

Funding Proposal

FP305: Building the resilience of Togo's national health system and vulnerable communities to climate-sensitive health outcomes

Togo | Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH | Decision B.45/08

23 July 2026



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Note to Accredited Entities on the use of the funding proposal template

- Accredited Entities should provide summary information in the proposal with cross-reference to annexes such as feasibility studies, gender action plan, term sheet, etc.
- Accredited Entities should ensure that annexes provided are consistent with the details provided in the funding proposal. Updates to the funding proposal and/or annexes must be reflected in all relevant documents.
- The total number of pages for the funding proposal (excluding annexes) **should not exceed 60**. Proposals exceeding the prescribed length will not be assessed within the usual service standard time.
- The recommended font is Arial, size 11.
- Under the [GCF Information Disclosure Policy](#), project and programme funding proposals will be disclosed on the GCF website, simultaneous with the submission to the Board, subject to the redaction of any information that may not be disclosed pursuant to the IDP. Accredited Entities are asked to fill out information on disclosure in section G.4.

Please submit the completed proposal to:

fundingproposal@gcfund.org

Please use the following name convention for the file name:

“FP-[Accredited Entity Short Name]-[Country/Region]-[YYYY/MM/DD]”

A. PROJECT/PROGRAMME SUMMARY				
A.1. Project or programme	Project	A.2. Public or private sector	Public	
A.3. Request for Proposals (RFP)	If the funding proposal is being submitted in response to a specific GCF Request for Proposals, indicate which RFP it is targeted for. Please note that there is a separate template for the Simplified Approval Process and REDD+. <u>Not applicable</u>			
A.4. Result area(s)	Check the applicable GCF result area(s) that the <u>overall</u> proposed project/programme targets below. For each checked result area(s), indicate the estimated percentage of GCF and Co-financers' contribution devoted to it. The total of the percentages when summed should be 100% for GCF and Co-financers' contribution respectively.			
		GCF contribution	Co-financers' contribution¹	
	Mitigation total	<u>Enter number</u> %	<u>Enter number</u> %	
	☐ Energy generation and access	<u>Enter number</u> %	<u>Enter number</u> %	
	☐ Low-emission transport	<u>Enter number</u> %	<u>Enter number</u> %	
	☐ Buildings, cities, industries and appliances	<u>Enter number</u> %	<u>Enter number</u> %	
	☐ Forestry and land use	<u>Enter number</u> %	<u>Enter number</u> %	
	Adaptation total	<u>Enter number</u> %	<u>Enter number</u> %	
	☒ Most vulnerable people and communities	14 %	14 %	
	☒ Health and well-being, and food and water security	81 %	81 %	
	☒ Infrastructure and built environment	5 %	5 %	
	☐ Ecosystems and ecosystem services	<u>Enter number</u> %	<u>Enter number</u> %	
A.5. Expected mitigation outcome (Core indicator 1: GHG emissions reduced, avoided or removed / sequestered)	Indicate greenhouse gas (GHG) emission reductions or removals in tCO ₂ eq over total lifespan of the project/programme ²	A.6. Expected adaptation outcome (Core indicator 2: direct and indirect beneficiaries reached)	4,013,183 Total Beneficiaries	
			1,841,389 Direct	2,171,794 Indirect
			23 % of direct beneficiaries vis-à-vis total population	27 % of indirect beneficiaries vis-à-vis total population
A.7. Total financing (GCF + co-finance³)	49.93 M Euros	A.9. Project size	Medium (Upto USD 250 million)	
A.8. Total GCF funding requested	37.6 M Euros			

¹ Co-financer's contribution means the financial resources required, whether Public Finance or Private Finance, in addition to the GCF contribution (i.e. GCF financial resources requested by the Accredited Entity) to implement the project or programme described in the funding proposal.

² The total lifespan of the project/programme is defined as the maximum number of years over which the outcomes of the investment are expected to be effective. This is different from the project/programme implementation period.

³ Refer to the Policy of Co-financing of the GCF.

