INTERNATIONAL RESCUE COMMITTEE

Support for Social Recovery Needs of Vulnerable Groups in Beirut (P176622)

Medical Waste Management Plan

1 September 2021

ABBREVIATIONS AND ACRONYMS

3RF	Reform, Recovery and Reconstruction Framework
CAS	Country Assistance Strategy
CCSAS	Clinical Care of Sexual Assault Survivors
CMR	Clinical Management of Rape
COVID-19	Coronavirus Disease of 2019
CPF	Country Partnership Framework
CPI	Consumer Price Index
CSOs	Civil Society Organizations
EU	European Union
FCV	Fragility Conflict and Violence
FHH	Female-Headed Households
FM	Financial Management
FPI	Food Price Index
GBV	Gender-Based Violence
GBVIMS	Gender Based Violence Information Management System
GOL	Government of Lebanon
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Services
IIA	Interim Implementation Agency
INGOs	International Non-Governmental Organizations
IOM	International Organization for Migration
IRC	International Rescue Committee
LBP	Lebanese Pound
LCRP	Lebanon Crisis Response Plan
LFF	Lebanon Financing Facility
M&E	Monitoring and Evaluation
MAPS	Methodology for Assessing Procurement Systems
MEAL	Monitoring Evaluation Accountability and Learning
MHPSS	Mental Health and Psycho-Social Support
MMU	Mobile Medical Units
MoPH	Ministry of Public Health
MOSA	Ministry of Social Affairs
MWMP	Medical Waste Management Plan
NCLW	National Commission for Lebanese Women
NGOs	Non-Governmental Organizations
NMHP	National Mental Health Program
PDO	Project Development Objective
PEERS	Partnership Excellence for Equality and Results System

PHC	Primary Healthcare Centers
PMT	Program Management Team
POB	Port of Beirut
POM	Project Operations Manual
RDNA	Rapid Damage and Needs Assessment
SbS	Step-by-step
SDC	Social Development Centers
SH+	Self Help Plus
SOP	Standard Operating Procedures
TPMA	Third Party Management Agent
UN	United Nations
UNESCWA	United Nations Economic and Social Commission for Western Asia
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Emergency Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WBG	World Bank Group
WHO	World Health Organization

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1. INTRODUCTION

The August 4, 2020 Port of Beirut explosion compounded Lebanon's existing economic and social challenges and disproportionally affected Beirut's vulnerable populations. Since the explosion the efforts of civil society have been crucial for recovery and rehabilitation efforts. Several obstacles remain that challenge the effectiveness, inclusivity and sustainability of the broader recovery and rehabilitation process, which include coordination challenges between ongoing efforts and the ad hoc or temporary nature of interventions. The situation of Beirut's population remains precarious and the need for support to recovery and reconstruction efforts urgent.

Supporting Beirut's Immediate Social Recovery Services: The project will focus on reducing vulnerabilities prevalent amongst three groups affected by the blast in Beirut: (i) survivors of Gender-Based Violence (SGBV); (ii) those suffering from deteriorated psycho-social wellbeing; (iii) and/or those facing limitations related to being a person with disabilities and older persons. Supporting Beirut's Immediate Social Recovery Services interventions will entail providing grant financing directly to a selected number of NGOs, to enable them to provide social services to reduce vulnerabilities in these groups.

This will be achieved by supporting non-government stakeholders that are engaged and have a track record in delivering social recovery services and working with target groups by improving their capacity to participate in the broader social recovery and reconstruction processes.

The World Bank has selected the IRC to act as the Intermediary Implementing Agency (IIA) to implement the Supporting Beirut's Immediate Social Recovery Services project. The IRC will take on project management, grant provision and/or procurement of services from NGOs, and will be responsible for the fiduciary supervision of the selected NGO partners.

2. BACKGROUND

On August 4, 2020, a massive explosion in the Port of Beirut (POB) resulted in over 200 deaths, wounded over 6,000 and displaced 300,000 people. Beyond the severe loss of life, due to the blast's scale and location, the impact on public infrastructure and on economic activity was and continues to be significant. Beirut's population density, the concentration of economic activity in the affected areas, especially commerce, real estate and tourism, and the damage to the port itself, meant that the blast was particularly damaging to prospects of economic recovery. The Rapid Damage and Needs Assessment (RDNA) estimated damages of US$3.8–4.6 billion, economic losses of US$2.9–3.5 billion, and a priority recovery and reconstruction need of US$1.8–2.0 billion.[1]

The explosion came at a time when Lebanon faced a multitude of compounding challenges that include economic and banking crises, a severe balance-of-payments deficit, and recurring social

[1] World Bank Group; European Union; United Nations. 2020. Beirut Rapid Damage and Needs Assessment. World Bank, Washington, DC. © World Bank. https://openknowledge.worldbank.org/handle/10986/34401

unrest, and the onset of COVID-19, which exposed and exacerbated pre-existing vulnerabilities.[2] In 2019-2020, a shortage of US dollars in the market resulted in parallel exchange rates, as well as capital controls – an unprecedented situation for Lebanon's historically free capital account. A survey administered before COVID-19 found that 220,000 jobs had been temporarily or permanently lost between October 2019 and February 2020, one-third of companies reduced their workforce by 60% on average and 12% ceased or suspended their operations.[3] On March 7, 2020, the Government of Lebanon (GoL) defaulted on US$1.2 billion Eurobond debt. Much of Lebanon's current economic and social crisis is attributable to a system of corrupt elite capture that has failed to deliver adequate services to its people. The impact of the COVID-19 pandemic further exacerbated the precarious situation in the country. The pandemic overloaded a crippled public health infrastructure, exposing decades of underinvestment for public services. As of June 21, 2021, 543,505 cases have been reported, with over 7,822 deaths due to the pandemic.[4] The 12-month inflation rate rose steadily in 2019-2020 and sharply from 10% in January 2020, to 46.6% in April, 89.7% in June, and in August, 120 percent. Importantly, inflation is a highly regressive tax, affecting the poor and vulnerable disproportionately, as well as people on fixed income, such as pensioners.[5]

