



THE WORLD BANK
IBRD • IDA | WORLD BANK GROUP

FOR OFFICIAL USE ONLY

Report No: PAD3922

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED INTERNATIONAL DEVELOPMENT ASSOCIATION CREDIT

IN THE AMOUNT OF SDR 9.2 MILLION
(US\$12.5 MILLION EQUIVALENT)
IN CRISIS RESPONSE WINDOW RESOURCES

AND A

PROPOSED GRANT FROM THE PANDEMIC EMERGENCY FINANCING FACILITY
IN THE AMOUNT OF US\$2.7 MILLION

TO

THE REPUBLIC OF UGANDA

FOR A

COVID-19 RESPONSE AND EMERGENCY PREPAREDNESS PROJECT

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

USING THE MULTIPHASE PROGRAMMATIC APPROACH (MPA)
WITH A FINANCING ENVELOPE OF
UP TO US\$ 6 BILLION

APPROVED BY THE BOARD ON APRIL 2, 2020

Health, Nutrition and Population Global Practice
Africa Region

This document has a restricted distribution and may be used by recipients only in the performance of their official duties. Its contents may not otherwise be disclosed without World Bank authorization.



CURRENCY EQUIVALENTS

Exchange Rate Effective (April 11, 2020)

Currency Unit = Ugandan Shilling (UGX)

UGX 3790 = US\$1

US\$1= SDR 0.73

FISCAL YEAR

January 1 - December 31

Regional Vice President: Hafez M. H. Ghanem

Acting Country Director: Camille Ann Nuamah

Regional Director: Amit Dar

Practice Manager: Francisca Ayodeji Akala

Task Team Leaders: Julia Mensah, Rogers Ayiko



ABBREVIATIONS AND ACRONYMS

BFP	Bank Facilitated Procurement
CDC	Centers for Disease Control and Prevention
CERC	Contingency Emergency Response Component
COVID-19	Coronavirus Disease
CPF	Country Partnership Framework
EAPHLNP	East Africa Public Health Laboratory Network Project
EID	Emerging Infectious Diseases
EOC	Emergency Operations Center
E&S	Environmental and Social Standards
ESF	Environmental and Social Framework
FM	Financial Management
GBV	Gender-based Violence
GHSA	Global Health Security Assessment
GRS	Grievance Redress Service
IBRD	International Bank for Reconstruction and Development
ICU	Intensive Care Unit
IDA	International Development Association
IDSR	Integrated Disease Surveillance and Response
IFR	Interim Unaudited Financial Report
IHR	International Health Regulations
IMF	International Monetary Fund
JEE	Joint External Evaluation
LQMS	Laboratory Quality Management Systems
LTIA	Long-term Institutional Arrangements
M&E	Monitoring and Evaluation
MoH	Ministry of Health
OPCS	Operations Policy and Country Services
PAD	Project Appraisal Document
PDO	Project Development Objective
PIU	Project Implementation Unit
PoE	Points of Entry
PPE	Personal Protective Equipment
RMNCAH	Reproductive, Maternal, Neonatal, Child, and Adolescent Health
RRH	Regional Referral Hospital
SARS	Severe Acute Respiratory Syndrome
SARS-CoV-2	2019 Novel Coronavirus
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-based Violence
SLIPTA	Stepwise Laboratory Quality Improvement Process Towards Accreditation



SLMTA	Strengthening Laboratory Management Toward Accreditation
SPRP	Strategic Preparedness and Response Program
SSA	Sub-Saharan Africa
UN	United Nations
UNICEF	United Nations Children's Fund
URMCHIP	Uganda Reproductive Maternal and Child Health Services Improvement Project
WASH	Water, Sanitation, and Hygiene
WB	World Bank
WHO	World Health Organization



TABLE OF CONTENTS

DATASHEET	1
I. PROGRAM CONTEXT	7
A. MPA Program Context	7
B. Updated MPA Program Framework	7
C. Learning Agenda	8
II. CONTEXT AND RELEVANCE	9
A. Country Context	9
B. Sectoral and Institutional Context.....	10
C. Relevance to Higher Level Objectives.....	14
III. PROJECT DESCRIPTION	15
A. Development Objectives	15
B. Project Components.....	15
C. Project Beneficiaries.....	18
IV. IMPLEMENTATION ARRANGEMENTS	19
A. Institutional and Implementation Arrangements	19
B. Results Monitoring and Evaluation Arrangements.....	19
C. Sustainability.....	19
V. PROJECT APPRAISAL SUMMARY	20
A. Technical and Economic Financial Analysis.....	20
B. Fiduciary.....	21
C. Legal Operational Policies.....	25
D. Environmental and Social Standards	25
VI. GRIEVANCE REDRESS SERVICES	28
VII. KEY RISKS	28
VIII. RESULTS FRAMEWORK AND MONITORING	30
ANNEX 1: Project Costs	36
ANNEX 2: Implementation Arrangements and Support Plan	37
ANNEX 3: 2017 Joint External Evaluation (JEE) Scores for Uganda	38



DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Uganda	Uganda COVID-19 Response and Emergency Preparedness Project	
Project ID	Financing Instrument	Environmental and Social Risk Classification
P174041	Investment Project Financing	Substantial

Financing & Implementation Modalities

<input checked="" type="checkbox"/> Multiphase Programmatic Approach (MPA)	<input type="checkbox"/> Contingent Emergency Response Component (CERC)
<input type="checkbox"/> Series of Projects (SOP)	<input type="checkbox"/> Fragile State(s)
<input type="checkbox"/> Performance-Based Conditions (PBCs)	<input type="checkbox"/> Small State(s)
<input type="checkbox"/> Financial Intermediaries (FI)	<input type="checkbox"/> Fragile within a non-fragile Country
<input type="checkbox"/> Project-Based Guarantee	<input type="checkbox"/> Conflict
<input type="checkbox"/> Deferred Drawdown	<input checked="" type="checkbox"/> Responding to Natural or Man-made Disaster
<input type="checkbox"/> Alternate Procurement Arrangements (APA)	<input checked="" type="checkbox"/> Hands-on Enhanced Implementation Support (HEIS)

Expected Project Approval Date	Expected Project Closing Date	Expected Program Closing Date
15-Jul-2020	31-Dec-2022	31-Mar-2025

Bank/IFC Collaboration

No

MPA Program Development Objective

The Program Development Objective is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness

MPA Financing Data (US\$, Millions)



MPA Program Financing Envelope	4,053.59
with a reduction of IDA	250.00

Proposed Project Development Objective(s)

The objective of the Project is to prevent, detect and respond to COVID-19 and strengthen national systems for public health emergency preparedness in Uganda.

Components

Component Name	Cost (US\$, millions)
Component 1: Case Detection, Confirmation, Contact Tracing, Recording, Reporting	7,233,852.00
Component 2: Strengthening Case Management and Psychosocial Support	6,810,595.00
Component 3: Project Management, Monitoring and Evaluation	1,156,100.00

Organizations

Borrower: Ministry of Finance, Planning and Economic Development

Implementing Agency: Ministry of Health

MPA FINANCING DETAILS (US\$, Millions)

Board Approved MPA Financing Envelope:	4,303.59
MPA Program Financing Envelope:	4,053.59
of which Bank Financing (IBRD):	2,278.60
of which Bank Financing (IDA):	1,774.99
of which other financing sources:	0.00

PROJECT FINANCING DATA (US\$, Millions)**SUMMARY**

Total Project Cost	15.20
Total Financing	15.20



of which IBRD/IDA	12.50
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	12.50
IDA Credit	12.50

Non-World Bank Group Financing

Trust Funds	2.70
Pandemic Emergency Financing Facility	2.70

IDA Resources (in US\$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
Uganda	12.50	0.00	0.00	12.50
Crisis Response Window (CRW)	12.50	0.00	0.00	12.50
Total	12.50	0.00	0.00	12.50

Expected Disbursements (in US\$, Millions)

WB Fiscal Year	2020	2021	2022	2023
Annual	0.50	7.00	7.00	0.70
Cumulative	0.50	7.50	14.50	15.20

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Social, Water

Climate Change and Disaster Screening

This operation has not been screened for short and long-term climate change and disaster risks



SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

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

COMPLIANCE

Policy

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

Yes No

Does the project require any waivers of Bank policies?

Yes No

Have these been approved by Bank management?

Yes No

Is approval for any policy waiver sought from the Board?

Yes No



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

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

NOTE: For further information regarding the World Bank’s due diligence assessment of the Project’s potential environmental and social risks and impacts, please refer to the Project’s Appraisal Environmental and Social Review Summary (ESRS).

Legal Covenants

Sections and Description

Project Implementation Manual: The recipient shall no later than thirty (30) days after the Effective Date of the Grant Agreement, prepare a Project Implementation Manual containing detailed arrangements and procedures for implementation of the Project including inter alia: (A) administration and coordination; (B) monitoring and evaluation; (C) financial management, procurement and accounting procedures’ (D) environmental and social risks management; (E) corruption and fraud mitigation measures; (F) a grievance redress mechanism; (G) Personal Data collection and processing in accordance with applicable national law and good international practice; (H) roles and responsibilities for Project implementation; and (I) and such other arrangements and procedures as shall be required for the effective implementation of the Project. (Section I.B (1) (i) of Schedule 2).

Sections and Description

Annual Work Plans and Budgets: By no later than one (1) month after the Effective Date under the Grant



Agreement, prepare a draft work plan and budget for Project implementation, setting forth, inter alia: (i) a detailed description of the planned activities, including any proposed conferences and training, under the Project for the period covered by the plan; (ii) the sources and proposed use of funds therefor; (iii) procurement and environmental and social safeguards arrangements therefor, as applicable and; (iv) responsibility for the execution of said Project activities, budgets, start and completion dates, outputs and monitoring indicators to track progress of each activity. (Section I.B (2) (a) of Schedule 2).

Conditions

Type

Effectiveness

Description

That the Pandemic Emergency Financing Facility 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 effectiveness of this Agreement) have been fulfilled (within 120 days). Article V, 5.01(i).

Type

Effectiveness

Description

A memorandum of understanding has been entered into between the Recipient and the Ministry of Defense and Veteran Affairs to facilitate cooperation by the Military with the Recipient, with respect to the beneficiary Military Hospitals under the Project, and, to establish the administration arrangements necessary to enable the Recipient fulfill its responsibilities under the Project, in a manner and in form and substance satisfactory to the Association (within 120 days). Article V, 5.01(ii).



I. PROGRAM CONTEXT

1. This Project Appraisal Document (PAD) describes the emergency response of the Republic of Uganda under the COVID-19 Strategic Preparedness and Response Program (SPRP) using the Multiphase Programmatic Approach (MPA), approved by the World Bank's Board of Executive Directors on April 2, 2020 (PCBASIC0219761) with an overall Program financing envelope of up to US\$6.00 billion.

