PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: PIDA776

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<th>Project Name</th>
<th>West Africa Regional Disease Surveillance Capacity Development (P125018)</th>
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<td>Region</td>
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<tr>
<td>Country</td>
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<td>Implementing Agency</td>
<td>WAHO</td>
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<td>Environmental Category</td>
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<tr>
<td>Date PID Prepared/Updated</td>
<td>28-Mar-2013</td>
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<tr>
<td>Estimated Date of Appraisal Completion</td>
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I. Project Context

Country Context

Regional Context

Both communicable and non-communicable diseases remain among the leading causes of death, illness, and disability in African communities. When disease surveillance information is available and supported by laboratory confirmation, these diseases, conditions, and events can be detected and investigated in a timely manner, and support an effective public health response. In 1998, the World Health Organization, Africa Regional Office (WHO/AFRO) instituted Integrated Disease Surveillance and Response (IDSR), a strategy for strengthening the availability and use of surveillance and laboratory data for detecting, reporting, investigating, confirming, and responding to well-known and largely preventable priority diseases as well as other public health events.

Disease control and the prevention of epidemics are among the core concerns and priorities of the countries of West Africa. In sub-Saharan Africa, communicable diseases are the largest cause of death and debility, affecting the population more adversely than any other population in the world. In the Africa Region, 55% of all deaths are from communicable diseases, including HIV/AIDS, tuberculosis, malaria, and lower respiratory infections (WHO, 2011). High levels of inter-country and regional collaboration, collective action and resource-sharing among nations are required to ensure the effective and efficient preparedness for potential outbreaks, epidemics, and pandemics.
The eradication of smallpox and the major strides in the elimination of onchocerciasis (river blindness), polio and measles have all required regional or global approaches. The same is true for the control of malaria, HIV/AIDS, tuberculosis, influenza, and other epidemic-prone and neglected tropical diseases.

Disease outbreaks are taking a particularly heavy toll among the populations in the Economic Community of West African States (ECOWAS) member countries. Epidemic-prone diseases frequently encountered in the West African region include meningococcal meningitis, yellow fever, Lassa fever, cholera, poliomyelitis, measles, and dengue fever. The resurgence of meningitis periodically puts an estimated 300 million people at risk across Africa in what is known as the “meningitis belt”, stretching from Senegal in the west to Ethiopia in the east. Fourteen of the fifteen ECOWAS countries experienced at least one epidemic outbreak during the period 2008-2009; half of these countries experienced two outbreaks.

Between 2005 and 2011, almost half a million cases of epidemic-prone diseases were recorded, including meningitis (194,940), measles (225,112), and cholera (87,582). About 18,000 of these cases were fatal and more than 70% of the victims were children under 15 years. From 2008 to 2009, the number of meningitis cases almost tripled (ECOWAS, 2009), while measles cases almost doubled from 2010 (29,726) to 2011(44,623), in the same period the number of cholera reported cases remained high: 46,238 cases in 2010 and 41,344 cases in 2011, with a case fatality rate above 3% (WHO 2012).

Disease control is a regional and global public good; thus mitigating the adverse effects of communicable diseases on population health requires a collective effort. Without regional collaboration, national health program efforts are undermined. In a closely interdependent world, global partnerships and good coordination are essential to the successful implementation of the International Health Regulations (IHR). Partnership is required between all countries to share technical skills and resources, to support capacity strengthening at all levels, to support each other in times of crisis and promote transparency. Examples of resurgent polio, meningitis, cholera and yellow fever in West African countries that had been thought to have eliminated it demonstrate the need for a coordinated regional response.

There have been a number of partners active in promoting improved disease surveillance and response in West Africa, including: the WHO, West African Health Organization (WAHO), the European Commission, the United States Agency for International Development (USAID), the United States Centers for Disease Control and Prevention (CDC), the Agence de Médecine Préventive (AMP), the Fondation Mérieux, and the Centre de Coopération Internationale en Santé et Développement (CCISD), among others.

