers should be avoided, but if necessary, should follow the mechanisms set out in employees' contracts and labour laws of the project country.

118. In situations where the Contractor has arranged with the local community for short-term assistance with labour intensive work and the Project Owner decides to stop works, the Contractor should agree with the Project Owner how to compensate the loss of community revenue. The Contractor may seek to make arrangements with the community leaders such as for the project to provide support to local communities (see section [G.7].

119. In situations where the Contractor has established individual (renewable) short-term contracts (<1 month) with local people, and the Project Owner decides to stop works, the Contractor should continue to pay the persons salary for the contract duration and the person should have access to the project's health care facilities for a period of time that is to be agreed with the Project Owner.

G.4 SUPPORT FOR VULNERABLE PROJECT WORKERS

120. COVID-19 may disproportionately impact vulnerable people and consequently project workers from the following groups are more at risk:

i. Casual, temporary, gig economy or informal workers may face elevated job insecurity, have less recourse to state protection mechanisms, and face literacy (or other) challenges when receiving COVID-19 related information.

ii. Older workers, workers with underlying health issues, and workers with disabilities may be more vulnerable to illness, may be a higher risk group for COVID-19 infection, and may already be subject to social stigma.

iii. Migrant workers may face added vulnerabilities due to greater reliance on the employer. Job loss may be accompanied by an inability to return home, to access state protection mechanisms, or to apply for alternative employment, and could lead to potential immigration law violations. Migrant workers may also face literacy or comprehension challenges when receiving COVID-19-related information.

iv. Women may face direct or indirect discrimination if workforce restructuring or dismissals are considered, for instance where women are overrepresented in noncore areas of a business. Added vulnerabilities may stem from additional unpaid responsibilities resulting from the traditional caregiving role of women, including risks of transmission to / from those in receipt of elder care. Also, there could be an increased risk of gender-based violence, including domestic and intimate partner violence due to reasons noted above. Pregnant women are also advised to take all preventive actions to avoid infection.

121. The Contractor (and the Owners' Engineer as applicable) should adopt measures to avoid or minimise disproportionate impact of COVID-19 on vulnerable contracted workers:

i. Consider developing additional policies for contracted workers who are considered as vulnerable (see item [120] above) or who may have caretaking responsibilities for individuals who fall under these categories.

ii. Consider how to identify the contracted workers who may be at risk (e.g. due to a pre-existing condition such as diabetes, heart and lung disease, or as a result of older age), and support them, without inviting stigma and discrimination into workplace.

iii. Vulnerable contracted workers should be given priority to access to the project's health care facilities, and the project's medical staff should be aware of the situation of these workers and prepared to address specials needs.

iv. Pregnant women, older workers, workers with underlying health issues, workers with disabilities should be instructed to stop work, stay at home or go into isolation at the project worker accommodation camp(s) (without loss of salary) if COVID-19 cases occur at the project site(s) or in local communities.

v. If the Project employs casual, temporary, gig economy, informal workers and migrant workers and can't continue to employ them because of a COVID-19 outbreak it should define criteria's to identify which workers are particularly dependent of the project income in order to guarantee them a minimal amount of money for food and health expenses in case that such dispositive is not already provided by the state. The project should communicate clear criteria to define the eligibility of such workers in order to avoid opportunism.

G.5 PREVENTION OF SOCIAL STIGMA

122. Social stigma in the context of health is the negative association between a person or group of people who share certain characteristics and a specific disease. In an outbreak, this may mean people are labelled, stereotyped, discriminated

against, treated separately, and/or experience loss of status because of a perceived link with a disease. Such treatment can negatively affect those with the disease, as well as their caregivers, family, colleagues and communities. The presence of international workers, especially if they come from countries with high infection rates, may also cause social tension between the foreign workers and local workers and communities. The presence of COVID-19 cases on the project can create tensions between local communities and workers from the project, even against workers from the local communities seen as contagious, and against the project perceived as a COVID-19 contamination source.

123. In order to prevent social stigma, the Project Owner, assisted by the Owners' Engineer and the Contract(s) should communicate the project's COVID-19 control measures to both the workforce and the local communities, to reassure them that the movement of staff is controlled, and to ensure that stigma or discrimination is reduced in the event of an outbreak.

124. The Project Owner, Owners' Engineer and the Contractor(s) should take care in the choice of words when communicating on COVID-19 to avoid words and language that may cause stigmatizing attitudes:

i. Prefer use of "new coronavirus disease (COVID-19)" rather than "Chinese Virus" or "Asian Virus". Prefer the use of "people who may have COVID-19" rather than "COVID-19 suspects" or "suspected cases".

ii. Communicate facts and accurate information about the disease with the workforce and communities. Stigma can be heightened by insufficient knowledge about the COVID-19.

iii. Communicate information rapidly to the workforce and communities to prevent potential rumours and false information spreading.

iv. Communication materials should show diverse communities and ethnic groups as being impacted and working together to prevent the spread of COVID-19.

v. If appropriate, develop and communicate a clear policy of non-discrimination to reduce stigma so that employees feel safe reporting illness of themselves or within their families.

G.6 MANAGEMENT OF GENDER ISSUES

125. The COVID-19 outbreak may enhance existing gender inequalities between male and female workers and within local communities, in particular:

i. The closure of schools to control the transmission of COVID-19 has a different effect on women economically, given their role in providing most of the informal care within families with consequences that limit their possibilities to work. Most primary caregivers to the ill are women.

ii. Women are more likely to be engaged in the informal sector and be hardest hit economically by COVID-19 outbreak. There are informal activities (principally done by women) which depend on the project and can be seriously affected by the COVID-19 measures (i.e. providing food to workers around or inside the project area, workers' cloths cleaning, daily goods selling, e.g.).

iii. Women and girls may be at higher risk of intimate partner violence and other forms of domestic violence due to increased tensions in the household.

iv. Women's access to information on outbreaks and available services are severely constrained when community engagement teams are dominated by men.

v. Women often comprise a disproportionate part of the health care workforce.

