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INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT AND
INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

**COVID-19 STRATEGIC PREPAREDNESS AND RESPONSE PROGRAM
AND PROPOSED 25 PROJECTS UNDER PHASE 1**

USING THE MULTIPHASE PROGRAMMATIC APPROACH

WITH AN OVERALL FINANCING ENVELOPE OF UP TO US\$6.00 BILLION EQUIVALENT,
OF WHICH UP TO \$4 BILLION FOR HEALTH FINANCING (UPTO US\$ 1,300 MILLION IDA
AND UP TO US\$2.7 BILLION UNDER THE IBRD)

APRIL 2, 2020

Human Development Practice Group

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CURRENCY EQUIVALENTS

(Exchange Rate Effective March 23, 2020)

Currency Unit = US\$

SDR1 = US\$1.346

US\$1 = SDR 0.743

FISCAL YEAR

January 1 - December 31

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ABBREVIATIONS AND ACRONYMS

ACG	Anti-Corruption Guidelines
BFP	Bank Facilitated Procurement
CDC	Center for Disease Control and Prevention
CEN	Country Engagement Note
COVID-19	Coronavirus Disease 2019
CPF	Country Partnership Framework
CERC	Contingent Emergency Response Component
EID	Emerging Infectious Diseases
EOC	Emergency Operations Center
ESF	Environmental and Social Framework
FCV	Fragility, Conflict and Violence
FM	Financial Management
FTCF	Fast Track COVID-19 Facility
GDP	Gross Domestic Product
GDI	Graduation Discussion Income
GFF	Global Financial Facility
GRM	Grievance Redress Mechanism
GRS	Grievance Redress System
HCWMP	Health Care Waste Management Plan
HMIS	Health Management Information System
HNP	Health, Nutrition, and Population
IBRD	International Bank for Reconstruction and Development
ICT	Information and communications technology
IDA	International Development Association
IFR	Interim Financial Report
IFC	International Finance Corporation
IMF	International Monetary Fund
IHR	International Health Regulation
IPF	Investment Project Financing instrument
M&E	Monitoring and Evaluation
MPA	Multiphase Programmatic Approach
NCD	Non-Communicable Disease
OECD	Organization for Economic Cooperation and Development
OIE	World Organization for Animal Health
PAD	Project Appraisal Document
PrAD	Program Appraisal Document
PDO	Project Development Objectives
PrDO	Program Development Objectives



PPE	Personal Protective Equipment
PforR	Program-for-Results financing instrument
PLR	Performance and Learning Review
PSW	Private Sector Window
SEA/SH	Sexual Exploitation and Abuse, and Sexual Harassment
SDG	Sustainable Development Goals
SPRP	Strategic Preparedness and Response Program
TPM	Third-party monitoring
WBG	World Bank Group
WHO	World Health Organization



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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
World	COVID-19 Strategic Preparedness and Response Program (SPRP)	
Project ID	Financing Instrument	Environmental and Social Risk Classification
P173789	Investment Project Financing	Substantial

Financing & Implementation Modalities

☒ Multiphase Programmatic Approach (MPA)	☒ Contingent Emergency Response Component (CERC)
☐ Series of Projects (SOP)	☒ Fragile State(s)
☐ Disbursement-linked Indicators (DLIs)	☒ Small State(s)
☐ Financial Intermediaries (FI)	☐ Fragile within a non-fragile Country
☐ Project-Based Guarantee	☐ Conflict
☐ Deferred Drawdown	☒ Responding to Natural or Man-made Disaster
☐ Alternate Procurement Arrangements (APA)	

Expected Project Approval Date	Expected Project Closing Date	Expected Program Closing Date
02-Apr-2020	31-Mar-2025	31-Mar-2025

Bank/IFC Collaboration

No

MPA Program Development Objective

The Program Development Objective is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness

MPA Financing Data (US\$, Millions)



MPA Program Financing Envelope	4,000.00
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Proposed Project Development Objective(s)

The Program Development Objective is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness

Components

Component Name	Cost (US\$, millions)
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Organizations

Borrower:

Implementing Agency:

MPA FINANCING DETAILS (US\$, Millions)

MPA Program Financing Envelope:	6,000.00
of which Bank Financing (IBRD):	
of which Bank Financing (IDA):	
of which other financing sources:	

PROJECT FINANCING DATA (US\$, Millions)**SUMMARY**

Total Project Cost	4,000.00
Total Financing	0.00
of which IBRD/IDA	0.00
Financing Gap	4,000.00

IDA Resources (in US\$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
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World	1,000.00	300.00	0.00	1,300.00
Crisis Response Window (CRW)	1,000.00	300.00	0.00	1,300.00
Total	1,000.00	300.00	0.00	1,300.00

Expected Disbursements (in US\$, Millions)WB Fiscal
Year

Annual

Cumulative

INSTITUTIONAL DATA**Practice Area (Lead)****Contributing Practice Areas**

Other

Climate Change and Disaster Screening

This operation has not been screened for short and long-term climate change and disaster risks

Explanation

Responding to Natural or Man-made Disaster

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	● High
2. Macroeconomic	● High
3. Sector Strategies and Policies	● Substantial
4. Technical Design of Project or Program	● Substantial
5. Institutional Capacity for Implementation and Sustainability	● High
6. Fiduciary	● High
7. Environment and Social	● Substantial



8. Stakeholders	● Substantial
9. Other	● Substantial
10. Overall	● High
Overall MPA Program Risk	● High

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

☐ Yes ☐ No

Does the project require any waivers of Bank policies?

☒ Yes ☐ No

Have these been approved by Bank management?

☒ Yes ☐ No

Is approval for any policy waiver sought from the Board?

☒ Yes ☐ No



Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
Assessment and Management of Environmental and Social Risks and Impacts	Yes
Stakeholder Engagement and Information Disclosure	Yes
Labor and Working Conditions	Yes
Resource Efficiency and Pollution Prevention and Management	
Community Health and Safety	Yes
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	
Biodiversity Conservation and Sustainable Management of Living Natural Resources	
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	
Cultural Heritage	
Financial Intermediaries	Yes

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

Legal Covenants

Conditions



I. STRATEGIC CONTEXT

1. On March 3, 2020, the Board of Executive Directors endorsed the World Bank Group (WBG) to take urgent action supporting client countries' response to the COVID-19 pandemic. The Board further authorized the establishment of a US\$12 billion WBG Fast Track COVID-19 Facility (FTCF or "Facility") to assist IDA and IBRD eligible countries in addressing this global pandemic and its impacts. Of this amount, US\$6 billion would come from IBRD/IDA ("the Bank"). International Finance Corporation (IFC) has subsequently increased its amount from US\$6 billion to US\$8 billion, which brings the FTCF total to US\$14 billion. On March 17, 2020, the Executive Directors granted approval of specific waivers and exceptions required to enable the rapid preparation and implementation of country operations processed under this Facility. Given the impact of the outbreak on economic activity, there will also be need for response to economic and social disruption resulting from the spread of the virus. As announced by WBG President in the remarks to G20 Leaders' Virtual Summit on March 26, 2020, the WBG has capacity to provide US\$150-160 billion in total financial support over the next 15 months, and US\$330-350 billion until the end of June 2023.^{1 2} The WBG would support countries to shorten the time to recovery; create conditions for growth; support small and medium enterprises; and help protect the poor and vulnerable. Additionally, the Bank is restructuring existing projects in 23 countries, many of these through the use of contingent emergency response components (CERCs)³. IFC is already working on new investments in 300 companies and extending trade finance and working capital lines to clients. IFC is already working on new investments in 300 companies and extending trade finance and working capital lines to clients.

2. This document⁴ describes a programmatic framework responding to the global coronavirus (COVID-19) pandemic, the 'COVID-19 Strategic Preparedness and Response Program (SPRP)', which utilizes the Multiphase Programmatic Approach (MPA), to be supported under the FTCF. The proposed Program, by visibly committing substantial resources (IBRD/IDA financing for SPRP is US\$6 billion), and complementing funding by countries and activities supported by other partners, would help ensure adequate resources to fund a rapid emergency response to COVID-19. In parallel, it is being submitted for approval the financing of Phase 1 of the Program for 25 Investment Project Financing operations under the SPRP for countries across the world. **The 25 countries are: Afghanistan, Argentina, Cabo Verde, Cambodia, Congo Democratic Republic of, Djibouti, Ecuador, Ethiopia, Gambia, Ghana, Haiti, India, Kenya, Kyrgyz Republic, Maldives, Mauritania, Mongolia, Pakistan, Paraguay, San Tome & Principe, Senegal, Sierra Leone, Sri Lanka, Tajikistan, and Yemen** (the list of country operations is in Annex I of this document and the country operations are described in their respective Project Appraisal Documents (PADs)). The PADs for the 25 country projects included in this Phase 1 package are available online.

3. The Phase 1 Bank financing for these 25 operations consists of: (i) IBRD loans, in the amount of US\$1,123.8 million; and (ii) IDA credits in the amount of US\$774.75 million. Given the emergency of the situation, ***procurement under these projects will be frontloaded to the maximum extent possible according to the availability of medical supplies during the first year of project implementation. Most of the funds under each of the country projects has been allocated for supporting priority containment and mitigation activities under Component 1--Emergency COVID-19 Response.***

¹ "World Bank Group President David Malpass Remarks to G20 Leaders' Virtual Summit". March 26, 2020. Available at:

<https://www.worldbank.org/en/news/speech/2020/03/26/world-bank-group-president-david-malpass-remarks-to-g20-leaders-virtual-summit>

² These numbers are based on current market conditions and includes the \$14 billion Fast Track COVID-19 Response Program.

³ World Bank Management is keeping the Board of Executive Directors fully informed on progress with work under different operations, including a briefing to take place on March 26, 2020. The Bank is also preparing a paper on economic impacts which will be made available to the Board.

⁴ On March 17, 2020, the WBG Executive Directors approved a Fast Track COVID-19 Facility (FTCF) of \$14 billion for an emergency response to the virus.

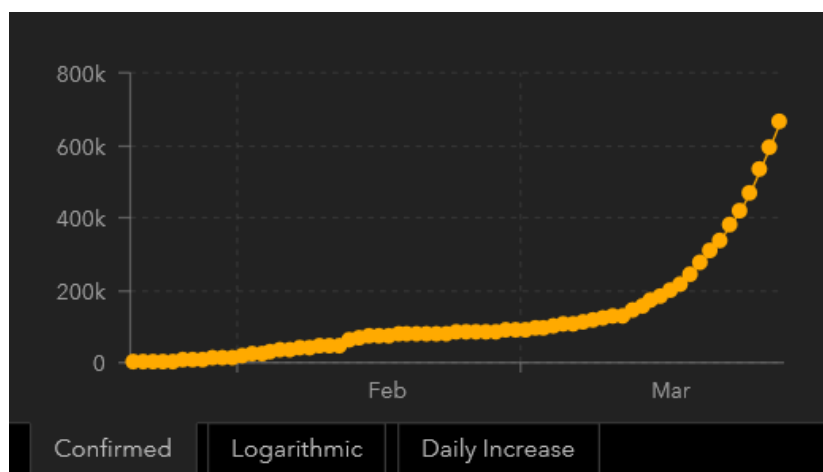


4. **Urgency of the Global Response.** Differing from a gradual-onset disaster (such as a drought), where a more thorough preparation of a standard investment operation may be feasible and preferable, the COVID-19 pandemic is dramatically increasing its global toll on morbidity and mortality on a daily basis. The COVID-19 pandemic has the potential to reverse the health and development gains achieved in recent decades, as a result of both progress against communicable diseases and improved social and economic conditions. Ominously, even if the COVID-19 transmission could be halted today in the most heavily affected countries, the spread of new infections in poor, densely populated countries, where weak health systems need massively scalable investments in human capital, supplies and infrastructure, will continue to threaten the entire global community. This pandemic context demands an evidence-based and well-coordinated global containment and mitigation strategy, with the highest priority, as no country is immune to the spread of a virus that does not respect national borders.

5. **Global Public Goods and Externalities.** As observed by leading global experts, the COVID-19 outbreak is a stark reminder of the ongoing challenge of emerging and reemerging infectious diseases and the need for constant disease surveillance, prompt diagnosis, and robust research to understand the basic biology of new organisms and our susceptibilities to them, as well as to develop effective countermeasures to control them.⁵ Transmissibility and severity are the two most critical factors that determine the effect of an epidemic. New epidemics may cause rapid and large spill-over effects that transcend national boundaries. The worldwide spread of COVID-19 is demonstrating the impact that infectious diseases of animal origin can exert on the global health and development. A key justification for the Bank's involvement, therefore, is the Global Public Goods aspect of the COVID-19 response. To be successful, effective containment and mitigation of COVID-19, and eventual suppression of the virus, will require that all IDA/IBRD countries to jointly support a prevention and control effort of unprecedented scale to be successful. It is especially important that support be available to low-and lower middle-income countries, where health systems are weaker, living conditions often more overcrowded, and populations most vulnerable.

6. **The Global Spread of the of COVID-19.** Since December 2019, following the diagnosis of the initial cases in Wuhan, Hubei Province, China, the number of cases outside China has increased rapidly and the number of affected countries continues to grow (Figure 1). On March 11, 2020, the World Health Organization (WHO) declared a global pandemic. Figure 1 details the exponential global spread of COVID-19.

Figure 1: VIRUS SURGE: New Infections are Accelerating Across the World (as of March 29, 2020)



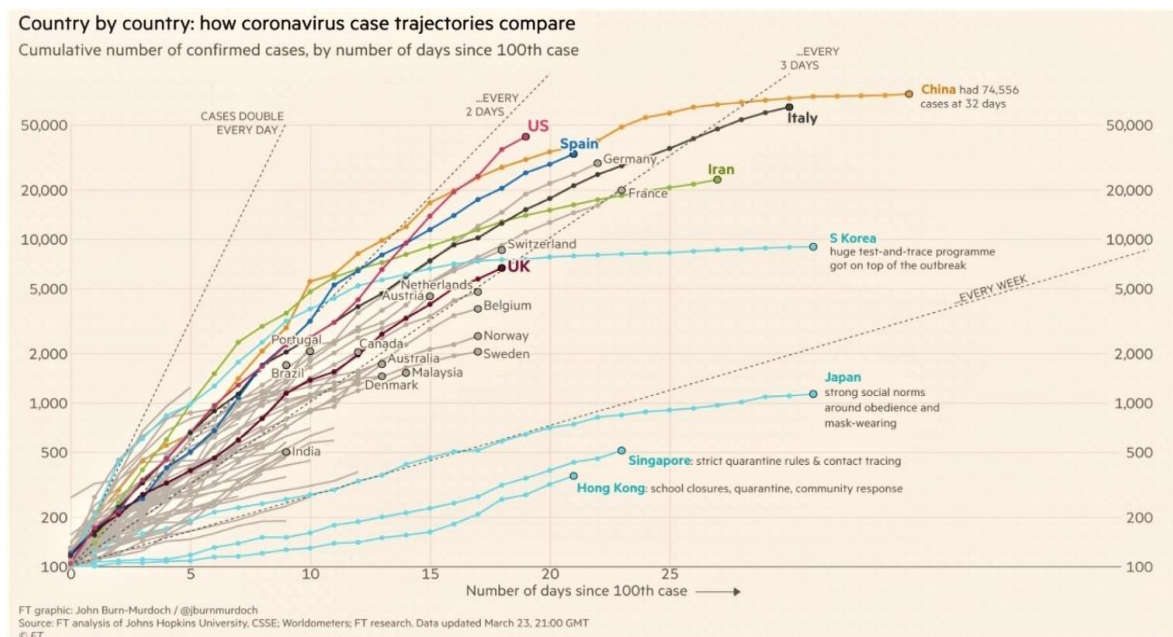
Source: Johns Hopkins Center for Systems Science and Engineering

⁵ Fauci, AS, Lane, Clifford, L, and Redfield, RR. 2020. "Covid-19---Navigating the Uncharted." N Engl J Med, DOI: 10.1056/NEJMe2002387.



7. Figure 2 compares the case trajectory of COVID-19 in key countries, by number of days since the 100th case. This figure highlights the fact that COVID-19 infections are still growing exponentially in many countries across the world. The doubling time has been increased to six days or more in South Korea but remains between 2 and 4 days in countries like Sweden, France, Italy, Australia, Spain, the Netherlands, and the United States. This exponential growth is fueled by the presence of three conditions: (i) there is at least one infected person in the population pool; (ii) regular contact between infected and uninfected members of the population occurs; (iii) and there are large numbers of uninfected potential hosts among the population. Exponential growth is so powerful, not because it is necessarily fast, but because it is relentless⁶. Without introducing a factor to suppress it, exponential growth becomes a difficult challenge, because it doubles its presence/population in a given amount of time.

Figure 2: Case Trajectory of COVID-19 in countries



8. **COVID-19 is one of several emerging infectious diseases (EID) outbreaks in recent decades.** Recent zoonotic diseases impacting human populations include Hendra virus (1994), Nipah (1998), SARS-CoV (2003), H5N1 Avian Influenza (2005), MERS-CoV (2012), Ebola (2014 and 2018), Lassa Fever (annual outbreaks) and the most recent, COVID-19. These diseases emerge from animals contact with humans and have resulted in major outbreaks with significant public health, social and economic impact. Increasing dynamic interactions of humans, animals, infectious agents and the environment in a hyperconnected world, suggest the likely continuation of such infectious disease outbreaks. Therefore, aggressive public health measures to stem the COVID-19 pandemic, and other such zoonotic diseases, require a rapid, multi-faceted, cross-sectoral and globally coordinated response.

