

**INDONESIA – EMERGENCY FINANCING SUPPORT FOR COVID-19
PROGRAM-FOR-RESULTS (PFORR)
P173843**

**ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT REPORT
(ESSA)**

May 2020

Prepared by the World Bank

ABBREVIATIONS AND GLOSSARY

TERM	EXPANDED TERM/ DEFINITION
AIDS	Acquired Immune Deficiency Syndrome
AF	Additional Financing
AMDAL	Environmental Impact Analysis or <i>Analisis Dampak Lingkungan</i>
BAPPEDA	District Planning Agency or <i>Badan Perencanaan Pembangunan Daerah</i>
BBTKLPP	Environmental Health and Disease Control Centre or <i>Balai Besar Teknik Kesehatan Lingkungan Dan Pengendalian Penyakit</i>
BNPB	National Disaster Management Authority or <i>Badan Nasional Penanggulangan Bencana</i>
BPBD	District Disaster Management Agencies or <i>Badan Penanggulangan Bencana Daerah</i>
BPJS	National Social Health Insurance Agency or <i>Badan Penyelenggara Jaminan Sosial</i>
BPKP	Finance and Development Monitoring Agency
BPRS	Hospitals oversight boards or <i>Badan Pengawas Rumah Sakit</i>
BSL	Bio-Safety Level
CISDI	Center for Indonesia’s Strategic Development Initiatives (CISDI)
COD	Chemical Oxygen Demand
COVID-19	Coronavirus Disease 2019
CSO	Civil Society Organization
DAK	Special Allocation Funds or <i>Dana Alokasi Khusus</i>
DAK Akreditasi	Special Allocation Funds for Accreditation or <i>Dana Alokasi Khusus Akreditasi</i>
DAK non-fisik	Non-physical Special Allocation Funds or <i>Dana Alokasi Khusus non-fisik</i>
DDG	Deputy Director General
DG	Director General
DHIS2	District Health Information System
DHO	District Health Office
DLI	Disbursement Linked Indicator
EHS	Environment, Health, and Safety
ESSA	Environmental and Social Systems Assessment
Fasyankes	<i>Fasilitas Pelayanan Kesehatan</i>
FGRM	Feedback and Grievance Redress Mechanism
FY	Financial Year
GERMAS	Community Campaign for Healthy Living or <i>Gerakan Masyarakat Hidup Sehat</i>
GIIP	Good International Industry Practice
GOI	Government of Indonesia
GRS	Grievance Redress System
HCF	Health Care Facilities
HIV	Human Immunodeficiency Viruses
HRH	Human Resources for Health
HWMS	Healthcare Waste Management System
ICU	Intensive Care Unit
IPC	Infection Prevention and Control
I-SPHERE	Indonesia – Supporting Primary Health Care Reform
ISQua	International Society for Quality in Healthcare
JCI	Joint Commission International
JKN	National Health Insurance Program or <i>Jaminan Kesehatan Nasional</i>
KARS	Hospital Accreditation Commission or <i>Komisi Akreditasi Rumah Sakit</i>
KKI	Indonesian Medical Council or <i>Komite Kesehatan Indonesia</i>
KOMINFO	Ministry of Information and Communication Technology or <i>Kementerian Informasi dan Teknologi Komunikasi</i>
KTP	Civil ID Card <i>Kartu Tanda Penduduk</i>
LGBT	Lesbian, Gay, Bisexual, and Transgender

MENKES	Ministry of Health or <i>Kementerian Kesehatan</i> (same as MOH)
MKDKI	Indonesian Medical Disciplinary Board or <i>Majelis Kehormatan Disiplin Kedokteran Indonesia</i>
MOEF	Ministry of Environment and Forestry (from 2015 onwards)
MOF	Ministry of Finance
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
NCD	Non-communicable Disease
NGO	Non-Governmental Organisation
NIHRD	National Institute for Health Research and Development
OHS	Occupational Health and Safety
PAD	Project Appraisal Document
PCR	Polymerase Chain Reaction
PDO	Project Development Objective
<i>Permen</i>	Ministerial Regulation
<i>Perpres</i>	Presidential Regulation
PforR	Program-for-Results
PHO	Provincial Health Office
PKH	Ideal Family Program or <i>Program Keluarga Harapan</i>
<i>Polindes</i>	Village level delivery posts or <i>Pondok bersalin desa</i>
<i>Posyandu</i>	Village health posts
<i>PP</i>	Government Regulation or <i>PP</i>
PPE	Personal Protective Equipment
PSC	Program Steering Committee
<i>Pusdatin</i>	Center for Health Data and Information or <i>Pusat data dan informasi</i>
<i>Puskesmas</i>	Public Primary Health Center
<i>Pustu</i>	Auxiliary <i>puskesmas</i>
RA	Result Area
<i>Rorenggar</i>	Bureau of Planning and Budgeting
RPJMN	Medium-Term National Development Plan
SARI	Severe Acute Respiratory Infection
SIHA	HIV AIDS Information System or <i>Sistem Informasi HIV AIDS</i>
SISMAL	Malaria Surveillance Information System or <i>Sistem Informasi Surveilans Malaria</i>
SITT	Tuberculosis Information System or <i>Sistem Informasi Tuberkolosis Terpadu</i>
SNARS	National Hospital Accreditation Standard or <i>Standard Nasional Akreditasi Rumah Sakit</i>
SOP	Standard Operating Procedure
TB	Tuberculosis
TCLP	Toxicity Characteristic Leaching Procedure
WB	World Bank
WBG	World Bank Group
WHO	World Health Organization
WWTP	Wastewater Treatment Plant
YPBB	Bioscience and Biotechnology Development Foundation or <i>Yayasan Pengembangan Biosains dan Bioteknologi</i>
WWTP	Wastewater Treatment Plant

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EXECUTIVE SUMMARY

- 1. The proposed Program Development Objective (PDO) of the PforR is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Indonesia.** The PforR will be hosted within the Ministry of Health (MOH), with multiple implementing units responsible for different DLIs including the departments of Health Services, Public Health, Research and Planning. It is being proposed that the overall coordination responsibility remains with the Director of Planning, who could also utilize the existing secretariat created for the ongoing Indonesia-Supporting Primary Health Care Reform (I-SPHERE – P157150) Program for Results (PforR) with additional human resources hired in due course, as needed.
- 2. The PforR Program focuses on the immediate health sector needs and represents a sub-set of the overall GoI's emergency response to the COVID-19 outbreak.** The GoI's program for COVID-19 response represents a multi-sectoral approach which encompasses a spectrum of interventions covering health, public communication, social impact mitigation and cross-sectoral coordination. The PforR consists of three Result Areas, including:
 - a. **Result Area 1:** Addressing hospital and health system readiness and systemic improvements in the quality of care, with specific activities to support the expanded network of MOH-owned health facilities that have been designated as COVID-19 referral hospitals.
 - b. **Result Area 2:** Strengthening Public Health Laboratory and Surveillance System.
 - c. **Result Area 3:** Strengthening Communication and Coordination for Pandemic Response and Preparedness.
- 3. The PforR Program boundaries will focus on referral hospitals and designated laboratories for COVID-19 testing in the network of facilities vertically managed by the MOH.** The PforR does not cover primary healthcare facilities (Puskesmas), referral hospitals which are not managed by MOH, private clinics and non-referral hospitals. An on-going PforR Indonesia - Supporting Primary Health Care Reform (P164277) by MOH offers complementary activities on strengthening primary healthcare systems, including referral systems between primary and higher levels of care.
- 4. The PforR Program is not envisioned to support infrastructure investments and/or infrastructure-financing instruments for the construction and rehabilitation of healthcare facilities (HCF).** The PforR Program does not require infrastructure investments for the achievement of the PDO and/or Disbursement Linked Indicators (DLIs).
- 5. The scope of the Environmental and Social System Assessment (ESSA) focuses on the current surge in system capacities within the MOH in managing environmental and social risks associated with the PforR operations in response to COVID-19 emergency.** Specific risks have been assessed in view of the six core principles and key planning elements of the PforR ESSA (refer **Annex 3**). Relevant risks within the proposed result areas under the PforR include:
 - a. Medical waste management, including solid and liquid wastes;
 - b. Public and community health and safety, including patients' safety;
 - c. Occupational, Health and Safety (OHS) for healthcare workers and health facility and laboratory staff;
 - d. Medical consent and civil rights to privacy in the context of mass testing and surveillance, including contact tracing and;
 - e. Social stigma against people who may have COVID-19 and patients as well as healthcare workers and health facility staff; and
 - f. Use of security forces at facilities, warranting risk assessments and mitigation measures.

- 6. Environmental and social risk is assessed to be substantial.** While the PforR is not envisaged to result in adverse environmental and social impacts under normal circumstances, the current capacity constraints faced by the GoI to respond to the COVID-19 crisis may effectively limit the PforR's ability to achieve its environmental and social operational objectives. Such contextual risks within which the PforR is operating justify the risk rating of substantial. The unprecedented speed of the COVID-19 infection across population groups will likely strain the existing health care capacities, including supplies of medical workers and required equipment, which may potentially get worse as the pandemic continues. Such capacity constraints can potentially increase the level of potential environmental and social risks associated with the operation. Main areas of concerns include availability of medical waste and wastewater treatment facilities to process the increasing volume of medical wastes (both solid and liquid), as well as the adequate supply of Personal Protective Equipment (PPE) for the healthcare workers and personnel involved in the handling of COVID-19.
- 7. Optimal implementation of the relevant government regulations pertaining to environmental and social management will likely be compromised due to the potential sheer scale of the outbreak and capacity constraints.** A combination of the expanding scale and geographic spread of the outbreak, strained capacities in the country's healthcare system and lack of availability of critical life-saving equipment and PPE and other Infection Prevention Control (IPC) measures will likely heighten the environmental and social risks associated with the PforR. The baseline capacity for the healthcare system is unequal, with geographical disparities in terms of access to health care, handling of medical wastes, and availability of critical services particularly in Eastern Indonesia.
- 8. Alternative approaches for the handling of COVID-19 medical wastes have been endorsed by the Ministry of Environmental and Forestry (MOEF) as the authority in charge.** Use of existing incinerators in the hospitals is temporarily permitted to respond to shortages in medical waste treatment facilities. For facilities without access to third-party operators, particularly primary healthcare facilities, on-site waste burial is allowed as per relevant regulation, as long as prior disinfection is performed, adherence to site selection as per the regulation and consultations with relevant local environmental agencies. However, the current inter-agency cooperation in addressing the concern on medical waste management during this pandemic has been undertaken on an ad-hoc basis, with no sufficient legal and technical basis for need and gap assessments and enforcement of alternative approaches, including oversight.
- 9. With the current world-wide shortage of PPE, a contingency plan for procurement and distribution of PPE for all personnel involved in the handling of COVID-19 becomes very critical at this juncture.** Although additional budget has been allocated to procure PPE, strategy on procuring and distributing the PPE is needed to ensure its availability across the country. Additional measure to prevent infection to healthcare workers and the public has been conducted by MOH by issuing a specific COVID-19 infection prevention and control protocols, which include the guideline to maintain proper hand hygiene, to use proper PPE based on the workplace risks, to manage medical waste and to disinfect equipment and facilities.
- 10. Mass testing and surveillance to curb the spread of COVID-19 may have implications for patient consent and civil rights to privacy, often leading to social stigma.** Strained healthcare capacities may likely challenge the ability of healthcare facilities to exercise proper consent processes as required by law. Additionally, mass surveillance often followed by contact tracing may potentially interfere with civil rights to privacy and data security. Key measures being considered include strengthening of public communication and outreach, measures for personal data protection in the context of surveillance, and enhancement of the Feedback and Grievance Redress Mechanism (FGRM).
- 11. The proposed PforR is not envisaged to exacerbate existing inequity against vulnerable groups, which is reflective of the running of the country's healthcare system.** Vulnerable groups considered under the PforR include poor households, particularly those living in slum areas due to their inability to exercise proper social distancing measures and dependence on the informal sector, people in rural and remote areas, including indigenous peoples, due to their limited access to healthcare services and other

marginalized groups whose access to formal healthcare system may be impeded due to the existing discrimination in the health system. The PforR seeks to enhance preparedness of COVID-19 referral hospitals in various locations where COVID-19 cases are emerging and where there are chronic shortages of critical equipment, medical supplies, care facilities and PPE. The Program also seeks to support the MOH in developing and disseminating relevant technical guidance, particularly related to IPC measures in healthcare settings for non-referral hospitals and primary care. Through these actions, the PforR is expected to alleviate strained capacities, expand available services to peripheral areas and provide just-in-time support to healthcare facilities to meet the growing demand of the wider population nation-wide.

- 12. The speed and urgency with which this project has been developed to meet the growing threat of COVID-19 in the country have limited the project's ability to broadly consult with relevant stakeholders.** Virtual consultations have been held to overcome limitations on the level of proposed direct engagement with stakeholders. A series of virtual meetings were held with relevant agencies within the MOH as well as non-governmental organizations. Furthermore, an electronic survey will be deployed for rapid and broad-based data collection at the facility level. The PforR consultations will be revisited periodically as necessary, with further consultations following project approval, including during project implementation through the activities for result area 3.
- 13. The proposed PforR environmental and social action plans correspond to relevant risks considered within the scope of the ESSA (refer Section E).** The focus will be on enhancing the capacity of the MOH as the implementing agency to provide technical guidance, oversight, and capacity building for environmental and social risks, particularly on aspects related to medical wastes, OHS, public health and safety, medical consent and civil rights to privacy, as well as measures to enhance public health communication and risk management pertaining to use of security forces. Critical measures to enhance health facilities' capacity for safe clinical management of COVID-19, testing and emergency planning will be included as part of the proposed PforR DLIs. This includes ensuring availability and distribution of critical equipment and PPE across health facilities designated as COVID-19 referrals.
- 14. Communities and individuals who believe that they are adversely affected as a result of a World Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WB's Grievance Redress Service (GRS).** The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate GRS, please visit <http://www.worldbank.org/GRS>. For information on how to submit complaints to the World Bank Inspection Panel, please visit <http://www.inspectionpanel.org>.

A BACKGROUND AND SCOPE

A.1 Program Description

1. **The proposed Program Development Objective (PDO) of the PforR is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Indonesia.** The PDO will be monitored through the following PDO level outcome indicators:
 - a. Reduced service readiness gap in treating serious respiratory illness patients (as measured by the available number of critical care beds fully equipped as per national protocol);
 - b. Strengthened laboratory capacity (measured as the total capacity for quality assured tests per day)
 - c. Improved reporting and surveillance system;
 - d. MOH response integrated into a multi-sectoral response;
 - e. Enhanced community engagement and risk communication.The Summary of DLIs for the Indonesia Emergency Response to COVID-19 PforR is presented in **Annex 1**.
2. **The PforR will be hosted within the Ministry of Health (MOH), with multiple implementing units responsible for different DLIs including the departments of Health Services, Public Health, Research and Planning.** It is being proposed that the overall coordination responsibility remains with the Director of Planning, who could also utilize the existing secretariat created for I-SPHERE with additional human resources hired in due course, as needed. Possible support of technical expertise for assessing hospital readiness coming from the Hospital Accreditation Commission (KARS) or another suitable technical agency is being explored. MOH's counterparts relevant to the management of environmental and social aspects of the PforR will be MOEF and provincial and/or district environmental agencies.
3. **The duration of the program is projected to be 18 months (April 2020 to October 2021) that addresses emergency needs and also builds resilience to future outbreaks, including any subsequent wave of COVID-19.** The scope will be nationwide, and the primary beneficiaries will include people who may have COVID-19, visiting hospitals and health facilities, the community at large, especially vulnerable and high-risk populations such as the elderly and those with chronic conditions, and health care providers who will be providing care to COVID-19 infected and other patients. The PforR accounts for 19 percent of the GOI's COVID-19 response.

A.2 Program Boundaries and Activities

4. **The PforR Program focuses on the immediate health sector needs and represents a sub-set of the overall GoI's emergency response to the COVID-19 outbreak.** The GoI's program for COVID-19 response represents a multi-sectoral approach which encompasses a spectrum of interventions covering health, public communication, social impact mitigation and cross-sectoral coordination. The proposed PforR will focus on the health sector with MOH as the leading agency for implementation. The PforR Program focuses on the following result area:
 - a. **Result Area 1: Addressing hospital and health system readiness and systemic improvements in the quality of care,** with specific activities to support the expanded network of MOH-owned health facilities that have been designated as COVID-19 referral hospitals. In particular, the PforR will focus on:
 - ensuring target hospitals are fully equipped to manage and treat the increase in severe respiratory illness and critical care patients.

- ensuring adequacy of hospital recurring costs such as salaries and top-ups for health care providers, especially COVID-19 related specialists (e.g. internists, pulmonologists, and critical care specialists or intensivists), training for human resources, and additional medical equipment, PPE and test kits that may be needed.
 - MOH's development and implementation of infection control and safety measures in healthcare settings as well as treatment protocols to manage cases at all stages – for potential cases, referrals, confirmed cases, and critical care patients. Through these actions supported by the PforR, it will provide guidance to the wider health system.
 - In the medium-term, support the updating of the national pandemic preparedness plan including emergency funds flows and emergency procurement systems, development of a communication strategy and the improvement of reporting and strengthened surveillance system incorporating lessons from COVID-19 experience.
- b. Result Area 2: Strengthening Public Health Laboratory and Surveillance System, with specific activities to support:**
- Development of national guidelines for laboratories adhering to Bio-safety Level 2 or higher standards, that covers sample collection, transportation and laboratory testing procedures for potential SARI or Coronaviruses.
 - Subject to the availability of affordable COVID-19 cartridges for GeneXpert machines, provisions of consumables for testing to every province and district of the country, utilizing the large installed base of GeneXpert machines provided by the tuberculosis program.
 - Development and implementation of laboratory quality assurance mechanisms for laboratories in the network, assessing the adequacy of laboratory equipment and supplies.
 - Strengthening of the GoI's capacity to undertake contact tracing and surveillance by supporting surveillance hotline for community-based reporting of outbreaks and new illnesses among humans and animals. The PforR will also encourage the expansion of Indonesia's use of information systems, such as the District Health Information System (DHIS2)¹ platform used by MOH's Center for Health Data and Information (*Pusdatin*), to include adoption of the event and/or tracker-based modules for COVID-19 and other notifiable diseases. DHIS2 is an open-source, web-based platform that has several customizable modules.
- c. Result Area 3: Facilitating Communication and Coordination for Pandemic Response and Preparedness, with specific activities to support MOH's inter-sectoral coordination and the development and establishment of mechanisms for communication of COVID-19 test results (in coordination with the subnational level), including supporting the National Disaster Management Authority (*Badan Nasional Penanggulangan Bencana* or hereafter BNPB) and other agencies in developing messages on personal hygiene promotion and other preventive communications.**

The details on how the program fits into the GOI's health program is presented in **Annex 2**.

- 5. The PforR Program boundaries will focus on referral hospitals and designated laboratories for COVID-19 testing in the network of facilities vertically managed by the MOH.** The PforR does not cover primary healthcare facilities (*Puskemas*), referral hospitals which are not managed by MOH, private clinics and non-referral hospitals. An on-going PforR Indonesia - Supporting Primary Health Care Reform (P164277) by MOH offers complementary activities on strengthening primary healthcare systems, including referral systems between primary and higher levels of care.

¹ MOH's Pusdatin has recently adopted DHIS2 as its national standard for housing data from various sources <https://www.dhis2.org/covid-19>

6. **The PforR focuses on the immediate health sector needs being led by MOH.** GoI's efforts on public risk communication and mitigation of socio-economic impacts of COVID-19 on households, businesses, and the economy are outside the scope of the PforR. On public communication, the proposed PforR's Result Area 3 focuses on strengthening MOH's capacity in supporting BNPB and other agencies in developing public health communication messages and/or campaign on personal hygiene promotion and other preventative communication. An Additional Financing (AF) for the on-going Social Assistance Reform PforR (P172381) under GoI's flagship Conditional Cash Transfer (*Program Keluarga Harapan* or hereafter PKH) is currently being processed at the request of GoI to support the Ministry of Social Affairs (MoSA) to strengthen the PKH's delivery system to provide temporary emergency cash benefit to the poor and vulnerable in response to the COVID-19 pandemic, targeting approximately 15 million households across the country.