A. MPA Program Context

2. **An outbreak of the coronavirus disease (COVID-19) caused by the 2019 novel coronavirus (SARS-CoV-2) has been spreading rapidly across the world since December 2019, following the diagnosis of the initial cases in Wuhan, Hubei Province, China.** Since the beginning of March 2020, the number of cases outside China has increased thirteenfold and the number of affected countries has tripled. On March 11, 2020, the World Health Organization (WHO) declared a global pandemic as the coronavirus rapidly spread across the world. As of July 12, 2020, there have been 12,552,765 confirmed cases of COVID-19, including 561,617 deaths in 216 countries, reported to WHO.¹

3. **COVID-19 is one of several emerging infectious diseases (EID) that have originated from animals in contact with humans in recent decades, resulting in major outbreaks with significant public health and economic impacts.** The last moderately severe influenza pandemics were in 1957 and 1968; each killed more than a million people around the world. Although countries are now far more prepared than in the past, the world is also far more interconnected, and many more people today have behavioural risk factors such as tobacco use² and pre-existing chronic health problems that make viral respiratory infections particularly dangerous.³ While 4.5 percent of people worldwide confirmed as having been infected have died (per the July 12 numbers quoted above), the WHO has been careful not to describe that as a mortality rate or death rate. This is because in an unfolding epidemic it can be misleading to simply look at the estimate of deaths divided by cases tested positive so far. Hence, given that the actual prevalence of COVID-19 infection remains unknown in most countries, it poses unparalleled challenges with respect to global containment and mitigation. These issues reinforce the need to strengthen the response to COVID-19 across all International Development Association/International Bank for Reconstruction and Development (IDA/IBRD) countries to minimize the global risk and impact posed by this disease.

4. This project is prepared under the global framework for the World Bank COVID-19 Response financed under the Fast Track COVID-19 Facility (FTCF) and co-financed through the Pandemic Emergency Financing Facility (PEF).

B. Updated MPA Program Framework

5. **The proposed Project for Uganda will be added to the overall MPA Program Framework.** Table 1 provides an updated overall MPA Program framework.

¹ WHO Coronavirus Disease (COVID-19) Dashboard. <https://covid19.who.int/>

² Marquez, P. V. 2020. "Does Tobacco Smoking Increases the Risk of Coronavirus Disease (Covid-19) Severity? The Case of China." <http://www.pvmarquez.com/Covid-19>.

³ Fauci, A. S., Lane, C., and Redfield, R. R. 2020. "Covid-19 — Navigating the Uncharted." *New England Journal of Medicine*, DOI: 10.1056/NEJMe2002387.



Table 1. MPA Program Framework

Phase #	Project ID	Sequential or Simultaneous	Phases Proposed DO*	IPF, DPF or PforR	Estimated IBRD Amount (\$ million)	Estimated IDA Amount (\$ million)	Estimated Other Amount (\$ million)	[Estimated] Approval Date	Estimated Environmental & Social Risk Rating
2	Uganda	Simultaneous	Please see above	IPF		12.5	2.7	July 15, 2020	S
Total			Board Approved Financing Envelope		2,700	1,300	2,000		

6. All projects under SPRP are assessed for Environmental and Social Framework (ESF) risk classification following the World Bank procedures and the flexibility provided for COVID-19 operations.

C. Learning Agenda

7. The proposed Project, under the MPA Program, will support adaptive learning throughout implementation, as well as from international organizations including Africa Centers for Disease Control, World Health Organization (WHO), International Monetary Fund, United States Centres for Disease Control and Prevention, United Nations International Children's Fund, and others. The Global MPA aims to enhance knowledge and learning in the following broad areas:

- Forecasting: Modeling the progression of the pandemic, both in terms of new cases and deaths, as well as the economic impact of disease outbreaks under different scenarios.
- Technical: Cost and effectiveness assessments of prevention and preparedness activities; research may be financed for the repurposing of existing antiviral drugs and development and testing of new antiviral drugs and vaccines.
- Supply chain approaches: Assessments of options for timely distribution of medicines and other medical supplies.
- Social behaviors: Assessments of the compliance and impact of social distancing measures and hygiene behaviours under different contexts.

8. Uganda will contribute towards this global learning agenda by distilling lessons learned within the local context from addressing key challenges, and through any innovations that can inform future preparedness and response efforts. Emerging areas include the use of GPS tracking to strengthen the tracking and tracing of suspected patients and their contacts.



II. CONTEXT AND RELEVANCE

A. Country Context

9. **Uganda is a landlocked country located in East Africa with an estimated population of 41.6 million, and a population density of 173 persons per square kilometer.**⁴ Over the past eight years, the country's economy has grown at a slower pace in comparison to past trends and peer countries. Annual real Gross Domestic Product (GDP) growth rate was 7.2 percent on average between 2000 and 2011, compared to 4.6 percent between 2012 and 2018.⁵ The slowdown was mainly driven by adverse weather, unrest in South Sudan, private sector credit constraints, and poor public finance management.⁶ Consequently, the GDP per capita (current US\$) rose from US\$262 in 2000 to US\$739 in 2014 after which it started declining—reaching a low of US\$609 in 2016—before increasing slightly to US\$643 in 2018⁷ and US\$ 732 in 2019.⁸ With the majority of the population reliant on subsistence agriculture and/or small informal enterprises with low productivity and little prospects for growth, the bottom 40 percent of the population has not sufficiently benefited from incomes arising from economic progress. Consequently, the national poverty level increased from 19.7 percent in 2012/2013 to 21.4 percent in 2016/2017, with the number of rural poor increasing by 1.1 million as compared to an increase of 200,000 for the urban poor.⁹

10. **The disconnect between economic growth and poverty reduction could be attributed to the high population growth rate of 3.7 percent per annum over the period 2015–2018, which is higher than the average for low income countries.** High levels of population growth reflect persistently high levels of fertility among adolescents, and this has created pressure on the existing public services and constrained growth in annual GDP per capita to 1.1 percent on average over the period 2012–2018. As large cohorts of children enter the reproductive age, Uganda is expected to continue experiencing significant population growth, and this will outstrip the capacity of the economy to generate enough jobs and provide quality services. With a Human Capital Index (HCI)¹⁰ of 0.38 in 2018, vulnerability to falling back into poverty remains very high in Uganda as the majority of the population is unable to cope with negative shocks. Therefore, the COVID-19 pandemic is most likely to have adverse effects on incomes at household level and economic growth. Economic growth had been projected at 6.1 percent per annum over the period 2020–2022,¹¹ however, these estimates have now been revised downwards to account for the shock to the economy as a result of the COVID-19 pandemic.¹² Specifically, economic growth is expected to slow down due to direct health and social effects of the disease and preventive measures such as social distancing and lockdowns to contain the spread. Preventive measures to contain the pandemic have initially affected households engaged in the services sector (around 30 percent of the labor force),

⁴ Uganda Bureau of Statistics: <https://www.ubos.org/uganda-profile/>.

⁵ <https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=UG>.

⁶ World Bank (2020). *Uganda Economic Update, 14th Edition: Strengthening Social Protection to Reduce Vulnerability and Promote Inclusive Growth*. Washington, D.C.: World Bank.

⁷ <https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=UG>.

⁸ http://macropovertyoutlook.worldbank.org/mpo_files/mpo/mpo-sm20-uga.pdf.

⁹ Uganda National Household Survey 2016/17.

¹⁰ <https://www.worldbank.org/en/data/interactive/2018/10/18/human-capital-index-and-components-2018>. The HCI measures the amount of human capital that a child born today can expect to attain by the age of 18, given the risks of poor health and poor education that prevail in the country where he/she lives. A child born in Uganda today will be 38 percent as productive when she grows up as she could be if she enjoyed full health and complete education. In 2018, Uganda's HCI score was below the average for the SSA region.

¹¹ https://www.imf.org/external/datamapper/NGDP_RPCH@WEO/OEMDC/UGA.

¹² The COVID-19 pandemic and locust invasion are expected to reduce average real GDP growth to about 3.8 percent over the next two years. Source: World Bank (2020). *Sub-Saharan Africa Macro Poverty Outlook*. Washington, D.C.: World Bank.



tourism, and agriculture. Eventually, disruptions in supply are expected to lower the aggregate demand, which added to an overall slowdown in trade, will reduce the demand for food and agricultural products, and this will further decrease rural incomes.¹³

11. **Slowdown of the economy due to the COVID-19 pandemic is expected to further reduce the fiscal space for health and other social sectors.** This is compounded by the fact that Uganda already has one of the lowest domestic revenue mobilization rates in East Africa and donor grants have almost halved over the past five years due to challenges with public finance management. The COVID-19 pandemic is already disrupting essential health and other social services which is critical, given the high degree of vulnerability for the bottom 40 percent of the population, particularly in rural areas and refugee-host communities.

12. **Increasing violence against women and children and social protection risks.** Gender-Based Violence (GBV) is likely to increase on account of the breakdown of economic and social activities, restrictions on movement, and closure of schools. These factors place women and girls at heightened risks of intimate partner violence and other forms of exploitation and sexual violence. In addition, life-saving care, and support to GBV survivors—such as clinical management of rape and mental health and psychosocial support—is already limited and may be disrupted when health service providers are overburdened and preoccupied with handling COVID-19 cases. Other vulnerable groups also face increased risk of exclusion during the pandemic.

B. Sectoral and Institutional Context

13. **Over the past two decades, Uganda has made significant progress in improving health and nutrition outcomes, but progress is inadequate to achieve the Sustainable Development Goals (SDGs) on health and nutrition.** About 60 percent of the Years of Life Lost in Uganda is attributable to reproductive, maternal, neonatal, child, and adolescent health (RMNCAH) and nutrition conditions, while non-communicable diseases (NCDs) have also been increasing. Much of this is attributable to the low provision and poor quality of essential health services. A recent study by the Uganda Ministry of Health (MoH) rated the quality of healthcare in 98 percent of health facilities in 74 selected districts—covering 55 percent of the districts in Uganda—as poor.¹⁴ There are also inequities in coverage and access to quality healthcare by income status, education, and geographical location. The key constraints in the health system include: (i) critical shortages in human resources for health, especially in specialized fields and in intensive care; (ii) erratic supply of critical inputs such as drugs and medical supplies; (iii) inequitable distribution of health infrastructure; and (iv) insufficient funding to sustain and expand access to quality healthcare. The health sector is mainly financed by development partners who contribute 42 percent of the total health expenditure, followed by households at 41 percent, and the Government of Uganda (GoU) domestic resources at 15 percent.

14. **Despite its challenges, Uganda remains a regional leader in outbreak preparedness and response.** This is demonstrated through its relatively strong performance on the 2019 Global Health Security Assessment (GHS), ranking 63 out of 195 countries,¹⁵ and in the WHO's Joint External Evaluation (JEE)¹⁶ (see Annex 3). Leveraging these strengths, the country has successfully contained a series of outbreaks in the last few years, including Crimean Congo hemorrhagic

¹³ World Bank (2020). Concept Note - Uganda Systematic Country Diagnosis.

¹⁴ World Bank (2020). Concept Note - Uganda Systematic Country Diagnosis.

¹⁵ Worldwide, the average score on the GHS index is 40.2 percent. The average for the African region is 30.8 percent and only four countries in the region exceed the world average (South Africa, Kenya, Uganda, and Ethiopia). However, the overall score for Uganda on the GHS is 44.3 percent which means that there is scope for improvement.

