Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 02-Jun-2020 | Report No: 149155
## BASIC INFORMATION

### A. Basic Project Data

<table>
<thead>
<tr>
<th>Country</th>
<th>Project ID</th>
<th>Project Name</th>
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<tr>
<td>Investment Project Financing</td>
<td>Central African Republic</td>
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### Proposed Development Objective(s)

To prepare for and respond to the threat posed by COVID-19 in the Central African Republic.

### Components

- Preparedness and Response
- Project implementation
- Contingent Emergency Response Component

## PROJECT FINANCING DATA (US$, Millions)

### SUMMARY

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<table>
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### DETAILS

**World Bank Group Financing**

- International Development Association (IDA) 7.50
- IDA Grant 7.50
Environmental and Social Risk Classification
Substantial

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Multiple conflicts have emerged since the major civil conflict in 2013, and the Central African Republic (CAR) is still in the long process of rebuilding.** The crisis reduced gross domestic product (GDP) per capita by more than one third, and it has still not reached its pre-crisis level. The country’s first democratic elections were held in 2016. In February 2019, the Khartoum Peace Accord was signed between 14 major armed groups and the government. Despite these advancements, as of January 2020, the United Nations maintains a strong presence in the country with more than 12,870 uniformed United Nations (UN) Peacekeepers (MINUSCA). Rebel groups continue to control approximately 80 percent of the country. The government’s reach outside of the capital of Bangui has improved but is still weak. Development outcomes in health and education are still extremely low, and CAR ranks 188 out of 189 countries on the 2019 Statistical Update of the Human Development Index, with corresponding high levels of gender-based violence and alarming gender disparities. While CAR has a population of approximately 4.9 million people, a high proportion of the population remains displaced, with an estimated 600,150 internally displaced persons and 592,000 refugees in surrounding countries as of 2019. Displaced populations face a multitude of challenges – including poor living conditions and sanitation, deteriorating health and weak coping mechanisms. The country is now approaching its next democratic election in December 2020, which threatens its current stability. The fragile political and economic context in CAR will pose challenges to responding to the emerging COVID-19 pandemic.

2. **CAR identified its first case of COVID-19 on March 14, 2020 and has now six detected cases as of March 30, 2020.** To date, four cases have been defined as imported cases, while the two other cases point towards local transmission. In addition, two people who arrived from CAR in France on March 21 tested positive immediately upon arrival – another strong indication that local transmission has been circulating in CAR for at least two weeks. To date, all cases have been defined as imported cases, and community transmission has not yet begun. However, the situation can change rapidly. The number of cases escalated throughout sub-Saharan Africa as presented in Figure 1. Of the six countries that surround CAR, all have reported cases except for South Sudan. The magnitude of the pandemic across the continent is likely

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underestimated due to weak disease surveillance systems. The actual number of cases are likely to be higher, but only a few cases have been diagnosed.

3. **The government has taken immediate action to limit the spread of COVID-19.** On March 6, 2020, the Government issued a directive for travelers entering the country. All people were to be screened before entering CAR, and those with a temperature greater than 38 degrees Celsius or respiratory symptoms were to undergo a more in-depth evaluation, as were all travelers that arrived from or had been in countries with local transmission of the virus within 14 days of arriving in CAR. Preventive measures are now in place at the international airport in Bangui. The WB-financed Health System Support and Strengthening (SENI) project (P164953) has allocated US$50,000 for the immediate set up of screening tables, hand washing stations, data collection forms health forms and financing other urgent needs for initial preventative measures. Since the closure of the airport for commercial flights, the efforts have now shifted towards the follow-up of people who were exposed to the imported cases. 896 people have been identified for follow-up. As of March 29, of those 896, the government has been able to locate 148. All others have yet to be contacted or provided wrong or erroneous contact information, which is an indication of the weakness of the screening system which was put in place.

4. **CAR’s response to COVID-19 builds on preparations made during the 10th Ebola Virus Disease outbreak (EVD10) in the neighboring country of Democratic Republic of Congo (DRC).** EVD10 in DRC is the second largest Ebola outbreak in history and was declared a national emergency by the government of DRC in August 2018. It is not yet contained. CAR developed and updated its national EVD Preparedness and Response Plan to prepare and respond to a possible importation of EVD from DRC. The public health actions in the EVD Preparedness Plan include, among others, strengthening surveillance at ports of entry, establishing of a rapid response team and multidisciplinary and coordinated interventions at the Public Health Emergency Response Center (Centre d’Opération pour les Urgences en Santé Publique – COUSP) coordinated by the Ministry of Health (MOH), systematic screening of travelers, among others.

