



Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 12-Apr-2020 | Report No: PIDA29009



BASIC INFORMATION

A. Basic Project Data

Country Cote d'Ivoire	Project ID P173813	Project Name Cote d'Ivoire COVID-19 Strategic Preparedness and Response Project (SPRP)	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 13-Apr-2020	Estimated Board Date 31-Mar-2020	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Republic of Cote d'Ivoire	Implementing Agency Ministry of Health	

Proposed Development Objective(s)

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

Components

- Component 1: Emergency COVID-19 response
- Component 2: Supporting preparedness through laboratory system strengthening
- Component 3: Health Communication and Community Engagement
- Component 4: Project implementation management and monitoring and evaluation

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

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

DETAILS

World Bank Group Financing



International Development Association (IDA)	35.00
IDA Credit	35.00

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

- Cote d'Ivoire (CIV) has experienced almost a decade of robust economic growth since the end of the political crisis in 2011.** Cote d'Ivoire is a lower-middle income country (LMIC) with a Gross National Income (GNI) per capita of US\$1,532.5 in 2017 and is the second largest economy in West Africa. It has a large (25.1 million in 2017) and a young population (42 percent under 15 years), 49.5 percent of which are women¹. Independent since August 1960, CIV experienced a long period of instability from 2002-2011, marked by two armed conflicts in 2002-2007 and 2010-2011. This not only led to loss of life, but also slowed the country's economic development, with a drop in GDP growth of 4.7 percent during the post-election crisis. Thereafter, CIV has experienced strong economic growth, which averaged 8 percent from 2011-2018 driven by the modern service (e.g. communication) and construction sectors. Although the macroeconomic outlook has remained positive, until recently 2019-2020 growth was expected to stay on its recent trend at around 7 percent², supported by resilient investment, higher cocoa sector incomes and the increased emphasis on social spending. The economy is strongly dependent on the production and export of primary agricultural products, particularly cocoa, coffee, bananas, cashew and palm oil. Although a net oil importer (by a small margin), Côte d'Ivoire is a net exporter of energy. However, recently the government has revised 2020 growth to 3.5 percent³.
- CIV's strong economic performance in recent years has not translated to improved human development or human capital outcomes.** Despite its LMIC status, CIV was one of the worst performers on the 2019 Human Development Index - ranking 165 of 189 countries tracked⁴ - and in 2018, it was ranked as the 9th lowest country in (149 of the 157 countries; HCI: 0.35) on the Human Capital Index (HCI). The average child in CIV will realize,

¹ Source: WDI 2018.

² IMF (2019). Sixth reviews under the arrangement under the extended credit facility and the extended arrangement under the extended fund facility, and request for extension and augmentation of access.

³ <https://www.financialafrik.com/2020/03/31/covid-19-en-cote-divoire-le-premier-ministre-projet-une-croissance-35-au-lieu-de-72-en-2020/>

⁴ UNDP (2019) Human Development Report 2019



at best, 35 percent of their human capital potential. This is much lower than the average for the region and for economically comparable countries such as Kenya (0.52), Bangladesh (0.48) and Ghana (0.44), and is largely driven by the low adult survival rates (only 61 percent of 15 year olds will survive to age 60) and poor learning outcomes.

3. **Within the existing fiscal space, the share of social spending remains low and health expenditure is about 5 percent of general government spending**, which is among the lowest in Africa and well below the Abuja target of 15 percent. Health spending has grown more slowly than other public spending for other sectors. Moreover, the Government has spent a substantial share of this on reconstruction of health facilities after the conflict: for tertiary facilities, with a total construction and rehabilitation budget of 739 billion FCFA (US\$1.34 billion) from 2018-2020 targeting health facilities at all levels, but with a strong focus on secondary and tertiary care in urban areas as well as training institutions.