126. To best manage gender issues, the Owners' Engineer and Contractor(s) should endeavor to put in place processes to implement the following:

i. In the event that local schools are closed by authorities to prevent the spread of COVID-19, where possible, the working hours of male and female workers with children should be adapted to allow them to be at home when needed to care for the children without loss of salary.

ii. Provide specific advice on preventing the transmission of COVID-19 to project workers (usually women) who care for children, the elderly and other vulnerable groups in quarantine.

iii. Ensure project health carers are gender balanced and project health facilities are culturally and gender sensitive, e.g. separate toilets and washrooms for male and female workers.

iv. Ensure the response to COVID-19 does not reproduce or perpetuate harmful gender norms, discriminatory practices and inequalities, such as (a) ensure that showers, toilets and locker rooms and handwashing points are available separately for women and men, (b) PPE should be sized for men and women, (c) project communications on COVID-19 should be gender sensitive (i.e. do not spread the stereotype that childcare is only a female role or only representing male workers).

v. Include women in COVID-19 response planning and ensure women's representation in project management and COVID-19 policy and project's Environment, Health, Safety Committee.

vi. Consideration should also be given to address obstacles to women's access to support services, especially female workers and the wives/daughters of workers, who may be subject to violence or who may be at risk of violence in quarantine.

vii. The existing project general grievance mechanism and workers' grievance mechanism should include mechanisms for gender-based violence. If this in not already the case, the grievance mechanisms should be updated. When making grievance, a woman should be able to speak with a female member of the project's social team and the grievance mechanism should guaranty anonymity.

viii. Information should be posted on notice boards, and awareness sessions organised, to inform workers of local/national gender-based violence information such as related laws, emergency numbers, informational web sites and campaigns.

ix. If the project or the worker grievance mechanism receive a violence related grievance from a woman, appropriate officials or traditional authorities should be advised, and always with prior agreement from the women and the guaranty of her safety.

x. The project should develop a gender policy an anti-violence policy and the policies should be reviewed and updated regularly. The project should communicate widely its position on not tolerating sexism, violence and gender-related discrimination to all project staff.

xi. In the event that public transport is suspended, the project should consider providing transport for female workers who rely on the public transport to get to work.

G.7 SUPPORT TO LOCAL COMMUNITIES

127. The Project Owner, in coordination with the Owners' Engineer and Contractors, should put in place processes for the following prescriptions to be implemented:

i. Communicate with local communities and its supply chain to promote awareness about the virus and good hygiene practices and precautionary measures.

ii. Community-based surveillance should be encouraged whenever it is feasible. Project workers and representatives of local communities are important allies for the early detection of COVID-19 cases at the project site(s) and within local communities. When cases are reported, the community-based surveillance can assist in tracking people potentially infected by the virus. Community health volunteers and other community workers from the project and local communities can be trained on identifying potential and alert notification procedures. Case investigation need to be ensured following alert notification.

iii. If there are restrictions to project site access that will impact the community, (i.e. by closing access paths), clearly communicate the information to community leaders and discuss the implications.

iv. Voluntary quarantine of a community may be considered based on the local epidemiologic and social assessment of the situation. In this event, a transparent dialogue with local authorities and local representants to expose the risks of COVID-19 and benefits of a quarantine should be initiated.

128. The Project Owner, in coordination with the Owners' Engineer and Contractors, should coordinate with representatives (men and women) of local communities, local NGOs, charities, religious organisations or associations already in place locally and international aid agencies, with regard to implementing risk mitigation measures and where possible should:

i. Provided local communities with masks and protective equipment to support emergency and health professionals.

ii. Provide water access points, soap distribution and hand washing training in communities.

iii. Make donations to national and local communities and hospitals.

iv. Assist in providing ventilators, PPE and temporary medical units to communities.

129. The project should make special attention to the needs of women, vulnerable groups and traditionally marginalised groups.

G.8 PREVENTION OF TRANSMISSION OF COVID-19 DURING STAKEHOLDER ENGAGEMENT

130. The Project Owner, assisted by the Owners' Engineer as appropriate, should assess the risk of transmitting COVID-19 during stakeholder engagement. If the risk cannot be mitigated effectively with the measures below the Project Owner should consider postponing the activities. The measures to prevent transmission should include – but not be limited to – the following:

i. Identify and examine the activities planned by the Project requiring the engagement of stakeholders and public consultations.

ii. Assess the level of direct engagement proposed with stakeholders, including the location and size of proposed meetings, the frequency of engagement, categories of stakeholders (international, national, local).

iii. Assess the level of risk of virus transmission for these stakeholders' commitments and how the restrictions in force in the country / project area would affect these commitments.

iv. Identify the project activities for which consultation / engagement is essential and cannot be postponed without having a significant impact on the project schedule. I.e. the selection of resettlement options by affected people during the implementation of the project. Depending on the specific activity, consider viable ways to obtain the necessary participation from stakeholders.

v. Assess the level of use of technologies and internet among the main stakeholder groups, in order to identify the type of communication channels that can be used effectively.

vi. Make a particular effort to understand and use the most appropriate way for women to have access to the information.

131. The Project Owner, assisted by the Owners' Engineer as appropriate, should consider the following when selecting communication channels for stakeholder engagement in the context of the COVID-19 pandemic:

i. Avoid public gatherings (taking into account national restrictions), including public hearings, workshops and community meetings.

ii. If smaller meetings are allowed, conduct consultations in small groups, such as focus group meetings. If this is not allowed, make all reasonable efforts to conduct the meetings through online channels.

iii. Diversify means of communication and rely more on social media and online channels. When possible and appropriate, create online platforms and specialized discussion groups tailored to the objective, depending on the type and category of stakeholders.

iv. Use traditional communication channels (television, newspapers, radio, dedicated telephone lines and mail) when stakeholders do not have access to online channels or do not use them frequently. Traditional channels can also be very effective in conveying relevant information to stakeholders and allowing them to share their reactions and suggestions.

v. When direct engagement with affected people or beneficiaries of a project is necessary, as would be the case for the preparation and implementation of resettlement action plans and awareness-raising actions, identify the channels of direct communication with each household affected by a specific combination of electronic messages, mail, online platforms, dedicated telephone lines with knowledgeable operators.

vi. Each of the engagement channels proposed must clearly specify how the stakeholders, in particular the women, old peoples and illiterates, can provide feedback and suggestions.

G.9 COMMUNICATION CHANNELS WITH CONTRACTED WORKERS AND LOCAL COMMUNITIES

132. The Contractor(s), in coordination with the Owners' Engineer, should adopted the following when engaging with contracted workers and local communities as below:

i. Inform workers' collective bargaining organisations (e.g. trade unions) or worker associations or the COVID-19 situation at the project site(s) and include representative in the COVID-19 management team.

ii. Ensure that communications on the project's COVID-19 situation and management is accessible, understandable and culturally adapted for the local contracted workers including those who cannot read.

iii. Make use of the communications channels used by the local contracted workers. These channels can be used to communicate the project's response to COVID-19 and to COVID-19 prevention information to communities in a culturally appropriate way.

iv. Make information available in local communities, including offices of local authorities and community health centres.

G.10 GRIEVANCE MECHANISM

133. The Contractor (or Owners' Engineer as applicable) shall adapt the existing grievance mechanism to the COVID-19 situation so that workers and community members can raise their grievances through the existing mechanism. Workers and community members shall be informed of the mechanism and there shall be processes to ensure that the COVID-19 related grievances are prioritized and resolved promptly.

134. The Contractor (or Owners' Engineer as applicable) shall put in place processes to ensure that prescriptions regarding social distancing as described in section [E.5] are applied to the grievance mechanism.