¹⁶ The JEE is a voluntary, collaborative, multisectoral process to assess country capacities to prevent, detect and rapidly respond to public health risks whether occurring naturally or due to deliberate or accidental events.



fever, Marburg virus disease, Rift Valley fever, Anthrax, Meningitis, Measles, Cholera, and Ebola. At the height of the West Africa Ebola outbreak in 2014-2015, Uganda provided technical support to the most affected countries. Furthermore, between June 2019 and March 2020, the country implemented several activities to prevent the Ebola outbreak from the neighboring Democratic Republic of the Congo (DRC) from spilling into Uganda. The Ebola outbreak provided an opportunity for authorities to step up disease outbreak preparedness efforts by: (i) strengthening capacities in 23 districts along the DRC border; (ii) intensifying screening and surveillance capacity at Points of Entry (PoE); (iii) vaccinating nearly 5000 health workers and contacts; and (iv) establishing nine Ebola Treatment Units in the five highest risk districts. The experiences acquired in containing past outbreaks will help Uganda to manage the COVID-19 pandemic. However, responding to the COVID-19 pandemic also presents a unique set of challenges given the gaps in knowledge worldwide on the pathogenesis and epidemiological characteristics of the disease, the considerable toll on the economy (from lockdown and social distancing), and the tremendous pressure that the outbreak could place on an already fragile health system. These challenges underscore the need for additional investments in prevention, detection, and response to COVID-19 pandemic.

15. **On March 21, 2020, Uganda confirmed its first case of COVID-19. Since then, the number of confirmed cases has been steadily increasing** As of 7th July 2020, the country had registered 977 cases of COVID-19 from 216,000 tests and no deaths. Sixty-six percent of the confirmed cases were imported, while 34 percent were locally transmitted. As testing and early detection efforts pick up pace in Uganda, the country anticipates higher levels of infection and more rapid community transmission.¹⁷ Currently, the country has three centralized COVID-19 testing facilities at Uganda Virus Research Institute, Central Public Health Laboratories at Butabika, and Molecular Biology Laboratory at College of Health Sciences, Mulago. It also has three decentralized testing facilities at high-volume and high-risk Points of Entry (PoEs) at Mutukula, Tororo Hospital (serving Busia, Lwakhakha, Malaba, and Suam), and Adjumani Hospital (Elegu).

16. **Current global evidence on the evolution of the pandemic suggests that: (i) 80 percent of cases will experience mild illness up to and including mild pneumonia; and (ii) the remaining 20 percent will experience moderate to severe illness, with about 5 percent requiring intensive care.** Although in most countries mild cases are managed at home through self-quarantine, in Uganda prior violations of “stay-at-home” orders for infected patients has made it necessary for the Government to mandate institutional quarantine for all. This has meant isolating all confirmed cases in hospitals and ensuring that all severe cases have adequate support at the Regional Referral Hospitals (RRHs) for intensive care. All the confirmed cases have been hospitalized at nine hospitals with capacity for COVID-19 case management. This approach, though necessary in Uganda, puts significant pressure on the health system both from an infrastructure and a human resource perspective. Currently, Uganda has less than one hospital bed per 1,000 people, and there are only 60 fully operational Intensive Care Unit (ICU) beds nationwide. Lessons learned from countries like Italy, Spain, and USA also emphasize the importance of health system readiness to manage the investable caseload of COVID-19 patients adequately and safely.

17. **To ensure a comprehensive response to the COVID-19 outbreak, the GoU has developed a one-year Integrated National COVID-19 Preparedness and Response Plan (the ‘National Plan’) costed at US\$126.2 million.** Through this plan, the GoU, the World Bank, and other development partners have prioritized interventions and aligned financial support to respond to the outbreak. The goal of this plan is to provide a framework for prevention and control of COVID-19 by curtailing importation of the disease; interrupting transmission early and fast through rapid detection and containment; and minimizing morbidity, mortality, and social and economic disruption. This goal will be achieved through the following pillars: (i) development of country capacity for early detection, confirmation, reporting, and

¹⁷ According to projections by the MoH, it is expected that there will be 1.7 million cases, with 336,000 (20 percent) hospitalized and 50,400 (3 percent) in intensive care 80 days after the first case. Such an astronomical increase in infection would completely outstrip the health system.



referral of suspected cases to designated isolation units; (ii) development of the capacity for case management including management of severe case; (iii) raising of public awareness on the risk factors for transmission, prevention and control of COVID-19; (iv) strengthening of infection prevention and control measures required to mitigate spread of COVID-19 in health facilities, institutions and at the community level; (v) strengthening of capacities for coordination, data management and surge capacity; and (vi) application of multi sectoral approach to minimize social and economic impact. The plan was developed by the Ugandan Government in collaboration with several development partners, including the World Bank, and is aligned with the WHO's 2019 Novel Coronavirus Strategic Preparedness and Response Plan.¹⁸ However, there is a large financing gap with a number of the key areas in the plan such as laboratory services (-77 percent), logistics (-63 percent), and case management (-30 percent) still critically underfunded..

18. **In addition to the National Plan, on March 18, 2020 (before first case was confirmed), the President of the Republic of Uganda declared COVID-19 a national emergency, and issued several directives aimed at controlling the spread of the disease, including social distancing.** These measures included: (i) suspension of passenger travel across Uganda's borders; (ii) closure of all education institutions; (iii) suspension of mass gatherings; and (iii) a 14-day lockdown—later extended by 21 days—which prohibits people from moving around, suspension of public transportation, restricting markets to selling foodstuffs, and shutting down of shopping malls, lodges, bars, and restaurants. Since May 26, 2020, these restrictions have been progressively eased with new requirements for mandatory wearing of masks in public places, while allowing use of private vehicles (with limited occupancy), reopening of schools for exam writing and the lifting of the national curfew. In addition, the MoH has: (i) activated the National Task Force committee which meets regularly to provide technical guidance to the response; (ii) triggered the incident management system and the Emergency Operations Center to respond to the outbreak; (iii) deployed officers to conduct surveillance, active case search, contact tracing, and follow up of high risk travelers; and (iv) intensified screening and management of patients at the Mulago and Entebbe National Teaching Referral Hospitals.

19. **Furthermore, while responding to the COVID-19, the MoH has deployed some innovative interventions with support from the National Information Technology Authority (NITA-Uganda) and the Telecommunications companies.** These include: (i) Integrated Voice Response for following up on travellers that have made contact with confirmed cases by the surveillance teams of the MoH; (ii) digital tracking mechanism for truck drivers using Global Positioning Systems (GPS); and (iii) use of barcode in tracking of samples collected and test results from COVID-19 suspects. These innovations have helped strengthen disease surveillance at PoEs as well as enhanced the tracking of samples from collection point to final confirmation of results to individuals/patients.

20. **Through this proposed Project, the GoU will build upon the ongoing activities noted above and expand delivery of emergency response services, especially in areas where resources have been limited. As of June 8, 2020, the financing gap in the National Response Plan is estimated at US\$77.9 million.¹⁹ This Project, costed at US\$15.2 million, will reduce the funding gap by nearly 20 percent to US\$62.7 million.** A summary of the total cost of the COVID-19 national plan, committed funds, and the funding gap is provided in Table 2.

¹⁸ WHO (February 2020). 2019 Novel Coronavirus (2019-nCoV) Strategic Preparedness and Response Plan. <https://www.who.int/docs/default-source/coronaviruse/srp-04022020.pdf>.

¹⁹ The estimation of the financing gap is subject to change, based on evolving guidance provided by the scientific committee and additional contributions from the Government and development partners.



Table 2: National COVID-19 Response Budget and Development Partner/World Bank Contributions
(as of June 11, 2020)

Total Cost of the National COVID-19 Plan	GoU	Confirmed Donor Financing ²⁰	IDA Financing		Remaining Gap
			CERC ²¹	UCREPP	
126,171,450	25,967,519	7,290,903	15,000,000	15,200,000	62,713,028

21. **The World Bank support for COVID-19 response in Uganda draws on different instruments**, including the activation of a Contingent Emergency Response Component (CERC) of an existing operation, as well as the preparation of a new operation. Both are financed through the country’s allocation under the FTFC (US\$27.5 million). Interventions thus far are:

- **CERC Activation for COVID-19 (US\$15 million):** As a first step, the CERC under the Uganda Reproductive, Maternal, and Child Health Services Improvement Project (URMCHIP, P155186) was activated on March 30, 2020—one week after the first confirmed case in Uganda. The activation of the CERC provides US\$15 million of catalytic resources to ramp up efforts on prevention and early detection, with considerable investments in Personal Protective Equipment (PPE) for health workers, hand sanitizers, testing kits and GeneXpert cartridges, thermal scanners, PoE screening equipment and universal media transportation. It also supports risk communication and community engagement to raise awareness about the risk factors for COVID-19 and how best to avoid infection.
- **Uganda COVID-19 Response and Emergency Preparedness Project (UCREPP, US\$15.2 million).** This new operation will complement the support provided through the CERC by consolidating prevention and early detection investments, but also focus on overall health system readiness and strengthening, with emphasis on disease surveillance and point of entry screening; laboratory capacity strengthening for rapid testing, diagnosis and reporting; case management with investments in the provision of equipment, effective triage of patients, training in the provision of intensive care; psychosocial support; and critical infrastructural investments to bolster the delivery of core public health functions for the current outbreak and beyond. The Project is funded through a combination of IDA credit (US\$12,500,000 million) and Trust Funds (Pandemic Emergency Financing Facility, US\$2,700,547).

22. **Other health sector support from the World Bank has a direct bearing on Uganda’s COVID-19 Response.** In addition to COVID-19 specific support, the Government activated a CERC under the URMCHIP mentioned above for US\$5 million in December 2019 for Ebola. The resources, which were focused primarily on strengthening prevention and early detection, helped strengthen capacities in cross-border zones, upon which the COVID-19 interventions will build. Furthermore, the Uganda Health Systems Strengthening Project (P115563) (now closed), the East Africa Public Health Laboratories Networking Project (EAPHLNP, P111556), and the URMCHIP have all strengthened national health systems and public health capacities and provided a solid foundation for the support proposed through this project. The EAPHLNP, in particular, has invested resources in the strengthening of laboratory capacity, the establishment and activation of five cross-border committees along Uganda’s international frontiers with her neighbours, and the installation of key PoE screening infrastructure such as thermo scanners and isolation tents, which have proven

²⁰ Includes reprogrammed funds from Global Fund for HTM and Gavi, the Vaccine Alliance.

²¹ CERC was approved in March 2020.



invaluable in improving Uganda’s disease surveillance, case detection, and contact tracing capabilities. The EAPHLNP has also contributed to generating new evidence on disease surveillance and outbreak response in Uganda through various operational research studies and publications.

C. Relevance to Higher Level Objectives

23. **The Project is aligned with World Bank Group (WBG) strategic priorities, particularly the WBG’s mission to end extreme poverty and boost shared prosperity.** The Program is focused on pandemic preparedness, a critical element to achieving Universal Health Coverage in Uganda. It is aligned with the World Bank’s support for national plans and global commitments to strengthen pandemic preparedness in three key areas : (i) improving national preparedness plans including organizational structure of the government; (ii) promoting adherence to the International Health Regulations (IHR); and (iii) utilizing the international framework for monitoring and evaluation of IHR. The economic rationale for investing in the MPA interventions is strong, given that success can reduce the economic burden suffered by individuals and countries.

24. **The Project, being part of the Global MPA, complements both WBG and development partner investments in health systems strengthening, disease control and surveillance, attention to changing individual and institutional behaviour, and citizen engagement.** Further, as part of the IDA19 commitments, the World Bank aims to “support at least 25 IDA countries to implement pandemic preparedness plans through interventions including strengthening institutional capacity, technical assistance, lending and investment.” The Project contributes to the implementation of IHR (2005), Integrated Disease Surveillance and Response (IDSR), the World Organization for Animal Health (OIE) international standards, the Global Health Security Agenda, the Paris Climate Agreement, attainment of Universal Health Coverage and SDGs, and the promotion of a One-Health approach.

