



Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 24-Mar-2020 | Report No: PIDA28937



BASIC INFORMATION

A. Basic Project Data

Country Ghana	Project ID P173788	Project Name Ghana COVID-19 Emergency Preparedness and Response Project	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 24-Mar-2020	Estimated Board Date 20-Mar-2020	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Republic of Ghana	Implementing Agency Ghana Health Services, Ministry of Health	

Proposed Development Objective(s)

To prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Ghana

Components

Emergency COVID-19 Response
 Strengthening Multi-sector, National Institutions and Platforms for Policy Development and Coordination of Prevention and Preparedness using One Health approach
 Community Engagement and Risk Communication
 Implementation management and monitoring and evaluation and project management

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	35.00
Total Financing	35.00
of which IBRD/IDA	35.00
Financing Gap	0.00

DETAILS

World Bank Group Financing



International Development Association (IDA)	35.00
IDA Credit	35.00

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

A. Country Context

- 1. The global COVID-19 outbreak is expected to have a significant negative impact on Ghana’s economy.** For example, the reduction in global air travel is expected to result in a decline in Ghana’s forex reserves. The economic situation is expected to be deteriorated with more restrictions of non-essential travels, which is part of the President’s COVID-19 disease response plan. In addition to the direct impact of COVID-19, the anticipated slowdown in the global economy will likely reduce trade and disrupt global manufacturing supply chains that involve Ghana. The effects of a pandemic-driven global economic downturn are impossible to predict. However, highly affected countries are experiencing dramatic reductions in economic activity, with a high risk of damage to financial markets.
- Ghana forecasts a reduction in trade volumes and values both domestic and international. The country is already seeing significant reduction in trade volumes and values with China which constitutes the highest of imports US\$ 2,272.6 million (3.64 percent of GDP) and the second highest of Ghana’s exports US\$ 2,032.27 million (3.26 percent of GDP). The significant decline in global crude oil price will reduce projected petroleum revenues for 2020. Ghana had programmed a petroleum price of US\$ 62.60 per barrel in the 2020 Budget. As at March 2, 2020 petroleum prices were down to US\$ 51.8 per barrel. Crude oil price further declined to US\$ 36 per barrel on March 9, 2020. At an average price of US\$ 50.00 per barrel for 2020, government could lose about US\$ 484 million in petroleum receipts. This shortfall increases to US\$ 936.4 million if crude oil price declines to US\$ 30 per barrel.
- Given the global downturn the positive economic forecast of 6-8 percent between 2019 and 2023 in the recently completed SCD may require major modification. The SCD had projected that non-oil growth, the primary driver of overall growth is projected to average 6.5 percent over the medium term (2019-2023), significantly higher than the 3.8 percent over 2014-2018. Non-oil growth is expected to be driven by the agriculture sector as the Government “Planting for Food and Jobs” program begins to take effect, and increased investment into agribusiness. Yet, the informal sector



and self-employment continue to absorb a large share of the labor supply, which put them vulnerable to shocks. Fiscal consolidation will continue to keep the fiscal deficit contained between 3 and 4 percent of GDP over until 2023. However, the revenue side of fiscal policy needs to gain greater than proportionate traction under the current circumstance. Tax revenue is estimated to be five percent of GDP below potential, with tax exemptions of around 5.2 percent (World Bank PER, 2016). With elections scheduled for 2020, and given experience of fiscal election cycles, the challenge of keeping fiscal policy on track is likely to increase.

4. The socioeconomic impact on the population will be significant. Ghana had achieved significant poverty reduction in the last 25 years. Based on the measure of US\$ 1.90 per day, poverty rates declined from 47.4 percent in 1991 to 13.6 percent in 2012 – much lower than not only the mean poverty rate of Sub-Saharan Africa, but also below that of lower-middle income countries (LMICs). The growth model that delivered large overall gains in income and declines in poverty in the past had also left significant parts of the country behind. More than 23 percent of Ghana’s population still live below the poverty line, with the poor concentrated in the five northern regions and the Volta region. In many rural areas poverty rates have fallen relatively slowly and remain above 50 percent in the Northern, North-east, Savannah, Upper West and Upper East regions. Approximately half the workforce is employed in the agriculture and agribusiness sector where skills, productivity and incomes remain low: self-employed agricultural workers continue to make up most of the poorest 40 percent of the population. The cocoa sector, traditionally a source of higher incomes, has been losing market share in recent years and now faces an uncertain future due to climatic factors, the poor underlying quality of tree stock, issues with land tenure and land degradation.
5. Moreover, rapid urbanization has brought rising disparities within cities. Even though urban poverty rates significantly dropped over this period, the number of urban poor has not been reduced much. In fact, the number of the poor increased in urban areas in the Eastern, Volta, and the northern parts of the country. Even in Accra, which successfully absorbed massive waves of rural-urban migration, poverty varies greatly between neighborhoods. Greater Accra saw a large reduction in poverty rates and in the absolute number of urban poor, however, poverty has become more concentrated in certain areas. Poverty is more prevalent in slums of lower elevation, where communities have higher fertility, lower school attendance, and very low access to sanitary services and are prone to floods.

