Public Disclosure Authorized

PROPOSAL FOR A WORLD BANK COVID-19 RESPONSE UNDER THE FAST TRACK COVID-19 FACILITY

March 11, 2020

David Malpass
President

March 12, 2020

PROPOSAL FOR A WORLD BANK RESPONSE UNDER THE FAST TRACK COVID-19 FACILITY

1. **On March 3, 2020, Executive Directors discussed how the World Bank Group would respond to the global outbreak of the coronavirus disease (COVID-19)**.[1] Executive Directors expressed broad support for the WBG to take urgent action to support the global public good by helping client countries to respond to the outbreak and prevent and reduce contagion and loss of life. They supported the establishment and launch of a US$12 billion World Bank Group Fast Track COVID-19 Facility (FTCF or "Facility") to assist countries coping with the impact of the global outbreak. Of this amount, US$6 billion would come from IBRD and IDA. IFC has subsequently increased its amount from US$6 billion to US$8 billion, which brings the FTCF total to US$14 billion. IFC is presenting a separate paper that will cover its response to the outbreak.

2. **This Memorandum seeks the endorsement of Executive Directors of the proposed IBRD and IDA response under the Facility ("WB COVID-19 Response")**, including the approval of specific waivers and exceptions set forth in Section IV of the attached paper.

3. **Recommendation**. I am satisfied that the recommendations set out in Section IV of the attached paper comply with the Articles of Agreement of IBRD and IDA and recommend that Executive Directors approve them.

David Malpass
President

---

[1] See "Briefing Note for Board of Executive Directors on Launch of World Bank Group Fast Track COVID-19 Facility" (SecM2020-0060[IDA/SecM2020-0058, IFC/SecM2020-0024, MIGA/SecM2020-0023]), March 3, 2020.

Table of Contents

LIST OF TABLES

PROPOSAL FOR A WORLD BANK RESPONSE
UNDER THE FAST TRACK COVID-19 FACILITY

I. Introduction

1. **On March 3, 2020, Executive Directors discussed how the World Bank Group (WBG) would respond to the global outbreak of the coronavirus disease (COVID-19)**.[2] Executive Directors expressed broad support for the WBG to take urgent action to support the global public good by helping client countries to respond to the outbreak and prevent and reduce contagion and loss of life. They supported the establishment and launch of a World Bank Group Fast Track COVID-19 Facility (FTCF or "Facility"), that would provide up to US$12 billion in immediate support to assist countries coping with the impact of the global outbreak. Of this amount, US$6 billion would come from IBRD and IDA. IFC has subsequently increased its amount from US$6 billion to US$8 billion, which brings the FTCF total to US$14 billion (see Annex 1). The FTCF was announced in a press release the same day.

2. **Since the initial Board discussion, the spread of the coronavirus outside China has accelerated**. On March 11 the World Health Organization (WHO) declared that COVID-19 had reached pandemic proportions, having spread to 114 countries, with 118,000 reported cases and 4,291 deaths from the disease. Given the fluidity of the situation this paper does not seek to provide additional data on the outbreak but is focused instead on setting out the details that will allow IBRD and IDA to mount a fast and flexible response. Management will keep Executive Directors apprised of how the outbreak evolves as new information becomes available.

3. **The objective of this paper is to describe the framework for the World Bank response under the Facility ("WB COVID-19 Response")**. IFC is presenting a separate paper that will cover its response to the outbreak. The paper is organized as follows: Section II describes the approach underpinning the World Bank's response, including how this response supports country-level and global efforts. Section III describes the proposed WB COVID-19 Response, including funding, allocation and processing modalities. Section IV provides a summary of the recommendations.

II. World Bank Response

4. **The rapid spread of COVID-19 calls for a global, coordinated, flexible and fast response**. It is in the interest of all countries to support the global public good by mustering a robust response that seeks to contain the pandemic in order to help prevent greater loss of life and avoid deeper economic consequences. The breath of the response by countries and by the international community will be critical to the overall effectiveness of the effort to contain COVID-19. The WBG is committed to playing its part in the global response, working in close partnership with member governments and other agencies. The proposed WB response to COVID-19 is therefore broad-based and will include emergency financing, policy advice, and technical

[2] See "Briefing Note for Board of Executive Directors on Launch of World Bank Group Fast Track COVID-19 Facility", March 3, 2020.

assistance, building on existing instruments to support IDA and IBRD-eligible countries in addressing the health-related and broader development impacts of COVID-19.

5. **The initial US$6 billion response from IBRD and IDA is focused on addressing, in the first instance, the health-related aspects of the outbreak**. While the WB COVID-19 Response is designed to respond to the health emergency, in a second phase additional operations may be prepared to assist with the unfolding impact on households, businesses and governments. Such operations would be prioritized within the country program. The WBG is working closely with the IMF and other institutions to assess the economic impact of the outbreak. Should the impacts of the outbreak push countries into economic crisis, the WBG will be ready to participate in global support efforts with all its available instruments and resources. In this context, it is important to note that with the recent completion of the 2018 IBRD capital increase and the IDA19 Replenishment, the World Bank is well positioned to mount a robust response to the COVID-19 pandemic.[3, 4]

III. Proposed WB COVID-19 Response[5]

6. ***Objective***. The objective of the proposed WB COVID-19 Response is to assist IBRD and IDA-eligible countries in their efforts to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness. Immediate action is needed in multiple areas to anticipate impacts. There is also a longer-term agenda given systemic shortcomings with respect to core public health functions. Work on both the short and long-term fronts, therefore, needs to proceed in tandem, and efforts should be made to ensure that short-term responses are consistent with and contribute to proposed longer-term interventions. Setting priorities in both cases is essential. Concentrating the efforts on these dual-use investments would generate benefits both during normal times and during a pandemic.

