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Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 25-Jan-2017 | Report No: PIDISDSA20435

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Western Africa	P159040	Regional Disease Surveillance Systems Enhancement (REDISSE) Phase II	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	01-Dec-2016	28-Feb-2017	Health, Nutrition & Population
Lending Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Federal Republic of Nigeria, Republic of Togo, Government of Liberia, Republic of Guinea Bissau	West African Health Organization (WAHO)	

Proposed Development Objective(s)

The PDOs are : (i) to strengthen national and regional cross-sectoral capacity for collaborative disease surveillance and epidemic preparedness in West Africa, thereby addressing systemic weaknesses within the animal and human health systems that hinder effective disease surveillance and response; and (ii) in the event of an Eligible Emergency, to provide immediate and effective response to said Eligible Emergency.

Components

Component 1: Surveillance and Information Systems
Component 2: Strengthening of Laboratory Capacity
Component 3: Preparedness and Emergency Response
Component 4: Human Resources Management for Effective Disease Surveillance and Epidemic Preparedness
Component 5: Institutional Capacity Building, Project Management, Coordination and Advocacy

Financing (in USD Million)

Financing Source	Amount
International Development Association (IDA)	147.00
Total Project Cost	**147.00**

Environmental Assessment Category

B - Partial Assessment

Have the Safeguards oversight and clearance functions been transferred to the Practice Manager? (Will not be disclosed)
No

Decision
The review did authorize the preparation to continue

Note to Task Teams: End of system generated content, document is editable from here.

Other Decision (as needed)

B. Introduction and Context

Country Context

1. The Ebola Virus Disease (EVD) epidemic in West Africa confirmed the critical importance of strengthening national disease surveillance systems and inter-country collaboration in order to detect disease outbreaks earlier and respond more swiftly and effectively, such that the loss of human lives and economic costs are minimized. The West Africa Ebola outbreak demonstrated that there can be rapid and large spill-over effects of disease outbreaks that can transcend local and national boundaries. Ebola emerged in a remote rural area of Guinea, but spread rapidly to neighbouring nations across porous borders (Liberia, Sierra Leone), within the broader sub-region (Mali, Nigeria, Senegal), and then to other parts of the globe given the inter-connectedness of today's commerce and transport systems.[1] The concept of the proposed Regional Disease Surveillance Systems Enhancement Program ("REDISSE" and/or "Program") is thus linked to the commitment that the global community has made to the countries of West Africa in light of the huge human and economic costs of Ebola, to strengthen weak human health, animal health, and disaster response systems to improve the preparedness of the region to handle future disease outbreaks, and thereby minimize the national, regional, and potential global effects of such events.

2. **The regional benefits and positive externalities of effective disease surveillance and response are substantial**. Collective action and cross-border collaboration are essential and emphasized throughout the Program: (i) the Program will support countries' efforts to harmonize policies and procedures; (ii) countries will be empowered to engage in joint planning, implementation and evaluation of program activities across borders at regional, national and district levels, and; (iii) the Program will promote resource sharing of high-cost specialized assets. The cross-border spread of pathogens is extremely important well beyond shared borders

[1] The WBG financial support following the Ebola crisis amounted to US$1.62 billion. This support included IDA financing of $1.17 billion and $450 million from IFC, which supported critical emergency and humanitarian response control efforts in Guinea, Liberia, and Sierra Leone. The proposed REDISSE project is part of the Bank's longer-term support following the Ebola crisis.

as the migration of birds, bats, and other wild animals travel with impunity. The surveillance and response capacity of the regional system depends on the strength of the individual national systems and the front-line or community-level capacities that need to be in place throughout the countries. In other words, a regional disease surveillance network is only as strong as its weakest link. The Program thus proposes to strengthen the full "value-chain" of disease surveillance across community, national, and regional institutions.

3. **REDISSE II is a second project under the REDISSE Program, which is being prepared as a series of interdependent projects (SOP).** The utilization of an SOP approach is deemed necessary given high country demand for participation in the program, the multiple and complex issues involved, and the large number of stakeholders. The projects in the series support a program involving multiple borrowers –i.e. ECOWAS member countries. The program promotes a "One Health" (OH) approach that provides a platform for high-level policy and regulatory harmonization, cooperation, and coordination between the animal health and human health sectors within and across countries for the earlier detection of infectious diseases, and a more effective response to infectious disease outbreaks. The expected benefits from participation in the program will go beyond each country's boundaries; creating regional public goods that generate positive externalities, and/or mitigate negative ones. Overall, the program aims to address the gaps and weaknesses in disease surveillance, preparedness and response systems across all countries in West Africa and will support country-led efforts to increase the resilience of the animal and human health systems of countries in the sub-region to better prevent and control infectious disease outbreaks.

4. The countries under REDISSE I are Guinea, Senegal and Sierra Leone. REDISSE I also included a regional IDA Grant and donor co-financing[2] for the West African Health Organization (WAHO) was approved by the World Bank Board of Directors on June 29, 2016. REDISSE II will engage Guinea Bissau, Liberia, Nigeria and Togo. Since two countries share borders with countries included in REDISSE I (Guinea Bissau is bordered by Guinea and Senegal and Liberia shares borders with Guinea and Sierra Leone), this will increase the scope for cross-border collaboration under the Program. The Program will be further expanded to include other ECOWAS member states in subsequent phases to ensure that countries with contiguous borders are included in the program, and have the means for cross-border collaboration and exchange. REDISSE III, presently at the inception stage, targeting Benin, Burkina Faso, Côte d'Ivoire, and Ghana will help to fill in the REDISSE "map" so that a continuous band of 11 countries with shared borders –from Senegal in the west to Nigeria in the east - will be participating in the program by the end of CY 2017. Meanwhile cross-border collaboration between REDISSE program countries and other ECOWAS member states will be facilitated by WAHO and the Regional Animal Health Center (RAHC), with support from international partners.

[2] CAD $20 million has been committed by the Government of Canada, Department of Foreign Affairs, Trade and Development to support activities under the REDISSE Program. These fund has been used to establish a flexible multidonor trust fund mechanism capable of financing both Bank-executed and recipient-executed activities. This mechanism is available to other donors who wish to co-finance the REDISSE Program, including through support to specific countries, institutions or program components.

5. **The countries of West Africa belong to the ECOWAS, which comprises 15 countries and is home to more than 335 million people**. ECOWAS is a regional organization that serves to promote economic integration across the West Africa region. The region is very heterogeneous in terms of cultural, economic, and human development. Overall, member states rank low on the United Nations Development Programme's (UNDP) human development index[3]; as of 2015, life expectancy at birth and gross national income per capita of countries in the region ranged from 50.9 to 73.3 years and from $805 to $6,094 respectively (Table 1).

Table 1: Human Development index and selected components for ECOWAS member countries (ranked from highest to lowest HDI)

Country	Human Development Index	Life expectancy at birth (years)	Gross national income per capita (US$)
Cape Verde	0.65	73.3	6,094
Ghana	0.58	61.4	3,852
Nigeria	**0.51**	**52.8**	**5,341**
Benin	0.48	59.6	1,767
Togo	**0.48**	**59.7**	**1,228**
Senegal	0.47	66.5	2,188
Côte d'Ivoire	0.46	51.5	3,171
Gambia	0.44	60.2	1,507
Liberia	**0.43**	**60.9**	**805**
Mali	0.42	58.0	1,583
Guinea-Bissau	**0.42**	**55.2**	**1,362**
Guinea	0.41	58.8	1,096
Sierra Leone	0.41	50.9	1,780
Burkina Faso	0.40	58.7	1,591
Niger	0.35	61.4	908

Source: Data adopted from UNDP Human development report (2015)
http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf

[3] Human Development index is defined as the summary measure of average achievement of countries in key dimensions of human development: a long and health life; knowledge; and having a decent standard of living (UNDP, 2015).

