Report Number: ICRR0022793

1. Project Data

Project ID	Project Name
P149526	Sahel Malaria and NTDs Project
Country	**Practice Area(Lead)**
Western Africa	Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-56670,IDA-56680,IDA-56690,IDA-D0710	31-Dec-2019	111,846,599.22
Bank Approval Date	**Closing Date (Actual)**	
11-Jun-2015	31-Mar-2021	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	121,000,000.00	0.00
Revised Commitment	111,310,462.62	0.00
Actual	111,846,599.22	0.00

Prepared by	Reviewed by	ICR Review Coordinator	Group
Rocio Manchado Garabito	Judyth L. Twigg	Eduardo Fernandez Maldonado	IEGHC (Unit 2)

2. Project Objectives and Components

a. Objectives

According to the Financing Agreements with the three participating countries, the objective of the project was to increase access to and use of harmonized community-level services for the prevention and treatment of malaria and selected neglected tropical diseases in targeted cross-borders areas in participating countries in the Sahel region.

The statements of objectives in the Project Appraisal Document and ICR were identical to those of the Financing Agreements.

During a project restructuring in 2018, some outcome targets were revised upwards. As the project scope was not reduced, a split rating is not applied.

b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

Did the Board approve the revised objectives/key associated outcome targets?

No

c. Will a split evaluation be undertaken?

No

d. Components

Component 1: Improve regional collaboration for stronger results across participating countries (Appraisal: US$26.5 million; Revised: US$30.7 million; Actual: US$29.9 million). This component was to support countries' efforts to harmonize policies and procedures and engage in joint planning, implementation, knowledge exchange, and evaluation of malaria and Neglected Tropical Diseases (NTDs) service delivery. There were three subcomponents:

- Subcomponent 1.1: Regional coordination: The project was to support: (i) the creation of a Regional Coordinating Committee (RCC) supported by a technical advisory group (TAG) to harmonize technical strategies, implementation, and monitoring across countries; conduct planning of campaigns and cross-border evaluations and identify operational research priorities; and disseminate lessons learned; and (ii) the establishment of local committees to plan the cross-border implementation of interventions and the monitoring and evaluation (M&E) activities of two or more districts from different countries.
- Subcomponent 1.2: Regional research: The project was to support the establishment or strengthening of regional networks for research and M&E to increase the usefulness of the information generated by countries' M&E systems. This was to be done by: (i) short- and long-term training and technical assistance to improve skills and know-how, provided by regional institutions; (ii) establishing and upgrading communication networks and data management systems; (iii) financing research; and (iv) strengthening the existing network of sentinel sites across the three countries.
- Subcomponent 1.3: Regional pooled drug procurement: The project was to support the pooled procurement of Amodiaquine and Sulfadoxine-Pyrimethamine (AQ+SP) for Seasonal Malaria Chemoprevention (SMC) to facilitate timely delivery of the drugs ahead of the malaria high transmission season.

Component 2: Support coordinated implementation of technical strategies and interventions (Appraisal: US$74.1 million; Revised: US$73.7 million; Actual: US$66.6 million). This component was to support countries' efforts to jointly control malaria and NTDs (schistosomiasis, lymphatic filariasis (LF), soil-transmitted helminths (STH), onchocerciasis, and trachoma) through community-based interventions in cross-border areas. The project was to finance: (i) hiring of non-governmental organizations (NGOs) to implement community-level interventions; (ii) information, education, and communication activities (IEC) to ensure demand for and uptake of project interventions and behavior change; (iii) acceleration of the introduction and scaling up SMC, giving children ages 3-59 months in eligible border areas a combination of two affordable drugs (AQ+SP) during the rainy season; and (iv) community-based diagnosis and treatment strategies, scaling up and complementing existing efforts to reach the poorest and more remote communities, which meant the integration of malaria diagnosis and treatment into community-based primary care approaches; (v) integrated treatment of preventive chemotherapy for NTDs, delivered through the community health care system (mass drug administration – MDA); and (vi) the treatment of reversible consequences of NTDs, promoting the mobilization of multi-country teams to provide these services "campaign style" once or twice a year for in-service training of health care providers.