Compounded by the global economic shock presented by COVID-19, disruptions in international food supply chains and trade networks exacerbate Lebanon's food security vulnerabilities. Lebanon's remittances dropped by 20%, from 3.9 billion U.S. dollars in the first half of 2019 to 3.1 billion dollars in the first half of 2020, according to Bank Byblos' Lebanon This Week report released on Tuesday. [6] Furthermore, the restrictions on movement to combat the pandemic have hindered food-related logistic services, disrupting food supply chains and jeopardizing food security for millions of people. The higher levels of export restrictions particularly leave food-importing countries vulnerable to commodity price fluctuations. The CPI witnessed an annual inflation of 133% between October 2019 and November 2020ii, while Food Price Index (FPI) registered an inflation of 423% – representing an all-time high since CAS started price monitoring on a monthly basis in 2007.[7] This is particularly relevant as Lebanon imports at least 80% of its food supplies (ESCWA 2016). As a result of these crises, the real GDP growth of Lebanon contracted by 20.3% in 2020 and a further contraction of about 9.3% is projected for 2021. These severe economic crises forced over 45% of the Lebanese population below the poverty line.

The pandemic and ensuing lockdowns have affected the poor, refugees and other vulnerable populations disproportionately, on a global scale as well as on a national scale. In Lebanon, a wide range of vulnerable groups have been negatively impacted by the pandemic ranging from the loss of livelihoods of informal workers and micro-entrepreneurs, additional economic

[2] World Bank Group; European Union; United Nations. 2020. Beirut Rapid Damage and Needs Assessment. World Bank, Washington, DC. © World Bank. https://openknowledge.worldbank.org/handle/10986/34401

[3] Conducted by InfoPro: http://www.businessnews.com.lb/cms/Story/StoryDetails/7423/220,000-jobs-lost-estimated-by-InfoPro.

[4] World Meter Coronavirus https://www.worldometers.info/coronavirus/country/lebanon/, dd June 21, 2021

[5] Lebanon Economic Monitor, Fall 2020.

[6] Bank Byblos (February 2020) Lebanon This Week 'Lebanon's expats' remittances drop by 20% in H1 of 2020 in Xinhuanet.

[7] World Food Program (December 202) Lebanon, VAM Update of Food Price and Market Trends.

insecurity for refugees and migrants, to the overlook of the health needs of the elderly and the disabled.[8] Lockdown measures to fight the pandemic, topped by the global recession, have resulted in permanent and temporary lay-offs with particularly detrimental effects on informal workers. Syrian refugees have experienced particular economic hardship in 2020: there was a 44% increase in refugees under the Survival Minimum Expenditure Basket (SMEB), meaning that 89% now cannot meet their basic needs and are prone to a deprivation of a series of rights.[9] In addition, 83% of migrants surveyed in May 2020 reported that they struggled to make payments for food in the last 30 days. [10] Older people suffer from a lack of health and protection systems. Persons with disabilities have also been disproportionately affected by interrupted health services and social support at home, including personal assistance.[11]

The blast further exacerbated socioeconomic hardship, undermined trust in governmental institutions and increased existing pressures for emigration. Even before the explosion, the fallout of the economic crisis and the pandemic had led to a significant increase in poverty and a shrinking middle class. Projections estimate that poverty rates have surged from 28% in 2019 to 55.3% in 2020, bringing the total number of poor Lebanese to about 2.7 million.[12] These developments increase pressures for emigration, especially among the middle class. Such deprivations have further degraded the relationship between people and the state. Grievances with the political system and dissatisfaction with the state's mismanagement of the economy and its entrenched corruption resulted in nationwide protests in late 2019. Since, intermittent social unrest highlights the needs for a new social contract between citizens and the government. In a survey conducted by the World Bank among victims of the blast, the overwhelming majority of respondent's report having "no trust at all" in political parties, the Council for Development and Reconstruction, or municipalities.[13]

Several assessments conducted after the POB explosion highlight the priority areas for recovery and reconstruction, as well as the main weaknesses in the social safety net system in Lebanon. Consultations with local CSOs and NGOs in December 2020 revealed heightened vulnerabilities amongst the following three population groups affected by the blast in Beirut:

a) survivors of Gender-Based Violence (GBV);
b) those suffering from deteriorated psycho-social wellbeing;
c) and the elderly and Persons with Disabilities.

3. PROJECT DESCRIPTION

[8] https://www.unicef.org/lebanon/media/5616/file
[9] https://reliefweb.int/report/lebanon/vasyr-2020-key-findings-2020-vulnerability-assessment-syrian-refugees-lebanon
[10] https://migration.iom.int/reports/lebanon%E2%80%94-migrant-worker-vulnerability-baseline-assessment-report-may-july-2020
[11] Lebanon: People with Disabilities Overlooked in Covid-19. Human Rights Watch
[12] Lebanon Economic Monitor, Fall 2020
[13] Ranking on a 5 point scale, where 1 = "no trust at all" and 5= "complete trust." Average score was 1.2 for political parties, 1.5 for CDR, and 1.7 for municipalities. Survey not strictly representative due to its design. Source: http://documents1.worldbank. org/curated/en/899121600677984471/pdf/Beirut-Residents-Perspectives-on-August-4-Blast-Findings-from-a-Needs-andPerception-Survey.pdf

The project's objetive is to support the immediate social recovery needs of vulnerable groups who remain impacted by the port of Beirut explosion.