A.3 Scope of the ESSA

7. **The scope of the ESSA focuses on the current surge system capacities within MOH in managing environmental and social risks associated with the PforR operations in response to COVID-19 emergency.** Specific risks have been assessed in view of the six core principles and key planning elements of the PforR ESSA (refer **Annex 3**). Relevant risks within the proposed Result Areas under the PforR include:
 - a. Medical waste management, including solid and liquid wastes;
 - b. Public and community health and safety, including patients' safety;
 - c. Occupational, Health and Safety (OHS) for healthcare workers and health facility and laboratory staff;
 - d. Medical consent and civil rights to privacy in the context of mass testing and surveillance, including contact tracing and;
 - e. Social stigma against people who may have COVID-19 and patients as well as healthcare workers and health facility staff.
 - f. Use of security forces at facilities, warranting risk assessments and mitigation measures
8. **Environmental and social risk is deemed to be substantial.** While the PforR is not envisaged to result in adverse environmental and social impacts under normal circumstances, the current capacity constraints facing GoI to respond to COVID-19 crisis effectively may limit the PforR's ability to achieve its environmental and social operational objectives. Such contextual risks within which the PforR is operating justifies the risk rating of substantial. The unprecedented speed of COVID-19 infection across population groups likely strain the existing health care capacities, including supplies of medical workers and required equipment, which may potentially get worse as the pandemic continues. Such capacity constraints can potentially increase the level of potential environmental and social risks associated with the operation.
9. **Depending on the spread of COVID-19, the medical waste management system might not timely respond to the increase of medical waste from hospitals and laboratories.** Such situation may force hospitals and laboratories to implement less than optimal waste management measures, posing a risk to healthcare workers and the public.
10. **The PforR Program is not envisioned to support infrastructure investments and/or infrastructure-financing instruments for the construction and rehabilitation of healthcare facilities (HCF).** The PforR Program does not require infrastructure investments for the achievement of the PDO and/or DLIs. System assessments with regards to environmental and social risk and impact management emerging from land acquisition, land conversion and infrastructure activities are therefore not within the scope of this ESSA. However, the PforR may finance physical investment in the form of equipment for COVID-19, which will be assessed as part of the ESSA. It is anticipated that by effectiveness the MOH would have already procured big ticket items such as intensive care equipment (e.g. ventilators, oxygen tanks) and initial supplies of PPE and test kits

using their own funds. No large contracts for item procurement are envisaged under the proposed PforR.

- 11. People in remote areas, including vulnerable groups such as Indigenous Peoples, may face accessibility and equity issues, which reflect the overall running of the country's healthcare system.** The ESSA acknowledges that access equity remains low, with disparities in geographical access, health worker distribution, and quality of services, particularly in Eastern Indonesia. Gender inequalities may likely exacerbate access to healthcare. Such issues reflect the whole running of the healthcare system in Indonesia, which the PforR is not being prepared to address. The GoI's COVID-19 pandemic emergency response has acknowledged the importance of communicating effectively to the public on the pandemic and strengthening primary healthcare readiness and non-referral hospitals, including those in rural areas, to provide a safe initial response to COVID-19. The PforR will support aspects of these efforts by enhancing public health communication and issuance and dissemination of protocols for Infection Prevention Control (IPC) measures and clinical management to non-referral facilities.
- 12. The proposed PforR is not envisaged to exacerbate the existing inequity.** The Program seeks to enhance preparedness of COVID-19 referral hospitals in various locations where COVID-19 cases are emerging and where there are chronic shortages of critical equipment, medical supplies, care facilities and PPE. The Program also aims to support MOH's in developing and disseminating relevant technical guidance, particularly related to infection control and prevention measures in healthcare settings for non-referral hospitals and primary care. Through these measures, the PforR is expected to alleviate strained capacities, expand available services to peripheral areas and provide just-in-time support to healthcare facilities to meet the growing demand of the wider population nation-wide.
- 13. The ESSA will inform relevant action plans and additional resources to enhance MOH's capacity to manage potential environmental and social risks for the proposed operation.** Such action plans, along with the required resources, will be agreed bilaterally between the World Bank and GOI as part of the PforR preparation

A.4 Approach to the ESSA

- 14. An environmental and social risk screening was undertaken at the concept stage (refer to Annex 4).** The purpose of the screening is two-pronged. First, the screening is to confirm that there are no activities which meet the defined exclusion criteria included in the PforR in line with the Bank Guideline for the ESSA. Secondly, the screening established the initial scope of the ESSA. This includes identification of relevant systems under the PforR and relevant stakeholders for engagement and consultations both within MOH and external parties.
- 15. The ESSA process is informed by the Bank Guidance on PforR Environmental and Social System Assessment (June 28, 2019).** The guidance sets out core principles and planning elements used to ensure that PforR operations are designed and implemented in a manner that maximizes potential environmental and social benefits while avoiding, minimizing or mitigating environmental and social harm.
- 16. Following the initial screening, the system review was conducted using a two-step approach:**
 - a. Identification of relevant systems that are pertinent to the ESSA will be addressed in **Section C** on Review of Policy, Regulatory, and Institutional Frameworks; and
 - b. Analysis of the implementation of the systems, including capacity and enforcement of certain environmental and social measures, to respond to COVID-19 crisis will be addressed in **Section D**.

- 17. In undertaking the ESSA, a performance assessment at a sample of designated referral facilities was undertaken as part of the ESSA process to understand existing practices and challenges in response to the pandemic.** An electronic survey was distributed to 55 hospitals across the country, consisting of MOH's vertical hospitals, local government-owned hospitals and private hospitals. Due to a low response rate, the analysis for the ESSA was substantiated by a baseline assessment undertaken by the National Institute for Health Research and Development's (NIHRD) on COVID-19 emergency preparedness at hospitals and laboratories across the country. This was followed by a series of virtual consultations with relevant units within MOH and other relevant stakeholders, including representatives of the Hospital Accreditation Committee (Komisi Akreditasi Rumah Sakit or hereafter KARS), Non-Governmental Organizations (NGOs) and think-tank groups. Care was taken to ensure that the assessment process did not interfere with emergency response operations where the existing resources are under strain. Detailed minutes of these virtual meetings and workshops are appended in **Annex 6**.
- 18. An assessment of the adequacy of MOH's operating framework in the management of environmental and social risks is benchmarked the core principles and key planning elements defined in the Bank's internal guidance note on preparing an ESSA for PforR operations (refer Annex 2).** This was supplemented, where relevant, with reference to Good International Industry Practices (GIIP), in particular those recommended by the World Health Organization (WHO). The key GIIP guidelines reviewed include:
- a. WBG ESH guidelines on/for (i) health care facilities; (ii) waste management (iii) community health and safety.
 - b. WHO guidelines on (i) safe management of waste in healthcare facilities; (ii) infection prevention and control of epidemic- and pandemic-prone acute respiratory infections in health care (iii) COVID-19 technical guidelines on various topics, among others: surveillance, rapid response teams, and case investigation; health workers; and risk communication and community engagement; water, sanitation, hygiene and waste management.
- 19. There is no single system under the ESSA.** The PforR is built on multiple MOH's interventions to respond to and address COVID-19 situation. Various systems were assessed as part of the ESSA process, depending on how such systems are relevant to the management of potential environmental and social risks and impacts. The assessment of the MOH's systems for the management of environmental and social aspects considers relevant elements within the existing broader systems and selection was based on the level of potential environmental risks and impacts as well as social considerations. The assessment focuses on the adequacy of the relevant systems, including implementation, and MOH's capacity to provide technical guidance, enforcement, and audit at the facility level.
- 20. The ESSA process enabled the identification of gaps in the documented systems and their implementation, enabling the development of specific actions for improving environmental and social performance (Section E) under the Program.** The actions outline measures to address environmental and social risks and impacts, when the actions are considered complete, as well as the timeframe, responsibility and resource requirements. The majority of the actions are focused on environmental risks that have been identified while the social aspect is focused on the effectiveness of the current systems to understand and manage complaints and consent processes, protection of patient rights, data privacy and social stigma and other risks, particularly related to use of security forces.

B STAKEHOLDER ENGAGEMENT

- 21. This section provides a summary of the engagement activities undertaken for the PforR and specifically for the ESSA, as well as future engagement activities for ESSA disclosure.** Stakeholder engagement will form part of the PforR implementation, particularly in multi-sectoral coordination and planning for COVID-19 response as well as the development of a public health communication strategy, which involves external agencies, media, and civil society organizations.
- 22. The speed and urgency with which this project has been developed to meet the growing threat of COVID-19 in the country have limited the project’s ability to broadly consult with relevant stakeholders.** Virtual consultations have been held in order to overcome limitations on the level of proposed direct engagement with stakeholders. With the outbreak and spread of COVID-19, populations have been advised or mandated by law, to exercise social distancing, and specifically to avoid public gatherings to prevent and reduce the risk of the virus transmission. Consultations and stakeholder feedback are an integral part of Bank operations and so rather than defer stakeholder engagement, virtual consultations have been designed to be fit for purpose. A series of virtual meetings were held with relevant agencies within MOH as well as non-government organizations. Furthermore, an electronic survey was deployed for rapid and broad-based data collection at the facility level. The objective of the survey is to understand the current level of preparedness of hospitals and laboratories, particularly those designated as the COVID-19 referral facilities in managing environmental and social aspects related to COVID-19 emergency response. On the basis of information generated at the facility level, relevant additional measures to enhance capacities to manage environmental and social aspects will be proposed as part of the PforR action plans. The PforR consultations will be revisited periodically as necessary, with further consultations following project approval, including during project implementation through the activities for result area 3.
- 23. Understanding the immense workload amongst hospital and laboratory staff at the present, the choice of the survey instrument enables efficient data collection, which is user-friendly.** The survey employed an electronic survey platform using KoBoToolBox and consists of two streams of data collection, covering:
- Hospital Preparedness instrument (refer to <https://ee.kobotoolbox.org/x/#NtiyFM3f>)
 - Laboratory Preparedness instrument (<https://ee.kobotoolbox.org/x/#q5IUGblA>)
- The survey was deployed through WhatsApp Messages and/or other electronic mail/messaging, thus enabling respondents to complete the survey using devices of their own preferences (i.e. cellphones, tablet and/or laptop) at their own convenience. The survey is not expected to take more than 20 minutes to complete.
- 24. Stakeholder groups consulted included relevant agencies within MOH, civil society and non-government representatives and representatives of designated COVID-19 referral hospitals and laboratories, including frontline healthworkers** Details of the stakeholders consulted as part of the preparation are presented in Table 1.

Table 1: Stakeholders consulted in the preparation of the Program.

Stakeholder Group	Stakeholders
Government Stakeholders	
Central Government	Ministry of Health - Bureau of Planning - Directorate of Occupational Health and Sport, Directorate General of Community Health

Stakeholder Group	Stakeholders
	<ul style="list-style-type: none"> - Directorate of Health Service Facility of Directorate General of Health Service - Directorate of Environmental Health, Directorate General of Community Health - Environmental Health and Disease Control Centre (BBTKLPP) Jakarta
Non-Government Stakeholders	
NGOs	<ul style="list-style-type: none"> - NGO Kawal COVID-19, a coalition of NGOs/CSOs, experts and activists focusing on risk communication and public awareness - Balifokus, greeneration and YPBB – NGOs focusing on waste management
Think Tank Group	<ul style="list-style-type: none"> - Center for Indonesia's Strategic Development Initiatives (CISDI)
Association	<ul style="list-style-type: none"> - KARS, hospital accreditation body in Indonesia
Health Facilities and Laboratories	
Referral Hospitals	<ul style="list-style-type: none"> - Electronic survey distributed to 55 hospitals, consisting of MOH's vertical hospitals, local government-owned hospitals and private hospitals
COVID-19 laboratories	<ul style="list-style-type: none"> - Environmental Health and Disease Control Centre (BBTKLPP)

25. **The consultations indicate that there are general shortages of the overall capacities for effective response to COVID-19, which will likely worsen as the pandemic escalated.** Key emerging concerns and issues from various consultations were related to a) general capacity constraints amongst health facilities, with non-referral hospitals and primary care facilities at a risk of being overwhelmed with a surge of cases. Critical life-saving equipment, particularly ICU ventilators, is currently in serious deficit with the population ratio, b) OHS risks to health workers and facility staff with direct contact with people who may have COVID-19 and patients due to lack of requisite PPE, testing constraints, and awareness for first handling (i.e. screening and triage, c) limited testing capacities, due to outdated testing machines and deficiency in testing supplies, RT Polymerase Chain Reaction (PCR) machines and GeneXpert cartridges in the market, d) lack of contingency plans and financing availability, particularly amongst non-referral private hospitals, e) overall capacity constraints for safe handling of bio-medical wastes (both solid and liquid) at the facility level, particularly those with low levels of accreditation and amongst primary healthcare facilities, f) lack of stringent and robust measures in COVID-19 prevention has resulted in widespread, community-level transmission which is costly and damaging to the overall economy. Indonesia has lost an important window of opportunity by not taking proactive measures since the first COVID-19 reporting in the mainland China, g) lack of public information leadership, exacerbated by limited availability of credible data and information and with actual risks being downplayed, has resulted in public ignorance, confusion and speculation. A complete documentation of the stakeholder consultations is appended in **Annex 6**.

26. **Due to engagement limitations during the ESSA preparation, views of vulnerable groups were sought through engagement with advocacy groups and civil society organizations.** Community views will be captured as part of the PforR implementation, particularly through the Program's efforts to strengthen public communication and community outreach. Vulnerable groups considered under the PforR include poor households, particularly those living in slum areas due to their lack of ability to exercise proper social distancing measures and dependence on the informal sector, people in rural and remote areas, including Indigenous Peoples, due to their limited access to healthcare services and other marginalized groups whose access to the formal healthcare system may be impeded to the existing discrimination in the health system. These groups include members of

Lesbian, Gay, Bisexual, Transgender, Queer and Intersexed (LGBTQI) community and religious and ethnic minorities. Through strengthening the overall GoI's health emergency response to COVID-19, the PforR is expected to benefit the entire population of 268 million and covering all 514 districts, particularly people who may have COVID-19 visiting hospitals and health facilities, the community at large, especially vulnerable and high-risk populations such as the elderly and those with chronic conditions, and health care providers who will be providing care to COVID-19 infected and other patients.

- 27. ESSA consultations will continue as part of the PforR implementation.** As there were engagement limitations during the preparation, environmental and social actions recommended through the ESSA will be consulted continuously to relevant stakeholders during the Program implementation. The draft ESSA has been disclosed prior to negotiation and the final version will be disclosed prior to the Board approval.

C POLICY, REGULATORY AND INSTITUTIONAL FRAMEWORKS

- 28. The review of systems covers the current existing system to manage environmental and social risks associated with the PforR operations in response to COVID-19 emergency.** This section covers the review of:
- Relevant policy and regulations to respond to the COVID-19 emergency, including guidelines on COVID-19 prevention and control.
 - The country systems on the management of environmental and social risks in the health care settings that are relevant to the PforR and COVID-19 situation. These include the management of medical waste, occupational health and safety, public health and safety, patient rights including consent, grievance mechanism, as well as data and privacy.

Following consideration of the relevant policy, legal and regulatory frameworks, a summary of the institutional responsibilities is provided as they relate to environmental and social performance as part of the PforR activity implementation.

C.1 Policy, Legal and Regulatory Framework

- 29. A summary of the review of pertinent policies, laws and regulations is presented in this subsection, while full analysis of the country's legal framework is appended in Annex 5.** Further analysis on enforcement, capacity, as well as challenges, will be further elaborated in Section D.

C.1.1 COVID-19 Management Framework

- 30. The GoI has declared COVID-19 outbreak as a health emergency (*Darurat Kesehatan Masyarakat*),** following a Presidential Decree No 11/2020 signed on 31st of March 2020. This upgraded the previous status of Disaster of Special Circumstances², which was first announced on 28th of January 2020, followed by evacuation of 238 citizens Wuhan, China. Under the Disaster Management Law No. 24/2007, the President has the authority to determine the status of disaster emergency at the national level (Article 51). Such declaration provides a legal basis for the government to enforce social restriction measures and mobilization of requisite resources for the emergency response. The National Disaster Management Agency (BNPB) is in charge of leading and coordinating emergency response to disasters of a national scale. The agency is granted with authority to exercise flexibility in its response, often over-riding specific mandates of sectoral agencies. The current emergency status has been extended until 29th of May 2020 (Head of BNPB Decree No. 13 A 2020).
- 31. The outbreak has not reached the status of a civil emergency, which if enforced enables the government to enforce martial law** as per Law No.23/1959 on the State of Emergency. Such a civil emergency status may be triggered if the outbreak leads to a) large-scale civil disorder, b) wars, c) circumstances threatening the survival of the state. Under martial law, the military force will be in charge of the government, under command from the President. As of the date of the ESSA, use of the military and police is limited to the provision of security services in referral hospitals owned and operated by the military (i.e. Navy and Army).
- 32. Once declared as a state of emergency, the National Disaster Management Agency (BNPB) has the flexibility to exercise necessary measures to respond to and address the pandemic at the**

² Disaster of special circumstances refer to the situation “where the status of a disaster emergency has not been established or the status of a disaster emergency has expired and/or is not extended, but actions are still needed to reduce the disaster’s risks and wider impacts” (Presidential Regulation No.17/2018, Article 1, point 1)

GoI's discretion. Such flexibility includes manpower mobilization from technical agencies, logistics procurement and distribution, taxation and immigration, licensing, financial management and response command. As of the date of the ESSA, current flexibility afforded to BNPB is limited to the ability to access “on-call funds” in the government budget and temporary easement of import restrictions for the response of the outbreak (Article 13 A).

- 33. MOH declared COVID-19 as an emerging outbreak warranting special measures following the President's declaration of the initial emergency status.** In its first response, a COVID-19 emergency hospital was set up by converting the former Asian Games athlete's dorm (known as Wisma Atlet Kemayoran) and has received patients since 23rd of March 2020. The facility is able to accommodate 3,000 people in its current condition. Further 132 referral hospitals have been designated for COVID-19 management (Decree of Minister of Health No. 169/2020) across the country, which may be expanded to ramp up the country's capacity to respond to the outbreak. Instruction for self-isolation and self-treatment has been publicly communicated for those with mild-symptoms to ease up the current pressure in the health system, which may increase as the outbreak expands.
- 34. No complete lockdown measures, as seen in other countries, have been adopted by the Central Government.** Indonesia is currently enforcing large-scale social restrictions (*Pembatasan Sosial Berskala Besar* or PSBB) in response to the coronavirus pandemic. The restrictions are implemented by local governments with the approval of the MoH. It includes measures such as closing public places, restricting public transport, and limiting travel to and from the restricted regions. Public transport services, including air, water and land transports are currently under temporary suspension to limit regional mobility in the lead up to Eid.
- 35. In an effort to streamline collaboration of various ministries and agencies from the central and sub-national levels, a National Task Force was established and is being led by the National Disaster Management Agency (BNPB).** A Presidential Decree No. 7/2020 on the establishment of the Task Force for was signed on March 13, 2020, two weeks following the first official reporting of people with confirmed COVID-19. The decree was subsequently amended through Presidential Decree No. 9 of 2020, which confers a critical role to the Ministry of Health (MOH) under its Secretary-General as the deputy head of the Task Force. In addition, responsible ministries and agencies, as well as various financing sources for the emergency response, were also clarified through this decree. This response to the technical capacity and financing needs for the Task Force to undertake its mandates, which may likely be escalating in the coming weeks or months as the pandemic expands. These decrees lay the legal foundation for the Task Force to operate, as it helps to address the usual red-tape and bureaucratic inertia, deemed to be the main challenge in rapid emergency response. MOEF is not specifically identified as one of the ministries in the taskforce.
- 36. At the sub-national level, measures are being undertaken by Provincial, District and Village Governments.** Various task forces have been established by respective Governors and District Heads/Mayors and spearheaded by the Provincial and District Disaster Management Agencies (BPBDs). A recent circular issued by the Minister of Villages (No. 8/2020) on the management of COVID-19 at the village level covers the establishment of a village-level Task Force to extend COVID-19 surveillance and a cash-for-work program using village funds (*Dana Desa*) to cushion economic downturns. A Government Regulation No. 21/2020 calls for large scale social restriction measures and delegates authority for enforcement to sub-national governments, subject to MOH's recommendation and approval. Potential measures include quarantine, mobility restrictions, temporary closure of schools, offices and religious activities and activities at public places. The government is responsible for the fulfilment of the basic needs of the population when such measures are being enforced.