A.10. Financial instrument(s) requested for the GCF funding	<i>Mark all that apply and provide total amounts. The sum of all total amounts should be consistent with A.8.</i> ☒ Grant <u>37.6 M Euros</u> ☐ Equity <u>Enter number</u> ☐ Loan <u>Enter number</u> ☐ Results-based payment <u>Enter number</u> ☐ Guarantee <u>Enter number</u>		
A.11. Implementation period	5 years	A.12. Total lifespan	20 years
A.13. Expected date of AE internal approval	12/11/2025	A.14. ESS category	<i>Refer to the AE's safeguard policy and GCF ESS Standards to assess your FP category.</i> B
A.15. Has this FP been submitted as a CN before?	Yes ☒ No ☐	A.16. Has Readiness or PPF support been used to prepare this FP?	Yes ☐ No ☐
A.17. Is this FP included in the entity work programme?	Yes ☐ No ☒	A.18. Is this FP included in the country programme?	Yes ☐ No ☒
A.19. Complementarity and coherence	<i>Does the project/programme complement other climate finance funding (e.g. GEF, AF, CIF, etc.)? If yes, please elaborate in section B.1.</i> Yes ☐ No ☒		
A.20. Executing Entity information	The Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH, besides being the Accredited Entity (AE) of the project, acts as well as an Executing Entity (EE). Apart from GIZ, there will be the following Executing Entities: - Ministry of Health, Public Hygiene, Universal Health Coverage, and Insurance, Togo - Ministère de la Santé, de l'Hygiène Publique, de la Couverture Sanitaire Universelle et des Assurances (MSHPCSUA) - National Meteorological Agency - Agence Nationale de la Météorologie (ANAMET)		
A.21. Executive summary (max. 750 words, approximately 1.5 pages)			
- The proposed project, "Building the resilience of Togo's national health system and vulnerable communities to climate-sensitive health outcomes," seeks to strengthen national and local capacity to manage the growing health impacts of climate change. The project directly responds to the Green Climate Fund (GCF)'s Updated Strategic Plan 2024-2027 (USP-2), addressing the intersection of climate, health, and resilience through data-driven systems, resilient infrastructure, and sustainable governance to enable long-term adaptation. - Togo is highly vulnerable to climate variability and change. Rising temperatures, changes in rainfall patterns and recurrent extreme climate events, including heatwaves, and extreme rainfall, increasingly threaten livelihoods, and public health, particularly in the northern regions of Centrale, Kara, and Savanes, where poverty rates, on average, exceed 60 percent⁴. These climate hazards are driving changes in malaria, diarrhoeal diseases, and heat-related illnesses, while also aggravating maternal, infant and child health risks. The health system's capacity to adapt remains limited by institutional fragmentation, data and information gaps, infrastructural deficits, and financial constraints, leaving the population exposed to recurring climate-induced health risks.			

⁴ INSEED (2020). [Note synthétique sur les résultats de pauvreté 2018-2019](#). Enquête harmonisée sur la condition de vie des ménages (EHCVM).

3. The project adopts a systemic approach to reduce climate-health vulnerability through four mutually reinforcing components, i) strengthening the surveillance system for climate-sensitive health outcomes, ii) building an enabling environment to increase health sector resilience, iii) climate-resilient and low-carbon infrastructures, technologies, and supply chain, and iv) enhancing community adaptation and engagement.
4. A central feature of the intervention is the establishment of a functional Health Early Warning System (H-EWS) that links meteorological and health data to enable predictive, evidence-based decision-making. Through new data integration protocols, the project will ensure full interoperability between the National Meteorological Agency (ANAMET)'s climate information systems and the Ministry of Health, Public Hygiene, Universal Health Coverage, and Insurance (MSHPCSUA)'s District Health Information System, version 2 (DHIS2) database⁵. Predictive models for malaria, diarrhoeal diseases, and heat-related illnesses will be developed to guide prevention and response measures, allowing authorities and communities to act pre-emptively.
5. The project also addresses governance and institutional sustainability by formalising the currently temporary Climate-Health Task Force into a permanent Climate Change Unit (CCU) within the MSHPCSUA, supported by five regional CCUs, covering the totality of the country's population. These units will serve as coordination and resource-mobilisation hubs, ensuring climate-health initiatives are institutionalised and integrated into national and regional budgets. Targeted capacity-building will strengthen technical, managerial, and gender mainstreaming skills among health, meteorological, and academic personnel to enable long-term ownership and leadership.
6. At the service delivery level, the project will rehabilitate or construct Peripheral Care Units (USPs) – particularly maternity and neonatal units – designed to improve thermal comfort and improve resilient access to water. Upgraded Water, Sanitation and Hygiene (WASH) systems and solar-powered cold chain equipment will ensure continuity of essential services, including immunisation and emergency care, even during climate disruptions. To sustain these investments, the project will also operationalise a decentralised maintenance unit, ensuring regular upkeep, rapid repairs, and long-term functionality of climate-resilient infrastructure and equipment.
7. Community resilience is further strengthened through localised interventions that improve access to safe WASH and health services, while enhancing climate-health awareness. Community health workers (CHW) will be trained as multipliers to disseminate inclusive, accessible, and gender-sensitive information, promoting appropriate community-level WASH and larval control measures and ensuring early warning response in the most remote and vulnerable populations. These measures will empower households to adopt protective behaviours, respond effectively to alerts, and reduce the burden of climate-sensitive health outcomes.
8. Overall, the project will shift Togo's health governance from a reactive to a proactive and predictive risk management model. It will ensure that essential health services – especially those related to maternal and childcare – are increasingly climate-resilient, while strengthening national systems to anticipate, plan for, and respond to future climate threats. By embedding climate-resilient practices in governance, finance, and infrastructure, the initiative will generate lasting benefits that extend well beyond its implementation period. It is expected to reduce disease burden incidence, protect human capital, and safeguard livelihoods, particularly among women, children, and marginalised groups who bear the brunt of climate impacts.
9. In doing so, the project contributes directly to the GCF USP-2 outcomes:
 - To **Targeted Result 3 (Climate information and EWS)** improving the existing Multi-Hazard Early Warning System (MHEWS) by integrating meteorological and health data for anticipatory decision-making;
 - To **Targeted Result 6 (Resilient infrastructure)** through investment in climate-resilient health facilities (HFs) and the establishment of sustainable maintenance systems; and
 - To **Targeted Result 9 (Adaptation)** by institutionalising climate resilience within national systems and increasing climate change awareness, improving climate-resilient behaviours adoption and empowering appropriate and locally led response to alerts.
10. Through this holistic, system-wide approach, the project will support Togo in building a health system that not only withstands the impacts of climate change but also transforms them into opportunities for resilience, equity, and sustainable development.