Component 3: Strengthen institutional capacity to coordinate and monitor implementation (Appraisal: US$20.40 million; Revised: US$16.6 million; Actual: US$15.30 million). This component was to support country-level implementing agencies and regional institutions to perform core functions and ensure proper project implementation, monitoring, and evaluation. This was to entail: (i) strengthening project capabilities in implementing agencies (recruiting and training critical technical and operational staff and support operating costs); (ii) training and study tours for critical technical staff in selected NTDs and malaria programs and national and regional institutions such as the West Africa Health Organization (WAHO), *Centrale d'Achats des Médicaments Essentiels Génériques- Burkina Faso* (CAMEG), and other regional research institutions, and funding of equipment and operating costs for malaria and NTD programs; (iii) strengthening routine national health information systems; and (iv) financing for supplemental surveys to monitor project implementation, coverage, and access, and for revision of the national medical waste plans in Mali and Burkina Faso

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

Cost: The estimated cost at appraisal was US$121 million. The total actual cost was US$111.8 million, reflecting US$/SDR exchange rate fluctuations.

Financing: The project was financed by three IDA credits of US$37 million each to Burkina Faso, Mali, and Niger, and a US$10 million grant to the Economic Community of West African States (ECOWAS), bringing the total planned financing to US$121 million. The credits and grant were fully disbursed. There was no planned or actual direct financial contributions from the governments.

Dates: The project was approved on June 11, 2015 and became effective on January 5, 2016. A mid-term review was carried out on December 4, 2017.

- The first Level II restructuring was approved on August 3, 2018. It reviewed the results framework, reallocated funds between expenditure categories and components, and extended the project closing date from December 31, 2019 to December 31, 2020. Credit proceeds were reallocated to fill a gap created by

having underestimated the cost of drugs purchased through CAMEG for SMC, as well as higher-than-expected costs associated with SMC campaigns and treatment of reversible complications of NTDs. Changes to the results framework followed recommendations made at the mid-term review in December 2017. The definitions of some PDO indicators and some outcome target values were revised upwards to better measure outcomes and to reflect progress already made.

- The second Level II restructuring on October 13, 2020. further extended the closing date to March 31, 2021.

- The project closed on March 31, 2021, fifteen months later than the original closing of December 31, 2019.

3. Relevance of Objectives

Rationale

The objectives were responsive to disease conditions in the Sahel region and in the three targeted countries. The Sahel region bore the highest morbidity, disability, and mortality burden associated with malaria and NTDs in Sub-Saharan Africa. Malaria was the primary cause of outpatient consultations, hospitalizations, and hospital deaths in all three countries. Access and quality of health services were inadequate, and there were significant disparities, exacerbated by security concerns that caused many preventive programs to stop their operations. To address this challenge, all three countries adopted and began to roll out policies that allowed community health workers (CHWs) to diagnose malaria with rapid diagnostic tests and treat confirmed cases. The project aimed to accelerate the scale-up of disease control interventions to reach at-risk populations living in border areas with poor access to facility-based health services.

A regional and cross-border focus was justified, as malaria is not limited to or affected by national borders, and the countries are contiguous with shared and porous borders. The prevalence of malaria and NTDs was higher in cross-border areas because of lower access to prevention and treatment services. Limited disease control in one country may impact a more effective program in another country. The PAD (p. 7) stated that the total population at risk of malaria living in areas amenable to Seasonal Malaria Chemoprevention or SMC was 40.1 million people, including 7.8 million children under the age of 5 years. The project targeted a total of 56 border districts: 20 districts in Burkina Faso, 19 districts in Mali, and 17 districts in Niger.

Objectives were in full alignment with national plans and regional initiatives. For Malaria**,** ECOWAS Regional Strategy for controlling and eliminating malaria for 2014-2020 included technical guidance from the World Health Organization (WHO), and emphasized the intensification of cross-border cooperation, coordinating inter-country efforts, mobilizing resources to increase efficiency, and strengthening member countries' national response capacity and performance to control malaria. A Regional Action Plan for Malaria Control in West Africa supported this strategy. Each of the three countries had National Malaria Control Programs that developed strategic plans consistent with the ECOWAS Regional Strategy. For NTDs, WHO/AFRO developed a Regional Strategy and a Plan for 2014-2020 based on WHO's Global Plan

to Combat NTDs. The above strategies served as a framework for developing national plans to control and eliminate NTDs in Burkina Faso, Mali, and Niger.