7. Knowledge about COVID-19 preparedness and prevention continues to evolve. Given the diversity of the countries affected, each response will be tailored to the specific needs and circumstances of eligible countries and will be designed with the necessary flexibility in mind. In some cases, this may require country programs to depart from existing Country Partnership Frameworks (CPF), Country Engagement Notes (CEN) and Performance and Learning Reviews (PLR). Annex 2 provides a list of indicative components that projects supported by the WB COVID-19 Response are likely to include.

---

[3] For IBRD, the response is expected to be accommodated within the sustainable financing capacity. The IBRD's crisis buffer (per FY20 approval at US$10 billion) would allow for scaling up the financing response further should the situation call for it. The size of IBRD crisis buffer for FY21 and the resulting FY21 SALL-adj will be approved by the Board as part of the FSF discussions that are due to commence with an Audit Committee discussion on March 30.

[4] For IDA, in addition to regular country allocations, US$2.5 billion is available from the Crisis Response Window for IDA19, which can be further augmented as necessary at the IDA19 Mid-Term Review in November 2021.

[5] The approach taken in the WB COVID-19 Response builds on previous crises response efforts, including the response to the global financial crisis in 2008. See "Proposal for an IDA Financial Crisis Response Fast-Track Facility", December 16, 2008.

8. ***Eligibility***. Management expects that all countries eligible to receive IDA and IBRD resources would be able to access support under the WB COVID-19 Response.[6]

9. ***Components of the US$6 billion WB COVID-19 Response.*** The WB COVID-19 Response comprises two components.

- **Component 1** would entail US$4 billion in additional IBRD and IDA resources that would be channeled under a global emergency Multi-phase Approach (MPA) that will focus on health-related support.

- **Component 2** in an amount of US$2 billion would be mobilized through any combination of: (i) new stand-alone Investment Project Financing (IPF) or Development Policy Financing (DPFs) from existing IDA and IBRD envelopes; (ii) restructuring existing operations; and (iii) cancellation of undisbursed amounts under existing operations and recommitment under the WB COVID-19 Response.

Given the urgency of the needed response, IBRD and IDA-financed activities under the WB COVID-19 Response will be subject to the flexibilities embedded in operational policies, directives and procedures governing emergency response, including expedited and streamlined processes and procedures, as well as customized documentation and templates.[7]

Component 1.

10. **The US$4 billion in additional resources from IBRD and IDA would be programmed as IPF using a menu of activities, under a global emergency MPA.** Such an MPA allows fast-track preparation of similar projects as part of a global emergency response program, and enables a coordinated and effective response to COVID-19 by borrowing countries facing similar emergency needs (including assistance with disease containment, diagnosis, and treatment). The MPA would be available to all borrowing and recipient countries that seek help with emergency response given that COVID-19 was declared a pandemic by WHO. In line with the Environmental and Social Framework (ESF) policy[8], the scope and timing of ESF requirements will be appropriate to the nature and scale of the individual projects and proportionate to their potential environmental and social risks and impacts. With regards to procurement, there may be greater reliance on sole-sourcing, hands-on implementation support (especially in low capacity environments), and simplified processes (e.g., no bid security) as allowed by the Bank's procurement framework. As the program development objectives (PDOs), results chains and components will be similar across countries and once the Board approves the overall MPA, Management can move quickly to commit funds for projects with approval delegated to Regional

---

6 Countries must be in accrual status with IBRD and IDA; IBRD countries must be creditworthy. For countries where the Bank is unable to use its regular financing instruments, it will work *inter alia* to mobilize and channel trust fund resources from bilateral donors.

7 These include: paragraph 12 of IPF Policy, that applies to "Projects in Situations of Urgent Need of Assistance or Capacity Constraints", the IPF Procedure: Preparation of Investment Project Financing - Situations of Urgent Need of Assistance or Capacity Constraints, and Paragraph A.2 (a) Section III of the Bank Directive, "Procurement in IPF and Other Operational Procurement Matters".

8 World Bank Environmental and Social Policy for Investment Project Financing.

Vice Presidents up to US$100 million, and on an absence of objection basis approval by the Board otherwise.

11. **Management is already well advanced in preparing for Board consideration the umbrella document for the MPA along with several country programs**. The MPA would cover eligible IBRD and IDA countries and would specify the resource envelope available under the MPA for each set of countries. Management will seek Board approval if the need arises to expand the financing envelope of the proposed MPA or to approve a second MPA, as most appropriate, if and when the resources available are fully utilized.