37. **Review of sectoral laws and regulations pertaining to the ESSA is presented in the following sub-sections.**

C.1.2 Health Service Quality Assurance

38. **Hospital accreditation serves as an important avenue to provide check and balance of service quality, which also includes management of environmental and social aspects.** The implementation of hospital accreditation has been on-going since 1995 and is being administered by the Indonesia Commission on Accreditation of Hospitals (Komisi Akreditasi Rumah Sakit or hereafter KARS), which is an independent accreditation entity. By law, hospital accreditation is a mandatory requirement and is subject to renewal every three years (Article 40, Law on Hospitals no. 44/2009). Government oversight was provided through the regulation sub-directorate in MOH as well as through provincial and district health offices. The Law on Hospitals also provides for the establishment of independent national and provincial oversight boards (BPRS), which report directly to the President and provincial governors, respectively. Their roles are to receive reports from hospitals on their performance and provide advisory on hospital performance improvements.
39. **All COVID-19 referral hospitals designated by MOH have been accredited by KARS.** By the end of 2019, around 85 percent of registered hospitals were accredited by KARS, and around 40 percent of those have received the highest two levels of accreditation *Paripurna* (Prime) and *Utama* (First). Starting in 2013, the Joint Commission International (JCI) hospital accreditation standards that focus more on the process of care with patient safety as the ultimate goal and consider hospitals as an integrated system was adopted. The official National Standards for Accreditation of Hospitals (hereafter SNARS³) consist of assessment elements related to access to care and continuity of care, quality improvement and patient safety, facility management and safety, including Occupational, Health and Safety (OHS) and medical waste management, prevention and control of infections, patient and family rights, including feedback and grievance mechanism processes.
40. **All referral laboratories have the minimum of Bio-Safety Level 2 (BSL-2) with one laboratory, National Institute for Health Research and Development’s (NIHRD), certified as BSL-3 laboratory.** WHO recommends that diagnostic laboratory work on clinical specimens from people who may have COVID-19 or people who are confirmed with COVID-19 should be conducted at a facility using a procedure equivalent to BSL-2. BSL-2 laboratory requirements include specific laboratory design and equipment to prevent or limit contact between workers and material, PPE for laboratory technicians and other workers, health and medical surveillance for all workers, and standard for waste handling among others.

C.1.3 Medical Waste (Hazardous Waste) Management

41. **The country’s approach in medical waste (hazardous waste) management is built upon “cradle to grave” principle with a rigid manifest system to track the flow of waste from the generator to the disposal facility.** The requirements prescribed in the key regulations are harmonized with the GIIP⁴, including the provisions on waste identification, reduction, segregation, storage, transport, disposal and occupational health and safety for waste handler – with all activities to managing medical (hazardous) waste, including to store, transport, treat or dispose, require valid permit/license from relevant agencies. The country’s main framework on hazardous waste management is cast in Government Regulations No.101/2014 regarding Hazardous waste management, whereas the specific regulations on hazardous waste management in health care

³ first edition effective 1st of January 2018

⁴ GIIP includes WBG General EHS Guideline: Waste Management and WHO safe management of wastes from health-care facilities

settings are prescribed in MOEF Regulation No. 56/2015 on Hazardous waste management in health care facilities (this regulation applied for hospitals as well as clinical laboratories), MOH Regulation No. 7/2019 regarding Provision on environmental health in hospitals and MOH regulation No. 43/2013 regarding Proper management of the clinical laboratory. Similar requirements on hazardous waste management are also part of the hospital accreditation criteria, in which MOH makes it mandatory for all hospitals to get accredited by an independent accreditation body every three years, as well as the requirements for Bio-safety level-2 (BSL-2) laboratory accreditation requirements. The further requirements on the management of air emissions from the medical incinerator are outlined in MOEF regulation No. 56/2019, in which the regulation set the technical specifications of the incinerator and the allowed emissions threshold.

- 42. Standards on wastewater effluent from healthcare facilities in Indonesia is comparable with the GIIP⁵.** MOH regulation No.7/2019 outlines the requirement to manage the wastewater from healthcare facilities, this includes the requirement to have wastewater treatment plant, conduct routine effluent monitoring, meet the effluent threshold requirements and report the monitoring to relevant government agencies. The effluent standard from the wastewater treatment plant is prescribed in the MOE regulation No. 5/2014 on the wastewater effluent standard.⁶ The threshold set in the regulation is comparable with the performance standard set in WBH EHS Guideline for healthcare facilities (performance indicators for wastewater). MOEF Regulation No. 56/2015 requires wastewater from incinerators to comply with MOE regulation No. 5/2014.
- 43. With the current COVID-19 situation, MOH issued a guideline⁷ on the treatment of COVID-19 wastes in healthcare facilities.** This guideline provides technical standards on the management of hospitals' wastewater, as well as domestic and hazardous solid waste. The standards are generally in line with WHO guideline on water, sanitation, hygiene and waste management for COVID-19, in which it requires the healthcare facilities to have a wastewater treatment plant, to conduct disinfection with 0.5% chlorine solution and to properly manage the infectious waste through proper packaging and treatment. The guideline from MOH also covers the waste management in the pre-existing structure that was or will be transformed into a field hospital.
- 44. Meanwhile, MOEF issued a notice letter⁸ specific to the management of infectious waste from healthcare facilities.** Through this letter, MOEF advises healthcare facilities, which treat COVID-19 patients and people who may have COVID-19, to do onsite treatment for its infectious waste using onsite incinerator or autoclave before handing over the waste to a licensed hazardous waste management company. This implies that all hospitals, with or without valid hazardous waste treatment license/permit⁹, can treat their infectious waste onsite during COVID-19 pandemic, provided they will proceed to send the treated waste to licensed disposal site afterwards. Onsite treatment for COVID-19 infectious waste is also recommended by WHO¹⁰. The guideline from MOEF also covers hazardous waste management in a field hospital.

⁵ WHO guidelines on safe management of waste from healthcare activities (section 9 – collection and disposal of wastewater) and WBG EHS guidelines for healthcare facilities

⁶ The effluent standard for healthcare facilities is outlined in Annex XLIV of the regulation

⁷ MOH issued a guideline on COVID-19 waste management in March 2020, this guideline includes protocols for wastewater treatment, as well as domestic and hazardous solid waste management

⁸ Notice Letter No. SE.2/MENLHK/PSLB3/PLB.3/3/2020 on infectious (hazardous) and domestic waste management from COVID-19 response, dated March 24, 2020

⁹ Under normal circumstances, Government Regulation No. 101/2014 and MOEF Regulation No. 56/2015 require all incinerators and autoclaves that are used to treat medical waste to obtain treatment permit/license from MOEF

¹⁰ WHO Interim Guidance on water, sanitation, hygiene and waste management for the COVID-19 virus, dated March 19, 2020

- 45. Although an alternative to manage the infectious waste is provided by MOEF, the alternative is not addressing the possible constraint on the availability of transporter or disposal facilities.** As the volume of hazardous waste increases, the demand for licensed hazardous waste transporter and final disposal facilities will also increase. With stretched resources during the pandemic, hospitals might face difficulties in managing their waste.

C.1.4 Occupational Health and Safety

- 46. The applicable laws and regulations in Indonesia make it mandatory for every workplace to implement OHS management system, including hospitals and laboratories.** The country's OHS regulation regime consists of a comprehensive set of regulations to govern this aspect, such as Law No. 36/2009 on Health (section XII) and Government Regulation (PP) No. 50/2012 on Health and Safety Management, which required hospitals and other health care facilities to oversee and ensure the workers' safety and health by implementing an OHS management system. Specific guideline on how to implement the management system in a hospital setting are prescribed in MOH regulation No. 66/2016 on Hospital's occupational health and safety. The requirements cover risk management, OHS practices, waste management, fire prevention, mandatory immunization for workers, mandatory training, availability of PPE, among others. The requirements prescribed in this regulation are harmonized with relevant GIIP such as the WBG EHS Guidelines for healthcare facilities and WBG EHS General Guidelines for OHS.
- 47. In a bid to prevent infection to health care workers in hospitals, MOH issued regulation No. 27/2017 on infection prevention and control, which took reference from several WHO publications related to infection prevention and control guidelines.** The regulation covers detail building construction requirement, zoning guideline, safe practices, appropriate PPE for workers, among others. The requirements prescribed in the regulation address the guideline issued by WHO on key OHS considerations for health workers during COVID-19 outbreak and guideline on OHS in public health emergencies. Similar requirements on OHS and infection prevention and control in the hospitals are included as criteria for hospitals accreditation. Further, MOH regulation No. 43 Year 2013 regarding Proper management of clinical laboratory provides comparable requirements to ensure OHS management in laboratories. The use of BSL-2 laboratories for COVID-19 testing is also in line with WHO's laboratory biosafety guidance related to COVID-19, as these BSL-2 laboratories provide appropriate biosafety standard and practices for the testing of COVID-19 specimens.
- 48. A recent MOH's guideline on COVID-19¹¹ is generally aligned with WHO's guidelines on measures related to IPC in healthcare settings.** This covers requirements for safe screening and triage by ensuring immediate isolation of patients with potential COVID-19 and cohorting based on disease severity, hospitalization for isolation (cohorting), surveillance for employees (including removal from service) and visitors, physical distancing measures at the facility, signage of droplet and contact precautions, use of Personal Protective Equipment (PPE) for healthcare workers, cleaners, and facility staff, biosafety practices, including safe-handling of biological specimens, medical wastes and medical equipment.

C.1.5 Public Health and Safety, including Patient Safety

- 49. Law on Health No. 36/2009 requires a regional and inter-sectoral approach for Infection, Prevention and Control (IPC) measure in community settings.** The central government declares specific diseases with a potential of a widespread infection, warranting health quarantine (Law No. 6/2018 on Health Quarantine, Law on Health No. 36/2009, articles 155 – 157). The Law on Health

¹¹ Issued on 16th of March 2020 by the Directorate General of Disease Prevention and Control

Quarantine also mandates the designation of referral hospitals with the competency to handle relevant infection cases. A large-scale quarantine, covering regional quarantine and social distancing measures is established by the Minister of Health. Under such circumstances, every individual has equal rights to receive health treatments, food and basic daily needs (Law on Health Quarantine, Article 52).

- 50. MOH regulation No. 66/2016 on hospitals occupational health and safety and MOH regulation No. 27/2017 on infection prevention and control cover not only health care workers, but also patients and visitors of the hospitals.** The basic requirements on facility location, building standards, ancillary facilities (laboratory, blood banks, temporary waste storage), disinfection and sterilization of equipment, sanitation services, staff competency and monitoring and evaluation are important to ensure the health and safety of patients, especially to prevent nosocomial infections at the facility. MOH Regulation No. 27/2017 on infection prevention and control covers all key important aspects above. Appendix III of MOEF Decree no 56/2015 regarding Procedures and Technical Requirements of Hazardous Waste Management from Health Care Facilities regulates the requirement for hazardous storage location to protect patient safety and visitors. Further, specific criteria in hospital accreditation have also included the provision to ensure patient and visitor health and safety in hospitals.

C.1.6 Patient Rights

- 51. Citizen rights are fully protected and comprehensively defined by Law.** Patient rights, including their access to healthcare and safety, are protected by the Indonesian's Constitution (Article 1) and Laws (Law on Health Articles 4 – 8, Law on Hospitals No. 44/2009, Article 2, Article 43). The GoI is responsible for providing for accessible health care to all and fair distribution of health services, which remain persistent challenges in the context of Indonesia, particularly in the eastern-most region of the country. Citizens have the right to choose services, to be treated without prejudice and discrimination, to have access to information regarding services, to be heard and complaint as well as legal access to litigation (Law No. 8 of 1999 on Consumer Protection). Access to health services for people with special needs is also protected by law, with health providers required to ensure their facilities are accessible and services are non-discriminatory. The information regarding the illness, treatment, prognosis, and alternative treatments should be accessible to patients and families regardless of information requests. Under COVID-19 circumstances, GoI's ability to meet these regulatory provisions may likely be compromised due to the already strained resources as well as capacities to address the emergency.
- 52. All fees and charges incurred for treatments of COVID-19 patients and people who may have COVID-19 at the designated COVID-19 referral facilities shall be borne by MOH,** which is consistent with the Law on Health 36/2009 (Articles 82-85), ministerial regulation of MOH No. 59/2016 on Fee Waiver for Patients with Emerging Infection and MOH's decree No. HK.01.07/104/2020. Health facilities are prohibited from refusing patients and/or charging costs, including down-payments for any healthcare services required (Law on Health 36/2009, Article 85). This provision provides safety nets for the poor who may not be able to afford healthcare under normal circumstances as well as those who may not be covered under the GoI's universal healthcare program (i.e. BPJS).
- 53. Patients' consent requirements can be waived under emergency situations in the interest of public safety (Law on Health no. 36/2009, Article 56 – 58).** This suggests that consent requirements for the purpose of testing and treatments for COVID-19 are not mandatory requirements. Under ordinary circumstances, protection of patients' confidentiality, information about treatment and costs, and informed consent to any procedures as well as rights to refuse any medical treatments/procedures and seek for the second opinion prevails prior to any medical

treatment. Healthcare workers cannot be sued through any legal means in the context of emergency for life-saving treatments (Law on Health no.36/2009, Article 58, point 2).

C.1.7 Feedback and Grievance Mechanism

- 54. In terms of management of public feedback, grievances, inquiries related to GoI's emergency response is coordinated under the COVID-19 Task Force.** A centralized web-page platform (<https://covid19.go.id>) has been established to provide the broader public with the latest information on COVID-19, including the geographic distribution of the outbreak, the number of confirmed patients with COVID-19, people who may have COVID-19, and mortality, referral hospitals, and other public messages on COVID-19, including factual information to counter hoaxes. A WhatsApp with a chatbot feature (+62 811 3339 9000) and a hot-line 119 (toll-free) have also been created and administered by COVID-19 Task Force. With other agencies, including MOH, healthcare facilities and sub-national governments.
- 55. In terms of quality of services, grievance management is decentralized at the facility level.** Each hospital under the Program operates its own FGRM, which varying avenues and response mechanisms. Under the hospital accreditation system, such facility-level FGRM is subject to audit and assessment by KARS (Family and Patients' Rights under Hospital Accreditation Standards HPK 3). By law, patients have the option to file a lawsuit in court or to appeal to the Indonesian Medical Disciplinary Board (MKDKI) (Law on Health No. 36/2009, Article 58, Law No. 8/1999 on Consumer Protection). The role of MOH in terms of addressing complaints tends to be on an ad-hoc basis, and the current operating GRM platform (Halo Kemkes 1500-567, SMS 081281562620, fax (021)5223002, 52921669 and/or kontak@kemkes. go. id) is not specifically designed to address health-related grievances, but rather overall health administration.
- 56. Under the current system, it is difficult for patients and families to charge medical professionals malpractices leading to injury, disabilities or even deaths under the criminal code (Kitab Undang-Undang Hukum Pidana).** Medical negligence and litigation implicating medical professionals (doctors and dentists) are investigated by the Indonesian Medical Disciplinary Board (Majelis Kehormatan Disiplin Kedokteran Indonesia/MKDKI). The MKDKI is an autonomous body of the Indonesian Medical Council (KKI) and is authorized to issue testimony/statements with regards to negligence or mistakes or ethical issues in medical practices as well as remedial measures necessary including sanctions. Under these circumstances, the use of civil code (Kitab Undang-Undang Hukum Perdata) may be pursued, and complaints may be settled through financial compensation for improper services.

C.1.8 Data and privacy

- 57. Protection on of civil rights to privacy and private data is fragmented across regulations and no overarching law in existence for the purpose, with weak protection of individual rights to personal data.** Indonesia has 32 laws and regulations which govern the protection of personal data/privacy. Six of those are related to health sector include Law No 29/2004 on Medical Practice, Law No 36/2009 on Health, Law No 44/2009 on Hospital, Law No 18/2014 on Mental Health, and Law No 35/2009 on Narcotics. Article 57 (2) of Law, No 36/2009 on health, stated that exception on data protection could be made in several conditions include for public health interest by respecting the necessity and proportionality principles. Furthermore, Minister of Health Regulation No. 269/MenKes/Per/III/2008 on Medical Records stated that all health facilities must maintain the confidentiality of the patient's medical records except for extraordinary circumstances for health and safety reasons, law enforcement, at the request of the patient(s) concerned, and for research and education purpose without disclosing the patient's identity. No single comprehensive law is in place for the protection of private data, which in some circumstances results in abuse of private data collected through Banking transactions and social media for commercial purposes, with risks of

fraudulent appropriation of personal data for criminal conducts. The Draft Bill on Private Data Protection, which is expected to consolidate citizens' rights to data protection and privacy is pending approval from the Parliament. This represents a gap in the regulatory framework.

C.2 Institutional Responsibilities

58. MOH is the proposed implementing agency for the PforR with the overall coordination responsibility in the Director of Planning. Possible support of technical expertise for assessing hospital readiness coming from KARS or another suitable technical agency is being explored. As part of the stakeholder identification for the ESSA, key stakeholders are categorized as follows:

- a. Category 1: Implementing stakeholders, which include the Departments of Health Services, Public Health, and Research and Planning as well as target MOH's vertical hospitals and a network of laboratories (both government and non-government owned) under the Program;
- b. Category 2: External stakeholders contributing to the management of environmental and social aspects of the PforR. These include KARS and hospital and laboratory associations.
- c. Category 3: External stakeholders responsible for COVID-19 emergency response (GoI's Program), where the PforR is part of. These include central government ministries, agencies, sub-national government agencies, non-government agencies under the COVID-19 Task Force.
- d. Category 4: PforR beneficiaries benefitting from COVID-19 testing and medical care and communities at large, benefitting from public communication and outreach.

59. The proposed PforR institutional arrangement takes cognizance of Indonesia's decentralized government system and hence, the focus will be placed on facilities where MOH has direct influence and control. The Indonesian system of government is devolved, with all three levels of government having significant responsibilities for health care and regulation of hospitals. Within the decentralized health system¹², the relationships between MOH, PHOs, and DHOs is not a strictly hierarchical one, with each level having its own authority and mandates. PHOs and DHOs are under their respective provincial and district governments, which are under the Ministry of Home Affairs. MOH is responsible for the regulation of vertical hospitals, Provincial Health Offices (PHOs) for provincial hospitals (both government and private-owned) and District Health Offices (DHOs) for district hospitals (both government and private-owned). However, there are still many roles retained by MOH in the context of COVID-19, such as providing technical guidance, establishing the regulatory framework, and some strategic interventions for the management of disease control.

60. While broader risks were assessed under the ESSA, PforR action plans (PAPs) for the environment and social management were intended for relevant departments within MOH responsible for Program implementation (i.e. stakeholders under Category 1). Direct interventions which form the scope of the PforR include MOH hospitals (or hereafter vertical hospitals) and a network of both MOH and non-government laboratories. For laboratories, testing was recently expanded from the National Institute for Health Research and Development's (NIHRD) biosafety level 3 (BSL-3) laboratory to a broader network that now includes nine regional MOH laboratories and six non-government laboratories. While not directly benefitting from the Program, technical guidance issued by MOH under the Program is expected to benefit non-MOH hospitals designated as COVID-19 referral hospitals and other non-referral hospitals, and primary health facilities (*Puskesmas*), potentially receiving people who may have COVID-19 and patients. Additional risk oversight measures by MOH for activities being implemented by other agencies and entities were also included as part of PAPs to the extent they are technically and financially feasible.

¹² According to Law No.32/2004, decentralization is defined as transfers of authority by the central governments to autonomous regional governments to regulate and manage their own affairs.

61. The following table provides a summary of the institutional responsibilities with respect to the GoI's overall response to COVID-19 and how they are related to the proposed PforR.