5. **The virus’ potential impact on mortality in CAR remains unclear.** Emerging research indicates that the disease caused by COVID-19 is most serious in the elderly, and the top six causes of deaths of the population of all ages were tuberculosis, diarrheal diseases, malaria, HIV/AIDS, diarrheal diseases, lower respiratory infections. Although CAR’s population is predominantly young, the COVID19 disease impact on the population with weakened immune systems could be very severe. This, coupled with the exponential increase in COVID-19 cases in countries throughout the world, indicate that effective measures should be taken urgently to contain the virus in CAR before community and nationwide transmission occurs, in an extremely weak health system which cannot treat or bear the burden of a catastrophic disease outbreak.

6. **The COVID-19 pandemic will have a significant effect on CAR’s already weak economy.** The global economic impact of COVID-19 is already evident and reaches well beyond the disease’s impact on morbidity and mortality. The global economy has slowed, interrupting production and global supply chains. Transport has been limited or restricted between and within countries. School closures, social distancing and voluntary or mandated isolation have changed people’s behavior and productivity. Global financial markets have responded to the vast uncertainty among consumers and firms, with global stock

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indices plummeting. In CAR and other low- and middle-income countries, the economic consequences of the pandemic will likely be substantial. In addition, local transmission of COVID-19 and its spread to provinces and rural areas with minimal health infrastructure, personnel, and equipment will disrupt the economy and have lasting impacts on human capital development.

Sectoral and Institutional Context

7. **CAR’s health system will face major constraints to contain and respond to the COVID-19 pandemic.** During the 2013 crisis, property and infrastructure across the country was destroyed and the government did not have a source of revenue. Yet, even before 2013, the state’s ability to deliver essential services was limited. Much of CAR is highly inaccessible, with a road density of 1.5 kilometers per 1000 km², and access to electricity standing at 8 percent nationally and only 2 percent outside of Bangui. Lack of physical access to health facilities due to the lack of roads—whether dirt or paved—is a large bottleneck to deliver critical services to the population. Unavailability of health services, along with other social and economic factors, contributes to the country’s poor health outcomes: life expectancy at birth was estimated at 52.2 years in 2016, maternal mortality is estimated at 882 per 100,000 live-births, where one in approximately 25 women dies during child birth.\(^5\) Child mortality is also extremely high with 130 per 1000.\(^6\) Government health facilities have started to function again after the crisis of 2016-2017 due to WB support and a compilation of multiple health-supporting partners, but much of the health services are still not adequately attending the population in need. The health system is not currently equipped to identify and report potential cases of COVID-19, nor is it equipped to care for those with aggravating and critical conditions.

8. **Households have limited financial risk protection when they seek health services.** Most people in CAR work in the informal sector where they are not protected by any social safety net. The main sources of financing for health are households (43.7 percent), external donors (43.5 percent) and then the government (12.8 percent).\(^7\) In 2015, the government spent only US$2.21 per capita on health – far short of the global target of US$86 per capita.\(^8\) Out of pocket (OOP) expenditures for health services are high in CAR at 39.6 percent of current health expenditures and amounting to US$6.59 per capita out-of-pocket for health services – approximately three times more than government per capita spending on health.\(^9\) Households are at risk of being pushed into poverty due to catastrophic health expenditures if they need to seek health services related to COVID-19.

9. **The health sector does not meet the requirements of International Health Regulations (IHR) to manage COVID-19.** The main challenges in CAR as it relates to COVID-19 are as follows:

   a) **Absence of a functioning Epidemiological Surveillance System.** The country has a list of diseases under surveillance for immediate, weekly, and monthly reporting. However, ailments of coronavirus, and especially COVID-19, is an unregistered viral disease on the CAR Surveillance monitoring list. As a result, health staff do not have any knowledge on the diseases from coronaviruses. Health facilities all lack any

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\(^5\)UNICEF, Multiple Indicator Cluster survey (MICS), 2010.
\(^6\)UNICEF, 2010.
\(^8\)WHO, 2020.
personal protective equipment (PPE) for front-line workers. Furthermore, the outdated airport facilities lack potential of screening or immediate quarantine space for suspected cases.

