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Report No: PAD 3828

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT
PROPOSED INTERNATIONAL DEVELOPMENT ASSOCIATION GRANT
IN THE AMOUNT OF SDR 59.1 MILLION
(US$81 MILLION EQUIVALENT)

AND A

PROPOSED INTERNATIONAL DEVELOPMENT ASSOCIATION GRANT
IN THE AMOUNT OF SDR 14.1 MILLION
(US$19.4 MILLION EQUIVALENT)
IN CRISIS RESPONSE WINDOW RESOURCES

TO THE

ISLAMIC REPUBLIC OF AFGHANISTAN

FOR A

COVID-19 EMERGENCY RESPONSE AND HEALTH SYSTEMS PREPAREDNESS PROJECT

UNDER THE
COVID-19 STRATEGIC PREPAREDNESS AND RESPONSE PROGRAM (SPRP)

USING THE MULTIPHASE PROGRAMMATIC APPROACH (MPA)
WITH A FINANCING ENVELOPE OF
US$2.7 BILLION IBRD AND $1.3 BILLION FROM IDA CRISIS RESPONSE WINDOW
APPROVED BY THE BOARD ON APRIL 2, 2020

HEALTH, NUTRITION AND POPULATION
SOUTH ASIA REGION

CURRENCY EQUIVALENTS

(Exchange Rate Effective February 29, 2020)

Currency Unit =	Afghani (AFN)
AFN 0.0131 =	US$1
US$1=	SDR 0.7282

FISCAL YEAR
December 21 - December 20

Regional Vice President:	Hartwig Schafer
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ABBREVIATIONS AND ACRONYMS

ARTF	Afghanistan Reconstruction Trust Fund
BPHS	Basic Package of Health Services
CDC	Community Development Councils
CERC	Contingent Emergency Response Component
COVID-19	Coronavirus Disease 2019
CPF	Country Partnership Framework
EMDE	Emerging Markets and Developing Economies
ESCP	Environmental and Social Commitment Plan
ESMF	Environmental and Social Management Framework
EPHS	Essential Package of Hospital Services
EVD-WA	West Africa Ebola virus disease
FAs	Framework agreements
FM	Financial Management
FTF	Fast Track Facility
GCMU	Grant and Services Contract Management Unit
GCC	Gulf Cooperating Council
GDP	Gross Domestic Product
GRS	Grievance Redress System
HEIS	Hands-on Expanded Implementation Support
HMIS	Health Management Information System
IHR	International Health Regulations
IMF	International Monetary Fund
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IDP	Internally Displaced People
IFC	International Finance Cooperation
IPF	Investment Project Financing
JEE	Joint External Evaluation
M&E	Monitoring and Evaluation
MDB	Multilateral Development Bank
MOF	Ministry of Finance
MOPH	Ministry of Public Health
NGO	Nongovernmental Organization
NPA	National Procurement Authority
PDO	Project Development Objective
SCD	Systematic Country Diagnostics
SEP	Stakeholder Engagement Plan
SOE	Statements of Expenditures
SOP	Standard Operating Procedure
SP	Service Providers

STC	Short-term Consultants
TPM	Third-Party Monitoring
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Country	Project Name	
Afghanistan		
Project ID	**Financing Instrument**	**Environmental and Social Risk Classification**
P173775	Investment Project Financing	High

Financing & Implementation Modalities

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

Expected Approval Date	Expected Closing Date
March 17, 2020	March 31, 2024
Bank/IFC Collaboration	
NO	

MPA Program Development Objective

The Program Development Objective (PDO) 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

Proposed Development Objective(s)

The proposed project development objective is to respond to, and mitigate the threat posed by COVID-19 and strengthen national systems for public health preparedness in Afghanistan.

Components

Component Name	Cost (US$, millions)

Component 1: Emergency COVID-19 Response (US$14 million from COVID19 FTF, US$20 million IDA)
Component 2: Health Care Strengthening (US$46 million IDA)
Component 3: Mitigation of Social Impacts (US$5.4 million from COVID19 FTF)
Component 4: Implementation Management and Monitoring and Evaluation (US$5 million IDA)
Component 5: Contingent Emergency Response Component (CERC) (US$0 million)
Unallocated Amount of US$10 million (IDA) available for reallocation across the project component as may be needed over the project life.

Organizations

Borrower: The Islamic Republic of Afghanistan

Implementing Agency: Ministry of Public Health

MPA FINANCING DETAILS (US$, Millions)

Board Approved MPA Financing Envelope:	0.00
MPA Program Financing Envelope:	4,000.00
of which Bank Financing (IBRD):	2,700.00
of which Bank Financing (IDA):	1,300.00
of which other financing sources:	0.00

PROJECT FINANCING DATA (US$, Millions)

CRW: US$19.4 Million
IDA Grant: US$ 81.0 Million

World Bank Group Financing

International Development Association (IDA)	100.4
IDA Grant	19.4
IDA Grant	81.0

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
Afghanistan				
Crisis Response Window (CRW)		19.4	0.00	19.4
IDA		81.0	0.00	81.0
Total		**100.4**	**0.00**	**100.4**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2020	2021	2022	2023	2024
Annual	30	20	25	15	10.4
Cumulative	30	50	75	90	100.4

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

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

[X] Yes [ ] No

Have these been approved by Bank management?

[X] Yes [ ] No

Is approval for any policy waiver sought from the Board?

[ ] Yes [X] 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	Relevant
Stakeholder Engagement and Information Disclosure	Relevant
Labor and Working Conditions	Relevant
Resource Efficiency and Pollution Prevention and Management	Relevant
Community Health and Safety	Relevant
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
Cultural Heritage	Relevant
Financial Intermediaries	Not Currently Relevant

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. **This Project Appraisal Document (PAD) describes the emergency response to Afghanistan under the COVID-19 Strategic Preparedness and Response Program (SPRP) using the Multiphase Programmatic Approach (MPA),** with an overall Program financing envelope of International Development Association (IDA) US$100.4 million.

A. MPA Program Context

2. **An outbreak of the coronavirus disease (COVID-19) caused by the 2019 novel coronavirus (SARS-CoV-2) has been spreading rapidly across the world since December 2019, following the diagnosis of the initial cases in Wuhan, Hubei Province, China.** Since the beginning of March 2020, the number of cases outside China has increased thirteenfold and the number of affected countries has tripled. On March 11, 2020, the World Health Organization (WHO) declared a global pandemic as the coronavirus rapidly spreads across the world. As of March 25, 2020, the outbreak has resulted in an estimated 414,179 cases and 18,440 deaths in 169 countries.

3. **COVID-19 is one of several emerging infectious diseases (EID) outbreaks in recent decades that have emerged from animals in contact with humans, resulting in major outbreaks with significant public health and economic impacts.** The last moderately severe influenza pandemics were in 1957 and 1968; each killed more than a million people around the world. Although countries are now far more prepared than in the past, the world is also far more interconnected, and many more people today have behavior risk factors and pre-existing chronic health problems that make viral respiratory infections particularly dangerous.[1] Studies of hospitalized patients have found that about 83 percent to 98 percent of patients develop a fever, 76 percent to 82 percent develop a dry cough and 11 percent to 44 percent develop fatigue or muscle aches.[2] Other symptoms, including headache, sore throat, abdominal pain, and diarrhea, have been reported, but are less common. While 3.7 percent of the people worldwide confirmed as having been infected have died, WHO has been careful not to describe that as a mortality rate or death rate. This is because in an unfolding epidemic it can be misleading to look simply at the estimate of deaths divided by cases so far. Hence, given that the actual prevalence of COVID-19 infection remains unknown in most countries, it poses unparalleled challenges with respect to global containment and mitigation. These issues reinforce the need to strengthen the response to COVID-19 across all IDA/IBRD countries to minimize the global risk and impact posed by this disease.

4. **This project is prepared under the global framework of the World Bank COVID-19 Response financed under the Fast Track COVID-19 Facility (FTCF).** It combines the US$19.4 million from the IDA FTCF allocation for Afghanistan and US$81 million from Afghanistan's IDA Performance based allocation (PBA). The total amount of US$100.4 million is an IDA Grant.