B. Sectoral and Institutional Context

6. The health outcomes in Ghana have generally been positive but with some challenges. Maternal deaths declined from 580 per 100,000 live births in 2007 to 310 per 100,000 live births in 2017. In 2017, 98 percent of pregnant women visited a skilled health personnel for antenatal care (ANC) at least once, 89 percent at least four times. Institutional delivery has significantly increased from 54 percent in 2007 to 79 percent in 2017. Seventy-nine percent of the last live births and stillbirths were delivered by a skilled provider. Eighty-four percent of women had a postnatal check during the first 2 days after the most recent birth or stillbirth. Neonatal, infant and under-five mortality have been declined in the past decade.
7. **The burden of disease and coverage of treatment and prevention interventions has shown mixed results.** DPT3 coverage is over 95 percent. Other vaccination coverages are below 70 percent. While



prevalence is low, progress in pediatric HIV and AIDs response is modest. Tuberculosis case detection and cure rate is also low. Micronutrient deficiencies resulting in anemia and obesity in children (malnutrition 24 percent, stunting 8 percent) and in pregnant women puts them at risks of death or under-development. Under-nutrition negatively affect the growth and cognitive capacity of children. Generally, access to water and sanitation is poor leading to a high prevalence of intestinal worms, meningitis outbreaks, dysentery and diarrheal disease. On average only 14.9 percent of the population had access to improved sanitation in 2014–2016, far below any of Ghana’s structural or aspirational peers. The 2018 holistic sector assessment using a WHO approved tool showed that the health care system remains significantly weak. The UHC Roadmap 2020-2030 indicated that the sector is inadequately resourced to provide the services anticipated to achieve the goals set. The assessment showed that human resources are poorly distributed across country. Ghana’s current health expenditure was 4 percent of GDP or US\$ 68 per capita in 2016. Overall, government prioritization on health fell from 14 percent, or US\$ 58.4 per capita in 2011 to 7 percent in 2016, or US\$ 29.3 per capita.

8. **The Ebola outbreak in West Africa in 2014-2015 brought a sense of urgency to strengthen public health emergency preparedness and response.** COVID-19 has also raised the immediate need for strengthened health security as Ghana has already recorded 16 confirmed as of March 20, 2020. Ghana already has a network of laboratories from national to the district level and well-equipped laboratories at the Noguchi Memorial Institute for Medical Research (NMIMR), Kumasi Centre for Collaborative Research in Tropical Medicine (KCCR) and the National Public Health and Reference Lab (NPHRL). These have capacity to diagnose highly infectious pathogens. Yet, they face challenges including weak coordination mechanisms, absence or inadequately resourced treatment, quarantine and containment centers, irregular supply of reagents and other laboratory supplies, lack of a national regulatory legislation or policy that defines the role and responsibilities of laboratories and facilities at different levels in the health sector. The World Health Organization, the Centers for Disease Control, Atlanta, the Japanese Government and the World Bank have provided some support to strengthen the emergency preparedness and response systems. A lot more needs to be done to enhance capacity in the short to medium term.

9. **The Maternal Child Health and Nutrition Project (MCHNP; P145792) has provided support in building institutional capacity for emergency preparedness and response, yet, limited in its scope.** There is the Inter-Ministerial Coordination Committee (IMCC) made up of Ministries of Finance, Health, Local Government, Gender, Children and Social Protection, Information, Transport, Interior and Defense and Office of the President as the apex coordinating body for COVID-19 response. The Emergency Operations Center (EOC) was created with support from the MCHNP. The government has activated activities under the Emergency Operations Center (EOC) established with support from the MCHNP. These include risk communication, point of entry surveillance, laboratory diagnostics capacity building for case management and coordination of preparedness and response actions. Other partners such as WHO, the CDC-USAID, DFID-UK and the Japanese government contribute mainly to technical logistics and financial support. The anticipated scale of the COVID-19 outbreak can however not be contained without further strengthening of institutional and human resource capacity as an integral part of health systems strengthening efforts in alignment with prioritized interventions listed in the government’s UHC Roadmap.

