COMMUNITY HEALTH AND SAFETY PLAN

GLOSSARY

AIDS	Acquired Immunodeficiency Syndrome
AHSPR	Annual Health Sector Performance Report
CCM	Country Coordinating Mechanism
CHIMP	Community Health Impact Management Plan
CHSP	Community Health and Safety Plan
CDHP	Comprehensive District Health Plan
CHASL	Christian Health Association of Sierra Leone
CHC	Community Health Centre
COMAHS	College of Medicine and Allied Health Sciences
DLGAs	District Local Government Authorities
DMO	District Medical Officer
DOTS	Directly Observed Treatment Strategy
DPC	Disease Prevention and Control
DPI	Directorate of Planning and Information
ECOWAS	Economic Community of West African States
EMP	Environmental Management Plan
EIA	Environmental Impact Assessment
ESIA	Environmental and Social Impact Assessment
FGM/C	Female Genital Mutilation/Cutting
FHCI	Free Health Care Initiative
GAVI	Global Alliance for Vaccine and Immunisation
GoSL	Government of Sierra Leone
HAMP	HIV AIDS Management and Prevention Act
HDP	Health Development Partners
HSCC	Health Sector Coordinating Committee
HMIS	Health Management Information System
HSSG	Health Sector Steering Group
HIS	Health Information System
HIV	Human Immunodeficiency Virus

HRD	Human Resources Development
HSCC	Health Sector Coordinating Committee
ICS	Integrated Child Survival
IHP	International Health Partnerships
Km2	Kilometre square
MDG	Millennium Development Goals
MoHS	Ministry of Health and Sanitation
M&E	Monitoring and Evaluation
NAS	National AIDS Secretariat
NASHI	National Social Health Insurance
NGO	Non-Governmental Organisation
PMTCT	Prevent Mother to Child Transmission
PPP	Public Private Partnership
PPTCT	Prevent Parent to Child Transmission
PSI	Population Services International
SECHN	State Enrolled Community Health Nurse
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
WHO	World Health Organisation

1 INTRODUCTION

A Community Health and Safety Plan contains measures to ensure that project-generated health and safety risks to local communities are minimised. It entrenches a preventative approach to community health and safety, and addresses infrastructure and equipment safety, hazardous materials safety, environmental health, communicable diseases, emergency preparedness and response, and the community-oriented responsibilities of security personnel.

The objectives of the Community Health and Safety Plan are:

1. To avoid or reduce risks to and impacts on community health during project life cycle from both routine and non-routine circumstances;
2. To ensure that the safeguarding of personnel and property is carried out in a legitimate manner that avoids or minimizes risks to the community's safety and security; and
3. Establish a monitoring and evaluation (M&E) program that is community based, participatory, transparent and covers all phases of construction, operations and decommissioning.

The CHSP is to be read in conjunction with the following documents:

- Waste Management Plan;
- Community Development Action Plan;
- Sections dealing with management, mitigation and monitoring measures in the Digby Wells ESIA report, especially for Air monitoring and Noise and vibration.

1.1 Limitations and Perspectives of Report

This report recognises the fact that Community Health and Safety in the Project Affected Area should be of concern to the company and that reasonable measures should be put in place to address the mitigation and management of salient issues. Notwithstanding this, it should be acknowledged that there are several other external factors which could contribute to the state of affairs. It is also acknowledged that the Government will have some responsibility for addressing many issues through the ambit of relevant Ministries, Departments and Agencies. The emphasis in this report is therefore on collaborative efforts with other stakeholders. It should also be made clear that many programmes envisaged could be accommodated under the ambit of various plans including the Community Development Action Plan already formulated by the company

1.2 Project Details, Location, Setting and Settlements

The mining site is near the town of Lunsar in the Marampa Chiefdom, Port Loko District on the coastal plain of Sierra Leone. The jetty project is located in the Maforkie Chiefdom also in the Port Loko District.

Several communities are present within the project area, living in settlements. The mining concession area comprises inland valley swamps, the Masaboin and Gafal Hills and

interfluves of variable heights. The Batbana and the Baki and their tributaries, being the main streams within the concession boundary, comprise the catchments draining the area. The hills and valley swamps within the area have been largely altered by previous iron ore mining activities so that the hills portray terraces with sparse grass cover, while the swamps reveal streams with hampered flows.

The mining concession area can mainly be accessed through mostly rough and rugged laterite roads and motorable tracks branching off from the well constructed tarmacadam highway leading from the town of Lunsar. The unpaved secondary roads and tracks generally form links to the sites of the various settlements.

Further accessibility into the interior of the surveyed project area is possible mainly by footpaths and traverses. Where streams cut across the road network, bridges and/or culverts have been constructed to connect the settlements but sometimes, going through valley on foot is the only access to get from one landform or habitat to the other.

The jetty site at Thofayim is in the Maforkie Chiefdom, Port Loko District in the Northern Province of Sierra Leone. The site is located about 12km south west of Port Loko town, at the settlement and environs of Thofayim located on the banks of the Port Loko Creek.

2 PROJECT DESCRIPTION

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3 REGULATORY ND ADMINISTRATIVE FRAMEWORK

3.1 Regulatory framework

The Company intends that relevant Sierra Leone legislative requirements, applicable international standards and guidelines, as well as relevant Company policy and commitments, will guide the management of the project through its various stages from an environmental and social perspective, including Community Health and Safety.

3.1.1 International Guidelines and Standards

Various international standards and guidelines apply to community health. Those that are relevant to the Project activities include:

- IFC Performance Standard 4: Community Health, Safety and Security, the objective of which is to:
  - Avoid or minimize risks and impacts on the health and safety of the local community during the Project life cycle from both routine and non routine circumstances; and
  - Ensure that the safeguarding of personnel and property is carried out in a legitimate manner that avoids or minimizes risks to the community's safety and security.
- IFC Performance Standard 1: Social and Environmental Assessment and Management System;
- 'The Migration Effect'- Risk Assessment and Management Strategies for Addressing Project-Induced In-Migration; IFC, 2009;
- IFC's Good Practice Note on HIV/AIDS in the Workplace (IFC, 2004);
- IFC Introduction to Health Impact Assessment Toolkit, 2009;
- International Labor Organizations Code of Good Practice on HIV/AIDS.