Major infectious diseases affecting human population in West Africa

6. **Over the last four decades, the world has witnessed one to three newly emerging infectious diseases annually.** Of infectious diseases in humans, the majority have their origin in animals, with more than 70 percent of emerging zoonotic infectious diseases coming from wildlife. Recent outbreaks, such as EVD, H7N9 avian influenza, Middle East Respiratory Syndrome (MERS-CoV), Marburg virus, Nipah virus infection, bovine spongiform encephalopathy and HIV/AIDS provide abundant evidence of the catastrophic health and economic effects of emerging zoonotic diseases. The West Africa region is both a hotspot for emerging infectious diseases (EIDS) and a region where the burden of zoonotic diseases is particularly high. In this region, emerging and re-emerging diseases at the human-animal-ecosystems interface are occurring with increased frequency, which makes it paramount to adopt a OH approach to addressing infectious diseases outbreak threats.

7. In West Africa, communicable diseases (CDs) and neo-natal conditions remain the predominating disease groups affecting the region, and have devastating impacts that result in severe human and economic losses. The World Health Organization (WHO) reports that of the 55 registered disease outbreaks that occurred in Africa over the last decade, 42 took place in West Africa.[4] The sub-region also bears a disproportionate burden of malaria, TB, HIV and the neglected tropical diseases, many of which are at risk of resurgence due to drug and insecticide resistance. Most recently, there have been reported cases of Zika virus in Cape Verde and Guinea Bissau, wild polio virus and vaccine-derived polio in Nigeria (the first since 2014), and 2016 outbreaks of H5N1 and Crimean-Congo fever in parts of several countries in West Africa, each of which if not properly contained, can easily spread to other countries.

8. **The impacts of infectious disease outbreaks can be devastating to the fragile social and economic situation of countries.** The World Bank (WB) estimates a global cost of US$3 trillion[5] in the event of a severe global pandemic such as the 1918 Spanish Flu. In addition, the occurrence of a global pandemic could have a death toll in the millions. In the West Africa region, the 2014 EVD outbreak eroded hard-won gains in the fight against poverty, including gains in human development and economic growth in Guinea, Liberia and Sierra Leone and the region as a whole. In these three countries 28,616 suspected cases of EVD resulted in 11,310 deaths, and the estimated forgone output reached US$1.6 billion, which represents over 12 percent of the countries' combined outputs. The outbreak also resulted in school closure for at least 6 months in the three countries and over 16,600 children lost one or both parents to the epidemic. Overall, the estimated loss in Gross Domestic Product (GDP) for the 15 countries in the ECOWAS region was approximately US$1.8 billion in 2014, and was projected to increase to US$4.7 billion in 2016.[6] These economic losses were over and above the day to day burden

[4] Some common outbreaks in the region include Cholera, Dysentery, Malaria, Hemorrhagic fevers (e.g. Ebola, Rift Valley fever, Crimean-Congo fever, Lassa fever, and Yellow fever), and Meningococcal Meningitis outbreaks endemic to countries along the "meningitis belt

[5] Burns et al. (2008) Evaluating the economic consequences of avian influenza (http://siteresources.worldbank.org/EXTAVIANFLU/Resources/EvaluatingAHIeconomics_2008.pdf).

[6] UNDG (2015) Socio-Economic impacts of EVD in West African Countries: A call for national and regional containment, recovery and prevention.

that endemic human and animal diseases, including zoonoses, inflict on the people of West Africa.

9. The accelerated emergence of infectious diseases has been the result of multiple factors, including:

- Population growth and rapid urbanization: As of 2015, the population of sub-Saharan Africa (SSA) was estimated at 1 billion, with the African Population and Health Research Centre projecting an increase up to 1.9 billion by 2050. Urban population densities have dramatically increased (by 223 percent in Guinea between 1960 and 2012; and by 178 percent, and 275 percent respectively in Sierra Leone and Liberia between 1961 and 2013) due largely to migration from rural to urban areas. Improved infrastructure has led to increases in travel and trade in the sub-region. Further, civil war and social turmoil have also been common in West Africa. Population growth coupled with social instability and its consequent population relocation and breakdown of government services provide fertile ground for the rampant spread of infectious diseases.
- Changes in land use including deforestation: According to the Food and Agriculture Organization of the United Nations (FAO) data, Western Africa is suffering deforestation at approximately twice the world rate. The links between deforestation and infectious disease outbreaks is well documented; deforestation and encroachment into natural habitats is also claimed to be responsible for the EVD outbreak in West Africa.
- Other factors that facilitate and accelerate the spread of infectious diseases include, international travel and trade, microbial adaptation and change, cultural aspects, availability of infrastructure, water/sanitation and breakdown of public health measures.

10. Effect of Climate Change: Changes in the epidemiology of infectious diseases associated with climate variability in West Africa over the last 40 years has been reviewed and documented, and there is also growing evidence of the impact of climate change on infectious disease transmission patterns, nutritional status, reproduction and geographic range.[7,8] According to the WHO, the risk of malaria and other mosquito-borne disease outbreaks increases by approximately five-fold in the year following an El Nino event a climate cycle that occurs when unusually warm sea surface temperatures develop off the Pacific coast of South America and the effects felt mostly in tropical regions including West Africa. Similarly, climate impacts could increase the burden of diarrhea by up to 10 percent by 2030 in some regions, and partly because of impact on agriculture, climate change could sharply increase rates of severe stunting, leading to an absolute increase in the number of stunted children in some parts of Africa.

Sectoral and Institutional Context

[7] Thompson et al (2004) Impact of Climate Variability on Infectious Disease in West Africa
[8] WHO (2015) Climate Change and Human Health - Risk and Responses

Human Health

11. **The performance of health systems in many countries in West Africa is weak.** They suffer from chronic insufficiency of financial and human resources, limited institutional capacity and infrastructure, weak health information systems, prevailing inequity and discrimination in availability of services, absence of community participation, lack of transparency and accountability, and a need for management capacity building. Public sector spending on health is generally low. None of the ECOWAS member states exceeds the Abuja target of ensuring 15 percent of Gross Government Expenditure (GGE) is allocated to health.

12. Country-led self-assessment on disease surveillance, preparedness and response capacity in Nigeria and Togo, as well as the lessons learnt from the EVD outbreak revealed some key weaknesses of health systems in terms of infectious disease surveillance, epidemic preparedness and response. These include: (i) a fit for purpose health workforce for disease surveillance, preparedness and response is lacking at each level of the health pyramid; (ii) community level surveillance and response structures either do not exist or need significant improvement; (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) infection prevention and control standards, infrastructure and practices are generally inadequate; (vi) management of the supply chain system is weak and inefficient; and (vii) there are significant gaps in regional level surge capacity for outbreak response, stockpiling of essential goods, information sharing and collaboration. Similar findings were also documented by the Global Health Security Agenda (GHSA) baseline assessments in a number of countries including Liberia.

13. **Guinea-Bissau has achieved some progress in health in recent years, nevertheless some critical challenges remain.**[9] According to the last Multi Indicators Cluster Survey (MICS), the maternal mortality rate (MMR) is estimated at 900 maternal deaths per 100,000 live births, one of the highest rates in the world.[10] Progress has been made to reduce infant mortality, but both infant mortality rate (IMR) and under-five mortality rate (U5MR) remain among the highest in the world, 60 and 88.8 per 1,000 live births, respectively.[11] Malaria is the single largest cause of deaths (15.8%), followed by HIV, neonatal disorders, lower respiratory infections, diarrheal diseases and nutritional deficiencies. The burden of HIV in Guinea-Bissau is the highest in West Africa. The country's health system faces persistent challenges related to inadequate supply of health workers, low public spending, poor infrastructure, and weak governance.