⁶ Siegel, S. 2020. "Why 'Exponential Growth' Is So Scary For The COVID-19 Coronavirus." Mar 17, 2020. Available at: <https://www.forbes.com/sites/startswithabang/2020/03/17/why-exponential-growth-is-so-scary-for-the-covid-19-coronavirus/#744a71114e9b>



9. **Older adults with coexisting chronic health conditions,^{7 8} like coronary heart disease and hypertension, lung disease, or diabetes; health risk factors such as tobacco use⁹ and air pollution (e.g., in international hotspots for COVID-19, such as Wuhan, Northern Italy, and South Korea, which have pretty high levels of air pollution)¹⁰, make viral respiratory infections such as COVID-19 particularly dangerous.** Given the recency of the COVID-19 pandemic, scientists are still determining the full picture of the disease symptoms and severity. The U.S. Centers for Disease Control and Prevention (CDC) suggests that symptoms of COVID-19 may appear in as few as 2 days or as long as 14 days after exposure to the virus¹¹. Reported symptoms in patients have varied from mild to severe, and can include fever, cough and shortness of breath¹². In general, studies of hospitalized patients have found that about 83 to 98 percent of patients develop a fever, 76 to 82 percent develop a dry cough and 11 to 44 percent develop fatigue or muscle aches. Other symptoms, including headache, sore throat, abdominal pain, and diarrhea, have been reported, but are less common. While 4 percent of the people worldwide confirmed as having been infected have died, WHO has been careful not to describe this figure as a mortality rate or death rate. This is because during an evolving epidemic it can be misleading to look simply at the estimate of deaths divided by cases to date. Given that the actual prevalence of COVID-19 infection remains unknown in most countries, it poses an unparalleled challenge with respect to global containment and mitigation. These issues reinforce the need to strengthen the response to the COVID-19 pandemic across all IDA/IBRD countries to minimize the global risk and impact posed by this disease.

10. **Containment and Mitigation Response.** As of March 29, 2020, the outbreak has resulted in an estimated 685,623 confirmed cases, 32,137 confirmed deaths, and 145,696 recovered cases in 177 countries/regions¹³. COVID-19 continues to infect thousands and spread rapidly across the globe (Figure 3). As COVID-19 seems to spread from person to person in a similar manner as other cold or influenza viruses (i.e., face to face contact with a sneeze or cough, or from contact with secretions of those infected), non-pharmaceutical interventions, both individual and collective, constitute a critical pillar for COVID-19 control—particularly, since there are no licensed vaccines or antivirals for treatment yet. Experience from different countries is now demonstrating that in the face of wider community transmission with multiple foci, a strategy of containment must be complemented by mitigation strategies¹⁴. These include: (i) close monitoring of changes in epidemiology and the effectiveness of public health strategies and their social acceptance; (ii) enhanced communication strategies to provide the population with information for self-protection, including hand washing; (iii) intensive control measures, including isolation of patients and persons testing positive for the virus, contact tracing and health monitoring, strict health facility infection prevention and control, including safe water and sanitation in health facilities, and active disease surveillance and containment activities; (iv) preparation for resilience of health systems in all countries, as is done at the time of seasonal influenza, anticipating severe infections and the course of disease in older people and other vulnerable populations at risk of severe disease (e.g., people with co-occurring chronic health conditions); and (v) in the case of widespread community transmission, mitigation activities, such as social distancing measures (e.g.,

⁷ Fauci, AS, Lane, C, and Redfield, RR. 2020. "Covid-19 — Navigating the Uncharted." *New Eng J of Medicine*, DOI: 10.1056/NEJMe2002387

⁸ Shi, S. 2020. "Association of Cardiac Injury with Mortality in Hospitalized Patients with COVID-19 in Wuhan, China." *JAMA Cardiol*. Published online March 25, 2020, doi:10.1001/jamacardio.2020.0950.

⁹ Marquez, PV. 2020. "Does Tobacco Smoking Increases the Risk of Coronavirus Disease (COVID-19) Severity? The Case of China." <http://www.pvmarquez.com/Covid-19>

¹⁰ Calma, J. 2020. "Air pollution could make the COVID-19 pandemic worse for some people. Pollution piles on top of other risk factors." Accessed at: <https://www.theverge.com/2020/3/19/21186653/coronavirus-covid-19-air-pollution-vulnerable-lung-disease-pandemic>

¹¹ US Centers for Disease Prevention and Control site. Accessed at: <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

¹² Del Rio, C. and Malani, PN. 2020. "COVID-19—New Insights on a Rapidly Changing Epidemic." *JAMA*, doi:10.1001/jama.2020.3072

¹³ <https://coronavirus.jhu.edu/map.html>, Johns Hopkins Center for Systems Science and Engineering

¹⁴ Heymann, DL, Shindo, N, on behalf of the WHO Scientific and Technical Advisory Group for Infectious Hazards. 2020. "COVID-19: What is Next for Public Health?". *The Lancet*, DOI.org/10.1016/S0140-6736(20)30374-3.



cancelling public gatherings, school closes, remote working) and provision of essential life support care in intensive care units in hospitals such as oxygen supplies, mechanical ventilators and oxygenation equipment. The effective adoption of social distancing measures can help slow the "exponential growth" of the pandemic by significantly slowing the rate of infection (or "doubling time") in the uninfected population. The more successful the interventions are, the more spread out in time further infections will be among the population (referred to as "flattening the curve"). These efforts, however, can be undone by one infected individual — whether through malice or ignorance — who goes out in public and has close contact with many others and infects them.

11. Recent country evidence shows that although containment measures in China have reduced new cases by more than 90 percent, this reduction is not the case elsewhere. The rapid surge of cases is posing a serious challenge to health systems across countries. This situation underscores the need for governments to urgently allocate enough resources (including personnel, beds, and intensive care facilities) in the short-and medium-terms. This means that, in parallel to adopting restrictive measures to limit viral diffusion in communities, countries also need to ensure appropriate health-system response to reduce mortality.

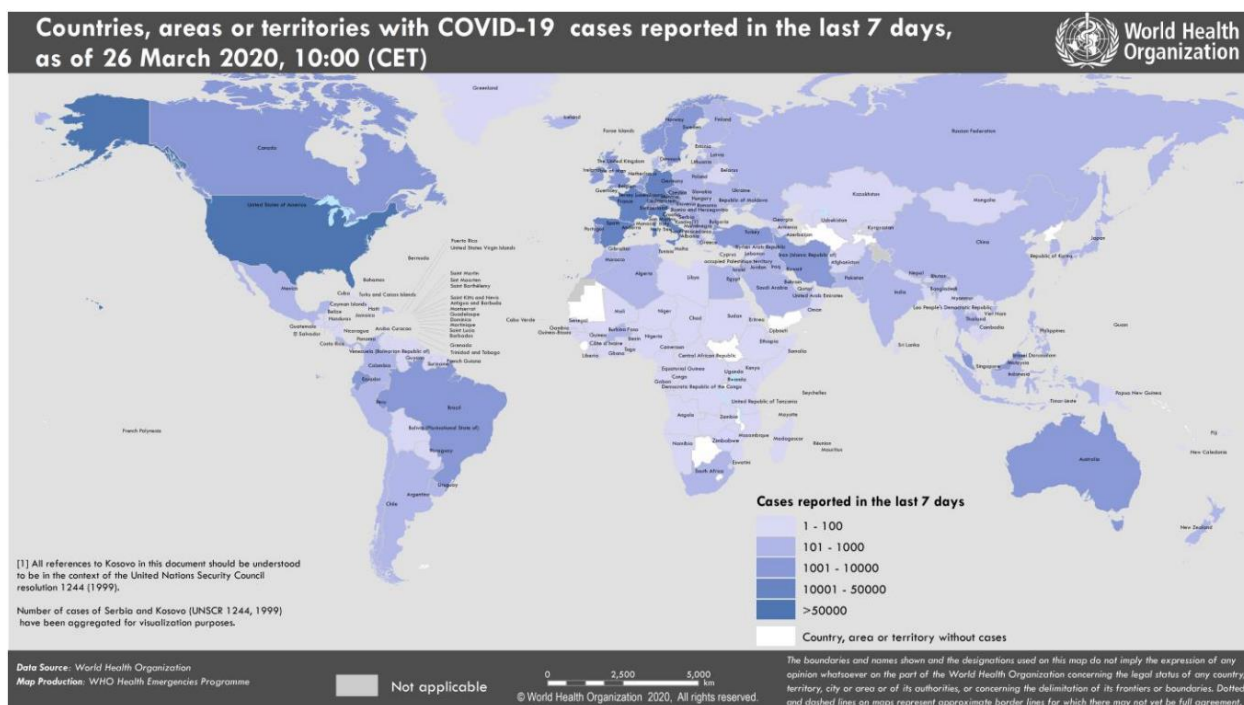
12. The Risk of Resurgence or New Wave of Infections. As shown in a recent study, substantial undocumented infection facilitates the rapid dissemination of COVID-19¹⁵. In China, it has been estimated that undocumented infections were the infection source for 79 percent of documented cases. In addition, it should be clear that because it is unknown how effective the body's immune response is in conferring long-term immunity, there is no guarantee that recovering from the disease once will prevent people from getting it a second time. The results of a mathematical model assessment conducted by researchers at Harvard University¹⁶, show **that one-time interventions will be insufficient to fully inhibit increases in a country's COVID-19 prevalence**. This analysis emphasizes that seasonal variation in transmission will facilitate epidemic control during the summer months but could lead to an **intense resurgence or a new wave of infections in the autumn**. Intermittent distancing measures can maintain control of the epidemic, but in the absence of a vaccine or effective treatment, the continuation of these measures may be necessary over time. Increasing critical health care capacity, therefore, could reduce the overall duration and impact of the COVID-19 pandemic while ensuring that critically ill patients receive appropriate care. As a result, a false dichotomy between COVID-19 emergency response and health system strengthening priorities should be avoided.

¹⁵ R. Li et al. 2020. "Substantial undocumented infection facilitates the rapid dissemination of novel coronavirus (SARS-CoV2)." Science 10.1126/science.abb3221 (2020).

¹⁶ Kissler, S, Tedijanto, C, Lipsitch, M, and Grad, Y. 2020 "Social distancing strategies for curbing the COVID-19 epidemic". Available at: <https://dash.harvard.edu/handle/1/42638988>.



Figure 3: COVID-19 Cases Across the World¹⁷



13. Impact of COVID-19. Over the coming months, the COVID-19 pandemic has the potential to exert greater morbidity and mortality impacts, as well as to negatively impact social and economic conditions in countries, as was observed in previous infectious disease outbreaks like the Ebola epidemic in West Africa in 2014-2015.¹⁸ The IFC is already observing the direct and indirect effects of the COVID-19 pandemic on the private sector. To date, the largest impact on the private sector has been on services such as travel, tourism and conferencing as well as disruption in supply chains of different industries. In the near term, public health objectives necessitate that people stay home from shopping and work, especially if they are sick or at risk. It is inevitable that production and spending will decline for a time¹⁹. The education system is also been impacted, hindering human capital development in countries. As of March 24, 2020, World Bank data shows that 161 countries are mandating school closures (out of the 181 reporting cases). Of these, 148 countries have closed on a national scale. This puts about 1.5 billion children and youth out of school. The timing is also unfortunate as many national examinations are now on hold or cancelled.

14. Protecting the Poor. The poor stand to be hit particularly hard due to loss of jobs and income. Current estimates suggest that a one percent decline in developing country growth rates would trap an additional 20 million people into poverty. In addition, several countries in East Africa, Horn of Africa, and South Asia are struggling to deal with the historic locust infestation, and COVID-19 is putting such countries and the poorest at extremely high risk, including imminent food shortages. Potential tightening of credit conditions, weaker growth, and the diversion of expenditures to fight the pandemic are likely to cut into government revenues and their ability to invest to meet infrastructure, health, education, and other priority development goals. In countries without universal health

¹⁷ https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200323-sitrep-63-covid-19.pdf?sfvrsn=d97cb6dd_2, World Health Organization

¹⁸ World Bank Group. 2015. "The economic impact of Ebola on sub-Saharan Africa: updated estimates for 2015". Washington, DC. Available at: <http://documents.worldbank.org/curated/en/2015/01/23831803/economic-impact-ebola-sub-saharan-africa-updated-estimates-2015>

¹⁹ Bernanke, B, and Yellen, J. 2020. "Reviving crisis-era programmes is a first step but the central bank may need to buy corporate bonds." Financial Times, March 18, 2020. At: <https://www.ft.com/content/01f267a2-686c-11ea-a3c9-1fe6fedcca75>



coverage, the financial impact of COVID-19 on the population, particularly low-income groups, could be significant or even catastrophic due to increased out-of-pocket payments to access medical care.

15. The imperative of Healthy Populations. Available evidence now shows that COVID-19 is causing mild and self-limiting disease in most people who are infected, with severe disease more likely among older people or those with comorbidities, such as pulmonary disease, and other chronic health conditions. Data from China indicates, unsurprisingly, that tobacco smoking is playing a large part in the gender distribution and severity of COVID-19^{20 21}. As made clear by the COVID-19 outbreak, governments have an obligation to protect their population's wellbeing by adopting population-based disease prevention measures (for example, fiscal and regulatory measures supporting tobacco taxation and other "health taxes"²²), in addition to providing medical care to those persons who fall ill. This approach can yield major gains for people's health and countries' social and economic development. In contrast, a reduced ratio of healthy to sick workers, older dependents, will certainly increase the odds of future economic slowdowns and pose a significant social challenge to countries. Keeping people healthy is vital for the future development of countries in an aging world, particularly as skills shortages pose an increasing challenge to economies.

16. Critical Steps for the COVID-19 Response. Some critical activities can be undertaken in countries as the initial phase of the outbreak moves accelerates (Box 1). The virus and response interventions will differ in higher-resource than in lower-resource countries, depending on crowding, capacity for diagnosis and treatment, and ability to reduce spread. A recent report²³ prepared for the UK government, which has informed policy making in the UK and other countries in the last weeks, shows that a suppression strategy of social distancing, home isolation, and household quarantine of family members, can help arrest the growth of the epidemic. These measures may be complemented by school and university closures to help suppress transmission below the basic reproduction number of 1.0 (R_0), which is necessary to rapidly reduce case incidence, keep case numbers to low levels, and maintain that situation over time. In contrast, the report shows that adoption of a mitigation strategy, focusing on slowing but not necessarily stopping the epidemic spread, is unlikely to be achieved without a substantial surge of capacity in the healthcare systems. The report points out that disentangling the relative effectiveness to date of different interventions in different countries is challenging because they have implemented multiple measures with varying degrees of success. However, it notes that through the hospitalization of all cases (not just those requiring hospital care), China in effect initiated a form of case isolation, reducing onward transmission. At the same time, by implementing population-wide social distancing, the opportunity for onward transmission in all locations has been rapidly reduced. In recent days, these robust measures have begun to be relaxed. The report suggests that close monitoring of the situation in China and other countries, such as the South Korea, Singapore, Italy, Spain, and the United States, in the coming weeks will help to inform strategies in other countries.

²⁰ Cai, W. 2020. "Sex difference and smoking predisposition in patients with COVID-19." *Lancet Respir Med*, Doi.org/10.1016/Pii. At: <https://www.thelancet.com/action/showPdf?pii=S2213-2600%2820%2930117-X>

²¹ Parascandola M, Xiao L. 2019. "Tobacco and the lung cancer epidemic in China." *Transl Lung Cancer Res*;8(Suppl 1):S21-S30.. At: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6546632/pdf/tlcr-08-S1-S21.pdf>

²² Marquez, PV, and Moreno-Dodson, B. 2017. "Tobacco tax reform at the crossroads of health and development." A technical report of the World Bank Group Global Tobacco Control Program Washington, DC: World Bank Group. At: <http://documents.worldbank.org/curated/en/491661505803109617/Main-report>

²³ Imperial College COVID-19 Response Team. Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand. <https://doi.org/10.25561/77482>



Box 1: Critical Steps to Respond to COVID-19

- **Find out more about how COVID-19 spreads, how deadly it is and what can be done to reduce its harm.** As many as half of the infected people have no symptoms, and at least 80% of those who do feel ill have only mild symptoms.
- **Reduce the number of people who get infected. If it turns out that many of those infected become severely ill, this would justify measures such as closing or curtailing hours of schools, limiting public gatherings and reducing social contact.** The lower the risk of death from infection, the less sense it makes to take these and other actions that disrupt social and economic stability. Spread can be minimized by quickly isolating those who are ill, cleaning potentially contaminated surfaces often and changing common routines. Some little things that make a big difference are: washing hands, covering coughs and, if a person is sick, staying home or wearing a mask when he/she goes out.
- **Especially protect the elderly and those with co-morbidities/underlying conditions,** especially respiratory conditions and focus particularly on those living together in elderly care facilities.
- **Protect health care workers.** Even before COVID-19, far too many health workers and patients got infections in health care facilities. A fast and drastic improvement is needed in triage, treatment, cleaning and overall infection prevention. A shortage of medical masks is likely so there is a need to ensure health care workers have enough, as should household members caring for sick relatives and people who are ill and need to go outside. For health care workers, newer, longer-lasting technologies such as elastomeric and positive air pressure respirators could address an otherwise inevitable shortage of medical masks.
- **Improve medical care and prevention of COVID-19.** A vaccine is at least a year away, and success is uncertain. Treatments that hold promise need to be evaluated rigorously. In a moderately severe pandemic, there would not be enough ventilators to support patients' breathing. Health facilities and health departments can prepare for a worst-case scenario -- with training, equipment, and detailed operational plans - for a surge in the number of patients who seek care and for the subset of those who need to be mechanically ventilated.
- **Protect health services.** During the 2014-2016 Ebola epidemic in West Africa, more people died because of disruptions of day-to-day health care than died from the disease. Telemedicine needs to become much more accessible, and people with chronic conditions should receive three months of medications whenever possible, in case there are supply disruptions. Routine vaccinations and other preventive services need to be maintained.
- **Support social needs.** Patients and their families will need support, especially those who are isolated and less familiar with virtual or delivery services. Continuing to support individuals and groups, ranging from community centers to nursing homes, will require detailed plans.
- **Invest in multisectoral health response.** It will cost about \$1 a person or US\$25 billion per year for at least a decade to build the health protection systems needed in Africa and Asia.