At project closing, the current WBG Regional Integration and Cooperation Assistance Strategy for Supporting Africa's Transformation, FY18-FY23, included support to the prevention and setting-up of innovative financing of *potential* regional epidemic outbreaks and cross-border natural disasters, with a focus on surveillance and piloting innovative financing arrangements.

Similarly, at project closing, development objectives had elements of alignment with the current Country Partnership Frameworks in the three countries, but, overall, alignment was not full, as project objectives were not sufficiently reflective of the main thrusts of the *proposed* Bank engagements in health and human development, beyond existing engagement:

In Burkina Faso CPF (FY18-23), Focus Area 2 on investing in human capital and social protection system included objectives to support inclusive, high-quality education and skills development; expand access to reproductive and child health services and improved nutrition; expand social protection to the most vulnerable; and expand access to water and sanitation services.

In Niger CPF (FY18-22), Focus Area II on improved human capital and social protection explained the issues to be addressed and noted that the WBG program in this area is built around three main avenues: health services, education and social protection, including a focus on forced displacement. In health, the CPF aims at bringing demographic growth rates down to sustainable levels, improve maternal health and nutrition, and empower women and girls. Objective 3 on increasing access to quality health services was associated with SDG3 to ensure healthy lives and promote well-being for all, at all ages; and with SDG4 to ensure inclusive and equitable quality education and promote life-long learning opportunities for all. Objective 4 pertained to increasing access to quality education and training services, particularly for women; and Objective 5 pertained to improving social protection system and ability to manage forced displacement.

In Mali, a new CPF is being prepared, and the CPF (FY16-19) proposed orientations for WBG engagement in three areas of focus: (i) improve governance by strengthening public resource management at central and local levels and fostering citizen engagement; (ii) create economic opportunities by enhancing the productive capacity of smallholders, increasing agricultural value added and diversification to catalyze transformation, and improving basic services by developing infrastructure and connectivity; and (iii) build resilience, by developing human capital, strengthening safety nets, improving risk management mechanisms for the poor and vulnerable and mitigating climate shock.

In conclusion, based on the proposed Bank engagements under the current CPFs and upon balancing country and regional considerations, this ICR Review concluded that there was almost full alignment between project objectives and country CPFs and regional initiatives at project closing.

Rating

Substantial

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Increase access to and use of harmonized community-level services for the prevention and treatment of malaria and selected neglected tropical diseases in targeted cross-border areas in participating countries in the Sahel region.

Rationale

Theory of change

The theory of change assumed that promoting collective actions to coordinate activity implementation among the three participating countries would improve their ability to reach targeted populations. At the national level, project implementation would be strengthened by supporting national stakeholders to participate in planning and execution of activities starting at the district level, prepare and validate regional plans, and support implementation and monitoring of SMC and NTD activities. This would be supported through community-based interventions that would contribute to improving the quality and efficiency of community health delivery platforms. Strengthening of regular health services in remote communities in border areas would increase access to harmonized community-level services (coordinated and synchronized by the three countries) to prevent and treat malaria and selected NTDs. The distribution of drugs to remote border areas, community mobilization, IEC campaigns, and training of stakeholders would be expected to scale up community-based services for SMC and NTDs, raising awareness, and keeping the population informed on prevention and treatment. The above actions would enable CHWs to provide routine services, undertake targeted health campaigns, and provide malaria and NTD preventive treatments. The result would be increased demand for preventive and treatment services, promoting behavioral change to increase the use of community-level services.

Outputs

- The project funded regional meetings to establish the RCC and TAG. The three countries validated their national action plans, synchronized annual campaigns, and planned activities through regional meetings. Country teams created a collaboration framework that did not exist before, allowing them to overcome obstacles and share knowledge and best practices.
- In each country, officials of the ministries of health met with key actors to engage in micro-planning. The process was carried out in various workshops that included health districts representation, and integrated the needs and priorities of the most remote communities and their health centers. Cross-border planning and implementation committees were established.
- Annual Work Programs and Budgets for SMC campaigns were established and validated at the local level. This approach facilitated community planning and contributed to building trust.
- The three countries carried out four IEC campaigns each year between 2016 and 2020, except for 2020 when only three took place. The project financed IEC activities, technical assistance, and training of community health workers and parent/teacher associations. Activities aimed at sensitizing the population and improving service utilization of services by building awareness about malaria and NTDs.