Sectoral and Institutional Context

4. **The socio-political instabilities of 2002-2007 and 2010-2011 exacerbated challenges in health system equity, access, and quality, leading to poor health outcomes.** The main factors contributing to the weak health system and its poor performance include the lack of infrastructure and limited physical access to health facilities, the lack of basic medical equipment and essential medicines, weak governance and poor financial management. In addition, health personnel are unevenly distributed across the country, have limited training, and are poorly motivated, leading to poor-quality services. While CIV satisfies WHO norms for the number of medical doctors (general practitioners), nurses and midwives at the national level, the majority are concentrated in Abidjan and urban areas, leaving the 49 percent of the population that reside in rural areas with limited access to health personnel.
5. **The epidemiological profile of CIV continues to be dominated by communicable, maternal, neonatal and nutritional diseases.** Increasing prosperity, rising urbanization and increase in unhealthy lifestyles have also driven a rise in the burden of non-communicable diseases (high blood pressure, diabetes and cancer), resulting in a dual burden of disease taxing an already fragile health system.
6. **Given its fragile Public Health systems and its ties to China and European countries, especially France and Italy, Cote d'Ivoire is vulnerable to the spread of COVID-19.** It has been identified by the World Health Organization (WHO) as one of 13 high priority African countries based on the volume of travel from China. Moreover, CIV shares borders with five countries, all of which have been reporting growing numbers of cases of COVID-19, and its land borders remain a cause for concern as unchecked migration and transport between neighboring countries could spread the virus quickly. The country has, however, benefitted from the somewhat slow arrival of the virus: the first case was diagnosed on 11 March.
7. **Current statistics on COVID-19 in CIV.** As of April 5, 2020, the Ministry of Health and Public Hygiene (MSPH) has confirmed 245 cases. The government has implemented measures to limit the spread of COVID-19. Schools (including pre-schools and universities) were closed for 30 days on March 16. Sporting events, festivals, and gatherings larger than 50 people were banned as of March 18. Social distancing is in effect: no handshakes, maintain at least one-meter distance from other persons. All confirmed and suspected cases of COVID-19 are to be quarantined in state-run centers. In addition, land, aviation, and maritime borders have been closed since March 22 for an indeterminate period. Cargo shipments are not affected. There are isolation wards in Abidjan that are arranged for COVID-19 preparedness, including one at FHB International Airport as well as isolation rooms within the Infectious and Tropical Diseases Unit at Treichville University Teaching Hospital (CHU).



Residents in Cote d'Ivoire who are ill can call 143 or 101 to speak with an official at the National Institute of Public Hygiene. Trained Rapid Response Teams (RRTs) in each of the twenty regions have been placed on alert.

8. **CIV has taken important steps by implementing the World Bank-funded Health System Strengthening and Ebola Preparedness Project between 2015 and 2020 (P147740).** As a national structure of emergency coordination, the capacity of the National Public Hygiene Institute (*Institute Nationale d'Hygiène Publique*) (INHP) was reinforced with the acquisition of vehicles, motorcycles and IT equipment (computers, printers, and laptops). In addition, vehicles, motorcycles and ambulances were also procured for MOH. Nine multidisciplinary national Emergency Response Teams, each comprising 30 members from different ministries and specialized institutes, were trained and equipped. In addition, 120 health workers were trained at regional level on the integrated disease surveillance and response strategy, based on the WHO standard. Two warehouses have been rehabilitated for the storage of Personal Protective Equipment (PPE) for health workers, medicines and other medical equipment/accessories. The remainder of this equipment is currently being used in the fight against COVID-19.
9. **The Government has established an organizational framework for coordination, prevention and control of the coronavirus COVID-19.** The framework is composed of a National Steering Committee, chaired by the Prime Minister and the MSPH as secretariat, and several subcommittees, and action units in each sector. The Steering Committee provides both strategic and policy guidance and oversight for the Governments' emergency response; it coordinates the activities of the other committees and mobilizes resources for the implementation of the Government's emergency response plan and response. The secretariat of the Steering Committee is led by the MSPH.
10. **At the operational level,** the MHPH's main body for multisectoral coordination to public health emergencies responses called the Centre for Public Health Emergency Operations (COUSP) chaired by INHP has been activated. All health key stakeholders including the World Bank and WHO are invited to participate in the weekly coordination meeting organized by COUSP. The operational response of COVID-19 is led by the General Director of Health under the leadership of the MOH.
11. **Despite these efforts, the emergency preparedness capacity of the country still requires strengthening.** CIV urgently needs to accelerate response planning. Its initial Emergency Preparedness and Response Plan assumed COVID-19 cases would arrive from China. But as the country is now already affected by the disease, the preparedness and response plan has been revised to assume community transmission. Preventing further spread and responding to the outbreak will require additional budget. The USD 159 million budget of the Government plan for the different phases of preparedness and response reflects the current low capacities of the country to face the crisis on its own and its low prior investment in the health system. Immediately following the outbreak of the COVID-19 epidemic in CIV, the Government committed EUR 1 million, and the WB about USD 642,000 from the SPARK Project for initial screening and COVID-19 control measures.
12. **CIV could take lessons from Liberia's experience during the Ebola epidemic in 2014.** Given the high burden of disease and weak health systems, the Government of CIV may benefit from the experience of Liberia during the Ebola crisis, and (i) couple its emergency response with efforts to ensure continuity of care of the general population; (ii) ensure that healthcare workers receive all material that they need to protect themselves; and (iii) engage the community and build trust by implementing an adaptive bottom-up communication mechanism. In 2014, the Ebola crisis decimated Liberia's health care system and severely constrained the Government of Liberia's ability to deliver essential health services, which led to many preventable deaths. By March 2016, an