G.11 MANAGEMENT OF SECURITY PROVIDERS

135. The Project Owner, Owners' Engineer or Contractor as appropriate, should put in place processes to manage private security providers and the risk of transmission of COVID-19, including (but not limited to) the following:

i. In coordination with the project's security providers, the existing conflict risk assessment or conflict scenario planning should be updated to include COVID-19. Existing security situation response plans should be updated to include possible security situations that could occur as a result of the COVID-19 outbreak. All the security staff should be aware of the updates.

ii. It should be ensured that enough security staff are available to protect the project site in regard of the updated security situation, and if not mobilisation of additional private or state security forces should be envisaged (see section [C.4]).

iii. The staff of security providers should be considered as project workers and are subject to the same processes as the other workers described in this document.

H. Plans, Procedures and Processes

H.1 PROJECT CONTINUITY PLAN

136. The Project Owner, in coordination with the Owners' Engineer and the Contractor(s), should prepare a Project Continuity Plan. The depth and breadth of the plan should be commensurate with the scale of the project and the context and project risks. The purpose of the plan should be to minimise disruption to the project activities and ensure that project remains viable during the virus outbreak. The Project Owner should take the following steps to ensure adequate preparation for project continuity (see guidance note for the Project Owner - provided as a separate document):

i. Appoint a project Continuity Manager whose responsibility will be ensure that the Project Owners' employees, Owners' Engineer and Contractor(s) are familiar with the Project's Continuity Plan and comply with plan's actions.

ii. Define the processes, resources, responsibilities, and decision-making processes necessary for the continuation of the project, including the contractual aspects with the Owners' Engineer and the Contractor(s).

iii. Develop a plan for the continuity of leadership in the event of absence of key decision makers and executives.

iv. Develop a communications plan to maintain regular and effective communications with the project stakeholders, in particular the AFD and government authorities and agencies, including health authorities.

v. Update the project Stakeholder Engagement Plan – and link it to the Project Continuity Plan.

vi. Adapt the existing grievance mechanism and link it to the Project Continuity Plan.

vii. If necessary, update the project Resettlement Action Plan and link the update to the Project Continuity Plan.

H.2 INFECTIOUS DISEASE PREPAREDNESS AND RESPONSE PLAN (COVID-19 RESPONSE PLAN)

137. The Contractor should prepare an Infectious Disease Preparedness and Response Plan (COVID-19 Response Plan) that should set out the procedures that will be put in place in the event of COVID-19 reaching the site. The plan may be developed through the adaption/modification of existing components of the project environmental and social management system or plans (see §142):

i. The plan should be developed in consultation with national and local healthcare facilities and authorities, to ensure that arrangements are in place for the effective containment, care and treatment of workers who have contracted COVID-19.

ii. The plan should consider the response if a significant number of the workforce become ill, when it is likely that access to and from a site will be restricted to avoid spread.

iii. The plan should be updated on a regular basis and reflect that the Project Owner may instruct the Contractor to continue, scale-down, (temporary) stop or re-start stopped project activities.

138. The Contractor should include measures that address – but not limited to - the following:

i. Isolation and testing procedures for workers (and those they have been in contact with) that display symptoms.

ii. Care and treatment of workers, including where and how this will be provided.

iii. Getting adequate supplies of water, food, medical supplies and cleaning equipment in the event of an outbreak on site, especially should access to the site become restricted or movements of supplies limited.

139. The Contractor should develop the plan to specifically set out what will be done if a project worker becomes ill with COVID-19 at a worksite. The plan should:

i. Set out arrangements for putting the person in a room or area where they are isolated from others in the workplace, limiting the number of people who have contact with the person and contacting the local health authorities;

ii. Consider how to identify persons who may be at risk (e.g. due to a pre-existing condition such as diabetes, heart and lung disease, or as a result of older age), and support them, without inviting stigma and discrimination into your workplace; and

iii. Consider contingency and business continuity arrangements if there is an outbreak in neighbouring communities.

140. The Contractors should include in the plan the following information:

i. Arrangements for the storage and disposal of medical waste, which may increase in volume and which can remain infectious for several days (depending upon the material). The support that site medical staff may need, as well as arrangements for transporting (without risk of cross infection) sick workers to intensive care facilities or into the care of national healthcare facilities should be discussed and agreed.

ii. How to maintain worker and community safety on site should work be suspended or illness affect significant numbers of the workforce at any point. It is important that worksite safety measures are reviewed by a safety specialist and implemented prior to work areas being suspended.

iii. Communications with other projects/workforces in the area, to coordinate their responses and share knowledge. It is important that local healthcare providers are part of this co-ordination, to minimize the changes of the local providers being overwhelmed in the event of an outbreak and unable to serve the community.

141. The Contractor will include in the plan a section on communications, including – but not limited to – the following:

i. The measures and actions included in the plan should be communicated to the workforce.

ii. Measures to reduce the risk of stigma or discrimination should be included in the plan and communicated widely.

iii. Individuals' roles and responsibilities are to be clear and communicated widely.

iv. Workers, sub-contractors, suppliers, adjacent communities, nearby projects/workforces, and local healthcare authorities should all be made aware of the preparations that have been made.

v. When communicating to the workforce, their roles and responsibilities should be outlined clearly, and the importance for their colleagues, the local communities and their families that the workers follow the plans should be stressed.

vi. Workers may need to be reassured that they there will be no retaliation or discrimination if they self-isolate as a result of feeling ill, and also with respect to the compensation or insurance arrangements that are in place.

142. If appropriate, the Contractor may develop the plan through the adaption/modification of existing components of the Projects Environmental and Social Management Plans (ESMS) or Environmental and Social Management System (ESMS), and which may comprise the following plans or sub-plans.

i. Worker Health Monitoring Plan

ii. Emergency Response Plan

iii. Waste Management Plan

iv. Sanitary Wastewater Management Plan

v. Communications Plan

vi. Workers Grievance Redress Mechanism

vii. Additional plan to address prescriptions from §137-141 that are not captured in plans i-viii.

I. Monitoring and Reporting

143. The Project Owner should document in the Project Continuity Plan (see section [H.1]) the processes for implementing the adopted prescriptions regarding monitoring and reporting below.

144. The Contractor(s) should document in the COVID-19 Response Plan (see section [H.2]) the processes for implementing the adopted prescriptions regarding monitoring and reporting below.

