



Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 28-Apr-2020 | Report No: PIDA29138



BASIC INFORMATION

A. Basic Project Data

Country Egypt, Arab Republic of	Project ID P173912	Project Name Egypt COVID-19 Emergency Response	Parent Project ID (if any)
Region MIDDLE EAST AND NORTH AFRICA	Estimated Appraisal Date 28-Apr-2020	Estimated Board Date 04-May-2020	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Arab Republic of Egypt	Implementing Agency Ministry of Health and Population	

Proposed Development Objective(s)

The Project Development Objective (PDO) is to strengthen the prevention, detection and response to the COVID-19 pandemic in Egypt.

Components

- Component 1: Emergency COVID-19 Response
- Component 2: Implementation Management and Monitoring and Evaluation
- Component 3: Contingent Emergency Response Component (CERC)

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	469.00
Total Financing	469.00
of which IBRD/IDA	50.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	50.00
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Non-World Bank Group Financing



Counterpart Funding	419.00
Borrower/Recipient	419.00

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

- Egypt has adopted a bold and important reform program to redress long-standing economic challenges.** Macroeconomic conditions broadly improved, following several years of slowing economic activity, and large external and fiscal imbalances that have been further exacerbated by the economic downturn in 2011. The reforms have been widely endorsed, including by the World Bank Group’s (WBG) programmatic Development Policy Financing and the International Monetary Fund’s three-year Extended Fund Facility.
- Before the outbreak of the COVID-19 pandemic, economic growth remained robust and macroeconomic imbalances had broadly improved.** Growth increased to 5.6 percent in FY19 (up from 5.3 percent the previous year), a rate that was sustained through Q1-FY20. Meanwhile, inflation declined remarkably to 5.3 percent in February 2020, down from a three-decade high of 33 percent in July 2017. On the fiscal side, primary surplus improved, inching up to 0.5 percent of gross domestic product (GDP) in H1-FY20, up from 0.4 percent a year earlier. Government debt is declining as a ratio to GDP but remains high at 90.3 percent of GDP at end-FY19. The external accounts are broadly stabilizing, where the balance of payments achieved a marginal surplus of 0.1 percent of GDP in Q1-FY20, in line with its ratio a year earlier. Net international reserves reached US\$45.5 billion by end-January 2020, covering around 8 months of merchandise imports. However, vulnerabilities persist including sluggish private consumption and the underperforming exports and foreign direct investment (FDI), which will be aggravated by the disruptive repercussions of the COVID-19 pandemic.
- COVID-19 context in Egypt.** The first case of COVID-19 in Egypt was diagnosed on February 14, 2020. As of April 24, 2020, Egypt has reported 4,092 confirmed cases (Figure 1), 2,270 hospitalizations, 1,334 discharges and 294 deaths, with a crude case fatality rate of 7.4 percent. Among all governorates, Cairo, Alexandria and Damietta have the highest numbers of cases. Males make up 60.7 percent of confirmed cases and more than 70 percent of COVID-19 deaths. Most of confirmed cases are among those above 60 years of age.