B. Updated MPA Program Framework

5. Table-1 provides an updated overall MPA Program framework.

[1] Fauci, AS, Lane, C, and Redfield, RR. 2020. "Covid-19 — Navigating the Uncharted." New Eng J of Medicine, DOI: 10.1056/NEJMe2002387
[2] Del Rio, C. and Malani, PN. 2020. "COVID-19—New Insights on a Rapidly Changing Epidemic." JAMA, doi:10.1001/jama.2020.3072

Table 1. MPA Program Framework

Phase #	Project ID	Sequential or Simultaneous	Phase's Proposed DO*	IPF, DPF or PforR	Estimated IBRD Amount ($ million)	Estimated IDA Amount ($ million)	Estimated Other Amount ($ million)	Estimated Approval Date	Estimated Environmental & Social Risk Rating
1.	P173775	Simultaneous	Please see relevant PAD	IPF		US$100.4		April 2, 2020	Moderate

6. All projects under SPRP are assessed for ESF risk classification following the Bank procedures and the flexibility provided for COVID-19 operations.

C. Learning Agenda

7. Given the limited experience with COVID-19, Afghanistan will engage in exchange of information across countries, facilitated by international partners such as the World Bank. Learning will focus on, inter alia, supply chain approaches during times of emergencies and disrupted global supply chains, including assessments for timely distribution of medicines and other medical supplies. Another area of learning will be how to engage in social distancing and risk communication in an FCV context. A mixed method approach will be employed, using quantitative and qualitative methodologies.

II. CONTEXT AND RELEVANCE

8. This Project Appraisal Document (PAD) describes the emergency response to the Islamic Republic of Afghanistan under the COVID-19 Strategic Preparedness and Response Program (SPRP) using the Multiphase Programmatic Approach (MPA) with an overall Program financing envelope of International Development Association (IDA) US$1.3 billion and of International Bank for Reconstruction and Development (IBRD) US$2.7 billion.

9. **An outbreak of the coronavirus disease (COVID-19) caused by the 2019 novel coronavirus (SARS-CoV-2) has been spreading rapidly across the world since December 2019, following the diagnosis of the initial cases in Wuhan, Hubei Province, China**. Since the beginning of March 2020, the number of cases outside China has increased thirteenfold and the number of affected countries has tripled. On March 11, 2020, the World Health Organization (WHO) declared a global pandemic as the coronavirus rapidly spreads across the world. Figure 1 provides details about the global spread of COVID-19. As of March 13, 2020, the outbreak has resulted in an estimated 145,369 cases and 5,429 deaths in 139 countries.

10. **COVID-19 is one of several emerging infectious diseases (EID) outbreaks in recent decades that have emerged from animals in contact with humans, resulting in major outbreaks with significant public health and economic impacts.** The last moderately severe influenza pandemics were in 1957 and 1968; each killed more than a million people around the world. Although countries are now far more prepared than in the past, the world is also far more interconnected, and many more people today have behavior risk factors such as tobacco use[3] and pre-existing chronic health problems

[3] Marquez, PV. 2020. "Does Tobacco Smoking Increases the Risk of Coronavirus Disease (Covid-19) Severity? The Case of China."

that make viral respiratory infections particularly dangerous[4]. With COVID-19, scientists are still trying to understand the full picture of the disease symptoms and severity. Reported symptoms in patients have varied from mild to severe, and can include fever, cough and shortness of breath. In general, studies of hospitalized patients have found that about 83% to 98% of patients develop a fever, 76% to 82% develop a dry cough and 11% to 44% develop fatigue or muscle aches[5]. Other symptoms, including headache, sore throat, abdominal pain, and diarrhea, have been reported, but are less common. While 3.7% of the people worldwide confirmed as having been infected have died, WHO has been careful not to describe that as a mortality rate or death rate. This is because in an unfolding epidemic it can be misleading to look simply at the estimate of deaths divided by cases so far. Hence, given that the actual prevalence of COVID-19 infection remains unknown in most countries, it poses unparalleled challenges with respect to global containment and mitigation. These issues reinforce the need to strengthen the response to COVID-19 across all IDA/IBRD countries to minimize the global risk and impact posed by this disease.

11. This project is prepared under the global framework of the World Bank COVID-19 Response financed under the Fast Track COVID-19 Facility (FCTF) and IDA grant.

A. Country Context

12. **Substantial improvements in development outcomes have been observed in Afghanistan since 2001, particularly in expanded access to water, sanitation and electricity, education, and health services.** Macroeconomic management remains strong, government revenues have grown consistently since 2014, and the government has engaged in a range of business environment and public financial management reforms. Expanded access to health, education, and infrastructure has seen rapid improvements in outcomes, with Afghanistan catching up with other low-income countries against key development indicators. While progress has been uneven, increased access to services and infrastructure has driven significant development gains.

13. **At the same time, Afghanistan continues to experience insecurity and political uncertainty**. The final results of the September 2019 Presidential elections were announced only in February 2020. Civilian causalities from ongoing conflict exceeded 10,000 again in 2019: 3,403 civilians killed and 6,989 injured. Displacement crisis persisted and the number of conflict-induced internally displaced people (IDPs) increased from 369,700 in 2018 to more than 400,000 in 2019. About 505,000 refugees returned to Afghanistan, mainly from Iran, during 2019. Negotiations between the US and the Taliban were concluded on February 29, 2020, but the process of a political settlement is only beginning. Meanwhile, current international support pledges are due to expire in December 2020, creating uncertainty regarding the sustainability of security and development expenditures. This has fundamental implications for the economy, with growth and investment constrained by weak confidence.

14. **Afghanistan's economy is estimated to have grown by 2.9 percent in 2019 due to easing of drought conditions and significant agricultural growth.** The trade deficit remains extremely large, over 30 percent of GDP, financed mostly by grant inflows. Fiscal performance continued to improve with domestic revenues reaching 14.1 percent of GDP. Political uncertainties, however, dampened private sector confidence and non-agriculture growth. The basic needs poverty rate was 55 percent at the time of the last survey (2016/17) and is expected to have worsened since. Poverty is expected to remain high. Short-term priorities include continued implementation of reforms to improve private

http://www.pvmarquez.com/Covid-19

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

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

sector confidence, mobilize investment, and ensure confidence of the international community. Over the medium-term, reforms should focus on attracting additional investment in agriculture and extractives, to deliver increased employment, exports, government revenues, and growth. To ensure that benefits of growth are maximized, and widely shared, continued investment is required in human capital, regional connectivity, expanded infrastructure, and an improved business regulatory environment.

15. **The poverty rate in Afghanistan increased markedly from 38 percent in 2012 to 55 percent in 2017.** It is estimated to have grown and deepened since then. Drought-induced displacement has reached record levels of nearly 300,000 individuals. Poverty is expected to remain high in the medium-term due to weak labor demand and security-related constraints on service delivery. Afghanistan's projected growth path will not be strong enough to improve livelihoods for a population expanding at 2.7 percent annually. The widespread poverty makes the population especially vulnerable to extreme weather events such as droughts and floods, and other shocks such as this pandemic.

16. **Afghanistan has a Human Capital Index of 0.39 and ranks 133 out of 157 countries.** This suggests that children born in Afghanistan today will be on average 61 percent less productive than they would be if there was perfect survival, education and health in the country. About 7 out of 100 children do not survive to age 5; children on average have only about 4.9 learning-adjusted years of school (out of a maximum of 14 years); 41 out of 100 children are stunted;[6] and only 78 percent of the population over 15 years survive to the age of 60. In addition to increasing the intrinsic benefits and values of optimal health and education of its people, Afghanistan could more than double its GDP by improving its health and education outcomes.