25. **The WBG remains committed to providing a fast and flexible response to the COVID-19 epidemic, utilizing all WBG operational and policy instruments and working in close partnership with government and other agencies.** Grounded in One-Health, which provides for an integrated approach across sectors and disciplines, the proposed WBG response to COVID-19 will include emergency financing, policy advice, and technical assistance, building on existing instruments to support IDA/IBRD-eligible countries in addressing the health sector and broader development impacts of COVID-19. The WBG COVID-19 response will be anchored in the WHO’s COVID-19 global SPRP outlining the public health measures for all countries to prepare for and respond to COVID-19 and sustain their efforts to prevent future outbreaks of emerging infectious diseases.

26. **The proposed Project is aligned with the World Bank’s Country Partnership Framework (CPF) for the Republic of Uganda 2016–2021(Report No. 101173-UG).** The Project focuses on improving health service delivery and supports engagement under the CPF strategic focus area A, which prioritizes improving governance, accountability, and service delivery, and the CPF’s strategic objective on improving social service delivery. The Project is also consistent with the development agenda at national and sector levels. It is aligned with the second and third National Development Plan (NDPII and III), which seeks to increase human capital development and to strengthen mechanisms for quality, effective and efficient service delivery. Further, the proposed project is aligned with the second National Health Policy (2010/11–2019/20), the Health Sector Development Plan (2020/21–2024/2025), and the National Action Plan for Health Security (2019–2023), which together provide strategies to strengthen the health system including capacities for health security and attainment of Universal Health Coverage.



III. PROJECT DESCRIPTION

27. **This Project (UCREPP) is designed to fit within the context of Uganda’s overall COVID-19 preparedness and response plan, as well as its broader readiness for public health emergencies.** It builds upon prior interventions funded through the Government, the World Bank, and other partners to respond to COVID-19. Its scope and components are fully aligned with the World Bank’s COVID-19 SPRP, and focus on areas that: (i) are currently underfunded in the national plan (i.e. case management, laboratory capacity strengthening, and psychosocial support); (ii) scale up prevention and early detection efforts in a quest to better control the spread of the pandemic; and (iii) are geared towards strengthening core public health functions, infrastructure, and health systems for COVID-19 and beyond.

28. **The description of the components, activities, and indicators follows the standard guidance as indicated in Annex 2 of the COVID-19 Board Paper.** However, there are some adaptations where necessary to fit the evolving context in Uganda while maintaining the overall objectives and strategic direction of the SPRP. Given the limited resources (US\$15.2 million), the Project focuses interventions on a limited number of districts, RRHs, and General Hospitals (GHs). The selection of these beneficiaries is based on considerations of current capacity, geographical location, equity, and level of susceptibility to cross-border threats.

29. Project cost by components is provided in Annex 1.

A. Development Objectives

30. The Project objectives are aligned with the results chain of the SPRP.

Project Development Objective (PDO) statement: To prevent, detect and respond to COVID-19 and strengthen national systems for public health emergency preparedness in Uganda.

31. **PDO level indicators:** The PDO will be monitored through the following PDO-level outcome indicators.

- Proportion of targeted Regional Referral Hospitals with clinical capacity to manage COVID-19 cases in line with clinical guidelines.²²
- Proportion of COVID-19 suspected cases, having laboratory confirmation within 48 hours.

B. Project Components

Component 1: Case Detection, Confirmation, Contact Tracing, Recording, Reporting (US\$7,233,852, of which SDR 3.8 million {US\$ 5,128,445 equivalent} is credit and US\$ 2,105,407 is grant)

32. **This component leverages investments made through the EAPHLNP to enhance early detection and reporting of COVID-19 cases.** The interventions proposed take cognizance of the fact that prevention activities for public health emergencies like COVID-19 rely on effective screening, including of travellers at PoEs as well as effective testing of samples. Such screening and testing allow the quick identification of reported alerts to confirm/detect aetiology of

²² Clinical capacity here refers to staffing, medicines, equipment, and working space.



individuals' symptoms, which in turn informs appropriate case management to contain the spread of the virus. In this regard, the Project will focus broadly on interventions to: (i) strengthen disease surveillance systems, including screening and contact tracing; (ii) strengthen public health laboratories and epidemiological capacity for early detection and confirmation of COVID-19 cases; and (iii) provide on-time data and information to guide real-time decision-making. In addition, it will provide cascade training for screeners, laboratory personnel, and public health staff, and advance innovative approaches for testing by leveraging GeneXpert for the detection of COVID-19. Specific activities are summarized below:

- **Disease Surveillance**
 - Procurement of a package of inputs to enhance PoE screening at 10 designated areas. The package will include tents, tables, chairs, washing basins and supplies and scanners.
 - Refresher training of PoE screeners at sites of thermal scanner installation.
 - Orientation of District Health Teams in Integrated Disease Surveillance and Response Version 3 (IDSR version 3).

- **COVID-19 Testing and Laboratory Capacity Strengthening**
 - Procurement of COVID-19 PCR test kits, COVID-19 GeneXpert test cartridges, COVID-19 RDTs, as well as reagents for specialized testing for comorbidities and universal transport media.
 - Procure one GeneXpert machine each (16 module) for six RRHs including Entebbe, and two GeneXpert 80 Infinity machines (84 module) for the Central Public Health Laboratory and Tororo General Hospital given its proximity to the four high volume and high risk PoEs (Busia, Lwakhakha, Malaba, and Suam) in Eastern Uganda.
 - Procure reagents for specialized testing of face masks by the National Drug Authority (NDA) —one set of Bacterial Filtration Efficiency Apparatus for Face Masks and one Apparatus for Measuring Air Resistance (breathability of face masks).
 - Procurement of laboratory equipment,²³ reagents, and supplies for enhanced testing, diagnosis, and reporting of COVID-19 in selected RRHs.
 - Expand existing laboratory capacity in two RRHs (Lira, Fort Portal).²⁴
 - Support laboratory quality improvement at Centers of Excellence by: (i) Sustaining the ISO Accreditation status for the WHO Supranational TB Reference Laboratory, Mulago National Referral Hospital, Moroto RRH, and Fort Portal RRH; (ii) support the SLMTA²⁵/SLIPTA²⁶ accreditation application for Arua RRH, Mbale RRH, and Lacor Hospital; (iii) sustain the SLIPTA program at 12 select hospitals, and (iv) provide operational budget support for satellite laboratories.
 - Training of laboratory staff from 16 RRHs in COVID-19 diagnosis and response on IDSR version 3.

Component 2: Strengthening Case Management and Psychosocial Support (US\$6,810,595, of which SDR 4.8 million

²³ The project will procure two Xpert Infinite 80 machines, and an Xpert 16 for installation at selected high-volume points of entry.

²⁴ These two laboratories have been prioritized because they are in high-risk densely populated cross-border areas and lack capacity for diagnosis and handling of COVID-19 samples.

²⁵ SLMTA is an acronym for *Strengthening Laboratory Management Toward Accreditation*. The foundation of this program is a framework that defines the tasks a laboratory manager must perform in order to deliver quality laboratory services which support optimal patient care. Training activities are designed to enable laboratory managers to accomplish those tasks, using tools and job aides to enhance their management routines. It empowers laboratory managers to initiate immediate laboratory improvement measures, even without additional resources. Source: <https://aslm.org/what-we-do/>.

²⁶ SLIPTA is an acronym for *Stepwise Laboratory Quality Improvement Process Towards Accreditation*. It is used to measure and evaluate the progress of laboratory quality system and award a certificate of recognition (five star levels). It can be used at baseline, during supervision, and for monitoring and evaluation of laboratory progress towards accreditation. Source: <https://aslm.org/what-we-do/>.



{US\$ 6,526,595 equivalent} is credit and US\$ 284,000 is grant)

33. **Component 2 focuses on strengthening the capacity of the health system** to: (i) respond to the disease burden of COVID-19; (ii) improve infection prevention control within hospitals; enhance clinical and intensive care; and (iii) equip key personnel to care for COVID-patients and their families—both from a clinical and a psychosocial perspective, through two sub-components.

Subcomponent 2a: Strengthening COVID-19 Case Management (US\$6,575,595, of which SDR 4.6 million {6,291,595 equivalent} is credit and US\$ 284,000 is grant)

34. **To ensure that Uganda’s health system is adequately prepared for the projected caseload of COVID-19 patients, this subcomponent will focus on strengthening the capacity for case management and clinical care, especially in hospitals designated to treat the severely and acutely ill patients.** Interventions in this sub-component will contribute towards ensuring that COVID-19 patients can access life-saving treatment, without compromising public health objectives of safety for health workers including by operationalizing the case management protocols for COVID-19 at Regional Referral and Select General hospitals across the country.

35. **Specific activities to be funded are as follows.**

- **Infrastructure, Equipment & Medical Supplies:** This will focus primarily on procurement of equipment and supplies, as well as refurbishing of selected facilities. It will include:
 - Remodeling of isolation facility infrastructure in selected regional referral and general hospitals, as well as provision of continued operations of water supply, sanitation, and handwashing facilities within the targeted RRHs and GHs.
 - Procurement of equipment for managing COVID-19 cases, for example, PPE (including soap, alcohol-based hand rubs, and relevant cleaning and disinfectant materials); ICU beds with monitor and suction machine for 6 Regional Referral Hospitals (Arua, Jinja, Kabale, Lira, Masaka, Mbale); 30 ICU ventilators; and oxygen supply equipment (e.g. pulse oxymeters, oxygen concentrators, nebulizers, humidifiers) for 54 Public GHs, based on need.
 - Procure Infection Prevention Equipment and Control (IPC) materials, for example, biowaste disposal bins, biosafety cabinets (6ft) for RRH labs, and vertical autoclaves for RRHs isolation facilities.
 - Procurement of medicines and consumables for managing COVID-19 cases.
- **Strengthening Health Workforce Capacity:**
 - Support development of guidelines for: (i) clinical care of acutely and severely ill COVID-19 cases, and (ii) triage and safety of COVID-19 patients and clients seeking other health services.
 - Long- and short-term trainings for emergency physicians and Critical Care staff. This will include a one-week training on emergency medicine and critical care for 240 staff, longer-term training in Emergency Medicine, Anesthesiology, and critical care nursing.
 - Quality of care activities such as mentorship and support supervision for Case Management teams at RRHs and General Hospitals. This will include engagement of Emergency Medicine Physicians, Anesthesiologists, and Critical Nurses to provide mentorship to case management personnel countrywide.
 - Support operationalizing the case management protocols for COVID-19 at Regional Referral and select general hospitals across the country.



Subcomponent 2b: Psychosocial Support and Gender-Sensitive Considerations (SDR 0.2 million {US\$235,000 equivalent} credit)

36. **Psychosocial Support: Patients, care givers, and their families would need support, especially those who are isolated.** Consistent with the recommendations of the SPRP document, mental and psychosocial support will be provided to COVID-19 patients, survivors, their families, and frontline health providers. Specifically, the Project will recruit two psychosocial specialists to support case management and counselling. For health workers, the Project will provide guidance and counselling on how to better manage burnout and stress, given the enormous strain on the health workforce.

37. **Gender considerations: Experience from past outbreaks—such as Ebola—also show the importance of placing attention on gender issues in containment and mitigation efforts to improve the effectiveness of health interventions and promote gender and health equity goals.** Within this context, the Project intends to address gender norms and roles that influence differential vulnerability to infection, exposure to pathogens, and treatment accessibility. The Project will also provide essential medical supplies for comprehensive care of Sexual and Gender-Based Violence (SGBV) survivors. The MoH will collaborate with the Ministry of Gender and other relevant actors to ensure the dissemination of information on available services for SGBV, use of established response hotlines, and community outreach. These interventions are also being supported through the COVID-19 CERC under the URMCHIP.