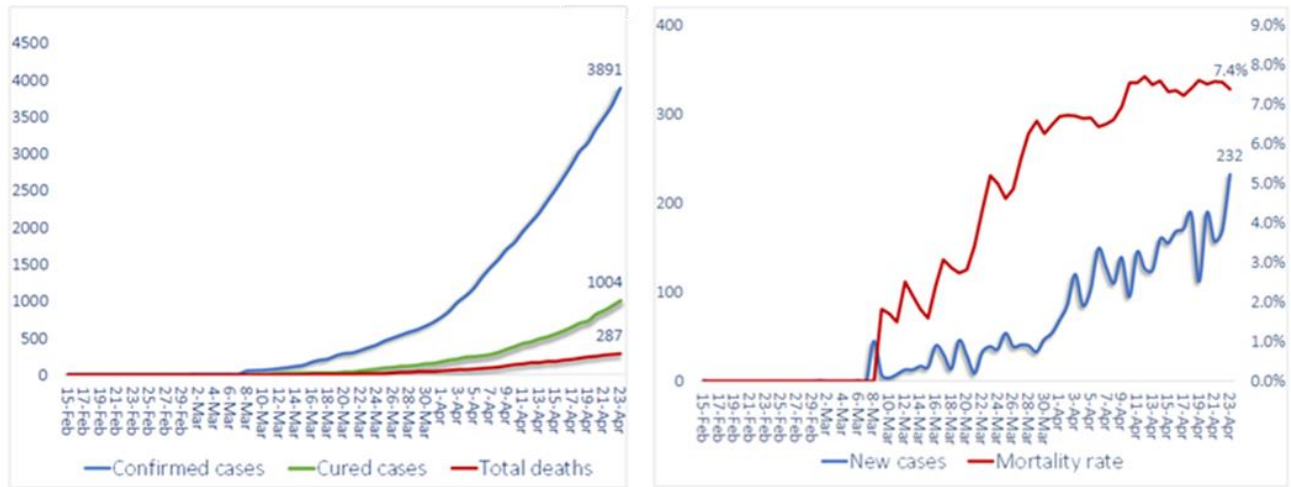


Figure 1. Egypt COVID-19 cases and deaths

4. **Similar to other countries, COVID-19 poses a threat to Egypt.** The pandemic risks putting a strain on the country’s healthcare system, in addition to other significant implications on the economy. The pandemic is expected to hamper growth through both supply-side and demand-side effects. Disruption in global trade and supply chains, tighter financing conditions, compromised tourism and remittances receipts will impact external balances. On the fiscal front, while the recent collapse in oil prices may ease some pressure on the imports bill, the pace of fiscal consolidation may slow down due to higher spending and lower revenues.

Sector Context

5. **Egypt has significantly improved health outcomes, yet many challenges persist, particularly with regard to the high prevalence of NCD and ongoing care may be disrupted by the COVID-19 outbreak.** Egypt has a high prevalence of NCDs, mainly due to poor prevention and control of NCD risk factors such as hypertension, obesity, high cholesterol levels, diabetes and smoking. NCDs now account for 82 percent of all deaths and 67 percent of premature deaths in the country. The recent national screening campaign under the “100 million healthy lives” program funded by the WBG-financed Transforming Egypt’s Healthcare System Project (TEHSP) showed that 6 percent of the adult population were diabetic, 26 percent were hypertensive, and 70 percent were overweight. Populations with co-morbidities such as NCDs, smokers, the obese and the elderly are at higher risk of COVID-19 infection and of mortality once infected. In addition, due to the social distancing and lockdown measures, NCD patients who require continuing care are more susceptible to interrupted medical services. Targeted interventions for such patients to strengthen prevention efforts and maintain essential services for their routine medical needs are critical.

6. **Egypt’s existing health systems challenges are also further exacerbated by COVID-19.** These include:

- a. **Low levels of government expenditures in health:** Egypt has one of the lowest levels of government health expenditures in the MENA region, at 1.7 percent of GDP. Only 5.6 percent of total government budget is spent on health, with public spending accounting for 38 percent of the total health expenditure. More than half of total health expenditures (61 percent) is private, of which 90 percent is paid out of pocket by households and 10 percent in the form of prepaid private voluntary health insurance. Families in the lowest income quintile spend 21 percent of their income on health in



comparison to 13.5 percent for those in the highest income quintile. Also, women usually spend more on all type of healthcare. Medical financial burden is a key barrier to access to health care. Acknowledging this challenge, the GOE has declared that all activities related to prevention, testing, care and treatment for COVID-19 will be provided free of charge for citizens and residents alike. However, this puts further strain on the government budget for health in the middle of the budgetary cycle and given uncertain fiscal outlook. Meanwhile, securing sufficient government funding for other essential public health programs and the universal health insurance program remain critical.

