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Report No: PAD00117

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT
ON
PROPOSED CREDITS

TO THE REPUBLIC OF CABO VERDE
IN THE AMOUNT OF SDR 19.1 MILLION (US$25.0 MILLION EQUIVALENT)

TO THE REPUBLIC OF GUINEA
IN THE AMOUNT OF US$90.0 MILLION

TO THE REPUBLIC OF LIBERIA
IN THE AMOUNT OF US$18.0 MILLION

A PROPOSED GRANT

TO THE ECONOMIC COMMUNITY OF WEST AFRICAN STATES (ECOWAS)
IN THE AMOUNT OF SDR 19.1 MILLION (US$25.0 MILLION EQUIVALENT)

A PROPOSED GRANT FROM THE PANDEMIC PREVENTION, PREPAREDNESS AND RESPONSE TRUST FUND
TO THE REPUBLIC OF CABO VERDE
IN THE AMOUNT OF US$4.0 MILLION

A PROPOSED GRANT FROM THE GLOBAL FINANCING FACILITY
FOR WOMEN, CHILDREN AND ADOLESCENTS
TO THE REPUBLIC OF GUINEA
IN THE AMOUNT OF US$16.0 MILLION

FOR A

HEALTH SECURITY PROGRAM IN WESTERN AND CENTRAL AFRICA

AS PHASE I OF THE MULTI-PHASE PROGRAMMATIC APPROACH

WITH AN OVERALL FINANCING ENVELOPE OF US$500 MILLION EQUIVALENT

November 28, 2023

Health, Nutrition and Population Global Practice
Western and Central Africa Region

CURRENCY EQUIVALENTS

Exchange Rate Effective September 30, 2023

Currency Unit = Special Drawing Rights (SDR)

US$1 = SDR 0.76

FISCAL YEAR
January 1 - December 31

Regional Vice President: Ousmane Diagana

Acting Regional Director: Meskerem Mulatu

Country Director: Boutheina Guermazi

Practice Manager: Trina S. Haque

Task Team Leaders: Carolyn J. Shelton, Andre L. Carletto, Joao Pires

ABBREVIATIONS AND ACRONYMS

AFW	Western and Central Africa
AHSA	Africa's Animal Health Strategy
AM	Accountability Mechanism
AMR	Antimicrobial Resistance
APS	Accredited Procurement Specialist
AU	African Union
AWP/B	Annual Work Plan and Budget
CERC	Contingent Emergency Response Component
CHW	Community Health Worker
COVID-19	Coronavirus Disease 2019
CPF	Country Partnership Framework
DA	Designated Account
DFIL	Disbursement and Financial Information Letter
DHIS2	District Health Information System 2
ECOWAS	Economic Community of West African States
e-IDSR	Electronic Reporting of Integrated Disease Surveillance and Response
EMIS	Environment Information Management System
EOC	Emergency Operations Center
EPA	Environmental Protection Agency
ESCP	Environmental and Social Commitment Plan
ESF	Environmental and Social Framework
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
ESS	Environmental and Social Standards
EVD	Ebola Virus Disease
FAO	Food and Agriculture Organization of the United Nations
FELTP	Field Epidemiology and Laboratory Training Program
FETP	Field Epidemiology Training Program
FM	Financial Management
GAC	General Auditing Commission
GBV	Gender-Based Violence
GCP	Global Challenge Program
GDP	Gross Domestic Product
GFF	Global Financing Facility for Women, Children and Adolescents
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
HMIS	Health Management Information System
IA	Implementing Agency
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IFR	Interim Financial Report
IHR	International Health Regulation
IPC	Infection Prevention and Control
IPF	Investment Project Financing
ISAVET	In Service Applied Veterinary Epidemiology Training
JEE	Joint External Evaluation
JRA	Joint Risk Assessment

LIMS	Laboratory Information Management Systems
LMIS	Logistics Management Information System
LMP	Labor Management Procedures
M&E	Monitoring and Evaluation
MAE	Ministry of Agriculture and Environment, Republic of Cabo Verde
MoA	Ministry of Agriculture, Republic of Liberia
MoH	Ministry of Health
MoU	Memorandum of Understanding
MPA	Multiphase Programmatic Approach
NAPHS	National Action Plans for Health Security
NDC	Nationally Determined Contribution
NHD	National Health Directorate, Cabo Verde
NPF	National Procurement Framework
NPHI	National Public Health Institute
NPHIL	National Public Health Institute of Liberia
OH JPA	One Health Joint Plan of Action
PAD	Project Appraisal Document
PCU	Project Coordination Unit
PDO	Project Development Objective
PF	Pandemic Fund
PFMU	Project Financial Management Unit
PFS	Project Financial Statement
PHE	Public Health Emergency
PHEOC	Public Health Emergency Operation Center
PIU	Project Implementation Unit
PoE	Points of Entry
POM	Project Operations Manual
PPSD	Project Procurement Strategy for Development
PrDO	Program Development Objective
PSC	Project Steering Committee
PVS	Performance of Veterinary Service
RAHC	Regional Animal Health Center
RCC	Regional Coordinating Center
RCCE	Risk Communication and Community Engagement
REDISSE	Regional Disease Surveillance Systems Enhancement
RSC	Regional Steering Committee
SCD	Systematic Country Diagnostic
SDR	Special Drawing Rights
SEA/SH	Sexual Exploitation and Abuse/Sexual Harassment
SEP	Stakeholder Engagement Plan
SLIPTA	Stepwise Laboratory Improvement Process Towards Accreditation
SOE	Statements of Expenditure
SOP	Standard Operating Procedure
SPAR	State Party Self-Assessment Annual Report
SPRP	Strategic Preparedness and Response Program
STEP	Systematic Tracking of Exchanges in Procurement
TA	Technical Assistance
ToR	Terms of Reference
UGPE	Special Projects Management Unit (*Unidade de Gestão de Projectos Especiais)*

WAHO	West African Health Organization
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
WOAH	World Organization for Animal Health

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DATASHEET

BASIC INFORMATION

Project Beneficiary(ies)	Operation Name		
Cabo Verde, Guinea, Liberia	Health Security Program in Western and Central Africa		
Operation ID	Financing Instrument	Environmental and Social Risk Classification	
P179078	Investment Project Financing (IPF)	Substantial	

Financing & Implementation Modalities

[✓] Multiphase Programmatic Approach (MPA)	[✓] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[ ] Performance-Based Conditions (PBCs)	[✓] Small State(s)
[ ] Financial Intermediaries (FI)	[✓] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternative Procurement Arrangements (APA)	[ ] Hands-on Expanded Implementation Support (HEIS)

Expected Approval Date	Expected Closing Date	Expected Program Closing Date
19-Dec-2023	31-Jan-2032	31-Jan-2032
Bank/IFC Collaboration		
No		

MPA Program Development Objective

Increase regional collaboration and health system capacities to prevent, detect and respond to health emergencies in Western and Central Africa.

MPA FINANCING DATA (US$, Millions)

MPA Program Financing Envelope	500.00

Components

Component Name	Cost (US$)
Component 1 - Prevention of Health Emergencies	27,280,000.00
Component 2 - Detection of Health Emergencies	71,940,000.00
Component 3 - Health Emergency Response	63,580,000.00
Component 4 - Program Management and Institutional Capacity	15,200,000.00
Component 5 - Contingent Emergency Response Component	0.00

Organizations

Borrower:	Republic of Cabo Verde, Economic Community of West-African States (ECOWAS), Republic of Liberia, Republic of Guinea
Implementing Agency:	Guinea Ministry of Health, Cabo Verde Ministry of Finance, West African Health Organization (WAHO), Liberia Ministry of Health

MPA FINANCING DETAILS (US$, Millions)

MPA Financing Envelope:	500.00
of which Bank Financing (IBRD):	0.00
of which Bank Financing (IDA):	500.00
of which Other Financing sources:	0.00

PROJECT FINANCING DATA (US$, Millions)

Maximizing Finance for Development

Is this an MFD-Enabling Project (MFD-EP)?	No
Is this project Private Capital Enabling (PCE)?	No

SUMMARY

Total Operation Cost	**178.00**
Total Financing	**178.00**
of which IBRD/IDA	**158.00**

Financing Gap	**0.00**

DETAILS

World Bank Group Financing

International Development Association (IDA)	158.00
of which IDA Recommitted	11.00
IDA Credit	133.00
IDA Grant	25.00

Non-World Bank Group Financing

Trust Funds	20.00
Miscellaneous 1	4.00
Global Financing Facility	16.00

IDA Resources (US$, Millions)

	Credit Amount	Grant Amount	SML Amount	Guarantee Amount	Total Amount
Cabo Verde	25.00	0.00	0.00	0.00	25.00
National Performance-Based Allocations (PBA)	6.00	0.00	0.00	0.00	6.00
Regional	19.00	0.00	0.00	0.00	19.00
Western and Central Africa	0.00	25.00	0.00	0.00	25.00
Regional	0.00	25.00	0.00	0.00	25.00
Liberia	18.00	0.00	0.00	0.00	18.00
Regional	12.00	0.00	0.00	0.00	12.00
National Performance-Based Allocations (PBA)	6.00	0.00	0.00	0.00	6.00

Guinea	90.00	0.00	0.00	0.00	90.00
Regional	60.00	0.00	0.00	0.00	60.00
National Performance-Based Allocations (PBA)	30.00	0.00	0.00	0.00	30.00
Total	**133.00**	**25.00**	**0.00**	**0.00**	**158.00**

Expected Disbursements (US$, Millions)

WB Fiscal Year	2024	2025	2026	2027	2028	2029	2030	2031	2032
Annual	3.48	14.00	34.00	56.00	35.00	14.52	5.00	5.00	7.00
Cumulative	3.48	17.48	51.48	107.48	142.48	157.00	162.00	167.00	174.00

PRACTICE AREA(S)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Agriculture and Food; Environment, Natural Resources & the Blue Economy

CLIMATE

Climate Change and Disaster Screening

Yes, it has been screened and the results are discussed in the Operation Document

SYSTEMATIC OPERATIONS RISK- RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Substantial

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	Substantial
7. Environment and Social	Substantial
8. Stakeholders	Moderate
9. Overall	Substantial
Overall MPA Program Risk	Substantial

POLICY COMPLIANCE

Policy

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

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

ENVIRONMENTAL AND SOCIAL

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

E & S Standards	Relevance
ESS 1: Assessment and Management of Environmental and Social Risks and Impacts	Relevant
ESS 10: Stakeholder Engagement and Information Disclosure	Relevant
ESS 2: Labor and Working Conditions	Relevant
ESS 3: Resource Efficiency and Pollution Prevention and Management	Relevant
ESS 4: Community Health and Safety	Relevant
ESS 5: Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Relevant
ESS 6: Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
ESS 7: Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant

ESS 8: Cultural Heritage	Relevant
ESS 9: 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

Legal Covenants

Sections and Description
CABO VERDE (IDA Financing Agreement and Pandemic Fund Grant Agreement): PROJECT COORDINATION UNIT (UGPE) - Schedule 2. Section I.A.1(c) (i). The Recipient shall, through the UGPE, not later than three (3) months after the Effective Date, customize the existing accounting software to include the Project.
CABO VERDE (IDA Financing Agreement and Pandemic Fund Grant Agreement): PROJECT COORDINATION UNIT (UGPE) - Schedule 2. Section I.A.1(c) (ii). The Recipient shall, through the UGPE, not later than three (3) months after the Effective Date, update the current annual internal audit work plans to integrate the review of the Project.
CABO VERDE (IDA Financing Agreement and Pandemic Fund Grant Agreement): PROJECT COORDINATION UNIT (UGPE) - Schedule 2. Section I.A.1(c) (iii). The Recipient shall, through the UGPE, not later than six (6) months after the Effective Date, recruit an external auditor.
CABO VERDE (IDA Financing Agreement and Pandemic Fund Grant Agreement): PROJECT OPERATIONS MANUAL (POM) - Schedule 2. Section I.B.1. Not later than three (3) months after the Effective Date, the Recipient shall prepare and adopt an implementation manual acceptable to the Association ("Project Operations Manual" or "POM"), which shall contain detailed work flow, methods and procedures for the implementation of the Project, including but not limited to: (i) administration and coordination arrangements, including placement of necessary human resources for Project implementation; (ii) performance indicators of the Project; (iii) disbursement arrangements, reporting requirements, financial management procedures and audit procedures; (iv) monitoring and evaluation; (v) procurement guidelines and procedures; (vi) corruption and fraud prevention measures; (vii) roles and responsibilities of various agencies and stakeholders including technical directorates at the Ministry of Health and the Ministry of Agriculture and Environment; (viii) Personal Data collection and processing requirements in accordance with applicable national law and good international practice; (ix) environmental and social framework aspects, including a detailed description of the grievance redress mechanism process as well as any process for recording and reporting project-related accidents and incidents; (x) details on the composition and working arrangements of the Project Steering Committee; (xi) details on the composition and working arrangements of the Regional Steering Committee; and (xii) such other arrangements and procedures as shall be required for the effective implementation of the Project.
GUINEA (IDA Financing Agreement and GFF Grant Agreement): PROJECT COORDINATION UNIT - Schedule 2. Section I.A.2 (e). (i) Not later than three (3) months after the Effective Date, the Recipient shall assign, recruit or appoint an additional procurement specialist for the PCU; (ii) not later than three (3) months after the Effective Date, the Recipient shall assign, recruit or appoint five (5) accountants for the PCU regional offices; all with qualifications and under terms of reference acceptable to the Association.
GUINEA (IDA Financing Agreement and GFF Grant Agreement): PROJECT COORDINATION UNIT - Schedule 2. Section I.A.2 (g). Not later than three (3) months after the Effective Date, the Recipient shall: (i) update the configuration of the existing accounting software for the Project, in terms acceptable to the Association; and (ii) update the annual audit

work plans of is internal audit team to include the activities of the Project; all with qualifications and under terms of reference acceptable to the Association.
GUINEA (IDA Financing Agreement and GFF Grant Agreement): PROJECT COORDINATION UNIT - Schedule 2. Section I.A.2 (h). Not later than six (6) months after the Effective Date, the Recipient shall recruit an external auditor with qualifications and under terms of reference acceptable to the Association.
GUINEA (IDA Financing Agreement and GFF Grant Agreement): PROJECT OPERATIONS MANUAL (POM) - Schedule 2. Section I.B.1. Not later than three (3) months after the Effective Date, the Recipient shall prepare and adopt an implementation manual acceptable to the Association ("Project Operations Manual" or "POM"), which shall contain detailed work flow, methods and procedures for the implementation of the Project, including but not limited to: (i) administration and coordination arrangements, including placement of necessary human resources for Project implementation; (ii) performance indicators of the Project; (iii) disbursement arrangements, reporting requirements, financial management procedures and audit procedures (iv) monitoring and evaluation; (v) procurement guidelines and procedures; (vi) corruption and fraud prevention measures; (vii) roles and responsibilities of various agencies and stakeholders in the implementation of the Project; (viii) Personal Data collection and processing requirements in accordance with applicable national law and good international practice; (ix) environmental and social framework aspects, including a detailed description of the grievance redress mechanism process as well as any process for recording and reporting project-related accidents and incidents; (x) details on the composition and working arrangements of the Project Steering Committee; (xi) details on the composition and working arrangements of the Regional Steering Committee; and (xii) such other arrangements and procedures as shall be required for the effective implementation of the Project.
LIBERIA: PROJECT IMPLEMENTATION UNIT (PIU) - Schedule 2. Section I.A.2(c). Not later than three (3) months after the Effective Date, the Recipient shall update the terms of reference of the existing PIU staff to include the Project as further described in the Project Operations Manual.
LIBERIA: PROJECT IMPLEMENTATION UNIT (PIU) - Schedule 2. Section I.A.2(d). Not later than two (2) months after the Effective Date, the Recipient shall recruit, assign or appoint to the PIU a technical coordinator, a monitoring and evaluation specialist, and two procurement assistants; all with qualifications and under terms of reference acceptable to the Association.
LIBERIA: PROJECT FINANCING MANAGEMENT UNIT - Schedule 2. Section I.A.3.(b). Not later than three (3) months after the Effective Date, the Recipient shall, through the PFMU: (i) update the configuration of the existing accounting software for the Project, in terms acceptable to the Association; (ii) update the terms of reference of the existing PFMU staff to include the Project; and (iii) update the annual audit work plans of the internal audit section within the PFMU to include the activities of the Project; and (iv) recruit, appoint, assign a financial management officer; all with qualifications and under terms of reference acceptable to the Association.
LIBERIA: PROJECT FINANCING MANAGEMENT UNIT - Schedule 2. Section I.A.3.(c). Not later than six (6) months after the Effective Date, the Recipient shall recruit an external auditor with qualifications and under terms of reference acceptable to the Association.
LIBERIA: PROJECT OPERATIONS MANUAL (POM) - Schedule 2. Section I.B.1. Not later than three (3) months after the Effective Date, the Recipient shall prepare and adopt an implementation manual acceptable to the Association ("Project Operations Manual" or "POM"), which shall contain detailed work flow, methods and procedures for the implementation of the Project, including but not limited to: (a) administration and coordination arrangements, including placement of necessary human resources for Project implementation; (b) performance indicators of the Project; (c) disbursement arrangements, reporting requirements, financial management procedures and audit procedures; (d) monitoring and evaluation; (e) procurement guidelines and procedures; (f) corruption and fraud prevention measures; (g) roles and responsibilities of various agencies and stakeholders including NPHIL, MoA, EPA and

technical directorates in the implementation of the Project and coordination arrangements between the PIU and the PFMU; (h) Personal Data collection and processing requirements in accordance with applicable national law and good international practice; (i) environmental and social framework aspects, including a detailed description of the grievance redress mechanism process as well as any process for recording and reporting project-related accidents and incidents; (j) details on the composition and working arrangements of the Project Steering Committee; (k) details on the composition and working arrangements of the Regional Steering Committee; and (l) such other arrangements and procedures as shall be required for the effective implementation of the Project.
ECOWAS: PROJECT IMPLEMENTATION UNIT (PIU) - Schedule 2. Section I.A.1(c). Not later than three (3) months after the Effective Date, the Recipient shall, through the Project Implementing Entity: (i) update the configuration of the existing accounting software for the Project, in terms acceptable to the Association; (ii) in addition to the requirements under the ESCP, update the terms of reference of the financial management specialist, accountant(s), procurement specialist, and monitoring and evaluation specialist at the PIU to include the Project; (iii) update the annual audit work plans of its internal audit team to include the activities of the Project; all with qualifications and under terms of reference acceptable to the Association.
ECOWAS: PROJECT IMPLEMENTATION UNIT (PIU) - Schedule 2. Section I.A.1(d). Not later than six (6) months after the Effective Date, the Recipient shall, through the Project Implementing Entity recruit an external auditor with qualifications and under terms of reference acceptable to the Association.
ECOWAS: PROJECT IMPLEMENTATION UNIT (PIU) - Schedule 2. Section I.A.1(e). Without prejudice to Article 6.01 of the Agreement, not later than three (3) months after the Effective Date, the Recipient shall, for purposes of overseeing day-to-day implementation of the Project, delegate authority to the Director General of the Project Implementing Entity.
ECOWAS: REGIONAL STEERING COMMITTEE (RSC) - Schedule 2. Section I.A.2. Not later than ninety (90) days after the Effective Date, the Recipient shall, through the Project Implementing Entity, establish and thereafter convene throughout Project implementation, a Regional Steering Committee (RSC). The RSC shall support coordination of the MPA Program at regional and national levels and ensure alignment with the overall regional agenda and global priorities. The RSC shall include representatives of key ministries from all Participating Countries, members of the Association as observers, and regional and global experts as needed and as further described in the Project Operations Manual. The terms of reference, composition, resources, mandate, powers and functions of the Regional Steering Committee shall be further set out in the Project Operations Manual in terms acceptable to the Association.
ECOWAS: PROJECT OPERATIONS MANUAL (POM) - Schedule 2. Section I.C.1. Not later than three (3) months after the Effective Date, the Recipient shall, through the Project Implementing Entity, prepare and adopt an implementation manual acceptable to the Association (“Project Operations Manual” or “POM”), which shall contain detailed work flow, methods and procedures for the implementation of the Project, including but not limited to: (i) administration and coordination arrangements, including placement of necessary human resources for Project implementation; (ii) performance indicators of the Project; (iii) disbursement arrangements, reporting requirements, financial management procedures and audit procedures (iv) monitoring and evaluation; (v) procurement guidelines and procedures; (vi) corruption and fraud prevention measures; (vii) roles and responsibilities of various agencies and stakeholders in the implementation of the Project; (viii) Personal Data collection and processing requirements in accordance with good international practice; (ix) environmental and social framework aspects, including a detailed description of the grievance redress mechanism process as well as any process for recording and reporting project-related accidents and incidents; (x) details on the composition and working arrangements of the RSC; and (xi) such other arrangements and procedures as shall be required for the effective implementation of the Project.
ECOWAS: AGREEMENT WITH THE WORLD ORGANIZATIOON FOR ANIMAL HEALTH (WOAH) - Schedule 2. Section I.F.1. For the purposes of and prior to carrying out any relevant activity under of the Project, the Recipient through the Project Implementing Entity shall, no later than ninety (90) days after the Effective Date or any later date agreed upon

in writing with the Association, enter into an agreement with the World Organization for Animal Health (the "WOAH Agreement") under terms and in form and substance satisfactory to the Association and in accordance with the Procurement Regulations, as such terms shall include, without limitation, the obligation of and the commitment from WOAH to: (a) provide technical assistance to the Recipient, as necessary, to enhance the PVS, as well as One Health coordination, in accordance with terms of reference acceptable to the Association; (b) carry out these activities in accordance with the Project Operations Manual, the ESCP, the Procurement Regulations and the Anti-Corruption Guidelines as they apply to recipients of Financing proceeds other than the Recipient; and (c) to the extent applicable, (i) cooperate with the Recipient in order to maintain the Association suitably informed of the progress in the implementation of the Project, as the case may be, through the information to be prepared and furnished to the Association pursuant to the provisions of Section II.A of Schedule 2 to this Agreement; and (ii) allow the Recipient and the Association to inspect, at their request, sites and records relevant to the implementation of the Project for purposes of Section 5.11 of the General Conditions.
CABO VERDE (ESCP). The UGPE will establish the grievance mechanism within three months after the effective date of the project.
GUINEA (ESCP). The PCU shall maintain or hire an Environmental Specialist, the Social Specialist and the GBV Specialist (part-time) a Healthcare Waste Management Specialist (part-time) and four Environmental and Social Assistants within six months of project effective date and maintain these positions throughout project implementation.
GUINEA (ESCP). The first audit of medical waste management plan will be submitted to the Association within one year of project effective date.
GUINEA (ESCP). The PCU will adopt and implement an SEA/SH Prevention and Response Plan within three months of project effective date and to be implemented throughout the project life cycle.
GUINEA (ESCP). The PCU and the National Agency for Financing Local Communities (ANAFIC) will establish and maintain grievance mechanism within three months of the project effective date and throughout project implementation period.
GUINEA (ESCP). The PCU and the National Agency for Financing Local Communities (ANAFIC)will ensure that the grievance mechanism shall be equipped to receive, register, and facilitate the resolution of SEA/SH complaints within six months of project effective date and implement throughout the project life cycle.
LIBERIA (ESCP). The PIU, MoH, NPHIL, MOA will hire the two Environmental and Social assistants within six months after the effective date, and thereafter maintain these positions throughout project implementation.
LIBERIA (ESCP). The PIU, MoH, NPHIL, MoA, EPA will update COVID GBV/SEA/SH Prevention and Response Plan within three months after project effective date and to be implemented throughout the project life cycle.
ECOWAS (ESCP). WAHO will hire the Environmental and Social Specialist within five months of the effective date, and thereafter maintain this position throughout project implementation.
ECOWAS (ESCP). WAHO, will establish the grievance mechanism within six months from the effective date, and thereafter maintain and operate the mechanism throughout project implementation.

Conditions

Type	Citation	Description	Financing Source
Effectiveness	CABO-VERDE: Article IV, Section 4.01 (IDA Financing Agreement)	The Additional Condition of Effectiveness consists of the following, namely, that the Cabo Verde Grant Agreement has been	IBRD/IDA

		executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled.	
Effectiveness	CABO-VERDE: Article V, Section 5.01 (Pandemic Fund Grant Agreement)	This Agreement shall not become effective until evidence satisfactory to the Bank has been furnished to the Bank that the conditions specified below have been satisfied. (a) The execution and delivery of this Agreement on behalf of the Recipient have been duly authorized or ratified by all necessary governmental action; and (b) The Cabo Verde Financing Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled.	Trust Funds
Effectiveness	GUINEA: Article IV, Section 4.01 (IDA Financing Agreement)	The Additional Condition of Effectiveness consists of the following, namely, that the Guinea Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the	IBRD/IDA

		effectiveness of this Agreement) have been fulfilled.	
Effectiveness	GUINEA: Article V, Section 5.01 (GFF Grant Agreement)	This Agreement shall not become effective until evidence satisfactory to the Bank has been furnished to the Bank that the conditions specified below have been satisfied. (a) The execution and delivery of this Agreement on behalf of the Recipient have been duly authorized or ratified by all necessary governmental action; and (b) the Guinea Financing Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled.	Trust Funds
Effectiveness	ECOWAS: Article V, Section 5.01 (IDA Financing Agreement)	The Additional Condition of Effectiveness consists of the following, namely, that the Subsidiary Agreement has been executed and delivered in form and substance satisfactory to the Association and all conditions precedent to its effectiveness or to the right of WAHO to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled.	IBRD/IDA

I. STRATEGIC CONTEXT

1. **Western and Central Africa (AFW) is highly vulnerable to disease outbreaks and has the highest number of antimicrobial resistance (AMR) deaths in the world**. The region has experienced two major outbreaks of international significance in the last decade—the West Africa Ebola outbreak of 2014-2016 and the COVID-19 pandemic; and in West Africa alone, 123 public health events were reported between 2020 and 2022.[1] In the aftermath of the Ebola crisis, the World Bank partnered with the Economic Community of West African States (ECOWAS) and the Economic Community of Central African States to pioneer investments to strengthen disease surveillance and diagnostic capacity through an inter-dependent series of operations [the Regional Disease Surveillance Systems Enhancement (REDISSE) Phases 1-4[2]] as well as other investments, which were instrumental for countries in the region to mount early and more effective responses to the COVID-19 pandemic. Building on experiences from previous health system investments, lessons from the COVID-19 pandemic and other health threats, and the need to protect fragile gains in light of new and emerging pathogens, *the proposed regional Program aims to provide a transformational approach to health security grounded in five "game-changers*": (i) Prioritize the intersection of human, animal and environmental health through a cross-sectoral One Health[3] approach with an emphasis on regional collaboration and impact at scale; (ii) Take a holistic view to health security interventions that address the intertwined nature of pandemics, AMR and climate challenges and include gender and equity considerations; (iii) Engage and build trust with communities as the first line of defense of early warning systems and whole-of-society approaches necessary to build strong national and regional capacities to detect, notify and respond to health emergencies[4] and ensure access to countermeasures; (iv) Break siloed approaches to health systems strengthening and health security investments by placing emphasis on the continuity of essential health services during health emergencies; and (v) Measure real-time performance in preparing for and responding to health emergencies guided by international standards. The economic consequences of persistent weaknesses in the health security agenda across an already fragile region are enormous, while the proposed Program will make significant returns on investments both in human capital accumulation and economic growth.