Table 2: Institutional Responsibilities for Environmental and Social Performance

Institutions	Institutional Responsibilities in the COVID-19 Emergency Response	Institutional Responsibilities in PforR
Category 1: Implementing Stakeholders		
Ministry of Finance	<ul style="list-style-type: none"> - Develop a national-level fiscal policy as an emergency response to the pandemic including but not limited to budget supplements, budget reallocation for the health sector at the central and sub-national levels, and other fiscal measures to all affected sectors. - Resource mapping and mobilization to ensure sufficient financing for the overall national COVID-19 pandemic response for health as well as other non-health issues. 	<ul style="list-style-type: none"> - Allocate sufficient budget for vertical hospitals designated as COVID-19 referral facilities, designated COVID-19 testing laboratories, and activities for surveillance and MoH's cross-sectoral coordination.
Bureau of Planning of MOH	<ul style="list-style-type: none"> - Coordinate the planning of COVID-19 related logistics needs and activities from all relevant units within the MoH and develop a proposal that reflects comprehensive needs for the health sector response which will be submitted to the National COVID-19 Task Force (henceforth 'The Task Force). - Reallocate MoH FY 2020 budget allocation to COVID-19 pandemic response - Provide guidance to the sub-national governments to reallocate the Central transfers (Special Allocation Funds for Hospital Infrastructure) for the pandemic response 	<ul style="list-style-type: none"> - Lead the program coordinating unit in the implementation of the PforR - Ensure the availability of information needed to monitor the Program implementation - Ensure the requisite supervision schedule and reporting during the Program implementation
Secretary-General of MOH	<ul style="list-style-type: none"> - Provide technical inputs to the national emergency response as the Vice-Chair of the Task Force representing MOH. - Provide strategic direction and guidance for the coordination of the health sector's emergency response. 	<ul style="list-style-type: none"> - Chairing the Program Steering Committee and ensure communication and coordination at the Echelon 1 level (relevant DGs and SG) - Lead the coordination with the other relevant ministries/government agencies during the implementation of the Program
Directorate General (DG) of Disease Prevention and Control of MOH	<ul style="list-style-type: none"> - Provide technical inputs related to disease control measures to the Task Force. - Provide technical guidance, including the formulation of technical policies/SOPs of disease control management to, and oversight and monitoring of the national and sub-national levels' response. - Develop a workplan for disease control, especially surveillance, that includes detailed activities and logistics needs as inputs to the MOH overall emergency response plan. 	<ul style="list-style-type: none"> - Serve as a Program Steering Committee member - Provide strategic guidance on the strengthening of the disease control especially on surveillance of emerging infectious diseases - Ensure the availability of information to monitor the program achievements related to surveillance

Institutions	Institutional Responsibilities in the COVID-19 Emergency Response	Institutional Responsibilities in PforR
DG of Health Services of MOH	<ul style="list-style-type: none"> - Provide technical inputs related to health services during the emergency response by the Task Force. - Provide technical guidance, including the formulation of technical policies/SOPs on health services to, and oversight and monitoring of the national and sub-national levels' response. - Develop a work plan that includes detailed activities and logistics needs for health services as inputs to the MoH's overall emergency response plan 	<ul style="list-style-type: none"> - Serve as a member of the Program Steering Committee - Provide strategic guidance on improving the hospital preparedness and quality of health services for COVID-19 - Ensure the availability of information to monitor the Program's achievements related to hospital preparedness - Lead/co-Lead the coordinated efforts to develop and disseminate protocols on the management of emergency and severe cases, as well as protocols on infection control and waste management
DG of Public Health of MOH	<ul style="list-style-type: none"> - Provide technical inputs related to environmental health, including waste management, and occupational health for health workers during the emergency response to the MoH. - Provide technical guidance, including the formulation of technical policies/SOPs on environmental and occupational health, and oversight and monitoring of the national and sub-national levels' response. - Provide inputs on environmental and occupational health to the MOH's emergency response plan 	<ul style="list-style-type: none"> - Ensure the availability of information to monitor the environmental and occupational related issues during the Program implementation - Lead the coordinated efforts on waste management by hospitals and laboratories - Provide inputs to the protocol for infection control and waste management for health facilities/ health services during the COVID-19 pandemic
The National Institute for Health Research and Development's (NIHRD) of MOH	<ul style="list-style-type: none"> - Provide technical inputs related to testing activities, including laboratory functions during the emergency response to the Task Force. - Provide technical guidance, including the formulation of technical policies/SOPs to, and oversight and quality monitoring of the national and sub-national levels' response related to testing and laboratory functions. - Develop a workplan that includes detailed activities and logistics needs for health services as inputs to the MoH's overall emergency response plan 	<ul style="list-style-type: none"> - Serve as a member of the Program Steering Committee - Provide strategic guidance on improving the preparedness and quality of laboratories in conducting COVID-19 testing. - Ensure the availability of information to monitor the program achievements related to laboratory functions and testing for COVID-19. - Lead coordinated efforts to develop and disseminate protocols on the surge management of laboratory and testing.
Center for Health Promotion of MOH	<ul style="list-style-type: none"> - Provide technical inputs to the Task Force on COVID-19 health messages and education material for the public 	<ul style="list-style-type: none"> - Provide oversight and monitoring the use of the COVID-19 hotline, as well as other communication platforms (website) by the public, and activities to counter misinformation. - Monitor complaints and grievances related to COVID-19 health-related emergency response.
Vertical Hospitals Designated as COVID-19 Referral Hospitals (owned and	<ul style="list-style-type: none"> - Provide medical services for COVID-19 Severe Acute Respiratory Illnesses (SARI) and critical care patients. - Develop logistics needs plan to provide treatment and care for SARI and critical care patients 	<ul style="list-style-type: none"> - Provide medical services for COVID-19 Severe Acute Respiratory Illnesses (SARI) and critical care patients - Ensure to observe the infection prevention protocol and waste management

Institutions	Institutional Responsibilities in the COVID-19 Emergency Response	Institutional Responsibilities in PforR
administered by MOH)		- Ensure to maintain a high quality medical record of COVID-19 patients
MOH laboratories Designated as COVID Tests facilities (i.e. Environmental Health and Disease Control Centers (BBTKLPP)	<ul style="list-style-type: none"> - Provide testing services for COVID-19 in accordance with the testing protocols - Ensure the results from the testing is reported in a real-time manner to the surveillance team. - Observe the internal and external quality assurance mechanism - Develop logistics plans including equipment, reagent/primer/cartridges and PPE for the designated laboratories 	<ul style="list-style-type: none"> - Provide testing services for COVID-19 in accordance with the testing protocols - Provide baseline information on the laboratory capacity and monitor the progress on the capacity of the laboratories in the COVID-19 referral laboratory network.
Category 2: External Stakeholders Contributing to Environmental and Social Management for the PforR		
MOEF	<ul style="list-style-type: none"> - Issue permits for hazardous waste transportation and disposal, including for the handling of medical waste. - Conduct audits on facilities' compliance on hazardous waste management and audit. - Jointly worked with MOH to issue regulation related to public health and safety in the healthcare setting. 	- Provide advice on the management of medical waste from hospitals and laboratories
KARS	<ul style="list-style-type: none"> - Conduct accreditation for hospitals based on its accreditation standard (SNARS) - Manage an accreditation system for hospitals. 	- Provide technical support for result verification in line with the DLIs (to be confirmed)
Provincial and/or District Environmental Agencies	<ul style="list-style-type: none"> - Issue permits for hazardous waste facilities and oversight of the management of environmental aspects - Conduct audits on facilities' compliance on hazardous waste management and audit in their province and/or district 	Not involved
Category 3: COVID-19 Task Force stakeholders (GoI Program)		
BNPB	<ul style="list-style-type: none"> - Lead overall national planning and operational measures to respond to COVID-19 emergency - Lead coordination and provide oversight to the COVID-19 Task Force - Mobilize requisite resources, including financing, staffing, and procurement of equipment for goods and supplies for the acceleration of COVID-19 emergency measure - Provide reports of COVID-19 emergency response implementation to the President 	Not involved

Institutions	Institutional Responsibilities in the COVID-19 Emergency Response	Institutional Responsibilities in PforR
Ministry of Information and Communication Technology (KOMINFO)	<ul style="list-style-type: none"> - Lead overall public communication and engagement, including strategy setting and media monitoring - Act as a spokesperson for the Task Force 	Not involved
Provincial Health Offices	<ul style="list-style-type: none"> - Provision of technical oversight and monitoring of DHOs, including the formulation of technical policies/SOPs with regards to health services and management of wastes if needed. - Facilitate cross-district coordination (e. g. managing exchanges of specialists to fill gaps, capacity building) and extension of MoH for the implementation of national programs¹³. - Mediation of grievances (although on an ad-hoc basis). 	Not involved
District Health Offices	<ul style="list-style-type: none"> - Organizing and implementing various health interventions such as epidemiology surveillance, communicable and non-communicable diseases, environmental health, HRH, promotional and preventive health measures. - Management of <i>Puskemas</i> (and their auxiliary facilities (<i>Pustu</i> and <i>Polindes</i> as well as private clinics). - Mediation of grievances (although on an ad-hoc basis). 	Not involved
Non-MOH laboratories	<ul style="list-style-type: none"> - Provide testing services for COVID-19 in accordance with the testing protocols - Observe the internal and external quality assurance mechanism 	Not included
Ministry of Social Affairs	<ul style="list-style-type: none"> - Social impact mitigation for vulnerable households through the Cash Transfer Program (PKH). 	Not involved
Ministry of Home Affairs	<ul style="list-style-type: none"> - Sub-national government coordination and issuance of technical guidance on measures to be taken in responding to COVID-19 by sub-national governments (districts and provinces) 	Not involved
Ministry of Villages	<ul style="list-style-type: none"> - Issuance of technical regulations on the use of village funds to mitigate and cushion socio-economic impacts at the village level (i.e. cash for work) 	Not involved

¹³ Although Provincial Health Offices (PHOs) serve as an extension to MOH, there is no clear statement/regulation requiring District Health Offices (DHOs) to answer/ report to PHO unless PHO is managing specific transfers from MOH for certain programs

D INSTITUTIONAL CAPACITY AND PERFORMANCE ASSESSMENT

- 62. This section summarises key findings or gaps on the assessment of system implementation, including the capacity of the relevant institutions to effectively implement the environmental and social management systems under the PforR.** The review is conducted by assessing the current capacity and performance of MOH and some sample health facilities and laboratories to understand their readiness and preparedness in enhancing their COVID-19 surge capacities.
- 63.** The section also summarises the extent to which the applicable systems are consistent with the key elements, as well as statements on the commitment of the relevant institutions to undertake measures to address the key gaps.

D.1 COVID-19 Surge Capacities

- 64. Recent GOI's policies have augmented the roles of both central and sub-national governments and streamlined bureaucracy to enable fast response.** The multi-sector 'COVID-19 Mitigation Acceleration Task Force' led by the National Disaster Risk Management Agency (BNPB) aims to improve coordination and increase the intensity of the national COVID-19 emergency response. The task force mobilizes the relevant government ministries and agencies, as well as the private sector and community. The central government has also requested local governments establish local coordination units for COVID-19 that would feed into the national task force. In addition to the health sector fiscal stimulus package, government funding for the national emergency response was also made available by reallocating a Special Allocation Fund for physical infrastructure (DAK-fisik) which is normally given to districts as an intergovernmental fiscal transfer. The declaration of a 'State of Emergency' has also legally enabled BNPB to access 'On-call Funds' in the government budget. MOH is also currently revising their budget to reallocate MOH staff travel funds for the emergency response. As MOEF is not part of the task force, the streamlined bureaucracy has not touched upon the waste management aspect, with cooperations between MOEF and MOH is on an ad-hoc basis.
- 65. The capacity to provide care for severe acute respiratory cases and other related COVID-19 complications is limited.** Indonesia has 2,877 hospitals with a bed capacity of more than 300 thousand¹⁴, about 7,000 of which are intensive care unit (ICU) beds. That is 2.7 ICU beds per 100,000 population. There are more than 8,000 ventilators across the entire country but only around 2200 are available in the 132 COVID-19 designated referral hospitals¹⁵. A recent survey by NIHRD indicates that the majority of 82 hospitals surveyed are equipped with less than ten ventilators (62 percent, ranging between one and ten within the bracket. The same survey also indicates that 45 percent of the hospitals surveyed are equipped between one and five functioning ambulances¹⁶, with less-equipped facilities being skewed in peri-urban and rural areas.
- 66.** While the network of designated COVID-19 referral hospitals has been expanded, **the overall health facility readiness is likely challenged by lack of well-equipped and trained personnel to respond to COVID-19 particularly as the pandemic spreads to outside major city capitals.** Major issues include lack of trained personnel, PPE, testing equipment and capacities. Availability

¹⁴ By end of 2019, around 85 percent of registered hospitals were accredited by the National Commission of Hospital Accreditation (KARS) – a national independent body – and around 40 percent of those have received the highest two levels of accreditation *Paripurna* (Prime) and *Utama* (First).

¹⁵ Hospital ASPAK Data

¹⁶ Courtesy of NIHRD 2020

and distribution of critical medical supplies and PPE remain a challenge, and they are skewed at the designated COVID-19 referral hospitals, thus raising the level of risks of infection at non-referral hospitals. Where there is a chronic lack of PPE, anecdotal evidence indicates that some doctors and other medical staff are having to improvise with things like plastic raincoats and bin bags. As of the date of the ESSA, at least 18 doctors across Indonesia have died in the fight against COVID-19 based on the statement from the Indonesian Doctors Association (IDI). The Center for Health Crisis Management in MOH has been mandated to plan, procure and distribute PPE for healthcare workers and other supporting workers such as ambulance drivers, housekeeping personnel and waste handlers to improve the PPE availability in the country. An assessment on the numbers of PPE required has been conducted using WHO planning instruments.

- 67. Testing capacity is limited, with only 6,663 people being tested for COVID-19 as of April 1st for a population of more than a quarter of a billion.**¹⁷ In Indonesia, testing was recently expanded from the National Institute for Health Research and Development (NIHRD) – a BSL3 facility – to a broader network that now includes nine regional MOH laboratories and six non-government laboratories. The President has recently pledged to ramp up the country’s testing capacity up to 10,000 PCR tests per-day. However, the current capacity currently stands at approximately 4,500 tests per-day according to MoH. In addition, there have been limited supplies for laboratory testing (e.g. few PCR machines, reagents, and cartridges), and capacity to respond to the surge in demand as the epidemic progresses. The expansion of the network will also require a strong quality assurance mechanism and integration with surveillance information systems – linkages that do not currently exist. As of to date, the GoI has prioritized people who have been in contact with confirmed patients or who have been travelling to infected countries and show symptoms such as fever, cough, sore throat and shortness of breath. This has resulted in statistical misrepresentation with Indonesia’s reported death rate as one of the highest in the world. Worse, this has consequently masked the actual scale of the outbreak, which prevents the authority’s ability to curb further spread and make informed decisions on required measures. Lack of data likely limits the GoI’s ability to plan and allocate resources proportionally to tackle the outbreak.
- 68. There has been generally low surveillance preparedness.** According to the 2019 Global Health Security assessment, Indonesia did not show evidence of conducting ongoing event-based surveillance and analysis for infectious disease nor did it collect ongoing or real-time laboratory data limiting its ability to carry out contact tracing. While there are separate disease surveillance systems for TB (SITT), HIV (SIHA), and malaria (SISMAL) – the only notifiable diseases in Indonesia – they rely on manual reporting at the facility level which then gets sent first to the district health office as aggregate data and then to the MOH. The burdensome number of different reporting forms at the facility level also make reporting compliance an issue. However, the MOH’s Center for Health Data and Information has recently adopted DHIS2 as its national standard for housing data from various sources. While currently the MOH is only using DHIS2’s routine or aggregate data entry functions, it does provide applications that can be downloaded in the web-browser portal to enter event and/or tracker-based data¹⁸ that would allow more advanced functionality as a surveillance system for COVID-19 as well as other notifiable diseases
- 69. Further spread of the outbreak to peripheral areas will likely stretch the already limited capacities of health facilities in the outer region.** COVID-19 cases have been reported in all Indonesia’s 34 provinces. In the lead up of Idul Fitri, when Indonesia’s predominantly Muslim population travels to hometowns and villages across the archipelago will increase the risk of a

¹⁷ <https://covid19.kemkes.go.id/>

¹⁸ Routine data generally records aggregate counts at predefined intervals (e.g. monthly, quarterly, annually). Event-based data captures individual data at a particular time and place but is usually anonymous (i.e. without patient registration). Tracker-based data is an advanced form of event-based data with registration.

nationwide outbreak. As the pandemic expands, the speed of the country's readiness to curb the outbreak and provide proper treatments may be questioned. Indonesia has not issued any instruction for lockdown measures. A more stringent regulation for social restrictions in the capital of Jakarta was recently issued by MOH on 7th of April 2020, which may be followed by other provinces. In the context of larger outbreaks, the government's ability to procure and distribute critical medical supplies, life-saving equipment, and PPE may equally be overwhelmed due to the size and the country's geography. The same also applies to the capacity for safe handling of medical wastes, particularly amongst facilities not equipped to receive COVID-19 cases.

D.2 Environmental Considerations

70. Environmental aspects that were assessed are based on the potential environmental risks in the current emergency response system for COVID-19 pandemic. This includes potential risks associated with medical waste, as well as the testing of specimens and the treatment of COVID-19 patients and people who may have COVID-19.

71. Medical waste treatment system in Indonesia is diverse in quality, with better services are concentrated in Java. According to the latest data from the MOH in December 2019¹⁹, there are around 294.66 tonnes of hazardous waste produced each day from 2,820 hospitals and 9,884 community health centres (*puskesmas*), while there are 82 licensed incinerators and three licensed autoclaves across 20 out of 34 provinces (Figure 1), with the treatment capacity of around 53.12 tonnes/day. Almost 55% of the incinerators and autoclaves are on the island of Java. Beside licensed incinerators and autoclaves, licensed cement kilns with a capacity of up to 248.88 tonnes of hazardous waste per day are available to process medical waste.²⁰ However, these kilns are located only in seven provinces, again, most of which are situated in Java (Figure 2). The limited number and uneven presence of licensed incinerators and cement kilns in Indonesia indicate areas of attention for the planning of additional facilities or alternatives for medical waste management. MOEF and MOH are partnering to improve the management of medical waste, including the availability of medical waste treatment, through an on-going medical waste management strategy. The strategy includes: i) short-term solution to treat the cumulation of medical wastes by processing it through cement kilns, ii) increasing the capacity of licensed third-party treatment facilities, iii) developing a 10-year roadmap of medical waste management, iv) developing an electronic instrument to monitor medical waste treatment from source to a disposal site, and v) construction of a region-based medical waste treatment facility (e.g. incinerator).²¹

¹⁹ Data on licensed incinerators and autoclaves as well as the total waste generated from hospitals are taken from MOH presentation in a Webinar "Medical Waste Management During COVID-19 Pandemic" which was organized by Indonesia Hospital Association on April 1, 2020.

²⁰ Data on licensed thirdparty treatment facilities (cement kilns) is taken from MOEF presentation on "Hazardous Waste Management from Healthcare Facilities" dated March 12, 2020.

²¹ *ibid*

Figure 1. Licensed incinerators and autoclaves in Indonesia

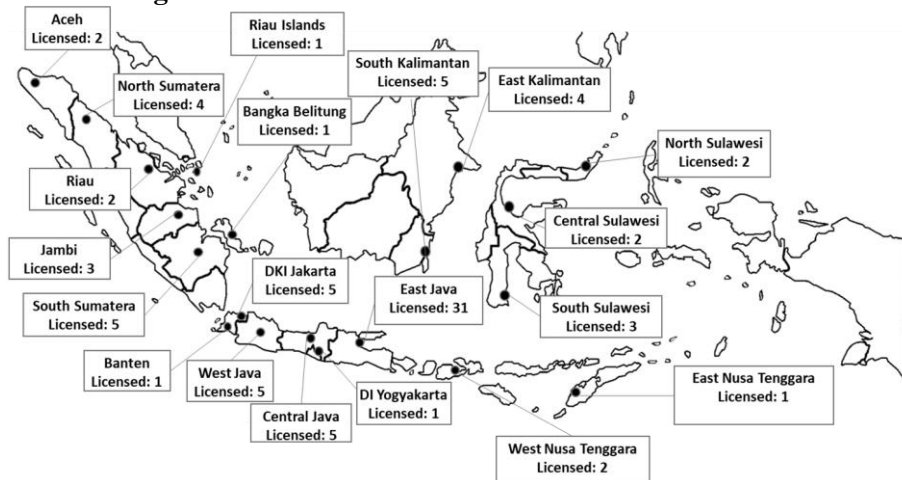
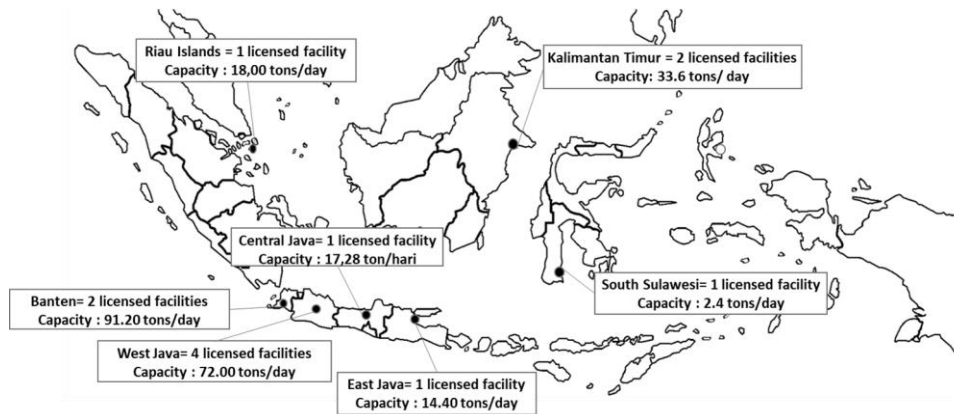


Figure 2. Licensed cement kilns in Indonesia



72. There are strict requirements on the management of medical incinerator ash (e.g. bottom ash, fly ash). MOEF regulation No. 56/2015 required all incinerator residue from medical waste treatment to be disposed to i) sanitary landfill, ii) controlled landfill, or iii) licensed hazardous waste landfill. For the disposal to sanitary and controlled landfill, the regulation requires the healthcare facilities to conduct pre-treatment to the wastes by encapsulation or inertization and ensures the pre-treatment product meets the stipulated toxicity characteristic leaching procedure (TCLP) standard. With the pre-treatment and TCLP test requirements, the disposal of incinerator ash to sanitary or controlled landfill might not be practical options. The disposal of incinerator ash to hazardous waste landfill could be a more practical alternative, as the healthcare facility can directly engage licensed third-party to manage it. However, there is only one licensed hazardous waste landfill in Indonesia, located in West Java Province.