- The interventions supported each country's specific priority areas and reinforced national efforts regarding mass distribution of drugs, surgery camps, and strengthened physical and human resource capacity. For instance, the project helped upgrade countries' technical and medical capacity at the health district level through specialized training for medical staff. Also, it supported the strengthening of community-level services by training, hiring, and supervising CHWs.
- The project supported the acquisition of equipment (vehicles, hardware, and software), furniture, medical equipment, laboratory equipment, surveillance kits and equipment, and health and sanitation supplies.
- The project carried out operational research on malaria and NTDs, mainly in Mali and Burkina Faso, in collaboration with the following institutions: Institut de Recherche en Sciences de la Santé in Burkina Faso, the Malaria Research and Training Center based at the University of Science Techniques and Technologies in Mali, and L'Institut National de Santé Publique in Mali.

Intermediate Outcomes

- The three participating countries and the regional coordination unit provided their procurement plans on time to the regional purchasing agency for the duration of the project.
- The three countries revised and elaborated new standards and guidelines for recruiting and retaining CHWs and for drug distribution.
- In 100% of targeted districts, local leaders participated in the planning of campaigns, exceeding the target of 75%.
- The percentage of community health agents who received a quarterly supervision visit during which registers or reports were reviewed increased from a baseline of 40% in 2015 to 100% in 2020, exceeding the target of 70%.
- The percentage of completeness of target district reporting on SMC and NTD drug distribution reached 100% at the end of the project.
- The coverage of preventive chemotherapy achieved by project campaigns among eligible populations in targeted districts increased from a baseline of 0% in 2015 to 97% in 2020, exceeding the target of 80%. By the end of the project, the rates at the regional level were: schistosomiasis, 98%; LF, 96%; STH, 98%; trachoma, 92%; and onchocerciasis, 100%.
- 5,781 trichiasis surgeries were performed, exceeding the target of 2,500. 2,489 hydrocele surgeries were performed, not reaching the target of 4,200.

Outcomes

- The percentage of target districts with at least 70% coverage of three or more courses of SMC for children under five years increased from a baseline of 0% at the beginning of the project to 100% of districts throughout the life of the project, exceeding the original target of 50% of districts and meeting the revised target of 100% of districts.
- The percentage of children under five years in the target districts receiving at least three courses of SMC increased from a baseline of 0% in 2015 to 100% in 2020, exceeding the original target of 50% and the revised target of 80%.
- The percentage of targeted districts providing integrated annual treatment for schistosomiasis and STH for school-aged children (5-14 years) increased from a baseline of 0% in 2015 to 100% in 2018, exceeding the original target of 80% and achieving the revised target of 100%. In Niger, coverage for integrated mass treatment of children ages 5-14 for schistosomiasis and STH increased from 70% in

2018 to 100% in 2019 and 2020. The prevalence of LF declined from 17.4% in 2016 to 3.8% in 2020. Onchocerciasis was eliminated in Niger by project completion, and a committee to achieve certification of elimination was created. In Burkina Faso, coverage targets for onchocerciasis, schistosomiasis, LF, and STH were surpassed almost every year. In Mali, coverage rates fluctuated by year and district.

- The percentage of border districts that initiated SMC campaigns within two weeks of the planned timeline increased from a baseline of 0% in 2015 to 100% in 2018, exceeding the target of 80%.
- The percentage of children under five years with fever in last two weeks who had a finger or heel stick (for malaria diagnosis) in the targeted districts increased from a baseline of 0% in 2015 to 90.16% in 2018, reaching the target of 90%. The three countries increased access to RDT, microscopy, or finger or heel stick for children under five with fever in the previous two weeks.
- The number of direct project beneficiaries increased from a baseline of 0 in 2015 to 23.7 million in 2018, exceeding the revised target of 21.1 million. The percentage of female beneficiaries increased from a baseline of 0% to 52.6%, exceeding the target of 45%.
- The project achieved positive behavior change. There was evidence of a change of attitudes toward the use of treated mosquito nets, hand washing practices, and other behavioral practices (such as taking sick children to health posts and regularly visiting health centers). Moreover, the incidence of malaria and NTDs decreased in all targeted health districts that implemented SMC and preventive MDA. Malaria incidence in children under five in the targeted regions declined from 556 cases/1000 in 2015 to 2916 cases/1000 in 2019.