This will be done by supporting non-government stakeholders that are engaged and have a track record in social recovery services by improving their capacity to participate in the broader social recovery and reconstruction processes.

3.1. Project Components

The project includes the following 2 Components: (1) Support for Social Services for Vulnerable Groups affected by the Explosion, and (2) Capacity Building and Project Management.

Component 1. Support for social services for vulnerable groups affected by the explosion

This component will finance NGOs to provide social services to vulnerable groups affected by the crises including: (i) survivors of GBV; (ii) those suffering from deteriorated psycho-social wellbeing; (iii) and Persons with Disabilities and OPs facing limitations related to their disabled or elderly status. Given the cross-cutting nature of their vulnerability, refugees and migrant domestic workers will be targeted across these beneficiary groups. The component includes the following three sub-components: (i) Enhanced Support for Survivors of GBV in Beirut; (ii) Enhanced Support for psycho-social wellbeing in Beirut; and (iii) Enhanced Support for to Persons with Disabilities and OPs.

Sub-Component 1.1 Enhanced Support for Survivors of GBV in Beirut

This component will provide support for a small-scale effective, inclusive and sustainable model for non-government support for social services for survivors of GBV as well as first responder service workers. The project will finance holistic services for survivors of GBV by NGOs in line with international good practices. Support will be provided for (i) expand the capacity of existing shelters to include GBV services; (ii) case management; (iii) psycho-social support; (iv) life skills; (v) referrals for tailored services, including medical services and psychosocial and legal assistance, and (vi) provision of education for children in shelters.

In addition, this sub-component will also finance:

- Capacity-building, training, and ongoing mentoring with full range of adapted tools, materials, training and coaching for service providers in the non-government and public sectors
- Adoption of Standard Operating Procedures (SOP) and protocols for supporting different categories of GBV cases especially in the context of the Covid-19 pandemic, including on safe and integrated digital case management systems and protocols. This will include supporting the implementation of GBV case management, including technical support and supervision for GBV response staff/ case workers (for example, including support to suicidal and self-harming survivors in line with IRC MHPSS COVID-19 learning series14, WHO mhGAP humanitarian intervention guide15 and WPE program tools) and case management supervision.
- Moreover, the support will include a comprehensive integrated package of primary and secondary health care referral services through the available MOPH networks and

[14] IRC MHPSS COVID-19 Learning Series (IRC, 2020)
[15] mhGAP Humanitarian Intervention Guide (WHO, 2015)

responding to specialized needs of boys and girls survivors of GBV as well as children from survivors. Additionally, discussions would be convened with all stakeholders to consider adopting the SOP as a permanent component of case management, thus ensuring sustainability of services during any emergency or period of constraint.

- Offer support towards improving GBV Information Management Systems (GBVIMS); particularly aimed at upgrading GBVIMS to a more user-friendly and easy access version, providing further training to enhance skills related to preserving the security and confidentiality of data shared by survivors; operating and maintaining safe and integrated digital case management systems; public information sharing, and complaint management mechanisms.
- Training for staff/volunteers responding to the national hotline as well as other front liners on GBV Core Concepts and Safe Referrals.

The project will also support awareness raising of GBV and availability of services via community communication channels and the development of a social media communication strategy and dissemination of information to women and girls and other vulnerable and at-risk groups. Extensive consultations have already been undertaken with civil society organizations working with survivors through the WB's partners on the ground. Through the Citizen Engagement program and outreach activities, via the NGO sector, survivor inputs would be considered during the design for implementation. Moreover, while no additional analytical work is possible under the scope of this project, the social norms surrounding GBV and gender inequalities are structural factors that cannot be ignored in any serious medium to long-term strategy to address these vulnerabilities. Accordingly, the findings of pre-existing research and analytics conducted by stakeholders in Lebanon, as well as the extensive experience of partners on the ground, will be integrated in the implementation approach of this sub-component.

The proposed activities are in alignment with existing but limited country systems for survivors of GBV and build upon extensive consultations with government agencies, national and international NGOs, UN agencies and bi-lateral donors. The activities are aligned with the National Women Strategy endorsed by *National* Commission for *Lebanese Women* (*NCLW*) (in consultation with relevant concerned Ministries), and in line with the National Women and Children Safeguarding Strategy endorsed by MOSA (and UNICEF in coordination with concerned Ministries). In addition, it will contribute to operationalizing the National GBV Standard Operating Procedures (SOP), under leadership of MOSA and ownership\endorsement of Ministry of Justice, Ministry of Interior and Municipalities, Ministry of Public Health (MoPH) and NCLW. The project will also work closely with and through the network of the MoPHs SDCs to ensure that existing initiatives build on existing initiatives.

Sub-Component 1.2 Enhanced Support for psycho-social wellbeing in Beirut

This sub-component supports vulnerable individuals and households in the Greater Beirut area to improve their psycho-social wellbeing. Support will be provided mainly for the following two psychos-social interventions:

- Fine tuning/adaptation of Step-by-Step (SbS)[16] program in an initial phase to support provision to a range of target groups including youth, persons who have lost livelihoods, Persons with Disabilities and migrants in Lebanon.

[16] https://pubmed.ncbi.nlm.nih.gov/30225240/

- Adaptation of Self Help Plus (SH+)[17], to the local context and target groups including employees, health workers, and NGO workers as well as the development of a protocol for online delivery in English and Arabic.