73. An increasing number of COVID-19 patients or people who may have COVID-19 means an increasing volume of medical waste from hospitals and laboratories. The rise of medical waste volume is mainly attributed to the use of PPE, specimen testing, and other single-use medical equipment. The volume of medical wastes, including additional wastes following COVID-19 pandemic, is yet to be further assessed, but one of the referral hospitals in Jakarta, who is currently treating COVID-19 patients and people who may have COVID-19, reported the volume of medical waste is nearly doubled during this pandemic. Laboratories may also experience the same situation. One of the referral laboratories in Jakarta, who is currently testing around 2,000 COVID-19

specimens, estimated their wastes also had been nearly doubled. Support and response planning by MOH for the referral hospitals is additionally challenged by lack of coherent data on waste management in these referral hospitals. With the current diverse quality in the country's medical waste treatment facilities, additional waste from this pandemic could add more burden to the now-strained medical waste treatment system in the country.

- 74. Upon further consultations with MOEF, MOH received a verbal recommendation²² that allows the burial of COVID-19 infectious waste, provided that these wastes have been previously disinfected, the burial site meets the requirement prescribed in relevant regulation and coordination with the local environmental agency is conducted.** The practice for the onsite burial of infectious wastes during an emergency is in line with MOEF regulation No. 56/2015 and also listed as one of the alternatives from WHO to manage healthcare wastes during emergencies²³. Based on MOEF Regulation No. 56/2015, there are several required criteria for the location of the onsite burial, it should: i) be safe from flooding risk, ii) have a minimum of 20 meters distance to the nearest well or residential area, iii) be equipped with fences and warning sign. The regulation also outlines the technical requirements on the burial cell, such as i) the depth should be more than 1.8 meters, ii) the bottom layer of the cell should be coated with clay with minimum 20 centimetres in thickness among others. It is recommended that the onsite burial site is within the healthcare facilities boundary to ensure the facility has control over the site and minimize the needs for thirdparty involvement such as transporter. As of now, the ad-hoc meetings between MoH and MoEF did not result in a decision or a plan to purchase new treatment equipment (e.g. autoclaves, incinerators) or to use other facilities, such as other cement kilns which are yet to receive a license, to manage the possible surge of medical waste volume. The key obstacle for such planning process is the lack of baseline data on waste management capacities in referral hospitals.
- 75. MOEF temporarily allowed the use of installed, but not yet licenced, incinerators and autoclaves in referral hospitals.** The recent notice letter from MOEF²⁴ allows referral hospitals for COVID-19 to use their incinerators and autoclaves in treating the waste generated, although the said equipment have not yet secured treatment permit (license) from MOEF. This means that there are around 115 additional incinerators that can be used for treating medical waste during COVID-19 pandemic. The current discretion comes with a limitation, as MOEF required the hospitals to further handed over the treated waste from incinerators (ash) or autoclaves to licensed third party hazardous waste disposal. As the third-party hazardous waste transporters and disposals are relatively limited in number and distribution, additional alternative measures to handle the surging volume of waste is needed.
- 76. Although standard on wastewater effluent from healthcare facilities in Indonesia is comparable with the GIIP, systems readiness may vary across the country.** As physical improvements in wastewater treatment cannot be expected during COVID-19 response, MoH issued measures to minimize the spread of COVID-19 based on WHO guideline on water, sanitation, hygiene and waste management for COVID-19, in which it requires the healthcare facilities to have a wastewater treatment plant and to conduct disinfection with a chlorine solution. Further, all

²² This is a verbal recommendation received by MOH, following the meeting with MOEF to discuss about medical waste issue during COVID-19 pandemic

²³ WHO guideline on safe management of wastes from healthcare activities, Chapter 14 – healthcare waste management in emergencies.

²⁴ Notice Letter No. SE.2/MENLHK/PSLB3/PLB.3/3/2020 on infectious (hazardous) and domestic waste management from COVID-19 response, dated March 24, 2020.

accredited hospitals in Indonesia have an existing wastewater treatment plant in their facility, as the hospital accreditations system in Indonesia make it mandatory for hospitals to install it.

- 77. The current inter-agency cooperation in addressing the concern on medical waste management during this pandemic has been on an ad-hoc basis.** Multiple meetings discussing the current issues of medical waste management have been held between MOH and MOEF. Recommendations on how to address the emerging issues are provided in these meetings, although not all of it was provided in a formalized written recommendation. More structured and coordinated communication is needed to streamline the bureaucracy in decision making related to managing medical waste during this pandemic. Establishing coordination mechanism between MOH and MOEF could help expedite the decision-making process. Such arrangement will have the decision-making power to advise hospitals and laboratories in managing their wastes and facilitate dialogue with other stakeholders in the medical waste management chain, such as transporters and disposal facilities, among others.
- 78. Strained capacities in responding to COVID-19 pandemic will likely challenge the optimal implementation of the OHS system in healthcare facilities.** The primary occupational health and safety issues are related to the treatment of COVID-19 patients and people who may have COVID-19, as well as testing and handling of supplies and the possibility that they are not safely used by laboratory technicians and medical crews. While the country has a comprehensive regulatory framework on OHS management, protocols for infection prevention and control in the healthcare setting, the optimal implementation of the system might be hindered due to the stretched capacity in the healthcare facilities. This includes the limited availability of PPE for lab technicians, healthcare workers and other supporting workers such as ambulance drivers, housekeeping personnel and workers who are handling medical waste - which expose the healthcare workers to nosocomial infections.
- 79. Resources have been allocated to improve OHS implementation in healthcare facilities during COVID-19 pandemic.** This includes allocating additional budget to purchase PPE for all workers in the healthcare facilities (lab technicians, doctors, nurses, ambulance drivers, housekeeping personnel), disinfectant, among others. MOH also issued a specific COVID-19 infection prevention and control protocols, which includes the guideline to maintain proper hand hygiene, to use proper PPE based on the workplace risks, to manage medical waste and to conduct thorough disinfecting of equipment and facilities.
- 80. The Directorate of Environmental Health in MOH is mandated to manage policies and provide supervision on environmental health aspect in healthcare facilities, including medical waste and wastewater.** A sub-directorate of waste and radiation management is leading the efforts in this area. Targets on the percentage of hospitals that are in compliance with relevant regulations on medical waste management have been set as part of its annual and 5-year target. The directorate is also mandated to provide technical assistance to healthcare facilities for the management of environmental health. Training on waste management procedures and protocols are conducted annually. The directorate has been partnering with MOEF for the improvement of medical waste management in the country. Despite being mandated to provide supervision, the directorate has no enforcement role in regard to hazardous waste management in the country, the enforcement of medical waste (hazardous waste) related regulations falls on MOEF and provincial/district level environmental agency.

D.3 Social Considerations

81. Social aspects to be assessed were informed by the PforR of supporting systems towards strengthening emergency response towards COVID 19 outbreak and future pandemic. The social considerations were:

- a. Concerns related to patient consent and grievance redress (associated with tracing, treatment, isolation and movement of infected populations)
- b. Risks associated with data privacy associated with surveillance and contact tracing with potential to exacerbate social stigma and marginalization of certain groups
- c. Risk of miscommunication and tension associated with COVID 19 management, including perceptions of inequity in receipt of treatment/care, urban/ethnicity/geographical biases, particularly if resources and protocols are stretched thin and/or poorly handled
- d. Risks associated with mobilization of security forces in the overall GoI's response to COVID-19 emergency

82. Existing inequity in the healthcare system may potentially amplify perceptions of lack of fairness in COVID-19 emergency response, which may lead to social tension and discontent. Such risks may increase in the context of healthcare rationing due to lack of medical supplies, staff and care facilities. The GoI's COVID-19 pandemic emergency response has acknowledged the importance of communicating effectively to the public on the pandemic and the government response. A recent survey by KANTAR²⁵ involving 6430 respondents across rural and urban areas indicate that the increase in COVID cases and deaths is clearly linked to a rapid rise in concern levels although public panic has not been observed beyond panic buying of masks and logistics. The GoI has included public risk communication as one of the critical areas in its pandemic response in anticipation of widespread fear and speculation related to the pandemic. While the PforR will focus primarily on vertical hospitals assigned as COVID-19 referrals, efforts to enhance the public health communication strategy and non-referral health facilities' preparedness through the issuance of guidelines will be included under the scope of the PforR.

83. Strained healthcare capacities may likely challenge the ability of healthcare facilities to exercise proper consent processes as required by law. Such a consent requirement is enshrined under Law No. 29/2004 on Medical Practice. The law concerns the protection of confidentiality, information about treatment and costs, and informed consent to any procedures as well as rights to refuse any medical treatments/procedures and seek a second opinion. The provision may be waived under emergency situations in the name of public security.

84. Despite GOI's instruction on data confidentiality, adherence to such a protocol is inconsistent, at the expense of people who may have COVID-19 and patients. While GOI has released a public communication protocol on COVID-19²⁶ for national and sub-national governments, with an emphasis on patient data confidentiality, anecdotal evidence indicates that adherence to such requirements has been lacking. The GoI announced the first confirmed case of COVID-19 in Jakarta followed by extensive media coverage which disclosed the patients' personal identity including photograph, occupation and home address, with reported subsequent stigmatization faced by the patients following recovery. Furthermore, MOH's current guideline on COVID-19 management is also silent on the provisions of confidentiality in the context of surveillance, which warrants additional measures.

²⁵ KANTAR is an international consulting firm with expertise in data and evidence-based analysis

²⁶ <https://www.indonesia.go.id/layanan/kependudukan/ekonomi/protokol-komunikasi-publik>

- 85. Mass testing and surveillance to curb the spread of COVID-19 may have implications on patient consent and civil rights to privacy, often leading to social stigma.** Mass surveillance often followed by contact tracing, may potentially interfere with civil rights to privacy and data security. While South Korea's model for contact tracing is unlikely replicable in Indonesia for a number of reasons, particularly due to the already sporadic patterns of the outbreak, concerns related to data privacy in terms of disclosure of private information may have potentially adverse consequences on people who may have COVID-19 and patients. GOI announced the first confirmed case of COVID-19 in Jakarta followed by extensive media coverage which disclosed the patient's personal identity including photograph, occupation and home address, with reports of stigmatization by the surrounding community following recovery²⁷. In the absence of comprehensive legal protection of private data, people who may have COVID-19 and patients have a weak bargaining power to seek justice.
- 86. Stigma and discrimination against healthcare workers are increasingly being reported.** Nurses and doctors face stigmatization and discrimination due to fears of infection²⁸. In the absence of adequate temporary accommodation for these workers, such as stigmatization and ostracization, represent a double burden. Furthermore, fear and stigma against healthcare workers may also prevent the public from seeking proper consultations and treatment, thus potentially furthering the spread of the disease.
- 87. People from low-income groups, particularly those living in a slum, densely populated areas, are particularly more vulnerable compared to the rest of the population** due to their lack of ability to exercise social distancing measures, dependence on the informal economy and lack of social safety nets. High morbidity due to COVID-19 was observed amongst the elderly (≥ 60 years) and people with underlying medical conditions such as cardiovascular disease, chronic respiratory diseases, diabetes and cancer (WHO) and these vulnerability factors may be more acute amongst the poor in the context of a potentially strained public healthcare system. Health service rationing may also lead to social tension and conflicts, particularly when prioritization is placed upon the elites or certain ethnic groups.
- 88. Communication remains a challenge for rural and remote catchment areas.** Many clinics and health posts lack mobile phones and/or short-wave radio capacity, which reduces options for readily communicating with communities. Improved telecommunication technology and connectivity, particularly for mobile phones, present an opportunity to strengthen communication, increase access to information on COVID-19, including prevention measures and access to healthcare facilities and strengthen surveillance to prevent the spread of the virus.
- 89. Since grievance management is decentralized at the facility level, MOH's ability to supervise how grievances are being handled will be challenged, particularly in the context of emergency response.** Under MOH, there is no centralised system addressing patient feedback and complaints. At the national level, the MOH operates "*Halo Kemkes*" or they can be contacted by email both of which are not specifically designed functions as a grievance mechanism by health care clients but rather feedback on overall health administration. Most patient care related complaints are handled at the facility level. Existing MOH, District Health Offices (DHO) and Provincial Health Offices (PHO) mechanisms to address complaints may be loosely linked with improvements in the overall

²⁷ <https://www.liputan6.com/news/read/4203687/kisah-sedih-pasien-01-virus-corona-hampir-setiap-hari-saya-menangis>

²⁸ <https://megapolitan.kompas.com/read/2020/03/26/06184641/saat-perawat-dan-dokter-rsuh-persahabatan-jadi-korban-stigma-negatif>

health system since issues are likely to be underreported at the central level. This prevents understanding of systemic issues in health-care provisions at all levels.

90. People in very remote areas, Indigenous Peoples, and those who are not formally registered or transient populations (including nomadic, seafaring, farming communities, temporary and migrant workers) often lack access to health services. In the context of COVID-19 emergency, such lack of accessibility likely stems from limited services available in rural and remote areas, instead of financing for COVID-19 treatment. While these issues reflect the whole running of the healthcare system in Indonesia, which the PforR is not being prepared to address, the GoI's COVID-19 pandemic emergency response has acknowledged the importance of strengthening primary healthcare operating in rural and remote areas in anticipation of further spread. The PforR will support aspects of these efforts by enhancing public health communication and issuance and dissemination of protocols for Infection Prevention Control (IPC) measures and clinical management to non-referral facilities.

E ENVIRONMENTAL AND SOCIAL RECOMMENDATIONS AND ACTIONS

- 91. The recommended measures (on the following page) were shared in writing with MoH.** The draft ESSA report has been circulated with an executive summary in Bahasa Indonesia. A formal response has been received pertaining to the ESSA actions. Further consultation with MOH and relevant stakeholders is still being awaited to enable finalization of the environmental and social actions, which will form part of the Program Action Plan (PAP).
- 92. The World Bank will undertake periodic monitoring of the progress of the proposed environmental and social action plans.** Such monitoring will be part of joint-regular implementation support missions between MOH and the World Bank and DLI verification processes by independent verifiers (i.e. Finance and Development Monitoring Agency or hereafter BPKP and KARS). Technical support for the implementation of the proposed action plans will be provided on a need basis.

Table 3: Environmental and Social Plans

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
Management of Medical Wastes							
1.	Nominate responsible staff from the MOH and MOEF to jointly advise hospitals and laboratories in managing the increasing volume of medical waste during the pandemic, including through	Directorate Environmental Health	Yes (Subset of DLI 4)	No	n.a.	31 May 2020	Letters which indicate the nomination of responsible staff from MOH and MOEF
a.	Conduct rapid assessment on current capacity/practice in the MOH's vertically managed hospitals, laboratories and field hospitals to manage medical waste and the expected volume of waste generated during the pandemic		Yes (subset of DLI 4)	No	n.a.	30 June 2020	Rapid assessments of MOH's vertically managed referral hospitals, field hospitals and laboratories
b.	Advising hospitals and laboratories on the alternatives to manage their wastes (in house and external services), support approval of agreed options and develop the necessary work instructions for these alternatives. Based on agreed options for medical waste management jointly with the MoH, support procurement for goods/equipment where needed, facilitate dialogue with third parties (waste transporters, cement kilns, landfills for ash disposal, and so on)		No	Yes	n.a.	Ongoing	Administrative records
c.	Providing training to hospitals and laboratories on the alternatives to manage COVID-19 wastes (web-based training) and providing		No	Yes	n.a.	Ongoing	Number of e-training sessions delivered

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
	guidance for third parties on medical waste management.						
Occupational Health and Safety (OHS)							
2.	Training manuals and cascade training to hospital and laboratory workers for the proper handling of COVID-19 cases and specimens, including the proper usage of PPE (web-based training)	Directorate of Occupational Health of the MOH and National Institute of Health Research and Development of the MOH	No	Yes	Based on needs, maintained through emergency response	Ongoing	Number of e-training sessions delivered
3.	Priority testing for healthcare workers and facility staff responsible for direct handling of COVID-19 at MOH vertical hospitals (i.e. cleaners, ambulance drivers, receptionists, etc.)	Directorate General of Health Service	Yes (subset of DLI 1)	Yes	n.a.	30 June 2020	A guideline which prescribes priority testing for healthcare workers and facility staff has been developed
Public Health and Safety							
4.	Additional capacity for patient isolation and low-intensity medical care by converting non-medical establishments with the needed equipment and human resources	DG of Health Service (Directorate of Health Facility and/or Directorate of Hospital Services)	Yes (DLI 3)	No	n.a.	Ongoing	MOH administrative records
5.	A system for assessing needs and monitoring distribution of PPE to health facilities based on needs across Indonesia.* <i>This action plan also addresses equity issues in PPE distribution.</i>	The Center for Health Crisis of MOH for PPE; Directorate of Surveillance and Health Quarantine for Testing Kits;	Yes (sub-set of DLI 5)	No	n.a.	30 June 2020	Evidence of an operating system to monitor and track procurement, need assessment and distribution

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
		DG of Pharmaceutical Services for medical supplies					
Medical Consent and Civil Rights to Privacy							
6.	Measures to enhance the existing public Feedback and Grievance Mechanism (FGRM) for COVID-19 response, such as https://covid19.kemkes.go.id/ and hotline 119 ext. 9, and ‘Halo Kemkes’ in terms of their accessibility, credibility and level of response	Directorate of Referral Services Bureau Communication Public Service, Secretary General	No	Yes	Monthly	Ongoing	Grievance records on COVID-19 management tracked with resolution status
7.	A protocol for surveillance incorporating data protection measures and consent is developed and disseminated to health facilities	Directorate for Surveillance and Health Quarantine; Center of Health Data and Information (Pusdatin)	Yes (sub-set of DLI 6 and 10)	No	n.a.	Ongoing	Completion and issuance of protocols and evidence of dissemination incorporating, as a minimum, the principles set forth in the Personal Data Management Protocol
Social Stigma							
8.	A communication strategy on public health messaging and community outreach on COVID-19 related facts, in coordination with media and civil society organizations and in line with good practice guidelines such as https://www.who.int/docs/default-source/coronaviruse/covid19-stigma-guide.pdf	Directorate of Health Promotion Media: Bureau Communication And Public Service	Yes (sub-set of DLI 9)	Yes	n.a.	31 May 2020	Communication strategy issued

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
Patients' security and safety							
9.	Strengthen the existing system to monitor patients' security and safety during isolation & treatment at COVID19 referral hospitals, including on aspects related to Sexual, Exploitation & Abuse/Violence against Children (SEA/VAC)	Directorate General of Health Service (Directorate of Health Facility and/or Directorate of Hospital Services)	No	Yes	Monthly	Ongoing	Evidence of an operating system to monitor and track risks related to patients' wellbeing, including their security and safety during isolation and treatments at COVID-19 referral hospitals

F ENVIRONMENTAL AND SOCIAL RISK RATING

93. Environmental and social risk is assessed to be substantial. While the PforR is not envisaged to result in adverse environmental and social impacts under normal circumstances, the current capacity constraints facing GoI to respond to COVID-19 crisis effectively may limit the PforR's ability to achieve its environmental and social operational objectives. Such contextual risks within which the PforR is operating justifies the risk rating of substantial. The unprecedented speed of COVID-19 infection across population groups likely strain the existing health care capacities, including supplies of medical workers and required equipment, which may potentially get worse as the pandemic continues. Such capacity constraints can potentially increase the level of potential environmental and social risks associated with the operation. Risk areas of concerns include medical waste and wastewater, Occupational Health and Safety (OHS) for medical workers, community health and safety-related to the handling of medical waste, transportation, treatment and isolation of people with confirmed COVID-19 and/or people who may have COVID-19, poor consent processes, communication and outreach, and privacy concerns due to mass surveillance. These potential environmental and social risks may likely be exacerbated by lack of capacity to contain COVID-19 infection risks due to the country's strained healthcare system for testing, treatment, isolation and safe-handling of medical wastes and lack of protective gear for medical health workers.

