Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 30-Jul-2020 | Report No: PIDC29556

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Togo	P174266		Togo Essential Quality Health Services For Universal Health Coverage Project (P174266)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA WEST	Dec 16, 2020	Sep 30, 2020	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Office of the President	MINISTRY OF PUBLIC HEALTH AND HYGIENE	

Proposed Development Objective(s)

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

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	50.00
Total Financing	50.00
of which IBRD/IDA	50.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	50.00
IDA Credit	25.00
IDA Grant	25.00

Environmental and Social Risk Classification	Concept Review Decision
Moderate	Track I-The review did authorize the preparation to continue

B. Introduction and Context

Country Context

1. **Togo is a West African country with an area of 56,600 km² and subdivided into five economic regions.** In 2020, the population of Togo was estimated at 8.24 million[1] with an average annual growth rate of 2.31 percent and an average density of 152 inhabitants per km². The median age is 19.4 years. About 60 percent of the population is under 25. Approximately 57 percent of the population live in the rural area. The capital Lomé is inhabited by a quarter of the population[2]. The country is a low-income category with a per capita GDP of US$663 in 2018. The main economic activities are agriculture, animal husbandry, phosphate mining, trade and transit.

2. **The country experienced strong economic growth over the last 10 years; the GDP was above 6 percent per annum from 2010 to 2013 and around 5.4 percent from 2013 to 2019[3].** This was largely driven by government investment in infrastructure and agricultural production. The rate of investment increased the public debt from 56 percent of GDP in 2013 to 81.4 percent of GDP in 2016. This was driven by government overall fiscal balances on cash basis that went from -5.8 percent in 2013 to -9.6 percent in 2016. Government shifted its fiscal policy substantially and concluded an agreement for an Extended Credit Facility with the IMF. The economy decelerated in 2017 but has since rebounded to 5.3 percent growth in 2019 and public debt was 70.9 percent of GDP at end-2019. However, social sector spending has not been protected as planned and was 0.2 percent of GDP below the end-2017 target, one percent of GDP below the quantitative performance target for the first half of 2018, and still below the target at end-2018.[4]

3. **Despite these positive developments, progress in improving living standards is slow.** Real GDP per capita of US$ 606 in 2017 is still lower than its 1980 peak of US$ 683. Poverty and vulnerability remain high and geographically concentrated in rural areas. Though poverty has declined in recent years, more than half of the population still lives in poverty. The poverty rate using the national poverty line[5] decreased from 58.7 percent in 2011 to 55.1 percent in 2015. The extreme poverty rate of US$1.90 per day at 2011 purchasing power parity is estimated to have declined to 46.4 percent in 2018 from 49.2 percent in 2015. This is projected to fall to 45 percent by 2020. Poverty reduction has resulted from a strong performance in agriculture, greater employment opportunities in semi-urban areas, and community development programs implemented since 2017. The extreme poverty headcount ratio has modestly decreased relative to the 1990s, while income inequality has increased and is above the West African Economic and Monetary Union (WAEMU) and the Sub-Saharan Africa (SSA) averages.

[1] *http://www.stat-togo.org/index.php/statistiques-demographiques* accessed on 18 May 2020
[2] Perspectives démographiques du Togo 2011-2031 (INSEED-Togo)
[3] FMI staff report 2019
[4] IMF Second, Third, and Fourth Reviews under the Extended Credit Facility Arrangement Staff Report.
[5] The national poverty line is a threshold of consumption or income in local currency below which a household is considered poor.

4. **Governance and institutional capacities remain relatively weak, with a Country Policy and Institutional Assessment (CPIA) score of 3.2 out of 5 in 2018.** The political environment is fragile. The political and governance risk is heightened by a continuing uncertain socio-political situation. In February 2020 the President of the Republic of Togo HE Faure Gnassingbé was re-elected.

5. **Togo ranked 122 out of 157 countries on the Human Capital Index (HCI) in 2017.** The Human Capital Index in 2017 was 41. The average child is projected to complete approximately 9.1 years of schooling. Factoring in what children effectively learn reduces the actual educational attainment of a given child to 5.6 years. The HCI for girls is lower than that for boys, with girls benefitting from just 8.6 years of expected schooling compared to 9.5 years for boys. The Government's priorities outlined in the National Development Plan (NDP) for 2018-2022 aim to structurally transform the economy in order to achieve strong, sustainable, resilient and inclusive growth, create good jobs, and improve social welfare. Human development is among the top priorities identified in that regard.

6. **A recent report assessed the economic impact of the COVID-19 global crisis which began in March 2019 in Togo[6]**. The crisis is expected to impact the economy through three key channels; one domestic and two externals. First, containment measures, travel restrictions and border closures are expected to lead to domestic shortfalls in both supply and demand. Second, global trade disruptions are expected to lower exports and reduce activity at its main port. Third, tighter global financial conditions are expected to make it harder to finance its deficit and service debt. Results of the analysis show that in the baseline scenario growth is projected to decline from 5.3 percent in 2019 to 1.0 percent in 2020. This will widen the external account marginally and the fiscal deficit will grow from 1.2 percent of GDP in 2019 to 4.1 percent in 2020. In the higher case scenario, a much larger economic downturn is expected with the economy contracting by 1.5 percent and the fiscal deficit increasing to 8.6 percent of GDP.