b) Until a new rapid testing mechanism of COVID-19 is developed, expansion of testing and diagnosis capacity outside of Bangui will be very challenging. CAR has limited capacity to conduct testing, as there is only one WHO-accredited laboratory in the country, the Pasteur Institute Bangui (IPB) which is able to diagnose COVID-19. The national level network of laboratories with over 41 public laboratories, which includes the National Public Health Laboratory and Clinical Biology (LNSPBC) and the country’s 5 regional laboratories, and 35 district health laboratories, with the national laboratory in Bangui, all need to be equipped with all necessary laboratory materials, personal protective equipment (PPE) for the laboratory technicians and workers, to ensure case samples can be taken and safely transferred to IPB. The only source of diagnosis can be met by the French cooperation-supported IPB which has the qualified personnel to diagnose, detect and identify a wide range of viruses and bacteria including the new COVID-19 virus. IPB has recently been provided with additional testing regents and laboratory supplies to diagnose COVID-19 from other donors. The other public laboratories including the National Public Health Laboratory in Bangui lack sampling equipment, storage and transport and technical skills to take samples of COVID-19 and other diseases.

c) Unless rapid COVID-19 testing kits are developed to be used even in the peripheral level laboratories, it is very unlikely that we can get labs in the districts outside of Bangui to conduct COVID-19 testing. The only way to have the population outside the capital be tested is to have the lab technicians in the districts bring samples to Bangui, which is logistically very difficult and the process too long even to obtain timely results. The project will thus strengthen skills of public laboratories in and near Bangui first for them to be able to bring COVID-19 test samples to Institut Pasteur lab. As more portable and easier-to-use COVID-19 testing kits become available globally, the project will procure these testing kits to be used in the peripheral laboratories at a later stage.

d) Limited case management capacity. The country has five university hospital centers in Bangui, 35 district hospitals, and over 500 public and private small health centers and health posts. All health facilities are inadequately equipped overall, and none are currently equipped to diagnose or provide any drugs to patients who come forward with symptoms of COVID-19, such as with malaria, diarrheal diseases and acute respiratory infections. The lack of hospitals and emergency wards is an extreme problem in the country, needless to say, oxygen bags, ventilators, personal protective equipment (PPE), soap, hygiene materials, water, and other essentials for the healthcare workers are paramount to ensure that they are protected from patients coming in with COVID-19 or other infectious diseases. Lack of basic essential medicine for treatment for malaria, fever, diarrheal diseases and other respiratory infections are also lacking, which would need to be supplied to the health facilities to treat other disease that might be causing the symptoms similar to COVID-19.

e) Weak medical supply and distribution system: The country lacks access to quality essential drugs to treat the simplest fevers and infections in the country, as counterfeit drugs are rampant, lacking a systematic medical supply distribution system to the districts outside of the capital. High quality medicines and pharmaceutical products are unavailable in most parts of the country except those provided by international NGOs. A key essential achievement of this project would be that essential supplies and goods be brought into the country, distributed, and reach the intended destination. The procuring, delivering
from Europe, storage and distribution of high-quality and low-cost essential drugs, medical supplies and equipment will be conducted by UNICEF Bangui office, which has the logistical capability for storage, disbursement, logistical staff and knowhow of supply disbursement from Bangui to the six (6) sub-offices in the country. UNICEF is the only organization which has the network and system in place to be able to disburse medical and essential supplies necessary to the health facilities and workers in very difficult and hard-to-reach zones in the country. For very specialized medical equipment such as the specialized masks and other medical equipment, WHO will be bringing them in through the project.

f) Risk communication and community outreach: The Health Communication Department of the Ministry of Health is responsible for all aspects of communication and health promotion. The country has a network of public and private radio stations, newspapers, and community associations that can play an important role in disseminating information about the risks and prevention measures for COVID-19. Efforts to further conduct community mobilization through community relays has been more often used recently for previous outbreak awareness such as for measles, Ebola and vaccination campaigns. Intense, nationwide communication and community sensitization campaigns might become necessary if the progress of the COVID-19 disease stretches out to the peripheral districts. As the rural areas are sparsely populated, it is utmost urgent to reach the urban areas first with preventive messages of basic hygiene and basic self-care during the first symptoms of COVID-19. Radio connection is improving throughout the country, but the majority of the country beyond Bangui and larger urban areas do not yet have access to electricity or internet connectivity.

