Project Information Document/
Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 21-Jul-2017 | Report No: PIDISDSC21124
### BASIC INFORMATION

#### A. Basic Project Data

<table>
<thead>
<tr>
<th>Country</th>
<th>Project ID</th>
<th>Parent Project ID (if any)</th>
<th>Project Name</th>
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<tr>
<td>Caribbean</td>
<td>P162877</td>
<td></td>
<td>Caribbean Regional Health Project (P162877)</td>
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<thead>
<tr>
<th>Region</th>
<th>Estimated Appraisal Date</th>
<th>Estimated Board Date</th>
<th>Practice Area (Lead)</th>
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<tr>
<td>LATIN AMERICA AND CARIBBEAN</td>
<td>Dec 11, 2017</td>
<td>Apr 26, 2018</td>
<td>Health, Nutrition &amp; Population</td>
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<table>
<thead>
<tr>
<th>Financing Instrument</th>
<th>Borrower(s)</th>
<th>Implementing Agency</th>
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#### Proposed Development Objective(s)

The objective of this Project is to strengthen national and regional disease surveillance and public health emergency preparedness and response efforts.

#### Financing (in USD Million)

<table>
<thead>
<tr>
<th>Financing Source</th>
<th>Amount</th>
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<tr>
<td>International Development Association (IDA)</td>
<td>45.00</td>
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**Total Project Cost** 45.00

<table>
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<tr>
<th>Environmental Assessment Category</th>
<th>Concept Review Decision</th>
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<tbody>
<tr>
<td>B-Partial Assessment</td>
<td>Track II-The review did authorize the preparation to continue</td>
</tr>
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</table>

Other Decision (as needed)
B. Introduction and Context

1. The Caribbean Regional Health Project is the first project in the Latin America and the Caribbean region focused on a regional approach to strengthening preparedness and response to public health emergencies. The Caribbean has been challenged by frequent disease outbreaks such as swine flu, dengue fever, Chikungunya, and Zika. Most recently, the 2016 Zika outbreak exposed gaps in public health preparedness and response that were not adequately addressed following the 2014 Chikungunya outbreak. The fight against new and emerging diseases in the region has been hampered by limited in-country capacity and the substantial share of resources devoted to addressing the growing burden of noncommunicable diseases, leaving limited resources for addressing public health emergencies.

Country Context

2. The Caribbean Community (CARICOM) is a consortium of twenty countries consisting of fifteen Member States and five Associate Members. CARICOM is home to approximately sixteen million citizens, 60 percent of whom are under the age of 30. The region houses great diversity with a variety of ethnic groups and spoken languages. English is the major language complemented by French and Dutch. Stretching from The Bahamas in the north to Suriname and Guyana in South America, CARICOM comprises states that are largely considered developing countries. With the exception of Belize, Guyana, and Suriname, all Members and Associate Members are island states. While these states are all relatively small in population and physical size, they contain great diversity in geography and population as well as with the levels of economic and social development. Member states generally rank high on the United Nations Development Programme’s (UNDP) Human Development Index (HDI) with Haiti and Guyana serving as notable exceptions (Table 1). Gross National Income (GNI) per capita varies widely, from US$810 (Haiti) to US$20,740 (Bahamas). This project will support Saint Lucia, Saint Vincent and the Grenadines, and Guyana, all of which are Member States of CARICOM and which have moderate to high levels of human development and life expectancy at birth that ranges between 66 (Guyana) and 75 (Saint Lucia).

3. Strong growth in the 1980s and early 1990s led to the achievement of important human development milestones in the Caribbean region, but these have been challenged by the 2008 financial crisis. Among the three participating countries, Saint Lucia has the highest GNI per capita at US$7,350 while Guyana has the lowest at US$4,090 (2015; Table 1). Following the 2008 financial crisis, the countries have struggled to regain precrisis growth levels. Up until 2015, Saint Lucia and Saint Vincent and the Grenadines saw GDP growth rates below 2 percent following the crisis, in contrast to GDP growth rates of 3 percent (Saint Lucia) and 6.5 percent (Saint Vincent and the Grenadines) in 2008. Guyana has fared slightly better and maintained growth at above 2 percent in the postcrisis period (with growth exceeding 4 percent in some years) though the economy has been growing more slowly since 2013. Regional cooperation continues to remain strong, with plans to implement a common market (Caribbean Community Single Market and Economy) to promote regional integration recently announced. Regional cooperation has been long standing in the health sector, beginning with the adoption of the Caribbean Cooperation in Health (CCH) Initiative in 1984 and most

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2 Anguilla, Bermuda, the British Virgin Islands, Cayman Islands and Turks and Caicos Islands are Associate Members of CARICOM.
4 The Human Development Index is a summary measure of average achievements of countries in three key measures of human development: a long and healthy life, knowledge, and achievement of a decent standard of living (UNDP, 2016).
5 Other countries interested in participating could potentially be included in a second phase of the Project. Such an approach has been taken in the Regional Disease Surveillance Systems Enhancement (REDISSE) series of Projects, which is now in Phase III (third group of countries).
recently with the establishment of the Caribbean Public Health Agency (CARPHA) in 2014. These regional collaborations have been instrumental in addressing the health needs of the population, and have continued to play an important role in driving the health agenda forward, particularly during times of limited resources.