Source: Adapted from Frieden, T. 2020

A. Bank Response to COVID-19

17. The WBG is committed to supporting the global response, working in close partnership with member governments and other agencies. In addition to the World Bank's IBRD and IDA financing available to the countries, the dedicated Fast Track COVID-19 Response Program and IFC's Trade Solutions and Working Capital Liquidity Facilities build on the experience and credibility of both institutions in responding to global crisis. They allow the institutions to provide emergency support to countries as they respond to the health and economic impacts of the spread of COVID-19. They also build on the experience and high standards that are needed so that the approaches work well in fast moving environments. The proposed FTCTF is broad-based and will provide emergency financing, policy advice, and technical assistance, building on existing instruments to support IDA and IBRD eligible countries in addressing the health related and broader development impacts of COVID-19.

18. The World Bank is well positioned to respond to this pandemic given its global, cross-sectoral expertise combined with its understanding of country conditions and needs. In addition, the World Bank has extensive experience in responding to crises (pandemics, natural disasters, economic shocks), while building resilience and improving future preparedness and response capabilities, respect and trust of its client countries and global partnerships (UN agencies, WHO, other Multilateral Development Banks (MDBs), IMF, bilateral organizations, and



private sector). The proposed first phase response will be implemented under the framework of the Fast Track COVID-19 Response Program, allowing a rapid response to short-term needs. Also, depending on needs, the Program may provide for a second project in a given country depending on the availability of resources. Given the impact of the outbreak on economic activity, there will also be need for response to economic and social disruption resulting from the spread of the virus. As announced by WBG President in the remarks to G20 Leaders' Virtual Summit on March 26, 2020, the WBG has capacity to provide US\$150- 160 billion in total financial support over the next 15 months, and US\$330-350 billion until the end of June 2023.²⁴ ²⁵ The WBG will support countries to shorten the time to recovery; create conditions for growth; support small and medium enterprises; and help protect the poor and vulnerable.

B. Relevance to Higher Level Objectives

19. The SPRP is aligned with World Bank Group (WBG) strategic priorities, particularly the WBG's mission to end extreme poverty and boost shared prosperity. The Program with its focus on preparedness, grounded in a multi-sector public health approach, is also critical to achieving Universal Health Coverage. It is also aligned with the World Bank's support for national plans and global commitments to strengthen pandemic preparedness through three key actions under Preparedness: (i) improving national preparedness plans including organizational structure of the government; (ii) promoting adherence to the International Health Regulations (IHR); and (iii) utilizing an international framework for monitoring and evaluation of IHR. The economic rationale for investing in the Program's interventions is strong, given that success can reduce the economic burden suffered both by individuals and countries. A country specific project would complement both WBG and development partner investments in health systems strengthening, disease control and disease surveillance, attention to changing individual and institutional behavior, and citizen engagement. Further, as part of the proposed IDA19 commitments, the World Bank is committed to "support at least 25 IDA countries to implement pandemic preparedness plans through interventions (including strengthening institutional capacity, technical assistance, lending and investment)." A country project would contribute to the implementation of IHR (2005), Integrated Disease Surveillance and Response (IDSR), and the World Organization for Animal Health (OIE) international standards, the Global Health Security Agenda, the Paris Climate Agreement, the attainment of Universal Health Coverage, and the Sustainable Development Goals (SDG).

C. Multiphase Programmatic Approach

20. The Multiphase Programmatic Approach (MPA), approved by the Executive Directors of the WBG on July 21, 2017²⁶, is considered the most flexible way to launch an emergency response with flexibility to quickly adapt to the changing situation and learning lessons.

²⁴ "World Bank Group President David Malpass Remarks to G20 Leaders' Virtual Summit". March 26, 2020. Available at:

<https://www.worldbank.org/en/news/speech/2020/03/26/world-bank-group-president-david-malpass-remarks-to-g20-leaders-virtual-summit>

²⁵ These numbers are based on current market conditions and include the \$14 billion Fast Track COVID-19 Response Program.

²⁶ Multiphase Programmatic Approach, report number 117742.

<http://documents.worldbank.org/curated/en/203081501525641125/Multiphase-Programmatic-Approach>



21. **(i) Rationale for Using MPA**

22. The MPA is the most suitable approach for channeling IBRD/IDA support to deal with the COVID-19 pandemic for the following reasons:

- The MPA is global, but it also takes a series of national and regional organizations perspectives, allowing countries and regional organizations to join when they are ready, and to join at different implementation levels insofar as they subscribe to the same Program Development Objectives (PrDO) and take the same basic approach.
- The MPA will enable a response to many countries with tailored approaches while at the same time endorsing an integrated approach and common objectives across sectors and regions for dealing with the emergency. The MPA also allows—and encourages—adjustments based on learned implementation experience within the framework of the PrDO. Most importantly the MPA allows the Bank to quickly respond to changing client needs and timing, while maintaining the overall objectives and approach.
- The MPA provides an important opportunity to reinforce a multi-sector public health approach to effectively address threats and reduce risks of detrimental zoonotic diseases at the animal-human-ecosystem interfaces.
- The MPA provides a global platform for collaborative learning and quick response adaptation as knowledge about COVID-19 preparedness and prevention continue to evolve. Given the diversity of the countries affected, the MPA will allow countries to capture the lessons learned from each phase more efficiently.
- The MPA provides a logical platform to support both short- and medium-term actions needed, as well as striking an appropriate balance between the two in a response. Immediate action is needed in multiple areas, but there is also a longer-term agenda given systemic shortcomings with respect to core public health functions and global health security. Work on both the short- and medium-term fronts, therefore, needs to proceed in tandem. Efforts should be made to ensure that short-term responses are consistent with and contribute to proposed longer-term interventions. Setting priorities in both cases is essential. By concentrating the efforts on these, dual-use investments would generate benefits during normal times and in a pandemic.

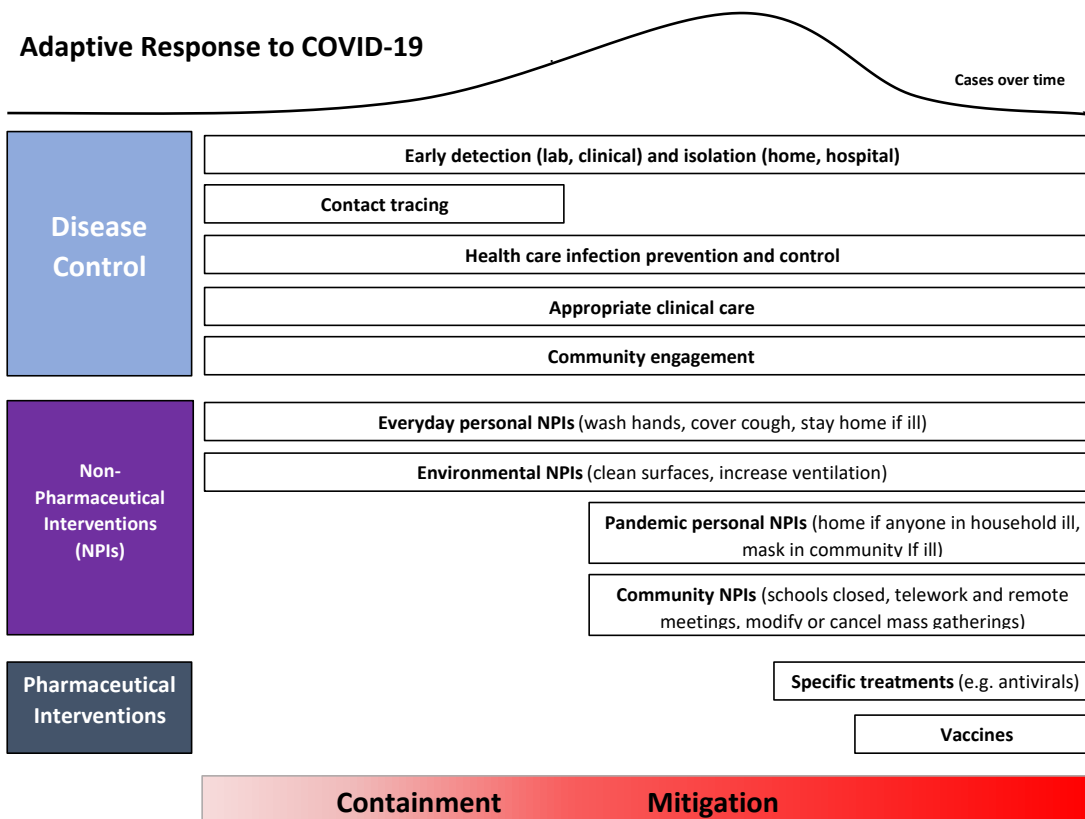
23. **The Program would be implemented through individual operations/projects, which will be prepared and supervised** in close coordination with all multilateral, donor and regional agencies that are active in this area. This would avoid a fragmented approach to providing country assistance and help build a common strategy and program for each of the countries. This is also intended to draw on the expertise of each of these agencies and avoid duplication of investments and efforts.

(ii) Program Results Chain

24. **The Program Supports an Adaptive Emergency Response to COVID-19 (Figure 4).** Swift detection of an infectious disease outbreak, assessment of its epidemic potential and rapid response, containment, and mitigation can reduce avoidable mortality and morbidity. It can also reduce the economic, social, and security impact. Delays in rapid mobilization of financing and coordination of response, results in unnecessary casualties and significant socioeconomic consequences. By focusing on early detection, diagnosis, confirmation, and treatment of patients (including those afflicted with other chronic conditions that increase risk of COVID-19 severity and mortality), the Program seeks to support countries in preventing the spread of the disease and limiting socioeconomic losses. It will also help strengthen public health and essential medical care structures and operations to build resilience and reduce the risk from emerging and re-emerging pathogens.



Figure 4: An Adaptive Emergency Response to COVID-19

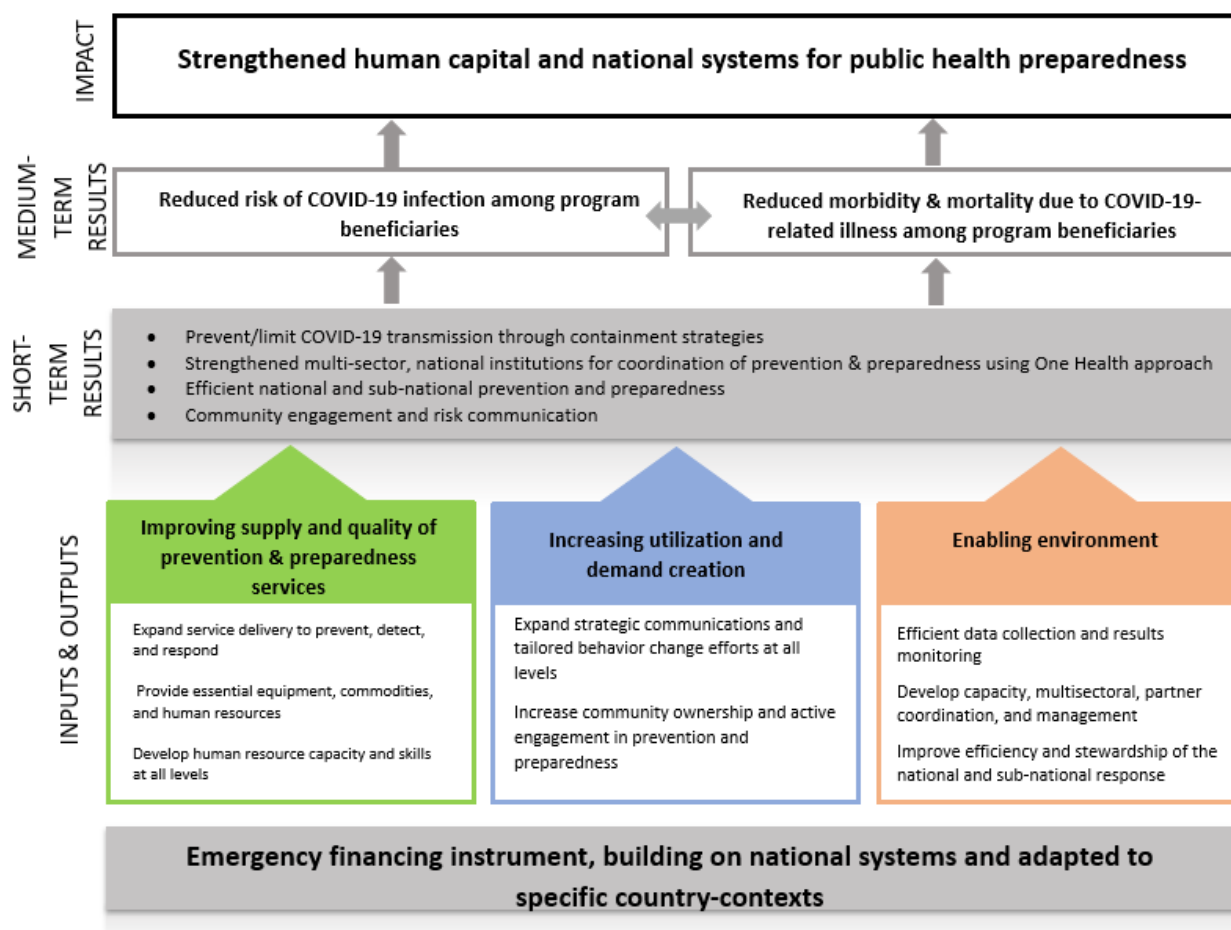


Source: Resolve to Save Lives

25. Critical interventions would be supported under the Program to help achieve the objectives of the Program (Figure 5). The development of national COVID-19 preparedness and response plans will improve disease surveillance and emergency measures in the countries. Measures would include the establishment/strengthening of command centers for efficient emergency response for multiple hazards, the strengthening of disease surveillance and information systems, increased laboratory capacity, improved infection and prevention control and case management, particularly to protect health workers. Health care workers trained in critical skills involved in disease detection and response will improve the system's effectiveness, while risk communication and behavioral change interventions, including social distancing measures, will contribute to slowing the spread of COVID-19 and other disease outbreaks. Public health and essential medical services along a care continuum would be strengthened to timely prepare, respond, contain, and mitigate the impact of COVID-19 and other diseases of public health importance.



Figure 5. Theory of Change



(iii) Program Development Objective with Key Program DO Indicators

26. The **Program Development Objective (PrDO)** is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness. Countries and regional organizations under the Program would aim to address all aspects of the PrDO, or the ones that are most relevant for them. Collectively the PrDO will help measure progress at the global level.

27. Immediate action is needed in multiple areas to prevent pandemic emergence and future resurgence and rebound and to avert multiple, recurring epidemic waves. In some countries, work on both the short and medium-terms would proceed in tandem, and efforts would be made to ensure that short-term responses are consistent with and contribute to proposed longer-term prevention of pandemic resurgence and multiple successive, pandemic waves. Setting priorities in both instances is essential. Concentrating efforts on immediate prevention and resurgence prevention would generate benefits both during normal times and in subsequent waves of this pandemic and future pandemics.



28. **Progress towards the achievement of the PrDO would be measured by outcome indicators.** Individual country-specific projects (or phases) under the Program will identify relevant indicators, including among others:

PrDO indicators for country projects

- Country has activated their public health Emergency Operations Centre or a coordination mechanism for COVID-19
- Number of designated laboratories with COVID-19 diagnostic equipment, test kits, and reagents;
- Number of acute healthcare facilities with isolation capacity
- Number of suspected cases of COVID-19 reported and investigated per approved protocol;
- Number of diagnosed cases treated per approved protocol
- Personal and community non-pharmaceutical interventions adopted by the country (e.g., installation of handwashing facilities, provision of supplies and behavior change campaigns, continuity of water and sanitation service provision in public facilities and households, school closures, telework and remote meetings, reduce/cancel mass gatherings)
- Policies, regulations, guidelines, or other relevant government strategic documents incorporating a multi-sectoral health approach developed/or revised and adopted
- Multi-sectoral operational mechanism for coordinated response to outbreaks by human, animal and wildlife sectors in place
- Coordinated disease surveillance systems in place in the animal health and public health sectors for zoonotic diseases/pathogens identified as joint priorities
- Mechanisms for responding to infectious and potential zoonotic diseases established and functional
- Outbreak/pandemic emergency risk communication plan and activities developed and tested

Intermediate Results Indicators for country projects

Component 1:

- Number of health staff trained in infection prevention and control per MOH-approved protocols
- Number of health facilities with access to safe water and basic sanitation services
- Referral systems to care for COVID-19 patients established and functioning
- First COVID-19 case reported to WHO within 24 hours of confirmation reported per IHR requirements
- Percentage of acute healthcare facilities with triage capacity
- Number of households provided with cash transfers among affected populations; and
- Number of households provided with food and basic supplies within quarantined populations

Component 2:

- At least one multi- sectoral simulation exercise conducted with results incorporated into national COVID-19 preparedness and response plans

Component 3:

- Number of designated laboratories with staff trained to conduct COVID-19 diagnosis

Component 4:

- Country has reported to have contextualized their risk communication and community engagement strategies



- Number of individuals reached with tailored information (e.g., individuals and decision makers in different sectors — travel and tourism, food and agriculture, healthcare workers and businesses)

Component 5:

- M&E system established to monitor COVID-19 preparedness and response plan

(iv) Program Framework.

29. This Program has horizontal and vertical features, since the COVID-19 pandemic respects no national boundaries. While the proposed recipients of under Phase 1 of Program financing have been identified, recipients under subsequent Phases cannot be pre-identified with certainty at this stage. All of this calls for extra flexibility in some procedural requirements.²⁷

30. Project documents for all countries will be disclosed as they are approved

(v) Learning Agenda.