3.1.2 National legislation, Guidelines, Standards and Administrative structure Guidelines on Health

A National Health Policy developed in 2002 and revised in 2009 has provided an environment for health reconstruction. The Government of Sierra Leone in consultation with partners has developed a 6-year National Health Sector Strategic Plan (NHSSP), which provides the framework for improving the health of the nation. The implementation of this plan will require concerted effort from all stakeholders in the health sector. Guidelines are

derived from this National Health Sector Strategic Plan, 2010-2015 (NHSSP). The following provide the basis for this plan:

- The Sierra Leone Constitution (1991)
- The National Health Policy 2002
- The Public Health Act 1960
- The Local Government Act (2004)
- The Medical and Dental Act
- The Pharmacy Board Act
- The National Poverty Eradication Plan and
- The "An Agenda for Change", 2008-2012

Specifically, the NHSSP forms the basis for:

a. Developing and implementing strategic and operational plans of central MoHS directorates, at the districts and in all hospitals.

b. Formalising coordination mechanisms and guiding participation of all stakeholders in health development in Sierra Leone.

c. Developing the long term expenditure framework (LTEF), medium term expenditure framework (MTEF) and the annual budget framework paper (ABFP) for the health sector.

The National HIV and AIDS Commission Act, 2011

The Act established the National HIV and AIDS Commission which is responsible for making policies for the prevention, management and control of HIV and AIDS and also to provide for the treatment, counselling, support and care of persons infected with, affected by or at risk of HIV and AIDS and for other related matters. The Commission consist of the President as Chairman; some Ministers; NGO, Religious, medical, persons living with HIV representatives; and also the Chairman of the Parliamentary Committee on HIV and AIDS. Functions of the Commission are to:

- formulate policies for the prevention, control, management and treatment of HIV

  and AIDS

- identify obstacles to the implementation of HIV and AIDS control policies and programmes and ensure the implementation and attainment of programme activities and targets
- • mobilize, expedite and monitor resources for the control of HIV and AIDS and

- • foster partnership with national and international development partners and the private sector for the effective implementation of HIV and AIDS interventions

The Commission shall establish in each District an HIV and AIDS Committee which will consist of:

1) the Chairman of the local council who shall be the chairman
2) the Chief Administrator
3) the Finance Officer
4) the District HIV and AIDS focal person
5) the chairman of the health committee of the local council
6) the District Medical Officer
7) representatives from persons living with HIV, NGOs, Workers Union, Religious Council, Women's Groups and Youth Groups

Legislation on safety and security

The constitution and other relevant laws and regulations for the security sector also provide for safety and security of communities.

The Constitution of Sierra Leone, 1991

Chapter 111 of the Constitution of Sierra Leone, 1991 on "The recognition and protection of fundamental human rights and freedom s of individuals" inter alia addresses the following issues:

Section 16. Protection of Right to Life

Section 17. Protection From Arbitrary Arrest or Detention

Section 18. Protection of Freedom of Movement

Section 20. Protection From Inhuman Treatment

Section 21. Protection From Deprivation of Property

Section 22. Protection for Privacy of Home and Other Property

Section 23. Provision to Secure Protection of Law

Section 28. Enforcement of Protective Provisions

Part 11 of the Constitution on "The Police Force" alludes to the establishment of the Police force to maintain law and order. The Police force is decentralized at the Provincial, District and Local levels with the Local Unit Commander (LUC) being in charge of a station.

National Security and Central Intelligence Act, 2002

This Act establishes the following security structures:

- National Security Council
- Provincial and District Security Committees

- Central Intelligence and Security Unit (CISU)
- Office of National Security (ONS)

3.2 Administrative Framework

3.2.1 Health Sector

Ministry of Health and Sanitation

The Ministry of Health and Sanitation has responsibility for health issues. It is organised into two main divisions at the central level: medical services and management services. District health services form the core component of primary health care. They are composed of a network of peripheral health units (PHUs), the district hospital and the District Health Management Team (DHMT). The PHUs are the first line health services, and are further sub-classified into three levels. Community Health Posts (CHPs) are at small town level with population between 5,000 and 10,000 and are staffed by State Enrolled Community Health Nurses (SECHNs) and MCH Aides. Development partners and International and Local NGOs play significant roles in the health sector.

Company Health Structure

MML has a small clinic, with a full-time medical doctor, a paramedic and nurses. The facility caters mainly for employees and their families. The Chief Medical Officer reports directly to the Chief Operating Officer.

3.2.2 Security Structure

Sierra Leone Police

The Sierra Leone Police (SLP) is the national police force. It is responsible for law enforcement and crime investigation throughout Sierra Leone. The paramilitary unit of the Sierra Leone Police is known as the Operational Support Division (OSD). The key mission of the Sierra Leone Police include to prevent crime, to protect life and property, to detect and prosecute offenders, to maintain public order, to ensure safety and security, to enhance access to justice and to ensure police primacy for internal security and safety.

The SLP is headed by The Inspector General of Police, the professional head of the Sierra Leone Police forces who is appointed by the President. The Inspector General of Police is assisted by the Assistant Inspector General of Police. At the national command level, are six Assistant Inspector Generals of Police (AIG) with responsibility for Personnel, Training and Welfare; Operations; Crime Services; Support Services; Professional Standards; and the Operational Support Division (OSD), (the armed wing of the SLP). Regional commanders known as Regpols who are also AIGs carry regional responsibilities for the Western, Northern, Southern and Eastern regions. Each one of Sierra Leone's 12 administrative districts is headed by a local unit commander.

National Security structure

The President presides over the National Security Council which comprises several Ministers, with the National Security Coordinator serving as Secretary. The object of the

Council is to provide the highest forum for the consideration and determination of matters relating to security in Sierra Leone.

There are security and intelligence committees for each Province and District. CISU is under the authority of the President and the ONS is headed by a National Security Coordinator appointed by the President.

Safety and Security Structure of Company

The company administers internal security within its lease area. This structure deals with the safety of the diamonds recovered, safety of assets and of personnel. In addition the company has a Safety Department., headed by a Safety Manager for occupational health and safety issues. The company has security staff to assist with internal security issues. For community-related security and safety issues the company liaises extensively with the Local Police headquarter in the handling of relevant issues. It also has an extensive network with the community through its Community Relations Department.

4 BACKGROUND TO COMMUNITY HEALTH AND SAFETY

The mining is not associated with the use and release of hazardous substances, a health baseline assessment was not conducted. . However, there is adequate information on health issues in the baseline socio-economic study and in Government documents on the health sector to be able to draw up a comprehensive plan. This will enable the prediction of health impacts in order to determine measures to reduce negative health consequences and enhance beneficial ones.