Table 1: Basic Development Indicators of CARICOM Member States

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Antigua &amp; Barbuda</td>
<td>0.79</td>
<td>13,270</td>
<td>76</td>
<td>8</td>
</tr>
<tr>
<td>Bahamas</td>
<td>0.79</td>
<td>20,740</td>
<td>75</td>
<td>12</td>
</tr>
<tr>
<td>Barbados</td>
<td>0.80</td>
<td>14,510</td>
<td>75</td>
<td>13</td>
</tr>
<tr>
<td>Belize</td>
<td>0.71</td>
<td>4,490</td>
<td>70</td>
<td>17</td>
</tr>
<tr>
<td>Dominica</td>
<td>0.73</td>
<td>6,800</td>
<td>-</td>
<td>21</td>
</tr>
<tr>
<td>Grenada</td>
<td>0.75</td>
<td>8,650</td>
<td>73</td>
<td>12</td>
</tr>
<tr>
<td>Guyana</td>
<td>0.64</td>
<td>4,090</td>
<td>66</td>
<td>39</td>
</tr>
<tr>
<td>Haiti</td>
<td>0.49</td>
<td>810</td>
<td>63</td>
<td>69</td>
</tr>
<tr>
<td>Jamaica</td>
<td>0.73</td>
<td>4,930</td>
<td>76</td>
<td>16</td>
</tr>
<tr>
<td>Montserrat</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>St. Kitts &amp; Nevis</td>
<td>0.77</td>
<td>15,060</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>St. Lucia</td>
<td>0.74</td>
<td>7,350</td>
<td>75</td>
<td>14</td>
</tr>
<tr>
<td>St. Vincent &amp; the Grenadines</td>
<td>0.72</td>
<td>6,630</td>
<td>73</td>
<td>18</td>
</tr>
<tr>
<td>Suriname</td>
<td>0.73</td>
<td>9,360</td>
<td>71</td>
<td>21</td>
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<tr>
<td>Trinidad &amp; Tobago</td>
<td>0.78</td>
<td>17,640</td>
<td>70</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: United Nations Development Programme (HDI) and World Bank (World Development Indicators)

4. In addition to economic shocks, countries in the region continue to be vulnerable to natural disasters and climate change, with greater mobility also contributing to the risk of disease spread. Hurricanes are the most threatening natural hazard facing the region, posing significant destructive potential due to high wind speeds, heavy rains, and powerful storm surges that produce flooding which may increase the threat from vector-borne diseases. Beyond concerns related to natural disasters, the Caribbean region is prone to the adverse impacts of climate change. Climate change leads to rising temperatures, changes in rainfall patterns, and more and longer periods of extreme weather, with implications for water-borne and vector-borne diseases. In addition to climate change, greater mobility and the growth in regional and international travel also represents a possible source of disease spread. In recent years, an upward trend in tourist arrivals has been observed in Saint Lucia and Guyana, while the number of tourists have been relatively unchanged in Saint Vincent and the Grenadines. Tourism accounted for 41.5 percent of GDP in Saint Lucia, 23.2 percent of GDP in Saint Vincent and the Grenadines and 8.2 percent of GDP in Guyana (2015). The tourism sector is responsible for 46.3 percent of employment in Saint Lucia, 21.3 percent in Saint Vincent and the Grenadines, and 8.7 percent in Guyana (2015). This increased mobility represents a substantial source of revenue, but can also contribute to disease spread (both as the source of and destination for outbreaks). Recently, the Caribbean was identified as the most likely route of transmission of Zika into the United States of America. The virus was thought to have been introduced in April 2015, but was only detected in January 2016, a substantial lag which may have major consequences for a deadlier virus. Tourism has not been implicated as a source of disease outbreaks in the region, and preparedness efforts are essential in ensuring that this continues to be the case in the future.
In view of these challenges, the Caribbean has been unable to adequately manage and contain the spread of infectious diseases, particularly vector-borne diseases. In the four-year period between 2013 and 2017, more than 42 countries and territories in the Americas suffered from a series of disease outbreaks including chikungunya, cholera, dengue, and most recently, Zika. These vector-borne diseases are the most common types of outbreaks in the Caribbean and require prioritization as actions to address one type of vector-borne disease can be of benefit across different outbreaks. The 2016 Zika outbreak brought to light the gender dimensions of public health outbreaks with an increase in the cases of microcephaly, not a common condition, which was attributed to pregnant women infected with the Zika virus. In the Caribbean, the Chikungunya outbreak began in December 2013 and spread to more than 350,000 people by July 2014, highlighting the rapid spread of disease in the region. Two years later, the Zika outbreak in the Latin American and the Caribbean (LAC) region exposed gaps in public health preparedness and response that had not been adequately addressed following the previous Chikungunya outbreak. All countries in the Caribbean have now been affected, with the region implicated as the likely source of introduction of the virus into the United States.

The fight against new and emerging diseases in the Caribbean has been hampered by limited in-country capacity and the substantial allocation of resources towards addressing the growing burden of NCDs. The vector-borne nature of recent outbreaks, and the ease with which the viruses cross national borders underscores the importance of well-coordinated responses and containment strategies to avoid the high costs associated with outbreaks, including productivity and investment opportunity loss. To tap into economies of scale, the Caribbean can benefit from exploring opportunities for specialization, where the Caribbean has a strong track record. By strengthening existing country capacity and existing national efforts to address disease outbreaks, a regional approach can be designed tapping into different country specializations which would bring regional spillover benefits.