Sectoral and Institutional Context

7. **Progress on women and children health outcomes has been mixed. According to the WHO[7] Life expectancy at birth in Togo is 60 years.** Skilled attendance is relatively high at 59 percent. Maternal mortality ratio is 396 per 100,000 live births. Neonatal mortality rate is 25 per 1000 and under-five mortality rate is 59.8 per 1000 live births. 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). Many of these can be mitigated against by proper family planning (16.8 percent of women use modern methods), antenatal, and delivery care. Diphtheria, Tetanus Toxoid and Pertussis (DPT3) immunization coverage among children under one year is 88 percent. Anemia in children under five is 71 percent while that in women of reproductive age is 48.9 percent. Children under five years with diarrheal disease receiving oral rehydration therapy (ORT) is 19.2 percent. Vitamin A supplementation for under-five children – which is shown to have reduced all-cause mortality by 24 percent and diarrhea-related mortality by 28 percent in children aged 6-59 months (Imdad et al. 2010) – has increased to approximately 90 percent (MICS 2010; UNICEF 2012).

8. **The Service Availability and Operational Capacity Index report (SARA, 2012)** showed that 9 out of 10 facilities surveyed offered prenatal care services. 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

[6] Report "Togo: The Economic Impact of the COVID-19 Global Crisis". Prepared on April 23, 2020 by Ernest John Sergenti (Senior Economist, EA2M1) and Urbain Thierry Yogo (Senior Economist, EA2M1) and cleared by Lars Christian Moller (Practice Manager, EA2M1). Other GPs contributed also to the report

[7] https://apps.who.int/gho/data/node.cco.ki-TGO?lang=en Accessed May 25, 2020

however at 30 percent. 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.

9. **Meningitis and Lassa Fever outbreaks have been known in recent times. On March 6, 2020, the Ministry of Health announced the first confirmed cases of COVID-19 in Lomé.** The country has instituted an action plan to address the pandemic. This includes surveillance of air, land and maritime borders, limits on the size of gatherings, sensitization and information sharing, clinical and para-clinical screening and intensified management of hospitals' human resources, infrastructure, and equipment resources. Government has reinforced measures to prevent the spread of COVID-19, including enforcing a curfew, revising working hours to allow workers to return home before the curfew and the suspension of all cultural and sporting events. All air travel has been suspended until further notice.

10. **Equity of access to health care remains a major problem**: geographical accessibility to health services has remained stable at the national level since 2016, with 30 percent of the population on average living more than 5 kilometers from a health center or in areas that are difficult to access. This rate increases to 66 percent in the Savane region[8](northern part of the country). In addition, there is an unequal distribution of qualified health personnel in the country. Indeed, 64.2 percent of health workers are in Lomé-Commune region against 4 percent[9] in the Savane region. According to the latest Demographic and Health Survey 2013/2014 (EDST3), a birth was 2.25 times more likely to be attended by skilled personnel in urban areas (92 percent) than in rural areas (41 percent). This situation is also linked to poverty, which is higher in rural areas: women in the richest quintile (95 percent) were 3.5 times more likely to be assisted by skilled personnel than those in the poorest quintile (27 percent). Similarly, the poorest populations are three times more likely to suffer of child under 5 years of age death than the richest.

11. **Quality of health care provided in health facilities is low due to the deterioration of hospital structures and the lack of qualified health personal and equipment in hospitals**. The government invests almost nothing in infrastructures and equipment essential for the diagnosis and treatment of diseases. The country has limited diagnostic imaging capacity. Tracer drug availability was 44%. Essential and generic drugs are usually substandard in quality in some parts of the country and not widely available in Togo because the supply chain is weak[10]. The regulatory authority has recently relaunched the drug licensing commission. The Central Purchasing Agency for Medicines (CAMEG) faces structural and organizational problems that prevent it from playing its role to the fullest.

12. **The SDI survey (2013) assessed three broad categories of indicators**: provider effort (what providers do); provider knowledge and ability (what providers know); and inputs (what providers must work with). The survey found that 40 percent of staff were usually absent with as high as 63% absent in urban public facilities. Adjusting for provider absence, health providers in Togo see 7.4 outpatients per provider day. The volumes are higher in rural areas than in urban areas. on average, providers successfully diagnosed 52 percent of the five tracer conditions (malaria with anemia, acute diarrhea with severe dehydration, pneumonia, pulmonary tuberculosis, and diabetes mellitus). These pathologies are commonly seen by providers.

