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Report No: PAD4119

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT
IN THE AMOUNT OF EUR 28.9 MILLION
(US$35.0 MILLION EQUIVALENT)

AND

A PROPOSED GRANT

IN THE AMOUNT OF SDR 24.3 MILLION
(US$35.0 MILLION EQUIVALENT)

TO THE

REPUBLIC OF TOGO

FOR A

TOGO ESSENTIAL QUALITY HEALTH SERVICES FOR UNIVERSAL HEALTH COVERAGE PROJECT

February 18, 2021

Health, Nutrition and Population Global Practice
Western and Central Africa Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective January 31, 2021)

Currency Unit =	XOF (West African CFA franc)
=	US$1
US$1 =	SDR 0.694
US$1 =	EURO 0.825

FISCAL YEAR
January 1 - December 31

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ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
AFD	*Agence Française de Développement* (French Development Agency)
AfDB	African Development Bank
AMR	Antimicrobial Resistance
APA	Alternate Procurement Arrangements
AWPB	Annual Workplan and Budget
BOAD	*Banque Ouest Africaine de Développement* (West African Development Bank)
CAMEG	*Central d'Achat des Médicaments Essentielles et Générique* (Central Purchasing Agency for Medicines)
CBA	Cost-Benefit Analysis
CDQ	*Comité Villageois de Quartier* (Village Quarter Committee)
CERC	Contingent Emergency Response Component
CHP	*Centre Hospitalier Préfectoral* (Prefectural Hospital Center)
CHW	Community Health Worker
COVID-19	Coronavirus Disease 2019
CPF	Country Partnership Framework
CPIA	Country Policy and Institutional Assessment
CRI	Corporate Result Indicator
CVD	*Comité Villageois de Développement* (Village Development Committee)
DA	Designated Account
DALY	Disability-Adjusted Life Years
DH	District Hospital
DHIS	District Health Information System
DHIS2	District Health Information Software 2
DHS	Demographic and Health Survey
DPO	Development Policy Operation
DPT3	Diphtheria, Tetanus Toxoid and Pertussis
DRG	Diagnostic-Related Group
DSSI	Debt Service Suspension Initiative
EmONC	Emergency Obstetrical and Newborn Care
ESCP	Environmental and Social Commitment Plan
ESF	Environmental and Social Framework
ESIA	Environment and Social Impact Assessment
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
ESRS	Environmental and Social Review Summary
ESS	Environment and Social Safeguards
EU	European Union
FCV	Fragility, Conflict and Violence
FHI	Family Health International
FM	Financial Management
FY	Fiscal Year
G2P	Government-to-persons
GBV	Gender-based Violence
GDP	Gross Domestic Product

GII	Gender Inequality Index
GIZ	*Deutsche Gesellschaft für Internationale Zusammenarbeit* (German Development Agency)
Global Fund	The Global Fund to Fight Against AIDS, Tuberculosis and Malaria
GM	Grievance Mechanism
GoT	Government of Togo
GRS	Grievance Redress Service
HCI	Human Capital Index
HEIS	Hands-on Enhanced Implementation Support
HMIS	Health Management Information System
HNP	Health, Nutrition and Population
HWMP	Hazardous Waste Management Plan
IBRD	International Bank for Reconstruction and Development
iCCM	Integrated Community Case Management
ICER	Incremental Cost-Effectiveness Ratios
IDA	International Development Association
IFC	International Finance Corporation
IFR	Interim Financial Report
IHR	International Health Regulations
IMF	International Monetary Fund
INAM	*Institut National d'Assurance Maladie* (National Institute of Health Insurance)
INSEED	*Institut National de Statistiques et des Etudes Economiques et Démographiques* (National Institute of Statistics and Economics and Demographics Studies)
IPF	Investment Project Financing
IPT	Intermittent Preventive Therapy
JEE	Joint External Evaluation
LMP	Labor Management Procedure
M&E	Monitoring and Evaluation
MHPHUAC	Ministry of Health, Public Hygiene and Universal Access to Care
MICS	Multiple Indicator Cluster Survey
MoU	Memorandum of Understanding
MPA	Multiphase Programmatic Approach
MUAC	Mid-upper Arm Circumference
MWMP	Medical Waste Management Plan
NDP	National Development Plan
NPV	Net Present Value
OP	Operational Policy
OPD	Out-patient Department
PASMIN	*Projet d'Appui aux Services de Santé Maternelle, Infantile et de Nutrition* (Maternal and Child Health and Nutrition Service Support Project)
PBA	Performance-based Allocation
PBC	Performance-based Conditions
PBF	Performance-based Financing
PCU	Project Coordination Unit
PDO	Project Development Objective
PEPFAR	United States President's Emergency Plan for AIDS Relief
PFM	Public Financial Management

PforR	Program for Results
PHC	Primary Health Care
PHCPI	Primary Health Care Performance Initiative
PHU	Peripheral Health Unit
PIM	Project Implementation Manual
PIU	Project Implementation Unit
PLR	Performance and Learning Review
PNDS	*Plan National de Développement Sanitaire* (National Health Development Plan)
PPSD	Project Procurement Strategy for Development
PRMP	*Personne Responsable des Marchés Publics* (Person Responsible for Public Procurement)
PSC	Project Steering Committee
QIP	Quality Improvement Plan
RAP	Resettlement Action Plan
REDISSE	Regional Disease Surveillance Systems Enhancement Project
RPF	Resettlement Policy Framework
SARA	Service Availability and Readiness Assessment
SCD	Strategic Country Diagnostic
SDG	Sustainable Development Goal
SDI	Service Delivery Indicator
SDR	Special Drawing Rights
SEA	Sexual Exploitation and Abuse
SEP	Stakeholder Engagement Plan
SH	Sexual Harassment
SME	Small and Medium Enterprise
SMS	Short Message System
SORT	Systematic Operations Risk Tool
TEQHS	Togo Essential Quality Health Services for Universal Health Coverage
TSHIA	Togo Social Health Insurance Agency
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
US$/USD	United States Dollars
USR	Unified Social Registry
TB	Tuberculosis
VAC	Violence Against Children
WAEMU	West African Economic and Monetary Union
WB	World Bank
WBG	World Bank Group
WHO	World Health Organization
XOF	West African CFA franc

TABLE OF CONTENTS

DATASHEET 1

I. STRATEGIC CONTEXT 7

A. Country Context 7

B. Sectoral and Institutional Context 8

C. Relevance to Higher Level Objectives 12

II. PROJECT DESCRIPTION 13

A. Project Development Objective 13

B. Project Components 13

C. Project Beneficiaries 20

D. Results Chain 20

E. Rationale for World Bank Involvement and Role of Partners 21

F. Lessons Learned and Reflected in the Project Design 22

III. IMPLEMENTATION ARRANGEMENTS 23

A. Institutional and Implementation Arrangements 23

B. Results Monitoring and Evaluation Arrangements 25

C. Sustainability 25

IV. PROJECT APPRAISAL SUMMARY 26

A. Technical, Economic and Financial Analysis 26

B. Fiduciary 27

C. Legal Operational Policies 29

D. Environmental and Social 29

E. Climate Co-benefits 32

F. Gender 33

V. GRIEVANCE REDRESS SERVICES 34

VI. KEY RISKS 35

VII. RESULTS FRAMEWORK AND MONITORING 37

Annex 1: Project Budget by Component 67

Annex 2: Economic and Financing Analysis 70

Annex 3: Implementation Arrangements and Support Plan 80

Annex 4: Togo country program adjustment responding to COVID-19 95

DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Togo	Togo Essential Quality Health Services For Universal Health Coverage Project	
Project ID	Financing Instrument	Environmental and Social Risk Classification
P174266	Investment Project Financing	Moderate

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[✓] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[✓] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternate Procurement Arrangements (APA)	[ ] Hands-on Enhanced Implementation Support (HEIS)

Expected Approval Date	Expected Closing Date
11-Mar-2021	30-Apr-2026

Bank/IFC Collaboration

No

Proposed Development Objective(s)

To improve the provision of essential health and nutrition services and quality of care for pregnant women, children and vulnerable populations

Components

Component Name	Cost (US$, millions)
Increasing demand and supply of quality health and nutrition services	32,600.00

Bringing health facilities and services close to households	30,000.00
Strengthening the national social health insurance scheme	4,300.00
Improving stewardship, oversight and management	3,100.00
Contingency Emergency Response Component	0.00

Organizations

Borrower:	Office of President Republic of Togo
Implementing Agency:	Ministry of Health, Public Hygiene and Universal Access to Care

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	70.00
Total Financing	70.00
of which IBRD/IDA	70.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	70.00
IDA Credit	35.00
IDA Grant	35.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
Togo	35.00	35.00	0.00	70.00
National PBA	35.00	35.00	0.00	70.00
Total	**35.00**	**35.00**	**0.00**	**70.00**

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Substantial
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	Moderate
10. Overall	Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
Assessment and Management of Environmental and Social Risks and Impacts	Relevant
Stakeholder Engagement and Information Disclosure	Relevant
Labor and Working Conditions	Relevant
Resource Efficiency and Pollution Prevention and Management	Relevant
Community Health and Safety	Relevant
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
Cultural Heritage	Relevant
Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

Legal Covenants

Sections and Description
Schedule 2-I. A.1.(a). No later than six (6) months after the Project Effective Date, the Recipient shall establish within the Office of the President, and thereafter maintain, throughout Project implementation, a project coordination unit with terms of reference, composition and resources acceptable to the Association ("Project Coordination Unit" or "PCU").

Sections and Description
Schedule 2-I. B.1. No later than six (6) months after the Effective Date, the Recipient shall adopt and thereafter implement the Project in accordance with the project implementation manual ("Project Implementation Manual" or "PIM"), with terms and conditions satisfactory to the Association.

Sections and Description
Schedule 2-I. C.3. For purposes of the implementation Parts 1.1, 1.2 and 1.4, the Recipient, through the Ministry of

Health, Public Hygiene and Universal Access to Care, shall enter into an agreement ("Subsidiary Agreement") with the Togo Social Health Insurance Agency ("TSHIA"), in form and substance acceptable to the Association.

Sections and Description
Schedule 2-I. D.(b).(i). For purposes of counter verification of the payments under the Eligible Expenditures for the PBCs under Part 1.1, 1.2 and 1.4 of the Project, the TSHIA shall:
(i) No later than twelve (12) months after the Effective Date, and with the approval of the PCU, contract and maintain throughout Project implementation pursuant to the Procurement Regulations and in accordance with terms of reference satisfactory to the Association, one or more Independent Counter-Verification Agency (ICVA), with experience and qualifications in the health and social sectors acceptable to the Association, to conduct independent third-party counter-verifications, in compliance with the verification protocols included in the PIM.

Sections and Description
Schedule 2-IV. No later than six (6) months after the Effective Date, the Recipient shall provide evidence to the Association, acceptable to the Association of: (a) the issuance and approval of a Presidential Decree creating the integrated national health insurance entity, "Togo Social Insurance Agency ("TSHIA"), which shall absorb the existing entities such as Institut National d'Assurance Maladie ("INAM"); and (b) the establishment of a PIU within the TSHIA, in a manner acceptable to the Association.

Sections and Description
Schedule 2-I.D.(c) (i) for purposes of counter verification of the payments for the Eligible Expenditures for the PBCs under Part 1.3 of the Project, the Ministry of Health, Public Hygiene and Universal Access to Care:
(i) No later than six (6) months after the Effective Date, and with the approval of the PCU, contract and maintain throughout Project implementation pursuant to the Procurement Regulations and in accordance with terms of reference satisfactory to the Association, one or more Independent Counter-Verification Agency (ICVA), with experience and qualifications in the health and social sectors acceptable to the Association, to conduct independent third-party counter-verifications, in compliance with the verification protocols included in the PIM.

Conditions

Type	Description
Disbursement	Schedule 2-III. B.1.(b) for payments under Categories (1) and (4) each withdrawal shall be made only after the; (i) evidence of the establishment of the TSHIA pursuant to Section IV of this Agreement has been provided to the Association; and (ii) the Subsidiary Agreement has been adopted by the Recipient, through the Ministry of Health, Public Hygiene and Universal Access to Care and the TSHIA, in a manner acceptable to the Association.

Type	Description
Disbursement	Schedule 2-III.B.1.(c) For payments under Categories (1) and (2): (i) each withdrawal shall be made only after the Association has received evidence acceptable to the Association in its form and content and following the requirements set forth in the Project Implementation Manual and the Disbursement and Financial Information Letter, confirming the achievement of the respective PBCs; and evidence, in form and content acceptable to the Association confirming that expenditures under the relevant

	Eligible Expenditures for the PBCs in an amount equal to at least the amount to be withdrawn under each Category in respect of each PBC, have been incurred, and that said expenditures have not been presented before to the Association as satisfactory evidence for withdrawals under this Agreement.
Type Effectiveness	Description Article IV: The Recipient shall establish the PIU within the Ministry of Health, Public Hygiene and Universal Health Access with sufficient resources to carry out its operational and management responsibilities, and with competent staff, as set forth in Section I. 2 of Schedule 2 to this Agreement.

I. STRATEGIC CONTEXT

A. Country Context

1. **Togo is a West African country covering 56,600 km² with five administrative regions namely Maritime, Plateaux, Central, Kara and Savanes.** The estimated population is 7.98 million and growing at an average annual growth rate of 2.31 percent. About 60 percent of the population is under 25 years old. Approximately 57 percent of the population live in rural areas. The capital Lomé is inhabited by a quarter of the population.[1] While French is the official language, two native languages are considered national languages: Mina (a dialect of Ewé), widely spoken in the South, and Kabiyé, primarily spoken in the North.

2. **The Coronavirus disease (COVID-19) pandemic caused an abrupt halt to Togo's strong growth momentum.** Between 2017 and 2019, the country's growth was robust, averaging 5 percent (2.4 percent in per capita terms) supported by a stable macroeconomic framework and significant improvements in the business climate. Togo's Ease of Doing Business ranking jumped by more than 50 places, from 156th in 2018 to 97th in 2020, and its Country Policy and Institutional Assessment (CPIA) score rose from 3.1 in 2017 to 3.3 in 2019, reflecting a gradual improvement in macroeconomic management and business regulation. Since FY20, Togo is no longer included in the harmonized list of countries in fragile situations. However, the eruption of the COVID-19 pandemic in early 2020 forced the economy to a near halt. Growth is estimated to have declined to 0.7 percent in 2020 and the fiscal deficit widened to 6.1 percent of gross domestic product (GDP), reflecting a sharp increase in public spending to protect lives and livelihoods of poor households as well as to support firms facing revenue losses as the economic activity contracted.[2]

3. **The extreme poverty headcount ratio modestly decreased relative to the 1990s, while income inequality has increased.** The 2018-19 West African Economic and Monetary Union (WAEMU) harmonized household survey confirms that poverty and vulnerability remain high and geographically concentrated in rural and remote areas. Although poverty has declined in recent years, more than two fifths of the population still live in poverty. The poverty rate (using the national poverty line of CFAF 743.2 per day) was 45.5 percent in 2018-2019. The extreme poverty rate (at US$1.9 PPP per day) is estimated to have declined to 45.3 percent in 2019 compared to 46.4 percent in 2018, and 58.8 percent in 2011. Extreme poverty is projected to rise to 46.2 percent in 2020 as a result of price increases for basic goods and services combined with lower income for the poorest and most vulnerable, particularly those working in agriculture and tourism. The situation directly affects nutritional values. Twenty-three percent of children under five years of age are stunted and about twice that are underweight.[3] Anemia among children under five is 71 percent, while that among women of reproductive age is 48.9 percent. Vitamin A supplementation for children under -five increased to approximately 90 percent in 2018. Children under five years of age with diarrheal disease receiving oral rehydration therapy (ORT) is 19.2 percent.

4. **Government plans have a strong focus on human capital and the Human Capital Index (HCI) in Togo has**

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[1] *Institute National de la Statistique et des Etudes Economiques et Démographiques* (National Institute of Statistics and Economics and Demographics Studies, INSEED)-Togo. Perspectives démographiques du Togo 2011-2031.
[2] International Monetary Fund (IMF). Country Report No. 20/107. Togo sixth review under the Extended Credit Facility arrangement and request for augmentation of access. Staff Report. April 2020.
[3] Global Nutrition Report. *https://globalnutritionreport.org/resources/nutrition-profiles/africa/western-africa/togo/* accessed on January 28, 2021.

improved. The HCI increased from 0.41 in 2017 to 0.43 in 2020 compared to the Sub-Sahara Africa average of 0.40. The average child is projected to complete approximately 9.7 years of schooling. Factoring in what children effectively learn reduces the actual educational attainment of a given child to six years. Girls spend 9.4 years of expected schooling compared to 10.1 years for boys.[4] The National Development Plan (NDP) for 2018-2022 and the government 2020-2025 roadmap aim to structurally transform the country's human capital potential through universal education, resilient and inclusive growth, job creation, and improvement of social welfare.

5. **The COVID19 crisis has had significant economic and fiscal repercussions as a result of both external and domestic shocks**. On the external side, global trade disruptions lowered Togo's exports and reduced activity at its main port. On the domestic side, containment and mitigation measures are negatively impacting economic activity, leading to supply and demand shortfalls. As a result, growth is estimated to have slowed from 5.5 percent in 2019 to 0.7 percent in 2020, driven by a slowdown in services and export growth as tourism and transport suffer a standstill and key markets are shut. The current account deficit widened from 2.5 percent of GDP in 2019 to 3.7 percent of GDP in 2020, and the fiscal deficit deteriorated from 0.9 percent of GDP in 2019 to 6.1 percent in 2020. Real growth is projected to expand to 3.4 percent in 2021 supported by a significant increase in private consumption and investment and by higher exports as activity gradually resumes in key trade partners. The current account balance is expected to improve slightly, while the fiscal deficit will remain at around 6.1 percent of GDP in 2021 and decline over the forecast period to reach 3.0 percent of GDP in 2023.

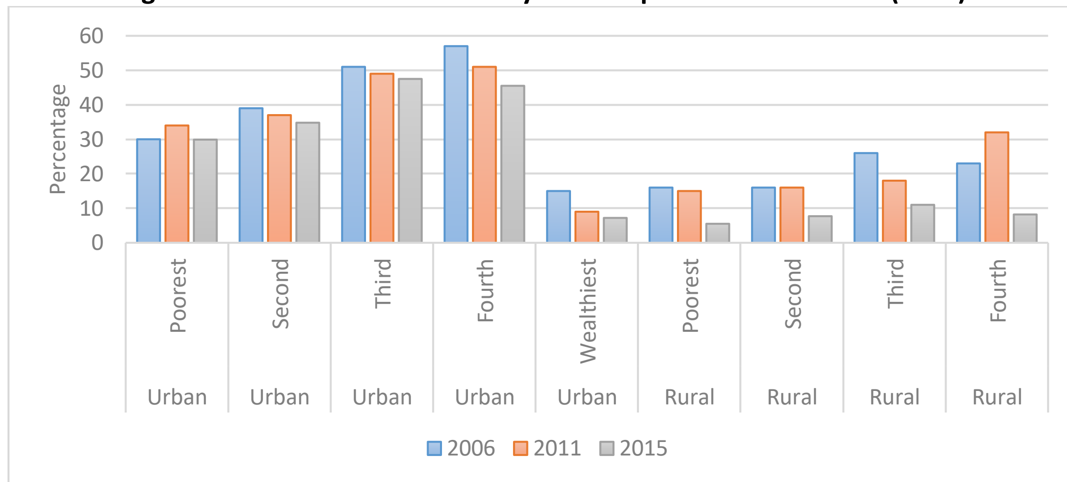
B. Sectoral and Institutional Context

6. **Progress on health outcomes for women and children has been mixed.** According to the World Health Organization (WHO), life expectancy at birth is 60 years.[5] Maternal mortality ratio is 396 per 100,000 live births and the neonatal mortality rate is 25 per 1,000 live births. Under-five mortality rate is 59.8 per 1,000 live births. Compared to Ghana's 308 per 100,000 maternal mortality, 28 per 1000 neonatal and 50 per 1000 live births child mortality Togo is within the region's average. Child stunting is 27.5 percent and wasting is 6.7 percent.[6] Most maternal deaths are due to obstetrical causes such as hemorrhage (36.4 percent), eclampsia (23.5 percent), dystocia (22.3 percent), abortion complications (16.9 percent), and post-partum infections (14 percent). About 17 percent of women use modern family planning methods. About 33 percent of health facilities did not have the capacity to offer antenatal services and only 25 percent of health workers have had any structured training in antenatal care within the past two years. Intermittent Preventive Therapy (IPT) against malaria and tetanus vaccination was widely available. Provision of micronutrients such as iron and folic acid to pregnant women was at 30 percent. Skilled birth attendance has increased to 59 percent in 2018, up from 44.6 percent in 2014.

7. **The wealthiest quintile has more access to health services than the poor**. Expectant women in urban areas are 2.25 times more likely to be attended by skilled personnel (92 percent) than in rural areas (41 percent). Women in the wealthiest quintile (95 percent) were 3.5 times more likely to be assisted by skilled personnel than those in the poorest quintile (27 percent). Similarly, among the poorest populations, children under five years of age are three times more likely to die than the richest population.[7] Diphtheria, Tetanus Toxoid and Pertussis (DPT3) immunization coverage among children under one year is 88 percent.

[4] World Bank. Togo Human Capital Index 2020. *https://databank.worldbank.org/data/download/hci/HCI_2pager_TGO.pdf?cid=GGH_e_hcpexternal_en_ext* Accessed February 10, 2021.
[5] WHO. Key country indicators. *https://apps.who.int/gho/data/node.cco.ki-TGO?lang=en* Accessed May 25, 2020.
[6] SDG dashboard. *https://dashboards.sdgindex.org/profiles/tgo* Accessed November 4, 2020.
[7] Demographic and Health Survey 2013/2014 (DHS3).

Figure 1: Use of health services by wealth quintile and location (2015)



Source : INSEED (2016): Togo Poverty Profile 2006-2011-2015.

8. **Based on the capacity of Togo's health system to ensure continuity of immunization and therapeutic care, the public health and community outreach system is considered efficient in reaching the population with essential services.** Using DPT3-dropout rate and tuberculosis (TB) treatment success rate as proxies for analysis, the Multiple Indicator Cluster Surveys (MICS) 2017 show that more than three-quarters of children (87 percent) received the full dose of DPT vaccine after the initial dose. Similarly, more than three-quarters of TB patients complete their treatment. This shows the strength of the country's public health and outreach system amid all its challenges.

9. **Equitable access to essential health and nutrition services remains a major challenge**. Over 30 percent of the population live more than five kilometers from the nearest health center and accessibility varies by region. In the Savanes region, over 70 percent live more than five kilometers from a health center.[8] The unequal distribution of facilities affects the distribution and availability of qualified health personnel, particularly in Savanes, Kara, Centrale, and Plateaux regions. In 2015, physician density was 0.05 per 1,000 people, far below the average for low-income countries (LICs) (0.325).[9] Similarly, the density of nurses and midwives was much lower than the average of Sub-Saharan African countries (0.3 per 1,000 people and 1.029 per 1,000 people, respectively). About 64 percent of health workers are in Lomé-Commune alone, compared with 4 percent in the Savanes region.[10]

10. **The 2013 Service Delivery Indicator (SDI) survey found that 40 percent of staff were absent from work, with as high as 63 percent absenteeism in urban public facilities.** The high number of health workers in urban areas therefore does not translate into service availability. Adjusting for provider absence, health providers see 5.42 out-patients per provider day.[11] The competence of providers is an additional bottleneck to the quality of PHC service delivery. Health workers generally have some of the lowest adherence to clinical guidelines compared to peer countries. In terms of clinical adherence, 35.6 percent of service providers complied with these protocols and 48.5 percent of them accurately diagnosed the five tracer conditions (malaria with anemia, acute diarrhea

[8] Ministère de la Santé et de l'Hygiène Publique Togo. Rapport de performance 2018.
[9] Global Health Observatory. May 2016 *http://apps.who.int/gho/data/node.cco accessed December 17*, 2020.
[10] Ministère de la Santé et de l'Hygiène Publique Togo. Rapport de performance 2018.
[11] World Bank. Togo SDIs. Health 2013 Report No: AUS5476, June 2016.

with severe dehydration, pneumonia, pulmonary tuberculosis, and diabetes mellitus), which is below other SDI countries like Uganda, Kenya, and Tanzania.

Table 1: Benchmarking the quality of care in Togo with SDI survey results

	Togo 2013	SDI avg.	SL 2018	Niger 2015	MDG 2016	MOZ 2015	TZA 2016	NGA* 2013	UGA 2013	KEN 2013	SEN 2010
Caseload (per provider per day)	5.2	9.03	10.0	9.8	5.2	17.4	7.3	5.2	6.0	15.2	-
Absence from facility (% providers)	37.6	30.2	29.9	33.1	27.4	23.9	14.3	31.7	46.7	27.5	20
Diagnostic accuracy (% clinical cases)	48.5	47.2	44.5	31.5	30	58.3	60.2	39.6	58.1	72.2	34
Adherence to clinical guidelines (% clinical guidelines)	35.6	33.4	30.2	17.5	31	37.4	43.8	31.9	41.4	43.7	22
Management of maternal and neonatal complications (% clinical guidelines)	26.0	23.5	31.2	12.0	21.9	29.9	30.4	19.8	19.3	44.6	-
Drug availability (% drugs)	49.2	53.5	56.0	50.4	48	42.7	60.3	49.2	47.2	54.2	78
Equipment availability (% facilities)	92.6	55.8	31.9	35.9	62	79.5	83.5	21.7	21.9	76.4	53
Infrastructure Availability (% facilities)	39.2	38.6	47.7	13.3	28.4	34	50.0	23.8	63.5	46.8	39

Notes: Nigeria is the weighted average of 12 states. Details are available at *http://www.sdindicators.org*.
Abbreviations: "SL" is Sierra Leone, "MDG" is Madagascar, "MOZ" is Mozambique, "TZA" is Tanzania, "NGA" is Nigeria, "UGA" is Uganda, and "KEN" is Kenya. Some indicators were not comparable in the survey for Senegal.

11. **The majority of health facilities have waste management and infection prevention and control systems in place.** Findings from the Service Availability and Readiness Assessment (SARA) Survey in 2012 show that most facilities (93 percent) had adequate waste disposal, as assessed by the availability of three tracer items: safe final disposal of sharps, safe final disposal of infectious/hazardous waste, and guidelines for waste management in place. Infection control was assessed by the availability of six tracer items: disposable gloves, disposal syringes, surface disinfectant, soap and running water, appropriate storage of sharps and appropriate storage of infectious waste. On average, more than two-thirds of facilities (69 percent) had the six tracer items in place.

