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

Appraisal Stage | Date Prepared/Updated: 15-Mar-2018 | Report No: PIDISDSA23338



**BASIC INFORMATION**

**A. Basic Project Data**

Country Western Africa	Project ID P161163	Project Name Regional Disease Surveillance Systems Enhancement (REDISSE) Phase III	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 05-Mar-2018	Estimated Board Date 07-May-2018	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Republic of Benin, Republic of Mali, Republic of Mauritania, Republic of Niger	Implementing Agency Mauritania - Ministry of Livestock, Benin - CNLS-TP, Présidence de la République du Bénin, Mali - Ministry of Health, Niger - Ministry of Health	

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; 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 Resource 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)	120.00
IDA Grant	0.00
<b>Total Project Cost</b>	<b>120.00</b>



Environmental Assessment Category

B - Partial Assessment

Decision

The review did authorize the preparation to continue

Other Decision (as needed)

## B. Introduction and Context

### Country Context

1. The Ebola Virus Disease (EVD) epidemic in West Africa highlighted the importance of strong disease surveillance systems and inter-country collaboration in order to minimize economic costs and the loss of human lives in an outbreak. The West Africa Ebola outbreak demonstrated that the rapid and large spill-over effects of disease outbreaks can transcend local and national boundaries<sup>1</sup>. Recent reports have also highlighted the strong case for investing in preparedness, especially strengthening of core country capabilities for International Health Regulations (IHR), and the World Animal Health Organization's Terrestrial Animal Health Code<sup>2</sup>. The concept of the proposed Regional Disease Surveillance Systems Enhancement Program ("REDISSE" and/or "Program") aims to strengthen human health, animal health, and disaster response system in West Africa to ensure resilience to future outbreaks and health emergencies. 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 country efforts to harmonize policies and procedures; (ii) Empower countries to engage in joint planning, implementation and evaluation of program activities across borders at regional, national and district levels, and; (iii) Promote resource sharing of high-cost specialized assets. 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.

2. REDISSE 3 is the third project under the REDISSE Program, which is being prepared as a series of interdependent projects (SOP) and detailed in REDISSE 2 (Report No. PAD2200). The utilization of a 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.

### Major infectious diseases affecting human populations in West Africa

<sup>1</sup> The World Bank Group (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 the International Financial Corporation (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.

<sup>2</sup> Sands, P., Mundaca-Shah, C., & Dzau, V. J. (2016). The neglected dimension of global security—a framework for countering infectious-disease crises. *New England Journal of Medicine*, 374(13), 1281-1287.



3. The impacts of infectious disease outbreaks can be devastating to the fragile social and economic situation of countries. 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 West Africa region. Overall, the estimated loss in Gross Domestic Product (GDP) for the 15 ECOWAS countries was approximately US\$1.8 billion in 2014, and was projected to increase to US\$4.7 billion in 2016. It is estimated a moderate influenza pandemic can lead to annual pandemic losses of approximately 2% of Gross National Incomes for the ECOWAS countries and Mauritania<sup>3</sup>. This would mean annual losses ranging between US\$108 million for Mauritania to US\$263 million for Mali for the REDISSE 3 countries.

4. The major drivers of the emergence of novel infectious diseases are population growth and rapid urbanization; land use changes (including deforestation); human behavior and cultural practices; international travel and trade; civil unrest; microbial adaptation and weak public health infrastructure. Urban population densities have dramatically increased due largely to migration from rural to urban areas. The link between deforestation and infectious disease outbreaks is well documented<sup>4</sup>. As per the Food and Agriculture Organization of the United Nations (FAO) data, Western Africa is suffering deforestation at approximately twice the world rate. Civil war and social turmoil have also been common in West Africa. Social instability and its consequent population relocation and breakdown of government services provide fertile ground for the rampant spread of infectious diseases.

5. 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 well-established evidence indicating that climate change is having an impact on infectious disease transmission patterns. Vector-borne diseases are susceptible to changes in temperature, humidity and precipitation; water-borne diseases are correlated with precipitation and flooding; animal migration patterns vary according to climatic conditions affecting water and feed resources; and, human displacement can result in novel disease emergence due to geography or population density. Periods of heavy rainfall (observed in both 1992 and 2016) favor the development of competent mosquito vectors, which drives epidemics in both ruminants and people (E.g. Rift Valley Fever epidemics in Niger). All REDISSE 3 countries are characterized as “hotspots” for climate-sensitive health impacts, meaning they occur in climate-vulnerable geographic regions, have vulnerable populations, and have pre-existing burdens of infectious diseases that are likely to increase with climate change<sup>5,6</sup>.

6. The REDISSE Program has systematically engaged the technical expertise of institutions and individual experts from across sectors. The REDISSE Program has also been supporting the establishment of coordinating mechanisms, such as a regional and national OH platforms and a Monitoring and Evaluation Reference Group for disease surveillance and response systems.

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<sup>3</sup> World Bank. 2017. From panic and neglect to investing in health security: financing pandemic preparedness at a national level. Washington, D.C.: World Bank Group.

<http://documents.worldbank.org/curated/en/979591495652724770/From-panic-and-neglect-to-investing-in-health-security-financing-pandemic-preparedness-at-a-national-level>.