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ANNEX 1: Summary of DLIs for the Indonesia Emergency Response to COVID-19 PforR

Category (including Disbursement Linked Indicator as applicable)	Disbursement Linked Result (as applicable)	Amount of the Loan Allocated (expressed in USD)	Formula
(1) DLI #1: Specific additional measures to support and compensate health professionals for added COVID-19 related workload and risk are implemented	DLR #1.1: The Implementation Guidelines for Health Professionals' Support for COVID-19 response have been issued and the payment of benefits have commenced	50,000,000	DLR #1.1: \$50,000,000
(2) DLI #2: MOH works closely in coordination with the country's multi-sectoral National Task Force to Accelerate the Response to the COVID-19 Emergency	DLR #2.1: The Borrower has: (i) established the National Task Force to Accelerate the Response to the COVID-19 Emergency with an MOH official as its Vice-Chair; and (ii) finalized and issued a national response plan to respond to Covid-19	10,000,000	DLR #2.1: \$10,000,000
(3) DLI #3: Increased capacity for patient isolation and medical care	DLR #3.1: 1500 beds belonging to non-medical establishment(s) have been converted and suitably adapted to serve as temporary, low-intensity medical facilities DLR #3.2: MOH has issued the MOH Guidelines on Claims Reimbursement for different levels of severity of COVID-19 patients managed in health facilities.	7,500,000 7,500,000	DLR #3.1: \$7,500,000 DLR #3.2: \$7,500,000
(4) DLI #4: Health facilities' readiness for emergency response	DLR #4.1: At least 3000 critical care beds in existing medical facilities are fully equipped to manage serious respiratory illnesses pursuant to Protocol A (of which at least 50% are equipped with ventilators)	75,000,000	DLR #2.1: \$75,000,000 Unit Price: \$25,000 per critical care bed fully equipped pursuant to Protocol A

<p>(5) DLI #5: Strengthen the implementation of optimal infection and control measures in healthcare settings</p>	<p>DLR #5.1: At least 1,000,000 sets of Personal Protective Equipment (PPE) have been procured and distributed by the Borrower.</p> <p>DLR #5.2: As of January 1, 2021 or later, at least 100,000 sets of Personal Protective Equipment (PPE) are available as reserves for future emergency needs.</p>	<p>20,000,000</p> <p>10,000,000</p>	<p>DLR #5.1: \$20,000,000</p> <p>Unit Price: \$20 per PPE</p> <p>DLR #5.2: \$10,000,000</p>
<p>(6) DLI #6: Protocols for infection prevention and clinical management of patients with respiratory symptoms</p>	<p>DLR #6.1: MOH has developed protocols for infection prevention and clinical management of patients with respiratory symptoms and disseminated them to all Non-Referral Facilities</p>	<p>10,000,000</p>	<p>DLR #6.1: \$10,000,000</p>
<p>(7) DLI #7: Installed capacity of quality-assured COVID-19 confirmatory tests per day</p>	<p>DLR #7.1: The Borrower has established and maintained an external quality assurance system for the entire installed capacity of COVID-19 confirmatory Polymerase Chain Reaction (PCR) tests – including MOH and non-MOH hospitals authorized to carry out COVID-19 testing.</p> <p>DLR #7.2: The Borrower has made at least 350 quality-assured rapid molecular testing machines regularly functional for undertaking COVID-19 confirmatory tests.</p>	<p>6,000,000</p> <p>14,000,000</p>	<p>DLR #7.1: \$6,000,000</p> <p>DLR #7.2: \$14,000,000</p> <p>US\$ 40,000 per regularly functional machine</p>
<p>(8) DLI #8: Updated National Pandemic Preparedness Plan and regular simulation exercises</p>	<p>DLR #8.1: On or after January 1, 2021, the Borrower has: (a) Updated its National Pandemic Preparedness Plan, including revised emergency</p>	<p>20,000,000</p>	<p>DLR #8.1: \$20,000,000</p>

	funds flow mechanisms, as well as improved emergency procurement systems; and (b) rolled out and conducts regular emergency simulation exercises based on the updated Plan.		
(9) DLI #9: Communications strategy on COVID-19 status, responses, and personal hygiene promotion updated based on COVID-19 experience	DLR #9.1: On or after January 1, 2021, the Borrower has developed and rolled out a communications strategy on COVID-19 status, responses, and personal hygiene promotion, based upon its experience and lessons-learned up to such date.	10,000,000	DLR #9.1: \$10,000,000
(10) DLI #10: Improved reporting and strengthened surveillance system in place, incorporating lessons from COVID-19 experience	DLR #10.1: MOH has developed an improved event- and/or tracker-based health surveillance system, based upon its experience and lessons-learned on COVID-19 up to such date.	10,000,000	DLR #10.1: \$10,000,000
TOTAL AMOUNT		250,000,000	

ANNEX 2: Alignment of PforR Program with GoI program for COVID-19 Emergency Response

	Government program	Program supported by the PforR (PforR Program)	Reasons for non-alignment
<i>Objective</i>	The National Medium-Term Development Plan 2020 - 2024 Health Sector Strategy #3 Strengthening disease control Including Point #”3.b” Strengthening health security functions to detect, prevent, and respond in the event of pandemic and other health threats, including the epidemic monitoring, and health quarantine Health Sector Strategy # 5 Strengthening health service delivery in point #”5.g” Ensuring the availability of health facility and equipment	i) addressing the immediate needs of designated COVID-19 referral facilities, ii) strengthening the laboratory network and surveillance system, and iii) ensuring communications and coordination across sectors and levels of government	The P4R focuses on the subset supporting the country’s emergency response and strengthening the capacity of laboratories and other key elements of detection and prevention.
<i>Duration</i>	2020-2024	2020-2021	The P4R is a shorter-term intervention aimed at strengthening the response in the emergency phase and contributing to longer term resilience and readiness.
<i>Geographic coverage</i>	Nationwide	Nationwide	
<i>Results areas</i>	<ol style="list-style-type: none"> Platform for Internal and Cross Sectoral Coordination: A national level emergency task force has been established and the MOH is expected to actively contribute to the same. Health system preparedness: The availability and readiness of hospitals to treat COVID-19 cases especially the severe cases that require critical care. Laboratory testing and Surveillance: Increase the capacity for testing including expanding laboratory network. Contact tracing capacity and using surveillance data to inform decision making. Public Risk Communication: Provide technical information to inform communications, and counter misinformation. 	<p>Results Area 1: Addressing Hospital and Health System Readiness Needs</p> <p>Results Area 2: Strengthen Public Health Laboratory and Surveillance System</p> <p>Results Area 3: Communication and Coordination for Pandemic Response and Preparedness</p>	As the P4R focuses on MOH activities, RA 4 and RA5 are beyond the PforR scope. MOH’s support to RA1 is included in the program boundaries, but not the remaining activities of this platform.

<i>Overall Financing</i>	Being estimated	USD 250 million	
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ANNEX 3: Core Principles and Planning Elements

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
Core principle 1: Program E&S management systems are designed to (a) promote E&S sustainability in the Program design; (b) avoid, minimize, or mitigate adverse impacts; and (c) promote informed decision-making relating to a Program’s E&S effects.				
1	The PforR system operate within an adequate legal and regulatory framework to guide E&S impact assessments, mitigation, management and monitoring at the PforR Program level.	Relevant	Relevant laws and regulations are available i.e. environmental impact assessment (AMDAL), handling of medical waste, occupational health and safety, patient safety, public health and safety, patients’ rights including consent, grievance management, access and inclusion; Assessment on relevant laws and regulations was conducted for Indonesia-Supporting Primary Health Care Reform Project (I-SPHERE) – Pfor R (P.164277) which confirmed no significant gaps with regards to policies, laws, and regulation.	Referral hospitals and testing laboratories are required to conduct environmental and social impact assessment (AMDAL) which assess the potential risks and impacts and provide mitigation measures in order to obtain environmental permit prior to construction of the facilities.
2	The PforR system incorporate recognized elements of good practice in E&S assessment and management including: <ul style="list-style-type: none"> i. Early screening of potential impacts. ii. Consideration of strategic, technical, and site alternatives (including the “no action” alternative). iii. Explicit assessment of potential induced, cumulative, and transboundary impacts. iv. Identification of measures to mitigate adverse E&S risks and impacts that cannot be otherwise avoided or minimized. 	Relevant	Accreditation system and provisions and also national regulatory system as it applies to environment.	The referral hospitals and laboratories are required to report their environmental management report every 6 months.

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
	<ul style="list-style-type: none"> v. Clear articulation of institutional responsibilities and resources to support implementation of plans vi. Responsiveness and accountability through stakeholder consultation, timely dissemination of the PforR information, and responsive GRMs. 			
<p>Core principle 2: Program E&S management systems are designed to avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program. Program activities that involve the significant conversion or degradation of critical natural habitats or critical physical cultural heritage are not eligible for PforR financing.</p>				
1.	The PforR Program system identify, and screen for adverse effects on potentially important biodiversity and cultural resource areas and provide adequate measures to avoid, minimize, or mitigate adverse effects.	Not relevant	Not relevant	Not relevant
2.	The PforR Program system support and promote the protection, conservation, maintenance, and rehabilitation of natural habitats.	Not relevant	Not relevant	Not relevant
3.	The PforR Program system avoid significant conversion or degradation of critical natural habitats. If avoiding the significant conversion of natural habitats is not technically feasible, include measures to mitigate or offset the adverse impacts of the PforR Program activities and take into account potential adverse effects on	Not relevant	Not relevant	Not relevant

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
	physical cultural property and provide adequate measures to avoid, minimize, or mitigate such effects.			
Core principle 3: Program E&S management systems are designed to protect public and worker safety against the potential risks associated with (a) the construction and/or operation of facilities or other operational practices under the Program; (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials under the Program; and (c) reconstruction or rehabilitation.				
1.	<p>The PforR Program system promote adequate community, individual, and worker health, safety, and security through the safe design, construction, operation, and maintenance of Program activities; or, in carrying out activities that may be dependent on existing infrastructure, incorporate safety measures, inspections, or remedial works as appropriate.</p> <p>The PforR Program system promote measures to address child and forced labor.</p>	Relevant	<p>Accreditation system for hospital.</p> <p>Minister of Health Regulation 66/2016 on Occupational Health and Safety at Hospital</p>	Increased health risks to medical workers treating COVID-19 patients due to shortage of PPE in some of referral hospitals and laboratories testing for COVID-19.
2.	The PforR Program system promote the use of recognized good practice in the production, management, storage, transport, and disposal of hazardous materials generated under the PforR.	Relevant	<p>MOH Regulation No. 34/2017 on Hospital accreditation system.</p> <p>National laws and regulations that governs the following:</p> <ul style="list-style-type: none"> ▪ <u>Law No. 32/2009</u> on The Protection and Environmental Management, requires management of materials and wastes that are classified as dangerous and/or poisonous or B3 (<i>Bahan Berbahaya dan Beracun</i>) ▪ <u>Government Regulation No. 74/2001</u> on Management of Hazardous Materials), 	<p>The referral hospitals and laboratories are required to report their environmental management report every 6 months including issues on hazardous waste management.</p> <p>Potential issues on hospitals and laboratories' capacity to manage significantly increased volume of hazardous waste during the pandemic.</p>

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
			<p>Government Regulation No. 101/2014 on Management of Toxic and Hazardous Waste</p> <ul style="list-style-type: none"> ▪ <u>Government Regulation No. 27/2012</u> on Environmental Permit). ▪ <u>MOEF Decree No. 56/2015</u> on Procedures and Technical Requirement of Hazardous Waste Management from Health Care Facilities <p>1. <u>MOH Regulation No. 7/2019</u> on hospitals' environmental health</p>	
3.	The PforR Program system promote the use of integrated pest management practices to manage or reduce the adverse impacts of pests or disease vectors	Not relevant	Not relevant	Not relevant
4.	The PforR Program system provide training for workers involved in the production, procurement, storage, transport, use, and disposal of hazardous chemicals in accordance with the relevant international guidelines and conventions	Relevant	Minister of Health Regulation 66/2016 on Occupational Health and Safety at Hospital includes provisions for hazardous waste management. The hospital's occupational health and safety plan must be implemented by skilled personnel supported with adequate budget and tools and equipment. Training and education on OHS issues are mandatory for the relevant personnel	Potential issues on hospitals and laboratories' capacity to manage significantly increased volume of hazardous waste during the outbreak.
5.	The PforR Program system include adequate measures to avoid, minimize, or mitigate community, individual, and worker risks when the PforR Program activities are located in areas prone to natural hazards such as floods, hurricanes,	Relevant	<p>Law No 44/ 2009 on Hospital regulates that location of the hospital must comply with environmental health and safety and spatial planning consideration.</p> <p>Ministry of Health Regulation No. 24/2016 on Technical Requirements for Hospital Buildings regulates that hospital buildings</p>	No significant gaps

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
	earthquakes, or other severe weather or affected by climate events.		must be free from natural hazards such as hurricanes, floods, earthquake (faults), steep slope, tsunami, at river bank area (erosion potential) etc.	
Core Principle 4: Program E&S systems manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement and assists affected people in improving, or at the minimum restoring, their livelihoods and living standards				
1.	The PforR Program system avoid or minimize land acquisition and related adverse impacts.	Not relevant as the PfR is not envisaged to finance infrastructure construction that requires land acquisition	Not relevant	Not relevant
2.	The PforR Program system identify and address economic or social impacts caused by land acquisition or loss of access to natural resources, including those affecting people who may lack full legal rights to resources they use or occupy.	Not relevant, as above	Not relevant	Not relevant
3.	The PforR Program system provide compensation sufficient to purchase replacement assets of equivalent value and to meet any necessary transitional expenses, paid before taking land or restricting access.	Not relevant, as above	Not relevant	Not relevant
4.	The PforR Program system provide supplemental livelihood improvement or restoration measures if taking of land causes loss of income-	Not relevant, as above	Not relevant	Not relevant

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
	generating opportunity (e.g., loss of crop production or employment).			
5.	The PforR Program system restore or replace public infrastructure and community services that may be adversely affected by the Program; include measures in order for land acquisition and related activities to be planned and implemented with appropriate disclosure of information, consultation, and informed participation of those affected.	Not relevant, as above	Not relevant	Not relevant
Core principle 5: Program E&S systems give due consideration to the cultural appropriateness of, and equitable access to, Program benefits, giving special attention to the rights and interests of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities, and to the needs or concerns of vulnerable groups				
1.	The PforR Program system undertake meaningful consultations if the Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities are potentially affected (positively or negatively), to determine whether there is broad community support for the PforR Program activities.	Focus of the Program primarily in system improvements while there is outreach, opportunities will exist for strengthening existing systems.	Not relevant	Not relevant
2.	The PforR Program system ensure that Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local	Not relevant	Not relevant	Not relevant

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
	Communities can participate in devising opportunities to benefit from exploitation of customary resources and indigenous knowledge, the latter (indigenous knowledge) to include the consent of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities.			
3.	The PforR Program system give attention to groups vulnerable to hardship or discrimination, including, as relevant, the poor, the disabled, women and children, the elderly, ethnic minorities or other marginalized groups; and if necessary, take special measures to promote equitable access to PforR Program benefits.	Relevant.	<p>Provisions in the hospital accreditation system.</p> <p>Law No. 29/2004 on Medical Practice, Article 52 and the Health Act, the Hospital Act and the Medical Practice Act: Citizens have the rights to choose services, to be treated without prejudice and discrimination, to have their record and treatments kept confidential, to receive information about treatment and costs as well as seek for second opinion.</p> <p>Law No. 8 of 1999 on Consumer Protection: Citizens have the right to choose services, to be treated without prejudice and discrimination, to have access to information regarding services, to be heard and complaint as well as legal access to litigation. Procedures governing access to <i>JKN</i> require the possession of an ID Card (<i>Kartu Tanda Penduduk or KTP</i>) which then impacts on people being able to access healthcare.</p>	Although the key regulations contain provisions for community outreach as well as improvements in access and appropriateness of health care services, efforts to achieve equal health outcomes especially for people in Eastern provinces in Indonesia have been constrained by limited connectivity due to geographical barriers (islands, mountainous terrains), unequal distribution of health workers and availability of the right skills to address specific health needs, legal identity to access <i>JKN</i> and other social assistance programs), social and cultural factors (e. g. stigma, cultural practices and preferences)

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
			Access to health services for people with special needs is also protected by law, with health providers being required to ensure their facilities are accessible and services are non-discriminatory.	
Core principle 6: Program E&S systems avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes				
1	The PforR Program system consider conflict risks, including distributional equity and cultural sensitivities.	Not relevant	Not relevant	Not relevant

ANNEX 4: Preliminary Environmental and Social Screening

EMERGENCY FINANCING TO SUPPORT COVID-19 RESPONSE IN INDONESIA (P173843, PE) PROGRAM FOR RESULTS Environmental and Social Initial Screening

Introduction: To prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Indonesia.

Program Boundary: The Program for Results (PforR) is part of the World Bank's support which in the short-term focuses on strengthening the Government of Indonesia's (GOI) to respond to the recent COVID 19 outbreak and escalate the capacity for case detection and investigation. In the medium-term, the Program also aims to strengthen and further reform the country's health system by enhancing its resilience and preparedness to better address similar situations in the future.

The PforR will focus on supporting key aspects of Indonesia's emergency response to the COVID-19 outbreak by strengthening i) emergency health facilities designated as national referral facilities for Covid, and ii) the laboratory network and surveillance system to detect potential threats from new emerging diseases. While support will be needed to respond to the socio-economic impact of COVID-19 on households, businesses and government budgets, the World Bank's approach is to lead with the health response. Therefore, this project focuses primarily on health sector operations to respond to urgent preparedness and response needs related to the COVID-19 outbreak. The program boundaries will focus on the referral facilities and laboratories in the network that are vertically managed by the Ministry of Health, and the national surveillance and laboratory units at the central level. As this program is intended to support the GoI's COVID-19 emergency response, the duration of the program is projected to be 18 months, and within the first three months would be the emergency response period.

Purpose of initial screening:

The initial screening mainly serves as a preliminary diagnostic exercise to identify potential environmental and social risks associated with the Program, specifically on the following aspects:

- c. Environmental considerations: handling of medical solid waste and wastewaters, occupational health and safety issues related to healthcare worker and public / community health and patient safety focusing on COVID-19 prevention and containment
- d. Social considerations: consent processes, patient rights, and data and privacy concerns associated with COVID-19 surveillance

Once a formal decision is obtained to proceed using the proposed PforR instruments, a more technical environmental and social system assessment (ESSA) will be carried out and measures to address weaknesses and to enhance risk and impact management agreed between the World Bank and MOH and other potential implementing partners. The ESSA for this program will build on the ESSA of the current ongoing program: Indonesia – Supporting Primary Health Care Reform Program (I-SPHERE, P164277).

Key results and findings of the initial screening:

Initial screening was carried out based on the proposed result areas and inclusion of potential activities within each area. Further assessment, including stakeholder consultations, will be conducted during the Program preparation.

