I. Introduction and Context

1. Disease control and the prevention of epidemics are among the core concerns and priorities of the countries of West Africa. 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\(^1\). 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.

2. The project will strengthen the capacity of the West Africa Health Organization (WAHO) and the World Health Organization in Africa (WHO/AFRO) to design and cost a regional disease surveillance and response system for ECOWAS. As this project would be the initial phase to create a solid regional foundation, it will focus on strengthening regional bodies, specifically WAHO and the World Health Organization, Regional Office for Africa and its Inter-country Support Team (WHO-AFRO/IST) for West Africa. The project will aim to: (i) support the development of a framework and operational strategy for a regional disease surveillance and response system, including specimen management; (ii) develop an integrated regional health

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1 Letter from H.E. James Victor Gbeho to Africa Region Vice President, Obiageli Katryn Ezekwesili on 6\(^{th}\) May 2010.
information management system; (iii) develop a resource mobilization strategy to support the operationalization of the regional disease surveillance and response system; and (iv) increase the quantity and quality of human resources within the West African subregion for field epidemiology and laboratory diagnostics. The project will not finance facility upgrades, equipment, vaccines, or consumables.

Health as a Regional Public Good: The African Regional Framework for Communicable Disease Control and Preparedness

3. **The proposed project fits into the World Bank’s Regional Framework for Communicable Disease Control and Preparedness (RFCDCP).** The framework focuses on three objectives: (a) develop regional integrated multidisease surveillance and response capacity; (b) strengthen regional capacity for laboratory diagnostics of infectious diseases; (c) strengthen regional institutions and net work for intercountry collaboration. (See Annex IV for the complete framework.) The project addresses objectives 1 and 3. Complementing the objectives of national disease control and health systems programs, the RFCDCP aligns with one of the key six strategic directions for the World Bank as presented by President Zoellick in February 2008: “playing a more active role with regional and global public goods on issues crossing national borders”, including communicable diseases and public health. The framework also prioritizes the West African sub-region based on its commitment to disease surveillance and control, as well as its assets, which increase well-organized subregional institutions such as ECOWAS and the West African Health Organization (WAHO).

4. **There are assertive epidemiological and economic arguments for improving regional and global disease control mechanisms.** 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, 72% of all deaths are from communicable diseases, including HIV/AIDS, tuberculosis, malaria, lower respiratory infections, and complications of pregnancy and childbirth (WHO, 2011). Endemics, epidemics and emerging communicable diseases do not respect the national boundaries that separate sovereign states. 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, 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, other epidemic-prone and neglected tropical diseases.

5. **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, dengue fever and A/H1N1 influenza. The periodic resurgence of meningitis affects an estimated 300 million people across Africa in what is known as the “meningitis belt”, stretching from Senegal in the west to Ethiopia in the

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2 [http://go.worldbank.org/1UW79XZJ00](http://go.worldbank.org/1UW79XZJ00)

3 Benin, Burkina Faso, Cape Verde, Côte d’Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.
east. Fourteen of the 15 ECOWAS countries experienced at least one epidemic outbreak during the period 2008-2009; half of these countries experienced two outbreaks. Between 2005 and 2009, almost half a million cases of epidemic-prone diseases were recorded, including meningitis (178,681), measles (150,753), and cholera (13,958). 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) Additional information on West African reports of selected disease morbidity and mortality can be found in Annex III.

6. **Disease control is a regional and global public good, therefore mitigating the adverse affects of communicable diseases on population health requires a collective effort.** Throughout Africa, communicable diseases decrease productivity, undermine human capital development, and deter foreign investment. In 2002 the Commission on the Macroeconomics of Health published “Global Public Goods for Health” which proposed that priority should be placed on three areas of great importance to international health which clearly require or benefit from multi-country collaboration: (i) the control and prevention of cross-border spread of communicable disease; (ii) research, including targeted research and development; and (iii) standardized data collection efforts. To the first priority, in the control and prevention of cross-border spread of communicable disease, “three areas in which countries have organized collectively to respond to health risks that emanate beyond their borders [are]: (1) disease control, elimination and eradication programs; (2) global surveillance activities; and (3) the containment of antimicrobial resistance (AMR). The global architecture to address the first two is in place but chronically underfunded. A global strategy in the third area is just beginning to emerge.” To the second priority, activities supporting basic and applied research are the engine of knowledge generation, which has been widely recognized as one of the most valuable global public goods for development (Stiglitz, 1999). Finally, to the third priority, the collection of standardized data is a mutually beneficial goal that strictly requires international coordination and collaboration.