<sup>4</sup> Olivero, Jesús, et al. "Recent loss of closed forests is associated with Ebola virus disease outbreaks." *Scientific Reports* 7 (2017): 14291.

<sup>5</sup> Geographic Hotspots for World Bank Action on Climate Change and Health (2017); Climate-Smart Healthcare - Low-Carbon and Resilience Strategies for the Health Sector (2017); Climate Change and Health - Approach and Action Plan (2017)

<sup>6</sup> WHO (2015) Climate Change and Human Health - Risk and Responses.



7. The Program is developed jointly by the Bank's Health, Nutrition and Population (GHNDR) and Agriculture (GFADR) Global Practices. The Program will contribute to the region's progress in meeting obligations under the IHR 2005, the Integrated Disease Surveillance and Response strategy (IDSR), and the World Organization for Animal Health (OIE) international standards. The Program is also in line with the Global Health Security Agenda (GHSa) objectives and is structured to contribute to four of the key action packages defined in the GHSa strategy: surveillance and reporting; laboratory capacity; health workforce; and, epidemic preparedness and response. As with REDISSE 1 and 2, this project will support the countries to establish a coordinated approach to detecting and swiftly responding to regional public health threats.

8. The preparation of REDISSE 3 is based on the experience and lessons learned during the preparation and early implementation of the first two projects in the series, and are summarized in Section II C. and in Annex I, Detailed Project Description.

## Sectoral and Institutional Context

### **Human Health**

9. 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, absence of community participation, and lack of transparency and accountability. 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.

10. Joint External Evaluation (JEE) of several countries in the West African region as well as country-led self-assessments reveal key weaknesses in health systems in terms of infectious disease and antimicrobial resistance (AMR) surveillance, epidemic preparedness and response. These include a lack of the following: (i) fit for purpose health workforce for disease surveillance, preparedness and response at each level of the health pyramid; (ii) functional community level surveillance and response structures; (iii) sufficient availability of laboratory infrastructure for timely and quality diagnosis of epidemic-prone diseases; (iv) interoperability of different information systems; (v) adequate infection prevention and control standards, infrastructure and practices; (vi) efficient management of the supply chain system; and (vii) regional surge capacity for outbreak response, stockpiling of essential goods, information sharing and collaboration.

11. Although the countries included in REDISSE 3 vary in their health indicators and population size (see Annex 1), all four countries have poor public health outcomes and are at risk for epidemics. Some REDISSE 3 countries are experiencing improvement in certain health indicators such as Diphtheria Tetanus Toxoid Pertussis (DTP3) immunization coverage (for example, Benin has an immunization coverage of 79% as indicated by DTP3 coverage among 1 year old)<sup>7</sup>. However, improvements of other health indicators remain a challenge. All REDISSE 3 countries have high infant mortality rates (ranging between 51 per 1000 live births in Niger to 74.5 per 1000 live births in Mali), high under-five mortality rates (ranging between 84.7 deaths per 1000 live births in Mauritania to 114.7 deaths per 1000 live births in Mali). Across all REDISSE 3 countries, children suffer from both chronic and acute malnutrition with high prevalence of

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<sup>7</sup> WHO Global Health Observatory Data <http://apps.who.int/gho/data/?theme=main>



stunting (as high as 43% in Niger) and wasting in children under five years old.

12. Infectious diseases burdens are high in the REDISSE 3 countries. Mortality and morbidity in all four REDISSE 3 countries is dominated by many endemic and epidemic communicable diseases (including malaria, Acute Respiratory Illness (ARI), diarrheal diseases, malnutrition, cholera, meningitis, HIV/AIDS, tuberculosis). All four countries fall in the African Meningitis Belt and have reported outbreaks/epidemics of major infectious diseases, including Yellow Fever, Rift Valley Fever (RVF), Crimean-Congo Hemorrhagic Fever (CCHF) and Lassa Fever. More details are shared in Annex I in the Table on Human Health Diseases in REDISSE 3 countries.

13. Globally, there is an increasing concern over antimicrobial resistance (AMR).<sup>8</sup> Sub-Saharan African countries, including the REDISSE countries, are highly vulnerable<sup>9</sup> to AMR related diseases due to significant gaps in disease surveillance systems, and human resource capacities to deal with infectious diseases, especially drug-resistant or AMR infections. In fact, a high level of drug resistance exists to commonly prescribed antibiotics on the African continent<sup>10</sup>.

14. The adverse effects of diseases are further exacerbated by lack of education, gender disparities, ineffective communication and poor availability of quality health services. Moreover, REDISSE 3 have porous borders, large populations, high mobility of people, animals and goods and rapid urbanization which present major challenges in terms of epidemiological surveillance and health security. Typically, these systems also suffer from insufficient appropriations, insufficient human resource capacity and low community involvement.

### Animal Health

15. The animal health sector of countries in the ECOWAS region is characterized by a high incidence and prevalence of infectious communicable diseases, impacting veterinary and public health, trade, rural development and livelihoods. A 2013 summary of evaluations of Veterinary Services by the OIE in the ECOWAS countries highlighted the lack of budgetary resources and human resources for preventing and controlling animal diseases. In terms of the strategic action required to sustain animal health, the four countries have identified the need to improve the coverage of their surveillance programs for control of high-priority animal diseases<sup>11</sup>. 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 (HPAI) in the region.