Sectoral and Institutional Context

The growing burden of noncommunicable diseases have left limited resources for addressing public health emergencies. Saint Lucia has reported a rapid increase in the number of adults with elevated blood pressure, Saint Vincent and the Grenadines has seen an increase in the number of amputations secondary to diabetes mellitus, and Guyana fares worse than comparator countries in the years of life lost due to early death due to noncommunicable diseases. At the same time, poverty rates continue to be high. The most recent available poverty data illustrates high levels of poverty in the participating countries, at 28.8 percent for Saint Lucia (2006) and 30.2 percent in Saint Vincent and the Grenadines (2008) (estimates for Guyana were not available). The countries are also affected by a shortage of human resources for health (HRH), limiting the region’s ability to sustain their current health systems and meet key health service needs. There are 4.169 nurses per 1,000 people in LAC, less than half the density observed in high-income countries. Guyana has as little as

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http://www.who.int/csr/don/archive/year/en/


9 Data were obtained from the NCD Risk Factor Collaboration (NCD-RisC; 2017) (Saint Lucia), Ministry of Health (Saint Vincent and the Grenadines; 2016) and Institute for Health Metrics and Evaluation (Guyana; 2013).
0.531 nurses and midwives per 1,000 people. Community health workers could be a potential strategy to support detection as a first point of entry considering the nursing shortages, but may be more applicable in Guyana with hard-to-reach and far-spread communities compared to Saint Lucia and Saint Vincent and the Grenadines where community health workers are already based at the health facilities. Overall, these shortages have significantly negative impacts on the capacity of Caribbean countries to offer quality health care services and prepare for and respond to public health emergencies. For example, there is an absence of specialists in key areas as seen by the lack of an entomologist in Guyana.

8. Saint Lucia, Saint Vincent and the Grenadines and Guyana continue to have a high degree of reliance on out-of-pocket (OOP) payments, which result in a lack of financial protection and may deter people from seeking care in the event of an outbreak. The share of GDP spent on health ranges from 5.1 percent in Guyana to 6.7 percent in Saint Vincent and the Grenadines but there is wide variation in health expenditure per capita. Health expenditure per capita has increased since 1995, but continues to lag behind the LAC average, even in Saint Vincent and the Grenadines, which has the highest per capita health expenditure at $917 (Table 2). Approximately 50-60 percent of health expenditure is public, with OOP payments constituting a substantial share of health expenditures. OOP payments constitute 37.4 percent of total health expenditures in Guyana, 45.6 percent in Saint Lucia, and 49.2 percent in Saint Vincent and the Grenadines. In contrast, OOP payments average 20 percent of total health expenditure in the OECD. This results in a lack of financial protection in times of sickness, which may impact care-seeking behavior following a disease outbreak.

Table 2. Key Health Expenditure Data for St. Lucia, Guyana, St. Vincent & the Grenadines, and Comparators

<table>
<thead>
<tr>
<th></th>
<th>St. Lucia</th>
<th>Saint Vincent and the Grenadines</th>
<th>Guyana</th>
<th>Caribbean Small States</th>
<th>Latin America &amp; the Caribbean</th>
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</thead>
<tbody>
<tr>
<td>Health expenditure, total (% of GDP)</td>
<td>6.1</td>
<td>6.7</td>
<td>6.7</td>
<td>8.6</td>
<td>5.1</td>
</tr>
<tr>
<td>Health expenditure per capita, PPP (constant 2011 international $)</td>
<td>393</td>
<td>698</td>
<td>296</td>
<td>917</td>
<td>168</td>
</tr>
<tr>
<td>Public health expenditure (% of total)</td>
<td>50.0</td>
<td>53.6</td>
<td>56.2</td>
<td>50.8</td>
<td>81.4</td>
</tr>
<tr>
<td>Out-of-pocket health expenditure (% of total)</td>
<td>49.1</td>
<td>45.6</td>
<td>43.8</td>
<td>49.2</td>
<td>16.3</td>
</tr>
</tbody>
</table>

9. Rapid Needs Assessments conducted following the 2016 Zika outbreak revealed key weaknesses in preparedness and response of the national and regional health systems. Assessments conducted in Dominica, Saint Vincent and the Grenadines, and Guyana (an assessment has not yet been conducted in Saint

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Lucia), revealed the following shortcomings in infectious disease surveillance, epidemic preparedness, and response: (i) lack of a fit for purpose health workforce for disease surveillance, preparedness and response at each level of the health pyramid; (ii) nonexistent or insufficient facility level surveillance and response structures; (iii) limited availability of laboratory infrastructure in place for timely and quality diagnosis of epidemic-prone diseases; (iv) lack of interoperability of different information systems hampers analysis and utilization of information for decision-making and disease mitigation measures; (v) generally inadequate infection prevention and control standards, infrastructure and practices; (vi) weak and inefficient management of the supply chain system; and (vii) significant gaps in regional level surge capacity for outbreak response, stockpiling of essential goods, information sharing, and collaboration.

10. **The health systems of Saint Lucia, Saint Vincent and the Grenadines, and Guyana are similarly structured, and have overlapping gaps in preparedness and response capacity.** At the health facility level, typically the first point of contact with the health system, surveillance and response protocols and structures are inadequate. Laboratory confirmation of diagnoses is challenging due to limited laboratory infrastructure at the national level, and laboratory infrastructure at the regional level has not been able to cope with the surge in demand during outbreaks. Many countries in the region (including the three participating countries) have some form of health information systems, but these are not updated in real time and are poorly connected at the different tiers (primary, secondary, tertiary) of the health system. Similarly, while some infection prevention and control standards, infrastructure, and practices are in place, these are inadequate, with standard operating procedures and protocols lacking in some areas. These shortcomings subsequently translate to weaknesses in supply chain management and surge level capacity at the national and regional level, making it difficult for countries and/or the region to mount a coordinated response to outbreaks.

