Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 23-Mar-2022 | Report No: PIDA32874

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Cote d'Ivoire	P177836	Côte d'Ivoire COVID-19 Strategic Preparedness and Response Project Second AF	P173813
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
Cote d'Ivoire COVID-19 Strategic Preparedness and Response Project (SPRP)	AFRICA WEST	13-Dec-2021	27-Apr-2022
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	Government of Côte d'Ivoire	Ministere de la Sante et de l'Hygiene Publique (MSHP)

Proposed Development Objective(s) Parent

To prevent, detect, and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Cote d'Ivoire.

Components

Component 1: Emergency COVID-19 response
Component 2: Health Communication and Community Engagement
Component 3: Project implementation management and monitoring and evaluation

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	180.00
Total Financing	180.00
of which IBRD/IDA	80.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	80.00
IDA Credit	80.00
Non-World Bank Group Financing	
Other Sources	100.00
Asian Infrastructure Investment Bank	100.00

Environmental and Social Risk Classification

Substantial

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **This Project Paper seeks the approval of the World Bank's (WB) Board of Executive Directors to provide an International Development Association (IDA) credit in the amount of US$80 million equivalent for a second Additional Financing (AF) to the Côte d'Ivoire COVID-19 Strategic Preparedness and Response Project (CIV-SPRP), and at the request of the Government of Côte d'Ivoire (GOCI), to restructure the project to integrate a US$100 million co-financing from the Asian Infrastructure Investment Bank (AIIB).** The CIV-SPRP was prepared under the COVID-19 Strategic Preparedness and Response Program (SPRP) using the Multiphase Programmatic Approach (MPA), approved by the Board on April 2, 2020, and the vaccines AF to the SPRP approved on October 13, 2020[1]. It consists of an original IDA credit of US$35 million equivalent, approved on May 2, 2020, and an AF IDA credit of US$100 million equivalent approved on April 16, 2021. The proposed WB-AIIB co-financing will expand activities under the Parent Project and the first AF to enable the GOCI to (i) expand COVID-19 vaccination coverage to reach the new coverage target of 70 percent and provide booster doses to 9.9 million people (35.0 percent of the population)[2]; (ii) reinforce preparedness and response interventions at scale; and (iii) strengthen relevant health systems to ensure effective vaccine deployment in Côte d'Ivoire (CIV), sustained containment of COVID-19, and position the country to detect and respond to future disease outbreaks in

[1] The WB approved a US$12 billion WBG Fast Track COVID-19 Facility (FTCF or "the Facility) to assist IBRD and IDA countries in addressing the global pandemic and its impacts. Of this amount, US$6 billion came from IBRD/IDA ("the World Bank) and US$6 billion from the International Financing Corporation (IFC). The IFC subsequently increased its contribution to US$8 Billion, bringing the FTCT total to US$14 billion. The AF of US$12 billion was approved on October 13, 2020, to support the purchase and deployment of vaccines as well as strengthening the related immunization and health care delivery system.

[2] The Ministry of Health (*Ministére de la Santé, de l'Hygiène Publique et de la Couverture Maladie Universelle; MSHP-CMU)* recommends a COVID-19 booster dose for adults and adolescents (12 years and older) at six months after completion of the primary vaccination series.

a swift, effective and efficient manner.

2. **The WB-AIIB co-financing will**: (i) scale-up activities under the Parent Project and first AF, and finance new activities based on lessons learned during implementation; (ii); revise the Results Framework (RF) to measure the impact of the expanded financing envelope; (iii) establish AIIB as a co-financing partner for the project and modify the fiduciary and disbursement arrangements and estimates to include AIIB contribution; (iv) modify the institutional arrangements to enhance project implementation; and (v) extend the closing date of the project from June 30, 2022, to June 30, 2024. The need for additional resources to expand the COVID-19 response was formally conveyed to the WB by the GOCI on September 22, 2021.