Community Health Management focuses on 'environmental health'. Environmental health encompasses the human living environment and emphasizes primary prevention through interventions in: housing; sanitation; solid waste control; water; food; transportation; and communication, and differentiates from "public health" with its disease specific focus. Approximately a third of the global burden of disease can be attributed to environmental risk factors.

The environmental health approach includes an examination of the relationships between overall disease burden and infrastructure impacts through a cross-sectoral examination that combines and integrates the broader potential adverse and beneficial effects of non-health sectors, as opposed to an assessment focused only on the immediate Project workforce.

Human resource staffing and skill levels correlate significantly with health outcomes and health systems performance and are a major social determinant of the overall burden of disease. The combination of the environmental burden of disease and health systems deficiencies could account for a high proportion of the overall burden of disease. An environmental health area (EHA) framework has been drawn up that categorizes the variety of bio-medical and key social determinants of health into twelve environmental health areas as indicated below.

4.1 Environmental Health Areas (EHAs)

1. Health services infrastructure and capacity and Program management delivery systems: physical infrastructure, staffing levels and competencies, technical capabilities of health care facilities; coordination and alignment of the Project to existing national and District level health programs, (e.g., TB, HIV/AIDS, malaria); and future development plans.
2. Sexually transmitted infections including HIV/AIDS.
3. Vector-related disease: malaria; and other arboviral diseases
4. 4.Vaccine Preventable Diseases: pneumococcus; measles; tetanus; typhoid; etc.
5. 5.Soil, Water, Waste and Sanitation related diseases: e.g hook and pinworms, etc.
6. Food and nutrition related issues: changes in subsistence practices; stunting, wasting, anemia, micro-nutrient diseases , gastroenteritis (bacterial and viral); and food inflation
7. Accidents/injuries and Community Safety: road traffic related spills and releases; construction; and drowning.
8. Social Determinants of Health (SDH): psychosocial; resettlement/relocation; violence; security concerns; substance misuse (drugs, alcohol, smoking); depression; and changes to social cohesion.
9. Exposure to potentially hazardous materials: road dusts; air pollution (indoor and outdoor related to industrial activity, vehicles, cooking, heating or other forms of combustion/incineration); landfill refuse or incineration ash; any other Project related solvents, paints, oils or cleaning agents, by-products; noise; and illumination.
10. Housing and Respiratory issues: acute respiratory infections (bacterial and viral); pneumonias.

5 HEALTH AND SAFETY SITUATION

5.1 National Health situation

The Human Development Index rank for Sierra Leone is 182 out of 189 countries (UNDP, 2020). The country's health indicators are still among the worst in the world. Under-5 mortality and maternal mortality remain intractably high - 122/1,000 (DHS 2019) and 717/100,000 live births (DHS 2019), respectively. Communicable diseases contribute to 65 percent of the total disease burden, though non communicable diseases (29 percent) and injuries (6 percent) are on the rise. The leading causes of death are malaria, lower respiratory infections, cardiovascular disease, and diarrheal disease. Although there are many medical facilities, they lack medical professionals and equipment and infrastructure services

Table 5-1 Information on National Health-related Indicators

Key Social Indicators	Rate	Source
National Population	7,076,641	Statistic Sierra Leone, 2015 Census
Human Development Index	0.452 in 2019. Ranked 182 out of 189 countries	UN Human Development Report, 2020-The next frontier Human development and the Anthropocene.
Infant mortality rate (IMR)	56 deaths per 1000 live births in 2017	Government of Sierra Leone (2019). Sierra Leone Medium Term National Development Plan, 2019-2023. [online] Available at http://www.moped.gov.sl/wp-content/uploads/2019/03/Medium-Term-National-Development-Plan-Volume-I.pdf
Life expectancy at birth	54.7 years	UN Human Development Report, 2020-The next frontier Human development and the Anthropocene.
Maternal Mortality ratio	1,100/100,000 in 2013	WHO (2014). Sierra Leone. [online] Available at http://www.who.int/maternal_child_adolescent/epidemiology/profiles/maternal/sle.pdf
Teenage pregnancy (15-19 years)-	Total 21% (Urban 14%, Rural 29%)	Sierra Leone Demographic and Health Survey, 2019
HIV prevalence-	1.7% (Urban 2.3%, Rural 1.2%)	Sierra Leone Demographic and Health Survey, 2019
% of population with access to improved water	67% (Urban 92%, Rural 49%)	Sierra Leone Demographic and Health Survey, 2019
% of population	55% (Urban 84%,	Sierra Leone Demographic and Health

Key Social Indicators	Rate	Source
with access to improved sanitation facility	Rural 33%)	Survey, 2019

Sierra Leone has roughly 1,200 public health facilities, although the number of facilities and their designated levels of care frequently change as new facilities open and existing facilities close (Ministry of Health and Sanitation, 2017). There are 24 hospitals in the country, 9 of which are located in the Western Area, including the three primary tertiary hospitals.

A Majority of the causes of illness and death in Sierra Leone are preventable, with most deaths attributable to nutritional deficiencies, pneumonia, anaemia, malaria, tuberculosis and now HIV/AIDS. Diarrhoeal diseases and acute respiratory infections are also major causes of out-patient attendance and illness in the country. The greatest burden of disease is on rural populations, and on females within the rural population. Women are also more likely to have to stop their economic activities due to illness than men.

Malaria remains the most common cause of illness and death in the country. Insufficient numbers of health facilities are equipped and staffed to acceptable standards to provide emergency obstetric care. There is also no functional referral system in many districts, leading to delays in provision of comprehensive emergency obstetric care.

Children in Sierra Leone are generally malnourished. Children in rural areas are more likely to be stunted and wasted than children in urban areas.

Availability of clean water and safe sanitation is a major factor affecting the health status of the population. The situation is worse in rural areas than in urban communities, with rural communities.

Health care costs remain very high in Sierra Leone, resulting in poor utilization. Implementation of free health care in all peripheral health facilities and district hospitals is recommended as the practical policy option that will address the health of the poor majority.

5.2 Health Services Profile

The country's health service delivery system is pluralistic. Government, religious missions, local and international NGOs and the private sector all provide services. There are public, private for profit, private non-profit and traditional medicine practices. The private sector is underdeveloped compared to countries in the sub-region such as Ghana and involves mainly curative care for inpatients and outpatients on a fee-for-service basis. Private health facilities operate under the authority of individual owners and/or boards of directors, mainly in urban areas. The non-poor tend to use private health facilities more often than the poor. Traditional healers and Traditional Birth Attendants (TBAs) are reported to be providing a significant amount of health care, with TBAs attending to almost 90% of the deliveries at the community level.