13. **Comparatively Togo has mixed performance compared to peers** as shown in Table 1 below. Togo ranks well on basic equipment availability, but was average in drug and infrastructure availability, which reflects constraints to care. Providers are too often absent (second worst) and fail to diagnose conditions that cause a large share of under-five

[8] Rapport de performance 2018 ; Ministère de la Santé et de l'Hygiène Publique
[9] Rapport de performance 2018, Ministère de la Santé et de l'Hygiène Publique
[10] 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

morbidity (40.8 percent rate) and mortality (62 percent) and fail to manage hemorrhage (29 percent of maternal deaths). Part of the problem stems from inadequate adherence to clinical guidelines. Only 36 percent of providers follow the guidelines for a given case such not asking for key danger signs on a child presenting with diarrhea. About 52 percent of those who asked failed to properly the information received.

Table 1. Benchmarking quality of care in Togo with Service Delivery Indicators

	Togo 2013	SDI avg.	Niger 2015	MDG 2016	MOZ 2015	TZA 2016	NGA* 2013	UGA 2013	KEN 2013	SEN 2010
Caseload (per provider per day)	5.2	8.8	9.8	5.2	17.4	7.3	5.2	6.0	15.2	-
Absence from facility (% providers)	37.6	28.6	33.1	27.4	23.9	14.3	31.7	46.7	27.5	20
Diagnostic accuracy (% clinical cases)	48.5	50.1	31.5	30	58.3	60.2	39.6	58.1	72.2	34
Adherence to clinical guidelines (% clinical guidelines)	35.6	35.9	17.5	31	37.4	43.8	31.9	41.4	43.7	22
Management of maternal and neonatal complications (% clinical guidelines)	26.0	27.4	12.0	21.9	29.9	30.4	19.8	19.3	44.6	-
Drug availability (% drugs)	49.2	54.4	50.4	48	42.7	60.3	49.2	47.2	54.2	78
Equipment availability (% facilities)	92.6	61.3	35.9	62	79.5	83.5	21.7	21.9	76.4	53
Infrastructure Availability (% facilities)	39.2	40.6	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: "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 Senegal survey.

14. **The focus of decision makers is shifting towards exploring private sector participation in service delivery.** The government had previously experimented with contracting management of public facilities to the private sector to improve efficiency, quality and value for money. The government has indicated its desire to expand on the approach to privately health care management organizations particularly for specialist and teaching hospitals.

15. **National budget allocation to the health sector remains relatively low at less than 7 percent**. The volume of total health expenditure increased on average by 28percent between 2013 and 2016[11]. The contribution of the national budget to public expenditure remains modest: 5.95 percent in 2014 and 6.6 percent in 2018[12]. Households out-of-pocket expenditure accounted for 57.5 percent and 50.4 percent[13] of total health expenditure respectively in 2015 and 2016. This exposes families to the risk of tipping into extreme poverty due to catastrophic health expenditure.

16. **Government introduced a contributory health insurance mechanism**. The Government by decree No 2011-034/PR introduced a National Health Insurance Scheme managed by the l'Institut National d'Assurance Maladie (INAM) in February 2011. The scheme started by covering only employees and retirees of the State as well as their dependents. As of 2018 it had a total membership of 357,196 made up of 104,306 main contributors and 252,890 dependents. The institute has a large network of contracted service providers including 1065 health centers and 206

[11] Les comptes nationaux de la santé 2015-2016, Ministère de la Santé et de l'Hygiène Publique
[12] Système intégré de gestion des finance publique (SIGFIP)
[13] Les comptes nationaux de la santé 2015-2016, Ministère de la Santé et de l'Hygiène Publique

pharmaceutical dispensaries across country. A School Assure scheme was also introduced in 2017 covering only students during term time. Despite these efforts, the population is still confronted with direct payments of health expenditure, which increases their vulnerability. Although plans for extension existed these plans have not materialized yet as 90 percent of workers operating in the informal sector do not have a health insurance scheme[14].

Relationship to CPF

17. **CPF (FY17-20) and extended in March 2020 to now end in 2022 is the first full WBG country strategy for Togo since 1995**[15]. The CPF marked the end of a period of isolation and donor disengagement from during more than a decade of political and economic instability. The Framework set out a plan that supported the Government's ambitious program in 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 CPF integrated both the IDA 18 principles including jobs and economic transformation and encapsulates the IDA19 special themes of Fragility, Conflict and Violence (FCV)[16] . Critical to this special themes effort is building the state's legitimacy and capacity, inclusive institutions; and renewing the social contract between citizens and the state. Foundational investments are needed to improve human development outcomes, including investments to improve maternal and infant mortality rates, address mental health challenges, increase access to services of people with disabilities, and enable more children to access essential services, as well as to take advantage of windows of opportunity to provide critical support and build momentum. World Bank Group resources available to finance the CPF program doubled as a result of the increased poverty orientation of the performance-based allocation available under IDA18, and the use of the Regional Program windows. Reforming the economy will require focusing on improving the country's human capital outcomes particularly in health and addressing disparities in poor and remote areas.