14. **A recent CDC assessment identified critical challenges in the disease surveillance strategies in the country.** These include: (i) analysis and interpretation of surveillance data as

[9] World Bank (2016). Guinea-Bissau Systematic Country Diagnostic: turning challenges into opportunities for poverty reduction and inclusive growth. World Bank, Washing/DC
[10] UNICEF (2014). Multi Indicators Cluster Survey (MICS)
[11] World Development Indicators (2014)

well as reports and outbreak summaries are not routinely performed; (ii) data quality assurance protocols and supervision to ensure data completeness and accuracy are not fully implemented; (iii) functional field epidemiology and laboratory capacity in the country are limited (iv); deficiencies in infrastructure affect the ability for staff to complete required functions (sanitary areas often lack a surveillance office with appropriate equipment to efficiently perform surveillance duties); and (v) laboratory and drug supply chains are not fully capable of ensuring effective use of surveillance and detection tests.[12]

15. **Prior to the EVD crisis, Liberia's health outcomes had been improving steadily since the end of the second civil war in 2003.** Figures from the 2013 Liberia Demographic Health Survey (LDHS) showed a 15 percent decline in U5MR and a corresponding decline in two subset indicators of U5MR, in the 10 year period prior to the survey. By 2012, Liberia was also one of the first countries in SSA to achieve its MDG target of reducing U5MR to less than one-third of its 1990 level (as of 2015, U5MR was estimated at 70 per 1,000 live births compared to 255 in 1990). However, the EVD crisis led to a devastation of the already fragile healthcare system in Liberia and severely constrained the ability of the Government of Liberia (GOL) to deliver key social services, including basic and secondary health services, thereby leading to many preventable deaths.

16. A WHO-led IHR (2005) core capacity assessment was carried out in Liberia in September 2016 using the Joint External Evaluation (JEE) tool. It shows significant improvements in the national surveillance systems post-EVD crisis, with country-wide coverage on the human health side, and the establishment of a robust emergency operations center (EOC) and incidence management system at the national and sub-national level. However, key weaknesses continue to exist including reported challenges with the community level surveillance structure; lack of a national laboratory network and national laboratory quality standards/quality management system; the shortage of a multidisciplinary workforce to implement the IHR core capacities; and the absence of a multi-hazard National Public Health Emergency Preparedness and Response Plan. Overall, the assessment report emphasizes an urgent need to strengthen and sustain a multidisciplinary coordination and communication mechanism required for the implementation of the IHR core capacities in the country.

17. The health sector of Nigeria is characterized by vast regional disparities in service delivery, health outcomes and resource availability. The adverse effects of diseases in the country are often exacerbated by lack of education and ineffective communication, especially in the North-eastern zones where health outcomes are grimmer than other parts of the country (as of 2014 U5MR was reported to be 54% higher; and DPT3 immunization coverage was only 20.6% in the North East compared to 72% in the southern zones).[13] Training on the implementation of the Integrated Disease Surveillance and Response (IDSR) strategy[14] has been facilitated by the

[12] CDC (2015). Guinea-Bissau Country Work Plan. Field Epidemiology Training Program Frontline (FETP-Frontline), US Centers for Disease Control
[13] Nigeria Demographic and Health Survey (2013)
[14] An Integrated Disease Surveillance and Response (IDSR) strategy is a tool developed by the WHO to promote rational use of resources by integrating and streamlining common surveillance activities

establishment of Nigeria Field Epidemiology and Laboratory Training Programme (NFELTP) in 2008.[15] However, threats to the implementation of the IDSR is mainly attributable to the non-activation of the community level surveillance system and inefficient coordination and collaboration across all levels of the health system in the country.

18. Health outcomes in Togo remain characterized by high levels of morbidity and mortality due to infectious diseases (overall mortality rate is estimated at 8 per 1,000 live births; as of 2015, U5MR was estimated at 78 per 1,000 live births) although the rise in non-communicable diseases (NCDs) provides growing evidence of the epidemiologic transition currently underway in the region. As a major hub for air and ground transportation in the sub-region, the country is ranked by the WHO as "high risk" for Ebola and other public health emergencies of international concern (PHEIC). Surveillance of epidemic-prone diseases remains a key priority of the Togolese Government. Notwithstanding, a major obstacle to better stewardship, planning and coordination of the health sector in Togo is the fragmentation of the country's disease surveillance and other health information across dozens of different, inconsistent and sometimes overlapping vertical systems. Limited capacities for data collection, reporting and analysis, especially at decentralized levels, create difficulties in the efficient and effective monitoring of health interventions and their outcomes.

Animal Health

19. The animal health sector of countries in the ECOWAS region is characterized by a high incidence and prevalence of infectious communicable diseases, both zoonotic and non-zoonotic, impacting veterinary and public health, trade, rural development and livelihoods. A recent summary of evaluations of Veterinary Services by the World Organization for Animal Health (OIE) in ECOWAS countries highlighted the services' lack of budgetary resources and mismatch between the human resources required and those actually available for preventing and controlling animal diseases. In terms of the strategic action required to sustain animal health, all of the countries identified the need to improve the coverage of their surveillance programs as well as the control of high-priority animal diseases[16]. Lack of preparedness, insufficient human, physical and financial resources, and the lack of cross-sector collaboration were again emphasized by the FAO and OIE as causes for failure to address promptly and efficiently the resurgence of highly pathogenic avian influenza in the region.

20. Improvement of animal health requires increased and sustained investments in national Veterinary Services (VS) to meet international standards of quality defined by the OIE. Any country failing to prevent, detect, inform, react and control sanitary issues, such as infectious diseases or antimicrobial resistance places other countries at risk, hence the importance of regional approaches. All countries in the region have engaged in the OIE Performance of

[15] The Nigeria Field Epidemiology and Laboratory Training Program (NFELTP) is a two-year training program aimed at improving public health systems in Nigeria through training of field epidemiologists and public health laboratorians and provision of epidemiological services.
[16] OIE (2013). Feasibility study for a programme to improve veterinary governance and the control of priority transboundary animal diseases in West Africa

Veterinary Services (PVS) Pathway[17], a program which provides independent qualitative (PVS evaluation) and quantitative (PVS Gap Analysis) evaluations of VS, identifying their strengths and weaknesses, prioritizing interventions and costing activities needed to address deficiencies.[18] Some countries have also received support to review their veterinary legislation

21. In Guinea Bissau, the 2015 PVS evaluation mission found that the Veterinary Services could not ensure the sanitary security of livestock and animal products, nor the security of the population against zoonotic and animal production food safety risks. Lacking critical competencies include human resources, financial resources, legal basis and enforcement as well as all technical capacities, including laboratory diagnostics, risk analysis, border security, epidemiosurveillance, prevention and control of diseases, rapid response to emergencies, veterinary medicinal products and food inspection. Among major diseases reported to be present in the country, brucellosis, bovine tuberculosis, anthrax, cysticercosis, and rabies are considered endemic, as well as other non-zoonotic ones such as small ruminant plague (PPR), trypanosomiasis, ASF, African horse sickness, and Newcastle disease (ND) which greatly reduce production and productivity of livestock. Livestock is estimated to contribute 17% of the national GDP.

22. Liberia faces major gaps in VS which are still critically understaffed, thereby affecting its overall capacity to tackle immediate and future challenges of a growing, unchecked livestock population. In 2013, there was no veterinarian in the country, no formal passive or active epidemiosurveillance program, no diagnostic capacity in the field nor in laboratories, hence the sanitary status could not be ascertained. Similar diseases to those present in neighbouring countries were deemed to be present. Various externally funded projects have helped Liberia to implement some programs over the past decade, such as the Support Programme for Integrated National Action Plans for Avian and Human Influenza (SPINAP) Avian flu 2007/2011; the Control of transboundary animal diseases in Africa (VACNADA) with a massive vaccination campaign against PPR; the Reinforcing Veterinary Governance in Africa Program (Vet-Gov) with activities on modernization of veterinary legislation; and currently the USAID financed Emerging Pandemics Threats Program (EPT2). The country underwent a PVS GAP Analysis in the summer of 2016 that will provide a solid basis for a stepwise holistic strengthening of the Liberia VS.