The Government had passed the Hospital Boards Act of 2003 and the Local Government Act of 2004 in the context of the civil service reforms. Both laws seek to devolve responsibility and accountability of some government functions to the local level for effectiveness and efficiency of service delivery.

The health service organization is based on the primary health care concept which was started in the 1980s. The public health delivery system comprises three levels: (a) peripheral health units (community health centres, community health posts, and maternal and child health posts) for first line primary health care; (b) district hospitals for secondary care; and (c) regional/national hospitals for tertiary care.

As part of the public sector reforms started in 2003, the Ministry of Health and Sanitation is now organised into two main divisions at the central level: medical services and management services.

District health services form the core component of primary health care. They are composed of a network of peripheral health units (PHUs), the district hospital and the District Health Management Team (DHMT). The PHUs are the first line health services, and are further sub-classified into three levels. The maternal and child health posts (MCHPs) are situated at village level for populations of less than 5000. They are staffed by MCH Aides who are trained to provide numerous services: antenatal care, supervised deliveries, postnatal care, family planning, growth monitoring and promotion for under-five children, immunisation, health education, management of minor ailments, and referral of cases to the next level. The MCH Aides are supported by community health workers (TBAs, Community volunteers, etc).

Community Health Posts (CHPs) are at small town level with population between 5,000 and 10,000 and are staffed by State Enrolled Community Health Nurses (SECHNs) and MCH Aides. They provide the same types of services that are provided at the MCHPs but they also include prevention and control of communicable diseases and rehabilitation. They refer more complicated cases to the Community Health Centres (CHCs) which are located at Chiefdom level, usually covering a population ranging from 10,000 to 20,000 and staffed with a community health officer (CHO), SECHN, MCH Aides, an epidemiological disease control assistant and an environmental health assistant. They provide all the services provided at the CHP level in addition to environmental sanitation and supervise the CHPs and MCHPs within the Chiefdom.

The District Health Management Team (DHMT) is responsible for the overall planning, implementation, coordination, monitoring and evaluation of the district health services under the leadership of the District Medical Officer (DMO). Other members include the medical officer in charge of the district hospital and scheduled officers for various programs and units.

5.3 Health related issues in District

Port Loko is one of the largest districts in the Northern Province of Sierra Leone, and is administratively divided into 11 chiefdoms. Health services in the district are provided by the district health management team (DHMT), headed by the district medical officer and a

team of Ministry of Health and Sanitation (MOHS) staff. The district provides primary health services through 33 community health posts (CHPs), 62 maternal child health posts (MCHPs),14 community health centers (CHCs), and three private clinics (Sierra Leone Ministry of Health and Sanitation, WHO, Service Availability and Readiness Assessment [SARA], 2017), serving a population of 615,376 (Statistics Sierra Leone and Government of Sierra Leone, 2016). Services are provided by 617 salaried staff and 243 volunteers (Ministry of Health and Sanitation, Sierra Leone, Directorate of Human Resources for Health). Among the staff, 50 are state-enrolled community health nurses (SECHNs); 207 are maternal and child health (MCH) aides; 15 are community health assistants (CHAs); 13 are community health officers (CHOs); 89 are nurses; and 16 are midwives.

Table 5-2 indicates that there is a dearth of senior health personnel in the District

Table 5-2: Port Loko-Major health personnel requirements

Category	Available	Need	Gap
Surgeon specialist	0	2	2
Paediatrician	0	2	2
Gynaecologist	0	2	2
Dentist	0	2	2
Radiologist	0	1	1
Medical superintendent	1	3	3

Source: District development plan study (field data) 2017

The Health Sector continues to provide a challenge to the district medical team. The District Council has listed down below the priority requirements for the District.

i) Provision of more Traditional Birth attendants (TBAs) to at least two per village

ii) Rehabilitation of Primary Child Health (PCHs) facilities according to the population of women in the area

iii) Improve on the water, sanitation and hygiene facilities in the district

iv) Improved extension of child nutrition centers for malnourished children

v) More sensitization of pregnant women and husbands on pre-natal and or clinic attendance

vi) Increase the number of Doctors and trained Nurses in the district

6 Mitigation And Management Measures

6.1 Measures already being Undertaken by Company

6.1.1 Health Care Facilities

MML has established a clinic, with a full-time medical doctor, an advanced life support (ALS) paramedic and three nurses in the project site area.

6.1.2 Fuel storage and handling

Fuel is stored in tanks and is distributed through a metered electric pump. Fuel is obtained from fuel bowsers. Fuel is delivered into the tank that is used for daily distribution. From there, fuel is pumped via a fuel polishing filtration system to the main storage tank. Heavy machinery working in the different areas of the mining lease area are supplied fuel by a mobile fuel bowser which receives its fuel from the fuel station. In turn, the fuel bowser is equipped with a metered pump. A fuel consumption database is maintained by the logistics department and audited by the finance department.

6.1.3 Waste Management

Domestic waste

No hazardous waste is generated during operations and all domestic waste that is generated will be collected and disposed of by use of the incinerators.

Tailings management

The tailings are disposed of via several deposition points into the tailings storage facility (TSF). The TSF is equipped with a penstock- this is used to recover water from the dam, and is equipped with trenches to catch any water that leaks out of the dam. All water recovered from the dam will be channelled into a return water dam. From the return water dam, the water will be pumped into the processing plant for re-use. The tailings will be transported by a conveyor belt to the tailings deposition dump.

6.2 Guiding Principles For New Mitigation and Management Measures

MML project will ensure that government's ability to deliver on providing services and utilities is not detrimentally affected as a result of the Project. It is emphasised, however, that the Project will not take on government's responsibility as service provider to resettlement villages.

The provision of community health care services is a complex and sensitive undertaking that requires significant planning and resources. In addition, there are important long-term transition considerations that must be analyzed, i.e., sustainability issues. There is a complex intersection between: (1) Company procedures and practices; (2) community expectations; and (3) existing customary practice by current industrial operators.

Issues can be identified which could be potentially avoided or minimized by focused primary project design changes, such as re-routing roadways, etc. From a health perspective,

this can be considered as primary prevention of potential effects. Similarly, secondary prevention strategies can be utilized to reduce impacts at both a defined geographical location and or to a given population or community. Tertiary prevention or overt treatment (remedy) is the third level of mitigation that can be employed. Remedy interventions may include restoration or repair to essential needs like water well.