Rating
High

OVERALL EFFICACY
Rationale
The objective to increase access to and use of harmonized community-level services for the prevention and treatment of malaria and NTDs in targeted cross-border areas was fully achieved. Since the project interventions were the only active ones in cross-border areas, the achievement of the observed outcomes can be plausibly attributed to the project. The level of achievement is consistent with a high rating for overall efficacy.

Overall Efficacy Rating
High

5. Efficiency

The PAD (p.136) assessed the economic consequences of malaria and NTDs, together representing an important share of total lost disability-adjusted life years (DALYs) in Burkina Faso (22.5%), Mali (24.8%), and Niger (15.3%), especially when compared with Western Sub-Saharan Africa region (19.7%) and globally (4.4%). Global literature suggests that nations with high malaria incidence also exhibit low levels of economic development, and that countries lose between 0.5% and 1.3% of GDP growth annually due to endemic malaria. NTDs also have a negative effect on the economy of households and affect worker productivity (PAD, p. 137). The PAD discussed the conclusions of the 2013 Lancet Commission on Investing in Health, which noted that addressing malaria and NTDs could contribute to substantial improvements in health and sizeable economic benefits in the medium to long run. The Commission estimated that scaling up malaria and NTD control interventions could prevent 10 million deaths across low-income and middle-income countries through 2035.

The PAD's economic analysis avoided overestimating the benefits and applied an individual recurrence rate for malaria episodes at 40 percent, with the assumption of an average 2.5 episodes per year. This rate reflects the fact that an individual can be exposed to malaria episodes more than once per year. Using a discount rate of 3 percent, the PAD (p. 136) estimated a net present value for the project at US$54.7 million, a benefit-cost ratio of 1.3, and an internal rate of return of 10%.

The ICR's analysis focused on DALYs and cost-effectiveness. It estimated that malaria control and treatment alone were found to avert an excess of 20.1 million DALYs at an average cost of US$2.3 per DALY. Given a value of DALY for low-income countries at US$ 5,000 (Jamison et al. 2012), this indicates nominal benefits of approximately US$100.7 billion. As for NTDs interventions, it was estimated that they prevent the loss of one million DALYs, valuing nearly US$5.2 billion at a cost per DALY of roughly US$68.2. When declared in 2015 constant prices and discounted at 3 percent, the project cost of US$118.30 million yielded US$114.9 million and US$105.8 million, respectively. This would generate a benefit-cost ratio of 867 and an incremental cost-effectiveness ratio (ICER) or cost per DALY of US$5 for the project. The large-benefit cost ratio and ICER were significantly lower than the least of the three countries' GDP per capita (US$484) for 2015 and suggested that the project was highly cost-effective (ICR, p. 67).

However, there were moderate shortcomings in operational efficiency: (i) the costs of campaigns were higher than anticipated. (ii) Long delays in drug delivery and occasional CAMEG reluctance to comply with national customs procedures were reported. (iii) There were delays in the parliamentary ratification of the financing agreements and in appointing project coordinators. (iv) Health ministries had difficulties in retaining talent, leading to implementation slowdowns. (v) There were delays related to a lack of familiarity with Bank fiduciary requirements; delays in obtaining no-objections for the award of contracts; long procurement processes in all three countries; lengthy processes for the development of research protocols; and delays in conducting Lot Quality Assurance Sampling (LQAS) surveys in Burkina Faso and Niger. (vi) Remoteness and security concerns presented implementation challenges. And, (vii) the COVID-19 pandemic led to lockdowns and border closings for several months during 2020. The limitation of mobility affected the SMC campaigns and other activities that required face-to-face interactions.

On balance, given positive returns suggested by the economic analysis, but with adverse aspects of implementation that reduced efficiency, overall project efficiency is rated substantial.