31. The Program will support adaptive learning in countries where FTCT financing is provided, working with partners from international organizations including IMF, CDC, WHO, UNICEF, FAO, OIE, and others. Each country-specific project under the Program will develop and implement a country-specific learning agenda to support a continued evidence-based response, focusing on key issues such as the following:

- **Forecasting:** modeling the progression of the pandemic, both in terms of new cases and deaths, as well as the economic impact of disease outbreaks under different scenarios.
- **Technical:** Cost and effectiveness assessments of prevention and preparedness activities; research may be financed for the re-purposing of existing anti-viral drugs and development and testing of new antiviral drugs and vaccines.
- **Supply chain approaches:** assessments may be financed on options for timely distribution of medicines and other medical supplies.
- **Social behaviors:** assessment on the compliance and impact of social distancing measures under different contexts.
- **Comparative analysis:** rapid learning from programmatic comparisons of countries attempting similar approaches.
- **Service Delivery:** rapid learning on service delivery models of adaptation that have been successful (or not) based on country context and the evolution of the outbreak.

II. PROGRAM DESCRIPTION

32. The Program Development Objective of the COVID-19 Strategic Preparedness and Response Program is to assist IBRD and IDA-eligible countries in their efforts to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness.

²⁷ The Articles of Agreement of IBRD and IDA (IBRD Article III, Section IV, and IDA Article V, Section 1 (d)) require that before making IBRD/IDA financing, a report of a Statutory Committee (StatCom) be completed. The StatCom must include the signature of representative of the member country where the project is located. Although the Articles do not require that a StatCom be made available before the EDs approve Bank financing, it has been a long-standing practice that StatComs are in fact obtained before the EDs decide on Bank financing. For this SPRP, EDs' approval is being sought for the overall Program financing, when all possible recipients of such financing are not yet identified. Therefore, Management will obtain a StatCom from each member state that will be the recipient of the SPRP financing before the funds are committed by Management (i.e., before the legal agreement is signed). Such approach is fully consistent with the requirements of the Articles.



A. Program Components (indicative for country projects)

33. **Urgency to contain and mitigate the impact of COVID-19.** COVID-19 responses should be tailored to specific country circumstances and risks, considering the spread of COVID-19, level of pandemic preparedness, and the capacity of the health systems. The selection of components and activities in each country project would support results that are realistic, considering the risks to those results (e.g., weak institutional capacity, political/governance risks, social risks), as well as unintended consequences (e.g., impact of social distancing on the economy, impacts and social cohesion). Needs will be assessed on an ongoing basis in a very fluid environment as the pandemic evolves and information becomes available. Retroactive financing will be available under country projects for disbursing resources quickly in response to urgent needs for medical supplies. In principle, the MPA will allow for disbursements of up to 40 percent for such retroactive financing. However, consideration will be given for a higher percentage under exceptional circumstances, while ensuring due diligence of the procurement arrangements. It is expected that a key focus in many countries will be on strengthening the country's basic prevention response: (i) handwashing behavior change and promotion, including provision of fixed and portable handwashing facilities, purchase of soap and alcohol-based hand rubs, provision of water supplies for handwashing, along with targeted messaging campaigns; (ii) improved and targeted case detection and confirmation; (iii) isolation of confirmed cases; (iii) social distancing and associated communications; (iv) sharing of data and information; and (v) boost hospital capacity (ICUs, increase number of available hospitals beds for infected people who require medical care) to the extent possible. Concentrating the efforts on these dual-use investments would generate benefits both during normal times and in a pandemic.

34. **The components described below comprise a menu of options that countries and regional organizations eligible for FTCF support can tailor to respond to their country context and epidemic status.** Within the framework of the Program, it is recognized that given the rapidly evolving pandemic, necessary flexibility will be exercised in country projects to adjust priorities between components (and activities) as well as with respect to results indicators and targets during implementation.

35. While under Component 1 support to participating countries would focus on immediate, emergency containment and mitigation activities to respond to COVID-19 outbreaks and resurgent waves, support under Components 2 and 3 of the Program would further strengthen the capacity of countries to deal with the reemergence and emergence of COVID-19 and other pathogens of animal origin. Under the other Program's components, support would be for community engagement and risk communication (Component 4), implementation management and monitoring and evaluation (Component 5), and contingency emergency response (CERC) (Component 6).

Component 1: Emergency COVID-19 Response

36. This component would provide immediate support to prevent the spread of COVID-19 and deaths through containment and mitigation strategies. It would support enhancement of disease detection capacities through provision of technical expertise, laboratory equipment and systems to ensure prompt case finding and contact tracing, consistent with WHO guidelines and the Strategic Response Plan. It would enable countries and regional organizations to mobilize surge response capacity through trained and well-equipped frontline health workers. In addition, in the case of community transmission, support for the adoption of social distancing measures would be provided, along with support to strengthen the capacity of the health system to manage the surge of infected people, provide care, and minimize the number of deaths. There would be a sub-component, where applicable, targeted at migrant and displaced populations in fragile, conflict or humanitarian emergency settings compounded by COVID-19. Supported activities would include:



- **Case Detection, Confirmation, Contact Tracing, Recording, Reporting.** This sub-component would help: (i) strengthen disease surveillance systems, public health laboratories, and epidemiological capacity for early detection and confirmation of cases; (ii) combine detection of new cases with active contact tracing; (iii) support epidemiological investigation; (iv) strengthen risk assessment; and (v) provide on-time data and information for guiding decision-making and response and mitigation activities. Additional support could be provided to strengthen health management information systems (HMIS) to facilitate recording and on-time virtual sharing of information, with respect to COVID-19 disease monitoring and surveillance, including the use of innovative technology as may be appropriate and feasible.

- **Social Distancing Measures.** An effective measure to prevent contracting a respiratory virus such as COVID-19 would be to limit, as possible, contact with the public. Therefore, the Program would support the implementation of immediate term responses, i.e., classic “social distancing measures” such as school closings, escalating and de-escalating rationale, backed up by a well-designed communication strategy. The social distancing measures will be developed and enforced on advice from appropriate regulatory institutions. As a result, financing would be made available to develop guidelines on social distancing measures (e.g., in phases) to operationalize existing or new laws and regulations, support coordination among sectoral ministries and agencies, and support the ministries of health on the caring of health and other personnel involved in pandemic control activities. Additional preventive actions would be supported that would complement social distancing such as personal hygiene promotion, including handwashing, and distribution and use of masks, along with increased awareness and promotion of community participation in slowing the spread of the pandemic.

- **Health System Strengthening.** Assistance would be provided to national health care systems for preparedness planning to provide optimal medical care, maintain essential health services and to minimize risks for patients and health personnel (including training health facilities staff and front-line workers on risk mitigation measures, and providing them with the appropriate protective equipment and hygiene materials). Strengthened clinical care capacity could be achieved through financing plans for establishing specialized units in selected hospitals, adaptation of treatment guidelines and hospital infection control guidelines (as needed), and training of health workers and laboratory technicians. Also, strategies would be developed to increase hospital bed availability, including deferring elective procedures, more stringent triage for admission, and earlier discharge with follow-up by home health care personnel.

37. As COVID-19 would place a substantial burden on inpatient and outpatient health care services, support would be provided to rehabilitate and equip selected primary health care facilities and hospitals for the delivery of critical medical services and to cope with increased demand of services posed by the outbreak, develop intra-hospital infection control measures, and necessary improvements in blood transfusion services to ensure the availability of safe blood products. This would include support for intensive care facilities within hospitals with medical equipment and training of health teams. There would be support for ensuring safe water and basic sanitation in health facilities, as well as to strengthen medical waste management and disposal systems, mobilize additional health personnel, training of health personnel, provision of medical supplies, diagnostic reagents, including kits, other operational expenses such as those related to mobilization of health teams and salaries, and hazard/indemnity pay consistent with the governments’ applicable policies. Additionally, support would be provided to improve access to information and scientific knowledge using appropriate tools, including the review and synthesis of scientific information for distribution to the public health community and populations. This component would also support building capacities for applied and clinical research, including ethical aspects.

- **Communication Preparedness.** Activities would include developing and testing communication messages and materials to be used in the event of a pandemic or emerging infectious disease outbreaks and enhancing infrastructures to disseminate information from national to state and local levels and between the public and



private sectors. Communication activities would support cost effective and sustainable methods such as marketing of “handwashing” through various communication channels via mass media, counseling, schools, workplace, and integrated into specific interventions. Support would also include ongoing outreach activities of ministries and sectors, especially ministries of health, education, agriculture, and transport. Further, support would be provided for (i) information and communication activities to increase the attention and commitment of government, private sector, and civil society; and (ii) to raise awareness, knowledge and understanding among the general population about the risk and potential impact of the pandemic and to develop multi-sectoral strategies to address it. In some countries, community mobilization would take place through institutions that reach the local population, especially in rural areas (e.g., church and tribal leaders). In addition, support would be provided for: (i) the development and distribution of basic communication materials (such as question and answer sheets and fact sheets in appropriate languages) on COVID-19 and general preventive measures such as “dos” and “don’ts” for the general public; (ii) information and guidelines for health care providers; (iii) training modules (web-based, printed, and video); (iv) presentations, slide sets, videos, and documentaries; and (v) symposia on surveillance, treatment and prophylaxis.

- **Social and Financial Support to Households.** Psychosocial support and other mental health interventions would be offered to minimize the impact on the mental well-being of people facing long periods of social isolation due to the adoption of social distancing measures, particularly the elderly, as well as among infected populations, and people that have lost family members due to COVID-19²⁸, and frontline workers involved in the response. Continuing to support individuals and groups ranging from community centers to nursing homes would require detailed plans. Additional social support activities would be geared to reduce/eliminate financial barriers to families to seek and utilize needed health services, as well as to help mitigate economic impact on households, particularly among the poor. To this end, financing would be provided for fee-waivers to access medical care and cash transfers to mitigate loss of household income due to job losses that may result from the closure of firms and enterprises, informal sector businesses, as well as government agencies, during the outbreak. These provisions would help women as many still cannot access essential health services and continue to suffer from preventable and treatable diseases. Also, as women make up to 70 percent of the global health workforce, cash transfers would help mitigate job burden due to surge of cases in health facilities in parallel to caring for infected family members, particularly the elderly, who are at higher risk of contracting COVID-19 disease, and children who may be out of school due to closures. In addition, under this component the provision of food and basic supplies²⁹ to quarantined populations and COVID-19 affected households would be supported. Experience from past outbreaks shows the importance of placing attention on gender issues in containment and mitigation efforts to improve the effectiveness of health interventions and promote gender and health equity goals. During West Africa’s 2014–15 Ebola epidemic, gender norms meant that women were more likely to be infected by the virus, given their predominant roles as caregivers within families and as front-line health-care workers. In addition, public health emergencies can have a substantial impact on livelihoods - particularly for women, who are more likely to be engaged in informal or low-wage activities or migrant work. To ensure that programmatic responses under the Program are optimally effective, the design of country projects will consider and address gender norms and roles that influence differential vulnerability to infection, exposure to pathogens, and treatment accessibility.

Component 2: Strengthening Multi-sector National Institutions and Platforms

38. While under Component 1 support to participating countries would focus on immediate, emergency containment and mitigation activities to respond to the COVID-19 outbreaks and resurgent waves, support under

²⁸ For reference see: Marquez, PV. 2018. “Mental health among displaced people and refugees: Making the Case For Action Under Humanitarian Response and Development Programs”. At: <http://documents.worldbank.org/curated/en/916131486730755271/pdf/112742-REVISED-JULY20-RMHPwebpdfjuly.pdf>

²⁹ Regional Vice-President’s approval of provision of food is required under the IPF Instructions for each IPF operation under the Program.



Components 2 and 3 of the Program would further strengthen the capacity of countries to deal with the reemergence and emergence of COVID-19 and other pathogens of animal origin. It will also support multi-sector efforts to improve Water, Sanitation and Hygiene (WASH).

39. Based on the Joint External Evaluations of country IHR core capacities and related performance of veterinary services assessments and gap analysis, support would be provided to strengthen national public health preparedness using one health approach. This component would support implementation of activities to strengthen the core capacities as developed in National Action Plans for Health Security. Such support would include: (i) technical assistance support for strengthening governance and updating legislation; (ii) support for institutional and organizational restructuring and training of staff; and (iii) upgrading of priority infrastructure (civil works, equipment, materials and supplies, technical assistance).

40. To assess risks to public health, prevent spillover events from wild and domestic animal populations and establish early warning systems to guide protective measures, information is needed on the extent of infection in animals and humans and on circulating viruses. National disease surveillance systems must be improved in potentially affected and at-risk countries. When outbreaks of zoonotic potential occur in animals, active human case detection should be done by a coordinated animal-public health team.

41. The country projects would support disease surveillance systems for emerging infectious diseases by using a risk-based approach. In general, the system comprises the following components: (i) disease reporting system for priority infectious diseases; (ii) laboratory investigation of priority pathogens, be it bacterial or virus, or others, in terms of their presence, susceptibility and sub-typing in some cases; (iii) community event-based disease surveillance and (iv) rumor-based disease surveillance and verification. Country projects would also support the development and/or enhancing performance of early warning systems. The lack of reliable epidemiological information in domestic and wild animal populations, and the sound analysis thereof, has hampered the development of rational, targeted disease control measures in many countries. Thus, well-structured epidemiological studies and disease surveillance activities would be integrated with the disease control measures, which would be then adjusted and improved as new information becomes available. Strengthening animal and human disease surveillance and diagnostic capacity would be supported through the following activities: (i) improving animal and human health information flow among relevant agencies and administrative levels; (ii) detection, reporting and follow-up of reported cases; (iii) public and community-based disease surveillance networks; (iv) routine serological surveys; and (v) improving diagnostic laboratory capacity.

42. The component would support enhancing zoonotic diseases information systems through development of a uniform disease information system in each participating country. This would help countries enhance their capacity to participate in global disease information sharing and comply with their obligations as members of WHO and OIE, thereby contributing to improve global and regional disease prevention and control. The system would be linked to rapid, standardized methods of routine analysis of disease surveillance data, which would demonstrate important changes in the animal health situation, and promptly supply this information to field personnel.

Component 3: Supporting National and Sub-national, Prevention and Preparedness

While under Component 1 support to participating countries would focus on immediate, emergency containment and mitigation activities to respond to the COVID-19 outbreaks and resurgent waves, support under Components 2 and 3 of the Program would further strengthen the capacity of countries to deal with the reemergence and emergence of COVID-19 and other pathogens of animal origin.

43. The component would finance requirements of Infrastructure (observatories, reference labs, clinical capacity), equipment, reagents and commodities, analytical and assessment capacity with trained local capacities embedded



in National Primary Human and Animal Health Systems. The component would support improving prevention of and response planning for Emerging Infectious Diseases (EIDs) in the context of human and animal health system development. This component would provide support to activities needed to help countries to prepare National Emergency Contingency Plans according to country specific conditions, constraints and possibilities (the capacity of its Veterinary Services, structure and importance of its livestock sector, wildlife, risk of new, emerging and re-emerging diseases, and its status regarding major animal diseases). The component would also support simulation exercises.

44. Zoonotic disease specific control strategies and programs should include the principle of targeting the disease at the source of infection. This refers predominantly to the smallholder sector, informal sector, wild-life exploitation, and a major carrier host reservoir. Eradication of the disease source would be a difficult and long-term task, especially in poor countries with limited resources. This component would therefore explore disease control options in domestic and wild animal populations, including restructuring of farming systems to separate domestic from wild and feral animals, strategic culling of livestock, and progressively enhancing herd/flock immunity through vaccination to reduce pathogen shedding. The short to medium-term task of controlling the disease by reducing pathogen circulation in the livestock sector, large-scale breeder units, and medium to small-sized commercial units is feasible.

45. On a longer-term basis, improving bio-security in animal production and trade is an important strategy to guard against the damaging effects of animal diseases, but it is also a complicated intervention requiring understanding of the whole value chain. Moreover, restructuring requires different approaches in different countries by virtue of the differences in their livestock sector infrastructures, marketing characteristics, household-based versus commercial production systems, and socio-economic impact. This component would also support the restructuring of the industry when needed. Restructuring and consolidation should be a gradual process, affecting the various segments of the sector in different ways and at different rates.

Component 4: Community Engagement and Risk Communication

46. Support would be provided to develop systems for community-based disease surveillance and multi-stakeholder engagement, including to address issues such as inclusion and healthcare workers safety, among others. This component would support rebuilding community and citizen trust that can be eroded during crises. It would also include community-based animal disease surveillance and early warning networks. It would support the establishment at the community level of early warning systems to support a robust emergency reporting and feedback system against notifiable diseases. A critical objective of this sub-component would be to improve the commitment of all participants of the “epidemiological surveillance networks”. Country projects would support training for animal health workers, and treatment of infected animals and reporting procedures. Farmers, extension professionals, and paraprofessionals would receive hands-on training in detection of clinical signs. Country projects would also provide basic biosecurity equipment such as sprayers and protective equipment. Other activities to be funded include: (i) improving animal health information flow among relevant agencies; (ii) detection, reporting and follow-up of reported cases; (iii) public veterinary surveillance networks; (iv) routine serological surveys; (v) event-based and epidemio-surveillance; and (vi) improving diagnostic laboratory capacity. Participatory methodologies involving farmers, para-veterinarians, and community workers, would be used extensively, given the fact that the major control targets are the small-scale and semi-commercial poultry production systems. Disease surveillance activities would be planned and implemented jointly with the public health personnel in accordance with OIE standards and guidelines.