10. **A Simulation Exercise (SIMEX) was conducted in Ghana on March 6-7, 2020 to test capacities,**



systems and mechanisms to respond to public health emergencies. The exercise exposed gaps and weaknesses that currently exist and help prioritize where to support the country's response efforts:

- (a) **Coordination:** Coordination, action and reporting mechanisms between health, security, customs and immigration authorities, EOC management and development partners need to be strengthened at the national, regional and district levels. The Points of Entry except the Kotoka International Airport are ill-equipped to support case surveillance. None had a satisfactory port health and holding room.
- (b) **Workforce development:** While national level staff are familiar with existing Standard Operating Procedures (SOP), International Health Regulations (IHR) 2005 and its requirements, service delivery, laboratory and surveillance information management staff need to be sensitized with the IHR guidelines and their requirement to ensure full-scale implementation. Staff at the community and district level for contact tracing and isolation management are yet to be identified and trained.
- (c) **Preparedness:** EPR plans are in place but implementation is fragmented and shows discrepancies in roll out. There is very limited capacity in key case management facilities identified, quarantine and containment facilities are not available or prepared for the anticipated emergency. There is a need for mapping, identification and equipping of isolation facilities and healthcare facilities across the country to be readied for outbreak response activities. There is a general stock out of Personal Protection Equipment (PPE), Infection Prevention and Control (IPC) and medical consumables.
- (d) **Emergency response operations:** The confirmation of the first two cases took over 24 hours to isolate the patients or initiate contact tracing. There was no emergency response scale in place. Not a single facility compliant to accept patients immediately. Procedures for correct use of Personal Protective Equipment (PPE) during emergency response at the subnational level need to be strengthened. SOPs describing clear lines of reporting were not in place. Flow of operational information between national and subnational levels needs to be strengthened. The national EOC and teams were unable to change the emergency response scale to handle the evolving scenario. Infection prevention and control measures need to be developed disseminated through easy/readable SOPs for PPE donning and doffing. COVID-19 specific drills and trainings through simulations need to take place at all levels. Resources, expertise and technical support are needed at all levels to undertake trainings at all levels.
- (e) **Risk Communication:** The adoption of risk communication guidelines needs to take place at all levels. Currently there are no policies, procedures and mechanisms to follow while engaging the public during an emergency.

11. Ghana's Emergency Preparedness and Response Plan (EPRP): The overall objectives of the strategic Preparedness and Response Plan for COVID-19 being prepared by countries around the world aim to: (a) slow and stop transmission, prevent outbreaks and delay spread; (b) provide optimized care for all patients, especially the seriously ill; and (c) minimize the impact of the epidemic on health systems, social services and economic activity. The EPRP, prepared by the Government of Ghana (GoG), has the objective to "enhance surveillance system and build response capacity to detect, contain, delay and respond to a possible COVID-19 outbreak in Ghana." The strategic objectives of the EPRP are to: limit human-to-human transmission; identify, isolate, and care for patients early; address crucial unknowns regarding clinical severity, extent of transmission and infection, treatment options, communicate critical risk and event information to all communities, and counter misinformation; and



minimize social and economic impact through multi-sectoral partnerships. To support these, the Ghana Plan relies on three pillars:

- (a) Leveraging international coordination to deliver strategic, technical, and operational support through existing mechanisms and partnerships;
- (b) Scaling up country preparedness and response operations; and
- (c) Accelerating priority research and innovation.

12. The GoG has conducted risk assessment and established alert levels designed to coincide with the ongoing stage of the COVID-19 outbreak. Annex 1 shows the summary of the definition of phases. It should be noted that while this phasing protocol has specific standards identified for declaration of each level, other unique factors may be present which might warrant variation from these standards in determining the appropriate level. As of March 20, 2020, Ghana has sixteen confirmed cases of COVID-19, which makes the country fall into Level 5 alert (highest).