B. Sectoral and Institutional Context

17. **Despite rising levels of violence over the last decade, notable improvements in the coverage and quality of health services have been made.** Data from household surveys between 2003 and 2018 show significant declines in infant, child and maternal mortality that were driven largely by improvements at the primary and secondary health care levels. Newborn mortality rate fell from 53 to 23 per 1,000 live births from 2003 to 2018 and under-five mortality rate from 257 to 50 per 1,000 live births from 2003 to 2018. However, despite progress on the maternal mortality ratio from 1,600 maternal deaths per 100,000 live births in 2002 to 638 maternal deaths in 2019, the maternal mortality ratio remains among the highest globally.

18. **While basic health care delivery has expanded and improved across the country, the overall health system remains weak.** The Afghan health system has made considerable progress during the past decade thanks to strong government leadership, sound public health policies, prioritization of investments in primary care and the introduction of a basic package of health services (BPHS) and essential package of hospital services (EPHS) for implementation by contracted service providers (SP) except in three provinces where the Ministry of Public Health directly manages health facilities offering BPHS and EPHS. While the nationwide contracting out of public health services to non-governmental organizations is successful with innovative service delivery, strong and focused investments on health information system including third party monitoring (TPM); and donor financial assistance under one umbrella through the Afghanistan Reconstruction Trust Fund (ARTF) platform, the overall health system is fragmented with a considerable amount of funding and health facilities being off-budget.

[6] Afghanistan's HCI is based on 2017 data including the stunting rate of 41. The latest update on the national stunting rate is 36.6 which is from the 2018 Afghanistan Health Survey (AHS).

19. **The COVID-19 situation in Afghanistan is quickly evolving due to cross border concerns.** Afghanistan has already reported cases of COVID-19 and is very vulnerable to a more widespread outbreak. Afghans are frequent travelers to different parts of China for both trade and education. Around 2,000 students are currently studying in different universities in China, among them around 50 in Wuhan City, the epicenter of COVID-19. Many Afghans are also in China for commercial and business purposes.[7] Afghanistan (Herat Province in particular) shares a porous border with Iran which has a large and rapidly evolving outbreak of COVID-19 with serious transmission implications. Along with daily flights from Herat Province to Kabul, local containment of the virus in Afghanistan is more difficult. Eleven cases of COVID-19 have been confirmed in Afghanistan by March 14; most from Herat Province and with travel history to Iran. But recognizing the rapidly contagious nature of the virus, the relatively free population movement over the border, and limited public health capacity, it is very likely that the virus has spread more widely than currently reported, as in other countries, and has the potential to cause substantial harm.

20. **The public health system's capacity for disease outbreak response and preparedness needs strengthening.** A Joint External Evaluation (JEE) of the core capacities in the International Health Regulations (IHR) assessed the strengths and weaknesses in Afghanistan in 2016 and provided a set of recommendations on areas requiring priority interventions to improve the preparedness of the health system. These include: legislation to enable IHR implementation and coordination functions; routine capacity at points of entry, which is currently missing; strengthening capacity for real-time surveillance for surveillance staff on emerging and re-emerging diseases; improving emergency response operations to all public health events through integrating relevant IHR-related functions within the Command and Control Center under Emergency Preparedness and Response for coordinated risk assessment and response; and improving risk communication by developing a national strategic framework and plan for multi-hazard risk communication. Some of the strengths included a national network of active surveillance established as part of the national polio eradication program and a functional public health surveillance information system. The Government has developed a costed national action plan, which includes strengthening the basic health services package to incorporate health security considerations, amounting to US$17.5 million. However, investments and implementation have lagged.

21. **COVID-19 is expected to have negative impacts on Afghanistan's economy.** Trade disruptions are the most important transmission channel, with potential closure of border crossings and export corridors negatively impacting agricultural exports to Pakistan, Iran, India, China, and the Middle-East. Remittance flows (3-7% of GDP), though limited in comparison to some of the neighboring countries, may also be negatively affected. COVID-19 is likely to have further negative impacts on already-low private sector confidence. The risks of major economic disruption, travel restrictions, and public disorder add to existing political and security risks. COVID19 risks may be perceived as substantial by investors. Slower economic growth resulting from COVID-19 could negatively impact already-overstretched fiscal resources available for provision of healthcare services. For those sections of the population directly impacted by economic disruptions arising from COVID-19, reduced incomes may impact access to health services in a country where health expenditure is dominated by out-of-pocket expenditures.

22. **The Government is working closely with technical partners such as; WHO, UNICEF, Humanitarian Health Cluster partners, International Organization for Migration and other relevant stakeholders** to rapidly expand in-country preparedness and containment capacity, to strengthen detection and surveillance capacity at points-of-entry into Afghanistan, such as airports and border-crossing sites (especially in the west), and to continue the training of medical

[7] WHO AFGHANISTAN EMERGENCY RESPONSE to 2019-nC (5 March 2020)

staff on case-management, risk communication and community engagement. The level of support and activities in all key areas will need to be expanded rapidly to manage further spread of the disease. The Ministry of Public Health (MOPH) has established five committees[8] for the surveillance of COVID-19 at the national and provincial level. At the national level, WHO together with the Health Cluster has developed and is implementing a COVID-19 Preparedness Plan to complement the MOPH Emergency Response Plan for Coronavirus 2020 and additional funding is currently being sought for this plan. The current WHO preparedness plan would be updated to cover response activities and include more inter-sectoral components. At the sub-national level, WHO and The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) Western Region (Herat) are supporting the MOPH and humanitarian partners to scale-up their response to COVID-19. Activities that will be financed under the COVID-19 Fast-Track Facility will be coordinated to ensure that gaps are covered, and duplication is minimized.

C. Relevance to Higher Level Objectives

23. **This project was not included in the Country Partnership Framework (CPF), but the emergency has further increased the priority of health protection and treatment in Afghanistan.** This project is aligned with the Afghanistan CPF for 2017–2020 (October 2, 2016), which was extended to FY2022 through the Program and Learning Review (PLR) presented to the Board in July 2019. It supports deepening social inclusion through improved service delivery as well as protection of vulnerable groups in society as one of its priorities. This project is fully in line with the social inclusion objective of the CPF as well as the Bank's commitment to supporting human capital development. Afghanistan joined the Human Capital Project in December 2019. It also supports the Government's commitment as reflected in the Afghanistan National Peace and Development Framework to improve access to services in rural areas and the Afghanistan costed national pandemic preparedness action plan which includes strengthening of the BPHS and EPHS to incorporate health security considerations.

III. PROJECT DESCRIPTION

24. **This project was selected for COVID-19 financing because Afghanistan borders Iran and China with frequent travels to and from the countries and together with the weak capacity to deal with pandemics, puts the country at elevated risk for COVID-19 outbreak spread.** The scope and the components of this project are fully aligned with the COVID-19 Fast Track Facility, using standard components as described in Annex 2 of the COVID-19 Board paper. It complements longer-term development investments in the Health Sector, including the Afghanistan Sehatmandi Project (IDA-D2850), which seeks to increase the utilization and quality of health, nutrition, and family planning services. This COVID-19 project has triggered paragraph 12 of the Investment Project Financing Bank Policy to enable processing and delivery on an emergency basis.

25. **A phased response through the COVID-19 Fast Track Facility is proposed.** While support will be needed to respond to the economic impact of COVID-19 on households, businesses and government budgets, the World Bank's approach is to lead with the health response. As a first phase, most operations processed through the Fast Track Facility will be

[8] Points of Entry Committee; Population Surveillance Committee; Data Management Committee; National COVID-19 Contact Tracing Committee; and the Lab Surveillance Committee.

health sector operations to respond to urgent preparedness and response needs related to the COVID-19 outbreak. In the Afghanistan context, the initial priority will be in the high-risk border provinces (such as Herat which borders Iran), urban areas and major transport centers. In order to address the broader economic impacts of the pandemic, options for support through other financing instruments will be explored as the Facility is established and through country consultations.