estimated 10,675 people were infected with Ebola, 5000 people died, and fear and community distrust led to a rapid decline in the utilization of health care services. EVD deaths were disproportionately concentrated among Liberia's health personnel, further depleting an already depleted health workforce. The loss in health personnel is estimated to have contributed to a 111 percent increase in the maternal mortality ratio from pre-Ebola levels (from 640 to 1347 deaths per 100,000 live births); a 20 percent increase in infant mortality (from 54 to 64 deaths per 1000 live births) and a 28 percent increase in child deaths (from 71 to 91 deaths per 1000 live births)⁵.

13. **The World Bank is coordinating with several key Development Partners in the sector.** The National Emergency plan is budgeted at about US\$160 million for 6 months. The government has allocated around US\$45 million from its own resources to finance the national plan. With an envelope of over US\$75 million the WB is the largest supporter of the national plan, including this COVID-19 SPRP project and US\$40 million from the SPARK-Project's CERC. Under the leadership of WHO, key partners including GAVI, KFW, AFD, the Global Fund, UNICEF, and the French embassy are supporting (technically and financially) the National Emergency plan. These partners are working to (i) coordinate on the co-financing of activities under the Government's Plan and avoid duplication; (ii) support the Government to procure the necessary equipment and material in the most timely, efficient and effective manner possible; and (iii) provide technical assistance during the preparation and implementation of the response. Activities financed by these partners include reinforcing the national laboratory network for COVID-19 testing, supporting communication, and community engagement and monitoring, supporting the expansion of intensive care units and patient treatment, and providing technical assistance for operational research including epidemic modeling.

C. Proposed Development Objective(s)

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

Project Development Objective (PDO) statement: To prevent, detect, and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Cote d'Ivoire.

PDO level indicators:

- a. Number of suspected cases of COVID-19 cases reported and investigated based on national guidelines;
- b. Percentages of acute healthcare facilities with isolation capacity (Percentage)
- c. Number of COVID-19 patients treated
- d. Country adopted personal and community non-pharmaceutical interventions (Yes/No)

D. Project Description

Component 1: Emergency COVID-19 Response [US\$ 24 million].

14. **This component will provide immediate support to CIV to prevent importation and local transmission of COVID-19 through containment strategies.** It will support the enhancement of disease detection capacities

⁵ Salm-Reifferscheidt.(2019) Liberia post Ebola: ready for another outbreak? Lancet vol 393 pg 1583-1584



through the provision of technical expertise, training, laboratory equipment, and reagents for testing to ensure prompt case finding and contact tracing, consistent with WHO's SPRP for COVID-19. It will enable the country to mobilize surge response capacity through trained and well-equipped (with personal protection equipment) frontline health care workers. Activities included in this component are complementary to those financed under the CERC component of the SPARK-Health project (P167959), which is being activated simultaneously.