CCISD has worked with ministries of health and partners in Benin, Burkina Faso, Guinea, Mali, and Niger to support the development of functional Center for Epidemiological surveillance (CES) at district level. On another level, CDC has worked closely with ministries of health and partners such as WHO, WAHO and USAID to support field epidemiology and laboratory training programs (FELTP) in Ghana, Nigeria and Burkina Faso. The Burkina Faso program served Benin, Burkina Faso, Togo and Niger. FELTP is a two-year in-service applied epidemiology modeled after the CDC Epidemic Intelligence service to address the needs for skilled epidemiologists at national and regional levels of the health system.
The Réseau Ouest Africain des Laboratoires (RESAOLAB) has worked with laboratory experts in Burkina Faso, Mali and Senegal to develop harmonized laboratory training modules for frontline laboratory personnel. WAHO is in dialogue with these experts on ways to scale-up their efforts to strengthen a regional disease surveillance and response in the ECOWAS region.

II. Sectoral and Institutional Context

West African countries have established or are linked to regional institutions to manage their collective action in health in general and specifically in disease prevention and monitoring. These institutions include: (i) WAHO, a branch of ECOWAS, and (ii) the World Health Organization Regional Office for Africa (WHO-AFRO) and its Inter-country Support Team (IST) for West Africa, which is responsible for providing technical support to countries. Improved disease surveillance is a critical component of WAHO’s Strategic Plan as well as WHO-AFRO’s Strategic Direction 2010-2015. All 15 ECOWAS countries have adopted the WHO-AFRO Regional Strategy on Integrated Disease Surveillance and Response (IDSR) and have begun developing plans for its implementation.

Formed as a specialized agency of ECOWAS, WAHO became operational in March 2000 with the mandate to facilitate the health agenda for ECOWAS member states. It is based in Bobo Dioulasso, Burkina Faso. Member states of WAHO are the fifteen countries forming the ECOWAS. In keeping with its mission, WAHO mobilizes resources to achieve better control of major diseases and improve health outcomes through facilitation of sub regional coordination of health policies; capacity building (harmonization of training programs, promotion of exchange of medical manpower and knowledge); research and information management (collection, management and dissemination of health-related information); and political advocacy (to ensure that critical health issues are recognized and adequately addressed at the sub regional, national and community levels).

In May 2010 the President of the Economic Community of West African States (ECOWAS) Commission requested the assistance of the Africa Region of the World Bank to develop a regional project to support disease surveillance and epidemic response in the sub-region. Investment in regional disease surveillance and control is consistent with World Bank goals, objectives and strategies and is justifiable in both economic and epidemiological terms.

III. Project Development Objectives

The project development objective is to strengthen regional disease surveillance and response system of ECOWAS member states.

IV. Project Description

Component Name
Regional Capacity Development
Strengthening Human Resources
Project Management, and Monitoring and Evaluation

V. Financing (in USD Million)

<table>
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<th>For Loans/Credits/Others</th>
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<tbody>
<tr>
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VI. Implementation
Institutional and Implementation Arrangements

Project Management Unit

The West African Health Organization (WAHO) will be responsible for the overall coordination and oversight of the project through a project management team comprising a Project Coordinator, a Procurement Specialist, a Financial Management Specialist, and a Monitoring and Evaluation Specialist. The WAHO Professional Officer for Epidemics and Disease Control shall serve as Technical Advisor to the team. The project governance structure comprises a Regional Steering Committee (RSC), a Project Technical Committee (PTC), and a Project Management Unit (PMU) as detailed below:

Regional Steering Committee (RSC)

A Regional Steering Committee shall be chaired by the Director General of WAHO and shall be comprised of, inter alia, representatives at the higher level of major stakeholders (WHO, AMP, USAID, UNICEF, etc…), one (1) person from a training institution, one (1) person from the Chair Country of the Assembly of Health Ministers and one (1) from the civil society.

The committee shall comprise of nine (9) members with the PMU as secretariat and shall carry out the following activities: (i) Resolve any implementation problems or conflicts; and assist the implementing agency in obtaining, whenever needed, Member State Governments assistance and contribution to the project; (ii) Meet at least once every quarter; (iii) Maintain policies and procedures adequate to enable it to monitor and evaluate on an ongoing basis, in accordance with the Monitoring and Evaluation Indicators, the carrying out of the Project and the achievement of the objectives thereof; and (iv) Approve and evaluate the projects annual work program and budget.

Project Technical Committee (PTC)

The Project Technical Committee shall be chaired by the Director for Epidemics and Disease Control with the Project Coordinator as Secretary. Other members shall include: five (5) persons representing major participating organizations/institutions (example: AFNET, MRU, WHO, AMP, CDC), three (3) WAHO professionals (PO Epidemics, PO M&E and PO Finance/Budget), two (2) representing training institutions, and three (3) representing countries (one each – language block).