26. **Alternative sources of financing considered to support COVID-19 response.** The team considered using existing CERCs and the ongoing Sehatmandi operation. Afghanistan has no CAT-DDO operation. While Afghanistan has 2 operations with CERCs, none of these were found suitable to be used. The Kabul Municipal Development Program is only specific to Kabul and therefore cannot be used to trigger a CERC for the COVID-19 outbreak since not a nation-wide operation. As to the Afghanistan Rural Access Project, it is closing on December 31 and has no remaining IDA available. Regarding reprogramming Sehatmandi resources, it was deemed unwise to restructure an operation which supports basic health service delivery of maternal and child health, at the outset of a health emergency that is expected to worsen. Indeed, past experiences from epidemic outbreaks strongly advise against diverting funds from such basic health services, since it is important that the focus on basic services is not lost. Otherwise, strong reversals in health outcomes will materialize. COVID-19 is expected to create a huge additional burden on the health care system as well as disruption in basic health services delivery. All the undisbursed balance in Sehatmandi will be required to continue delivery of the basic maternal and child health services in the next 18 months.

Project Development Objective

27. The Project objectives are aligned to the results chain of the COVID-19 Strategic Preparedness and Response Program (SPRP)[9].

28. **PDO Statement:** The proposed project development objective is to respond to, and mitigate the threat posed by COVID-19 and strengthen national systems for public health preparedness in Afghanistan.

29. **PDO Level Indicators**

- Proportion of laboratory-confirmed cases of COVID-19 responded to within 48 hours;
- Proportion of specimens submitted for SARS-COV-2 laboratory testing confirmed within WHO stipulated standard time;
- Proportion of population able to identify three key symptoms of COVID-19 and/or seasonal influenza and three personal prevention measures (as assessed by a representative population survey).

30. **The proposed Project will address critical country-level needs for preparedness and response for COVID-19.** It will fill critical financing gaps that have been identified due to the new emergency preparedness and response needs created by COVID-19. To the extent practicable, the project will rely on the proven implementation and fiduciary oversight arrangements currently being used in the Afghanistan Sehatmandi Project, as described below.

[9] See the main text above

31. **Project size and absorptive capacity. The proposed financing amount for the project is US$100.4 million, with US$19.4 million from the World Bank COVID19 Fast-Track Facility and US$81 million from the Afghanistan Regular IDA18 allocation.** The combined IDA financing for Afghanistan will be on a Grant basis. While no-one can predict the trajectory of COVID-19 in Afghanistan, it is extremely important to slow down the spread of the virus such that possible projected high caseloads do not materialize. To be effective, a response/mitigation plan would have to choose strategically where to invest and to use to its maximum efficiency and effectiveness the project amount. Furthermore, the current performance-based contracts with health service providers under the Sehatmandi project are about US$6.5 per capita per year, for a country of 35+ million inhabitants. This financing level is barely sufficient for the provision of basic health services let alone also financing pandemic preparedness. The proposed COVID-19 project provides incremental budget of less than US$1 per capita per year to cover, for example, investments in improving infection prevention and control at hospitals, health worker capacity building, capacity for community-based disease surveillance, a surge in health workers who can deal with the additional caseload expected, increase in quality and capability of diagnostic capacity, and essential equipment, materials, and drugs. Hence the proposed project is an effort to address the constrained fiscal environment. With regards to the absorptive capacity, the health sector has a good track record. Besides that, the UN Agencies can further enhance the implementation capacity. The proposed operation will use the ongoing implementation mechanisms of Sehatmandi (contracted NGOs as experienced services providers who are already mobilized) which will allow the COVID-19 operation to fast track implementation.

32. **Retroactive financing**. Retroactive financing up to US$40 million of the total Grant amount will be allowed for eligible expenditures incurred by the Government from January 1, 2020. The Bank will review related Government expenditures for eligibility to be reimbursed.

B. Project Components

33. The project components are aligned with the objectives of the COVID-19 Strategic Preparedness and Response Program (SPRP), and will comprise five components, including one contingent financing component:

34. **Component 1: Emergency COVID-19 Response (US$14 million from COVID-19 FTF, US$20 million from IDA):** The aim of this component is to slow down and limit as much as possible the spread of COVID-19 in the country. This will be achieved through providing immediate support to enhance disease detection capacities through increasing surveillance capacities, provision of technical expertise, strengthening laboratory and diagnostic systems to ensure prompt case finding and local containment. Enhanced detection capacities will be supported through updated training to existing surveillance workers, improving reporting by frontline health workers using existing surveillance information and, where possible, contact tracing of known cases. Laboratory capacity to diagnose both human and animal health potential diseases at national and provincial level will be strengthened; standardized sample collection, channeling and transportation will be established; introduce point of care diagnostics at selected sites; and establish national accreditation process for testing in public and private laboratories.

35. Local containment will be supported through the establishment of local isolation units in hospitals and widespread infection control training and measures will be instituted across health facilities. This component will enable Afghanistan to mobilize surge response capacity through procurement of essential protective equipment, diagnostics and other essential items, and personnel if needed. There will be a comprehensive communication and behavior change intervention to support key prevention behaviors (washing hands, proper care of livestock to minimize zoonosis, etc.) including developing and testing messages and materials and further enhancing infrastructures to disseminate information from national to provincial and local levels and between the public and private sectors.

Community mobilization will take place through existing community institutions such as community development councils (CDCs), health and school management *shuras* (traditional community councils) as well as religious and tribal leaders. These methods will include TV, radio, social media and printed materials as well as the community health workers who need to be trained and compensated. Provisions will also be made to establish a call center for responding to inquiries about coronavirus from the public and health care providers and screening for suspect cases for testing.

36. **Component 2: Health Care Strengthening (US$46 million from IDA):** The aim of this component is to strengthen essential health care service delivery to be able to provide the best care possible for people who become ill despite a surge in demand. It will also ensure ongoing support for people ill in the community to minimize the overall impact of the disease on society, public services and on the economy. Assistance will be provided to the health care system for preparedness planning to provide optimal medical care and maintain essential lifesaving services and minimize risks for patients and health personnel. Strengthened clinical care capacity will be achieved through financing plans for establishing specialized units in selected hospitals, treatment guidelines, and hospital infection control interventions and procurement of essential additional inputs for treatment such as oxygen delivery systems, medicines and retention of skilled health workers through extra payments (such as hazard pay and death benefits). As COVID-19 will place a substantial burden on inpatient and outpatient health care services, support will be provided to rehabilitate and equip selected health facilities for the delivery of critical medical services and cope with increased demand of services posed by the outbreak, develop intra-hospital infection control measures, including necessary improvements in safe water and sanitation in the 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 technical assistance.

37. Management capacity to respond rapidly to outbreaks will be built through technical, personnel, legal, financial management, and logistics. Social and environmental safeguard mechanisms will be supported. Public health workforce development will be supported to ensure that a complete spectrum of expertise is covered, including epidemiologists, data managers, laboratory technicians, emergency management and risk communications specialists, and public health managers. This will be achieved in part through knowledge exchange and operational research. These activities and investments will strengthen Afghanistan's preparedness to respond early and effectively to future infectious disease outbreaks.

38. Component 3: Mitigation of Social Impacts (US$5.4 million from COVID19 FTF): This component will address significant negative externalities expected in the event of a widespread COVID-19 outbreak and include comprehensive communication strategies. The primary focus will be on addressing social distancing measures such as avoiding large social gatherings and to mitigate against the negative impacts on children's learning and wellbeing in light of the Government's decision (announced on March 14) to close all educational institutions until April 20. Investments will be made to have plans in place to ensure the continuity of learning, including remote learning options such as radio broadcast and other means of distance delivery of academic content in the areas of literature, science and mathematics. Additional preventive actions would be supported that would complement social distancing such as personal hygiene promotion, including promoting handwashing and proper cooking, and distribution and use of masks, along with increased awareness and promotion of community participation in slowing the spread of the

pandemic. This component will also include provision of mental health and psychosocial services for vulnerable communities.

39. **Component 4: Implementation Management and Monitoring and Evaluation (US$5 million IDA):** Support for the strengthening of public structures for the coordination and management of the project would be provided, including central and local (decentralized) arrangements for coordination of activities, financial management and procurement. This component would also support monitoring and evaluation of prevention and preparedness, building capacity for clinical and public health research, and joint-learning across and within countries. As may be needed, this component will also support third-party monitoring of progress. Collection use and processing (including transfers to third parties) of any personal data collected under this Project will be done in accordance with best practice ensuring legitimate, appropriate and proportionate treatment of such data.