13. **Links between economic effects of COVID-19 and the health sector in Ghana:** As mentioned above, an expected decrease in the availability of forex in the country may impact the country's ability to purchase essential medical commodities and drugs (insulin, antibiotics, etc.) on the global market. While the proposed Project will specifically address the emergency response to COVID-19, it should be noted that existing World Bank operations and financing mechanisms broadly will be used to strategically address gaps that may arise for the purchase of these essential commodities.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

14. The project development objective (PDO) is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Ghana.

Key Results

15. The PDO will be monitored through the following PDO level outcome indicators:

- (a) Diagnosed cases treated in the designated treatment centers per approved protocol (Percentage);
- (b) Designated acute healthcare facilities with isolation capacity (Number);
- (c) Confirmed COVID-19 cases that conducted contact tracing (Percentage); and
- (d) Country adopted personal and community non-pharmaceutical interventions.



D. Project Description

16. **The proposed Project was selected for COVID-19 financing because of the strategic place Ghana holds in global connectivity and travel, and the associated risks for the country.** Ghana is classified among 13 Priority-1 countries in the WHO Africa region for being at risk, based on flights and passenger volumes. As of March 20, 2020, a total of 16 cases have been confirmed in the country. There are also confirmed cases in Cote d'Ivoire, Togo and Burkina Faso, which share borders with Ghana and Nigeria which has high trade exchange with Ghana. The Bank received a request and the plan for US\$100 million from the Government of Ghana to help the country respond to the outbreak and mitigate related socioeconomic impact (See attached copy of EPRP as Annex 2). The scope and the components of this Project are fully aligned with the Bank's COVID-19 Fast Track Facility, using standard components as described in para 8 of the COVID-19 Board paper. The proposed Project complements the longer-term development work in the health sector, including the Maternal Child Health and Nutrition Project (P145792) which seeks to improve maternal and child health and nutrition outcomes, as well as the Emergency Preparedness and Response. The Contingency Emergency Response Component (CERC) of the Greater Accra Resilient and Integrated Development Project (GARID) (P 164330) has been triggered in response to COVID-19. The proposed Project will supplement the support from CERC for immediate response to COVID-19 as well as ensure longer-term systems strengthening for public health preparedness at both national and subnational levels. This project has triggered paragraph 12 of the Investment Project Financing Bank Policy.
17. **The proposed Project intends to fill critical gaps in implementing the EPRP, strengthen the prevention activities, rapid detection, preparedness and response to COVID-19 outbreak.** The finance under this Project will be utilized to enhance preparedness activities for COVID-19 and strengthen the health system both at the national and subnational levels. The project's objectives and design are in line with the broad objectives of the government's US\$ 100 million request. Given the allocation for Ghana from the COVID-19 Fast Track Facility is only US\$ 35 million, an additional US\$ 65 million has been activated through the GARID-CERC project. These will be aligned to the national plan but support critical activities up to the allocated amount for the project.
18. The project comprises four components.
19. **Component 1: Emergency COVID-19 Response (US\$ 21.5 million)**
20. **Sub-Component 1.1: Case Detection, Confirmation, Contact Tracing, Recording and Reporting (US\$ 4.5 million)**
21. This sub-component would help (i) strengthen disease surveillance systems at points of entry (POEs), public health laboratories, and epidemiological capacity for early detection and confirmation of cases; (ii) combine detection of new cases with active contact tracing; (iii) support epidemiological investigation; (iv) strengthen risk assessment; and (v) provide on-time data and information for guiding decision-making and response and mitigation activities. The project will support surveillance systems strengthening for emerging infectious diseases by using a risk-based approach. The surveillance system comprises the following components (i) disease reporting system for the priority infectious diseases; (ii) laboratory investigation of priority pathogens; (iii) community event-based surveillance; and (iv) contact tracing, rumor surveillance and verification.



22. Well-structured epidemiological studies and surveillance programs would be integrated with the disease control measures, which would be then adjusted and improved as new information becomes available. Strengthening animal and human disease surveillance and diagnostic capacity would be supported through the following activities: improving health information flow among relevant agencies and administrative levels; detection, reporting and follow-up of reported cases; public and community-based surveillance networks; routine serological surveys; and improving diagnostic laboratory capacity. Support would be provided to strengthen the network of the designated laboratories for COVID-19. With the existing Noguchi Memorial Institute for Medical Research (NMIMR) and the Kumasi Collaborative Center for Research (KCCR) would investigate pathogens under the One Health approach and lead infectious diseases research and development in the country.