The selected specialized NGOs organization will work closely with The National Mental Health Program in the Ministry of Public Health (NMHP-MoPH) and WHO specialists to assist with:

- Recruiting and training master and councillor e-helpers and facilitators, and resourcing NGOs to deliver services training using the existing WHO training tools for delivery of the programs, adapted for local context.
- Monitoring the delivery of interventions to target beneficiaries.
- Conduct technical debriefing sessions with stakeholders to support future adaptation to make necessary adjustments to the program after implementation and provide refresher trainings.
- Identifying cases and referring them to different levels of specialized services (i.e. case management, psychotherapy, management through mhGAP protocols and advanced psychiatric services.

All products and materials developed will be subject to NMHP-MoPH review. In addition, this sub-component will include:

- Developing and piloting a program for Training for Managers and Small Business Owners on how to support the mental health of their staff.
- Development of a new and improved software platform for delivery of the Step-by-Step program suited for implementation in Lebanon and building on results from findings of recent research trials of the intervention.18
- Development and implementation of sensitization and awareness programs on mental health awareness in general and specifically for participation in SbS and SH+ interventions. This awareness component support the operationalization of the community component of the NMHP strategy.

Sub-Component 1.3 Enhanced Support for to Persons with Disabilities and OPs

The project will provide support for the piloting of support services through specialized NGOs and CSOs to improve access to quality healthcare for Persons with Disabilities and OPs, through outreach, at-home health, physiotherapy services and other interventions[19]. Specifically, the project will support: (a) the undertaking of a local pilot participatory needs assessment; (b) training of caregivers to deliver at-home therapies including physiotherapies; and (c) development of peer-to-peer activities and self-help groups.

As part of this initiative the project will develop and pilot an Identification, Counselling and Referral portal through the CBR program for Persons with Disabilities and OPs in order to match potential beneficiaries to existing services.

[17] SbS and SH+ are previous collaborations between the World Health Organization (WHO) and the National Mental Health Programme

[18] This will be built as an open source product for other countries to be able to use the Application.

[19] While Children with Disabilities represent a critical sub-group of the most vulnerable populations, the project cannot directly address their needs considering that they have a unique set of needs which requires further expertise and specialization that cannot be covered due to the project's limited finances.

In addition, the project will support:

- Mobile Medical Units (MMUs) and their outreach teams in identifying Persons with Disabilities and older persons in remote and hard-to-reach parts of Beirut who are at risk of being excluded due to: a) lack of assistive devices, b) inaccessible physical environments, and c) unaffaordability and lack of accessible transport. These MMUs can then provide transport and referrals to NGO CBR teams, and therefore play a supporting role to the CBR initiative more broadly.
- Capacity building and financing for NGO-run Primary Health Care Centres (PHC) for the procurement and delivery of assistive devices (e.g. crutches, hearing aids and visual aids) along with the provision of promotive, preventive, therapeutic (including NCDs, essential and life-saving medications), rehabilitative and palliative services. This activity will only be implemented if aligned to existing MoPH-approved service plans, whereby distribution is done in a coordinated manner with leading local stakeholders. The project will align with and engage in a system of distribution of assistive devices. The principles underpinning the distribution will be derived from the WHO's 'Guidelines on the provision of assisted devices in less-resourced settings[20], which outlines how devices should be resourced and distributed.

Finally support will also be provided for the development of NGO-led social media communication strategy and dissemination of information aimed at reducing stigma related to Persons with Disabilities and OPs and inform potential beneficiaries of available services.

All activities for this sub-component will, wherever possible, be synchronized and aligned with existing services and plans approved by the Ministries of Public Health and Social Affairs (MoPHSA) and current CSO initiatives targeting Persons with Disabilities. The IRC, together with local NGOs will work with the MoPHSA to ensure that there is synergy and in doing so develop a set of protocols.

Cross-Cutting Component Support to migrant domestic workers and refugees working as domestic workers

It is estimated that at least 24,500 migrants were directly affected by the blast – having lost their livelihoods[21]. The situation for many has deteriorated since then. The enhanced support for survivors of GBV, and support mental health and Persons with Disabilities initiatives are open to all migrants and refugees. In addition, within each of these initiatives, provision has been made to develop sensitized awareness-raising material targeting migrant (domestic) workers, including dissemination plans and identifying local community focal points and NGOs to provide support for outreach and referrals, to migrant and refugees domestic workers will in need for SGBV, psycho-social and physical rehabilitation services. However, due to the limited financial resources and the complexities of the challenges faced by the refugee and migrant population in Lebanon, the services delivered through this project will only target them indirectly as described above.

[20] For full guidance see here: https://www.who.int/publications/i/item/guidelines-on-the-provision-of-manual-wheelchairs-in-less-resourced-settings

[21] IOM; Well-Being and Security of Migrant Workers in Lebanon Deteriorate Since Beirut Blast, https://www.iom.int/news/well-being-and-security-migrant-workers-lebanon-deteriorate-beirut-blast, dd 10.16.20

Component 2. Capacity Building and Project Management

This component will finance project management costs over the project life. The International Rescue Committee (IRC) has been selected to be the Interim Implementation Agency (IIA). Costs of the IIA include management and consultancy fees and operations and administrative costs for the management and supervision of the project activities. Project management activities led by the IIA will include: (i) overall project management, fiduciary and safeguards management, (ii) providing technical assistance and institutional strengthening measures, (iii) developing and (iv) implementing a monitoring and reporting plan to provide visibility of the results and a transparent model for the development and implementation of all activities.

4. PROJECT BENEFICIARIES

Vulnerable groups specifically supported by the project supports, include women and children survivors and at risk of GBV, people with mental health challenges, Persons with Disabilities and older. Included are also migrants and refugees working as domestic workers in Beirut.