Component 3. Project Management, Monitoring and Evaluation (US\$1,156,100, of which SDR0.6 million {US\$ 844,960 equivalent} is credit and US\$311,140 is grant)

38. **This component will focus on two main areas: (i) Project Management; and (ii) Communications and Informative Technology Capacity.**

- **Project Management.** The implementation period of this Project is expected to be 2.5 years during which the Project will use and extend the existing Project Implementation Unit (PIU) of the ongoing EAPHLNP (closing on March 30, 2021). The PIU will perform the following functions: (i) preparation and implementation of annual work plans and budgets; (ii) implementation of the Project against the agreed work plan; (iii) monitoring and evaluation of Project performance against the Results Framework; and (iv) preparation of the Implementation Completion Report. This component will support costs associated with Project management and coordination and monitoring and evaluation for this Project. The component will also support the grievance redress mechanism and other activities in the Environmental and Social Commitment Plan (ESCP).
- **Information and Communications Technology (ICT) Capacity:** Given the current context of social distancing, the Project will procure ICT equipment to facilitate remote meetings and trainings. These technologies will serve both the immediate needs of the COVID-19 response as well as future emergencies and events of public health concern. The EAPHLNP sites have videoconferencing capacity that could be further leveraged to support implementation and virtual supervision.

C. Project Beneficiaries

39. **The Project is nationwide in scope, and the expected primary beneficiaries will be the general population, suspected and confirmed COVID-19 cases, medical and emergency personnel, port of entry officials, medical and**



testing facilities, and other public health agencies engaged in the response. The Project will also benefit refugee hosting communities and refugees in line with the Government policy of integrating refugee health services into the routine service delivery systems.²⁷

IV. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

40. **The Project will be fully embedded within the MoH Long-Term Institutional Arrangements (LTIA) which aim to strengthen ministry structures and ensure broad-based ownership.** The Project will be under the supervision of the Permanent Secretary/Accounting Officer, MoH and implemented through the Department of Integrated Epidemiology, Disease Surveillance and Public Health Emergencies. Where necessary, the PIU will liaise with other departments within the MoH, and other relevant sectors on the cross-sectoral determinants for effective prevention and response.

41. Fiduciary activities for the Project will be managed by a dedicated team in the MoH under the Accounting and Procurement units. A similar arrangement will be used for Social and Environmental Safeguards. The Fiduciary and Safeguards Specialists are consultants, hired to support IDA projects within the MoH. They currently support the URMCHIP and EAPHLNP PIUs, and by extension, will also support this Project. Their full costs are absorbed by URMCHIP, but will be transferred to this Project's PIU once the URMCHIP closes in June 2021. The costs of PIU staff currently covered by EAPHLNP will be covered by this Project after it becomes effective.

42. **The PIU consists of a Project Coordinator, Operations Officer, Monitoring and Evaluation Specialist, six Laboratory Mentors, ICT Officer, a Project Administrative Officer, and two drivers.** For the purposes of this Project, additional technical experts including a Medical Epidemiologist may be recruited to support the PIU.

43. The National COVID-19 Taskforce will provide overall oversight for the implementation of the Project.

B. Results Monitoring and Evaluation Arrangements

44. **The Project's Results Framework aligns with the COVID-19 SPRP and includes both outcome and intermediate results indicators.** Each component is aligned to at least one intermediate results indicator, reflecting the recommendations of the 2013 Independent Evaluation Group (IEG) report on managing epidemics. The monitoring and evaluation system has been specifically designed to track incremental improvements and regular reporting on outcomes. This will help improve the efficiency of Project implementation and inform key decisions on the efficacy of ongoing interventions. The PIU will be responsible for: (i) compiling data; (ii) monitoring and tracking results; and (iii) reporting.

C. Sustainability

45. **The sustainability of the Project-supported activities will hinge on continued and strong government commitment, enhanced institutional capacity, and predictable financing.** The commitment of the Government of

²⁷ The refugee population in Uganda is indirectly catered for through Subcomponent 2a. Support to the Regional Referral Hospital in Arua, for example, will benefit at least 810,000 refugees from settlements.



Uganda to protecting the health of the population, and its track record on epidemic preparedness, has been strong and augurs well for sustainability of this Project's interventions. Key stakeholders at the national and decentralized levels continue to demonstrate strong ownership to contain outbreaks swiftly. Institutional capacity has been built over time with the proposed Project further strengthening critical disease outbreak response and preparedness capacity. Further work is needed to ensure the financial sustainability of these activities, particularly greater levels of domestic financing.

V. PROJECT APPRAISAL SUMMARY

A. Technical and Economic Financial Analysis

46. **Preventing and minimizing the transmission of infectious diseases is one of the most important functions of public health policy.** This is because disease outbreaks can lead to prolonged illnesses and mortality that can affect the productivity of labor and the economy at large. Although there are substantial knowledge gaps on the epidemiology of the COVID-19 pandemic, it is apparent that the disease will have a negative effect on economic growth and revenues through losses in labor productivity, investments and trade, and capital formation for almost all the countries worldwide. In Uganda, foreign financing flows from remittances, and foreign aid will also be negatively affected. The COVID-19 pandemic is a stark reminder of the astronomical human and economic costs associated with pandemics which can throw the global economy into a recession if not prevented or controlled. While the actual magnitude of the economic impact of the COVID-19 is still largely unknown, April 2020 estimates from the World Bank show that economic growth in Sub-Saharan Africa (SSA) will be significantly impacted by the disease.²⁸ It is projected that economic growth for SSA will fall from 2.4 percent in 2019 to between -2.1 and -5.1 percent in 2020, which will drive the SSA region to a recession.

47. **The prevention, management, and control of COVID-19 cases in Uganda relies heavily on the capacity of the health system.** By preventing and limiting the spread of the disease, several lives will be saved, and this will safeguard the economy. Therefore, the planned investments in the health system through the proposed Project have huge potential to reduce the costs of stringent containment measures in future. Studies on the 1918 flu pandemic show that areas where extensive interventions were implemented early slowed the spread of the pandemic and reduced the severity of economic disruption. Considering that the number of COVID-19 cases which have been reported in Uganda so far are significantly lower than earlier predicted, this provides a huge opportunity to limit the spread of the virus through prevention. However, while prevention is critically important and cost-effective, it is also essential to strengthen the capacity of the health system to effectively respond in an event of a widespread outbreak. Therefore, it makes economic sense to anticipate and plan for case management. Given the fragile health system in Uganda – insufficient medical personnel, inadequate supply of medicines and other medical supplies, inadequate hospital beds and equipment, and low funding to the health sector – making investments in the health system before a full-blown outbreak is advisable. Further, the COVID-19 pandemic also provides an opportunity to strengthen the health system.

48. **The Project draws upon lessons learned from past Bank responses on epidemic preparedness and control at national, regional, and global level.** Uganda's decade-long implementation experience under the EAPHLNP also guides the technical approach. Fundamentally, the major lesson is that swift detection of a disease outbreak, assessment of its epidemic potential, and rapid emergency response can reduce avoidable morbidity and mortality as well as the health, social, and economic impacts. Key lessons learned from Uganda's experience under the EAPHLNP, and incorporated in

²⁸ <https://www.worldbank.org/en/news/press-release/2020/04/09/covid-19-coronavirus-drives-sub-saharan-africa-toward-first-recession-in-25-years>.



this Project include: (i) early deployment of competent and adequate multidisciplinary teams is critical, thus the need to quickly cascade training of clinical, laboratory, screening, and surveillance teams at sub-national level in a widespread epidemic; (ii) laboratory diagnostic capacity is essential to facilitate rapid testing and reporting to inform real-time decision making; (iii) psychosocial support to patients, survivors, responders, families, and communities is critical to improving health outcomes and addressing issues related to stigma; and (iv) qualified and motivated human resources are critical and should be appropriately mentored and supervised. Additionally, the global experience from COVID-19 has emphasized the following: (i) the need for PPE; (ii) adequate training of frontline health workers to quickly diagnose and triage patients; (iii) appropriate balance in the procurement of goods and services to ensure safe clinical management of severe and acute cases (involving trained personnel to use intensive care equipment, adequate supply of medicines, selective use of ventilator support); and (iv) prioritization of cost-effective interventions like oxygen therapy and chest physiotherapy.

49. **Notwithstanding the negative effect that the COVID-19 pandemic could have on the Ugandan economy, a very modest benefit-cost analysis shows that the Project will be a good investment.** Using the Uganda MoH's projection—1,680,000 cases, 336,000 hospitalizations, and 8,736 deaths—it was assumed that the Project will: (i) reduce the number of infections by 20 percent (336,000 cases) through prevention measures in the health sector (i.e. increased testing, contact tracing, isolation of suspect cases, etc.), and (ii) reduce the number of deaths by 20 percent (saving 1,747 lives) through intensified case management and psychosocial support. The reduced number of cases²⁹ was translated into monetary value by using the medium cash earnings per day for Uganda (estimated at US\$2.6 per day), while the value of a statistical life saved was equated to Uganda's GDP per capita of US\$732 in 2019. Further, it was assumed that the individuals whose lives would be saved would have 15 years of productive life. The costs and benefits were then discounted at a rate of 3 percent in line with recommendations on cost-effective analysis by the WHO. The results show that the total present value of costs will be US\$11.9 million while the total present value of benefits will be US\$17.0 million. This will yield a net present value of benefits of US\$5.1 million. As such, the benefit-cost ratio is estimated at 1.4 : 1, which implies that for every US\$1 invested in the Project there will be a yield of US\$1.4.

B. Fiduciary

Procurement:

50. **Procurement under the Project will be carried out in accordance with the World Bank's Procurement Regulations for IPF Borrowers for Goods, Works, Non-Consulting and Consulting Services, dated July 1, 2016** (revised in November 2017 and August 2018). The Project will be subject to the World Bank's Anticorruption Guidelines, dated October 15, 2006, revised in January 2011, and as in operation from July 1, 2016. The country will use the Systematic Tracking of Exchanges in Procurement (STEP) to plan, record, and track procurement transactions.

51. **The major planned procurement includes: (i) medical/laboratory equipment and consumables; (ii) PPE; (iii) clinical and waste management equipment, (iv) expanding of laboratory space, ICUs, and isolation units in RRHs; (v) PoE screening equipment; (vi) technical assistance; (vii) human resources for response; and (viii) expertise for development and training of frontline responders.** Finalization of the streamlined Project Procurement Strategy for Development (PPSD) has been deferred to implementation. An initial procurement plan has been agreed with the Borrower and will be updated during implementation.

²⁹ This is essentially wages or income that would have been lost due to sickness



52. **Country procurement approaches will use the flexibility provided by the Bank’s Procurement Framework for fast track emergency procurement by the countries.** Key measures to fast track procurement include: (i) use of simple and fast procurement and selection methods fit for an emergency situation including direct contracting, as appropriate; (ii) streamlined competitive procedures with shorter bidding time; (iii) use of framework agreements including existing ones; (iv) procurement from UN Agencies enabled and expedited by Bank procedures and templates; and (v) increased thresholds for Requests For Quotations and national procurement to US\$1 million for goods and services, and US\$5 million for works, among others. As requested by the Borrower, the Bank will provide procurement Hands-on Expanded Implementation Support (HEIS) to help expedite all stages of procurement—from help with supplier identification, to support for bidding/selection and/or negotiations to contract signing and monitoring of implementation. Bid Securing Declaration may be used instead of the bid security. Advance payments may be increased to 40 percent, secured with the advance payment guarantee. The time for submission of bids/proposal can be shortened to 15 days in competitive national and international procedures, and to three days for the Request for Quotations. If bidders request an extension it should be granted.