I.1 MONITORING OF NATIONAL AND LOCAL HEALTH SITUATION

145. The Project Owner assisted by the Owners' Engineer and if appropriate the Contractor(s), will establish channels of communication with local/regional authorities including health authorities and health care facilities. The purpose will be to ensure that that project is informed of development of the COVID-19 on a national, regional and local scale, so that informed decisions regarding the continuity of the project can be taken (see [D]). The types of information to be collected are as follows:

I.2 MONITORING OF PROJECT WORKERS' HEALTH

146. The Contractor will undertake health checks of workers arriving at the site (see [E.3] and keep records of all workers who develop symptoms while on site. The records and documents that should be kept should include – but not be limited to – the following:

i. Workers' health questionnaires (see §63) completed by workers from other regions and overseas arriving at the site and accommodated in the project worker accommodation camp(s).

ii. Workers 'health questionnaires completed by new workers from the local communities not accommodated in the project accommodation camps but at their homes nearby. These workers will not be required to complete a questionnaire each time they come to the site, unless there has been a break of >14 days.

iii. Register of all workers present at the project site(s). The register should record the name, home address, telephone number, ID/passport number, date/time arrived and date/time departure, the workers temperature. Workers accommodated in the project accommodation camp(s) do not need to enter details in the register book each day, only on the day of arrival/departure from the project.

iv. Name and date of workers turned away at the entrance because of their responses to the health questionnaire or because of the detection of a high temperature (>38°C).

v. Records of all workers' consultations with the project site's health care team.

vi. Names and personal details of all workers suspected of being infected with COVID-19 and put into isolation at the project accommodation camp(s). Records will be kept of the patients' evolution: ongoing recovery, transfer to hospital, recovery and return to work/lockdown, or death.

vii. Names and personal details of all workers transferred to local/regional hospitals for medical assistance, and details of the outcomes – ongoing recovery, recovery and discharge, or death.

viii. Quantities of COVID-19 management materials that have procured, including PPE.

ix. Quantities of health care waste generated how it has been managed.

I.3 MONITORING OF RESOURCES AND WASTE

147. The Contractor will keep records of resources used and wastes generated in the management of COVID-19, including – but not limited to – the following:

i. Staff recruited to assist in managing COVID-19, such as additional cleaners and healthcare staff.

ii. Material resources procured such as PPE, disinfectant and materials required for isolation/quarantine of staff.

iii. Health care waste generated and details of how it has been managed.

I.4 REPORTING

148. The Contractor will prepare and issue to the Owners' Engineer a weekly report on the COVID-19 management and situation. If appropriate, the report may be integrated into weekly HSE reports. The contents of the weekly report will be agreed with the Owners' Engineer, and should include – but not limited to - the following:

i. Update on progress with strengthening of the project's management capacity for COVID-19 response.

ii. Key statistics from the monitoring of workers' health (as listed in section [I.2] and [I.3] above).

iii. Specific Areas of Concern.

149. The Contractor will prepare and issue to the Owners' Engineer a monthly report which consolidates and summarises the Contractor's weekly reports.

150. The Owners' Engineer will forward the Contractor's weekly and monthly reports to the Project Owner and attach a note to each report:

i. Informing on any major issues or concerns that need specific monitoring.

ii. Summary of the evolution of COVID-19 on a local level, regional and national levels and the management by authorities, including information on travel restrictions, lockdown requirements and security issues.

iii. Health monitoring statistics for the Owners' Engineer's team at the project site(s).

151. The Project Owner will agree with the AFD the frequency with which the reports are provided to the AFD, such as on a weekly or monthly basis.

J. References

Below is a comprehensive list of all documents that have been consulted during the preparation of this document.

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K. Annex – Template for FAQ for Workers

GENERAL QUESTIONS ABOUT COVID-19

What is COVID-19?

Coronaviruses are a large family of viruses which may cause illness in animals or humans. In humans, several coronaviruses are known to cause respiratory infections ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). The most recently discovered coronavirus causes coronavirus disease COVID-19.

What are the symptoms?

The most common symptoms of COVID-19 are fever, tiredness, and dry cough. Some persons may have aches and pains, nasal congestion, runny nose, sore throat or diarrhea. These symptoms are usually mild and begin gradually. Some people become infected but don't develop any symptoms and don't feel unwell. Most people (about 80%) recover from the disease without needing special treatment. Around 1 out of every 6 people who gets COVID-19 becomes seriously ill and develops difficulty breathing.

Older people, pregnant women, and those with underlying medical problems like high blood pressure, heart problems or diabetes, are more likely to develop serious illness. If you are in this case, please contact your COVID-19 referent.

People with fever, cough and difficulty breathing should contact their COVID-19 referent or the project medical staff.

How does COVID-19 spread?

People can catch COVID-19 from others who have the virus. The disease can spread from person to person through small droplets from the nose or mouth which are spread when a person with COVID-19 coughs or exhales. These droplets land on objects and surfaces around the person. Other people then catch COVID-19 by touching these objects or surfaces, then touching their eyes, nose or mouth. People can also catch COVID-19 if they breathe in droplets from a person with COVID-19 who coughs out or exhales droplets. This is why, it is important to stay more than 1 metre (3 feet) away from a person who is sick.

Can the virus that causes COVID-19 be transmitted through the air?

Studies to date suggest that the virus that causes COVID-19 is mainly transmitted through contact with respiratory droplets rather than through the air.

Can COVID-19 be caught from a person who has no symptoms?

The main way the disease spreads is through respiratory droplets expelled by someone who is coughing. The risk of catching COVID-19 from someone with no symptoms at all is very low. However, many people with COVID-19 experience only mild symptoms. This is particularly true at the early stages of the disease. It is therefore possible to catch COVID-19 from someone who has, for example, just a mild cough and does not feel ill.

What can I do to protect myself and prevent the spread of disease?

You can reduce your chances of being infected or spreading COVID-19 by taking some simple precautions:

- Regularly and thoroughly clean your hands with an alcohol-based hand rub or wash them with soap and water.

  Why? Washing your hands with soap and water or using alcohol-based hand rub kills viruses that may be on your hands.

- Maintain at least 1 metre (3 feet) distance between yourself and anyone who is coughing or sneezing.

  Why? When someone coughs or sneezes, they spray small liquid droplets from their nose or mouth which may contain virus. If you are too close, you can breathe in the droplets, including the COVID-19 virus if the person coughing has the disease.

- Avoid touching eyes, nose and mouth.

  Why? Hands touch many surfaces and can pick up viruses. Once contaminated, hands can transfer the virus to your eyes, nose or mouth. From there, the virus can enter your body and can make you sick.

- Make sure you, and the people around you, follow good respiratory hygiene. This means covering your mouth and nose with your bent elbow or tissue when you cough or sneeze. Then dispose of the used tissue immediately.

Why? Droplets spread virus. By following good respiratory hygiene, you protect the people around you from viruses such as cold, flu and COVID-19.

- Stay home if you feel unwell. If you have a fever, cough and difficulty breathing, seek medical attention and call in advance. Immediately advise your COVID-19 representant. Follow the directions of your local health authority.

  Why? National and local authorities will have the most up to date information on the situation in your area. Calling in advance will allow your health care provider to quickly direct you to the right health facility. This will also protect you and help prevent spread of viruses and other infections.

- Keep up to date on the latest COVID-19 hotspots (cities or local areas where COVID-19 is spreading widely). If possible, avoid traveling to places – especially if you are an older person or have diabetes, heart or lung disease.