12. **The quality of care is limited due to the challenging health facility environment where services are delivered.** Most facilities lack maintenance, equipment and logistics to deliver care. The Government spent less than 8 percent of the total public health expenditure allocated in the 2020 amended finance law. There is limited diagnostic imaging capacity. Tracer drug availability is low (45.6 percent in 2018, 46.4 percent in 2017 and 51 percent in 2016).[12] Essential and generic drugs are usually substandard in quality in parts of the country and not widely available. This is due to poor regulatory compliance and a weak supply chain management system.[13] The regulatory authority has recently relaunched the drug licensing commission. However, the Central Purchasing

[12] Ministère de la Santé et de l'Hygiène Publique Togo. Rapport Annuel de Performance Année 2018.
[13] Schäfermann S, Wemakor E, Hauk C, Heide L (2018) Quality of medicines in southern Togo: Investigation of antibiotics and of medicines for non-communicable diseases from pharmacies and informal vendors. PLoS ONE 13(11): e0207911. *https://doi.org/10.1371/journal.pone.0207911* accessed on 30 May 2020.

Agency for Medicines (*Central d'Achat des Médicaments Essentielles et Générique,* CAMEG) faces structural and organizational problems that prevent it from playing its role to the fullest.

13. **National budget allocation to the health sector remains relatively low at less than 7 percent**.[14] Total health expenditure increased on average by 28 percent between 2013 and 2016.[15] Households' out-of-pocket expenditure accounted for 56.3 percent of total health expenditure in 2018. This exposed families and women to the risk of tipping into extreme poverty due to catastrophic health expenditure. The Government introduced a contributory health insurance mechanism in 2011 by decree No 2011-034/PR managed by the National Institute of Health Insurance (*Institut National d'Assurance Maladie, (INAM).* This health insurance scheme covers active and retired civil servants and their dependents. As of 2018, it had a total membership of around 350,000 or 5 percent of the total population, made up of around 100,000 direct contributors and 250,000 dependents. The scheme has a large network of contracted service providers, including 1,065 health centers and 206 pharmaceutical dispensaries across country. The first cycle of school-based insurance schemes, known as the School Assur, was also introduced in 2017 providing health insurance coverage for pupils during school term time. The non-coverage during holidays however has left school children exposed to out-of-pocket payments for health services when they are home. The scheme also does not cater to the large swaths of youth and adolescents who are not in school. There is no scheme for the informal sector.[16]

14. **The overall Joint External Evaluation (JEE) score of the International Health Regulations (IHR) for Togo is 39 out of 100.**[17] Out of the 19 technical areas of the JEE, only one aspect of the national laboratory system had a favorable rating of 4, while the majority of the technical areas scored 2 or 3, on a scale of 1 (no capacity) to 5 (sustainable capacity). The following technical areas were rated as weak: (i) legislation, politics and national financing; (ii) antimicrobial resistance (AMR); (iii) emergency response operations; (iv) system to transfer and transport sample; (v) biosafety and biosecurity; (vi) medical countermeasures; and (vii) public health actions at point of entry. The following areas were noted for further strengthening: (i) zoonotic diseases; (ii) reporting; (iii) preparedness; (iv) risk communication; and (v) development of personnel. Togo is prone to infectious diseases. Meningitis and Lassa Fever outbreaks occurred in recent times.

15. **On March 6, 2020, the Ministry of Health, Public Hygiene and Universal Access to Care (MHPHUAC) announced the first confirmed cases of COVID-19 in Lomé.** The Government developed the country's COVID-19 action plan, which includes surveillance of air, land and maritime borders, restrictions on the size of gatherings, sensitization and information sharing, and clinical and para-clinical screening. A prolonged COVID-19 pandemic increases risks of health professionals staying away from their work, thus, leading to the disruption of essential health and nutrition services. This project will not directly support the COVID-19 response, but it lays foundations that will reinforce the resilience of the basic health system against future pandemic risks. Other IDA-funded projects directly support the national COVID-19 response plan: (i) the World Bank has been supporting the Government efforts through the Regional Disease Surveillance Systems Enhancement Project (REDISSE: P159040), which became effective in 2017; and (ii) The Togo COVID-19 Emergency Response and Systems Preparedness Strengthening Project (P173880), which became effective in April 2020, using the Multiphase Programmatic

[14] Système intégré de gestion des finance publique (SIGFIP).
[15] Ministère de la Santé et de l'Hygiène Publique Togo. Les comptes nationaux de la santé 2015-2016.
[16] Atake E. H., Amendah D.D. Porous safety net: catastrophic health expenditure and its determinants among insured households in Togo. 2-18. BMC Health Services Research, 18:175. *https://doi.org/10.1186/s12913-018-2974-4*
[17] Joint External Evaluation of the International Health Regulations main capacities of the Togolese Republic. Geneva: World Health Organization; 2018 WHO/WHE/CPI/REP/2018.31). License: CC BY-NC-SA 3.0 IGO.

Approach (MPA). An Additional Financing (AF) by the Government to support COVID-19 vaccine purchases and effective deployment under the specific approved MPA-AF for COVID-19 vaccines is under preparation. The summary of Togo's country program adjustment in response to COVID-19 is provided in Annex 4.

16. **The project is designed to contribute to the implementation of the National Health Development Plan (*Plan National de Développement Sanitaire, PNDS)* 2017-2022).** Under the PNDS, the MHPHUAC plans to carry out strategic reforms to improve the efficiency of its intervention in the fields of: (i) governance and strategic piloting; (ii) health financing; (iii) human resources management; (iv) management of medicines, reagents, consumables and essential medical devices; and (v) service delivery. The project will consolidate these initiatives to improve inclusive public service delivery and build on the lessons learnt from the recently completed Maternal and Child Health and Nutrition Services Support Project (*Projet d'Appui aux Services de Santé Maternelle, Infantile et de Nutrition,* PASMIN: P143843). It will also draw on other initiatives of the Togolese authorities supported by the World Bank such as the Unified Social Registry (USR) (financed under West Africa Unique Identification for Regional Integration and Inclusion - WURI 2, P169594). These will provide a basis for the identification and registration of the poor onto a social health insurance scheme. Recently, the Government has been working on a Bill which aims at introducing a social health insurance scheme. The project will support this effort by strengthening institutional and project management capacity and give citizens a voice through the community feedback mechanisms (external accountability) that will be coordinated with activities envisaged under the Togo Economic Governance Project (P158078).

C. Relevance to Higher Level Objectives

17. **The Country Partnership Framework (CPF) for FY17-20, extended to the end of FY22, is the first full World Bank Group (WBG) country strategy since 1995.**[18] The CPF addresses the International Development Association (IDA) priorities of jobs and economic transformation and IDA19 special themes of Fragility, Conflict and Violence (FCV).[19] Critical to this special theme is building the state's legitimacy and capacity, inclusive institutions, and renewing the social contract between citizens and the state towards achieving Universal Health Coverage (UHC). The current CPF has three focus areas: (i) private sector performance and job creation; (ii) inclusive public service delivery focused on human capital development; and (iii) environmental sustainability and resilience. The project will contribute to attaining CPF Objective 2.1: strengthen health services, using a two-pronged approach: (i) support quality health care and service delivery reforms in the health sector; and (ii) remove geographical and financial barriers to equitable access to care by women, children, the poor and vulnerable. Foundational investments are required to improve human development outcomes, including maternal and infant health and nutrition status.

18. **As described above, the project will not directly fund the national COVID-19 response, which is supported by two ongoing World Bank operations**. The REDISSE Project (P159040) strengthened the country's public health emergency preparedness and response alongside the Togo COVID-19 Emergency Response and Systems Preparedness Strengthening Project (P173880). There is a new request for AF by the Government to support effective COVID-19 vaccine deployment. Through strengthened primary health systems, the project will provide a

[18] World Bank. 2017. Togo - CPF for the period FY17-FY20 (English). Washington, D.C.: World Bank Group. *http://documents.worldbank.org/curated/en/953481513100047718/Togo-Country-partnership-framework-for-the-period-FY17-FY20* was presented to the Board of Executive Directors on May 16, 2017.
[19] World Bank. 2019. IDA 19 Second Replenishment Meeting: Special Theme - FCV; IDA 19, Washington DC *http://documents.worldbank.org/curated/en/515831563779134705/pdf/IDA19-Second-Replenishment-Meeting-Special-Theme-Fragility-Conflict-and-Violence.pdf* accessed on 31 May, 2020.

strong platform for the delivery of essential health and nutrition services at the lower health facilities and household levels. The community engagement framework is provided in Annex 3.

II. PROJECT DESCRIPTION

19. This project uses Investment Project Financing (IPF) with Performance-based Conditions (IPF-PBC),[20] which combines results-based disbursement with input-based financing. The results-based financing will promote equitable access to essential health and nutrition services for deprived communities by linking services availability and utilization with payment for quality services. The input-based financing will ensure that infrastructure, human resources and access to health insurance are brought nearer to the patients and households in the rural and deprived communities. Specifically, the project will assist the Government of Togo (GoT) to: (i) provide essential primary health and nutrition services, targeting women, children and the vulnerable; (ii) support the roll out of the integrated health insurance scheme under health facility accreditation, to purchase services; and (iii) improve access to health facilities and services. The focus is on the protection of vulnerable populations from high out-of-pocket health expenditures.

A. Project Development Objective

PDO Statement

20. The project development objective (PDO) is to improve the provision of essential health and nutrition services and quality of care for pregnant women, children and vulnerable populations.

PDO Level Indicators

(a) People who have received essential health, nutrition and population services (HNP) (number, disaggregated by sex);
(b) Persons receiving services from newly established health facilities (number, disaggregated by sex);
(c) Health facilities on health insurance contract passing minimum national accreditation standards (number); and
(d) Tracer drug availability in peripheral health unit (PHU) facilities (percentage).

B. Project Components

Component 1: Increasing demand and supply of quality health and nutrition services (US$32.60 million equivalent)

21. This component focuses on providing opportunities for Government to deliver services and improve access to the most vulnerable populations. The emphasis is to improve equity by reaching deprived communities with the needed services. Payment for these services is therefore linked to PBCs.[21] There are four PBCs, each of which

[20] World Bank Guidance IPF with PBC; January 29, 2020.
[21] Eligible expenditures for the PBCs payment are defined expenditures, in the project implementation manual, that are eligible for financing as follows: (a) for Sub-component 1.1: fuel and transportation for home visits and outreach, maintenance of motorbikes, maintenance of weighing scales, dry batteries, refreshment during outreach and community durbars, per diem, allowances for facilitators at community durbars, allowances for health workers, including community health workers and volunteers, renting of furniture and

constitutes sub-components under Component 1.

(a) PBC 1: People who have received essential HNP services (Corporate Result Indicator: CRI, number, disaggregated by sex);
(b) PBC 2: Persons registered onto the health insurance scheme (number, disaggregated by target group);
(c) PBC 3: Newly recruited staff deployed to the four most deprived regions (number, disaggregated by doctors and other health professionals,); and
(d) PBC 4: Tracer drug available at the primary health care (PHC) level (percentage).

Sub-component 1.1: Increasing access to essential health and nutrition services (US$6.70 million equivalent)

22. **The project will purchase a basic package of essential health, immunization and nutrition services delivered at the households, in communities and PHU type I and type II and District Hospitals (DH type I and type II).** The service package, at the primary level of care, will include maternal and child health and nutrition services, immunization, outpatient or inpatient care, birth deliveries and attendance, newborn care, malaria, TB, HIV/AIDS, acute respiratory tract infection, diarrheal disease, hypertension, anemia, intestinal worms disorders, fevers, ear, eye, nose and oral health services, and key additional or tracer services. The provinces will be the Fund Management Centers (FMC), contracted to deliver specific services to a target population on an annual basis. Participating health facilities will be assessed by the Togo Social Health Insurance Agency (TSHIA). Health facilities which meet the minimum quality standards will be accredited to provide the package of services.

23. **Payment for services will be directly linked to the proportion of target achieved as a national aggregate.** While the targets are aggregated, a weighting formula will be determined to reward differentially the rural and urban contributions to the achieved results. Targets are set by calendar year as milestones but the cumulative results for this five-year project may be achieved up and until the project closing date (non-time-bound). Unachieved results can be rolled over and added to the subsequent year's targets. Disaggregated facility-level results will be submitted and verified by the TSHIA and the national audit agency. Those accessing services will be encouraged to register for the health insurance scheme. This will yield important data on performance, cost and efficiency of the various facilities and help with policy and health financing and systems planning. It is expected that the payments received by the Government will reward better- performing facilities. The reward criteria will, however, be at the discretion of the Government. About 20 percent of the results submitted will be randomly selected and independently validated by an appointed independent agency acceptable to the World Bank. All results must be accepted and cleared by the World Bank before payments are made by the TSHIA to the provinces. The performance targets for each province will be detailed in the Project Implementation Manual (PIM) to be prepared and adopted within six months after the project effectiveness date.

24. The essential package of services will be linked with the Togo COVID-19 Emergency Response and Systems Preparedness Strengthening Project (P173880) to ensure the protection of vulnerable populations. These activities also complement the Togo Improving Quality and Equity of Basic Education Project (P172674) and

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canopies, meeting package for quality review at the local government level; (b) for Sub-component 1.2: Payment for premiums or contributions for households registered onto the social health insurance scheme among the poor and the vulnerable, which eligibility will be defined by the Safety Nets and Basic Social Services project, per diem and transportations; (c) for Sub-component 1.3: hardship allowances, accommodation, school fees for children under the age of eighteen (18) in public institutions, relocation grant, monthly transport or fuel allowances, premiums for comprehensive health insurance above basic package, pre-and post-basic training for candidates from, *inter alia*, Kara, Savanes, Central and Plateau regions to attain nursing, midwifery and physician assistant first level degree qualification; and (d) for Sub-component 1.4: payment for primary health care level medicines, infection prevention and non-drug consumables,

ongoing communication on the importance of health care and user rights. Some development partners have already developed a core cadre of volunteers, including community health workers (CHWs), who are already supporting nutrition and homebased care activities. The project will seek to collaborate with these partners to enhance the project and avoid duplication. The project will also monitor the proportion of female health workers who are involved in community outreach and PHC provision to improve the accessibility and acceptability of services among the vulnerable, women and children.

25. For the purpose of quality enhancement, this sub-component is directly linked to Component 3 under which quality assurance processes and tools will be deployed as part of the accreditation measure. A systematic approach will be introduced for: (i) facility-based assessment of entry-level quality; (ii) the preparation of a facility-specific Quality Improvement Plan (QIP); (iii) the implementation of the QIP through supervision/quality counseling; and (iv) the development of harmonized monitoring tools. Emphasis will be placed on accurate diagnosis and treatment protocols. Rational medicines prescription and use will be strengthened. An active program to contain AMR will be implemented to stem microbial resistance and anti-biotic abuse. Patient and client satisfaction surveys will be undertaken to inform the development of people centered care standards.

Sub-component 1.2: Increasing membership of the poor and vulnerable in health insurance (US$8.00 million equivalent)

26. The project aims to provide financial protection for the poor against catastrophic health expenditures. To target the vulnerable more precisely, payments under Sub-component 1.1 will be directly linked to access to services by those registered onto the health insurance scheme. This will encourage registration onto the health insurance scheme. Registration and issuance of registration cards will be free for the vulnerable population. It is expected that deprived communities, pregnant women, children and school-aged children will be prioritized. To examine the eligibility for fee exemption, the project will leverage on the Safety Nets and Basic Social Services Project (P157038) or e-ID Project and other data base systems e.g., school enrolment to enrol members in the scheme. The vulnerability criteria will be defined in a consensus with all actors, including community-based actors Village Development Committee (*Comité Villageois de Développement,* CVD), Village Quarter Committee *(Comité de Développement de Quartier,* CDQ), women's groups, and youth groups, among others.

27. **Payment for members registered will be directly linked to the proportion of target achieved as a national aggregate.** As the targets are aggregated, a weighting formula will be determined to reward differentially for pregnant women, children under five years of age, school-aged children at age of 6-19, rural and urban populations in the achieved results. Targets are set by calendar year as milestones but the cumulative results for the project may be achieved up and until the project closing date (non-time-bound). Unachieved results can be rolled over and added to the subsequent year's targets. The national audit agency will validate all results, including cross referencing of the various databases. About 20 percent of the submitted results will be randomly selected and independently validated by an appointed independent agency acceptable to the World Bank. All results must be accepted and cleared by the World Bank before payments are made to the TSHIA by the World Bank. The performance targets for each province will be detailed in the PIM to be prepared before the project effectiveness and validated within three months after the project effectiveness date.

Sub-component 1.3: Improving equitable distribution of health professionals (US$2.90 million equivalent)

28. **To enhance equity in access to quality healthcare services, the project will target the training and posting of qualified health professionals to the most deprived and rural communities.** Consideration will be given to another region on a justified need basis except the Lomé Commune and its immediate environs. The Government will map and provide a staffing norm and a list of vacancies to be filled. The project will pay for incentives and school fees of qualified persons who are identified from these regions and chosen to be trained as midwives or physician assistants. These persons will be chosen in consultation with the communities. Serving professionals who agree to serve in the deprived areas may be considered for this subsidized training opportunities. The beneficiaries must have signed a bond to serve their community.

29. **The project will also provide incentives for persons accepting posting to the target areas.** The incentive will include deprived area and hardship allowances, accommodation, school fees for children under the age of eighteen (18) in public institutions, and relocation grant. The funds will only be released on verification of the professional taking up a position in the deprived area for not less than twelve (12) months. All dependents will be verified through birth certificates. The fund will be reimbursable with an initially agreed frontloading of resources for up to 40 percent of the target to be achieved in the first year. The Government agrees to match the advance payment with an equal amount.

30. **The PIM will detail the cost of the incentives and benefit scheme.** Each beneficiary will receive the incentives from the project for not more than three (3) years. Once a recipient has been identified, remaining in that post is a factor that counts as part of the subsequent year's target. The benefits from the project fund will be ceased when the beneficiary has received the incentives for three years. The Government may pose a condition and commit to continue the payment for benefits to the individuals after the third year of project funds receipt by the beneficiaries. The graduation from the project to the government financing is to ensure the sustainability of this activity. The request for release of funds will be made on a signed verification letter by the regional/provincial director of health services and the administrative head of the local government responsible for the province, commune or district in which the person has assumed post. About 50 percent of the submitted results will be randomly selected and independently validated by an appointed independent agency acceptable to the World Bank. All results must be accepted and cleared by the World Bank before payments are made to the MHPHUAC by the World Bank. The annual targets may be rolled over to the subsequent year.

Sub-component 1.4: Increasing tracer drug availability at PHU facilities (US$15.00 million equivalent)

31. **A key complement to ensure quality healthcare services delivery is essential medicines and non-drug consumables.** The project will reward availability of essential medicines in health facilities accredited by the TSHIA across the country. The list will be drawn from the country's essential medicines list and included in the PIM. The minimum tracer drug availability to receive payment will be 70 percent. This target is both a stock measure and a vetting of prescriber behavior in terms of diagnostics, prescription and availability of the appropriate medication disbursed to the patient. The data will be based on routine reporting by facilities through the province verified through random selection of 10 percent of public facilities in the country. The verification function will be performed by the TSHIA and the national audit service whose report must be cleared and accepted by the World Bank. The World Bank may request for independent verification, including a sample survey of beneficiaries. While the targets are aggregated, a weighting formula will be determined to reward differentially tracer drug availability in facilities in the deprived regions and rural areas. The targets to be achieved is a constant percentage. The residual value of partially achieved results will be canceled and not rolled over to the subsequent year.

Component 2: Bringing health facilities and services close to households (US$30.00 million equivalent)

Sub-component 2.1: Increasing access of vulnerable populations to health facilities and services (US$27.30 million equivalent)

32. **The Government is decided to improve access to and quality of professionally provided services through the building of community-based facilities and the refurbishing or renovation of existing ones.** This is an essential intervention needed to support the achievement of Component 1. A facilities availability mapping is being undertaken to digitally locate all PHC facilities on a geospatial map. The priority list will be validated through stakeholder and community consultations and approved by the World Bank. Based on the priority list, the project will fund the construction or renovation/refurbishment of Type I PHUs or Type II PHUs. Facility renovations will be based on consultant estimates. For new facilities, a prototype design will be developed and approved by the World Bank. In communities where rental accommodation is not available, the project will finance a two-room studio type residential facility. The principle of 2,500-5,000 population per facility within a 5-kilometer radius for a Type I PHU and 5,000-15,000 for a Type II PHU will be used to determine their locations. Special dispensations may be given to spatial locations with smaller population size but in a greater need. The structures will mostly be prefabricated turn-key facilities with minimal on-site construction e.g., water and sewage and connection to other public utilities. Facilities will be equipped with human waste biodigester and an off-grid solar power system to generate electricity for health facilities and accommodation for staff. Resources will be provided for monitoring and ensuring safeguards compliance.

Sub-component 2.2: Providing equipment to the newly built health facilities (US$2.70 million equivalent)

33. **The project will provide each newly built facility with soft furnishing, motorbikes/bicycles and/or pick up vehicles to support service delivery and supervision.** Each motorbike will be mounted with a service delivery kit to support community outreach and home-based care. The service delivery kit will contain basic out-patient department (OPD) equipment, including a baby hanging weighing scale, thermometer, measurement of mid-upper arm circumference (MUAC) for under-five children, sphygmomanometer, over the counter-compliant first aide medication and icepacks or portable vaccine carriers. Resources will be provided for riders training under the procurement contract.

Component 3: Strengthening the national social health insurance scheme (US$4.30 million equivalent)

Sub-component 3.1 Establishing and supporting the operations of the TSHIA (US$3.70 million equivalent)

34. **To achieve UHC, the Government has initiated the processes of consolidating various existing schemes into a single purchaser of services to cover the entire population through the development of a national social health insurance scheme.** The project will recruit consultants and support workshops to develop, review and adopt policies, operating procedures, institutional manual and legislation. The consultants will also develop a comprehensive but layered benefits package. The first layer will be free to all the population and additional layers that will attract payment of contributions and premium. The project will purchase the first layer linked to Sub-components 1.1, 1.2 and 1.4. The consultants will support the development of tariffs to be paid to service providers for the additional layers of benefits and the method of payment – diagnostic-related group (DRG), capitation or fee for service. The aim is to focus the scheme on prioritizing PHC while ensuring the continuum of care at the specialized level. The project will fund technical assistance to review and introduce process efficiency, reduce fraud, guarantee value for money and long-term sustainability of the scheme.

35. **Enhanced biometric registration and mobile renewal systems:** An aggressive membership drive particularly in the deprived areas will be pursued to achieve the objectives of Sub-component 1.1, 1.2 and 1.3. The project will leverage on the World Bank-supported Safety Nets and Basic Services Project (P157038)[22] and other data base systems e.g., school enrolment and youth-ID card to enrol members in the scheme. Having a national ID under the Safety Nets and Basic Service Project will automatically qualify the bearer to access project services. The scheme will tie its hardware and software to the existing project and share a common database. Consultants will be recruited to support hardware, software and data management system integration. The membership enrolment software and database will be both on-line and off-line compliant while ensuring that data protection laws are complied with.

36. **The review and setting of the clinical standards and the facilities contracting process will be done.** New and simpler assessment tools will be developed to rationalize facilities categorisation, licensing, accreditation and contracting linked to Component 1. Only accredited facilities will be allowed to provide services under the project. The aim is to reduce multiplicity and transaction cost to both providers, Government, and the insurance agency. All assessment tools will be deployed electronically with automated scoring and grading system. A core group of staff will be trained to support scheme management, monitoring and evaluation (M&E) of activities of the scheme. Where needed technical experts may be recruited. The sub-component will also support operating costs of the TSHIA.

Sub-component 3.2: Promoting demand for health insurance services (US$0.60 million equivalent)

37. This innovative reform program needs community engagement, public education, awareness and demand generation to be successful. The project will support the development and roll-out of a national health insurance campaign, using both traditional and social media information sources. Emphasis will be on the design of the scheme, its benefits and the rights of the beneficiaries. Several communication support materials will be developed in print, for radio, television and social media in local and sign languages and in braille, after testing to be proved socio-culturally acceptable. The project will also fund community engagement and social mobilization activities at the community level. Building on the School Assur Program, school-aged children, both in school and out-of-school, will also be reached to fulfill the needs of adolescent health.

Component 4: Improving stewardship, oversight and management (US$3.10 million equivalent)

Sub-component 4.1: Assuring the social, environmental safeguards of the project (US$0.50 million equivalent)

38. Social, environmental, fiduciary and other safeguards specialists will be assigned or recruited to support the project's implementation. Once in place, they will be responsible for the development and implementation of the Environment, Procurement, Financial, Social and Community Engagement plans and instruments developed for the project. The specialists will assess and improve the plans and oversee the installation of adapted waste disposal systems as needed to improve waste management in the project areas. The resources may also be used for training. Several mitigation measures may be relevant, including adjusting infrastructure norms to address known risks and possible climate change. Project proceeds will not finance land acquisition.

39. Key personnel on the project will benefit from training in the prevention of workplace sexual exploitation and abuse (SEA), sexual harassment (SH) and gender-based violence (GBV). A code of conduct for those who will be

[22] *https://projects.banquemondiale.org/fr/projects-operations/project-detail/P157038*

involved in the project implementation will be detailed in the PIM, which provides operational guidelines. The project will adhere to the fundamental principles and standards of conduct that apply to all employees, partners and representatives of the project, including subcontractors and suppliers without exception.

Sub-component 4.2: Providing project management and coordination (US$2.60 million equivalent)

40. This sub-component will finance the operating costs of a Project Coordination Unit (PCU) and the Project Implementation Unit (PIU) in the MHPHUAC. The allotted budget will be split equally between the two agencies. Specifically, it will support costs of coordination, contracting and management of project implementation consultants, M&E, independent verification, quality surveys, external audit and project management. Workshops and seminars to advance the work under the project will be eligible for financing. There will be comprehensive training and coaching for all implementing agencies. Support will also be provided for additional fiduciary functions; the exact nature will depend on needs assessment and the corresponding action plans prepared.