10. DRC’s ongoing experience in containing EVD10 has important implications for CAR’s response to COVID-19. EVD10 is taking place in Eastern DRC, where similar to CAR, there is a longstanding history of violence and a large population of displaced people. The population in eastern DRC has limited trust in government and government services. Containing a communicable and deadly virus in this setting has posed many challenges. The EVD10 response in DRC became more effective when it used a community-centered approach with feedback mechanisms to follow-up and address rumors emerging with the community. Response teams worked to build trust with local religious, traditional and community leaders to mitigating community resistance. Community structures and community health workers who speak local language were used to better communicate with communities. This approach was also critical to contain the West Africa Ebola outbreak in 2014-16. In CAR, it will be imperative to engage communities to communicate critical risk and to counter misinformation about COVID-19.

11. Inadequate preventive measures and infection control: Lack of clean water and lack of basic hygiene and sanitation behavior such as washing hands are extremely widespread, posing a challenge for disease prevention. Less than a third of CAR’s population has access to piped water, and barely two percent pipe on-premises. In 2015, an estimated one-fourth (24%) of the population practiced open defecation. Though the very commonly advised self-isolation and social distancing as a strategy to use in case of emerging symptoms of COVID-19 and referral in case of severe symptoms, in the congested living spaces in the homes in CAR, self-isolation probably would be a challenge and ineffective. For preventive and basic self-treatment measures, access to basic medicine such as fever-reducers, and basic behavior promotion such as hand-washing with soap, social distancing as much as possible even within the household, and if possible, access to clean water would be essential for a wide-scale preventive measure.

10 World Bank. 2020. World Development Indicators.
12. **CAR COVID-19 Preparedness and Response Project will coordinate with, leverage and build on existing WB health projects in CAR.** The Health System Support and Strengthening (SENI) project (US$53 million – P164953) operates in five regions\(^{11}\) and covers 392 health centers in 15 health districts and district hospitals. There are bottlenecks to the SENI project, especially in enabling the health facilities that the project support in accessing non-counterfeit drugs, high quality and low-cost medicine. But what the SENI project does provide is, access to health professionals and networks especially in the 15 districts (out of 35), and it has the ability to monitor and communicate with the 35 health districts with the close collaboration of the Minister of Health. The project has also recruited 55 data gathering and surveillance staff to be placed in all the health district facilities and regional branches to establish the Health Management Information System (HMIS) which can support disease surveillance. SENI supports all pillars of the health system, in training and hiring to increase human resource capacity for health, provision of technical support to the Ministry, establishing the HMIS to kick-start the disease surveillance system, and enhancing governance at all levels.

13. **The Regional Disease Surveillance Systems Strengthening Phase IV (REDISSE4, US$15 million for CAR – P167817)** is a regional project that aims to build national capacity for strengthening epidemiological surveillance for human health and attempts to enhance epidemiological surveillance network for animal health, to improve analytical capacity and epidemic preparedness. As REDISSE4 is not yet effective in CAR, it is imperative that the financing from the CAR COVID-19 project urgently support the country in getting in the supplies, technical support and funding for them to prepare and respond accordingly for COVID-19. Through REDISSE4, however, a disease surveillance specialist is being recruited (and will be selected by late-April) who will be the focal point in the PIU to support the CAR COVID-19 project. As SENI and REDISSE4 projects will merge to house the disease surveillance specialist, the unified project unit (SENI-REDISE4 National Technical Unit *(Comitee Technique Nationale* - CTN) will coordinate technical aspects to the project.