A. Regional and Country Context

2. **With a population of half a billion across 22 culturally and geographically diverse countries, AFW remains among the most unstable regions in the world.** The COVID-19 pandemic slowed economic growth [real gross domestic product (GDP) fell to -0.8 percent in 2020][5] and reversed gains in poverty reduction over the past decade. Since 2021, the economies in the region have resumed a pattern of growth, but it is expected to slow following rising inflation, conflict, food insecurity, food and fuel prices, adverse climate conditions, and the overall risk of debt distress. Rapid population growth over the last half century is projected to increase the region's population by 800 million working-aged people over the next 30 years,[6] slowing per capita income growth to approximately 1 percent in 2022.[7]

3. **As the region faces growing risks of health emergencies driven by zoonotic pathogens, climate change, high migration, and other factors, the prominence of emerging infectious diseases and novel health threats has also grown.** The health and economic impacts of such health emergencies are significant and lasting. Over the last 20 years, at least 13 Ebola Virus Disease (EVD) reported outbreaks were primarily in equatorial Africa. The largest and most devastating

[1] West Africa Health Organization, WAHO; provided February 2023.
[2] The REDISSE series of operations financed by the World Bank include: REDISSE I (P154807); REDISSE II (P159040); REDISSE III (P161163); and REDISSE IV (P167817).
[3] One Health is an approach recognizing that the health of people, the health of animals and the viability of our shared ecosystems are inextricably linked. One Health is a collaborative, multidisciplinary, and multisectoral approach that addresses urgent, ongoing, or potential health threats at the human-animal-environment interface.
[4] For the purposes of the Program, health emergencies are defined as inclusive of infectious disease outbreaks with epidemic and pandemic potential, transmission of zoonotic diseases to humans, and increased risk of human exposure to wildlife pathogens.
[5] World Bank. 2023. Global Economic Prospects, June 2023. World Bank. doi:10.1596/978-1-4648-1951-3. License: Creative Commons Attribution CC BY 3.0 IGO.
[6] World Bank (2021). Supporting a Resilient Recovery: The World Bank's Western & Central Africa Region Priorities 2021-2025.
[7] Calderon, C et al. 2022. "Africa's Pulse, No. 26" (October), World Bank, Washington, DC. Doi: 10.1596/978-1-4648-1932-2.

multi-country epidemic in Guinea, Liberia, and Sierra Leone from 2013 to 2016, resulted in thousands of deaths, long-term negative effects on health systems,[8] and widespread supply chain disruptions. The EVD outbreak cost directly affected countries at least US$2.8 billion combined, with regional impacts due to interruptions in travel, trade, and population movements.[9] At the same time, West Africa has the highest AMR mortality rate in the world at 27.3 deaths per 100,000, considered one of the most imminent critical health threats worldwide.[10] This rising threat extends beyond human health as the number of zoonotic outbreaks across Africa has increased by over 60 percent in the last two decades.[11]

4. **Susceptibility to health emergencies in AFW is compounded by the impacts of environmental degradation and climate change.** Over the past 20 years, more than half of over 2,000 reported public health events in Africa were climate-related, and the frequency of these climate-related events increased by 25 percent between the first and second decades.[12] These trends are likely to increase with AFW's vulnerability to changes in climate (e.g., temperatures in the Sahel are increasing 1.5 times the global average). Changes in temperature and rainfall will drive migration, with climate change migrants within West Africa estimated to reach 54.4 million by 2050,[13] and alter the human-animal-environment interface. Such environmental shifts will impact local disease profiles - including greater risk of vector-borne diseases affected by climate change such as dengue, malaria, and other arboviruses; spread of water-borne diseases including diarrheal diseases; and exposure to novel pathogens. Changes to the human-animal-environment interface such as deforestation is associated with risk of human EVD outbreaks.[14] Extreme weather events, from droughts to floods, will further increase the risk of outbreaks, both due to the acute potential for spread of infectious diseases during natural emergencies, and the downstream impact on environmental drivers.

B. Sectoral and Institutional Context

5. **Countries in AFW are among the least prepared to cope with health emergency threats.** While timely and well-placed investments in regional and country-level preparedness efforts have reaped some positive results, sustained financing for improving and maintaining International Health Regulations (IHR) capacities and World Organisation for Animal Health (WOAH) International Standards, through the Performance of Veterinary Services (PVS) Pathway are required to address persistent weaknesses. Health security metrics consistently rank AFW among the lowest performing regions: in 2021, the region's average ranking on the Global Health Security Index was 28.1 (out of 100) below the global average of 38.9,[15] and countries self-report their performance on average at 46.7 percent, lower than the global average (64 percent).[16] *While IHR and WOAH capacities vary by country, gaps in the region largely include* laboratory capacities for diagnosis; human and animal disease surveillance and information systems; supply chain infrastructure and management; and the health workforce's ability to carry-out disease surveillance, preparedness, and response functions. These gaps are underpinned by insufficient domestic resources, weak institutional capacities and governance mechanisms, and inadequate multisectoral coordination at national and regional levels.

6. **The enduring impacts of outbreaks in the region demonstrate that future health emergencies risk further deteriorating chronically strained health systems and undermining long-term gains in human capital and economic prosperity**. AFW countries face complex and growing health burdens, spanning maternal, infant and child mortality,

[8] CDC. Cost of Ebola on the Healthcare System. 2016. https://www.cdc.gov/vhf/ebola/pdf/impact-ebola-healthcare.pdf
[9] World Bank. 2014-2015 West Africa Ebola Crisis: Impact Update. 2016.
[10] Antimicrobial Resistance Collaborators. Global burden of bacterial antimicrobial resistance in 2019: a systematic analysis. Lancet 399 (10325): 629-655. Doi: 10.1016/S0140-6736(21)02724-0.
[11] WHO, 2022. https://www.afro.who.int/news/africa-63-jump-diseases-spread-animals-people-seen-last-decade
[12] WHO. Africa faces rising climate-linked health emergencies. 2022.
[13] Rigaud, Kanta Kumari; de Sherbinin, Alex; Jones, Bryan; Bergmann, Jonas; Clement, Viviane; Ober, Kayly; Schewe, Jacob; Adamo, Susana; McCusker, Brent; Heuser, Silke; Midgley, Amelia. 2018. Groundswell: Preparing for Internal Climate Migration. World Bank, Washington, DC. World Bank.
[14] Olivero J, et al. Human activities link fruit bat presence to Ebola virus disease outbreaks. Mammal Review 50(1): 1-10. Doi: 10.1111/mam.12173
[15] Global Health Security Index. https://www.ghsindex.org/ Other preparedness metrics such as ReadyScore illustrate similar weaknesses.
[16] The State Party Self-Assessment Annual Report tool is used to evaluate implementation of IHR core capacities. WHO e-SPAR Database.

communicable diseases: prior to the COVID-19 pandemic, this was the only region in the world where absolute numbers of stunted children were increasing.[17] Countries also bear substantial burdens of significant infectious diseases, such as HIV and tuberculosis, vector borne diseases such as malaria, while managing the rise of non-communicable diseases within a growing and aging population. Disruption of essential services during the COVID-19 pandemic exacerbated the limited ability to address these disease burdens worldwide, including in AFW. According to World Health Organization (WHO) global pulse surveys, service disruption remained at 48 percent across African countries at the end of 2021. In Liberia, disruptions in routine immunizations in 2021 were estimated at 5-25 percent while routine primary care visits were interrupted up to 50 percent in Guinea and sexual and reproductive health (SRH) services interrupted up to 5-25 percent in Cabo Verde.[18] Such disruptions in health services induce further knock-on effects across a range of economic interests and essential human development themes and underline the importance of investing in health security.[19]

7. **Resounding lessons from Ebola and COVID-19 responses underscore the need to fundamentally revise the approach to preventing and preparing for health emergencies.** Effective health emergency prevention, timely detection and rapid response efforts cannot lose sight of focusing on community engagement, equity, resilient health systems, and multisectoral linkages across health, agriculture, and environment. In many countries in sub-Saharan Africa, communities, with an emphasis on vulnerable groups including minorities and women, have not been included in health security structures (e.g., surveillance and risk communication). When the necessary technical capacities to analyze and address human, animal and environmental health aspects of local epidemic risks fall short at the community level, enormous opportunities for early detection, community mobilization for risk communication and response, and minimization of the impacts of outbreaks, with attention to equity, are missed. Today, there is a strong need to engage communities (with attention to including women) on prevention, detection, and response efforts that are designed with and for them. Moreover, the disruption of health services during the COVID-19 pandemic highlighted the need to ensure that community and primary health care systems not only detect and report health threats at the frontlines, but also continue to deliver essential services while responding to health emergencies.

8. **Leaders across Africa have prioritized defining a fit-for-purpose health security agenda.** The West Africa Health organization (WAHO), a specialized institution of ECOWAS, works to improve health through coordination of regional health interventions, harmonization of policies, pooling of resources, and cooperation across ECOWAS member states. In 2007, the Regional Animal Health Center (RAHC) was also established as a joint venture of WOAH, the Food and Agriculture Organization of the United Nations (FAO) and the Inter-African Bureau for Animal Resources. While RAHC remains a nascent partner in the region, WAHO has become a leading public health regional entity in AFW, coordinating comprehensive programming across all public health domains for the 15 ECOWAS member states. WAHO manages finances and partnerships primarily derived from ECOWAS as well as partnership financing from the World Bank, German Agency for International Cooperation, United States Agency for International Development (USAID), French Development Agency (*Agence Française de Développement*), among others.[20] In 2017, the Africa CDC was established to support public health initiatives in its member states and strengthen the capacity of public health institutions to detect, prevent, control, and respond quickly and effectively to disease threats. The Africa CDC works through five regional coordinating centers (RCC) that serve as subregional hubs for surveillance, preparedness, and emergency response and play a role in coordinating regional public health initiatives by member states. The West Africa RCC function is carried out by WAHO, while the Central Africa RCC is in Gabon. WOAH is an intergovernmental organization that assists national veterinary services to improve animal health and welfare worldwide. It maintains permanent relations with international and regional organizations and sustains regional collaboration through its subregional offices, including in the ECOWAS region.

[17] United Nations Children's Fund. The State of Child Wasting in West and Central Africa, 2020.
[18] WHO Global pulse survey on continuity of essential services during the COVID-19 pandemic. November-December 2021.
[19] Health security is defined by WHO as activities required, both proactive and reactive, to minimize the danger and impact of acute public health events that endanger people's health across geographical regions and international boundaries. *Health security and preparedness are used interchangeably throughout the document.*
[20] WAHO. Partners. 2022. https://www.wahooas.org/web-ooas/en/partners

9. **In the past decade, the World Bank has made foundational regional investments to support harmonized approaches to health emergencies across AFW**. Large-scale health emergencies such as EVD exposed long-standing weaknesses in national and regional health security architecture in the region. Regular incidents of failing to counter infectious threats have continuously demonstrated the critical need for multisectoral engagement and cross-country collaboration to prevent, detect, and respond to health emergencies. In the aftermath of the late 2013-2016 EVD outbreak in West Africa, the World Bank, through the REDISSE series of projects, was among the first institutions to provide financing for disease surveillance and response for human and animal health. The REDISSE portfolio strongly positioned these countries to respond to the COVID-19 pandemic, among other outbreaks prior to the pandemic, such as Lassa fever. The COVID-19 Strategic Preparedness and Response Program (SPRP) also showed the impact of investing in preparedness and response to the pandemic. An Independent Evaluation Group review of regional projects' contribution to the COVID-19 pandemic response noted that in West Africa in particular, the COVID-19 response benefited from rapid and ongoing high-level political leadership and technical coordination at the regional level supported by REDISSE. The SPRP implementation also highlighted areas for improvement, namely better preparedness of countries to deliver emergency services that reach local levels; more resilient systems in countries to protect health, education, and gender equality; improved support for cross-sectoral coordination; data for managing quality implementation; regional learning and cooperation; and stronger internal preparedness to respond quickly in a crisis, including partner coordination. This Program proposes to capitalize both on the SPRP achievements, and the many lessons learned in its implementation.

10. **Investments in regional institutions are essential to improving effectiveness and efficiency of responses to health emergencies.** West Africa adopted a coordinated approach to controlling the COVID-19 pandemic, led by a Ministerial Coordination Committee (comprised of Ministers of Health) and a regional coordination platform comprised of National Public Health Institutes (NPHIs). Moreover, regional assets established and strengthened following prior outbreaks (e.g. 2013-2016 EVD epidemic) were leveraged and activated, such as: (i) the ECOWAS Regional Centre for Surveillance and Disease Control; (ii) technical capacities supported through REDISSE; (iii) investments in mobilization of epidemiologists, rapid response teams, and regional network of public health reference laboratories;[21] and (iv) Africa CDC, which has emerged as an increasingly strong public health leader that has provided critical support to African Union (AU) member states to improve preparedness capacities. Working with the Africa CDC and WAHO, many countries expanded capacity for surveillance and detection amidst a rapidly changing environment in response to a novel pathogen. Regional institutions, partnerships, and initiatives also supported access to health products and technologies including diagnostics, pharmaceuticals, medical equipment, and COVID-19 vaccines. Importantly, countries with pre-positioned financing (e.g., REDISSE) were able to quickly implement response efforts, without losing critical time mobilizing the financing needed.

11. **Given ongoing fiscal constraints at country level, significant funding will be required to maintain and accelerate gains in health security with a strong source of coordinated financing.** The prioritization of a regional health security Program presents an opportunity for the World Bank to strengthen its engagement in the AFW region. The proposed regional Program using an MPA aligns interventions with the existing World Bank portfolio, within and beyond the health sector (e.g., Africa CDC Support Program to Prevent and Combat Public Health Threats, REDISSE projects, analytic work on health security). The Program also aligns with partner agendas in the region, namely Africa CDC, WAHO, WHO, WOAH, and FAO. The Program will complement Africa CDC's continental leadership in areas such as health workforce as well as surveillance and laboratories. Finally, the Program is positioned to support a regional health security agenda through activities that align with and complement the region's political and technical leadership; build on prior investments in coordinated regional and national preparedness as well as health systems strengthening projects; and work with regional and national institutions to ensure that health security efforts are effective, consistent, and sustained.

[21] Ahanhanzo C. et al. COVID-19 in West Africa: regional resource mobilisation and allocation in the first year of the pandemic. BMJ Glob Health. 2021 May;6(5):e004762. doi: 10.1136/bmjgh-2020-004762.

C. Relevance to Higher Level Objectives

12. **The proposed Program aligns with the World Bank's mission and is poised to contribute to IDA20 policy commitments dedicated to strengthening health security to prevent and prepare for future pandemics or other major health emergencies.** The IDA20 commitments prioritize improving overall human capital and focus on pandemic prevention and preparedness at the nexus of human, animal, and environmental health, including zoonotic diseases and AMR (One Health). Furthermore, the Program offers a forward looking and transformational approach in line with the World Bank Evolution Roadmap[22] and the World Bank's new Global Challenge Program (GCP). The regional Program aligns with GCP 3 "Enhanced health emergency prevention, preparedness and response" which aims to: (a) build 'emergency-ready' health systems; and (b) mainstream One Health capacities to prevent and prepare for health emergencies, as part of the World Bank's Evolution Roadmap, and addresses four other GCPs: (i) "*Fast-Track Water Security and Climate Adaptation* in addressing water-borne, water- and climate-related outbreaks of transmissible and epidemic prone diseases; (ii) *Food and Nutrition Security* by increasing regional capacity to address zoonotic diseases that impact food insecurity and economic loss using the One Health approach; (iii) *Energy efficiency and access* by implementing energy efficiency measures in health facilities and accessing critical diagnostic and treatment equipment to ensure the provision of essential health services during health emergencies; and (iv) *Accelerated digitization*, upon which surveillance, reporting, distance learning, supportive supervision and telemedicine rely.

13. **A regional MPA in AFW is well placed within the World Bank's 2021-2025 regional priorities to build strong and pandemic ready health systems.**[23] Further, the proposed Program supports the implementation of the World Bank Regional Integration and Cooperation Assistance Strategy for Africa with attention to efforts to support human capital development. The proposed regional Program will also contribute to the World Bank's 2020-2025 Fragility, Conflict, and Violence Strategy, specifically to pillars of engagement on prevention and transition out of fragility. Furthermore, the Program is consistent with the World Bank Gender Strategy 2024-2030 on building and protecting human capital, and the AFW Region Gender Action Plan (2023-2027). Finally, investments in regional collaboration to increase health system capacities will advance World Bank commitment to the Next Generation Africa Climate Business Plan for 20 countries.

14. **The proposed Program is consistent with Phase I country strategies on climate change as well as the World Bank's Climate Change Action Plan (2021–2025) and will support countries in achieving their Nationally Determined Contributions (NDCs) to the Paris Agreement and contribute to climate change adaptation and mitigation.** In the latest NDCs submitted to the United Nations Framework Convention on Climate Change, Phase I countries identify the health sector as a vulnerable sector to be prioritized. Moreover, Phase I countries include measures for climate change adaptation for the health sector in national health policies such as the National Health Developmental Plans. The Program aims to provide targeted support to select bottlenecks identified for the health sector, especially to improve health facilities' climate resilience as well as the population knowledge of the links between climate change and health.

15. **The World Bank has a unique opportunity to support an innovative and robust country, regional, and global approach towards strengthening health emergency preparedness and response.** Newly established frameworks provide opportunities to engage and ensure financing priorities, including the: (i) One Health Quadripartite Memorandum of Understanding (MoU)[24] signed between WHO, WOAH, FAO and the United Nations Environment Program in 2022 to provide a framework for addressing One Health including AMR, emerging and endemic zoonotic diseases and health systems strengthening, and their One Health Joint Plan of Action (OH JPA) 2022-2026; as well as: (ii) the Pandemic Treaty, under development. The MPA is also well-aligned with the AU and Africa CDC strategies, including Africa 2063, the AU Health Strategy (2016-2030), Africa's Animal Health Strategy (AHSA) 2019-2035, WHO/Africa CDC Emergency

[22] Evolving Operations, and Resources: A Roadmap, December 2022.
[23] World Bank, Supporting a Resilient Recovery. The World Bank's AFW Region Priorities 2021-2025.
[24] WHO. Quadripartite MoU signed for a new era of One Health Collaboration. 2022 April 29.

Preparedness and Response Flagship Initiative, Africa CDC New Public Health Order, the Africa CDC Strategic Plan 2022-2026,[25] and the Africa Regional Strategy for Health Security and Emergencies 2022–2030, all of which center on health security and preparedness, as well as regional integration, as core objectives. The Program also contributes to the implementation of IHR, WOAH International Standards and the Global Health Security Agenda as well as World Bank priorities for improving pandemic prevention and preparedness, health systems strengthening, and universal health coverage. Finally, the Program will complement World Bank and partner investments in analytics and operations for health systems strengthening, disease control and surveillance.

16. **The Program will leverage financing from the International Development Association (IDA) Regional Window supporting regional solutions for shared regional challenges and promoting global or regional public goods.** The Program meets the World Bank criteria for a regional operation, namely: (i) economic and social benefits across national boundaries demonstrated by at least one Project Development Objective (PDO) level indicator; (ii) country and regional ownership of the operation; (iii) participation of at least two IDA-eligible countries; and (iv) harmonization across several high-level policy dimensions. The Program will also leverage financing from other partners, namely the Global Financing Facility for Women, Children and Adolescents (GFF)[26] and the Pandemic Fund (PF).[27] The GFF contribution has been enabled by the Program's design focus on prevention and mitigation of disruptions in access to essential health services consistent with the intent and purpose of the GFF Essential Health Services Grants. Although this grant co-financing is a first for the GFF which previously co-financed country-specific World Bank operations, this Program is an opportunity to demonstrate the advantages of a regional approach and added value of a regional platform to accelerate the adoption of demonstrated best practices across a group of countries facing common challenges. Additionally, the PF provides a dedicated stream of financing to strengthen pandemic prevention, preparedness, and response capabilities in low- and middle-income countries, strongly anchored in One Health principles. While PF grant funds have been awarded to Cabo Verde, the PF Trust Fund is under establishment at the time of the proposed Program. It is expected that the PF Trust Fund is established, and funds are made available for implementation in early 2024.[28] Finally, these partnerships draw on strengths and comparative advantages of key institutions, including WHO, FAO, WOAH, and Africa CDC.

17. **The Program is consistent with the Country Partnership Frameworks (CPF) of Phase I countries and ECOWAS priorities.** The Program directly supports the Cabo Verde CPF (FY20-25) (Report No. 127164-CV) Result Area I focus on accelerating human capital development for services-led growth. Furthermore, the Program aligns with the Guinea CPF (FY18-23) (Report No. 125899-GN) Pillar 2 on human development, Objective 2 of decentralizing service delivery, including health, and Objective 5 of improving health in rural areas, aiming to enhance human capital to foster inclusive growth. Similarly, the proposed operation aligns with the CPF for Liberia for FY19-24 (Report No. 130753-LR), specifically Objective 6: Improving access and quality of health services in a COVID-19 environment and Indicator 4, in which national and decentralized surveillance and emergency response for priority zoonotic diseases and outbreaks is front and center, as part of World Bank support. The Program is also in line with ECOWAS Vision 2050, Pillar 4.

D. Multiphase Programmatic Approach

[25] African Union. Africa Centers for Disease Control and Prevention Strategic Plan 2022-2026.
[26] The GFF supports low- and lower-middle income countries to accelerate progress on reproductive, maternal, newborn, child and adolescent health and nutrition, and strengthen financing and health systems for universal health coverage. The GFF supports government-led, multi-stakeholder platforms to develop and implement a national, prioritized health plan (called an investment case), that aims to help mobilize sustainable financing for health and nutrition. The GFF Trust Fund, hosted by the World Bank, links moderate amounts of resources to World Bank financing, and supports countries to strengthen their focus on data, quality, equity, results, and domestic resources for health.
[27] The Pandemic Prevention, Preparedness and Response Trust Fund (Pandemic Fund/PF) is a collaborative partnership among donor countries, co-investors (countries that are eligible to receive funding), foundations and civil society organizations.
[28] In the event of the PF funds not materializing, this phase would be restructured to adjust the affected activities.

(i) Rationale for Using MPA

18. **This regional Program builds on prior and ongoing World Bank investments in health security as well as development partner efforts in the region**, and strives to ensure that hard-won progress in prevention, early detection, and response to health emergencies[29] is protected and accelerated while ensuring continuity of essential health service delivery. The Program will complement current and planned investments at regional and national levels, aligning health security investments in the region with the World Bank's investment in Africa CDC, as well as with subregional institutions. Moreover, the Program will complement national health systems strengthening investments in the region to improve harmonization of the health security agenda within countries while avoiding duplication with other efforts. Multisectoral health security activities that require multi-country coordination and investments in shared assets [e.g., borders and points of entry (PoE), regional laboratory networks and deployable health emergency response teams] will be supported. At the same time, the Program will support complementary regional and national level activities for health emergency response, including targeted activities to improve agility of health systems to pivot functions and delivery mechanisms to minimize impacts of health emergencies (e.g., contingency plans to be activated in health emergencies).

19. **The Program is timed to be a transformative investment with significant returns.** Consistent and dependable investments in health security contribute to shared economic prosperity by avoiding or minimizing potentially catastrophic social and economic losses due to outbreaks and climate shocks. Recognizing that cross-border health threats require cross-border solutions to control and limit the impacts of potential future outbreaks, the Program takes a longer-term strategic vision to provide dependable financing. By strengthening a regional platform that will harmonize and coordinate health security investments, the Program will deploy lessons from a robust history of implementing regional health programs in sub-Saharan Africa, foster cross-country learning and support more resilient and better prepared health systems that can cope with and minimize the devastating social and economic impacts of future health emergencies.

20. **Building on the SPRP and previous regional approaches, the Program is a critical element of the World Bank's next phase of accelerating health security in AFW.** For decades, health emergencies have caused global panic and neglect followed by underinvestment as conditions transition between emergency and routine contexts. Limited fiscal space and inadequate financial resources often compel government authorities to prioritize financing for short-term needs, instead of allocating national funds. Additionally, maintaining and accelerating interconnected regional health systems' prevention, detection and response capacities requires consistent effort. Recent pandemics and disease outbreaks underscore the costs of improving and maintaining health security, estimated at US$43 billion per year in low- and middle-income countries.[30] A G20 High Level Independent Panel estimated it would take US$75 billion over the next five years to expand financing for health security, two thirds of which would be directed to lower income countries and lower middle-income countries. Further, it would take an additional US$9 billion annually to address AMR globally. The Program provides the flexibility to prioritize activities based on country needs, capacities, and regional complementarities, but also on the shifting nature of threats and demonstrated ability to respond. The Program design reflects the fundamental uncertainty of infectious threats and the need to adapt to strengthen capacity across borders over an entire region.

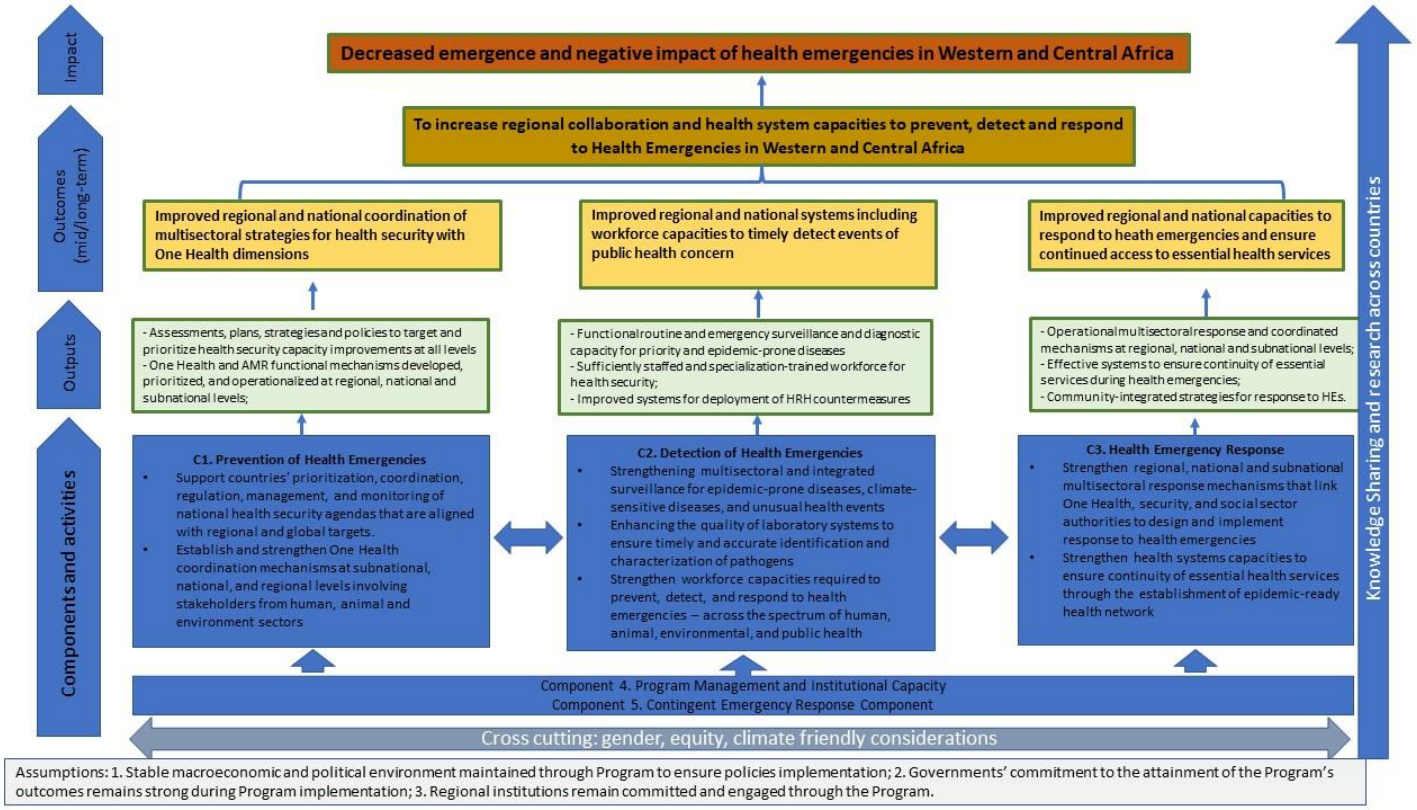
21. **The MPA design brings flexibility and adaptability to Participating Countries** as it allows for Participating Countries to decide when and how they may join the Program based on their respective levels of readiness, evolving country and regional priorities, complementarities with existing and planned national engagements as well as lessons learned in previous phases. This approach enables the World Bank to support tailored country interventions, while endorsing an integrated approach and common objectives across the region. Finally, Phase 1 countries would contribute to the learning agenda and inform the design of subsequent phases through collaboration and convening of development

[29] The Program defines health emergencies as being inclusive of infectious disease outbreaks with epidemic and pandemic potential, transmission of zoonotic diseases to humans, and increased risk of human exposure to wildlife pathogens.