It is important to mention here that no data is available nor can be collected to measure what percentage of the still vulnerable populations of women and children are covered under the scope of the project. This is due to a number of challenges including i) determining whether the new beneficiaries are availing of the services because of the intervention as opposed to simply availing of services; ii) there are no means to measure the percentage of women who are FHH not be able to differentiate from external studies data, what impact exogenous factors have in order to attribute any change to our intervention; iii) the intervention aims not only at creating additional space but also improving the quality of existing services to current and future caseloads of survivors.

4.1. Project locations

For the GBV component, all the shelters will be located in Beirut and Mount Lebanon. Therefore, all the activities that are included in the first component will be delivered in these 2 areas. However, the capacity building and the awareness campaigns components will be delivered across Lebanon. Regarding support to shelters for boys, the location will be depend on the selection of the implementing partners and the availability of suitable locations (Bekaa or Mount Lebanon). The shelter will accept children with protection orders from all over Lebanon.

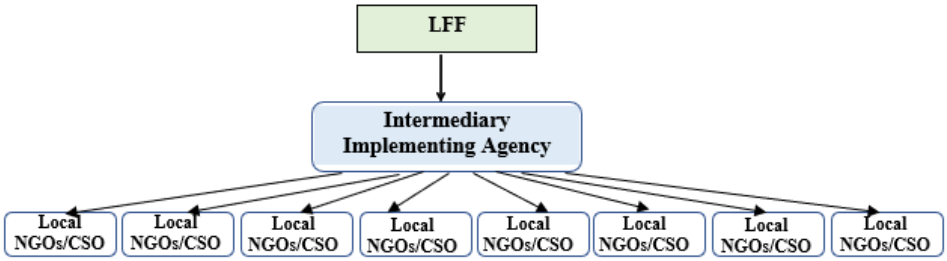
Health services will be provided in the aforementioned shelters along with home visits for Older Persons and those health services will be linked with Primary Health Care Centers (PHCCs). The main focus for the services will be in Beirut, however, some services will be provided through an electronic platform, which might benefit people out of Beirut.

5. INSTITUTIONAL AND REGULATORY ARRANGEMENTS

5.1. Institutional arrangements

Due to the current political context in Lebanon, the central involvement of non-governmental and civil society actors in recovery and small-scale reconstruction efforts is crucial in order to restore trust in existing institutions. The architecture of the NGO-financing mechanism is designed to ensure that there is transparency, legitimacy, and oversight, particularly in terms of citizens' recognition and acceptance of interventions. These implementation arrangements aim to ensure that reconstruction and reform efforts are underpinned by inclusive and meaningful citizen engagement efforts.

NGO Funding Mechanism



Governance arrangements for the Lebanon Financing Facility (LFF) is included under the broader 3RF institutional architecture under which this project operates. Broad strategic direction, oversight of implementation and coordination across stakeholders and financing will be provided by the 3RF Consultative Group (CG). Under this, the LFF Steering Committee will guide and monitor disbursement of funds through the NGO-financing window and implementation of 3RF activities. The LFF trust fund management for the NGO financing window will be entrusted to the care of a trust fund manager and team that will be part of the 3RF Secretariat. The Secretariat's Program Management Team (PMT) would be responsible for administration and regular progress and financial reporting. The PMT also be responsible for preparing a program level results framework. The PMT will also be responsible for program level work plans and budgets that will be endorsed by the 3RF Steering Committee. An Independent Oversight Body, to be established as part of the 3RF, will monitor the use of LFF funds and implementation of all interventions.

An Intermediary Implementing Agency (IIA) with World Bank required fiduciary capacity and project management expertise, was selected as "Grant Recipient". The International Rescue Committee was selected as the IIA as part of a competitive selection process, in which 7 international NGOs submitted an expression of interest. Legal and fiduciary due diligence of the IIA was carried out by the World Bank before signing a Grant Agreement with the IRC. Accordingly, the IRC will serve as "Project Management Unit" to implement activities through grants to local NGOs, take on the role of fiduciary supervision of the subcontracted NGOs and will set out reporting standards. Partnering NGOs will have to comply with reporting standards set out by the IIA in order that the latter can report to the WB and ensuring there is a documentation trail that allows for independent audits. In addition, NGOs will be bound to the WB Environmental and Social Safeguards, as applicable to their interventions.

The International Rescue Committee (IRC), a longstanding partner to the World Bank, has been identified as the recipient of the grant and IIA for project implementation due to its technical expertise in supporting interventions focused on GBV survivors, psychosocial wellbeing and supporting persons with disabilities and the elderly. The IRC is currently already working in the three targeted sectors and will expand the networks built on the ground in Lebanon to include a greater number of local and international stakeholders.

The IRC has been operating in Lebanon since 2012 and its portfolio in Lebanon exceeds $66 as of May 2021. IRC's Partnership Excellence for Equality and Results System (PEERS) provides a comprehensive framework for building effective partnerships, including an institutional policy, step-by-step guidance, and tools spanning the partnership lifecycle. The PEERS process enables IRC to work with partners to identify, allocate and appropriately manage programmatic, operational, financial, and reputational risks, including risks to the people IRC serves, and to partners. IRC has worked in partnership with over 40 Lebanese civil society and government actors through various types of sub-grants and collaboration agreements.

For this project, the IRC will put in place an Environmental and Social Focal Point who will be responsible for ensuring adequate risk identification, management and reporting of the Environmental and Social Commitment Plan (ESCP) and its instruments including this Medical Waste Management Plan. The Environmental and Social Focal Point will be the main focal point for coordination of the ESCP and its requirements and will delegate specific tasks/areas as needed to the rest of the Project Team. The Environmental and Social Focal Point will be supported by the IRC Lebanon's Senior Management Team (SMT) who will monitor and ensure accountability throughout the project for the implementation of the ESCP.