11. **Addressing these gaps have been challenging due to relatively low levels of economic growth and limited external support of the health sector.** Following the closing of the Bank-financed Caribbean Multi-country HIV/AIDS Program (MAP) in November 2013, which included a total of 11 country-specific and one regional project totaling nearly US$157 million, investments to the health sector have drastically fallen. From 2013 to 2015, the Bank presence in the English-speaking Caribbean health sector dwindled down to one US$3 million Japanese Social Development Fund (JSDF) Grant to Belize and small trust funds in support of limited technical assistance (TA). Since 2015, the Bank has had no investments in the English-speaking Caribbean health sector and donor partner financing presence has scaled down significantly to TA from USAID/PEPFAR and a reduced Global Fund intervention, both of which primarily focus on HIV/AIDS. Under IDA 17, the health sector received zero funds resulting in zero investments for health. Other agencies have been involved in the health sector, but this has been limited to capital investments or specific areas within the health system. For example, in Saint Lucia, the European Union has funded the construction of the new Owen King EU Hospital, while USAID is active in Guyana, focusing on HIV/AIDS prevention and response, and supply chain management of drugs and medical supplies. Most recently, the Inter-American Development Bank (IDB) has approved a US$8 million loan to help reduce maternal, perinatal, and neonatal deaths in Guyana.

12. **Other agencies have provided technical assistance in the region, but there continues to be room for improvement in the regional coordination of public health emergency preparedness and response efforts (see Box 1 for the rationale behind the regional coordination).** Established in 2014, CARPHA is the lead technical body in the region and brings together five former key public health regional agencies that had operated independently of one another to now provide a coordinated public health platform across the region. As part of its mandate, CARPHA provides TA through state-of-the-art validated laboratory facilities, accurate
and reliable services for surveillance and disease control, training for health officials in various areas related to health, defining quality standards and standard operating procedures, and serves as the Caribbean Reference Laboratory. In addition to CARPHA, the Pan American Health Organization (PAHO) also maintains an active presence in the region. PAHO has established an Emergency Operations Center for the LAC region (which includes a Caribbean subregional office) through which the Disaster and Epidemic Alert and Response Task Forces operate to collect, analyze, prioritize, monitor and disseminate information about health crises and disasters to health authorities in member states and the international community to make timely and effective decisions. Furthermore, while the United States Government (USG) support through USAID focused on HIV/AIDS, technical assistance through the United States Center for Disease Control (CDC) has been focused on the area of strengthening laboratory information systems and surveillance capacity. In addition, the CDC is engaged in efforts to strengthen laboratory services in Barbados, where a new reference laboratory which aims to consolidate the HIV and TB functions of public health labs in the country is currently under construction. Thus, despite this new reference laboratory, there continues to be a gap in laboratory services for tests associated with other public health emergencies, such as Zika. This gap, as well as others, were identified as part of the Rapid Needs Assessments, but an in-depth stock taking exercise is planned as part of project preparation. Following this exercise, project activities will look to build on efforts in place by other partners where practical.

Box 1: Why a Regional Approach to Public Health Preparedness and Response?\(^{13}\)

- There is (i) a policy commitment as seen through the Caribbean Cooperation in Health, the regional framework through which member states of the Caribbean community, including Guyana, St. Lucia, and St. Vincent and the Grenadines, come together to cooperate with each other, regional institutions and development partners to improve the health status of the Caribbean people and a (ii) platform for policy harmonization provided by the Caribbean Public Health Agency (CARPHA) with the technical support from the Pan American Health Organization (PAHO). CARPHA has most recently provided essential technical support to countries in the region following the Zika outbreak, but has found itself challenged by capacity constraints such as a lack of manpower and limited laboratory testing facilities including reagents and equipment. In this regard, CARPHA will be responsible for the regional coordination and day-to-day oversight of this Project building on its experience as a regional coordination platform across the Caribbean, while also benefitting from the project in strengthening its capacity to provide enhanced services to the region. In addition, a regional approach also confers (iii) economies of scale, which are particularly important in the Caribbean where the populations are relatively small. Regionalization of certain aspects of public health preparedness and response will result in lower costs per unit for select public health activities.\(^{14}\) Finally, a regional approach is also thought to be appropriate given the (iv) positive externalities associated with and public goods nature of public health emergencies given the transmissibility associated with communicable diseases, including cross-border transmissions. The regional benefits and positive externalities of effective disease surveillance and response and common platforms for behavior change are substantial.

- The Caribbean Public Health Agency (CARPHA) will be responsible for the regional coordination and day-to-day oversight of this Project with technical oversight from the Pan American Health Organization (PAHO). Collective action and cross-border collaboration will be emphasized throughout the Project:
  - the Project will support countries’ efforts to harmonize policies and procedures;

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\(^{13}\) Preparedness for pandemics refers to a variety of health and non-health interventions, capabilities and capacities put in place at community, country, regional and global levels to better detect, prevent, protect, control and respond to the spread of disease and other hazards as well as mitigate risks to international travel and trade and social disruptions.

o countries will be empowered to engage in joint planning, implementation and evaluation of program activities across borders at regional and national levels, and;
o the Project will promote resource sharing of high cost specialized assets such as reference laboratories, training programs, health information systems, and pooled procurement of difficult to access commodities.

It is anticipated that the overall Caribbean Regional Health Project will have a regional approach that could benefit and eventually be adopted by neighboring countries. By considering activities that can only be achieved through multi-country collaboration, priority will be placed on two areas:
- control and prevention of cross-border spread of communicable disease;
- harmonized policies, standardized technical guidelines as well as information collection and sharing for public health emergencies

Relationship to CPF

13. **The proposed Project is in line with the Bank’s twin goals of eliminating extreme poverty and boosting shared prosperity.** The proposed Project will strengthen the preparedness and response capacity across Caribbean countries to manage the challenges from new and emerging diseases. Such communicable diseases are a major constraint on the health, education, and potential earnings of people living in the Caribbean region and have significant impacts across the population due to the high and frequent volume of travel within the Caribbean and the ease by which disease carrying vectors can cross borders. Weak preparedness and response capacity to handle communicable disease outbreaks is exacerbated by the imminent threat of climate change, which is expected to impact already weak regional and national systems, displace populations, and create environmental conditions more favorable for disease. The poor are likely to be disproportionately affected considering the high levels of OOP payments. Hence, the economic rationale for investing in strengthening the region’s ability to mount a robust response to outbreaks is key to mitigating the economic burden not only on individuals, but also on the countries and the region as a whole.