40. **Component 5: Contingent Emergency Response Component (CERC) (US$0 million):** In the event of an Eligible Crisis or Emergency, the project will contribute to providing immediate and effective response to said crisis or emergency.

41. Given the uncertainties associated with the scale and trajectory of the COVID-19 outbreak, approximately 10 percent of the resources (US$10 million IDA) are unallocated but will be available for reallocation to the project components as needed to enable rapid redeployment within the project depending on the specific needs that may arise.

C. Project Beneficiaries

42. **The scope of this project will be nationwide, covering all 34 provinces of the country.** The primary project beneficiaries will be infected people, at-risk populations, medical and emergency personnel as well as service providers (both public and private), medical and testing facilities, and national health agencies. Staff of key technical departments and provincial health offices will also benefit from the project as their capabilities increase through the strengthened institutional capacity of the MOPH.

D. Rationale for Bank Involvement and Role of Partners

43. **The Bank's dedicated umbrella 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 crises.** They allow the institutions to move nimbly to support countries as they respond to the health and economic impacts of the spread of COVID-19 and build in the experience and high standards that are needed so that the approaches work well in fast moving environments.

44. The European Union has committed €232 million for global efforts to tackle the COVID-19 outbreak. Part of these funds will be allocated immediately, while some will be released in the coming months. The IMF has announced US$50 billion to support economies impacted by COVID-19. The Global Fund to fight HIV, TB and Malaria has allowed the country to utilize up to 5 percent of its available grant for COVID-19 response. The Asian Development Bank has indicated support to Afghanistan, but the amount is yet to be confirmed. To avoid any duplication, this project financing is being coordinated closely with Government (MOPH and MOF), UN agencies and other development partners through Government coordination mechanisms. The UN Humanitarian Coordinator, supported by the Advisory Board of the Afghanistan Humanitarian Fund, allocated US$1.5 million for urgently required COVID-19 preparedness and response capacity in-country. In addition, the Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator released US$15 million from the Central Emergency Response Fund to support

global efforts to contain the COVID-19 virus. The project will ensure coordination with humanitarian organizations to provide seamless humanitarian-development support in the fragile mechanisms.

E. Lessons Learned and Reflected in the Project Design

45. **The WB is well positioned to respond to this pandemic given its global expertise combined with understanding of country conditions and needs, prior experience in responding to crises (pandemics, natural disasters, economic shocks) while building resilience and improving future preparedness and response capability, respect and trust of client countries, and global partnerships** (UN agencies/WHO, other MDBs, IMF, etc.). The proposed first instance response will follow a cross-sectoral One Health approach within the framework of a Fast Track COVID-19 Response Program, allowing a rapid response to short-term needs. Depending on how the outbreak progresses and impact on economic activity unfolds there may be need for a second phase with a greater focus on support for economic and social disruption resulting from the spread of the virus.

46. **The Fast Track COVID-19 Facility and the proposed operation draw upon lessons learned from past Bank responses to recent global crises and outbreaks, including the various Ebola outbreaks, the Global Food and Avian Influenza Crises in 2007-2008, and the 2017 Food Crisis Response, among others.** The experience of Avian Flu project in Afghanistan reiterates the importance of effective Government/UN engagement in the implementation of a successful disease outbreak response. Swift detection of an outbreak, assessment of its epidemic potential and rapid emergency response can reduce avoidable mortality and morbidity and reduce the economic, social, and security impacts. Failure in the rapid mobilization of financing and coordination of response results in unnecessary casualties and significant socioeconomic consequences. As highlighted by the SARS and the West African EVD (EVD-WA) outbreak, the cost of outbreak control and socioeconomic losses rises exponentially with delayed detection, reporting, and action, and close technical coordination is needed across countries to prevent and control the transboundary spread of the disease. Although delayed by several months from the onset of cases, the global response to EVD-WA was eventually effective in stopping the outbreak. The failure in the rapid mobilization of financing and the coordination of response resulted in unnecessary casualties of over 11,000 persons, and significant socioeconomic consequences across the sub-region. These economic and social costs of the EVD-WA crisis are estimated to be US$53 billion.[10]

47. **There is need to invest in underlying health systems during the emergency response to minimize risks of gains being reversed.** This includes a surge in medical personnel, ramping up diagnostic capacity and infrastructure for patient management, including isolation facilities**.** Based on the Ebola Virus Disease outbreaks in West Africa and currently in the Democratic Republic of Congo it is important that interventions under this project should support both COVID-19 health services as well as non-COVID-19 health services.

48. **Use of an umbrella programmatic approach adaptable to country needs can also facilitate a flexible rapid response.** Such programmatic approaches also help to reduce project preparation times, [11] enabling countries to choose from a menu of relevant activities depending on country conditions and can provide such a platform for high-level policy and regulatory harmonization, cooperation, and coordination between countries,[12] especially in times of emergency.

[10] Huber C, Finelli L, Stevens W. The economic and social burden of the 2014 EVD outbreak in West Africa. The Journal of infectious diseases. 2018; 218(suppl_5): S698-S704.
[11] The World Bank Group and the Global Food Crisis: An Evaluation of the World Bank Group response. IEG June 2013
[12] Multiphase Programmatic Approach, OPCS July 2017.

IV. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

49. **Project management arrangements, like those under the Sehatmandi Project (IDA-D2850), currently functioning satisfactorily, will be adopted to utilize existing capacity in MOPH and prevent unnecessary fragmentation and duplication.** This will also ensure efficient coordination of activities within the Ministry. The Deputy Minister for Policy and Planning in the MOPH will serve as the Project Coordinator with support of the Sehatmandi Coordination Office (SCO) of the MOPH which will coordinate project activities with all stakeholders. Project oversight will be provided through the recently-established COVID-19 Emergency Response Committee. The COVID-19 Emergency Response Committee meets on a regular basis. It will review progress of the project, ensure coordinated efforts by all stakeholders and conduct annual reviews of the project. Through its central departments and provincial offices, the MOPH will be responsible for implementation of the project. The multisectoral aspects of the COVID-19 response will be guided by Presidential Multisectoral COVID-19 Response Committee chaired by H.E. the President/Vice President.

50. **The health services will be delivered using the same arrangements as for the Sehatmandi Project.** Health services are delivered through contracted service providers (SPs) in 31 provinces under Sehatmandi. Sehatmandi has developed a customized performance management framework and standard operating procedures (SOP) with a clearly defined process to render performance as central metric for reward and sanction of the SPs based on their performance (Pay for Performance or P4P). For this project also, the procurement and contract management for SPs will be carried out by the MOPH. The provision of services by SPs will be monitored through the regular Health Management Information System (HMIS) and through facility and household surveys carried out by a third-party monitoring (TPM) firm. Based on the performance reviews of the SPs under the Sehatmandi project, their performance has been generally satisfactory. For the remaining three provinces (Parwan, Kapisa, and Panjshir) which is managed by MOPH, under this project, technical assistance will be financed to support the MOPH to implement services delivery for the COVID-19 response. The communication between the MOPH and the contracted SPs as guided by the Standard Operating Procedure (SOP) will be strengthened to avoid multiple, often conflicting, communications from Technical Departments, the MOPH leadership, and the Performance Management Office (PMO). For tertiary hospitals in Kabul managed by MOPH, isolation wards will be needed to treat complicated cases that are referred there. Options for managing this may include contracting to an NGO service provider or to a UN Agency. For provincial hospitals and comprehensive health centers in the 31 provinces managed by SPs, installation and management of isolation wards for the treatment of cases referred there will be the responsibility of the contracted SPs.

51. All procurement under the project will be undertaken by the Implementing Unit, GCMU-MOPH/Sehatmandi, within the Ministry of Public Health. All high value procurement above the threshold of delegated authority of MOPH that requires facilitation support from National Procurement Authority, the specialized unit for Donor Funded Procurement within the Facilitation Directorate of NPA will provide fast track review and clearance support.