7. **The proposed project directly responds to these priorities to control and prevent cross-border communicable disease spread by focusing on disease surveillance and the collection of standardized data.** The project would indirectly address the other areas of importance through capacity development and the promotion of applied research.

8. **In order to efficiently control communicable diseases in a global context, evidence has shown that regional resource sharing and collaboration are critical.** A 2009 cholera outbreak in Zimbabwe quickly spread to neighboring countries in southern Africa and the response to this sub-regional epidemic required collective action from Zimbabwe, South Africa, Swaziland, Malawi, Mozambique, Namibia, Angola, Botswana and Zambia, as well as the intervention and resources of international, bilateral and multi-lateral technical and development organizations. One of the Bank’s most effective HIV projects implicated the five countries on the Abidjan-Lagos transport corridor; health projects in the Horn of Africa region have also benefitted by taking a regional approach. The Great Lakes HIV/AIDS regional project has bolstered regional collaboration for improved disease control outcomes. The newly approved East African Public Health Laboratory Networking project is focusing on regional capacity building and targeting TB control. In its first year of effectiveness, it has been observed that by assigning each of the four

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participating countries leading technical working groups for specific aspects of the network, contributes to the strengthening of both the regional and national institutions. More recently, taking a regional approach to surveillance and vaccine stockpiling and management has also improved the effectiveness of the meningitis outbreak response in West Africa.

9. **Without regional collaboration, national health program efforts are undermined.** Examples of resurgent polio, meningitis, cholera and yellow fever in West African countries that had thought to have eliminated it demonstrate the need for a coordinated regional response. Similarly, pooled procurement and management of other commodities or services, such as long-lasting insecticidal nets or TB treatments could result in financial savings due to economies of scale. In addition, costly high-level resources, such as high biosecurity reference laboratories, specialized research institutions and advanced training facilities may efficiently serve the needs of more than one country. It would be wasteful and duplicative to establish these resources in every country, particularly when the critical mass of highly trained personnel and the optimal volume of services needed to maintain efficiency are taken into account.

**Institutional Context: Non-Sovereign Regional Bodies**

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

11. The Heads of State and Governments of ECOWAS are committed to providing their respective countries with the means and resources to better track diseases and combat epidemics. In October 1996, they signed a protocol for cooperation called *The Ouagadougou Protocol for epidemics control in West Africa, Algeria and Chad*. In April 2001 in Nigeria at the *Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases*, the Head of States and Government of the Organization of African Unity (now the African Union), expressed their commitment to take necessary measures to mobilise resources and to utilise them judiciously and efficiently for infectious disease control. Most recently, the health ministers of African countries within the meningitis belt met on the occasion of the 58th Session of WHO’s Regional Committee in Yaoundé, Cameroon in September 2008 and pledged to put in place quick-to-mobilise funds in each of the countries to contribute to the operational costs of epidemic control campaigns, such as for meningitis.

12. Within ECOWAS’ 15 member states, public health laboratory capacity is heterogeneous. In general, diagnostic lab capacity for onchocerciasis and meningitis are relatively more advanced than others, with capacity for HIV and malaria having recently improved to a certain

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5 High biosecurity reference laboratories are equipped to handle highly infectious pathogens such as Lassa, Ebola, and Marburg.
However, TB surveillance indicates many unknowns. The West African region relies heavily on South Africa, Tunisia and France for diagnostic and surveillance activities.