23. Sub-Component 1.2: Containment, Isolation and Treatment (US\$ 12.7 million)

24. An effective measure to prevent contracting a respiratory virus such as COVID-19 would be to limit, as possible, contact with the public. Therefore, the project would support the government for implementation of immediate term responses, i.e., classic “social distancing measures” such as school closings, escalating and de-escalating rationale, in compliance with the IHR. A number of holding, isolation, quarantine and treatment centers have been identified across the country. This sub-component supports the leasing, renting, establishment and refurbishing of designated facilities and centers to contain and treat infected cases in a timely manner. Support would be provided to ensure the operations of effective case containment and treatment with IPC measures to be enforced at all time with necessary equipment, commodities and basic infrastructure. Psychosocial and essential social support would be provided to those who are in isolation and quarantine centers with consideration of gender sensitivity and special care for people with disabilities and/or chronic conditions. Additional trained health workers would be deployed to the designated isolation/treatment centers for COVID-19 case management, not to disrupt the general health services. It is important to clarify that the Bank will not support the enforcement of such measures when they involve actions by the police or the military, or otherwise that require the use of force. Financing would also be made available to develop guidelines on social distancing measures (e.g., in phases) to operationalize existing or new laws and regulations, support coordination among sectoral ministries and agencies, and support the MOH on the caring of health and other frontline personnel involved in pandemic control activities with IPC measures and psychosocial support when distressed. Compensation payments, life and health insurance for staff working in the frontlines of fighting the disease will be paid.

25. Sub-Component 1.3: Social and Financial Support to Households (US\$ 0.7 million)

26. Patients and their families needing support, especially those who are isolated or quarantined would be provided psychosocial counseling support, food-baskets and feeding during the isolation, quarantine and treatment period. Active social support would also be provided to reduce the impact of COVID-19 on the finances of directly affected to families. This will include cash transfers and support to access and use needed health services. To this end, financing would be provided for fee-waivers to access medical care and cash transfers to mitigate loss of household income due to job losses that may result from the closure of firms and enterprises, informal sector businesses, as well as government agencies, during the COVID-19 outbreak. The government would develop a COVID-19 Compensation Benefit Framework to roll out this sub-component within a month on this project



becoming effective.

27. Sub-Component 1.4: Health System Strengthening (US\$ 3.6 million)

28. Human resource and institutional capacity are key to addressing the COVID-19 outbreak as well as to strengthen health systems to ensure the constant provision of general health services without disruption. This activity is related to training and capacity building for preparedness and response as well as service delivery guided by the different pillars and activities of the NAPHS and the UHC Roadmap. These include: (i) training of contact tracing coordination teams and networks at the national, regional and district levels; (ii) recruitment of technical experts and human resources for technical work and supportive supervision; (iii) training of district and sub-district level health workers and volunteers for surveillance and case management; (iv) training of laboratory personnel to build diagnostic capacity for COVID-19 at the subnational (regional/district) level; (v) orientation of POE staff for screening people entering the country at designated points of entry (airports, border crossings, etc.); (vi) capacity building for call/hotline centers; (vii) strengthening PHEM and community- and event-based surveillance for COVID-19; (viii) capacity building and orientation of national, regional and district Rapid Response Teams (RRTs), Doctors, Physician Assistants, staff of quarantine facilities, surveillance and point of entry teams across country and particularly in treatment centers at all border districts; and (ix) simulation exercises and scenarios conducted in facilities and communities marked as Demographic Surveillance Sites (DSS) sites and quarantine facility to ensure that facilities measure up to the required standards.

29. Component 2: Strengthening Multi-sector, National Institutions and Platforms for Policy Development and Coordination of Prevention and Preparedness using One Health approach (US\$ 3.4 million)

30. The main implementing agency of this Project will be MOH, working in collaboration with the Ghana Health Service (GHS), other ministries, departments and agencies. The project would support costs associated with project coordination. The country has set up an Inter-Ministerial Coordinating Committee (IMCC) and an Emergency Operations Center (EOC) under GHS is operational. These bodies are the main coordinating points for the COVID-19 preparedness and response in Ghana. This component would also support implementation of the IHR as incorporated in National Action Plans for Health Security. Such support would include: (i) technical support for strengthening governance and updating policies and plans; (ii) support for institutional and organizational restructuring to respond to emergencies such as pandemic diseases; (iii) Operating Costs of the IMCC, EOC, quarantine centers and the Ghana Center for Disease Control (CDC) including transport, communication support equipment and other administrative-related costs for coordination meetings and supportive supervision and monitoring; and (iv) contracts for private management of newly established infectious disease centers and medical villages. Support would be also provided to MOH with oversight from IMCC to develop standardized life insurance package, overtime and hazard payments, which are to be made for those directly involved in surveillance and case management.