12. **In some cases where country needs differ from what can be accommodated under the MPA described above, free-standing IPF projects may be prepared.** Such projects would also be processed under emergency procedures, using the flexibilities available in the IPF policy. IPFs with a contingent financing feature (Deferred Draw Down option) may also be used.

Component 2.

13. **Beyond their respective MPA allocations, countries could also fast track up to US$2 billion in additional resources from their country program (pipeline or portfolio) for new health related projects to deal with COVID-19 impacts.** Countries also have the option to restructure ongoing operations typically by using Contingent Emergency Response Components (CERCs), which allow countries to quickly reallocate funds within an existing project to be used for emergency needs. Countries using CERC resources for COVID-19 response could request replenishment of these resources for original project purposes. Projects without CERCs may also be restructured to support an emergency response to COVID-19 and request additional resources from the proposed WB COVID-19 Response. For countries that already have CAT-DDOs, these may be triggered due to the imminent or occurring emergency conditions created by COVID-19. There may be cases where the triggers of existing CAT-DDOs do not cover public health-related shocks or emergencies. In such cases, the CAT-DDOs may be restructured by modifying the trigger to cover such public health-related high-impact, low-frequency events. Countries that have Program-for-Results (PforR) operations in the health sector may also restructure to support results related to support COVID-19 response where appropriate. Finally, countries may request cancellation of undisbursed amounts in the existing operations, and the subsequent recommitment of cancelled resources to new operations

14. **For countries with existing DPF operations, if an unanticipated financing need arises owing to the impact of COVID-19, supplemental operations can be rapidly prepared**. New DPFs, including those with catastrophe deferred drawdown option (CAT-DDOs), can also be prepared on a fast-track basis with prior actions that focus on the government's preparedness and response efforts, as well as those that lay the basis of recovery from the crisis. In cases where CAT-DDOs have been recently triggered and now have insufficient funds to respond to the disaster, these may be topped-up with additional financing using resources in regular IBRD and IDA lending envelopes. Financing under a CAT-DDO could also be increased in cases where the financing amount of the existing non-triggered CAT-DDO is deemed insufficient to respond to the emergency.

15. ***IBRD and IDA Amounts and Funding***. The WB COVID-19 Response will make available initial crisis resources of up to US$6 billion in financing on a fast track basis. The resources are anticipated to be utilized in the course of the next 12 months. These resources comprise (i) up to US$2.7 billion of new financing from IBRD for IBRD-eligible countries; (ii) up to US$1.3 billion of new financing from IDA for IDA-eligible countries; and (iii) reprioritization of up to US$2 billion within the existing IBRD and IDA portfolio. Management will track the extent of such reprioritizations.

- **IBRD**: Current lending projections for FY20 are between US$21 billion and US$24 billion, subject to disruptions due to COVID-19. At this stage, Management does not anticipate needing to access the IBRD crisis buffer, given that the lending ceiling for FY20 (SALL-adj.) is US$28 billion. WB COVID-19 Response lending in FY21 will be accommodated within the FY21 SALL-adj.

- **IDA**: The US$1.3 billion in additional IDA resources are proposed to be reallocated from the Private Sector Window (PSW) and the set-aside for Syrian Refugees in Lebanon and added to the US$328 million remaining in the IDA18 Crisis Response Window (CRW).[9] These amounts have been determined based on the latest available assessments of likely commitments before the end of the IDA18 period (Table 1). Since FY20 is the last year of the IDA18 replenishment period, utilization of these resources will be carefully monitored in the course of the next few months with a view to making sure that available IDA18 resources are committed by end-June 2020. For this reason, Management proposes to manage the resources flexibly, so that those resources that cannot be utilized in support of the COVID-19 response by end-June, can be committed to IDA countries for other development purposes. From the start of FY21, the balance of IDA resources in the WB COVID-19 Response would be financed from resources available in the IDA19 CRW.

Table 1: IDA sources of Finance for WB COVID-19 Response

	US$ m	**% of total**
Existing CRW resources	328	25
Reallocation from PSW	865	67
Reallocation from the set-aside for Syrian Refugees in Lebanon	100	8
Total	**1293**	**100**

16. **IDA financing WB COVID-19 Response will be allocated largely through the CRW.** In its briefing note to Executive Directors dated March 3, Management indicated its intention to access CRW resources in response to the COVID-19 emergency. This satisfies the first step of the governance requirements for CRW to inform the Board of Management's intention to access CRW resources.[10] In the second step, Board approval for the provision of CRW support as well as specific amounts will be sought as operations are presented to the Board. Given its focus on responding to severe crises and emergencies, and its explicit health crisis response mandate, the

[9] IDA Deputies and Borrower Representatives have been consulted on the proposed Facility and the reallocations needed to finance it. Beyond the proposed reallocations, Management anticipates a final round of IDA reallocations in April 2020, in line with the agreement with IDA Deputies and Borrower Representatives at the 2019 Annual Meetings.

[10] See IDA18 Replenishment Report, January, 2017, Annex 7 on "Implementation Arrangements: the Crisis Response Window".