16. Improvement of animal health requires increased and sustained investments in national veterinary services to meet OIE international standards of quality. Any country failing to prevent, detect, and control infectious diseases places other countries at risk, hence the importance of regional approaches. All countries in the sub-region have engaged in the OIE Performance of Veterinary Services (PVS) Pathway, which

<sup>8</sup> Adeyi, Olusoji O.; Baris, Enis; Jonas, Olga B.; Irwin, Alec; Berthe, Franck Cesar Jean; Le Gall, Francois G.; Marquez, Patricio V.; Nikolic, Irina Aleksandra; Plante, Caroline Aurelie; Schneidman, Miriam; Shriber, Donald Edward; Thiebaud, Alessia. 2017. final report. Washington, D.C.: World Bank Group. <http://documents.worldbank.org/curated/en/323311493396993758/final-report>.

<sup>9</sup> Leopold SJ, van Leth F, Tarekegn H, Schultsz C. Antimicrobial drug resistance among clinically relevant bacterial isolates in sub-Saharan Africa: a systematic review. *J Antimicrob Chemother.* 2014;69(9):2337–53.

<sup>10</sup> Antimicrobial resistance in Africa: a systematic review,

<sup>11</sup> OIE (2013). Feasibility study for a program to improve veterinary governance and the control of priority transboundary animal diseases in West Africa



provides independent qualitative and quantitative summaries of veterinary services, identifying their strengths and weaknesses, prioritizing interventions and costing activities needed to address deficiencies<sup>12</sup>. A Table in Annex I provides details on REDISSE 3 countries and Animal Health Diseases.

17. REDISSE 3 countries are major producers of livestock.<sup>13</sup> The majority of REDISSE 3 labor force (ranging from 50% in Mauritania to 90% in Niger), depends on agriculture for its livelihood<sup>14</sup>. Consequentially, there is an increased likelihood of interactions between wildlife, domesticated animals, and humans. Increased interactions between humans and animals can expose humans to sylvatic cycles of pathogen transmission; and livestock can become intermediate or amplifying hosts for pathogens that may infect humans or spill over into humans<sup>15</sup>. The abuse of antimicrobials for prophylactic purposes, and the use of substandard veterinary medicinal products make livestock a driver of AMR<sup>16</sup>. Given that most of the REDISSE 3 countries rely heavily on livestock; infectious diseases can lead to high economic costs: by affecting livestock production and reducing market access. Aftermath of outbreaks in animal can often result in food insecurity and financial catastrophe for vulnerable populations. The importance of animal movements, porous borders, and trade in the region further increases the risk of disease occurrence and disease spread. Consequentially, there is not only higher risk of disease (both in animals and humans) but also higher risk of loss of livelihood, nutritional insecurity and poverty due to animal disease outbreaks. In the last few years, multiple countries in REDISSE 3 have experienced outbreaks of HPAI. (See Annex 1 for further details.)

18. Insufficient government funding and limited interest from donors to support VS have constrained progress in addressing systemic issues. However, some important programs are worth noting in the animal health sector, such as USAID's multi-country Emerging Pandemic Threats (EPT-2) program which is implemented in many 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 sub-region. The lessons and best practices derived from these two programs are reflected in this Program. The Regional Network of National Epidemic Surveillance 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 to ECOWAS in 2012. OIE has a network of national focal points for laboratories and for veterinary medicinal products.

19. ECOWAS and the West African Economic and Monetary Union (WAEMU) have set a target of

<sup>12</sup> All four countries have completed PVS pathway evaluations while Benin, Mali and Mauritania have also had JEEs (Niger has not but a JEE is in process).

<sup>13</sup> FaoStat 2014 <http://www.fao.org/faostat/en/#data/QA>

<sup>14</sup> CIA Factbook, 2013 <https://www.cia.gov/library/publications/the-world-factbook/fields/2095.html#uv>

<sup>15</sup> Narrod C, Zinsstag J, Tiongco M. A OH Framework for Estimating the Economic Costs of Zoonotic Diseases on Society. *Ecohealth*. 2012;9(2):150-162. doi:10.1007/s10393-012-0747-9.

<sup>16</sup> Richardson J, Lockhart C, Pongolini S, Karesh WB, Baylis M, Goldberg T, Slingenbergh J, Gale P, Venturini T, Catchpole M, de Balogh K, Pautasso M, Broglia A, Berthe F, Schans J and Poppy G, 2016. Special issue: drivers for emerging issues in animal and plant health. *EFSA Journal* 2016;14(S1):s0512, 11 pp.

doi:10.2903/j.efsa.2016.s0512



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 Regional Animal Health Center (RAHC) the ECOWAS specialized technical center for animal health. An operational plan for RAHC was developed in August 2014. The RAHC is currently supported through a limited number of initiatives with specific objectives, including to further develop the OH agenda in the sub-region, and to develop Integrated Regional Coordination Mechanisms for the control of transboundary animal diseases (TADs) and Zoonoses (IRCM). The Bank's Regional Sahel Pastoral Support project (PRAPS), which supports the improvement of animal health in six West African Sahel countries, the European Union and OIE project for "Capacity building and surveillance for Ebola Virus Disease (EVD)" (EBO-SURSY project) and REDISSE 3 specifically aim to contribute to the operationalization of the RAHC.