47. In many regions of the world, the smallholder sector has little or no access to animal health services and is highly exposed to the consequences of an epidemic. Globally, 640 million smallholders and 190 million pastoralists



raise livestock. Smallholder livestock keepers make up 70% of the world's poor. This component would support low-income population by: (i) improving animal health services at the village or community level by means of organizing community-based early warning networks, utilizing the existing pool of para-veterinary village workers (specific guidelines have been issued by OIE to fully integrate these human resources in the Veterinary Services system); (ii) increasing farmers' general awareness through simple biosecurity guidelines on animal disease control using publications in local languages; (iii) providing grants for direct compensation and/or for cost-sharing of vaccination campaigns, which some countries may not be able to afford through their own budgetary resources; and (iv) supporting farmers' groups and/or associations to help improve awareness and dissemination of information.

Component 5: Implementation Management and Monitoring and Evaluation

48. Project Management. Support for the strengthening of public structures for the coordination and management of the individual country projects would be provided, including central and local (decentralized) arrangements for coordination of activities, financial management and procurement. Existing coordination structures operating in the sector ministries/agencies or working to support Bank-financed operations in the agriculture/livestock/health sectors would be entrusted with coordination of project activities, as well as fiduciary tasks of procurement and financial management. The relevant structures will be strengthened by the recruitment of additional staff/consultants responsible for overall administration, procurement, and financial management under country specific projects. To this end, under this component, funding would be available to cover costs associated with project coordination.

49. Monitoring and Evaluation (M&E). This component would support monitoring and evaluation of prevention and preparedness, building capacity for clinical and public health research, including veterinary, and joint-learning across and within countries. This sub-component would also support training in participatory monitoring and evaluation at all administrative levels, evaluation workshops, and development of an action plan for M&E and replication of successful models.

50. The Program will include a monitoring and prospective evaluation framework for the overall facility and for operations at the country and sub-regional or regional levels. The approach will include baseline assessments, benchmarking, rapid learning, and multi-country analysis to inform tactical adaptations within and across countries. The monitoring and prospective evaluation framework will focus on: (i) strategic relevance to the near-term support for disease outbreak detection and response, with clarity of pathways from WBG contributions to the expected outcomes; (ii) client responsiveness; (iii) WBG capacity to sustain client efforts to prevent future outbreaks of emerging infectious diseases; and (iv) timeliness and agility of co-convening functions with country policymakers and strategic partners who complement the WBG's comparative advantages. For operations at the country and sub-regional or regional levels, the monitoring and prospective evaluation will provide a menu of options to be customized for each operation, together with performance benchmarks. The indicators will include those for: (i) measuring elements of emergency COVID-19 response; (ii) strengthening national institutions for policy development and coordination of multisectoral prevention and preparedness activities; (iii) enabling regional, national, and sub-national estimates and projections of equipment and supplies for disease prevention, detection, response and recovery requirements; building regional and national capacity for biomedical, clinical, and public and veterinary health research and technical resource networks; and (iv) building systems to perform disease surveillance at the community level.

Component 6: Contingency Emergency Response Component (CERC)

51. Country specific phases (or projects) under the Program could include a CERC component under which recipients of financing, following an eligible crisis or event, may request the Bank to re-allocate project funds to support additional emergency response. This component would draw from uncommitted resources under the



project from other project components to cover an emergency within the COVID-19 context, if applicable. CERCs can be activated without needing to first restructure the original project, thus facilitating rapid implementation. To facilitate a rapid response, formal restructuring would be deferred for three months after the CERC is activated.

52. The above description is provided for the Program with the expectation that all countries under the Program would have similar needs, typically related to component 1. Based on initial and expected country requests, the categories of support needed for COVID-19 surveillance, prevention and control, and case management, may include the following: (i) Technical assistance: updating or reviewing national plans and costs, specialized health human resources to be deployed at ports of entry/exit, and expertise for development and conduct of training of front-line responders; (ii) Goods and Services: materials for disease surveillance (sample collection and diagnostics, including viral transport medium, secure transport containers, sharps container boxes); personal protective equipment (PPE) at triage (gloves, masks for health workers and patients); clinical management (oxygen concentrators, tubes, portable ventilators, pulse oximeter, laryngoscope, tubes, ultrasound, non-heating humidifiers, nasal prongs, catheters, etc.); PPE in facilities (scrubs, aprons, fit testers, goggles, biohazard bags, chlorine, protective goggles, single-use gowns, alcohol-based hand sanitizer, soap, hand drying paper towels, etc.); ambulances for patient transportation; (iii) vaccines and therapeutics, when available; (iv) civil works, establishment/refurbishments of isolation wards and intensive care units in hospitals and other facilities associated with the COVID-19 response.

B. Program Beneficiaries

53. It is expected that projects under the Program would benefit the population at large given ongoing community spread (a situation where some people are being infected and it is not known how or where they became exposed). It is estimated that, on average, each infected person spreads the infection to an additional two persons. The Program would benefit in particular: (i) infected people; (ii) the elderly and people with chronic health conditions, who are at higher risk of getting very sick, hospitalized or even dying from COVID-19; (iii) people in long-term facilities who are also at risk of severe health consequences if they become infected; (iv) medical and emergency personnel, as well as; (v) medical and testing facilities, and (vi) public health agencies engaged in preparedness and response efforts in participating countries, since their capacity would be strengthened with the support of country projects.

C. Role of Partners

54. The Bank and the international community will play a key role in the response to COVID-19 following the technical lead of WHO, especially at the country level to develop an overall framework to guide national action plans that can be the basis for government and donor support. Such a framework should address both animal and public health aspects as well as economic impact. Many of the investments needed to address this disease are core public health and animal health functions that are considered “global public goods”, thus, necessitating a global and regional response with support from the international community. Where appropriate, the Bank and partners will seek joint opportunities to help countries.



D. Lessons Learned³⁰

55. The World Bank response draws upon lessons learned from past Bank responses to recent global crises and outbreaks, including HIV/AIDS in the early 2000s, the SARS outbreak in 2003, the Avian Influenza and Food Security crises in 2006 and 2008, and more recently, the West Africa Ebola emergency in 2014-2015, and the Ebola outbreak in the Democratic Republic of Congo in 2019. Lessons include:

- **The flexibility of the Crisis Response Window and country projects were critical.** In the case of Ebola, the Bank allowed for a special exception to the CRW eligibility criteria to support a regional emergency operation and additional financing, followed by post crisis initiatives in the areas of health, education, social safety nets, and infrastructure. Subsequently, health outbreaks/epidemics were included and approved as eligible events to be funded under the CRW, obviating the need for seeking special exceptions to access the CRW. Complementary support was also provided through the restructuring of projects. In the case of IFC, the Ebola Emergency Liquidity Facility provided an immediate response to the Ebola outbreak in West Africa. The facility provided IFC clients with liquidity for their working capital to maintain trade flows, support employment, and restore supplies of key goods and services. In the case of the food crisis, a temporary facility – the Global Food Crisis Response Program – was also critical in helping a broad set of clients address the spike in food prices, reaching a total of 49 countries.
- **Rapid preparation of projects risks lowering quality at entry, but recent experiences suggest this risk may be mitigated through partnerships.** The CRW reduced the average time to project delivery for public health emergencies to 3.5 months from concept review to first disbursement (within two months for the Yemen additional financing). While this can pose challenges to ensure quality at entry, evaluations of CRW operations have identified partnering with UN institutions as a factor mitigating this risk because of the specialized knowledge to quickly and successfully implement project support – other features contributing to better project performance were careful instrument choice and good project design. IPF accounted for 86 percent of CRW commitments, of which about half were additional financing, which could leverage existing operational arrangements. A key lesson on good project design is the inclusion of analytic work and client capacity building support. In contrast, earlier projects tackling Avian influenza had lower performance due to issues of quality at entry. During the avian influenza partnering was extremely difficult because of challenges around Bank funds flowing to UN agencies.
- **Real time monitoring of behavioral change messages and other key interventions to prevent and control infection is needed to ensure they are achieving the intended results.** Successful response to public health crisis requires communication with key groups on hygiene and control and these communication strategies require regular assessment to both determine their relative effectiveness and to inform any necessary course correction. Experience from the Avian Influenza Program suggests that assessing the impact of communications and public awareness activities is important to assess the extent to which the public changes its behavior. In

³⁰ See the following World Bank Independent Evaluation Group (IEG) evaluations:

(2014) The World Bank Group and the Global Food Crisis And Evaluation of the World Bank Group Response

<http://documents.worldbank.org/curated/en/543311468323944900/pdf/The-World-Bank-Group-and-the-global-food-crisis-an-evaluation-of-the-World-Bank-Group-response.pdf>

(2013) Responding to Global Public Bads Learning from Evaluation of the World Bank Experience with Avian Influenza 2006-13

<https://openknowledge.worldbank.org/bitstream/handle/10986/24131/Responding0to00an0influenza02006013.pdf?sequence=1&isAllowed=y>

(2018) World Bank Group Support to Health Services: Achievements and Challenges

https://ieg.worldbankgroup.org/sites/default/files/Data/Evaluation/files/WBG_Support_Essential_Health_Services.pdf

(2018) Liberia's Completion and Learning Review <http://documents.worldbank.org/curated/en/843731544238101948/pdf/CLRR-for-Liberia-to-Board-Nov-13-2018-11152018-636798168966300821.pdf>

(2019) IDA's Crisis Response Window: Lessons from IEG Evaluations. Synthesis Report

https://ieg.worldbankgroup.org/sites/default/files/Data/reports/syn_idacrisisresponse.pdf



Ebola, the training of health workers on Infection Prevention and Control was critical, but successful outcomes required those protocols to be consistently practiced.

- **Successful disease monitoring and disease surveillance systems need support of grassroots networks to report cases and trace disease contacts.** In the case of Avian influenza, poor relationships between government and grassroots networks in some countries meant that information was not reported for disease monitoring and surveillance. This reduced the effectiveness of investments into the formal institutional platforms in some countries. In the case of Ebola, the mobilization of civil society groups was essential to communicate information on the disease and to trace contacts, as were cellular telephones. During Ebola, contact tracing was rigorous and most identified contacts were monitored in isolation. Local staff and existing infrastructures were used in innovative ways. For example, Mali used medical students with training in epidemiology to increase staff numbers for contact tracing, which was a key first step in controlling the epidemic, together with monitoring and rapid isolation of potentially infectious contacts.
- **While country projects are at the core of the response, coordinated response across countries may strengthen performance.** Disease control and public health functions are handled largely through national institutions. All available evidence from past public health emergencies show the importance of supporting the client country's own systems for emergency preparedness, response, and recovery systems. However, during Ebola, the World Bank was the member of a coalition, led by WHO, that worked across countries in West Africa from 2014-2015 to fight the virus outbreak. The coalition prepared a coordinated plan to contain the Ebola outbreak, and the Bank quickly restructured ongoing health projects, together with the African Development Bank, just 28 days after the WHO declaration of the public health emergency. The coalition also enabled technical coordination of knowledge and skills across West African countries to prevent and control the transboundary spread of the disease. After Ebola, the Africa Centers for Disease Control and Prevention (CDC) was set up as a regional network to strengthen the continent's public health institutions and response to disease threats and outbreaks. In contrast, during Avian influenza there was a limited effort to encourage intercountry cooperation at the regional level, such as sharing of data, samples, and technical resources (such as advanced laboratory facilities).
- **Support to technology and equipment needs to be balanced with investments in human resources and knowledge to support laboratory diagnostics.** There is a risk of over-investing in infrastructure and equipment. Most Avian influenza projects aimed to improve laboratory capacity through facility upgrades, equipment purchases, and training. Technical training of health workers and systems for knowledge sharing and communication may be the most important and rapid way to build this capacity. Laboratory upgrades usually proved to be more complex, expensive, and time consuming than initially projected. Laboratory training and diagnostic capacity building could be supported by existing active regional and country projects, where practicable, for more rapid response.
- **Anticipate procurement challenges.** A major driver of implementation delays of Bank projects during the Avian influenza epidemic was the difficulty in procurement processes, particularly for laboratory equipment. The main challenge was procurement being cancelled and re-procured, because of, for example, overly narrow specifications for technical equipment.

56. Lessons for medium-term response include:

- **Strengthen the preparedness plans and frameworks of countries with weaker health systems.** Preparedness of the health system is the first line of defense. This was a main recommendation of the IEG health services evaluation. Bank performance in pandemic preparedness and control has improved with successive outbreaks but the Bank has typically not mainstreamed pandemic preparedness in its country operations. Stronger health



systems could have helped mitigate the spread of Ebola. The outbreak affected not only Guinea, Liberia, and Sierra Leone, but also Mali, Nigeria, and Senegal. The latter countries could mount a more effective response because of better staffed health services, protective equipment, laboratory diagnosis, clinical management, and disease surveillance for quick diagnosis and rapid contact tracing.

- **It pays to invest in prevention.** A key lesson from the Global Program for Avian Influenza Control and Human Pandemic Prepared and Response in 2006 is that it pays to invest in prevention, in all the countries that request help, no matter the severity of a crisis or its geographical footprint. The public health and economic benefits were substantial both to the borrowing countries and to the world. At the same time, another lesson from that time is more sobering: the window of opportunity to decisively act in putting in place robust systems for preparedness and prevention eventually ended when the emergency was declared over, and the world's attention diminished. The Program seeks to mitigate this risk by adopting a One-Health approach and explicitly incorporating a medium-term perspective into its menu of support, to shift attention from response to prevention.
- **If a vaccine or efficacious antiviral becomes available, purchasing it for use by health workers or other vulnerable persons could be valuable but logistics issues are key.** While an efficacious antiviral or vaccine is not currently available for Coronavirus, this may change over the medium term with international efforts. The Avian influenza experiences show the importance of logistics management of these supplies to ensure value added use of scarce funds, and access to vulnerable persons. Antiviral drugs have a limited shelf-life and in the case of Avian influenza large stockpiles of purchased drugs went unused even during outbreaks.
- **As broader macro-fiscal impacts are likely to emerge both the speed and sustainability of any compensating mechanisms need to be considered.** The Bank has been able to assist countries better targeting the most vulnerable in other emergency situations, like the food and fuel crisis. In that case, leveraging existing conditional cash transfers which had been set up for other purposes was a particularly effective way of channeling resources quickly. At the same time ensuring the sustainability of responses was one of the explicit objectives, and success factors, of the Global Food Crisis Response Program.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

57. Given the context of the COVID-19 pandemic, the implementation and supervision of Program-supported country operations will take place under extraordinarily challenging circumstances. Under the Program supported country projects and regional organizations, existing coordination structures operating in the sector ministries/agencies or working to support Bank-financed operations in the health sector will be entrusted with coordination of project activities supported by individual country projects, as well as fiduciary tasks of procurement and financial management. The relevant structures will be strengthened, if required, by the recruitment of additional staff/consultants responsible for overall administration, procurement, and financial management under country specific projects.

58. Hence, coordination would build on existing arrangements, facilitating close coordination and collaboration between the human and animal health sectors. Arrangements are also needed at both regional and global levels to achieve global alignment and harmonization at a working level among the interested parties; facilitate information exchange among these parties; set global and technical standards; and prioritize activities against the broader objectives of the overall partnership. Finally, there is also a need for a high level of coordination to address key



issues around aligning global strategies, tracking progress against key indicators, identifying gaps and blocks, and providing the impetus to drive forward ways to overcome such blocks.

59. Box 2 shows the implementation arrangements which have been put in place by the Bank to ensure systematic coordination of activities for COVID-19 pandemic response.

60. **Supervision Arrangements Under the Program.** As with project preparation, implementation support by the Bank during implementation of country projects will be coordinated as much as possible with all multilateral and regional agencies that are active in this area. When appropriate, a division of labor between the different international and local agencies will be agreed taking into consideration the comparative advantage of each of them. This will avoid a piecemeal approach to helping and help build a common strategy for each of the countries. It will also be done with the intention to draw on the expertise of each agency and avoid duplication of investments and efforts. Implementation support by the Bank will focus on internal coordination with the various departments/units to ensure that we all work together towards a common objective, to help our countries fight the disease in the most efficient and effective manner.

61. Given that COVID-19 related quarantines and social distancing measures will impact the supervision of these emergency operations for at least the immediate-term, the Bank will be utilizing innovative approaches to supervision. These approaches will build upon measures developed for the supervision of projects in high-risk Fragility, Conflict, and Violence (FCV) environments, and will be further adapted to address the supervision constraints posed by the COVID-19 epidemic. With respect to effective information and communications technology (ICT), the Bank is scaling up fit-for-purpose and cost-effective ICT methods to contribute to effective project implementation and supervision in access-constrained environments. The recently launched Geo-Enabling initiative for Monitoring and Supervision (GEMS) supports project teams to use ICT solutions to enhance monitoring and evaluation; remote supervision, real-time safeguards monitoring and portfolio mapping and coordination. GEMS has met with widespread demand from clients and WBG country teams and has been implemented across 10 CMUs covering about 65 WBG-funded projects. This has provided teams operating in FCV settings such as Burundi, DRC, Myanmar, Northern Mali, Northeast Nigeria, Pakistan and South Sudan with sustainable real-time insights into dynamics in the field. This has been crucial for enhancing the Bank's reach, operational effectiveness and delivery of development outcomes to vulnerable populations. In Mali, an Iterative Beneficiary Monitoring approach was developed to support project implementation and supervision to adapt and course-correct using local knowledge, small samples, and phones where available.

62. The Bank also has expanded its approach to supervision in FCV contexts through Third-Party Monitoring (TPM). In FY18, the Bank conducted the first systematic review of TPM, consulting with 70+ staff from 16 units to gather data on implementation models, costs, best practices, risks and benefits. The Bank has so far elicited 16 contracts for TPM in seven countries (Afghanistan, Pakistan, Iraq, Yemen, Cameroon, South Sudan, and Somalia) totaling US\$51.5 million; 96 percent are financed by trust funds and only 4 percent from Bank Budget (BB). At an average contract cost of US\$2 million for 3 years, TPM is far costlier than the average annual BB allocation (US\$200,000). TPM presents opportunities but also challenges, ranging from increased access to insecure areas to potential conflicts of interests among others. To help teams navigate this process, the Bank is developing practical guidance and is piloting portfolio-wide TPM approaches to increase efficiency and improve economies of scale and knowledge sharing across operations. These lessons can further inform appropriate supervision approaches for COVID-19 emergency operations, which likely will differ both between and within countries in the different regions.