CRW is the most appropriate IDA vehicle to support immediate interventions to combat COVID-19. WHO has already declared the COVID-19 as a pandemic, thus triggering one condition for accessing CRW resources. Management is requesting a blanket waiver of the second condition, which requires that a country must also declare a national public health emergency in order to access CRW resources. This request reflects the need to shore up readiness in IDA countries where preparedness and response capacities are the weakest. Other CRW eligibility criteria that do not require Board-approved waivers would be applied flexibly, including with respect to severity of impact, burden-sharing, availability of needs assessment etc. These are expected to be limited to circumstances where the Bank does not have a presence, such as countries in active conflict. In the event that some WB COVID-19 Response funding may have to be channeled through non-sovereign third parties such as UN agencies and regional organizations, any necessary waivers to facilitate such arrangements would be sought from the Board.

17. ***WB COVID-19 Response allocation methodology*.** Management proposes to allocate IBRD and IDA resources using a simple, transparent and equitable methodology. Each country would have access to 0.1 percent of GDP subject to floors and caps. A minimum allocation of US$2.5 million applies for countries with populations below 500,000 and a minimum allocation of US$5 million applies for countries with populations above 500,000. In addition, allocation caps are calibrated by population size as outlined in Table 2. Resources that are used for regional operations would be deducted from the allocations of the participating countries in proportion to their respective allocations. Resources used to replenish CERCs that have been drawn down in support of a COVID-19 response would also be deducted from the country's allocation under the WB COVID-19 Response.

Table 2: Allocation caps and population thresholds with IBRD/IDA distribution

Population Threshold (millions)	Allocation Cap (US$ millions)	Number of IBRD Countries	Number of IDA Countries
20m	$20m	*40*	*53*
50m	$35m	*12*	*11*
100m	$50m	*6*	*4*
250m	$100m	*4*	*4*
1 billion	$250m	*1*	-
Over 1 billion	$350m	*2*	-

18. **The allocation methodology generates an efficient distribution of available resources to IDA and IBRD countries**. In IDA, the four largest countries by population would be allocated US$100 million each, with another four countries receiving US$50 million or more.[11] Twenty-eight countries would access the minimum allocation. In IBRD, the two largest countries would

[11] To provide some flexibility to meet country demand, IDA19 eligible countries can exceed their allocations by up to 50 percent in the IDA18 period, as long as the exceeded amounts are returned to the Facility from the country's FY21 PBA envelope.

be allocated US$350 million each, one country is allocated US$250 million, four countries are allocated US$100 million or more, and six countries would have access to US$50 million. Eight IBRD countries would receive the minimum allocation. Aggregate IBRD financing to countries will be accommodated within SALL-adj, and shares of lending to above and below Graduation Discussion Income (GDI) countries will be consistent with the Capital Increase Policy Package commitments.

19. ***Pricing*.** For IDA, Management expects to apply regular country terms, as IDA countries would receive additionality through increased volumes of resources (beyond their country envelopes) that are already highly concessional.[12] For IBRD, commitment or standby fees associated with IBRD financing that remains undrawn may discourage borrowers from seeking IBRD financing, risking delays in timely response and disbursement of funds when needed. To mitigate this concern, in particular given the public goods aspect of COVID-19 response and containment, Management proposes to waive the commitment/standby fees for the first year for any IBRD loan approved for health-related COVID-19 operations.[13] In addition, in situations where the most effective Bank response in specific country circumstances would merit the use of a new CAT-DDO under the DPF policy, Management proposes a reduction of the front-end fee for such CAT-DDOs from 50bps to 25 bps, given that the pricing for CAT-DDOs entails a higher front-end fee of 50 bps (vs. 25 bps for regular IBRD loans) in lieu of a commitment fee.

20. ***Processing and approvals***. In light of the urgency of the response, processing of operations will be accelerated. Documentation will be based on simplified project templates for operations under the WB COVID-19 Response. Since project rationale, results framework, components, etc., are expected to be similar across projects, teams will prepare streamlined, short and focused Project Appraisal Documents (PADs). Consistent with the principles embedded in the ESF policy, Environmental and Social activities will be timed and sequenced to fit the needs and risks of the project, with a particular focus on (i) the development of waste management plans; (ii) worker safety; (iii) community safety plans; and (iv) communications and stakeholder engagement. The relevant Environment and Social documentation is standardized and streamlined, as feasible. Given that dissemination of information to the affected and neighboring communities is critical, and cooperation by and communication with the population is key to the success of projects, an important component in each project will be a comprehensive community engagement and participation plan.

21. Given the scale and the speed with which COVID-19 is spreading, expedited processing timelines will be needed across all review stages, including review by Management and the Board. Management proposes that the current SEC submission and circulation period of 10 days for emergency operations and Level I Project Restructurings (20 days for DPFs, including CAT DDOs) be reduced to 5 days for operations under the WB COVID-19 Response.

---

[12] To the extent IDA funds would be provided to UN agencies or regional organizations, these resources may be provided on grant terms.

[13] The foregone revenues due to the waived fees is limited by both the size of the IBRD portion of MPA at US$2.7 billion, as well as the waiver applying for only the first year of the approved loans, with an estimated upper bound of US$7 million for the illustrative scenario where all of the US$2.7 billion approved loans remain entirely undisbursed for the first year. In the more likely scenario where most loans would be drawn down within the first year, the amount of waived fees would be significantly smaller.