The overall mitigation strategies are organized around two fundamental public health concepts:

- Health promotion / education defined as:
    - Any intervention that seeks to eliminate or reduce exposure to harmful factors by modifying human behaviors; and
    - Any combination of health education and related organizational, political and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health; and
- Disease prevention defined as:
    - Any intervention that seeks to reduce or eliminate diagnosable conditions; and
    - May be applied at the individual level, as in immunization, or the community level, as in the chlorination of the water supply.

Disease prevention is often illustrated by the prevention pyramid which is composed of:

- Primary: the base of the pyramid which covers population-oriented actions designed to be implemented before health problems develop;
- Secondary: the second level covering actual clinical preventive services for populations at high risk, where interventions are designed to prevent a condition; and
- Tertiary: top of the pyramid covering treatment intervention or rehabilitation with existing, serious problems.

The placement of population-oriented prevention at the base is significant due to its:

- Focus on all of the people as recipients;
- Broad, long-lasting impact on health; and
- Role in defining and facilitating the whole system to work.

Because of the geographical extent of the Project, a combination of health promotion/education and primary disease prevention is the most efficient and cost-effective method of managing potential impacts. Therefore, a workforce health promotion/education effort spearheaded by the Company can significantly impact or influence behaviors and practices in local communities by using the Project's workforce as "peer educators and ambassadors" in their home villages. Political reality refers to the problem of constructing

strategies that are reasonably cost-effective, sustainable and aligned with Government plans and capacity to deliver.

The project will have a large national workforce which comes from geographic areas where the Project is active. Project workers have the potential to mitigate potential negative health impacts and effect positive change at both a household and community level because they live in the potentially affected communities. In a given location, the size of the local national workforce is larger than any group of similar community activists or organizations that could be easily, cost-effectively or efficiently created and reached on a continuous basis. Therefore, using local workers is a more effective strategy in order to meet government health strategies.

6.3 Measures recommended in Environmental management plan Minimize noise impact

- The blasting operations are generally intermittent and should be limited to daylight hours when ambient noise levels are highest;
- The use of millisecond delays between rows of blast holes in a given blasting pattern in order to reduce the amount of explosive charge detonated at any given instant is recommended;
- Reduction of the powder factor, that is, use of less explosive per cubic yard of overburden;
- Restriction of blasting to daylight hours are mitigation measures that should be followed;
- Maintaining good public relations with the surrounding communities i.e warning the villagers in advance before blasts;
- Vehicles to be switched off when not in use;
- Regular maintenance on mining vehicles to insure silencing equipment is still effective i.e. exhaust mufflers; and
- Fixed noise producing sources such as generators, pump stations and crushers to be to be either housed in enclosures or barriers put up around the noise source. The barriers should be installed between the noise source and sensitive noise receptor, as close to the noise source as possible.

Minimise the risk for spillage of fuel and oil on site.

- Limit the movement of vehicles on site as much as is practical;

Drawdown of Water Table

- Monitoring of borehole levels
- The impacts on MML's water supply wells for the camp, office, and resettlement areas should also be evaluated.

Enhance local government capacity for infrastructure and service delivery

- Investigate the establishment of capacity building and institutional strengthening programme for both local and district government.
- Investigate, in collaboration with government departments, feasible options for public-private partnerships in order to plan for anticipated increased demand.
- Explore opportunities for collaboration with local police with regard to safety and security issues relating to mining activities in general and contractor movement in particular.

Mitigation measures suggested in the RPF

- Explore opportunities for collaboration with national organisations involved in capacity building, training and the provision of specialised health and educational services.
- Form partnerships with organised business to address the provision of bulk services and infrastructure.

Improve road networks in the broader project area

- Carefully plan and design the location of replacement land to minimise changes to movement patterns
- Upgrade and surface main routes used by project vehicles in the broader project area.
- Implement education and awareness programme for health and safety (with a focus on traffic) in villages along transport routes.
- Ensure appropriate placement of signage around the project area
- Ensure resettlement of households before the construction of the wall to avoid temporary disruption of movement patterns?
- Construct the road diversion before (or as soon as possible) closing the existing road

Promote community well being

- Ensure that resettlement is undertaken with sensitivity to the reestablishment of social networks that have provided material and social security in the community, e.g. providing the opportunity for households to select the their new housing plot in order to be in proximity to current neighbours and relatives.
- Take into account measures to mitigate the loss of social networks and promote the restoration of livelihoods.
- Provide access to appropriate information for the affected community well in advance of project impacts occurring.

- Manage the location of contractor accommodation to limit the impact of foreign workers on local settlements.
- Develop and implement induction programmes for new contract workers to increase sensitivity to local norms and customs.
- Work closely with local health services in monitoring and addressing changes in levels of community health and well being.
- Implement a HIV/AIDS awareness programme on health issues and behavioural change amongst contractors, employees and villagers.
- Support inter-village recreational competitions to foster increased healthy lifestyles a round sport and recreation.
- Partner with local education NGO's in the area and provide assistance in developing education within the project area.
- Identify suitable local scholars and students and provide them with bursary and internship opportunities.
- Partner with local schools and assist with education enhancement and the provision of supplies and services wherever possible.

Implement monitoring plans

Comprehensive monitoring plans are recommended for the following in the Environmental Management Plan

- Noise including blasting
- Vibration
- Groundwater monitoring
- Surface water monitoring
- Air quality

6.4 Additional Recommended Mitigation and Management Measures

A series of mitigation strategies will be developed into detailed implementation plans describing timeframes, responsibilities, collaborating agencies/organizations and performance indicators.

6.4.1 Environmental Health Area 1: Health Services Infrastructure

Health services infrastructure and capacity and program management delivery systems includes physical infrastructure, staffing levels and competencies, technical capabilities of health care facilities; coordination and alignment of the Project to existing national and District level health programs,(e.g., TB, HIV/AIDS, malaria), and future development plans.

Key concerns and mitigation measures

Health Statistics indicate little improvement in health service delivery for the PIA communities. Numerous problems impact the capacity of the present District health

infrastructure to adequately service existing constituencies. These include inadequacies in drug supplies, training, staffing and resources at all levels. There are inadequacies in health policy, planning and regulatory framework identified in the National Health Plan which need to be addressed.

Possible collaborating and implementing partners

- Health Development partners (Donors and UN Agencies)
- Health implementing partners (INGO and LNGO)
- District Health Management Teams
- Local Councils

Role of company

Company will support the effort of collaborating and implementing partners for projects in this area selected by the Committee set up to recommend and approve CDAP projects.

Cost details

Cost details will be as provided for in the approved CDAP budget.