13. The World Bank has been engaging in dialogue with West African partners about the potential expansion and integration of disease surveillance and response since the close of the Onchocerciasis Control Program (OCP) in December 2002. The Africa Region prepared a project concept note for a relatively large scale ($150 million IDA) regional operation in support of integrated disease surveillance and response to build on the residual assets of the OCP in the subregion. The PCN was reviewed and preparation approved on November 24th, 2009. Unfortunately, in April 2010 project preparation was halted due to non-availability of IDA. The current project proposal builds on the work conducted during the earlier project preparation. However the scope of the project has been significantly reduced and its objectives modified.

14. The region is strongly invested in improving regional disease surveillance systems. West African Health Ministers recently committed to a 10-year plan to create a regional network of centers of excellence for disease surveillance. In addition to this commitment, during the regional committee meeting held in Kigali in 2009, the Ministers of Health in the Africa region adopted a resolution on establishing centers of excellence for: disease surveillance, public health laboratories and food and drugs. These two ministerial commitments will require technical as well as financial support to reach fruition.

**Economic Community of West African States (ECOWAS)**

15. The Economic Community of West African States (ECOWAS) was formally established in May 1975 by the ECOWAS Treaty. In 1993, the ECOWAS Treaty was revised to accelerate the process of integration and establish an economic and monetary union to stimulate economic growth and development in West Africa. ECOWAS is now a regional grouping of fifteen countries, including the eight Western African Economic and Monetary Unit (WAEMU) members. The member states of ECOWAS are: Benin, Burkina Faso, Cape Verde, Côte d’Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.

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

**West African Health Organization (WAHO)**

17. Formed as a specialized agency of ECOWAS, WAHO became operational in March 2000 with the mandate to facilitate the WHO agenda for ECOWAS member states. Its Headquarters is established in Bobo Dioulasso, Burkina Faso. Member states are the fifteen countries forming the ECOWAS. In keeping with this 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).

18. 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, and its capacity to collect, manage and disseminate health information specific to West Africa to help guide the development of future health interventions. In addition, they have familiarity with receiving funds from bilateral and multilateral partners, such as the European Union.

**World Health Organization Regional Office for Africa (WHO-AFRO)**

19. The WHO Regional Office for Africa (AFRO) has been in existence since 1954. Its office in Brazzaville, Congo Republic supports 46 member states and is responsible for implementing the core functions of the organization which includes: setting norms and standards, monitoring health trends, setting research agenda, global leadership in public health, providing technical support and ethical and evidence based policy options. The regional office is also responsible for strategic planning, monitoring and evaluation, coordination and resource mobilization to support the various programs in the sub-region.

20. Some of the operations of the Regional Office have been decentralized to three inter-country support teams based in Ouagadougou, Harare and Libreville. These teams are responsible for providing and coordinating technical support to defined member states. ECOWAS countries are supported by WHO-AFRO/IST West Africa, 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 already has a well-established Step-Wise Accreditation program for the Africa region, upon which the project will build. The WHO-AFRO also 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.

**Relationship to Broader Program Goals**

21. The project is consistent with the objectives of the World Bank Regional Integration Assistance Strategy (RIAS), the Africa Action Plan and the Africa Region’s Health Nutrition and Population Strategy as it aims to deal with cross-border health issues, namely the detection and control of communicable diseases, and equip sub-regional organizations with the knowledge and resources required to meet the challenges of the integration agenda. The project is aligned with and will add value to Bank’s country level strategies intended to combat diseases of poverty and improve the quality, efficiency and effectiveness of health care system. The project will contribute to several higher level objectives and strategic global agendas, including (i) the Millennium Development Goals (MDGs), (ii) the World Bank’s Global Public Goods priorities,
including HIV/AIDS, malaria and other communicable diseases, (iii) good governance and poverty alleviation, and (iv) Health System for outcomes.

22. The Bank’s comparative advantages for this project are its global and regional public goods focus, its convening power. With the ACGF, the project will fill a significant funding gap and support catalytic growth for disease control in the subregion. The proposed project aims to catalyze additional larger operations by laying the foundation for the surveillance network, reinforcing partnerships and building key capacities. It also has the potential to affect national financing decisions on disease control through resource mapping and the development of costed strategic plans.