### **One Health**

20. Tackling multisectoral issues efficiently requires working across sectors and disciplines. Yet, except for those already engaged in REDISSE 1 and 2, very few countries have adopted coordinated approaches, along the lines of the OH concept. In addition, animal and human health disease surveillance systems across the ECOWAS region and Mauritania have experienced major setbacks due to general funding shortfalls that have had a severe impact on both animal health and human health care delivery systems. 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, multidiscipline approach to disease surveillance and response.

### **Partner Coordination**

21. The Development Partner landscape for disease surveillance and response for both human and zoonotic diseases in the sub-region is complex. The World Bank Group is well positioned to promote regional and global propositions that address the fundamental weaknesses of health systems and their interoperability. Project preparation financing has been mobilized from the Bill and Melinda Gates Foundation, co-financing from the Government of Canada's 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 OH Platform and a Monitoring and Evaluation Reference Group for disease surveillance and response systems (See Section IV Implementation, D. Role of Partners, for more information).

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

### Development Objective(s) (From PAD)

22. The PDOs, key results and indicators under REDISSE remain the same across the SOPs. As adopted under REDISSE 1 and 2, the PDOs of REDISSE 3 are: (i) to strengthen national and regional cross-sectoral capacity for collaborative disease surveillance and epidemic preparedness in West Africa; and (ii) in the event of an Eligible Emergency, to provide immediate and effective response to said Eligible Emergency.





## Key Results

23. The proposed Program will contribute to: (i) develop national and regional capacity to fully implement the IHR through the 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:

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

- a. Progress in establishing indicator and event-based surveillance systems: number of countries that achieve a JEE score of 4 or higher out of 5;
- b. 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;
- c. 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;
- d. 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;
- e. Progress towards establishing an active, functional regional OH Platform (Number based on 5 point Likert scale).
- f. Indicators (a) through (d) are based on JEE monitoring progress for the implementation of the WHO IHR (2005)<sup>17</sup>, as well as OIE PVS assessments. Indicators (e) and (f) are based on self-assessment by the region and individual countries.

## D. Project Description

### A. Project Components

25. An extensive and in-depth consultative process forms the basis for the overall REDISSE Program. REDISSE 3 will enhance the capacities of the human and veterinary public health systems of Benin, Mali,

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<sup>17</sup> 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://www.who.int/ihr/publications/WHO\\_HSE\\_GCR\\_2016\\_2/en/](http://www.who.int/ihr/publications/WHO_HSE_GCR_2016_2/en/)). 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/>).



Mauritania and Niger and via a collaborative regional approach that promotes the OH approach and supports the implementation of the IHR and OIE standards. (Annex I provides detailed information on "REDISSE 3 Country Epidemiological Surveillance and Preparedness Capacity".)

26. The REDISSE 3 project will comprise 5 components as follows:

**Component 1: Surveillance and Information Systems (US\$34.9 Million)**

27. This component will support: enhancement of national surveillance and reporting systems and their interoperability at the different tiers of the health systems; cross-border coordination in the surveillance of priority diseases, and 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 will strengthen the linkages of surveillance and response processes: at the local level through citizen and community engagement; sub-national and national levels of the health system; and at the regional level. Linkages along these different levels and steps within an animal health epidemiology and surveillance system shall be analyzed, optimized and formalized.

28. 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.

**Component 2: Strengthening of Laboratory Capacity (US\$22.1 Million)**

29. This component will involve the identification and/or establishment of networks of efficient, high quality, accessible public health and veterinary laboratories (public or private). This component will also support the establishment of a regional networking platform to improve collaboration for laboratory investigation. Adapting some lessons learned from the East Africa Public Health and Laboratory Networking project (EAPHLN) project, the regional laboratory network will contribute towards strengthening the capacities of national veterinary and public health laboratories in the areas of surveillance, pathology, diagnosis of priority infectious disease pathogens and AMR, and insecticide resistance monitoring and mapping. The national laboratory networks in each country will be linked to and supported by the networks of human and animal regional reference laboratories (RRL) being established with support from the Program through the REDISSE 1 project. Human Health RRLs are being developed in five ECOWAS member states: Burkina Faso, Côte d'Ivoire, Ghana, Nigeria and Senegal.

30. The sub-components are: (i) Review, upgrade and network laboratory facilities; (ii) Improve data management and specimen management systems; and (iii) Enhance regional reference laboratory networking functions.

**Component 3: Preparedness and Emergency Response (US\$19.1 Million)**

31. This component will support national/regional efforts to enhance infectious disease outbreak preparedness and response capacity by improving local (community), national and regional capacities to prepare for and respond effectively to animal and human disease outbreaks. Project interventions will provide support to improve country and regional surge capacity to ensure both a rapid response and continuity of essential services during an emergency. This component will seek to better educate/change behavior and prepare communities for outbreaks and emergencies as part of the routine delivery of health services. Joint planning and joint implementation will be pursued. The project will also support enhancing



country health system capacities for management of disaster recovery priorities including the capacity for the integration of community-center emergency care into the broader healthcare system.

32. The sub-components are: (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 12 (Rapid Response to Crisis and Emergencies).