6.4.2 Environmental Health Area 2: Sexually Transmitted Infections including HIV/AIDS

Sexually transmitted infections: HIV/AIDS and other sexually transmitted diseases

Key concerns and mitigation measures

The Project will trigger economic activity across a broad geographical area. However, this is also potentially associated with:

- Significant population influx issues; and
- Potential rises in sexually transmitted infections (STIs) including HIV/AIDS.
- The expansion of operations is also associated with an expanded workforce mine and its contractors.

The approach to mitigation will focus on supporting existing local measures aimed at reducing the incidence of objective disease. The Company goal is to prevent a significant increase of STIs within the Project area.

The Company will monitor and evaluate STIs for its workforce and initiate and participate in information, education and information programs.

Possible collaborating and implementing partners

- Health Development partners (Donors and UN Agencies)
- Health implementing partners (INGO and LNGO)
- District Health Management Teams
- Local Councils
- National Aids Secretariat

Role of company

Company will support the effort of collaborating and implementing partners for projects in this area selected by the Committee set up to recommend and approve CDAP projects. Company will also initiate projects on its own accord.

Cost details

Cost details will be as provided for in the approved CDAP budget. Additional costs will be borne within the company's operating budget.

6.4.3 Environmental Health Area 3: Vector Related Issues

Vector-related disease: malaria and other diseases.

Key concerns and mitigation measures

The Project may produce changes in the existing landscape that will have both physical and social effects. These may involve new surface water bodies and land grading and surface changes. Associated with the physical environment are a large variety of indigenous vectors (mosquitoes, flies etc.) that are capable of acting as hosts for several significant parasitical diseases. The Project has the potential to alter, positively or adversely, the nature and extent of these vectors and their associated diseases in humans. Social changes are related to creation of new spatial relationships between water sources/flow patterns and human settlements.

The mitigation strategies focus on common vector diseases already present in the Project area population, the most important of which is malaria. In order to control vector breeding sites, efficient environmental management of surface water is essential. Public health engineering and water management are essential strategies. Vector control in local communities using Indoor Residual Spraying (IRS) is possible; however, sustainability issues are extremely important. In addition, coordination with national vector control program authorities is essential. Primary prevention malaria control measures are:

- Environmental modification and manipulation; and
- Changes in man-vector contact.
- These strategies are non-toxic, cost-effective, and typically sustainable. Environmental modification refers to measures that try to create a permanent or long-lasting effect on land, water, or vegetation in order to reduce vector habitats including:
- Improved surface water drainage for Project roadways and other construction activities;
- Systematic elimination of standing pools of water;
- Installation and maintenance of drains;
- Deepening, filling, leveling;

Although all standing water will not be able to be prevented, design plans will address appropriate drainage, shoring, sloping, etc. Modification or manipulation of human habitation or behaviour, which reduces man–vector contact including:

- Mosquito proofing Project houses and tanks;
- Improved design and construction of Project housing, closing eaves and bednets.

In local communities, the use of pesticide application either in the form of indoor residual spraying (IRS) or as external fogging requires careful consideration and review. Decisions regarding IRS and/or fogging should be driven by:

- The findings of entomological surveys;
- Coordination with relevant national programs;

Possible collaborating and implementing partners

- Health Development partners (Donors and UN Agencies)
- Health implementing partners (INGO and LNGO)
- District Health Management Teams
- Local Councils

Role of company

Company will support the effort of collaborating and implementing partners for projects in this area selected by the Committee set up to recommend and approve CDAP projects. Company will also initiate projects on its own accord.

Cost details

Cost details will be as provided for in the approved CDAP budget. Additional costs will be borne within the company's operating budget.

6.4.4 Environmental Health Area 4: Vaccine Preventable Diseases

Vaccine Preventable Diseases – pneumococcus, measles, typhoid, etc.

Key concerns and mitigation measures

Project triggered influx can create potential mixing of households with variable levels of immunization for key communicable diseases. In this situation, communities can be prone to sudden epidemics of highly communicable diseases, e.g., measles, influenza, pneumococcal pneumonia, etc. Government health Department staff usually take on a greater responsibility in managing immunization programs, They however require support, particularly in vaccine procurement, distribution and logistics.

Possible collaborating and implementing partners

- Health Development partners (Donors and UN Agencies)
- Health implementing partners (INGO and LNGO)
- District Health Management Teams

- Local Councils

Role of company

Company will support the effort of collaborating and implementing partners for projects in this area selected by the Committee set up to recommend and approve CDAP projects. Company will also initiate projects on its own accord.

Cost details

Cost details will be as provided for in the approved CDAP budget.

6.4.5 Environmental Health Area 5: Soil, Water, Sanitation and Waste Related

Issues

Soil, Water, Waste and Sanitation related diseases – e.g., hook and pin worms, etc.

Key concerns and mitigation measures

The majority of the soil, water, sanitation and waste related impacts above background are

related to the influx of job seekers and other extended family/clan members into communities surrounding the project. The most significant issues are:

- Water source and access ;
- Increase in unimproved sanitation (overburdened latrines, increase in use of 'the bush', toilet facilities and excrement management); and
- Increased household waste and Project landfill waste increasing fly/sanitation related diseases (Municipal solid and liquid waste management).

The overall proposed strategy is based on:

- Support to community water sanitation hygiene programs; and
- Adequate design of resettlement housing where significant water and sanitation enhancements are built into the housing and community level designs, e.g., water sources and latrines.

The aim of Water Environmental Sanitation (WES) projects and programs is to prevent the degradation of existing WES status in nearby communities due to Project triggered influx.

The major problems relating to excreta and sanitation which result in health risks are:

- Open defecation;
- Not washing hands properly;
- Sanitary structures not used correctly, are poorly designed, or are poorly maintained; and
- Contact with excreta of infected animals.

Overall knowledge, attitudes and practices related to sanitation are poor and many residents will have a similar lack of education regarding soil/water/sanitation related illnesses and safe practices. "Clean Hands Program" targeting children and mothers with children under age 5 could be adopted in the Project areas. Current evidence shows that washing hands with soap can reduce diarrhoeal diseases by 42 to 47%. Hand washing programs could also lower incidences of pneumonia and diarrhoea.

Several pathogens can be transmitted through infectious skin or contaminated clothes. Diseases associated with fleas, mites, flies and lice are easily spread by crowded living Conditions, poor personal hygiene and ineffective laundry services. The community demands for water and sanitation services will exceed the 'true' actual impacts, particularly for water source and access improvements. Therefore, the Project must decide what level of effort to make, i.e., differentiating between impact mitigation and philanthropy. The community water/sanitation/municipal sanitation 'deficit' is so substantial that it is not possible to 'fix' this problem.