31. The component would support enhancing diseases information systems through development of a disease surveillance information system, as part of the disease control program. The aim is to provide better analytical capacity to Ghana; and to participate in global disease information sharing, complying with national obligations as members of OIE and WHO. A strengthened national system



will contribute progressively towards better global and regional control. The information system and data management would be linked to rapid and standardized methods of routine analysis of surveillance data, which would demonstrate important changes in the health situation, and promptly supply this information to field personnel.

32. Component 3: Community Engagement and Risk Communication (US\$ 7.4 million)

33. Risk communication: The project will focus on risk communication and community engagement at the points of entry, engaging key decisions makers and stakeholders, community leadership and opinion leaders. The first level will be points of entry communication targeting travelers. Mass communication and social media will be key in bringing the message to individual households using various methods including community van announcements for community sensitization. A series of executive briefings will be held for parliament and the media. The plan focuses on both the process and development of broadcast and communication support materials including billboards, printing of leaflets and pocket cards, epidemiological bulletins, TV documentaries and payment for broadcast of informercials, civic education and faith-based organization engagements. Where needed, technical assistance will be procured, and technical facilitator and expert commentator allowances paid for discussants on key media outlets.

34. Community Engagement: Various approaches for community engagement including: (i) surveillance, home visits and contact tracing at the district, sub-district and community levels; (ii) risk communication through a well-established network of call center, community health officers and community volunteers; and (iii) community mass communication and announcements and outreach services and sensitization through community announcement centers, sensitization, information sharing and counter misconceptions information sharing. Support provided under this sub-component would be supplementary to support from the GARID-CERC.

35. Component 4: Implementation Management, Monitoring and Evaluation and Project Management (US\$ 2.7 million)

36. Project Management: activities of the Project include: (a) providing support for the strengthening of public structures for the coordination and management of the Project, including central and local (decentralized) arrangements for the coordination of Project activities; (b) the carrying out of financial management and procurement requirements of the Project; (c) the recruitment of additional staff/consultants responsible for overall administration, procurement, and financial management under country specific projects; and (e) the financing of project coordination activities.

37. Monitoring and Evaluation: The project activities include a monitoring and prospective evaluation framework for the project and for operations at the country and sub-regional or regional levels. For operations at the country and sub-regional or regional levels, the monitoring and prospective evaluation will provide a menu of options to be customized for each operation, together with performance benchmarks. The activities include: (a) monitoring and evaluating prevention and preparedness; (b) building capacity for clinical and public health research, including joint-learning across and within countries, and this could include: (i) training in participatory monitoring and evaluation at all administrative levels, including: (1) the carrying out of evaluation workshops; and (2) the development of an action plan for monitoring and evaluation; and (3) the replication of



successful models. Monitoring and evaluation activities such as (1) Supporting the PIU in the monitoring of Project implementation through, inter alia: (I) the collection of data from line ministries and other implementation agencies; (II) the compilation of data into progress reports of Project implementation; (III) the carrying out of surveys; (IV) the carrying out of annual expenditure reviews; and (3) Carrying out an impact evaluation on quantitative and qualitative aspects of the Project interventions, including the collection of qualitative information through site-visit interviews, focus groups and respondent surveys.

Legal Operational Policies

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

Summary of Assessment of Environmental and Social Risks and Impacts

Environmental and Social Risk Classification (ESRC) Substantial

38. Environmental Risk Rating Substantial

39. The Environmental Risk Rating is Substantial. The main environmental risks are: (i) occupational health and safety issues related to testing and handling of supplies and the possibility that they are not safely used by laboratory technicians and medical crews; and (ii) medical waste management and community health and safety issues related to the handling, transportation and disposal of healthcare waste. WHO has reported that 20% of total healthcare waste would be infectious waste, and improper handling of health care waste can cause serious health problem for workers, community and the environment.