⁵ DHIS2 is an open-source software platform developed and implemented by the HISP network, a global collaboration between the HISP Centre at the University of Oslo and local HISP groups in Africa, Asia, the Middle East, and the Americas.

B. PROJECT/PROGRAMME INFORMATION

B.1. Climate context (max. 1000 words, approximately 2 pages)

B.1.1 Socio-economic context

11. Togo is a West African country located between 6° and 11° North latitude and 0° and 1°40' meridian East longitude. It covers an area of 56,600 square kilometres (km²) and is considered as a corridor extending 600 kilometres (km) long with a coastline of nearly 50 km. Togo has been classified among the Least Developed Country (LDC) since 1982, with graduation from this status requiring it to meet thresholds across three areas: Gross National Income (GNI) per capita, Human Assets Index (HAI) and Economic and Environmental Vulnerability Index (EVI). Currently, Togo remains below the GNI per capita graduation threshold (US\$1,306), with a value of US\$942⁶. Its HAI score (61.1), which assesses health and education, falls short of the required 60 or below, underscoring ongoing human-capital development challenges. While Togo meets the EVI graduation level (which considers factors like agricultural share in Gross Domestic Product (GDP) and vulnerability to disaster), the country must satisfy all three criteria for LDC graduation. Consequently, Togo remains classified as an LDC.
12. The country's GDP is estimated at US\$9.93 billion in 2024, with a GDP per capita of US\$1,043 and an average economic growth rate of 5.3% for the same year⁷. The primary sector, which relies mainly on agriculture, contributed 20% of the GDP in 2024, while the secondary sector accounted for 23% of GDP. The informal sector remains predominant, accounting for more than 48.9% of the value added from the various branches of the economy⁸. The poverty level is high, especially in rural areas (58.8%) (2024)⁹. Women remain more vulnerable as they have less access to economic opportunities, education, health, and other basic socioeconomic opportunities.
13. Togo's population has reached 8.1 million in 2022, sustaining a demographic growth rate of 2.4% and a projected increase of 68% to 15.6 million by 2050¹⁰. The population is predominantly young, with more than 20% under the age of 14 (2023), with the largest part located in the southern Maritime region. In contrast, the northern regions of Centrale, Kara, and Savanes are mainly rural and less densely populated yet are among the country's most climate-vulnerable areas, making them priority areas for climate resilience interventions.
14. These three northern regions, home to approximately 2.9 million people, are largely agricultural¹¹ including local communities (LC) with traditional livelihoods such as the Fulani, who practice semi-transhumant pastoralism. Rising temperatures, changing precipitation patterns and extreme weather events (heatwaves, droughts, intense rainfall, flooding) threaten livelihoods, health, and infrastructure. High poverty rates – reaching 65% in Savanes – coupled with limited access to safe water and sanitation and weakened health systems marked by deteriorated facilities and staff shortages, place a significant burden on service delivery.
15. Vulnerability to climate-sensitive diseases is particularly acute, with a high prevalence of malaria and diarrhoea. In the target regions, positivity rates for malaria testing remain above 60%¹² and more than two-thirds of suspected cases are confirmed (incidence rates relative to suspected cases) in Centrale (68%), Kara (67%) and Savanes (63%) (2023)¹³. Diarrhoeal diseases also remain widespread, exacerbated by poor water quality and seasonal flooding. Strengthening health services, EWS, and local resilience in these regions is vital to protect lives and sustain progress under growing climate pressures. Furthermore, maternal and neonatal health is increasingly impacted by extreme heat, with the incidence of preterm births (PTB) affected by the increased occurrence.
16. Overall, Togo ranked 127th (out of 187) in the Notre Dame Global Adaptation Initiative (ND-GAIN) index (2023), which measures vulnerability to climate change¹⁴. Togo has a high vulnerability score (0.503) and low readiness score (0.326). Readiness measures a country's ability to leverage investments and convert them to adaptation actions, for which Togo ranks the 119th most ready country. The cost occurring from the impacts of climate change on GDP with a current warming trajectory of 3°C would be 20% of the GDP by 2050¹⁵.
17. Togo's health sector is facing significant challenges and is characterised by its high susceptibility to climate change risks. The life expectancy in Togo is of 63, much lower than the world average of 71.4¹⁶. Communicable, maternal, perinatal and nutritional conditions, all related to climate change impacts and risks account for 45.5% of deaths by broad cause¹⁷. The maternal mortality rate remains extremely high at 329 deaths per 100,000 live births (2023)¹⁸. Climate sensitive health

⁶ UN DESA (n.d.). [Least Developed Country Category: Togo Profile](#) [Data set]. Retrieved 6 November 2025.