[30] The costs of improving health emergency preparedness: A systematic review and analysis of multi-country studies. eClinicalMedicine 2022;44: 101269 Published online 27 January 2022. https://doi.org/10.1016/j.eclinm.2021.101269

partners focused on various aspects of the health security agenda in the region.[31]

Figure 1: Program Results Chain



(ii) Program Development Objective (PrDO) with PrDO Indicators

22. **The PrDO is to *increase regional collaboration and health system capacities to prevent, detect and respond to health emergencies in Western and Central Africa***. Building from World Bank and partner efforts, the proposed Program provides a platform to strengthen critical capacities for preparedness and response to health emergencies. The Program will invest in key interconnected systems for improving health security[32] designed with a One Health approach, capitalizing on multisectoral collaboration, and convening partner investments.

23. **PrDO Level Indicators:**

(i) Regional signed agreements for cross-border information sharing on health security guided by the One Health principles (Number)
(ii) Routine multisectoral cross-border investigations/simulations conducted in the region (Number)
(iii) Participating Countries that have adopted metrics to timely detect and respond to health emergencies (Percentage)
(iv) Participating Countries having addressed gaps in veterinary services core capacities (Percentage)

[31] The MPA learning agenda presents benefits for countries not part of the Program and where the World Bank is supporting health security through other operations.
[32] Ten proposals to build a safer world together – Strengthening the Global Architecture for Health Emergency Preparedness, Response and Resilience WHO/2022.

(v) Participating Countries with adopted/updated contingency plans to ensure delivery of identified essential health services during a health emergency (Percentage)

Table 1: Program Framework

Phase #	Operation ID	Sequential or Simultaneous	Phase's Proposed DO	IPF or PforR	Estimated IBRD/IDA Amount (US$ million)	Estimated Other Amount (US$ million)	Estimated Approval Date	Estimated Environmental and Social Risk Rating
1	P179078	Simultaneous	*Increase regional collaboration and health system capacities to prevent, detect and respond to health emergencies in Western and Central Africa (Annex 1 lists Phase 1 countries)*	IPF	158.00	20.00	December 19, 2023	Substantial
2+		Simultaneous	Same as above	IPF	342.00	0.00	As countries join	
Total					500.00	20.00		
Board Approved Financing Envelope					**500.00**			

(iii) Learning Agenda

24. **The Program's learning agenda will provide structured opportunities to enhance Program implementation and make a significant contribution to the evidence base in health security.** The Learning Agenda focuses on the generation of knowledge, evidence, and best practices and prioritizes peer to peer learning and knowledge exchange as a built-in feature of the Program. Along with the inherent cross-border characteristics of health security (i.e., epidemiological early warning and data sharing, interventions at ports of entry, sharing of laboratory capacity), there is meaningful scope for learning between countries and capitalizing on their comparative advantages. For example, some countries may have more experience with responding to large-scale outbreaks (Ebola) or community-based surveillance efforts while others have gone through the process of establishing NPHIs. This collaboration promotes the creation of synergies and economies of scale and seeks to leverage existing institutions and platforms for cross-country learning and information sharing. Learning opportunities will also focus on experiences with overcoming implementation challenges and regional-level solutions to maximize efficiency gains (e.g., joint capacity building and on the job training, sharing of bottlenecks and resolutions). Research findings will enable the Program to fulfill one of the key advantages of the MPA design and allow for adjustments and shared innovations during Program implementation. While the Program has identified specific gaps for learning, it is anticipated that the Program will support adaptive learning in collaboration with national, regional, and international partners on a range of demand-led issues. Finally, the learning agenda will benefit not only Program Participating Countries, but also countries where the World Bank is supporting strengthening IHR and PVS capacities through other means. WAHO's regional mandate and role in the Program will potentially result in a much larger number of countries benefitting from the learning agenda from the start and any regional actions to promote agreements on information exchange, resource sharing and regulatory harmonization.

II. PROGRAM DESCRIPTION

A. Program Components

25. **The Program has five components grounded in IHR and WOAH core capacities that all countries are committed to strengthening.** Each component describes a menu of activities that will be supported under the overall Program. Participating countries (at all phases) will have the flexibility to select relevant activities under the components, based on country context and priorities, provided these are well-aligned with the PrDO and theory of change.

26. **The Program prioritizes cross-cutting themes to protect the most vulnerable, ensure climate resilience, share cross-border solutions to challenges and harness the MPA's learning agenda.** Lessons and guidance developed from REDISSE implementation will be deployed to integrate gender considerations into Program activities (e.g., gender-based violence (GBV) risks during an emergency, maintaining essential reproductive, maternal, child and adolescent health services during health emergencies and carrying out a gender analysis for One Health related interventions). While regional institutional capacity building will be supported through Component 4, a strong focus on equity and inclusion, effective governance and coordination, information sharing, research, capacity building and experience exchange, cross-border surveillance, and robust technology transfer among relevant regional agencies and Participating Countries cuts across all components. Program components are mutually supportive by design and given the broader objective of strengthening regional collaboration for increasing health system capacities in the face of health emergencies, elements of some subcomponents cut across all components, e.g., governance and stewardship (Subcomponent 1.1) and multi-disciplinary human resources for health emergencies (Subcomponent 2.3).

27. **Component 1. Prevention of Health Emergencies (US$27.08 million equivalent IDA, US$0.20 million equivalent PF).** This component focuses on strengthened planning and management of health security resources, as well as preventing and minimizing impacts of health threats such as zoonoses and AMR.

28. **Subcomponent 1.1 Health Security Governance, Planning, and Stewardship.** *At the regional level*, this subcomponent will support (i) mapping of regional and national resources for prevention, detection, and response to health emergencies; (ii) alignment of development partners and financing to country needs and priorities for health security; (iii) standardized regulations supporting the handling and transfer of biological materials (e.g., specimen sample transportation); and (iv) regional, cross-border and national information sharing, as well as coordination of core prevention, detection, and response capacities. *At country level*, the subcomponent will support countries' prioritization, coordination, regulation, management, and monitoring of national health security agendas that are aligned with regional and global targets. Regional level support will also review/support the required governance, legal and regulatory authorities in place for NPHIs including institutional capacity support. This encompasses extensive technical support to the development and management of National Action Plans for Health Security (NAPHS); and support to the review of public health laws, policies, and regulations (e.g., updating legal frameworks to operationalize health emergency management and response efforts outlined in multisectoral, multi-hazard national plans). Benefitting from the adaptive MPA approach, this subcomponent will support the monitoring of IHR core capacities using tools such as the Joint External Evaluation (JEE) and PVS Pathway, particularly at borders and PoE, to inform planning and priority setting.

29. **Subcomponent 1.2 Scaling-up One Health Agenda and combatting AMR.** This subcomponent is dedicated to the multisectoral collaboration embedded in the One Health approach (the intersection of animal, environmental, and human health) and aimed at preventing spillover events, considering the growing threat of zoonoses-related outbreaks, with attention to AMR and vector-borne diseases affected by climate change. Program supported activities would establish and strengthen One Health coordination mechanisms at *subnational, national, and regional levels* involving stakeholders

from human, animal and environment sectors. *The subcomponent will finance the:* (i) development, prioritization, and operationalization of multisectoral, regional One Health and AMR action plans (with a gender focus); and (ii) development, dissemination, and monitoring of guidelines and regulations for prevention including optimizing antibiotic use in animal and human health sectors, sanitary animal production practices,[33] and water, sanitation, and hygiene practices (WASH) including use of the WASH Facility Improvement Tool. Supported activities on dissemination of these prevention practices will include community engagement to improve uptake and contextualize interventions to community needs with a gender lens to maximize focus on equity and inclusion.

30. **Component 2. Detection of Health Emergencies (US$64.14 million equivalent IDA, US$5.00 million equivalent GFF, US$2.80 million equivalent PF).** This component focuses on multisectoral surveillance systems and mechanisms for data sharing within and across borders, strong regional laboratory networks and multisectoral and integrated workforce required to enable early detection of health emergencies.

31. **Subcomponent 2.1. Collaborative Surveillance.[34]** This subcomponent will focus on strengthening multisectoral and integrated surveillance capacities (including indicator and event-based surveillance), particularly for epidemic-prone diseases, climate-sensitive diseases, and unusual health events. *Activities at cross border and national levels* relate to real-time monitoring and quality improvement for early detection and response and will operationalize early warning surveillance systems in One Health sectors (animal, environment, and human health) with an emphasis on PoE. Early warning surveillance systems will focus on engagement of community-level actors (with attention to vulnerable populations – including women). In addition to data collection and management, the subcomponent will support training and tools for data analysis, and platforms for information sharing at all levels (community, national, and regional) and across One Health sectors. This capacity building will aim to strengthen linkages between community, national, and regional surveillance systems, to improve the rapidity with which data on potential health threats are shared within and across countries. Program supported activities will include training and logistics support (i.e., transport) to strengthen capacity for event verification, investigation, and risk assessment to inform the level of threat and response - as well as support to the Field Epidemiology Training Program (FETP) at basic, intermediate, and advanced levels. To support closing the gender gap in women's access to formal trained technical roles in the health sector, outreach efforts will be done to ensure purposeful targeting of women in administrative or informal positions to be included in these professional training programs. The increased rate of women graduating and institutionalized within the health workforce will be critical to ensure FETP and health security related community-based approaches and activities are designed and implemented with a gender lens which in turn will improve access and quality of community health approaches. Finally, activities will also build on gains in national and cross-border regional surveillance activities across One Health sectors including PoE, with an emphasis on data sharing and feedback loops to ensure effective data usage for decision-making.

32. **Subcomponent 2.2. Laboratory Quality and Capacity**. This subcomponent will focus on enhancing the quality of laboratory systems to ensure timely and accurate identification and characterization of pathogens. Importance will be placed, at both regional and national levels, on ensuring that laboratories implicated in human, animal, or environmental health function in an integrated fashion to ensure the One Health approach is operationalized and maximize sharing of materials/supplies and transportation capacities across sectors and countries. Expanded laboratory capacity would also focus on the ability to carry out surge testing and build capacity for genomic sequencing in AFW with sharing of information across countries to inform surveillance and risk assessment related activities. *Regional level activities* aim to strengthen regional interconnected laboratory networks and the requirements to test for specialized pathogens and conduct quality control by supporting the establishment and implementation of regional laboratory protocols, biosafety and biosecurity

[33] In line with the Africa CDC Framework for Antimicrobial Resistance; 2018-2023.
[34] WHO defines Collaborative surveillance as "the systematic strengthening of capacity and collaboration among diverse stakeholders, both within and beyond the health sector, with the ultimate goal of enhancing public health intelligence and improving evidence for decision-making."

guidelines, regional standards, guidance, and material transfer agreements for cross country specimen transportation. *National level activities* include efforts to strengthen laboratory information management systems (LIMS), support public health laboratory accreditation efforts, expand laboratory and diagnostic coverage through necessary laboratory infrastructure and laboratory supplies for testing for a variety of pathogens, and include national public health laboratory systems as part of the in-country early warning system.

33. **Subcomponent 2.3. Multi-disciplinary human resources for health emergencies.** This subcomponent aims to strengthen workforce capacities required to prevent, detect, and respond to health emergencies – across the spectrum of human, animal, environmental, and public health. This workforce spans frontline health (e.g., Community Health Workers (CHWs), nurses, midwives, physicians); public health (e.g., disease surveillance officers, epidemiologists, biostatisticians, laboratory technicians); animal health (e.g., veterinarian and wildlife health officers, animal health epidemiologists, veterinary paraprofessional, community animal health workers); environmental health (e.g., food safety officers, environmental health specialists); and multisectoral surge workforce plans in the event of health emergency. *At the regional level*, activities include support to the regional harmonization of competency standards, regional education and training programs including continuous support to the Field Epidemiology and Laboratory Training Program (FELTP) at national and subnational levels, regional veterinary paraprofessional workforce development program, as well as for regional health emergency rapid response teams. *National level* supported activities will focus on strategic resource planning to support medium to longer term staffing, including multidisciplinary One Health workforce plan development (i.e., field visits for data collection on workforce, relevant stakeholder meetings, etc.) and implementation (i.e., curriculum development; training for cadres at subnational, national, and regional levels, including on topics such as infection, prevention, and control (IPC); mobilization of resources for worker incentives, budgeted positions, etc.).

34. **Component 3. Health Emergency Response (US$51.78 million equivalent IDA, US$11.00 million equivalent GFF, US$0.80 million equivalent PF).** This component will build and sustain capacities that can prevent and prepare for an outbreak from becoming an epidemic or pandemic, through a focus on disease control and effective health emergency response.

35. **Subcomponent 3.1. Health Emergency Management.** This subcomponent will focus on the management capacities required at *subnational, national, and regional levels* to respond to public health threats. This includes support to development of and/or monitoring and support to national multi-hazard, multisectoral plans and maintaining and operationalizing standard operating procedures (SOPs). Activities will focus on (i) multisectoral response mechanisms that link One Health, security, and social sector authorities to design and implement response to health emergencies (i.e., travel-related measures, border policies, lockdowns, social supports, etc.); (ii) support to the establishment and functioning of public health emergency operations centers (PHEOCs); (iii) access to countermeasures through strengthening emergency logistics and supply chains, including supply chain monitoring, stockpiling, and procurement plans at national and regional levels; and (iv) management and deployment of national and regional surge workforce. For the stewardship of these response structures and tools – i.e., multisectoral response mechanisms, PHEOCs, supply chains, surge workforce management – supported activities will include logistics and technical support for meetings, training, infrastructure, and simulations/tabletop drills to regularly test capacities. Finally, this subcomponent will support Intra-Action Reviews as well as Rapid After-Action Reviews that collect and disseminate findings to key stakeholders across sectors at national levels and through cross-country/regional collaboration.

36. **Subcomponent 3.2. Health service delivery for health emergencies.** This subcomponent focuses on health systems' response to health emergencies, including the maintenance of essential health services. Activities include the development and/or updating of contingency plans that also address relevant climate exposures such as high temperatures or flooding, patient referral systems/networks of facilities to be activated in health

emergencies, innovations (i.e., telemedicine), as well as information systems strengthening (i.e., digital systems for health records, health workforce, supply chains, etc.). To strengthen health facility response in the event of a health emergency, investments for "epidemic ready" health facilities including one-off capital investments such as green and resilient measures,[35] IPC requirements and adaptability for surge capacity (e.g., WASH facilities, isolation areas, ventilation, electricity). This subcomponent also supports broader health systems response, such as case management, point of care testing (where feasible), design and implementation of multisectoral risk communication and community engagement (RCCE) strategies with a focus on vulnerable populations (i.e., training for risk communication, logistics support for health services demand generation, platforms for community engagement spanning digital, radio, schools, etc.). Cross border RCCE activities include regional or multi-country strategies focused PoE given high levels of migration within the region and the need to engage mobile communities across borders. The subcomponent also supports regional training on a minimal initial service package in SRH in the context of public health emergencies (PHEs).

37. **Component 4. Program Management and Institutional Capacity (US$15.0 million equivalent IDA, US$0.20 million equivalent PF).** This component will support the critical building blocks for strong implementation and coordination required for implementing a regional program. Specific institutional capacity building activities at national and regional levels include program coordination, hands-on technical assistance for improving contract management (e.g., hands on extended implementation support or other fiduciary coaching), monitoring and evaluation (M&E) including data collection, tracking, reporting and knowledge management, procurement, financial management (FM) and disbursement monitoring, management of social and environmental risks, including climate change (e.g., capacity building, M&E). This component will also finance personnel (consultants) for project execution at national and regional levels as appropriate to the context. Regional coordination platforms [coordinated at the regional level through the Regional Steering Committee (RSC)] for knowledge sharing and promotion of cross-country learning in specific technical areas (e.g., community-based surveillance, NPHIs) among the implementing entities and collective monitoring of implementation status. Finally, related operating expenses and equipment will also be financed under this component.

38. **Component 5. Contingency Emergency Response Component (CERC) (US$0.00 million).** This no cost component will facilitate access to rapid financing by allowing for the reallocation of uncommitted project funds in the event of a PHE in a country, either by a formal declaration of a national emergency or upon a formal request from the respective government of a Participating Country. Following an eligible crisis or emergency, the government may request the World Bank to reallocate project funds to support emergency response and reconstruction. A CERC Manual and Emergency Action Plan, acceptable to the World Bank, will be prepared and constitute a disbursement condition for this component.

Project Beneficiaries

39. **Everyone in the AFW region (estimated 627 million population) is expected to benefit from the Program given its significant contribution to protecting global public goods.** The Program will target infants and children, adolescents, mothers (given the high burden on maternal and perinatal conditions in the region), and the elderly (who are the most vulnerable to illness and risk factors). In addition, due to the One Health focus, beneficiaries also include livestock farmers, as well as the general population, who will benefit from less exposure to zoonoses. The Program targets disadvantaged populations, including internally displaced persons and refugees. Regional institutions, such as ECOWAS, will benefit from investments in institutional capacities and efforts to fortify their respective regional agenda and country network.

B. Rationale for World Bank Involvement and Role of Partners

[35] Examples include energy-efficient upgrades such as structural improvements, roofing, electrical safety, improvements in lighting, telecommunications, plumbing and water storage as well as inclusion of ramps to facilitate access for persons with disabilities. Minor refurbishments to existing health facilities will benefit, when possible, from energy-efficient ventilation and air conditioning systems to reduce related costs and enhance IPC, as well as other energy-efficient and cost saving investments.

40. **The World Bank is well placed to establish a regional multisectoral phased Program focused on improving prevention, preparedness, and response capacities for health emergencies**. Through its lending, knowledge work, and advisory engagements across sectors, the World Bank has built expertise and produced a wealth of analytical products on health security. The World Bank is also well positioned to work with countries and partners to share knowledge that is rooted in evidence, as well as to lead coordination aspects of health security. Furthermore, the World Bank is uniquely placed to take results to scale. As such, World Bank investments can assist countries to shift from a constellation of discrete interventions to large-scale initiatives required to accelerate outcomes and impact. The Program will provide multisectoral platforms for cross-country collaboration, tapping into the World Bank's established partnerships with countries, development partners, and continental institutions focusing on preparedness and response, such as the Africa CDC.

C. Lessons Learned

41. **Efforts to strengthen preparedness capacities in the region have gleaned important lessons from numerous recent health emergencies.** The REDISSE series of projects helped incentivize countries to invest in modern disease surveillance systems, laboratory capacity, the health security workforce, and outbreak planning and readiness. Further, REDISSE's One Health approach fostered cross-border collaboration among multiple sectors, through the: (i) establishment of One Health coordination mechanisms and platforms at country and sub-regional levels; (ii) assessment and optimization of national IHR capacities and institutional arrangements; and (iii) development of regional cross-sectoral strategies, efforts to integrate surveillance systems for diseases in humans and animals, and scenario-based modeling to enhance country capacities. REDISSE helped established a network of 15 regional reference laboratories for human and animal health, advanced FELTP, and a regional stockpile for personal protective equipment, drugs, and vaccines for epidemic response which made it possible for countries to quickly mount COVID-19 response. *Major lessons from REDISSE underline the need to:* (i) maintain and improve preparedness for health emergencies, with a focus on collaborative surveillance aligned with a One Health approach; (ii) integrate gender considerations; (iii) invest in ensuring the continuity of essential health services before, during and after health emergencies; and (iv) create a platform for health security coordination with other investments including national health system strengthening projects, and other related country operations. Finally, support to regional institutions in health security by complementing continent-wide investments provides greater opportunities for learning and regional cooperation including course correction as needed. Capacity constraints coupled with limited fiscal space have hampered the ability of the AFW region to adequately strengthen preparedness efforts. By ensuring strong regional collaboration for health security, the promotion of strategic and complementary investments at the regional level can help mitigate the disruptions and contain cross-border and spillovers of communicable disease beyond what countries can achieve by acting alone.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

42. **At country level, project implementation is primarily the responsibility of the respective Ministries of Health, NPHIs or equivalent and conducted through existing Project Implementation Units (PIUs).** At the regional level, ECOWAS will serve as the Recipient and WAHO as the implementing entity accountable for implementation of regional led activities in West Africa. While implementation arrangements are similar across Participating Countries, there are slight differences given capacities and existing structures (e.g., in Cabo Verde, a central PIU manages fiduciary aspects for all World Bank projects while technical implementation is supervised by sector ministries). Arrangements for Phase I are detailed in the respective annexes for each Participating Country and ECOWAS. In addition to working through multisectoral national steering committees (in most cases existing structures) to coordinate Program activities, the RSC will be convened by ECOWAS/WAHO and support Program coordination at regional and national levels to ensure alignment with the overall regional agenda and global priorities. The RSC will include representatives of key Ministries (Health, Agriculture/Livestock,

and Environment) from Participating Countries with the World Bank as an observer. The RSC arrangements will include an option to engage regional and global technical partners (e.g., WHO, Africa CDC, FAO) as needed as described in the Project Operations Manual (POM).

43. **Program Management functions across each implementing entity will ensure national and regional coordination with accountability for:** (i) development of annual work plans and budget (AWP/B); (ii) monitoring and reporting on the Results Framework; (iii) coordination and follow-up on project fiduciary matters; and (iv) implementation and monitoring of environmental and social standards (ESS). National-level implementation arrangements will seek to build on existing implementation experience and capacities both within the respective ministries of health (MoH), and centralized fiduciary functions as applicable to each country. Implementing agencies (IAs) will be required to: (a) set up a dedicated PIU or equivalent within the MoH; (b) designate staff with appropriate skill sets and recruit on an exceptional basis to fill skills gaps; (c) build staff capacity; (d) ensure multi-sectoral coordination with other relevant line ministries, consistent with One Health; and (e) make resources available to conduct day-to-day functions. The PIUs will be led by a dedicated coordinator responsible for coordinating and managing the timely and effective implementation of the country project. The MoH and IAs will release staff assigned to the PIU of any other duties and responsibilities. The PIUs will prepare quarterly financial and technical reports and submit to the World Bank within the stipulated timelines.

B. Results Monitoring and Evaluation Arrangements

44. **The respective PIUs will be responsible for M&E of specific project activities.** Each will collect information and report progress at national and regional levels in accordance with the methodology defined in the Results Framework. WAHO will coordinate technical assistance (TA) aimed to support countries to ensure that data collected at the national level is harmonized and comparable. At the regional level, an existing data sharing platform will be strengthened to allow countries to directly report on Program indicators and facilitate free access to Participating Countries and regional entities. An M&E community of practice comprised of the M&E responsible teams at country and regional levels will reinforce quality reporting, share good practices, and serve as another avenue for coordinating implementation across the region.

C. Sustainability

45. **Program sustainability will be enhanced by the flexible yet standardized menu of activities and the regional approach of the project.** The Program will support: (i) green and resilient refurbishments to prioritized health facilities (including laboratories); (ii) technical and institutional capacity; (iii) establishment of regional standards, policies, and protocols with buy-in at country and regional level; (iv) training on the use of equipment and their warranties; and (v) establishment of new and reinforcement of existing citizen engagement mechanisms. Refurbishments to health facilities are expected to improve their long-term sustainability and contribute to efficiency gains through more efficient utilization of water and energy. It is expected that improved energy efficiency will result in reduced power consumption, and savings obtained will be reinvested into maintenance costs. Select investments also aim to address regional challenges in a sustainable manner, such as addressing the need to harmonize regional regulatory policies. Sustainability at the national level will be further enhanced through the regional aspect of the project. This includes encouraging national-level investments in FETP and PVS training through provision of regional level support for higher level training, both for practitioners in working in human and animal health. Knowledge sharing will also be facilitated through the RSC as well as other technical working groups convened by WAHO and will include countries across the region. Finally, development of standard protocols at the regional level, initiatives for cross-country collaboration, such as established protocols and training for cross border efforts to prevent, detect and respond to health emergencies including improved data and information sharing, are also expected to contribute to the sustainability of Program investments.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

Technical

46. **The Program design is guided by global evidence that simultaneous investments in health security and health systems are critical to improve prevention, detection and response to health emergencies and safeguard the lives and livelihoods of the population.** By integrating investments in health security, the Program aims to remove the artificial dichotomy between health systems strengthening and health preparedness related efforts. With a focus on One Health, the proposed regional Program will ensure stronger links between human and animal health services at regional, national and subnational levels. Community-based interventions focus on integrating surveillance, laboratory systems, RCCE and essential services continuity to improve uptake of facility-based health security related interventions. The Program will also foster a bottom-up multisectoral approach to health systems strengthening and support synergies between prevention, early warning and detection, emergency response, and improved health outcomes. Furthermore, the Program will bring innovative solutions to leverage health security investments for managing growing threats such as AMR.

Economic

47. **Most countries in AFW have inadequate capacities to respond to health emergencies at scale, and their investment in prevention, detection and response has been inadequate.** Estimates indicate that COVID-19 reduced global economic growth in 2020 to an annualized rate of around 3.2 percent. Data from previous epidemics have also shown the catastrophic effects of health emergencies on economies. In 2015, Guinea, Liberia, and Sierra Leone losses were an estimated US$2.2 billion in GDP; and by the end of 2015, US$3.6 billion was spent to fight the Ebola epidemic in West Africa. Conservative estimates suggest that a pandemic could destroy over 1.0 percent of global GDP, comparable to other global threats such as climate change.[36] While smaller outbreaks can cause significant loss of life and economic disruption, evidence draws a direct link between health prevention, preparedness, and economic well-being. Globally, the return on country system investments and operations to reduce pandemic risk are more than tenfold.[37] Evidence estimates that for every dollar spent on pandemic preparedness, the expected economic gain in averted deaths would be US$1,703.[38]

48. **The EVD epidemic and COVID-19 pandemic will not be the last cross border health emergencies in AFW, underscoring the need to invest more in regional coordination to strengthen health systems capacities to cope.** Among the known health crises are reemerging or completely new pathogens, as well as different infectious disease threats (e.g., AMR, avian influenza, Marburg virus disease). Known health crises also include vector-borne diseases and other endemic conditions that spread with potentially new transmission patterns due to climate change. The WHO estimates that in 2020, malaria caused an estimated 241 million clinical events and 627,000 deaths globally, with an estimated 95 percent of deaths in the WHO African Region.[39] Malaria's economic burden in sub-Saharan African is estimated to reduce GDP for sub-Saharan African countries by 10 percent.[40] An analysis on the global impact of AMR estimates that it caused 1.27 million deaths in 2019, more than deaths related to HIV/AIDS or malaria that year, and that AMR infections played a role in another 4.95 million deaths.[41] Such potential health emergencies are perhaps more frequent than is recognized: in the past 15 years, there have been at least five (Severe Acute Respiratory Syndrome, H5N1, H1N1, EVD, cholera, and Middle East Respiratory Syndrome).

[36] *From panic and neglect to investing in health security: financing pandemic preparedness at a national level (English).* Washington, D.C.: World Bank Group. 2017
[37] Global Commission on Adaptation, Adapt Now: A Global Call for Leadership on Climate Resilience September 2019
[38] Jameel Institute, Imperial College London. October 2021. "What is the Return on Investment of Pandemic Preparedness."
[39] WHO, World Malaria Report, 2021.
[40] Sachs J, Malaney P. The economic and social burden of malaria. Nature. 2002 Feb 7;415(6872):680-5. doi: 10.1038/415680a. PMID: 11832956.
[41] Antimicrobial Resistance Collaborators. (2022). Global burden of bacterial antimicrobial resistance in 2019: a systematic analysis. The Lancet; 399(10325): P629-655. DOI: https://doi.org/10.1016/S0140-6736(21)02724-0

B. Paris Alignment

49. **Phase I of the Program is fully aligned with the adaptation and mitigation goals of the Paris Agreement on Climate Change.** The Program supports the implementation of climate adaptation related activities at national and regional levels, with the aim of contributing to health systems' resilience to climate shocks. Alignment with NAPHS, and health sector strategies, along with adaptation and mitigation risks and measures to address these, have been assessed for each country and implementing agency. Further details on specific adaptation and mitigation risk reduction measures are included in Annex 7.