14. **The proposed Project is also consistent with the World Bank Group strategies for the Organization of Eastern Caribbean States (OECS) and Guyana, the countries targeted by this proposed project.** The OECS Regional Partnership Strategy (RPS) FY2015-2019 Framework endorsed by the Board of Executive Directors on November 13, 2014 aims to support sustainable inclusive growth through three areas of engagement with the third of these being resilience. The Guyana Country Engagement Note (CEN) for the FY16-18 period focuses on three objectives with the first being the need to “[enhance] resilience of selected infrastructure and building disaster risk management (DRM) capacities”. The proposed project is in direct alignment with the OECS RPS area of engagement and the Guyana CEN priority objective of “resilience” as the project will focus on building and strengthening health systems in the target countries and enhancing their interoperability from a regional-level which is the key building block for a resilient health system able to reduce the vulnerability faced by the challenges of emerging and re-emerging disease outbreaks.

15. **Furthermore, there is direct alignment between the proposed project and existing regional structures, partnerships and priorities.** The CCH Initiative promotes collective and collaborative action to solve critical health problems best addressed through a regional approach, rather than by individual country action. Adopted by CARICOM Health Ministers in 1984, the CCH optimizes the utilization of resources, promotes technical cooperation among member countries, and works to secure funding for the implementation of projects in priority health areas. The initiative was approved by CARICOM Heads of Government in 1986
when CCH Phase I was launched. In September 2016, CCH Phase IV was launched and its priority action areas include the implementation of an integrated vector-borne management strategy and full implementation of the International Health Regulations (IHR) (2005). The proposed project would directly support the achievement of these priority action areas by working with countries at the national-level to develop vector-borne management strategies and at the regional-level by harmonizing actions to reach IHR compliance.

16. **The establishment of the Global Health Security Agenda (GHSA) provides a global coordination platform from which the proposed project can directly benefit and contribute.** The Global Health Security Agenda (GHSA) aims to accelerate progress toward a world safe and secure from the threat of infectious diseases. In recognizing the importance of infectious diseases and the gaps in global preparedness for and response to infectious diseases, the GHSA is a partnership of nations, international organizations, and stakeholders created in February 2014 through a shared understanding of the “essential need for a multilateral and multi-sectoral approach to strengthen both the global capacity and nations’ capacity to prevent, detect, and respond to infectious diseases threats.” Since then, more than a dozen countries have drafted roadmaps to strengthen global health security at a national level. In November 2016, the Caribbean region took the established roadmap one step further by convening a regional meeting with more than 70 participants representing 11 Caribbean countries, several regional bodies, the private sector, and development partners to develop the first regional-level GHSA Roadmap. The proposed project is in line with the GHSA objectives and is structured to contribute to four of the key actions defined in the GHSA strategy: (i) surveillance and reporting; (ii) laboratory capacity; (iii) health workforce; and (iv) epidemic preparedness and response. To ensure complementarity of the WBG investment with other GHSA activities and investments, the Task Team will work closely with the USG, particularly with the US CDC in preparing the project.

17. **Beyond the CPF, the proposed project is in line with the World Bank’s efforts to improve support in the context of pandemics, as seen through the recent launch of the Global Pandemic Emergency Facility (PEF) by the World Bank and key partners.** The PEF aims to provide immediate support to countries experiencing any infectious disease outbreak that meets predefined triggers, either defined as a public health emergency or international concern (PHEIC) or certain disease outbreak notification (DON), through insurance funding mechanisms and public funding mechanisms. The PEF aims to mobilize the funds to a country within a maximum of one to two days of an official request. The proposed project complements the PEF in the following ways by: (i) focusing on capacity for disease surveillance and epidemic preparedness countries will be better able to detect and contain outbreaks before they develop into PHEIC or DON event and trigger the PEF; and (ii) including a Contingency Emergency Response Component (CERC), so that countries will be able to mobilize funds quickly from within the project in the event of an outbreak (thereby assisting in containing outbreaks before they escalate to trigger the PEF, or for outbreaks that do not meet PEF’s parametric criteria). In addition, CERC complements PEF by serving as a conduit for PEF’s surge financing for client countries.

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**C. Proposed Development Objective(s)**

The objective of this Project is to strengthen national and regional disease surveillance and public health emergency preparedness and response efforts.
Key Results (From PCN)

18. The following key results would be supported through the project:

(i) Number of national-level certified laboratories implementing the regional harmonized protocols and procedures to be followed during public health emergencies
(ii) Number of participating countries that achieve the core capacities of the 2005 International Health Regulations (IHR).
(iii) Number of national and regional preparedness and response action plans for priority infectious diseases developed and approved.

19. These are potential key results indicators that will be refined during the appraisal period. The Project Appraisal Document (PAD) will include a detailed description of the proposed PDO and intermediate outcome indicators. A draft Results Framework is provided in Annex 1, and includes proposed indicators.

D. Concept Description

20. Specific activities will be determined through consultations with participating countries, namely Saint Lucia, Saint Vincent and the Grenadines, and Guyana. Country selection was based on expression of interest from the countries either in the context of being involved in the health component of the OECS HD Project (St. Lucia and St. Vincent and the Grenadines) or as they had specifically requested support from the Bank following the Zika outbreak (Guyana). The project will pursue a programmatic approach to engage additional Caribbean countries based on expressed interest and demand. The proposed Project will be structured around three main pillars (surveillance and information systems, laboratory services, and preparedness/response) with an additional component on institutional capacity building. These components are described in greater detail below.