Component 5: Contingent Emergency Response Component (CERC) (US$0 equivalent)

41. This component is included under the project in accordance with World Bank IPF Policy, paragraphs 12 and 13, for contingent emergency response to an eligible crisis or emergency, as needed. It will allow the Government to request the World Bank for rapid reallocation of project funds and respond promptly and effectively to an eligible emergency or crisis that is a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact. If the World Bank agrees with the determination of the disaster and associated response needs, this component will draw resources from the categories financing other components and/or allow the Government to request the World Bank to recategorize and reallocate financing from other project components to cover emergency response and recovery costs. This component could also be used to channel additional funds should they become available in the event of an emergency. Disbursements will be made against a positive list of critical goods or the procurement of works and consultant services required to support the immediate response and recovery needs. The details will be defined on activation of the component as per World Bank Operational Policy.

42. **Project Cost and Financing**. The proposed total project cost is US$70 million over five years (Table 2).

Table 2: Project Costs by Component (in US$ million equivalent)

Project Components	IDA Financing
Component 1: Increasing demand and supply of quality health and nutrition services	**32.60**
Sub-Component 1.1: Increasing access to essential health and nutrition services	6.70
Sub-Component 1.2: Increasing membership of the poor/vulnerable on health insurance	8.00
Sub-Component 1.3: Improving equitable distribution of health professionals	2.90
Sub-Component 1.4: Increasing tracer drug availability at PHU facilities	15.00
Component 2: Bringing health facilities and services close to households	**30.00**
Sub-Component 2.1: Increasing access of vulnerable populations to health facilities and services	27.30

Sub-Component 2.2: Providing equipment to the newly built health facilities	2.70
Component 3: Strengthening the national social health insurance scheme	**4.30**
Sub-component 3.1: Establishing and supporting the operations of the TSHIA	3.70
Sub-component 3.2: Promoting demand for health insurance services	0.60
Component 4: Improving stewardship, oversight and management	**3.10**
Sub-component 4.1: Assuring the social, environmental safeguard of the project	0.50
Sub-component 4.2: Providing project management and coordination	2.60
Component 5: Contingent Emergency Response Component	**0.0**
Total Project Cost	**70.00**

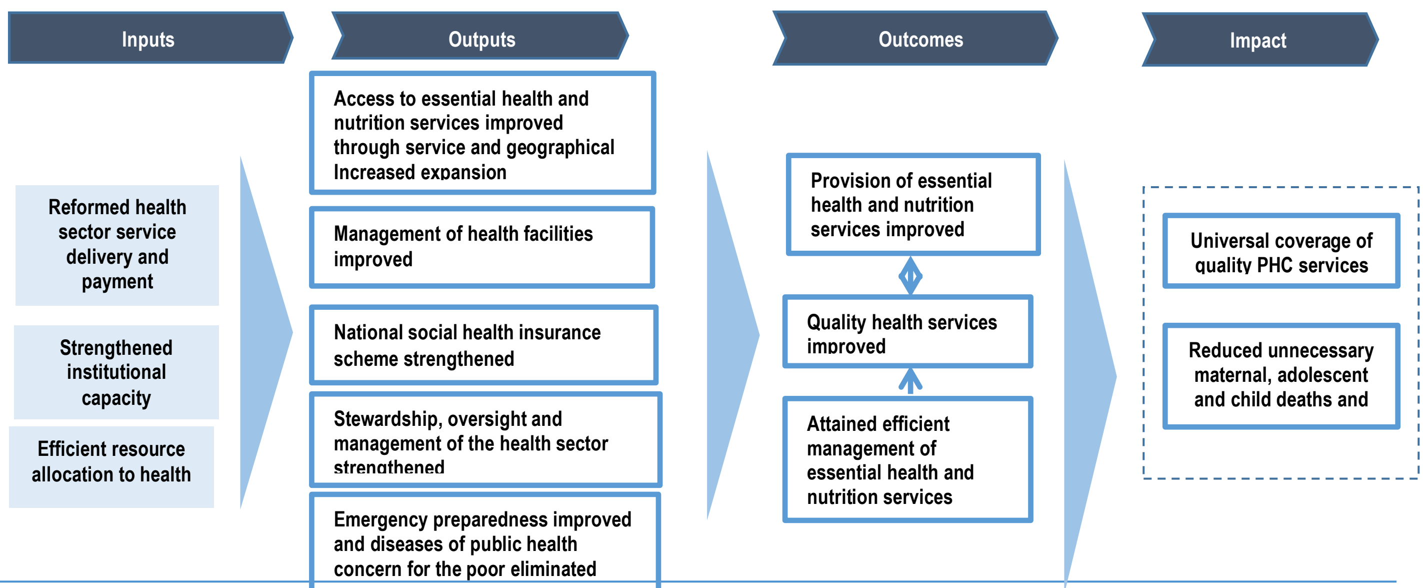
C. Project Beneficiaries

43. The project anticipates providing essential health and nutrition services to sixty percent of the population. The main project beneficiaries are children under the age of 18 (estimated numbers: 923,000), women with emphasis on pregnant women (estimated numbers: 320,000) and mothers taking care of children under five years of age (estimated numbers: 1,100,000), the poor and persons living in the most deprived communities..

D. Results Chain

44. The theory of change underlying the project draws on the key results areas that produce outcomes and impact leading to the whole system transformation in the short- to medium-term. The results chain also links discrete process of service delivery to ensure quality, efficiency, equity, and cost effectiveness. It addresses cross-cutting areas such as human resource capacity building and distribution, stewardship and governance, technology, infrastructure, budgeting and procurement. These are presented in Figure 2 below.

Figure 2: Results chain



E. Rationale for World Bank Involvement and Role of Partners

45. **The 2016 Systematic Country Diagnostic (SCD)[23] highlights poor health as an obstacle to poverty reduction in Togo.** Poor health is an economic burden that disproportionately affects poor children and women and represents a key constraint to inclusive economic growth and well-being. There are disparities between rural and urban areas and the poorest and wealthiest quintiles in accessing health services and the overall decline in the use of health services. The project will contribute to the WBG's Twin Goals of ending poverty and boosting shared prosperity. The World Bank brings a great deal of experience with performance-based contracting across the globe, which will help the Government in refining and executing its vision.

46. **There are several development partners active in Togo's health sector with a national platform for coordination of their activities.** The main ones include the French Development Cooperation (*Agence Française de Développement*: AFD) supporting Muskoka project to upgrade 12 Emergency Obstetrical and Newborn Care (EmONC) facilities (eight Basic, three Comprehensive, and one hospital) and to conduct training in Plateaux and Maritime regions. The collaboration with AFD will be explored to synergize in the overlapping targeted areas of the Project. United Nations Development Program (UNDP) has been engaged in construction, rehabilitation, and provision of equipment and has renovated the Prefectural Hospital Center (*Centre Hospitalier Prefectoral,* CHP) in Bè and Kpalimé. United States Agency for International Development (USAID) is supporting the GoT towards achieving UHC, especially in the field of social responsibility with the development of a roadmap with the MHPHUAC and the Ministry of Public Service, Labor, Administrative Reform and Social Protection. It has a regional project (Family Health International: FHI 360; 2017-2022) on HIV prevention, targeting the poor, in collaboration with the United States President's Emergency Plan for AIDS Relief (PEPFAR). Another regional project of USAID: Amplify-FP supports in the areas of sexual and reproductive health and family planning. USAID also supports nutrition programs and COVID-19 response. German Development Agency (*Deutsche Gesellschaft für Internationale Zusammenarbeit,* GIZ) has been supporting the enhancement of reproductive health and sexual health and rights, primarily in the Kara region for a period of 2018-21. The added value of this project in taking initiative to bring together various experiences and provide leadership in transforming the sector at the primary level through community care mechanisms. United Nations Children's Fund (UNICEF) has been supporting the integrated community case management (iCCM) of childhood illness in the Northern region. United Nations Population Fund (UNFPA) contributes to building capacities for emergency obstetric and newborn care, reliable family planning, and sexual and reproductive health services for youth. WHO provides technical advice to the MHPHUAC, especially in the fields of human resources for health and public health emergency preparedness and response.

47. **There is potential to collaborate with the Global Fund to Fight Against AIDS, Tuberculosis and Malaria (the Global Fund).** The Global Fund supports fiduciary capacity building including an integrated financial management (FM) software, technical assistance and capacity building for public financial management (PFM). These present opportunities to work together for the IDA-funded project to leverage on the capacities being developed.

48. **An in-depth assessment of the performance of the Togo PHC systems is being carried out by** the Primary Health Care Performance Initiative (PHCPI). The PHCPI is a partnership of the WBG, the Bill and Melinda Gates Foundation, and WHO that aims to support countries to improve PHC. PHCPI uses a framework to assess strengths

[23] World Bank. 2016. *Togo - Systematic Country Diagnostic*. Washington, D.C.: World Bank Group. https://hubs.worldbank.org/docs/imagebank/pages/docprofile.aspx?nodeid=26816188

of PHC policies and governance, availability and distribution of resources, as well as the organization and management of PHC services. PHCPI uses a mixed methodology of quantitative and qualitative instruments. The project will provide technical assistance and will engage with other participating countries to consider interventions and policies leading to higher performing PHC delivery models and monitor results over time.

F. Lessons Learned and Reflected in the Project Design

49. **The project design considers the lessons learned from the previous project, PASMIN: P143843,[24] which proved that flexibility and adaptability are key for successful project implementation.** The rigidity of the proposed drug and medical acquisition mechanism and the prolonged discussion on the procurement of anthropometric equipment did not only significantly delay project implementation but also demotivated the government partners and missed opportunities to create a competitive market for supplies. The previous project has also proved the importance of CHWs in delivering a range of family planning, malaria and even health consultations within their catchment communities. Therefore, in consultation with government partners, the proposed project has selected the IPF with PBC, which focuses on results in the areas of PHC systems strengthening to improve the utilization of essential health and nutrition services in communities.

50. **Past experiences have shown that investing in health systems improve equity in access particularly for the poor.** The PASMIN (P143843) focused mainly on malaria prevention and control and nutrition at the community level. Therefore, its contribution to overall health systems strengthening was limited to specific health programs and capacity building of cadres at the lower level. High concentration of qualified health workers in the capital city, their high absenteeism and poor quality of care exacerbate the situations and disproportionately affects the deprived areas. With the leading causes of maternal deaths are obstetrical, the continuum of care is required for further improving maternal and newborn health. The proposed project will invest in holistic PHC systems with an equity lens, including upgrading infrastructure, equipment and supply of essential drugs and commodities, and improving health facility management of limited number of secondary and tertiary hospitals.

51. **Output based financing and social health insurance has been shown to protect the poor and provides opportunities for the country to achieve UHC**. The use of external verification agencies under traditional performance-based financing (PBF) as an alternative has proven expensive in several countries. Previous experiences and lessons from countries such as Ghana and Rwanda show that health insurance schemes by default follow the same principles of output-based payment mechanisms but without the burden of extra wage payments and high costs of external verification. The World Bank investing in health insurance mechanisms is therefore an appropriate investment promoting equity and sustainability. While the social insurance scheme will cover everyone, the World Bank financing will provide an incentive for the informal sector to join the scheme by encouraging the registration and enrolment of the poor through the introduction of an enrolment subsidy.[25]

[24] *https://projects.banquemondiale.org/fr/projects-operations/project-detail/P143843*

[25] World Bank Group. 2018. *Couverture sanitaire universelle et secteur informel en Afrique de l'Ouest francophone: Etat actuel, perspectives et proposition d'orientations stratégiques; Washington DC* (Universal Health Coverage and the Informal Sector in Francophone West Africa: Current Status, Prospects and Proposed Strategic Directions)

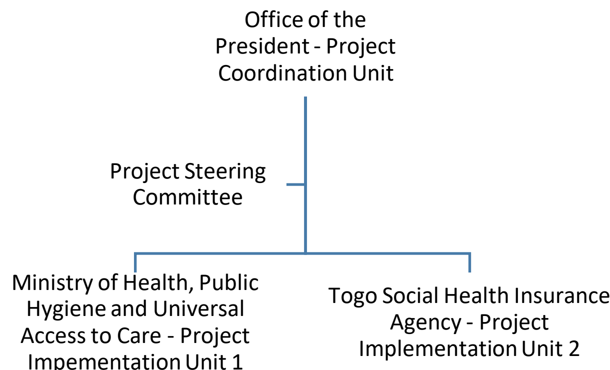
III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

52. **The project institutional arrangements and design envisages a split between the provider (MHPHUAC) and the purchaser (TSHIA), constituting an internal market.** The clear split in responsibilities and roles will allow for cross accountability. This warrants a clear separation of accounts and resources so the purchaser can buy services from the provider based on the PBC achieved. The Ministry of Health PIU will be referred to as PIU1 and that of the TSHIA as PIU2. The Office of the President will assume the role of the PCU and serve as the project manager and an arbiter of sorts. Figure 3 below shows the relationships.

53. **The project design also follows the principle of preserving institutional integrity and accountability of the main agencies to manage their own resources, based on their responsibilities under the various components.** This will enhance transparency in expenditures and accountability for results. In view of this, the proposed arrangement is to have separate Designated Accounts (DAs) for the MHPHUAC and the TSHIA. Funds from the PIU 1 will be disbursed into a transaction account of the PCU as stated in the details in Annex 3.

Figure 3: Institutional arrangement



54. **The project will adopt a system of centralized disbursement and payment processing at the Head Offices of the MHPHUAC and the TSHIA**. All transfers to sub-agencies and other allied health facilities will be channeled through the existing FM procedures of the government. Internal audit departments will be empowered to undertake regular financial monitoring of sub-implementing agencies and the World Bank FM Specialists will undertake periodic on-site supervision and support missions. It is also proposed that the Terms of Reference for the audit will be expanded to include additional in-depth fiduciary reviews. Additionally, based on the finding of supervision missions, the World Bank may consider the possibility of using independent third-party agencies to compliment financial monitoring on the use of the funds.

55. **A PCU under the Office of the President will have oversight responsibility for the overall coordination of the project.** The PCU will be headed by a Project Coordinator with the support of a health planner and a M&E officer. The PCU will coordinate the development of all work plans and requests to the World Bank. To assist in their work, the PCU also recruit technical consultants as necessary.

56. **A Project Steering Committee (PSC) will be established and chaired by a person designated by the Office of the President, supported by the PCU, and will be maintained throughout the implementation of the project.** The membership composition, mandate, terms of reference and resources shall include ministerial and heads of agencies satisfactory to the Association. The Project Coordinators or persons not below the rank of a Director will be in attendance from the determined ministries. The PSC will meet at least once a quarter to review progress in project implementation. A representative of the World Bank will attend the PSC meetings.
57. **The MHPHUAC will designate a person at the Ministerial level not below the rank of a Director General to serve as the Coordinator of PIU1. The PIU1 will present all reports to the World Bank through the PCU.** The MHPHUAC will be responsible for the implementation of the following components of the project as shown below with some joint responsibility with TSHIA for Sub-components 1.1 and 1.4. Both PIUs have fiduciary responsibilities for the implementation of respective components. The process for submitting and validating Sub-component 1.3 has been described under the respective component and will be further elaborated in the PIM.

58. **The MHPHUAC PIU1 Coordinator will have oversight responsibility for project implementation, technical day to day supervision of project interventions and overall coordination of their components.** The Directors of the Regional/Province Health Directorates will oversee the implementation of project activities at the regional/province level. The PIU1 will be responsible for monitoring the performance, equipment distribution, and supervision of the quality of essential PHC services. In effect, the Ministry will retain oversight of activities financed by the project related to health care facilities and service providers within existing decentralized structures of health service provision at the regional and district levels. A cascade of contracts will run from the fundholder to the ministry to the regions, the prefectures and facilities. Each level will supervise the level(s) beneath it. The contracts signed between the Ministry and the Office of the President or the TSHIA, will be detailed in the PIM. It will ensure that the normative functions of the various levels are strengthened; while teams become accountable for their performance at all levels. The Ministry will have its own internal verification system to increase efficiency, minimize or avoid rejected claims and loss of revenue. Receiving resources for some of the responsibility areas under the MHPHUAC/PIU 1 is however dependent on performance reported through the TSHIA. The TSHIA therefore will be holding the resources to be disbursed to the MHPHUAC after verification and approval for Sub-components 1.1 and 1.4. The process for submission and validation for Sub-component 1.3 has been described earlier in this document under the referred component. It is the TSHIA that will submit the verified results to the World Bank and pay the approved amount to the MHPHUAC. The resource disbursements and management are further clarified under the Financing Arrangements in this document.

59. **Preparations are underway to amend decree No 2011-034/PR and establish the TSHIA within six months after effectiveness.** The approach follows recommendations by the Paris Declaration for Harmonization and Alignment of Development Partner support with government systems. It will allow the Government to leverage on existing institutional and human resource capacity, consolidate all the various insurance schemes into one scheme and efficiently crowd in all resources. It will also limit the need to use external verification agents for all results and release extra resources for service delivery.

60. The procedure for submitting and obtaining clearance for results achieved under Sub-components 1.1, 1.2, 1.4 and Component 3 have been described earlier under the respective components. This will be further elaborated in the PIM.

B. Results Monitoring and Evaluation Arrangements

61. **Responsibility for M&E will rest with each of the implementing agencies coordinated by the PCU.** The project indicators focus on using proxies to catalyze change at the various levels. As much as possible all the data to be collected are from either routine or regular surveys done by the Government and its various agencies. Support to M&E will aim to improve the quality of data collection, processing and reporting. The responsibilities of each of implementing agencies and that of the independent verification agencies will be further elaborated in the project implementation manual.

C. Sustainability

62. **The proposed operation will make use of the country's own systems and processes rather than introducing parallel mechanisms.** In this way, the project enhances the likelihood of sustaining the changes made to the health systems. The project uses the Government's existing structures for implementation, oversight and financial and procurement mechanisms. It will not directly finance human resources of the government officials not to distort the existing incentive mechanisms. Capacity building of the government officials at both national and subnational levels is necessary and motivates them to thrive for results. The Government and the World Bank will explore possibility of identifying qualified national entities as a verification agency of PBC.

63. **Citizen engagement is critical in designing an inclusive and responsive project to address needs of various sociodemographic groups and effective implementation.** The project will conduct periodic public consultations according to the stakeholder engagement plan (SEP) in order to increase awareness of all stakeholders and collect their feedback throughout the project cycle. Community sensitization and capacity building activities will be carried out in order to engage the project's key stakeholders, including community leaders, women's groups, youth groups, schools, associations to support persons with disabilities, and other community-based and/or faith-based organizations. Women and adolescents would become more vulnerable to uncertainties, economic difficulties and acute shocks. While the current sex-disaggregated data for COVID-19 does not show differences in the number of cases between men and women, there are differences in vulnerability to infection, exposure to pathogens, and treatment received The poor and vulnerable populations are most severely affected by the disruption of routine essential health and nutrition services amid the global pandemic. Women, young people, ethnic minorities, elders, and persons with disabilities are also the most vulnerable in the aftermath of disease. Therefore, the proposed project will promote building community resilience and empowerment as a key element to staying healthy and minimize adverse effects. Particular attention will be paid to indigenous people and households residing in geographically isolated and disadvantaged areas. The Results Framework contains an indicator measuring beneficiary satisfaction, that is the share of "*beneficiaries of these newly refurbished health facilities satisfied with the quality of services and facilities*". The feedback received from beneficiary surveys, spot checks, and stakeholder engagements will inform the operation to strengthen the service delivery. Moreover, citizen engagement for a broader population beyond the project beneficiaries will be further facilitated by the grievance redress mechanism.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

64. **The need to invest in the provision of and access to essential quality health services transcends the benefits of sound physical, psychological and emotional health to individual beneficiaries.** It translates into direct favourable productivity and macroeconomic outcomes. Human capital (an encapsulation of health, knowledge and skills) is a significant determinant of economic growth and development and as such, investments that enhance any aspect of it will have large and consequential positive effects on the Togolese economy through enhanced labour productivity. Interestingly, universal access to essential quality health services does not merely fuel economic growth and development through increases in labour productivity, but also reflects economic development.

65. **Most recent data estimates loss of about two million years of life of nationals and residents of Togo to diseases and death.**[26] This is mainly a result of communicable, maternal, neonatal, and nutritional diseases. This translates into about US$9.6 billion at an estimated Disability-Adjusted Life Year (DALY) value of US$5,000.[27] Similarly, years of life lost to disability and death as a result of non-communicable and other diseases (excluding injuries) is estimated at 1.1 million or approximately US$5.6 billion of yearly loss to the state.

66. **The economic benefits of the Togo Essential Quality Health Services for UHC Project have been analysed.** It is estimated that besides the salient positive externalities such as improvement in the HCI and cognitive abilities of children, an overhaul of the Togolese health system will accrue direct economic benefit to the country. This conclusion is arrived at based on both a Cost-Benefit Analysis (CBA) and Incremental Cost-Effectiveness Ratios (ICER). The analysis draws on the DALYs approach to arrive at the monetary benefits accruable.

67. **The benefit-cost ratio of the project yields positive benefits of averting and gaining over seven thousand disability adjusted live years over five years.** In arriving at the gains, the disbursement of funds is spread over the course of the project, were deflated to yield 2021 constant price thus yielding approximately US$25.5 million. Costs are further discounted at a 3 percent annual rate to arrive at US$23.6 million which together with estimated DALYs of almost 2.3 million produces a cost of almost US$10.3 per DALY to be averted (with drug treatment for uncomplicated malaria for children under 5 years) and 723,068 DALYs at a cost per DALY of US$32.6 without the treatment. Since the per capita GDP for Togo is US$690, it is concluded that the ICERs of US$10.3 (with drug treatment for uncomplicated malaria for children under 5 years) and US$32.6 (without it) are highly cost-effective. Benefit-cost ratio (BCR) of 107 obtained without drug treatment for uncomplicated malaria for children under 5 years and 337 with drug treatment are evidence of the highly beneficial nature of this component. The summary of data is shown in the tables below.

[26] Roser, Max, and Hannah Ritchie. 2016. "Burden of Disease". *Published online at OurWorldInData.org*

[27] Jamison Dean T., Prabhat Jha, Ramanan Laxminarayan, and Toby Ord. 2012. "Infectious Disease". Copenhagen Consensus. Though Jamison et al. 2012 estimated the value of a DALY to be US$5,000 for Low Income Countries about eight years ago, the Togolese GNI per capita between 2012 and 2019 augmented by only US$100 from US$590 US$690 over the period and as such, will not impact the value of the DALY.

Table 3: Cost- Benefit and Cost-effectiveness Analyses Summary of Component 1 (with and without Drug Treatment for Uncomplicated Malaria for Children Under 5 years)

Discount rate of 3%	(With Drug Treatment) Value in US$	(Without Drug Treatment) Value in US$
PV of Total Benefits	7.9 billion	2.5 billion
PV of Total Costs	23.5 million	23.5 million
NPV of investment	7.9 billion	2.4 billion
BCR	337	107
Total number of DALYs to be averted	2.2 million	0.7 million
Cost per DALY Averted TEQHS	10.34	32.63

Table 4: Cost-Benefit and Cost-Effectiveness Analyses Summary of the project (with and without Drug Treatment for uncomplicated malaria for children under 5 years)

Discount rate of 3%	(With Drug Treatment) Value in US$	(Without Drug Treatment) Value in US$
PV of Total Benefits	17,060,278,416	5,405,249,829
PV of Total Costs	49,529,210	49,529,210
NPV of investment	17,010,749,206	5,355,720,619
BCR	344	109
Total number of DALYs to be averted	4,896,492	1,551,367
Cost per DALY Averted TEQHS	10.12	31.93

68. **Strikingly, drug treatment for uncomplicated malaria for children under 5 years alone accounts for about 72 percent of the total number of DALYs while reducing cost per DALY of the entire project by more than 68 percent from US$31.9 to US$10.1**.[28]. A GDP per capita of US$690 for Togo[29] indicates the entire project is highly beneficial.

Sensitivity Analyses

69. **When returns on investment is examined, increasing the discount rate by 400 percent from 3 percent to 15 percent results in less than 3 percent reduction in BCR for Component 1**. A five-times change in interest rate from 3 percent to 15 percent causes just about a percentage change in BCR. This points to BCR resilience which is crucial to the reliability of any CBA' outcome. The full economic analysis is provided in Annex 2.

B. Fiduciary

(i) Financial Management

70. **An FM assessment was conducted on the FM arrangements for the Togo Essential Quality Health Services For UHC Project**. Project activities and payments will be executed by (i) the PIU1 to be established under the MHPHUAC (for Components 2 and 5; Sub-components 1.3, and 4.1; and Sub-components 1.1 and 1.4 jointly with TSHIA, and Sub-component 4.2 jointly with the PCU); (ii) the PIU2 to be established under TSHIA (for Component 3; Sub-component 1.2; Sub-components 1.1 and 1.4 jointly with the PIU1); and (iii) the PCU to be established under the Office of the President (for the Sub-component 4.2 jointly with the PCU1). The assessment focused on

[28] Project Team's estimation.
[29] World Bank 2020. "GDP Per Capita (Current US$) – Togo." World Bank, Washington DC.

the FM capacity in terms of planning and budgeting, financial accounting, financial reporting, and internal controls and external auditing in place to satisfy the World Bank's Policy and Directive – IPF. The implementing entities' arrangements are found to be acceptable if they are capable of: (i) recording all budgets and transactions and balances correctly; (ii) supporting the preparation of regular and reliable financial statements; (iii) safeguarding the entities' assets; and, (iv) subject to auditing arrangements acceptable to the World Bank. This FM assessment was conducted in accordance with the FM Manual for World Bank IPF Operations that became effective on March 1, 2010 and was re-issued on February 10, 2017, and the World Bank Guidance on IPF with PBC issued on January 29, 2020. This FM assessment conducted to ensure that the PIU1, PIU2 and the PCU have the minimum requirements to ensure project's FM revealed some weaknesses. These include: (i) lack of familiarity with IDA procedures for reporting, disbursement arrangements, and auditing; (ii) lack of qualified FM staff; and (iii) lack of FM tools: accounting software, and manuals of accounting procedures and FM.

