# Project Information Document (PID)
## Concept Stage

<table>
<thead>
<tr>
<th><strong>Project Name</strong></th>
<th>Maternal and Child Health Support Project (P143843)</th>
</tr>
</thead>
<tbody>
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<td><strong>Region</strong></td>
<td>AFRICA</td>
</tr>
<tr>
<td><strong>Country</strong></td>
<td>Togo</td>
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<tr>
<td><strong>Sector(s)</strong></td>
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<td><strong>Theme(s)</strong></td>
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<td><strong>Project ID</strong></td>
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<td>Ministry of Health</td>
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<td><strong>Environmental Category</strong></td>
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<td><strong>Date PID Prepared/Updated</strong></td>
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<td><strong>Date PID Approved/Disclosed</strong></td>
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<td><strong>Estimated Date of Appraisal Completion</strong></td>
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## I. Introduction and Context
### Country Context
The Republic of Togo counts among the least developed countries in Africa with per capita revenue of just US$440 in 2009 and a total population of slightly over 5.75 million inhabitants in 2010. Togo is gradually emerging from a long period of political isolation and economic stagnation. Despite recent improvements in political stability and economic reforms, Togo’s growth has remained low, below the regional average, and poverty has remained high. GDP growth showed a modest acceleration from 3% in 2009 to 4% in 2010 and to 5% in 2011 despite a difficult international economic environment. Economic growth rates higher than population growth rate in 2010 and 2011 are encouraging signs of economic recovery; however, these growth figures still remain well below the regional average. While incidence of poverty improved slightly from 62% to 59% between 2006 and 2011, the situation is still worse than the 32% figures seen in the 1980s. Poverty remains highly concentrated in rural areas where the poverty headcount is above 74%,
compared to 23% in Lomé and 45% in other urban areas. In 2011 the country was ranked 162 out of 187 countries (UNDP Human Development Index).

**Sectoral and Institutional Context**

Compared to the average of other countries in its income class, Togo has a mixed performance on key development indicators.

- The life expectancy at birth in 2010 of 63 years is better than the Low Income Country (LIC) average of 59 years.
- So are all the nutrition indicators, including an impressive drop in acute malnutrition from 14% to 4.8% in four years, but these data do not tell the whole story about the evolution of different forms of malnutrition in Togo, nor do they tell the story of the performance on other key maternal and child health indicators.

Other key development indicators are worse than the LIC average figure and the country remains highly unlikely to achieve the Millennium Development Goals (MDGs), principally due to lack of sufficient progress in maternal and child health outcomes.

- For example, infant mortality has not improved, at around 80 per thousand since 1988, and child mortality remains stagnant at 123 deaths per thousand.
- Infant mortality has not improved either, at around 80 per thousand since 1988.
- Malaria is the first cause of morbidity and mortality of children, and fever comprises approximately 40% of all outpatient consultations.
- While progress in reducing acute malnutrition has been impressive, chronic malnutrition has been on a steady increase since 1998.

The long period of the country’s isolation and political disorder have resulted in low funding and weakened performance of the health sector. Only 6.2% of the overall national budget is dedicated to health (NHA 2008). Donors are gradually coming back but contribution is limited to around 18% of total health expenditures, much lower than other post-crisis countries of similar income levels.

Weak stewardship, planning and coordinating capacity hamper mobilization of resources. In addition, the country’s health information system is fragmented across dozens of different, inconsistent and sometimes overlapping vertical systems. Limited capacities for data entry and analysis, especially at decentralized levels, create difficulties in effective monitoring of health interventions and their outcomes.

**Relationship to CAS**

This project is fully in line with the Bank’s Global, Regional and Country-level strategies for economic development, poverty reduction and health (including World Bank’s Strategy for Africa and Second Interim Strategy Note (ISN-II) for Togo covering 2012-2013). A 2011 Health Country Status report identified priority needs and informed current government policies on health (such as maternal and child health, nutrition, community health, better governance and health systems strengthening etc). Togo is also party to international initiatives and partnerships supported and promoted by the Bank including MDGs, IHP+, RCM, SUN, etc. and this project will facilitate achievement of the Government’s targets associated with these initiatives.

**II. Proposed Development Objective(s)**

**Proposed Development Objective(s) (From PCN)**

The proposed new project aims to support MCH improvement in Togo and thereby improve health outcomes for pregnant women and children in the country. To that end, the project development
Objective (PDO) is to increase access to maternal and child health services for pregnant women and children in the country.