53. **The Project may be significantly constrained in purchasing critically needed supplies and materials due to significant disruption in the global supply chain, especially for PPE.** The supply problems that have initially impacted PPE are emerging for other medical products (e.g. reagents, medicines, and possibly oxygen) and more complex equipment (e.g. ventilators) where manufacturing capacity is being fully taken up by rapid orders from developed countries.

54. **Recognizing the significant disruptions in the usual supply chains for medical consumables and equipment for COVID-19 response, in addition to the above country procurement approach options available to countries, the Bank will provide, at Borrower’s request, Bank-Facilitated Procurement (BFP) to proactively assist clients to access existing supply chains.** Once the suppliers are identified, the Bank could proactively support the Borrower with negotiating prices and other contract conditions. The Borrower will remain fully responsible for signing and entering into contracts and implementation, including assuring relevant logistics with suppliers such as arranging the necessary freight/shipment of the goods to their destination, receiving and inspecting the goods, and paying the suppliers, with the direct payment by the Bank disbursement option available to them. The BFP would constitute additional support to Borrower over and above HEIS, which will remain available.

55. **BFP in accessing available supplies may include aggregating demand across participating countries, whenever possible, and extensive market engagement to identify suppliers from the private sector and UN agencies.** The Bank is coordinating closely with the WHO and UNICEF, which have established systems for procuring medical supplies and charge a fee that varies across agencies and type of service and can be negotiated (around five percent on average). In addition, the Bank may help Borrower to assess Government’s available stock in order to determine supplies needed.

56. **Procurement implementation will be undertaken by the MoH.** Implementation will be supported by Procurement Specialists within the MoH currently engaged on active IDA Projects (i.e. URMCHIP and EAPHLNP). During negotiations, MoH will share with the Bank the internal approval timelines to ensure that procurement processing is appropriately modified to accommodate the emergency nature of the Project.

Procurement Risks and Mitigation Measures.

57. **The key risks and preliminary risk mitigation action plan is presented below in Table 4.** The residual risks after the implementation of the mitigation measures would be reduced to “Substantial.”



Table 4: Procurement: Key Risks and Mitigation Measures

Key Risks	Recommended Mitigation Measures	Institutional Responsibility
Implementation delays due to slow procurement processing and decision making.	Put in place an internal mechanism for tracking and monitoring of procurement processes with clear timelines between activities to ensure expedited review and approval. Hands-on Expanded Implementation Support (HEIS).	MoH MoH, WB
Heavy workload at PIU could lead to delays in procurement.	MoH to dedicate one experienced procurement officer for the project.	MoH
Global nature of the COVID-19 outbreak has created shortages of supplies and services resulting in price volatility, bidders offering short validity periods.	Put in place emergency procurement approval mechanisms and dedicated teams to ensure evaluation and contract awards are concluded in 3-5 days after receipt of bids; UN agencies may be used as well as other direct procurement methods as suggested by WB global procurement team.	MoH
Lack of familiarity in dealing with such a novel pandemic and need for flexibility in procurement processing.	Allow for electronic submission, share bid opening outcome electronically and other streamlined measures as will be advised by the Bank.	MoH
Lack of adequate global supply of critical equipment and supplies given significant disruptions in supply chains globally.	World Bank to provide BFP to facilitate the Borrower's access to available supplies, clearly delineating the roles of all parties to avoid perception of conflict of interest.	MoH and World Bank
Challenges of bids submission due to COVID-19 movement restrictions imposed by many countries worldwide; and limited competition as some bidders may refrain from bidding.	MoH to closely watch market trends, promptly propose more efficient procurement approaches and methods as need arises, and update procurement plan accordingly; procurement process and contract management issues.	MoH



Lack of adherence to procedures due to inadequate experience in use of Bank Procurement Regulations.	Seek Bank support as need arises. Training on the World Bank Procurement Regulations for IPF Borrowers. Use of HEIS.	MoH
--	--	-----

58. The Bank’s oversight of procurement will be done through increased implementation support, and increased procurement post review based on a 20 percent sample. Prior review by the Bank will not apply.

Financial Management

59. **The Project will leverage the existing financial management (FM) and disbursement arrangements in the MoH for its implementation.** The Project will rely on the existing accounting capacity at the MoH, currently supporting other IDA-financed projects (EAPHLNP and URMCHIP). The designated accountant/FM Specialist will ensure timely financial reporting to the World Bank. The Project will submit quarterly interim unaudited financial reports (IFRs) to the Bank within 45 days after the end of the quarter. The format of the IFRs will follow the standard format used for other IDA-financed projects in the MoH and will include key details of funds received and expenditure incurred under the Project. External auditing of the Project’s financial statements will be conducted by the Auditor General of Uganda and the audit report will be submitted to the World Bank within six months after the financial year end.

60. **The Project involves several potential FM risks.** Key potential risks include dilution of internal controls, non-confirmation of delivery of the right quality and quantity of medical supplies and equipment, possibility of payments being made for substandard products or outputs or unintended beneficiaries, payments for items, goods or services not delivered. Furthermore, given that the Project activities will be implemented in diverse places across the country, there is a risk of difficulty in ensuring confirmation of Project outputs and deliverables. This could be exacerbated by the current COVID-19 challenges restricting movement for both Bank and Government staff. In addition, potential fund flow delays could impact delivery of key interventions under this emergency operation. There could also be challenges of Project supervision as well as delayed financial and audit reports due to government-implemented measures to contain the spread of COVID-19. To address these risks, the Project will rely on the country’s internal control systems that are currently applied to IDA-financed projects within the MoH. This includes proper documentation on delivery, confirmation of delivery/receipt of the right quantity and quality of medical supplies and equipment and certification of services rendered before payment and verification of deliveries by the hospital/ district internal auditor. For refurbishment of laboratories, certification of work done, evidence of status before and after, verification by district internal auditors and certificates of completion from district engineers will be required as proof of work done and evidence to support payments. Payments will be made to beneficiaries’ bank accounts to mitigate the risk of loss or diversion of funds. The fund flow arrangements include flexibility of direct payments to suppliers and contractors. This will facilitate efficient implementation of the emergency operation. The Bank team will closely monitor the Project and provide appropriate FM support in response to the evolving COVID-19 crisis. In particular, the team will enhance virtual engagement with the government Project team to obtain relevant information regarding the effectiveness of Project financial management arrangements. This includes desk review of IFRs, audit reports and similar reports, and use of questionnaires for FM supervision.

61. **Disbursements will be based on Statements of Expenditures (SOEs), and the Bank will review the expenditures in the SOEs on a quarterly basis.** The Project will open and maintain one Designated Account denominated in US\$ at the Bank of Uganda (BoU), for the credit and grant, from where payments, in United States Dollars (USD), for Project activities will be made. A local currency Project account will also be opened and maintained at BoU for payments



denominated in local currency. Advances from IDA credit and grant to the Project will be made upon request by the Project. Direct payments from IDA and the grant to the beneficiaries, suppliers, and contractors can also be made upon request by the Project following the laid-down procedures. To facilitate efficient implementation of the emergency operation, Reimbursements and Special Commitments methods of disbursement will be applicable to this Project. Flow of funds to the lower levels of implementation will follow the existing government systems currently used by URMCHIP and EAPHLNP. The current policies, guidelines, and procedures in use by both projects will also apply to this operation.

62. **The FM risk of the Project is assessed as Substantial and the residual risk is Moderate.** The assessment is based on the risks and their respective mitigation measures discussed above. The implementation of the mitigation measures will be reviewed, and the FM risk will be reassessed as part of the continuous implementation support to the Project.

C. Legal Operational Policies

63. **Large volumes of personal data, personally identifiable information, and sensitive data are likely to be collected and used in connection with the management of the COVID-19 outbreak under circumstances where measures to ensure the legitimate, appropriate, and proportionate use, and processing of that data may not feature in national law or data governance regulations, or be routinely collected and managed in health information systems.** To guard against abuse of that data, the Project will incorporate best international practice for dealing with such data in such circumstances. Measures may include data minimization (collecting only data that is necessary for the purpose); data accuracy (correct or erase data that are not necessary or are inaccurate); use limitations (data are only used for legitimate and related purposes); data retention (retain data only for as long as they are necessary); informing data subjects of use and processing of data; and allowing data subjects the opportunity to correct information about them; etc. In practical terms, the Project will ensure that these principles apply through assessments of existing or development of new data governance mechanisms and data standards for emergency and routine healthcare, data sharing protocols, rules or regulations, revision of relevant regulations, training, sharing of global experience, unique identifiers for health system clients, strengthening of health information systems, etc.

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

D. Environmental and Social Standards

Environmental Management

64. **The Project will finance infrastructure for COVID-19 isolation, labs, and ICU units, procurement of medicines, supplies, and medical equipment.** The environmental risks will mainly be associated with civil works, the operation of the labs, the quarantine and isolation centers, screening posts, and management of generated medical waste by the participating facilities. The environmental, health, and safety risks associated with the civil works can easily be managed through standard construction mitigation measures listed under ESS1.³⁰ Given that COVID-19 is a highly infectious

³⁰ ESS1 sets out the Borrower’s responsibilities for assessing, managing and monitoring environmental and social risks and impacts associated with each stage of a project supported by the Bank through Investment Project Financing, in order to achieve environmental and social outcomes consistent with the Environmental and Social Standards (ESSs).



disease, the Project will require that appropriate precautionary measures are planned and implemented. However, given Uganda's past 10 years' experience in managing a wave of epidemics such as Ebola, Marburg, Cholera, Influenza virus, and others, the country developed—in collaboration with WHO—the Uganda National Infection Prevention and Control Guidelines, 2013, providing guidance for treating all patients in the health care facility with the same basic level of “standard” precautions which involves work practices that are essential to provide a high level of protection to patients, healthcare workers, and visitors. These include: (i) hygiene (personal hygiene and safety, hand hygiene, facility hygiene and hygiene in special areas); (ii) use of PPE; (iii) care for patient equipment; (iv) observing aseptic techniques; and (v) management of healthcare waste. The Project's Environmental Risk Classification is therefore considered *Substantial*. Through its experience and increased investment in environmental and social safeguards systems and processes, the Government has in place adequate measures to mitigate the risks associated with COVID-19. The 2013 guidelines shall be followed, in addition to the current WHO COVID-19 guidelines.

65. **During Project design, the activities and infrastructure did not have clearly defined items and designs.** As such, an Environmental and Social Management Framework (ESMF) is being prepared by MoH to provide guidance on assessment and management of likely environmental and social impacts during Project implementation. The ESMF shall be completed and disclosed by June 30, 2020. All Project activities shall be subjected to environmental and social screening and, where necessary, site-specific instruments shall be prepared before commencement of such activities.