Efficiency Rating

Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal	✓	10.00	100.00 ☐ Not Applicable
ICR Estimate		0	0 ☐ Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

Relevance of objectives is rated Substantial, as there was almost full alignment between project objectives and Country Partnership Frameworks and regional objectives at project closing. Efficacy is rated High, as development objectives were fully achieved. Efficiency is rated Substantial, in view of the cost-effectiveness of project interventions, but with moderate implementation shortcomings that reduced efficiency. The overall outcome is rated Satisfactory, indicative of essentially minor shortcomings in the project's preparation, implementation, and achievement.

a. Outcome Rating

Satisfactory

7. Risk to Development Outcome

Several factors are likely to negatively affect the sustainability of development outcome. Funding for wide regional collaboration has not been secured. This may affect the sustenance of joint planning and synchronized implementation. There are constraints to the international supply of SMC drugs, as confirmed by UNICEF. Political developments may impact governments' priorities concerning health programming. A deterioration of the security situation in cross-border areas might negatively affect access to community-based health services. Likewise, there are mobility limitations due to the COVID-19 pandemic, and many activities require face-to-face interactions. Overall attention shifted to COVID-19, putting a strain on available resources and weakening efforts to prevent seasonal malaria and NTDs.

However, strengthened institutional capacities, collaboration with WAHO, and the support of international partners would be expected to alleviate some of the above risks. According to the ICR, support from

international partners would continue, including from the Global Fund, the United States Agency for International Development, Helen Keller International, and Sightsavers.

8. Assessment of Bank Performance

a. Quality-at-Entry

Engagement in preparation included the three FCV countries, the Bank and regional institutions. Engagement of development partners was not elucidated by the ICR. Preparation was informed by lessons from other experience such as the African Program for Onchocerciasis Control and from IEG portfolio review on communicable disease. The project complemented existing Malaria and NTDs prevention, control, and elimination strategies. The M&E framework was adequate overall with some lapses related to PDO indicators and a missing baseline (2018 Restructuring Paper). Preparation included arrangements to build national capacities required for implementation. In the case of Niger and Burkina Faso, the Bank was already supporting active PIUs. In Mali, the Bank supported the creation of a new PIU. Environmental safeguards were prepared.

In general, risks and mitigation measures were adequately identified, including risks related to political instability, institutional capacity for implementation and sustainability, fiduciary capacity, and uncertain supply of drugs due to the limited number of pre-qualified manufacturers and their production capacity. Effectiveness was delayed mainly due to administrative reasons and parliamentary ratification, and insecurity issues. But other factors included difficulties in coordinating the actions of ECOWAS headquarters in Abuja (Nigeria) with those of WAHO based in Bobo Dioulasso (Burkina Faso). The appointment of coordinators at WAHO, Niger and Mali were delayed. The risk of a rise in drug prices was somewhat underestimated at entry.

Readiness was not complete. There was insufficient staffing in some implementation units. Niger and Burkina Faso PIUs' capacities to implement the project with concurrent existing responsibilities may have been overestimated. Measures for mitigating coordination challenges arising from differences in procurement practices among the three countries and unfamiliarity with Bank processes were insufficient.

The project planned, under a legal covenant, to make payments to community health workers through a service provider, even though this mechanism was disruptive to existing arrangements that functioned well for a long time through Community Health Centers. Also, suitable service providers were difficult to find. This planned mechanism under the project was not implemented. The legal covenant was subsequently revised during the 2018 restructuring, and the previously existing payment system was maintained (2018 Restructuring Paper).

Overall, the design and its implementation arrangements were complex. The project encompassed three FCV countries, four implementing agencies, a regional organization governed by different systems, and a vast array of peripheral actors and communities. Supervision arrangements were heterogeneous and were shared between the Bank Team and WAHO

Quality-at-Entry Rating
Moderately Satisfactory

b. Quality of supervision
The Bank Team reportedly provided continuous support to participating countries and WAHO in addressing implementation challenges. Two supervision missions were undertaken every year with a mid-term review in December 2017. During the COVID-19 pandemic restrictions, the Team continued supervision in a virtual manner. The continuity of the Task Team was a point of strength during implementation (ICR, p. 29). The quality of reporting was not addressed by the ICR, but in-depth interviews were carried out with key implementing actors at regional, national and district levels. Health staff at the district level organized interviews with local actors. Beneficiaries were eager to participate in the phone calls and were candid in sharing their experiences during interviews, and completed beneficiary surveys. Such interviews were helpful in capturing local challenges encountered in cross-border areas.