15. **This component will finance:** (i) Case Detection, Confirmation, Contact Tracing, Recording, and Reporting; (ii) case management and Health System Strengthening; (c) Social and Financial Support to Households. Amounts for subcomponents will be specified before ROC

16. **Sub-component 1.1: Case Detection, Confirmation, Contact Tracing, Recording, and Reporting.** This sub-component will finance activities that strengthen disease surveillance and epidemiological capacity for early detection and confirmation of cases and active contact tracing. This includes financing for: (i) the development of multisectoral plans and standard operating procedures and joint coordination (including all relevant ministries and sectors), and logistics related to the implementation of preparedness and response activities using the One Health approach; (ii) development and/or procurement, and deployment of tools and information and communication technology (ICT) to support surveillance and contact tracing; (iii) strengthening public health emergency management and community and event-based surveillance; (iv) support for epidemiological investigations, multi-sectoral simulation exercises and strengthening of the GOC's risk assessment capabilities; (v) rehabilitation of screening posts/rooms at designated Points of Entry (POEs) and isolation sites; (vi) training and equipping of human resources, including POE staff, contact tracers, and frontline healthcare and support workers; and (vii) equipment for the functionality of emergency operations centers at the subnational level. This subcomponent will also cover costs related to the use of digital solutions to facilitate the response.

17. **Sub-component 1.2: Case Management Health System Strengthening.** This subcomponent supports (i) activities to ensure adequate case management, including contingency planning (surge capacity), and (ii) activities to minimize risks for non-COVID-19 patients and for health personnel managing COVID-19 patients,⁶ including basic handwashing and sanitation facilities, and adequate medical waste management and disposal systems in permanent and temporary healthcare facilities.⁷ The sub-component will finance, among others: (i) procurement of COVID-specific medical supplies, COVID-19 specific equipment for intensive care units and medical equipment for designated health facilities; (ii) costs related to the mobilization of additional health personnel to support the surge response, establishing and equipping rapid response teams (RRT) and provision of salaries and hazard/indemnity pay consistent with the Government's applicable policies; (iii) procurement of infection prevention and control (IPC) materials and personal protective equipment (PPE) kits for frontline health personnel involved in case management of patients; (iv) training of health care workers and support personnel on case management, personal protection, and infection control; (v) supplies for water, sanitation

⁶ As COVID-19 places a substantial burden on inpatient and outpatient health care services, support could be provided for minimum rehabilitation and equipment of selected health facilities for the delivery of critical medical services and to help them cope with the increased demand of services likely to arise due to the pandemic, while strengthening intra-hospital infection control measures. Steps could be taken to increase hospital bed availability, including deferring elective procedures, more stringent triage for admission, and earlier discharge with follow-up.

⁷ Temporary health care facilities will need to factor in safe water, sanitation and hygiene facilities (meeting quality standards; separation of infected vs. non-infected patients).



and hygiene (WASH) for health facilities using JMP standards⁸ in critical areas, including basic handwashing and sanitation facilities, and adequate medical waste management and disposal systems in permanent and temporary healthcare facilities;⁹ and (vii) limited rehabilitation or purchase of prefabricated units to expand infectious disease bed capacity and isolation units for critical patients.

- 18. Sub-component 1.3: Urgent Social, Financial and Safety Net Support to Affected Households.** This subcomponent aims to address the significant negative economic impact on COVID-19 affected households using different safety net mechanisms. Specifically, it will support COVID-19 patients, their families, and contacts under isolation by covering costs related to: (i) the lodging, feeding and provision of basic supplies for patients who test positive for COVID-19, as well as traced contacts, to be quarantined in government-managed facilities/hotels or at home; (ii) fee waivers under the Governments National Health Insurance Program (*Couverture Maladie Universelle*, or CMU) to access testing for COVID-19, medical care, and psychosocial support; (iii) emergency financial support to quarantined households in need, if not lodged in government managed quarantine facilities; (iv) food provision and basic supplies to quarantined populations; (v) costs related to the training of support staff and families in risk mitigation measures and providing them with the appropriate protective equipment and hygiene materials. Beneficiaries of financial support in the form of cash transfers will systematically be enrolled in the CMU. Premiums for the first month of the CMU for newly enrolled households will be supported by the project, which will promote the enrollment of households, increase the risk pool and expand financial risk protection for households and communities impacted by COVID-19. For families in high density, low income communities, as well as university students residing in overcrowded dormitories, the project will support the procurement and distribution of sanitation kits (e.g. handwashing stations, soap, etc.).