Possible collaborating and implementing partners

- Health Development partners (Donors and UN Agencies)
- Health implementing partners (INGO and LNGO)
- District Health Management Teams
- Local Councils
- SALWACO

Role of company

Company will support the effort of collaborating and implementing partners for projects in this area selected by the Committee set up to recommend and approve CDAP projects. Company will also initiate projects on its own accord.

Cost details

Cost details will be as provided for in the approved CDAP budget. Additional costs will be borne within the company's operating budget.

6.4.6 Environmental Health Area 6: Food and Nutrition Related Issues

Food and nutrition related issues - changes in subsistence practices; stunting, wasting, anemia, micro-nutrient diseases (including folate, Vitamin A, iron, and iodine), gastroenteritis (bacterial and viral); food inflation.

Key concerns and mitigation measures

There are four main issues surrounding Project impacts on food and nutrition:

- Potential transmission of food related illnesses from the Project to the surrounding communities;
- Understand the risk of food related illness transmission from the community to the Project;

- Food inflation will occur in the PIAs and may disproportionately affect vulnerable g roups; and
- Understand nutritional status of key vulnerable groups in local communities.

Anthropometric measurement (physical dimensions and gross composition of the body) of children (under age 5) and adults is a safe and non-invasive method of obtaining important data regarding nutrition status across PIAs and for specific sub-populations, e.g., potential vulnerable groups. Physical measurement techniques can be supplemented with field assessment of haemoglobin levels using simple equipment that requires finger stick quantities of blood. Nutritional surveys should be expanded and performed periodically for all potential vulnerable populations.

Possible collaborating and implementing partners

- Health Development partners (Donors and UN Agencies)
- Health implementing partners (INGO and LNGO)
- District Health Management Teams

Role of company

Company will support the effort of collaborating and implementing partners for projects in this area selected by the Committee set up to recommend and approve CDAP projects.

Cost details

Cost details will be as provided for in the approved CDAP budget.

6.4.7 Environmental Health Area 7: Accidents and Injuries; Community Safety

Accidents/injuries and Community Safety– road traffic related spills and releases, construction and drowning.

Key concerns and mitigation measures

Transport activities have potential to cause direct injuries and road traffic accidents. The existing national road traffic accident burden is poorly quantified. In addition, there are often very high underlying rates of household level injuries and accidents, e.g., burns and slip/falls. Dramatic upsurges in local populations can accentuate these trends and overwhelm an existing fragile medical system. Large projects like this will trigger a rapid improvement and expansion in the local and regional transportation infrastructure.

General parameters of concern are:

- Volume of traffic (function of commercial and other vehicles (cars/trucks/buses/bicycles) and pedestrians on the road);
- The road conditions themselves (sealed, poor shoulders, potholes, winding conditions, hilly conditions, width, etc.); and
- The nature of activities on the side of the road (degree of commercial activity including agricultural produce selling and trading).

Mitigation measures regarding transport activities and behaviour will address:

- Driver competency-Drivers typically undergo internal training
- Enforcement-The volume of traffic appears low except for motorbykes. Enforcement is however poor.
- Speed- Speed control appears minimal.
- Alcohol-There is no consistent system that enforces highway alcohol testing in country. It should be anticipated that a high portion of accidents are probably alcohol related.
- Vehicle Conditions-It is unclear if there are uniform and enforced vehicle maintenance standards or frequency of testing required, e.g., tire wear, placarding and signage, mirrors, physically securing loads/containers, etc.
- Fatigue-This could be caused by a combination of factors including a push for extra hours.
- Security-There could be theft of materials from the general stores and a moderate risk for hazardous materials exposure. The contributing factors to this risk are associated with a lack of governance, high poverty rate and unemployment. Security issues such as robbery and assault increase in market areas and significantly at night.
- Medical Support-In the relevant Project areas, medical support is limited. The few clinics that are along the routes are equipped, staffed and trained to a level that would be inadequate for any significant road trauma event. Also, there is no reliable ambulance service.
- Community Conditions-Vehicles passing through or near communities will encounter high pedestrian traffic, congestion and narrowing of roadways. In the event of an incident, the population will have a tendency to swarm the area and become extremely agitated. Life and property could be at an extreme risk should the crowd deem the accident in any way personal.
- Additional Items-Agriculture\vegetation grows right to the shoulder of many roadways. In the event of a hazmat spill, these areas have a very high likelihood of being damaged. This problem is compounded when considering both the 'rainy season' and should a spill occur into a river especially when commuting over a bridge.

It is also necessary for the following to be put in place:

- •Adequate roadway signage in all Project areas;
- Accident prevention programs at a community level should be put in place;
- Law enforcement for (speeding, reckless driving, alcohol use, seat belt usage,
- use of mobile phones while driving etc.) should be stepped up;
- Medical emergency response systems for off-site accidents, injuries or hazardous materials release events should be put in place;

- Changes to road conditions, road access, river access, electricity and power supplies, water supply & distribution, telecommunications should be addressed in the Community Infrastructure Plan;
- Traffic related issues should be addressed in the Traffic Management Plan;
- Community interaction with site-related potentially hazardous materials should be addressed;
- Site physical water structures such as fire water ponds are attractants for
- people and animals;
- Within the work zone accident/injury prevention, control and management is a major function of the Environmental Health and Safety Department and is not directly covered in this analysis.

Possible collaborating and implementing partners

- Health implementing partners (INGO and LNGO)
- District Health Management Teams
- Sierra Leone Police
- Office of National Security
- Sierra Leone Roads Authority
- Sierra Leone Road Traffic Authority
- Drivers' Unions

Role of company

Company will support the effort of collaborating and implementing partners for projects in this area selected by the Committee set up to recommend and approve CDAP projects. Company will also initiate projects on its own accord.

Cost details

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6.4.8 Environmental Health Area 8: Social Determinants of Health; Community

Security

Social Determinants of Health (SDH): psychosocial, resettlement/relocation, violence, security concerns, substance misuse (drugs, alcohol, smoking),depression and changes to social cohesion

Key concerns and mitigation measures

PIA communities have some underlying level of drug and alcohol use, smoking, and gender violence. In addition, local social cohesion, or lack thereof (crime and security fears), is present to some degree. Community concerns related to security and violence are significant and in many locations Project triggered influx is a general stressor to the community and

typically accentuates fissures and pathologies that may already be present. There will be an influx of personnel and job seekers into the Project Impact Area, particularly. This has the potential to disrupt social cohesion and stress communities. This also has the potential to increase law and order issues. Gender violence is an important issue related to influx and dramatic changes in income. Rising incomes and influx will attract a variety of service providers both positive and negative.