  Why? You have a higher chance of catching COVID-19 in one of these areas.

In addition to these measures, you should observe the instructions given by your team manager at the beginning of the shift.

How long is the incubation period for COVID-19?

The "incubation period" means the time between catching the virus and beginning to have symptoms of the disease. Most estimates of the incubation period for COVID-19 range from 1-14 days, most commonly around five days.

How do I protect my family from COVID-19?

Ensure your family follows the same steps described above for yourself.

Who I can contact if I feel unwell or if a colleague feels unwell?

[INSERT project's COVID-19 referent, phone number]

What are the COVID-19 public health phone numbers to contact?

[INSERT local public health service phone number, localisation and timetable]

Where can I access the most up to date information on the COVID-19 virus?

The COVIID-19 situation is changing rapidly.

We recommend keeping updated on the latest information issued by the World Health Organisation (www.who.int) and your regional health and national health authorities: [INSERT WEB SITES OF REGIONAL AND NATIONAL HEALTH AUTORITIES]

I'm at camp and not feeling well. What do I do?

If you feel sick, especially with flu-like symptoms, please do not leave your room or distance yourself from other workers.

Contact your COVID-19 representant at [INSER NUMBER OF THE COVID-19 REPRESENTANT] and the Health Clinic located in camp at [INSER NUMBER OF THE MEDICAL STAFF] for a pre-screening.

I'm at home and not feeling well. What do I do?

If you feel sick at home, contact your employer and stay home to prevent spreading any illness to others. If you live with others, stay in a separate room or keep a 2 metres distance.

Call your local public health authority or a health care professional. Tell them your symptoms and follow their instructions. If you need immediate medical attention, especially if you are experiencing difficulty breathing, call [INSERT NUMBER OF EMERGENCY is existent in the country/area, if not put the number of the COVID-19 representant or of the project medical staff] and tell them your symptoms.

HEALTH AND SAFETY MEASURES

Are there any people in the camp with COVID-19?

[ANSWER WITH CLEAR AND CONCISE INFORMATION]

What has the Project done to protect all the project workers?

[LISTE THE MEASURES TAKES BY THE PROJECT TO PROTECT WORKERS]

Are there project spaces and facilities closed due to COVID-19?

[List project's shared areas closed and any changes in these places timetable]

Who are the persons in charge of handle COVID-19 measures?

[LISTE OF PERSONS IN CHARGE AND USEFUL CONTACTS]

What happens if there is a case of COVID-19 in the camp?

[EXPLAIN THE MEASURES PLANNED TO HANDLE A POTENCIAL COVID-19 CASE ON SITE]

What happens if I am required to go home due to scaling back of some project activities?

[EXPLAIN THE MEASURES TAKEN TO HANDLE A POTENCIAL COVID-19 CASE ON SITE]

Pay and compensation

What government benefits am I covered for in the event I am exposed to COVID-19?

[ANSWER WITH CLEAR AND CONCISE INFORMATION]

What government benefits am I covered for in the event I can't go to work due to scaling back of some project activities?

[ANSWER WITH CLEAR AND CONCISE INFORMATION]

If, due to COVID-19, the project is paused for a prolonged period of time, am I able to collect Employment Insurance?

[ANSWER WITH CLEAR AND CONCISE INFORMATION]

If I get sick and stay home, or even get COVID-19, will I get paid?

[ANSWER WITH CLEAR AND CONCISE INFORMATION]

Do I get paid if I have to be isolated based on the project's recommendations?

[ANSWER WITH CLEAR AND CONCISE INFORMATION]

If I must stay home to care for my children will I get paid?

[ANSWER WITH CLEAR AND CONCISE INFORMATION]

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Agence Française de Développement – Division Appui Environnemental et Social

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DE DÉVELOPPEMENT

15 May 2020

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PRESCRIPTIONS FOR INCLUSION IN CONSTRUCTION/WORKSITE ESMPS TO STRENGTHEN COVID-19 HEALTH CONTROL

PRESCRIPTIONS POUR RENFORCER LE CONTROLE SANITAIRE DANS LES PGES TRAVAUX/CHANTIERS

GUIDANCE NOTE FOR PROJECT OWNERS
GUIDE À L'ATTENTION DES MAITRISES D'OUVRAGE

#MondeEnCommun

AFD
AGENCE FRANÇAISE DE DÉVELOPPEMENT

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CONTENTS

A. Introduction

In response to the COVID-19 pandemic, the *Agence Française de Développement* (AFD) has prepared a document titled *"Prescriptions for Inclusion in Construction/Worksite ESMPs to Strengthen COVID-19 Control" (*the "Prescriptions Document"), destined for projects at the (pre-) construction phase which it finances. This note provides guidance for Project Owners on how to use the Prescriptions Document.

B. Purpose of the Prescriptions Document

The key purpose of the Prescriptions Document is to assemble COVID-19 control measures gathered from the numerous guidance documents that are available in the public domain and from non-published working papers prepared by various International Financial Institutions. The intention is that the Project Owner can select those prescriptions it wishes to adopt and integrate them into contractual agreements with contractor(s). The Prescriptions have been structured and worded to facilitate copy and paste.

It should be noted that the prescriptions are not exhaustive and reflect the understanding of the characteristics of COVID-19 and its control at the time of writing. There are currently many unknowns about the disease and approaches for the control of risks may change as knowledge about the disease improves. Consequently, the Project Owners should seek regular updates on COVID-19 management from national health authorities and the World Health Organization (WHO) and advise the Contractor(s) accordingly.

C. Overview of Key Plans for COVID-19 Risk Management

The Prescription Document refers to two key plans which should be prepared, and this is explained below:

C.1 PROJECT CONTINUITY PLAN

The Project Owner should prepare a Project Continuity Plan (PCP), the purpose of which is to define processes to be implemented to minimise disruption to the project activities and ensure that the project remains viable during the virus outbreak. The depth and breadth of the plan should be commensurate with the scale of the project, the context risk and project risks. The preparation by the Contractor(s) of a COVID-19 Response Plan should be one of the actions included in the PCP.

The PCP should define the decision-making process with regard to project continuation; i.e. to continue project activities, stop or scale-down activities and to re-start any stopped activities when the pandemic situation improves. To this end the Project Owner should also keep informed of decisions taken and recommendations made by the government of the project country and ensure that the project aligns with any such decisions or recommendations, which may include instructions to stop activities and put workers into lockdown.

C.2 COVID-19 RESPONSE PLAN

One of the actions included in the PCP should be for the Contractor to prepare a COVID-19 Response Plan with depth and breadth commensurate with the scale of the construction works and the context and project risks. The plan may, as appropriate, be developed through the adaption/modification of existing components of the project environmental and social management system or plans.