50. **Assessment and reduction of adaptation risks.** The Program is expected to have limited activities at risk of climate shocks, as activities primarily focus on the development of structures, systems, and processes to enhance health system resilience, directly contributing to adaptation goals. Equipment purchased (such as solar panels and solar direct-drive refrigerators) will be placed to reduce the risk of climate shocks, through for example energy-efficient structural improvements such as roofing, electrical safety, plumbing and water storage. Limited building rehabilitation and construction will include climate-adaptive building measures, informed by local and global building codes, with TA for climate-resilient design financed by the project as needed.

51. **Assessment and reduction of mitigation risks.** The Program is not expected to have any activities that will result in significant greenhouse gas emissions or cause carbon lock-in. Equipment purchases and rehabilitation measures will incorporate energy efficiency measures, aiming for a 20 percent reduction in energy use, based on developmental, economic, and technical feasibility, which will be assessed on a project-by-project basis. Best practices will be used to handle any waste generated from medical supplies such as the use of low-emission incineration platforms. Other activities financed by the Program, such as institutional capacity building for the detection, prevention, and response to health emergencies, are universally aligned. This operation is considered economically viable after an assessment was undertaken that determined that the transition risks to a low carbon development pathway are considered low.

C. Fiduciary

(i) Financial Management

52. **FM capacity assessments.** FM Assessments were undertaken for the IAs, and subject to the implementation of the proposed mitigation measures, FM arrangements in place will meet the World Bank's minimum FM requirements under the World Bank Investment Project Financing (IPF) Policy and Directive and, are adequate to provide, with reasonable assurance, accurate and timely information on the status of the project required by the World Bank.

53. **The FM risk rating before mitigation measures is Substantial and after considering proposed mitigation measures, the overall FM residual risk is considered as Moderate.** The four selected implementing entities in Phase I countries and ECOWAS (WAHO) are familiar with the implementation of the World Bank financed projects. At the IA level, this risk is deemed Moderate for Cabo Verde, Guinea, and ECOWAS (WAHO), while it is Substantial for Liberia. All internal controls will be detailed in each country and regional FM manuals of procedures, and the World Bank FM team will provide training to project staff on World Bank policies and guidelines. FM risks and compliance will be monitored during World Bank biannual implementation support missions and annual external audits. With implementation of these measures, the respective implementing entities will have FM systems that should be able to provide accurate and timely information on the status of the funds as the World Bank requires.

54. **To mitigate the fiduciary risk to the extent possible, the following actions need to be implemented**: (i) all selected IAs will: (a) update the existing FM manuals in use under World Bank financed projects; (b) upgrade the existing accounting software to include the needs of the new project; (c) update the internal audit work plan to include the audit

of the new project; and (d) recruit an external auditor; (ii) each country and regional entity internal auditor needs to conduct a project risk review and make a plan which will be followed when conducting semi-annual internal audits; (iii) for Liberia, and ECOWAS (WAHO), update the terms of reference (ToRs) of existing FM staff to include the new project; (iv) for Guinea, recruit five accountants for the new regional sub-PCUs, based on ToRs acceptable to the World Bank; and (v) for Liberia, recruit an FM Officer, based on ToRs acceptable to the World Bank.

55. **Disbursements will be carried out in line with the World Bank Disbursement Guidelines for IPF dated February 2017.** The funds will be disbursed following IPF disbursement methods, including advances, reimbursements, direct payments, and special commitments. The advance method and related Designated Accounts (DA) will be used only if required by the recipient countries and institutions. In that case, one segregated DA denominated in dollars will be opened in each country at a bank acceptable to the World Bank. The DA ceiling and minimum amount for direct payments will be flexible enough to allow for quick emergency payments. The advanced funds will be earmarked for the proposed operation. Eligible expenditures will be documented through interim financial reports (IFRs) or Statements of Expenditures (SOEs) and records. The project's disbursement arrangements will be managed by the designated institution as described in each IAs' annex. Disbursement arrangements are set out in the Disbursement and Financial Information Letters (DFIL).

56. **The unaudited IFRs and annual project financial statements (PFS) will present all project sources and operations.** Regarding the FM requirements included in the DFIL, (i) quarterly and semiannual IFRs, in the form and substance agreed with the World Bank, will be submitted to the World Bank no later than 45 days after the end of each quarter or semester; and (ii) annual PFS will be audited by external auditors under ToRs acceptable to the World Bank. The audited financial statements will be presented to the World Bank no later than six months after the end of the fiscal year and made publicly available in a manner acceptable to the World Bank. There are no overdue audits for the assessed IAs. Further detailed FM information is outlined in Annex 6 - Financial Management and Disbursement.

(ii) Procurement

57. **Procurement will be carried out in accordance with the World Bank Procurement Regulations** for IPF Borrowers, 5th edition', dated September 2023; 'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants,' dated July 1, 2016 (Anti-Corruption Guidelines); and other provisions stipulated in the Legal Agreements. Systematic Tracking of Exchanges in Procurement (STEP) is the World Bank system to be used by IAs for procurement planning, review, and no objection, including prior review procurements, as well as contract management information, and complaints handling. All post review procurements will be uploaded in STEP all in real time. Procurements not uploaded in STEP and/or not receiving World Bank clearance/No objection will not be eligible for project financing. Procurement plans will emanate from the Project Procurement Strategy for Development (PPSD) prepared by the IAs. The PPSD and first 18-month Procurement Plan have been prepared and approved. The latest World Bank published Standard Procurement Document will be used and international approach to the market as reflected in the Regulation, which allows the use of National procedures and related Procurement Documents. Procurement procedures will be reflected in the POM. Regionality in procurement approaches will be recommended when it fits the purpose and brings integration and collaboration across countries to achieve value for money.

58. **Procurement arrangements, capacity assessment, risks, and risk mitigation for Recipients - three national agencies and one regional organization** (i.e., Ministry of Finance- Cabo Verde; MoH- Guinea, MoH- Liberia; and WAHO) are detailed in their respective annexes. The IAs' capacity assessments show that they have experience in the use of the Regulations, with available capacity, though risks were observed, and mitigations recommended. The overall procurement residual risk rating after implementing the mitigations is Moderate. Assessment will be continuous throughout and the ratings will reflect the outcomes of periodic assessments. The World Bank will provide continuous support to IAs to ensure effective and efficient procurement implementation.

D. Legal Operational Policies

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Area OP 7.60	No

E. Environmental and Social

59. **The environmental and social risks and impacts of the Program have been assessed as Substantial**, as while some of these risks may be significant, particularly those associated with renovation works, as well as the construction and exploitation of the new health structures and laboratories, most of the risks are site-specific, predictable, medium in magnitude in terms of geographical areas, and can be attenuated through the application of mitigation measures. The environmental and social risks and potential impacts include the generic risks associated with civil works [waste, dust emission, occupational health and safety, and Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH)], and the risks associated with the exploitation of infrastructure and the use of the medical equipment. The latter include the risks of infections, improper waste management (i.e., biomedical waste, e-waste, hazardous waste), improper management of handling and keeping animals and animal tissue specimens. Other possible risks are elite capture and the potential exclusion of vulnerable or disadvantaged groups and individuals, as impacts associated with land acquisition and restriction of land use in the cases of Guinea. To address these risks, each country PIU prepared an Environmental and Social Management Framework (ESMF),[42] a Stakeholder Engagement Plan (SEP),[43] simplified Labor Management Procedures (LMP) for Cabo Verde[44] and Liberia[45] are annexed to the ESMF, while Guinea prepared a stand-alone LMP document.[46] In addition, Guinea prepared a Resettlement Policy Framework.[47] Given its SEA/SH substantial rating, Guinea will prepare a SEA/SH Prevention and Response Plan within three months of project effectiveness. Within three months of project effectiveness, Liberia will update the GBV action plan prepared under the COVID-19 Response Program. The ESMFs prepared by the countries have an exclusion list that outlines activities that cannot be financed by the Program (i.e., subprojects that result in "High" environmental and social rating, activities involving managing asbestos, activities that require partnering or benefitting military or para-military entities, etc.). The ESMFs include procedures to screen and rate environmental and social subprojects, assess for ESS5 impacts, manage health and safety risks particular to the health sector, and a CERC-ESMF addendum. With regards to the regional organization WAHO, a SEP was prepared[48] and a stand-

[42] Cabo Verde ESMF disclosed on October 16, 2023: https://backend-ugpe.gov.cv/wp-content/uploads/2023/09/QGAS_PSSAOC_CABO-VERDE.pdf; Guinea ESMF disclosed on October 12, 2023: https://www.ugp-passp-ms.org.gn/2023/10/12/projet-de-renforcement-de-la-securite-sanitaire-et-de-la-resilience-en-afrique-de-louest-et-du-centre-p179078/; and Liberia ESMF disclosed on October 17, 2023: https://www.nphil.gov.lr/index.php/validated-data-and-research-related-documents/

[43] Cabo Verde SEP disclosed on September 28, 2023: https://backend-ugpe.gov.cv/wp-content/uploads/2023/09/PEPI_SEP_PROJETO-DE-SEGURANCA-SANITARIA-NA-AFRICA-OCIDENTAL-E-CENTRAL-FINAL.pdf; Guinea SEP disclosed on October 3, 2023: https://www.ugp-passp-ms.org.gn/2023/10/03/projet-de-renforcement-de-la-securite-sanitaire-et-de-resilience-en-afrique-de-louest-et-du-centre-p179078/; Liberia SEP disclosed on October 2, 2023: Liberia: Health Security Program in West and Central Africa, Phase I (Stakeholder Engagement Plan) – Ministry of Health (moh.gov.lr)

[44] Cabo Verde ESMF with LMP disclosed on October 16, 2023: https://backend-ugpe.gov.cv/wp-content/uploads/2023/09/QGAS_PSSAOC_CABO-VERDE.pdf https://backend-ugpe.gov.cv/wp-content/uploads/2023/09/ANEXOS-QGAS-PSSAOC.pdf

[45] Liberia ESMF with LMP disclosed on October 17, 2023: https://www.nphil.gov.lr/index.php/validated-data-and-research-related-documents/

[46] Guinea stand-alone LMP disclosed on October 20, 2023: https://www.ugp-passp-ms.org.gn/2023/10/19/procedures-de-gestion-de-la-main-doeuvre-pgmo-du-projet-de-renforcement-de-la-securite-sanitaire-et-de-resilience-en-afrique-de-louest-et-du-centre-p179078/

[47] Disclosed on October 20, 2023: https://www.ugp-passp-ms.org.gn/2023/10/19/cadre-de-reinstallation-du-projet-de-renforcement-de-la-securite-sanitaire-et-de-resilience-en-afrique-de-louest-et-du-centre-prssr-aoc-p179078/

[48] WAHO SEP disclosed on October 9, 2023: https://www.wahooas.org/web-ooas/sites/default/files/publications/2377/clean-pmpp-waho-03102023.pdf

alone LMP.[49] All participating countries and WAHO prepared Environmental and Social Commitment Plans (ESCP), which have been disclosed in countries and on the World Bank website.[50]

60. **Gender.** The Program identified and will address a key gender gap of lower female participation in the health security agenda at technical levels and gender related dynamics associated with specific vulnerabilities and lack of participation in the broader health security agenda. A 2019 WHO analysis of 91 countries revealed that only 28 percent of physicians in Africa are women,[51] and among those female workers payment is much lower than men.[52] This is also the case among most frontline, low paid health workers across the AFW region that are women, while higher-trained, higher-paid health staff are typically male. Supporting formal training of females and their participation in preparedness for health emergencies is critical given that women and children are predominantly involved in the care of animals which exposes them to zoonotic risks. Ensuring that women are formally trained in field epidemiology programs including zoonoses surveillance will contribute to the prevention and early identification of potential outbreaks. While rigorous data are lacking, anecdotal evidence from Participating Countries and research strongly suggests that few women are represented in the ranks of epidemiologists or other key technical positions, in part due to limited access to training opportunities compared to their male colleagues,[53] such as the FETP and In Service Applied Veterinary Epidemiology training (ISAVET) programs. Therefore, the Program will address this gender gap by targeting women working in the provision of care in the animal and health sectors. *Immediate benefits of including women in such training programs are two-fold*: (i) by opening opportunities for formal training for women, there is increased potential for women to receive better pay and assurance of a more stable job; and (ii) by increasing the number of trained female workers, women who receive health services are more likely to seek care and answer questions to women than to men. Activities supported under subcomponents 1.2, 2.1, and 2.3, as well as efforts to address data gaps through the learning agenda - are designed to address these gender gaps. Moreover, the Program will address vulnerabilities to women during natural disasters, conflicts, climate, and health emergencies given the need to preserve essential health services for women in crises, address increased risks of sexual violence towards women and girls and mitigate greater exposure to infectious diseases. The Program will also address such gendered risks under Subcomponent 3.2 by investing in the maintenance of essential health services (which includes SRH services as well as maternal, newborn and child health care). The MPA will measure activities to address the gender gap through two PrDO level indicators: (i) *Participating Countries reporting at least 10 percent increase in female epidemiologists who have received basic, intermediate, and advance level training and are working in the field (Percentage); and (ii) Participating Countries with adopted/updated contingency plans to ensure delivery of identified essential health services during a health emergency (Percentage).*" Three Intermediate Results Indicators will measure progress, specifically: (i) Countries where at least 30 percent of women are trained in FETP in basic, intermediate, and advanced levels; (ii) Countries where at least 30 percent of women are trained in veterinary and para-veterinary studies and In-Service Applied Veterinary Epidemiology Training; and (iii) At least one-third of Participating Countries have a developed RCCE plan and SOP that includes collection of community feedback, applies to both routine and emergency contexts, and accounts for gender dimensions.

61. **Citizen Engagement.** The Program design integrated citizen engagement mechanisms such as consultations and grievance redress mechanisms (GRMs). The Program will ensure that each country establishes a strong, adequately budgeted, and operational GRM that will track and respond to grievances from target populations. Projects will solicit

[49] WAHO stand-alone LMP disclosed on October 9, 2023: https://www.wahooas.org/web-ooas/sites/default/files/publications/2378/clean-corrected-pgmo-ooaswith-qa05102023.pdf
[50] ESCPs disclosed on November 23, 2023: https://documents1.worldbank.org/curated/en/099112323061027506/pdf/P17907803342710c80a6c60bf8eda407e68.pdf
[51] WHO-2014 Gender equity in the health workforce: Analysis of 104 countries: https://iris.who.int/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf
[52] https://www.ituc-csi.org/frozen-in-time-gender-pay-gap,10763
[53] Boniol M, McIsaac M, Xu L, Wuliji T, Diallo K, Campbell J. Gender equity in the health workforce: analysis of 104 countries. Working paper 1. Geneva: WHO; 2019; Collins, D., Diallo, B.I., Bah, M.B. et al. Evaluation of the first two Frontline cohorts of the field epidemiology training program in Guinea, West Africa. Hum Resour. Health 20, 40 (2022).

community feedback through the development and engagement on RCCE related activities, which include consultations and community outreach activities. Feedback will inform Program implementation. Country adapted GRMs will be deployed, and an indicator in the Results Framework measures the number of registered grievances addressed. Feedback received will be integrated into the implementation of related activities and through any necessary corrective measures.

F. Climate Vulnerability and Climate Adaptation and Mitigation

62. **Climate-related shocks are among the core health emergencies the Program aims to address and building climate change resilience and preparedness are fundamental Program activities**. As such, the proposed Program was screened for short- and long-term climate change and disaster risks. The impact of climate and geophysical hazards on Program activities is expected to be moderate across all countries but could have far-reaching consequences for targeted beneficiaries. Detailed information on the climate vulnerability context and climate adaptation and mitigation measures for Phase 1 of the Program is detailed in Annex 7.

V. GRIEVANCE REDRESS SERVICES

63. **Grievance Redress.** Communities and individuals who believe that they are adversely affected by a project supported by the World Bank may submit complaints to existing project-level grievance mechanisms or the World Bank'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 World Bank's independent Accountability Mechanism. The Accountability Mechanism houses the Inspection Panel, which determines whether harm occurred, or could occur, as a result of World Bank non-compliance with its policies and procedures, and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted to the Accountability Mechanism at any time after concerns have been brought directly to the attention of World Bank management and after management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's GRS, visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank's Accountability Mechanism, visit https://accountability.worldbank.org.

VI. KEY RISKS

64. **The overall risk rating for the Program is Substantial.** This rating is based on an assessment of potential residual risks to Program implementation as described below.

65. **Residual political and governance risk is rated Substantial**. The Program will be carried out in a region affected by fragility, socio-political instability, violence, weak governance, and low levels of accountability. Insecurity risks also have the potential for hindering regional cooperation and community level implementation in areas where security risks are high. These risks will be mitigated by close dialogue with key government personnel, the World Bank, and PIUs, and tight coordination with partners. Personal data, personally identifiable information, and sensitive data are likely to be collected and used in connection with the management of program interventions. To guard against abuse of such data, the Program will incorporate best international practices for dealing with data, including data minimization, data accuracy, use limitations, data retention, informing data subjects of use and processing of data, and allowing data subjects the opportunity to correct information about themselves.

66. **Residual technical design risk is Substantial.** The Program introduces reforms, as well as sustained investments in health security with a strong focus on One Health interventions across health, agriculture, and environment sectors. These approaches are complex and require significant coordination and political will to allocate national budget resources to maximize benefits at both national and regional levels. Furthermore, the Program requires multisectoral and

intersectoral collaboration to achieve the PrDO. This approach deviates from the standard practice of a siloed sectoral focus and can present some unique coordination challenges. These risks are mitigated by building on existing multisectoral One Health platforms and appointing strong conveners at regional and national levels, capable of bringing countries and sectors together to forge a consensus on sectoral and multisectoral priorities and approaches. The residual risk, however, remains substantial even after mitigation measures due to the ambitious vision of the Program, which will require dedicated hands-on support to countries, sectors, and regional implementing bodies to achieve the PrDO.

67. **Residual institutional capacity for implementation and sustainability risk is rated Substantial**. Most countries have limited capacity for implementation on a technical and administrative level, especially multi-sectoral projects that require inter-ministerial coordination. To address this, partnership and implementation arrangements will be kept as simple as possible. The Program will also plan for close engagement by the World Bank to coordinate activities with other key partners; and provide well structured, organized implementation support by the World Bank including alignment with investments in the relevant health, agriculture, and environment sectors, including technical assistance as well as training and coaching on fiduciary processes and managing environmental and social risks. The sustainability risk is considered substantial due to the large recurrent costs for health security and preparedness combined with the lack of budget allocation at country and regional level. Program sustainability risk will be mitigated by investments to harmonize and institutionalize regional and national regulatory policies, by advocating and providing TA support for countries' institutionalization of national-level investments in FETP and PVS training, and support countries to establish provisions to ensure retention of trained resources within the public health system.

68. **Residual environmental and social risks are rated Substantial** as detailed in paragraph 59.

69. **Residual fiduciary risk is rated Substantial**. While the Procurement rated risk is Moderate, the FM risks are rated Substantial. While FM arrangements are considered adequate, review of the FM capacity of IAs identified inherent and control risks, for which corresponding mitigation measures were developed and outlined in each annex.

VII. RESULTS FRAMEWORK AND MONITORING

PDO Indicators by PDO Outcomes

Baseline	Closing Period
Increase regional collaboration to prevent, detect and respond to health emergencies in AFW	
Regional signed agreements for cross-border information sharing on health security guided by the One Health principles (Number)	
Aug/2023	Dec/2031
0	5
Routine multisectoral cross-border investigations/simulations conducted in the region (Number)	
Aug/2023	Dec/2031
0	7
Increase health system capacities to prevent, detect and respond to health emergencies in AFW	
Participating Countries that have adopted metrics to timely detect and respond to health emergencies (Percentage)	
Aug/2023	Dec/2031
0	66
Participating Countries having addressed gaps in veterinary services core capacities (Percentage)	
Aug/2023	Dec/2031
0	66
Increase health system capacities to prevent, detect and respond to health emergencies in AFW	
Participating Countries with adopted/updated contingency plans to ensure delivery of identified essential health services during a health emergency (Percentage)	
Aug/2023	Dec/2031
0	66

Intermediate Indicators by Components

Baseline	Period 1	Closing Period
Component 1 - Prevention of Health Emergencies		
Regional standards established for operationalization of National Action Plans for AMR (Yes/No)		
Aug/2023		Dec/2031
No		Yes

Regional standards adopted for laboratory specimen transportation policies (Yes/No)		
Aug/2023		Dec/2031
No		Yes
IHR related One Health capacity assessments conducted per Participating Country (Number)		
Aug/2023		Dec/2031
3		12
Component 2 - Detection of Health Emergencies		
Participating Countries with surveillance systems that include early warning functions at community level and PoEs (Percentage)		
Aug/2023		Dec/2031
0		66
Participating Countries with project-supported laboratories have achieved a 3-star rating or higher during a SLIPTA audit (Percentage)		
Aug/2023		Dec/2031
0		66
Participating Countries reporting early detection of health events as per standard guidelines (Percentage)		
Aug/2023		Dec/2031
0		66
People trained in Field Epidemiology Training Program (FETP) in basic, intermediate, and advanced levels across Participating Countries (Number)		
Sep/2023		Dec/2031
0		1200
➢Women trained in Field Epidemiology Training Program (FETP) in basic, intermediate, and advanced levels across Participating Countries (Percentage)		
0		30
People trained in veterinary and para-veterinary studies and In-Service Applied Veterinary Epidemiology Training across Participating Countries (Number)		
Sep/2023		Dec/2031
0		1200
➢Women trained in veterinary and para-veterinary studies and In-Service Applied Veterinary Epidemiology Training across Participating Countries (Percentage)		
0		30
Participating Countries reporting at least 10 percent increase in female epidemiologists who have received basic, intermediate, and advance level training and are working in the field (Percentage)		
Nov/2023	Dec/2027	Dec/2031
0	66	80
Component 3 - Health Emergency Response		
Participating Countries with capacity to mount an effective response to health emergencies as per standard guidelines (Percentage)		
Aug/2023		Dec/2031
0		66

Participating Countries with established functional emergency response coordination mechanism or incident management system at subnational levels that includes PoEs (Percentage)		
Aug/2023		Dec/2031
0		66
Participating Countries routinely monitoring the use of PHC services (Percentage)		
Aug/2023		Dec/2031
0		66
Participating Countries with a developed RCCE plan and SOP that includes collection of community feedback, applies to routine and emergency contexts, and accounts for gender dimensions (Percentage)		
Aug/2023		Dec/2031
0		100
Health infrastructure interventions financed by the Program using green and resilient approaches (Percentage)		
Aug/2023		Dec/2031
0		80
Component 4 - Program Management and Institutional Capacity		
Registered grievances addressed through the project GRM (Percentage)		
Aug/2023	Dec/2026	Dec/2031
0	66	100
Component 5 - Contingent Emergency Response Component		

Monitoring & Evaluation Plan: PrDO Indicators by PrDO Outcomes

Increase regional collaboration to prevent, detect and respond to health emergencies in AFW	
Regional signed agreements for cross-border information sharing on health security guided by the One Health principles (Number)	
Description	Agreements refer to regional/subregional and bilateral type of agreements related to operationalizing cross border sharing of key information related to monitoring health emergencies across sectors. This indicator reflects the overlapping nature of cooperation across countries and the regional coordination required to improve health security in the region.
Frequency	Annual
Data source	WAHO Report
Methodology for Data Collection	Documentation of signed agreements
Responsibility for Data Collection	WAHO
Routine multisectoral cross-border investigations/simulations conducted in the region (Number)	
Description	Cross border investigation/simulation to include a regional institution and participation of at least 2 countries. Where possible and especially at PoE and/or other remote areas, exercises include scope for engagement of community stakeholders. This indicator represents the operationalization of the joint regional coordination of multisectoral strategies to address health emergencies in line with One Health dimensions.
Frequency	Annual
Data source	WAHO and government reports
Methodology for Data Collection	WAHO and governments report the conduct of the exercise.
Responsibility for Data Collection	WAHO responsible for monitoring and government responsible for maintaining records of the exercise.
Increase health system capacities to prevent, detect and respond to health emergencies in AFW	
Participating Countries that have adopted metrics to timely detect and respond to health emergencies (Percentage)	
Description	Adopted metrics according to WHO guidance used to assess the effectiveness of clinical, laboratory, and public health detection and response. Sensitization, training and experience sharing is required to ensure regional and multisectoral collaboration.
Frequency	Every six months
Data source	Country Progress Reports
Methodology for Data Collection	Surveillance data reports
Responsibility for Data Collection	Country PIUs
Participating Countries having addressed gaps in veterinary services core capacities (Percentage)	
Description	Priority veterinary core capacities defined by a PVS gap analysis carried out at baseline and monitored through PVS assessments.
Frequency	Every six months
Data source	Country Progress Reports
Methodology for Data Collection	Participating countries having moved from baseline to projected level in PVS gap assessment for top 5 core capacities.
Responsibility for Data Collection	Country PIUs
Increase health system capacities to prevent, detect and respond to health emergencies in AFW	
Participating Countries with adopted/updated contingency plans to ensure delivery of identified essential health services during a health emergency (Percentage)	
Description	This indicator addresses the potential negative impacts on essential health sercvices during a health emergency.
Frequency	Every six months
Data source	Country Progress Reports
Methodology for Data Collection	Documentation of Contingency Plans to be provided
Responsibility for Data Collection	Country PIUs

Monitoring & Evaluation Plan: Intermediate Results Indicators by Components

Component 1 - Prevention of Health Emergencies	
Regional standards established for operationalization of National Action Plans for AMR (Yes/No)	
Description	Regional standards and guidance to be issued and established on implementation of plans
Frequency	Every six months
Data source	WAHO and government documentation
Methodology for Data Collection	Technical Review of National Action Plans
Responsibility for Data Collection	WAHO
Regional standards adopted for laboratory specimen transportation policies (Yes/No)	
Description	Regional standards adopted according to IHR guidance
Frequency	Annual
Data source	WAHO Report
Methodology for Data Collection	Documentation of signed standards and policies adopted
Responsibility for Data Collection	WAHO
IHR related One Health capacity assessments conducted per Participating Country (Number)	
Description	IHR and PVS core capacity assessments
Frequency	Every four years
Data source	JEE, PVS, PVS gap analysis
Methodology for Data Collection	Assessment reports
Responsibility for Data Collection	Governments/PIUs
Component 2 - Detection of Health Emergencies	
Participating Countries with surveillance systems that include early warning functions at community level and PoEs (Percentage)	
Description	This indicator will track engagement of community-level actors and at PoEs in disease surveillance systems to ensure information sharing at community, national, and regional levels and across One Health sectors.
Frequency	Every six months
Data source	Monthly surveillance network reports
Methodology for Data Collection	Governments/PIUs
Responsibility for Data Collection	Governments/PIUs
Participating Countries with project-supported laboratories have achieved a 3-star rating or higher during a SLIPTA audit (Percentage)	
Description	Laboratory performance measured using the WHO SLIPTA scoring checklist according to star criteria ratings.
Frequency	Annual
Data source	SLIPTA Audit report
Methodology for Data Collection	SLIPTA Audit report
Responsibility for Data Collection	Government/PIU
Participating Countries reporting early detection of health events as per standard guidelines (Percentage)	
Description	This indicator will follow WHO guidance and tools for conducting an early action review to assess rapid performance improvement for outbreak detection and response.
Frequency	Every six months
Data source	Country surveillance systems
Methodology for Data Collection	Government report