3. **The purpose of the proposed WB-AIIB co-financing is to provide upfront financing to support the GOCI purchase and deploy COVID-19 vaccines that meet the WB's vaccine approval criteria (VAC), whilst strengthening the resilience of the health system. This financing will support the country expand COVID-19 vaccination coverage, namely supporting the acquisition and deployment of vaccines to reach the new goals of 70 percent vaccination coverage and booster doses for 9.9 million people (35.0 percent of the population)[3].** The national COVID-19 immunization coverage target for the country is to reach at least 70 percent of the population by December-2022. The COVID-19 Vaccines Global Access (COVAX) Advance Market Commitment (AMC) Facility[4] is expected to support the cost of vaccines for 36.6 percent of the country's population (10.4 million people) by December 2023. The GOCI has procured vaccines for 4.7 percent of the population, it received bilateral donations[5] for an additional 9.1 percent of the population and donations from Master Card for 6.4 percent of the population. The first AF is supporting the purchase of COVID-19 vaccines for 21.1 percent of the country's population (5.9 million people), through the COVAX Facility and the African Vaccine Acquisition Trust (AVAT)[6]. It also covers the deployment costs, including for subsidized doses. As of April 16, 2021, the WB accepts as the threshold for eligibility of IBRD/IDA resources in COVID-19 vaccine acquisition and/or deployment under WB-financed projects: (i) the vaccine has received regular or emergency licensure or authorization from at least one of the stringent regulatory authorities identified by the World Health Organization (WHO) for vaccines procured and/or supplied under the COVAX Facility, as may be amended from time to time by

[3] The Ministry of Health (*Ministére de la Santé, de l'Hygiène Publique et de la Couverture Maladie Universelle; MSHP-CMU)* recommends a COVID-19 booster dose for adults and adolescents (12 years and older) at six months after completion of the primary vaccination series.

[4] **COVAX** is one of three pillars of the Access to COVID-19 Tools (ACT) Accelerator, which was launched in April 2020 in response to the COVID-19 pandemic. It brings together governments, global health organizations, manufacturers, scientists, private sector, civil society, and philanthropy, with the aim of providing innovative and equitable access to COVID-19 vaccines. COVAX is coordinated by the Global Alliance for Vaccines and Immunization (GAVI), the Coalition for Epidemic Preparedness Innovations (CEPI) and WHO, and acts as a platform that supports research, development, and manufacturing of a wide range of COVID-19 vaccine candidates and negotiates their pricing. It includes 192 countries covering more than 7 billion people and ensures fair and equal access to COVID-19 vaccines supplied through UNICEF.

[5] Bilateral COVID-19 vaccine donations were made to the GOCI from the governments of India, France, and China.

[6] **AVAT**: The African Vaccine Acquisition Trust (AVAT) is a special purpose vehicle, incorporated in Mauritius. AVAT acts as a centralized purchasing agent on behalf of the African Union (AU) Member States, to secure the necessary vaccines and blended financing resources for achieving Africa's COVID-19 vaccination strategy which targets vaccinating a minimum of 60 percent of Africa's population based on a whole-of-Africa approach. AVAT was established by the COVID-19 African Vaccine Acquisition Task Team, which was set up in November 2020 by President Cyril Ramaphosa, President of the Republic of South Africa, in his capacity as Chairperson of the AU, as a support component to the COVID-19 Immunization Strategy that was endorsed by the AU Bureau of Heads of State and Government in August 2020.

WHO; or (ii) the vaccine has received WHO Prequalification or WHO Emergency Use Listing. The proposed financing will (i) help CIV fulfill its vaccine order through AVAT and procure additional vaccine doses covering 27.1 percent of the population; (ii) deploy all vaccines that meet the WB's VAC, including those received through COVAX and from donations to reach the 70 percent vaccination coverage and provide booster doses for those eligible by 31, December 2022 and (iii) will also strengthen relevant health systems, based on lessons learned from the ongoing campaign, to ensure effective vaccine deployment and position the country to be better prepared for future public health emergencies. The country will continue providing free of cost COVID-19 vaccinations to the population.

4. **The WB-AIIB co-financing maximizes synergies among partners** by supporting the Ministry of Health (*Ministére de la Santé, de l'Hygiène Publique et de la Couverture Maladie Universelle; MSHP-CMU)* to mount a coordinated and effective health response, guided by the GOCI's COVID-19 Health Response Plan[7], as well as the National Deployment and Vaccination Plan for COVID-19 vaccines[8] (NDVP) (*Plan National de Vaccination et de Déploiement des vaccins contre la COVID-19 en Côte d'Ivoire*), both of which were developed with support from WHO, the United Nations International Children's Emergency Fund (UNICEF) and other partners in the sector. The NDVP is being updated with the support of technical partners in the sector, to incorporate the new vaccination coverage target of 70 percent, the introduction of booster doses and the revision of the deployment strategy to integrate COVID-19 vaccinations in routine health services. The WB-AIIB co-financing will minimize the transaction costs and administrative burden on the GOCI during the emergency. The proposed co-financing will follow the institutional Co-financing Framework Agreement signed between the two Multilateral Development Banks in December 2021. Therefore, the co-financing will use the WB's policies and procedures on the Environmental Social Framework (ESF), fiduciary, project monitoring and reporting. The WB and AIIB Task Teams are coordinating closely during project preparation and will continue this approach during implementation including conducting joint supervision missions. A Project Co-Lender's Agreement (CLA) will be developed between the WB and AIIB outlining all services to be carried out by the WB under this project.