63. In addition, the Bank will establish an implementation support group led by the Operations team (Regions/Global Practices) and include necessary units including OPCS, WFA, LEG and others, as needed. This implementation support group will monitor implementation of the individual projects and keep Bank Management



and the Board of Executive Directors informed. In addition, a Procurement and Financial Management “SWAT Team”, including GGH, OPCS, WFA, DFI, LEG, Regions, EFI will be set up to coordinate and support implementation of projects under the Program to monitor real time procurement under the country projects, including Bank-facilitated procurement.

64. **Activities involving Military and Security Forces.** Under Operational Policy 8.00 (Rapid Response to Crises and Emergencies), the Bank may assist “all borrower agencies and institutions” involved in an emergency response within the areas of its core competencies (e.g., support for infrastructure, public financial management, and capacity building).³¹ The Bank has experience with implementing projects in humanitarian crises and in insecure conflict-affected areas that include certain activities undertaken by security or military forces unrelated to any strategic or security objectives. For instance, in 2010, following the devastating floods in Pakistan, the Bank financed fuel required for rescue operations undertaken by military aircraft. More recently, in Cameroon, the Bank financed road construction in an active conflict zone by the Army Corps of Engineers as no private contractors were available.

65. Member countries may seek the Bank’s assistance for certain COVID-19 activities carried out by security or military forces, such as the procurement and distribution of medical supplies and drugs or the construction of treatment centers and isolation rooms. Given both the necessity to resort to military support in responding to the public health emergency of COVID-19 in all countries, and the risks associated with such use of the military including possible abuses, the Bank will undertake, when and as reasonably feasible, a rapid assessment of relevant factors and include appropriate environmental and social risk mitigation measures reflected in relevant operation’s documents. Staff will be provided with guidance on such assessments and supervision of activities involving military and security forces.

³¹ (n1) OP 8.00 paragraph 5.



Box 2. The Program and the Bank's COVID-19 Task Force

The implementation of the Program will be supported by the Bank-wide COVID-19 Task Force and Emergency Operations Center (EOC), which is already established to enable the institution's global emergency response coordination to the COVID-19 pandemic. The overall MPA Task Team Leader and the sub-project task team leaders are the members of the Task Force.

One-Stop-Shop Expertise. The Task Force is a technical-level World Bank-wide group that provides timely operational, technical, and implementation support to our country teams and our clients. It is comprised of technical expertise from across the World Bank's General Management Units and Practice Groups.¹ The Task Force includes three sub-groups: (1) Regional Task Teams from the Health, Nutrition, and Population Global Practice; (2) Technical Focal Points from DFI, OPCS, LEG, and SD-Safeguards, who provide just-in time support as our task teams respond to country requests for emergency financing; and (3) Sectoral Focal Points from other Global Practices, including Education; Social Protection and Jobs; and Agriculture and Food. The Task Force meets weekly. A sub-set of the Task Force (the Regional Task Teams and representatives from the Technical Focal Points) meets daily. The specific roles of the Task Force include to: (i) provide effective, cross-sectoral, technical-level coordination, both internally and externally, to ensure timely response and reporting to the GCRP through its secretariat; (ii) develop further substantive content and provide timely technical and operational support to the country teams for the new fast-track facility; (iii) facilitate efficient, wholesale resolution of technical and operational bottlenecks in a streamlined manner; and (iv) continue with the current daily updates on the outbreak and facilitate information flows on status of Bank's operational responses.

Just-In-Time Operational Support. The Task Force is supported by a just-in-time EOC, comprised of core staff members and consultants of the Health, Nutrition, and Population Global Engagement Unit possessing experience and expertise gained from dealing with prior pandemics and outbreaks. The EOC tracks, coordinates, and accelerates in a timely and transparent manner all COVID-19 related information and requests. It has been organized around four workstreams:

- Data & epidemiology
- Operational support
- Internal/external communications
- Knowledge management

The EOC convenes daily calls for the Regional Task Teams to share updates/help resolve questions. The EOC documents all incoming questions in an FAQ Tracker and aims to resolve these incoming questions within a 24-hour period. The EOC has also launched and maintains an *internal platform* that serves as a central landing page for key operational templates, technical guidelines, and policy briefs. The EOC circulates daily the latest FAQ Tracker and a summary of on-going work.

Governance. The Task Force and EOC are governed by a director-level Steering Committee that guides the work of the Task Force. It is chaired by the Global Director for Health, Nutrition, and Population and the GFF. Membership includes the Task Team Leader for the overall MPA operation; HD Regional and Global Directors; the Agriculture and Food Global Director; directors from OPCS and DFI; and advisers from the Health, Nutrition, and Population Global Practice.

Global Coordination & Partnerships. The Task Force and Steering Committee work closely with external partners, including WHO, UNICEF, MDBs, OIE, IMF, and others, to contribute to global coordination efforts across critical areas beyond the immediate health response and medium-to-long term preparedness efforts. Emerging areas include:

1. Monitoring impact of the pandemic and outlining options for practical policy actions that countries may consider in response to health, social and economic consequences in a coordinated manner, alongside the UN Crisis Management Team, which had asked Bank to coordinate its working group in this area.
2. Mapping the pandemic supply chain situation and identifying bottlenecks and opportunities for creating solutions for public and private sectors in responding to the COVID-19 outbreak. This may include limited direct purchase, storage and distribution using existing entities such as UNICEF or WHO.
3. Exploring development of multi-lateral mechanism for financing global public goods, such as for research and development of vaccines, diagnostics and therapeutics. This is to potentially solve speed, scale and global access challenges. The Bank is in discussions with the Coalition for Epidemic Preparedness Innovations (CEPI), WHO, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), and the Global Vaccine Alliance (Gavi) along these lines.

Footnote 1: Development Economics; Development Finance; Legal; Operations, Policy and Country Service; Equitable Growth, Finance and Institutions; Human Development, including the Health, Nutrition and Population, Education and Social Protection and Jobs Global Practices; Infrastructure; and Sustainable Development, including the Agriculture and Environmental and Social teams.



Key Factors Affecting Design and Implementation of the Program and Waivers

66. Given the emergency conditions, Management identified a few additional areas that would benefit from narrow and targeted waivers on issues within the authority of the Executive Directors, to enable a more agile and timely delivery of Bank financing under the SPRP, while ensuring compliance with substantive fiduciary, environmental and social requirements and standards.

(i) **Flexibility to enable Management approval of individual projects under SPRP rated Substantial for Environmental and Social (ES) risks.** The Bank's extensive experience in helping countries address global, regional and national health emergencies, such as Ebola, SARS, and MERS equipped us with a solid knowledge and ability to identify four main types of environmental and social risks that require close attention and effective mitigation as part of a pandemic response to COVID-19. These are: (i) risks revolving around proper management of medical waste generated by the outbreak; (ii) risk of exposure to medical and health care workers and a wider swath of the professional and civic community; (iii) the need to protect the vulnerable and the disadvantaged by ensuring their access to project benefits and safeguarding them from a risk of further stigmatization and abuse; and (iv) inadequate public engagement and lack of adequate consultation that contribute to inadequate disease prevention and control. Based on lessons and experience, we have a solid knowledge and ability to embed the use of the tools and measures most appropriate to address these four types of risks, with any adaptations that may be needed as we learn more about the nature and impact of COVID-19 relating to these risks. Given the commonality of risks and approaches for their management and mitigations across all projects under the SPRP, and to maximize the speed and urgency of the Bank's financing, we propose that Executive Directors approve a partial waiver to enable Management to approve individual SPRP projects of \$100 million or less that are rated *Substantial* for ES risks.³² Future projects under SPRP classified *High* for ES risks will be submitted to the Executive Directors for approval on absence of objection basis. Such projects will include those which represent a risk of significant adverse environmental risk or impact.

(ii) **Flexibility in application of Anti-Corruption Guidelines to Bank-financed procurement where retroactive financing is used.** Consistent with the Bank's procurement policy, all contractors, suppliers and consultants receiving financing under SPRP projects will have to comply with the Bank's Anti-Corruption Guidelines (ACGs). This means that the Bank will be able to audit, investigate (through INT) and sanction such contractors if they are determined to have engaged in fraud and corruption. These requirements will equally apply to retroactive financing under SPRP projects, which can finance eligible contracts concluded by the borrower prior to effectiveness of such projects, if they comply with the Bank's procurement requirements. To qualify a given contract for such retroactive financing, a borrower must ensure that it is subject to ACGs (which may require the borrower to amend the contract concluded with the winning bidder). However, it would not be possible for the borrower to extend the application of ACGs to losing bidders with whom it has no relationship once the contract is awarded to someone else. (When the bidding is carried out under the Bank's procurement rules, ACGs extend to all bidders participating in the process, not just the winning bidder; this enables INT to investigate allegations of collusion among bidders etc.). A limited waiver with respect to the application of ACGs to such losing bidders is therefore required.

IDA Waivers

(iii) Although implementation of projects under the SPRP is expected to be through government systems of recipient countries, there are a selected few country contexts where implementation is likely to require

³² Projects under the Program that are rated Low or Medium ES risks are approved by Management under the IPF Policy.



working through third parties. Based on the unique and urgent circumstances of the SPRP, and consistent with a number of past precedents where waivers were granted to operations in FCV contexts such as Yemen, Somalia, and South Sudan, several IDA waivers are needed to be able to maximize the effectiveness of IDA resources and achieve the SPRP development objectives.

67. With respect to third parties (such as UN Agencies, INGOs, and regional organizations which IDA has experience working with):

a) A waiver of the Crisis Response Window (CRW) eligibility criteria, to allow CRW financing to flow directly to third parties and on all grant terms, and the waiver of the application of the IDA Commitment Charge to such third parties for the duration of the SPRP.

b) For projects in areas where the Bank does not have a physical presence, such as in countries in active conflict, or where country capacity is insufficient to implement the urgent activities under the SPRP, the following waivers:

- i. application of the criteria related to eligible recipients of funding under the policy relating to IDA;
- ii. application of the IDA Commitment Charge to such third parties for the duration of the SPRP;
- iii. application of the Anti-Corruption Guidelines³³; and
- iv. the requirement that IDA financing terms be the same as those for IDA country allocations, and instead be on all grant terms.

c) For countries receiving IDA Transitional Support, waiver of first-year commitment fee with respect to IDA Transitional Support, consistent with the waiver approved under the Fast Track Facility for IBRD projects processed under COVID-19 Response. This would be consistent with these borrowers not having access to IDA's concessional windows.

B. Results Monitoring and Evaluation Arrangements

68. Monitoring and evaluation (M&E) activities related to country projects supported under the Program will be the responsibility of the coordinating structures, with the participation of the relevant implementing agencies in each participating country. Depending on the specific situation in each case, these activities could be carried out by the regular staff of the agencies (with technical assistance) or by contracting out these functions with specialized agencies/institutes when appropriate. For individual countries, detailed information on the M&E capacity of the relevant implementing agencies and their specific responsibilities for M&E under the project should be described in project documents. Each individual operation will have its own set of objectives, targets, benchmarks, and key performance indicators (determined by specific country contexts and capabilities) to monitor progress and to report results in accordance with Bank's policies. There will be heavy burden on countries and institutions to put in place effective M&E systems. Also, implementation capacity will vary widely between countries related to human, financial, and technical resources. Governments and institutions are also likely to be overwhelmed with response activities that fall outside the Program. In this context, it would be important to build on systems and arrangements established under ongoing health projects, not just Bank-financed, but seek opportunities also outside Bank-financed projects.

C. Sustainability

69. Critical to the sustainability of country projects under the proposed Program would be the continuous ownership of response by the various stakeholders, coupled with strong political support and the availability of an

³³ Agreements with UN agencies include requirements that make them consistent with the Bank's ACGs.



adequate flow of financial resources to carry out country projects. In addition, institutional sustainability would be ensured by: (i) strengthening communication activities to maintain public awareness of the threat of COVID-19 and other rapidly spreading infectious diseases; (ii) sustained disease surveillance and prevention and control activities, particularly in high risk regions; (iii) strengthened country capacity to manage at national and local levels the risk factors associated with the spread of COVID-19 and other infectious diseases; and (iv) effectiveness of activities to control the spread and mitigate the impact of COVID-19 and other zoonotic diseases from animals to the general population.

IV. PROGRAM APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

70. Although there are very significant gaps in knowledge of the scope and features of the COVID-19 pandemic, it is apparent that one main set of economic effects will derive from increased sickness and death among humans and the impact this will have on the potential output of the global economy. In the Spanish Influenza pandemic (1918-19) 50 million people died - about 2.5% of the then global population of 1.8 billion. The most direct impact would be through increased health care costs, particularly hospital stay costs, and the risk of impoverishment for vulnerable population groups with limited access to health services or lack of financial health protection, who may have to incur high out-of-pocket payments to obtain needed medical care. Available data from the United States, shown in table 1, broadly describe the estimated average cost for possible procedures that might occur for COVID-19 treatment and the significant disparity between people with health insurance and those who lack insurance or have limited access to publicly-funded health services. For people with health insurance who have met the required deductible, they would need to pay only the co-pay or co-insurance, while the insurance plan would pay the remaining balance. In the case of people without insurance, they would have to pay 100 percent of the price of COVID-19-related medical costs, which could set a patient and his/her family back financially. Since health systems, financial protection arrangements, and medical cost structures vary from country to country, the data presented are for illustrative purposes only. However, it should be clear that in countries without universal health coverage, the financial impact of COVID-19 on the population, particularly low-income groups, could be significant or even catastrophic. In terms of indirect economic costs, the loss of productivity due to COVID-19 may be significant. In normal influenza episodes, for example, these indirect costs have been estimated to be ten times larger than all other costs combined.

Table 1. Average cost for COVID-19 treatment in the United States

Procedure	Non-Insured / Out-of-Network	Insured
CBC Blood Test	\$36	\$11
CMP Blood Test	\$58	\$16
Flu Testing: A Virus	\$43	\$16
Flu Testing: B Virus	\$43	\$16
Office Outpatient Visit: 15 Min.	\$149	\$74
Office Outpatient Visit: 25 Min.	\$222	\$110
Office Outpatient Visit: 40 Min.	\$327	\$161
Global Urgent Care Visit	\$239	\$129
ER Visit: Moderate Severity	\$441	\$169
ER Visit: High/Urgent Severity	\$708	\$280
ER Visit: High Severity & Threat	\$1,151	\$443
<i>Source: FAIR Health/CPT @2018 AMA in Business Insider</i>		



71. Another significant set of economic impact will result from the uncoordinated efforts of private individuals to avoid becoming infected or to survive the results of infection. The SARS outbreak of 2003 provides a good example. The number of deaths due to SARS was estimated at “only” 800 deaths and it resulted in economic losses of about 0.5% of annual GDP for the entire East Asia region, concentrated in the second quarter. The measures that people took resulted in a severe demand shock for services sectors such as tourism, mass transportation, retail sales, and increased business costs due to workplace absenteeism, disruption of production processes and shifts to more costly procedures. Prompt and transparent public information policy can reduce economic losses.

72. Other economic impacts are those associated with governments’ policy efforts to prevent the epidemic, contain it, and mitigate its harmful effects on the population. These policy actions can be oriented to the short, medium or long-term or, in spatial terms to the national, regional or global levels.

73. In addition to its heavy health and human toll, the coronavirus outbreak further clouds an already fragile global economic outlook and can further set back the fight against poverty. Potential tightening of credit conditions, weaker growth and the diversion of expenditures to fight the outbreak are likely to cut into government revenues and governments’ ability to invest to meet education, health and gender goals. The poor stand to be hit particularly hard due to loss of jobs and income. Current estimates suggest that a one percent decline in developing country growth rates traps an additional 20 million people into poverty.

74. The outbreak weighs on economic activity through both demand and supply channels. On the demand side, activities involving face-to-face interaction are heavily affected. On the supply side, prevention measures, such as factory closures have significantly disrupted production of tradable and non-tradable goods across the country.

B. Fiduciary

75. Considering the urgency of the response, processing of operations will be accelerated. Documentation will be based on simplified project templates for operations under the WB COVID-19 Response. Since project rationale, results framework, and components are expected to be similar across projects, teams will prepare a streamlined, short and focused PAD.

(i) Financial Management

76. Financial Management (FM) under the Program will be carried out in accordance with the Bank Directive: Financial Management Manual for World Bank Investment Project Financing (last revised in February 2017) and documented in accordance with the World Bank’s Guidance: Preparing the Project Appraisal Document (PAD) for the Multiphase Programmatic Approach (MPA) Using Investment Project Financing (IPF) (issued May 2018).

77. Flexible FM arrangements, modeled along those allowed under emergency operations, will be applied to the Program. Streamlined procedures to expedite decision making and approval of FM exceptions under country projects would be agreed for implementation. For operations engaging UN agencies, the FM arrangements are based on the Financial Management Framework Agreement (FMFA) which includes the Single Audit Principle.

78. The agencies defined in each country project will be responsible to maintain adequate financial management arrangements. The key FM risks pertaining to the implementation of the proposed country projects, together with the residual FM risk rating will be noted in the PAD for the individual country projects and will be updated during implementation.

79. **Disbursement.** The intention is to disburse the largest share of this operation within the next 12 to 18 months. The speed of disbursements will be significantly influenced by the availability of medical supplies. As countries get a clearer picture of the supplies of medical goods and equipment over the next few months, updated disbursement schedules will become available.