23. The Bank’s high-level management commitment has translated into several strategies to encourage regional initiatives and projects. In the Africa Region this is highlighted by the development of the RIAS for Sub-Saharan Africa. RIAS aims at strengthening collaboration and integration across Africa’s borders to facilitate the continent’s integration in the global economy for stronger growth and poverty alleviation. Among other components, the strategy promotes coordinated investments in support of regional public goods by focusing on shared water resources, climate change, emergency response, agricultural productivity, cross-border transmission of HIV/AIDS, malaria and other diseases, and rationalization of research and tertiary education. Within the context of the greater focus on regional integration in Africa, the Bank completed targeted strategies for West and Central Africa in FY06 and is preparing strategies for East and Southern Africa. Additional justifications for Bank involvement can be found in Annex IV: the Regional Framework for Communicable Disease Control Preparedness, Section II, starting on page 47.

24. In addition to being consistent with World Bank strategies and policies, the proposed project aligns with international and regional mandates for health. The project will directly address health sector priorities in the Africa region by building core technical capacities in order to meet legally binding requirements of the 2005 International Health Regulations (IHR) through implementation of the Integrated Disease Surveillance and Response (IDSR) system strategy. The 2005 International Health Regulations 6 comprise the new legal framework adopted by the 194 WHO member states to ensure maximum protection against the international spread of infectious diseases while minimizing restrictions on travel and trade. With the support of WHO, member states have begun implementing global requirements to enhance national, regional and global public health security. June 2009 was set as the deadline for countries to assess their surveillance and response capacities and develop plans of action to address weaknesses. In the ECOWAS countries, progress to meeting the IHR benchmarks has been modest. Indeed, Sierra Leone, Gambia and Nigeria have been the only countries to conduct an assessment of core capacities. In order for new IHRs to be fully effective, state parties are required to ensure that their national health surveillance and response capacities meet core functional criteria by June 2012.

25. Driven in part by the increased number of severe outbreaks — such as the meningococcal disease, cholera, viral hemorrhagic fevers and measles and the expansion of diseases outbreaks across national borders in sub-Saharan Africa in the 1990s — the Integrated Disease surveillance

6 http://www.who.int/ihr/en/
and Response system (IDSR) was adopted by the WHO regional committee for Africa in 1998. WHO member states in Africa committed to the long-term vision of the IDSR, which is to establish a functional disease surveillance system for timely provision of information for prompt public health action, thus contributing to the improvement of epidemic preparedness and response and to the control of communicable diseases in the African Region.

26. The IDSR strategy aims to: (i) develop, adapt and implement an integrated communicable diseases surveillance strategy; (ii) develop a computerized database for priority communicable diseases surveillance; (iii) generate information on communicable diseases; and (iv) share information through the publication of periodic feedback and epidemiological bulletins. All fifteen countries of the ECOWAS have adopted the IDSR strategy. In 2010, the WHO-AFRO, with assistance from the United States Centers for Disease Control and Prevention (CDC), revised the technical guidelines for IDSR in the Africa region to incorporate the IHRs, non-communicable diseases, and maternal mortality notification. This project will help ECOWAS member states establish a platform for collective action for the control of communicable diseases, which will include the mobilization of resources for an integrated multi-disease surveillance and response network.

27. At present, there are several development partners active in promoting improved disease surveillance and response in West Africa, including: the WHO, WAHO, the European Commission, the United States Agency for International Development (USAID), the CDC, the Agence de Medicine Preventive (AMP), the Fondation Mérieux, and the Canadian International Development Agency (CIDA), among others. Although the activities that are being supported are critical to achievement of the broader objectives for disease surveillance and control in the sub-region, a larger funding envelope would be necessary in the future to support a full and comprehensive array of activities that benefit all countries in the region. The proposed project has benefitted from the significant input from representatives of Tulane/USAID/AED, the CDC, MDSC, the Fondation Mérieux, WHO-AFRO and WAHO.