The safety and security of the Project operations is an important focus while ensuring respect for human rights.

Possible collaborating and implementing partners

- District Health Management Teams
- Local Councils
- Police
- Office of National Security

Role of company

Company will support the effort of collaborating and implementing partners for projects in this area selected by the Committee set up to recommend and approve CDAP projects. Company will also initiate projects on its own accord.

Cost details

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6.4.9 Environmental Health Area 9: Hazardous Materials Exposure

Exposure to potentially hazardous materials: road dusts, air pollution (indoor and outdoor related to industrial activity, vehicles, cooking, heating or other forms of combustion/incineration), landfill refuse or incineration ash, any other Project related solvents, paints, oils or cleaning agents, by-products, noise and illumination.

Key concerns and mitigation measures

Hazardous materials issues are related to the following:

- Accidental releases of on-site materials that could affect nearby communities,
- e.g., diesel fuel, sewage effluent, insecticides;
- Air emissions from plant operations, particularly related to diesel emissions from power generating equipment;
- Transportation related leaks/spills. These events are covered under accidents and injuries;
- "Poison Centre" concerns: exposures of workers to pesticides; exposures to pesticides and faecal coliforms via food residues; and snakebites and other events in communities; and

- Risk communication in local communities related to hazardous materials and also f eedback of sampling results, e.g., water, soil and air monitoring.

Possible collaborating and implementing partners

- District Health Management Teams
- Local Councils
- Police
- Office of National Security

Role of company

Company will support the effort of collaborating and implementing partners for projects in this area selected by the Committee set up to recommend and approve CDAP projects. Company will also initiate projects on its own accord.

Cost details

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6.4.10 Environmental Health Area 10: Respiratory/ Housing

Housing and Respiratory issues: acute respiratory infections (bacterial and viral), pneumonias, tuberculosis; respiratory effects from housing, overcrowding, housing inflation.

Key concerns and mitigation measures

Many respiratory diseases are highly communicable and could be transmitted back and forth between the community and a large onsite workforce.

The key goals are:

- Prevent rapid rise and further transmission (worksite and community) of communicable respiratory diseases in workforce populations, particularly onsite construction workers in temporary barrack-style housing;
- Prevent rapid rise and further transmission of communicable respiratory diseases in resettlement households;
- Prevent introduction of communicable respiratory diseases via Other Country Nationals (OCNs) into local communities, specifically pandemic flu and tuberculosis; and
- Establish a monitoring and evaluation program for respiratory diseases.

Primary prevention (i.e., immunizations for adults and children) is the most cost effective method of managing communicable respiratory disease impacts.

Possible collaborating and implementing partners

- Health Development partners (Donors and UN Agencies)
- Health implementing partners (INGO and LNGO)

- District Health Management Teams
- Local Councils

Role of company

Company will support the effort of collaborating and implementing partners for projects in this area selected by the Committee set up to recommend and approve CDAP projects. Company will also initiate projects on its own accord.

Cost details

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6.4.11 Environmental Health Area 11: Non-Communicable Diseases

Non-Communicable Diseases - hypertension, diabetes, stroke, and cardiovascular disorders

Key concerns and mitigation measures

Due to the improvement in income generation and changes in nutrition the Project is likely to trigger an epidemiologic transition from infectious to non-communicable diseases (NCD) in both the workforce and PIAs. The following measures should be put in place:

- Review of medical clinic databases to see if there are indications of the rapid transition from infectious to NCDs.
- Local care service providers should be trained in NCDs.
- Significant pharmaceutical supply and storage issues for many of the medications used for the most important NCDs, e.g., insulin and antihypertensives should be addressed.

6.4.12 Resettlement Populations

Key concerns and mitigation measures

Multiple potential health impacts are related to involuntary resettlement, such as access to health care, nutrition status, and movement from an area of low malaria transmission to an area of high transmission, increases in violence, etc. Household health status will be assessed as part of the supplementary social survey efforts that will be performed at a later date.

Possible collaborating and implementing partners

- Health implementing partners (INGO and LNGO)
- District Health Management Teams
- Local Councils

Role of company

Company will support the effort of collaborating and implementing partners for projects in this area selected by the Committee set up to recommend and approve CDAP projects. Company will also initiate projects on its own accord.

Cost details

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6.4.13 COVID-19

World Bank and national guidelines for COVID should be followed;

WB COVID guidelines

The WB guidelines recommend assessing the current situation of projects, putting in place mitigation measures to avoid or minimize the chances of infection (Corona virus) and planning what to do if either project workers become infected or the work force including workers from proximate communities are affected by COVID-19.

https://worldbankgroup.sharepoint.com/sites/wbunits/opcs/Knowledge%20Base/ESF%20Safeguards%20Interim%20Note%20Construction%20Civil%20Works%20COVID.pdf-).

The guidelines acknowledge that national and local laws may impose social distancing, restriction on movement and large gatherings as measures to minimize the spread of COVID 19 together with the fact the general public may be averse to large gathering as they protect themselves from COVID 19. It further acknowledges that these realities can adversely affect the extent to which Borrowers can meet the requirements of ESS10. The guidelines go ahead to proffer strategies on how to manage stakeholder engagement and consultation amidst these challenges. The guideline stipulates that public gathering such as workshops should be avoided but small group meetings like focus group meetings can be carried out, if permitted by national and local laws. For detail, see-

https://worldbankgroup.sharepoint.com/sites/wbunits/opcs/Pages/pc/Operations-COVID19-Coronavirus-Information-03092020-081859/Environmental-a-04202020-163137.aspx

7 MONITORING, EVALUATION, REPORTING AND NOTIFICATION

Accurate and timely data allows for objective, evidence based decision making. The Project is an extremely high profile undertaking that will have ongoing scrutiny from an extremely diverse set of stakeholders including NGOs, multilateral institutions, international financial institutions, host government and company shareholders. While stakeholders are "free" to develop and hold their own opinions, these beliefs should be based on a transparent, coherent, and objective set of data. While the Project cannot control beliefs, it can manage data collection by using a scientific and defensible process that is best practice in a developing country setting.

The Project Community Health and Safety Manager will work with the Project Team and other Social Programs representatives to develop procedures for reporting community health and safety program evaluations, results of demographic surveillance system activities, and responses to community health and safety related grievances.