⁷ WBG (2024). [Togo- Vue d'ensemble](#); WBG (2024). [GDP growth \(annual %\) – Togo](#) [Data set]. Retrieved 6 November 2025.; WBG (2024). [GDP \(current US\\$\) – Togo](#) [Data set]. Retrieved 6 November 2025.; WBG (2024). [Data: GDP per capita \(current US\\$\) – Togo](#) [Data set]. Retrieved 6 November 2025.

⁸ INSEED (2022). [Résultats définitifs du RGPH-5 de Novembre 2022](#). Institut National de la Statistique et des Études Économiques et Démographiques.

⁹ WBG (2024). *op. cit.*

¹⁰ INSEED (2023). [Annuaire Statistique National 2023](#); INSEED (2022). *op. cit.*

¹¹ *Ibid.*

¹² *This metric indicates the overall percentage of malaria tests (Rapid Diagnostic and Thick/Thin Films) that returned a positive result in 2023.*

¹³ INSEED (2023). [Annuaire Statistique National 2023](#). Institut National de la Statistique et des Études Économiques et Démographiques.

¹⁴ Notre Dame Global Adaptation Initiative (2023). [Country Rankings: Togo. ND-Gain Country Index](#).

¹⁵ Climate Analytics (n.d.). [The economic damages of 3°C warming for SIDS and LDCs](#) [Data set]. Retrieved 12 March 2025.

¹⁶ UNDP (2025). [Human development summary capturing achievements in the HDI and complementarity metrics that take into account gender gaps, inequality, planetary pressures and multidimensional poverty](#) [Data Set]. Human Development Reports. Retrieved 6 November 2025.; INSEED (2023). *op. cit.*

¹⁷ WHO (2023). [Health data overview for the Togolese Republic](#) [Data Set]. Retrieved 10 October 2025.

¹⁸ WHO (2025). [Maternal mortality ratio \(modeled estimate, per 100,000 live births\): Trends in maternal mortality estimates 2000 to 2023](#) [Data set].

outcomes (CSHO) contribute significantly to the burden of disease, with malaria and diarrhoeal notably being the 4th and 5th top causes of death¹⁹. Togo also faces significant food insecurity challenges, with 280,000 people (3.45% of the population) at risk of falling into food insecurity in Togo, while 10.9% of the population experiences severe food insecurity²⁰. In terms of other environmental determinants of health, WASH related risk factors are also high with only 8% of the rural population having access to safely managed drinking water services (19% for total) and only 9.8% to hand-washing facility with soap and water (17.3% total)²¹.

18. The public health system operates under significant fiscal constraints and important capacity, technical and institutional barriers (see *Table 6*). Health expenditures account for 7.3% of the national budget according to the national estimation, with 34% of them coming from technical and financial partners²². According to the World Health Organisation (WHO) data, the domestic general government health expenditure was only 2.6% in 2021 following a contracting trend²³. The density of health professionals in Togo is very low, with only 3.15 professionals per 10,000 inhabitants, which is significantly below the target of 23 recommended by the WHO²⁴. Domestic private health expenditure accounts to 67.7% of the total health expenditure putting significant strain especially for the most vulnerable populations²⁵. The sector is characterised by a lack of intersectoral collaboration and integration of climate change data to inform health planning and policy, a lack of capacity and understanding of the impact of climate change on health, as well as an absence or inadequacy of certain services, such as water for hygiene and essential drugs for malaria and diarrhoea. For a more detailed account of project barriers, refer to section B2.a.2.

B.1.2 Climate change context

19. Togo's current climate is shaped by its location in the intertropical zone and its geography. Its southern part, roughly from the 8th parallel north to the coast (including the Maritime region), has a tropical Guinean (subequatorial) climate with four distinct seasons. Moving northward, the Centrale region features a transitional climate. Beyond the 10th parallel, the northernmost Savanes region is characterised by a semi-arid, tropical Sudanese climate with two seasons, notably featuring dry Harmattan (desert) winds from November to April²⁶.

Observed climate change

20. A comparison of the temperature (T) between the baseline (1980-2000) and recent (2001-2024) periods demonstrate a strong and consistent warming trend across the country, observed across all months of the year and in all administrative regions (Savanes, Kara, Centrale, Plateaux and Maritime). The northern regions of Kara and Savanes are the warmest areas, with the highest absolute temperatures. The analysis confirms this double burden, as the magnitude of national warming is most pronounced in those same northern and central-northern regions, with the increase approaching +0.8°C.²⁷