Responsibility for Data Collection	Governments/PIUs
People trained in Field Epidemiology Training Program (FETP) in basic, intermediate, and advanced levels across Participating Countries (Number)	
Description	This indicator aggregates the number of persons trained in FETP at basic, intermediate and advance levels.
Frequency	Every six months
Data source	Administrative records maintained by the government
Methodology for Data Collection	Governments report the status of personnel.
Responsibility for Data Collection	Governments/PIUs
Women trained in Field Epidemiology Training Program (FETP) in basic, intermediate, and advanced levels across Participating Countries (Percentage)	
Description	This indicator places importance of developing human resources with capacities in One Health, with a priority to women professionals and paraprofessionals/allied professionals.
Frequency	Every six months
Data source	Administrative records maintained by the government
Methodology for Data Collection	Governments report the status of personnel.
Responsibility for Data Collection	Governments/PIUs
People trained in veterinary and para-veterinary studies and In-Service Applied Veterinary Epidemiology Training across Participating Countries (Number)	
Description	This indicator aggregates the number of persons trained in ISAVET and related training programs at basic, intermediate and advance levels.
Frequency	Every six months
Data source	Administrative records maintained by the government
Methodology for Data Collection	Governments report the status of personnel.
Responsibility for Data Collection	Governments/PIUs
Women trained in veterinary and para-veterinary studies and In-Service Applied Veterinary Epidemiology Training across Participating Countries (Percentage)	
Description	This indicator places importance of developing human resources with capacities in One Health, with a priority to women professionals and paraprofessionals/allied professionals.
Frequency	Every six months
Data source	Administrative records maintained by the government
Methodology for Data Collection	Governments report the status of personnel.
Responsibility for Data Collection	Governments/PIUs
Participating Countries reporting at least 10 percent increase in female epidemiologists who have received basic, intermediate, and advance level training and are working in the field	
Description	This indicator tracks the anticipated outcome of opening more formal training opportunities for females.
Frequency	Every six months
Data source	Administrative records maintained by the government
Methodology for Data Collection	Governments report the status of trained personnel.
Responsibility for Data Collection	Governments/PIUs
Component 3 - Health Emergency Response	
Participating Countries with capacity to mount an effective response to health emergencies as per standard guidelines (Percentage)	
Description	This indicator follows WHO guidance and tools for conducting an early action review to assess rapid performance improvement for outbreak detection and response.
Frequency	Every six months

Data source	Administrative records maintained by the government
Methodology for Data Collection	Governments report status through PHEOCs or other relevant parties
Responsibility for Data Collection	Governments/PIUs
Participating Countries with established functional emergency response coordination mechanism or incident management system at subnational levels that includes PoEs (Percentage)	
Description	Functional mechanism defined by IHR benchmarks: development of SOPs with levels for activating the emergency response coordination mechanism; roster of Emergency Operations Center (EOC) staff with defined roles; training plan developed and deployed; SOPs for coordination across PoEs.
Frequency	Every six months
Data source	Administrative reords maintained by the government
Methodology for Data Collection	Governments/PIUs responsible for maintaining documentation.
Responsibility for Data Collection	Government/PIUs responsible for maintaining documentation.
Participating Countries routinely monitoring the use of PHC services (Percentage)	
Description	This indicator routinely monitors the provision of essential health services, namely PHC, to track the frequency of active data monitoring and its usage and contribute to increasing countries' ability to detect and respond to disruptions in service delivery over time. This indicator will also inform the PrDO indicator related to contingency plans to ensure delivery of identified essential health services during a health emergency.
Frequency	Data for this indicator will be reported every 6 months
Data source	National HMIS and supplemental facility surveys, or other sources
Methodology for Data Collection	Summary reports, presentations should summarize quarterly updates
Responsibility for Data Collection	Government/PIUs responsible for maintaining documentation.
Participating Countries with a developed RCCE plan and SOP that includes collection of community feedback, applies to routine and emergency contexts, and accounts for gender dimensions (Percentage)	
Description	Multisectoral RCCE plans/SOPs on training for risk communication addressing gender dimensions, and logistics support using platforms for community engagement and including community feedback. RCCE activities have regional scope with a focus on borders and PoE.
Frequency	Every six months
Data source	JEE assessment and IHR benchmarking tools
Methodology for Data Collection	JEE methodology (3rd Edition)
Responsibility for Data Collection	Governments are responsible for organizing and executing the JEE assessment and for reporting results
Health infrastructure interventions financed by the Program using green and resilient approaches (Percentage)	
Description	This indicator monitors health infrastructure interventions using criteria defined in the POM.
Frequency	Annual
Data source	Technical Specifications, Progress Reports
Methodology for Data Collection	Verification of green and resilient criteria to be developed and incldued in POM
Responsibility for Data Collection	Government/PIUs
Component 4 - Program Management and Institutional Capacity	
Registered grievances addressed through the project GRM (Percentage)	
Description	This indicator is calculated by dividing the number of registered grievances addressed by the GRM in participating countries (numerator) by the total number of registered grievances received by the GRM in participating countries.
Frequency	Every six months
Data source	PIU GRM mechanisms
Methodology for Data	Data collection and reporting from PIU's Social Specialist and M&E Teams

Collection	
Responsibility for Data Collection	Government/PIU
Component 5 - Contingent Emergency Response Component	

ANNEX 1: Phase I Program Financing and Future Phases

Countries and Regional Entities	MPA Phase	IDA PBA Amount (US$ million)	IDA Regional Window Amount (US$ million)	Other Amount (US$ million)	Total IDA Financing (US$ million)
Cabo Verde	1	6	19	4 *(source: PF)*	25
Guinea	1	30	60	16 *(source: GFF)*	90
Liberia	1	6	12	--	18
WAHO	1	--	25	--	25
TOTAL PHASE I		**42**	**116**	**20**	**158**
To be determined*	2+				**342**
TOTAL					**500**

*Subsequent phases under the MPA, estimated at US$342 million, will benefit additional countries in AFW. In line with the ambition of the World Bank's GCP on "*Enhanced health emergency prevention, preparedness and response*," at the time of preparation of Phase 1, discussions have been held with countries to confirm potential participation in future phases of the MPA. Participation of future countries will be based on country ownership, and gaps in their current health programs.

ANNEX 2: Economic Community of West African States (ECOWAS)

I. STRATEGIC CONTEXT

A. Sectoral and Institutional Context

1. **ECOWAS was established on May 28, 1975, by the Treaty of Lagos, with the objective of promoting cooperation and integration among its member states**, economic and political stability, and increasing economic opportunities and well-being for its peoples. As a specialized institution of ECOWAS, WAHO is tasked with: (i) promoting health research to eradicate key regional endemic diseases; (ii) facilitating the training of health staff; (iii) advising ECOWAS countries on all health aspects of their development programs; (iv) collaborating with international, regional, and national organizations to resolve health issues; and (v) proposing for adoption of conventions, agreements and regulation that promote regional responses to health matters.

2. **At the regional level, WAHO will leverage its comparative advantages to implement regional level activities, including:** (i) its political mandate and direct line of communication with the political decision-makers of ECOWAS states; (ii) capacity to propose the adoption of regional conventions, agreements, and regulations for the regional health sector; (iii) advocacy at the highest level for the adoption and implementation of international health resolutions; (iv) ability to leverage and facilitate the exchange and mobilization of resources between countries and to harmonize health policies; and (v) capacity to collect, manage, and disseminate health information to guide interventions in the region.

B. Relevance to Higher-Level Objectives

3. **Program objectives are aligned with the ECOWAS 2050 Vision and WAHO's 2030 Strategic Plan**, which emphasize: (i) having the best health and wellbeing indices in the continent, through harmonization, multisectoral collaboration, coordination and evidence-based policymaking, in accelerating access to and availability of inclusive and affordable quality health services, ensuring effective PHE preparedness and response capabilities across the ECOWAS region, and strengthening WAHO's institutional processes and promoting organizational excellence; and (ii) strengthening human capital, promoting good governance in ECOWAS countries and within institutions, intensifying digital transformation, strengthening the fight against climate change and resilience to exogenous shocks, etc. Program objectives are also aligned with the OH JPA 2022-2026 developed by the One Health Quadripartite to respond to requests from ECOWAS member countries to be better prepared for future pandemics and promote health worldwide. Finally, Program objectives also align with the AHSA 2019-2035, which provides a framework to AU institutions and Regional Economic Community members for a sustainable animal health system that meets relevant international standards.

II. PROJECT DESCRIPTION

4. **Project Development Objective (PDO):** *Increase regional collaboration and health system capacities to prevent, detect and respond to health emergencies in Western and Central Africa.*

Table 2.1. Proposed PDO-Level Outcome Indicators

No.	Indicator	Baseline	Target
1	Agreements signed for cross-border collaboration and information sharing facilitated by WAHO (Number)	0	5
2	Regionally harmonized policies/strategy frameworks/protocols developed by ECOWAS to strengthen Health Security and Systems Resilience (Number)	0	5

	Sub-indicator • Regionally harmonized policies/strategy frameworks/ legislation/protocol adopted by ECOWAS (Number)	0	5
3	Participating countries with costed 5-year plans to address gaps in Veterinary Services' Critical Competencies based on PVS Gap Analysis (Number)	0	7
4	Costed One Health roadmaps developed and implemented by a national coordination mechanism (Number)	0	7

Table 2.2. Proposed Intermediate Results Indicators

No.	Indicator	Baseline	Target
1	People trained (Number) Sub-Indicator: • People trained in FELTP-advanced (Number) • People trained in health security short courses (Number) *Laboratory/specimen/sample diagnostic and transportation capacity, RCCE courses by WAHO* • Women trained in all the courses (Percentage)	0 0 0 0	2200 200 2000 30%
2	Regional activities on gender mainstreaming and technical assistance in health security provided to ECOWAS countries (Number)	0	15
3	Annual cross-border health security collaboration activities organized (Number)	0	5
4	People trained in animal health (Number) Sub-indicator • Women trained (Percentage)	0 0	1500 30%
5	PVS Pathway missions – including targeting support - conducted in the participating countries (Number)	0	30
6	Complaints or grievances addressed related to WAHO's interventions (Percentage)	0	100%

A. Project Components

Component 1: Prevention of Health Emergencies (US$7.00 million).

5. **Subcomponent 1.1. Health Security Governance, Planning, and Stewardship (US$3.00 million)**. Proposed activities include the mobilization of TA to Participating Countries for the: (i) development and monitoring the implementation of the NAPHS; (ii) fostering of joint cross-border disease outbreak preparedness activities and joint investigations for priority diseases, climate change, and other health emergencies; (iii) regional knowledge and evidence generation through selected regional operational and analytical research; (iv) assessment of compliance of countries' interventions with IHR 2005 and PVS core capacities through the conduct of periodic JEE, IHR State Party Self-Assessment Annual Report (SPAR), PVS, National Bridging Workshops between JEE and PVS, joint risk assessments (JRAs); and (v) establishment and/or implementation of ECOWAS regional cross-border strategy, human resources for health regional strategy to expand capacities in field epidemiology and laboratory, risk communication, health information and data management, One Health, and in other relevant strategies.

6. **Subcomponent 1.2. Scaling-up One Health Agenda and combatting AMR (US$4.00 million)**. The subcomponent will finance the (i) mobilization of technical support in profit to member states to improve the operationalization of the One Health approach including establishment and/or reinforcement of coordination platforms, development of guidelines and SOPs at operational level for diseases surveillance; (ii) setting up of real-time One Health surveillance (risk

assessment and early warning, early response and cross-sectorial information system), detection and response; (iii) monitoring implementation and learning lessons to inform strategies and working tools review; and (iv) learning and sharing experiences and lessons. Combatting AMR will be done through: (a) development of regional guidelines for AMR surveillance; (b) education, sensitization and awareness raising activities towards regional authorities and national governments on AMR; (c) support to public health research on AMR; (d) use of behavioral science to promote best practices for responsible use of antibiotics and reduce AMR; and (e) finance IPC.

Component 2. Detection of Health Emergencies (US$9.00 million).

7. **Subcomponent 2.1. Collaborative Surveillance (US$2.00 million).** Specifically, the subcomponent will support: (i) review and update of the lists of priority diseases based on results from country-level One Health priority disease assessments; (ii) development and implementation of a regional strategy to enhance collaborative surveillance; (iii) reinforcement of technical capacity of Health Information System Unit of WAHO; (iv) integration of One Health data using interoperable digital platform; (v) developing dashboards to support scenario planning; and (vi) developing real-time digital surveillance capabilities; (vii) mapping health, livestock, and wildlife surveillance systems and identifying opportunities for interoperability; (xiii) development of protocols, tools, and platforms for collaborative multisectoral data collection and analysis; (x) support of the conduct of JRAs; (xi) conduct complex cross-sectoral health emergencies simulations to identify critical control points in digital systems; (xii) development of a machine learning platform processing cross-analyze regional epidemiological data, media, and other unstructured information and data sources; (xiii) model disease spread patterns and identify predictive factors from past outbreak data; (xiv) production of regular reports and projections for decision making; (xv) promotion and adoption of emerging technologies at WAHO and national HIS and surveillance units; and (xvi) regular production and dissemination of epidemiological information at regional level.

8. **Subcomponent 2.2. Laboratory Quality and Capacity (US$2.00 million).** Proposed activities aim to strengthen regional and national interconnected laboratory networks by providing technical support to Participating Countries to: (i) strengthen their testing capacities: quality control, biosafety & biosecurity, informatics policies, establishment of LIMS, SOPs towards accreditation; (ii) improve AMR and zoonotic diseases diagnostic capacity; (iii) strengthen the twinning program between national reference laboratories and centers of excellence (for human and animal health); (iv) conduct biospecimen surveillance through encapsulation technologies at the Regional Biobank; (v) sample transportation including protocols and facilitation for shipments to referral laboratories; and (vi) conduct Quality Management System (QMS) implementation mentoring sessions in additional reference laboratories.

9. **Subcomponent 2.3. Multi-disciplinary Human Resources for Health Emergencies (US$5.00 million).** Proposed activities under this subcomponent include: support to develop and implement ECOWAS region's Public Health Workforce strategy for Health Security; to assess quality of the FETP and FELTP offered in Participating Countries for curricula updating and standardization (Frontline, Intermediate and Advanced); and to develop new expertise in technical areas, including disaster management, public health informatics, epidemic modeling (forecasting and scenario planning), and technical training/capacity building (veterinarians, RCCE, socio-anthropology; environmental health, climate change, emergency management; laboratory and biology scientists; etc.).

Component 3. Health Emergency Response (US$4.00 million).

10. **Subcomponent 3.1. Health Emergency Management (US$2.50 million)**. The proposed activities of this subcomponent include: (i) support to develop/update a standardized training program in Public Health Emergency Management and FAO/WOAH Good Emergency Management Practice training to build preparedness capacities of

veterinary services to respond to zoonotic emergencies; (ii) develop and keep up-to-date a roster of an integrated regional rapid response teams to ensure an effective and quicker deployment in the advent of epidemic; (iii) conduct regular simulation exercises (tabletops, drills, functional exercises) to improve capabilities to prevent, detect and respond to PHEs; (iv) support the integration of gender transformative initiatives; (v) support countries to establish a robust RCCE system to prepare and respond to PHE; (vi) conduct training of RCCE officers at all levels in the targeted countries; (vii) train other cadres in biosafety and biosecurity, IPC, rapid response teams, emergency management system, genomic sequencing, climate change emergency preparedness and response, and gender and social determinants of health, among others; and (viii) strengthen regional regulatory and management mechanisms of health professionals (surge capacity) to enable swift mobilization of health workers across borders during health emergencies.

11. **Subcomponent 3.2. Health Service Delivery for Health Emergencies (US$1.50 million).** Activities to be carried out under this subcomponent include: (i) comprehensive regional assessment of protocols in place for Participating Countries to address infection prevention control; (ii) assessment of outbreak impacts in health care services across the region to inform the development of a regional guidelines for continuity of health service delivery during emergencies; (iii) development of regional guidelines to establish units/centers for isolation and infection prevention; (iv) capacity building in clinical management for PHE and IPC; (v) support to members states to develop disease outbreak response plans, including stockpiling and planning of medical commodities (drugs, vaccines, personal protective equipment, etc.); and (vii) support countries to conduct operations research amidst a disease outbreak to assess the uptake of the response strategies, equity, and fairness in services delivery.

12. **Component 4. Program Management and Institutional Capacity (US$5.00 million).** This component will support Project implementation and management including: (i) procurement, FM, environmental and social management, and M&E; (ii) training of staff at the PIU (iii) the organization of the RSC; and (iii) Operating Costs. Additional activities include: (i) mobilization and coordination technical and financial partners to support countries during health emergencies to ensure synergetic and effective responses; (ii) lead advocacy and awareness raising activities towards various stakeholders, national officials on risk communication and citizen engagement before, amidst and post any PHE; and (iii) provision of TA including mobilization of financial, human, and logistic resources to Participating Countries.

III. IMPLEMENTATION ARRANGEMENTS

13. **The Project will be implemented by an existing PIU based in WAHO that will facilitate regional coordination of health security interventions and provision of TA to countries, through**: (i) the coordination of regional workshops to share results of analyses, contribute to building overall understanding and capacity on key areas such as gender, natural disasters, climate, safeguards, and provide a forum for countries to share lessons and experiences in addressing the identified gaps; (ii) spearheading efforts to factor in lessons learned in regional policies, strategies and procedures related to PHE response; (iii) timely and effective mobilization of tailored TA to Participating Countries; and convening the RSC.

14. **WAHO will partner with WOAH to support animal health and One Health activities.** Founded in 1924 as *Office International des Epizooties*, WOAH is the intergovernmental organization that assists national veterinary services to improve animal health and welfare worldwide. Specific One Health related activities supervised by WAHO, will be carried out by WOAH with a direct contract between WAHO and WOAH. WOAH will provide targeted support to Participating Countries to enhance the PVS, as well as One Health coordination through an implementation agreement with WAHO.

IV. APPRAISAL SUMMARY

Financial Management

15. **FM activities will be guided by the FM Manual for World Bank IPF Operations**; and the FM in World Bank IPF Operations (Catalogue Number OPCS5.05-GUID.02). WAHO will provide leadership on all the FM aspects of the project and appropriate internal controls and flow of funds arrangements will be instituted to ensure that project funds are used for the intended purposes. The Project will have its DA at a commercial bank for the receipt of funds, and this account will be managed by WAHO. Likewise, WAHO will be responsible for the internal audit of the project and will ensure that unaudited IFRs are submitted to the World Bank 45 days after the end of each quarter throughout the life of the project. WAHO will use private audit firms that are acceptable to the World Bank; the cost of hiring a private audit firm will be met by the Project. All audits should be carried out in accordance with International Standards on Auditing or International Standards for Supreme Audit Institutions issued by the International Organization for Supreme Audit Institutions. The external auditors should be appointed within six months after effectiveness. Audit reports together with management letters should be submitted to the World Bank within six months after the end of the government's fiscal year. Audit reports will be publicly disclosed by the World Bank in accordance with the World Bank's disclosure policy. The FM risk is rated Moderate.

Procurement

16. **ECOWAS -WAHO in Burkina Faso:** The procurement law within ECOWAS applies to WAHO activities, including internal audit controls. The WAHO procurement department has one qualified procurement staff experienced in World Bank procurement procedures. WAHO is currently implementing three World Bank financed projects and experienced with other donors (e.g., European Union, USAID). Key risks are: (i) centralization at the Office of the Auditor General of the ECOWAS Commission with the endorsement of all contracts, whatever their thresholds, and limitation for signing contracts above certain threshold limits. This slows down the procurement process; (ii) weak capacities (overload) in WAHO due to the limited staff in charge of procurement; and (iii) absence of updated detailed procurement procedures. The recommended mitigations are: (i) delegate the contract signature irrespective of the amounts to the Head of WAHO to allow the implementation of all procurement activities at WAHO level only; (ii) not later than three months after the effective date, update the ToRs for the PIU procurement specialist to include the Project; and (iii) update WAHO procurement manual with consultant selection procedure and World Bank procurement thresholds details that should be approved by the World Bank. The procurement risk is Substantial with a residual Moderate risk rating.

Environmental and Social

17. **There will be no environmental risks associated with WAHO led activities, while exposed to social risks.** To minimize this, an ESCP was prepared indicating mitigation and management measures. As environmental risks associated with the Project are considered Substantial and include the generic risks associated with civil works (waste, dust, emission, occupational health and safety, and SEA/SH) and the potential exclusion of vulnerable or disadvantaged groups, WAHO on its role of regional coordination shall facilitate safeguards instruments preparation and implementation. The PIU has experience with the environmental and social risk management and monitoring requirements under the environmental and social framework (ESF). The PIU shall recruit and maintain through Project implementation an environmental and social safeguards specialist to support and monitor countries compliance of safeguards requirement, as well to those related to WAHO activities.

ANNEX 3. Cabo Verde - Health Security Program in Western and Central Africa

I. STRATEGIC CONTEXT

A. Country Context

1. Cabo Verde has witnessed significant economic progress since 1990, driven in large part by the rapid development of tourism (25 percent of GDP), coupled with considerable social development due to strong social policies since the 1970s.[2] Until 2019, Cabo Verde was considered one of the champions among sub-Saharan African countries in terms of poverty reduction, but continues to be challenged by the impacts of COVID-19. The 2018 Systematic Country Diagnostic for Cabo Verde identified inadequate human capital as one of the country's most binding constraints to reducing extreme poverty and boosting shared prosperity.[54] Indeed, eradicating extreme poverty by 2026 is a commitment of the Government of Cabo Verde and is reflected in the new Strategic Plan for Sustainable Development 2022-2026 (PEDS II) for the country's economic and social development.

2. The shock resulting from the COVID-19 pandemic in 2020 produced the largest economic contraction on record and exposed the vulnerabilities of Cabo Verde's growth model.[55] The COVID-19 crisis had negative impacts on the tourism sector and the reduction of foreign direct investment. The crisis was driven by a nine-month shutdown of the tourism sector and the associated negative spillovers in upstream sectors. As a result, GDP contracted by 14.8 percent in 2020 (15.7 percent in per-capita terms), the second largest reduction in SSA. Reversing progress made since 2015, the national poverty rate (based on the lower-middle income poverty line of US$3.20 a day, 2011 PPP) increased from 10.2 percent in 2019 to 14.7 percent in 2020. A comprehensive vaccination campaign in 2021 (add the percentage coverage with 1 and 2 doses) was fundamental for the recovery of the economy, despite several waves of COVID-19 infections. As a result of the gradual resumption of tourism, and reflecting base effects, growth rebounded to 7 percent in 2021.[56]

B. Sectoral and Institutional Context

3. Estimated at 73 years, life expectancy in Cabo Verde is the second highest in Africa, after Mauritius. In the global gender gap index, Cabo Verde ranks among the world's best in the "health and survival" and "school enrollment" dimensions. Although Cabo Verde is among the 30 best performing countries in achievement of the Millennium Development Goals, the dispersion of the country's small population across nine islands raises costs of trade, prevents cost-effective integration of the domestic market for goods, services, and labor, and contributes to the high cost of delivering essential services, which include health, education, electricity, drinking water and sanitation services.[57]

4. The right to health is guaranteed by the Country's Constitution (Article 70). Investment in health is a top priority in Cabo Verde, as public expenditures in health account for approximately 6.02 percent of the country's GDP in 2020.[58] In 2007, Cabo Verde adopted the National Health Policy aimed at reforming the health sector and mobilizing society towards the "right to health". This policy is implemented and monitored through the medium-term National Health Development Plan (2008-2011; 2012-2016), as well as the Strategic Plan of the National Institute of Public Health (2019-2021).[59] The

[54] World Bank, 2018. Systematic Country Diagnostic for Cabo Verde.
[55] World Bank, 2023. Sailing Rough Seas: Accelerating Growth and Fostering Resilience to Climate Change in Cabo Verde. Country Economic Memorandum.
[56] International Monetary Fund, 2023. Cabo Verde: 2023 Article IV Consultation. https://doi.org/10.5089/9798400250170.002.A001
[57] World Bank. 2018. SCD.
[58] WHO, Global Health Expenditure Cabo Verde: https://apps.who.int/nha/database/country_profile/Index/en Accessed July 2023.
[59] Plano Estratégico do Instituto Nacional de Saúde Pública (2019-2021).

Government of Cabo Verde's Program for the 2021-2026 period commits the government to provide Cabo Verde, as a key priority, "with a good security system, a good justice system, and a good health system."[60]

5. In March 2023, the Government of Cabo Verde, through its National Institute of Public Health (*Instituto Nacional de Saúde Pública*, INSP), adopted a Strategic Plan for the One Health Approach. The Plan will be implemented by a Multisectoral Coordination Commission responsible for implementation of activities in human, animal, and environmental health, and will monitor the execution of the plan over the next five years.[61] Further, the Integrated Surveillance and Response Service (*Serviço de Vigilância Integrada e Resposta, SVIR*) coordinates national medical investigations and monitors various risks to public health. Information on health risks is reported weekly to SVIR by all municipal health offices.[62]

6. While progress has been made in increasing Cabo Verde's capacity to prevent, detect and respond to health emergencies, critical gaps remain in several areas. In November 2019, a JEE assessment carried out in Cabo Verde identified gaps in preparedness across all four public health functions (overall average score 2.03),[63] the country's capacity was assessed to be limited in prevention, detection, response, and other hazards. In the latest Global Health Security Index ranked Cabo Verde 105/195 countries and 9/54 countries in the Africa region. The country scored well in the response axis, ranking 76/195, lower in the prevent and health systems axis at around 105/195 and significantly low in the detect axis, where it ranked 151/195. Within the prevent axis, the country scored particularly low on the indicator for zoonotic disease and AMR, and within the detect axis, the country scored low in real-time surveillance and data transparency. Within the response axis, risk communication was the indicator with the lowest score. This context led the Pandemic Fund to grant Cabo Verde with US$4.45 million to carry out health security activities through this Project, where activities are designed to be complementary and for maximizing impact.

C. Relevance to Higher-Level Objectives

7. **The proposed Project aligns with the World Bank's FY18-23 CPF (Report No. 127164-CV) for Cabo Verde, specifically targeting Human Development (Results Area I), particularly support to enhanced education and skills (Objective 1), to boost human capital and promote inclusive growth.** The project is also aligned with the 2018 Cabo Verde Systematic Country Diagnostic (SCD) findings, which both acknowledges the country as one of the highest ranked in sub-Saharan Africa in terms of health indicators and highlights several concerns for the public health system, including the vulnerability to vector-borne diseases as a major challenge for health security. The Project is also aligned with the NAPHS, which underscores the importance of health system enhancement, including the recruitment of healthcare workers, rehabilitation and construction of healthcare facilities, and investments in medical equipment, medicines, and vaccines. Furthermore, Cabo Verde is proactively preparing its health facilities to be "epidemic-ready" by implementing climate-related green and resilient measures, IPC measures, and surge capacity adaptability. This comprehensive approach also extends to broader health system responses, including case management, immunization, point-of-care testing, and multisectoral RCCE strategies. Finally, the Project will support the Government in addressing their commitment to implementing their climate-related adaptation strategies stated in the Cabo Verde National Adaptation Plan 2022-2030 and the mitigation actions and policy measures included in Cabo Verde's Revised NDC 2021.

[60] Programa do VIII Governo Constitutional da II República.
[61] InforPress. INSP e parceiros validam Plano Estratégico Uma Só Saúde e preparam sua implementação. March 21,2023. https://inforpress.cv/insp-e-parceiros-validam-plano-estrategico-uma-so-saude-e-preparam-sua-implementacao
[62] Global Facility for Disaster Reduction and Recovery. 2020. *Diagnóstico da capacidade de prontidão e resposta a emergências Em Cabo Verde. Erigindo uma cultura de prontidão.*
[63] Avaliação Externa Conjunta das Principais Capacidades do RSI. República de Cabo Verde. Relatório de missão, 4-8 Novembro 2019, OMS; 2020.