B. Results Monitoring and Evaluation Arrangements

52. **The proposed operation will use the same M&E modalities put in place under the Sehatmandi operation.** The High-Level Health Program Oversight Committee ensures the independence of the third-party monitor (TPM) agency under

the Sehatmandi. The Committee will review the design, implementation, and reports of the TPM to include the proposed projects' key indicators. Joint External Evaluations (JEEs) will also be used to inform the Project's Results Framework indicators.

53. **Reporting:** The MOPH will produce a quarterly report based on agreed targets and the progress made of implementation of critical project activities. This report will contain tables of performance against indicators for the proposed project.

54. **Supervision and implementation support**: An experienced in-country World Bank team of health, operational, and fiduciary specialists will provide day-to-day implementation support to the MOPH with additional regular support from staff from other World Bank offices; implementation support missions will be carried on a regular basis and will include relevant partners.

C. Sustainability

55. **The sustainability of the project would largely depend on the capacity of MOPH and the specific activities.** The focus of some of the project activities on training and capacity building will further enhance the sustainability of the project. The outcomes of the project related to strengthening disease surveillance and pandemic preparedness (informed by the COVID-19 immediate response) will be a sustainable product of the project. This would help the health sector to effectively respond to any future pandemics.

V. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

56. **Initial analysis suggests that while COVID-19 could have substantial negative impacts on Afghanistan's economy as well as the global economy, further analysis is required to estimateg the extent to which macroeconomic indicators may worsen.** The major channels by which COVID-19 will impact Afghanistan's economy are:

- **Negative impact on exports.** Trade disruptions are the most important transmission channel, but impacts are likely to be modest given Afghanistan's low current exports (around five percent of GDP). Afghanistan's agriculture exports to the three main trading partners (Pakistan, Iran, and India) could be significantly affected due to closure of border crossings. Additionally, dry fruit exports to other countries through air-corridors, including China and Middle-east, may see a drastic decline if international flights to and from these countries are restricted. Closure of border points would also disrupt imports (many of which are aid-financed), leading to indeterminate aggregate impacts on GDP.

- **Negative impacts on remittance flows.** Inward remittance flows are estimated at between 3-7 percent of GDP, mainly from Iran, Pakistan, and GCC. Inflows may decline substantially if these countries experience major economic disruption. In the absence of high-frequency data, however, it is not clear how remittance flows are impacted by economic shocks.

- **Disruption to economic activity and human capital development.** Domestic travel restrictions, cancellation of festivals and other activities, closure of workplaces, and 'social distancing' practices will reduce opportunities for trade, negatively impacting production and consumption.

- **Further negative impacts on confidence.** COVID19 is likely to have further negative impacts on already-low private sector confidence. The risks of major economic disruption, travel restrictions, and public disorder add to existing political and security risks. Anecdotal evidence suggests COVID19 risks are perceived as substantial by investors, even despite broader political and security risks (Afghanistan so far has five confirmed cases of COVID19 while civilian casualties from conflict are over 10,000 per year).

57. **The project is expected to bring economic benefits in the short- and longer-term.** Project activities will help address the immediate and long-term impacts of COVID-19 on the domestic and international economy by:

- **Preventing loss of human capital.** Loss of life and negative impacts on productivity will be mitigated through: i) improving access to life-saving health services through training and equipment; ii) mitigating the spread of COVID-19 through education programs and provision of proper equipment, training, and facilities to health-sector workers; and iii) prevention of infection – especially vulnerable populations such as the elderly or those with existing conditions – through community education and communication campaigns.
- **Limiting the extent and duration of economic disruption.** While short-term containment and prevention measures are expected to disrupt economic activity over the short-term, longer-term impacts are expected to be positive as it would limit the need for more-sustained and intrusive containment and response measures. Measures to control the spread of COVID-19 in Afghanistan will have spillover positive impacts through mitigating risks of further outbreaks internationally and across porous borders with neighboring countries.
- **Broader health-system strengthening.** Many measures supported by the project will bring economic benefits through broader health system strengthening. Positive long-run returns are expected from activities related to: i) training of health sector workers; ii) provision of essential basic medical equipment; and iii) improvement in health facilities and infrastructure. International evidence shows that such investments deliver positive economic returns even in the absence of a major pandemic.

B. Fiduciary

(i) Financial Management

58. **The project will leverage the existing financial management and disbursement arrangements of the Sehatmandi project for its implementation, and the internal controls prescribed in the Financial Management Manual (FMM) for IDA-ARTF financed projects, being used by the Sehatmandi project, will also apply.** The funds flow arrangements include flexibility of direct disbursement to UN agencies, as advance, based on a six to a twelve-monthly forecast of expenditures, as approved by the government in a withdrawal application. Also, a lower threshold of US$ 50,000 for direct payments and a high ceiling of US$20 million for the project's Designated Account are allowed. The disbursements will be based on Statements of Expenditures (SOEs), and the Bank, through the ARTF Third-Party Monitoring Agent (TPMA), would review the underlying expenditures in the SOEs on a quarterly basis. MOF's Treasury Department will appoint a focal point to ensure the processing of project payments within three working days. The project will submit bi-annual interim financial reports to the Bank, and the Supreme Audit Office of Afghanistan will

conduct annual project audits. In respect of components that will be implemented with UN agencies' support, the UN agencies will account for the funds using their institutional accounting rules and regulations. These agencies will provide quarterly Fund Utilization Reports that show funds received and related expenditure, alongside progress reports, to the Bank and the Ministries of Public Health and Finance of Afghanistan. Retroactive financing up to US$40 million of the total Grant amount will be allowed for eligible expenditures incurred by the Government from January 1, 2020.

59. **The overall project FM risk is assessed High**. The table below includes the constituent elements of the risk and their respective mitigation measures. The implementation of the mitigation measures will be reviewed, and the FM risk will be reassessed as part of the continuous implementation support on the project.

Risks	Mitigation Measures
Political interference in awarding contracts to print and electronic media for the communication campaign.	Ex-ante agreement with the Bank on: i) criteria for selection of media houses for the communication campaign; ii) a ceiling for the value of contracts that can be awarded to a media house; and iii) use of UN agencies for the communication campaign.
Incomplete record and misuse of goods (Assets & Inventory) at the health facilities. Overdue unacquitted cash advances, incomplete documentation, and use of cash for ineligible expenditure.	Existing service providers through contract amendment or new contract made responsible to: i) maintain detailed records of assets and inventory at the health facilities; and ii) keep detailed records in the management of any cash advances in the provinces and districts.
No established procedure for recruitment and compensation of community health workers to be hired by any entity.	Notification of community health workers' qualification criteria, compensation, and recruitment process by MOPH to be used by all entities engaging community health workers.

(ii) Procurement

60. **Procurement for the project will be carried out in accordance with 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 Project will be subject to the World Bank's Anticorruption Guidelines, dated October 15, 2006, revised in January 2011, and as of July 1, 2016. The Project will use the Systematic Tracking of Exchanges in Procurement (STEP) to plan, record and track procurement transactions.

61. **The major planned procurement includes** medical equipment, supplies and commodities, diagnostic reagents, including kits; procurement and distribution of masks; development of communication messages and materials; establishment of a call center for responding to inquiries about coronavirus; development of online education courses and associated installation of Internet bandwidth for selected Higher Education Institutions; etc. Given the emergency

nature of the requirements, Borrower has agreed to develop a streamlined Project Procurement Strategy for Development during the implementation phase of the project and finalize the same early during the implementation. An initial procurement plan for the first three months has been agreed with the Borrower and will be updated during implementation.