14. **Complementarity of CAR COVID-19 and REDISSE4 projects.** REDISSE4 will primarily focus on strengthening the disease surveillance efforts in collaboration with human and animal health, with a more medium-term focus on surveillance for all types of diseases, while the CAR COVID-19 project is an emergency measure to support the country regarding COVID19 preparedness and response, also with a longer-term visit of strengthening the health system. CAR COVID-19 is multi-partnership and high-level nationwide efforts, involving the president, Prime Ministers and all Ministers, and it is an extremely essential and highly visible and emergency national effort to combat COVID-19 in the country. REDISSE4 will be the base to set up the surveillance system so future outbreaks of any infectious diseases can be prepared for, detected and respond accordingly. REDISSE4 and CAR COVID-19 projects will minimize duplication and maximize their synergies. CAR COVID-19 will establish standard operating procedures (SOP) to clarify coordination mechanisms between the three projects. In addition to facilitating the procurement of bringing in personal protective equipment (PPE), essential drugs, and highly technical materials required for case management, WHO will support the Ministry of Health by also bringing in international technical assistance, while UNICEF will collaborate in risk communication and community engagement to prevent and respond to the new viral pandemic.

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\(^{11}\) Regions 2, 3, 4, 5, and 6.
15. Given the vast needs of the health system and given the constantly evolving nature of the transmission of COVID-19 in CAR, the project scope must be flexible as the geographic coverage might change rapidly. Initial support will be focused in Bangui where all the COVID-19 cases have been found, as of March 29, 2020. The current risk is highest in Bangui. Therefore, the initial focus of the project will be on supporting the containment of the epidemic in the capital Bangui and surrounding communes where the imported cases are found. In parallel, preparedness activities will be supported to the surrounding health districts as possible and where it is epidemiologically necessary, accessible and financially possible, given the conflict and fragile context of the country. Areas nearby Bangui or districts that have stronger commuting links to the capital and where cases are likely to occur will be gradually focused, as the transmission coverage expands and becomes more widespread outside of Bangui.

16. As the viral transmission expands, the current amount of the project (US$5M) will not be sufficient to respond to this unprecedented outbreak as it spreads nationwide. When the first CAR COVID-19 global plan was sent to the WB for request for funding in early March, the state of COVID-16 was at a very initial stage with no detected case in CAR. But the transmission scenarios are now quickly evolving, ever so reaching a potential national outbreak once community transmission appears. WB is currently the sole financier of this response through this project, in addition to US$1.1M from UNOCHA. However, there is significant in-kind support provided by the Alibaba foundation (tests, gloves, masks), and from MINUSCA and other humanitarian actors, who are redirecting significant human and logistical resources to support the government response. In addition, other partners are starting to mobilize funds, including the United States, who announced $3M humanitarian funding to support water and sanitation efforts, the African Development Bank and UNDP.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)
To prepare for and respond to the threat posed by COVID-19 in the Central African Republic.

Key Results

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

- Health staff trained in infection prevention per MOH-approved protocols (Number)
- Personal protective equipment (PPE) kits delivered to targeted facilities (Number)
- COVID-19 risk communication messages broadcast to communities (Number of days)

D. Project Description

17. The project design will include components, implementation arrangements, fiduciary and procurement systems as described below.

18. Component 1. PREPAREDNESS AND RESPONSE (US$6.9 million equivalent): This component will finance
activities related to activities pertaining to preparedness, case management and response, risk communication and community engagement, including capacity building and coordination.

19. **Preparedness, capacity building, and coordination.** This part of the component will serve for: i) National and multi-sectoral coordination and support for preparedness; ii) training of health professionals and staff; iii) human resources for supportive supervision and subnational support; iv) strengthening of public health emergency management and community and event-based surveillance; v) building of national and district diagnostic capacity for COVID-19 and epidemics; and vi) capacity building (training, human resource at 3 ports of entries).

20. **Response:** Activities supported by this component will include procurement of medical supplies and equipment for response, such as personal protective equipment (PPE), drugs and medical supplies for infection prevention and symptoms alleviation, laboratory equipment for sampling and transporting COVID-19 test samples, reagents, testing kits for various diseases (and for COVID-19 when it becomes available), establishment and equipping of quarantine and treatment centers including the provision of nutrition and dignity kits; establishment and equipping of rapid response teams; simple rehabilitation of emergency centers if necessary at central and district hospitals; and establishing/rehabilitating screening posts/rooms at Bangui airport and designated land crossing port of entry (PoE).