II. PROJECT DESCRIPTION

8. **Project Development Objective (PDO):** *Increase regional collaboration and health system capacities to prevent, detect and respond to health emergencies in the Republic of Cabo Verde.*

Table 3.1. PDO and Intermediate Indicators

Indicators	Baseline	End Target
PDO Level Indicators		
1. Agreements signed on cross-border information sharing on health security guided by the One Health principles (Number)	0	3
2. Routine multisectoral cross-border investigations/simulations conducted (Number)	0	5
3. Detected health emergencies, where the country met the adopted metrics target (Percentage)	0	75%
4. Adoption/updating of contingency plans to ensure delivery of identified essential health services during a health emergency (including PoEs) (Number)	0	10
5. Gaps in veterinary services core capacities addressed (Percentage)	0	70%
Intermediate Results Indicators		
6. One Health multisectoral simulation exercises and/or after-action reviews performed to test the operationality of the response of zoonotic events (Number)	0	5
7. Health districts implementing antimicrobial stewardship programs, including monitoring of antimicrobial use, education/communication, and other interventions to improve antibiotic use, at designated facilities (Number)	0	15
8. Health districts with a fully developed and functional interoperable digital disease surveillance system (Number)	0	15
9. Priority diseases with fully developed and disseminated SOPs and procurement chains for laboratory sample management and testing (Number)	0	15
10. People trained in Field Epidemiology Training Program (FETP) in basic, intermediate, and advanced levels (Number)	0	100
11. Women trained in Field Epidemiology Training Program (FETP) in basic, intermediate, and advanced levels (Percentage)	0 %	30%
12. People trained in veterinary and para-veterinary studies and In-Service Applied Veterinary Epidemiology Training (Number)	0	100
13. Women trained in veterinary and para-veterinary studies and In-Service Applied Veterinary Epidemiology Training (Percentage)	0%	30%
14. A systematic assessment of gender gaps has been conducted in all IHR capacities and recommendations have been included in an action plan to address the gaps (Yes/No)	No	Yes
15. Core facility for genetic sequencing at the National Public Health Laboratory established and fully operational (Yes/No)	No	Yes
16. Health infrastructure interventions with climate-related green and resilient solutions (Number)	0	10
17. New resilient health infrastructure constructed for service continuation (Number)	0	4

A. Project Components

Component 1: Prevention of Health Emergencies (US$3.08 million IDA; US$0.20 million Pandemic Fund).

9. **Subcomponent 1.1 Health Security Governance, Planning, and Stewardship (US$2.25 million IDA; US$0.20 million Pandemic Fund)**. Proposed activities include: (i) development and disclosure of the Multi-Risk Plan for Operations in PHEs, operational plans and agreements for response to health emergencies, and the national risk communication plan

for PHEs; and (ii) support for updating of legal framework related to health emergency management and response and monitoring of IHR core capacities (JEE and PVS).

10. **Subcomponent 1.2 Scaling-up One Health Agenda and combatting AMR (US$0.83 million IDA)**. Proposed activities include: (i) development, dissemination, and monitoring of guidelines and regulations for prevention including optimizing antibiotic use in animal and human health sectors, sanitary animal production practices and WASH practices; (ii) technical and logistic support for cross sector studies/assessments and coordination with human and animal laboratories; and (iii) support to strategic targeted research and knowledge creation on priority infectious diseases.

Component 2. Detection of Health Emergencies (US$5.64 million IDA; US$2.80 million Pandemic Fund).

11. **Subcomponent 2.1. Collaborative Surveillance (US$1.99 million IDA; US$0.25 million Pandemic Fund)**. Proposed activities include: (i) support to real-time monitoring and quality improvement for early detection and response; (ii) establishment of digital early warning surveillance systems engaging community-level actors (with attention to vulnerable populations – including women); (iii) data collection and management for disease surveillance; (iv) acquisition of veterinary equipment (for processing, inspection, and surveillance) and medicines, investments to strengthen animal inspection service and registry; and (v) studies/assessments to identify risk of exposure to infectious diseases resulting from changes in environmental conditions, including climate-related changes, to human and animal populations, and logistical support.

12. **Subcomponent 2.2. Laboratory Quality and Capacity (US$1.80 million IDA; US$1.55 million Pandemic Fund)**. Proposed activities include: (i) strengthen laboratory quality management systems and diagnostic centers; (ii) support public health laboratory accreditation efforts, and expand laboratory and diagnostic coverage; (iii) operationalization of One Health approach for sharing of materials/supplies and transportation capacities across the country; (iv) expansion of laboratory test capacity; (v) capacity building to operationalize relevant biosafety and biosecurity guidelines; and (vi) procurement of equipment, consumables, minor civil works to accommodate equipment and secure optimal operation.

13. **Subcomponent 2.3. Multi-disciplinary human resources for health emergencies (US$1.85 million IDA; US$1.00 million Pandemic Fund)**. Proposed activities include: (i) support to the FELTP; (ii) human and animal laboratory personnel training in equipment operation and maintenance (preventive and corrective care); (iii) animal health surveillance related personnel training; (iv) digital health tools usage training; (v) CHWs (human and animal health) training on surveillance of waterborne and vector-borne diseases; and (vi) support the institutionalization of family health.

Component 3. Health Emergency Response (US$15.78 million IDA; US$0.80 million Pandemic Fund).

14. **Subcomponent 3.1. Health Emergency Management (US$1.60 million IDA; US$0.80 million Pandemic Fund)**. Proposed activities include: (i) development of and/or monitoring and support to national multi-hazard, multisectoral plans and SOPs; (ii) Rapid After-Action Reviews; (iii) establishment and functioning of PHEOCs; (iv) support supply chain monitoring, stockpiling, and management and deployment of national surge workforces; (v) logistics and technical support for meetings, infrastructure, training and capacity building of the national public health emergency management team, information sharing across all hazard-relevant sectors, and training in risk communication; and (vi) TA for health service quality improvement.

15. **Subcomponent 3.2. Health service delivery for health emergencies (US$14.18 million)**. Proposed activities include: (i) investments in connectivity infrastructure for health centers, equipment, and development of interoperability of surveillance and routine services platforms; (ii) construction/expansion of climate-related green and resilient

infrastructure for health services continuation, expansion/refurbishment of national vaccines and medicine warehouse, and WASH; (iii) acquisition of equipment for the operation of the EOC; (iv) awareness raising (campaign) and outreach materials on the impacts of infectious diseases on human and animal populations for prevention, detection and reporting in the context of climate change and deterioration of environmental conditions; (v) support to EOC operations; and (vi) procurement of intensive care equipment.

16. **Component 4. Program Management and Institutional Capacity (US$0.50 million IDA; US$0.20 million Pandemic Fund)**. This component will provide support to project implementation and management including: (i) procurement, FM, and environmental and social management; (ii) M&E; (iii) Training; and (iv) Operating Costs.

Component 5: Contingent Emergency Response Component (CERC) (US$0.00).

B. Project Geography/Areas of Intervention of the Project

17. Cabo Verde is a small low-middle-income archipelago country comprised of ten islands and 22 municipalities. The project will be implemented across the entire territory of Cabo Verde.

C. Project Beneficiaries

18. The project will target the entire population of Cabo Verde, estimated at 491,233 (2021 Census).

D. Project Costs

Table 3.2. Budget Allocation by Project Component

Project Components	IDA	Pandemic Fund	Total
Component 1: Prevention of Health Emergencies	3.08	0.20	3.28
Component 2: Detection of Health Emergencies	5.64	2.80	8.44
Component 3: Health Emergency Response	15.78	0.80	16.58
Component 4: Program Management and Institutional Capacity	0.50	0.20	0.70
Component 5: Contingent Emergency Response Component (CERC)	0.00	N/A	0.00
Total	**25.00**	**4.00**	**29.00**

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

19. **The overall coordination of Project implementation will be the responsibility of the Special Projects Management Unit (*Unidade de Gestão de Projectos Especiais*, UGPE) within the Ministry of Finance and Business Development (*Ministério das Finanças e Fomento Empresarial*).** The UGPE is the management unit in charge of all World Bank projects and is familiar with World Bank fiduciary procedures. Technical directorates at the MoH and Ministry of Agriculture and Environment (*Ministério da Agricultura e Ambiente,* MAE), as well as the UGPE will be given full responsibility for implementing their activities according to the POM and AWP/B of the project. A review of the POM and AWP/B implementation achievements and constraints will be carried out annually and will form the basis for the preparation of the following year's AWP/B, according to priorities and potential economic and social changes. Moreover, the project will engage key development partners (WHO, WOAH, others) to provide TA and implementation support as

needed. The UGPE will be responsible for consolidating inputs from the MoH and MAE to prepare semiannual progress reports and streamlining communication with the World Bank.

20. **The National Health Directorate (NHD) is responsible for the technical implementation of the Project under the overall stewardship of the MoH.** Therefore, the Project will be implemented within the existing health sector laws and regulations and its institutional and implementation arrangements will follow the current government administrative structure. The NHD will have primary technical responsibility in carrying out the Project and would play a role in the implementation of the components and their various activities, in accordance with the existing roles and responsibilities assigned to them within the ministry, as well as to coordinate with technical directorates of the MAE for project activities in animal and environmental health.

B. Monitoring and Evaluation

21. M&E activities will be the responsibility of the NHD, who will compile, consolidate, and report data and information from all IAs and beneficiaries to the UGPE.

IV. APPRAISAL SUMMARY

Financial Management

22. **The NHD will have primary technical responsibility in carrying out the project and UGPE will be responsible for the coordination and fiduciary management.** The FM arrangements will be based on the existing arrangements in place within UGPE which has the fiduciary responsibility of five active World Bank-financed projects. The overall FM performance of the UGPE is Satisfactory. Proper books of accounts and supporting documents have been kept in respect to all expenditures. The UGPE is familiar with the World Bank FM requirements. The un-audited IFRs for the ongoing projects are also submitted on time, acceptable to IDA and the external auditors issued an unqualified (clean) opinion on the 2018 Financial Statements of active projects. UGPE has an adequate FM manual of procedures that will be used for this project. However, UGPE internal control environment is weakened by the lack of internal audit function despite the growing number of World Bank-financed projects they are managing.

23. In order to accommodate the project in the existing FM system and ensure readiness, the following measures should be taken: (i) customization of the existing accounting software to include the bookkeeping of the project no later than three months after effectiveness; (ii) recruitment of an internal auditor who will cover all bank financed projects no later than three months after effectiveness; and (iii) recruitment of an external auditor to conduct a single audit of the PFS no later than six months after effectiveness.

24. **The overall FM risk is moderate.** UGPE has the overall responsibility of the fiduciary functions and has proven experience with World Bank-financed projects. UGPE's FM arrangements in place satisfy the World Bank's minimum requirements under World Bank Policy and Directive on IPF effective in 2017.

Procurement

25. **Procurement will be carried out in accordance with the World Bank's Procurement Regulations for IPF Borrowers for Goods, Works, Non-Consulting and Consulting Services,** 5th edition', dated September 2023. 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 STEP to plan, record and track procurement transactions and clearance processes.

26. **The Recipient prepared a PPSD, and an initial procurement plan has been agreed that will be updated during implementation to include all activities, procurement methods, thresholds, and other relevant information.** The proposed procurement approach prioritizes fast track emergency procurement for the required emergency goods, particularly for the prevention and response phases in case of need. In this regards, key measures to fast track procurement include the following: (i) Direct Contracting and/or Limited Competition and request for quotations with identified manufacturers, suppliers and providers for most of the items; (ii) In case of emergency, if needed, United Nations agencies and nongovernmental organizations and any other fit for purpose methods agreed with the Accredited Procurement Specialist (APS) will be approved through the procurement plan; (iii) Other measures like shorter bidding time, no bid security, advance payments, direct payments, will be applied on a case by case basis with guidance from the APS; and (iv) Post review of procurement processes.

27. **The UGPE has experience with World Bank procurement rules and procedures, including with the World Bank Procurement Regulations for Borrowers (IPF)** 5th edition', dated September 2023. All ongoing projects, except the Tourism Development Project (P176981), are implemented under the new Procurement Regulations. The staff has acceptable backgrounds in World Bank procedures and the use of the World Bank's Standard Bidding Documents. The UGPE is implementing these projects with two procurements specialists and two assistants. An additional procurement assistant will be recruited to strength the procurement capacity of UGPE.

28. **The following risks were identified:** limited national and international market for epidemic-response medical materials including personal protective equipment; limited knowledge of flexible arrangements that are part of the new procurement framework; lack of technical expertise; lack of planning of several activities; lack of collaboration between UGPE and technical stakeholders from the identification of project needs to plan contract award and contract management. The **Substantial** risk will be mitigated through hands-on support, including arranging practical trainings on World Bank National Procurement Framework (NPF) for UGPE staff, hands-on support throughout procurement processes, and supporting other needs as they arise.

Table 3.4. Major risks to procurement and proposed mitigation measures

Risks	Mitigation Measures
Increased workload and overloaded activities to conduct procurement	• The UGPE will reorganize staff workload • Staff will need capacity building on the flexibility of the NPF to allow staff to respond quickly to emergencies if needed • The World Bank could provide hands-on support to UGPE • Archiving documents in STEP as processes advance
Lack of technical expertise at UGPE to prepare technical parts of procurement document	• Close collaboration with the technical stakeholders to ensure that technical inputs are reflected in relevant procurement documents and processes
The POM does not account for the flexibly of the NPF in an emergency response	• Include all flexibility and options to expedite procurement for an emergency response as part of the revised POM
Capacity of the market and supply chain to meet the demand	• Identify qualified providers at national and international level for direct selection • Proposed mobilization of existing service providers consisting in the possibility to proceed with contracts extension for additional activities through contract amendment are expected to address the emergency medical service requirements • Measures for supplier preferences such as direct payments by World Bank, advance payments, etc. will be applied on need basis

Environmental and Social

29. **The Project is prepared under the World Bank's ESF**. The following ESS are relevant: ESS1, ESS2, ESS3, ESS4, ESS5 and ESS10. The environmental risks associated with the Project are considered Substantial and include the generic risks associated with civil works (waste, dust, emission, occupational health and safety, and SEA/SH) and the potential exclusion of vulnerable or disadvantaged groups. Although the main long-term impacts are likely to be positive, it is noted that the laboratories will be supplied with reagents, chemicals, and equipment that may constitute medical waste once used. To minimize this, the proper storage, handling, use, and disposal needs to be carefully incorporated into the design to minimize the impact on both the environment and communities. The PIU has experience with the environmental and social risk management and monitoring requirements under the ESF. Currently, the PIU has two social and environmental safeguards specialists. For the purposes of strengthening capacity, the Cape-Verdean Institute for Gender Equity and Equality will be the Project GBV/SEA/SH services provider. Civil and construction works will be monitored through the various instruments that have been prepared (ESMF with LMP and SEP) by the Project with support from the MoH, MAE, and the UGPE. Site-specific Environmental and Social Management Plans (ESMP) will be required for each activity involving civil works. The Project will also take advantage of the existing National Healthcare Waste Management Plan and the GBV SEA/SEAH Plan, developed during the COVID-19 Emergency Response Project (P173857), which will be updated to include the activities of this Project.

ANNEX 4: Guinea - Health Security Program in Western and Central Africa

I. STRATEGIC CONTEXT

A. Country Context

1. **Guinea's economy has recorded sustained growth in recent years, after socio-economic turmoil due to the 2014 Ebola Outbreak aggravated by the COVID-19 pandemic.** Guinea has been adversely affected by external and internal shocks including the pandemic, numerous and concurrent epidemics, and political instability. On September 5, 2021, a coup d'état overthrew the 2020 elected President after a controversial third term of the President. Following this, the military power established a transitional government in line with an adopted transition charter, to guide Guinea's transition to civilian rule. However, since then, the country has been experiencing a volatile socio-political environment due to persistent political unrest including a series of demonstrations against military power. After a year of disagreements on the duration and priorities of the transition, ECOWAS and the Guinean transitional government agreed on a twenty-four-month transition, thereby averting potential economic and diplomatic sanctions. Moreover, the COVID-19 pandemic, beyond its effect on public health and the resurgence of Ebola in early 2021, negatively affected Guineans' livelihoods due to movement restrictions and market closures. This resulted in food and fuel price inflation, amplifying the challenges to food security, nutrition, and livelihoods of the most vulnerable people, particularly the poorest households. The country's GDP growth over 2018-22, was robust averaging 5.2 percent (2.6 percent per capita), and expanded by an estimated 4.6 percent in 2022.[64] As a result, Guinea moved from low-income to a lower-middle-income category[65] with a US$1,519.60 GDP per capita. Growth in 2023 is projected to be at 5.1 percent, followed by an increase to 5.5 percent in 2024.[66]

2. **Despite recent economic performance and a growing population, Guinea faces challenges in achieving inclusive economic prosperity, human capital development, and social equality.** With a population of over 13.5 million[67] and more than 48 percent under age 15, the country ranks low in the 2021 United Nations Development Programme Human Development Index (182 out of 191 countries) and consistently among the bottom 12 in the World Bank Human Capital Index.[68] Guinea lags behind the average for sub-Saharan Africa and middle-income countries at 0.37[69] and the population is projected to exceed 14 million by 2024[70] due to a 2.4 percent population growth rate. [71] Despite a per capita income of US$1,180 in 2023 and a GDP of US$16 billion in 2021, categorizing it as a middle-income nation, key socio-economic statistics[72] reveal a 41.8 percent poverty rate, with rural areas at 53.1 percent and urban areas at 21.2 percent. Furthermore, in 2019, the overall literacy rate was 39.6 percent, while rural areas stand at 24.4 percent and urban areas at 63.6 percent. Gender disparities persist, with men at 54.4 percent literacy compared to women at 27.7 percent. While primary education achieved a 53.1 percent gross enrollment rate in the 2019/2020 academic year,[73] lower secondary enrollment fell to 44.7 percent, and upper secondary enrollment declined to 27.3 percent, highlighting the need for enhanced access and retention in higher education levels.

3. **Climate impacts have resulted in ecological imbalances, challenging living conditions, and intensified effects of climate change**. These include rising temperatures, sea level increases, flooding, and disruptions to rainfall patterns,

[64] International Monetary Fund.
[65] World Bank Country and Lending Groups – World Bank Data Help Desk.
[66] World Development Indicators. Macro Poverty Outlook, and official data. 2023.
[67] Republic of Guinea. National Institute of Statistics. Population of Guinea's administrative divisions from 1996 to 2025. https://population.insguinee.org/resultat/
[68] World Bank. 2021. The Human Capital Index 2020 Update: Human Capital in the Time of COVID-19. Washington, DC: World Bank. doi:10.1596/978-1-4648-1552-2.
[69] Ibid.
[70] Republic of Guinea. National Institute of Statistics. Population of Guinea's administrative divisions from 1996 to 2025. https://population.insguinee.org/resultat/
[71] World Bank, World Development Indicators. 2022
[72] Republic of Guinea. National Institute of Statistics report. 2019.
[73] The United Nations Educational, Scientific and Cultural Organization. Guinea country profile trends SDG4 September 2023. http://sdg4-data.uis.unesco.org/

leading to habitat degradation, biodiversity loss, and land conflicts. The 2019 national climate change strategy by the Ministry of Environment and Sustainable Development (*Ministère de l'Environnement et du Développement Durable*), notes that the country is grappling with these consequences. Anticipated changes include rainfall deficits and rising temperatures contributing to shifts in the current vegetation map by 2025. The North-East and North-West zones are expected to transition from wooded savannah to dry savannah. This transformation could result in a decline in forest species (both plant and animal) that are less resilient to drought.

B. Sectoral and Institutional Context

4. **The population's health status is reflected in the 2018 Demographic and Health Survey.** Anemia prevails among children aged 6 to 59 months at a rate of 75 percent while chronic malnutrition affects 30 percent of children under 5. The maternal mortality ratio stands at 550 per 100,000 live births, and the infant mortality rate is 67 per 1,000 live births. Vaccination coverage is at 24 percent for children aged 12-23 months and 22 percent of this demographic have not received any vaccines from the Expanded Program for Immunization. The mortality rate for adults aged 15-60 is 148.7 per 1,000 population, with an improvement in life expectancy at birth, up from 58 years in 2014 to 61.6 years in 2020.

5. **The National Health Development Plan (2015-2024) is guided by three strategic directions: strengthening disease and emergency prevention and management, promoting health across various life stages, and reinforcing the national health system**. The organizational structure of the Ministry of Health and Public Hygiene (*Ministère de la Santé et de l'Hygiène Publique*) operates across three levels: central, intermediate (regional), and peripheral (prefectural and community). The central level regulates the sector, guides actions, and allocates resources. The regional level provides technical support to health districts, while the prefectural level (encompassing the health districts) is responsible for policy implementation. At the community level, essential family and individual health services are delivered.

6. **Supply Chain**. Despite efforts to strengthen the supply chain, stock-outs of essential medicines at the health facility level continue to pose challenges to the continuity of essential health services in Guinea. To overcome distribution bottlenecks, the Central Pharmacy implemented a 'last mile' delivery system to hospitals and health centers, which initially reduced stock-out rates. However, both the rolling stock and infrastructure are outdated, necessitating more investment to sustain the system. Procurement remains a challenge, and the availability of medicines at the national level often depends on donor funding. A Logistics Management Information System (LMIS) and Warehouse Management System are managed by different government entities (Ministry of Health and Central Pharmacy) and are not interoperable. Interoperability has, however, been established between the LMIS and the District Health Information System 2 (DHIS2) health management information system (HMIS), enabling logistics data to be integrated into HMIS reporting.

7. **Health Information System.** In 2018, Guinea's well-established epidemiological surveillance system and HMIS incorporated DHIS2. With partner support, data completeness and quality have progressively improved in recent years. Individual patient trackers were implemented for surveillance, yet data completeness challenges persist. The focus now shifts to enhancing data utilization, aided by recent internet connectivity at health centers for direct DHIS2 data entry and increased data access. However, sustainability remains a concern, as both surveillance and HMIS DHIS2 systems heavily depend on external experts for configuration and server management.

8. **Health Financing**. Health financing is largely provided by households (out-of-pocket payment), with 59.2 percent of current healthcare expenditure,[74] indicating high exclusion risk of the poor from regular access to healthcare. External funding for the health sector in Guinea increased during the 2014-2016 Ebola epidemic, then fell sharply from 27 percent,

[74] Comptes nationaux de la sante de la Guinée (2019).

in 2016, to 11 percent in 2019. Moreover, the 2022 resources mapping and expenditure tracking[75] displayed a considerable equity gap in the distribution of resources with only 22 percent of health financing allocated to the peripheral level while 78 percent are allocated to central level.

9. **IHR capacities.** Guinea improved its IHR core capacities over the recent years, primarily through investments made under the REDISSE I project. The effective management of recent epidemics (COVID-19, Avian Influenza, 2021 EVD, Lassa Fever, Marburg, Yellow Fever, and Meningitis) highlights Guinea's improved preparedness and response capabilities. However, the 2023 JEE draft report reveals that the country still has no capacity on 14 indicators (compared to 18 indicators in 2017), limited capacity on 18 indicators (compared to 20 indicators in 2017), developed capacity on 15 indicators (compared to nine indicators in 2017) and demonstrated capacity on nine indicators (compared to one indicator in 2017). These results highlight the remaining challenges in Guinea's health security preparedness stemming from factors such as insufficient legal instrument analysis, funding constraints, poor implementation of IPC strategies, lack of enforcement of rules for dispensing and proper use of antibiotics, insufficient laboratory capacity (especially for animal and environmental health), inadequate health infrastructure, and shortage of qualified human resources. JEE findings serve to inform the NAPHS development for the period 2024-2028 as well as the interventions supported by the Program.

C. Relevance to Higher-Level Objectives

10. **The proposed project aligns with the World Bank's FY18-23 CPF (Report No. 125899-GN) for Guinea, specifically targeting human development (Pillar 2), decentralizing service delivery (Objective 2), and improving health in rural areas (Objective 5) to boost human capital and promote inclusive growth.** The project is also aligned with the findings of the 2018 Guinea Systematic Country Diagnostic (SCD), which highlighted low financing levels and inequitable health funding, mainly favoring Conakry, and addresses the challenge of limited capacity to deliver essential public services. It also in agreement with Guinea's post-Ebola Recovery Plan, which underscores the importance of health system enhancement, including the recruitment of healthcare workers, rehabilitation and construction of healthcare facilities, and investments in medical equipment, medicines, and vaccines. Furthermore, Guinea is proactively preparing its health facilities to be "epidemic-ready" by implementing climate-related green and resilient measures, IPC measures, and surge capacity adaptability. This comprehensive approach also extends to broader health system responses, including case management, immunization, point-of-care testing, and multisectoral RCCE strategies. The Project will also support the MoH in addressing their commitment to implementing their climate-related adaptation goals in the Guinea National Adaptation Plan and mitigation actions and policy measures included in Guinea's Revised NDC 2021.

II. PROJECT DESCRIPTION

11. **The Project Development Objective (PDO) is to:** *Increase regional collaboration and health system capacities to prevent, detect and respond to health emergencies in the Republic of Guinea*.

Table 4.1. Proposed PDO-Level Outcome Indicators and Intermediate Results Indicators

Indicators	Baseline	End Target
PDO Level Indicators		
1. Agreements signed on cross-border information sharing on health security guided by the One Health principles (Number)	0	2
2. Routine multisectoral cross-border investigations/simulations conducted (Number)	0	5
3. Detected health emergencies, where the country met the adopted metrics target (Percentage)	0	75%

[75] Republic of Guinea. Ministry of Health and Public Hygiene. Resources mapping and expenditure tracking.

Indicators	Baseline	End Target
4. Adoption/updating of contingency plans to ensure delivery of identified essential health services during a health emergency (including PoEs) (Number)	0	8
5. Gaps in veterinary services core capacities addressed (Percentage)	0	70%
Intermediate Results Indicators		
6. One Health multisectoral simulation exercises and/or after-action reviews performed to test the operationality of the response of zoonotic events (Number)	0	5
7. Health districts implementing AMR stewardship programs, including monitoring of antimicrobial use, education/communication, and other interventions to improve antibiotic use, at designated facilities (Number)	0	15
8. Priority diseases with fully developed and disseminated SOPs and procurement chains for laboratory sample management and testing (Number)	0	8
9. People trained in Field Epidemiology Training Program (FETP) in basic, intermediate, and advanced levels (Number)	0	500
10. Women trained in Field Epidemiology Training Program (FETP) in basic, intermediate, and advanced levels (Percentage)	0 %	30%
11. People trained in veterinary and para-veterinary studies and In-Service Applied Veterinary Epidemiology Training (Number)	0	100
12. Women trained in veterinary and para-veterinary studies and In-Service Applied Veterinary Epidemiology Training (Percentage)	0%	30%
13. A systematic assessment of gender gaps conducted in all IHR capacities and recommendations have been included in an action plan to address the gaps (Yes/No)	No	Yes
14. New resilient health infrastructure constructed for service continuation (Number)	0	5
15. Months in the past year in which the number of first antenatal care visits in any region dropped more than 15 percent below average (Number)	1	0
16. Rapid cycle monitoring of PHC service continuity has been implemented and a country coordination platform discusses reports and identifies corrective actions at least quarterly (Yes/No)	No	Yes

D. Project Components

Component 1: Prevention of Health Emergencies (US$15.00 million IDA).

12. **Subcomponent 1.1 Health Security Governance, Planning, and Stewardship (US$9.00 million IDA).** This subcomponent aims to support Guinea in enhancing its national health security program in alignment with regional and global goals. Key activities involve assisting in the development and management of national health security action plan for the period 2024-2028, mapping regional and national resources for health emergency preparedness, and aligning development partner support with country-specific needs. The subcomponent will also strengthen national capacities for crucial prevention activities that require regional harmonization, such as biosafety measures and sample transport regulations, in collaboration with Africa CDC and other regional partners. Furthermore, it will facilitate the monitoring of IHR core capabilities, especially at borders and PoE, utilizing tools like the JEE and PVS to inform planning and prioritize actions. TA will be provided to revise strategic documents related to animal, human, and environmental health.

13. **Subcomponent 1.2 Scaling-up One Health Agenda and combatting AMR (US$6.00 million IDA).** This subcomponent will support the government's ongoing effort to consolidate and sustain the operationalization of the One Health Platform at national, regional, and local levels engaging stakeholders from the human, animal, and environmental sectors. Efforts encompass logistical and technical support, development of comprehensive work plans, ensuring seamless communication across administrative levels, and convening regular meetings involving stakeholders, development

partners, and technical agencies. Activities will finance the development, prioritization, and operationalization of regionally harmonized, multi-sectoral action plans focusing on the fight against AMR and climate-sensitive diseases like dengue, Lassa fever and other vector-borne and water-borne diseases. This includes enforcing antibiotic prescription and dispensation to ensure proper use in the animal and human health sectors, promoting sanitary practices in animal production, and enhancing WASH practices. Additionally, this subcomponent will facilitate the creation, dissemination, and monitoring of prevention guidelines and regulations. The dissemination process will encompass community engagement and implementing gender analysis to emphasize equity and inclusion. The subcomponent will also aim to revitalize Technical Working Groups, facilitate disease response planning, and reinforce epidemic response mechanisms. Priority will be given to the acquisition and maintenance of essential equipment, community risk communication, AMR awareness raising and negative climate impacts on health, as well as JRAs. The subcomponent's focus on AMR monitoring involves strengthening the laboratory system, including infrastructure renovation, aligned with AMR strategic plans, as well as support to human resource capacity strengthening aimed at bolstering health safety.