66. **The Project will be implemented by the existing Project Implementation Unit (PIU) of the East Africa Public Health Laboratory Networking Project (EAPHLNP), which will lead coordination and implementation of the Project-funded activities.** It will use existing Safeguards Specialists, recruited by the MoH, and under the overall supervision of the MoH Environmental Health Division. The costs of these specialists are currently covered by URMCHIP, which closes in June 2021. After Project closure, the full costs of the Safeguards Specialists will be borne by this Project. The designated Environmental and Social Specialists will provide support and coordinate management of the environmental, social, health and safety risks, and impacts posed by the Project at central level. The National Environment Management Authority (NEMA) and the Ministry of Gender, Labour, and Social Development, by virtue of their statutory mandates, shall provide operational guidance on management of environmental and Occupational Health Safety (OSH) aspects, respectively. District Environment Officers of the participating RRHs and GHs or other health facilities will provide support in managing environmental-health and safety aspects at the grassroots level. Periodic ESF capacity training will be provided to the environmental management teams under Component 3 of the Project.

Social Safeguards

67. **Social impacts under the Project are likely to emanate from activities to be carried out under Components 1 and 2.** The remodelling of isolation facilities and laboratories under Components 1 and 2 will likely induce an influx of labor into the selected facilities and potentially impact neighbouring communities during construction and operation phases. They include health and safety risks to construction/health workers and communities (exposure to COVID-19, stigma associated with the proximity to infected patients, sexual/ harassment and exploitation and abuse, etc.), potential labor issues, inadequate engagement /sensitization of both workers and communities, and lack of access to functioning grievance redress mechanisms. The client will address these risks through the preparation of an Environmental and Social Management Framework (ESMF) as guided under ESS1. The ESMF is expected to be finalized by July 31, 2020.

68. **As construction activities are expected to be carried out within the footprint of existing facilities, they are not expected to require land acquisition and/or cause physical and economic displacement.** Although some of the facilities benefiting from the Project have vulnerable and marginalized groups (Batwas and Iks) in their catchment areas, the



planned activities – construction/remodeling and supply of material and equipment – are not expected to impact them. The Project will however put in place measures targeted to marginalized groups to ensure that they receive benefits from the operation in an inclusive and culturally appropriate manner. This will be done by ensuring that their views are sought as detailed in the Stakeholder Engagement Plan (SEP), and more specifically, that public consultations with their representatives and organizations are carried out. The Project will also ensure that all other relevant activities related to sensitization on prevention/response, gender-based violence/sexual exploitation and abuse (GBV/SEA), etc. include provisions to specifically target these groups as well. The Project will exclude any activities which would require Free, Prior and Informed Consent and prepare the SEP as guided under ESS10³¹ for that purpose. The SEP was finalized and disclosed on the Ministry of Health’s website on April 24, 2020.³²

69. **Under Subcomponent 2b, Psychosocial Support & Gender-sensitive considerations, the Project plans on recruiting two psychosocial specialists to support case management and provide counselling services to patients, their care givers, and families, as well as to frontline workers.** Additional activities to help address gender related risks associated with government mandated measures to respond to COVID-19 (Lockdowns, curfews, etc.) such as increased incidence of Gender Based Violence (GBV), Violence Against Children (VAC), etc. will be included in the Stakeholder Engagement Plan. The Project will also ensure that services provided under it are of high quality and inclusive and that no one will be excluded on the basis of ethnicity, gender, nationality, religious affiliation, sexual orientation, disability, etc. For that purpose, MoH will: (i) provide training to healthcare workers in the public and private sectors on established guidelines for testing and treating patients in a manner that is fair, equitable and non-discriminatory in line with the national constitution;³³ and (ii) by monitoring service delivery standards and relevant grievance redress reports.

70. **Support to Military-Operated Hospitals:** Of the 54 General Hospitals expected to receive support through this Project, three of them – Bombo, Entebbe-Katabi and Nakasongola – are operated by the military. These hospitals serve military personnel and civilians in the surrounding communities. While administratively managed by the Ministry of Defence, the military hospitals operate under the policy direction of the MoH, obtain their supplies from the National Medical Stores, and provide reports to the MoH. The hospitals meet the MoH’s selection criteria for the Project based on: (i) their geographical location; (ii) availability of skilled health care personnel to support the clinical care of COVID-19 patients including non-military patients; and (iii) the availability of infrastructure to complement and support the ICU critical care interventions being proposed under the Project. Several health workers from these three hospitals have participated in public health emergencies both in-country and internationally (e.g. Ebola outbreak in West Africa and Cholera in Somalia) and thus have the necessary technical expertise to utilize equipment to be acquired through the Project, as well as provide care in line with guidelines for COVID-19. These hospitals will receive goods and services – oxygen equipment, PPEs, and WASH amenities – to be financed under the Project. Medical personnel in the hospitals (both civilian and military) will also benefit from capacity development/training in the provision of COVID-19 health services, including in supportive care for patients and their families as well as in providing a safe and inclusive environment for all patients. The performance of the selected hospitals, as with all the other hospitals funded under the Project, will be monitored and supervised by the Permanent Secretary for Health who is the Accounting Officer for the Project.

³¹ ESS10 recognizes the importance of open and transparent engagement between the Borrower and project stakeholders as an essential element of good international practice. Effective stakeholder engagement can improve the environmental and social sustainability of projects, enhance project acceptance, and make a significant contribution to successful project design and implementation.

³² <https://www.health.go.ug/cause/stakeholder-engagement-plan-sep/>.

³³ Article 21(2) of the Constitution of the Republic of Uganda (1995) prohibits discrimination on grounds of sex, birth, religion, social or economic standing, or disability (Article 21(3)).



71. **Based on the World Bank’s Safeguards of risks, the provision of support to these military hospitals does not pose major risks to the achievement of Project development objectives.** In the context of COVID-19 response, their personnel will be receiving guidance on service delivery from MoH’s National Task Force on COVID-19. All goods and equipment to be procured for these hospitals will become part of the hospitals’ inventories as has happened in previous emergencies. Therefore, the risk of these being used for unintended purposes is likely to be low, and in any case, not higher than in the general public hospitals. Strong supervision will be provided to ensure that the appropriate equipment and goods reach the hospitals, and that they are duly maintained and used in accordance with the Environmental and Social (ES) arrangements set out in the ESCP.

72. **Applicable Waivers: The relevant waiver of Paragraph 22 of the IPF Policy has been approved by the Board for the Global Emergency MPA Program.** Paragraph 22 specifically relates to the requirement to seek the approval of the Board prior to signing the legal agreements for individual projects, under the Global Emergency MPA Program, classified as High or Substantial Risk (pursuant to the Environmental and Social Policy). This waiver has been provided for the MPA Program given the similarity of environmental and social risks across COVID-19 operations and the commonality of approaches to their mitigation, which are specifically embedded in the project design and ES requirements that apply to each project, as set out in paragraph 66 the MPA PAD.

VI. GRIEVANCE REDRESS SERVICES

73. **Communities and individuals who believe that they are adversely affected by a World Bank-supported project may submit complaints to existing project-level grievance redress mechanisms or the Bank’s Grievance Redress Service (GRS).** The GRS ensures that complaints received are promptly reviewed to address project-related concerns. Project-affected communities and individuals may submit their complaint to the Bank’s independent Inspection Panel which determines whether harm occurred, or could occur, as a result of Bank non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank’s attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the Bank’s corporate Grievance Redress Service (GRS), please visit: <http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service>. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VII. KEY RISKS

74. **The overall Project risk rating is Substantial.** There are several substantial risks to the Project: (i) fiduciary concerns, including procurement-related problems, stemming from potential difficulties in procuring critical equipment given the disruptions in global supply chains; (ii) adverse effects on the macroeconomic and fiscal situation of the GoU stemming from COVID-19; (iii) health sector institutional capacity, which can be easily overwhelmed if there is a surge in the number of new cases; and (iv) environmental and social safeguards, which are discussed earlier. Table 5 below identifies the main risks, proposes mitigation measures, and notes the residual risks. Additional risks, moderate, are indicated in the SORT. Based on the assessment of these important risks, which stem in large part from the heavily constrained global supply chain, the overall risk of the proposed Project is therefore rated *Substantial* (see Table 5).



Table 5: Project Risks

Main Risks	Mitigation Measures	Rating
<p>Fiduciary: The key fiduciary risk is failed procurement due to lack of sufficient global supply of essential medical consumables and equipment needed to address the health emergency as there is significant disruption in the supply chain, especially for PPE. This is associated with increased risk of cost overruns. Given the emergency situation, there is also risk related to adequate equipment identification and confirmation of quality and quantity.</p>	<p>The World Bank will leverage its comparative advantage, as convener, and facilitate Borrower’s access to available supplies at competitive prices with the BFP described in the procurement section of this document.</p> <p>The risks associated with confirming equipment quantity and quality will be managed by maintaining due diligence on implementation and procurements, drawing on the World Bank’s integrity guidance notes on medical equipment and supplies. As is the case with other procurements of medical equipment, the National Advisory Committee on Medical Equipment (NACME) sets specifications and verifies all procured equipment to ascertain whether it is of the specified quality and approves or rejects. This role will be maintained in the Project.</p>	S
<p>Macroeconomic: COVID-19 is expected to negatively impact economic growth. The resulting fiscal constraints could have adverse effects on public health service delivery with respect to COVID-19 prevention, mitigation, and treatment in addition to other essential health services.</p>	<p>The Project would partly mitigate this risk by strengthening capacity in public health, in addition to the COVID-19 response and mitigation efforts. It will also benefit from the World Bank’s ongoing efforts to support government in stabilizing the economy and stimulate private sector activity. These include the proposed DPO for epidemic preparedness and response, economic recovery, and resilience.</p>	S
<p>Health sector institutional capacity for implementation and sustainability: The severity and unpredictability of the coronavirus global pandemic poses potential high risks to Uganda, both in terms of its ability to respond swiftly to a rapid rise in the number of reported cases as well as to sustain other critical health services.</p> <p>The Project is being implemented within the context of a national lockdown, social distancing, and curfews. These conditions make it difficult for rapid implementation and could potentially cause delays.</p>	<p>The Government has put in place measures to recruit a “surge” workforce to support the national response to COVID-19. This effort will be complemented by the Project through intensive capacity building for clinicians, and laboratory and surveillance staff.</p> <p>The MoH and PIU will leverage ICT to enable remote communication between the center and the sub-national levels. In addition, within Uganda, key personnel—including the PIUs—are designated as frontline and are therefore working (essential workers). This will help ensure timely follow-up and supervision.</p>	S
<p>Social: As the number of cases increases, there are potential social risks from panic and lack of adequate and appropriate information about the pandemic to manage anxieties.</p>	<p>This risk will be mitigated through appropriate messaging from political and administrative leadership and the healthcare work force.</p>	S
Environmental and Social	<i>See section on Environmental and Social Safeguards</i>	



VIII. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY: Uganda

Uganda COVID-19 Response and Emergency Preparedness Project

Project Development Objective(s)

The objective of the Project is to prevent, detect and respond to COVID-19 and strengthen national systems for public health emergency preparedness in Uganda.