Sectoral and Institutional Context

5. **Since its first case of COVID-19, detected on March 11, 2020, CIV has experienced recurrent waves of the pandemic with the most recent ending in January 2022 (Figure 1). The resurgence in cases has been driven by the spread of highly transmissible COVID-19 variants, low COVID-19 vaccination coverage, increasing social interactions and the inconsistent application of public health measures (e.g., social distancing, handwashing, mask wearing etc.).** As of March 15, 2022, CIV reports a total of 81,616 COVID-19 cases, including 796 deaths. The highest incidence of COVID-19 cases was observed in December 2021 due to the Omicron variant, while the deadliest wave was associated with the spread of the Delta variant between July-October 2021 (Figure 1). The majority of persons who have died of COVID-19 in CIV were not vaccinated, and around 80 percent of deaths were amongst individuals over 50 years old and/or persons with chronic diseases. Hospitalizations increased significantly, with most public and private hospitals reportedly more than 80 percent saturated, and oxygen supplies were low, which put a strain on the already fragile, health system. The country aims to significantly accelerate COVID-19 vaccination coverage before a next wave emerges.

[7] MSHP-CMU (2020) : Plan de riposte contre les infections respiratoires aiguës a Coronavirus-COVID-19 Côte d'Ivoire.
[8] MSHP-CMU (2021) : Plan national de vaccination et de déploiement des vaccins contre la COVID-19 en Côte d'Ivoire.

6. **CIV's COVID-19 vaccination campaign has accelerated following a slow start.** The vaccination campaign was launched on March 1, 2021. However, high levels of misinformation, lack of trust in the vaccine, and vaccine hesitancy[9] hindered the uptake of the vaccine and the vaccination rate stagnated at ~2000 doses administered a day. Daily vaccination rates increased by mid-April 2021 to ~20,000 following the launch of a robust communication and community mobilization campaign, and to ~150,000 by mid-December 2021 following an intensification of the vaccination campaign in response to the third wave of the outbreak. As of March 14, 2022, CIV has administered 10.5 million COVID-19 vaccine doses; 5.9 million people have received at least one dose and 4.2 million people have been completely vaccinated (14.8 percent of the population and 29.0 percent of adults over 18 years old). The GOCI provides free of cost COVID-19 vaccinations to the population.

7. **COVID-19 vaccine supply was initially unpredictable, largely due to limited global production of vaccines and its inequitable distribution**. **Supply and donations have since increased since August 2021, and the priority has shifted to enhancing deployment capacity to reach the 70 percent coverage target and administer booster doses, and to strengthening national systems for public health preparedness.** During the first five months of the campaign, only 1.9 million COVID-19 doses were delivered to CIV. Disruptions in the availability of specific vaccines (e.g., AstraZeneca), coupled with inconsistent delivery schedules of available vaccines, led to periods of vaccine stock-outs in CIV, which had a negative impact on the campaign. Vaccine deliveries have accelerated since August 2021, with 19.7 million doses delivered over the past seven-months (August 20 - March 16, 2022), and the Government has since intensified the vaccination campaign to accelerate the deployment of vaccines. As of March 16, 2022, CIV has received 21.0 million COVID-19 vaccine doses, enough to completely vaccinate 13.1 million people (46.2 percent of the population)[10]. The challenge today for the country remains to (i) create a growing and consistent demand for COVID-19 vaccinations, (ii) strengthen the resilience of the health system, and (iii) accelerate the complete reopening of the country and the recovery of the Ivorian economy.