5.2. Regulatory frameworks

International and national legislation is the basis for improving health-care waste practices in any country. It establishes legal controls and permits the national agency responsible for the disposal of health-care waste. For this project, the following legal and regulatory guidelines apply.

Lebanese national laws

The decree-law n°13389 of September 18th, 2004 is an update to previous laws that defines types of medical waste and regulates its storage and disposal, making healthcare waste classification and disposal mandatory based on four categories, namely non-hazardous municipal-like, hazardous infectious, hazardous non-infectious and special wastes.

WHO Guidelines

The following WHO guidelines apply for this project:

- WHO guidelines on hand hygiene in health care of 2009
- Management of Wastes from Health-Care Activities of 2013
- Management of waste from injection activities at district level: guidelines for district health managers of 2006

- Management of solid health-care waste at primary health-care centers of 2005

More of WHO resources & guidelines are accessible under:
https://www.healthcare-waste.org/resources/documents/

World Bank Environmental and Social Framework and World Bank Group Environmental Health and Safety Guidelines

The World Bank Group Environmental, Health and Safety (EHS) apply to this project in respect to healthcare waste. Environmental and Social Standard (ESS) number 3 - Resource Efficiency and Pollution Prevention and Management applies to this project in regards to healthcare waste.

6. MEDICAL WASTE MANAGEMENT PLAN (MWMP):

The medical waste management (MWM) is a public health priority and it is a responsibility of health partners under the leadership and regulation of the Ministry Of Public Health (MOPH). Medical waste is considered hazardous to users, healthcare workers, community and environment, which emphasizes the importance of having a medical waste management plan for all health-related projects. Medical waste refers to all the waste generated by health care and medical research facilities and laboratories.

The main objectives of this medical waste management plan are to reduce disease burden and ensuring proper health spending.

The effective management of medical waste includes delegation of responsibilities, involvement of occupational health and safety staff, considering of Infection Prevention and Control standards, waste minimization and segregation, the development and adoption of safe and environment-friendly technologies, and staff capacity building.

6.1. Objective

The overall objective of the MWM plan is to prevent and/or mitigate the negative effects of medical waste on human health and environment. The plan has been designed according to the local regulations,laws, as well as global WHO guidelines and World Bank frameworks discussed in section 7. All health facilities and services supported through the World Bank project are to have clear SOPs and protocols to manage medical waste.

6.2. Occupational health and safety (OHS)

The IRC has existing occupational, health and safety (OHS) procedures that support the implementation of this plan. These procedures are reflected in the Staff Health page on IRC Portal

which is available to all staff and is updated and shared periodically through a newsletter and Safety and Security communication. These procedures and guidance include:

- Preventing Illness and Injury at Work
- Managing Injuries and Illness while working at IRC
- Health Risk Education
- Primary Health Care Services for IRC Staff and Family
- Travel Health
- Mental Wellbeing

The global Staff Health team and dedicated Staff Health Advisor provides guidance to all staff on Staff Health policies, practices and the training materials related to personal health of staff and the health and safety of IRC workplaces.

In addition, the IRC has developed the following dedicated website to guide staff on the support they can receive, including COVID-19 specific resources: https://doc.rescue.org/staff/.

6.3. Storage Of Consumable Materials and Vaccines

Pharmaceutical and non-pharmaceutical medical supplies and consumables have to be stored and handled with certain precautions according to the good storage, handling and dispensing practices approved by MOPH that are in line with internationally recognized standards that include;

- Ensuring limited access to those materials
- Proper storage conditions to all materials according to manufacturer instructions to avoid their spoilage. Also, having an emergency storage plans for certain materials that need specific storage conditions.
- Systematize use of “first in , first out (FIFO)”
- Frequent ordering of small quantities rather than large amounts at one time, especially for relatively unstable products or unpredictable consumption rates
- Using all contents of each container (before opening the next one)
- Checking expiry dates of all products at the time of delivery and determining correct stocking levels based on its optimum consumption rate, as well as disposal of expired supplies.

Measures to Prevent / Reduce Exposure to Infections / Diseases

Health care staff are at risk of general infections, blood-borne pathogens, and other potential infectious materials (OPIM) during their duties, as well as during collection, handling, treatment, and disposal of medical waste. The following measures are recommended to mitigate the risk of protracting or transferring infectious diseases to health care staff or clients:

- Have a post exposure prophylaxis and management plan for blood-borne pathogens;
- Have clear instructions and labelling on infection control policies and procedures;
- Have a plan to adapt and implement the MOPH established precautions and protocols to prevent, mitigate or treat all hazardous materials and their exposure, which might include;
    - Immunization for staff members as necessary (e.g. vaccination for hepatitis B virus and Tetanus toxoid)-
    - Use of proper PPEs depending on the staff responsibilities
    - Adequate functional facilities for hand washing
    - Appropriate cleaning and waste disposal practices for the health care workplace

- The following recommendations are related to the use and handling of needles / sharps:
    - Use safer needle devices and needleless devices to decrease needle stick or other sharps exposures.
    - Do not bend, recap, or remove contaminated needles and other sharps unless such an act is required by a specific procedure or has no feasible alternative
    - Do not shear or break contaminated sharps
    - Have needle containers available near areas where needles may be found
    - Discard contaminated sharps immediately or as soon as feasible into appropriate containers
    - Used disposable razors should be considered contaminated waste and disposed of in appropriate sharps containers
- Have policies to exclude animals from facility property

To manage the impacts of the COVID-19 pandemic, the IRC has an existing Pandemic Management Plan which will apply to this project.

6.4. Medical Waste Management Procedures

As highlighted by WHO recommendations, the first step in medical waste management is to minimize waste. Though all staff are responsible for managing waste, to ensure optimal waste management, it is recommended to establish a facility-based Waste Management responsible team that can be the IPC team themselves. The project responsible team should coordinate the medical waste management activities and be supported by the health facility management. In addition, the IPC/ MWM team should be engaged in all waste management steps (i.e. generation, segregation, transportation and final disposal).