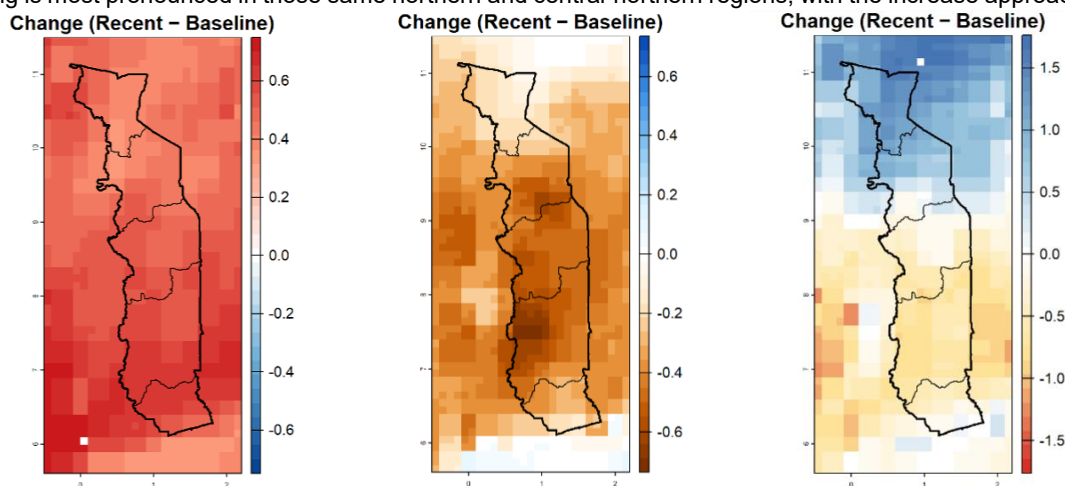


Figure 1: Observed change (ΔT) in annual mean temperature (°C), annual mean precipitation (mm/day) and annual mean relative humidity (%) comparison Baseline (1981-2000), recent (2001-2024)²⁸.

¹⁹ *Ibid.*

²⁰ INSEED (2022). *op. cit.*; WFP (2022). [Annual Country Report: Togo](#); WBG (2022). [Prevalence of severe food insecurity in the population \(%\) – Togo](#) (No. World Bank Group) [Data set].

²¹ *Ibid.*

²² GIZ (2022). *ProSanté II: Project Progress Report*.

²³ WHO (2023). [Health data overview for the Togolese Republic](#) [Data Set]. Retrieved 10 October 2025.

²⁴ GIZ (2021). *Les besoins émergents des prestations du système de la santé dû aux changements climatiques au Togo* (Rapport ProSanté).

²⁵ WBG (2022). [Domestic private health expenditure \(% of current health expenditure\) – Togo](#) [Data Set].

²⁶ MERF (2018). [Plan National d'Adaptation aux Changements Climatiques du Togo](#) (PNACC). Ministère de l'Environnement et des Ressources Forestières.

²⁷ Annex 2.a Togo Climate Rationale

²⁸ Historical climate data are based on the Multi-Source Weather (MSWX) dataset (1980-2024), a global product at 0.1° (~11km) resolution combining station data, satellite observations, and reanalysis data. For more information, please see Annex 2.a.

21. Togo is experiencing a significant and widespread shift in its hydrological regime, exhibiting a pronounced and uniform drying trend across the country. The comparison confirms a nationwide decrease in rainfall. Overall, Togo has experienced an approximate 10.8% decline in rainfall between historical comparison periods. Relative Humidity has decreased since 2000 in all regions except Savanes. The analysis confirms a predominant drying trend across the entire southern and central half of the country, with locally intense areas showing a decline of -1.0 to -1.5 on the relative scale.²⁹
22. Extreme heat days showed no change in the baseline period (1981-2000) but increased significantly across all regions in the recent period (2001-2024), particularly in the southern regions. Similarly, extreme precipitation events show marked increases in the second half of the time series (2001-2024) across most regions, particularly during the wettest months in the Maritime and Savanes regions.

Projected climate change

23. Future climate projections for Togo are derived from the NASA NEX-GDDP-CMIP6 dataset. Across all regions and both Shared Socioeconomic Pathways (SSP), the projections show a very robust warming signal in all regions consistent with a continuation of the observed climate trends. The analysis indicates that maximum, mean and especially minimum temperatures increase significantly everywhere with typical rates of about +0.35–0.45°C per decade under SSP2-4.5 and up to +0.5–0.57°C per decade for minimum temperature under SSP5-8.5 in Centrale, Kara and Savanes regions.
24. Notably, projections indicate that the minimum temperature will rise at the highest rate, consistently showing the greatest absolute projected increase across most regions compared to mean and maximum temperatures. This differential warming reduced the diurnal temperature range and limits nocturnal cooling, exacerbating heat stress impacts on health. The warming is projected to be most severe under the high-emission SSP5-8.5, and the Savanes and Kara regions are projected to remain the hottest, consistently recording the highest absolute temperatures across both future scenarios.