C. Proposed Development Objective(s)

Original PDO

8. To prevent, detect, and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Cote d'Ivoire.

Current PDO

9. The Project Development Objective (PDO) of the Parent Project and first AF, is to prevent, detect, and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in CIV. The PDO will remain the same for the proposed WB-AIIB co-financing

Key Results

10. The Results Framework will be modified (Table 1) to reflect the expanded scope and the new

[9] A UNICEF survey including 2,266,329 individuals in CIV showed that 55 percent of people did not plan on being vaccinated. The main reasons presented by those refusing to be vaccinated included: (i) do not want to be infected with COVID-19 (40 percent); (ii) does not believe in the COVID-19 vaccine (34 percent); (iii) not interested or concerned (14 percent) and (iv) rumors circulating. Source: UNICEF: U-REPORT survey on the COVID-19 vaccination within the context of the COVID-19 response

[10] Total COVID-19 vaccine doses received as of March 16, 2022: AstraZeneca (3,342,490 doses); Pfizer (6,199,830); Sinopharm (6,197,200); Johnson & Johnson (5,272,600).

activities under the proposed WB-AIIB co-financing and measures overall progress in the coverage and deployment of the COVID-19 vaccine.

Table 1: Results Framework modifications		
		Modifications
	PDO Indicators	
1.	Number of COVID-19 tests conducted (disaggregated by sex of beneficiary) (number).	**Formulation modified and target revised**
2.	Percentage of positive COVID-19 cases (disaggregated by sex) (percentage)	**Formulation modified**
3.	Percentage of the target population fully vaccinated against COVID-19 vaccine (disaggregated by sex) (percentage).	**Target revised**
4.	Percentage of priority population vaccinated, based on the targets defined in the National plan (disaggregated by priority group and sex).	**Target revised**
5.	Percentage of population covered by the communication, consultation, social and community mobilization interventions.	**Revised target**
6.	Proportion of regional health poles that has an operational Emergency Operations Centre (EOC).	**New**
C1	**Intermediate Indicators**	
(1)	Number of healthcare workers trained by project on COVID-19 infection, prevention, and control (IPC) preparedness and response (disaggregated by sex).	**Revised target**
(1)	Percentage of target structures (health facility, isolation centers, and cold chain) renovated and/or equipped.	**Formulation modified and target revised**
(1)	Total number of cases of AEFI notified (disaggregated as severity or non-severe).	**Revised target**
(1)	Proportion of health districts with a budgeted micro-plan for COVID-19 vaccination campaign.	**Unchanged**
(1)	Proportion of regional health poles containing a laboratory with the capacity to conduct PCR tests.	**New**
(1)	Number of women accessing COVID-19 vaccinations on mobile vaccination clinics	**New**
(1)	Proportion of the population that received a booster dose	**New**
C2		
(2)	• Proportion of local radio stations communicating awareness campaigns about COVID-19 and the COVID-19 campaign	**Formulation modified and target revised**
(2)	• Proportion of planned communication interventions implemented	**Revised target**
(2)	• Proportion of health districts covered by communication activities	**Revised target**
C3		
(3)	Proportion of vaccination files captured in the digital vaccination platform	**New**
(3)	Number of vaccinators trained on SEA/SH (disaggregated by sex)	**Revised target**
(3)	Proportion of health districts that have functional committees in place for management of complaints	**Revised target**
SC = Sub-component		

D. Project Description

11. **The proposed WB-AIIB co-financing and restructuring of the CIV-SPRP includes the following changes**:

a) **Scale-up of activities under Component 1, 2 and 3 of the project** to (i) procure additional COVID-19 vaccines and related consumables; (ii) support operational costs for the deployment of vaccines that meet the WB's VAC, including those donated through COVAX and other sources; (iii) monitor and track vaccine deployment, and record and manage adverse reactions to vaccinations; (iv) intensify social mobilization and community engagement activities to enhance demand for COVID-19; and (v) support key investments to ensure effective vaccine deployment, improve health service delivery, and reinforce the laboratory surveillance network .

b) **Introduce new activities based on lessons learned**: Specifically, the project will:

1) Support prevention and preparedness activities in the 10 regional health poles[11] to enhance the country's capacity to deal with the re-emergence of COVID-19 and other pathogens of animal origin.
2) Procure mobile clinics to strengthen vaccination deployment in large informal markets, rural communities, and cultural events.
3) Support the software and hardware costs for the deployment of electronic medical records at select vaccination sites (primary health facilities and *Treichville-Marcory Parc des sport* vaccination center), training of users of the system, and costs related to (i) the integration of COVID-19 and vaccination data into the DHIS2 system, (ii) linking this data to patient medical records, and (iii) using data to generate digital vaccination cards. The WB-AIIB co-financing support to strengthen the digital health infrastructure will complement that provided under WB's SPARK-Health Project (P167959)[12] and the Enhancing Government Effectiveness for Improved Public Services project (P164302)[13].
4) Maintenance cost for cold-chain equipment procured under the first AF.
5) Recruit recent graduates from the National Health Worker's training Institute (*l'Institute National de Formation des Agents de Santé; INFAS*) as contractual frontline health workers in vaccination sites at health facilities situated outside Abidjan, in deprived or rural health districts, to reinforce vaccine deployment, support the integration of the vaccination campaign into routine services, and enhance delivery of routine health services.
6) Contracting with private health facilities (hospitals, clinics, and pharmacies) for COVID-19 vaccine deployment and COVID-19 case management services.
7) Strengthen clinical care capacity in the 10 regional health poles by financing the rehabilitation and equipping of medical imagery units in regional hospitals and laboratories (peripheral and regional) for the diagnosis of priority diseases, and the procurement and installation of oxygen generator machines. Strengthen the capacity of the National Public Health laboratory (*Laboratoire National de la Santé Publique; LNSP)* to conduct external quality evaluations of

[11] The 10 regional health poles include: Abidjan, San Pedro, Man, Odienné ; Korhogo; Daloa, Bouaké, Yamoussoukro, Abengouru and Bondoukou.

[12] SPARK-Health project: Financing the deployment of electronic medical records in hospitals (regional and district level) across the country.

[13] The Enhancing Government Effectiveness for Improve: Financing the deployment of the Hospital Information System (HIS) software, which will digitalize and integrate all patient, clinical, administrative, and financial workflows across the three levels of the health pyramid (primary, level, tertiary) of Côte d'Ivoire's public health sector.

laboratories supported by the project, and the Regional Center for Evaluation in Education, Environment, Health and Accreditation in Africa (*Centre regional d'évaluation en education, environnement, santé et d'accréditation en Afrique; CRESAC*) to undertake their certification.

8) Logistic support for the transport and deployment of vaccines at the subnational level including the procurement of trucks and motorbikes, maintenance costs for these items, as well as fuel.
9) Link monthly financial incentives (per diems and allowance) for vaccinators to the digital transmission of COVID-19 vaccination data to the COVID-19 digital vaccination platform and the DHIS2.

c) **Revise the RF** to measure the impact of the expanded financing envelope.
d) **Extend the closing date** of the project from June 30, 2022, to June 30, 2024, to allow sufficient time for the implementation of activities, especially considering the uncertainties around evolution of the pandemic.
e) **Establish AIIB as a co-financing partner for the project and modify the fiduciary and disbursement arrangements and estimates** to include AIIB contribution.
f) **Modify the institutional arrangements** to improve coordination and enhance project implementation.

Project Components

12. **Component 1: Emergency COVID-19 Response: US$267.4 million (parent project: US$28.8 million; first AF: US$93.7 million; proposed WB-AIIB co-financing: US$144.9 million (WB = US$64.4 million, AIIB = US$80.5 million)).** The proposed WB-AIIB co-financing will finance the scale-up of activities under the parent project and first AF.

13. **Sub-component 1.1: Strengthening national and sub-national capacities for COVID-19 case detection and clinical management.** The proposed WB-AIIB co-financing will support the scale-up of the following key activities: (i) procurement of COVID-19 diagnostic tests, personal protective equipment (PPE), sanitation kits (handwashing stations, soap, sanitizer, face masks etc.); (ii) procure COVID-19 specific medical equipment, medicine and consumables for designated COVID-19 treatment centers and intensive care units (ICUs); (iii) procurement of essential laboratory and diagnostic equipment to strengthen COVID-19 testing, genomic sequencing, surveillance capacity; (iv) costs related to hazard/indemnity pay for health personnel directly involved in the COVID-19 response, consistent with the Government's policies; and (iv) costs related to medical waste management and disposal systems for health facilities and mobile vaccination units, and operationalization of the grievance redress mechanism. **The following new activities will be financed** in the 10 regional health poles (Abidjan, San Pedro, Man, Odienné ; Korhogo; Daloa, Bouaké, Yamoussoukro, Abengouru and Bondoukou): (a) costs to establish a network of public health emergency operating centers (EOCs) to strengthen preparedness, response, coordination, and resilience at the sub-national level during public health emergencies. This includes costs related to the rehabilitation and equipping (including information systems) of the EOC, development and validation of EOC plans, simulation exercises, training of staff, and operational costs; (b) equip and support operational costs of the National Public Health Institute sub-national branches (*l'Institute National d'Hygiene publique; INHP*), the regional warehouses of the Expanded Programme on Immunization (EPI) and sub-national structures of the MSHP-CMU (e.g. district health office, regional directorates, etc.) to reinforce their operational capacity to manage public health emergencies; (c) rehabilitate and equip medical imagery departments of regional and general hospitals; (d) procure and install oxygen generator