Current state of implementation

The IRC has consulted the MOPH to confirm the level of compliance of Mobile Medical Units (MMUs) and Primary Healthcare Centers (PHCC) with MOPH guidelines. The following emerged:

- The disposal of sharps at the PHCCs is being done according to the MoPH guidelines, with a close monitoring through different MoPH offices located in all the districts.
- As for the other infectious and hazardous waste, each PHCC has an agreement with a service provider who is in charge of the waste transportation, after its collection and sorting at the PHCC, based on the MoPH guidelines.

Medical Waste Segregation, Collection, and Transport

Waste Segregation. Waste Segregation (i.e. separating the different waste streams based on the hazardous properties of the waste, the type of treatment, and disposal methods) should take place at the source (the point of production) to effectively reduce the amount of hazardous waste and the risk of contamination. The segregation of the different waste streams is necessary for the following reasons:

- Health and safety: reducing the risk of infections and injury (for example needle-stick) through handling of hazardous materials
- Environmental: waste minimization, recycling, and decrease in waste incorrectly classified as hazardous or infectious
- Financial: reduction of hazardous waste volume through correct classification prevents unnecessary treatment of non-hazardous waste that can substantially increase healthcare waste treatment and disposal cost

Color-Coding. In accordance with National and WHO Guideline recommendations on color-coding, healthcare waste should be collected in dedicated color-coded, well packed, and labeled containers according to its contents for safe handling. National Guidelines, where they exist, should prevail over others and in their absence, WHO Guidelines should be used.

Color-coding facilitates easy identification and segregation on the basis of waste hazard classification and suitability of treatment and disposal. Color-coding also makes the process understandable for low-skilled workers with limited literacy and aids staff training (recognizing the frequent staff movement in many of our programs).

It is essential that the adopted color-coding system is used consistently throughout the healthcare waste management chain (segregation, collection, storage, transport, and disposal) for the entire health facility to avoid confusion and mismanagement of the waste. Containers for hazardous waste are typically yellow or red in color and should be accompanied by the international bio-hazard symbol for infectious substances.

Container Labeling. Each container should be labeled to clearly identify the waste type(s) contained in it and its origin. This is to ensure that waste is not moved in anonymous containers that may lead to its subsequent mismanagement.

Containers should be labeled to indicate the content's origin. For example, permanent marker should be used to code directly on the container prior to use. The label should clearly show the name of the section, ward or department. In addition, pre-coded plastic ties or pre-printed self-adhesive labels or tape should be used. Labeling in this way makes it easy to detect which sections or departments of the health facility have good or poor segregation and labeling practices, so that appropriate action can be taken if necessary.

If different color bags are not available, a biohazard label can be placed on black bags to indicate their hazardous content.

Implementing Waste Segregation. Implementation of proper waste segregation requires:

- Provision of waste collection receptacles of appropriate design for different categories of healthcare waste to ensure that all waste is effectively containerized when segregated
- Provision of collection and transportation equipment of appropriate design for internal transportation of waste (e.g. trolleys)
- Establish a uniform color-coding and labeling system to ensure safe waste containerization once segregated
- Necessary training, support and equipment (including appropriate color-coded and labeled waste containers) should be provided to facilitate effective waste segregation
- The location and positioning of waste containers is critical to the success in meeting the requirements of proper segregation practice. Staff, patients and visitors are likely to adapt to segregation systems if the design of the system allows their actions to be intuitive. If

the actions required are time-consuming or laborious, they may struggle to comply with the system, resulting in the inappropriate segregation of waste
- The systems and procedures used for segregating waste need to be regularly monitored and evaluated

The following should be considered in the design and supply of containers for waste segregation:

- Strong enough so that they do not leak or break
- Provide adequate volume for the amount of waste produced. At a minimum, the container should be big enough to hold a full day's waste when only ¾ full
- Easy to seal and transport without risk of spills, leaks, or breaks
- Clearly marked or labeled with colors and/or symbols. It is advisable to use containers and bags that are the same color for the same kind of waste. If this is not possible, marking them with colored tape or paint is advised (See 'Container Labeling')
- Containers should be placed as close to the point of production as possible
- Hazardous waste containers should not be placed by hand washing basins, in patient bays, or in other patient and visitor-accessible areas
- Non-hazardous waste containers (without liner bags) should be emptied when ¾ full
- Liner bags for hazardous and non-hazardous waste should be replaced when ¾ full
- Containers should be easily and securely closed. Plastic tie closures should be used for infectious and anatomical waste bags. Containers such as pedal bins for bagged waste and small aperture rugged cardboard or plastic boxes for sharps waste should be used
- Collections should be at an appropriate frequency (see 'Storage and frequency of collection')

To improve segregation efficiency and minimize incorrect use of containers, proper placement of color-coded containers must be carefully determined. Sufficient numbers and types of waste collection containers should be clearly identified and placed in all locations where waste may be generated and disinfected - never in hallways, bathrooms, wash basins, or other places where people might spill them or fill them with mixed waste. Non-hazardous waste containers placed besides infectious waste containers could result in better segregation.

Information, training, and regular communication should be provided to staff in order for them to fully understand why waste segregation is required. Waste segregation and identification information in the form of posters should be provided and displayed at strategic points (i.e. waste bin locations) to emphasize waste management requirements, prohibitions and precautionary information.

Posters should be explicit, using diagrams and illustrations that convey the message to a broad audience, including illiterate people. For maximum effectiveness, all information should be displayed or communicated in an attractive manner that will hold people's attention. Language used for communication should be one which can be understood by the message recipients.