22. ***Monitoring, evaluation and reporting***. A results framework for the WB COVID-19 Response is being developed. It will be based on the results framework for each operation at the country level, to be supplemented by regional and sub-regional level results, as appropriate.

a) **For the overall WB COVID-19 Response, the framework will focus on**: (i) strategic relevance to the near-term support for disease outbreak detection and response, with clarity of pathways from WBG contributions to the expected outcomes; (ii) responsiveness to client needs; and (iii) timeliness and agility of co-convening functions with country policymakers and strategic partners who complement the WBG's comparative advantage.

b) **For operations at the country, regional or sub-regional levels**, the framework will provide a menu of options to be customized for each operation, together with performance benchmarks. Among other things, the indicators could cover: (i) measuring elements of the emergency COVID-19 response; (ii) strengthening mission-critical national institutions for policy development and coordination of prevention and preparedness; (iii) enabling regional, national, and sub-national estimates and projections of equipment and supplies for disease prevention, detection, and response requirements; (iv) building regional and national capacity for biomedical, clinical, and public health research and technical resource networks; and (v) building systems to perform disease surveillance at the community level.

23. **Implementation of the WB COVID-19 Response will be reported to the Board through a fact sheet, initially on a monthly basis, and a quarterly progress report embedded in the Quarterly Operations Update**. Information will include: (i) utilization of the WB COVID-19 Response in terms of volume and number of operations; (ii) synopsis of operations approved; (iii) disbursement levels; and (iv) any challenges and achievement, as implementation progresses. The content and frequency of reporting will be adjusted as the situation evolves.

IV Summary of Recommendations

24. **To operationalize the proposed WB COVID-19 Response under the FTCF, it is recommended that the Executive Directors approve**:

- ***Reallocations of unutilized IDA18 resources to IDA's Crisis Response Window (CRW)*** by adding the amounts below to remaining CRW resources of US$328 million and to utilize these resources for the COVID-19 response:

  a. US$865 million from the Private Sector Window.

  b. US$100 million from the set-aside for Syrian Refugees in Lebanon.

- ***Flexible allocation management*** by authorizing Management to allocate to IDA country programs such resources as are not needed for the COVID-19 response before the IDA18 period ends on June 30, 2020.

- ***Waiver related to IDA CRW***:

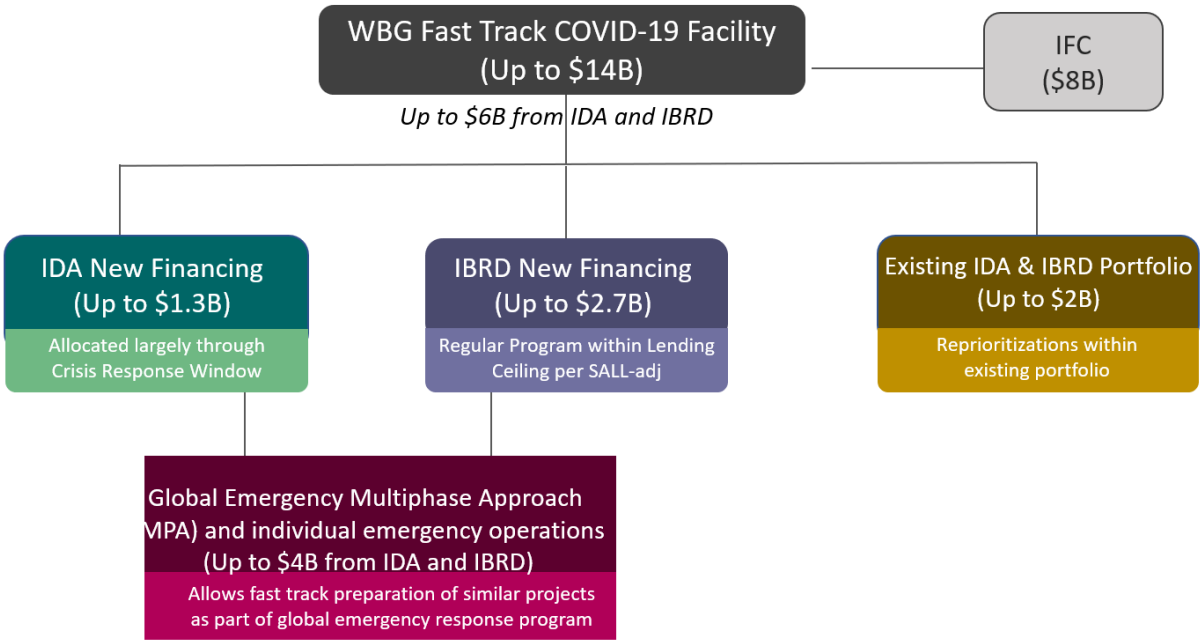
  c. the requirement for a country to declare a national public health emergency to access CRW resources.