[17] The PVS evaluation tool is composed of 46 critical competencies, grouped in 4 components (Human, Physical, and Financial Resources, Technical Authority and Capability, Interaction with Interested Parties, Access to Markets), each being evaluated on a scale of 1 (no compliance) to 5 (full compliance). The evaluations of VS are expected to be done regularly in order to measure progress made and establish recommendations for continuous improvement. This tool, and the JEE which is to periodically monitor progress in the implementation of the WHO International Health Regulations (IHR), will be central to project monitoring and evaluation activities.

[18] State of play of PVS pathway evaluations in, Guinea Bissau, Liberia, Nigeria, and Togo: Guinea Bissau (PVS evaluation in Mar 2008, Gap Analysis in Sept 2009, PVS Follow-up in Nov 2015); Nigeria (PVS evaluation in Aug. 2007, the PVS Gap Analysis in Sep. 2010, legislation mission in Jan. 2011); Liberia (PVS evaluation in Jan 2013, Gap Analysis in July 2016); Togo (PVS evaluation in Oct/Nov 2007, Gap Analysis in Jan 2010, Legislation mission in Jan 2010)

23. Nigeria's animal disease surveillance and control system has suffered from setbacks in recent times, linked to general funding shortfalls as well as security challenges that have hampered operations in some parts of the country. Nigeria has the largest population of animals in West Africa, and is also a net importer of livestock, mainly from neighbouring countries. The recent resurgence of HPAI (January 2015) in the country, a strain closely related to an isolate from China, highlighted again the risks of occurrence of disease through both formal and informal trade as well as wildlife, requiring strengthened systems and sustained efforts to assess and mitigate them. Surveillance activities focus on selected priority diseases present in the country,e.g. CBPP, ASF, PPR, FMD, bovine TB and brucellosis, ND, HPAI, and rabies, however strong linkages with communities, private sector veterinarians and vet paraprofessionals as well as other sectors like environment are still missing.

24. In Togo, the national economy pays a heavy price for the rise in the number of deadly diseases of livestock that pose a threat to humans including Anthrax, Bovine Tuberculosis, Cysticercosis, Salmonellosis and Canine Rabies Infectious diseases of livestock that remain a key priority for the country's network of epidemiologic surveillance of animal diseases (REMATO) include Pleuropneumonia Contagious Bovine (CBPP), Foot and Mouth Disease (FMD), lumpy skin disease of cattle, sheep and goat plague, African Swine Fever (ASF), and Newcastle disease in poultry. In the case of African Animal Trypanosomiasis (AAT), the disease remains endemic to the country. Additionally, Highly Pathogenic Avian Influenza H5N1 has resurfaced in Nigeria since January 2015 and most recently, spread to various countries in the region including Togo where it was diagnosed and reported in August 2016 to the OIE.

25. Insufficient government funding and limited interest from donors to support VS have not allowed significant progress to date in addressing systemic issues. However, some important programs are worth noting in the animal health sector, such as USAID's multicountry Emerging Pandemic Threats (EPT2) program which is implemented in many of the ECOWAS countries through FAO and other implementing agencies; FAO support to HPAI infected countries; and Inter-African Bureau for Animal Resources of the African Union (AU-IBAR) support through the Vet-GOV program. In the last 15 years, two main regional and global programs significantly contributed to strengthening national VS, namely the Pan-African Program for the Control of Epizootics (PACE) program and the World Bank financed Avian Influenza Global Program which were implemented in many countries of the region. The lessons and best practices derived from these two programs are reflected in this project. The Regional Network of National Epidemiosurveillance Systems for HPAI and other Priority Animal Diseases in West-Africa (RESEPI) and Veterinary Laboratory Network for Avian Influenza and other Transboundary Animal Diseases in West-Africa (RESOLAB) networks were also supported and facilitated by FAO under different projects and handed over in 2012 to ECOWAS.

26. ECOWAS and the West African Economic and Monetary Union (WAEMU) have set a target of harmonizing national animal health systems. WAEMU, which covers 8 countries in the region, has moved forward on the harmonization of regulations on veterinary medicinal products, but progress has been slow due to administrative, human, organizational and financial constraints. In 2012, ECOWAS member countries declared the RAHC —an informal platform

originally set up in 2006 by OIE, FAO and AU-IBAR— as the ECOWAS specialized technical centre for animal health. An operational plan for RAHC was developed in August 2014. However, delays in staff recruitment and establishment of a dedicated operational budget have kept the institution from implementing this plan and rolling-out activities in accordance with its mandate. The RAHC is currently supported through a limited number of initiatives with specific objectives, including to further develop the One Health agenda in the region, and to develop Integrated Regional Coordination Mechanisms for the control of transboundary animal diseases (TADs) and Zoonoses (IRCM). The International Development Association (IDA)-financed Regional Sahel Pastoral Support project (PRAPS), which supports the improvement of animal health in six West African Sahel countries, and REDISSE I, specifically aims at contributing to the operationalization of the RAHC.

27. Tackling multisectoral issues efficiently requires working across sectors and disciplines. Yet very few countries have adopted coordinated approaches, along the lines of the OH concept. The response to the HPAI crisis since 2005 contributed to enhancing cooperation between the human and veterinary health sectors in many countries in the region, but in the absence of a dedicated program incentivizing such a joint approach, a silo approach still prevails. In Nigeria for instance, an OH approach to tackling infectious diseases has been widely publicized and conceptualized in key ministries. However, animal and human health disease surveillance systems have experienced major setbacks due to general funding shortfalls that have severely impacted both animal health and human health care delivery system in the country. Nonetheless, important lessons have been learned and experience gained, and successful regional programs for the control of selected priority diseases, both within and outside the region, have demonstrated the efficiency of a regionally coordinated approach to disease surveillance and response. In November 2016, technical and ministerial meetings on One Health took place in Senegal. The Communique highlighted the role of Governments in articulating intersectoral coordination (human, animal and environmental health), conducting sub-regional hazards and risk assessments, setting up national and sub-regional alert mechanisms as well as regular information sharing, carrying out joint external evaluations of IHR (2005) and in joint planning of preparedness and response interventions.[19]

Partner Coordination

28. The Development Partner landscape in the sub-region is complex, particularly in the countries most affected by the 2014-2015 EVD epidemic. The Ebola outbreak triggered a significant international response that brought many partners together to address the crisis and support the post-Ebola agenda of health systems recovery and strengthening. It also highlighted the need to focus attention on building the capacity for disease surveillance and response in the sub-region for both human and zoonotic diseases. Development partners engaged in the EVD response included development banks, multilateral and bilateral donors and private foundations, UN system agencies other technical agencies, academic and research institutions and large

[19] Communique: One Health Ministerial Meeting to Address Zoonotic Diseases and other related Health threats. Dakar, Senegal 11 November 2016

numbers of international and local non-governmental organizations. Collaboration on Ebola containment in the most affected countries continues and has been extended beyond Ebola.

29. The World Bank Group is well positioned to promote regional and global propositions that address the fundamental weaknesses of health systems and their interoperability. The World Bank's convening power is highly instrumental to forging a coalition of national, regional, and global technical and financial institutions to support this neglected agenda in West Africa including the U.S. Centers for Disease Control (CDC), The China CDC, the WHO, the OIE, the African Development Bank, bi-lateral development partners and private foundations. To date, the Bank team has been successful in mobilizing project preparation financing from the Bill and Melinda Gates Foundation, co-financing from the Government of Canada, Department of Foreign Assistance, Trade and Development and Trust Funds from the Government of the People's Republic of China. The REDISSE Program has systematically engaged the technical expertise of institutions and individual experts from across multilateral, governmental, non-governmental academic and private institutions and is establishing coordinating mechanisms, such as a Regional One-health Platform and a Monitoring and Evaluation Reference Group for disease surveillance and response systems.