Project Development Objective Indicators

Indicator Name	PBC	Baseline	End Target
To strengthen Uganda's capacity to respond to the COVID-19 outbreak			
Proportion of targeted Regional Referral Hospitals with clinical capacity to manage COVID-19 cases in line with clinical guidelines (Percentage)		25.00	85.00
Proportion of COVID-19 suspected cases, having laboratory confirmation within 48 hours (Percentage)		50.00	90.00



Intermediate Results Indicators by Components

Indicator Name	PBC	Baseline	End Target
Case Detection, Confirmation, Contact Tracing, Recording and Reporting			
Cumulative number of laboratory tests done for suspected COVID-19 cases (Number)		194,872.00	1,000,000.00
Cumulative number of laboratories enrolled on ISO 15189 accreditation maintaining or achieving ISO 15189 accreditation (Number)		4.00	6.00
Cumulative number of staff trained in laboratory diagnosis of SARS-CoV-2 and other important pathogens (Number)		250.00	700.00
Cumulative number of targeted hospitals whose laboratory spaces have been remodeled/upgraded (Number)		0.00	2.00
Proportion of RRHs enrolled on the LQMS scoring >90% in the annual biowaste management audits (Percentage)		30.00	70.00
Proportion of people travelling through the targeted designated PoEs screened (Percentage)		10.00	90.00
Strengthening Case Management and Psychosocial Support			
Proportion of targeted hospitals with functional oxygen delivery equipment (Percentage)		20.00	90.00
Cumulative number of targeted hospitals whose isolation and/or ICU facility has been upgraded (Number)		0.00	12.00
Cumulative number of staff trained in critical and acute medical care (Number)		35.00	400.00



Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Proportion of targeted Regional Referral Hospitals with clinical capacity to manage COVID-19 cases in line with clinical guidelines	Indicator Calculated as: Numerator: Number of targeted RRHs with adequate clinical capacity to treat COVID-19 cases Denominator: Total number of RRHs targeted for COVID-19 treatment capacity enhancement	Quarterly	Administrative data and verification reports	Review of Administrative data and verification reports	M&E Specialist, CHS Epidemiology and Disease Surveillance, CHS Clinical Services
Proportion of COVID-19 suspected cases, having laboratory confirmation within 48 hours	Numerator: Number of COVID-19 suspected cases with laboratory confirmation of diagnosis within 48 hours Denominator: Total number of COVID-19 suspected cases reported to the Emergency Operations Center	Quarterly	Review of the EOC Situation Reports (SITREP) and the Reports of the National Task Force	Review of the EOC Situation Reports (SITREP) and the Reports of the National Task Force.	M&E Specialist, CHS Epidemiology and Disease Surveillance



Monitoring & Evaluation Plan: Intermediate Results Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Cumulative number of laboratory tests done for suspected COVID-19 cases	Total number of COVID-19 tests performed.	Quarterly	Laboratory Registers, LMIS and EOC SITREP	Periodic data collection, Structured Checklist	M&E Specialist, CHS Epidemiology and Disease Surveillance.
Cumulative number of laboratories enrolled on ISO 15189 accreditation maintaining or achieving ISO 15189 accreditation	Numerator: Cumulative number of laboratories enrolled on the LQMS maintaining or achieving ISO 15189 accreditation. Denominator: Not applicable.	Annually	Periodic SLIPTA/SANAS audits reports	Periodic data collection, Structured Checklist	M&E Specialist, CHS Planning
Cumulative number of staff trained in laboratory diagnosis of SARS-CoV-2 and other important pathogens	Numerator: Cumulative total number of laboratory staff trained in laboratory diagnosis of Novel SARS-CoV-2 and other important pathogens. Denominator: Not applicable	Quarterly	Training reports.	Review of training reports.	M&E Specialist, CHS Planning.
Cumulative number of targeted hospitals whose laboratory spaces have been remodeled/upgraded	Numerator: Cumulative number of targeted laboratory spaces have been remodled/upgraded.	Quarterly	Health Infrastructure Inventory MoH; Activity	Periodic data collection, Structured Checklist.	M&E Specialist, CHS Planning.



	Denominator: Not applicable.		Progress Reports.		
Proportion of RRHs enrolled on the LQMS scoring >90% in the annual biowaste management audits	Numerator: Number of project supported health facilities that score >90% from the biowaste management audits conducted annually. Denominator: Total number of health facilities supported by the project.	Quarterly	Periodic biowaste management audits reports	Periodic data collection, Structured Checklist.	M&E Specialist, CHS Planning.
Proportion of people travelling through the targeted designated PoEs screened	Numerator: Number of people screened at the targeted designated PoEs. Denominator: Total number of passengers travelling through the targeted designated PoEs screened.	Quarterly	Ministry of Health and Ministry of Internal Affairs PoE Reports	Review of the MoH and Ministry of Internal Affairs PoE Reports.	M&E Specialist, CHS Epidemiology and Disease Surveillance.
Proportion of targeted hospitals with functional oxygen delivery equipment	Numerator: Number of targeted hospitals with functional oxygen delivery equipment. Denominator: Total	Quarterly	Health Infrastructure and Equipment Inventory Reports	Review of the Health Infrastructure and Equipment Inventory Reports	M&E Specialist, CHS Clinical Services, CHS Infrastructure



	number of hospitals targeted for supply of oxygen delivery equipment.				
Cumulative number of targeted hospitals whose isolation and/or ICU facility has been upgraded	Numerator: Cumulative number of targeted hospitals with at least one upgraded isolation and or ICU facility. Denominator: Not applicable.	Quarterly	Activity Progress Reports	Periodic data collection, Structured Checklist	M&E Specialist, CHS Planning, CHS Infrastructure
Cumulative number of staff trained in critical and acute medical care	Numerator: Cumulative number of staff trained in critical and acute care. Denominator: Not applicable.	Quarterly	Training reports.	Review of training reports.	M&E Specialist, CHS Clinical Services, CHS Human Resources.



ANNEX 1: Project Costs

COUNTRY: Uganda

Uganda COVID-19 Emergency Response Project

COSTS AND FINANCING OF THE COUNTRY PROJECT

Program Components	Total Project Cost	IDA Financing	Trust Funds
Component 1: Case Detection, Confirmation, Contact Tracing, Recording, Reporting	7,233,852	5,128,445	2,105,407
Component 2: Strengthening Case Management and Psychosocial Support	6,810,595	6,526,595	284,000
<i>Subcomponent 2a: Strengthening COVID-19 Case Management</i>	<i>6,575,595</i>	<i>6,291,595</i>	<i>284,000</i>
<i>Subcomponent 2b: Psychosocial Support and Gender-Sensitive Considerations</i>	<i>235,000</i>	<i>235,000</i>	<i>0</i>
Component 3: Project Management, Monitoring and Evaluation	1,156,100	844,960	311,140
Total Costs	15,200,547	12,500,000	2,700,547
Front End Fees	0	0	0
Total Financing Required	15,200,547	12,500,000	2,700,547



ANNEX 2: Implementation Arrangements and Support Plan

COUNTRY: Uganda

Uganda COVID-19 Emergency Response Project

Supervision Arrangements: Given that COVID-19 related quarantines and social distancing measures will impact the supervision of emergency operations for at least the immediate term, the task team will strengthen virtual supervision methods. This will involve: (i) agreeing on realistic annual work plans for implementation; (ii) diligent monitoring of activities against the approved annual work plan; (iii) quarterly check-ins via virtual meetings to discuss and resolve implementation challenges/bottlenecks; (iv) implementation support missions held every six months (via teleconference to start with). With respect to effective information and communications technology (ICT), the Project is scaling up fit-for-purpose and cost-effective ICT methods to contribute to effective project implementation and supervision. This includes the acquisition of Zoom and internet connectivity for more effective remote meetings and consultations. The task team is also exploring how best to utilize the recently launched Geo-Enabling initiative for Monitoring and Supervision (GEMS), designed by the Bank to support project teams in using ICT solutions to enhance monitoring and evaluation; remote supervision, real-time safeguards monitoring and portfolio mapping and coordination. GEMS has met with widespread demand from clients and WBG country teams and has been implemented across 10 CMUs. There is interest from the client to use GEMS and its utility within the context of this Project will be further explored.



ANNEX 3: 2017 Joint External Evaluation (JEE) Scores for Uganda

<i>Metric (JEE Assessment Tool indicators)</i>	<i>Uganda</i>
P.1.1 Legislation, laws, regulations, administrative requirements, policies, or other government instruments in place are adequate for implementation of IHR.	3
P.1.2 The state can demonstrate that it has adjusted and aligned its domestic legislation, policies, and administrative arrangements to enable compliance with the IHR (2005).	3
P.2.1 A functional mechanism is established for the coordination and integration of relevant sectors in the implementation of IHR.	2
P.3.1 Antimicrobial resistance (AMR) detection.	2
P.3.2 Surveillance of infections caused by AMR pathogens.	2
P.3.3 Healthcare associated infection (HCAI) prevention control programs.	3
P.3.4 Antimicrobial stewardship activities.	3
P.4.1 Surveillance systems in place for priority zoonotic diseases/pathogens.	2
P.4.2 Veterinary or Animal Health Workforce.	3
P.4.3 Mechanisms for responding to infectious zoonoses and potential zoonoses are established and functional.	2
P.5.1 Mechanisms are established and functioning for detecting and responding to foodborne disease and food contamination.	2
P.6.1 Whole-of-government biosafety and biosecurity system is in place for human, animal, and agriculture facilities.	3
P.6.2 Biosafety and biosecurity training practices	3
P.7.1 Vaccine coverage (measles) as part of national program.	3
P.7.2 National vaccine access and delivery.	4
D.1.1 Laboratory testing for detection of priority diseases.	4
D.1.2 Specimen referral and transport system.	3
D.1.3 Effective modern point of care and laboratory-based diagnostics.	3
D.1.4 Laboratory Quality System.	3
D.2.1 Indicator and event-based surveillance systems.	4
D.2.2 Interoperable, interconnected, electronic real-time reporting system.	3
D.2.3 Integration and analysis of surveillance data.	3
D.2.4 Syndromic surveillance systems.	3
D.3.1 System for efficient reporting to WHO, FAO and OIE.	3
D.3.2 Reporting network and protocols in country.	3
D.4.1 Human resources are available to implement IHR core capacity requirements.	3
D.4.2 Applied epidemiology training program in place such as FETP.	4
D.4.3 Workforce strategy	3
R.1.1 Multi-hazard national public health emergency preparedness and response plan is developed and implemented.	1
R.1.2 Priority public health risks and resources are mapped and utilized.	1
R.2.1 Capacity to Activate Emergency Operations.	4
R.2.2 Emergency Operations Center Operating Procedures and Plan.	4
R.2.3 Emergency Operations Program.	4



R.2.4 Case management procedures are implemented for IHR relevant hazards.	3
R.3.1 Public Health and Security Authorities, (e.g. Law Enforcement, Border Control, Customs) are linked during a suspect or confirmed biological event.	2
R.4.1 System is in place for sending and receiving medical countermeasures during a public health emergency.	2
R.4.2 System is in place for sending and receiving health personnel during a public health emergency.	2
R.5.1 Risk Communication Systems (plans, mechanisms, etc.).	2
R.5.2 Internal and Partner Communication and Coordination.	4
R.5.3 Public Communication.	4
R.5.4 Communication Engagement with Affected Communities.	4
R.5.5 Dynamic Listening and Rumor Management.	3
PoE.1 Routine capacities are established at PoE.	1
PoE.2 Effective Public Health Response at PoEs.	1
CE.1 Mechanisms are established and functioning for detecting and responding to chemical events or emergencies.	2
CE.2 Enabling environment is in place for management of chemical event.	2
RE.1 Mechanisms are established and functioning for detecting and responding to radiological and nuclear emergencies.	2
RE.2 Enabling environment is in place for management of Radiation Emergencies.	2
Average score	2.75
Overall Performance (%)	56.0

1= No capacity --- 5 = strong capacity