18. **The Project will contribute to attaining the CPF's second focus area: improving inclusive public service delivery.** This will be done using a twin track 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. The project will consolidate the gains achieved and build on the lessons learnt from the just ended Maternal and Child Health and Nutrition Services Support Project (P143843) and other initiatives of the Bank. For example, Togo has started the development of a Unified Social Registry (USR) with the support of the World Bank-financed Safety Nets and Basic Social Services project (P157038). This provides a basis for the identification and registration of the poor for benefits. With support from the World Bank-financed Safety Nets and Basic Social Services project (P157038); exploratory work is underway between the SPJ and HNP GPs to undertake an Identity Management Systems Assessment. This is based upon the ID4D methodology to support activities related to targeting. The project will strengthen 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). To strengthen the disease surveillance system and better control epidemics and epizootics in the country, Togo joined the IDA-financed REDISSE Project (P159040) supporting the countries of the Economic Community of West African States (ECOWAS). REDISSE, which became effective in

[14] 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*

[15] World Bank. 2017. *Togo - Country partnership framework 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 accessed on 31 may 2020

[16] World Bank. 2019. IDA 19 Second Replenishment Meeting: Special Theme - Fragility, Conflict and Violence; 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

2017, has been very useful for the initial response to the COVID-19 epidemic in Togo. The project will build on the gains of this project and the Togo COVID-19 Response Project (P173880) to strengthen the country's public health emergency preparedness and response activities.

19. **The COVID-19 pandemic is likely to impact the proposed project design**. A prolonged COVID-19 persistence will most likely draw away most of the key health professionals engaged in service delivery from existing essential services. Community health workers (CHWs) who are the primary focus of this project are already heavily involved at the peripheral level in the implementation of health interventions, early warning and awareness-raising. The project also envisages additional strain to be put on an already fragile health system. The Republic of Togo's International Health Regulations (IHR) core capabilities and found that out of the 19 technical areas assessed on a scale of 1 (no capacity) to 5 (sustainable capacity), only one aspect of the national laboratory system had a favorable rating of 4 (Laboratory analysis for the detection of priority diseases) while the majority of the technical areas rated as 2 or 3. The following technical areas were rated as 1 (no capacity) for all of their indicators: Legislation, Politics and national financing; antimicrobial resistance; emergency response operations ; system to transfer and transport sample; biosafety and biosecurity; medical countermeasures; and Public health actions at point of entry. Some technical areas were rated as 2 (limited capacity) or below for all their indicators: zoonotic diseases, reporting, preparedness; risk communication and development of personnel among others

C. Proposed Development Objective(s)

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

Key Results

20. The proposed PDO indicators are the following:

Access

a. Children under 18 covered with social health insurance (Number)
b. Provinces with at least three (3) new Community Clinics and Services (CCS) established (Number)
c. Pregnant women completing at least one antenatal care visit to a health facility during the first two trimesters of pregnancy (Number).

Quality

d. Health facilities passing national accreditation standards and on health insurance contract (Number and percentage)
e. Tracer drug availability in primary health facilities (percentage)
f. Number health facilities achieving a percentage score of quality of care as measured by a set of standard indicators (number)

D. Concept Description

21. **The proposed operation will have four components that aim to improve availability and access to quality of health care specially for to pregnant women, children under 18 and vulnerable persons**. The interventions will focus primarily on access and supply of quality health care, prevention and project management. Strong primary and community health services including health promotion and prevention, continuity of care, and early detection and

treatment are associated with more effective and less costly care, as well as lower rates of hospitalization, avoidable admissions, and emergency department visits.

Component 1: Increased access to health services through service, HR and facilities expansion

22. **Increasing access to primary health services:** The project funds will be used to generate demand for essential services, undertake risk communication and promote healthy lifestyles. The service package will include maternal, child health and nutrition services, outpatient care; birth deliveries and attendance; newborn care; malaria, 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 project activities will also complement the Togo COVID-19 Education Response Project (P174166), communication on the importance of health care and user rights. Health promotion focus will emphasis prevention and healthy lifestyles and supplement on-going deworming and a package of home-based messages on diseases related to nutrition and hygiene[17]. Based on the progress of indicators, resources, and needs, the package may evolve over time to maximize value-for-money. The services and performance indicators will be clearly detailed in the project implementation manual to be prepared. The quantity and quality indicators will yield revenues for the health facility after verification and counter-verification by the designated health insurance or fundholding agency. The resulting resources will be primarily used to provide services, pay for inputs received from CAMEG and performance incentives to staff. The implementation guidelines will be provided in the project implementation manual.

23. **Small investment grants will be made available to eligible public district health facilities to help them increase their services and receive referrals from the CHC.** These resources, which will take the form of lump-sum grants, will be used to finance small-scale facility upgrades for selected facilities. The eligible facilities and expenditures will be detailed in the project implementation manual but will include considerations of service availability and possibly adherence to norms. Eligible expenditures may include computers, technical equipment, medical supplies and consumables, and small-scale upgrading.