C. Proposed Development Objective(s)

Note to Task Teams: The PDO has been pre-populated from the datasheet for the first time for your convenience. Please keep it up to date whenever it is changed in the datasheet.

Development Objective(s) (From PAD)

30. The PDOs are: (i) to strengthen national and regional cross-sectoral capacity for collaborative disease surveillance and epidemic preparedness in West Africa, thereby addressing systemic weaknesses within the animal and human health systems that hinder effective disease surveillance and response; and (ii) in the event of an Eligible Emergency, to provide immediate and effective response to said Eligible Emergency.

Key Results

31. The proposed PDO will contribute to: (i) develop national and regional capacity to fully implement the integrated disease surveillance and response (IDSR) strategy, which calls for the continuous monitoring of mortality and morbidity to identify and respond to threats before they can develop into large scale or transboundary epidemics; (ii) facilitate country and regional compliance with international standards for veterinary services, with a particular focus on early detection and rapid response capacity, as adopted by the OIE members states in the Terrestrial Animal Health Code , and utilize the findings and recommendations from the OIE PVS pathway; and (iii) ensure more efficient collaboration and synergies between human and animal

epidemiological surveillance and response networks at country and regional levels. The following key indicators will be used to track progress towards the PDOs:

a. Progress towards establishing an active, functional regional One Health Platform (Number based on 5 point likert scale);

b. Laboratory testing capacity for detection of priority diseases: number of countries that achieve a JEE score of 4 or higher out of 5;

c. Progress in establishing indicator and event-based surveillance systems: number of countries that achieve a JEE score of 4 or higher out of 5;

d. Availability of human resources to implement IHR core capacity requirements; number of countries that achieve a JEE score of 3 or higher out of 5;

e. Multi-hazard national public health emergency preparedness and response plan is developed and implemented: number of countries that achieve a JEE score of 4 or higher out of 5;

f. Progress on cross-border collaboration and exchange of information across countries: number of countries that achieve a score of 4 or higher out of 5.

Four of the six PDO level indicators will be based on the periodic Joint External Evaluation (JEE) for monitoring progress in the implementation of the WHO IHR (2005)[20].

D. Project Description

32. A streamlined consultative process was adopted under REDISSE to inform the detailed project design, which will enhance the capacities of the human and veterinary public health systems of Guinea Bissau, Liberia, Nigeria, and Togo for efficient and effective surveillance, preparedness and early response to infectious disease threats, and via a collaborative regional approach that promotes the One Health approach and supports the implementation of the IHR (2005) and OIE standards.

33. Adopting the same design under REDISSE I, the REDISSE II project will comprise 5 components as follows:

Component 1: Surveillance and Information Systems (US$35.3 Million)

[20] The World Health Organization, together with other partners, has developed a Joint External Evaluation Tool-International Health Regulations (2005) (JEE-IHR) to assess country capacity to prevent, detect, and rapidly respond to public health threats. The tool allows countries to identify the most urgent needs within their health security system, to prioritize opportunities for enhanced preparedness, response and action, and, through regular evaluations, will help monitor the progress by country in implementation of the International Health Regulations (2005). http://apps.who.int/iris/bitstream/10665/204368/1/9789241510172_eng.pdf. The JEE makes use of the PVS evaluation missions results which provide an assessment of the strengths and weaknesses of the national Veterinary Services (http://www.oie.int/support-to-oie-members/pvs-evaluations/oie-pvs-tool/)

34. A key component of the project will involve the enhancement of national surveillance and reporting systems and their interoperability at the different tiers of the health systems. This component will support national and regional efforts in the surveillance of priority diseases (including emerging, re-emerging and endemic diseases) and the timely reporting of human public health and animal health emergencies in line with the IHR (2005) and the OIE Terrestrial Animal Health Code. This component also seeks to strengthen the linkages of surveillance and response processes at the local (community), sub-national and national levels of the health system to ensure the rapid detection of new cases and potential disease outbreaks within high-risk communities via early reporting to local/district health structures in real-time; and laboratory confirmation and classification of collected samples, supported by a regional network (a presentation of the linkages between community action and regional surveillance and response is provided in Annex 1, paragraph 13, page 111). The linkages along these different levels and steps within an animal health epidemiology and surveillance system shall be analysed, optimized and formalized.

35. The sub-components are: (I) support coordinated community-level surveillance systems and processes across the animal and human health sectors; (II) develop capacity for interoperable surveillance and reporting systems; and (III) establish an early warning system for infectious disease trends prediction.

36. Potential activities under this component will include: (i) the establishment of appropriate linkages between national animal health and human health surveillance information systems, between national systems to regional/international disease surveillance and reporting systems, and adaptation of potentially cost-effective risk-based approaches to surveillance; (ii) cross-border collaboration in surveillance (including active/event-based, passive and syndromic surveillance) for the early detection of cases; (iii) timely reporting by community-level surveillance agents as well as district health and veterinary facilities, and minimization of turnaround time from specimen collection to laboratory confirmation and reporting; (iv) the use of surveillance data for risk analysis (assessment, management and communication) to implement appropriate outbreaks prevention and control interventions across the sub-region.

Component 2: Strengthening of Laboratory Capacity (US$27.9 Million)

37. The second project component will involve the identification and/or establishment of networks of efficient, high quality, accessible public health, and veterinary laboratories (public or private) for the diagnosis of infectious human and animal diseases, and the establishment of a regional networking platform to improve collaboration for laboratory investigation. Adapting some lessons learned from the EAPHLN project, the regional laboratory network will contribute towards strengthening the capacities of national veterinary and public health laboratories as well as public health institutes, most notably in the areas of surveillance, pathology for the earlier identification and diagnosis of priority infectious disease pathogens, AMR and insecticide resistance monitoring and mapping. The national laboratory network in each country will be linked to and supported by the network of regional reference laboratories (RRL) being established with support from the Program through the REDISSE 1 project. RRLs are being

developed in five ECOWAS member states: Burkina Faso, Cote d'Ivoire, Ghana, Nigeria and Senegal.

38. The sub-components are as follows: (I) Review, upgrade and network laboratory facilities; (II) Improve data management and specimen management systems; and (III) Enhance regional reference laboratory networking functions.

39. Potential project activities under this component include: (i) provision of technical support for laboratory information systems and the interoperability with disease surveillance and reporting systems; (ii) streamlining of laboratory specimen referral process and improving the efficiency of the specimen transport and disposal systems; (iii) application of the World Health Organization – Africa Region (WHO/AFRO) five-step accreditation process and technical assistance to support accreditation of regional reference laboratories.

Component 3: Preparedness and Emergency Response (US$30.9 Million)

40. Component 3 of the project will support national and regional efforts to enhance infectious disease outbreak preparedness and response capacity by improving local, national and regional capacities to prepare for impending epidemics in humans and animals, and to respond effectively to disease outbreak threats including the resulting mortality risks posed by infectious diseases. Project interventions will provide support to improve country and regional surge capacity to ensure a rapid response during an emergency and, for what concerns the human health sector, a better performance of the healthcare system in service delivery. This component will seek to better educate and prepare communities for outbreaks and emergencies as part of the routine delivery of health services. As part of the cross-sectoral efforts, the development of joint planning and joint implementation will be pursued. The project will also support enhancing countries' health system capacities for management of disaster recovery priorities including the capacity for the integration of community-centred emergency care into the broader healthcare system.

41. The sub-components are as follows: (I) Enhance cross-sectoral coordination and collaboration for preparedness and response; (II) Strengthen Capacity for emergency response; and (III) Contingency emergency response; a sub-component, which has the objective to improve the Government's response capacity in the event of an emergency, following the procedures governed by OP/BP 10.00 paragraph 13 (Rapid Response to Crisis and Emergencies) (see box 3).