Component 2. Detection of Health Emergencies (US$42.00 million IDA, US$5.00 million GFF).

14. **Subcomponent 2.1. Collaborative Surveillance (US$12.00 million IDA, US$4.00 million GFF).** This subcomponent will support a comprehensive surveillance and early warning system that will involve (i) the support to the training, equipment, transportation means and operation cost of the rapid response teams (national, regional and communes level); (ii) the operationalization of digitalized one health community-based surveillance system, (iii) the construction of five border veterinary inspection posts; (iv) the data-sharing through interoperable digital data systems that integrate medical, animal, and environmental records with surveillance efforts; (v) trainings and tools for data analysis, as well as (v) platforms and logistical support including vehicles acquisition to enhance event verification, investigation, and risk assessment capabilities for information sharing across all levels, spanning from community to national. To this extent, a priority will be the strengthening of each sector's information systems namely the DHIS2 case-based surveillance for human diseases, the Global Animal Disease Information System (EMPRES-i) and the Environment Information Management System (EMIS). Guinea will also serve as a pilot country for institutionalizing the Global Financing Facility's Monitoring of Essential Health Services (mEHS) approach, with the MoH taking over the routine production and use of its analyses. To break down data silos and enable more holistic surveillance approaches in the health sector, the surveillance and HMIS instances of DHIS2 will be merged, and interoperability between DHIS2 and other systems (e.g., logistics systems) will also be strengthened. In addition, HMIS in the health private sector will also be leveraged to strengthen private sector (in both human and animal sector) participation in surveillance and monitoring activities, enabling true sector-wide planning for health emergency response and essential health service continuity.

15. **Subcomponent 2.2. Laboratory Quality and Capacity (US$17.00 million IDA)**. This subcomponent will provide technical and financial support for: (i) construction and equipment of one new laboratory of viral and hemorrhagic fevers, new animal laboratories consisting of one regional animal laboratory in Boké, one new laboratory for fish products and environment at Conakry, and the construction and rehabilitation of an applied biology research institute of Guinea at Kindia; (ii) acquisition of a mobile laboratory using the One Health approach for the control of fish products, and ensuring collaborative mechanisms for the confirmation of suspected cases for animal health, public health, environmental and fish products; (iii) set up of a national bio-bank at the National Institute for Public Health (*Institut National de Santé Publique,* INSP) in the light of the One Health approach; (iv) procurement of consumables, supplies and equipment for laboratories; (v) maintenance and calibration of equipment; and (vi) training/capacity building to diagnose emerging pathogens and operationalize relevant biosafety and biosecurity guidelines. This subcomponent will scale up and expand the pilot phase of digitalized transport of samples to animal and environment health laboratories. Efforts will also focus on reinforcing veterinary laboratories' leadership, especially the development and implementation of operational action plans.

16. **Subcomponent 2.3. Multi-disciplinary Human resources for Health Emergencies (US$13.00 million IDA, US$1.00 million GFF)**. This subcomponent will support activities focusing on strategic resource planning to assist medium to longer term staffing, including multidisciplinary One Health workforce plan development and implementation. Proposed activities will include (i) trainings and coaching (notably, with diploma) in FETP in basic, intermediate, and advanced levels; in veterinary and para-veterinary studies and In-Service Applied Veterinary Epidemiology, and other trainings and coaching on essential health service provision such as on basic emergency obstetric and neonatal care, on integrated disease surveillance and response extended to midwives, on IPC, on biomedical waste management, on climate change and health for human, animal and environmental health. All the workforce capacity building/training will meet the gender equity criteria; and (ii) hiring of primary health care human resource to ensure the continuity of care as needed, and of frontline veterinary and environmental workers. Proposed activities are complementary to the Africa CDC's initiative to strengthen continental health workforce development, including their support to CHW programs and African Epidemiologic Services platform that will share a continental roster of public health specialists.

Component 3. Health Emergency Response (US$27.00 million IDA, US$11.00 million GFF).

17. **Subcomponent 3.1. Health Emergency Management (US$10.00 million IDA, US$3.00 million GFF).** This subcomponent will support the: (i) construction of the headquarter for the national public health EOC and support the functionality, equipment, training; (ii) strengthening of the alert system including the uninterrupted service of the toll-free emergency call centers; (iii) preparation and coordination of emergency response interventions in the health sector; (iv) strengthening emergency logistics and supply chains, including supply chain monitoring, ensuring the critical "last-mile" delivery, stockpiling, streamlining and integrating the LMIS and Warehouse Management System; and (v) procurement of essential medicines at the health facility and community levels with a focus on medicines and commodities for essential health and nutrition services, with stock levels sufficient to ensure the continuity of these core services during health emergencies and other service disruptions. Additional supported activities will include logistics and technical support for meetings, training, infrastructure, intra-action and post action reviews and simulations/tabletop drills and regular test implementation and research and studies on epidemic and multi-hazard public health.

18. **Subcomponent 3.2. Health Service Delivery for Health Emergencies (US$17.00 million IDA, US$8.00 million GFF).** Proposed activities aim to: (i) construct/rehabilitate, and equip, epidemic treatment centers, intensive care units in hospitals, regional and prefectural health directorates and health centers with respect to climate preservation; (ii) refurbish and equip the institute for the Training of Healthcare Professionals; (iii) procure energy-efficient equipment and material and implement energy efficiency measures in the new buildings; and (iv) install facilities/supplies for clean drinking water access. In addition, activities will support the development and implementation of communication plans on risks and community engagement, taking into account gender considerations and persons with disabilities; and strengthening and decentralization of the use of the health information system, enabling more localized decision-making and, ultimately, more rapid responses to health emergencies and service disruptions. The project will implement a new Data Use initiative, which will leverage Guinea's success in deploying DHIS2 into health facilities to digitize and strengthen the use of data for decision-making at the facility level. A wide range of activities to improve data quality for surveillance and HMIS will also be supported. Finally, this subcomponent will support interventions for maternal and child health in priority regions in Guinea, to enhance service delivery and utilization of basic reproductive maternal, newborn, child, and adolescent health services at health facilities in these regions including vaccine deployment. This holistic approach ensures the continuity of essential health services while contributing valuable insights to inform broader health financing reforms.

19. **Component 4. Program Management and Institutional Capacity (US$6.00 million IDA).** This subcomponent will support Project implementation and management including: (i) procurement, FM, environmental and social management, and M&E; (ii) Training and hiring of staff for the Project Coordination Unit (PCU); (iii) TA and implementation support; and

(iv) Operating Costs.

20. **Component 5: Contingent Emergency Response Component (CERC) (US$0.00).**

E. Project Geography/ Areas of Intervention of the Project

21. Guinea is a lower-middle-income country comprised of eight regions. The project will be implemented across the entire territory including some specific essential health service interventions in selected regions of Guinea.

F. Project Beneficiaries

22. The project will target the entire population of Guinea, estimated at 13.5 million inhabitants with specific essential health services activities in four select regions.

G. Project Costs

Table 4.2. Budget Allocation by Project Component

Project Components	IDA (US$ million)	GFF (US$ million)	Total (US$ million)
Component 1: Prevention of Health Emergencies	15.00	0.00	15.00
Component 2: Detection of Health Emergencies	42.00	5.00	47.00
Component 3: Health Emergency Response	27.00	11.00	38.00
Component 4: Program Management and Institutional Capacity	6.00	0.00	6.00
Component 5: Contingent Emergency Response Component (CERC)	0.00	0.00	0.00
Total	**90.00**	**16.00**	**106.00**

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

23. **The MoH will be the IA for the proposed project in Guinea and oversee project implementation.** The existing PCU has experience with World Bank projects and is coordinating the ongoing Guinea Health Service and Capacity Strengthening project (P163140) and the Guinea COVID-19 Emergency Response and System Preparedness Strengthening Project (P174032). The PCU will oversee the day-to-day management and coordination of the project, including overseeing critical aspects such as procurement, FM, M&E, and ensuring compliance with ESS as well as preparation of consolidated AWP/B, completion of progress implementation reports. The National Agency for Health Security and technical directorates for other sectors involved in the One Health approach will oversee the project's technical implementation. The PCU is staffed with a qualified Project Coordinator, a newly hired deputy coordinator, an experienced operations manager, a dedicated M&E Specialist, FM specialist, accountant, and procurement specialist. It is also composed of an environmental specialist, a social development specialist, a GBV/SEA/SH specialist, and an internal auditor. Seven regional PCU offices will be set up to ensure close monitoring of activities as well as hands-on fiduciary support to the decentralized level. Each regional office will be composed of a regional coordinator, an accountant, and a social development specialist. The two latter staff will report to the regional coordinator and the regional coordinator will report to the PCU coordinator.

24. **The technical directorates at the MoH, the Ministry of Agriculture and Livestock (*Ministère de l'Agriculture et de l'Élevage*), the Ministry of Environment and Sustainable Development and the Ministry of Fisheries and Maritime Economy (*Ministère de la Pêche et de l'Économie Maritime*) as well as the PCU will be given full responsibility for implementing their activities according to the POM and AWP/B of the project.** A review of the POM and AWP/B

implementation achievements and constraints will be carried out annually and will form the basis for the preparation of the following year's AWP/B, according to priorities and potential economic and social changes.

B. Monitoring and Evaluation

25. The PCU will be responsible for monitoring project implementation including: (i) collecting and analyzing data for the Results Framework; (ii) ensuring alignment of project's activities with other interventions and activities implemented in the country; and (iii) enhancing synergies between this Project and other World Bank-financed operations in Guinea.

IV. APPRAISAL SUMMARY

Financial Management

26. The project will be implemented using the World Bank Directive: FM Manual for World Bank IPF Operations, and World Bank Guidance: Reference material - FM in World Bank IPF Operations (Catalogue Number OPCS5.05-GUID.02). A full set of unaudited IFRs will be submitted to the World Bank quarterly throughout the life of the project, 45 days after the end of each fiscal quarter. The annual audited PFS will be provided to the World Bank within six months of the end of each fiscal year and at the closing of the project. Appropriate internal controls and flow of funds arrangements designed and instituted within the Project Financial Management Unit (PFMU), will be used. These are essential in ensuring proper controls, monitoring the flow of funds and to ensure that funds will flow and be used only for intended purposes. The overall FM residual risk is **Moderate**.

Procurement

27. The PCU has adequate procurement staff who are familiar with World Bank procurement procedures. The key procurement risks are as follows: (i) challenges in interaction with various partners that will be involved in the procurement process; (ii) high workload on the single procurement officer who handles all the procurement activities for two World Bank-financed projects [Guinea Health Service and Capacity Strengthening Project (P163140) and Guinea COVID-19 Preparedness and Response Project (P174032)]; and (iii) delays in procurement process. The mitigation measures are: (a) maintain the Procurement Specialist and recruit or appoint an additional procurement specialist with the requisite qualifications and experience to the PCU not later than three months after the effectiveness date; and (b) provision of a procurement training on World Bank procedures to the tender committee and other partners involved in the procurement process. The procurement inherent risk is Substantial with a residual **Moderate** risk.

Environmental and Social

28. **The environmental risks associated with the project are considered Substantial.** Although the main long-term impacts are likely to be positive, it is noted that the laboratories will be supplied with reagents, chemicals and apparatus that may constitute medical waste once used. To minimize this, the proper storage, handling, use and disposal needs to be incorporated into the design to minimize the impact on both the environment and social spheres. The PCU has experience with social and environmental risk management and monitoring requirements under the ESF, however, environmental, and social performance of existing health projects in Guinea is in general Moderately Unsatisfactory and therefore, there is a need for continued capacity building on environmental and social risk management, including implementation, monitoring, and reporting of the medical waste management. While construction activities are planned, there will be minimal infrastructure and it is envisaged that mainly small upgrades will be made to accommodate various technical requirements to support the building and strengthening of capacity. Activities will be monitored through various instruments including the ESMF, SEP, Resettlement Policy Framework, and ESMP required in the ESCP for each subproject supported by the project. The project will take advantage of the Integrated Medical Waste Management Plan developed during the COVID-19 Preparedness and Response Project (P174032).

ANNEX 5: Liberia - Health Security Program in Western and Central Africa

I. STRATEGIC CONTEXT

A. Country Context

1. **Liberia is a low-income country in West Africa with a GDP per capita (current US$) of US$754.50 and a total population of 5,302,681 in 2022.** The country is still recovering from the effects of two devastating civil wars (1989-1996 and 1999-2003), the EVD epidemic (2014-2016), and the COVID-19 pandemic (2020-2022). Liberia is challenged with low productivity of the primary sector, poor infrastructure and road network system, and extremely low access to energy. Economic growth shrunk by 2.5 percent and 3.0 percent in 2019 and 2020 respectively, followed by a rebound in 2021 and 2022 with the economy growing at 5.0 percent in 2021 and 4.8 percent in 2022. Despite strong economic performance, Liberia's fiscal position worsened in 2022. The overall fiscal deficit widened to 6.9 percent of GDP in 2022, up from 2.4 percent in 2021.[76] Consequently, human development outcomes in Liberia are low. The country's Human Capital Index score for 2020 of 0.32 is lower than the sub-Saharan Africa region's 40 percent average and Low-Income Countries (37 percent).[77] Poverty in Liberia is widespread with over half the population living below the national poverty line. [78] Liberia is lagging on gender equality and ranked 164 out of 170 countries on the Gender Inequality Index in 2021.[79]

B. Sectoral and Institutional Context

2. **Liberia has a huge and rising burden of communicable and non-communicable diseases and conditions, which are aggravated by adverse weather and climate change.** First, maternal and child health outcomes are among the worst in the world with the maternal mortality ratio being 742 deaths for every 100,000 live births. The neonatal mortality rate at 37 per 1,000 live births, accounts for a third of all under-five deaths.[80] In addition, owing to food insecurity at the household level, about 30 percent of children under the age of five are stunted and at risk of cognitive and physical limitations.[81] During the past decade, Liberia has also experienced several disease outbreaks such as Ebola (2014-2016), measles, Lassa fever, meningitis, pertussis, yellow fever, and COVID-19 (2020-2022). Liberia's vulnerability to these diseases is compounded by poor health and WASH infrastructure, weak laboratory system, insufficient number and skills-mix of the health workers in-post, insufficient funding to the health sector, and inadequate accountability. These factors hinder timely detection and effective response to outbreaks leading to rapid escalation and severity of impact. Consequently, results from the 2023 JEE show that from the 56 JEE indicators, Liberia has demonstrated capacity in 17 (30.4 percent), developed capacity in 18 (32.1 percent), limited capacity in 10 (17.9 percent), and no capacity in 11 (19.6 percent).[82] The lack of capacity was observed in AMR, biosafety and security, infection prevention and control, human resources, health emergency management, and health services provision.

3. **To overcome the above challenges, the Government of Liberia has developed several policies and strategic plans to guide the implementation of priority programs and interventions in the health sector.** These include the

[76] World Bank. 2021. Liberia Economic Update: Finding Fiscal Space. Washington DC, World Bank.
[77] World Bank. 2020. The Human Capital Index 2020 Update: Human Capital in the Time of COVID-19. © World Bank, Washington, DC. http://hdl.handle.net/10986/34432 License: CC BY 3.0 IGO
[78] World Bank Group. 2021. Poverty and Equity Brief Liberia. https://povertydata.worldbank.org/poverty/country/lbr
[79] United Nations Development Programme. 2021. Gender Inequality Report 2021. https://hdr.undp.org/data-center/thematic-composite-indices/gender-inequality-index#/indicies/GII
[80] Liberia Demographic and Health Survey 2019-2020.
[81] ibid
[82] Republic of Liberia. 2023. Report on the 2023 Liberia Multi-Sectorial Self-Assessment and Operational Planning Joint External Evaluation (JEE).

National Health Policy 2022-2031, a National Health Sector Strategic Plan 2022-2026, and a National Health Financing Strategy 2022-2026. Liberia is also currently updating its NAPHS which was developed in 2017.

C. Relevance to Higher-Level Objectives

4. **The Project is consistent with the World Bank's CPF FY19-24 (Report No. 130753-LR) for Liberia.** The Project will contribute to Policy Area B on Human Capital Development and Objective B2 on Expanding Healthcare Access and Improving Service Quality. The Project is also aligned with national policies and plans in the health sector in Liberia such as the National Health Policy 2022-2031, National Health Sector Strategic Plan 2022-2026, and the NAPHS. Through One Health supported activities, the Project will support the MoH and National Public Health Institute of Liberia (NPHIL) in addressing their commitment to implementing their climate-related adaptation strategies stated in the Liberia National Adaptation Plan 2020-2030 and the mitigation actions and policy measures included in Liberia's Revised NDC 2021.

II. PROJECT DESCRIPTION

5. **Project Development Objective (PDO)***: Increase regional collaboration and health system capacities to prevent, detect and respond to health emergencies in the Republic of Liberia*.

Table 5.1. Proposed PDO-Level Outcome Indicators and Intermediate Results Indicators

Indicators	Baseline	End Target
PDO Level Indicators		
1: Detected health emergencies, where the country met the adopted metrics target. (Number)	6	185
2: Gaps addressed in veterinary services core capacities (Number)	0	7
3: Country has adopted/updated contingency plans to ensure delivery of identified essential health services during a health emergency (including PoEs) (Number)	6	11
Intermediate Results Indicators		
Component 1 - Prevention of Health Emergencies		
IR#1 – One Health multisectoral simulation exercises performed to test the operationality of the response of zoonotic events. (Number)	2	7
Component 2 - Detection of Health Emergencies		
IR#2 – Counties with surveillance systems that include early warning functions at community level and PoEs (Number)	0	15
IR#3 –Project-supported laboratories that have achieved a 3-star rating or higher during a SLIPTA audit (Number)	0	2
IR#4 –Counties reporting early detection of health events as per standard guidelines (Number)	0	15
IR#5 - People trained in Field Epidemiology Training Program (FETP) in basic, intermediate, and advanced levels (Number)	374	524
Women trained in Field Epidemiology Training Program (FETP) in basic, intermediate, and advanced levels. (Percentage)	112	157 (30%)
IR#6 - People trained in veterinary and para-veterinary studies and In-Service Applied Veterinary Epidemiology Training. (Number)	91	241
Women trained in veterinary and para-veterinary studies and In-Service Applied Veterinary Epidemiology Training. (Number, Percentage)	11	72 (30%)
Component 3 - Health Emergency Response		
IR#7 –Health events for which an early action review to assess rapid performance improvement for outbreak detection and response was performed. (Percentage)	6	126
IR#8 – Counties with established functional emergency response coordination mechanism or incident management system at subnational levels that includes PoEs (Number)	0	15

Indicators	Baseline	End Target
IR#9 – Country is routinely monitoring the use of PHC services, both routinely and in emergency situations (Yes/No)	No	Yes
IR#10 – Country has developed an RCCE plan and SOP which applies to both routine and emergency contexts, and accounts for gender dimensions (Yes/No)	No	Yes
IR#11 - Health infrastructure interventions financed by the Project using energy-efficient approaches (Number)	0	8

A. Project Components

Component 1: Prevention of Health Emergencies (US$2.00 million)

6. **Subcomponent 1.1: Health Security Governance, Planning, and Stewardship (US$0.70 million).** Activities under this subcomponent aim to strengthen institutional structures and coordination arrangements within the implementing government ministries and agencies, namely: the MoH, NPHIL, Ministry of Agriculture (MoA), and the Environmental Protection Agency (EPA). The activities include policy and planning; supervision of core prevention, detection, and response interventions; and M&E. Multisectoral coordination of programs and activities on human, animal, and environmental health will also be strengthened. This will include harmonization of standard operating practices, planning and implementation; joint M&E; and cross-border engagement.

7. **Subcomponent 1.2: Scaling-up One Health Agenda and combatting AMR (US$1.30 million).** This subcomponent will provide TA to the One Health governance structure and functionality of the One Health Secretariat. The Project will strengthen One Health coordination mechanisms at national and subnational levels by: (i) Harmonizing guidelines, regulatory instruments, management systems, and data collection tools for M&E of One Health interventions; (ii) Guiding the stewardship of the One Health Secretariat in the implementation of AMR-related interventions for animal, environmental, and human health; and (iii) Enhancing the functionality of animal health. Additionally, this subcomponent will finance: (i) One Health simulation exercises; and (ii) Development and implementation of guidelines on the prevention and optimization of antimicrobial use and testing in animal and human health sectors, sanitary animal production practices, and WASH. To improve awareness and uptake of One Health and AMR guidelines and interventions, communities will also be sensitized.

Component 2. Detection of Health Emergencies (US$7.50 million)

8. **Subcomponent 2.1: Collaborative Surveillance (US$3.00 million).** Activities under this subcomponent will aim to improve surveillance capacities at all levels by: (i) Improving human, environmental, and animal surveillance workforce capabilities to prevent, detect, and respond to public health threats; (ii) Supporting emergency investigations including rumors, unexplained deaths, and outbreaks; (iii) Enhancing the electronic database and data warehouse (human, animal, and environment) for disease surveillance interoperability linked to electronic reporting of integrated disease surveillance and response (e-IDSR); and (iv) Strengthening cross-border surveillance and PoE surveillance through the One Health approach.

9. **Subcomponent 2.2. Laboratory Quality and Capacity (US$2.50 million).** Activities under this subcomponent will focus on strengthening the country's detection capacities for animal, human, and environmental health by: (i) Establishing and/or revising and implementing biosafety and biosecurity policies, in-country licensure and accreditation of institutions, and internal and external quality management programs for internal and external assurance; (ii) Implementing the LIMS and an electronic database for sample management linked to the e-IDSR; and (iii) Developing

performance monitoring mechanisms and frameworks, conducting routine supervision, and implanting a twinning program to ensure enhanced performance. The Project will also support the laboratory network by: (i) Strengthening laboratory workforce capabilities through trainings and continued education, including neglected areas such as genomic sequencing and AMR; (ii) Construction of the Palala Regional One Health Laboratory in Bong County; (iii) Procurement of equipment; reagents, and laboratory supplies for the whole network (including laboratories at animal quarantine centers); (iv) Regular maintenance and calibration of equipment at animal, human, and environmental laboratories; and (v) Conducting trainings in handling and transferring of biological samples and materials.

10. **Subcomponent 2.3: Multi-disciplinary Human Resources for Health Emergencies (US$2.00 million).** This subcomponent will support the Government of Liberia in ensuring sufficient and quality human resources to prevent, detect, and respond to disease outbreaks and events. Activities include: (i) Training of human health workers to acquire basic, intermediate, and advanced FETP certification in case investigation and management of priority diseases; (ii) Training animal health workers as veterinarians and para-veterinarians; and (iii) Training of environmental health workers including in-service training in Applied Veterinary Epidemiology; and (iv) Other trainings to address core IHR capacities gaps. The overall aim will be to provide a sustainable solution to the human resources capacity gap by: (i) Developing a One Health Workforce Strategy; (ii) Developing the curriculum and training program for public health emergency and incident case management; (iii) Institutionalizing the provision of the FETP and Applied Veterinary Epidemiology Training at the University of Liberia; and (iv) Developing information systems for tracking the availability and performance of frontline workers with specialized skills.

Component 3: Health Emergency Response (US$5.00 million)

11. **Subcomponent 3.1: Health Emergency Management (US$2.00 million).** This subcomponent aims to strengthen the country's capacity in timely responding to health emergencies by: (i) Enhancing the standard operating practices on public health emergency logistics and supply chain management; (ii) Developing the framework for the deployment of emergency personnel; (iii) Updating the Rapid Response Team Framework for deployment of surge teams under the One Health approach; (iv) Developing risk profiles, vulnerability, and capacity readiness assessments for all public health hazards; (v) Supporting the implementation of early and after-action reviews for performance monitoring; and (vi) Updating the national countermeasures plan. In addition, emergency supplies, commodities, equipment, and supplies for the PHEOC will be procured.

12. **Subcomponent 3.2: Health service delivery for health emergencies (US$3.00 million).** Activities under this subcomponent will include support to develop and implement a health emergencies action plan and framework for relevant health institutions, and risk communication and engagement at community level. To address the existing gap in infrastructure, the project will also support the construction and refurbishment of eight PoEs; three animal quarantine centers; and three health triage centers. This support will also include the procurement and installation of energy-efficient systems, water and sanitation systems, and construction and operationalization of waste management systems. Additionally, this subcomponent will support the patient referral system, the procurement of commodities for its operations, and develop joint monitoring mechanisms to assess performance, service continuity during emergency, compliance with guidelines, and effectiveness. Support will also be provided for the development of case management guidelines for animal health and updating case management guidelines for human health. This subcomponent will also support strengthening IPC capacities at health facility level through training of personnel and procurement of IPC commodities. Community engagement and risk communication activities will also be included in this subcomponent. Finally, this subcomponent will finance research in priority areas for development and innovation in emergency preparedness and response.

Component 4: Program Management and Institutional Capacity (US$3.50 million).

13. This component will support the implementation of project activities, coordination, and management by (a) supporting Project implementation, coordination, and management including: (i) procurement, FM, and environmental and social management; (ii) Training for the PIU and the PFMU; (iii) Training for staff of the MoH, NPHIL, MoA and EPA; and (iii) Operating Costs; and (b) supporting Project M&E including bi-annual performance reviews, and assessment of the implementation of IHR and PVS capacities through JEEs and other tools.

14. **Component 5: Contingent Emergency Response Component (CERC) (US$0.00).** This component will be activated as needed based on the established procedures described under the MPA.

B. Project Geography/Areas of Intervention of the Project

15. Liberia covers 111,369 square kilometers and is administered through 15 counties. The Project will be implemented nationwide.

C. Project Beneficiaries

16. The project will benefit the entire population of Liberia, estimated at 5,302,681 people in 2022.

D. Project Costs

Table 5.2. Budget Allocation by Project Component

Project Components	**Cost** (US$ million)
Component 1: Prevention of Health Emergencies	2.00
Component 2: Detection of Health Emergencies	7.50
Component 3: Health Emergency Response	5.00
Component 4: Program Management and Institutional Capacity	3.50
Component 5: Contingent Emergency Response Component (CERC)	0.00
Total	**18.00**

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

17. **The proposed operation will be implemented by the MoH, NPHIL, MoA, and EPA.** A Project Steering Committee (PSC) chaired by the Minister of Health will be established to oversee Project implementation. At the start of the Project, the PSC will hold monthly meetings and quarterly after six months of project effectiveness. For day-to-day management and coordination of Project activities, the existing PIU under the MoH will be responsible for implementation. Given the PIU's expertise in the implementation of World Bank-financed projects on preparedness and response, the existing positions will be largely maintained with additional positions based on need. In this regard, the current functional structure of the PIU will be retained. The technical directorates and units at the MoH, NPHIL, MoA, and EPA will be fully responsible for implementing activities under the project as provided in the Financing Agreement, POM, and AWP/B of the Project. More details will be provided in the POM.

B. Monitoring and Evaluation

18. **The PIU at MoH, working through the MoH, NPHIL, MoA, EPA, and the Ministry of Finance and Development Planning will be responsible for monitoring the implementation of Project activities.** This will include: (i) collecting and

analyzing data for the project's Results Framework; (ii) regular interaction with other development partners and stakeholders to ensure full alignment of activities under the project with activities supported by other development partners; and (iii) promoting synergies between this Project and the entire World Bank-financed portfolio in Liberia.