33. 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 Contingency Emergency Response Component (CERC) provides for a request from countries participating in REDISSE to the Bank to support mitigation, response, and recovery in the district(s) affected by such event. REDISSE's CERC component could complement contingency funding, which is often limited. (A table in Annex I presents the differences between REDISSE 3 CERC and other World Bank Group tools for crisis response.)

34. Following the procedures governed by OP/BP 10.00 Rapid Response to Crisis and Emergencies) a CERC Operations Manual (CERC OM) will be prepared by each country as a condition of disbursement. (A CERC OM workshop for all REDISSE countries was held on October 16-18, 2017). Triggers will be clearly outlined in the CERC OM acceptable to the World Bank. Disbursements will be made against an approved list of goods, works, and services required to support crisis mitigation, response and recovery. All expenditures under this activity will be in accordance with paragraph 12 of World Bank OP 10.00 IPF and will be appraised, reviewed, and found to be acceptable to the World Bank before any disbursement is made (Rapid Response to Crisis and Emergencies).

#### **Component 4: Human Resource Management for Effective Disease Surveillance and Epidemic Preparedness (US\$16.4 Million)**

35. This component is cross cutting and aims to strengthen government capacity to plan, implement and monitor human resource interventions. It will provide support to the development of institutional capacity for workforce training by leveraging existing training structures and programs 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 human/veterinarian health needs.

36. This component will support analysis to improve the incentive environment within which public health and veterinary health workers operate. This analysis will consider creating incentives that not only draw those with relevant skills to the public sector, but also improve staff motivation and retention, taking into account gender differences within the health workforce. 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.

37. The sub-components under this component are: (i) Healthcare workforce mapping, planning and



recruitment; and (ii) Enhance health workforce training, motivation and retention.

**Component 5: Institutional Capacity Building, Project Management, Coordination and Advocacy (US\$27.5 Million)**

38. This component 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, EAPHLN, GHSA, and EPT-2 and other discrete activities to foster the harmonization of a functional regional disease surveillance and response network in the ECOWAS region.

39. The sub-components are: (i) project coordination, fiduciary management, monitoring and evaluation, data generation, and knowledge management; and (ii) Institutional support, capacity building, advocacy, and communication at the regional level.

40. For the entire REDISSE Program WAHO will host the regional coordination unit and will be primarily responsible for regional coordination, including cross-border coordination, guided by the decisions of the REDISSE Regional Steering Committee under the political leadership of ECOWAS. WAHO will be responsible for supporting the establishment of national and regional OH coordination platforms for 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.

41. 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 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. Private medical practitioners, veterinarians and veterinary paraprofessionals may be entrusted with official tasks through contractual arrangements. Under similar contractual mechanisms, the project will 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.



*Table 1: Estimated Project Budget Allocations by Component*

Project Components	Budget Allocation (US \$ Million)	% of Total Budget
Component 1: Surveillance and Information Systems	34.9	29.1
Component 2: Strengthening of Laboratory Capacity	22.1	18.4
Component 3: Preparedness and Emergency Response	19.1	15.9
Component 4: Human Resources Management for Effective Disease Surveillance and Epidemic Preparedness	16.4	13.7
Component 5: Institutional Capacity Building, Project Management, Coordination and Advocacy	27.5	22.9
<b>Total</b>	<b>120.0</b>	<b>100.0</b>

*Table 2: Funding by component and sub-component*

Project activities	Benin	Mali	Mauritania	Niger	TOTAL
<b>COMPONENT 1</b>					
Sub-Component 1.1 Support coordinated community-level surveillance systems and processes across the animal and human health sectors	6.4	4.9	2.8	3.7	17.8
Sub-Component 1.2 Develop capacity for interoperable surveillance and reporting systems	2.3	2.7	1.6	3.2	9.8
Sub-Component 1.3 Establish an early warning system for infectious disease trends prediction	1.9	2.4	1.1	1.9	7.3
<b>Sub-total component 1</b>	<b>10.6</b>	<b>10.0</b>	<b>5.5</b>	<b>8.8</b>	<b>34.9</b>



Project activities	Benin	Mali	Mauritania	Niger	TOTAL
<b>COMPONENT 2</b>					
Sub-Component 2.1 Review, upgrade and network laboratory facilities	3.8	2.3	2.8	2.4	11.3
Sub-Component 2.2 Improve data management and specimen management systems	0.6	2.3	0.4	3.4	6.7
Sub-Component 2.3 Enhance regional reference laboratory networking functions	1.0	1.4	0.3	1.4	4.1
<b>Sub-total component 2</b>	<b>5.4</b>	<b>6.0</b>	<b>3.5</b>	<b>7.2</b>	<b>22.1</b>

Project activities	Benin	Mali	Mauritania	Niger	TOTAL
<b>COMPONENT 3</b>					
Sub-Component 3.1 Enhance cross-sectoral coordination and collaboration for preparedness and response	0.8	2.8	0.9	5.5	10
Sub-Component 3.2 Strengthen capacity for emergency response	2.8	3.2	1.6	1.5	9.1
Sub-Component 3.3 Contingency emergency response	0.0	0.0	0.0	0.0	0.0
<b>Sub-total component 3</b>	<b>3.6</b>	<b>6.0</b>	<b>2.5</b>	<b>7.0</b>	<b>19.1</b>