71. **The overall FM residual risk rating for the Project is assessed as Substantial,** considering the mitigation measures included in the project design. The proposed FM arrangements for this financing are considered adequate to meet the World Bank's minimum FM requirements under the FM Manual for World Bank for IPF with PBC. To mitigate the FM risks, the project design incorporates the following actions: (i) the recruitment of a qualified and experienced FM specialist and Accountant (housed at the PIU1), a qualified and experienced Chief Accountant (based at PIU2), and Accountant (housed at the PCU), dedicated to the project under the FM Specialist; (ii) the recruitment of a qualified and experienced internal auditor (housed at the PIU1) fully dedicated to the project internal auditing, based on quarterly internal audit report preparation using a risk-based approach; (iii) the development of a comprehensive Administrative, Accounting and Financial Manual of procedures, as part of the PIM (PIM) in form and substance acceptable to the World Bank and including a clear description of the PBC disbursement mechanism; (iv) the purchasing for the project of a multi-project and multi-site financial and accounting management software in a manner satisfactory to the World Bank; (v) the recruitment within six months after effectiveness of an external financial auditor who will express yearly an independent professional opinion on the project financial statements and an Independent Verification Agent who will be responsible for the certification of the accuracy of the PBC achievements and of the actual eligible expenditures for providing essential health and nutrition services package detailed in the PIM; and (vi) the rolling out of a training plan which includes, inter-alia, training on IDA disbursement procedures, and training on IDA financial reporting arrangements. Furthermore, prior to DA management responsibility transfer to PIU2, the World Bank FM team will conduct an assessment to determine whether the PIU2 has an adequate FM systems and related capacity which satisfies the World Bank's Policy and Directive – IPF, which describes the overall FM policies and procedures.

72. The proposed FM arrangements including the risk mitigation measures (see FM Action Plan) are considered adequate to meet the World Bank's minimum FM requirements under World Bank Policy and Directive – IPF with PBC. Detailed FM arrangements are provided in Annex 3.

(ii) Procurement

73. The Borrower will carry out procurement under the proposed project in accordance with the World Bank's 'Procurement Regulations for IPF Borrowers' (Procurement Regulations) dated July 2016, and revised in November 2017 and August 2018 under the 'New Procurement Framework' and the 'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by International Bank for Reconstruction and Development (IBRD) Loans and IDA Credits and Grants', dated July 1, 2016, and other provisions stipulated in the Financing Agreement.

74. As part of the preparation of the project, the Borrower (with the technical assistance from the World Bank) has prepared a Project Procurement Strategy for Development (PPSD), which describes how procurement activities will support project operations for the achievement of PDOs and deliver value for money. The procurement include purchase of pre-fabricated health facilities, refurbishment and renovations, consultancies and purchase of medical equipment. The procurement strategy is linked to the project implementation strategy ensuring proper sequencing of the activities. It also considers institutional arrangements for procurement, roles and responsibilities, thresholds, procurement methods, prior review, and the requirements for carrying out procurement. The PPSD also includes a detailed assessment and description of Government capacity for carrying out procurement and managing contract implementation, within an acceptable governance structure and accountability framework.

75. **The residual procurement risk for this project is rated Substantial,** after the implementation of the institutional arrangement described in Section III, where a detailed procurement description and institutional arrangements can also be found. The procurement risk will be mitigated through regular reporting on the progress and implementation of procurement activities by the PIU1, as part for the IFR, World Bank supervision, World Bank procurement team hands-on support when required, and further capacity building. The PIM framework will be drafted in accordance with the above-mentioned Procurement Regulations, Guidelines on Preventing and Combating Fraud and Corruption documents, and detailed procedures for administration and handling of procurement-related complaints.

C. Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

D. Environmental and Social

76. **The environmental and social standards (ESS) that are currently relevant to this project are**: (i) ESS1 Assessment and Management of Environmental and Social Risks and Impact; (ii) ESS2 Labor and working conditions; (iii) ESS3 Resources efficiency and pollution prevention and management; (iv) ESS4 Community Health and Safety; (v) ESS5 Land acquisition, restriction of land use and involuntary resettlement; (vi) ESS8 Cultural heritage; and, (viii) ESS10 Stakeholder engagement and information disclosure.

77. **The following instruments have been prepared and disclosed prior to the appraisal**:
    - The Environmental and Social Commitment Plan (ESCP) and the SEP that include a grievance mechanism (GM) and the Labor Management Procedure (LMP).
    - An Environmental and Social Management Framework (ESMF) and a Resettlement Policy Framework (RPF).

78. All these above-mentioned environmental and social documents have been consulted upon, validated, approved and disclosed in the country on February 1, 2021 (on the MHPHUAC's website) and February 3, 2021 (in Togo Presse No 10970) and on the World Bank website on February 2 and 3, 2021. All these documents were disclosed prior to the project appraisal.

Environmental Safeguards

79. **The environmental risk is rated as Moderate.** The project will fund the construction of PHUs and accommodation for health personnel to help expand health services to the most deprived regions and prefectures of Togo. This new operation will also support the construction of other additional facilities as part of the Environmental, Social and Community Engagement Strategy. In addition, small investment grants will be made available to eligible public district health facilities to help them increase their services and to help prepare them to receive patient referrals from the CHC. Based on the nature and magnitude of the activities and investments planned as well as medical waste due to project activities and existing Medical Waste Management Plan (MWMP) and available incinerators in some hospitals, potentially adverse impacts on the environment and risks to it are deemed site-specific, reversible, and manageable. A hazardous waste management plan (HWMP) has been prepared to improve the technology to manage medical solid waste and wastewater including those related to COVID-19. This plan focuses on the institutional capacity improvement as well as financing, M&E mechanisms. The ESMF and HWMP have been disclosed both in the country and on World Bank's website prior to the project appraisal. The appointed environmental specialist in the project preparation team will continue environmental risks management until the implementation phase. In case this option is not possible, another environmental specialist will be hired for the same responsibilities in the PIU.

80. **Resource Efficiency and Pollution Prevention and Management.** Regarding energy use efficiency, some equipment, such as vaccine fridges, medical imaging equipment, blood cold chain systems, and other technology will need energy to operate. For energy efficient use, rationalization measures need to be determined. Similarly, vaccine fridges and blood cold chain systems could induce environmental adverse impacts such as more CO2 emissions. Therefore, site specific Environment and Social Impact Assessment (ESIA)/ Environmental and Social Management Plan (ESMPs) will include adequate mitigation measures to address the issues of which chemicals are permissible in keeping with national and international conventions (Montreal Protocol). The project will support the target health facilities for being equipped with an off-grid solar power system to mitigate these adverse environmental effects by generating greener energy for the health facilities and housing for health workers. As for the air emissions during the project implementation phase, they will be moderate, generated by vehicles, machinery and construction, the rehabilitation of clinics and accommodation for health personnel and other additional facilities, as part of the Environmental, Social and Community Engagement Plan. To reduce the impact of smoke from vehicles and machinery, adequate measures need to be taken upstream to meet emissions norms. The project will promote and support the use of highly fuel-efficient, low-carbon fuels for project monitoring and supervision as well as deployment of health workers to the remote areas. Considering noise, some impact from noise is foreseen during construction/rehabilitation, which could be a nuisance for the surrounding communities. The ESMF includes general mitigation measures to minimize and manage the level of noise from the vehicles and equipment construction companies use to carry out civil works. These measures will be detailed in ESIAs, to be prepared later, as necessary. The waste management needs more attention as there will be more solid waste produced by the construction/rehabilitation of health facilities. Therefore, there will be solid waste management but likely not in large quantities. Notwithstanding this, waste coming from excavation and demolition is expected. Site specific safeguards' documents will include adequate measures to minimize waste production upstream and encourage recycling where possible. More especially regarding hazardous chemicals, medical materials and medical waste, the Borrower has prepared a HWMP outlining the measures to be taken during the project implementation. Besides, potential impacts on biodiversity are so far negligible.

Social Safeguards

81. **Land acquisition, restriction on land use and involuntary resettlement:** It is anticipated that most of the planned construction in the project would take place within existing health facilities. However, some construction activities planned in this project mainly Community Health Clinics and accommodation for health personnel to help expand health services, including additional facilities, could lead to economic and/or physical displacements. As the construction sites are not yet known at this preparation stage, an RPF has been prepared. This RPF will guide the preparation of subsequent site-specific Resettlement Action Plans (RAPs), if required when the construction sites are known, to manage the potentially negative impact of involuntary resettlement operations.

82. **The other key social risks of the project are**: (i) the potential exclusion of vulnerable communities during the process to select communities to benefit from the project, despite the fact that special dispensation will be given to certain locations, such as areas with a lower population but greater need; (ii) the potential exclusion of Community Health Nurses, Physician Assistant/midwives and community health volunteers from capacity building activities and training; (iii) SEA/SH, and violence against children (VAC) risks, during capacity building operations and the construction of PHUs; (iv) the risk of the use of child labor during civil works; and (v) social conflict within the same community and/or between communities during the project's implementation. The SEP includes a communication strategy with sensitization/information and citizen engagement activities oriented to the project's key stakeholders (mainly local communities), as well as social risks management measures to anticipate any potential risk and impact mentioned in ESMF to meet the project relevant ESSs of Environmental and Social Framework (ESF) requirements. The project will also include indirect workers, such as regional and provincial health administrators, community administrators, civil servants and consultants hired to support technical aspects, contractors and subcontractors, including potential workers from communities neighboring the investment sites and/or primary supply suppliers, as well as local community organizations and volunteers from project areas communities. The terms and conditions of the contracts of all the workers involved in the project need to be made in accordance with the national labor law and meet the requirements of ESS2 to ensure that working conditions be acceptable. Therefore, a LMP, drawn up in accordance with national regulations and the ESS2 requirements, has been developed. The LMP includes the terms and conditions of employment, nondiscrimination and equal opportunities, workers' organizations, measures to prohibit child labor and forced labor, grievance redress mechanisms for labor disputes, and occupational safety and health measures for the workers, including SEA-SH and VAC for both direct and contracted workers. A social development specialist will be hired to take over social risk management during the project's implementation. For all the civil works in this proposed project, subsequent ESMPs that include labor related clauses will require contractors to set up appropriate security measures (such as fences and security guards) around the project sites (such as fences and security guards) and issue a code of conduct to workers for the entire civil work period. There is no requirement for specialized labor for planned constructions (prefabricated buildings). However, measures will be taken to manage local labor including provisions to protect against COVID-19 and maintain work opportunities during this depressed economy period. Equipment and vehicles/engines will be brought together to the base building site and secured when the work is stopped to ensure both community and worker safety. Experience indicates that the influx of workers into project areas can lead to adverse social impacts on local communities, mainly in rural areas, such as SEA-SH and VAC, communicable diseases.

83. **SEA/SH risks and mitigation measures**. A SEA/SH risks assessment carried out using the World Bank's SEA/SH draft Health sector risk assessment tool and expert assessment, indicated a moderate risk level of project activities. Mitigation measures will be recorded in an appropriate and proportioned action plan to ensure SEA/SH survivors have a safe and confidential venue to report cases brought about by project implementation, such as

connections with local women's groups or *centres d'écoute*. The SEA-SH and VAC action plan disseminating risks will be regularly updated, and the appropriate mitigation measures will be fully reflected in the project's ESMPs and in bidding documents and ESMPs, including measure specific to health projects, such as training of service providers on clinical management of GBV and referral protocols. A code of conduct covering actions to prevent SEA-SH and VAC will be prepared and included in bidding documents.

84. **Stakeholder engagement and information disclosure**. An inclusive SEP in consultation with the World Bank has been prepared. The SEP outlines the key stakeholders of the project with the main characteristics and interests of the relevant stakeholder groups, including potentially affected people and vulnerable groups, as well as the timing and methods of engagement envisaged throughout the project lifecycle. The SEP articulates ways in which the project team will communicate with key stakeholders and include a mechanism by which key stakeholders—mainly those that will be potentially affected—can raise theirs concerns, provide feedback, or make complaints about activities related to the project. The approved SEP will be updated after the start of the project (and no later than the first six months of the project effectiveness date) to include more detailed information regarding the methodologies for information sharing, for more robust stakeholder mapping, and for the identification of existing community-based platforms that can be used to facilitate effective community engagement and participation, as well as M&E. The Borrower will engage in meaningful consultations on policies, procedures, processes and practices (including grievances) with all stakeholders throughout the project life cycle, and provide them with timely, relevant, understandable and accessible information. A project-wide GM, proportionate to the potential risks and impacts of the project and included in the SEP, will be established. The SEP includes measures to ensure effective and appropriate communication about the existence of the GM to the key stakeholders, including potentially affected people and vulnerable groups, in accessible formats and appropriate languages. The GM is designed to safely and ethically register complaints and address and properly document SEA/SH allegations during project implementation. Given the current situation of COVID-19, the SEP draws up in line with the guidance provided by the World Bank related to public consultation in a situation of constraint (March 2020), and in according with the country's own advocated measures against COVID-19.

85. **A grievance redress system to resolve complaints and grievances in a timely, effective and efficient manner for people impacted or likely to be impacted directly or indirectly, positively or adversely, by the project will be established.** The GRS will be built on the call centers (established for COVID-19) to ensure that beneficiaries have multiple channels to report grievances or suggestions at toll free number, through direct contact with the health personnel, or via a suggestion box at health facilities, the MHPHUAC website, a Facebook page, and short message system (SMS).

E. Climate Co-benefits

86. **Climate change risks and vulnerabilities**. Togo is exposed to extreme temperature and its seasonal irregularities resulting in both floods as well as periods of severe drought leading to declines in crop production, threats to livestock herds, each of which result in food shortages, and negative effects on human health.[30] Agriculture accounts for approximately 41 percent of Togo's GDP and is susceptible to climate change.[31]

87. The GoT adopted the National Plan for Adaptation in 2009, which included the adaptation for climate change. In

[30] Togo. *Plan national d'adaptation aux changements climatiques du Togo* 2017-2021.
[31] World Bank Group. 2016. Togo SCD.

2013, the Government put climate change as one of the most challenging thematic areas in its Accelerated Growth and Employment Promotion Strategy 2013-2017. The current National Climate Change Adaptation Plan 2017-2021 aims to ensure the sustainability of its socioeconomic development and to strengthen the resilience of vulnerable population through implementation of climate adaptation measures.[32] This project will further enhance the government's efforts for adaptation to climate change as well as mitigating Togo's contribution to global emissions through the measures outlined in the following paragraphs.

88. The project seeks to address climate vulnerability and enhance resilience and adaptation through the following activities. Under Sub-component 1.3: Improve equitable distribution of health professionals (US$2,928,000 equivalent), health professionals who are newly recruited and deployed to climate vulnerable rural communities in the target regions will be provided with training on climate sensitive diseases and/or disaster risk response in the event of a climate disaster. Expanding essential health and nutrition services in the most deprived regions will also help improve health access to climate vulnerable groups such as women and children. Under Component 2: Bringing clinics services close to the client (US$29,980,000 equivalent), the project will advise health facilities to incorporate climate consideration when they newly construct or renovate/refurbish health facilities. This component will also deliver improvements to the management of medical waste, which lead to strengthening the adaptive capacity of the health systems by reducing risks from waterborne diseases as well as reducing risks from exposure to medical waste following extreme weather events, in particular from flooding. Under Sub-component 3.2: Promote demand for health insurance services (US$600,000 equivalent), there would be a major focus on communication activities to strengthen financial protection through the enrolment to the TSHIA among climate vulnerable groups. With improved financial accessibility to necessary health and nutrition services, it is expected to prevent climate induced diseases and to lead to overall greater resilience against climate change impacts in the short and long term.

89. Specific project activities which will support **climate change mitigation** include the following activities. Under Component 2: Bringing health facilities and services close to households (US$29,980,000 equivalent), the provision of off-grid solar electricity for peripheral health facilities will avert greenhouse gas emissions from these facilities. The climate co-benefit through this activity is estimated to be US$1.01 million (1.44 percent of the total project budget of US$70.00 million). Component 2: Bringing health facilities and services close to households (US$29,980,000 equivalent) includes the re-equipping of primary healthcare facilities, following energy efficient principles and low carbon procurement criteria and medical waste management, including solid waste management, which would further avert greenhouse gas emissions. The project also ensures that vehicles and motorbikes for routine household visits by health workers at the health facilities and personnel transportation will use highly fuel-efficient vehicles or motorbikes or running on low-carbon fuels.

F. Gender

Gender gap analysis

90. **Togo is ranked 145th in the 2020 Gender Inequality Index (GII) and is classified under the Low Human Development group**.[33] Cultural and legal obstacles, coupled with inequitable access to health and nutrition services, affect the ability of Togolese girls and women to improve their incomes and well-being, thereby preventing them from optimizing their human capital. These access constraints have led to high rates of maternal

[32] Togo. *Plan national d'adaptation aux changements climatiques du Togo* 2017-2021.
[33] See: http://hdr.undp.org/en/composite/GII

mortality (396 per 100,000 live births), neonatal mortality (25 per 1,000 live births), under-five mortality (59.8 per 1,000 live births), child stunting (27.5 percent) and child wasting (6.7 percent). Only 30 percent of pregnant women access micronutrients such as iron and folic acid. Anemia among children under five (71 percent) and women of reproductive age (48.9 percent) is also a notable issue in Togo.

91. **Very high household out-of-pocket expenditures (56.3 percent of total health expenditure in 2018) exposes families and women to the risk of impoverishment due to health expenditure.** In general, women are also less likely than men to access health care, partially due to their financial vulnerability. The 2017 Multiple Indicator Cluster Survey (MICS) found that 28.1 percent of women reported that it was justified for a husband to beat his wife, with acceptance of domestic violence being most prevalent in the Savanes region (56.3 percent). Women in rural areas (34.0 percent) accepted physical violence as compared to a 21.6 percent in urban areas. It is also observed that there are the associations between the perceptions of domestic violence and the income level of households, and the level of the mother's education. Moreover, 14.9 percent of women thinks that a husband could beat his wife just because she went out without telling him.[34] Such lack of female autonomy compromises women's ability to participate in necessary health services, seek care for their family, and economic activities.

Gender-related actions

92. To address the above gender gaps, the project is designed to incentivize the improvement of health service utilization among the vulnerable, especially for pregnant women and children in rural areas. The project will support: (i) expanding community outreach for preventive and promotive care; (ii) increasing the number of health facilities in rural communities; (iii) providing necessary medicines, commodities and equipment to PHC facilities; and (iv) training and equitable deployment of health professionals. The Government has a strategy to increase the proportion of female CHWs from 19.21 percent in 2020 to 60 percent by the end of the project. While CHWs are not categorized as the formal cadres of health professionals, they play a critical role in community outreach and improving acceptability of services for women and children, especially in the fields of maternal and child health.[35] The Results Framework contains an indicator measuring gender-related actions, that is the number of "*females who have received essential HNP services*" and the percentage of "*households visited by female health workers, including CHWs*".

93. Building on the efforts to expand service coverage and the quality of care, the project will also support creating a mechanism to protect the vulnerable, including pregnant women and children, from financial risks due to health expenditures. The establishment of the TSHIA could contribute to achieving UHC. While the TSHIA aims for universal coverage of social health insurance, it is designed to extend its support with subsidies for the vulnerable, pregnant women and children. The TSHIA also addresses emerging issues of adolescent health by expanding the existing School Assur program to reach both school and out-of-school children and adolescents. The Results Framework contains an indicator measuring gender-related actions, that is the number of *"pregnant women and children under five years of age registered onto the health insurance scheme."*

V. GRIEVANCE REDRESS SERVICES

94. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance

[34] Togo MICS6. 2017.
[35] WHO. 2018. WHO guideline on health policy and system support to optimize CHW programmes.

Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and World Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VI. KEY RISKS

95. **Overall project risk rating is substantial.** The proposed project will build on the gains made from the previous Maternal and Child Health and Nutrition Services Support Project (P143843). While there are considerable inherent risks associated with fragility and weak governance from decades of isolation and donor disengagement in 1993–2007, the Government has explicitly committed to improving the health status of the population towards achieving UHC by 2030.

96. **Sector strategies and policies risks are substantial:** This is a relatively complex and new program to operationalize in Togo, specifically the new health insurance system which is a new set up to be embedded in the project. This health insurance scheme will be mainly funded by the Government. The government initiated a policy of Free care for all pregnant women in 2020. The Government has adopted a new PNDS for 2017-2022, based on the lessons of the previous strategy and a medium-term expenditure framework for 2017-2019. The four pillars of the PNDS described above respond to the county's disease burden and epidemiological shifts. The GoT has been making efforts to improve community health services and institutionalize financial risk protection schemes towards achieving UHC. The above government goals and priorities resonate with the global good practices and in alignment with the regional strategic direction in Africa. The project will support the health insurance scheme and health systems strengthening to make them resilient and sustainable going forward.

97. **Technical design residual risks are substantial:** The project design is fully aligned with the Government's priorities and focuses on bridging the gap between supply and demand while strengthening the policy and institutional environment. However, the project will support relatively new and complex approach in several areas—introduction of PBC, quality of care improvement, health insurance, nutrition, and strengthening capacity of institutions for health insurance and institutional arrangements between the Presidency Office and the Ministry of Health in addition to other players which are not directly linked to these entities. The interventions require careful change management to achieving the set objectives. While the nature of interventions is well articulated, entrenched practices will face difficulties in modifying institutional behavior and culture. Relying on the government-led processes and institutions to also support the roll out of innovations in health financing, supervision, monitoring and the use of internal market-type processes for results and payments could pose unexpected challenges. Budget limitations will be a major challenge where the Government is expected to provide counterpart funding to pay for services provided, and will not allow for supply guarantees despite the possible high demand for services in each of the target areas that the project intends to support. Therefore, the proposed project includes training for the PCU and PIU in organizational and project management. And the detailed project design of each component will be adopted from global good practices, especially for the establishment of a national social health insurance scheme.

98. **Institutional capacity risks are substantial:** This is the second World Bank-supported health PHC systems strengthening project in Togo. The PIU has gained experience from the previous project and has a basic knowledge of the World Bank's policies and procedures. Yet, it can face challenges in harmonizing these with the national guidelines, especially since the adoption of national procurement guidelines. The fiduciary management capacity is limited in quasi-agencies of MHPH with limited number of competent staff. Adequate monitoring of progress and data collection may be a challenge, as the existing health information system is fragmented and dysfunctional. Moreover, a large number of actors from different Programs and Divisions within the MHPH involved in the project may cause confusion in the roles and responsibilities and difficulties in coordination, resulting in delays in project implementation and lack of accountability and inadequate oversight. As part of mitigation measures, the proposed project invests in strengthening M&E system and the World Bank staff or expert consultants if necessary, will provide the PIU with extensive support to quality and timely project implementation.

99. **Fiduciary residual risks are substantial:** Overall FM residual risk rating for the Project is assessed as Substantial, considering the mitigation measures included in the project design described above in the FM section. The country has had previous experience with handling government resources at levels considered generally satisfactory. There are, however, large amounts of transactions handled manually with delayed reporting that are likely to affect the project remain. Other weaknesses include a lack of key FM competencies and strong internal controls, and fragmented country PFM legal framework, limited correspondent banking relationships and weak payment system infrastructure. While these pose risks the audit and treasury systems are robust to mitigate the risks. The residual procurement risk for this project is rated substantial, after the implementation of the institutional arrangement described in Section III, where a detailed procurement description and institutional arrangements and FM mitigation measures can also be found.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY: Togo
Togo Essential Quality Health Services For Universal Health Coverage Project

Project Development Objectives(s)

To improve the provision of essential health and nutrition services and quality of care for pregnant women, children and vulnerable populations

Project Development Objective Indicators

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
People who have received essential health, nutrition and population services (Number)								
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		0.00	1,806,721.00	2,519,336.00	3,094,651.00	3,586,577.00	4,007,915.00	15,015,200.00
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)		0.00	705,870.00	1,129,392.00	1,482,327.00	1,835,261.00	2,117,609.00	7,270,459.00
Persons receiving services from newly established health facilities (Number)								
Persons receiving services from newly established health facilities (Number (Thousand))	PBC 1.1	0.00	900,000.00	1,800,000.00	2,700,000.00	3,650,000.00	5,500,000.00	14,550,000.00

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Females receiving services from newly established health facilities (Number (Thousand))		0.00	450,000.00	900,000.00	1,350,000.00	1,825,000.00	2,750,000.00	7,275,000.00
Health facilities accredited to provide essential health services under insurance								
Health facilities on health insurance contract passing national accreditation standards (Number)		0.00	0.00	150.00	150.00	100.00	100.00	500.00
Tracer drug availability in peripheral unit health facilities								
Tracer drug availability in peripheral unit health facilities (Percentage)		0.00	50.00	55.00	60.00	65.00	75.00	75.00

Intermediate Results Indicators by Components

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Increasing demand and supply of quality health and nutrition services								
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)	PBC 1	0.00	1,806,721.00	2,519,336.00	3,094,651.00	3,586,577.00	4,007,915.00	15,015,200.00
People who have received essential health, nutrition, and		0.00	705,870.00	1,129,392.00	1,482,327.00	1,835,261.00	2,117,609.00	7,270,459.00

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
population (HNP) services - Female (RMS requirement) (CRI, Number)								
Number of children immunized (CRI, Number)	PBC 1.2	0.00	834,003.00	889,603.00	945,203.00	1,000,803.00	1,056,403.00	4,726,015.00
Number of women and children who have received basic nutrition services (CRI, Number)		0.00	917,457.00	973,891.00	1,030,334.00	1,086,786.00	1,143,246.00	5,151,714.00
Number of deliveries attended by skilled health personnel (CRI, Number)	PBC 1.3	57,917.00	58,418.00	60,688.00	63,848.00	66,207.00	69,474.00	318,634.00
Households visited by health workers, including CHWs (disaggregated by sex) (Number)	PBC 1.4	0.00	401,494.00	559,852.00	687,700.00	797,017.00	890,648.00	3,336,711.00
Persons registered onto the health insurance scheme (Number)	PBC 2, 2.1, 2.2, 2.3, 2.4	0.00	0.00	1,164,295.00	1,026,996.00	943,606.00	873,019.00	4,007,916.00
Pregnant women registered onto the health insurance scheme (Number)		0.00	0.00	75,292.00	78,453.00	80,811.00	84,078.00	318,634.00
Children under five years of age registered onto the health insurance scheme (Number)		0.00	0.00	264,101.00	264,101.00	264,101.00	264,101.00	1,056,403.00

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
School-aged children at age of 6-19 registered onto the health insurance scheme (Number)		0.00	0.00	288,716.00	239,555.00	209,543.00	183,694.00	932,458.00
Rural populations at the age 20 and above registered onto the health insurance scheme (Number)		0.00	0.00	536,186.00	444,887.00	389,151.00	3,411,146.00	1,700,419.00
Newly recruited health professionals deployed to the four most deprived prefectures (Number)	PBC 3	0.00	840.00	860.00	960.00	1,060.00	1,160.00	4,880.00
Newly recruited doctors (generalists and specialists) deployed to the four most deprived regions (Number)	PBC 3.1	0.00	60.00	60.00	60.00	60.00	60.00	300.00
Newly recruited nurses, midwives and physician assistants deployed to the four most deprived regions (Number)	PBC 3.2	0.00	780.00	800.00	900.00	1,000.00	1,100.00	4,580.00
Tracer drug available at the primary healthcare level (Percentage)	PBC 4	0.00	50.00	55.00	60.00	65.00	75.00	75.00
Bringing health facilities and services close to households								
Primary health facilities newly built (Number)		0.00	0.00	100.00	100.00	0.00	0.00	200.00
Primary health facilities renovated or refurbished		0.00	0.00	150.00	150.00	0.00	0.00	300.00