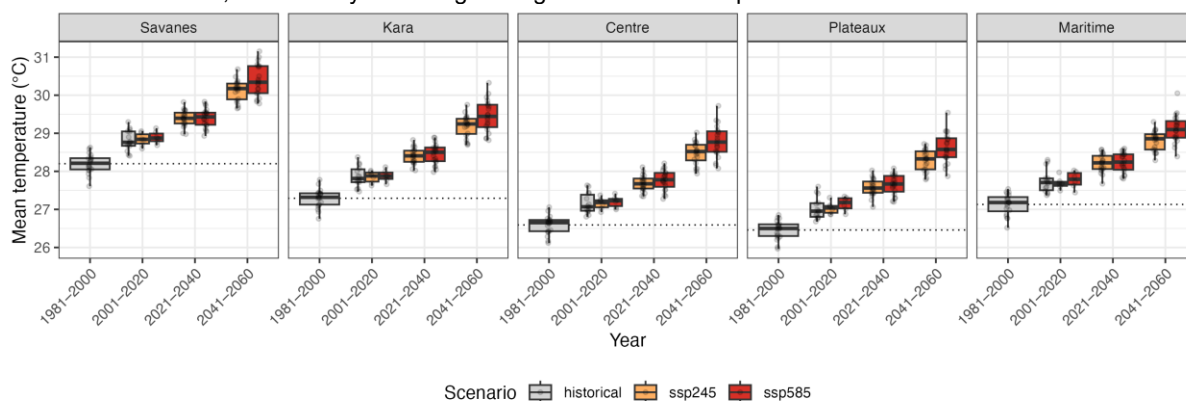


Figure 2: Projected changes in mean temperature by region and time periods (2021-2040 and 2041-2060 compared to baseline (1981-2000) and recent (2001-2024)) and SSPs 2-4.5 and 5-8.5³⁰.

25. Figure 3 illustrates the projected precipitation changes and highlights the complexity and regional divergence of Togo's future hydrological outlook. Mean precipitation generally declines under SSP2-4.5 in all regions except Savanes, with significant drops of around -0.05–0.08 mm/day per decade, and similar but slightly more mixed declines under SSP5-8.5 (strongest in Centrale, Plateaux and Maritime).

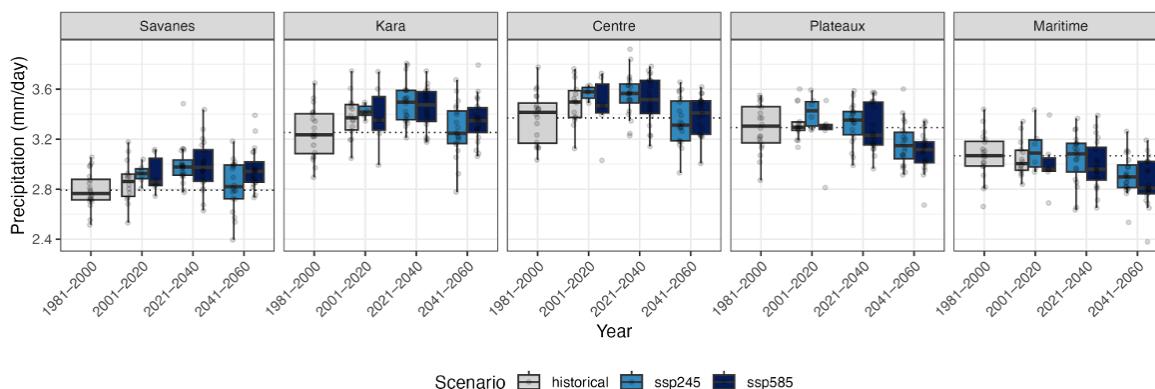


Figure 3: Projected changes in precipitation by region and time periods (2021-2040 and 2041-2060 compared to baseline (1981-2000) and recent (2001-2024)) and SSPs 2-4.5 and 5-8.5³¹.

²⁹ Op. cit. Annex 2.a

³⁰ Ibid.

³¹ Ibid.

26. Relative humidity tends to increase slightly in the near-term, but overall decreases are observed across most regions by mid-century under both SSPs.

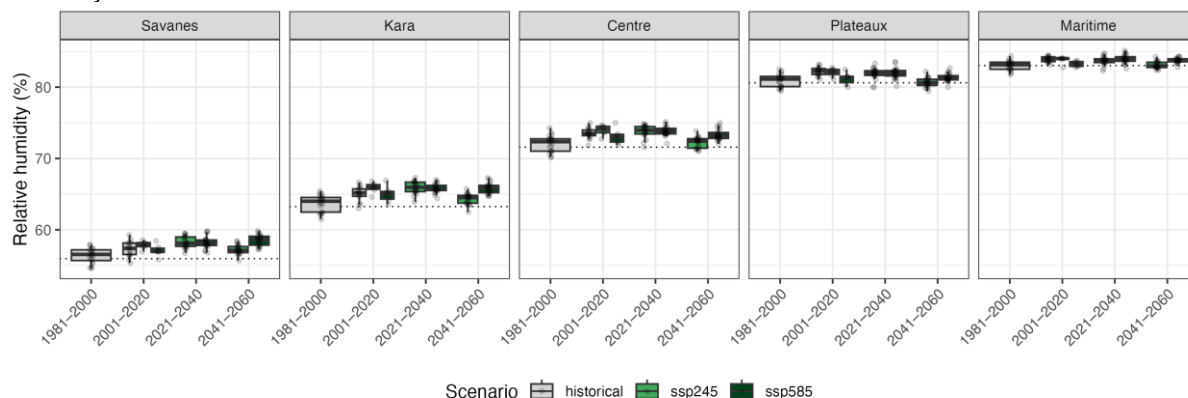


Figure 4: Projected changes in relative humidity (%) by region and time periods (2021-2040 and 2041-2060 compared to baseline (1981-2000) and recent (2001-2024)) and SSPs 2-4.5 and 5-8.5

27. Heat-related extremes are projected to intensify consistently across Togo. The frequency of hot days (> 95th percentile) is projected to increase significantly in all regions and under both scenarios, typically by +0.3–0.6 extremely hot days per month per decade. The impact is most severe in the northern regions: the Kara and Savanes regions are projected to experience the largest absolute increases in extreme heat days under the high-emission SSP5-8.5 scenario, rising from a historical median of approximately two days per month to around five to six days per month by mid-century (2041-2060). The Centrale region follows a similar pattern, with its median extreme heat days increasing from two days per month to approximately four to five days per month by 2041-2060 under SSP5-8.5.