62. **The proposed procurement approach prioritizes fast track emergency procurement for the required emergency goods, works and services.** Key measures to fast track procurement include the following measures:

    - Direct Contract with Sehatmandi Service Providers for all outpatient and inpatient medical services to be provided to the public. Unit rates established for various services will be followed in all possible areas and new uniform rates will be arrived at through negotiations with NGOs providing these services at present
    - Using existing framework agreements with international agencies like UNICEF, WHO and other UN agencies for procurement of medicines, medical supplies and equipment for emergency requirements;
    - Direct Contracting and/or Limited Competition with identified manufacturers and suppliers for other items
    - Increasing the threshold for goods Shopping to US$200,000 from the existing US$50,000 applied in country and increasing the threshold for National Procurement to U$500,000 from the existing US$200,000.
    - Conducting all emergency procurement under this project for relief phases as post review
    - Other measures like shorter bidding time, no bid security, advance payments, direct payments, etc. will be applied on a case by case basis by the Accredited Procurement Specialist

63. **All procurement under the project will be undertaken by the implementing Unit, GCMU-MOPH/Sehatmandi within the Ministry of Public Health.** All high value procurement above the threshold of delegated authority of MOPH that requires facilitation support from National Procurement Authority, the specialized unit for Donor Funded Procurement within the Facilitation Directorate of NPA will provide fast track review and clearance support. A streamlined process flow for emergency procurement facilitation by NPA and review and clearance by National Procurement Commission is being agreed.

64. **Given the limited capacity and the urgent requirement, Bank will continue with the Hands-on Expanded Implementation Support (HEIS) extended to MOPH for expediting procurement under the Sehatmandi project.** A Bank procurement accredited consultant will provide support to the implementation unit during all emergency procurement stages. Major risks to procurement and proposed mitigation measures are summarized below.

Risks	Mitigation Measures
Limited capacity to conduct emergency procurement.	GCMU and NPA Facilitation Unit will each maintain staff with the appropriate capacity dedicated to the COVID-19 response. Bank will provide HEIS through a procurement accredited STC
Managing fraud and corruption and noncompliance.	*Ex ante* due diligence of firms being selected will be attempted using databases available in country and externally. Post review of contracts will be scheduled immediately on award of contracts for all contracts that would have been usually prior reviewed. Oversight of the process would be ensured through HEIS Consultant and NPA Facilitation team. The ARTF-financed Anti-Corruption and Results Monitoring Action Program (ACReMAP) will monitor the compliance with anti-corruption guidelines. A TPM, to be contracted by MOPH, as well as the ARTF TPMA will verify the goods and services being delivered through the project.
Capacity of the market and supply chain to meet the demand.	Proposed mobilization of existing service provider contracts through amendment are expected to address the emergency medical service requirements. Using Framework agreements (FAs) with UN agencies for supply of medicines and medical supplies and early engagement with manufacturers in the region for direct contracting is proposed. Measures for supplier preferencing like direct payments by Bank, advance payments, etc. will be applied on need basis.
Impact of emergency on supply chains and lead times.	Advance procurement and using FAs of UN Agencies are expected to mitigate this to some extent, though the risks are high given low or nil production capacity of most of the items in country and spread of the infection in other countries.
Social impacts of emergency on markets especially on labor markets and acceptability of foreign labor.	There are no known restrictions on use of foreign personnel.

C. Legal Operational Policies

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

D. Environmental and Social

65. **The project will have positive environmental and social impacts, insofar as it should improve COVID-19 surveillance, monitoring and containment. The environmental risks are considered High.** The main environmental and social risks are: (i) the occupational health and safety issues related to testing and handling of supplies and the possibility that they are not adequately used by the laboratory technicians and medical crews; and (ii) environmental pollution and community health and safety issues related to the handling, transportation and disposal of healthcare waste. To mitigate these risks the Afghanistan Ministry of Public Health (MOPH) will update the existing Environmental and Social Management Framework (ESMF) prepared for the Afghanistan Sehatmandi Project in the health sector, applying international best practices in diagnostic testing for COVID-19, handling the medical supplies involved, and disposing of generated wastes. The ESMF will incorporate an updated version of the Sehatmandi Project's Health Care Waste Management Plan. Until the updated ESMF has been approved, the Project will apply the existing ESMF in conjunction with WHO standards on COVID-19 response. The relevant parts of the WHO COVID-19 quarantine guidelines and COVID-19 biosafety guidelines will be reviewed while updating the ESMF so that all relevant risks and mitigation measures will be covered. In addition to the ESMF, the client will implement the activities listed in the Environmental and Social Commitment Plan (ESCP).

66. **The social risks are also considered High.** One central social risk is that marginalized and vulnerable social groups are unable to access facilities and services, which could undermine the objectives of the project. To mitigate this risk the MOPH, in the ESCP, will commit to the provision of services and supplies based on the urgency of the need, in line with the latest data related to the prevalence of the cases. A draft Stakeholder Engagement Plan (SEP) that incorporates a preliminary stakeholder mapping has been prepared to guide MOHP in the early interactions with a wide range of citizens (including the most vulnerable among them) regarding basic health precautions and any coming emergency measures. This SEP will be revised within one month of project approval, as noted in the ESCP. The SEP will include a fully elaborated Grievance Redress Mechanism (GRM) for addressing any concerns and grievances raised.

67. **The Bank policy on Projects on International Waterway, OP 7.50, does not apply** because the project activities do not fall under the definition of "similar projects that involve the use or potential pollution of international waterways" according to paragraph 2(a) of OP 7.50. The project will not involve the construction of water supply schemes.

VI. GRIEVANCE REDRESS SERVICE

68. 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.

VII. KEY RISKS

69. The overall risk rating is High.

70. The political and governance risk is High. The President was sworn into his second 5-year term on March 9, 2020. However, the primary opponent also declared himself a victor. Although the opponent has not received international recognitions, the continued political divide has added to the prevailing political uncertainty. It is still uncertain whether the Taliban will accept to negotiate peace with the newly inaugurated government. In the meantime, localized security incidents have resumed including in Kabul. Continuation of violence may limit health workers' ability to reach insecure areas for surveillance, community awareness raising, and necessary medical care. The service delivery model used under Sehatmandi has proven resilient to conflict and insecurity. The services are provided nationwide including in insecure areas or areas where the Government's footprint is limited. But the SPs have also come under pressure from the anti-government elements (AGEs) with demands for more services as well as for illicit payments. These pressures have increased across the board for the past few months. The MOPH has issued a clear directive to the SPs prohibiting any form of payment to AGEs.

71. The technical design entails Substantial risk. One of the key challenges with the response to COVID-19 is the availability (and price) of medical equipment and supplies necessary for the immediate response, such as Personal Protective Equipment (PPE), Oxygen Concentrator, etc. The global PSCN (Pandemic Supply Chain Network), of which the World Bank is a co-convener, has identified the list of medical products critical to the response and the Bank will work with MOPH to customize this list further to develop a positive list of goods to be procured with World Bank financing. Furthermore, these essential goods and supplies are expected to be procured with project financing through Memoranda of Understanding to be agreed between the MOPH and UN agencies such as UNICEF, which are engaged in direct discussions with global suppliers. To the extent the project's success in containing the spread of the virus will depend on conducive social behavior, the high level of illiteracy, the limit in media reach in certain locations, and mistrust in the government among

segments of the population could prove a challenge in encouraging positive behavior change (adherence to social distancing or self-quarantine), as exemplified by Afghanistan's struggle to eradicate polio. The project will support advocacy and coalition building to sensitize key groups including policy makers, the media, and ensure consistent communication.

72. Despite the reliance on the proven delivery model, risks associated with institutional capacity are rated as Substantial. Afghanistan currently lacks adequate supply of trained staff for disease surveillance and frontline responses as well as necessary supplies and equipment for detecting and treating COVID-19 cases. The SPs are expected to be more nimble in mobilizing additional resources than the Government but their responses across the 31 provinces could prove uneven. These risks will be mitigated by a combination of intensive capacity building efforts and partnerships with international partners, especially specialized UN agencies (e.g., WHO, UNICEF).