- ***Waivers related to IBRD***:

  d. the waiver of commitment/standby fees for health-related COVID-19 operations payable during the first year of each financing, and

  e. for CAT-DDOs approved under the WB COVID-19 Response, a reduced front-end fee of 25 bps.

Annex 1. WBG Fast Track COVID-19 Facility



Annex 2. Example of Activities for WB COVID-19 Response Projects

The components described below comprise a menu of options that countries eligible for support under the WB COVID-19 Response can tailor to respond to their country context and epidemic status. It is anticipated that COVID-19 emergency operations would include some or all of these components.

Component 1: Emergency COVID-19 Response. This component would provide immediate support countries to prevent COVID-19 from arriving or limiting local transmission through containment strategies. It would support enhancement of disease detection capacities through provision of technical expertise, laboratory equipment and systems to ensure prompt case finding and contact tracing. It would enable countries to mobilize surge response capacity through trained and well-equipped frontline health workers. There would be a sub-component, where applicable, targeted at migrant and displaced populations in fragile, conflict or humanitarian emergency settings compounded by COVID-19. Supported activities include:

- **Case Detection, Case Confirmation, Contact Tracing, Case Recording, Case Reporting.** This sub-component would help strengthen disease surveillance systems, public health laboratories, and epidemiological capacity for early detection and confirmation of cases; combine detection of new cases with active contact tracing; support epidemiological investigation; strengthen risk assessment; and provide on-time data and information for guiding decision making and response and mitigation activities. Additional support could be provided to strengthen health management information systems to facilitate recording and on-time virtual sharing of information.

- **Social Distancing Measures.** An effective measure to prevent contracting a respiratory virus such as COVID-19 would be to limit, as possible, contact with the public. Therefore, the project would support the implementation of immediate term responses i.e. the classic "social distancing measures" such as school closings, escalating and de-escalating rationale, backed up by a well-designed communication strategy. The social distancing measures would probably be enforced on advice from health institutions, but health institutions would not be the enforcing group. As a result, financing would be made available to develop guidelines on social distancing measures (e.g., in phases) to operationalize existing or new laws and regulations, support coordination among sectoral ministries and agencies, and support the ministries of health on the caring of health and other personnel involved in pandemic control activities. Additional preventive actions would be supported that would complement social distancing such as personal hygiene promotion, including promoting handwashing and proper cooking, and distribution and use of masks, along with increased awareness and promotion of community participation in slowing the spread of the pandemic.

- **Health System Strengthening.** Assistance would be provided to the health care system for preparedness planning to provide optimal medical care and maintain essential community services and to minimize risks for patients and health personnel, including training health facilities staff and front-line workers on risk mitigation measures and providing them with the appropriate protective equipment and hygiene materials.

Strengthened clinical care capacity could be achieved through financing plans for establishing specialized units in selected hospitals, treatment guidelines, and hospital infection control guidelines. Also, strategies would be developed to increase hospital bed availability, including deferring elective procedures, more stringent triage for admission, and earlier discharge with follow-up by home health care personnel.

As COVID-19 would place a substantial burden on inpatient and outpatient health care services, support would be provided to rehabilitate and equip selected health facilities for the delivery of critical medical services and to cope with increased demand of services posed by the outbreak, develop intra-hospital infection control measures, including necessary improvements in blood transfusion services to ensure the availability of blood products and their safety to prevent the transmission of viruses (e.g., HIV, COVID-19) via blood transfusions to patients needing surgery or fighting cancer, as well as to COVID-19 patients themselves who end up in critical care and who may also need blood support. Moreover, support would be provided for ensuring safe water and basic sanitation in health facilities, as well as to strengthen medical waste management and disposal systems, mobilize additional health personnel, training of health personnel, provision of medical supplies, diagnostic reagents, including kits, other operational expenses such as those related to mobilization of health teams and salaries, hazard/indemnity pay consistent with the amounts currently paid by respective Governments during the crisis. Additionally, support would be provided to improve access to information and scientific knowledge using knowledge management tools, including the review and synthesis of scientific information for distribution to the public health community, and undertake applied and clinical research.

Furthermore, support would be provided to help establish health care facilities in non-traditional sites to help address temporary surge needs. As not all ill persons would require hospital care, but other support services, strategies would be developed to provide home care, delivery of prescription drugs, and meals to infected individuals. Local planning would be needed to address the delivery of these and other essential functions such as police, fire and utility services. The introduction of drone technology would be supported for the timely delivery of essential drugs, medical supplies, and blood products for the care of populations living in hard to reach regions, particularly in rural settings.

- **Communication Preparedness.** Activities would include developing and testing messages and materials to be used in the event of a pandemic or emerging infectious disease outbreak, and further enhancing infrastructure to disseminate information from national to state and local levels and between the public and private sectors. Communication activities would support cost effective and sustainable methods such as marketing of "handwashing" through various communication channels via mass media, counseling, schools, workplace, and integrated into specific interventions as well as ongoing outreach activities of ministries and sectors, especially ministries of health, education, agriculture, and transport. Support would be provided for information and communication activities to increase the attention and commitment of government, private sector, and civil society, and to raise awareness, knowledge and understanding among the general population about the risk and potential impact of the pandemic and to develop

multi-sectoral strategies to address it. In some countries, especially in Africa, community mobilization would take place through institutions that reach the local population, especially in rural areas like for example the church and tribal leaders. In addition, support would be provided for: (i) the development and distribution of basic communication materials (such as question and answer sheets and fact sheets) on (i) COVID-19; (ii) general preventive measures such as "dos" and "don'ts" for the general public; (iii) information and guidelines for health care providers: (iv) training modules (web-based, printed, and video); (v) presentations, slide sets, videos, and documentaries; and (vi) symposia on surveillance, treatment and prophylaxis.