- b. **High disparities in distribution of health care workers:** Mal-distribution, skills mix mis-match and low quality of care in the public sector are considerable health human resources challenges in Egypt. Most public sector healthcare jobs are low-paid and provide little incentive to improve performance. This has led to a mass exodus of Egyptian doctors and nurses either abroad or to the private sector. It is estimated that out of 200,000 registered doctors in Egypt, nearly half are working abroad, 30,000 are exclusively working in the private sector and only 70,000 are working for the public sector. As a consequence, quality of care is often poor, leading to low utilization and forgone care. In the COVID-19 emergency response, the public sector is handling most of the COVID-19 cases. Public sector doctors, nurses, and other health workers have to work long hours, and are faced with high risks of infection and psychological pressure as they may be required to work in infectious disease departments where the need is the highest. Further redeployment of workers into hotspots and to designated COVID-19 facilities is crucial to help serve the population most in need. Motivating public sector health workers to work in risky environments is a key challenge. Training health workers on the continuously changing protocols to meet the challenges of an epidemic where the world is learning as it progresses is vital. There is also the need to think of continuous and innovative ways of deploying knowledge.

7. **In response to the immense COVID-19 threat, the GOE has launched a rigorous emergency response.** A national COVID-19 emergency response steering committee has been established, which reports to the President and Prime Minister. The Egyptian Cabinet launched a dedicated COVID-19 response website which provides public access to key government COVID-19-related documents. A national public health emergency was declared on March 17, 2020 upon the first recorded death from COVID-19. Macro-fiscal and social policy responses to the COVID-19 shock are being put in place, including a 300-basis point monetary policy rate cut and forbearance measures on credit. There are also signals of a fiscal stimulus in the FY20/21 budget. Social safety net policy measures have also been adopted to support the informal workers and women in poorer areas.

8. **Egypt has been mobilizing resources and is acquiring supplies for its COVID-19 response.** For COVID-19 treatment, the MOHP has assigned 12 hospitals as dedicated COVID-19 treatment centers, with many others on standby. Egypt currently has nearly 30,000 Intensive Care Unit (ICU) beds, of which between 6,500 and 7,000 can be mobilized for critical COVID-19 cases. The MOHP has also developed guidelines and operation protocols for: (i) case definition; (ii) standard diagnosis protocols; and (iii) treatment guidelines for COVID-19. Such protocols and guidelines are being updated on a regular basis as new information emerges. A dedicated call center for case management has been set up. Hospital management teams have identified training needs and the MOHP is planning to conduct trainings for health workers especially on PPE use and case management.

9. **Significant gaps and challenges remain for Egypt's COVID-19 response despite MOHP's efforts.** Given the emergency nature of the epidemic and the mid-budgetary surge in funding demands to help the response efforts, the following areas were identified as critical needs for further support:



Timely procurement of equipment and supplies and associated budget pressure. While essential COVID-19 commodities and supplies are covered under the National COVID-19 Response Plan, sufficient budget is needed to ensure timely procurement and distribution of equipment and supplies to facilities and health workers in need.

Quarantine of suspect cases and isolation and treatment of patients. Hotels have been mobilized to serve as dedicated facilities for the quarantine of suspected cases, evacuees from overseas and direct contacts of confirmed cases. In order to cut the chain of transmission during the lockdown unoccupied university dorms and hotels are being used as isolation centers for positive cases with no or mild symptoms. As these are not planned in the budget, the day-to-day operational costs of these facilities (utilities, catering, waste management, and hazard pay compensation for the needed medical and technical teams operating the facilities) have posed a huge financial challenge.

Incentivizing public sector healthcare workers working in dedicated COVID-19 facilities. Only around 35 percent of all registered doctors in Egypt work in the public sector. The COVID-19 situation has further strained the health workforce through pathogen exposure, long working hours, psychological distress, fatigue, occupational burnout, stigma, and physical and psychological violence. To motivate and retain health workers and compensate for their increased workloads during the pandemic, the President of Egypt has announced a contingent 75 percent increase in incentives for the 15,000 medical health workers (0.05 percent of public sector health workers) working on dedicated COVID-19 tasks and in facilities, referred to as the “corona incentive pay”.