73. Fiduciary risk is High. Afghanistan's portfolio as a whole is characterized with high fiduciary risks with a number of allegations of fraud and corruption constantly reaching the Bank and numerous cases of procedural non-compliance frequently detected. Unsubstantiated allegations have occasionally been made in the health sector as well. The project adopts the enhanced fiduciary framework that the Bank has introduced to the entire Afghanistan portfolio under the Anti-Corruption and Results Monitoring Action Program (ACReMAP). This includes the use of SOE-based disbursement combined with ex-ante sample-based review of expenditure documents, HEIS as well as stepped-up post reviews in procurement, and deployment of the ARTF TPMA for both physical performance monitoring and fiduciary oversight. But the emergency nature of the project elevates the risk despite the mitigation measures being proposed.

74. Environmental and Social Risk is High because of occupational health and safety issues; environmental pollution and community health and safety issues; and the inability of marginalized and vulnerable social groups to access facilities and services. To mitigate this risk, the existing health sector ESMF will be updated to guide implementation and the ESCP will commit to the provision of services and supplies based on the urgency of the need, in line with the latest data related to the prevalence of the cases. A draft SEP has been prepared to guide MOHP in the early interactions with a wide range of citizens (including the most vulnerable among them) regarding basic health precautions and any coming emergency measures. Until the updated ESMF has been approved, the Project will apply the existing ESMF in conjunction with WHO standards on COVID-19 response.

Risk Categories	**Rating**
1. Political and Governance	H
2. Macroeconomic	M
3. Sector strategies and policies	M
4. Technical design of project	S
5. Institutional capacity for implementation and sustainability	S
6. Fiduciary	H
7. Environmental and social	H
8. Stakeholders	M
Overall	**H**

VIII. RESULTS FRAMEWORK AND MONITORING

COUNTRY: AFGHANISTAN

Project Development Objective: to respond to, and mitigate the threat posed by COVID-19 and strengthen national systems for public health preparedness in Afghanistan.

Project Development Objective Indicators

Indicator Name	DLI	Baseline	End Target
Proportion of laboratory-confirmed cases of COVID-19 responded to within 48 hours		0	70%
Proportion of specimens submitted for SARS-COV-2 laboratory testing confirmed within WHO stipulated standard time		0	70%
Proportion of population able to identify three key symptoms of COVID-19 and/or seasonal influenza and three personal prevention measures (as assessed by a representative population survey)		0	50%

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	End Target
Component 1: Proportion of identified contacts who are successfully traced		0	70%
Proportion of suspected cases who are tested within 2 days of being identified		0	70%
Component 2: Proportion of provincial hospital doctors and nurses who are trained on WHO standards of clinical treatment for COVID-19.		0	80%
Proportion of provincial hospitals with adequate personal protective equipment within a given month.		0	80%
Proportion of provincial hospitals with isolation treatment available within a given month.		0	80%
Presence of a Biosafety Level 2 facility in each of 5 regions and a Biosafety Level 3 facility at the national level		0	100%
Component 3: Number of radio, television, and print messages disseminated on COVID-19 symptoms and prevention between April-August 2020.		0	10,000
Component 4: Proportion of district hospitals who have submitted complete monthly reports on the number of suspected cases identified, number of cases tested, number of contacts traced, the presence of personal protective equipment, and the presence of an isolation unit.		0	90%

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Proportion of laboratory-confirmed cases of COVID-19 responded to within 48 hours	Denominator: Number of laboratory-confirmed cases of COVID-19. Numerator: Number of laboratory-confirmed cases of COVID-19 where there was deployment of a rapid response team, contract tracing was initiated, and public messaging was disseminated within 48 hours.	6-monthly	Health Management Information System	Monthly reports of (i) the number of laboratory-confirmed COVID-19 cases, and (ii) the number of cases responded to with rapid response teams, contact tracing, and public messaging within 48 hours	Sehatmandi Service providers
Proportion of specimens submitted for SARS-COV-2 laboratory testing confirmed within WHO stipulated standard time	Denominator: Number of specimens submitted for SARS-COV-2 laboratory testing Numerator: Number of specimens submitted for SARS-COV-2 laboratory testing confirmed within	6-monthly	Health Management Information System	Monthly reports of (i) the number of specimens submitted for SARS-CoV-2 testing, and (ii) Number of specimens submitted for SARS-COV-2 laboratory testing confirmed within WHO stipulated	Sehatmandi Service providers

	WHO stipulated standard time			standard time	
Proportion of population able to identify three key symptoms of COVID-19 and/or seasonal influenza and three personal prevention measures (as assessed by a representative population survey)	Denominator: Number of respondents to representative population survey. Numerator: Number of respondents to representative population survey who can accurately identify three key symptoms of COVID-19 and /or seasonal influenza and three personal prevention measures.	Once (by August 2020)	Represent-ative household survey	Random sampling of households. Adults within households randomly sampled for interview.	Third Party Monitor
Proportion of identified contacts who are successfully traced	Denominator: Number of contacts of COVID-19 cases identified. Numerator: Number of contacts of COVID-19 cases successfully traced.	6-monthly	Health Management Information System	Monthly reports of (i) Number of contacts of COVID-19 cases identified and (ii) number of contacts of COVID-19 cases successfully traced.	Sehatmandi Service Providers
Proportion of suspected cases who are tested within 2 days of being identified	Denominator: Number of suspected cases of COVID-19. Numerator: Number of suspected cases of COVID-19 who are tested within 2 days of being identified.	6-monthly	Health Management Information System	Monthly reports of (i) Number of suspected cases of COVID-19, and (ii) Number of suspected cases of COVID-19 who are tested within 2 days of being identified.	Sehatmandi Service Providers

Proportion of provincial hospital doctors and nurses who are trained on WHO standards of clinical treatment for COVID-19.	Denominator: Number of doctors and nurses working at provincial hospitals. Numerator: Number of doctors and nurses working at provincial hospitals who are trained on WHO standards of clinical treatment for COVID-19	6-monthly	Health Management Information System	Monthly reports of (i) the number of doctors and nurses working at provincial hospitals, and (ii) the number of doctors and nurses working at provincial hospitals who are trained on WHO standards of clinical treatment for COVID-19	Sehatmandi Service Providers
Proportion of provincial hospitals with adequate personal protective equipment within a given month.	Denominator: Number of provincial hospitals Numerator: Number of provincial hospitals with adequate personal protective equipment	6-monthly	Health Management Information System	Monthly reports of whether provincial hospital has adequate personal protective equipment within the month of reporting	Sehatmandi Service Providers
Proportion of provincial hospitals with isolation treatment available within a given month.	Denominator: Number of provincial hospitals Numerator: Number of provincial hospitals with isolation treatment available	6-monthly	Health Management Information System	Monthly reports of whether provincial hospital has isolation treatment available within the month of reporting	Sehatmandi Service Providers
Presence of a Biosafety Level 2 facility in each of 5 regions and a Biosafety Level 3 facility at the national level	Denominator: 6 (5 regional and 1 national) Numerator: The number of regions with a Biosafety Level 2 laboratory	Annual	Direct Report by Ministry of Public Health	Direct Report to Ministry of Public Health	Ministry of Public Health
Number of radio, television, and print messages disseminated on COVID-19	The following are counted as	May-Aug 2020	Direct Report by Ministry of	Public Health messages purchased by the	Ministry of Public Health

symptoms and prevention between May-August 2020.	one message: Radio: Message disseminated at a given time on a given radio frequency. Television: Message disseminated at a given time on a given television station. Print: (i) A newspaper issue containing a prominent message, or (ii) a large banner or sign placed in prominent location.		Public Health	Ministry of Public Health will be recorded and reported to the national MOPH office.	
Proportion of provincial hospitals who have submitted complete monthly reports on the number of suspected cases identified, number of cases tested, number of contacts traced, the presence of personal protective equipment, and the presence of an isolation unit.	Denominator: Number of provincial hospitals Numerator: Number of provincial hospitals who have submitted complete monthly reports on the number of suspected cases identified, number of cases tested, number of contacts traced, the presence of personal protective equipment, and the presence of an isolation unit.	6-monthly	Health Management Information System	Confirmation of completeness of monthly reports. Complete reports for a given provincial hospital contain no missing information on the number of suspected cases identified, number of cases tested, number of contacts traced, the presence of personal protective equipment, and the presence of an isolation unit.	Ministry of Public Health