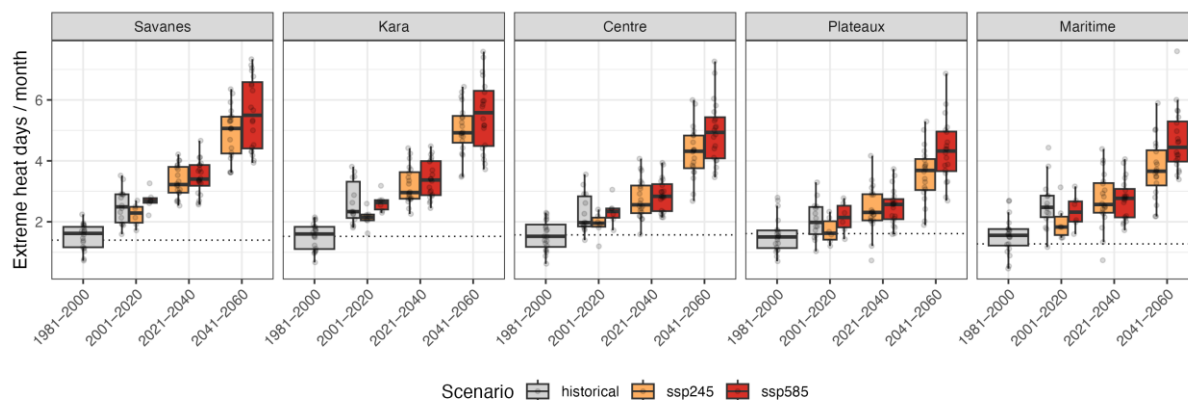


Figure 5: Projected changes in extreme temperatures (days/month) by region and time periods (2021-2040 and 2041-2060 compared to baseline (1981-2000) and recent (2001-2024)) and SSPs 2-4.5 and 5-8.5

28. Projected changes in extreme rainfall days (> 95th percentile) are highly variable across the country. The analysis shows a measurable increase in the frequency of extreme rainfall days primarily under the high-emission scenario, specifically in the Savanes and Kara regions, where the increase is approximated at $\approx +0.04$ – 0.05 extra days per month per decade.
29. In the Savanes region, the projected median number of extreme rainfall days increases from approximately 1.5 per month in the historical period to around 1.9 days per month by 2041-2060 under SSP5-8.5. The Kara region exhibits a similar positive shift. By contrast, the Centrale region and the southern regions show highly mixed or weak trends, with large inter-model uncertainty and median projections that remain close to or slightly below the historical baseline, particularly under the SSP2-4.5 scenario. The spatial contrast suggests that the northern regions face a specific and measurable increase in the frequency of intense rainfall events under the high-emissions path.

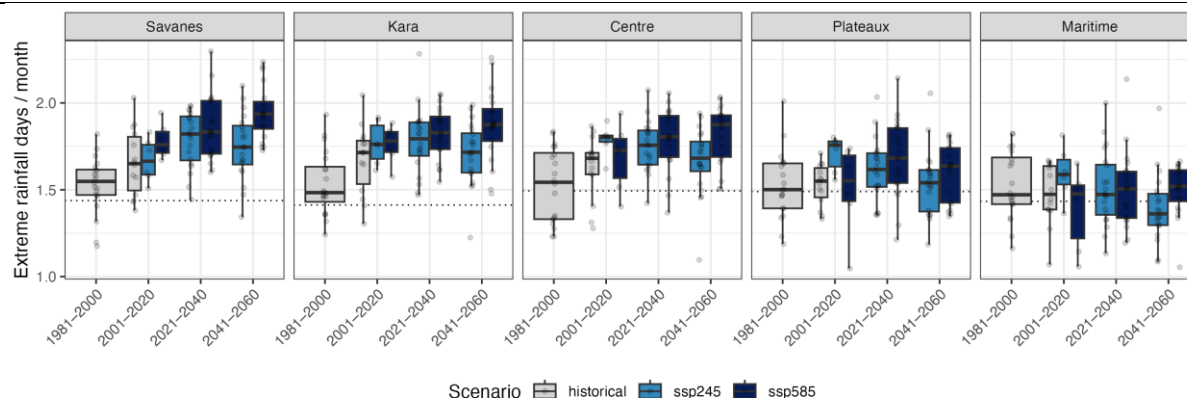


Figure 6: Projected changes in extreme precipitation (days/month) by region and time periods (2021-2040 and 2041-2060 compared to baseline (1981-2000) and recent (2001-2024)) and SSPs 2-4.5 and 5-8.5

30. These findings are further corroborated by Togo's fourth National communication to United Nations Framework Convention on Climate Change (UNFCCC) and the National Adaptation Plan to Climate Change (Plan National d'Adaptation aux Changements Climatiques - PNACC)³², which state that heavy rainfall is expected to increase by 43% in frequency and 12% in intensity. Consequently, the increase in flooding events has been identified as an impact of climate change in the country³³. However, due to the uncertainty in precipitation projections, there is no national quantitative data in terms of the future distribution of flooding events³⁴.