- The activities planned under this P4R will not have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected people. The PforR is not envisioned to support infrastructure investments and/or infrastructure-financing instruments for the construction and rehabilitation of health care facilities (HCF). There are no anticipated adverse impacts to natural habitats, physical cultural property, natural resources.
- Environmental risks are related to suboptimal management of medical solid waste and wastewater during hospitals operation. While most of activities will take place in existing hospitals and certified laboratory with the procedures and facilities to handle such waste are in place – the increasing volume of waste, lack of proper implementation and supervision due to the strains resources during this pandemic may increase the potential pollution risk to the environment. The expansion of hospital capacity by converting pre-existing structures to care for COVID-19 patients possess additional risks as these buildings might not be equipped with facilities to handle medical solid waste and wastewater during its operation. Further, there is a lack of harmonization between the MOH’s decree and MOEF’s regulation on requirements to handle medical waste which could lead to improper handling of the waste.
- Public/community health and safety concerns are related to existing capacities to contain COVID 19 and provide safe transportation, treatment and isolation to patients and people who may have COVID-19 as well as protection to surrounding communities where treatment facilities are being established. Such risks are anticipated to exponentially increase with a potential further outbreak combined with strained capacity to contain infection, especially in the outer regions of Java island where health services and capacities for safe-handling of bio-medical wastes are sub-par.
- Current Occupational Health and Safety (OHS) risks for medical workers and staff are high. Issues related to highly infectious diseases which require additional protective gear for medical health workers. As of 23rd of March 2020, 42 health workers were infected, six of whom passed away.
- Rapid and mass testing may also have implication on the ability of healthcare facilities to exercise proper consent processes as required by Law. Such a consent requirement is enshrined under Law No. 29/2004 on Medical Practice, which may be waived under emergency situations. The law concerns protection of confidentiality, information about treatment and costs, and informed consent to any procedures as well as rights to refuse any medical treatments/procedures and seek for second opinion.
- Mass surveillance and contact tracing may also interfere with civil rights to privacy. Concerns are related to potential abuse of data during and when the pandemic is over.

Institutional Capacity to manage environmental and social risks: the institutional set up for the project is yet to be confirmed and MOH is anticipated to serve as the leading implementing agency. The current capacity for the management of COVID-19 within MOH institution is not fully understood and will be assessed as part of the ESSA process. However, due to speed of COVID 19 infection across population groups, existing health care capacities, including supplies of medical workers are likely strained and will potentially get worse as the pandemic continues.

MOH is currently implementing a World Bank-funded PforR, namely the Indonesia – Supporting Primary Health Care Reform Program (I-SPHERE, P164277), which largely focuses strengthening a primary health care accreditation system and disease control and environmental health, including both:

a) Communicable diseases and b) Non-communicable diseases. While the proposed operation is not anticipated to directly engage with primary service providers (i.e. *Puskemas* and private clinics), I-SPHERE may potentially complement the implementation of activities under the PforR particularly in terms of COVID-19 risk communication and referral pathways.

Table A: Preliminary Risk Matrix

PDO	Result Indicators (tentative)	Expenditures	E&S Effects	Risks
To prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Indonesia.	<ul style="list-style-type: none"> • Number/percentage of designated Covid19 hospitals with personal protective equipment and infection control products and supplies per MOH guidelines • Number/percentage of designated laboratories with COVID-19 diagnostic capacities established per MOH guidelines • Number/percentage of potential COVID-19 reported and investigated per approved protocol • Number of prioritized ICU beds that are fully equipped and operational for serious respiratory cases • Number/percentage of diagnosed cases treated per approved protocol • Number of beneficiaries served by the COVID-19 hotline 	The GoI’s program costs is estimated 500 million USD, of which 250 million will be financed by the PforR. The proposed financing represents 50 percent of the total program costs.	<p>The overall environmental and social outcome is expected to be positive. The PforR is expected to strengthen health service system response, including improving community/ public health safety and OHS by preventing and containing COVID-19 transmission to the broader population and healthcare workers, ramp-up the capacity of health facilities to ensure provisions of proper treatment and care, and escalate GoI’s capacity for case detection and investigation through contact tracing and surveillance.</p> <p>In the longer-run, the PforR also seeks to promote further reform in Indonesia’s health system and enhance its resilience and preparedness for future pandemic.</p>	<p>The environmental and social risk is deemed to be substantial. Although there is a moderate likelihood that Program activities would lead to some E&S consequences but because of the current capacity constraints due to COVID-19 crisis, the program may not achieve its E&S operational objectives – therefore it is substantial.</p> <p>Risk areas of concerns include environmental pollution due to suboptimal management of medical solid waste and wastewater, COVID-19 infection control, Occupational Health and Safety (OHS) for medical workers, community health and safety related to handling of medical waste, transportation, treatment and isolation of people with and/or people who may have COVID-19, poor consent processes and privacy concerns due to mass surveillance. Further, the development of preparedness plans and protocols embedded in the program carry additional E&S risks as the plans and protocols often do not contain E&S assessments as part of it.</p>

	<ul style="list-style-type: none"> Number of health workers that have received modules/training on the new COVID-19 care protocols 			<p>These potential environmental and social risks may likely be exacerbated by lack of capacity to contain COVID-19 infection risks due to the country’s strained healthcare system for testing, treatment, isolation and safe-handling of medical wastes and lack of protective gear for medical health workers.</p> <p>While the current capacity for the management of COVID-19 within MOH is not fully understood and will be assessed as part of the ESSA process, the unprecedented speed of COVID-19 infection across population groups likely strain the existing health care capacities, including supplies of medical workers, which may potentially get worse as the pandemic continues. Such capacity constraints can potentially increase the level of potential environmental and social risks associated with the operation. Furthermore, poor inter-agency and government coordination may hamper the current GoI’s capacity to contain the pandemic.</p> <p>Further assessment of the existing GOI’s instruments, systems, resources and capacity (both at the national and sub-national levels) will be made through the ESSA process prior to the Program’s appraisal.</p>
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ANNEX 5: National Policy, Legal and Regulatory Frameworks

Aspect	Policy/Law/Regulation	Assessment
COVID-19 Emergency Response Coordination	<ul style="list-style-type: none"> - Law 24/2007 on Disaster Management - A Presidential Decree No. 7/2020 on the establishment of a national and regional COVID-19 Task Forces, amended by Presidential Decree No. 9/2020. - Presidential Regulation No. 17/2018 on the Implementation of Disaster Emergency Response under Specific Circumstances 	<p>COVID 19 is considered a non-natural disaster, as per Disaster Management Law No. 24/2007. The Indonesian government has not declared a National Emergency, but it has reached the status of Disaster of Special Circumstances as declared on 28th January 2020, which is still in effect as of publication. Under Presidential Regulation No. 17/2018, the National Disaster Management Agency (BNPB) is authorized to exercise discretion in response to emergencies based on the President’s instruction. Such discretion covers mobilization of quick financing, coordination, procurement, etc., which may be streamlined to expedite response measures. The Presidential Decree No. 9/2020 confers authority to BNPB to import required goods for the management of COVID 19, which is expected to address supply constraints of essential items, such as PPE, life-saving equipment, medicines, etc.</p> <p>A National Task Force led by the Head of the National Agency for Disaster Management (BNPB) has been created under the Presidential Decree No. 7 of 2020 – which was subsequently amended through Presidential Decree No. 9/2020. The aim is to ensure the collaboration of various ministries and agencies from the central and sub-national levels of government through to the ministries, agencies, the national police and military, private sector, social institutions, and universities in fighting the further spread of the virus. The Presidential Decree No. 9/2020 elevates the role of MOH in the overall COVID 19 as the vice to BNPB.</p>
COVID-19 Technical Guideline	<p>MOH’s guideline on the prevention and management of COVID 19 was published on 16 March 2020 in response to the escalating outbreak. The guideline consists of key elements in surveillance and response (Chapter II), Clinical Management (Chapter III), Infection Prevention and Control (Chapter IV), Laboratory and Biological Specimen Management (Chapter V)</p>	<p>The guideline is generally aligned with WHO guidelines on relevant topics outlined.</p>

Aspect	Policy/Law/Regulation	Assessment
<p>Medical Wastes (Hazardous wastes)</p>	<p>and Public Communication on Risks and Community Empowerment (Chapter 5).</p> <p>Law No.32/2009 on Environmental Protection and Management provides an umbrella framework on environmental management in Indonesia, including the requirement to manage hazardous material and waste</p> <p>Government Regulation No. 101/2014 on Management of Toxic and Hazardous Waste provides provisions on the management of hazardous waste, including (i) method of identifying, reducing, storing, collecting, transporting, utilizing, processing, and disposing of hazardous wastes; (ii) risk mitigation and emergency responses, and (iii) hazardous waste permitting, among others.</p> <p>MOEF Decree No 56/2015 on Procedures and Technical Requirement of Hazardous Waste Management from Health Care Facilities provides a guideline and requirements for health care facilities in managing hazardous waste, including the requirement on reduction, segregation, packaging, storage, transportation, treatment and disposal. Further technical requirements on the emissions standard from incinerator, including medical incinerator, is outlined in Kepbappedal No 03/Bapedal/09/1995.</p> <p>MOH Decree No 1204/Menkes/SK/X/2004 on Provision on Environmental Health of Hospital provides physical building requirements (construction, air quality, noise level, sanitation facility, etc.), food safety and hygiene, water, waste management, pest management, radiation management, etc. The waste management provision in this decree include the requirement on waste reduction, segregation packaging, storage, transport, treatment and disposal.</p> <p>MOH Regulation No. 34 Year 2017 regarding Accreditation for Hospitals mandated independent accreditation bodies to perform hospital accreditation in Indonesia, provided that these bodies</p>	<p>The country’s approach in hazardous waste management outlined in Government Regulation No. 101/2014. It is built upon “cradle to grave” principle, as per GIIP, with rigid manifest system to track the flow of waste from generator to disposal facility. Any activities to store, transport, utilize, treat, or dispose hazardous require valid permit/license from the government. All permitting, except for temporary storage, are mandated to MOEF, while the temporary storage permit is in the jurisdiction of sub-national environmental agency. The government regulation also prescribed technical requirement for incinerator, as well as the requirement for the disposal of combustion residue from medical waste incinerators, fly ash and bottom ash to licensed hazardous waste landfill.</p> <p>The requirements in MOEF Decree no 56/2015 and MOH Decree No. 1204/Menkes/SK/X/2004 are comparable to the WBG EHS Guidelines for Healthcare Facilities as the decree covers GIIP such as labelling and symbols for hazardous materials and waste, waste reduction, segregation, storage, transportation (including mandatory manifest), treatment and handling (with autoclave and/or incineration), health workers occupational health and safety and public health and safety. However, these decrees are not specifying the requirement to develop a Healthcare Waste Management System (HWMS).</p> <p>The decree from MOEF provides a more detailed requirement as compared to MOH decree. Key requirements that are not addressed in the MOH decree include the mandatory manifest requirement in transporting hazardous waste; the requirement to use licensed facilities for temporary storage, transportation, treatment and disposal of hazardous waste; and the requirement to dispose incinerator ash to licensed hazardous waste landfill.</p>

Aspect	Policy/Law/Regulation	Assessment
	<p>are accredited by International Society for Quality in Health Care (ISQua). Accreditation Commission for Hospitals (KARS) developed (National Standards for Hospital Accreditation - SNARS). The standard requires hospitals to identify the type of hazardous waste generated and develop hazardous waste policy and procedures, including handling, storing, transporting and disposing the waste, by referring to relevant government regulations.</p>	<p>MOEF Decree no 56/2015 also provides exceptions for hazardous waste treatment during emergency (e.g. disaster response) whereby appropriate hazardous waste treatment is not feasible. This include the possibility to bury infectious waste, provided that the waste has been previously disinfected. Technical specifications on the site are also regulated under this decree. However, the exceptions are limited to the treatment of hazardous waste and do not include other management of hazardous waste such as temporary storage and transportation.</p>
<p>Medical Wastewater</p>	<p>MOH regulation No. 7/2019 on Hospitals' environmental health prescribed the requirement on the environmental management in the hospitals, including on wastewater treatment.</p> <p>(aligned with WHO's guidelines) require all hospitals to apply the following measures in the handling of medical liquid wastes: Where possible, hospitals should be connected to municipal wastewater treatment plants (WWTP).</p> <p>MOE Regulation No. 5/2014 on water effluent standard. The water effluent standard from health care facilities are set in annex XLIV in the regulation. The</p> <p>MOH Regulation No. 34 Year 2017 regarding Accreditation for Hospitals mandated independent accreditation bodies to perform hospital accreditation in Indonesia, provided that these bodies are accredited by International Society for Quality in Health Care (ISQua). Accreditation Commission for Hospitals (KARS) developed (National Standards for Hospital Accreditation - SNARS). The standard requires hospitals to identify the type of hazardous waste generated and develop hazardous waste policy and procedures, including handling, storing, transporting and disposing the waste, by referring to relevant government regulations.</p>	<p>The MOH regulation No.7/2019 prescribed the requirement for hospitals to have a wastewater treatment plants (WWTP). This is aligned with the WHO guideline.</p> <p>Hospitals that are not connected to municipal WWTPs should install compact on-site sewage treatments (i.e. primary and secondary treatment, disinfection) to ensure that wastewater discharges meet applicable thresholds. Hospitals in remote locations should provide for minimal treatment of wastewater through affordable means (e. g. use of lagoons or wastewater treatment septic tanks) to achieve an acceptable level of purification, followed by infiltration of final effluent to the land).</p> <p>The MOE regulation No. 5/2014 provide a comparable standard threshold on the effluent discharge with WBG EHS Guidelines for Health Care Facilities (Performance Monitoring). For some indicators such as: Chemical Oxygen Demand (COD) and Total Suspended Solid (TSS), MOE regulation outlines more stringent threshold as compared to WBG standard.</p>

Aspect	Policy/Law/Regulation	Assessment
Occupational Health and Safety	<p>The Indonesian Law No. 36/2009 on Health (section XII) promulgates that PHOs/DHOs are required to oversee and ensure occupational health and safety for health workers and provide them with preventive, treatment, and rehabilitation services. Policies and guidelines are issued by MOH. By regulation, every health worker is also required to be enrolled in the JKN to obtain social protection related to work-related accidents or work-related diseases (Law No. 24/2011 on BPJS and Presidential Regulation No. 109/2013).</p> <p>Government Regulation (PP) No. 50/2012 on Practice of Health and Safety Management.</p> <p>Appendix VIII of MOEF Decree no 56/2015 about Procedures and Technical Requirement of Hazardous Waste Management from Health Care Facilities provides guidelines on health worker protection, health and safety.</p> <p>MOH Regulation No. 34 Year 2017 regarding Accreditation for Hospitals.</p> <p>National Health Accreditation Standards (SNARS), in effect 1st January 2018</p>	<p>The regulations ensure the right of every worker to protection, health and safety to achieve optimal work productivity, and requires implementation of a health and safety system.</p> <p>The OHS requirements in the hospital accreditation assessment (SNARS) include the requirement for identifying OHS risks in the facilities, developing, OHS policy, conducting risk assessment and training, and providing appropriate vaccinations and PPE for workers among others.</p> <p>The requirements prescribed in relevant regulations and accreditation criteria are generally equivalent with the criteria outline in WBG EHS Guidelines for Healthcare facilities for personnel safety, as well as the WHO guidelines on key considerations for occupational safety and health for health workers during COVID-19 outbreak.</p>
Public Health and Safety	<p>MOE Decree no 16/2012 about AMDAL Document preparation contains provisions about Public Health and Safety consideration (Appendix II and III).</p> <p>Article 15 and Appendix III, V, VI of MOEF Decree no 56/2015 regarding Procedures and Technical Requirement of Hazardous Waste Management from Health Care Facilities regulates the requirement for the minimum distance of incinerators, hazardous storage location to school, public facilities, residential area (about 30 m) protect surrounding community's health and safety.</p> <p>The MOH Decree no 1204/Menkes/SK/X/2004 regarding Provision on Environmental Health of Hospital regulates the</p>	<p>The requirements in MOEF Decree no 56/2015 and MOH Decree on 1204/Menkes/SK/X/2004 are comparable with the WBG EHS Guidelines for Healthcare Facilities and the WHO guidelines on safe management of wastes in health care facilities. Both decrees cover GIIP related to public health and safety such as infection prevention and control, pest management, decontamination and disinfections, proper incineration technique, manifest system for transportation of hazardous waste, and competency requirement for the environmental health officer.</p> <p>SNARS' accreditation criteria include the requirement for infection prevention and control (IPC). These requirements include assignment of dedicated health care workers for infection treatment, decontamination and disinfections, infectious waste management, hand hygiene practices, PPE requirements, which</p>

Aspect	Policy/Law/Regulation	Assessment
	<p>requirement of health care building, including location, construction, spatial arrangement based on health risk, air quality, food safety and hygiene, among others.</p> <p>National Health Accreditation Standards (SNARS), in effect 1st January 2018</p>	<p>sufficient GIIP for infection prevention and control in the health care facilities.</p> <p>The above-mentioned regulations and accreditation criteria address the requirements in the WHO guidelines related to infection prevention and control in the context of COVID-19.</p>
<p>Patient Rights including Consent</p>	<p>Several laws guarantee patient rights.</p> <p>Protection of confidentiality, information about treatment and costs, and informed consent to any procedures as well as rights to refuse any medical treatments/procedures and seek for second opinion (Law No. 29/2004 on Medical Practice, Article 52 and the Health Act, the Hospital Act and the Medical Practice Act).</p> <p>Citizens have the right to choose services, to be treated without prejudice and discrimination, to have access to information regarding services, to be heard and complaint as well as legal access to litigation (Law No. 8 of 1999 on Consumer Protection).</p> <p>Access to health services for people with special needs is also protected by law, with health providers required to ensure their facilities are accessible and services are non-discriminatory. The information regarding the illness, treatment, prognosis, and alternative treatments should be accessible to patients and families regardless information requests.</p> <p>Medical negligence and litigation implicating medical professionals (doctors and dentists) is investigated by the Indonesian Medical Disciplinary Board (<i>Majelis Kehormatan Disiplin Kedokteran Indonesia/MKDKI</i>). The MKDKI is an autonomous body of the Indonesian Medical Council (KKI) and is authorized to issue testimony/statements with regards to negligence or mistakes or ethical issues in medical practices as well as remedial measures necessary including sanctions.</p>	<p>In terms of regulations and procedures, patient rights are fully protected and comprehensively defined. However, enforcement varies with sanctions being rarely enforced.</p> <p>Access to information with regards to the quality of health services is limited both in public and private health facilities (Indonesia Health System Review, 2017).</p> <p>Accreditation status may serve as an indication of the quality and credibility of services provided by accredited facilities.</p>

Aspect	Policy/Law/Regulation	Assessment
Grievance Management	<p>By law, patients have two options, first to file a law suit in court or to appeal to the Indonesian Medical Disciplinary Board (MKDKI) (Law No. 8/1999 on Consumer Protection).</p> <p>The role of MOH in terms of addressing complaints tends to be on an ad-hoc basis and the current operating GRM platform (Halo Kemkes 1500-567, SMS 081281562620, fax (021)5223002, 52921669 and/or kontak@kemkes. Go. Id) is not specifically designed to address health-related grievances, but rather overall health administration which is challenging to track specific health issues by specific health facilities unless the issues are captured in the mass-media.</p>	<p>The legal recourse is likely to be inaccessible based on the inability of a majority of patients to engage with the system or afford the process and costs of raising a complaint.</p> <p>It is difficult to charge medical professionals under the criminal code (<i>Kitab Undang-Undang Hukum Pidana</i>) despite neglect and/or malpractices leading to injury, disabilities or even deaths. Under these circumstances, the use of civil code (<i>Kitab Undang-Undang Hukum Perdata</i>) may be pursued and complaints may be settled through financial compensation for improper services. There is no centralised grievance redress process or procedure for managing patient complaints.</p>
Data and Privacy	<p>Indonesia has 32 laws and regulations which govern protection of personal data/ privacy. Six of those are related to health sector include Law No 29/2004 on on Medical Practice, Law No 36/2009 on Health, Law No 44/2009 on Hospital, Law No 18/2014 on Mental Health, and Law No 35/2009 on Narcotics. Article 57 (2) of Law No 36/2009 on health stated that exception on data protection can be made in several conditions include for public health interest by respecting the necessity and proportionality principles. Furthermore, Minister of Health Regulation No. 269/MenKes/Per/III/2008 on Medical Records stated that all health facilities must maintain confidentiality of the patient’s medical records expect under several circumstances including for health reason, law enforcement, at request of the patient, and for research and education purpose without disclosing the patient’s identity.</p>	<p>Protection of civil rights to privacy and private data is fragmented across regulations and no overarching law in existence for the purpose, with weak protection of individual rights to personal data. The Draft Bill on Private Data Protection is pending approval from the Parliament. This has reportedly led to abuse of private data collected through Banking transactions and social media for commercial purposes, with risks of fraudulent appropriation of personal data for criminal conducts.</p>

ANNEX 6: Minutes of Stakeholder Consultations

Date	2 April 2020
Respondent	Dr. Naning (Head)
Institution	Environmental Health and Disease Control Centre (BBTKLPP) Jakarta, MOH
Topics	Meeting Notes
General Profile	<ul style="list-style-type: none"> • BBTKLPP provide laboratory testing and surveillance services for medical microbiology and virology (MMV) and covers the following provinces, including DKI Jakarta, West Java, Riau Archipelago, and West Kalimantan. • The laboratory is BSL-2 accredited and structurally reports to Directorate General of Disease Prevention and Control of MOH. • The lab facility is staffed by 24 technicians and currently equipped with two Polymerase Chain Reaction (PCR) machines, both of which are outdated with limited testing capacity of approximately 200 specimens/day. • Quality Assessment/Control of testing falls under the responsibility of MOH's National Institute of Health Research and Development with a periodic accreditation renewal by the National Accreditation Committee
Surge Capacity for COVID-19	<ul style="list-style-type: none"> • The facility prepared a contingency plan to respond to a potential spike for COVID-19 testing with an anticipated timeframe of two months since the first reporting of COVID-19 in Indonesia. • No additional capacities for an extended period of the outbreak, with increasing samples being handled. A proposal for additional equipment has been submitted to MOH for approval. However, there is no confirmation on how quickly resources can be mobilized to ramp up the current capacities. • While there is no formal mandate for training and knowledge transfer, BBTKLPP is taking initiatives to provide virtual coaching to district and provincial health agencies under its coverage to ease up surveillance (including contact tracing) responsibilities, especially due to a spike in confirmed and potential cases.
Key Issues	<ul style="list-style-type: none"> • Standard Operating Procedures (SOPs) for IPC control are available, however, capacity for enforcement may be stretched as demand for testing increases. • Capacity for COVID-19 testing is stretched due to lack of equipment, which is fully calibrated, staffing shortages, and increased demand for testing. With a testing capacity of 200 specimens/per-day, specimens for testing are piling up, with around 1200 samples waiting for further investigation. Up to June, additional 5000 – 6000 samples are expected. • While Personnel Protective Equipment (PPE) are available, risks for infection exposure are high with additional demand for testing, requiring additional skilled personnel on-call. Occupational Health and Safety (OHS) risks due to longer shifts and stress are also anticipated. Additional capacities are currently outsourced from other units within the laboratory, with ad-hoc training and on-the job mentoring prior to assignment. • Other personnel involved in the process of handling and storing of specimens and disposal of bio-wastes, with an additional volume of up to 200 percent also face similar risks of exposure to infection. These include security personnel who receive specimens outside working hours, cleaners, transporters/drivers and third-party company personnel managing laboratory wastes.