(ii) Procurement

80. Procurement under the Program will be carried out in accordance with the World Bank's Procurement Framework. Procurement by countries will follow the World Bank's Procurement Regulations for IPF Borrowers for Goods, Works, Non-Consulting and Consulting Services, dated July 1, 2016 (revised in November 2017 and August 2018). The projects will be subject to the World Bank's Anticorruption Guidelines, dated October 15, 2006, revised in January 2011, and as of July 1, 2016. Countries will use the Systematic Tracking of Exchanges in Procurement (STEP) to plan, record and track procurement transactions.

81. The major planned procurement across countries is expected to include: (i) medical/laboratory equipment and consumables, (ii) personal protective equipment (PPE) in facilities and triage, (iii) clinical management equipment, (iv) refurbishment and equipment of medical facilities, (v) technical assistance for updating or reviewing national plans and costs, (vi) human resources for response, and (vii) expertise for development and training of front-line responders. Country projects will prepare streamlined project procurement strategies for development (PPSD). Procurement plans will be agreed with individual countries.

82. Country procurement approaches will utilize the flexibility provided by the Bank's Procurement Framework for fast track emergency procurement by the countries. Key measures to fast track procurement include: (i) use of simple and fast procurement and selection methods fit for an emergency situation including direct contracting, as appropriate, (ii) streamlined competitive procedures with shorter bidding time, (iii) use of framework agreements including existing ones, (iv) procurement from UN Agencies enabled and expedited by Bank procedures and templates, (v) use of procurement agents, (vi) force account, as needed, and (vii) increased thresholds for Requests For Quotations and national procurement, among others. As requested by the borrower, the Bank will provide procurement hands-on expanded implementation support to help expedite all stages of procurement – from help with supplier identification, to support for bidding/selection and/or negotiations to contract signing and monitoring of implementation.

83. Country projects may be significantly constrained in purchasing critically needed supplies and materials due to significant disruptions in the supply chain, especially for PPE. The supply problems that have initially impacted PPE are emerging for other medical products (e.g., reagents and possibly oxygen) and more complex equipment (e.g. ventilators) where manufacturing capacity is being fully allocated by rapid orders from developed countries.

84. Recognizing the significant disruptions in the usual supply chains for medical consumables and equipment for COVID-19 response, in addition to the above country procurement approach options available to countries, the Bank will provide, at borrowers' request, Bank Facilitated Procurement (BFP) to proactively assist them in accessing existing supply chains. Borrowers will remain fully responsible for signing and entering into contracts and implementation, including assuring relevant logistics with suppliers such as arranging the necessary freight/shipment of the goods to their destination, receiving and inspecting the goods and paying the suppliers, with the direct payment by the Bank disbursement option available to them. The BFP would constitute additional support to borrowers over and above usual Hands on Expanded Implementation Support (HEIS) which will remain available. If needed, the Bank could also provide hands-on support to Borrowers in contracting to outsource logistics. Consistent with the HEIS framework, the Bank will not charge any fees for HEIS or BFP.

85. BFP in accessing available supplies may include aggregating demand across participating countries, whenever possible, extensive market engagement to identify suppliers from the private sector and UN agencies. The Bank is coordinating closely with the WHO and other UN agencies (specifically WHO and UNICEF) that have established systems for procuring medical supplies and charge a fee which varies across agencies and type of service and can be negotiated (around 5% on average.) In addition, the Bank may help borrowers access governments' available stock.



86. All the procurement approach options mentioned above remain available depending on country's preference in order to provide the most efficient and effective support to projects in the specific circumstances.

87. Procurement will be carried out by the agencies defined in each country project. Streamlined procedures for approval of emergency procurement to expedite decision making and approvals under country projects would be agreed for implementation.

88. Procurement under PforR projects will follow procurement arrangements that will be detailed in the fiduciary systems assessments for those projects.

C. Legal Operational Policies

89. Each project will identify if these policies are applicable to each individual project under the Program.

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

D. Environmental and Social

90. The management of environmental and social risks and impacts related to COVID-19 activities under the Program will be carried out in accordance with the World Bank Environmental and Social Framework (ESF), effective October 1, 2018. The scope and timing of ESF requirements will be appropriate to the nature and scale of the individual projects and their potential environmental and social risks and impacts. All COVID-19 operations will require an Environmental and Social Review Summary, Environmental and Social Commitment Plan and Stakeholder Engagement Plan and any instruments for those activities that have direct immediate high/substantial risks. To assist the borrowers and enable application of a consistent and robust approach in managing similar types of risks related to activities required to fight COVID-19, the Bank has developed templates for the instruments needed for key environmental and social risk and impacts and a menu of management tools for Borrowers to adopt and adjust to manage those first order impacts, where and as necessary.

91. This approach to ES aspects in the context of COVID-19 operations is informed by years of experience with the World Bank support for sovereign governments to address global, regional and national health emergencies, such as Ebola, SARS, MERS and now COVID-19. These situations provided the Bank with extensive experience helping our client countries classify and manage the environmental and social risks and impacts associated with public health crises. This experience tells us that for COVID-19 we can expect a similar array of E and S risks across our global operations, allowing us to consider risk in light of a commonality of approaches and how to address them, given the similarity and nature of the environmental and social risks and the commonality of approaches to their management and mitigation across all COVID-19 projects.

92. Thus, key environmental risks will revolve around properly managing, transporting and disposing the medical waste generated by the outbreak. In addition, there will be a risk of exposure to a wide range of potentially affected communities and individuals, starting with medical and health care workers, and extending from there to a wide swath of the professional and civic community. The nature of the measures taken to address these environmental risks will benefit from the experience in the medical crises described above.

93. Regarding social risks, two types tend to predominate. The first revolves around social inclusion and non-discrimination. In other words, ensuring that those most socially and medically vulnerable and disadvantaged effectively can properly share in the benefits of the project. Moreover, it is critical to ensure that the crisis does not



put the vulnerable at risk of even further stigmatization or abuse. For example, that risks of sexual exploitation and abuse, and sexual harassment (SEA/SH) are not exacerbated in the vulnerability caused by the outbreak. A second social risk revolves around inadequate public engagement and lack of adequate consultation, resulting in risk of degenerating social behavior, such as hoarding or price gouging, or the inadequate practice of, or interference with, disease prevention and control.

94. Based on lessons and experience, we have a solid knowledge and ability to embed the use of the tools and measures most appropriate to address these four types of risks, with any adaptations that may be needed as we learn more about the nature and impacts of Corona virus relating to these risks. For example, in considering the exposure risk of healthcare workers, it is noted that those exposed to the deadly Ebola suffered frequent fatalities but the mortality rate in the context of Corona virus appears to be much lower at this point. In considering how to classify project risk, it is also important, as the Environmental and Social Framework Policy dictates, to consider a range of factors. Under the ESF environmental and social risks associated with a project are classified as High, Substantial, Moderate or Low by considering more explicitly both, the social and environmental impacts as well as a range of factors that affect both the risks and the government's ability to manage them, such as borrower capacity, governance, and country context including stability, conflict and security. As a result, the same type of project in Country X could have a different rating than one in Country Y.

95. Indeed, in this context, the COVID-related role(s) and risks in using security/military forces may be significant and diverse. In line with the ESF, support is being provided to teams and borrowers to assess and address these associated risks at each country level. As a result of this myriad of factors the same type of project in Country X could have a different rating than one in Country Y.

96. In considering the likely ES risk rating of projects to specific countries under the Program, it was also considered that Bank-financed projects dealing with previous health crises have generally been rated "B" or "Substantial". Many of the countries that benefitted from the experience in carrying out these health emergency projects will now be beneficiaries of COVID-19 support. As a result of this experience and the health system capacity built at the national level, the environmental and social risks COVID projects will face, e.g., in handling medical waste, may be more moderate than in the past. We have noted that of approximately ten pandemic projects over the last several years, only two projects have been designated "A" or "High" for ES risks. For example, the Sudan Ebola response project was rated high risk due to lack of capacity and inevitable acute proximity of the health care worker population. Another pandemic response project has been rated "A" (Africa CDC Regional Investment Financing Project (P167916) for Ethiopia, Zambia and AU and was approved by the Board on December 10, 2019), due to: 1) the occupational and public health risks associated with a highly sophisticated lab in a densely populated area; 2) the risks and impacts associated with the storage, transportation, and disposal of medical wastes, notably wastewater treatment and waste incineration; and 3) the weak existing waste management infrastructure and management system.

V. GRIEVANCE REDRESS SERVICES

97. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project 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 Grievance Redress Service (GRS), please visit <http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service>. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VI. KEY RISKS

98. **Program and Country Risks.** While the Program provides fast and flexible support to countries to combat the health impacts of COVID-19, overall risk to development outcomes for the SPRP is High given the unprecedented global human, economic, and health challenges posed by COVID-19, the evolving understanding of the COVID-19 pandemic and approaches to its containment, the wide range of country circumstances, and the uncertainties surrounding global availability of the needed critical goods and capacity to fight the disease. The unique and numerous risks of the Program have been assessed and mitigated to the extent possible. Key risks to achieving the intended outcomes for the Program and corresponding mitigation measures are described below. For individual country projects under the Program, country-specific risks have been (and for projects in the next phases, will be) assessed and described in individual operations PADs, including mitigation measures.

99. The Program faces significant risks at the global level and within the individual countries supported. Globally, there are risks to the overall success of the Program. Within the Program, the risks to the success of the individual country operations will vary widely.

100. Globally, a key risk is whether the Program is fast enough and big enough to achieve its development objectives, and help countries respond appropriately to the pandemic. This is a technical design risk, which includes whether the design of the Program is flexible and scalable, tailored to individual country needs, evidence based. This risk is mitigated by enabling a rapid financing instrument and simplified processing templates and operational procedures, with technical design based on evolving international good practices. A related global risk is whether the Program design adequately incentivizes participating countries to adopt an evidence-based approach to assessing and allocating scarce resources between prevention, surveillance, and treatment. This risk is mitigated by supporting improved disease surveillance and national health systems to enable an appropriate balance in project activities based on specific country contexts. Governance risks will be mitigated by supporting projects with strong monitoring and evaluation systems, tracking that Program funding and Program-supported interventions address the needs of vulnerable groups (which includes the poor) in each country.

101. One of the main global risks to implementation is the lack of or limited knowledge that the world has about how deadly the virus is, exactly how it spreads, and how best to limit spread and reduce deaths. As the epidemic evolves and knowledge continues to accumulate, political leaders will need to have the capacity to adjust the response and adopt actions quickly (including those that may be politically difficult), to respond and mitigate the risk of contagion among the population. Fear is a critical challenge, both among the population but also in terms of its negative economic and social impact. Lessons learned from previous global responses to infectious disease outbreaks, such as the need to engage and closely work with political leaders, local communities, and private sector, will help mitigate these risks. The Program will partly mitigate this risk by helping to accelerate the flow of comprehensive data on the pandemic and appropriate responses between and within participating countries.

102. Risks to the Program's individual country operations are country-specific and will be assessed for each project. Risks common to multiple country projects are likely to include significant political and governance risks, macroeconomic risks, technical design risks, implementation capacity risks, and social risks. Political and governance risks to each country operation relate to the level of political commitment to an evidence-based set of prevention, containment, and mitigation interventions. Macroeconomic risks to each country operation relate partly to global macroeconomic risks from COVID-19, and more to the degree to which the macroeconomic situation in the



participating country enables or hinders an effective COVID-19 response. For many client countries, implementation capacity is one of the most significant risk, albeit one that varies widely depending on the strength of the country's health, social welfare, disaster preparedness and economic systems, and governance arrangements. Linked with this is the technical design risk – whether the design of the supported COVID-19 response is appropriate to the needs, capacity, and political situation in the client country. Underlying these risks is the social risk, especially the risk that the country's COVID-19 response is not adequate to respond to the threats to, or to the needs of, particular segments of the society and economy, particularly the poor, vulnerable, unemployed, (as well as to vulnerable sectors like tourism, aviation, hotels), triggering harms, unrest, etc. The Program is structured so that participating countries will comment on the robustness of the mitigation measures to buffer vulnerable populations (including specific segments of the economy like tourism, etc., as well as the unemployed and part-time workers, people without health insurance).

103. Political and governance. There are multiple sources of significant political and governance risk for this Program. As witnessed at the onset of previous major emergency responses in the past two decades—HIV/AIDS, Zika, H1N1, and Ebola, delays in timely response due to economic and social considerations occurred. The COVID-19 pandemic is an unprecedented threat - as learned from the experience of previous responses, public health must lead this response without political interference to organize and implement a timely and effective response supported under the Program. A key political risk is the commitment and ability of the authorities in participating countries to adopt proven containment and mitigation measures – especially social distancing – that can reduce the exponential growth of the pandemic. This risk is planned to be mitigated through support for strengthening the country response capacity based on the best and most current data and technical guidance from the WHO and other agencies involved in the global response. Support provided under the Program for strategic communication would help to develop clear, consistent communication from credible sources to build public trust and saves lives. There are also concerns about a risk of governance challenges in the health and other sector involved in country responses. To help address this risk, the Program would support the implementation of anti-corruption strategies and activities that have been adopted to guide the implementation of World Bank Group-funded portfolio of projects in participating countries.

104. Macroeconomic. The most significant macroeconomic risk to the Program objectives is the resilience of the country's economy to absorb the economic impact of disruptive prevention measures (e.g., social distancing) surveillance, and treatment, especially for vulnerable populations. An important way in which macroeconomic risks can affect an IPF project is through reduction in fiscal capacity of governments due to global economic disruption and slowdown. This would negatively impact public and provide allocations to fund the provision of regular health services for other health needs of the population during the COVID-19 outbreak (e.g., immunization activities, treatment for chronic conditions such a cardiovascular disease, cancer, and diabetes, as well as trauma care), as well as recurrent costs associated with project investments and activities over the medium term. The latter factor is important to consider as if not addressed would undermine essential public health structures and functions developed under the projects that are vital for countries to effectively respond to future health emergencies. As structured, the Program would minimize this risk by supporting critical public health activities, in addition to the COVID-19 response and mitigation effort. Lessons from the current global COVID-19 and its significant economic and social impact would help build the necessary political and social consensus in countries to maintain adequate funding levels to cover recurrent costs and build and sustain robust public health structures to timely detect, confirm, respond, and mitigate the risk posed by the onset and the rapid spread of infectious diseases that transcend national borders.

105. Sector policies/strategies/technical design. As described above, disease surveillance and response systems in many countries have significant weaknesses. The known epidemiological characteristics of COVID-19 underscore the



importance of improving related sector policies and strategies in many countries, including preparedness. Shortening the time from symptom onset to isolation is vital as it will reduce transmission and is likely to slow the epidemic. However, strategies are also needed for reducing household/community transmission, supporting home treatment and diagnosis, addressing the economic/social implications of quarantines (particularly for poor households). Contact tracing is of particularly high importance in the early stages of country-specific epidemics to contain spread of disease (model-based estimates for COVID-19 suggest that about 70 percent of contacts will have to be successfully traced to control early spread). Additionally, data collection and epidemiological analysis constitute essential parts of assessing the impacts of mitigation strategies, alongside on-going clinical assessments on how to best manage seriously ill patients with COVID-19, with respect to specific country capacities. Data from China, South Korea, Italy, and Iran suggest that the COVID-19 case fatality rate increases sharply with age and is higher in people with underlying chronic health comorbidities. Targeted social distancing for these groups could be the most effective way to reduce morbidity and concomitant mortality. During the outbreak of Ebola virus disease in west Africa in 2014–16, deaths from other causes increased because of a saturated health-care system and deaths of health-care workers. These events underline the importance of enhanced support for health-care infrastructure (including laboratory capacity, disease surveillance capacity, and supply chain issues) and effective procedures for protecting staff and health facility patients from infection. Operations supported under the Program will explicitly support countries to better prepared to deal with the ongoing challenge of emerging and reemerging infectious pathogens and the need for constant surveillance, prompt diagnosis, and robust research to understand the basic biology of new organisms and our susceptibilities to them, as well as to develop effective countermeasures over the short-and-medium terms.

106. Technical design. The key risk is whether the design of the supported Program-supported responses in individual countries is appropriate to the needs, capacity, and COVID-19 situation in the participating countries. This risk will be mitigated via a flexible approach and a focus on designing interventions that can be flexibly implemented as the situation unfolds.

107. Institutional capacity. For many participating countries, implementation capacity is one of the most significant risks to an effective COVID-19 response, depending on the strength of the country's health, social welfare, disaster preparedness and economic systems, and governance arrangements. This risk will be mitigated by tailoring individual country operations according to client capacity and demand. Institutional risk will also be reduced by building on existing institutional arrangements for active WBG sector operations when feasible. Under Program-supported country projects, existing coordination structures operating in the sector ministries/agencies or working to support Bank-financed operations in the health sector will be entrusted with coordination of project activities supported by individual country projects, as well as fiduciary tasks of procurement and financial management. In order to address identified risks, relevant institutional structures will be strengthened, as needed, by the recruitment of additional staff/consultants responsible for overall administration, technical guidance, procurement, and financial management under country specific projects. Particular attention will be given to the necessary cross-sectorial coordination in operationalizing One Health. Risk will be mitigated learning from Bank's previous experience (e.g., GPAI, REDISSE).

108. Procurement. To support the emergency response, country-specific projects will utilize rapid disbursement procedures and simplified procurement processes in accordance with emergency operations norms. The key procurement risk is failed procurement by countries due to lack of enough global supply of essential medical consumables and equipment needed to address the health emergency as there is significant disruption in the supply chain, especially for PPE. Other key procurement risks include Borrower import restrictions in place for goods/service providers/consultants/contractors from certain countries, as well as constraints in institutional and



implementing capacity in borrowing countries, particularly where there are quarantines be in place or other restrictions that impact on public administration.

109. To help mitigate this risk, the Bank will provide BFP leveraging its comparative advantage as convener with the objective of facilitating borrowers' access to available supplies at competitive prices, as described in the procurement section of this document.