21. **Many highly prevalent health sicknesses in CAR present with symptoms that are similar to COVID-19.** Without sufficient diagnostic capacity for COVID-19 for the majority of the population in CAR, it will be difficult for providers to initially distinguish the new virus from other very common conditions, such as malaria, lower respiratory infections or common bacterial or viral infections. As there will likely be a surge in patients seeking immediate health services and treatment due to the onset of the viral disease for which there is no cure, the support to the treatment of common mortality-prone but easily treatable illnesses will be included (i.e. malaria treatments and testing, oral rehydration salts for diarrhea, fever-reducing drugs, basic antibiotics for other infectious diseases and equipping laboratories with sampling supplies) without diverting too much funds from the COVID-19 response. This approach will instill trust by the population and support to longer-term health system strengthening.

22. Thus, component 1 will also allow for flexibility to allocate resources for the purchasing of essential pharmaceuticals, vaccines, health facilities supplies, furniture for quarantine and care centers, temporary and fixed health facilities, recovery rooms and shelters, and supplies to address any lack of critical health system needs. The project foresees in setting up temporary care centers (such as in large tents or gymnasiums) to attend the massive surge of patients in need of treatment for illnesses. For the first few months of the response, the project will prioritize in distributing personal protection equipment (PPE) for front-line healthcare workers, and temporary ‘beds’ (or floor mats) to create extra care and recuperation areas for the extremely ill in a country with a very few hospital or health facility to receive critical patients. The drugs for treatment for other common and easily treatable illnesses will be provided, according to the protocol of MOH. The project will first ensure laboratory technicians in and near Bangui are trained and equipped to transfer COVID-19 sample specimens rapidly and securely over to the Pasteur Institute Bangui laboratory. It will then consider the expansion of equipping and training laboratory technicians to the peripheral district laboratories.

23. **A large portion of the procurement arrangements will be conducted by UNICEF and WHO** due to their access to large quantities of essential supplies needed for the COVID-19 preparedness and response, and their capacity to quickly bring in direct low-cost and high-quality procurement orders from their supply warehouses. A strong element which UNICEF is able to do is to ensure distribution of the incoming supplies to the end delivery points.
Additionally, this component will bring in technical and operational management assistance from international agencies (such as from WHO, CDC, UNICEF, universities) to support the government for the preparedness and response.

24. **Risk communication and community engagement:** Additional activities supported in the same Component 1 include: i) development of risk communication strategy and training materials; ii) production and dissemination of communication materials at the community level (i.e. community radio, text messaging, etc); iii) establishment of communication and media tools; iv) dissemination of risk communication and community engagement materials; v) community outreach to youth movements, religious groups, civil society organizations and other community networks and through community relays; vi) technical assistance for communication; vii) outreach and advocacy with public officials at all levels; viii) press conferences and other communication methods.

25. **The overall coordination on risk community communication and community engagement of the COVID-19 project country-wide will be conducted by the MOH in collaboration with technical expertise from UNICEF and other non-governmental organizations (NGOs) such as the International Federation of the Red Cross and other community networks. UNICEF will hire a Communication for Development specialist for the coronavirus endeavor to support and coordinate with the government. Communication messaging will also include safeguards concerns in addition to hygiene, handwashing behavior change and awareness raising efforts.**

26. **Component 2. Project implementation.** (US$0.6 million equivalent) Implementing the proposed project will require monitoring and evidence generation, reporting and impact assessment. As administrative and human resources might exceed the current capacity of the implementing institutions, activities in this component include: support for procurement, financial management, and environmental and social assessment and management. This component also includes provision of technical assistance and operational management support by international technical organizations (such as from WHO, CDC, UNICEF, universities), and hiring of technical consultants upon need, and other operating costs for supportive supervision and monitoring.

27. **Components 1 and 2 will also support crisis preparedness and response for other disease outbreaks** as multiple outbreaks may occur simultaneously throughout the course of the project implementation.

28. **Component 3: Contingency Emergency Response Component (CERC) (US$ 0):** In addition, a CERC will be included for situations of other urgent need of assistance or capacity constraints. The CERC will allow for rapid reallocation of project proceeds in the event of a natural or artificial disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact. The objective of this component is to improve the Government’s response capacity in the event of an emergency, following the procedures governed by the WB IPF Policy, section III, paragraphs 12 and 13 (Projects in Situations of Urgent Need of Assistance or Capacity Constraints).