IV. APPRAISAL SUMMARY

Financial Management

19. FM activities under the project will be guided by the FM Manual for World Bank IPF Operations; and the FM in World Bank IPF Operations (Catalogue Number OPCS5.05-GUID.02). The PFMU will provide leadership on all the FM aspects of the project. In this regard, the FM Officer at the PIU will be guided by the PFMU. Through the PFMU, appropriate internal controls and flow of funds arrangements will be instituted to ensure that project funds are used for the intended purposes. The Project will have its DA at a commercial bank for the receipt of funds, and this account will be managed by the PFMU. The Internal Audit Section within the PFMU will be responsible for the internal audit of the project and will collaborate with the Internal Audit Agency. The PFMU will ensure that unaudited IFRs are submitted to the World Bank 45 days after the end of each quarter throughout the life of the project. The General Auditing Commission (GAC) will be responsible for ensuring compliance to the existing fiduciary arrangements by undertaking regular independent external audits. The GAC is expected to provide audited financial statements for the project to the World Bank within six months after the end of each fiscal year, and at the end the project. The FM risk is rated **Substantial**.

Procurement

20. The World Bank's Procurement Regulations for IPF Borrowers, dated July 1, 2016 (revised in November 2017, August 2018, November 2020, and September 2023) will be used to guide the procurement of good and services under the project. The Project will also be subject to the World Bank's Anticorruption Guidelines, dated October 15, 2006, revised in January 2011, and as of July 1, 2016. The procurement procedures under the proposed Project will be the same as the arrangements under the existing World Bank financed projects under the MoH. However, a procurement capacity assessment was conducted during project preparation which identified potential risks and mitigation measures. There are currently two procurement officers working under the PIU, who will be supported by two procurement assistants. The two officers are familiar with World Bank Procurement Regulations and one of them will be responsible for procurement activities under the proposed Project. The Project will use STEP for the planning, submission, review, clearance, and tracking of all procurement transactions during implementation. The PPSD previously prepared by the PIU was revised to reflect the targeted activities and markets under the Project. In addition, a procurement plan for the first eighteen (18) months of the project has been prepared and approved. Subject to applicable thresholds, all procurements above the approved thresholds will be prior reviewed by the World Bank and those below the thresholds will be post-reviewed. The procurement risk is rated Substantial with a residual **Moderate** risk.

Environmental and Social

21. The Project is prepared under the World Bank's ESF. The following ESS are relevant: ESS1, ESS2, ESS3, ESS4, ESS5 and ESS10. The environmental risks associated with the Project are considered **Substantial** and include the generic risks associated with civil works (waste, dust, emission, occupational health and safety, and SEA/SH) and the potential exclusion of vulnerable or disadvantaged groups. Although the main long-term impacts are likely to be positive, it is noted that the laboratories will be supplied with reagents, chemicals, and equipment that may constitute medical waste once used. To minimize this, the proper storage, handling, use, and disposal needs to be carefully incorporated into the design to minimize the impact on both the environment and communities. The PIU has experience with the environmental and social risk management and monitoring requirements under the ESF. Currently, the PIU has one social specialist. For the purposes of strengthening the capacity, an environmental and a social assistant will be hired, respectively. Civil and construction works will be monitored through the various instruments that have been prepared (ESMF with LMP and SEP)

by the Project with support from the MoH, NPHIL, MoA, and the EPA. The site-specific ESMPs will be required for each activity involving civil works. The Project will also take advantage of their existing National Healthcare Waste Management Plan and the GBV SEA/SEAH Plan, developed during the COVID 19 Project, which will be updated to include the activities of this Project.

ANNEX 6: Financial Management and Disbursement

1. As part of the Project preparation, an FM assessment of the proposed PIUs was conducted for Cabo Verde, Guinea, Liberia, and WAHO, a specialized institution of ECOWAS. The objective of the FM assessment was to determine whether the respective selected PIUs have adequate FM arrangements to ensure that: (i) Project funds will be used for purposes intended in an efficient and economical way; (ii) the Project financial reports will be prepared in an accurate, reliable, and timely manner; (iii) the Project's assets will be safeguarded; and (iv) the Project is subjected to a satisfactory auditing process.[83] The review of existing FM systems included budgeting, staffing, financial accounting, financial reporting, fund flow and disbursements, and internal and external audit arrangements.

2. FM arrangements are in place and meet the World Bank's minimum requirements under World Bank IPF Policy, and therefore are adequate to provide, with reasonable assurance, accurate and timely information on the status of the Project required by World Bank (IDA). The overall FM residual risk rating is *Moderate* for the IAs in Cabo Verde, Guinea, and ECOWAS (WAHO), and *Substantial* for Liberia.

(i) Budgeting Arrangements

3. The PIUs will each prepare a proposed draft consolidated AWP/B in accordance with ToRs acceptable to the World Bank not later than September 30 of each calendar year. The AWP/B will take into account comments from the World Bank before finalizing and be approved by respective PSCs before submission to the World Bank not later than November 30 of each calendar year throughout the implementation of the Project.

4. The implementing entities will monitor the Project's AWP/B execution with the Project accounting software in accordance with the budgeting procedures specified in the FM manual of procedures, and they will report on variances along with submitting the semi-annual unaudited IFRs. The budgeting system will need to forecast for each fiscal year the origin and use of funds under the Project. Only budgeted expenditures will be committed and incurred to ensure that resources are used within the agreed-upon allocations and for the intended purposes. The semi-annual IFRs will be used to monitor the execution of the AWP/B.

(ii) Accounting Arrangements

5. **Accounting policies and procedures, and information system.** Overall, accounting procedures are adequate for the selected Project implementing entities of the three countries, and ECOWAS (WAHO). All the four selected entities in Cabo Verde, Guinea, Liberia, and ECOWAS (WAHO) will update the configuration of the existing accounting software for the new project, not later than three (3) months after project effectiveness date. Any new FM staff in each Project implementing entity will be trained to be conversant with the accounting software. The existing FM manual of procedures in use in each selected implementing entity for any World Bank financed projects will be updated within three (3) months after project effectiveness date to consider the new Project.

6. **Accounting staff.** To strengthen the accounting staffing arrangements in the selected Project implementing entities for the three participating countries, and WAHO (ECOWAS) several actions are recommended. All accounting staff will be trained in World Bank FM and Disbursement procedures as well as in the use of the Project accounting software.

Regional level:

[83] The FM assessment was carried out in accordance with the Financial Management Manual for World Bank-Financed Investment Operations effective on the 1st March 2010, and reissued on the 10th of February 2017, and the supporting guidelines.

- ***ECOWAS (WAHO)***: No need to recruit additional FM staff. The ToRs of the current staff under the ongoing (P150080 – SWEDD 1 and P154807 – REDISSE) will be updated to include the new Project, within three (3) months after effectiveness.

Country level:

- ***Guinea***: The PCU/PRSCS will recruit four (5) accountants for the new regional sub-PCUs, within four (3) months after effectiveness.
- ***Liberia:*** No need to recruit additional FM staff. The ToRs of the current staff under the ongoing World Bank financed projects will be updated, within three (3) months after effectiveness, to include the new Project.

7. **Accounting standards and basis.** The PIU in Liberia will follow the adapted Cash Basis International Public Sector Accounting Standards by the Government of Liberia, while the PIUs in Cabo Verde, Guinea, and at ECOWAS (WAHO) will use the current SYSCOHADA accounting system customized for African francophone countries.

(iii) ***Internal Control and Internal Audit Arrangements***

8. **Internal controls.** The internal control procedures will be documented in the FM manuals of procedures for each of the Project implementing entities and their POMs, taking into consideration gaps in their existing FM Manuals/Regulations to ensure that Project FM arrangements are in line with the Financing Agreements. These efforts will ensure that the new Project has an effective internal control system covering the procedures required to support activities under different components, including those that will be carried out with subnational and local actors. A review of the internal control systems noted no major internal control or accountability issues.

9. **Internal audit.** Robust internal audit arrangements are in place in each of the four selected implementing entities. Each of the four selected implementing entities will need to include in the AWP/B of its current internal audit team the activities of the new Project within three (3) months of project effectiveness date.

(iv) ***Governance and Anti-Corruption Arrangements***

10. All country, continental, and regional implementing entities will follow their institutional rules/regulation/ guidelines/policies and procedures. FM arrangements will ensure that there are internal control systems in place and audits conducted to prevent and detect fraud and corruption. Transparency and accountability are highly encouraged by putting the Project budget and audited financial statements on the Project implementing entity's websites where applicable. Complaint-handling mechanisms should also be set up by the Project implementing entities so that beneficiaries who are not receiving services as planned have a mechanism to raise their complaints and ensure that they are followed up and addressed. This will involve putting a system in place to record all complaints received, direct them to the person responsible for addressing them, and record when a response is sent to the complainant. The Project must also comply with the World Bank Anti-Corruption Guidelines.

(v) ***Funds Flow Arrangements***

11. **Designated and Project Accounts.** The four selected implementing entities will open segregated DAs. In Guinea, the DA will be opened at the central bank of Guinea in US dollars, and a Project Account in GNF will be opened in a commercial bank under terms and conditions acceptable to the World Bank. At ECOWAS (WAHO), the DA in West African Franc (XOF) will be opened at the Central Bank (*Banque Centrale des Etats de l'Afrique de l'Ouest,* BCEAO), and the PIU will open in a commercial bank a Project Account, under terms and conditions acceptable to the World Bank, which will be managed by the FM Unit with signatories of the Project Coordinator and the Project FMS. The PIU in Cabo Verde will open the DA at the central bank of Cabo Verde in US dollars. Finally, in Liberia, the DA will be opened at a commercial bank acceptable to the World Bank in US dollars. The signatories to these bank accounts should be in line with the FM manuals of procedures of the respective implementing entities. Payments of eligible expenditures can be made from

either the DA or the Project operational accounts.

12. **Disbursements.** All Project implementing entities in Phase I countries and at ECOWAS (WAHO) will access funding from the World Bank using the disbursement methods described in the World Bank Disbursement Handbook (that is, advance, direct payment, reimbursement, and special commitments). Detailed disbursement procedures will be documented in the FM manuals of procedures. Upon Credit/Grant effectiveness, each entity will be required to submit a withdrawal application for an initial deposit to the DA, drawn from the IDA Credit/Grant, in an amount to be agreed to in the DFIL. Further deposit of funds from IDA to the DAs will be made upon evidence of satisfactory utilization of the advance, reflected in SOEs.

13. **If ineligible expenditures are found to have been made from the Designated and/or Project Accounts, the Recipient will be obligated to refund the same.** If the DA remains inactive for more than three months, the World Bank may reduce the amount advanced. The World Bank will have the right, as reflected in the terms of the Financing Agreement, to suspend disbursement of the funds if significant conditions, including reporting requirements, are not complied with. Additional details regarding disbursement will be provided in the disbursement letters.

(vi) ***Financial reporting arrangements***

14. The project implementing entities in Cabo Verde, Guinea, and Liberia will prepare quarterly unaudited IFRs in form and content satisfactory to the World Bank, which will be submitted to the World Bank within 45 days after the end of the calendar quarter to which they relate. ECOWAS (WAHO) prepare its IFRs on a semiannual basis which will be submitted to the World Bank no later than 45 days after the end of each calendar semester. The frequency, formats, and contents of the IFRs have been agreed between the World Bank and the national implementing and regional entities. The contents of the IFR for all implementing entities will include the following information to account for Project funds:

- Statement of Sources and Uses of Funds.
- Statement of Uses of Funds by Project Activity/Component.
- DA Activity Statement.
- Bank statements for both the Designated and Project Account and related bank reconciliation statements.
- Summary statement of DA expenditures for contracts subject to prior review.
- Summary statement of DA expenditures not subject to prior review.

15. The national PIUs in Cabo Verde, Guinea, and Liberia and ECOWAS (WAHO) will also prepare annual financial statements for the Project within three (3) months after the end of the accounting year, and these statements will comply with respective accounting standards and World Bank requirements. The audited financial statements will be required to be submitted to the World Bank within six (6) months after the end of the fiscal year.

(vii) ***External audit arrangements***

16. **Cabo Verde, Guinea, Liberia, and ECOWAS (WAHO) will use private audit firms that are acceptable to the World Bank**; the Project will meet the cost of hiring a private audit firm. All audits will be carried out in accordance with International Standards on Auditing. ToRs for each project implementing entity will be agreed with the World Bank. The external auditors must be appointed within six (6) months of the project's effectiveness date, to audit 2-3 years of the project's accounts. Audit reports for the Project accounts, together with management letters, should be submitted to the World Bank within six (6) months after the end of the government's fiscal year (December 31). The audit reports will be publicly disclosed by the World Bank in accordance with the World Bank disclosure policy. In addition, in accordance with the World Bank Policy on Access to Information, the World Bank requires the implementing entities to disclose the audited financial statements in a manner acceptable to the World Bank. A review of the audit reports of each of the Project

implementing entities (as documented under the internal control assessment reported above) found no major accountability and internal control issues that needed to be addressed for Phase I countries and ECOWAS (WAHO).

17. Table 6.1 presents the FM Action Plan, with the entity responsible for each action and the completion date.

Table 6.1. Financial Management Action Plan

Issue/topic	*Action recommended*	*Responsible body/person*	*Completion status/date*
All countries, and ECOWAS (WAHO)			
External Auditing	Recruit an external auditor, based on ToRs satisfactory to the World Bank	Respective governments/ECOWAS	Within six (6) months after effectiveness
Information system accounting software	Upgrade the accounting software to include the proposed project	Respective governments/ECOWAS	Within three (3) months after effectiveness
Internal Auditing	Update the current annual audit work plans to integrate the review of the new Project	Respective governments/ECOWAS	Within three (3) months after effectiveness
FM manual of procedures	Update the Project existing FM manuals to include the proposed project	Respective governments/ECOWAS	Within three (3) months after effectiveness
Specific			
Guinea			
Staffing	Recruit four (5) accountants for the new regional sub-PCUs, based on ToRs satisfactory to the World Bank	Government of Guinea	Within three (3) months after effectiveness
	Recruit or appoint an additional procurement specialist for the PCU	Government of Guinea	Within three (3) months after effectiveness
Liberia			
Staffing	Update the ToRs of existing PIU staff to include the new Project	Government of Liberia	Within three (3) months after effectiveness
	Recruit, assign or appoint to the PIU a technical coordinator, an M&E specialist, and two procurement assistants, based on ToRs satisfactory to the World Bank	Government of Liberia	Within two (2) months after effectiveness
	Recruit an FM Officer, based on ToRs satisfactory to the World Bank	Government of Liberia	Within three (3) months after effectiveness
ECOWAS (WAHO)			
Staffing	Update FM team TORs to include the management of the new project	ECOWAS	Within three (3) months after effectiveness

18. **Implementation Support Plan.** For FM, implementation support missions will be carried out twice a year during the first twelve months following the effectiveness, then for Liberia, based on the substantial FM residual risk rating, the subsequent ISMs will be carried out twice a year. For Cabo Verde, Guinea, and ECOWAS (WAHO), based on the moderate FM residual risk, ISMs for FM will be carried out at least every twelve months. Implementation support will also include desk reviews, such as the review of IFRs and audit reports. In-depth reviews and forensic reviews may be done where deemed necessary. The FM implementation support will be an integral part of the Project's implementation reviews.

ANNEX 7: Climate Vulnerability and Contribution to Climate Adaptation and Mitigation

1. **The MPA Program was screened for short- and long-term climate change and disaster risks.** The Program covers AFW countries which are highly vulnerable to climate change and hazards. Temperatures in both Western and Central regions of Africa have shown increasing trends. Compared to their respective regional average temperature in the period 1961–1990, the temperature in 2021 was 1.39°C and 1.01°C higher in West Africa and Central Africa, respectively.[84] Projections show an increase in temperature in West Africa by 3–6°C in 2100 compared to the late twentieth century,[85] and an increase in temperature between 1–3°C in Central Africa by 2100.[86] Precipitation varies , with West Africa experiencing shorter rainy seasons, and some countries in Central Africa experiencing higher than average rainfall in 2021.[87] Projections also show an increased frequency in extreme rainfall events in West Africa. Countries in Phase I are highly vulnerable to flooding, droughts, and extreme temperatures, as demonstrated through a series of recent climate events which affected large swaths of the population.

2. **The impact of climate and geophysical hazards on Program activities is expected to be moderate across all countries but could have far-reaching consequences for the Program's targeted beneficiaries.** Heavy precipitation and severe landslides may limit both the ability of beneficiaries to access health facilities and the ability of community workers to travel to remote areas to provide services, which increases the risk. Extreme temperatures may induce heat stress among beneficiaries and can impact productivity levels of health care workers/midwives and community leaders as well. These climate exposures will also impact the supply chain for medicines and essential health services commodities through heat exposure or transport disruption, which can increase morbidity and mortality. Finally, there is an increased risk of sexual abuse, GBV, and early marriage during climate emergencies. Stressors related to storms/flooding, such as financial instability and loss of possessions, may also exacerbate existing violence in the home.

3. **The vulnerability to climate hazards has impacted human health in the three proposed countries for Phase 1 of the Program. Guinea**: Malaria is a leading cause of mortality in Guinea, responsible for almost 30 percent of the deaths of children under five. Mosquitoes carrying yellow fever, chikungunya, and Zika virus are also prevalent. In areas along the coast and in the northeast, higher temperatures will limit mosquito survival and thus could reduce malaria transmission risk, even as soon as 2030. In other areas, such as the Fouta Djallon and Guinea highlands, transmission may shift to higher elevations. Climate change may also indirectly impact a range of infectious diseases such as Ebola, Lassa fever, Rift Valley fever, avian flu, anthrax, and zoonotic tuberculosis. As climate and other factors drive people to clear more land for agriculture, increased contact between humans and animals (both livestock and wildlife) becomes more likely. Food insecurity can push households to hunt for bushmeat as a source of animal protein, increasing risk of contracting Ebola or other zoonotic diseases through contact with reservoir species (e.g., bats). Changes in rainfall distribution and frequency, and rising temperatures may also impact the population density, migration, habitat use, reproduction, and feeding behaviors of species suspected to be disease carriers. **Liberia**: Increased temperatures will also be a problem, resulting in physiological stress and resulting impacts to productivity and epidemiological implications. Dengue fever is already present in neighboring Cote d'Ivoire and is likely to expand into Liberia as temperatures increase. Yellow fever is also likely to increase in wet weather; meningitis, prevalent in hot, dry months may expand in the country's inland zones. Respiratory diseases may be aggravated by heat stress and inhalation of pollutants from stagnant air. For Liberia, the annual distribution of days with a high heat index provides insight into the health hazard of heat. While high temperature alone

[84] World Meteorological Organization. 2021. State of climate in Africa. Accessed here: https://library.wmo.int/doc_num.php?explnum_id=11512.
[85] CILSS (2016). Landscapes of West Africa – A Window on a Changing World. U.S. Geological Survey EROS, 47914 252nd St, Garretson, SD 57030, United States.
[86] Hassan, M., Saif, K., Ijaz, M. S., Sarfraz, Z., Sarfraz, A., Robles-Velasco, K., and Cherrez-Ojeda, I. 2023. Mean Temperature and Drought Projections in Central Africa: A Population-Based Study of Food Insecurity, Childhood Malnutrition and Mortality, and Infectious Disease. *Int J Environ Res Public Health*Feb 2, 202320(3): 2697. doi:10.3390/ijerph20032697. PMID: 36768062; PMCID: PMC9915533.
[87] World Meteorological Organization. 2021. State of Climate in Africa.

can be compensated for by evaporative cooling such as from transpiration, if the air is nearly saturated with moisture (humidity), then cooling potential is reduced and the apparent temperature increases. Increased health threats can be projected and monitored through the frequency of tropical nights (>20°C). **Cabo Verde:** Due to its location and geography, Cabo Verde is exposed to volcanic eruptions, droughts, hurricanes, tropical storms, landslides, and flash floods. In addition, rapid rural-urban migration, continuous land degradation, high indebtedness, and persistent poverty have magnified Cabo Verde's vulnerability to natural hazards. Climate change is expected to further intensify floods and droughts, as well as impact sea-level rise, sandy beach erosion and coral reef bleaching. In this context, increasing resilience to such shocks and promoting proactive climate adaptation actions are becoming urgent priorities. In the context of a more comprehensive approach to disaster risk management (DRM) and climate-related risk management, the World Bank initiated a strategic policy dialogue to support the Government of Cabo Verde in identifying a set of policy reforms to strengthen the current disaster risk management system. A World Bank DRM Development Policy Financing operation with a Catastrophic Deferred Drawdown Option (Cat DDO) was designed to provide Cabo Verde with immediate liquidity in case of a disaster caused by natural hazard(s), and also supported a comprehensive DRM reform program. These reforms build upon analytical work and policy implementation efforts from various sectors, thus complementing the overall World Bank lending portfolio. The Program will build upon and leverage the previous work on mitigation and adaptation.

4. **The Program responds to threats posed by climate change in several ways.** Given the high vulnerability of the target population to impacts from climate and geophysical hazards, project activities have made provisions to mitigate the risks. The Program design includes specific activities to help alleviate potential risks as laid out below:

Table 7.1. Climate Action and Contribution to Adaptation and Mitigation

Component 1: Prevention of Health Emergencies (US$28.83 million)
Subcomponent 1.1: Health Security Governance, Planning, and Stewardship and 1.2 Scaling up One Health Agenda and combatting AMR
This subcomponent will strengthen multisectoral planning for health emergencies and will explicitly incorporate actions and contingencies for climate-related shocks in each activity including the legal analysis of all sectors, arrangements, and instruments for the National IHR focal point, the national action plan for IHR, and the systematic assessment of gender gaps and development of the gender equity plan for health emergencies. This will build legal and policy foundations to support the health system's resilience to climate change. Climate shocks are one of the fundamental health emergencies which the subcomponent aims to address. The subcomponent will also support three climate-specific activities in addition to the overall intentional focus on climate in the subcomponent: (i) develop a climate and health adaptation strategy; (ii) develop action and contingency plans for climate change related disasters; (iii) develop a national plan for climate change resilient healthcare infrastructure. **(adaptation)**
Component 2: Detection of Health Emergencies (US$73.89 million)
Subcomponent 2.1: Collaborative Surveillance
This subcomponent will explicitly include protocols for incorporation of climate-sensitive diseases in Program Phase I countries context (primarily vector- and water-borne diseases) to strengthen surveillance and laboratory diagnostics for these diseases. In addition to the overall intentional focus on climate in the subcomponent, it will also finance the development of a surveillance platform for monitoring climate change-related hazards. **(adaptation)**
Subcomponent 2.2: Laboratory Quality and Capacity
Rehabilitation of diagnostic centers will include measures to protect buildings from these risks such as extra securing of roofs, doors, and windows and appropriate drainage to reduce the impacts of floods. These measures will go beyond standard practice to ensure the buildings are equipped to be resilient to Program Phase I countries' storm and flooding risks. **(adaptation)** To support the rehabilitation of diagnostic centers, a consultant will be hired to conduct an energy efficiency assessment to ensure that all electrical systems and equipment in buildings, are at least 20 percent more energy-efficient than standard practice. **(mitigation)**

Subcomponent 2.3: Multi-disciplinary Human resources for Health Emergencies
This subcomponent will undertake measures to ensure the health workforce is trained and adequate to respond to climate shocks: (i) health workforce mapping will include analysis of needs based on current and projected climate vulnerability; (ii) development of the national Human Resources for Health (HRH) action plan will include specific analysis and planning for climate shocks and climate vulnerability; (iii) establishment of programs for adequate human resources will extend to human resource needs for adaptation to climate change and climate shocks; (iv) the multisectoral surge capacity plan will include ensuring such capacity to respond to climate shocks; and (v) enhance workforce training, motivation, and retention will train additional participants through the FETP, which includes modules on climate emergency preparedness and response as well as vector-borne and water-borne diseases, which are climate-sensitive in Program Phase 1 countries. There will be a focus on participation of female FETP trainees, including on climate emergency preparedness and response and the health impacts of climate change. These activities will help ensure the health workforce's resilience to climate change. **(adaptation)**
Modules on climate emergency preparedness and response will be incorporated into frontline health worker trainings. Incorporation of these modules in frontline health worker trainings will help improve the resilience of health service delivery to climate shocks. It will also increase health care workers' competency levels on climate change and health promotion/prevention activities to raise awareness among patients, as well as to improve their coping strategies for heat stress and exhaustion during hotter days. The training will also include the development of climate and health modules, including topics such as the nutritional impact of climate on crops; vector- and water-borne diseases; planning for climate-related extreme weather events; and the impact of household cooking technologies on climate and health to be delivered to health workers and midwives. **(adaptation)**
Health worker training on prevention of diarrheal and vector-borne diseases. Through expansive, competency-based capacity building of health staff, the project would incorporate training on climate risks in health care facilities. The training will focus on anticipating and activating prevention measures to minimize increases in diarrheal diseases following weather events. The provision of these services would contribute to better treatment of diarrhea and other climate-sensitive, vector-borne diseases among households with pregnant women and children under two years old. **(adaptation)**
Health worker training on nutrition and food security, including their climate aspects. Subcomponent 2.3 will support competency-based training of health care workers in the provision of food security and nutrition support, and in the climate aspects of undernutrition and food insecurity, to improve the adaptive capacity of populations. Provision of these services would contribute to greater resilience in the face of the adverse health and nutritional consequences of climate change. **(adaptation)**
Component 3: Health Emergency Response (US$58.58 million equivalent)
Subcomponent 3.1: Health Emergency Management
This subcomponent will directly support emergency preparedness and response capacity for climate shocks and climate-sensitive diseases, specifically: (i) cross-sectoral emergency preparedness and response plans for climate shocks; (ii) regular testing, assessment, and improvements of plans will also cover climate shocks; (iii) expansion of health system surge capacity will include mechanisms to expand this capacity in the event of climate shocks and climate-sensitive disease outbreaks; (iv) sharing of best practices will include explicit attention to those covering climate shocks and climate-sensitive diseases; and (v) establishment of financing mechanisms for PHEs will incorporate climate shocks and climate-sensitive diseases. **(adaptation)**
Subcomponent 3.2: Health Service Delivery for Health Emergencies
This subcomponent will also explicitly cover continuity of health service delivery during climate shocks by assessing the ability of each activity to cover and respond to climate shocks and incorporating mechanisms within each, in particular: (i) national critical care guidelines for priority events will include care guidelines for climate shocks and climate-sensitive diseases; (ii) the national patient referral and counter-referral system will include referrals for conditions resulting from climate shocks and climate-sensitive diseases as well as referrals during climate shocks; (iii) the package of services and guidelines on essential health services in emergencies will include services to be delivered and guidelines for service delivery during climate shocks.; (iv) establishment of national standards for a safe built environment will help reduce the spread of water-borne diseases, which are climate-sensitive in Program Phase 1 countries; and (v) the establishment of a national IPC program will also help prevent the spread of water-borne diseases. These actions will help ensure health service delivery is resilient to the impacts of climate change, particularly climate shocks. **(adaptation)**

The Project will use climate-shock-resilient building design for the design and construction of health facility infrastructure. The Project will finance TA to develop climate-shock-resilient design to ensure the hospitals are able to serve patients in highly vulnerable geographies and built to withstand the impact of Program Phase 1 countries' extreme climate events. This design will go beyond current national standards of construction to ensure that specific adaptation measures are integrated in the design. **(adaptation)**.
Aligned with Criteria 9.1 of the 'Buildings, public installations and end-use energy efficiency' section of the of the Multilateral Development Bank Mitigation Finance Methodology,[88] the Project commits to adopting measures that substantially reduce net energy consumption, resource consumption, and CO_2e emissions of the health facilities, guided by EDGE Level 1 building Criteria for the design and construction of energy-efficient municipal health infrastructure. **(mitigation)**
This subcomponent will explicitly include RCCE for climate shocks and climate-sensitive diseases through the inclusion of specific modules and materials. **(adaptation)**
Digitization of health sector processes will help to respond quickly and flexibly to climate shocks, including climate-sensitive diseases, storms, and the health impacts of floods. All activities under this subcomponent will explicitly incorporate monitoring of climate-sensitive diseases and climate shocks, including inclusion of measures to monitor these in platforms, explicit content on these in protocols policies, and systems. This will help the health system to improve resilience to climate change and shocks. **(adaptation)**
Component 4. Program Management and Institutional Capacity (US$16.70 million equivalent)
This component will monitor the Project's climate mitigation and adaptation aspects and as such should be assessed at the same rate as the Project's other climate activities **(adaptation and mitigation).**

[88] AfDB et al. 2021.