Key Results (From PCN)

The achievement of the above development objective will be assessed through the following key indicators:

- Percentage of women who received at least 2 doses of SP (IPTp) during their most recent pregnancy within the last 2 years.
- Percentage of women 15-45 who slept under a long-lasting insecticidal net (LLINs).
- Percentage of suspected malaria cases tested by a community health worker using a rapid diagnostic test (RDT).
- Number of children under age five receiving a basic package of nutrition services.

III. Preliminary Description

Concept Description

A - Description

The proposed project aims to contribute to the development process by seeking to tackle some key constraints to improved maternal and child health in Togo. The project will support the current efforts of the government and its partners, principally the GF, UNICEF and AFD, to improve access to proven, cost-effective malaria control and nutritional support interventions through routine delivery of maternal and child health services, particularly ante-natal care (ANC) and the integrated management of childhood illness (IMCI) at both facility and community levels. Specifically, the project will promote the scale-up of community based diagnosis and treatment of malaria using RDTs and ACTs and critical, high impact nutrition interventions for the prevention of malnutrition (including optimal infant and young child feeding practices and the prevention of growth faltering from common childhood illnesses), the management of malaria and nutritional risks during pregnancy with LLINs, IPT, iron folate supplementation and nutritional counseling. For both nutrition and malaria interventions significant financing gaps exist between current government and donor financing and the resources needed to make significant progress towards the country’s MCH and MDG goals. Improvement in maternal and child health outcomes cannot be achieved without increased investment in this area. The health management information strengthening part of the project will support the capacities of the government to improve the currently dysfunctional health management information systems, especially as it relates to the collection and analysis of MCH-related monitoring data. The project will therefore have two key components: Improved coverage of integrated malaria and nutrition services, and health systems strengthening (see sub-section 2. Project components, below).

It is important to stress that the interventions proposed under this project are not stand-alone activities or programs in their own right. The project seeks to reinforce existing approaches to promote and ensure maternal and child health. Distribution of LLINs to pregnant women, IPTp, malaria and nutritional counseling and FE supplementation are all part of the package of focused antenatal care that should be available to all pregnant women in Togo. It is hoped that when a complete ANC package is offered to women, uptake will improve and more pregnant women will demand the services earlier in their pregnancies. Similarly, community diagnosis and treatment of malaria is an integral part of community IMCI and fever is the most common symptom seen by
CHAs. If CHAs are able to adequately provide diagnosis and treatment for malaria fevers it will enhance their ability to deliver other community-IMCI interventions including health promotion and education to reduce malaria risk and improve nutrition. The health systems strengthening component will help the GoT to monitor progress in maternal and child health improvements, among others.

Project components

COMPONENT 1: Improved coverage of malaria and nutrition services (US$10 million)

Subcomponent 1.1: Support for (i) malaria control in pregnancy through contribution to package of services through ANC; (ii) community-based diagnosis and treatment of malaria; and (iii) management and supervision, as well as behavioral changes, to ensure effective utilization (US$8 million)

This sub-component responds to national priorities and both the general and specific objectives of the National Strategic Plan (NSP) for the Fight against Malaria (2011-2015). A recently completed gap analysis by the national malaria program (the PNLP) identified two priority areas for additional investment: 1) support for malaria in pregnancy and the routine distribution of LLIN through ante-natal care (ANC); and, 2) the roll out of parasitological diagnosis for malaria in the context of the integrated management of childhood illnesses at community level (C-IMCI).

This project will address malaria in pregnancy by contributing to the package of services delivered through ANC. Specifically the project will fill the funding gap for the provision of Intermittent Preventive Treatment of malaria in pregnancy (IPTp) with sulfadoxine-pyrimethamine (SP) and free LLINs, to pregnant women attending ANC. IPTp and LLIN, together with iron folate and nutritional counseling (see subcomponent 1.2 below) are part of the basic package of ANC services.

The project will also address community-based diagnosis and treatment of malaria by providing an adequate supply of RDTs (approximately 7.3 million test kits) to community health agents for parasitological confirmation of malaria in febrile patients prior to treatment with ACTs and, through activities described further below to promote effective uptake of the project’s services, ensure referral of negative cases to health facilities for follow-up. This is a core element of C-IMCI as fever (suspected malaria) is the most common reason for consultation with a community health agent. The cost of commodities to be provided under subcomponent 1.1 is inclusive of commodity cost, shipment, warehousing and distribution and provides partial funding for local planning, social mobilization, monitoring and evaluation and supervision which will be supplemented by additional project resources.