Waste Collection & Transport

Collection Containers for Hazardous Waste. Hazardous healthcare waste should be collected in plastic bags, plastic lined cardboard boxes or multi-layer coated paper bags that are capable of containing the waste without spillage or puncture, especially during transport and handling.

While in use, bags for healthcare waste must be placed firmly in dedicated bins. The bins should be made of rigid but smooth, easily cleanable material and able to hold a waste bag in place.

Storage and Frequency of Collection. Where waste accumulates in small quantities daily, the interval between collections should be as short as possible. With regard to infectious and anatomical waste, the collection period should ensure that odors from the waste do not cause nuisance. Arrangements should be made to routinely transport waste from ward level, treatment room, or department to the storage area, pending treatment and disposal. Waste should not be re-bagged, except under supervision in the event of a bag failure.

On-Site Collection. Healthcare waste collection practices should be designed to achieve an efficient movement of waste from generation points to storage or treatment, while minimizing risks to staff, patients, the general public and the environment

Waste should not accumulate at the point of production. A collection and transportation program should be established as part of the Healthcare Waste Management plan

All collection containers should be tightly closed and removed when they are 3/4 full

Waste should be collected daily (or as frequently as required) and transported to designated storage areas. The bags or containers should be replaced immediately with new ones of the same type. A supply of fresh collection bags or containers should be readily available at all locations where waste is produced.

On-Site Transport. Healthcare waste should be transported within the healthcare facility by means of wheeled trolleys and/or containers or carts not used for any other purpose. Transport should meet the following specifications:

- Easy to load and unload
- No exposure to sharp edges that could damage waste bags or containers during loading, transport and unloading
- Easy to clean
- On-site collection vehicles should be cleaned and disinfected daily
- Staff transporting waste must be equipped with appropriate personal protective equipment including heavy duty gloves, overalls/coveralls, thick soled boots, etc.

Off-Site Transport. The healthcare facility is responsible for safe packaging and adequate labeling of waste to be transported off-site and for authorization of its destination. Off-site transport, packaging, labeling and disposal must comply with national regulations governing the transport of healthcare waste. In the absence of local laws and regulations, healthcare facility management should adhere to the guidance provided by WHO[22].

Routing. Healthcare waste should be transported via the quickest or shortest possible route and should be planned before the collection trip starts. All efforts should be made to avoid further handling in route to storage, treatment or disposal. The following are general recommendations for efficient and effective transport routing:

- Avoid passing collected packages through congested areas
- Lay out collection route starting from the furthest point progressing towards the collection storage or treatment/disposal area

[22] World Health Organization, 1999. Pruss, A., Giroult, E., Rushbrook, P., (Eds). Safe Management of Wastes from Health-Care Activities.
http://www.who.int/water_sanitation_health/medicalwaste/wastemanag/en/

- Suggested collection frequency is once every shift or as often as necessary. Time of collection regardless of waste category should be at the start of every shift

Waste Storage

Storage Prior to Treatment or Disposal. When healthcare waste containers are full or bagged, they must be placed into storage areas within healthcare facilities awaiting on-site or off-site treatment and disposal. These storage areas must be in a secure location dedicated for this purpose and marked with a warning sign: "CAUTION: HEALTHCARE WASTE STORAGE AREA– UNAUTHORIZED PERSONS KEEP OUT."

Waste should not be allowed to accumulate in corridors, wards or other places. Furthermore, storage must be away from patient rooms, laboratories, facility's function/operation rooms and any other public access area accessible to unauthorized staff or members of the public.

The collection point should be an area of adequate size related to the volume of production and frequency of collection. It should also allow bagged waste or containers to remain segregated so as to avoid waste of different classifications getting mixed during storage.

Different waste streams in the same store should be clearly separated, such that a leak from one waste category cannot contaminate the contents or packaging of another.

Waste Treatment & Disposal

MOPH has existing partners for waste treatment and disposal and they will be responsible for waste collection in coordination with implementing partners and then disposal according to the approved procedures.

7. MONITORING PLAN

Monitoring of the MWMP will be a joint responsibility of IRC, MOPH and implementing partners and it will aim to;

- ensure that any additional impacts are addressed appropriately.
- check the effectiveness of the implementation of the recommended mitigation measures.
- ensure that the proposed mitigation measures are appropriate.
- demonstrate that medical waste management is being implemented according to plan and existing regulatory procedures and in line with the World Bank ESF requirements; and
- provide feedback to implementing agencies in order to make modifications to the operational activities where necessary.

In section 5 above, the standards and practices for which the IRC and its implementing partners will be held accountable for have been identified. In addition, as specified under section 5, implementing partners (local NGOs) will be bound to the Environmental and Social standards set by the World Bank. Implementing partners will be selected following a competitive process and will be evaluated on their capacity to achieve the objectives of the overall program and deliver the activities described in section 3. Detailed projects will be developed with implementing partners outlining how the activities will be delivered. The budget to implement these activities will be

allocated under each sub-award as part of Component 3 – Enhanced support for Persons with Disabilities and Older Persons (US$ 1,575,000). At this stage, the management and monitoring requirements of the MWMP under each project (sub-award) will be defined, and will include the following steps:

- Rapid projects review after the selection of implementing partners has been completed, to identify which projects (sub-awards) will be affected by waste management procedures;
- For identified applicable projects, due diligence of partners' waste management policies and procedures according to the standards and practices defined in this MWMP;
- Identification of gaps, support needed and other mitigation measures and actions, including any required training;
- Inclusion of any identified MWMP-related action in the partners' project plan;
- Implementation and monitoring of any identified MWMP-related actions fully integrated within project monitoring and management.