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
(Number)								
Newly built and refurbished health facilities with off-grid power solar electricity (Percentage)		0.00	0.00	250.00	250.00	0.00	0.00	500.00
Newly built and refurbished health facilities with disability friendly designs of access and water and sanitation facilities (Percentage)		0.00	0.00	250.00	250.00	0.00	0.00	500.00
Beneficiaries of these newly refurbished health facilities satisfied with the quality of services and facilities (Percentage)		0.00	0.00	15.00	35.00	60.00	80.00	80.00
Health facilities with Quality Improvement Plan (QIP) (Number)		0.00	0.00	0.00	250.00	250.00	0.00	500.00
Strengthening the national social health insurance scheme								
Established social health insurance scheme (Yes/No)		No						Yes
Health facilities accredited to the TSHIA (Number)		0.00	0.00	150.00	150.00	100.00	100.00	500.00
Improving stewardship, oversight and management								
Complaints for grievances responded and resolved within two weeks (Percentage)		0.00	65.00	75.00	75.00	75.00	75.00	75.00
Quarterly reports submitted in a timely manner		0.00	70.00	75.00	80.00	85.00	90.00	90.00

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
(Percentage)								

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
People who have received essential health, nutrition, and population (HNP) services		Annually	Project reports	Routine data generated from HMIS and DHIS2 Review of project reports	MHPHUAC and TSHIA
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)		Annually	Project reports	Routine data generated from HMIS and DHIS2 Review of project reports	MHPHUAC and TSHIA
Persons receiving services from newly established health facilities	This indicator measures number of person accessing services at new facilities	Semi-annually	Ministry of Public Health and Hygiene	Reports submitted by health facilities	MHPHUAC and TSHIA
Females receiving services from newly established health facilities	This indicator measures number of females accessing services at new facilities	Semi-annually	Reports submitted by health facilities	Reports submitted by health facilities	MHPHUAC and TSHIA

Health facilities on health insurance contract passing national accreditation standards	The indicator measures the number of facilities accredited who passed at mid-point and above of assessment grading and submitting service claims (annual and non cumulative)	Semi-annually	MHPHUAC and TSHIA	Routine data reporting from health facilities	MHPHUAC and TSHIA
Tracer drug availability in peripheral unit health facilities	Refers to the number of specific tracer drugs agreed nationally to be available at the primary level among all primary health facilities	Semi-annually	Routine data generated from HMIS	Reports submitted by health facilities	MHPHUAC

Monitoring & Evaluation Plan: Intermediate Results Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
People who have received essential health, nutrition, and population (HNP) services		This is a cumulative count indicator reported in 12 month cycles as measured by the intermedia te results timelines. It measures the contact	HMIS, DHIS2 and TSHIA database Project reports	Routine data generated from HMIS and DHIS2 Review of project reports	MHPHUAC and TSHIA

		use of services by the population.			
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)		Annually	HMIS, DHIS2 and TSHIA database Project reports	Routine data generated from HMIS and DHIS2 Review of project reports	MHPHUAC and TSHIA
Number of children immunized		Annually	HMIS and DHIS2	Routine reporting from health facilities	MHPHUAC
Number of women and children who have received basic nutrition services		Annually	HMIS and DHIS2	Routine data reporting	MHPHUAC
Number of deliveries attended by skilled health personnel		Annually	HMIS and DHIS2	Routine reporting	MHPHUAC
Households visited by health workers, including CHWs (disaggregated by sex)	This indicator measures the number of households visited by health workers, including CHWs, at the community level. Targets for the percentage of households visited by female health workers, including CHWs are 20% in Year 1, 30% in Year 2, 40% in Year 3, 50% in Year 4, and 60% in Year 5 and by the	Annually	Project reports	Review of project reports	MHPHUAC and TSHIA

	end of the project.				
Persons registered onto the health insurance scheme	This measure the number of person enrolled onto the scheme	Annually	TSHIA database	Review of TSHIA data	TSHIA
Pregnant women registered onto the health insurance scheme		Annually	TSHIA database	Review of TSHIA data	TSHIA
Children under five years of age registered onto the health insurance scheme		Annually	TSHIA database	Review of TSHIA data	TSHIA
School-aged children at age of 6-19 registered onto the health insurance scheme		Annually	TSHIA database	Review of TSHIA data	TSHIA
Rural populations at the age 20 and above registered onto the health insurance scheme		Annually	TSHIA database	Review of TSHIA data	TSHIA
Newly recruited health professionals deployed to the four most deprived prefectures	Indicator measures redistribution of health professionals to the most deprived communities to correct the inequities in staff availability	Annually	Project reports	Review of project reports	MHPHUAC
Newly recruited doctors (generalists and specialists) deployed to the four most deprived regions	Indicator measures redistribution of medical doctors to the most deprived communities to correct the inequities in staff availability	Annually	Project reports	Review of project reports	MHPHUAC
Newly recruited nurses, midwives and physician assistants deployed to the four most deprived regions	Indicator measures redistribution of paramedical staff to the	Annually	Project reports	Review of project reports	MHPHUAC

	most deprived communities to correct the inequities in staff availability				
Tracer drug available at the primary healthcare level	This indicator monitor the country specific tracer drugs agreed nationally to be available at the primary level for all health facilities. It will measure the indicator as a national aggregate.	Semi-annually	HMIS, DHIS2 and reports from health facilities	Reports submitted by health facilities	MHPHUAC
Primary health facilities newly built	This measures the number of PHC facilities built in the three target regions (Savane, Central and Kara)	Semi-annually	Project reports	Review of project reports	MHPHUAC and TSHIA
Primary health facilities renovated or refurbished	Number of PHC facilities renovated or refurbished in the three target regions (Savane, Central and Kara)	Semi-annually	Project reports	Review of project reports	MHPHUAC
Newly built and refurbished health facilities with off-grid power solar electricity	Referred to the number of newly built and refurbished health facilities with off-grid power solar electricity among the total newly refurbished health facilities	Semi-annually	Project reports	Review of project reports	MHPHUAC
Newly built and refurbished health facilities with disability friendly designs of access and water and sanitation facilities	Referred to as the number of newly built and refurbished health facilities with disability friendly designs of access and water and sanitation facilities	Semi-annually	Project reports	Review of project reports	MHPHUAC
Beneficiaries of these newly refurbished health facilities satisfied with the quality	Referred to as the proportion of beneficiaries	Semi-annually	Project reports and	Review of project reports and TSHIA	MHPHUAC and TSHIA

of services and facilities	of these newly refurbished health facilities satisfied with the quality of services and facilities		TSHIA reports	reports	
Health facilities with Quality Improvement Plan (QIP)	Indicator measures the number of accredited Health facilities with Quality Improvement Plan (QIP)	Annually	Project reports	Review of project reports	MHPHUAC
Established social health insurance scheme	The indicator validates the legal covenant/conditions and the establishment of the TSHIA's Office with the full complement of staff based on an existing manual and legislation	One time	Project reports and TSHIA reports	Review of project reports and TSHIA reports	MHPHUAC and TSHIA
Health facilities accredited to the TSHIA	This measures the number of facilities accredited and submitting claims to the scheme	Semi-annually	TSHIA database	Review of TSHIA reports	MHPHUAC and TSHIA
Complaints for grievances responded and resolved within two weeks	Refers to the number of grievances responded to and/or resolved within two weeks or within the stipulated service standard for response times, per the project implementing manual, among total number of complaints for grievances received in the project	Semi-annually	Project reports	Review of project reports	MHPHUAC
Quarterly reports submitted in a timely manner	Refers to the quarterly reports submitted in a	Quarterly	Project reports	Review of project reports	Office of the President,

	timely manner in the two previous quarters (average)				MHPHUAC and TSHIA

Performance-Based Conditions Matrix

PBC 1	People who have received essential health, nutrition, and population (HNP) services			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	667,343.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
June - December 2021	1,806,721.00		80,299.00	75% of children under five, 20% of women above the age 5, and 8% of men above the age 5
January - December 2022	2,519,336.00		111,970.00	80% of children under five, 32% of women above the age 5, and 15% of men above the age 5
January - December 2023	3,094,651.00		137,540.00	85% of children under five, 42% of women above the age 5, and 20% of men above the age 5
January - December 2024	3,586,577.00		159,404.00	90% of children under five, 52% of women above the age 5, and 22.5% of men above the age 5
January - December 2025	4,007,915.00		178,130.00	95% of children under five, 60% of

			women above the age 5, and 25% of men above the age 5

PBC 1.1	Number of people who have received essential health, nutrition, and population (HNP) services			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	667,343.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
June - December 2021	1,806,721.00		80,299.00	75% of children under five, 20% of women above the age 5, and 8% of men above the age 5
January - December 2022	2,519,336.00		111,970.00	80% of children under five, 32% of women above the age 5, and 15% of men above the age 5
January - December 2023	3,094,651.00		137,540.00	85% of children under five, 42% of women above the age 5, and 20% of men above the age 5
January - December 2024	3,586,577.00		159,404.00	90% of children under five, 52% of women above the age 5, and 22.5% of men above the age 5
January - December 2025	4,007,915.00		178,130.00	95% of children under five, 60% of women above the age 5, and 25% of men above the age 5

PBC 1.2	Number of children immunized			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	2,669,370.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
June - December 2021	834,003.00		471,065.00	75% of children under five
January - December 2022	889,603.00		502,469.00	80% of children under five
January - December 2023	945,203.00		533,874.00	85% of children under five
January - December 2024	1,000,803.00		565,278.00	90% of children under five
January - December 2025	1,056,403.00		596,684.00	95% of children under five

PBC 1.3	Number of deliveries attended by skilled health personnel			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	2,002,027.00	2.86
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	57,917.00			
June - December 2021	58,418.00		367,046.00	4% of the total number of women at reproductive age (age 15-49)
January - December 2022	60,688.00		381,309.00	Incremental increase by 1% from Year 1

January - December 2023	63,848.00		401,169.00	Incremental increase by 1% from Year 2
January - December 2024	66,206.00		415,986.00	Incremental increase by 1% from Year 3
January - December 2025	69,474.00		436,517.00	Incremental increase by 1% from Year 4

PBC 1.4	Households visited by health workers, including CHWs			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	1,334,684.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
June - December 2021	401,494.00		160,597.00	Number of households visited, multiplied by US$1 per HH visit x 2 times a year
January - December 2022	559,852.00		223,941.00	Number of households visited, multiplied by US$1 per HH visit x 2 times a year
January - December 2023	687,700.00		275,080.00	Number of households visited, multiplied by US$1 per HH visit x 2 times a year
January - December 2024	797,017.00		318,807.00	Number of households visited, multiplied by US$1 per HH visit x 2

			times a year
January - December 2025	890,648.00	356,259.00	Number of households visited, multiplied by US$1 per HH visit x 2 times a year

PBC 2	**Persons registered onto the health insurance scheme**			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	8,000,000.00	11.00

Period	**Value**	**Allocated Amount (USD)**	**Formula**
Baseline	0.00		
June - December 2021	0.00	0.00	0.00
January - December 2022	1,164,295.00	2,300,000.00	23.75% of children under five, 17% of women above the age 5, and 9% of men above the age 5
January - December 2023	1,026,996.00	2,100,000.00	23.75% of children under five, 15% of women above the age 5, and 7% of men above the age 5
January - December 2024	943,606.00	1,860,000.00	23.75% of children under five, 15% of women above the age 5, and 4.5% of men above the age 5
January - December 2025	873,018.00	1,740,000.00	23.75% of children under five, 13% of women above the age 5, and 4.5% of men above the age 5

PBC 2.1	Pregnant women registered onto the health insurance scheme			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	641,266.00	11.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
June - December 2021	0.00		0.00	Payment for reaching every 10,000 pregnant women enrolled onto the health insurance scheme will be US$20,125
January - December 2022	75,292.00		186,287.00	Payment for reaching every 10,000 pregnant women enrolled onto the health insurance scheme will be US$20,125
January - December 2023	78,453.00		164,319.00	Payment for reaching every 10,000 pregnant women enrolled onto the health insurance scheme will be US$20,125
January - December 2024	80,811.00		150,977.00	Payment for reaching every 10,000 pregnant women enrolled onto the health insurance scheme will be US$20,125
January - December 2025	84,078.00		139,683.00	Payment for reaching every 10,000 pregnant women enrolled onto the health insurance scheme will be

			US$20,125

PBC 2.2	Children under five registered onto the health insurance scheme			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	3,046,015.00	11.00

Period	**Value**	**Allocated Amount (USD)**	**Formula**
Baseline	0.00		
June - December 2021	0.00	0.00	Payment for reaching every 100,000 children under 5 years will be US$76,000;
January - December 2022	264,101.00	884,864.00	Payment for reaching every 100,000 children under 5 years will be US$76,000;
January - December 2023	264,101.00	780,517.00	Payment for reaching every 100,000 children under 5 years will be US$76,000;
January - December 2024	264,101.00	717,140.00	Payment for reaching every 100,000 children under 5 years will be US$76,000;
January - December 2025	264,101.00	663,494.00	Payment for reaching every 100,000 children under 5 years will be US$76,000;

PBC 2.3	Number of school aged children at age of 6-19 registered onto the health insurance scheme			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	2,164,274.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
June - December 2021	0.00		0.00	Payment for reaching every 100,000 school aged children will be US$54,000.
January - December 2022	288,716.00		628,719.00	Payment for reaching every 100,000 school aged children will be US$54,000.
January - December 2023	239,555.00		554,578.00	Payment for reaching every 100,000 school aged children will be US$54,000.
January - December 2024	209,543.00		509,547.00	Payment for reaching every 100,000 school aged children will be US$54,000.
January - December 2025	183,694.00		471,430.00	Payment for reaching every 100,000 school aged children will be US$54,000.

PBC 2.4	Number of rural populations registered onto the health insurance scheme			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	2,164,274.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
June - December 2021	0.00		0.00	Payment for reaching every 100,000 rural populations will be US$54,000
January - December 2022	536,186.00		628,719.00	Payment for reaching every 100,000 rural populations will be US$54,000
January - December 2023	444,887.00		554,578.00	Payment for reaching every 100,000 rural populations will be US$54,000
January - December 2024	389,151.00		509,547.00	Payment for reaching every 100,000 rural populations will be US$54,000
January - December 2025	341,146.00		471,430.00	Payment for reaching every 100,000 rural populations will be US$54,000

PBC 3	Newly recruited health professionals deployed to the four most deprived regions			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	2,900,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			

June - December 2021	840.00		520,000.00	Targeting pregnant women, children under five, school aged children, and rural populations
January - December 2022	860.00		530,000.00	Targeting pregnant women, children under five, school aged children, and rural populations
January - December 2023	960.00		550,000.00	Targeting pregnant women, children under five, school aged children, and rural populations
January - December 2024	1,060.00		650,000.00	Targeting pregnant women, children under five, school aged children, and rural populations
January - December 2025	1,160.00		650,000.00	Targeting pregnant women, children under five, school aged children, and rural populations
PBC 3.1	Newly recruited doctors deployed to the four most deprived regions			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	1,171,200.00	4.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
June - December 2021	60.00		234,240.00	Payment for reaching every 10 doctors deployed will be US$39,040

January - December 2022	60.00		234,240.00	Payment for reaching every 10 doctors deployed will be US$39,040
January - December 2023	60.00		234,240.00	Payment for reaching every 10 doctors deployed will be US$39,040
January - December 2024	60.00		234,240.00	Payment for reaching every 10 doctors deployed will be US$39,040
January - December 2025	60.00		234,240.00	Payment for reaching every 10 doctors deployed will be US$39,040

PBC 3.2	Newly recruited nurses, midwives and physician assistants deployed to the four most deprived regions			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	1,756,800.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
June - December 2021	780.00		299,193.00	Payment for reaching every 100 registered professional nurses, midwives and physician assistants deployed will be US$38,358
January - December 2022	800.00		306,865.00	Payment for reaching every 100 registered professional nurses, midwives and physician assistants deployed will be US$38,358

January - December 2023	900.00		345,223.00	Payment for reaching every 100 registered professional nurses, midwives and physician assistants deployed will be US$38,358
January - December 2024	1,000.00		383,580.00	Payment for reaching every 100 registered professional nurses, midwives and physician assistants deployed will be US$38,358
January - December 2025	1,100.00		421,939.00	Payment for reaching every 100 registered professional nurses, midwives and physician assistants deployed will be US$38,358

PBC 4	Tracer drug available at the primary healthcare level			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Percentage	15,015,200.00	24.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
June - December 2021	50.00		800,811.00	Payment for cost of essential medicines. Using OPD Medicines as proxy at US$1.0 per person per year
January - December 2022	55.00		1,801,824.00	Payment for cost of essential

			medicines. Using OPD Medicines as proxy at US$1.0 per person per year
January - December 2023	60.00	2,802,837.00	Payment for cost of essential medicines. Using OPD Medicines as proxy at US$1.0 per person per year
January - December 2024	65.00	3,803,851.00	Payment for cost of essential medicines. Using OPD Medicines as proxy at US$1.0 per person per year
January - December 2025	75.00	5,805,877.00	Payment for cost of essential medicines. Using OPD Medicines as proxy at US$1.0 per person per year

Verification Protocol Table: Performance-Based Conditions	
PBC 1	People who have received essential health, nutrition, and population (HNP) services
Description	
Data source/ Agency	Reimbursement claims records at the Togo Social Health Insurance Agency (TSHIA); DHIS2 data; Registries at PHC facilities
Verification Entity	District Health Management Team - Regional Health Team and then the TSHIA 1. PHC facilities submit claims and reports to prefectural health department (DPS) or health district directorate (DDS) 2. DPS or DDS submits claims and reports to regional health directorates (DRS) 3. DRSs submit claims and reports to TSHIA 4. TSHIA verifies the claim data and submit the reports to the PCU to request the World Bank for No Objection (The World Bank may request for an independent verification of the results as it deems appropriate) 5. Upon obtaining No Objection from the World Bank on the above, TSHIA or PCU submit the World Bank a six-month budget request, which includes detailed plan for respective local government areas and facilities

Procedure	Payment for reaching households with essential HNP services of every 100,000 people will be US$4,444.

PBC 1.1	Number of people who have received essential health, nutrition, and population (HNP) services
Description	Referred to the total Number of people who have received essential health, nutrition, and population (HNP) services
Data source/ Agency	Reimbursement claims records at the Togo Social Health Insurance Agency (TSHIA); DHIS2 data; Registries at PHC facilities
Verification Entity	District Health Management Team - Regional Health Team and then the TSHIA 1. PHC facilities submit claims and reports to prefectural health department (DPS) or health district directorate (DDS) 2. DPS or DDS submits claims and reports to regional health directorates (DRS) 3. DRSs submit claims and reports to TSHIA 4. TSHIA verifies the claim data and submit the reports to the PCU to request the World Bank for No Objection (The World Bank may request for an independent verification of the results as it deems appropriate) 5. Upon obtaining No Objection from the World Bank on the above, TSHIA or PCU submit the World Bank a six-month budget request, which includes detailed plan for respective local government areas and facilities
Procedure	Payment for reaching households with essential HNP services of every 100,000 people will be US$4,444.

PBC 1.2	Number of children immunized
Description	
Data source/ Agency	DHIS2
Verification Entity	DHMT - Regional Team and then TSHIA
Procedure	Payment for reaching every 100,000 children for immunization will be US$56,482.

PBC 1.3	Number of deliveries attended by skilled health personnel
Description	
Data source/ Agency	DHIS2
Verification Entity	DHMT - Regional Health Team and then TSHIA

Procedure	Payment for reaching every 10,000 pregnant women with skilled birth attendance will be US$62,831.
PBC 1.4	Households visited by health workers, including CHWs
Description	Referred to number of Households visited by health workers, including CHWs disaggregated by sex
Data source/ Agency	Reimbursement claims records at the Togo Social Health Insurance Agency (TSHIA); Registries at PHC facilities
Verification Entity	TSHIA
Procedure	Payment for reaching every 100,000 households for home visits and durbars will be US$40,000.
PBC 2	Persons registered onto the health insurance scheme
Description	This measure the number of person enrolled onto the TSHIA
Data source/ Agency	Registry records at the Togo Social Health Insurance Agency (TSHIA)
Verification Entity	1. TSHIA submits registry of TSHIA membership data to heads of local governments 2. Local government validates and confirms TSHIA membership data with the data in the e-registry of the Régime Social Unique 3. TSHIA submits the validated membership data by the local government to the Régime Social Unique 4. An independent consultant verifies insurance membership data and submits to the World Bank for No Objection, copying the PCU
Procedure	Payment for reaching every 10,000 pregnant women enrolled onto the health insurance scheme will be US$20,125; Payment for reaching every 10,000 children under 5 years old enrolled onto the health insurance scheme will be US$28,834; Payment for reaching every 10,000 school aged children enrolled onto the health insurance scheme will be US$23,210; and Payment for reaching every 10,000 rural populations enrolled onto the health insurance scheme will be US$12,728.
PBC 2.1	Pregnant women registered onto the health insurance scheme
Description	This measure the number of pregnant women enrolled onto the TSHIA
Data source/ Agency	Registry records at the Togo Social Health Insurance Agency (TSHIA)
Verification Entity	1. TSHIA submits registry of TSHIA membership data to heads of local governments 2. Local government validates and

	confirms TSHIA membership data with the data in the e-registry of the Régime Social Unique 3. TSHIA submits the validated membership data by the local government to the Régime Social Unique 4. An independent consultant verifies insurance membership data and submits to the World Bank for No Objection, copying the PCU
Procedure	Payment for reaching every 10,000 pregnant women enrolled onto the health insurance scheme will be US$20,125.

PBC 2.2	Children under five registered onto the health insurance scheme
Description	Referred to the number of Children under five registered onto the health insurance scheme
Data source/ Agency	Registry records at the Togo Social Health Insurance Agency (TSHIA)
Verification Entity	1. TSHIA submits registry of TSHIA membership data to heads of local governments 2. Local government validates and confirms TSHIA membership data with the data in the e-registry of the Régime Social Unique 3. TSHIA submits the validated membership data by the local government to the Régime Social Unique 4. An independent consultant verifies insurance membership data and submits to the World Bank for No Objection, copying the PCU
Procedure	Payment for reaching every 100,000 children under 5 years old enrolled onto the health insurance scheme will be US$76,000;

PBC 2.3	Number of school aged children at age of 6-19 registered onto the health insurance scheme
Description	Referred to the number of school aged children at age of 6-19 registered onto the health insurance scheme
Data source/ Agency	Registry records at the Togo Social Health Insurance Agency (TSHIA)
Verification Entity	1. TSHIA submits registry of TSHIA membership data to heads of local governments 2. Local government validates and confirms TSHIA membership data with the data in the e-registry of the Régime Social Unique 3. TSHIA submits the validated membership data by the local government to the Régime Social Unique 4. An independent consultant verifies insurance membership data and submits to the World Bank for No Objection, copying the PCU
Procedure	Payment for reaching every 100,000 school aged children enrolled onto the health insurance scheme will be US$54,000.

PBC 2.4	Number of rural populations registered onto the health insurance scheme
Description	Referred to as the number of rural populations registered onto the health insurance scheme
Data source/ Agency	Registry records at the Togo Social Health Insurance Agency (TSHIA)
Verification Entity	1. TSHIA submits registry of TSHIA membership data to heads of local governments 2. Local government validates and confirms TSHIA membership data with the data in the e-registry of the Régime Social Unique 3. TSHIA submits the validated membership data by the local government to the Régime Social Unique 4. An independent consultant verifies insurance membership data and submits to the World Bank for No Objection, copying the PCU
Procedure	Payment for reaching every 100,000 rural populations enrolled onto the health insurance scheme will be US$54,000.

PBC 3	Newly recruited health professionals deployed to the four most deprived regions
Description	Indicator measures redistribution of staff to the most deprived communities to correct the inequities in staff availability
Data source/ Agency	Training reports by 2 training institutions; Supervisory reports by nursing regulatory bodies and professional associations for the training of the CHNs
Verification Entity	Independent validation by consultants 1. Heads of health facilities submits a comprehensive list of staff having accepted posting and at post for not less than 12 months to local government authority 2. Local government authority reviews and endorses the above list 3. Local government authority submits a letter of endorsement to the MHPH, and a copy of the letter is to be forwarded to the World Bank for No Objection, copying the PCU (The World Bank may request for an independent verification of the results as it deems appropriate)
Procedure	Payment for reaching every 10 doctors deployed will be US$39,040; and Payment for reaching every100 registered professional nurses, midwives and physician assistants deployed will be US$38,358.

PBC 3.1	Newly recruited doctors deployed to the four most deprived regions
Description	Indicator measures redistribution of staff to the most deprived communities to correct the inequities in staff availability
Data source/ Agency	Training reports by 2 training institutions; Supervisory reports by nursing regulatory bodies and professional associations for the training of the CHNs

Verification Entity	Independent validation by consultants 1. Heads of health facilities submits a comprehensive list of staff having accepted posting and at post for not less than 12 months to local government authority 2. Local government authority reviews and endorses the above list 3. Local government authority submits a letter of endorsement to the MHPH, and a copy of the letter is to be forwarded to the World Bank for No Objection, copying the PCU (The World Bank may request for an independent verification of the results as it deems appropriate)
Procedure	Payment for reaching every 10 doctors deployed will be US$39,040.

PBC 3.2	Newly recruited nurses, midwives and physician assistants deployed to the four most deprived regions
Description	Referred to the number of Newly recruited nurses, midwives and physician assistants deployed to the four most deprived regions
Data source/ Agency	Training reports by 2 training institutions; Supervisory reports by nursing regulatory bodies and professional associations for the training of the CHNs
Verification Entity	Independent validation by consultants 1. Heads of health facilities submits a comprehensive list of staff having accepted posting and at post for not less than 12 months to local government authority 2. Local government authority reviews and endorses the above list 3. Local government authority submits a letter of endorsement to the MHPH, and a copy of the letter is to be forwarded to the World Bank for No Objection, copying the PCU (The World Bank may request for an independent verification of the results as it deems appropriate)
Procedure	Payment for reaching every 100 nurses, midwives and physician assistants deployed will be US$38,358.