24. **Training to upgrade skills will be core to the project.** A training curriculum and program will be developed in collaboration with the partners, nursing regulatory bodies and professional associations for the training of the CHNs and to upgrade the skills of existing ones. Three training institutions will be identified in the first instance and supported to run the programs. It will also support the funding of Community Health Teams which will include the participation of civil society organizations (CSOs) at the community level. Some partners have already developed a core cadre of volunteers 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 fund the development of hospitals management skills and specific certificate, diploma, fellowship and master level programs necessary for the efficient delivery and management of services. A deliberate attempt will be made to link training with accepting posting to deprived areas, be used to rewards and upgrade skills of persons serving in these deprived areas and that of tutors in nursing training institutions. Investments will be made to upgrade the skills laboratories and libraries of selected training facilities.

25. **All new community health clinics (CHC) will be provided medical and equipment support and soft furnishing**. The project will provide for each CHC motorbikes, bicycles, laptop or notepad; a set of anthropometric equipment and delivery kits, vaccine fridges and solar back up equipment. For each district, the project will provide for pick-up vehicles, a set of anthropometric equipment, delivery kit and essential inputs that supports their shared responsibility

[17] World Bank (2015, mimeo), “Costed plan for scaling up nutrition: Togo”.

and service delivery capacity. All regions will receive a package of essential logistics and medicines as back up stock capital to kick start the project and replenished from the facilities paid resources.

Component 2: Improve availability of health facilities and their efficient management

26. **Government has determined to improve and upgrade basic infrastructure and service availability.** The project will fund the construction of Community Health Clinics (CHC) and accommodation for health personnel to expand services to the most deprived regions, provinces. The structures will mostly be prefabricated turn-key facilities with minimal on-site construction – e.g. water and sewage and link to other public utilities. A prototype design will be developed. The principle of 2500-5000 population per facility within a 5-kilometer radius will be used to determine location. Special dispensations will however be given to spatial locations with lower populations but with greater need.

27. **The purchase or leasing of medical equipment to enhance and standardize service delivery capacity in selected secondary and tertiary facilities will be done.** These will include medical imagery, laboratory diagnostics and analyzers. Theatre sets including operating table and lamps, doppler scans, echograph sets and basic anthropometric equipment, delivery beds, blood cold chain systems, and power transformers or solar panels will also be purchased for beneficiary facilities. The project will hire an expert in biomedical technologies with proceeds from the Project Preparation Advance to advise on the equipment needs and approaches, including acquisition options such as leasing or outright purchase. Each of the identified facilities will also be provided a determined lump sum to refurbish, improve performance and face lift the facility based on an approved workplan and budget within the limit of resources allocated. The activities may include painting, purchase of furniture and equipment, specialist training, affluence and waste management.

28. **The project will support the engagement of the private sector to manage public facilities and improve secondary and tertiary hospital managerial and technical performance.** Project proceeds will be used to fund performance-based management contracting fees for the hospitals, which may include elements related to financial management, drug availability, service quantity and quality outputs and outcomes for maternal and newborn care as well as surgical services. A sliding scale ratio of payment of the contract between the facility and the project will be introduced after year 1 based on an independent review. A decision point will be reached after the first year to either continue or stop the support depending on outcome of performance. When stopped the resources will be reallocated in consultation with the government.

Component 3: Expand coverage of the national social health insurance scheme

29. **The project funds will be used to support the establishment and operations of a newly established Social Health Insurance Authority building on existing systems and lessons learnt.** The this will consolidate the various existing schemes including School Assure into a single harmonised scheme covering both the for and informal sector. The project activities will include the following:

    a. **Develop a policy and legislative framework to transform the health insurance system in Togo.** The project will fund a consultant or consulting firm to review the current health insurance industry and present a suggested policy change and new institutional framework for implementing a national social health insurance scheme. The project will support all processes for the review and adaptation of the agreed framework.

b. **Enhanced biometric registration and mobile renewal systems:** There are several innovative technologies being introduced to improve membership registration, retention and management. The project will leverage on the bank financed Safety Nets and Basic Social Services project (P157038) or e-ID project and other data base systems e.g. school enrolment and youth-ID card to enrol members onto the scheme. Hardware and software as well as consumables will be procured. Technical assistance will be provided to design the institutional framework; and support the determination of membership fees calibrated according to the formal and informal sector and socio-economic groupings. As this is a social insurance scheme, some cohorts particularly the vulnerable and poor may be exempted from payment of membership fees. The project will support the introduction of point of service member validation and equipment used to reduce fraud and overuse. A membership registration and service feedback and complaints handling call centre will be established.

c. **Streamline the benefit package and tariff system:** Technical assistance will be provided to review, streamline and rationalise the benefit package and the medicines list linked to the services financed under component 1. Assistance will also be provided to support the determination of the tariffs and methods of payment – diagnostic related group, capitation or fee for service. The aim is to focus the scheme on prioritising primary health care while ensuring continuum of care at the specialised level. It should also be cost effective, reduce fraud, guarantee value for money and long-term sustainability of the scheme. Under this activity, government will also be assisted to identify new sources of funding for the health insurance scheme.