	<ul style="list-style-type: none"> • Temporary storage for COVID-19 specimens currently utilize existing storage, with additional storage being requested to Ditjend P2P for procurement. Hazardous wastes are being managed by a third party with a regular pick-up once in every week. • No reports on social stigma amongst workers and their families as of to date.
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Date	3 April 2020
Respondent	Dr Kartini Rustandi (Director), Gatot Tasripin, Rumiwati, Dyah Mustikawati, Tuti and Febi (staff)
Institution	Directorate of Occupational Health and Sport, Directorate General of Community Health of MOH
Topics	Meeting Notes
General Profile	<ul style="list-style-type: none"> • Directorate of Occupational Health and Sport is responsible to provide technical guidelines on topics related to occupational health, community health and awareness related to infection prevention measures at workplace and community settings. • While the scope is not limited to health facility settings, the directorate is mostly responsible to establish an operational framework and is not responsible for implementation. Implementation falls under the mandates of relevant agencies, companies and sub-national governments
Surge Capacity for COVID-19	<ul style="list-style-type: none"> • The directorate is not formally involved in the COVID-19 Task Force but has been engaged to provide technical advice on OHS, community health as well as COVID-19 surveillance guidance in anticipation of population movement in the lead up of Eid. The directorate is not involved in the procurement of PPE for healthcare workers and health facility staff. • No additional financing specifically allocated for COVID-19 purpose as funds are being pooled under the Planning Bureau. As of to date, activities are limited to dissemination of hygiene practices and information on COVID-19 prevention. • The Directorate is currently planning COVID-19 measures in anticipation of population movement during Eid in coordination with other agencies, including the Transport Ministry.
Key Issues	<ul style="list-style-type: none"> • While hospitals have been equipped with IPC measures, such capacities are likely lacking or non-existent for primary healthcare facilities, which are anticipated as the first entry points of people who may have COVID-19. All referral hospitals are anticipated to have been accredited and hence, equipped with necessary measures to address IPC • Various regulations and operational guidelines are available however enforcement varies. • Population movement in the lead up of Eid and return of Indonesian overseas workers due to loss of jobs is anticipated to exacerbate COVID-19 crisis, with potential spread to outer regions with limited health care services. • Considerations of workers' wellbeing, particularly those directly handling COVID-19, are often secondary, and these include safe accommodation, health and work shifts. OHS measures for non-healthcare workers are often ignored, and much focus has been placed on provisions of PPE to healthcare workers.

	<ul style="list-style-type: none"> • COVID-19 infection to healthcare workers is reported from non-designated healthcare facilities, which are not properly equipped with necessary standards, and equipment for Infection, Prevention and Control (IPC) • The Directorate is engagement with insurance providers to clarify coverage insurance for COVID-19 related morbidity and mortality. • There are potential issues on mental health amongst medical workers following the outbreak.
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Date	3 April 2020
Respondent	Dr. Andi Saguni (Director)
Institution	Directorate of Health Service Facility of Directorate General of Health Service of MOH
Topics	Meeting Notes
General Profile	<ul style="list-style-type: none"> • Directorate of Health Service is structurally mapped under DG of Health Services of MOH. Main responsibilities include procurement and provisions of medical equipment to MOH’s vertical hospitals.
Surge Capacity for COVID-19	<ul style="list-style-type: none"> • Current roles and responsibilities in the COVID-19 emergency response include a) procurement of medical equipment of 13 priority items and b) preparation of ICU rooms, including those with negative pressure and/or isolation facilities • Focus is currently on MOH’s vertical hospitals, which are part of a network of 132 COVID-19 referral hospitals, including temporary hospital facility in the Galang Island of Batam.
Key Issues	<ul style="list-style-type: none"> • Shortage of essential medical equipment, particularly ICU ventilators, are envisaged. As of to date, the Directorate is planning to procure additional 433 ventilators from domestic suppliers (out of a predicted need of 700 ICU ventilators). The current spread, including geographical coverage of COVID-19 outbreak may warrant further assessment of the current estimation of medical equipment needs. These ventilators are anticipated to ramp up the current capacity of around 20 hospitals out of the 132 referral hospitals under the decree of the Minister of Health. • Procurement planning is informed by various estimation on the basis of predicted prevalence as well as self-assessment by hospitals in the network. While there is an internal process of verification of hospital needs, estimation currently relies on the hospitals’ self-assessment, which may underestimate the potential needs. • The direct mandate of the directorate is procurement of needed medical equipment of MOH’s vertical hospitals. Non-MOH hospitals fall under the responsibility of respective owners, including the military and local governments. The directorate has been advocating amendment of DAK (special allocation fund) Health for provisions of medical equipment. However, the available procurement modality is currently decentralized, with risks of slow mobilization of needed equipment due to bureaucratic processes. • No pooled procurement platform for sub-national and privately-owned hospitals is in place. BNPB’s capacity may also be overwhelmed to do so and hence, a further strategy for surge capacities is critically needed. • Temporary hospitals, such as the Athlete’s Dorm may not be necessarily equipped with solid and liquid waste treatment facilities, as the facility by design was not intended to provide care to severe cases. However, if there is

	a drastic spike of cases, available space may be converted for treatment without proper measures for IPC.
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Date	3 April 2020
Respondent Institution	Dr. Imran Nurali (Director), Jelsi Marampa, Cucu Cakrawati (Staff) Directorate of Environmental Health, Directorate General of Community Health of MOH
Topics	Meeting Notes
General Profile	<ul style="list-style-type: none"> Directorate of Environmental Health is responsible for provisions of technical guidance for health facilities, temporary hospitals as well as community health associated with operations of facilities in coordination with the Ministry of Environment and Forestry (MOEF).
Surge Capacity for COVID-19	<ul style="list-style-type: none"> The Directorate is not directly involved in the COVID-19 Task Force and no additional financing has been allocated for the purpose of supporting the COVID-19 response The Directorate's role is on the provision of guidelines as well as capacity building for environmental health personnel, particularly in response to establishment and operation of temporary hospitals/facilities for COVID-19 treatment No planning as of yet in anticipation of surge needs for environmental health measures, including PPE, disinfectants, bio-waste handling facilities (i.e. autoclaves), and disposal treatment MOEF has issued a discretionary policy which allows use of autoclaves and existing incinerators without formal licenses to respond to increased volume of COVID-19 wastes. Discretionary measures for disposal of disinfected COVID-19 wastes in burial pits are allowed for facilities without incinerators, autoclaves or access to third-party waste handling.
Key Issues	<ul style="list-style-type: none"> Volume of bio-medical wastes, including additional wastes following COVID-19 outbreak is yet to be further assessed. Anecdotal evidence indicates that the volume can be doubled and may increase further as the pandemic evolves and expands. Not all hospitals are equipped with medical waste facilities. As of to date, only 87 incinerators have formal licenses from MOEF, and 115 additional incinerators are under licensing processes. These incinerators are spread across 2000 hospitals in the country. Despite a circular from MOEF on COVID-19 medical waste handling to service providers (around 170 companies), some companies were reported to refuse COVID-19 medical wastes. In addition, depending on the MOU with third parties, there could be limiting clauses which prevent health facilities' ability to require third party operators and/or transporters to handle COVID-19 wastes. In some limited cases, transporters' licenses, such as in Bekasi and Cirebon where there is a surge in COVID-19 cases, were revoked due to previous law infringement (i.e. disposal of medical wastes in open landfills).

Date	6 April 2020
Respondent Institution	Diah Saminarsih, Olivia Herlinda, Nurul, Yurdhina Meilisa, Egi Abdul Wahid Center for Indonesia's Strategic Development Initiatives (CISDI)
Topics	Meeting Notes
General Profile	<ul style="list-style-type: none"> • CISDI is a think tank group, focusing on policy advocacy and technical advisory to the government. CISDI was previously a hybrid Govt-CSO entity, before becoming a standalone CSO.
Roles in COVID-19 emergency response	<ul style="list-style-type: none"> • As a think tank group, CISDI provides advisory on public policy related to COVID-19 as well as advocacy. Key areas of focus include promotion of safer working environments for health workers (in terms of priority for testing and PPE, capacity building through on-line classes), youth activism (Garda Muda), policy advocacy on key gaps in the government response to COVID-19. As of to date, CISDI has delivered three online classes, involving 1500 primary healthworkers out of a total target of 3000. CISDI serves as the secretariat of Solidaritas Berantas COVID-19, which represents a coalition of CSOs, academia, government stakeholders, and professionals, supporting GOI through action-oriented and evidence-based policy advice. • CISDI has been supported by philanthropic donors and has distributed PPE to target health care facilities with the objective of easing up current pressures and financial burden of the GOI.
Key Issues	<ul style="list-style-type: none"> • The current approach adopted by GOI emphasized a centralistic response to address the pandemic, thus pulling all efforts toward the central system at the expense of sub-national governments' ability to exercise discretion (i.e. social distancing policy) and quick action. There is a need to enable sub-national government to act quickly while at the same time provide necessary infrastructure for informed decision making through data (i.e. epidemiological • GOI has missed a critical window of opportunity since the first case was reported in China. This has multiplied requisite efforts needed to address the emergency, with a limited chance for success as seen in other countries with far more stringent measures • Jakarta is the largest COVID-19 epicenter in Indonesia, with more than 50 percent of the total case being reported. A significant number of health workers died due to infection and there is no stringent measure and policy actions to enforce social distancing and quarantine • There has been limited capacities for testing across the country and hospitals will soon become overwhelmed with a spike of new cases • A major gap is the lack of preparedness in equipping primary healthcare facilities with requisite skills and equipment to anticipate the outbreak. These primary healthcares often act as the first point of references for people who may have COVID-19 with symptoms. Cases of patient to healthworker infection were reported to occur more frequently in non-referral facilities, which as of date, receive lack of GoI's attention. • CISDI is advocating a whole of society approach in addressing the pandemic, encompassing engagement and collaboration with various actors, including communities, CSOs, as well as the private sector. Key major areas

	of system strengthening include public education and campaign, capacity building for primary healthcare workers, together with access to screening and testing, community roles in surveillance (i.e. contact tracing) as well as monitoring by primary healthcare facilities.
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Date	7 April 2020
Respondent	Agus Sari, Micky Salman, Elina Ciptadi, Dania, Ainun
Institution	KAWAL (CSO coalition)
Topics	Meeting Notes
General Profile	<ul style="list-style-type: none"> • KAWAL is a coalition of NGOs, activists, and professionals providing support on public risk communication. The organization was initially established as a watchdog group for the previous national government election. It has now transformed itself as a coalition with focus on risk communication, particularly on public education and awareness.
Roles in COVID-19 emergency response	<ul style="list-style-type: none"> • KAWAL COVID-19 was launched on 1st of March, which preceded Gol's media platform covid.go.id • As of now, there is no direct coordination with COVID-19 Task Force. Involvement was undertaken under coordination of the RCC group. • CISDI has also worked through journalist coalitions (i.e. Jurnalis Bencana dan Krisis, and Aliansi Cek Fakta), with the purpose of extending capacities of local media by ensuring availability of factual information and hence, enabling the public to be better informed.
Key issues	<ul style="list-style-type: none"> • Public communication related to COVID-19 has been characterized with weak leadership in dissemination of information on the basis of evidence. Indonesia was considered to be in-denial for a few weeks before the first case was reported, thus limiting Gol's actions and necessary public awareness and preparedness. There have also been inconsistencies in public messaging, with some officials and media downplaying the risks of COVID-19 which resulted in public ignorance and confusion (i.e. panic buying). • Lack of factual information and effective communication at the top level have also led to lack of preparedness across level. The fact that there was no robust measure to curb the virus at its early month has overwhelmed the country's capacity to effectively respond to the pandemic. For some weeks following the first reporting in Indonesia, populist public messaging, downplaying the actual risks, compromised the needed planning for emergency response, which has now entailed a high cost. • KAWAL COVID-19 has also evolved to provide alternative solutions, for instance innovation of makeshift ventilators, at a cost way lower than regular ICU ventilators (KAWAL VENTILATOR), crowd-funding apps for purchase of PPE. KAWAL RUMAH SAKIT was initiated with the intent of mapping emergency needs at the facility level, with the hope to be scaled up across the country to enable informed planning • One of the major gaps in the Gol's led efforts to respond to COVID-19 is lack of preparedness amongst primary healthcare facilities, with absence or shortages of requisite PPE and IPC measures. Furthermore, there has been an

	overall lack of testing capacity, and there has not been a robust measure to prevent infection particularly amongst those asymptomatic.
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Date	8 April 2020
Respondent	dr. Hanny Rono, dr. Sutoto, dr. Nico L, dr. Eka Viora, dr. Luwih, dr. Djono Darmajaya, dr. Sri Rachmani
Institution	Hospital Accreditation Commission (Komisi Akreditasi Rumah Sakit or hereafter KARS)
Topics	Meeting Notes
General Profile	<ul style="list-style-type: none"> KARS is an independent accreditation body for hospitals. The commission was initially established by MOH in 1996 before becoming fully independent. KARS has been accredited by the International Society for Quality in Healthcare (ISQua).
Roles in COVID-19 emergency response	<ul style="list-style-type: none"> KARS has been engaged in providing on-line courses to hospitals through Webinar, particularly related to self-assessment of current needs in the context COVID-19 emergency. KARS is also expected to be engaged as a potential technical verifier for the PforR's DLIs.
Key issues	<ul style="list-style-type: none"> Hospital preparedness in responding to COVID-19 can be assessed from their levels of accreditation. Higher level of accreditation is usually a credible proxy for preparedness, with lagging hospitals being concentrated amongst regional hospitals managed by sub-national governments. The majority of MOH vertical hospitals have received high-tiers of accreditation, with an exception of two hospitals in Papua (Jayapura) and West Kalimantan (Pontianak). Lack of availability of critical PPE and equipment in a large amount presents a risk and will continue to challenge for hospitals to adherence of required standards. In addition to PPE, many hospitals, particularly private hospitals, are also constrained in their internal financing due to late payments of Universal Health Coverage (UHC) reimbursement by BPJS. This has further strained the hospitals' resources to effectively provide requisite response and measures. COVID-19 will follow the same BPJS procedures with risks of late reimbursement. Many hospitals are not fully equipped to implement IPC measures at the first screening stage. Rapid test kits were only available recently and there are still many hospitals without such and hence presents public health risks to health workers. This, in addition to lack of awareness amongst some hospitals on proper and safe screening and triage, has further heightened potential risks facing healthworkers. Provisions of PPE should also be prioritized to those handling and administering patients at the emergency as well as outpatient units since they face a similar level of risk exposure. The hospital accreditation standards (SNARS) have outlined relevant provisions for IPC and infection detection. However, the current scale of the

	<p>outbreak is un-precedented and has overwhelmed the current capacities, which may get worse as the pandemic escalates.</p> <ul style="list-style-type: none"> Waste management capacities will also continue to be strained, and there has been deficiency in the current capacity amongst third-party medical waste companies to meet the increasing demand.
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Date	8 April 2020
Respondent	BaliFokus: Krishna Bayumurti M. Zaki, Yune Eribowo, Nindhita, Greeneration: Bijaksana Junerosano, Vanessa Letizia YPBB: David Sutasurya, Nur Septiani Hayati, Ricky Alamsyah
Institution	BaliFokus, Greeneration, YPBB (Environmental NGOs)
Topics	Meeting Notes
General Profile	<ul style="list-style-type: none"> Bali Fokus is Bali-based foundation which focuses on works to safeguard public, especially vulnerable populations, from environment, health and development towards a toxic-free, just, and sustainable for future generations. Greeneration is an NGO which focuses on Sustainable Consumption and Production (SCP) in Indonesia, including on waste management. YPBB is an NGO which promotes sustainable living, waste management, and strong involvement of the district government as well as the communities in the implementation and advancement of zero waste policies and programs
Roles in COVID-19 emergency response	<ul style="list-style-type: none"> BaliFokus, Greeneration and YPBB are not directly involve in COVID-19 emergency response, however, all NGOs have been extensively involve in waste management in Indonesia
Key issues	<p><u>COVID-19 wastes from household in domestic waste stream</u></p> <ul style="list-style-type: none"> The current pandemic and social distancing measures in Jakarta and some parts of West Java have reduced the overall domestic waste volume in the area, however, there is an increasing volume of disposable masks among the wastes. The masks were not shredded and there was no segregation between mask wastes and other domestic wastes. The increasing disposable mask wastes has raised concerns of the possible infection of the virus to domestic waste handlers. As there is a possibility that the wastes came from the people who are isolated at home due to possible COVID-19 infection. It is observed that the waste handlers do not equipped with proper PPE. The recent notice letter (circular) from MOEF, which also address the management of COVID-19 wastes from household, might not be effective as such circular is perceived more like a recommendation than a rule and has not been enforced. Although the project does not cover the management of COVID-19 wastes from household, it is expected that the project will help push clearer direction from MOEF on the management of COVID-19 waste, including from household.

COVID-19 wastes from healthcare facilities

- The possible rise in medical wastes volume in healthcare facilities raised a concern on the use of suboptimal incineration process. As the suboptimal incineration process (e.g. low temperature, high water content from unsegregated wastes, etc.) will create additional problems in the management of hazardous wastes.
- The current regulatory regime in Indonesia pushes more on the use of incineration to handle medical wastes, even though other treatment process such as the use of autoclaves and shredder can be more beneficial and environmentally friendly as it is not produced air and water emissions from the process.
- The recent circular from MOEF which recommends the use of incinerator and autoclaves to handle COVID-19 medical wastes might not be effective as the circular further ask the hospitals to hand-over the product from incineration process and disinfection using autoclaves to licensed hazardous waste company. It is understood that the output from autoclaves should not be categorized as hazardous wastes and should be treated as a non-hazardous wastes.
- Other alternatives for handling autoclaves output can be considered, such as onsite burial and/or stream the wastes to the current municipal landfill. This could be one of the alternatives to reduce the burden of hazardous waste facilities. Further for some healthcare facilities which do not have autoclaves and other treatment facilities, disinfecting the waste using chlorine could be one of the alternatives before proceeding to onsite burial.
- The alternatives for handling COVID-19 wastes, as mentioned above, should be considered by MOEF and the Ministry should revise the current circular which contain several limitations in the management of medical waste. Further, a stronger instruction in form of regulation is needed. As the recent circular is perceived more like recommendation rather than a rule and does not provide strong basis for enforcement.