PBC 4	Tracer drug available at the primary healthcare level
Description	This indicator monitor the country specific tracer drugs agreed nationally to be available at the primary level for all health facilities. It will measure the indicator as a national aggregate
Data source/ Agency	DHIS2 data; Monthly reports by PHC facilities
Verification Entity	1. PHC facilities in the 4 target prefectures submits reports to DPS or DDS on tracer drug availability, using proxy health facilities (20% of health facilities) 2. DPS or DDS undertakes an internal verification and certify the results 3. DPS or DDS submits the certified results to DRS 4. DRSs submit a consolidated regional report to the MHPH 5. MHPH conducts an independent verification of the results (An independent verification can be carried out by the government's verification agency) 6. MHPH submits reports to the World Bank for No Objection, copying the PCU

Procedure	MHPH conducts an independent verification of the results using proxy health facilities (20% of health facilities)

Annex 1: Project Budget by Component

Indicators			Baseline	Allocation by key indicator (full disbursement amounts if 91-100% achieved) Year 1	Year 2	Year 3	Year 4	Year 5	Cumulative Targets
Component 1: Increasing demand and supply of quality health and nutrition services (PBC)									
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)	Annual targets		0	1,806,721	2,519,336	3,094,651	3,586,577	4,007,915	**15,015,200**
	Weighted score	**10%**		$ 80,299	$ 111,970	$ 137,540	$ 159,404	$ 178,130	$ 667,343
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)	Annual targets		0	705,870	1,129,392	1,482,327	1,835,261	2,117,609	7,270,459
	Weighted score	**0%**							
Number of children immunized (CRI, Number)	Annual targets		0	834,003	889,603	945,203	1,000,803	1,056,403	**4,726,015**
	Weighted score	**40%**		$ 471,065	$ 502,469	$ 533,874	$ 565,278	$ 596,684	$ 2,669,370
Number of women and children who have received basic nutrition services (CRI, Number)	Annual targets		0	917,457	973,891	1,030,334	1,086,786	1,143,246	5,151,714
	Weighted score	**0%**							-
Number of deliveries attended by skilled health personnel (CRI, Number)	Annual targets		57,917	58,418	60,688	63,848	66,206	69,474	**318,634**
	Weighted score	**30%**		$ 367,046	$ 381,309	$ 401,169	$ 415,986	$ 436,517	$ 2,002,027
Households visited by health workers, including CHWs (Number)	Annual targets		0	401,494	559,852	687,700	797,017	890,648	**3,336,711**
	Weighted score	**20%**		$ 160,597	$ 223,941	$ 275,080	$ 318,807	$ 356,259	$ 1,334,684
Households visited by female health workers, including CHWs (Percentage)			**19%**	20%	30%	40%	50%	60%	60%
Total budget of PBC 1 (US$million)				**$ 1.12**	**$ 1.22**	**$ 1.35**	**$ 1.45**	**$ 1.56**	**$ 6.70**
Number of persons registered onto the health insurance scheme (Number)	Annual targets				1,164,295	1,026,996	943,606	873,018	**4,007,914**
Pregnant women	Annual targets				75,292	78,453	80,811	84,078	**318,634**
	Weighted score	**8%**		$ -	$ 186,287	$ 164,319	$ 150,977	$ 139,683	$ 641,266
Children under five	Annual targets				264,101	264,101	264,101	264,101	**1,056,403**
	Weighted score	**38%**		$ -	$ 884,864	$ 780,517	$ 717,140	$ 663,494	$ 3,046,015
School aged children at age of 6-19	Annual targets				288,716	239,555	209,543	183,694	**932,458**
	Weighted score	**27%**		$ -	$ 628,719	$ 554,578	$ 509,547	$ 471,430	$ 2,164,274
Rural populations (Target by end of Year 5: 60% rural populations enrolled to THIA)	Annual targets				536,186	444,887	389,151	341,146	**1,700,419**
	Weighted score	**27%**		$ -	$ 628,719	$ 554,578	$ 509,547	$ 471,430	$ 2,164,274
Total budget of PBC 2 (US$million)				**$ -**	**$ 2.30**	**$ 2.10**	**$ 1.86**	**$ 1.74**	**$ 8.00**
Newly recruited staff deployed to the four most deprived regions (Number)	Annual targets		0	840	860	960	1,060	1,160	4,880
Number of doctors (generalists and specialists)	Annual targets			60	60	60	60	60	300
	Weighted score	**40%**		$ 234,240	$ 234,240	$ 234,240	$ 234,240	$ 234,240	$ 1,171,200
Number of nurses, midwives and physician assistants	Annual targets			780	800	900	1,000	1,100	4,580
	Weighted score	**60%**		$ 299,193	$ 306,865	$ 345,223	$ 383,580	$ 421,939	$ 1,756,800
Total budget of PBC 3 (US$million)				**$ 0.52**	**$ 0.53**	**$ 0.55**	**$ 0.65**	**$ 0.65**	**$ 2.90**
Tracer drug available at the primary healthcare level (Percentage)	Annual targets		46%	50%	55%	60%	65%	75%	75%
Total budget for PBC 4 (US$million)	Weighted score	**100%**		**$ 0.80**	**$ 1.80**	**$ 2.80**	**$ 3.80**	**$ 5.80**	**$ 15.00**
Total budget of Component 1 (US$million)				**$ 2.44**	**$ 5.55**	**$ 6.70**	**$ 7.90**	**$ 10.01**	**$ 32.60**

Component 2: Bringing health facilities and services close to households								
Indicators			**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Cumulative Targets**
Primary health facilities newly built (Number)	Annual targets	0	0	100	100	0	0	200
Primary health facilities rennovated/refurbished (Number)	Annual targets	0	0	150	150	0	0	300
Newly built and refurbished health facilities with off-grid power solar electricity (Percentage)	Annual targets	0%	0%	15%	35%	60%	85%	100%
Newly built and refurbished health facilities with disability friendly designs of access and water and sanitation facilities (Percentage)	Annual targets	0%	0%	15%	35%	60%	85%	100%
Beneficiaries of these newly refurbished health facilities satisfied with the quality of services and facilities (Percentage)	Annual targets	0%	0%	15%	35%	60%	80%	80%
Budget (non-PBC)	**Budget items**				**Number**	**Frequency**	**Unit Cost**	**Amount**
Sub-component 2.1: Increasing access of vulnerable populations to health facilities and services	Construct and equip 200 new PHC health facilities, including medical waste				200	1	$ 120,000	$ 24,000,000
	Rennovation or refurbishment of primary health facilities				300	1	$ 10,000	$ 3,000,000
	Safeguards and field monitoring of construction works				1	1	$ 250,000	$ 250,000
Sub-component 2.2: Providing equipment of the newly build health facilities	Basic equipment and community service delivery kit/bag motorbike mountable				500	1	$ 3,000	$ 1,500,000
	Procurement of pick-up vehicles to support monitoring activities				10	1	$ 35,000	$ 350,000
	Procurement of motorbikes				400	1	$ 2,200	$ 880,000
Annually Budget PHC construction			$ -	$ 12,000,000.00	$ 12,000,000.00	$ -	$ -	
Annually Budget PHC renovation or refurbishment			$ -	$ 1,500,000.00	$ 1,500,000.00	$ -	$ -	
Basic equipment and community service delivery kit/bag motorbike mountable			$ 900,000.00	$ 300,000.00	$ 300,000.00	$ -	$ -	
Safeguards and field monitoring of construction works			$ 50,000.00	$ 50,000.00	$ 50,000.00	$ 50,000.00	$ 50,000.00	
Procurement of vehicles and motorbikes			$ 350,000.00	$ 440,000.00	$ 440,000.00	$ -	$ -	
Total budget of Component 2 (US$million)			**$ 1.30**	**$ 14.30**	**$ 14.30**	**$ 0.05**	**$ 0.05**	**$ 30.00**
Component 3: Strengthening the national social health insurance scheme								
Indicator			**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Cumulative Targets**
Togo Social Health Insurance Agency (TSHIA) established (Yes/No)	Annual targets	No	Yes					Yes
Health facilities accredited to the TSHIA (Number)	Annual targets	0	0	150	150	100	100	500
Budget (non-PBC)	**Budget items**				**Number**	**Frequency**	**Unit Cost**	**Amount**
Sub-component 3.1: Establishing and supporting the operations of the TSHIA	Update of the documents on health standards and standards and establishment of a contractual framework				1	1	$ 86,400	$ 86,400
	Recruit a consultant to develop the TSHIA roll-out plan				3	90	$ 300	$ 81,000
	Worshop to review and adopt TSHIA roll-out plan				1	3	$ 10,000	$ 30,000
	Purchase soft and hard ware to roll out membership and accreditation management				500	1	$ 3,000	$ 1,500,000
	Recruit experts and consultants to support the roll-out				6	1	$ 60,000	$ 360,000
	Support the accreditation of health facilities onto the TSHIA				500	2	$ 50	$ 50,000
	Support the administration, staff costs, monitoring and evaluation activities of the TSHIA				12	5	$ 20,000	$ 1,200,000
	Support the training of key staff in health insurance management				20	2	$ 10,000	$ 400,000
Sub-component 3.2: Promoting demand for health insurance services	Create brand awareness for health insurance				12	5	$ 10,000.00	$ 600,000
Total budget of Component 3 (US$million)			**$ 2.06**	**$ 0.56**	**$ 0.56**	**$ 0.56**	**$ 0.56**	**$ 4.30**

Composant 4: Improving stewardship, oversight and management								
Indicators			**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Cumulative Targets**
Quaterly reports submitted timely	Annual targets		70	75	80	85	90	90
Complaints or grievances responded and resolved within two weeks (Percentage)	Annual targets		65	75	75	75	75	75
Budget (non-PBC)	**Budget items**				**Number**	**Frequency**	**Unit Cost**	**Amount**
Sub-component 4.1: Assuring the social, environmental safeguard of the project	Sharing and dissemination of safeguards documents across the regions				6	1	$ 6,000	$ 36,000
	Elaboration of GRM				1	1	$ 30,000	$ 30,000
	Establishment and capacity building of GRM committee				6	2	$ 3,000	$ 36,000
	Commodities for GRM committee, equipements (electronic materials, registers,				6	5	$ 1,000	$ 30,000
	Mapping of GBV/SEA/SH service providers				1	1	$ 20,000	$ 20,000
	Stakeholders consultations for SEP				6	5	$ 2,000	$ 60,000
	Evaluation for social risks in health care settings				1	1	$ 20,000	$ 20,000
	Establishment or reactivation of WASH committees in the project target areas				6	1	$ 4,000	$ 24,000
	Capacity building for actors in national environmental regulations in accordance with the World Bank's social and environmental norms, incluidng case management for GBV/SEA/SH and VAC				1	4	$ 20,000	$ 80,000
	Support for hazardous waste management and establishment of IPC (capacity building, equipment for waste management, development of guidance, protcols and procedures etc.)				1	5	$ 20,000	$ 100,000
	Sensibilization of entreprises, communities and other implementation entities on the project sites, including on the aspects of GBV/SEA/SH and VAC				1	2	$ 10,000	$ 20,000
	Provision of obtaining certificates/environmental authorization				1	8	$ 500	$ 4,000
	Elaboration and implementation of a stakeholder consultation framework:				1	1	$ 4,000	$ 4,000
	Implementation and operationalization of hospital complaints systems				1	1	$ 2,000	$ 2,000
	Establishment of a call center for member registration for TSHIA and management of comments and complaints				1	1	$ 69,580	$ 69,580
Sub-component 4.2: Providing project management and coordination	Fees for consultancy services in support of the overall project including coordination, contracting, monitoring and evaluation				4	2	$ 30,000	$ 240,000
	Wages for procurement, safeguards, financial management, health finance and systems expert and project coordinator				5	2	$ 30,000	$ 300,000
	Support sector performance reviews, assessments and reports writing				2	4	$ 50,000	$ 400,000
	Field visits and supervion by staff of the Ministry of Public Health and Hygiene				2	5	$ 50,000	$ 500,000
	PBC independent verification				2	5	$ 15,000	$ 150,000
	Quality surveys				8	1	$ 50,000	$ 400,000
	External audit				1	5	$ 15,000	$ 75,000
	ICR preparation at the end of the project				1	4	$ 25,000	$ 100,000
	Provide operating resources for the PCU				2	5	$ 7,957	$ 79,567
	Provide operating resources for the PIU				2	5	$ 30,000	$ 300,000
Total budget of Component 4 (US$million)			**$ 0.62**	**$ 0.62**	**$ 0.62**	**$ 0.62**	**$ 0.62**	**$ 3.10**
Grand total of the project			**$ 6.42**	**$ 21.03**	**$ 22.18**	**$ 9.13**	**$ 11.24**	**$ 70.00**

Annex 2: Economic and Financing Analysis

1. The essence of investing to improve the provision of and access to essential quality health services transcends the benefits of sound physical, psychological and emotional health to individual beneficiaries into direct favourable productivity and macroeconomic outcomes. Human capital (an encapsulation of health, knowledge and skills) is a significant determinant of economic growth and development and as such, investments that enhance any aspect of it will have large and consequential positive effects on the Togolese economy through enhanced labour productivity. Interestingly, universal access to essential quality health services does to merely fuel economic growth and development through increases in labour productivity, but also reflects economic development.

2. Most recent data estimates show that Togo loses about **two million** years of life of its nationals and residents to diseases and death[36] from communicable, maternal, neonatal, and nutritional diseases. This translates into an annual loss of about US$9.6 billion at an estimated Disability-Adjusted Life Year value of US$5,000.[37] Similarly, years of life lost to disability and death as a result of non-communicable and other diseases (excluding Injuries) is estimated at 1.1 million which also implies an approximated US$5.6 billion yearly loss to the Togolese state.[38] This evolves into a direct financial loss of nearly US$15.2 billion annually, to Togo's Economy. Unfortunately, where the loss of DALYs is heavily skewed against the most productive human resources of the Togolese economy, these economic losses could be much graver and further dragging on Togo's macroeconomic targets.

3. While the importance of investing in the provision of a quality healthcare system with universal coverage in not questionable, the relative scarcity of economic resources to the copiousness of wants of the Togolese economy substantiates the need for an economic assessment of the investment to ensure the most prudent use of resources.

Methodological Approach

4. In assessing the economic and financial prudence of the World Bank in financing the project, economic benefits of the project vis-à-vis the cost involved in the project are examined. Besides the salient positive externalities such as improvement in the HCI score, cognitive abilities of children beneficiaries, competitiveness and attractiveness of quality human resource to the international investment community, among many, that such investment would yield, the overhaul of the Togolese health system will also accrue significantly large direct monetary advantages to the economy of Togo both in the short and long term. Both CBA and ICER are adopted to tell the profitability story of this Investment. A crucial direct benefit of the improved health services such as the redemption of life years which could have been otherwise lost to disability or death and the extension of healthy life expectancy (at birth) is used in the assessment. The analysis draws on the Disability-Adjusted Life Years (DALYs) approach to arrive at the monetary benefits accruable.

[36]Roser, Max, and Hannah Ritchie. 2016. "Burden of Disease". *Published online at OurWorldInData.org*

[37]Jamison Dean T., Prabhat Jha, Ramanan Laxminarayan, and Toby Ord. 2012. "Infectious Disease". Copenhagen Consensus. Though Jamison et al. 2012 estimated the value of a DALY to be US$5,000 for Low Income Countries about eight years ago, the Togolese GNI per capita between 2012 and 2019 augmented by only US$100 from US$590 US$690 over the period and as such, will not impact the value of the DALY.

[38] idem

5. For the dearth of relevant data on Togo to ascertain the financial cost of DALYs averted, useful data on Ghana are employed (given the demographic similarities) and adjustments are made to reflect the effectiveness of the Togolese health system based on the relative HCI score of the two countries. This will help portray a truer efficiency stance for Togo in their health delivery and its associated outcomes, as well as ensure the prediction of a more reliable reward on the investment to be undertaken.

6. To obtain comparable approximations of cost and benefits of the project, both costs and benefits are expressed in 2021 constant prices[39] using deflating and inflating factors computed from GDP deflators projected from past data (2015-2019) for the five-year project period (2021-2026). Subsequently, a 3 percent discounting rate [40] is employed to express projections into the present values required to compute the net present value (NPV) and the benefit-cost ratio (BCR) which determine the profitability of the Togo Essential Quality Health Services for UHC Project. While a BCR greater than one demonstrates the project is worth the investment, an ICER (Cost per DALY in this case) is compared to the Togo's per capita income. An ICER or cost per DALY less than GDP per capita depicts interventions are highly cost-effective. Additionally, interventions are cost-effective when the ICER or cost per DALY is between one- and three-times GDP per capita. Last, but not least, an intervention cannot be termed as cost-effective if the ICER or cost per DALY exceeds three times GDP per capita.[41]

7. It is acknowledged that arbitrary changes in economic and social factors could influence CBA outcomes. For this reason, the robustness of the BCR is investigated by means of a sensitivity Analysis.[42]

Computational adaptations

8. The adoption of data for DALYs averted by the provision of essential health services under Ghana's National Health Insurance Scheme is not merely useful, but more importantly, appropriate as the outcome of the project is substantially dependent on the Togolese National Health Insurance's coverage and strengthening. Due to variations in the efficiency of the health systems for the two countries, a global composite score, the HCI which is reflective of the knowledge, skill and health that residents and nationals of a country expectedly accumulate over the course of their lives, is used to modify the project's outcome to exhibit disparities in service delivery and efficiency of the Ghanaian and Togolese health sectors. Given the same level of all other productive resources, an HCI of 0.43 for Togo relative to Ghana's (0.45)[43] depicts a possible 4.7 percent lag in efficiency of the former nation. Subsequently, the cost of DALYs for Togo will be 4.9 percent higher than that of Ghana.

9. To project the economic impact of the project from health outcomes and their associated costs from the past, GDP deflators for Ghana from 2015 to 2019 were used to project future values for the period spanning 2020-2026. An inflating factor was then computed to project the cost of DALYs estimated in 2017 under the Ghana NHIS into their 2021-dollar equivalents. At the same time, deflating factors were calculated to generate 2021

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[39] Jamison Dean T., Joel G. Breman, Anthony R. Measham, George Alleyne, Mariam Claeson, David B. Evans, Prabhat Jha, Anne Mills, and Philip Musgrove (Editors). 2006. "Disease Control Priorities in Developing Countries." Second Edition. World Bank. Washington, D.C.
[40] Shepard, Donald, Wu Zeng, and Ha Thi Hong Nguyen. 2015. "Cost-Effectiveness Analysis of Results-Based Financing Programs: A Toolkit." World Bank, Washington D.C.
[41] WHO. 2015. "Trends in maternal mortality 1990 to 2015." WHO, Geneva.
[42] Parker. DJ. 2017. "Sensitivity Analysis within CBA." Mimeo.
[43] World Bank. 2020. *Human Capital Index 2020 Update. Human Capital in the time of COVID-19.* World Bank, Washington DC.

constant prices from yearly expenditures. At this juncture, with both the cost of project's outcome (DALYs to be averted) and total project's cost expressed in the same year's prices and currency unit, proportional DALYs to be averted under the project are estimated.

Discussion of CBA and ICER Results

10. In order to give better insight into how components of the project impact expected results, outcomes accruable to Component 1 are computed and compared to the joint outcomes of the entire project. Notably, while it is expected that inflating cost of DALYs in 2017 to reflect 2021 equivalents will yield significantly lower number of DALYs with the same level of cost, it is revealed that drug treatment for uncomplicated malaria for children under 5 years alone produces about 72 percent of the entire number of DALYs at just 10 percent the cost of the project (see Tables 2.1 and 2.2 below). This engenders very high BCRs and relatively lower cost per DALY to be averted for both Component 1 and the project as a whole (see Tables 2.1 and 2.4 below) and underscores the importance of this intervention as an essential part of TEQHS health package as it saves many years of many young children which could have been lost at ages 55.76, years short of their life expectancy.[44]

Component 1: Increase Access to Essential Primary Health Services

11. Component 1 costs US$32.6 million in nominal terms. Since the disbursement of funds is spread over the course of the project, yearly cost allocations for the project are deflated to yield 2021 constant price which yields approximately US$25.5 million. Costs are further discounted at a 3 percent annual rate to arrive at nearly US$23.6 million which together with estimated DALYs of almost 2.3 million produces a cost of almost US$10.3 per DALY to be averted (with drug treatment for uncomplicated malaria for children under 5 years) and 723,068 DALYs at a cost per DALY of US$32.6 without the treatment. Since the per capita GDP for Togo is US$690, it is concluded that the ICERs of 10.3 (with drug treatment for uncomplicated malaria for children under 5 years) and US$32.6 (without it) are highly cost-effective. BCRs of 107 obtained without drug treatment for uncomplicated malaria for children under 5 years and 337 with drug treatment are evidence of the highly beneficial nature of this component.

Table 2.1: Cost- Benefit and Cost-effectiveness Analyses Summary of Component 1 (with and without Drug Treatment for Uncomplicated Malaria for Children Under 5 years

Discount rate of 3%	**(With Drug Treatment) Value in US$**	**(Without Drug Treatment) Value in US$**
PV of Total Benefits	7.9 billion	2.5 billion
PV of Total Costs	23.5 million	23.5 million
NPV of investment	7.9 billion	2.4 billion
BCR	337	107
Total number of DALYs to be averted	2.2 million	0.7 million
Cost per DALY Averted	10.34	32.63

[44] World Bank 2020. "Life expectancy at birth, total – Togo." World Bank, Washington DC.

Table 2.2: Incremental Cost-Effectiveness Analysis of Component 1 (with Drug Treatment for Uncomplicated Malaria for Children Under 5 years)

Essential Health Services (with under 5 drug treatment for malaria)	No. of DALYs to be averted under Component 1 (2021-2026)	Cost per DALY (US$) 2021 prices
Skilled Maternal and New-born Care	74,445	79.7
Community-based Support for Low Birthweight Babies	57,179	0.1
Tetanus Toxoid Vaccination (as part of Antenatal Care)	21,932	15.4
Iron Supplementation for Pregnant Women	19,401	10.5
Syphilis Detection and Treatment (as part of Antenatal Care)	18,408	14.2
Corticosteroids for Preterm Labour	18,042	49.1
Drug Treatment of Neonatal Pneumonia	15,548	3.5
Antibiotics in Case of Preterm Premature rupture of Membranes (pPROM)	12,290	0.6
Intermittent Preventive Treatment of Malaria during Pregnancy	5,716	7.0
Iron Supplementation for Infants	4,755	47.5
Distribution Misoprostol for the Prevention of Post-partum Haemorrhage	2,019	48.5
Asymptotic Bacteriuria Detection and Treatment (as part of Antenatal Care)	1,042	513.8
First Hepatitis B Vaccine within 24 hours of Birth	431	1,274.0
Drug treatment for uncomplicated malaria (<5)	1,633,361	1.6
Pre-referral rectal drug treatment malaria for <5s	17,221	8.8
Pre-referral rectal drug treatment malaria for >5s	5,303	8.1
Emergency obstetric care	118,330	17.2
Use of insecticide treated bed nets	71,760	4.3
Drug treatment sexually transmitted infections (STIs)	45,372	79.8
Malaria vaccination	43,533	53.2
Anti-venom for snakebites	30,893	3.4
Oral rehydration solution (ORS) for diarrhoea in <5s	28,467	32.8
Male circumcision	13,276	92.5
Drug treatment epilepsy	8,491	91.1
Screening children 5-15 for uncorrected refraction error	4,986	106.0
Retinopathy screening and photocoagulation for diabetes	5,005	62.2
HPV (16,18) vaccination	2,611	119.4
Integrated mass drug administration for schistosomiasis and soil-transmitted helminthiasis (children 5-14)	2,358	477.4
Total Number of DALYS to be Averted	***2,282,177***	
Total Costs (at 3 percent Discount Rate)	***US$23,591,683***	
Cost per DALY	***US$10.34***	

Table 2.3: Incremental Cost-Effectiveness Analysis of Component 1 (without Drug Treatment for Uncomplicated Malaria for Children Under 5 years)

Essential Health Services (without under5 drug treatment for malaria)	No. of DALYS to be averted under Component 1 (2021-2026)	Cost per DALY (US$) 2021 prices
Skilled Maternal and New-born Care	82,964	79.7
Community-based Support for Low Birthweight Babies	63,723	0.1
Tetanus Toxoid Vaccination (as part of Antenatal Care)	24,441	15.4
Iron Supplementation for Pregnant Women	21,622	10.5
Syphilis Detection and Treatment (as part of Antenatal Care)	20,515	14.2
Corticosteroids for Preterm Labour	20,107	49.1
Drug Treatment of Neonatal Pneumonia	17,327	3.5
Antibiotics in Case of Preterm Premature rapture of Membranes (pPROM)	13,696	0.6
Intermittent Preventive Treatment of Malaria during Pregnancy	6,370	7.0
Iron Supplementation for Infants	5,299	47.5
Distribution Misoprostol for the Prevention of Post-partum Haemorrhage	2,250	48.5
Asymptotic Bacteriuria Detection and Treatment (as part of Antenatal Care)	1,161	513.8
First Hepatitis B Vaccine within 24 hours of Birth	480	1,274.0
Pre-referral rectal drug treatment malaria for <5s	19,192	8.8
Pre-referral rectal drug treatment malaria for >5s	5,910	8.1
Emergency obstetric care	131,872	17.2
Use of insecticide treated bed nets	79,972	4.3
Drug treatment sexually transmitted infections (STIs)	50,565	79.8
Malaria vaccination	48,515	53.2
Anti-venom for snakebites	34,428	3.4
Oral rehydration solution (ORS) for diarrhoea in <5s	31,725	32.8
Male circumcision	14,796	92.5
Drug treatment epilepsy	9,463	91.1
Screening children 5-15 for uncorrected refraction error	5,557	106.0
Retinopathy screening and photocoagulation for diabetes	5,577	62.2
HPV (16,18) vaccination	2,910	119.4
Integrated mass drug administration for schistosomiasis and soil-transmitted helminthiasis (children 5-14)	2,628	477.4
Total Number of DALYS to be Averted	***723,068***	
Total Costs (at 3 percent Discount Rate)	***US$23,591,683***	
Cost per DALY	***US$ 32.63***	

Entire Project

12. The project's aim of strengthening the Togolese health system; establishing, institutionalizing and overseeing the functionality of its health insurance; enhancing service providers' skill; among many, will significantly enhance efficacy in providing essential quality health to residents and nationals of Togo. Thus, it can be expected that at the completion of this project, Togo's lag behind Ghana in health service delivery will be partly bridged. As a result, for the entire project, a lag in efficiency of 3 percent is used rather than the 4.7 percent adopted for the analysis in Component 1.