Training of healthcare workers on IPC and clinical case management. As of April 16, 2020, healthcare workers represented an alarming 13 percent of all COVID-19 infected cases in Egypt. Combined with the dual risk of exposure to infection inside health facilities as well as in community and home settings, healthcare workers are seeding infections between hospitals, colleagues and patients. The WHO fact-finding mission noted that despite having no shortages of PPE supplies inside healthcare facilities, the staff were not trained properly in their use. Health professionals in Egypt receive life-long initial or specialized licenses with no continuing medical education requirements. Clinical COVID-19 treatment protocols are rapidly changing and being updated. This has generated a dire necessity to continuously train all healthcare personnel at COVID-19 facilities with updated clinical knowledge that would empower them to effectively provide appropriate care and protect themselves from infections.

Contextualized messaging to the public. While there is significant mass media attention on the COVID-19 pandemic owing to the magnitude and global scale of the disease, there is room to expand and contextualize messaging to the populace, especially the adult population who are at a higher risk of morbidity and mortality due to the disease. Messages for individual protection, decreasing spread, warning symptoms and signs and available care and treatment pathways are required and should optimally utilize social media platforms, mobile applications, dedicated hotlines and community education through well trained community health workers. Such methods have been persistently proven by research to be effective in changing behavior and attitude.

Monitoring and Evaluation (M&E) of the effectiveness of social distancing measures. Although



Egypt has initiated a set of mandatory social distancing measures, their efficacy and effectiveness remain questionable. Acknowledging that no one-size fits all, continuous monitoring and feed-back loops for finetuning decisions are much warranted for workplace and educational facilities' closure, mass gatherings, stay at home orders, as well as measures for special populations e.g. prisons, long-term care centers, psychiatric institutions, other healthcare facilities, etc. This wide-scale effort requires: (i) massive logistical support from different government agencies; (ii) use of smart innovative technology to monitor results e.g. satellite and mobile GPS technology; and (iii) proper training and compensation of civil servants and contracted personnel all of which are a shift from the regular modus operandi of the GOE.

Attention to high risk groups under the COVID-19 Pandemic. Some population groups are more prone to a higher morbidity and mortality risk if infected with COVID-19. These include: (i) people with NCDs; (ii) pregnant women who biologically have lower immunity and carry a risk to infect newborns; (iii) people with compromised immunity e.g. HIV-infected; and (iv) people living in urban slums where transmission is rampant and who tend to have compromised immunity and ill-health due to malnutrition and poor living conditions. Egypt lacks an actionable strategy for dealing with these vulnerable sub-groups.

Proper contact tracing of infected COVID-19 cases. It is widely considered that a best-buy measure to avoid community transmissibility of the disease and prevent the spread of a virus is by proactively finding those at high risk due to potential exposure, notifying them, and quarantining them if necessary. Egypt possesses a relatively strong public health and surveillance system at the national and local levels. However, given the magnitude of the pandemic, further capacity is warranted to ensure proper and complete tracing protocols are being followed as the number of positive cases increase over time. Costs associated with the scale-up for human labor, training, transportation, per diems and using of smart technology are becoming a burden for the MOHP

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

10. **Project Development Objective (PDO):** To strengthen the prevention, detection and response to the COVID-19 pandemic in Egypt.

Key Results

11. **PDO indicators:**

- Percentage of MOHP hospitals with PPE and infection control products and supplies, without stock-outs in preceding two weeks.
- Number of contextualized messages conducted for COVID-19 prevention.
- Number of confirmed COVID-19 cases whose contacts were traced as per the national protocol.
- Number of dedicated quarantines, isolation & treatment facilities for COVID-19.