D. General Approach for Use of the Prescriptions Document

The Project Owner (assisted as necessary by the Owners'Owner's Engineer) should undertake the following:

- Prepare the Project Continuity Plan as described above.
- Assess the project's capacity for COVID-19 response, context risk and project risk using a decision-making framework such as that set out in section 7 of this guidance note.

- Identify areas of the project's capacity for COVID-19 response that need to be strengthened, review the Prescription Document and identify prescriptions which could be incorporated into the project's health and safety management plans to strengthen the capacity for response.
- Incorporate[1] the required prescriptions into the Contractor(s) work scopes and contractual agreements and ensure implementation by the Contractor(s).
- The Contractor should be instructed to prepare a COVID-19 Response Plan as described above.
- Re-evaluate the context risk frequently as pandemic risk is changing rapidly, seek regular updates on COVID-19 management from national health authorities and the WHO and advise the Contractor(s) on any changes accordingly.

E. Overview of the Prescriptions Document Continuity

The Prescription Document is organised as follows:

Section		Content Overview
A	Introduction	Background and purpose of the prescriptions
B	Actors, Roles, Responsibilities and Resources	Roles, responsibilities and resources for the key actors: AFD, Project Owner, Owner's Engineer, Contractor(s) and Authorities.
C	Coordination with Stakeholders	Stakeholder groups and the types of coordination to be set-up and by whom.
D	Decision Process of Project Continuity	Major decisions that the Project Owner will need to take for the continuity of the project and outlines the decision-making process.
E	Prevention of Transmission of COVID-19 at the Project Sites(s)	Prescriptions to be implemented (as necessary) by the Contractor(s) at the project site(s) to prevent the transmission of COVID-19 at the project site(s). Certain prescriptions also apply to the Owner's Engineer.
F	Management of COVID-19 Cases Amongst Project Workers	Prescriptions to be implemented (as necessary) by the Contractor(s) at the project site(s) to manage any cases of COVID-19 amongst project workers. Certain prescriptions also apply to the Owner's Engineer.
G	Management of Community Health Risks	Prescriptions for managing the risk that project workers may facilitate the propagation of COVID-19 in local communities. Prescriptions with regard to maintaining salaries of workers are provided and measures to support the local communities, vulnerable groups and manage gender issues are provided.
H	Plans Procedures and Processes	Prescriptions with regard to preparation of the Project Continuity Plan and a Project COVID-19 Response Plan.
I	Monitoring and Reporting	Prescriptions on parameters to be monitored and recorded. Prescriptions on what information is reported to whom.
J	References	List of guidance documents consulted in the preparation of the Prescriptions Document.
K	Annex – Template for FAQ for Workers	Example of a FAQ sheet that can be used by Project Owner, Owners Engineer and Contractors.

[1] *When copying prescriptions from the Prescriptions Document and pasting them into a contractual agreement, it is recommended that the word "should" is replaced by "shall" to make the requirement stronger.*

F. Outline of Project Continuity Plan

The overarching action for Project Owners is to manage the continuity of the project, and to this end a PCP should be prepared with depth and breadth commensurate with the scale of the project, the context risk and project risks and which, as appropriate, includes the following:

- **Leadership, Human Resources and Governance Structure** - describing the Project Owner's human resources and governance structure for overall leadership, and decision-making processes for the continuity of the project. A project Continuity Manager should be appointed to ensure coordination with the Owner's Engineer and the Contractor(s).
- **Communications with Stakeholders** - Processes and procedures for communications with project stakeholders and partners such as the AFD, the Owner's Engineer, the Contractor(s) and local and national authorities and institutions.
- **Contractual Arrangements with the Owner's Engineer** - Processes to enable the update of contractual agreements with the Owner's Engineer to include assistance with managing of COVID-19 such as undertaking an assessment of the project's capacity for COVID-19 response, coordination with stakeholders, integrating COVID-19 prescriptions into the project's E&S management, supervising the implementation by the contractor of the COVID-19 prescriptions and monitoring and reporting.
- **Decision-Making Framework** - for making informed decisions on project continuity (see section 5).
- **Project Coordination** - Processes to enable coordination with the Owner's Engineer and the Contractor(s) to assess the project's management capacity for COVID-19 and contextual and project risk. This should include the processes for selection of those prescriptions set out in the Prescription Document that are needed by the project.
- **Contractual Arrangements with the Contractor(s)** - Processes to enable the integration of the necessary prescriptions into the Contractor(s) work scope(s), including processes for the management of budget.
- **Contractor Supervision** - Processes to monitor the situation and ensure that necessary prescriptions effectively translated into tangible measures and actions and implemented as per agreements and in a timely manner.
- **Monitoring of Context Risk** - how the Project Owner will seek updates on evolution of the COVID-19 situation on a local, regional and national level and developments with regard to recommendations on protection and treatment from national health institutions and international organisations such as WHO.

G. Guidance for Decision-Making

The Project Owner should develop a decision-making process for the continuity of the project. The approach outlined below is an example adapted from the decision-making framework developed by the Inter-American Development Bank (IDB)[2] and which is presented schematically on page 8.

G.1 ASSESS CONTEXT RISK AND PROJECT RISK[3]

The Project Owner will identify context and project-related risks that pertain to the location it operates in, and the nature of the project and workforce. This is accomplished using Table 1 below (numbers 1-12).

Table 1 – Context and Project Risk	Yes	Partial.	No
Context Risk			
1. Pandemic timeline in local jurisdiction – Data trends demonstrate a decrease in incidence and mortality rate of COVID-19 at the location where the project is located. Because the COVID-19 may come in waves this will need to be reassessed frequently to reflect resurgence.			

[2] *Guidance for Infrastructure Projects on COVID-19 Response – A Rapid Risk Profile and Decision framework (IDB INVEST, 2020)*

[3] *The scope of the assessment should cover the Project as a whole encompassing the capacity of the Project Owner, Owner's Engineer and the Contractor(s).*