Management strengthening and close supervision, as well as behavior change messages through community stakeholders, would be crucial for ensuring that bednets, RDTs and SP for pregnant women are appropriately distributed and adequately utilized. The GoT and project staff would be responsible for ensuring management strengthening and close supervision (including communication strategies, training, M&E, supervision and social mobilization), and community health workers and local NGOs would be involved in transmitting behavior change messages to promote effective uptake of the project’s services.

Stakeholders involved in the implementation would include communities and their volunteers, the direct beneficiaries, local governments in the project areas, the national malaria, maternal health, IMCI (and EPI) programs, health facility staff; and health sector NGOs.

Subcomponent 1.2: Community-based nutrition services for pregnant women and young children
The activities under this subcomponent are fully aligned with the country’s 2010 National Nutrition Policy and the 2012 National Nutrition Strategic Plan, and are complementary to those already carried out by other GoT partners in this area, especially UNICEF. They will support the expansion of the country’s community-based nutrition services to two central regions (Centrale and Plateaux) in the country through: (i) the reinforcement and implementation of community-based prevention of malnutrition; and (ii) provision of iron folate supplements to pregnant women as part of their basic package of prenatal care. The two geographic areas for this intervention have been selected based on two criteria: (i) complementarity with existing nutrition interventions, and (ii) prevalence of chronic malnutrition. Currently, all nutrition activities supported by UNICEF are heavily focused on the two northern regions of Savanes and Kara, which have a relatively high prevalence of stunting. The selected regions of the project’s interventions, Centrale and Plateaux, however, have the second and fourth highest prevalence of chronic malnutrition in Togo, respectively, and are currently not covered by any routine or preventive nutrition services. (Savanes and Kara regions have the first and third highest prevalence of chronic malnutrition.)

Activities will target the 1,000 day window of opportunity for nutrition (pregnant women and children 0-24 months) and will build on the country’s community-based growth monitoring and promotion program, the Programme de Controle et de Promotion de la Croissance (CPC). The CPC model was developed by the National Nutrition Program and was designed to be implemented collaboratively by community health agents (ASC) who are trained in growth monitoring and promotion activities, and volunteers who run the community based breastfeeding and complementary feeding support groups, Groupe de Soutien à l’Allaitement Maternel. ASC and community volunteers are not currently active in the two target regions, so this component includes the identification and training/retraining on the implementation of the CPC, in collaboration with communities, local governments and USPs (unités des soins primaires, or primary health care units) and NGOs.

The four main activities under this subcomponent include: (i) monthly child growth monitoring and counseling of improved infant and young child feeding practices, management of childhood illnesses, and safe water, hygiene, and sanitation practices; (ii) twice-monthly household visits by community volunteers to support breastfeeding mothers; (iii) referral of sick and acutely malnourished children to the local health center; and (iv) monthly feedback sessions with primary health care units (USP) to review progress, discuss challenges and potential solutions. The project will also support the provision of iron folate (IFA) supplementation for pregnant women who attend prenatal care services as part of the basic package of services in one region (Centrale), to be delivered in parallel with other services included in the basic package such as IPT and provision of ITNs.

The component includes goods (iron folate, scales) and services (community mobilization and training/retraining for community health agents and volunteers). Stakeholders involved in the implementation would also include the communities themselves and their volunteers, the direct beneficiaries, local governments in the project areas, the national nutrition program, health facility staff, and health sector NGOs.

COMPONENT 2: Strengthen the government capacity for oversight and evidence-based management of its MCH programs (US$4 million)

Sub-component 2.1 Strengthening Health Management Information Systems (US$ 3 million)

This component will strengthen the national Health Management Information Systems (HMIS), through the implementation of an integrated IT solution. As found by the latest assessment of the HMIS conducted by the Ministry of Health in April 2013, the national health information system is suffering from several problems. First, staff assigned to HMIS tasks have not been trained properly.
They sometimes do not have the required equipment. Secondly, the HMIS is highly fragmented, with various sub-systems for monitoring diseases, for facilities and resources. Integration is not done, except on an ad hoc basis at central level. And, thirdly, while HMIS data are used for planning, they are not used for allocating resources in the system (for instance, across districts). Finally, some data types (i.e. health expenditures) are not collected in a proper manner.