Component 1: Surveillance and Information Systems (US$14 Million)

21. This component focuses on strengthening country surveillance and information systems, including the establishment of a regional platform to strengthen collaboration for early detection. The climate variability in the Caribbean (including the occurrence of natural disasters, such as hurricanes) accentuates the need for strengthened surveillance. This component would ensure the completeness of the reporting chain for surveillance activities, as seen in Figure 1. This Figure highlights the links from the population to the national health facility-based disease surveillance and reporting system, and from the national health facility to the regional disease laboratory, surveillance, and response network (including CARPHA/PAHO where applicable). Current national surveillance efforts, where present, are incomplete and hampered by inadequate health information systems. However, there is a clear policy commitment as seen through the CCH, the regional framework through which member states of the Caribbean community, including Guyana, Saint Lucia, and Saint Vincent and the Grenadines, come together to cooperate with each other, regional institutions and development partners to improve the health status of the Caribbean people. Further, there is an existing platform for policy harmonization provided by the Caribbean Public Health Agency (CARPHA) with the technical support from the Pan American Health Organization (PAHO). Activities proposed under this component will build upon these policy tools in order to strengthen surveillance and information systems.
22. Possible activities under this component include country-level and regional-level activities:

**Country-level: (US$10 Million)**

(i) Scaling-up the primary health care system through civil works (i.e. refurbishment) and/or provision of equipment to allow health facilities to serve as the first point of detection;

(ii) strengthening of protocols (including the development of an active case-finding protocol for vector-borne diseases as well as clinical protocols); and

(iii) strengthening the health information systems for collection of incidence and prevalence data.

**Regional-level: (US$4 Million)**

(i) Roll-out of the Field Epidemiology and Laboratory Training Program (FELTP) among field-level epidemiologists (as needed);

(ii) development of harmonized technical procedures related to disease surveillance and information sharing with regard to infectious disease protocols, including specific guidelines for microcephaly testing and confirmation in pregnant women suspected to be Zika infected; and

(iii) development of a regional information and communications technology platform for surveillance and management, including Geographic Information Systems.

**Figure 1. Linkages between Action:**

**From Health Facility Surveillance to Regional Surveillance and Response**

![Diagram](image)

*Source: Adapted from Regional Disease Surveillance Systems Enhancement (REDISSE) Phase II (P159040) Concept Note*

**Component 2: Strengthening of Laboratory Capacity (US$13 Million)**

23. Essential to surveillance and information systems is sufficient laboratory capacity for diagnosis and case monitoring as seen in Figure 1. Component 2 will involve upgrading public health laboratories to strengthen capacity at the national and regional levels, including laboratory transportation and information systems. The
The recent Zika outbreak in the region was challenged by capacity constraints, hampering the ability of the regional public health agency (CARPHA) and countries in the region to adequately monitor the outbreak. As a result of capacity constraints, CARPHA limited testing to five cases per country per week at the height of the epidemic. Capacity constraints included a lack of manpower and limited laboratory testing facilities such as reagents and equipment. This component would strengthen capacity at the regional level while simultaneously ensuring that national laboratory networks are better linked to the regional reference laboratory at CARPHA. Investments under this component may include civil works (i.e. refurbishment), technical assistance, computer equipment, and training as needed.\textsuperscript{15}

24. Possible activities under this component include country-level and regional-level activities:

\textbf{Country-level: (US$8 Million)}

(i) Review the capacity of field-based and the national laboratories in the target countries to provide the needed laboratory facilities and capacity (e.g., collect, test, process, diagnose, and confirm cases);

(ii) upgrade laboratory facilities and capacity at the field- and national-levels based on gaps identified with regard to facilities and capacities they should possess;

(iii) strengthen the laboratory data management system and its interoperability with the surveillance information systems;

(iv) ensure adequate transportation of laboratory specimens, including a cold chain system;

(v) regional accreditation of laboratories with recognized quality standards and development of quality assurance programs; and

(vi) provide training to ensure sufficient human resource capacity for managing essential laboratory functions at the field and national level.

\textbf{Regional-level: (US$5 Million)}

(i) Strengthen the regional reference laboratory capacity to provide the region with the needed laboratory capacity (processing, diagnosing, confirming) priority infectious diseases;

(ii) implement the use of ICTs to put in place a regional laboratory data management system that is interoperable with national-level surveillance information systems;

(iii) establish partnerships with the private sector to ensure adequate transportation of laboratory specimens, including cold chain, across the region;

(iv) implement a regional quality assurance program and the development of common standards for country laboratories; and

(v) provide training at the regional-level and to national focal-point teams to ensure an information management chain is established and maintained from the country to regional-level and vice-versa for timely disease notification.

\textbf{Component 3: Preparedness and Emergency Response (US$10 Million)}

25. This component will support preparedness and emergency response efforts through improvement of local, national, and regional capacities (see Figure 1). As a key first step, a review of national and regional health emergency preparedness and response plans will be conducted. Routine external monitoring and

\textsuperscript{15} Investments for laboratory facilities are strongly aligned with several priority areas highlighted in the recent report \textit{From Panic and Neglect to Investing in Health Security: Financing Pandemic Preparedness at a National Level}, namely financing of capital investments or one-off expenditures to achieve a step change in preparedness capacities; and (ii) financing of regional initiatives, particularly regional laboratory facilities and cross-border disease surveillance systems in smaller countries to reinforce preparedness.
assessment of core public health capacities of national structures to meet IHR standards, such as through Joint External Evaluation (JEE)\(^\text{16}\) exercises, will also be conducted to identify weaknesses within the health system. Lastly, this component will strengthen citizen engagement mechanisms by providing the channels through which community members can participate in the development and updating of the health emergency preparedness and response plans. In the case of Guyana, the target community members will be those in border areas. In addition, communication materials to be used during disease outbreaks will be test-run and validated with community-level focus groups composed of community members. The citizen engagement activities will be preceded by a review of existing citizen engagement mechanisms already in place and functional in the target countries that could be tapped into or built upon to ensure a disease outbreak focus.