13. Drug treatment for uncomplicated malaria for children under 5 years alone accounts for about 72 percent of the total number of DALYs while reducing cost per DALY of the entire project by more than 68 percent from US$31.9 to US$10.1 (see Table 2.4). A GPD per capita of US$690 for Togo indicates the entire project is highly beneficial.

14. Moreover, while benefits accruing to both Component 1 and the whole project are already very high due to basic, but essential nature of services to be provided, it is remarkable that the benefit to cost ratio is three times higher with the inclusion of drug treatment for uncomplicated malaria for children under 5 years than without it.

Table 2.4: Cost- Benefit and Cost-effectiveness Analyses Summary of the project (with and without Drug Treatment for uncomplicated malaria for children under 5 years old

Discount rate of 3%	(With Drug Treatment) Value in US$	(Without Drug Treatment) Value in US$
PV of Total Benefits	17.0 billion	5.4 billion
PV of Total Costs	49.5 million	49.5 million
NPV of investment	17.0 billion	5.3 billion
BCR	344	109
Total number of DALYs to be averted	4.8 million	1.5 million
Cost per DALY Averted	10.12	31.93

Table 2.5: Incremental Cost-Effectiveness Analysis of the project (with Drug Treatment for Uncomplicated Malaria for Children Under 5 years old)

Essential Health Services (with under 5 drug treatment for malaria)	**No. of DALYS to be averted under Component 1 (2021-2026)**	**Cost per DALY (USD) 2021 prices**
Skilled Maternal and New-born Care	159,724	78.3
Community-based Support for Low Birthweight Babies	122,680	0.1
Tetanus Toxoid Vaccination (as part of Antenatal Care)	47,055	15.2
Iron Supplementation for Pregnant Women	41,626	10.3
Syphilis Detection and Treatment (as part of Antenatal Care)	39,496	14.0
Corticosteroids for Preterm Labour	38,710	48.2
Drug Treatment of Neonatal Pneumonia	33,359	3.5
Antibiotics in Case of Preterm Premature rapture of Membranes (pPROM)	26,368	0.6
Intermittent Preventive Treatment of Malaria during Pregnancy	12,264	6.9
Iron Supplementation for Infants	10,201	46.7
Distribution Misoprostol for the Prevention of Post-partum Haemorrhage	4,332	47.6
Asymptotic Bacteriuria Detection and Treatment (as part of Antenatal Care)	2,236	504.8
First Hepatitis B Vaccine within 24 hours of Birth	925	1,251.6
Drug treatment for uncomplicated malaria (<5)	3,504,434	1.6
Pre-referral rectal drug treatment malaria for <5s	36,949	8.6
Pre-referral rectal drug treatment malaria for >5s	11,377	7.9
Emergency obstetric care	253,881	16.9
Use of insecticide treated bed nets	153,963	4.2
Drug treatment sexually transmitted infections (STIs)	97,348	78.4
Malaria vaccination	93,402	52.3
Anti-venom for snakebites	66,281	3.3
Oral rehydration solution (ORS) for diarrhoea in <5s	61,078	32.2
Male circumcision	28,485	90.9
Drug treatment epilepsy	18,218	89.5
Screening children 5-15 for uncorrected refraction error	10,699	104.2
Retinopathy screening and photocoagulation for diabetes	10,738	61.2
HPV (16,18) vaccination	5,603	117.3
Integrated mass drug administration for schistosomiasis and soil-transmitted helminthiasis (children 5-14)	5,060	469.1
Total Number of DALYS to be Averted	***4,896,492***	
Total Costs (at 3 percent Discount Rate)	***US$49,529,210***	
Cost per DALY	***US$10.12***	

Table 2.6: Incremental Cost-Effectiveness Analysis of the TEQHS for UHC (without Drug Treatment for Uncomplicated Malaria for Children Under 5 years old)

Essential Health Services (without under 5 drug treatment for malaria)	No. of DALYS to be averted under Component 1 (2021-2026)	Cost per DALY (USD) 2021 prices
Skilled Maternal and New-born Care	178,003	78.3
Community-based Support for Low Birthweight Babies	136,720	0.1
Tetanus Toxoid Vaccination (as part of Antenatal Care)	52,440	5.2
Iron Supplementation for Pregnant Women	46,390	10.3
Syphilis Detection and Treatment (as part of Antenatal Care)	44,016	14.0
Corticosteroids for Preterm Labour	43,140	48.2
Drug Treatment of Neonatal Pneumonia	37,177	3.5
Antibiotics in Case of Preterm Premature rapture of Membranes (pPROM)	29,386	0.6
Intermittent Preventive Treatment of Malaria during Pregnancy	13,668	6.9
Iron Supplementation for Infants	11,369	46.7
Distribution Misoprostol for the Prevention of Post-partum Haemorrhage	4,828	47.6
Asymptotic Bacteriuria Detection and Treatment (as part of Antenatal Care)	2,491	504.8
First Hepatitis B Vaccine within 24 hours of Birth	1,031	1,251.6
Pre-referral rectal drug treatment malaria for <5s	41,177	8.6
Pre-referral rectal drug treatment malaria for >5s	12,679	7.9
Emergency obstetric care	282,936	16.9
Use of insecticide treated bed nets	171,583	4.2
Drug treatment sexually transmitted infections (STIs)	108,489	78.4
Malaria vaccination	104,091	52.3
Anti-venom for snakebites	73,867	3.3
Oral rehydration solution (ORS) for diarrhoea in <5s	68,068	32.2
Male circumcision	31,744	90.9
Drug treatment epilepsy	20,303	89.5
Screening children 5-15 for uncorrected refraction error	11,923	104.2
Retinopathy screening and photocoagulation for diabetes	11,967	61.2
HPV (16,18) vaccination	6,244	117.3
Integrated mass drug administration for schistosomiasis and soil-transmitted helminthiasis (children 5-14)	5,639	469.1
Total Number of DALYS to be Averted	***1,551,367***	
Total Costs (at 3 percent Discount Rate)	***US$49,529,210***	
Cost per DALY	***US$31.93***	

Sensitivity Analyses

15. In real life, changes in economic conditions impact outcomes of economic investments. Resultantly, the effect of fluctuations in a key determinant of returns on investment, the discount rate, is examined.

16. From Table 2.7a, it is evident that increasing the discount rate by 400 percent from 3 percent to 15 percent results in less than 3 percent reduction in BCR for component one. Similarly, it is shown in Table 2.7b that a five-times change in interest rate from 3 percent to 15 percent causes just about a percentage in BCR. These both point to BCR resilience which is crucial to the reliability of any CBA outcome.

Table 2.7a: Sensitivity of BCR and Cost per DALY Averted to Possible Changes in Discount Rate for Component 1 (with and without Drug Treatment for Uncomplicated Malaria for Children Under 5 years old).

Discount rate	Parameter of Interest	With treatment Value in US$	Without treatment Value in US$
3%	Total Benefits	7.9 billion	2.5 billion
	Total Costs	23.5 million	23.5 million
	Net Present Value	7.9 billion	2.4 billion
	BCR	**337**	**107**
	Cost per DALY	**10.34**	**32.63**
5%	Total Benefits	7.5 billion	2.3 billion
	Total Costs	22.4 million	22. 4million
	Net Present Value	7.5 billion	2.3 billion
	BCR	**336**	**106**
	Cost per DALY	**9.83**	**31.01**
10%	Total Benefits	6.5 billion	2.0 billion
	Total Costs	19.8 million	19.8 million
	Net Present Value	6.5 billion	2.0 billion
	BCR	**332**	**105**
	Cost per DALY	**8.72**	**27.51**
15%	Total Benefits	5.8 billion	1.8 billion
	Total Costs	17.8 million	17.8 million
	Net Present Value	5.8 billion	1.8 billion
	BCR	**328**	**104**
	Cost per DALY	**7.80**	**24.63**

Table 1.7b: Sensitivity of BCR and Cost per DALY Averted to Possible Changes in Discount Rate (with and without Drug Treatment for Uncomplicated Malaria for Children Under 5 years old)

Discount rate	Parameter of Interest	With treatment Value in US$	Without treatment Value in US$
3%	Total Benefits	17.0 billion	5.4 billion
	Total Costs	49.5 million	49.5 million
	Net Present Value	17.0 billion	5.3 billion
	BCR	**344**	**109**
	Cost per DALY	**10.1**	**31.9**
	Total Benefits	16.1 billion	5.1 billion

Discount rate	Parameter of Interest	With treatment Value in US$	Without treatment Value in US$
5%	Total Costs	46.9 million	46.9 million
	Net Present Value	16.0 billion	5.0 billion
	BCR	**344**	**109**
	Cost per DALY	**9.6**	**30.3**
10%	Total Benefits	14.1 billion	4.4 billion
	Total Costs	41.3 million	41.3 million
	Net Present Value	14.1 billion	4.4 billion
	BCR	**342**	**108**
	Cost per DALY	**8.5**	**26.7**
15%	Total Benefits	12.5 billion	.,9 billion
	Total Costs	36.8 million	36.8 million
	Net Present Value	12.5 billion	3.9 billion
	BCR	**341**	**108**
	Cost per DALY	**7.5**	**23.7**

Conclusions and Recommendations

17. Among the numerous financial investments which ought to be made amidst the paucity of economic resources, financing of the project is as economically advantageous to the Togolese nation as it is fundamental to its health outcomes.

Annex 3: Implementation Arrangements and Support Plan

I. Implementation and Fiduciary Arrangements

(i) Financial Management and Disbursements Arrangements

1. The implementing agencies (as described in Institutional and Implementation Arrangements) will be responsible for the FM aspects of the project. This includes budgeting, financial reporting, supervision, management of the DA, and auditing.

2. **Budgeting arrangements.** The PIU1 and the PIU2, under the oversight coordination of, the PCU and in collaboration with all other involved implementing partners and technical units, will prepare a consolidated annual workplan and budget (AWPB) for implementing project activities considering the project's objective. Approved activities on the budget will be captured in a Procurement Plan, which for IDA purposes will be the document driving implementation. The AWPB will be approved by the Steering Committee and submitted to the World Bank for no-objection not later than November 30 of each year proceeding the year the work plan should be implemented. The budgetary discussions will begin at least six months before the fiscal year of implementation and will consider the procurement plan as the starting point. Once the budget is approved, the budget execution will be monitored through the automated accounting software to serve as a basis for a budget execution monthly follow-up, based on variance analysis report comparing planned with actual expenditures that will be part of the quarterly unaudited Interim Financial Reports (IFR).

Accounting and Reporting Arrangements

3. **Accounting policies and procedures.** As part of the project preparation, and not later than six months after effectiveness, the Borrower will prepare the PIM. The accounting systems, policies, and administrative and financial procedures including a clear description of the PBC disbursement mechanism will be documented in this PIM.

4. **Accounting staff.** The implementing agencies will retain staffing resources that are adequate for the level of project operations and activities and are sufficient to maintain accounting records relating to project financed transactions and to prepare the project's financial reports. The FM functions will be carried out by a team including: (i) a qualified and experienced FM specialist and a qualified and experienced Accountant in charge of the project's FM activities under the PIU1's responsibility including coordination of project's overall FM activities. They are both to be based with the PIU1 in MHPHUAC; (ii) a qualified and experienced Chief Accountant to be hired and based with the PIU2; and (iii) a qualified and experienced Accountant to be hired and based with the PCU. All these FM staff will be recruited through a competitive process in compliance with World Bank's rules. The team at each implementing agency level will have the overall FM responsibility over budgeting, accounting, reporting, disbursement, internal control. There would be conducted a consolidated single external audit under the project. The FM staff will have their capacity reinforced over the project implementation through the rolling out of the training plan that includes training on IDA disbursement procedures and financial reporting arrangements, among others.

5. **Accounting information systems software.** It will be purchased an accounting software with multi-project, multi-site, and multi-donor features, and customized to generate its financial reports. This software must be installed within three months after project effectiveness at all the implementing agencies levels.

6. **Accounting standards.** All implementing agencies will use SYSCOHADA accounting standards, which is commonly used amongst West African Francophone countries. Accounting procedures will be documented in the PIM.

Internal Control and Internal Audit Arrangements

7. **Internal controls.** The internal control policies and procedures will be documented in the Administrative, Accounting and Financial Manual of procedures to be included in the PIM, which will be prepared and agreed by the World Bank before project effectiveness.

8. **Internal audit.** The PIM will document the FM and disbursement arrangements, including internal controls, budget process, assets safeguards, and clarify roles and responsibilities of all the stakeholders. An Internal Audit Unit will be established within the PIU1 and PIU2 will implement the project's internal audit annual work-program with special attention to operations costs, including per diems and other soft expenditures, to ensure they are used in an economical manner and for the purposes intended. This internal audit unit will be staffed with an experienced internal auditor to be recruited six months after project effectiveness and will need to strengthen project governance by providing governance advice to the project team and by conducting internal audit missions quarterly using a risk-based approach to ensure due compliance with agreed procedures. These quarterly internal audit reports need to be submitted to the World Bank within 45 days after the end of the quarter.

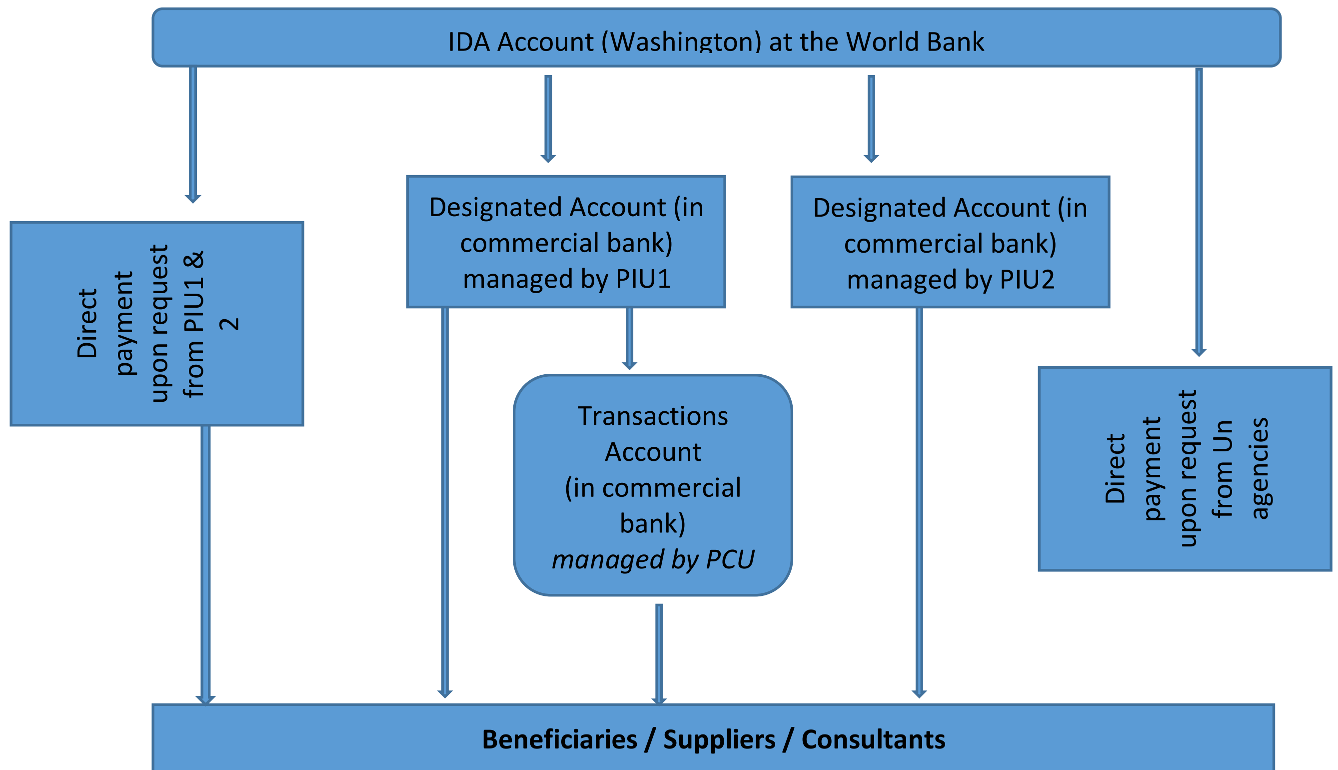
9. **Transparency, accountability and anti-corruption efforts will be encouraged,** including via a complaint handling mechanism; a communication strategy to inform the public through the media on all aspects of the project; and the publication on the implementing entities or the Government websites of budgets, financial reports and audited financial statements. The implementing entities will also have to deal with fraud and anti-corruption in accordance with the World Bank Anti-Corruption Guidelines referred to in the Financing Agreement.

Flow of Funds and Disbursements Arrangements

10. There will be two (02) DAs to be opened in a commercial bank on terms and conditions acceptable to IDA under the fiduciary responsibility of the PIU1 and PIU2. The first DA will finance eligible expenditures related to components and sub-components under PIU1's responsibility as described in the Institutional and Implementation Arrangements. The second DA will finance all eligible expenditures related to components and sub-components under PIU2's responsibility as described in the Institutional and Implementation Arrangements. One Transactions Account will be opened in a reputable commercial bank to be managed by the PCU to finance eligible expenditures related to sub-component under its responsibility as described in the Institutional and Implementation Arrangements. The authorization mechanism of cash withdrawal from the DAs and Transactions Account will be described in the PIM subject to acceptable arrangements for the World Bank. Figure below depicts the funds flow mechanism for the project. Prior to DA management responsibility transfer to PIU2, the World Bank FM team will conduct an assessment to determine whether the PIU2 has an

adequate FM systems and related capacity which satisfies the World Bank's Policy and Directive – IPF, which describes the overall FM policies and procedures.

Figure 3.1: Funds Flow Diagram



Disbursement arrangements

11. **Disbursements will be made in accordance with the Disbursement Guidelines for IPF dated February 2017.** Withdrawal application requests will be prepared by the Project's FM specialist signed by a designated signatory or signatories (the signature authorization letter is signed by the Minister of Finance) and sent to the World Bank for processing. The Project will submit applications using the electronic delivery tool, "e-Disbursements", available at the World Bank's Client Connection website/web-based portal. The Authorized Signatory Letter signed by the GoT will include authorization for the designated signatories to receive Secure Identification Credentials from the World Bank for delivering such applications by electronic means.

12. **Disbursements of IDA funds for the IPF activities will be transactions-based**. In addition to making advances to the DAs, other disbursement methods (reimbursement, direct payment and special commitment) will be available for use under the Project. Further instructions on the withdrawal of proceeds will be outlined in the Disbursement and Financial Information Letter (DFIL) and details on the operation of the DA will be provided in the Project Administrative, Accounting and Financial Manual of procedures (as part of the PIM).

13. **Disbursement of funds to UN Agencies (WHO, UNICEF and United Nations Office for Project Services (UNOPS) etc.):** Engagement of UN agencies through the Government is done pursuant to Standard Form Agreements signed between the Government and the UN agency. UN agencies are used mainly as suppliers. Upon signing of the Standards Form Agreements between the Government and UN agency, application for

withdrawal of proceeds will be prepared by the PCU and submitted to IDA. The special World Bank disbursement procedures will be used to establish a “Blanket Commitment” to allow the amount to be advanced. Funds withdrawn from the IDA loan account will be deposited directly into the UN bank account provided by UN agency for the project activities to be implemented by the UN agency. The amount advanced will be documented through the quarterly unaudited IFRs as actual expenditures are incurred by the UN agency.

14. **Disbursement arrangements under PBC Component**. For IPF-PBC Component 1, disbursements under the project will be made through the reimbursement method, which are triggered by the documentation of eligible expenditures incurred and evidence of achievement of PBCs. Eligible expenditures for the PBCs payment are defined expenditures, in the project implementation manual, that are eligible for financing as follows: (a) for Sub-component 1.1: fuel and transportation for home visits and outreach, maintenance of motorbikes, maintenance of weighing scales, dry batteries, refreshment during outreach and community durbars, per diem, allowances for facilitators at community durbars, allowances for health workers, including community health workers and volunteers, renting of furniture and canopies, meeting package for quality review at the local government level; (b) for Sub-component 1.2: Payment for premiums or contributions for households registered onto the social health insurance scheme among the poor and the vulnerable, which eligibility will be defined by the Safety Nets and Basic Social Services project, per diem and transportations; (c) for Sub-component 1.3: hardship allowances, accommodation, school fees for children under the age of eighteen (18) in public institutions, relocation grant, monthly transport or fuel allowances, premiums for comprehensive health insurance above basic package, pre-and post-basic training for candidates from, *inter alia*, Kara, Savanes, Central and Plateau regions to attain nursing, midwifery and physician assistant first level degree qualification; and (d) for Sub-component 1.4: payment for primary health care level medicines, infection prevention and non-drug consumables.

15. **PBCs will be verified by an Independent Verification Agent, to be contracted by the GoT within three months after effectiveness**. Eligible expenditures will be reported quarterly to the World Bank through IFRs, as well as through annual external audit reports. For the project incurred eligible expenditures, the World Bank will reimburse these expenditures according to the assigned values corresponding to the PBCs achieved with every verification cycle unless the amount of such eligible expenditures at the end of the cycle is less than the PBC values. In that case, the World Bank will reimburse an amount equals to the incurred eligible expenditures.

16. Table 3.1 below specifies the categories of eligible expenditures to be financed out of the proceeds of the financing, the amounts under each category, and the percentage of expenditures to be financed for eligible expenditures in each category.

Table 3.1: Eligible Expenditures per Category for IDA Credit and Grant Financing

Category	Amount of the Credit Allocated (expressed in Euro)	Amount of the Grant Allocated (expressed in SDR)	Percentage of Expenditures to be Financed (inclusive of Taxes)
(1) Eligible Expenditures for the PBCs for the PBCs under Parts 1.1, 1.2 and 1.4 of the Project	24,500,000		100%
(2) Eligible Expenditures for the PBCs under Part 1.3 of the Project	2,400,000		
(3) Goods, consulting services, non-consulting services, Training, and Operating Costs for Parts 2 and 4 of the Project	2,000,000	20,900,000	100%
(4) Goods, works, consulting services, non-consulting services, Training, and Operating Costs for Part 3 of the Project		2,900,000	100%
(5) Refund of Preparation Advances: (a) IDA V3180 (b) IDA V2750		 200,000 300,000	Amount payable pursuant to Section 2.07 (a) of the General Conditions
(6) Emergency Expenditures under Part 5 of the Project	0	0	100%
TOTAL AMOUNT	**28,900,000**	**24,300,000**	

17. **Financial Reporting Arrangements.** The PIU1 will prepare a consolidated quarterly un-audited IFRs in form and content satisfactory to the World Bank, which will be submitted to the World Bank within 45 days after the end of the quarter to which they relate.

18. **External Audit Arrangements**. An external independent and qualified private sector auditor will be recruited within six months after effectiveness to carry out the audit of the project's financial statements. It would be a single consolidated audit for the project covering all accounts. The annual audits will be conducted based on ToRs that are satisfactory to the World Bank. The Auditor will express an opinion on the Annual Financial Statements and perform his audit in compliance with International Standards on Auditing. The auditor will be required to prepare a Management Letter detailing observations and comments and providing recommendations for improvements in the accounting system and the internal control environment. The audit report on the annual Project financial statements and activities of the DA shall be submitted to the World Bank within six (6) months of the end of each fiscal year.

19. In accordance with World Bank Policy on Access to Information, the Borrower is required to make its audited financial statements publicly available in a manner acceptable to the World Bank; following the World Bank's formal receipt of these statements from the borrower, the World Bank also makes them available to the public.

Financial Management Action Plan

Table 3.2: FM Action Plan to Mitigate the overall FM Risks

Issue	Remedial action recommended	Responsible entity	Completion	Effectiveness conditions
Staffing	Recruit: (i) a qualified and experienced FM specialist and a qualified and experienced Accountant in charge of the project's FM activities under the PIU1's responsibility including coordination of project's overall FM activities; (ii) a qualified and experienced Chief Accountant to be based with the PIU2; and (iii) a qualified and experienced Accountant to be based with the PCU.	PIU/PCU	Three months after effectiveness	N
Information system accounting software	Set up a "multi-project" computerized accounting system to fit project needs and generate useful information and financial statements.	PIU1/PIU2	Three months after effectiveness	N
Financial reporting: IFR	Format, content, and frequency of the IFR will be agreed during project negotiation	PIU1/PIU2	Agreed during negotiations	N
Administrative , Accounting and Financial Manual of procedures	Develop a manual of financial and accounting procedures in form and substance acceptable to the World Bank and including a clear description of the PBC disbursement mechanism.	PIU1/PIU2	Six months after effectiveness	N
Internal audit	Recruit a qualified and experienced internal auditor who will have to submit quarterly internal audit reports to the World Bank within 45 days after the end of the audit period.	PIU1/PIU2/PCU	Six months after effectiveness	N
PBC Independent Verification	Recruit an Independent Verification Agent.	PIU1/PIU2/PCU	Twelve months after effectiveness	N
External financial auditing	Appoint an external auditor acceptable to IDA	PCU	Six months after effectiveness	N

20. **The conclusion of the assessment** is that the FM arrangements in place meet the World Bank's minimum FM requirements under World Bank Policy and Directive for IPF Operations, and subject to the implementation of the FM action plan above, are therefore adequate to provide, with reasonable assurance, accurate and timely information on the status of the project required by World Bank. The project's FM residual risk of the project is assessed as Substantial.

(ii) Procurement Arrangements

21. The Borrower will carry out procurement under the proposed project in accordance with the World Bank's 'Procurement Regulations for IPF Borrowers' (Procurement Regulations) dated July 2016 and revised in November 2017 and August 2018 under the 'New Procurement Framework'; the 'Guidelines on Preventing

and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants', dated October 15, 2006 and revised in January 2011 and as of July 1, 2016; and other provisions stipulated in the Financing Agreement.

22. All procuring entities as well as bidders and service providers, that is, suppliers, and consultants shall observe the highest standard of ethics during the procurement and execution of contracts financed under the project in accordance with paragraph 3.32 and annex IV of the Procurement Regulations.

23. The Borrower shall prepare and submit to the World Bank a General Procurement Notice (GPN) and the World Bank will arrange for publication of the GPN in United Nations Development Business (UNDB) online and on the World Bank's external website. The Borrower may also publish it in at least one national newspaper.