D. Project Description

12. **The Project will focus on the immediate operational challenges and critical areas of support identified as key gaps in Egypt’s national COVID-19 response.** To address the identified gaps, project funds will complement the activities of Egypt’s COVID-19 response plan through supporting the costs associated with: (i) procuring and distributing medical equipment and supplies that are necessary for the COVID-19 response; (ii) hazard/indemnity pay consistent with the government’s applicable policies for healthcare personnel working at COVID-19 facilities or COVID-19-related tasks; (iii) health worker training; (iv) operations of specifically designated quarantine, isolation and treatment centers; (v) mobilization of rapid response teams in contact tracing of COVID-19 cases; (iv) development of contextualized messaging platforms and tools; (vi) innovative M&E of social distancing strategies including community mobilization; and (vii) devising and adopting proper policy tools to optimize the COVID-19 response. The project design takes other donor support into account and complements such support. It will be implemented over a two-year period and will include the following three components:

13. **Component 1: Emergency COVID-19 Response (US\$49 million).** This component will provide immediate support to Egypt’s national response plan in the prevention, detection and treatment of COVID-19 cases, with a focus on addressing the identified shortage in medical equipment and supplies, the human resource gap, and the weaknesses in risk communication, contact tracing, IPC and case management as discussed above. Component 1 includes three sub-components:

Sub-component 1.1: Supporting COVID-19 prevention and case detection (US\$19 million). The aim of this sub-component is to limit and slow down the spread of COVID-19 in Egypt through: (i) supporting a national behavior change communication (BCC) campaign; (ii) building capacity for health workers and first responders in proper use of PPE and advanced infection control practices; (iii) conducting contact tracing; and (iv) implementing other public health measures (e.g. community non-pharmaceutical interventions to prevent the spread of the pathogen). It will disburse on the basis of 4 PBCs.

PBC 1: Number of contextualized messages conducted for COVID-19 prevention (US\$5 million). This PBC will support the development and implementation of cost-effective BCC modalities related to handwashing, social distancing, facemasks wearing by the public, protecting high risk groups and care seeking, etc. Eligible expenditures (EE) for this PBC will be non-salary operating costs such as internet platforms subscriptions, per diem, transportation, “corona incentive” pay for counselors, health workers in the front lines and hot line operators.

PBC 2: Training of health workers on IPC measures (US\$2 million). This PBC will support the training of health workers and first responders (those include physicians, nurses, dentists, pharmacists, physiotherapists, medical technicians, first responders and Community Health Workers) in IPC and risk mitigation measures. The training will include the proper use of PPE, other safety measures as techniques for infection prevention and control. The PBC will cover the non-salary operating costs for training.

PBC 3: Number of confirmed cases that have had their contacts traced as per protocol (US\$5 million). “Test, trace, isolate” is an important strategy to limit the spread of COVID-19. This PBC therefore supports containment/suppression of COVID-19 through: (i) combining detection of new cases with active contact tracing; (ii) supporting epidemiological investigation; (iii) strengthening risk assessment; and (iv) building capacity in recording and reporting of cases and their contacts to prevent spread and increase adaptation capacities. The PBC will support the non-salary operating costs such as per diem, transportation and appropriate “corona incentives” for dedicated rapid response teams to support tracing, contacting and isolating suspected cases.



PBC 4: Implementing other public health measures (US\$7 million). This PBC will support various government public health actions including inter-governmental coordination, policy making, planning, implementation and monitoring of other public health measures for COVID-19 response. This includes participation of women in policy making and implementation of such public health measures to ensure that their needs are identified and addressed. The EEs will include the non-salary operating costs associated with the development, implementation, M&E of such strategies/measures.

PBC 4.1: Development of a national comprehensive COVID-19 response plan (US\$2million). This PBC will support the development and adoption of a comprehensive national COVID-19 response strategy covering key areas such as: (i) stewardship; (ii) governance considering local or subnational capacities and coordination mechanisms for their adaptation plans; (iii) clinical definitions; (iv) prevention and control measures; (v) treatment; (vi) case detection, contact tracing and surveillance systems; (vi) citizen engagement and communication; and (vii) gender, environmental and social safeguards.

PBC 4.2: Implementation and monitoring of social distancing interventions at the local and national levels (US\$3 million). This PBC will support the costs associated with the design, implementing and monitoring social distancing and “smart lockdown” interventions at different levels, including closures of educational institutions, curfew hours, evacuations, working hour regulations for different types of services and/or commercial activities, etc. Smart technology tools will be used to monitor the measures. e.g. Google community mobility reports. Specifically, the PBC will also support the development of a report that illustrates the results of the measures over a 3-month period.