26. In addition to these reviews, potential project activities at the country and regional levels could include:

**Country-level: (US$7 Million)**

- (i) Routine external monitoring and assessment of core public health capacities of national structures to meet IHR (2005) to identify where the weaknesses exist within the health systems;
- (ii) Support the development and updating of health emergency preparedness and response plans to include the feedback and participation of community members through citizen engagement;
- (iii) Set-up adequately equipped EOCs and trained multi-disciplinary rapid response teams at the local, sub-national, and national level.
- (iv) Support targeted behavior change communication (BCC) activities at the district-level including disaster risk management (DRM).
- (v) Preparation and test-run of communication materials prior to an outbreak with community-level focus groups to promote education of priority issues and ensure local acceptance of contents.
- (vi) Identification, establishment, and upgrading of designated primary-level care health facilities for infection prevention and control (IPC) and clinical management of priority infectious diseases.

**Regional-level: (US$3 Million)**

- (i) Development of a regional preparedness and response action plan (including logistics plans and other institutional frameworks) for priority infectious diseases.
- (ii) Development and management of a real-time database of emergency response teams on standby for rapid deployment
- (iii) Simulation exercises and training on joint outbreak investigations as part of an early warning and response system
- (iv) Use of GIS and other ICT tools to identify potential high risk areas for disease outbreaks in the region
- (v) Support the development/upgrade of educational curriculums for training of country level health workforce in surveillance and response for priority infectious diseases.
- (vi) Facilitate the establishment of a contingency emergency response funding mechanism for swift mobilization and deployment of resources in response to major infectious disease outbreaks.

\(^{16}\) The Joint External Evaluation Tool - International Health Regulations (2005) aims to assess country capacity to prevent, detect, and rapidly respond to public health threats independently of whether they are naturally occurring, deliberate, or accidental. The purpose of the external evaluation process is to measure country specific status and progress in achieving the targets. As such, the initial external evaluation is used to establish a baseline measurement of the country’s capacity and capabilities, and following evaluations are used to identify progress made and ensure sustainability of improvements in capacity. More information is available at http://apps.who.int/iris/bitstream/10665/204368/1/9789241510172_eng.pdf
27. This component also embeds a Contingency Emergency Response Component (CERC). The purpose of the CERC is to provide surge funding at early stages of a disease outbreak to finance response efforts directed at preventing the outbreak from becoming a deadly and costly pandemic. The CERC is only triggered in the case of a public health emergency and when certain actions, as agreed by the Government and Bank teams, are met. These actions can include: (i) the country declares a national public health emergency; and (ii) presents a sound and actionable country-level response plan. Having the CERC in place provides a compelling platform for country-level discussions on the importance and need for country-level readiness to respond to disease outbreaks. Once triggered, the CERC is implemented following the exceptional policy requirements set out in OP 10, Paragraph 12 and enables rapid reallocation of funds between project components following an emergency. Together with the operational, fiduciary, procurement, disbursement and financial management arrangements that underpin its implementation, the CERC provides a conduit for flow of PEF funds (in the form of grant funds) into the project.

Component 4: Institutional Capacity Building, Project Management and Coordination (US$8 Million)

28. This component supports communication and training efforts that may be identified as necessary to support Components 1-3. In addition, this Component supports project implementation efforts, including project management, fiduciary tasks and monitoring and evaluation (M&E). At the country level, a total of US$5 Million will be allocated, and US$3 Million will be allocated at the regional level. At this time, institutional capacity is rated as high risk due to the heavy workload within the Project Implementation Units (PIUs) in Saint Lucia and Saint Vincent and the Grenadines, and the limited capacity within the PIU located in the MOH in Guyana. These risks are further detailed in the following section.

Project Financing

<table>
<thead>
<tr>
<th>Project Component</th>
<th>Budget Allocation (US$ million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component 1: Surveillance and Information Systems</td>
<td>14</td>
</tr>
<tr>
<td>Component 2: Strengthening of Laboratory Capacity</td>
<td>13</td>
</tr>
<tr>
<td>Component 3: Preparedness and Emergency Response</td>
<td>10</td>
</tr>
<tr>
<td>Component 4: Institutional Capacity Building, Project Management and Coordination</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
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<table>
<thead>
<tr>
<th>Country</th>
<th>Country IDA (US$ million)</th>
<th>Regional IDA (US$ million)</th>
<th>Total (US$ million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guyana</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Saint Lucia</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Saint Vincent and the Grenadines</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>TOTAL</td>
<td>30</td>
<td>15</td>
<td>45</td>
</tr>
</tbody>
</table>
29. Gender dimensions and citizen engagement are important aspects of the proposed project. The Zika outbreak in 2016 highlighted the potential gender dimensions of public health emergencies. In particular, the outbreak was associated with an increase in the number of cases of microcephaly, not a common condition, which was attributed to pregnant women infected with the Zika virus. The project will thus endeavor to ensure that pregnant women are included as part of citizen engagement efforts, tracked separately as part of future surveillance efforts, and included as part of preparedness and response efforts. In addition to pregnant women, citizen engagement efforts will be strengthened through Component 3 of the project, which aims to provide channels through which community members (including those in border areas) can participate in the development and updating of health response plans. A review of existing citizen engagement mechanisms in place and functional in the target countries will be completed prior to initiating citizen engagement activities under the project.

30. Climate co-benefits of the project are expected to be moderate at around 20 percent, largely due to climate mitigation activities. The project is expected to mitigate disease outbreaks, particularly those of vector-borne diseases, which have been fostered by extreme weather events and natural disasters (namely hurricanes) related to climate change. The climate co-benefits from a strengthened surveillance system lie in the availability of a mechanism in the region through which to monitor the potential threat of a disease outbreak following a natural disaster and curtail its potential regional spread.