machines; (e) support costs to contract private health facilities for COVID-19 case management services; (f) rehabilitate and equip regional laboratories to strengthen the diagnosis of priority diseases, strengthen the capacity of the LNSP to conduct external quality evaluations and CRESAC to undertake certifications. The GOCI will provide to the WB and AIIB laboratory norms, a gap analysis, and a list of laboratories to be supported.

14. **Sub-component 1.2: COVID-19 vaccine planning, procurement, and deployment**. The proposed WB-AIIB co-financing will scale-up the following activities: (i) procurement, importation, storage, and distribution, including operational costs, of COVID-19 vaccines that meet the WB's VAC through mechanisms selected by the country (COVAX, AVAT or from manufacturers); (ii) procurement and distribution of vaccine supplies (e.g., syringes, etc.), furniture for vaccination rooms, vaccination tents, PPE, and hygiene products for vaccinators. **The following new activities will also be financed:** a) procurement of 10 mobile vaccination clinics and maintenance costs; b) cost related to the maintenance of cold chain equipment procured under the first AF (c) logistic support for the transport and deployment of vaccines at the subnational level including the procurement of trucks and motorbikes, and maintenance costs for these items, as well as fuel; (d) contracting with private health facilities (hospitals, clinics and pharmacies) for COVID-19 vaccine deployment; (e) linking of monthly financial incentives (per diems and allowance) for vaccinators to their performance (in terms of doses administered) and the digital transmission of COVID-19 vaccination data to the COVID-19 digital vaccination platform and the DHIS2. The method of verification will be detailed in the Project Implementation Manual (PIM), to be updated and adopted before the project effective date. An independent agency may be recruited, if needed, to validate a sample of the vaccination data captured on the digital platform. (f) Recruitment of 1000 recent nursing graduates from IFAS as contractual frontline health workers in vaccination sites at health facilities situated outside Abidjan, in deprived health districts, for a period of 12 months, to reinforce vaccine deployment, support the integration of the vaccination campaign into routine services, and enhance delivery of routine health services. The GOCI will map and provide to the WB and AIIB staffing norms and a list of vacancies to be filled in deprived or rural health districts where COVID-19 vaccination deployment has been weak. The PIM will detail the remuneration of these surge staff, which should be consistent with the Government's policies. The funds from the WB-AIIB co-financing will only be released on verification of the staff taking up the position and remaining in the deprived area. The method of verification will be described in the PIM. The funds will be linked to the vaccination site and the location, not to the recipients. Therefore, if the recipients leave their posts, they will no longer be remunerated, and the funds will be directed to the new occupants of the posts.

15. **Sub-component 1.3: Pharmacovigilance and monitoring of patients (vaccine safety monitoring and management of adverse events following immunization (AEFI)).** The AIIB co-financing will support the continuation of activities related to the monitoring and management of occurrences of AEFIs, as outlined in the first AF. Specific activities to be scaled-up under this WB-AIIB co-financing: (a) support to health district teams and supervisors to investigate cases of AEFIs; (b) support to the coordination and functionality of the technical and expert structures involved in the management of AEFI, including the Ad hoc committee of AEFI experts; (c) collect and transport biological samples from cases of AEFI to designated laboratories, and analysis of samples (d) maintain an electronic notification system for cases of AEFI; (e) procure and disseminate emergency kits for anaphylactic shock management, and reinforce health structures with resuscitation equipment; (f) transport persons who are victims of severe AEFI to referral facilities and cover costs related to their medical care; (h) support MSHP-CMU to maintain contact

with individuals who have received the first COVID-19 vaccine dose and are awaiting the second dose of the vaccine, as well as individuals eligible for a booster dose. This includes costs related to the purchase of telephone credit and data bundles for site teams and coordination teams to send reminders by phone, text, or email two (02) days before the appointment for the second dose. This proposed WB-AIIB co-financing will not provide support to the national NFCS.