Table 1 – Context and Project Risk	Yes	Partial.	No
2. Public Prevention Campaign – Project operates in a jurisdiction where COVID-19 transmission risks, recommended preventive actions and communication are being successfully implemented and updated regularly, for example, local authorities are providing regular updates; ensuring information on symptoms and prevention are distributed widely; implementing relevant safety protocols and providing accessible testing and treatment.			
3. Testing – COVID-19 testing is available and contact tracing is occurring in the project's jurisdiction.			
4. Resilience of Health Care System – Local/regional health care system is obtaining additional resources to improve its overall capacity to respond to local/regional impacts of COVID-19 pandemic.			
5. Resilience of Local/Regional Population – There are strong health and wellbeing indicators among the general population in the project area, including low poverty rates, good access to basic services (water, sanitation, electricity) and infrastructure, including access to health services. If the local population is remote in location and/or comprised of vulnerable or Indigenous groups mark "NO".			
Project Risk			
6. Nature of the Workforce – Complexity of managing the workforce: Workforce is simple to manage (50 or less workers) and localised – choose "YES". Workforce is moderately challenging to manage (50-100 workers) and localised, with few subcontractors – chose "PARTIALLY". Workforce is complex to manage (100+), located across a geographical area requiring a diverse strategy to manage, house and provide health services to; and involves multiple contractors and subcontractors – choose "NO".			
7. Working Practices – Recommend and required physical distancing is possible. Where not feasible, workers are restricted in terms of their movements and potential exposure pathways. Work shifts have been modified as necessary to meet the most up-to-date recommendations on social distancing to reduce disease transmission Workers on same shifts can remain together to reduce potential for transmission across workers from different shift.			
8. Worker Mobility – Workers are localised and stationary. The workforce is not a fly-in / fly-out operation nor requires shift rotations (e.g. 2 weeks on, 1 week off) that brings people in from diverse geographic locations regionally, nationally and/or globally. The nature of the project location and the workforce allow for minimum interaction between workers onsite and the general population (e.g. workers tend not to be from the local community; tend to be housed on-site and there is no easy access outside of the project-fence line).			
9. Worker Housing – The majority of workers are housed in a closed or controllable localised manner. Single housing arrangements (e.g., closed worker camps) are used (i.e., multiple accommodation types such as private houses, hotels, etc, are <u>not</u> used). The project has control over where and how workers spend their leisure time outside of work hours and can feasibly implement control measures to promote social distancing during workers' leisure time.			
10. Health Care for Workers – Project provides in-house health services appropriate for the size of the workforce, geographic location, and current health risks with a trusted medical service provider this is available to the entire workforce. The project has sufficient infrastructure, equipment and resources (e.g., their own ambulances, doctors, PPE, ventilators) at project site to assist their workforce and not to overwhelm the local system. Project has planned for potential cases in the workforce which include protocols for isolation/evacuation under guidance of appropriate health authorities/service providers.			
11. Code of Conduct and Communications – The project has measures to effectively manage contractors and subcontractors, and temporary workers. Codes of conduct are in place for workers on and off the job, including expectations for conduct and interaction with the local community. There is a communication pathway established between the project and contractors/subcontractors, such that changes in working plans can be easily communicated and implemented.			
12. Security Risk – Security risk in the project area is considered to be negligible or low. Projects in a country identified as warning or alert levels based on the Fragile States index could be considered as higher risk security areas, mark "NO". A high-risk security context would include regions that experience or have experienced armed conflict, have demonstrated cases of human rights violations, and/or are unable to provide basic needs to the population. A conflict risk assessment or conflict scenario planning associated with COVID-19 has been undertaken (e.g. project has evaluated their potential role in triggering a conflict scenario or their potential impact if conflict were to emerge).			

G.2 ASSESS PROJECT MANAGEMENT CAPACITY FOR COVID-19 RESPONSE

The Project Owner should assess the project's current management capacity related to context and project risk (see table 1 above). When "**PARTIALLY**" or "**NO**" responses are obtained for Table 2 below, this reflects that minimum measures to manage COVID-19 are not in place and the project should develop or improve measures to close the gaps as described in Table 3 below.

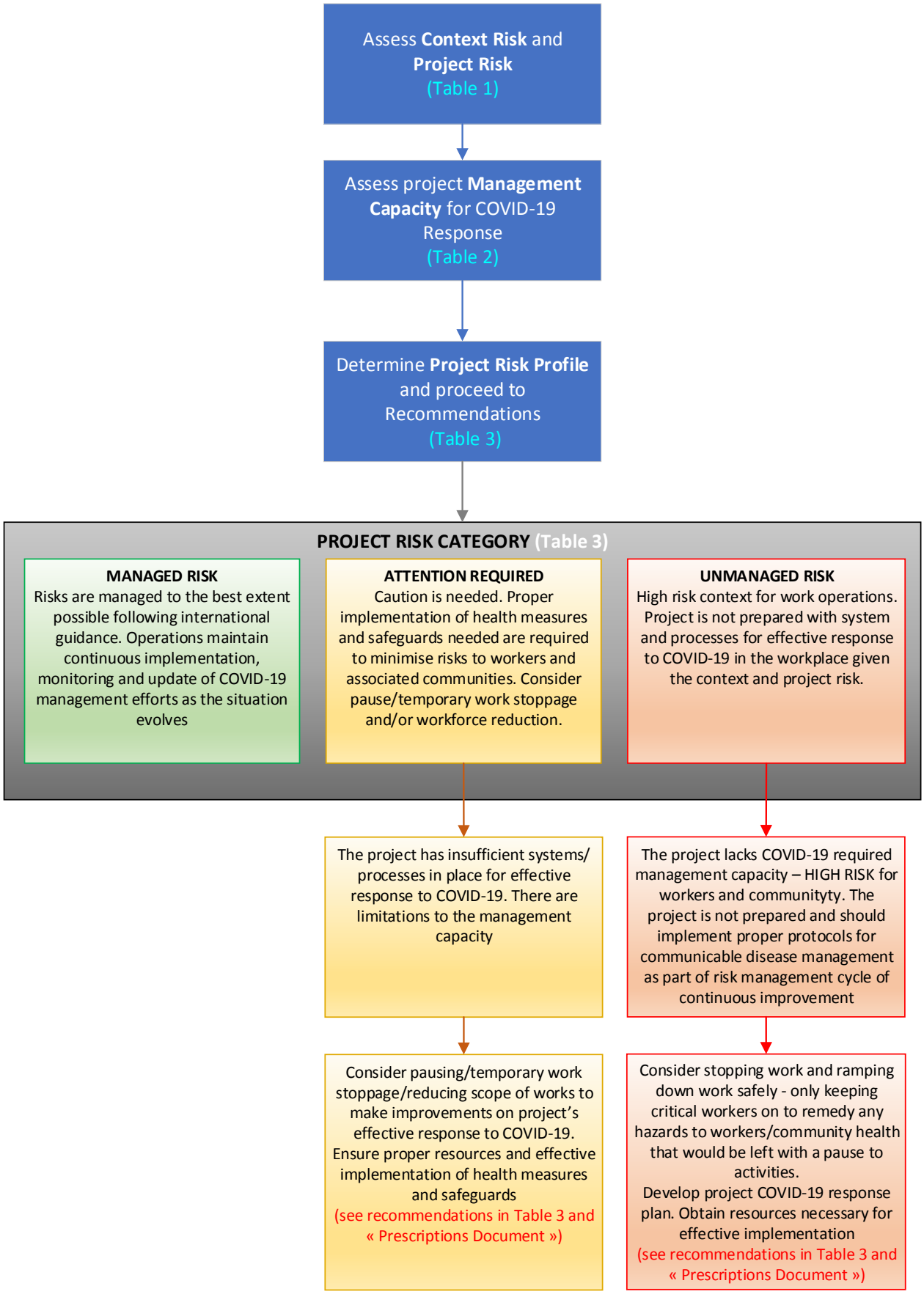
Table 2 – Management Capacity	Yes	Partial	No
Minimum Measures for COVID-19 Response			
13. Infectious Disease Preparedness and Response Plan (COVID-19 Response Plan). There is an infectious disease preparedness and response plan that provides specific actions on COVID-19 based on the unique risks faced by the project and its workforce (see Table 1 above). The plan may be stand-alone or integrated as part of another plan. The plan has been discussed and approved by the senior management. The plan is aligned with international guidance (IFC PS 1,2 4, OSHA 3990, WHO).			
14. Resources – COVID-19 Response Plan is activated, with responsible person assigned for plan execution and budgets allocated. Allocated resources are commensurate with the size of the workforce, and appropriate to address project and contextual risks. Person responsible has appropriate training in communicable diseases and necessary human resource capacity. The project has a dedicated point person for emergency preparedness and response (EPR) that has relevant training and that is coordinating with the responsible person for the COVID-19 Response Plan.			
15. Plan Implementation – Project's COVID-19 Response Plan is actively implemented, monitored and improved on an ongoing basis. There is evidence that the project is implementing basic infection prevention measures; flexible work policies and procedures; workplace control and other measures. The implementation of the COVID-19 Response Plan is monitored and progress reported regularly to the Project Owner.			
16. Communication and Training on COVID-19 for Workers – The project is implementing communication and appropriate training on COVID-19 for its workforce, based on the unique risks of different work functions. Relevant information is provided in a systematic, timely, culturally appropriate manner on an ongoing basis.			
17. Community Relations – The project has dedicated community outreach/community relations staff that have established channels of communication with local communities. These channels are used to communicate the project's response to COVID-19, and to provide COVID-19 prevention information to communities in a culturally appropriate way.			
18. Collaboration with Local/Regional Health Institutions – The project has established channels of communication and collaboration with local/regional health institutions in their jurisdiction. These channels are used to communicate and coordinate on the COVID-19 response, for reporting cases and contact tracing. The project is following health protocol form local health authorities regarding the management of cases and fatalities.			
19. Grievance Process for COVID-19 – The project has a grievance procedure in place that has been adapted for COVID-19 grievances. Both workers and community members have an immediate way to contact the project (e.g., by phone) regarding any potential grievance linked to COVID-19. There is evidence that grievance received linked to COVID-19 are being prioritised and resolved promptly.			