31. It is anticipated that the project will eventually engage and support additional CARICOM member states, particularly Dominica and Grenada in an effective and sustainable regional surveillance network, as resources become available.

SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

The project will take place in three countries, namely Saint Lucia, Saint Vincent and the Grenadines, and Guyana. Within each of the three countries, the location for conducting specific project activities is not yet known, and will be discussed as part of the appraisal process.

B. Borrower’s Institutional Capacity for Safeguard Policies

The Borrowers involved have previously participated in IDA projects in the health sector, most recently for HIV/AIDS. As the proposed Project represents a relatively new area of involvement, namely public health emergencies which may, in turn, involve vector-borne diseases, the World Bank social and environmental safeguards specialists will undertake in-depth assessments during project preparation and prior to project appraisal. These assessments will include assessments of the borrowers as well as the regional implementing agency (if applicable) and will focus on identifying areas and amount of scale-up needed for strengthening safeguard capacity.

C. Environmental and Social Safeguards Specialists on the Team

Gibwa A. Kajubi, Ximena Rosio Herbas Ramirez

D. Policies that might apply

<table>
<thead>
<tr>
<th>Safeguard Policies</th>
<th>Triggered?</th>
<th>Explanation (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Assessment OP/BP 4.01</td>
<td>Yes</td>
<td>The project is rated as an environmental risk category B. Component 1 and Component 2 of the project will finance scaling-up and upgrading of primary health care systems and laboratory facilities through civil works and/or provision of equipment to allow health facilities to serve as the first point of detection at local and regional level. At this stage we do not have specific information regarding which laboratories will be refurbished or rehabilitated, only that they will be located in current health facilities owned by governments, minor construction activities with low impacts are expected. There will also be transportation of laboratory specimens, including cold chain system, therefore attention should be paid to the transport, manipulation and storage of the specimens and chemicals needed and adequate disposal of laboratory waste. Component 1 will also finance activities to strengthen the health information systems for collection of incidence and prevalence data, If there is any purchase</td>
</tr>
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</table>
and replacement of computer equipment, then these equipment will be properly disposed, and preferably reused or recycled. As there is insufficient detail available to assess and address specific impacts an Environmental and Social Management Framework (ESMF) that will contain reference to the World Bank Group Environmental, Health, and Safety (EHS) Guidelines will be prepared per country with procedures to assess the environmental and social impacts, measures to reduce and mitigate the potential impacts, provision for estimating and budgeting the cost of such measures, and the responsible agencies for addressing project impacts. The EHS guidelines for Health Care Facilities will be used in preparing the ESMF.

<table>
<thead>
<tr>
<th>Natural Habitats OP/BP 4.04</th>
<th>TBD</th>
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<tbody>
<tr>
<td>The policy is not likely to be triggered as the project will not intervene in natural habitats, however, during preparation the Bank will assess if the emergency response planning (or actual responses) could include fumigation of natural areas such as wetlands and the appropriate measures and alternative selection of pesticides might need to be considered to minimize wildlife impacts. If this is the case, the mitigation measures will be included in the project ESMF or as a stand-alone PMP if warranted based on the scope and scale of pest management expected.</td>
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<thead>
<tr>
<th>Forests OP/BP 4.36</th>
<th>TBD</th>
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<tbody>
<tr>
<td>The policy is not likely to be triggered as the project will not intervene in natural habitats, however, during preparation the Bank will assess if the emergency response planning (or actual responses) could include fumigation of natural areas such as forests and the appropriate measures and alternative selection of pesticides might need to be considered to minimize wildlife impacts. If this is the case, the mitigation measures will be included in the project ESMF or as a stand-alone PMP if warranted based on the scope and scale of pest management expected.</td>
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<thead>
<tr>
<th>Pest Management OP 4.09</th>
<th>TBD</th>
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<tbody>
<tr>
<td>Potential activities to be financed may include fumigation to mitigate vector-borne transmitted diseases, therefore during project preparation the Bank will assess the need to trigger this policy and analyze if purchase, use or storage of pesticides will be included as part of the project.</td>
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<thead>
<tr>
<th>Physical Cultural Resources OP/BP 4.11</th>
<th>No</th>
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<tbody>
<tr>
<td>This policy should not be triggered because it will not affect Physical Cultural Resources.</td>
<td></td>
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<tr>
<td></td>
<td>OP/BP 4.10</td>
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<tr>
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<tr>
<td>Indigenous Peoples</td>
<td>Yes</td>
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<td></td>
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<tr>
<td>Involuntary Resettlement</td>
<td>No</td>
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<tr>
<td></td>
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<tr>
<td>Safety of Dams</td>
<td>No</td>
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<td></td>
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<tr>
<td>Projects on International Waterways</td>
<td>No</td>
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<tr>
<td></td>
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<tr>
<td>Projects in Disputed Areas</td>
<td>No</td>
</tr>
</tbody>
</table>
defined under the policy.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Dec 01, 2017

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

An Environmental and Social Management Framework (ESMF) will be prepared for every country and disclosed by appraisal.

An IPPF will be prepared. The focus will be inclusion through communication to ensure these communities are aware of the project, its intent and the services provided. The IPPF will be prepared and disclosed by appraisal.

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APPROVAL

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<th>Carmen Carpio</th>
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Approved By

<table>
<thead>
<tr>
<th>Practice Manager/Manager:</th>
<th>Andrew Sunil Rajkumar</th>
<th>21-Jul-2017</th>
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<tbody>
<tr>
<td>Country Director:</td>
<td>Galina Y. Sotirova</td>
<td>24-Jul-2017</td>
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