Component 2: Supporting Preparedness through Laboratory System Strengthening (US\$ 5 Million):

19. This component will finance the: (i) strengthening of the sample transfer system at national and county level; (ii) limited upgrading and equipping of up to seven satellite laboratories to carry out COVID-19 tests, covering the national territory; (iii) procuring laboratory COVID-19 tests and consumables kits, related reagents and sample transport kits ; (iv) training of laboratory staff and support to laboratory surge capacity to carry out COVID-19 tests; (v) securing sampling and analysis sites; (vi) purchasing and installing solar panels or electrical generators for the *Institut Pasteur de la Côte d'Ivoire* (IPCI).

Component 3: Health Communication and Community Engagement [US\$ 5.5 million]

20. This component will equip people with the necessary knowledge and motivation to adopt prevention-related behaviors, and counter misinformation. Activities will aim to influence widespread behavioral change and to ensure the COVID-19 -response is adequate and effective.

21. There are three sub-components: Sub-component 1: Community Engagement for Social Accountability and

⁸ WHO/UNICEF Joint Programme for Water Supply Sanitation and Hygiene (JMP) indicates that handwashing facilities include a sink with tap water, buckets with taps, tippy-taps, and jugs or basins designated for handwashing. Soap includes bar soap, liquid soap, powder detergent, and soapy water but does not include ash, soil, sand or other handwashing agents.

⁹ Temporary health care facilities will need to factor in safe water, sanitation and hygiene facilities (meeting quality standards; separation of infected vs. non-infected patients).



Prevention, Sub-component 2: Comprehensive Behavioral Change and Risk Communication, and Sub-component 3: Information dissemination and collection.

22. **Sub-component 3.1: Community Engagement for Social Accountability and Prevention.** Activities supported by this component include: (i) development of systems for community-based disease surveillance, and multi-stakeholder engagement, including addressing issues such as inclusion and healthcare workers' safety; (ii) development of community-based monitoring training and reporting material; (iii) training for community leaders, extension professionals, community health workers, and volunteers; and (iv) incentives to motivate reporting .
23. **Sub-component 3.2: Comprehensive Behavioral Change and Risk Communication.** This sub-component will support a comprehensive behavior change and risk communication intervention to support the reduction of the spread of COVID-19 by working with private, public and civil society actors to support the development of messaging and materials. This sub-component will finance: (i) a study to understand people's knowledge, attitudes and practices about the virus and its prevention; (ii) development and testing of a risk communication strategy and training materials; (iii) production and dissemination of messages and materials at the community level based on informed engagement and locally appropriate solutions; (iv) development of guidelines on social distancing measures (e.g. in phases) to operationalize existing or new laws and regulations; (v) technical assistance for communication; (vi) identification, engagement, and advocacy to key influencers (i.e. religious leaders, celebrities, etc.), and (vii) work with grassroots level organizations to engage hardest to reach groups and communities through community-based awareness campaigns.
24. **Sub-component 3.3: Information dissemination and collection.** This sub-component will ensure that information on COVID-19 is consistent and channeled through a limited amount of (recognized) platforms. This subcomponent will finance: (i) training on effective communication of communication officers within the MOH; (ii) development of a website that will function as the main platform to disseminate COVID-19 related information; (iii) production and dissemination of mass media campaigns through radio, television, SMS, newspaper, internet and social media; (iv) training of local media to tailor messages to the needs of their communities; and (v) training of local reporters to cover local initiatives and effective responses.