28. The African Catalytic Growth Fund (ACGF) financing of this project will be used, in part, to improve regional institution capacity to coordinate both donors and their resources in the context of a single strategy and planning process and to leverage additional resources from ECOWAS member states and development partners. Resource mobilization will be a specific objective of the project and preliminary assessments suggest that significant resources could be mobilized through traditional and non-traditional donors. They have not yet been mobilized because the region has not yet produced a comprehensive and costed framework and operational strategy for collective action in disease surveillance and response. This is a primary product of the proposed project and a absolute prerequisite for the mobilization of resources from national governments and the donor community. In the absence of ACGF financing, regional institutions, notably WAHO and WHO-AFRO, will not have the capacity to undertake the activities required to identify and coordinate resources and lay the foundations for a regional surveillance and response network. Investment by development partners is likely to remain modest and activities partial and fragmented in the absence of such a foundation.

II. Proposed Development Objective(s)
A. Proposed PDO

29. The project development objective is to strengthen the capacity of WAHO and WHO to design a regional disease surveillance and response system for ECOWAS.

B. Key Results

30. The project will contribute significantly to the capacity of WAHO and WHO-AFRO to provide technical and political leadership in the domain of surveillance and disease control in the sub-region. The project will aim to: (i) support the preparation of a framework and operational strategy for a regional disease surveillance and response system, including specimen management; (ii) develop an integrated regional health information management system; (iii) develop a resource mobilization strategy; and (iv) to strengthen the human resources capacity (both qualitatively and quantitatively) within the West African sub-region for field epidemiology and laboratory diagnostics. Strengthened regional institutions and increased manpower are prerequisites to the establishment of a regional disease surveillance and response network. This project will help establish the foundations for the network and a solid platform for resource mobilization to implement the regional multi-disease surveillance and response strategy.

III. Preliminary Description

31. The project will have two components:

32. Component 1 (Regional Capacity Development) will support regional capacity development for technical and political leadership in multi-disease surveillance and response. This involves enhancing the institutional capacity of WAHO and supporting discrete activities and technical support functions of WHO-AFRO. The project will provide assistance in three main areas: (i) framework and costed operational strategy formulation; (ii) health information management strengthening; and (iii) resource mobilization. The specific objectives of Component 1 are:

33. Framework and Operational Strategy Formulation

- Establishment of frameworks for the expansion of inter-country/cross-border collaboration, partnership, donor coordination, cooperation, information/knowledge sharing, and specimen management with international networks and partners (Article 21 of IHR 2005 and WAHO Strategic Objective No 2) (WAHO/WHO-AFRO);
- Preparation of a costed operational strategy endorsed by the 15 countries;
- IHR core capacity country assessments and spatial mapping of laboratory and diagnostic capacity in the 15 member states of ECOWAS (WAHO/WHO-AFRO);
- Support for the adaptation of the WHO accreditation process for quality assurance, laboratory procedures and specimen management (WHO-AFRO);
- Revision of national strategies and plans in line with WHO’s Technical Guidance for Integrated Disease Surveillance and Response in the African Region (WHO-AFRO);and
• Identification and evaluation of potential centers of excellence to serve as hubs for diagnostic reference, training and technical assistance at the regional level for selected priority diseases such as malaria, TB, HIV/AIDS, onchocerciasis, and epidemic prone diseases (WAHO/WHO-AFRO).

34. **Health Information Management Strengthening**

• Strengthening the capacity of WAHO and the WHO-AFRO to coordinate disease surveillance and response (WAHO strategic objective #9) through operational research and improved ICT capacity, building on WAHO’s Integrated Health Information Management System (WAHO/WHO-AFRO).

35. **Resource Mobilization Strategy**

• Estimation of resource requirements for the upgrading and expansion of facilities and services, including the IHIMS, operations research, which will contribute to the costed operational strategy (WAHO).