16. **Component 2: Health communication and community engagement: US$19.7 million (parent project: US$5 million; first AF: 1.9 million; proposed WB-AIIB co-financing: US$12.8 million (WB = US$5.7 million, AIIB = US$7.1 million).** The proposed WB-AIIB co-financing will provide additional funds to reinforce and scale all communication and community mobilization activities outlined in the first AF around the COVID-19 pandemic and the vaccination campaign under the first AF. It aims to support the population adopt prevention-related behaviors and counter misinformation around the COVID-19 pandemic, raise public awareness on the COVID-19 vaccination campaign and counter vaccine hesitancy. A survey in five West African countries (Benin, Liberia, Niger, Senegal, and Togo) found that 60 percent of those surveyed said it was "unlikely" that they would get vaccinated, including 44 percent who considered it "highly unlikely". The most common reason for the vaccine hesitancy was that they did not trust their government to ensure that vaccines were safe[14]. Moreover, a study conducted in CIV showed that the main reasons for vaccine hesitancy were a fear of side-effects (37 percent) and a lack of confidence in the vaccine (27 percent). As CIV receives more COVID-19 vaccines and strengthens its deployment capacity, more resources will be invested to build trust and confidence in and create demand for the COVID-19 vaccines.

17. **Sub-component 2.1: Strengthening Community Engagement and Risk Communications.** This sub-component will reinforce activities under the Parent Project aimed at (1) strengthening community engagement and social accountability around COVID-19, (e.g., development of systems for community-based disease surveillance, multi-stakeholder engagement, and training community leaders, extension professionals, community health workers, and volunteers); (2) promote behavior change and enhance risk communication around COVID-19. This will include support to: (i). conduct research to understand people's knowledge, attitudes and practices around COVID-19 and its prevention; (ii). develop, test, and adapt the risk communication strategy and training materials based on data generated from studies conducted; (iii). produce and disseminate messages and provide materials at the community level-based on informed engagement and locally appropriate solutions; (iv). develop guidelines on measures to prevent COVID-19 transmission to operationalize existing or new laws and regulations; (v). provide technical assistance for communication; and (vi). identifying key influencers and working with grassroots level organizations to engage hardest to reach groups and communities; (3) produce and disseminate evidence-based knowledge and information on the COVID-19 pandemic and ensuring this information is channeled through recognized platforms. This support includes a) Training on effective communication for MSHP-CMU staff; b) development of online platforms to disseminate COVID-19 related information; c) production and dissemination of mass media campaigns through radio, television, small message services newspaper, internet, and social media; d) training local media to tailor messages to the needs of their communities and local reporters to cover local initiatives and effective responses.

18. **Sub-component 2.2: Communication, social mobilization, and community engagement to**

[14] Afro barometer 9 march 2021: https://afrobarometer.org/sites/default/files/publications/Dispatches/ad432-covid-19_vaccine_hesitancy_high_trust_low_in_west_africa-afrobarometer-8march21.pdf

enhance demand for COVID-19 vaccines. The sub-component will reinforce activities that promote generalized behavior change and vaccines adherence. This includes costs related to the development and implementation of comprehensive and adaptable social and behavioral change communication interventions to address barriers to COVID-19 vaccine uptake based on public profiling, including : (i) carrying out of studies, surveys and opinion polls on priority groups to assess the level of acceptability and vaccine intention; (ii) development of a strategic communication plan based on the data from studies conducted; (iii) development of key messages and sensitization material; and (iv) targeted sensitization campaigns to remove barriers to vaccine adherence among priority groups.

19. **The proposed WB-AIIB co-financing will reinforce activities that promote social mobilization and community engagement for vaccine demand and use:** (i) capacity building of local traditional leaders, political and religious leaders, women and youth associations, community health workers and other community networks to promote immunization within communities and lead to change, ensuring that voluntarism and informed consent remain at the core of all information and advocacy efforts; (ii) collection and dissemination of experiences and positive stories of primary immunization recipients to build confidence in the vaccine; (iii) activities that support the community ownership process, that value local solutions to generate and increase demand for immunization, control the pandemic and mitigate its impacts, prevent and combat stigma and discrimination, and increase resilience to anti-vaccine rhetoric; and (iv) the collection and analysis of evidence in support of advocacy, decision-making and documentation of approaches, lessons and good practices.