Box 3: Contingent Emergency Response Component (US$0)

The objective of this sub-component is to improve the Government's response capacity in the event of an emergency, following the procedures governed by OP/BP 10.00 paragraph 13 (Rapid Response to Crisis and Emergencies). There is a moderate to high probability that during the life of the project one or more countries will experience an epidemic or outbreak of public health importance or other health emergency with the potential to cause a major adverse economic and/or social impact which would result in a request to the Bank to support mitigation, response, and recovery in the region(s) affected by such an emergency. In anticipation of such an event, this contingent emergency response component (CERC) provides for a request from countries participating in the REDISSE program to the Bank to support mitigation, response, and recovery in the district(s) affected by such event. This program provides an important opportunity for clients to stop epidemics from spreading within and across borders through early intervention, without the need to set financing aside in a conventional contingency fund.

An "Emergency Response Operational Manual" (EROM) will be prepared by each country as a condition of disbursement. Countries will begin drafting the EROM immediately to ensure that the CERC is in place as soon as possible in the event that an emergency occurs early in the implementation of the Project. Triggers for the CERC will be clearly outlined in the EROM acceptable to the World Bank. Disbursements will be made against an

42. Potential activities under Component 3 include: (i) updating and/or development of cross-sectoral emergency preparedness and response plans (national and regional) for priority diseases, and ensuring their integration into the broader national all-hazards disaster risk management framework; (ii) regular testing, assessment, and improvements of plans; (iii) expansion of the health system surge capacity including the allocation and utilization of existing pre-identified structures and resources (at the national and regional level) for emergency response, and infection prevention and control (IPC); (iv) establishment of multidisciplinary rapid response teams at both national and regional level; and, (v) periodic conduct of outbreak simulation exercises to assess functionality.

Component 4: Human Resource Management for Effective Disease Surveillance and Epidemic Preparedness (US$23.5 Million)

43. The fourth component is cross cutting of the previous three and aims to strengthen government capacity to plan, implement and monitor human resource interventions by establishing long-term capacity for improved management of human resources. This component will thus provide support to the development of institutional capacity for planning and managing continuing workforce training by leveraging existing training structures and programs across countries in the region such as the Field Epidemiology Training Program (FETP), Field Epidemiology and Laboratory Training Program (FELTP), Veterinary-FETP, and other workforce training programs that address critical public health and veterinary health needs.

44. This component will analyze and seek to address the incentive environment within which public health and veterinary health workers operate. The project will seek to implement activities which create incentives that not only draw those with relevant skills to the public sector, but also improve staff motivation and retention. Viable options will be explored under this component to

ensure a centrally coordinated and efficient process for the retention of a skilled workforce (for both animal and human health) available for routine surveillance and rapid deployment for case detection, laboratory confirmation of suspected cases, vaccine distribution logistics, and for the delivery of primary healthcare needs for common illnesses as part of outbreak response.

45. The sub-components under this component are as follows: (I) Health Workforce mapping, planning and recruitment; and (II) Enhance Health Workforce training, motivation and retention.

46. Potential activities include: i) assessments of current workforce in terms of quantity, geographical and gender distribution and capacity (including private actors); (ii) strengthening capacity for human resource management for disease surveillance and response; (iii) pre-service and in-service training for public human and veterinary professionals, at all levels (iv) supporting the capacity of governments to recruit human and veterinary health workers and create an incentive environment which encourages skilled individuals to work for the public sector

Component 5: Institutional Capacity Building, Project Management, Coordination and Advocacy (US$29.4 Million)

47. Component 5 focuses on all aspects related to project management. It includes fiduciary aspects (financial management and procurement), monitoring and evaluation (M&E), knowledge generation and management, communication, and management (capacity building, monitoring and evaluation) of social and environmental safeguard mitigation measures. It also provides for critical cross-cutting institutional support, meeting capacity-building and training needs identified in the four countries on top of specific technical capacity-building activities undertaken within the four technical components (including support to the management of operational research). It will support the routine external independent assessment of critical animal health and human health capacities of national systems using reference tools (such as OIE PVS and JEE) to identify weaknesses and monitor progress. This component will build on, and complement other projects and initiatives such as the West Africa Regional Disease Surveillance Project (WARDS) (which has been supporting the development of the institutional capacity of WAHO), East Africa Public Health and Laboratory Networking Project (EAPHLN), Global Health Security Agenda (GHSA), and Emerging Pandemic Threat (EPT2) and other discrete activities to foster the harmonization of a functional regional disease surveillance and response network in the ECOWAS region.

48. The sub-components are as follows: (I) Project coordination, fiduciary management, monitoring and evaluation, data generation, and knowledge management; and (II) Institutional support, capacity building, advocacy, and communication.

49. Potential activities under this component include: (i) strengthen the capacities of national institutions to efficiently perform core project management functions including operational planning, financial management, procurement arrangements, and environmental and social

safeguards policies in accordance with WB guidelines and procedures. (ii) enhance M&E systems including routine health management and information systems (HMIS) and other data sources, including regular Joint External Evaluations (JEE) of IHR (2005) and the PVS pathway evaluations; (iii) manage an operational research program and economic analysis of disease outbreaks and epidemics in the ECOWAS region implemented by national and regional institutions; (iv) promote the design of impact evaluation studies to measure the impact of project interventions; and (v) coordinate the roles of existing national and regional institutions to better support the planned project activities.

50. As with REDISSE I, WAHO will host the regional coordination unit and will be primarily responsible for regional coordination, guided by the decisions of the REDISSE Regional Steering Committee under the political leadership of ECOWAS. For the regional oversight of the animal health area, WAHO would delegate operational coordination and implementation of regional animal health activities to RAHC, with the support of OIE. WAHO will also be responsible for supporting the establishment of national and regional One Health coordination platforms for the purpose of developing synergies, joint planning, implementation and communication. Strategies will be adopted for generating evidence to be used to advocate for increased and sustained financing for disease surveillance and preparedness from domestic sources.

Private Sector Engagement

51. Across all project components, the project will promote partnership with the private sector to improve areas of known weaknesses in the provision of public goods across all project activities. Potential areas of private sector engagement will involve aspects where the private sector may have a comparative advantage over, or complementary to, the public sector such as in logistics and supply chain management, information communication and technology development, and improvement of specimen transportation systems. In order to take advantage of existing professional skills and to contribute towards achieving proper geographical meshing of the animal health and human health national surveillance networks, private medical practitioners, veterinarians and veterinary paraprofessionals may be entrusted with official tasks through contractual arrangements. Under similar contractual mechanisms, the project will also explore possible partnerships, with identified centers of excellence and private laboratories with the appropriate capacity to play a critical role in the provision of diagnostic and reporting services for diseases of national, regional and/or global importance.

52. The Project will engage the private sector to develop partnerships across three broad areas:

a. **Private Health Practitioners and NGOs:** The project will collaborate with private health practitioners and NGOs working across the animal and human health sector to strengthen disease surveillance, preparedness and response as a collective responsibility of both the public and private sector. To this end, policies, strategies, and action plans (including those that address the incentives and disincentives for early reporting of suspected cases at "point-of-care" (POC) and within the community will be developed with clearly defined roles and responsibilities of the various actors, and with the establishment of the appropriate legal frameworks and financing mechanisms. The project will support the development of effective evidence-based approaches to identify and engage with private health practitioners and local NGOs that will be a part of the long-term surveillance system, as well as those experts with skillsets to be contracted mainly for outbreak preparedness and response including the use of behavior change communication and the development of other effective public health communication/awareness strategies. Capacity building activities including the adoption of communities of practices (CoP) will also be supported to reinforce effective collaborations between the public and private healthcare providers.

b. **Private Centers of Excellence, Laboratories and Manufacturers:** Partnerships with identified centers of excellence, private laboratories, and manufacturers will be established for the purpose of improving rapid diagnostic tests (RDTs) capabilities and detection rates via the use of cost-efficient methods, including increasing the range of emerging and reemerging infectious disease pathogens that can be detected in each tests, and for making accurate diagnosis of disease pathogens at POC. Public-Private partnerships will also be established in specific areas of expertise for the delivery of animal health and human health laboratory services to enhance epidemiosurveillance and laboratory confirmation of notifiable diseases, and to improve the timeliness and completeness of the system of reporting surveillance data.

c. **Systems Development (ICT, Logistics and Supply Chain Management System):** The project will explore partnerships with the private sector in the development of efficient systems to improve surveillance data management, reporting and communication, and for preparedness planning before and during an outbreak response. This will include the

enhancement and/or development of (a) information communication and technology (ICT) such as the use of mobile technology and geographic information systems (GIS) for integrated and interoperable data reporting, adoption of unique identifier codes to improve surveillance records, and the integration of surveillance data into the national health management information systems; (b) specimen transportation systems to facilitate the shipping of specimens to national, regional and/or global reference laboratories; and (c) supply chain management systems to enhance the effectiveness of supply chain distribution logistics for outbreak preparedness planning and during an emergency response.