110. **Stakeholders.** Community engagement will be critical to the effectiveness of national COVID-19 responses. Key issues to be considered include establishing methods for understanding the concerns, attitudes and beliefs of key audiences; identifying target/highly vulnerable audiences and gathering information about their knowledge and behaviors (e.g., who they trust, how they are likely to receive information); engaging through social media; identifying community influencers (e.g., community leaders, religious leaders, health workers, traditional healers, alternative medicine providers) and networks (e.g., women's groups, community health volunteers, youth associations, religious groups, unions, and social mobilizers for polio, malaria, HIV) that can help with community engagement; and anticipate special information and engagement needs for people with disabilities or who are illiterate.

111. Risk analysis will be conducted when individual country projects under the Program are prepared. The following table provides indicative examples of typical inherent risks that may affect an individual project and provides examples of the mitigation measures that may be put in place. It is noted that the risks and mitigation measures listed below are indicative only. Country projects will adapt key risks to reflect specific country contexts and will (i) identify the most significant critical risks to the specific results and activities in the country operation; (ii) assess the ongoing and planned mitigation measures, considering the specific country situation, sector capacity, track record, etc.; (iii) assess the residual risk that cannot be readily mitigated, depending on (i) and (ii). The rating for each SORT category and for the overall risk, will reflect this assessment of residual risk.

112. **Additional risks.** The following additional risks are highlighted:

113. Use of military as part of borrowers' response to COVID-19. Member countries may seek the Bank's assistance for certain COVID-19 activities carried out by security or military forces, such as the procurement and distribution of medical supplies and drugs or the construction of treatment centers and isolation rooms. Given both the necessity to resort to military support in responding to the public health emergency of COVID-19 in all countries, and the risks associated with such use of the military including possible abuses, the Bank will undertake, when and as reasonably feasible, a rapid assessment of relevant factors. Appropriate environmental and social risk mitigation provisions may be included in the operation's documents and legal agreements. In addition, staff will be provided with a more detailed guidance on carrying out a risk assessment and conducting supervision for activities involving military or security forces.

114. Speed and mobility constraints. The Bank has put a massive effort under unprecedented working conditions and constraints in Washington and country offices to prepare the SPRP and individual projects under it with great speed and agility and due regard to fiduciary and technical standards. Despite the challenge faced by staff and counterparts in dealing with significant mobility and logistical constraints affecting working conditions in most countries, all efforts have been taken to ensure the required quality at entry. As we move into implementation phase of projects in the Phase 1 of the Program and continue active preparation of projects in other counties, all efforts will continue to ensure compliance and the success of the Program in meeting its objectives while adhering to our prescribed standards.

115. Table 2 includes indicative inherent risks and mitigation measures, which will be adapted for the countries financed under the SPRP.



Table 2. Indicative risk matrix for country operations

(i) Identify specific Inherent risks to the development outcome	(ii) Assessment of Mitigation measures (indicative)	(iii) Assessment of Residual risk (considering reliability of the mitigation measures)	Risk rating (to reflect assessment of residual risk)
Political & Governance Lack of adequate political commitment to address COVID-19 and the threat of a global pandemic and other infectious diseases as a national priority. Political commitment to initiate and implement proven prevention measures (social distancing, hygiene, etc.) Lack of accountability measures to ensure that resources supporting COVID-19 activities reach intended health care facilities and beneficiaries. Low priority given to public accountability and transparency in project management Difficulty of containing the populations of quarantined areas, particularly in food insecure or fragile contexts. Governance challenges in the health and other	Strong dialogue with authorities, willingness of authorities to mount effective responses, timely information exchanges, and mobilization of international commitment and resources. Dialogue, policy agreement on set of prevention measures (e.g., social distancing). Processes to disclose/document funding to support COVID-19 response (e.g., publication of audit results and achievements; transparency in decision and resource allocation, extent of stakeholder consultations) Presence of adequate feedback mechanisms to confirm that financing has reached intended health care facilities, beneficiaries. Provision of food supplies and safety equipment, as needed, to the affected populations will be supported. Specific anti-corruption, transparency, accountability		



sectors involved in country responses.	measures adopted to guide the implementation of World Bank Group-funded portfolio of projects in client countries.		
Macroeconomic Reduction in fiscal capacity of governments due to global economic disruption and slowdown, and potential unavailability of fiscal resources. This would negatively impact public health service delivery with respect to COVID-19 prevention, mitigation, and treatment, in addition to other essential health service delivery. Resilience of economy, government (fiscal policy) firms, individuals to absorb economic shocks resulting from prevention and treatment measures.	Project will provide resources to fund core COVID-19 and essential health service delivery activities. Support under the operation supporting critical public health programs, in addition to the COVID-19 response and mitigation effort.		
Sector policies/strategies National health policies do not provide adequate enabling environment for COVID-19 emergency response and supported activities (e.g., case detection & reporting, social distancing measures, health system strengthening, communications, multi-sector policy for prevention and preparedness, infrastructure, etc.)	Operation will support supplementary or emergency measures to support response activities, including for prevention, mitigation, treatment, surveillance, and health system strengthening.		
Technical design			



Intervention activities not effective in containing the spread of COVID-19, as well as of other infectious diseases of animal origin.	Operation will support improvement in the country plan for strengthening response capacity in selected priority areas in the short- and medium terms and lay the foundations for a broader-based One Health strategy and approach, including broad awareness and communication campaigns, which would be critical to containing the spread of these diseases.		
Lack of timely and predictable access to expert advice and technical support	Operation designed and implemented in partnership with leading multilateral agencies, such as WHO and FAO, regional/sub-regional entities; bilateral and other donors.		
Lack of enough quantity of drugs and other medical inputs needed to address the health needs of the general population during a pandemic	Operation will strengthen government capacity and commitment to coordinate project activities with efforts undertaken by other international organizations such as WHO, to facilitate access to laboratory and medical care supplies		
Lack of adequate national M&E to track progress and emerging issues	Operation will support national and/or project-specific M&E to flag emerging issues and to strengthen and learn from the crisis response.		
Institutional capacity			
Project implementing agencies do not have enough authority, leadership, and capacity to take leading role in COVID-19 prevention and control.	Operation will support project management during project implementation; technical assistance and training.		
Inadequate institutional capacity to manage	Operation will support urgent, targeted capacity building for		



country projects and perform effectively in each country to contain and mitigate the impact of COVID-19	disease preparedness in the short term and institutional strengthening and in the medium term to help build system resilience once the crisis has passed. Broader engagement and partnerships to be fostered to support effort		
Inadequate capacity for planned surveillance, surveys and monitoring and evaluation	Operation will support technical assistance and assist in the development of partnerships between local organizations and international institutions. M&E plan will include information on instruments for data collection, agencies responsible and a detailed timetable.		
Low-level commitment and engagement at local and community levels means that strong central commitment does not translate into action on the ground	Implementation mechanisms will explicitly address the link between the required centralized decision making (the principle of 'direct chain of command') with the needed local-level implementation, communication strategies include local-level implementing actors as targets; capacity building at different levels engaged in the response.		
Inadequate or lack of multi-sectoral participation	Operation will galvanize high level political support to implement a One Health response strategy given the significant economic impact of emerging and reemerging infectious diseases of animal origin.		
Fiduciary			
Financial resources not accessible in a timely manner, weak procurement management	Operation will make available rapid disbursement procedures and simplified public sector procurement within projects in		



Lack of independent internal audit function	accordance with emergency operations norms. Operation will support a robust Internal Audit function, independent from the operation, that reports to top management.		
Environmental and Social Risks These are: (i) risks revolving around proper management of medical waste generated by the outbreak; (ii) risk of exposure to medical and health care workers and a wider swath of the professional and civic community; and (iii) the need to protect the vulnerable and the disadvantaged by ensuring their access to project benefits and safeguarding them from a risk of further stigmatization and abuse. Stakeholders The existence of denial and misinformation associated with COVID-19, in addition to mistrust of some governments, which could lead to the rejection of public health interventions and information in some country contexts, contributing to the continued spread of the disease. Controlling the spread of COVID-19 spread may	Operations will pay close attention and support the adoption of effective mitigation measures to address these risks. Projects will finance infection prevention and control improvements in health facilities to minimize health risks to patients and health workers alike. Moreover, the projects will target interventions to reduce risk of COVID-19 disease and death among the elderly and those affected by chronic health conditions, who are more vulnerable to the virus. Operation will support government and civil society outreach, advocacy and coalition building to sensitize key groups including policy makers, the media, and ensure consistent communication. Operation will support advocacy and coalition building to sensitize		



expose the government to criticism for the curtailment of civil rights due to the adoption of quarantines and other related measures	key groups including policy makers, the media, and religious leaders. This will be complemented by carefully designed mass communication campaigns to build support for response and mitigation measures among the wider population.		
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VII. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY: World

COVID-19 Strategic Preparedness and Response Program (SPRP)

Project Development Objective(s)

The Program Development Objective is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness

Project Development Objective Indicators

Indicator Name	DLI	Baseline	End Target
To prevent, detect and respond to the threat posed by COVID-19			
Number of countries covered under the Program (Number)		0.00	50.00
Amount of funds disbursed (Percentage)		0.00	50.00
Number of contracts of COVID-19 disease commodity packages (Number)		0.00	150.00
Number of supported countries with pandemic preparedness and response plans (Number)		0.00	50.00
Number of countries with strengthened early detection capacity (lab, clinical) and isolation (hospital) (Number)		0.00	50.00
Number of countries with adopted guidelines and plans for health care prevention infection control (Number)		0.00	50.00



Indicator Name	DLI	Baseline	End Target
Number of countries with appropriate clinical care guidelines and improved capacity to deal with COVID-19 developed per WHO guidelines (Number)		0.00	50.00
Number of countries with adopted personal and community non-pharmaceutical interventions (schools closures, telework and remote meetings, reduce/cancel mass gatherings) (Number)		0.00	50.00
Number of countries with community engagement plans and activities (Number)		0.00	50.00
Number of countries with social and financial support activities targeted to at risk and vulnerable populations (Number)		0.00	50.00
Number of countries with outbreak/pandemic emergency risk communication plan and activities developed and tested (Number)		0.00	50.00
Number of countries with coordinated surveillance systems in place to monitor the emergence and re-emergence of zoonotic diseases (Number)		0.00	50.00
Number of countries with mechanisms for responding to the emergence and re-emergence of zoonotic diseases (Number)		0.00	50.00

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	End Target
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Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Number of countries covered under the Program	Number of countries covered under the Program	Monthly	WBG Operations Portal	WBG Operations Portal	WBG COVID-19 EOC
Amount of funds disbursed	Amount of funds disbursed (US\$)	Monthly	WBG Operations Portal	Cumulative country reports	WBG COVID-19 EOC
Number of contracts of COVID-19 disease commodity packages	Number of contracts of COVID-19 disease commodity packages	Monthly	COVID-19 task teams	Cumulative country reports	WBG COVID-19 EOC
Number of supported countries with pandemic preparedness and response plans	Number of supported countries with pandemic preparedness and response plans	Quarterly	COVID-19 task teams	Cumulative country reports	WBG COVID-19 EOC
Number of countries with strengthened early detection capacity (lab, clinical) and isolation (hospital)	Number of countries with strengthened early detection capacity (lab, clinical) and isolation (hospital)	Quarterly	COVID-19 task teams	Cumulative country reports	WBG COVID-19 EOC
Number of countries with adopted guidelines and plans for health care prevention infection control	Number of countries with adopted guidelines and plans for health care prevention infection control	Quarterly	COVID-19 task teams	Cumulative country reports	WBG COVID-19 EOC



Number of countries with appropriate clinical care guidelines and improved capacity to deal with COVID-19 developed per WHO guidelines	Number of countries with appropriate clinical care guidelines and improved capacity to deal with COVID-19 developed per WHO guidelines	Quarterly	COVID-19 task teams	Cumulative country reports	WBG COVID-19 EOC
Number of countries with adopted personal and community non-pharmaceutical interventions (schools closures, telework and remote meetings, reduce/cancel mass gatherings)	Number of countries with adopted personal and community non-pharmaceutical interventions (schools closures, telework and remote meetings, reduce/cancel mass gatherings)	Quarterly	COVID-19 task teams	Cumulative country reports	WBG COVID-19 EOC
Number of countries with community engagement plans and activities	Number of countries with community engagement plans and activities	Quarterly	COVID-19 task teams	Cumulative country reports	WBG COVID-19 EOC
Number of countries with social and financial support activities targeted to at risk and vulnerable populations	Number of countries with social and financial support activities targeted to at risk and vulnerable populations	Quarterly	COVID-19 task teams	Cumulative country reports	WBG COVID-19 EOC
Number of countries with outbreak/pandemic emergency risk communication plan and activities developed and tested	Number of countries with outbreak/pandemic emergency risk communication plan and activities developed and tested	Quarterly	COVID-19 task teams	Cumulative country reports	WBG COVID-19 EOC
Number of countries with coordinated disease surveillance systems in place to monitor the emergence and re-	Number of countries with coordinated disease surveillance systems in	Quarterly	COVID-19 task teams	Cumulative country reports	WBG COVID-19 EOC



emergence of zoonotic diseases	place to monitor the emergence and re-emergence of zoonotic diseases				
Number of countries with mechanisms for responding to the emergence and re-emergence of zoonotic diseases	Number of countries with mechanisms for responding to the emergence and re-emergence of zoonotic diseases	Quarterly	COVID-19 task teams	Cumulative country teams	WBG COVID-19 EOC

Monitoring & Evaluation Plan: Intermediate Results Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
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ANNEX 1: PROJECTS OF PHASE I OF THE PROGRAM

IDA/Blend BORROWERS IN PHASE 1

	Country	PID#	Project name	IDA FTF (CRW) Amount (\$m)	IDA PBA Amount (\$m)	Total IDA (\$ mil)	IBRD FTF Comp-2 Amount for Blend Countries (\$m)	Amount (other/TF) (\$M)	Total (\$mil)	Country IDA terms in FY20
1	Afghanistan	P173775	COVID-19 Emergency Response and Health Systems Preparedness Project	19.4	81.0	100.4		-	100.40	100% grants
2	Cabo Verde	P173857	COVID-19 Emergency Response Project	5.0	-	5.0		-	5.00	100% credits
3	Cambodia	P173815	COVID-19 Emergency Response	20.0	-	20.0		-	20.00	100% credits
4	Congo, Democratic Republic of	P173825	COVID-19 Strategic Preparedness and Response	47.2	-	47.2		-	47.20	50-50% credits/grants
5	Djibouti	P173807	COVID-19 Response	5.0	-	5.0		-	5.00	100% credits
6	Ethiopia	P173750	COVID-19 Emergency Response	82.6	-	82.6		-	82.60	50-50% credits/grants
7	Gambia, The	P173798	COVID19 Preparedness and Response Project	5.0	5.0	10.0		-	10.00	100% grants
8	Ghana	P173788	COVID-19 Emergency Preparedness and Response Project	35.0	-	35.0		-	35.00	100% credits
9	Haiti	P173811	COVID-19 Response	9.7	10.3	20.0		-	20.00	100% grants
10	Kenya	P173820	COVID-19 Emergency Response Project	50.0	-	50.0		3.2	53.20	100% credits
11	Kyrgyz Republic	P173766	Emergency COVID-19	12.2		12.2		-	12.15	50-50% credits/grants
12	Maldives	P173801	COVID-19 Emergency Response and Health Systems Preparedness Project	5.3	2.0	7.3		-	7.30	50-50% credits/grants
13	Mauritania	P173837	COVID-19 Strategic Preparedness and Response	5.2	-	5.2		-	5.20	100% grants



	Country	PID#	Project name	IDA FTF (CRW) Amount (\$m)	IDA PBA Amount (\$m)	Total IDA (\$ mil)	IBRD FTF Comp-2 Amount for Blend Countries (\$m)	Amount (other/TF) (\$M)	Total (\$mil)	Country IDA terms in FY20
14	Mongolia	P173799	COVID-19 Emergency Response and Health System Preparedness Project	13.1	-	13.1	13.8	-	13.10	100% credits from IDA and IBRD component 2 will follow IBRD pricing
15	Pakistan	P173796	Pandemic Response Effectiveness Project	100.0	100.0	200.0		-	200.00	100% credits
16	Sao Tome and Principe	P173783	STP COVID-19 Emergency Response Project	2.5	-	2.5		-	2.50	100% grants
17	Senegal	P173838	COVID-19 Response	20.0	-	20.0		-	20.00	100% credits
18	Sierra Leone	P173803	Sierra Leone COVID-19 Emergency Preparedness and Response Project	7.5	-	7.5		-	7.50	100% grants
19	Tajikistan	P173765	Tajikistan Emergency COVID-19 Project (P173765)	11.3		11.3		-	11.30	100% grants
20	Yemen, Republic of	P173862	Yemen COVID-19 Response Project	26.9	-	26.9		-	26.90	100% grants
Total				482.9	198.3	681.2	13.8	3.2	684.35	
						Sri Lanka	93.60	IDA Transitional support		
						IDA Total	774.75			



IBRD Borrowers in Phase 1

	Country	PID#	Project name	IBRD FTF Amount component-1 (\$m) (A)	IBRD FTF Component -2 (\$m) (B)	Other IBRD Amount (\$M) (D)	Total IBRD (\$m) (A) + (B) + (D)	IDA Financing for recent IDA graduates and Blends (\$m) (C)
1	Argentina	P173767	COVID-19 Response	35.00			35.00	
2	Ecuador	P173773	Covid-19 Response	20.00			20.00	
3	India	P173836	Emergency Response and Health Systems Strengthening Operation	350.00	400.00	250.00	1,000.00	
4	Paraguay	P173805	COVID-19 RESPONSE	20.00			20.00	
5	Sri Lanka	P173859	COVID19 Emergency Response and Health Systems Preparedness Project	35.00			35.00	93.60 (added above in the IDA table)
				460.00	400.00	250.00	1,110.00	93.60
						Mongolia	13.8	
						IBRD Total	1,123.80	