Project activities	Benin	Mali	Mauritania	Niger	TOTAL
<b>COMPONENT 4</b>					
Sub-Component 4.1 Healthcare workforce mapping, planning and recruitment.	3.1	2.0	0.5	3.7	9.3
Sub-Component 4.2 Enhance health workforce training, motivation and retention	0.2	1.5	3.4	2.0	7.1
<b>Sub-total component 4</b>	<b>3.3</b>	<b>3.5</b>	<b>3.9</b>	<b>5.7</b>	<b>16.4</b>



Project activities	Benin	Mali	Mauritania	Niger	TOTAL
<b>COMPONENT 5</b>					
Sub-component 5.1 Project coordination, fiduciary management, monitoring and evaluation, data generation, and knowledge management	7.1	4.5	4.6	11.3	27.5
Sub-component 5.2 Institutional support, capacity building, advocacy, and communication	0.0	0.0	0.0	0.0	0.0
<b>Sub-total of component 5</b>	<b>7.1</b>	<b>4.5</b>	<b>4.6</b>	<b>11.3</b>	<b>27.5</b>

## B. Project Cost and Financing

42. The tentative project financing in the amount of US\$116 million is considered a third project investment under the SOP approach of the Program. Project financing will be mobilized via contributions from individual country allocation of International Development Association (IDA) funds and a regional integration matching fund mechanism (1:2 IDA - RI match fund for Benin and Mali; and 1:1 IDA - RI match fund for Mauritania and Niger) (Table 3). Co-financing will also be mobilized through a multi-donor trust fund (MDTF) associated with the REDISSE Program. Current commitments under the MDTF total CAD 20 million for Bank executed and recipient (WAHO) executed activities.

*Table 3: Breakdown of Project Financing*

Country / Regional Institution	Country IDA (\$ Million)	Regional IDA (\$ Million)	Total (\$ Million)
Benin	10.0	20.0	30.0
Mali	10.0	20.0	30.0
Mauritania	10.0	10.0	20.0
Niger	20.0	20.0	40.0
<b>TOTAL</b>	<b>50.0</b>	<b>70.0</b>	<b>120.0</b>

## E. Implementation

### Institutional and Implementation Arrangements

43. Project implementation will be coordinated by WAHO. WAHO has taken steps to strengthen its procurement and financial management, M & E, communications, social and environmental safeguards and project management competencies. It will continue to do so with support provided under REDISSE 1 and 2. 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 Benin, activities will be managed out of the office of the President, National Council to fight AIDS, TB, Malaria and other epidemics. In Mali and Niger 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 Mauritania, country level activities will be led and coordinated by the Ministry of Livestock.

44. Regional level activities, including cross-border coordination efforts planned under REDISSE 3 will be coordinated by WAHO. WAHO will also ensure that the RAHC is supported (including through the contracting of support staff and contributions to operating costs) in performing regional animal health-related functions based on a memorandum of understanding. In addition, a contract was signed between WAHO and the OIE for specific activities related to its core mandate (e.g. PVS pathway-related activities, reference labs/collaborating centers, twinning arrangements, national focal points trainings). Under this contract, the OIE will also contribute to strengthening RAHC's capacity to perform its activities in accordance with WB rules and procedures.

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

**Benin:**

46. A multisectoral steering committee of the Global Health Security Agenda will be created, including the Ministry of Health (MOH) and Ministry of Agriculture and Livestock (MOA/L); the Ministry in Charge of environment (MOE), one representative of the Mayors, 2 representatives of Civil society. It will be chaired by the Head of the National Council to Combat HIV/AIDS, Tuberculosis, Malaria and Epidemics (CNLS-TP) assisted by a technical committee. It will oversee annual project planning, monitor project progress, and approve annual reports. Project implementation will be the responsibility of a Project Coordination Unit (PCU), which is under the aegis of the CNLS-TP. The new PCU will be headed by a Project Coordinator and staffed with qualified procurement, financial, M&E, and safeguard specialists. Further, the Benin PCU will recruit environmental and social safeguards specialists to work closely with the regional WAHO safeguards specialist. A sub-regional entity addressing the Abidjan-Lagos corridor will be looked to for cross-border aspects, while appropriate institutions will assist in the development of the One health approach.

**Mali:**

47. A multisectoral national committee for One Health will be created through the Office of the Prime Minister, chaired by the Minister of Health and Social Welfare (MOHSW), the ministry responsible for overall project implementation. The committee will include the ministries of livestock, economy and finance, education, agriculture, security, environment and sustainable development, communications, and representatives from local, regional and global partners. The committee will review annual workplans and budgets, monitor project progress and approve annual project reports, meeting at least twice annually. The existing PCU established for the World Bank-funded Malaria/NTD project within the MOHSW, will manage the project. The PCU is headed by a Program Coordinator. The project will hire qualified staff to strengthen the PCU, namely: a project coordinator, financial, accountant, procurement, M&E, communications, and safeguards specialists. Health centers and health personnel, community health workers, veterinarian staff, as well as community agricultural workers, and the private sector will be involved in project execution. Existing multisectoral/multidisciplinary cadres functioning at community and district levels will share information/best practices in dealing with endemics and catastrophic events. Further, the Mali PCU will recruit environmental and social safeguards specialists to work closely with the





regional WAHO safeguards specialist.