Component 4: Project Implementation Management and Monitoring and Evaluation (M&E) [US\$ 0.5 million].

25. This component has two sub-components: (i) project management and (ii) M&E.
26. **Sub-component 4. 1: Project Management.** Support will be provided to strengthen public structures for the coordination and management of the project, including central and local (decentralized) arrangements for coordination of activities, financial management and procurement. The existing Project Coordination Unit (PCU) for the World Bank supported health sector project will be entrusted with coordination of project activities, as well as fiduciary tasks of procurement, communications and financial management. The PCU will be strengthened by the recruitment of additional staff/consultants responsible for the overall administration, procurement, financial management, and potentially environmental and social specialists, under the project. To this end, the project will support costs associated with project coordination.
27. **Sub-component 4.2: Monitoring and Evaluation (M&E).** This component will support the monitoring and evaluation of prevention, preparedness, and response. This sub-component will support training in



participatory M&E at all administrative levels, evaluation workshops, and development of an action plan for M&E and replication of successful models.

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

Summary of Assessment of Environmental and Social Risks and Impacts

- 28. **The Project will cover the national territory.** Key envisaged environmental risks emanate from the management of biomedical waste (especially handling highly infectious medical wastes) as well as from the renovation of isolation and treatment centers. There will also be risks for health workers given the highly infectious nature of the Virus. Safety equipment is included in the project.
- 29. As with other infectious diseases, misinformation and stigma regarding COVID-19, transmission and treatments, as well as stigma for those that have been suspected or diagnosed with the disease and their families presents a social risk. Population's mistrust of the government information and capacity to contain the disease is also a risk.

Environmental Aspects:

- 30. The environmental risks associated with this operation are considered “High”. Although the main long-term impacts are likely to be positive, there are several short-term risks that need to be considered. The main environmental risks include: (i) environmental and community health related risks from inadequate handling, storage, transportation and disposal of infected medical waste; (ii) occupational health and safety issues related to the availability and supply of personal protective equipment (PPE) for healthcare workers and the logistical challenges in transporting PPE across the country in a timely manner; and (iii) community health and safety risks given close social contact and limited sanitary and hygiene services (clean water, soap, disinfectants) and isolation capabilities at health facilities across the country.
- 31. To mitigate these risks the Ministry of Health and Public Hygiene (MSPH) (with support from National Agency for Environment, ANDE) will update the existing Environmental and Social Management Framework (ESMF) prepared for the WBG-funded Strategic Purchasing and Alignment of Resources & Knowledge in Health Project -SPARK in Cote d’Ivoire (P167959), approved in March 2019.
- 32. The revised ESMF will contain updates on provisions for handling, storing, transporting, and disposing of contaminated medical waste and outline guidance in line with international good practice and WHO standards on COVID-19 response on limiting viral contagion in healthcare facilities. The relevant parts of the WHO COVID-19 quarantine guidelines and COVID-19 biosafety guidelines will be reviewed so that all relevant occupational



and community health and safety risks and mitigation measures will be covered. In addition to the ESMF, the client will implement the activities listed in the Environmental and Social Commitment Plan (ESCP). The Project will also support MP in coordination with WHO, UNICEF, and other partners in overcoming logistical constraints in the timely provision of technical expertise, supplies, equipment and systems across the country.