G.3 DETERMINE PROJECT RISK PROFILE AND FOLLOW RECOMMENDATIONS

A project's unique risk profile is determined by the rating in Table 3 below. If a project has any statements in Table 2 above marked "**NO**" it can be assessed that project is in the "**UNMANAGED RISK**" category and should follow the recommended next steps indicated in Table 3 below. Similarly, if a project has any statements marked as "**PARTIALLY**", it can assessed that the project is in the "**REQUIRES ATTENTION**" category. Only if all statements in Table 2 above are marked "**YES**" can the project be assessed to be in the "**MANAGED RISK**" category.

If there are any criteria in the "Context" or "Project Risks" sections of Table 1 above marked "**PARTIALLY**" or "**NO**", this should prompt Management to analyse these risks specifically, and to determine if/how they can be managed to the extent feasible (refer to recommendations in Table 3 below). The project risk profile can change rapidly, and thus continuous assessment is required to adapt measures to the changing COVID-19 pandemic situation.

Table 3 – Project Risk Categories and Recommendations		
Managed Risk	**Requires Attention**	**Unmanaged Risk**
Risks are managed to the best extent possible following available international guidance. Operations maintain continuous implementation, monitoring and update of COVID-19 management efforts as the situation evolves	Caution is needed. Proper implementation of health measures and safeguards needed are required to minimise risks to workers and associated communities. Consider pause/temporary work stoppage and/or workforce reduction.	High risk context for work operations. Project is not prepared with system and processes for effective response to COVID-19 in the workplace given the context and project risk.
Risk Profile • **Context risk**: Risk is low as possible given the current context. Project is abreast of COVID-19 evolution in the jurisdiction and it is possible to comply with COVID-19 mandates. • **Project Risk**: Project has demonstrated a high level of control of the workforce based on nature of workforce, location, mobility, accommodation, health services and contractor/subcontractor management. • **Management Capacity**: Evidence the project has the management capacity and is effectively responding to COVID-19 in the workplace. Planning, implementation, monitoring, reporting, training and outreach is occurring and being updated. The response is resourced appropriately.	**Risk Profile** • **Context risk**: Limitations identified in terms of prevention, testing, resilience of health sector and the overall health and wellbeing of the local population. • **Project Risk**: Project has demonstrated limitations in the control over workforce. Workforce may be primarily localised but may be also subcontractors or temporary workers that are highly mobile or residing in communities that have presented increasing COVID-19 cases and are not covered under project health services. • **Management Capacity**: Evidence the project has the management capacity to respond to COVID-19, but the context (state of pandemic and existing conditions) and the nature of the project limit the effectiveness of the response.	**Risk profile** • **Context Risk:** Prevention, testing, local resiliency, and health and wellbeing indicators are poor. The potential for conflict is already contextually high. Pandemic timeline is in upward trend. • **Project Risk**: The nature of the project is complex, with a large, mobile workforce using multiple forms of accommodation and varying degrees of access to health services, inkling for multiple contractors/subcontractors. • **Management Capacity**: Evidence the project has the management capacity to respond to COVID-19, but the context (state of pandemic and existing conditions) and the nature of the project do not allow for effective response.
Recommendations: • If operation continue, the project should follow all local, regional, national COVID-19 mandates. • Continue to work on COVID-19 prevention and management measures (see Prescriptions Document), making sure required protocols for communicable disease management are implemented and updated as required and are part of a risk management cycle of continuous improvement. • Re-evaluate context risk frequently as pandemic risk is changing rapidly.	**Recommendations:** • If construction continues, project should improve risk factors within the project's control (see Prescriptions Document). A pause in construction activities is recommended depending on the nature of the risk factor to be improved. • Consider reducing the scale of works, the size of the workforce and/or isolating workers who have travelled to address the influence of project risks. • Consider potential opportunities for project to provide support to health institutions/regional public health campaign efforts to reduce context risk factors where appropriate, possible and relevant. • Re-evaluate context risk frequently as pandemic risk is changing rapidly	**Recommendations:** • Consider stopping work and ramping down work safely – only keeping critical workers on to remedy any hazards to workers/community health that would be left with a pause to activities. • Implement measures to improve project's ability to reduce risk: o Relevant measures from the Prescriptions Document o Consider reducing the scale of works, size of workforce and/or isolation of workers who have travelled. o Consider potential opportunities for project to provide support to health institutions/regional public health campaign efforts to reduce context risk factors where appropriate, possible and relevant. • Re-evaluate context risk frequently as pandemic risk is changing rapidly.



Adapted from IDB INVEST (2020).

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