PBC 4.3: Community mobilization (US\$1 million). The PBC will support the mobilization and coordination of individual volunteers, 200 in number, and NGOs to support COVID-19 response, including their involvement in BCC contact tracing, protecting high risk groups against the COVID-19 threats, supporting the poor, etc. Community mobilization and participation in COVID-19 response will be through existing community institutions, including women’s organizations with priority given to the most vulnerable areas of the country.

PBC 4.4 National strategy to protect high risk groups against the threats of COVID-19 (US\$ 1 million). The PBC will support the development and adoption of a national plan addressing the needs of high-risk population groups under the COVID-19 response. Such groups will include the elderly, pregnant women, inhabitants of urban slums, people with NCDs, infants, people with compromised immunity e.g. HIV patients, etc. The plan will include the following: (i) identification of high-risk population groups; (ii) specific measures to protect those groups; and (iii) guidelines for health providers to manage such sub-groups with regards to COVID-19.

Sub-component 1.2: Strengthening clinical capacity for COVID-19 case management (US\$10 million). This sub-component will support and address the gaps in: (i) capacity building for selected health personnel: and (ii) the operationalization of dedicated quarantine, isolation and treatment centers so that they can better manage suspected and confirmed COVID-19 cases. This sub-component complements the ongoing GOE’s efforts to provide the essential medicines and medical equipment for COVID-19 case management through emergency budgetary and off-budget allocations e.g. monetary and in-kind donations. This sub-component will disburse on the basis of two PBCs (PBC 5 and 6).



PBC 5: Number of dedicated quarantine, isolation & treatment facilities for COVID-19 (US\$8 million). This PBC will support: (i) operationalizing selected quarantine, isolation, treatment facilities to manage suspected and confirmed cases; (ii) utility bill payments for water, sanitation, electricity, as well as trucking service fees for safe waste disposal of such facilities; (iii) operational costs for ambulances dedicated to such facilities; and (iv) costs of mobilizing additional health personnel to work in such facilities and associated operational expenses for such personnel including “corona incentive” pay. The PBC will support the aforementioned costs of 4 quarantine facilities, 4 isolation facilities and 20 dedicated COVID-19 hospitals, for a total of 28 facilities.

PBC 6: Number of health workers trained in COVID-19 case management (US\$2 million). This PBC will support the strengthening of clinical care capacity through: (i) development of additional COVID-19 case management protocols (as needed); and (ii) training of doctors and nurses in COVID-19 clinical protocols. The training will encompass both traditional structured trainings and innovative online approaches for all health workers of different specialties in all facilities dedicated to COVID-19. Training will be conducted in a way that ensures equal participation of both female and male health workers. In addition, the Project will support: (i) capacity building in applied and clinical research, including ethical aspects; and (ii) COVID-19 knowledge management, including the review, synthesis and dissemination of scientific information. EEs will be non-salary operating costs associated with training.

Sub-component 1.3: Support the supply and distribution of equipment and consumables (US\$ 20 million). This sub-component will finance the costs associated with procuring and distributing medical equipment and supplies¹ that are necessary for the COVID-19 response and include *inter alia* ICU equipment, laboratory testing equipment and supplies, infection control products, and PPE. This complements the MOHP COVID-19 response and addresses the equipment and supply gaps referenced above. Technical specifications of equipment will be based on WHO recommended standards and guidelines. Quantities of the items to be procured will consider the country’s needs as the pandemic evolves and availability of such equipment from other funding sources. Further, identification of the specific laboratories and health facilities which will be equipped with such medical equipment will be determined during implementation.

14. **Component 2: Implementation Management and Monitoring and Evaluation (US\$1 million).** This component will disburse against inputs and will finance: (i) staff and operational costs for the Project Management Unit (PMU); (ii) project M&E (iii) selected technical assistance; and (iv) an Independent Verification Agency (IVA) and an external financial auditor. To the extent possible, data collection and monitoring will be done in a gender- and age-disaggregated manner to contribute to a better understanding of the demographic profile of the affected population.