d. **Strengthen the clinical standards and contracting process:** The project will support the review and setting of the clinical standards and the facilities contracting process. New and simpler assessment tools will be developed to rationalise facilities categorisation, licensing, accreditation and contracting in collaboration with the MOH and all stakeholders. The aim is to reduce multiplicity and transaction cost to both providers, government and the insurance agency. As part of this, an accredited clinical and facility accessor program will be introduced supported by the project to improve regular inspection and supportive supervision. This will be jointly undertaken by the MOH, the insurance agency and key stakeholders. All assessment tools will be deployed electronically with automated scoring and grading system. All provider facilities will be trained on the tools and contracting process. A core group of staff will be trained to support this process. Where needed technical experts will be recruited to anchor the system for two years.

e. **Strengthen the health information and technology base:** Technology is considered important to improve efficiency, save cost and reduce corruption. The project will support an equipment and information system audit and develop an enterprise architecture for health insurance. It will also assist in determining the basic minimum requirements and assist in purchasing some essential hard and software. Fundamentally the capacity of the national insurance scheme servers will be expanded linked to the West Africa Regional Communications Infrastructure Project (WACIP) with the possibility of a cloud based back up. An electronic claims submission and payment software and system will be rolled out and will have both on-line and off-line capability. The project will also build capacity in software and hardware management for the insurance scheme to maintain the systems. A national call centre will be introduced to support service providers and membership software users in trouble shooting and handling of any technological challenges.

f. **Build core capacity for knowledge management:** The project will provide training opportunities and technical assistance to build capacity in data analytics and knowledge products development. It is expected that several dashboards will be built and made available to top decision makers, partners and the general public to promote timely information sharing, transparency and accountability.

g. **Build the leadership and technical capacity for scheme administration:** The project will finance the development of a new organisational manual and administrative operating procedures. All board members, senior management and staff of the transformed health insurance agency will be taken through a series of trainings, workshops and seminars to orient them on scheme management. Some key staffs will be taken for long term training at the master level to ensure that a critical mass of staff is developed to manage the scheme. This will be in the area of actuarial analysis, scheme management, finance and monitoring and evaluation.

h. **Create demand for health insurance services:** A national health insurance campaign, education and public awareness program will be rolled out. This will include health education and promotion activities to inform the public 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. There will also be community level durbars and mobilization activities funded under the project.

Component 4: – Stewardship, oversight and management of the sector

30. **Project proceeds will finance operating costs of a Project Implementation Unit (PIU) and salaries of international and national consultants who will be hired by this unit.** The project will also support operating costs of project including coordination, contracting, monitoring and evaluation as well as project management. There will be comprehensive training and coaching for all implementing agencies. This will include those involved in PPP and performance-based contract management for the specialist facilities and the verification and counter-verification processes in the primary facilities. Support will also be provided for the fiduciary functions; the exact nature will depend on the institutional arrangements and the corresponding action plans prepared with the fiduciary teams.

31. **Implementation of the social, environmental safeguard activities will be financed by the project.** The social and safeguards specialists are not yet assigned. Once in place these will be responsible for the development and implementation of the Environment, Social and Community Engagement plans. The government will receive technical assistance to assess and improve the plans and support the installation of adapted waste disposal systems as needed to improve biomedical waste management in the project areas. Project proceeds will also finance revisions and improvements to project-related safeguards instruments. 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.

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

Summary of Screening of Environmental and Social Risks and Impacts

32. The proposed operation will be nationwide. Based on an initial screening of proposed project activities and a preliminary assessment of the baseline characteristics for potential project sites, no major environmental issues are

anticipated. Only the project's waste management requires specific attention to ensure that hazardous and medical waste management are well managed and do not constitute a threat to community health, and also that groundwater resources are not placed at risk of contamination. In addition, the project will prepare appropriate instruments and establish specific environmental risks management as well as security and health measures to address potential environmental risks relating to the construction of the Community Health Clinics (CHC), the accommodation for health personnel and other major activities of the project.

33. On the social side, the construction of the Community Health Clinics (CHC) and of the accommodation for health personnel will largely avoid land acquisition, restrictions on land use or cause involuntary resettlement that could lead to economic and/or physical displacement. The proposed project will thus prepare appropriate instruments to address the impact of resettlement, should any happen. In addition, specific social risks management measures will be established to include vulnerable groups, including persons with disabilities, among the project's beneficiaries. Measures will also be taken to support a complaints management system, citizen engagement, Sexual Exploitation and Abuse or -Sexual Harassment (SEA/SH) and Violence Against Children (VAC) and prevent child labor. Community sensitization and capacity building activities will be carried out in order to engage the project's key stakeholders in E&S risks management; sensitization will include the management of solid waste and dissemination of information on the overall delivery of health centers, project complaints, SEA-SH and VAC, citizen engagement, and so on. women are fully in charge of taking care of their household's daily health and other needs and are often, more affected by disease due to their lack of voice and their lower access to public services and to other social, political, and economic resources. This negatively impacts their capacity to receive assistance from healthcare centers amid an outbreak of disease. Women, young people, ethnic minorities, elders, and disabled people are the most vulnerable in the aftermath of disease. Therefore, the proposed project will promote building community resilience and gender empowerment as a key element to staying healthy.