The Team was pro-active in restructuring the project after the mid-term review, and in providing technical assistance. Financial management and procurement specialists worked closely with PIU staff to address coordination challenges arising from differences in procurement practices among the three countries. Remoteness and security concerns presented challenges to project supervision that were proactively addressed by the Bank team. The team remained vigilant of political instability, identifying tailored approaches to delivering and administering drugs at the community level in conflict-afflicted areas. The team worked with local doctors and teachers to obtain information on drug delivery to the population.

The ICR (p. 29) reported two shortcomings: the long time taken to provide non-objections in some instances, making procurement processes cumbersome; and the lack of continued support to regional collaboration to carry out joint planning and synchronized implementation of field interventions, sharing know-how, and incorporating the information into the next campaign. Nevertheless, many related issues and processing delays encountered during implementation, including those related to insecurity or COVID-19 disruptions, were not necessarily under the control of the Bank Team.

Quality of Supervision Rating
Satisfactory

Overall Bank Performance Rating
Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design
The objectives were clearly stated and were reflected by the selected indicators. The outcome indicators had lapses that were noted in section 8a, and these were subsequently rectified during implementation. The results chain allowed adequate assessment of the links established in the theory of change. M&E arrangements were well planned, including data sources, frequency of collection, and quality assessment. The health ministries, national malaria control programs, and national NTD programs in all three countries

were tasked with monitoring results in their own countries. WAHO was accountable for gathering the countries' information and facilitating regional reporting to the Regional Steering Committee. Data sources included district reports, campaign reports, LQAS, regional reports prepared by WAHO, and health ministry data.

b. M&E Implementation

M&E activities were implemented as planned. Data were collected and analyzed for every campaign, and findings were shared in regional meetings to improve the planning and implementation of subsequent campaigns. Communications networks and computerized data management systems were established and upgraded. Existing networks of sentinel surveillance sites across all three countries were strengthened.

The results framework was improved at the project restructuring approved in August 2018, following recommendations made during the mid-term review in December 2017. The definition of some indicators was revised to better measure progress towards the PDOs while some targets were revised upwards to reflect the achievements already made. Some challenges affected M&E implementation, for instance, a health sector strike in Burkina Faso made data collection difficult in 2019, although this issue was ultimately overcome through close follow up with the government.

c. M&E Utilization

M&E information was used for regular project monitoring and for adapting project activities. Strong results from activities implemented by CHWs led to a decision to keep CHWs as the key actors on the ground versus the proposed use of NGOs. After collecting data on mass SMC and NTD campaigns, there were follow-up meetings to analyze the findings that led to commendations to improve subsequent campaigns. All three countries performed supplemental LQAS surveys to guide increased coverage and monitoring.

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

The project triggered Operational Policy (OP) 4.01 on Environmental Assessment and was classified under environmental Category B due to the generation of hazardous biomedical waste. The project updated the National Medical Waste Management Plan (NMWMPs) in Burkina Faso and Mali to ensure appropriate biomedical waste management in cross-border areas. Niger had updated its NMWMP during the Population and Health Support Project (P147638) to serve as a safeguard instrument for both projects. Each national team prepared strategic plans for medical waste management. National, regional, and community communication units elaborated and disseminated educational messages on managing medical waste generated by SMC and NTD campaigns. The project funded a nationwide waste management guide for

mass treatment campaigns. It also acquired hygiene and sanitation materials, and monitored and treated wastes resulting from the project-provided services during mass distribution campaigns. As per the operations portal, the overall safeguards rating was satisfactory throughout implementation and at closing. The project did not trigger any social safeguards.