29. **There is a moderate to high probability that during the life of the project, CAR will experience another epidemic or outbreaks of public health importance or other health emergency with the potential to cause a major adverse economic and or social impact.** This would result in a request to the WB to support mitigation, response, and recovery in the region(s) affected by such an emergency. In anticipation of such an event, the CERC allows CAR to request the World Bank to support mitigation, response, and recovery in the district(s) affected by such an epidemic. Following the procedures governed by World Bank IPF Policy section III, paragraphs 12 and 13 (Projects in Situations of Urgent Need of Assistance or Capacity Constraints), a CERC Operations Manual will be prepared as a condition of disbursement. Triggers will be clearly outlined in the CERC Operations Manual.
acceptable to the World Bank. Disbursements will be made against an approved list of goods, works, and services required to support crisis mitigation, response, and recovery. All expenditures under this activity will be in accordance with paragraph 12 of the World Bank IPF Policy and will be appraised, reviewed, and found to be acceptable to the World Bank before any disbursement is made.

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<td>Projects in Disputed Areas OP 7.60</td>
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Summary of Assessment of Environmental and Social Risks and Impacts

The Environmental Risk Rating is Substantial.

30. The four major areas of risks for the project are risks related to: (i) establishing/rehabilitation of screening posts/rooms at airport and designated land crossing port of entry and emergency operation centers; (ii) hazardous and medical waste management and disposal and; (iii) occupational health and safety (OHS) including the risk of spread of the virus among health care workers; and (iv) community health and safety.

31. The project will finance equipment, materials and small scale works for the (i) establishing and/or rehabilitation of screening posts and rooms at airport and designated land crossing ports of entry (POE), (ii) establishing and equipping quarantine and treatment centers, (iii) establishing and equipping mobile clinics, and (iv) rehabilitating emergency operations centers at central and districts hospitals. These interventions are expected to be site-specific and within the footprint of existing facilities, and no greenfield works are envisaged; therefore, environmental risks and impacts are expected to be temporary, predictable, and manageable. Risks and impacts of the small-scale works are anticipated to be moderate in their risk; and relate to the occupational health and safety risks undertaken by project workers and contractors, and construction waste management.

32. The project interventions are expected lead to the handling of COVID-19-related medical samples. Wastes anticipated to be generated from screening posts, quarantine facilities, treatment centers, mobile clinics, and emergency operation centers to be supported by the project interventions may include transmissible, infected, hazardous materials and wastes. Improper handling of hazardous and medical wastes can cause infection and health risks for workers, and the community as well as pollution to the environment. The substantial risk classification also takes into account the limited capacity of the designated PIU, as well as all the challenges of managing health care waste in CAR.

Social Risk Rating is Substantial
33. The social risk classification for the project is Substantial. Key social risks and impacts are those related to: (i) marginalized and vulnerable social groups (including the poor, Indigenous Peoples, minorities, and displaced persons and/or refugees) being unable to access facilities and services designed to combat the diseases in a way that could undermine the central objectives of the project; (ii) social conflicts resulting from false rumors and misinformation; (iii) issues resulting from people being kept in quarantine, including stigma faced by those being admitted to treatment or isolation facilities and the risk of stigma between the refugees or displaced people, and the host communities; (iv) issues resulting from social distancing and confinement measures, including risk of intimate partner violence during the quarantine as a result of household stress over economic and health shocks, forced coexistence in narrow living spaces and social unrest owing to prolonged confinement measures especially for the economically vulnerable, including the poor and informal workers; and (v) SEA/SH risks for project’s workers and beneficiaries, including attacks on female healthcare workers and patients.

34. The project has been given a preliminary rating of substantial risk for SEA/SH, based upon the country context and project-specific indicators. This risk rating is subject to validation following project approval, and SEA/SH risks will be further assessed and addressed during the implementation phase, which will include a review of the preliminary screening exercise and establishment of the corresponding measures to prevent and mitigate identified risks. The social risk classification also takes into account that (i) possible impacts are considered mostly temporary, predictable and/or reversible (but could become widespread), and that (ii) the nature of the project does not preclude the possibility of avoiding or reversing them (although substantial investment and time may be required); (iii) project activities and associated mitigation measures (e.g. related to quarantine facilities) may give rise to a limited degree of social conflict, harm; and (iv) labor management and OHS risks to human security. The MoH may be able to benefit from lessons learned through the Ministry of Public Health in neighboring Democratic Republic of Congo, which has been developing procedures during the Ebola response in Eastern Congo (a region bearing resemblance to the challenging conflict-affected context in CAR) that could be leveraged to manage and mitigate some of these risks.