36. **Component 2 (Strengthening Human Resources)** will support specialized training in disease surveillance and response in collaboration with the US Centers for Disease Control and Prevention (CDC), WHO and USAID. The project will expand ECOWAS member state access to two types of applied epidemiology training programs: the Field Epidemiology Training Program (FETP) and the Field Epidemiology and Laboratory Training Program (FELTP). The FELTP contains all the components of an FETP, but it also trains select laboratory scientists using a competency-based curriculum that supports laboratory-based surveillance and outbreak response. The programs allow MOHs to strengthen their disease surveillance, outbreak response, and program evaluation. They are modeled after the Epidemic Intelligence Service training of the CDC. The specific objective of Component 2 is:

• Strengthening human resources for improved national integrated disease surveillance and response capacity through the introduction/strengthening of field epidemiology and laboratory training programs (FELTP), guidance, technical assistance and quality assurance.

37. Training can be provided through in-service short courses in particular skills areas for field-based staff and through a two-year full-time training and service program for Ministry of Health employees who have medical or scientific training. Residents spend about 25% of their time taking courses and 75% performing duties in the field. This combination of classroom-based instruction and mentored practical work allows residents to receive hands-on multi-disciplinary training in public health surveillance, outbreak investigation, field laboratory management, program evaluation, and other aspects of epidemiologic research and methods. At present the first cohort of 12 Residents from 4 West African countries is being trained and there are approximately 100 graduates of FETP and FELTP short courses in the sub-region. The project will build on this achievement and provide funding for both short term and long term training.
The key outcomes of the project are itemized in the following table:

<table>
<thead>
<tr>
<th>Component 1 (Regional Capacity Development)</th>
<th>Outcomes</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| **Framework and Operational Strategy Formulation** | - Consensus on a framework and an operational strategy for regional collective action | - Framework adopted  
- A costed implementation plan for sub-regional multi-disease surveillance network adopted |
| | - Technical assistance to conduct IHR core capacity assessment | - Percentage of countries which complete assessment |
| | - A spatial mapping of disease control and surveillance assets in the sub-region | - Analysis of spatial information completed and incorporated into planning |
| | - Institutional assessments of potential centers of excellence | - Number of candidate centers of excellence assessed  
- Consensus among ECOWAS member states on the selection of centers of excellence |
| | - National IDSR action plans revised with 2010 guidance | - Percentage of countries revising action plan  
- Number of regional assessors trained in WHO-AFRO 5-step accreditation  
- Number of laboratories accredited under WHO-AFRO 5-step accreditation |
| | - Establishment/adaptation of quality assurance and laboratory accreditation procedures | - Procedures field-tested, published and disseminated  
- Information and tracking systems designed and tested |

<table>
<thead>
<tr>
<th>Health Information Management Strengthening</th>
<th>Outcomes</th>
<th>Indicators</th>
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</thead>
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| | - Strengthening the capacity of WAHO and the WHO-AFRO to coordinate disease surveillance and response | - Operational research on the effectiveness of the IHIMS  
- Increased number of health districts per country reporting priority disease incidence regularly  
- Development of a computerized database for priority communicable diseases surveillance  
- Timely publication of quarterly West Africa Regional Disease Surveillance bulletin |
<table>
<thead>
<tr>
<th>Resource Mobilization Strategy</th>
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<tbody>
<tr>
<td>- Development of resource mobilization strategy</td>
<td>- Development of a costed resources assessment and strategic action plan</td>
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<table>
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<tr>
<th>Component 2 (Strengthening Human Resources)</th>
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<tbody>
<tr>
<td>- Strengthened human resources in disease control and surveillance through the FELTP training</td>
<td>- Number of persons trained (short-term/long-term) - Number/percent of countries benefitting from training programs (short-term/long-term)</td>
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### IV. Safeguard Policies that might apply

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<td><strong>Environmental Assessment (OP/BP 4.01)</strong></td>
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<td>Projects on International Waterways (OP/BP 7.50)</td>
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### V. Tentative financing

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<tr>
<td>Total</td>
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</tbody>
</table>

### VI. Contact point

**World Bank**
Contact: John Paul Clark
Title: Senior Technical Specialist, AFTHE
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Email: jclark4@worldbank.org

*By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas.*
**Borrower/Client/Recipient**
West African Health Organization (WAHO)
Contact: Dr. Placido Cardoso
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Tel: +226.20.97.57.75 / 76.32.48.17
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**Implementing Agencies**
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