D. 2. Borrower's Institutional Capacity

34. The Government of Togo has an acceptable legal and regulatory environmental and social framework, as well as a national agency that oversees the approval of environmental and social studies, and the monitoring and evaluation of such studies. This agency is not well staffed but its capacities regarding environmental risks management are considered acceptable. On the side of social risks management, however, its capacities are deemed weak, even where it has received capacity-building support on environmental and social risk management through World Bank-financed projects, including on the Bank's environmental and social standards requirements. Capacity building is required to enable this structure to fully play its role. The project will be implemented by the Ministry of Health and Public Hygiene (MHPH). This Ministry has implemented numerous World Bank-financed projects in the health sector over the years, but this is only the second project to be prepared under the Bank's Environmental and Social Framework that Togo's MHPH will implement. This capacity is acceptable to implement the Bank's ESF if government strives to improve itself by appointing or hiring an environmental specialist and a social specialist on the project and attending various capacity building throughout the implementation of the project. The project's Environmental and Social Commitment Plan (ESCP) will therefore include targeted support to build the capacity of MHPH staff, including training topics on E&S risks management.

Environmental Risk Rating Moderate

35. The project will fund the construction of Community Health Clinics (CHC) and accommodation for health personnel to help expand health services to the most deprived regions and provinces 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), potentially adverse impacts on the environment and risks to it are deemed site-specific, reversible, and manageable. A detail assessment of government's capacity to manage medical waste will be done prior to the project's appraisal. For all these reasons, the Environmental risk is rated as Moderate.

Social Risk Rating Moderate

36. The social risks associated with the project's expected activities are considered Moderate. The proposed project will finance the construction of Community Health Clinics (CHC) and accommodation for health personnel to help expand health services, including additional facilities, as part of the Environmental, Social and Community Engagement Strategy. These activities could lead to economic and/or physical displacement. Therefore, the project will prepare a Resettlement Policy Framework (RPF) at the project preparation stage, as the precise construction sites are not yet known. Resettlement Action Plans (RAPs), if required when the construction sites are known, will be developed to manage the potentially negative impact of involuntary resettlement operations properly. The RPF, and possible RAPs, will be consulted upon, validated at a national level and approved by the Bank, and disclosed within the country and on the World Bank's web site. The RPF must be ready prior to project appraisal. The other key social risks of the project are: (i) the potential exclusion of vulnerable communities (such as ethnic minorities and pastoralists) 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 VAC risks, during capacity building operations and the construction of Community Health Clinics; (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.

37. The ESCP will include 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 above to meet the project relevant ESSs of ESF requirements. The Project Implementation Unit under the MoH must include a social specialist to take over social risks management during the project's preparation and implementation phases.

B. Environment and Social Standards (ESSs) that Apply to the Activities Being Considered

B.1. General Assessment

ESS1 Assessment and Management of Environmental and Social Risks and Impacts

Overview of the relevance of the Standard for the Project:

38. This standard is relevant. The ESS requires that the Borrower carry out an assessment of environmental and social risks and impacts of the project. An environmental and social risks assessment is required, and strong measures are advocated to mitigate the specific risks and impacts accordingly. The Borrower will prepare an Environmental and Social Management Framework (ESMF), as the exact locations of activities to be financed by the operation are not known yet. The ESMF will lay out procedures for screening and mitigating the potential impacts of sub-projects. It will include the following: (a) checklists of potential environmental and social impacts and their sources; (b)

procedures for the participatory screening of proposed sites and activities, and the environmental and social considerations; (c) procedures for assessing the potential environmental and social impacts of the planned project activities, including cumulative impact; (d) institutional arrangements for avoiding, minimizing, mitigating, and managing the identified impacts, according to mitigation hierarchy; (e) environmental and social management planning processes for addressing negative externalities in the course of project implementation; (f) a system for monitoring the implementation of mitigation measures; and, (g) institutional capacity assessment and capacity building measures.

39. The ESMF will also include, measures to address SEA-SH and VAC. Additionally, the ESMF will also make use of the general and sector-specific World Bank Group Environmental, Health and Safety Guidelines (EHSGs) for the identified sub-projects. When project sites are identified, and based on the results of the screening, the required site specific environmental and social instruments will be prepared. Lastly, the Borrower will prepare an ESCP that will include the commitment and the timeline for the preparation of subsequent environmental and social instruments and other actions and measures to comply with ESS1 and the other relevant ESSs requirements.

Areas where "Use of Borrower Framework" is being considered:

40. This project will not use the Borrower's Environmental and Social Framework in the assessment, nor in the development and implementation of investments. However, it will comply with relevant national legal and regulatory requirements.

ESS10 Stakeholder Engagement and Information Disclosure

41. The Borrower will prepare and disclose an inclusive Stakeholder Engagement Plan (SEP) in consultation with the Bank, prior to the project appraisal. Among the key stakeholders of this project, there are authorities responsible of health insurance agencies on national, regional and villages levels, formal and informal sectors, population groups most at risk from malaria (pregnant women, children under 18 years old, etc.). The SEP should outline 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 will include an outline for the establishment of a project Grievance Mechanism (GM). It will also outline the ways in which the project team will communicate with key stakeholders and will 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.