**Mauritania:**

48. A multi-sectoral national committee of the Global Health Security Agenda (GHSA), chaired by the Prime Minister will include representatives of the ministries of livestock, health, economy and finance, education, environment and sustainable development, communications and local, regional, and global partners. Additionally, the project will benefit from a technical committee comprised of representatives of the relevant sectors, and regional and departmental units of the national Epidemic Monitoring Commission. The national steering committee will oversee project annual planning and budgeting, monitor project progress and approve annual project reports, meeting at least twice annually. An existing Project Coordination Unit (PCU) in the Ministry of Livestock will be responsible for the overall project implementation. The PCU will be headed by a Project Coordinator supported with qualified staff including financial, auditing, procurement and M&E. Further, the Mauritania PCU will recruit environmental and social safeguards specialists to work closely with the regional WAHO safeguards specialist.

**Niger:**

49. A multisectoral national steering committee of the Global Health Security Agenda “One Health”, will be chaired by the Prime Minister. The Ministry of Health is responsible for overall project implementation. The project will be monitored by a National Steering committee, which will be established by the MOH, and will include all sectors involved in the implementation of the project and specifically the members of the Joint Epidemics Surveillance Steering Committee established in the country. Specifically, the committee will include representatives of the ministries of plan, agriculture and livestock, environment and sustainable development, communications as well as local, regional and global partners. The technical coordination of the project will be led by the head of the Directorate of Epidemic Surveillance and Response (DSRE). The National steering committee will oversee project annual planning and budgeting, monitor project progress, and approve annual reports, meeting at least twice annually. An existing PCU within the MOH will be headed by a Project Coordinator who will be supported by a qualified staff including financial, procurement, M&E, and safeguard specialists. (This arrangement is the same as for the WBG funded Sahel Malaria and NTD Project (P149526) and the Population and Health support project (P147638)). Further, the Niger PCU will recruit environmental and social safeguards specialists to work closely with the regional WAHO safeguards specialist.

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

This project is the third part/financing of the regional REDISSE Program, which, as mentioned in Section B1 above, is an interdependent series of projects. This third project in the series (REDISSE III) is extending the program to four (04) others western African countries, namely Benin, Mali, Mauritania and Niger. Activities with a physical footprint include upgrading of laboratory networking facilities, strengthening capacities to prepare for impending epidemics in humans and animals and to respond effectively to disease outbreak threats, surveillance, AMR and insecticides resistance monitoring and mapping. While some of these project activities have low to moderate environmental and social risks, the project will also strengthen the capacity of the above mentioned client governments to successfully manage environmental and social risks and impacts in the event of an infectious disease outbreak occurs among human and/or animal populations. The



physical locations and specific details of the proposed project interventions in the proposed four (04) countries are not known yet and will not be known by project appraisal.

**G. Environmental and Social Safeguards Specialists on the Team**

- Nicolas Kotschoubey, Environmental Safeguards Specialist
- Africa Eshogba Olojoba, Environmental Safeguards Specialist
- Emeran Serge M. Menang Evouna, Environmental Safeguards Specialist
- Bougadare Kone, Environmental Safeguards Specialist
- Joselyne Lisbeth Sena Godonou, Environmental Safeguards Specialist
- Mahamadou Ahmadou Maiga, Social Safeguards Specialist
- Mame Safietou Djamil Gueye, Social Safeguards Specialist

**SAFEGUARD POLICIES THAT MIGHT APPLY**

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The project triggers Safeguards Policy OP/BP 4.01 (Environmental Assessment) and is classified as category B project given the potential negative environmental and social impacts and risks associated with the construction of laboratory structures, and medical waste from the national veterinary and public health laboratories as well as public health institutes. These could include soil degradation due to civil works, nuisance caused by dust and noise from construction activities, risks of injury, increased prevalence of HIV/AIDS and other STDs due to workers potentially coming from other cities/villages, risks associated with the increased generation of infectious waste. Since the exact nature, scope and physical footprint of the proposed project activities' locations are not known, each participating countries prepared an Environmental and Social Management Framework and a Hazardous Waste Management Plan (HWMP). These were consulted upon and disclosed in-country and at the Bank website prior to appraisal.
Natural Habitats OP/BP 4.04	No	The policy is not triggered as the project will not affect natural habitats.