- **Social and Financial Support to Households.** Patients and their families would need support, especially those who are isolated and less familiar with virtual or delivery services. Continuing to support individuals and groups ranging from community centers to nursing homes would require detailed plans. Additional social support activities would be geared to reduce/eliminate financial barriers to families to seek and utilize needed health services, as well as to help mitigate economic impact on households, particularly among the poor. To this end, financing would be provided for fee-waivers to access medical care and cash transfers to mitigate loss of household income due to job losses that may result from the closure of firms and enterprises, and well as government agencies, during the outbreak. These provisions would help women in particular as many still cannot access essential health services and continue to suffer from preventable and treatable diseases. Also, as women make up to 70 percent of the global health workforce, cash transfers would help mitigate job burden due to surge of cases in health facilities in parallel to caring for infected family members, particularly the elderly, who are at higher risk of contracting COVID-19 disease, and children who may be out of school due to closures. Moreover, under this component the provision of food and basic supplies to quarantined populations and COVID-19 affected households would be supported.

Component 2: **Strengthening Multi-sector, National Institutions and Platforms for Policy Development and Coordination of Prevention and Preparedness using One Health approach.**

Based on the evaluation of Veterinary Services and related services completed through PVS assessments and gap analysis, support would be provided to strengthen national Veterinary Services to bring them into line with OIE standards. Such support would include: (i) technical support for strengthening governance and updating legislation; (ii) support for institutional and organizational restructuring and training of staff; and (iii) upgrading of priority infrastructure (civil works, equipment, materials and supplies, technical assistance).

To assess risks to public health, prevent spillover events from wild and domestic animal populations and establish early warning systems to guide protective measures, information is needed on the extent of infection in animals and humans and on circulating viruses. National surveillance systems, and in the case of many African and Asian low-capacity countries, as well as very small countries, regional or global surveillance, must be improved in potentially affected and at-risk countries. When outbreaks of zoonotic potential occur in animals, active human case detection should be done by a coordinated animal-public health team.

There are four main national surveillance areas that would need to be strengthened: (i) virologic surveillance to report the number of clinical specimens tested for influenza and the number of positive results by virus type and sub-type; (ii) surveillance for influenza-like illness (ILI) to report on the number of patient visits for IL1 by age group and the total number of patient visits each week; (iii) surveillance for influenza and pneumonia deaths to report the total deaths that may be influenza-related; and (iv) regional and local epidemiologists assess and report influenza activity levels in their respective localities. Current surveillance systems should be enhanced prior to the start of a pandemic, to assure that the high demand for timely information that can be anticipated in a pandemic can be met. In infected countries, it is also recommended to carry out active sero-surveillance of the population at risk to complement the animal health surveillance strategy. The lack of reliable epidemiological information in domestic and wild animal populations, and the sound analysis thereof, has hampered the development of rational, targeted disease control measures in many countries. Thus, well-structured epidemiological studies and surveillance programs would be integrated with the disease control measures, which would be then adjusted and improved as new information becomes available. Strengthening animal disease surveillance and diagnostic capacity would be supported through the following activities: improving animal health information flow among relevant agencies and administrative levels; detection, reporting and follow-up of reported cases; public and community-based surveillance networks; routine serological surveys, event-based surveillance and epidemio-surveillance; and improving diagnostic laboratory capacity.

The component would support enhancing zoonotic diseases information systems through development of a uniform disease information system in each participating country, as part of their control program to provide better analytical capacity to enable them to participate in global disease information sharing, complying with their obligations as members of OIE and WHO, thereby contributing towards progressively better global and regional control. The system would be linked to rapid and standardized methods of routine analysis of surveillance data, which would demonstrate important changes in the animal health situation, and promptly supply this information to field personnel.

Component 3: **Supporting National and Sub-national Forecasting, Prevention and Preparedness requirements of Infrastructure (observatories, reference labs, clinical capacity), Equipment, Reagents and Commodities, Analytical and Assessment Capacity with Trained Local capacities embedded in National Primary Human and Animal Health Systems.**

The component would support improving prevention of and response planning for Emerging Infectious Diseases (EIDs). This sub-component would provide support to activities needed to help countries to prepare National Emergency Contingency Plans according to country specific conditions, constraints and possibilities (in particular the capacity of its Veterinary Services, structure and importance of its livestock sector, wildlife, risk of new, emerging and re-emerging diseases, and its status regarding major animal diseases). The component would also support simulation exercises.