40. Social Risk Rating Substantial

41. The Social Risk Rating is Substantial. The main social risks are: (i) vulnerable groups not being about to access services, or (ii) issues, including discrimination or sexual exploitation or abuse, resulting from people being kept in quarantine. (iii) There are OHS related risks to health and laboratory workers, i.e. civil servants employed by the Government of Ghana. Activities include treatment of patients as well as assessment of samples. The key risk is contamination with COVID-19 or other contagious illnesses as patients taken seriously ill with COVID-19 are likely to suffer from illnesses which compromise the immune system, which can lead to illness and death of workers. (iv) if there is labor influx for the construction of health facilities, there could be related risks of GBV, sexual exploitation and use of child labor from the neighboring communities.

42. The project can thereby rely on standards set out by WHO as well as the Africa CDC to (1) facilitate noted appropriate stakeholder engagement and outreach towards a differentiated audience



(concerned public at large, suspected cases and patients, relatives, health workers, etc.) to ensure widespread sharing of project benefits (COVID-19 prevention and treatment) as well as avoidance of potential rumors and social conflicts; as well as (2) appropriate handling of quarantining interventions (including dignified treatment of patients; appropriate handling of the specific concerns of vulnerable groups, including cultural needs and Prevention of Sexual Exploitation and (SEA); as well as minimum accommodation and servicing requirements).

43. Since the project also includes construction and rehabilitation of facilities such as laboratories and quarantine centers, it also creates labor related risks involved in construction activity as well as issues of migrant labor, labor camps and risks of GBV for health care workers and communities where the construction will happen. Since the project may entail construction, there would be risk of land acquisition and impacts on people or any squatters if government land proposed to be used.

E. Implementation

Institutional and Implementation Arrangements

44. **The Inter-Ministerial Coordinating Committee (IMCC)** made up of the Ministries of Finance, Health, Local Government, Gender, Children and Social Protection, Information, Transport, Interior and Defense and Office of the President is chaired by the Minister of Health reporting to the Office of the President will serve as the steering committee. The Director General of GHS and the Presidential Coordinator for COVID-19 Response serve as advisers to the IMCC to provide technical direction.
45. **The MOH is the primary implementation agency for this Project.** The MOH Director, Policy Planning, Monitoring and Evaluation (PPME) supported by the Director of Public Health, GHS under the Office of the Director General and Minister of Health is responsible for overall project management and fiduciary requirements. Responsibilities of project management include, but not limited to: (i) collecting and compiling all data relating to their specific suite of indicators; (ii) evaluating results; (iii) providing relevant performance information; and (iv) reporting results, financial, procurement statements and implementation of environmental and social standards as outlined in ESMF, ESCP and other documents as per ESF to the World Bank immediately prior to each semiannual supervision mission. The Director PPME of MOH and the Director of Public Health of GHS will perform its functions in accordance with the methodology prescribed in its respective project implementation manual. During the project's lifetime, the MOH's self-assessed results will be reviewed semi-annually by the respective stakeholders and verify the findings of the self-assessments. The Director PPME will work in close collaboration and with key agencies involved in the preparedness and response agenda to implement the project. MOH and GHS have been involved in the implementation of the MCHNP in the past five years and benefitted immensely from the capacity building efforts under the MCHNP including fiduciary tasks of procurement and financial management. Additional staff will be assigned for overall administration, procurement, financial management and social and environment standards under this Project. Specific technical staff including Social & Community specialist and Environment specialist will be hired for implementation of social and environment standards.
46. The Director of Public Health of GHS, guided by the Presidential Coordinator for COVID-19 Response,



will oversee the operations of the isolation and quarantine centers and facilities and develop an institutional and operations manual for them. The Head of the Emergency Operations Center (EOC) will coordinate all technical partners to develop and determine strategies and implement them. Members of the EOC including development partners will be engaged to form sub-teams to support the activities of the MOH in the following areas: (i) Coordination (Command and Control and Continuity of operations, EOC, Official Communication, Finance, HR); (ii) Case Management and Rapid Response Teams (including Isolation, Referral); (iii) Point of Entry (Including cross border surveillance), (iv) Epidemiology/Surveillance (Data Collection and Analysis); (v) Risk communication and social mobilization); (vi) Laboratories, treatment centers, logistics and medicines and (vii) infection prevention and waste management The purpose of the sub-teams are to drive forward work, set and implement policies within the work-strand. The MCHNP monitoring and evaluation specialist, procurement specialist, communications expert and finance specialist will be assigned to this project. The environmental and safeguards specialist of GARID will provide safeguard support to the team.

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Country Director:	Agata Pawlowska	24-Mar-2020