Table 2: Estimated Project Budget Allocations by Component

Project Components	**Budget Allocation (US $ Million)**
Component 1: Surveillance and Information Systems	50.08
Component 2: Strengthening of Laboratory Capacity	28.71
Component 3: Preparedness and Emergency Response	26.46
Component 4: Human Resources Management for Effective Disease Surveillance and Epidemic Preparedness	23.97
Component 5: Institutional Capacity Building, Project Management, Coordination and Advocacy	17.78
Total	**147.0**

Table 3: Funding by component and sub-component

Project activities	**Guinea Bissau**	**Liberia**	**Nigeria**	**Togo**	**TOTAL**
COMPONENT 1					
Sub-Component 1.1 Support coordinated community-level surveillance systems and processes across the animal and human health sector	1.18	2.0	19.5	1.89	24.57
Sub-Component 1.2 Develop capacity for interoperable surveillance and reporting systems	3.64	2.0	8.0	1.26	14.9
Sub-Component 1.3 Establish an early warning system for infectious disease trends prediction	1.06	1.0	7.5	1.05	10.61
Sub-total component 1	**5.88**	**5.0**	**35.0**	**4.2**	**50.08**

Project activities	Guinea Bissau	Liberia	Nigeria	Togo	TOTAL
COMPONENT 2					
Sub-Component 2.1 Review, upgrade and network laboratory facilities	2.21	1.0	9.0	1.32	13.53
Sub-Component 2.2 Improve data management and specimen management	0.93	1.7	5.5	0.53	8.66
Sub-Component 2.3 Enhance regional reference laboratory networking functions	0.43	0.8	4.5	0.79	6.52
Sub-total component 2	**3.57**	**3.5**	**19.0**	**2.64**	**28.71**

Project activities	Guinea Bissau	Liberia	Nigeria	Togo	TOTAL
COMPONENT 3					
Sub-Component 3.1 Enhance cross-sectoral coordination and collaboration for preparedness and response	1.08	0.9	4.0	6.42	12.40
Sub-Component 3.2 Strengthen capacity for emergency response	2.28	1.0	6.5	4.28	14.06
Sub-Component 3.3 Contingency emergency response	0.0	0.0	0.0	0.0	
Sub-total component 3	**3.36**	**1.9**	**10.5**	**10.7**	**26.46**

Project activities	Guinea Bissau	Liberia	Nigeria	Togo	TOTAL
COMPONENT 4					
Sub-Component 4.1 Healthcare Workforce mapping, planning and recruitment.	1.59	0.6	4.5	0.36	7.05
Sub-Component 4.2 Enhance health workforce Training, Motivation and Retention	4.08	2.0	10.0	0.84	16.92
Sub-total component 4	**5.67**	**2.6**	**14.5**	**1.2**	**23.97**

Project activities	Guinea Bissau	Liberia	Nigeria	Togo	TOTAL
COMPONENT 5					
Sub-component 5.1 Project coordination, fiduciary management, monitoring and evaluation, data generation, and knowledge management	1.81	1.0	8.0	1.46	12.27
Sub-component 5.2 Institutional support, capacity building, advocacy, and communication	0.71	1.0	3.0	0.80	5.51
Sub-total of component 5	**2.52**	**2.0**	**11.0**	**2.26**	**17.78**

E. Implementation

Institutional and Implementation Arrangements

53. Following the same mechanism as under REDISSE I, project implementation will be coordinated by WAHO, an affiliate organization of ECOWAS, which will host the regional secretariat of the REDISSE Program. WAHO has taken steps to strengthen its procurement and financial management, M & E and project management competencies. It will continue to do so with support provided under REDISSE I. Governments of the four participating countries will implement country-level tasks and project funds will flow directly from IDA to the individual countries for country level activities. In Liberia, Guinea-Bissau and Togo, country level activities will be led and coordinated by the Ministry of Health (MoH) in the respective countries, while implementation will be carried out by the relevant programs and divisions under the MoH and Ministry of Agriculture/Livestock. In Nigeria, country level activities will be led and coordinated by the Nigeria Center for Diseases Control (NCDC).

54. Using the funding arrangements under REDISSE I, regional level activities planned under REDISSE II will be coordinated by WAHO. WAHO will also ensure capacity building for the RAHC to perform regional animal health related functions under the project through a contract and memorandum of agreement with the OIE until RAHC has achieved sufficient capability and capacity to perform these functions without external assistance. WAHO will also coordinate with and, when required, establish contracts and/or memoranda with other specialized technical agencies such as the WHO Regional Office for Africa and FAO.

55. The following country-specific arrangements have been proposed during project appraisal:

56. **Guinea Bissau:** A Project Steering Committee (PSC) will be established. Membership of the PSC will consist of representatives from MINSAP, MADR, Ministry of Finance, Ministry of Environment, Ministry of Education, Ministry of Communications, and representatives of local, regional and global partners (WAHO, CDC, European Union, UNICEF, UNFPA, OIE, WHO, USAID, and others), and will be based on existing One Health Network in Guinea-Bissau. The PSC will provide guidance and strategic directions, and monitor the implementation of the project on an annual basis. Multisectoral technical working groups (TWG) will be established with technical staff from relevant ministries and technical experts from partners. These TWGs will be responsible for ensuring the project's annual plan is consistent with local and regional priorities identified during project preparation and to adapt the project activities when necessary.

57. The MINSAP will lead the implementation of the REDISSE II in close collaboration with the MADR. The Project Coordination Unit (PCU) will be established within the office of the DGASS. The PCU will report directly to the Secretary-General of the MINSAP and will be responsible for: (i) ensure the financial management of the project activities in all components; (ii) prepare consolidated annual work plans, budgets, monitoring and evaluation report (M&E in English), and the implementation report of the project to be submitted to the steering committee and the World Bank.

58. **Liberia:** A One Health Steering Committee will be established and will serve as the advisory and oversight body for the project. The committee will meet once every quarter. Membership shall include the following: MOH, MOA, MFDP, FDA, MOCI, MIA, WHO, CDC, USAID, FAO and PREDICT-2. The PCU will be housed in the MOH and will provide oversight of procurement activities for both MoH and MoA, financial management and ensure adherence to all WBG implementation and reporting guidelines for the REDISSE Project. Other implementing agencies, such as the Ministry of Agriculture, will be financed through MOU for agreed deliverables with associated indicators and targets.

59. **Nigeria:** A National Steering Committee will be constituted and will have oversight responsibilities of the project including planning, management and monitoring of project activities. The committee will also focus on policy issues related to the project and ensure coordination and linkages across relevant agencies and international partners. The members of the steering committee will include Honourable Ministers of Federal Ministry of Health, Federal Ministry of Agriculture and Rural Development, Federal Ministry of Finance, Federal Ministry of Environment and Federal Ministry of Information. The Committee will also include the Chief Executive Officer (CEO) of Nigeria Center for Diseases Control (NCDC) and Director of the Department of Veterinary and Pest Control Services including two Commissioners each from State Ministry of Agriculture and Rural Development (SMARD) and State Ministry of Health (SMOH), one representative from the private sector, one representative from the CSOs, and two representatives from development partners. The Steering committee will be chaired by the Honourable Minister of Health and co-chaired by the Honourable Minister of Agriculture. There shall also be a National Technical Committee, chaired by the CEO of NCDC which will provide

guidance and supervision to the PCU on technical matters and shall meet quarterly or as may be necessary.