Nevertheless, the above conclusions may not be fully consistent with the ICR findings on incinerators (ICR, p. 28). The ICR stated that there were challenges regarding the correct use of incinerators that caused malfunctions. Also, the ICR noted that there were installation challenges. Niger requested more incinerators towards the end of project implementation, but these were not acquired, given that already acquired incinerators were not in use. The same situation was observed in Burkina Faso where incinerators provided by other projects were not fully utilized.

b. Fiduciary Compliance

Financial management (FM): The Bank assessed financial management arrangements at appraisal and found them to be adequate. The Bank's financial management team provided close support to the three country offices, and helped in addressing bottlenecks when needed. According to the ICR (p. 28), all three countries and WAHO complied with FM covenants, submitting quarterly unaudited financial management reports in a timely manner after each quarter. Audited financial statements covering each fiscal year were also submitted on time. The ICR did not report audit qualifications, and the ICR stated that fiduciary compliance during implementation was rated satisfactory by project completion (ICR, p. 28).

Procurement: Procurement was carried out in accordance with World Bank guidelines. Procedures were carried out under the institutional procurement system within the framework of public procurement in each country. All three countries prepared and signed cooperation agreements with CAMEG and submitted coordinated drug procurement plans to procure SMC medicines and praziquantel. The joint purchase of drugs allowed economies of scale and guaranteed the quality of the acquired drugs. According to the ICR, most project procurements pertained to the pooled purchase of medicines for SMC. The ICR noted that issues encountered were related to unfamiliarity with the STEP system, the slow process in public procurement in the countries, and the fact that drug prices for SMC kept increasing every year. The 2018 restructuring reallocated resources between categories to facilitate the purchase of the required medicines. As for the pooled procurement of medicines for SMC, there was a delay in pooled procurement during the last year of the project due to the Covid-19 pandemic combined with global supply chain issues.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Highly Satisfactory	Satisfactory	There was almost full alignment between project objectives and Country Partnership Frameworks and regional initiatives at project closing, consistent with a substantial rating for relevance of objectives.
Bank Performance	Satisfactory	Moderately Satisfactory	There were moderate shortcomings in the Quality-at-Entry, largely related to variable readiness and complexity of implementation arrangements that is inherent to regional operations.
Quality of M&E	Substantial	Substantial	
Quality of ICR	---	Substantial	

12. Lessons

The ICR (pp. 31-32) offered several valuable lessons, including the following adapted by IEG:

Collective and synchronized actions can improve project effectiveness. Joint work plans and joint supervision between countries was a learning-enhancing experience across the three countries. The joint approach allowed stakeholders on both sides of the border to engage in fruitful collaboration. It was the first time for the three countries to plan and implement a WHO strategy in a coordinated regional manner.

Micro-planning of disease control campaigns can significantly contribute to better results. Health ministries empowered the local levels to consider and incorporate the needs of individual districts. This entailed micro-planning activities through workshops that supported and trained actors at all levels. The inclusive approach strengthened ownership, built trust, and facilitated information dissemination.

Partnering with other institutions and development partners can contribute to supporting long-term national and regional policies. The project sought to promote a long-term regional approach and the countries were able to secure country-specific support from international development partners to tackle malaria and NTDs.

The engagement and support of community leaders and key local actors such as teachers can be crucial to the effectiveness of information and education campaigns to influence

population behavior. The participation of community leaders in micro-planning activities contributed to their close engagement in public education efforts and in gaining the population's trust. Teachers were key to providing awareness, education, and distribution of information in view of their status and credibility at the community level.

Long-term procurement contracts for drugs can contribute to cost-containment and can reduce the time-lapse for delivery. Long-term contracts brought more leverage to negotiate prices and improve contract terms. CAMEG emphasized the importance of negotiating multi-year contracts for the pooled acquisition of drugs, although it also pointed out that the need to negotiate contracts every year diminished the room for lowering drug prices.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR provided a thorough analysis of the project experience. It was concise, results-oriented, and carefully linked outputs with observed outcomes. The ICR, p. 18, added a third objective on improved regional collaboration, and the rationale behind the formal selection of three objectives was not clear. Per guidelines, objectives could have been segregated for access and use, however, based on the theory of change and the overlap between both objectives, IEG Review opted to summarize the efficacy section with one overarching objective. The evidence presented was well-referenced, with annexes that included relevant information to support the conclusions on project achievements. The ICR clearly described main project challenges and their impact on implementation. Lessons learned were insightful and well-drawn from the project's experience as described in the main narrative. There were information lapses on costs and financing, and on the quality of reporting.

a. Quality of ICR Rating

Substantial