Social Aspects

33. The Project will not involve resettlement or land acquisition for managed facilities (hotels, home, etc.); therefore, ESS5 is not considered to be relevant at this stage. The main social risks will be focus on (i) difficulties in access to services by marginalized and vulnerable social groups peoples, (people with chronic conditions/disabled, poor, migrants, the elderly and, disadvantages sub-groups of women); (ii) misinformation in social media networks and stigma for those who will be quarantined or admitted to isolation or treatment centers, which may contribute to propagate contagion. These risks will be mitigated through activities that (i) would ensure effective risk communication and community engagement to raise public awareness and knowledge on prevention and control of COVID-19 among the general population, (ii) will target various audiences to address issues of access, discrimination, and ethnicity; continuous awareness and education raising campaigns will help rebuilding community and citizen trust that can be eroded during crises, through engagement with religious leaders, political and local traditional leaders. (iii) will support the development of reporting tools).
34. A draft Stakeholder Engagement Plan (SEP) that incorporates a preliminary stakeholder mapping will be prepared to guide Ministry of Health and Public Hygiene (MSPH) on their interactions with a range of citizens regarding community engagement campaign for basic health prevention and precautions on behavioral changes. The project will work with private, public and civil society actors to support the development of messaging and materials to promote Coronavirus prevention. This will include among others handwashing promotion, social distancing measures, etc. As the project will benefit to entire Cote d'Ivoire population, it may also be supportive to conduct a regional and national communication interventions which will be very inclusive. The project will prioritize the necessary communication strategy involving keys stakeholders' groups The SEP will include a GRM for addressing any complaints. This GRM will also integrate GBV/ SEA for the women and children.
35. In addition, the client will implement the activities set out in the ESCP and the SEP within the proposed timeline.
36. To mitigate these risks, the Ivorian Ministry of Health in the ESCP, will commit to the provision of services and supplies based on the urgency of the need (the prevention, control and slowing down the spread of the outbreak, and by providing critical health care services needed by the infected populations), in line with the latest data related to the prevalence of the cases. MoH will also use the preliminary Stakeholder Engagement Plan (SEP) prepared for the emergency project to engage citizens and for public information disclosure while they update it to include more information on the environmental and social risks of project activities and new modalities that take into account the need for a comprehensive community engagement and Prevention Plan.

E. Implementation

Institutional and Implementation Arrangements

1. Implementations arrangements will mimic those of the Current SPARK-Health project P16. The Ministry of Health



and Public Hygiene (MSPH), will be the implementing agency, through its Project Coordination Unit (PCU) for World Bank Projects. The UCP will be responsible for implementing the project and its functions, which will include but is not limited to: (i) collecting and compiling all data relating to their specific suite of indicators; (ii) evaluating results; (iii) interacting with partners and other stakeholders in ensuring coordination in the implementation of COVID-19; and (iv) strengthening the link between current COVID-19 actions and the SPARK-Health project, for program sustainability. The current functional structure for SPARK-Health Project Coordination Unit will be retained to ensure project readiness and complementarity of interventions. The Project Operational Manual for the SPARK project or another document acceptable by the Bank will be applied, with the procurement and financial exceptions listed below. The Social and Environmental safeguards applied to SPARK will also apply to this project, plus whatever additional issues that may be identified at appraisal.

2. **The existing Project Coordination Unit (PCU) will be strengthened with technical staff** as follows one additional senior procurement specialist fully and one additional accountant, dedicated to the project. The PCU will be responsible for the day-to-day management of the project and will (a) coordinate the project activities; (b) ensure the FM of the project activities in all components; and (c) prepare consolidated annual work plans, budgets, M&E, and the implementation report of the project to be submitted to the COVID-19 Steering Committee and the WBG. The proposed institutional arrangements are based on lessons learned from coordination and implementation of the recently closed and the ongoing health projects.
3. **Supervision and implementation support:** An experienced in-country WBG team of health, operational, environmental and social specialists, and fiduciary specialists will provide day-to-day implementation support to the UCP with additional regular support from staff from other WBG offices; implementation support missions will be carried on a regular basis and will include relevant partners

CONTACT POINT

World Bank

Montserrat Meiro-Lorenzo
Sr Public Health Spec.

Opope Oyaka Tshivuila Matala
Young Professional

Borrower/Client/Recipient

Republic of Cote d'Ivoire

Implementing Agencies



Ministry of Health
Clovis Konan
Coordinator Project Coordination Unit
clovisko@yahoo.fr

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: <http://www.worldbank.org/projects>

APPROVAL

Task Team Leader(s):	Montserrat Meiro-Lorenzo Opope Oyaka Tshivuila Matala
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Approved By

Environmental and Social Standards Advisor:		
Practice Manager/Manager:		
Country Director:	Coralie Gevers	13-Apr-2020