Forests OP/BP 4.36	No	The policy is not triggered as the project activities are not expected to overlap or cause adverse impacts on forests or forestry activities.
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 and negative impacts on human health and/or the environment. These could include aspects related to misuse and/or over-use of chemicals due to lack of sufficient knowledge or awareness; insufficient availability and use of Personal Protective Equipment (PPE); unsafe and indiscriminate disposal of pesticide containers which can be recycled and reused without proper disinfection; haphazard disposal of chemicals resulting in pollution of land, living environment (air) and soil, etc. To manage these potential risks, and negative impacts all client countries prepared an Integrated Vector and Pesticide Management Plan (IVPMP) updated from the one in REDISSE II. The IVPMP was consulted upon and publicly disclosed both in-country and at the Bank website prior to appraisal.
Physical Cultural Resources OP/BP 4.11	No	The scale and scope and location of subprojects makes it an unlikely possibility of chance finds of physical cultural resources in the identified project areas.
Indigenous Peoples OP/BP 4.10	No	There are no Indigenous Peoples in the project areas, as defined by OP/BP 4.10.
Involuntary Resettlement OP/BP 4.12	No	The project activities will not involve land acquisition leading to the economic or physical displacement of project-affected people.
Safety of Dams OP/BP 4.37	No	The project interventions is not expected to require the construction of dams or impoundment structures, nor is it expected that they could cause impacts to existing structures as governed by this policy.
Projects on International Waterways OP/BP 7.50	No	The project interventions are not expected to cause any drainage or discharges to surface waters, nor entail any significant usage of surface water that would affect international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The project interventions 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 are not anticipating any potential large scale, significant impacts as most of the activities will focus on rehabilitation in the targeted locations that will be defined. The management of hazardous waste remains the key safeguard issue that will need particular attention. Specific EHS measures will also be taken to avoid any lethal incident during the rehabilitation activities. Land acquisition is expected.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

The project is not anticipating long term impacts due to anticipated future activities in the project area, nevertheless, the team will ensure regular environmental and social supervision and relevant mitigation measures will be taken in the case of such unexpected or indirect impact.

In addition, gender considerations will be an integral aspect of the project activities as a substantial portion of the health workforce front lines are nurses, health assistants, and community workers, the majority of whom are women. The risks of contagion for these workers are significant. Further, with respect to potential threats of infectious diseases, these present different risks for the girls, women of child bearing age, pregnant women, and mothers.

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

Not relevant.

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.

As the detailed activities and locations were unknown during the project preparation, the four countries ( Benin, Mali, Mauritania and Niger) prepared each, an Environmental and Social Management Framework (ESMF); an Hazardous Waste Management Plan (HWMP) and, an Integrated Vector and Pesticide Management Plan (IVPMP). The documents were prepared using participatory approach. The instruments were disclosed in country and at the Bank website. These instruments will guide the project environmental and social safeguards compliance during the implementation.

Institutional arrangement for safeguards implementation: At the regional level WAHO has existing environmental and social staff that will support the adherence to safeguards requirements across the participating counties. They will coordinate and liaise with the full time participating countries environmental safeguards specialists and social development specialists that will be recruited in each country. relevant environmental and social safeguards training will be provided at the regional and the national level. The project will provide an opportunity of information and experience exchange.

Integration of environmental and social measures in the Project Implementing Manual ( PIM). It was agreed that specific guidelines related to environmental and social safeguards compliance will be fully incorporated in the PIM.

Citizen engagement will be supported by communication activities to inform and sensitize stakeholders on issues of the REDISSE project. This consultation should be deepened with all stakeholders, including at the national, local, and



community levels (e.g., medical institutions, professional associations, civil society, NGOs, youth and women's groups). Citizen engagement will be used to mainstream particularly into feedback of the population on the REDISSE project. The indicator on Citizen engagement is "Citizens and/or communities involved in planning/implementation/evaluation of development program. Citizen engagement is further enhanced through the formal representation of civil society in the Project Steering Committees at national and regional levels. Steering committees are charged with the review and approval of the annual work plan and budget and the annual progress reports pertaining to the project.

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

During the safeguards preparation process, the key stakeholders were identified and were grouped in four main categories in participating countries. The key are the following:

Public administrations: These include among other the ministries in charge of Public Health; Livestock; Environment;

NGOs: these include local and international NGOs involved in Health sector;

Local authorities: These include mayors and decentralized traditional authorities;

Local communities: these include mainly the community-based organizations.

In each participating country, a consultant plan will be prepared and implemented. The periodic report of the project implementation will include a section on stakeholders consultation.

**B. Disclosure Requirements**

**Environmental Assessment/Audit/Management Plan/Other**

Date of receipt by the Bank  08-Mar-2018	Date of submission for disclosure  08-Mar-2018	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
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**"In country" Disclosure**

Benin

08-Mar-2018

Comments

Hazardous Waste Management Plan for Benin has been disclosed at the same time

Mali

08-Mar-2018

Comments

Hazardous Waste Management Plan for Mali has been disclosed at the same time

Mauritania

07-Mar-2018

Comments



Hazardous Waste Management Plan for Mauritania has been disclosed at the same time

Niger

08-Mar-2018

Comments

Hazardous Waste Management Plan for Niger has been disclosed at the same time

**Pest Management Plan**

Was the document disclosed prior to appraisal?

Yes

Date of receipt by the Bank

08-Mar-2018

Date of submission for disclosure

08-Mar-2018

**"In country" Disclosure**

Benin

08-Mar-2018

Comments

Mali

08-Mar-2018

Comments

Mauritania

07-Mar-2018

Comments

Niger

08-Mar-2018

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)**

**OP/BP/GP 4.01 - Environment Assessment**

Does the project require a stand-alone EA (including EMP) report?

No

**OP 4.09 - Pest Management**

Does the EA adequately address the pest management issues?

Yes

Is a separate PMP required?

No

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?

**The World Bank Policy on Disclosure of Information**

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

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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Task Team Leader(s):	John Paul Clark Francois G. Le Gall Patricia Geli
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**Approved By**

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Country Director:	Rachid Benmessaoud	27-Mar-2018

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