Zoonotic disease specific control strategies and programs should include the principle of targeting the disease at the source of infection. This refers predominantly to the smallholder sector, informal

sector, wild-life exploitation, a major carrier host reservoir. Eradication of the disease source would be a difficult and long-term task, especially in poor countries with limited resources. This component would therefore explore disease control options in domestic and wild animal populations, including restructuring of farming systems to separate domestic from wild and feral animals, strategic culling of livestock, and progressively enhancing herd/flock immunity through vaccination to reduce pathogen shedding. The short to medium-term task of controlling the disease by reducing pathogen circulation in the livestock sector, large-scale breeder units, and medium to small-sized commercial units is feasible.

On a longer-term basis, improving bio-security in animal productions and trade is an important strategy to guard against the damaging effects of animal diseases, but is also a complicated intervention requiring understanding of the whole value chain. Moreover, restructuring requires different approaches in different countries by virtue of the differences in their livestock sector infrastructure, marketing characteristics, household-based versus commercial production systems, and socio-economic impact. This component would also support the restructuring of the industry when needed. Restructuring and consolidation should be seen as a gradual process, affecting the various segments of the sector in different ways and at different rates.

Component 4: Community Engagement and Participation

Support would be provided to develop systems for real-time community-based disease surveillance and multi-stakeholder engagement, including to address through stakeholder engagement issues such as inclusion, healthcare workers safety, other. This component is to address issues of community and citizen mistrust that can be exacerbated during crises through proactive, evidence-based citizen engagement approaches. This component would also include community-based animal disease surveillance and early warning networks. It would support the establishment at the community level of early warning systems to support a robust emergency reporting and feedback system against notifiable diseases. A critical objective of this sub-component would be to improve the commitment of all participants of the “epidemiological surveillance networks”. The project would support training for animal health workers, and treatment of infected animals and reporting procedures. Farmers, extension professionals, and paraprofessionals would receive hands-on training in detection of clinical signs. The project would also provide basic biosecurity equipment such as sprayers, protective equipment. Other activities to be funded include: improving animal health information flow among relevant agencies; detection, reporting and follow-up of reported cases; public veterinary surveillance networks; routine serological surveys, event-based and epidemio-surveillance; and improving diagnostic laboratory capacity. Participatory methodologies involving farmers, para-veterinarians, and community workers, would be used extensively, given the fact that the major control targets are the small-scale and semi-commercial poultry production systems. Surveillance programs would be planned and implemented jointly with the public health personnel in accordance with OIE standards and guidelines.

In many regions of the world, the smallholder sector has little or no access to animal health services and is highly exposed to the consequences of an epidemic. Globally, six hundred and forty million smallholders and 190 million pastoralists raise livestock. Smallholder livestock keepers make up 70 percent of the world's poor. This sub-component would particularly support these low-income groups by: improving animal health services at the village or community level by means of

organizing community-based early warning networks, utilizing the existing pool of para-veterinary village workers (specific guidelines have been issued by OIE to fully integrate these human resources in the Veterinary Services system); increasing farmers' general awareness through simple biosecurity guidelines on animal disease control using publications in local languages; providing grants for direct compensation and/or for cost-sharing of vaccination campaigns, which some countries may not be able to afford through their own budgetary resources; and supporting farmers' groups and/or associations to help improve awareness and dissemination of information.

Component 5: **Implementation Management and Monitoring and Evaluation**

Project Management. Support for the strengthening of public structures for the coordination and management of the individual country projects would be provided, including central and local (decentralized) arrangements for coordination of activities, financial management and procurement. Existing coordination structures operating in the sector ministries/agencies or working to support Bank-financed operations in the agriculture/livestock/health sectors would be entrusted with coordination of project activities, as well as fiduciary tasks of procurement and financial management. The relevant structures will be strengthened by the recruitment of additional staff/consultants responsible for overall administration, procurement, and financial management under country specific projects. To this end, project would support costs associated with project coordination.

Monitoring and Evaluation (M&E). This component would support monitoring and evaluation of prevention and preparedness, building capacity for clinical and public health research, including veterinary, and joint-learning across and within countries. To this end, the following would be supported:

Training. This sub-component would support training in participatory monitoring and evaluation at all administrative levels, evaluation workshops, and development of an action plan for M&E and replication of successful models.

Program Monitoring and Impact Evaluation. Support would be provided to develop project monitoring and impact evaluation assessments. Two types of M&E are envisaged:

Monitoring of project implementation. This is a function of the Program Unit, which would collect relevant data from line ministries and other implementation agencies and then compile them into progress reports focusing on status of physical implementation by component, use of project funds and monitoring indicators. Specific surveys would be conducted to obtain data for this purpose. Annual expenditure reviews would be conducted to assess government commitment to strengthen the public health functions as measured by budgetary allocations and their distribution by activity.

Impact evaluation. The aim of evaluation is to assess whether the interventions are effective or the project activities are having the desired impact. The evaluation would include both quantitative and qualitative aspects. The quantitative aspects would rely on new information systems and surveys implemented as part of the various components of the project, currently existing data sources, and primary evaluative data collection efforts. The goal of the qualitative aspect of the

evaluation would be to document perceptions of program managers, staff, patients, and local and national leaders. Qualitative information would be collected using site-visit interviews, focus groups, and respondent surveys.