42. 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 monitoring and evaluation. The Borrower will engage in meaningful consultations on policies, procedures, processes and practices (including grievances) with all stakeholders throughout the project implementation 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, will be established. This will include a functioning GM that is accessible to the key stakeholders, that is mainly potentially affected people and vulnerable groups (including those with disabilities and those who are not literate or have a weak command of Togo's official language). The SEP will include 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 will be 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 will be drawn up in line with the guidance provided by the Bank related to public consultation in a situation of constraint, and in according with the country's own advocated measures against COVID-19.

B.2. Specific Risks and Impacts

A brief description of the potential environmental and social risks and impacts relevant to the Project.

ESS2 Labor and Working Conditions

43. This standard is relevant. The project activities will be carried out by a Project Implementation Unit (PIU) under the MoH. The PIU team will include civil servants and consultants hired to support the technical areas for which weak institutional capacities were assessed. The project will also include indirect workers, such as regional and provincial health administrators, community administrators, 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 described in ESS2 to ensure that working conditions be acceptable. A Labor Management Procedure (LMP), drawn up in accordance with national regulations and the ESS2 requirements, will be developed and disclosed by the Borrower prior to project appraisal. The LMP will include 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.

ESS3 Resource Efficiency and Pollution Prevention and Management

44. 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, adequate mitigation measures will be taken to address the issues of which chemicals are permissible in keeping with national and international conventions (Montreal Protocol).

45. Air emissions: During the project implementation phase, air emissions will be moderate, generated by vehicles, machinery and construction, and the rehabilitation of clinics and accommodation for health personnel and other additional facilities, as part of the Environmental, Social and Community Engagement Strategy. To reduce the impact of smoke from vehicles and machinery, adequate measures need to be taken upstream to meet emissions norms. Noise: Some impact from noise is foreseen during construction/rehabilitation, which could be a nuisance for the surrounding communities. The ESMF will include 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.

46. Waste management: The project will be involved in 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 are 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 will produce a Hazardous Waste Management Plan (HWMP) outlining the measures to be taken during the project implementation.

ESS4 Community Health and Safety

47. The project will finance the construction of Community Health Clinics (CHC) and accommodation for health personnel, including additional facilities. These activities may have negative effects on the health, safety, and security of the riverside communities at the work sites. The ESIAs to be developed for each of the construction sub-projects will determine whether a specific labor influx management plan is required (in the case of significant impacts) or whether (in a low risk scenario) the ESMP can include labor related clauses. For all the civil works in this proposed project, the ESMP will need to request the contractor to settle and regularly update a security system around the project sites (such as fences and security guards) and issue a code of conduct agenda to workers for the entire civil work 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. A SEA-SH and VAC risks assessment will be done using the GBV risks assessment tool to clearly indicate the project's SEA/SH risk level. Mitigation measures will be recorded in an action plan to ensure SEA/SH survivors, have a safe and confidential venue to report cases created or exacerbated by project implementation. 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 contractors' proposals and ESMPs. A code of conduct covering actions to prevent SEA-SH and VAC will be prepared and included in bidding documents. The project's GM will address any project-related SEA/SH or VAC complaint.

ESS5 Land Acquisition, Restrictions on Land Use and Involuntary Resettlement

48. This ESS is relevant even if it is clearly mentioned in the project document that the project proceeds will not finance land acquisition. It is anticipated that most of the planned construction in the project should take place within existing health facilities. However, some construction is expected to happen in sub-urban and rural areas, where acute land use and involuntary resettlement issues arise, leading sometimes to economic and/or physical displacement. As the specific sites of the planned construction are not yet known with any precision, the project will prepare an RPF as a due diligence measure. Thereafter, site-specific Resettlement Action Plans (RAPs)will be prepared to properly manage potential negative impacts of involuntary resettlement operations when the precise construction sites are known. The RPF will be consulted upon, validated at a national level, approved by the Bank, and disclosed both within the country and on the World Bank's web site prior to project appraisal.

ESS6 Biodiversity Conservation and Sustainable Management of Living Natural Resources

49. Not relevant at this stage, as the project does not involve biodiversity conservation and sustainable management of living natural resources. All clinics will be built in inhabited areas.

ESS7 Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities

50. Not relevant: There are no Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities in the project area.

ESS8 Cultural Heritage

51. Relevant: It is not anticipated that the project will impact cultural heritage. However, the project will finance the investments that will involve excavation during construction and demolition during the rehabilitation of some infrastructure. The environmental and social assessment will identify any cultural heritage in project areas, and provide details of chance finds procedures to be carried out if any cultural heritage is come across during civil works. All construction and rehabilitation contracts will include a “Chance Find” clause, and the chance finds procedures outlined in the E&S assessment, which will require contractors to stop construction/rehabilitation in the event that cultural property sites are encountered during civil works.

ESS9 Financial Intermediaries

52. This standard is not relevant for this operation.

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