20. **This sub-component will reinforce communication and advocacy activities in support of the COVID-19 vaccine deployment, including costs related to**: (i) capacity building and the day-to-day functioning of the National Working Group on Communication for Vaccines and Vaccination against COVID-19 (ii) upgrading the official digital platforms and strengthening telephone and online help lines; (iii) developing key messages and disseminating them through the mass media, mobile platforms, community channels and relays; (iv) the implementation of a nationwide media campaign following the phasing of the immunization campaign through mass media, social networks and local and community channels/media; (v) strengthening interpersonal communication, the training of front-line actors and the improvement of the flow of information to health professionals; (vi) strengthening the capacity of public and local media professionals to adapt key messages to the needs of local communities; (vii) rumor and crisis management; and (viii) support for feedback initiatives based on the social listening and community feedback.

21. **Component 3: Project implementation, Management and M&E: US$27.9 million (parent project: US$1.2 million; first AF: US$4.4 million; WB-AIIB co-financing: US$22.3 million (WB = US$9.9, AIIB = US$12.4 million)).** The proposed WB-AIIB co-financing will provide additional funds to support the coordination and management of activities under the parent project and first AF, as well as M&E of prevention and preparedness interventions, COVID-19 vaccine deployment, including for AEFI.

22. **Sub-component 3.1: Project management.** This sub-component will continue supporting the coordination and management of activities under the parent project and first AF. The WB-AIIB co-financing will use the existing Project Implementing Unit (PIU) (*l'Unité de Coordination des Projets de la Banque Mondiale; L'UCPS-BM*) for the overall administration, procurement, environmental and social aspects, and FM of the project. The WB-AIIB co-financing will partner and engage with other

organizations, particularly WHO and UNICEF, in various roles such as procurement agents and suppliers, and providers of specialized technical assistance.

23. **Sub-component 3.2: M&E.** This sub-component will continue supporting M&E activities under the parent project and first AF, including the expansion of the electronic system for COVID-19 registration, testing, and vaccination. **The following new activities will also be financed**: a) support the software and hardware costs for the deployment of electronic medical records at select vaccination sites, training of users of the system, and costs related to (i) the integration of COVID-19 and vaccination data into the DHIS system, (ii) linking this data to patient medical records; (iii) using data to generate digital vaccination cards and to use the data for guiding the policy decisions on COVID-19 related vaccination (iv) technical assistance..

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	
Projects in Disputed Areas OP 7.60	

Summary of Assessment of Environmental and Social Risks and Impacts

E. Implementation

24. **The MSHP-CMU is the implementing unit for the Parent Project and the first AF, and this will be maintained under the WB-AIIB co-financing. However, the institutional arrangements will be modified to enhance the implementation of the project at the operational level.** The MSHP-CMU has an established and well-functioning PIU (L'UCPS-BM) responsible for the overall project planning, oversight, coordination, and management, in collaboration with relevant divisions and departments of the MSHP-CMU. L'UCP-BM is organized in three services (i. administrative and financial management; ii. programs and M&E; and iii. Procurement and contract management) and has extensive experience in managing projects financed by the WB and other partners. The project will leverage the capacity of the existing PIU within the MSHP-CMU to ensure effective implementation of the WB-AIIB co-financing. The overall governance of the WB-AIIB co-financing will be provided by a new Steering Committee, which will be established by an order of the Minister of Health (*arrêté*) before effectiveness. The Steering Committee, whose composition will be approved by the WB and AIIB, will provide strategic and policy guidance and oversight, will ensure the supervision and execution of the project. The existing Steering Committee (for the parent project and first AF) was originally established in 2020 to coordinate the national COVID-19 Preparedness and Response Plan. With the evolution of the pandemic, the introduction of vaccines and the shift in priority towards the preparedness and resilience of health system, Government plans to modify the composition of the Steering Committee to better support project implementation. A technical monitoring committee will be established for the coordination of activities at the national level.

25. **As with the Parent Project and first AF, the MSHP-CMU' technical units[15] , under the supervision of the Direction General of health, will continue the technical implementation of activities under the WB-AIIB co-financing.** However, these technical units will benefit from reinforcements and technical assistance support by the project and intensive support and supervision of project implementation will continue. The MSHP-CMU will partner with other partners (United Nations (UN) Agency, civil society, private sector, etc.) for the deployment of COVID-19 vaccines. The project operational documents (Vaccine Delivery and Distribution Manual; VDDM/Project Operational Manual; POM) will make clear that the country's regulatory authority is responsible for its own assessment of the project COVID-19 Vaccines' safety and efficacy and is solely responsible for the authorization and deployment of the vaccines in the country.

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[15] The MSHP-CMU technical units include the National Institute of Public Health, the Expanded Program on Immunization.

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