24. The Borrower shall publish the Specific Procurement Notices (SPNs) for all goods, non-consulting services, and the Requests for Expressions of Interest on their free-access websites, if available, and in at least one newspaper of national circulation in the Borrower's country and in the official gazette. For open international procurement selection of consultants using an international shortlist, the Borrower shall also publish the SPN in UNDB online and, if possible, in an international newspaper of wide circulation; and the World Bank arranges for the simultaneous publication of the SPN on its external website.

25. **Procurement environment.** The public procurement system is governed by Law No. 2009-013 of June 30, 2009, on public Procurement and Public Service Delegations and by Decree No. 2009-277 of November 11, 2009, containing the code of public contracts and delegations of public service. The public procurement code transposes in Togolese law the provisions of the WAEMU Directives of 2005 (Directive 04 on the procedure for the procurement, execution, and regulation of public procurement and public service delegations; Directive 05 on the control and regulation code of public contracts and delegations of public service).

26. **Procurement institutional arrangement.** A Project Coordinating Unit (PCU) will be established under the Office of the President with no fiduciary responsibility. The **MHPHUAC (PIU1)** will be responsible for the implementation of some Component and Sub-components of the project (1.3, 2.1, 2.2, 4.1, 4.2 and 5) with some joint responsibility with **TSHIA (PIU2)** for Sub-components 1.1 and 1.4. Both PIUs have fiduciary responsibilities for the implementation of respective components.

27. The **MHPHUAC** has established a Public Procurement Control Commission (*Commission de contrôle des marchés publics*, CCMP) and a Public Procurement Control Commission (*Commission de la passation des marchés publics*, CPMP), each consisting of five members. The CPMP is chaired by the *Personne responsable des marchés publics* (PRMP). The procurement bidding documents to be elaborated by the Procurement Specialist of the project will be submitted to the PRMP for the review of the CCMP, or for the decision of the National Procurement Control Directorate (*Direction Nationale de Contrôle des Marchés Publics*, DNCMP) under the Ministry of Finance depending on the procurement control threshold described in the procurement code. For the **TSHIA**, it does not have any experience in the management of World Bank-financed projects. Furthermore, the level of complexity of the procurement activities managed so far are not like the one for this current project. Regarding the procurement implementation arrangement of the upcoming new agency to be created, it will be governed by Togo Public Procurement Law No. 2009-013 of June 30, 2009, on public Procurement and Public Service Delegations and by Decree No. 2009-277 of November 11, 2009, containing the code of public contracts and delegations of public service. This public procurement law requires any

autonomous Agency to establish a Public Procurement Control Commission (*Commission de contrôle des marchés publics*, CCMP) and a Public Procurement Commission (*Commission de la passation des marchés publics*, CPMP), each consisting of five members. However, these two entities aren't yet set up. The CPMP shall be chaired by the chief public procurement officer (*Personne responsable des marchés publics*, PRMP).

28. **Filing and record keeping.** The Procurement Procedures Manual will set out the detailed procedures for maintaining and providing readily available access to project procurement records, in compliance with the Financing Agreement. The procurement unit attached to the PRMP will assign one person responsible for maintaining the records. The logbook of the contracts with a unique numbering system shall be maintained. The signed contracts as in the logbook shall be reflected in the commitment control system of the Borrower's accounting system or books of accounts as commitments whose payments should be updated with reference made to the payment voucher. This will put in place a complete record system, whereby, the contracts and related payments can be corroborated.

29. **Project procurement strategy for development.** As part of the preparation of the project, the Borrower (with support from the World Bank) has prepared a PPSD which described how fit-for-purpose procurement activities will support project operations for the achievement of PDOs and deliver value for money. The procurement strategy has proper sequencing of the activities. It has considered institutional arrangements for procurement, roles and responsibilities, thresholds, procurement methods, and prior review, and the requirements for carrying out procurement. It has also included a detailed assessment and description of the Government's capacity for carrying out procurement and managing contract implementation, within an acceptable governance structure and accountability framework. Other issues taken into account has included the behaviors, trends, and capabilities of the market (that is, market analysis) to inform the Procurement Plan. The activities also require strong technical capability to prepare proper technical specifications to avert lack of, or inadequate, market response. This capability or a plan to enhance is considered in the strategy. Also, special arrangements like direct contracting, use of Statements of Expenses, UN agencies, third-party monitors, local NGOs, Force Account, or civil servants needs, results-based arrangements, need for prequalification, if any, has been considered and addressed.

30. The recruitment of civil servants as individual consultants or as part of the team of consulting firms will abide by the provisions of paragraph 3.23 (d) of the Procurement Regulations.

31. **Special considerations.** The project may trigger World Bank Policy IPF paragraph 12 of the Policy for IPF under a situation of emergency, as for example under the CERC, to apply flexibilities and simplification to facilitate procurement implementation. These procurement arrangements therefore draw on the World Bank Guidance on Procurement Procedures in Situations of Urgent Need of Assistance or Capacity Constraints issued on March 7, 2019.

32. **Procurement Plan.** The Borrower has prepared a detailed 18-month Procurement Plan which will be discussed during the appraisal mission and agreed by the Government and the World Bank during the loan negotiations. The Procurement Plan will be updated in agreement with the World Bank team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

33. **Services.** No work contract is foreseen on the project. The project will procure medical equipement and consultant contracts related the technical assistance contracts to improve hospital and technical

performance. The contracts to be procured during the project implementation are not subject to present specific constraints or require a particular technology.

34. **Training, workshops, study tours, and conferences.** Training activities would comprise workshops and training, based on individual needs, as well as group requirements, on-the-job training, and hiring consultants for developing training materials and conducting training. Selection of consultants for training services follows the requirements for selection of consultants mentioned earlier. All training and workshop activities (other than consulting services) will be carried out on the basis of approved annual work plans/training plans that would identify the general framework of training activities for the year, including: (a) the type of training or workshop; (b) the personnel to be trained; (c) the institutions which would conduct the training and reason for selection of this particular institution; (d) the justification for the training and how it would lead to effective performance and implementation of the project and or sector; (e) the duration of the proposed training; and (f) the cost estimate of the training. Report by the trainees, including completion certificate/diploma upon completion of training, shall be provided to the Project Coordinators and will be kept as part of the records, and will be shared with the World Bank if required.

35. A detailed training and workshops plan, providing the nature of training/workshop, number of trainees/participants, duration, staff months, timing, and estimated cost will be submitted to IDA for review and approval before initiating the process. The selection methods will derive from the activity requirement, schedule, and circumstance. After the training, the beneficiaries will be requested to submit a brief report indicating what skills have been acquired and how these skills will contribute to enhance their performance and contribute to the attainment of the project objective.

36. **Operational costs.** Operational costs financed by the project would be incremental expenses, including office supplies, vehicle operations and maintenance (O&M) costs, maintenance of equipment, communication costs, rental expenses, utilities expenses, consumables, transport and accommodation, per diem, supervision costs, and salaries of locally contracted support staff. Such service needs will be procured using the procurement procedures specified in the PIM accepted and approved by the World Bank.

37. **Procurement Manual.** Procurement arrangements, roles and responsibilities, methods, and requirements for carrying out procurement shall be elaborated in detail in the Procurement Procedures Manual which will be a section of the PIM. The Manual shall be prepared by the Borrower and agreed with the World Bank not later than six months from project effectiveness.

38. **Procurement methods.** The Borrower will use the procurement methods and market approach in accordance with the Procurement Regulations. Open National Market Approach is a competitive bidding procedure normally used for public procurement in the country of the Borrower and may be used to procure goods, works, or nonconsultant services provided it meets the requirements of paragraphs 5.3 to 5.6 of the Procurement Regulations. The thresholds for particular market approaches and procurement methods are indicated in Table 3.3 as well as the thresholds for the World Bank’s prior review requirements.

Table 3.3: Thresholds, Procurement Methods, and Prior Review

No.	Expenditure Category	Contract (C) Value Threshold* [equivalent to US$]	Procurement Method	Contracts Subject to Prior Review [equivalent to US$]
1	Goods, IT, and non-consulting services	C ≥ 500,000	Open Competition International Market Approach and Direct Contracting	≥1,500,000
		100,000 < C < 500,000	Open Competition National Market Approach	None
		C ≤ 100,000	Request for Quotations	None
2	Consulting Services	C < 100,000	National shortlist for selection of consultant firms	None
		C ≥ 100,000	International shortlist for selection of consultant firms	≥500,000
3	Individual consultants	All Values	All approaches	≥ 200,000
4	Direct contracting	All values	_____________________	As agreed in the Procurement Plan
5	Training, workshops, and study tours	All values	Based on approved annual work plans and budgets	Annual work plans and budgets

Note: a. These thresholds are for the purposes of the initial Procurement Plan for the first 18 months. The thresholds will be revised periodically based on reassessment of risks. All contracts not subject to prior review will be post-reviewed.

39. **Procurement risk rating.** The project procurement risk before the mitigation measures is High. The risk can be reduced to a residual rating of 'Substantial' upon consideration of successful implementation of the mitigation measures. The risks and mitigation measures are provided in Table 3.4 and 3.5.

A. The summary of the main identiable risks for the PIU1 (MHPHUAC) are:

40. Actually, for this PIU1, the risks are: (i) no qualified procurement specialist; (ii) absence of an acceptable procurement manual as part of the PIM; and (iii) weak capacity of the CCPM, CPMP, and the central procurement control body (DNCMP) in the New Procurement Framework procedures.

41. The procurement risk associated to the PIU1 before the mitigation measures is high. The risk can be reduced to a residual rating of 'Substantial' upon consideration of successful implementation of the mitigation measures in the Table 3.4 below:

Table 3.4: Procurement Risk Assessment and Mitigation Action Plan for MHPHUAC (PIU1)

Procurement Risk	Mitigation Measures	Responsibility and Deadline
A PIM including a section on procurement is not available	Elaborate and submit to IDA for agreement, a satisfactory version of the PIM comprising a section on procurement for use by the project	**MHPHUAC**; by six months after project effectiveness
An CERC manual including a section on procurement is not available	Elaborate and submit to IDA for agreement, a satisfactory version of the CERC Manual	**MHPHUAC**; by six months after project effectiveness and before the use of CERC
At present, there is no qualified Procurement Specialist within the procurement unit attached to the PRMP of the **MHPHUAC**	Recruit and maintain a Procurement Specialist with qualification and expertise satisfactory to the World Bank within the **MHPHUAC**	**MHPHUAC**; by three months after project effectiveness
Weak capacity of the CCPM, CPMP, and the DNCMP in the New Procurement Framework procedures of July 2016 and revised in November 2017 and August 2018	Reinforce the capacity the Procurement Commission, the PCC, the DNCMP in the New Procurement Framework procedures of July 2016, and revised in November 2017 and August 2018	Project Procurement Specialist to be recruited by the **MHPHUAC**; by three months after the project effectiveness
Long delay by the MEF for the approval of contracts	The MEF shall comply with procurement service standard times for contract approval time	**MHPHUAC** /DNCMP/MEF; as and when needed during project life
Unrealistic commitment in annual Government budgets	The MEF shall ensure the **MHPHUAC** has a realistic commitment in each annual Government budget	**MHPHUAC** /MEF; as and when needed during project life
There is limited knowledge by the **MHPHUAC** on the World Bank's online procurement planning and tracking tool named Systematic Tracking of Exchanges in Procurement (STEP)	Reinforce the capacity of the **MHPHUAC** on the World Bank's online procurement planning and tracking tool for the need to submit a Procurement Plan and manage procurement activities through STEP	**MHPHUAC** /World Bank; by three months after the project effectiveness

B. The summary of the main identiable risks for the PIU2 (TSHIA) are:

42. Actually, for this newly created autonomous agency known as PIU2 the risks are: (i) no qualified procurement specialist; (ii) absence of an acceptable procurement manual as part of the PIM; (iii) no nominated chief public procurement officer (*Personne responsable des marchés publics*, PRMP). (iv) no procurement unit attached to the PRMP; (v) lack of procurement commissions notably CCMP and CPMP; and (vi) weak capacity of the CCPM, CPMP, and the central procurement control body (DNCMP) in the New Procurement Framework procedures.

43. The procurement risk associated to the PIU2 before the mitigation measures is high. The risk can be reduced to a residual rating of 'Substantial' upon consideration of successful implementation of the mitigation measures in the Table 3.5 below:

Table 3.5: Procurement Risk Assessment and Mitigation Action Plan for TSHIA (PIU2)

Risk	Action	Responsibility and deadline
No qualified procurement specialist	Recruit and maintain a Procurement Specialist with qualification and expertise satisfactory to the World Bank.	TSHIA; and by the beginning of procurement responsibility of TSIA
Absence of an acceptable procurement manual as part of the PIM	Elaborate the procurement manual as part of the PIM.	TSHIA; and by the beginning of procurement responsibility of TSIA
No nominated chief public procurement officer (*Personne responsable des marchés publics*, PRMP)	Nomination of a chief public procurement officer (*Personne responsable des marchés publics*, PRMP).	TSHIA; and by the beginning of procurement responsibility of TSIA
Lack of procurement commissions notably CCMP and CPMP	Creation of the procurement commissions notably CCMP and CPMP, and nomination of its members.	TSHIA; and by the beginning of procurement responsibility of TSIA
Weak capacity of the CCPM, CPMP, and the central procurement control body (DNCMP) in the New Procurement Framework procedures	Training of the CCPM, CPMP, and the central procurement control body (DNCMP) in the New Procurement Framework procedures.	TSHIA/World Bank; and six months after the beginning of procurement responsibility of TSIA
There is limited knowledge by the on the World Bank's online procurement planning and tracking tool named Systematic Tracking of Exchanges in Procurement (STEP)	Reinforce the capacity of the **MHPHUAC** on the World Bank's online procurement planning and tracking tool for the need to submit a Procurement Plan and manage procurement activities through STEP.	**MHPHUAC** /World Bank; by three months after the project effectiveness

II. Implementation Support Plan

44. **The implementation support approach is based on the nature of the proposed project content and identified risk mitigation measures.** This support aims to ensure efficient implementation of project activities to achieve the PDO. The approach consists of mechanisms that will enhance PIUs and the PCU technical and fiduciary capacities and facilitate the timely implementation of the risk management measures. The support will includes: (i) real-time online support for technical, FM and procurement; (ii) joint review missions (virtual until travel restrictions are lifted); (iii) regular technical meetings and phone check-ins with the PIUs and PCU between official implementation support missions; (iv) biannual reporting based on the country monitoring system; (v) independent third-party evaluation where relevant and particularly for the PBC aspects of the project; and (vi) internal and external audit and FM reporting.

45. **Real-time support will be provided to help accelerate implementation.** To ensure high-quality implementation support, the WB team will comprise not only of health and economist specialists but also specialists in digital ID, FM, procurement, and environment and social management. The team composition for each mission will be determined based on supervision requirements and be communicated ahead of time with counterparts.

46. **Review missions will be organized jointly with other donors and stakeholder ministries to ensure coordinated action**, The WB team, in collaboration with other partners, will formally review project progress twice a year. Missions will be conducted virtually until field mission travel is safe and feasible. Missions will review progress and any issues related to project implementation. One month before each joint implementation review mission, the PIUs will share with the WB a comprehensive progress report on project activities and an updated plan and budget. At the conclusion of each mission, the World Bank team will update the PCU and management on the status of the project. Regular technical meetings and phone check-ins with the PIUs and PCU will complement these official implementation support missions. This will allow to deal with project implementation issues on a continuous basis and expediting the decision-making process.

47. **For the execution of the Implementation Support Plan, key World Bank team members are present at World Bank Office in Togo, Lomé.** Proper communications and support from the Country Office will be coordinated to ensure timely, efficient, and effective implementation support to the project. Task team leader and key specialists will also conduct semi-annual formal implementation support missions and field visits to follow up on the project implementation.

48. **Fiduciary capacity building of the staff PIUS will be key to ensure efficient financial and procurement management.** Support for procurement management will focus on effective implementation of the project in line with the World Bank's Procurement Regulations. The following activities will be carried out by WB procurement staff: (i) hands on and formal training as needed (application of the Procurement Regulations, use of STEP) for the PIUs staff before loan effectiveness and during project implementation; (ii) review of procurement documents prepared by the PIUs; and (iii) monitoring of progress against the Procurement Plan. In addition to the prior review of procurement transactions, two implementation support missions per year by the Bank will be fielded to look into the progress of the project. Conduct of procurement post reviews will be done during these missions. The post review sample size will not be less than 20 percent of the contracts that were not subject to the Bank's prior review. FM implementation support missions will be carried out twice a year. Implementation Support will include: (i) desk reviews such as the review of the IFRs and audit reports and in-depth reviews may be done where deemed necessary; (ii) training missions for all implementing entities and will be an integrated part of the project's implementation support plan.

49. **Implementation Support Plan.** FM implementation support missions will be carried out twice a year based on the substantial FM residual risk rating. Implementation Support will also include desk reviews such as the review of the IFRs and audit reports. In-depth reviews may be done where deemed necessary. The FM implementation support will include FM training missions for all implementing entities and will be an integrated part of the project's implementation support plan.

Table 3.6: Financial Management Implementation Support

FM Activity	Frequency
Desk reviews	
IFRs review	Quarterly
Audit report review of the project	Annually
Review of other relevant information such as interim internal control systems reports.	Continuous as they become available
On site visits	
Review of overall operation of the FM system	Twice per year (Implementation Support Mission)
Monitoring of actions taken on issues highlighted in audit reports, auditors' management letters, internal audit and other reports	As needed
Transaction reviews (if needed)	As needed
Capacity building support	
FM training sessions	During implementation and as needed.

50. **Environment and social safeguards support and oversight will be provided during the project implementation to ensure compliance with the Environmental and Social Framework.** The WB environmental and social specialists will support the PIUs to effectively implement and report on the environmental and social aspects of the project. Support will focus mainly on (i) regularly building capacities of PIUs staffs and relevant stakeholders; and (ii) reviewing of environmental and social safeguards including medical waste management, citizen engagement, grievance redress mechanism, and gender.

51. The project will require the following implementation support:

Table 3.7: Team Composition and Expertise Needed

Time	Expertise Needed	Number of Yearly Staff Weeks	Number of Yearly Implementation Support Missions
First 24 months	Senior Health Specialist (Task Team Leader)	**15**	**2**
	Health Specialist (Co-Task Team Leader)	**20**	**2**
	Senior Health Specialist	**10**	**2**
	Senior Health Specialist/M&E	**10**	**2**
	Health Economist	**8**	**2**
	Digital ID Specialist	**6**	**2**
	Senior Procurement Specialist	**6**	**2**
	Senior Financial Management Specialist	**6**	**2**
	Senior Social Development Specialist	**6**	**2**
	Environmental Specialist	**6**	**2**
Third to Fifth Years	Senior Health Specialist (Task Team Leader)	**15**	**2**
	Health Specialist (Co-Task Team Leader)	**20**	**2**
	Senior Health Specialist	**10**	**2**

Time	Expertise Needed	Number of Yearly Staff Weeks	Number of Yearly Implementation Support Missions
	Senior Health Specialist/M&E	**10**	**2**
	Health Economist	**8**	**2**
	Digital ID Specialist	**6**	**2**
	Senior Procurement Specialist	**6**	**2**
	Senior Financial Management Specialist	**6**	**2**
	Senior Social Development Specialist	**6**	**2**
	Environmental Specialist	**6**	**2**

Annex 4: Togo country program adjustment responding to COVID-19

1. **The WBG's engagement in Togo has been guided by the Performance and Learning Review (PLR),[45] which re-affirmed priority areas of the FY2017-20 WBG CPF and extended it to FY22.** With governance as a cross-cutting theme, the strategy is built on three pillars: (i) private sector performance and job creation; (ii) inclusive public service delivery focused on human capital development; and (iii) environmental sustainability and resilience. In addition to its jobs and economic transformation agenda, the PLR proposed increased focus on social inclusion and human capital development, plus greater use of digitalization.

<u>Impact of the COVID-19 pandemic on the country and the Government's response</u>

2. **Extreme poverty is projected to increase by one percent (an additional 80,000 people), compared to a pre-COVID-19 estimate that predicted a decline in the poverty rate from 45.8 to 43 percent.** This comes from declines in income and consumption by the most vulnerable, especially those working in sectors adversely impacted by the crisis (e.g., tourism, transport and agriculture). It also reflects an increase in the price of staple foods and imported goods. The projected economic downturn is expected to have adverse social effects and worsen human capital outcomes, which were already deficient with a low HCI score of just 0.43.

3. **The crisis affects Togo through two key channels, one external and one domestic**. First, global trade disruptions have lowered Togo's exports and reduced activity at its main port. On the domestic front, containment measures, travel restrictions and border closures have led to domestic supply and demand shortfalls. Government capacity to respond to the crisis is limited due to high debt, modest fiscal buffers, a large informal sector and limited health sector capacity. As a result, the growth is currently projected to decline to 0 percent in 2020 (vs a 5.5 percent pre-COVID-19 projection). The external current account deficit will widen, and the fiscal deficit is expected to increase to five percent of GDP in 2020 (compared to 1.9 percent expected pre-COVID-19). The COVID-19 crisis and Government's response opened a financing gap of US$345 million (5.9 percent of GDP) in 2020.

4. **Since the first case of COVID-19 was confirmed in Togo on March 6, 2020, the Government has launched a comprehensive COVID-19 response plan that aims to protect lives, livelihoods and future growth prospects.** The country's COVID-19 response plan has three pillars: (i) limiting the contagion of COVID-19 across the country and caring for the sick; (ii) preventing an increase in poverty, including through the introduction of Novissi, an innovative urban cash transfer program; and (iii) preparing for recovery with measures to support the private sector, protect jobs and stimulate agricultural production.

5. **In addition to participating in the G20 Debt Service Suspension Initiative (DSSI), the Government has called on its partners to support the national response plan**. The IMF disbursed US$131 million (Extended Credit Facility (ECF) disbursement and an augmented quota). European Union (EU) is providing EUR17 million along with other financing expected to come from concessional loans from the West African Development Bank (*Banque Ouest Africaine de Développement,* BOAD, US$26 million) and African Development Bank (AfDB, EUR 24.6 million). AFD provided EUR 3 million for Novissi. EU, GIZ, USAID and UN agencies have provided financing for the health plan.

[45] The PLR for Togo was presented to the Board of Executive Directors on February 27, 2020.

<u>WBG support for responding to the crisis</u>

6. **The lending program proposed in the CPF has been delivered, making full use of additional IDA18 resources**. Several analyses that will feed into the next SCD and form the basis for the next CPF (e.g., Public Expenditure Review, Country Economic Memorandum, Country Private Sector Diagnostic, a poverty analysis, and a human capital diagnostic) are under way or will be launched soon.

7. **Goals of the FY21-FY22 lending program are organized around two pillars:** (i) supporting private sector performance, economic transformation and job creation (with a focus on agriculture); and (ii) improving human capital (health, education and an expansion of the social safety net program). The COVID-19 crisis makes these priorities even more urgent. It would leave out an 'e-Government and private sector development' project, although some elements may be included in selected sectoral projects.

8. **Some active projects are being restructured to reorient activities to prioritize the COVID-19 response and a new FY21-22 lending program is being developed aligned to the WBG COVID-19 Response Framework Approach Paper, "*Saving Lives, Scaling-up Impact and Getting Back on Track*".** Options for re-allocation/cancellation within the existing portfolio are limited: only US$76.6 million in national IDA remains undisbursed due to a high disbursement ratio (34.5 percent as of January 25, 2021). Thus, the IDA19 program planned under the recent PLR will be adjusted by delaying some operations.

   (a) *<u>To save lives</u>*, the World Bank has provided US$16 million in health financing combining two sources: US$8 million from REDISSE (P159040), which is already financing the emergency response, augmented by a US$8 million MPA operation with the COVID-19 Fast-Track Facility (P173880) approved in April 2020. The World Bank will support Togo in procurement and deployment of vaccines through an AF to the existing MPA COVID-19 Fast-Track Facility (P173880).

   (b) *<u>To protect the poor and vulnerable</u>*, technical assistance is being provided to Government by improving the Novissi platform and transforming it into a modern G2P (government-to-persons) payment system, as well as the ongoing Urban Development and Infrastructure Project (P161772) which supports COVID-affected areas for WASH investments. Planned projects for FY21-F22 include Essential Health Services for Universal Coverage (P174266), a COVID-19 Education Response Project (P174166, GPE, FY20) to ensure learning continuity, Improving Quality and Equity of Basic Education (IDA+GPE, P172674); and a new Social Safety Net operation that will expand the current Safety Nets and Basic Services Project (P157038) into a national program. Teams will also explore ways to use Program for Results (PforRs) and more IPF-PBC.

   (c) <u>To *save livelihoods, preserve jobs, and ensure more sustainable business growth and job creation,*</u> the ongoing Employment Opportunities for Vulnerable Youth Project (P158036) will continue to provide jobs for the most vulnerable. The development policy operation (DPO) series and emergency DPO support reforms aimed at laying the foundations for economic recovery and improving the business environment and lowering energy and IT services costs. The Regional West Africa Food System Resilience Program (P172769, FY21) will support agriculture. The Lome-Ouaga-Niamey Corridor project (P168386) will improve the resilience of populations and the quality of transport services along the regional corridor. A potential energy access program to be funded from SUF could also be considered. International Finance Corporation (IFC) is adding new activities to its existing program by: (i) supporting digital financial services development to assist rural agent mobile money networks, implement agricultural value chain

digitization, and the roll out of new digital channels with local banks; (ii) working on a facility with local banks and aggregators to finance small agriculture producers affected by COVID-19; (iii) exploring risk-sharing facilities and the establishment of an small and medium enterprise (SME) guarantee fund; and (iv) providing technical assistance to Government to address microfinance institutions' needs and resilience.

(d) To strengthen policies, institutions and investments for resilient, inclusive, and sustainable growth – by sustaining the continuity of government services by restructuring the ongoing Economic Governance Project (P158078). Cross cutting themes of governance and institutional capacity building will be included in all sectoral operations, while budget support will address related system-wide reforms.

Selectivity, Complementarity, Partnerships

9. Portfolio restructuring and new lending have been discussed with the authorities and shared with the other development partners through the existing donor coordination mechanism. There is a close coordination with the IMF, AfDB, and EU on budget support operations.

❖ ***Status of COVID-19 cases as of February 16, 2021: (i) number of confirmed cases: 5,953; (ii) number of recovered people: 5,094; and (iii) death toll stands at 81.***