60. The Nigeria Center for Diseases Control will host the PCU. The PCU under the guidance of NCDC CEO will work with and ensure that Memorandum of Understanding (MOU) or services contracts are signed for technical support with development partners and other implementing partners with demonstrable capacity following due process.

61. **Togo:** The coordination and the daily management of the project will be the responsibility of the existing Project Management Unit (PMU) in the Ministry of Health and Social Protection. The PMU was established to manage the implementation of the WBG financed Maternal and Child and Nutrition Services Support Project (P143843). The PMU will be responsible for general planning, fiduciary management, internal audit, procurement and the M&E. The project will support the authorities responsible for animal and human health at the regional level and the prefect/health district for supervision and coordination of the activities at peripheral and community level including surveillance and reporting, data management, communications and community mobilization, and the provision of services in response to epidemics/epizootics. These activities will be implemented by health center and health unit staff, community health workers, the CSCV, the heads in charge of the veterinary observation, the private veterinarians and health practitioners, village auxiliaries and farmers. At the level of both prefectures and health districts, existing management frameworks for multisectoral and multidisciplinary response to epidemics and disasters will allow the actors to share and exchange information as well as best practices. The entities involved in the implementation of the REDISSE Project will sign contracts with the Project Management Unit.

Note to Task Teams: The following sections are system generated and can only be edited online in the Portal.

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F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

This project is a part of the REDISSE Program, which, as mentioned in Section B1 above, is a interdependent projects. The second project in the series (REDISSE II) is extending the program to Guinea Bissau, Liberia, Nigeria and Togo. Activities with a physical footprint includes upgrading of laboratory networking facilities, strengthening capacities to prepare for impending epidemics in humans and animals and to respond effectively to disease outbreak threat, surveillance, AMR and insecticide resistance monitoring and mapping. While some of these project activities have low to moderate environmental risks, the project will also strengthen the capacity of client governments to successfully manage environmental and social impacts in the event of a infectious disease outbreak among human and/or animals. The physical locations and specific details of the proposed project interventions in the four countries are not as yet known.

G. Environmental and Social Safeguards Specialists on the Team

Alexandra C. Bezeredi,Ruma Tavorath,Amos Abu

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The proposed project is categorized as B under this OP because its potential social and environmental risks are expected to moderate and mostly site specific, with no significant or long-term negative impacts. The potential environmental impacts are related to i) construction of laboratory structures (including indiscriminate disposal of construction waste, noise and temporary disruption of access of community; pollution of soil and water; insufficient attention to occupational health and safety of community and workers, etc); ii) ongoing operations of healthcare facilities and laboratories resulting in generation of infectious waste which needs to be managed to reduce potential health risks and iii) management of environmental impacts during epidemics to prevent further spread of disease through poor infection control and inadequate waste management practices. The potential risks, impacts and mitigation measures have been detailed in country-specific Environmental and Social Management Frameworks (ESMF) and Healthcare Waste Management Plans (HCWMP).
Natural Habitats OP/BP 4.04	No	Project activities will be undertaken within the premises of existing health facilities or existing structures and are not expected to have any impacts on natural habitats
Forests OP/BP 4.36	No	Project activities will be undertaken within the premises of existing health facilities or existing structures and are not expected to have any impacts on designated forest areas
Pest Management OP 4.09	Yes	The surveillance, monitoring and containment of diseases including zoonosis could lead to increased use of chemicals, reagents, and pesticides. Poor management, including use and disposal of such

		chemicals can have potential risks on human health and have potential negative impacts on the environment. These could include aspects related to misuse or over-use of chemicals due to lack of knowledge or awareness; insufficient availability and use of Personal Protective Equipment (PPE); indiscriminate disposal of pesticide containers which can be recycled and reused without disinfection; haphazard disposal of chemicals resulting in pollution of land and soil etc. To manage these potential risks, all client countries have prepared an Integrated Vector and Pesticide Management Plan (IVPMP).
Physical Cultural Resources OP/BP 4.11	No	Project activities will be undertaken within the premises of existing health facilities or existing structures. While such activities are not expected to result in disruption of any archaeological or culturally sensitive resources, chance find procedures are built into the ESMF prepared for this project.
Indigenous Peoples OP/BP 4.10	No	Project activities will not have any impact on indigenous peoples
Involuntary Resettlement OP/BP 4.12	No	The project is not expected to involve land acquisition leading to economic or physical displacement in any of the participating countries, as civil works will take place within existing facilities on government owned lands.
Safety of Dams OP/BP 4.37	No	The project activities will not have any impact or are not associated with dams
Projects on International Waterways OP/BP 7.50	No	The project activities has no association with international waters
Projects in Disputed Areas OP/BP 7.60	No	Project activities are not in any disputed areas

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

The project activities related to enhancement of surveillance of animal and human health and improvement of laboratories have some social and environmental risks. The impacts of such impacts however are expected to moderate and mostly site specific, with no significant or long-term negative impacts, if well managed. The potential environmental impacts are related to i) construction of laboratory structures (including indiscriminate disposal of construction waste, noise and temporary disruption of access of community; pollution of soil and water through

misuse of chemical and their indiscriminate disposal; iii) insufficient attention to occupational health and safety of community and workers, lab technicians etc); iv) ongoing operations of healthcare facilities and laboratories resulting in generation of infectious waste which needs to be managed to reduce potential health risks and v) management of environmental impacts during epidemics to prevent further spread of disease through poor infection control and inadequate waste management practices.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
The potential impacts especially long-term are related to increased risks to public health due to uncontrolled spread of infectious diseases or increase in rates of hospital acquired infections. Poorly disposed chemicals also have the potential for polluting land and water, which have longer term impacts on public health,

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
n/a

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.
Each country has prepared Environmental and Social Management Frameworks (ESMF) which addresses the construction and occupational health related issues related to rehabilitation and construction of laboratories. A Healthcare Waste Management Plan (HCWMP) has also been prepared to institutionalize systems for segregation, treatment and disposal of infectious waste. Integrated Vector and Pesticide Management Plan (IVPMP) have been prepared by each country for sound management of theuse and disposal of chemicals, improved knowledge or awareness and use of Personal Protective Equipment (PPE) for occupational safety.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission to InfoShop	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
12-Jan-2017	12-Jan-2017	

"In country" Disclosure

Guinea-Bissau
13-Jan-2017

Comments

Liberia
27-Apr-2016

Comments

Nigeria
26-Apr-2016

Comments

Togo
12-Jan-2017

Comments

Pest Management Plan

Was the document disclosed prior to appraisal?	Date of receipt by the Bank	Date of submission to InfoShop
Yes	12-Jan-2017	12-Jan-2017

"In country" Disclosure

Guinea-Bissau
13-Jan-2017

Comments

Liberia
27-Apr-2016

Comments

Nigeria
26-Apr-2016

Comments

Togo
12-Jan-2017

Comments

If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/Audit/or EMP.

If in-country disclosure of any of the above documents is not expected, please explain why:

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?
Yes
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?
Yes
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?

OP 4.09 - Pest Management

Does the EA adequately address the pest management issues?
Yes
Is a separate PMP required?
Yes
If yes, has the PMP been reviewed and approved by a safeguards specialist or PM? Are PMP requirements included in project design? If yes, does the project team include a Pest Management Specialist?
Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank's Infoshop?
Yes
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?
Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?
Yes

Have costs related to safeguard policy measures been included in the project cost?
Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?
Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?
Yes

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APPROVAL

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Note to Task Teams: End of system generated content, document is editable from here.