15. **Component 3: Contingent Emergency Response Component (CERC) (US\$ 0).** In the event of an eligible crisis or emergency, the CERC will be activated to provide immediate and effective response to said crisis or emergency.

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No

¹ Equipment and supplies procured will be in line with WHO’s list of disease commodities for COVID-19 testing and case management including any updates.



Projects in Disputed Areas OP 7.60

No

Summary of Assessment of Environmental and Social Risks and Impacts

16. **The environmental and social risks are rated Substantial.** While the project is expected to contribute to better management of the health and economic implications resulting from the COVID-19 pandemic, there are number of associated environmental and social risks that may result from project activities.

17. A key social risk is the potential for social stigma for patients, families and contacts during the process of contact tracing that may make families feel discriminated and excluded. In addition, exposure to patients carrying the virus poses a serious risk of infection to health workers which could also be transferred to vulnerable individuals within their families and communities. This risk also applies to the volunteers who will join the medical crew to carry out contact tracing and other community-based activities. There is also growing evidence across countries of an associated increase in domestic GBV during the pandemic. Finally, due to the pandemic, the uncertainty involved, and the multiple stakeholders engaged in project implementation, there is a potential risk that the health system has insufficient capacity to respond to all needs, leading to increased complaints and grievances. The capacity of the existing Grievance Redress Mechanism (GRM) channels to handle citizens' complaints and queries should be tested, despite efforts by the GOE to establish a strong and dedicated platform.

18. From the environmental and health and safety perspective, as the project will finance the operation of a selected number of existing quarantine, isolation and treatment facilities. Such activities may entail: (i) occupational health and safety risks for health care workers, quarantined cases, patients, waste transporters and waste treatment operators including exposure to COVID-19 and hazardous materials and waste; (ii) risks associated with medical waste management and disposal; (iii) community health and safety issues related to uncontrolled transmission of COVID-19 due to poor management of medical wastes or lack of infection prevent control measures especially for healthcare workers; and (iv) air emissions and soil contamination resulting from improper treatment and disposal of medical waste.

19. To mitigate potential environmental and social risks, an Environmental and Social Management Framework (ESMF) will: (i) assess the environmental, social, health and safety risks and impacts associated with the project activities and recommend mitigation measures that are commensurate to the risk in accordance with the ESF requirements; (ii) include a Medical Waste Management Plan and IPC measures in accordance with the WBG Environmental, Health and Safety (EHS) Guidelines for healthcare facilities and the evolving WHO updated guidelines; (iii) consider the impacts associated with the decommission of the quarantine, isolation and treatment centers; (iv) assess and recommend mitigation measures to address risks of Sexual Exploitation, Harassment, and Abuse; (v) include monitoring plans for ensuring proper implementation of procedures and mitigation measures; and (vi) include a climate risks assessment and/or climate mitigation feasibility assessment. The ESMF will also suggest measures to: (i) ensure that the tracing and detection are managed in a manner that respects patients' privacy and destigmatize the targeted groups; (ii) ensure that appropriate training are offered to the health workers including the volunteers; and (iii) closely assess the GRM and suggest measures to strengthen its capacity. For the TA activities, the MOHP will ensure that the developed plans for Egypt's COVID-19 response will include the ESF-relevant standards and evolving WHO guidelines as committed in the ESCP.



E. Implementation

Institutional and Implementation Arrangements

20. **The MOHP will be the implementing agency, and the existing “Transforming Egypt’s Healthcare System Project” (TEHSP) PMU team will be in charge of day-to-day operations.** Various departments, directorates, hospitals and facilities within the MOHP will be involved in implementing activities under the project. Other ministries will also be involved in planning and implementing selected project activities such as the Ministry of Local Development, which will be involved in planning, enforcing and monitoring some of the social distancing measures. The TEHSP PMU team has a strong record of implementation experience and familiarity with WBG procedures including fiduciary, procurement, M&E, and verification of PBCs. This PMU will be responsible for overall fiduciary activities, documentation, procurement of goods as well as contracting consulting and non-consulting services, M&E and reporting to the MOHP on all aspects of project implementation.

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APPROVAL

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