E Implementation

Institutional and Implementation Arrangements

35. The Ministry of Health and Population (MOH) will be the implementing agency for the project. The technical PIU unit (SENI-REDISSE) under the Ministry of Health will serve as the technical unit of the CAR COVID-19 project, in charge of processing the project activities operations wise. Given that SENI is being restructured to address fiduciary issues, the AGIR PIU (Public expenditure and investment management reform (AGIR) project—AGIR) (P161730), housed within Ministry of Finance, will vest responsibility for fiduciary and procurement aspects of the COVID-19 project, as it was recognized by all parties in WB and with the government to entrust the project to this competent, quick and integral fiduciary team. Procurement under this proposed project will be also carried out by AGIR PIU reinforced with SENI-REDISSE’s Senior Procurement Specialist. The procurement unit may also benefit from the Bank’s Hands-on Expanded implementation support (HEIS) for procurement when needed. In addition, a Senior Financial Management specialist,
Senior monitoring and evaluation specialist with relevant experience, and a disease surveillance specialist will be hired with REDISSE4 financing. A Memorandum of Understanding (MOU) between the AGIR-PIU and the Ministry of Health will be in place to define the scope of the delegation.

36. A disease surveillance specialist will be hired as a focal point for epidemic responses from the REDISSE4 project. This specialist will cover this CAR COVID-19 project as well as REDISSE4 technically and to support the MOH to provide technical assistance. This disease surveillance specialist is currently being recruited and will be in mid-April to provide technical support and supporting project implementation. Technical members of the SENI-REDISSE4 CTN include: General Coordinator, international procurement specialist, environmental safeguards specialist, a monitoring and evaluation specialist and an online database manager, in addition to other technical units for gender-based violence, performance-based financing, and health information system who will provide cross-support as necessary. Due to the substantial environmental and social risk of the COVID-19 project, additional resources including an Environmental Specialist and a Social Specialist, will need to be hired or appointed no later than one month after project Effectiveness. The Social Specialist should have a background in stakeholder and community engagement and be familiar with gender-related programming and/or prevention and response of gender-based violence (GBV). CTN’s current GBV specialist will oversee GBV/SEA/SH risk mitigation measures for COVID-19, to be supported by the new COVID-19 Social Specialist once that person is on board.

CAR COVID-19 governance arrangements:

37. The Operational response is led by the Minister of Health, who chairs daily meetings of the National Strategy and Methodology Committee, which is at the heart of the response. Members are the senior management of MOH and key partners: WHO, UNICEF, UN Peacekeeping forces (MINUSCA), WB, Pasteur Institute (laboratory) and UNOCHA. The Strategy and Methodology Committee will also function as a de facto Steering Committee for the project. In addition to leading the operational response, the MOH, in consultation with the Strategy and Methodology Committee, prepares decisions that require political endorsement. The National Crisis Committee is chaired by the President and consists of Cabinet members, the mayor of Bangui, and key partners. The National Crisis Committee takes strategic decisions that affect the population at large, such as containment measures. Before discussion at the National Crisis Committee, decisions are validated by a Technical Committee, led by the Prime Minister, who also ensures that decisions have a legal basis through decrees issued by the relevant sector Ministers. This institutional structure is currently functioning efficiently in-country. The team will revise charts proposed under Annex 2 to reflect the arrangement above and better describe the coordination, oversight and accountability mechanisms in place.

38. On the implementation side, the project will be supported with collaboration with the national Public Health Emergency Response Center (COUSP, Centre d’operations d’urgence de la Santé Publique) which will be responsible to monitor project planning and technical aspects. COUSP is composed and led also
by the Minister of Health where all members of the Health humanitarian cluster (including senior health and technical specialists from the MOH, WHO, UNICEF, UNOCHA, and NGOs as International Federation of the Red Cross, Médecins sans Frontiers (MSF), etc) gather once a week or upon need to deal with epidemics and national health-related emergencies. Under the guidance of the Minister of Health, COUSP will technically provide inputs towards the achievement of the project’s objectives. However, despite the frequent meetings and communication, faster-responding and stronger technical support is required to help the MOH respond quickly and adequately. As a result, the project will hire a team from WHO to fully accompany the MOH to rapidly implement the COVID-19 preparedness and response.
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