The committee shall comprise of 15 members and shall carry out the following activities: (i) Meet at least once a month upon the request of the Project coordinator to review overall implementation performance; (ii) Provide inputs on monitoring indicators included in the project’s result framework; (iii) Make recommendations for consideration of the Regional steering committee as necessary; and (iv) Review and approve, physical progress report, prepared by the PMU.

The World Bank has worked previously with ECOWAS, and they have a demonstrated track record of collaboration in West Africa vis-à-vis regional projects, capacity building, and analytical work.

<table>
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<tr>
<th>Africa Catalytic Growth Fund (ACGF)</th>
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<td>Total</td>
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Over the years the Bank has provided considerable technical support in critical areas such as trade policy, macroeconomic and financial convergence, statistics, regional infrastructure, energy and health. There are several active lending projects in fisheries, agriculture, and transport, with additional projects on telecommunications and energy in the pipeline.

The ECOWAS Commission will sign, or delegate its power to the Director General of WAHO to sign on behalf of ECOWAS, the Grant Agreement. ECOWAS will be the recipient of the project funds, whereas WAHO will be the implementing entity and will enter into a separate Project Agreement with the Bank.

More specifically, within WAHO, the General Directorate will be the body responsible for the implementation of the Project, since according to the protocol this is the division responsible for the day-to-day administration of WAHO. The WAHO General Directorate may delegate this power to a specific WAHO unit responsible for the Project, which will report directly to the General Directorate.

ECOWAS will make the proceeds of the grant available to WAHO, through a subsidiary agreement. A project implementation manual, which will be prepared prior to the Project’s effectiveness, will set forth the detailed institutional arrangements both at the ECOWAS and at the WAHO, so as to build the necessary complementarities between the two organizations during the Project implementation. This will enable the Bank to more easily monitor progress and will contribute to strengthening WAHO’s capacity to contract out services.

WAHO will serve in a lead and convening role to facilitate agreement among ECOWAS member states and other stakeholders on strategies, policies, processes and technologies for establishing a functional regional disease surveillance and response system. The comparative advantage of WAHO rests in its ability to facilitate inter-country resource exchange and policy alignment, its established partnerships with health-related entities in the sub-region.

To implement project activities, WAHO will leverage the services of its current technical partners including the World Health Organization Regional Office for Africa, especially its West Africa Inter-country Team and the Multi-Disease Surveillance Center (MDSC) based in Ouagadougou, CCISD, CDC, and the Mérieux Foundation.

WHO/AFRO has a long-established relationship with both WAHO and the World Bank and will continue these partnerships through advisory services on this project. Close to WAHO headquarters in Bobo-Dioulasso, Burkina Faso, WHO/AFRO/IST West Africa is based in Ouagadougou, Burkina Faso. WHO is also represented at country level through WHO country representatives and their technical teams who act as first-line health advisors to the governments.

WHO/AFRO maintains the Multi Disease Surveillance Center (MDSC), which currently supports countries in the surveillance of onchocerciasis and meningococcal meningitis and is the institutional home for the field epidemiology and laboratory training programs (FELTP) in West Africa. WHO/AFRO is also well placed to lead the provision of technical assistance to ECOWAS member states to conduct IHR core capacity assessment and the development of IDSR plans of action based on revised technical guidance (2010).

CDC has been leadings efforts to expand ECOWAS member states access to the Field
Epidemiology Training Program (FETP) and the Field Epidemiology and Laboratory Training Program (FELTP) in the previous years in collaboration with WHO/AFRO (MDSC) through direct funding from CDC which unfortunately was suspended last year due to budget constraints. CCISD has been working on the development of CESs in 10 new ECOWAS countries (Cape Verde, Côte d’Ivoire, The Gambia, Ghana, Guinea Bissau, Liberia, Sierra Leone, Senegal, Togo, and Nigeria) and the provision technical support for CESs in five countries (Benin, Burkina Faso, Guinea, Mali, and Niger) of the PASEI project building on its more than 19 years intervention in the area of disease surveillance in the region. The Mérieux Fondation leads efforts to harmonize laboratory training curricula and expand the proven results producing RESAOLAB initiative to all the ECOWAS member states.

It is planned that these agencies will be hired on a single source basis, subject to satisfactory justifications to be reviewed by the Bank.

VII. Safeguard Policies (including public consultation)

<table>
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<th>Safeguard Policies Triggered by the Project</th>
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VIII. Contact point

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