Consequently, the proposed objectives of this sub-component are to (i) integrate all the data entry programs currently existing in health facilities and districts health authorities (ii) improve the skills & knowledge MOH staff responsible for HMIS as well as of data entry staff on data collection and analysis, including provision of IT equipment. (iii) ensure that HMIS data collected form the basis for evidence-based policies and decision making. Particular emphasis will be placed during the project, on reinforcing those areas of the HMIS that relate to monitoring of malaria and nutrition services.

This sub-component will require software, IT equipment, training and possibly consulting services.

Sub-component 2.2 Project coordination and implementation support (US$ 1 million)

The Project will also support the MoH to coordinate and implement the Project activities. This will require (i) A project team inside the MOH, including a project coordinator, reinforced where necessary by recruiting additional specialists such as a Procurement Specialist, a Financial Management Specialist and M&E specialist, (ii) Operating costs, including salaries for the Project team specialists recruited from outside the MOH, and office and IT equipment. (iii) Relevant additional support to technical programs involved in project implementation (malaria program, nutrition program, HMIS Division); in this case, the project would support only additional costs to those programs directly arising from their involvement in the project implementation.

B. Institutional arrangements

The proposed project will be implemented by the MoH. A national Project Coordinator will be appointed by the MoH. This Coordinator will need to work full time on the Project. At this stage, the exact MoH Directorate in charge of Project implementation remains to be determined with the Government. It is however highly probable that some capacity building will be needed regarding procurement and financial management. Within the MoH, there are already several persons with strong fiduciary and management capacities. But their number is very low and they need to be supplemented by external experts.

To ensure long-term capacity building, each of these experts will be accompanied by one or two MoH civil servant(s). The objective is to ensure that, before the end of the Project, the national capacity has been strengthened and is able to take over the Project activities without any external support. This arrangement has been already tested with the education sector and has so far yielded satisfactory results.

To ensure sufficient dedication and adequate learning, the proposed arrangement will have the following features:

- National secondees (“homologues nationaux”) will be selected through a competitive selection process. The list of selected candidates will have to be approved by the Bank.
- Each secondee will receive some logistical support. In particular, their communication and transportation costs (as long as they are incurred because of their involvement in the Project) will be covered by the Project.
- Each secondee will have a detailed and customized knowledge transfer plan. The coordinator and the Project specialists will be accountable for the implementation of these plans.
For procurement of drugs and medical supplies, it is envisaged to use the Central Drug Procurement Unit (Centrale d’Achats de Médicaments Essentiels et Génériques (CAMEG)) if the procurement capacity assessment determines that their procurement procedures are satisfactory. This will be determined during project preparation. If CAMEG is not appropriate, or needs further reinforcement, other procurement arrangements (eg procurement at least initially through appropriate UN agencies) will be developed.

For community-level activities, the MoH will implement two kinds of support. First, Community Health Workers (CHWs) will be supported with goods (for instance, RDTs) and training (use of RDTs, nutrition-related tasks). These goods will be supplied by the Government, while the training sessions will be delivered by MoH staff and external trainers. Secondly, for nutrition-related activities, communities will be directly supported through local NGOs, to be hired by the MoH. NGOs will also be involved in communication and transmitting behavior change messages to increase the uptake and effectiveness of the community malaria interventions. For these roles, it is envisaged that local NGOs will receive some training and support under the project to undertake them.

The overall project coordination will be ensured by the MOH while project oversight and supervision will be done through a steering committee. The latter’s exact composition has still to be determined but it is already agreed that it will include all the key stakeholders, especially those from other ministries (Finance, Planning).

C - M&E arrangements

During project preparation, the task team will work with the GoT and coordinate with the development partners to build the results framework to monitor implementation progress and project outcomes as well as to develop a plan for strengthening M&E capacity in the MoH. An M&E specialist will be recruited as part of the MoH project implementation team. This person will primarily be responsible for coordinating with different technical programs and services to obtain the data for measuring project progress.

As for malaria-related M&E, several indicators are already monitored by the existing HMIS (for instance, the number of distributed bednets). Others will require an update of the existing data entry tools. Also, quality of malaria care will probably require a specific survey, which could be a LQAS (Lot Quality Sampling Survey).

Regarding nutrition-related indicators, data will be collected and analyzed at community-level by local NGOs. In the meantime, the project’s component 2 will build the capacity for monitoring nutrition outputs.

As for indicators related to the health system, they will be produced by the MoH, with support from the project M&E specialist.

IV. Safeguard Policies that might apply

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VI. Contact point

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