B.1.3 Priorities for climate change adaptation in the health sector

31. A preliminary assessment, conducted at the Concept Note level, concerning the most relevant impacts of climate variability and change in the Togolese health sector identified i) malaria ii) diarrhoeal diseases and iii) heat-related morbidity and mortality outcomes for maternal, infant and child health (including maternal and neonatal mortality, preterm birth, birth complications) -as the most related health outcomes³⁵. This preliminary assessment was further explored with a more robust analysis presented in the Annex 2.a. Climate rationale. The relevance of the selected health outcomes is further supported by the data on the top causes of death in Togo for which malaria, diarrhoeal diseases and preterm birth complications rank between the third and fifth top causes for both males and females³⁶. Heat-related risks to maternal, infant and child health are operationalised in the analysis through measurable epidemiological indicators in the analyses for this proposal, including preterm birth and neonatal mortality, which capture the most acute and climate-sensitive outcomes along the pregnancy–newborn–early childhood continuum.
32. Malaria transmission is strongly influenced by environmental conditions, which affect mosquito vector (*Anopheles spp.*) ecology, parasite development and human vulnerabilities over short (days to weeks), medium (seasonal) and long term (interannual and decadal) time horizons³⁷. Humidity further affects adult survival and biting behaviour³⁸. Climate change therefore has potential to alter environmental suitability for malaria transmission, which may influence geographic distribution, length of the transmission season, intensity of transmission and long-term temporal trends in prevalence and burden³⁹. In addition, extreme events such as flooding can create temporary mosquito breeding sites and impact infrastructure, intervention campaigns and health care services, exacerbating malaria impacts⁴⁰. The Intergovernmental Panel on Climate Change Sixth Assessment Report (IPCC AR6) states with “very high confidence” that globally, the geographic area suitable for transmission will broaden (i.e. more areas will be susceptible to vector-borne diseases)⁴¹. Pronounced increases in the climatically suitable transmission season for malaria have been observed in African highland areas, with a 13.9% increase for *Plasmodium falciparum* and a 13% increase for *Plasmodium vivax* between 1951-1960 and 2015-2024, according to an analysis by the Lancet⁴². In relation to temperature, a 2021 risk analysis published by The Lancet Planetary Health found that optimal climate conditions for year-round malaria transmission are between 20.9°C and

³² MERF. (2018). Plan National d'Adaptation aux Changements Climatiques du Togo. <https://faolex.fao.org/docs/pdf/Tog192045.pdf>

³³ MERF. (2022). Quatrième Communication Nationale sur les Changements Climatiques au CCNUCC. Ministère de l'Environnement et des Ressources Forestières.

³⁴ GIZ. (2021). État des lieux de Connaissances des Risques Climatiques au Togo.

³⁵ Annex 1a Preliminary Climate Rationale, GCF Concept Note “Building the resilience of Togo's national health system and vulnerable communities to climate sensitive diseases”

³⁶ World Health Organization. (n.d.). Togo. Retrieved December 16, 2025, from <https://data.who.int/countries/768>

³⁷ Megersa, D. M., & Luo, X.-S. (2025). Effects of Climate Change on Malaria Risk to Human Health: A Review. *Atmosphere*, 16(1), 71.

³⁸ Komba, E. B. R. T. B. a. D. A. I. (2024). Contributions of time, temperature and humidity on the biting behaviour of *Anopheles funestus* at Lupiro village in Morogoro, Tanzania. *Acta Entomology and Zoology*, 5(2), 47-53.

³⁹ van der Deure, T. A.-O., Nogués-Bravo, D. A.-O., Njotto, L. A.-O., & Stensgaard, A. A.-O. (2025). Climate Change Favors African Malaria Vector Mosquitoes. (1365-2486 (Electronic)).

⁴⁰ Op. Cit. Megersa, 2025

⁴¹ Cissé, G., R. et al. (2022). Health, Wellbeing, and the Changing Structure of Communities. In: *Climate Change 2022: Impacts, Adaptation and Vulnerability. Contribution of Working Group II to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change* [H.-O. Pörtner, D.C. Roberts, M. Tignor, E.S. Poloczanska, K. Mintenbeck, A. Alegría, M. Craig, S. Langsdorf, S. Löschke, V. Möller, A. Okem, B. Rama (eds.)]: 1041–1170.

⁴² Romanello, M. et al. (2025). *The 2025 Report of the Lancet Countdown on Health and Climate Change*. The Lancet: 1–54.

34.2°C and between 5,050.5 mm and 15,959.6 mm precipitation per year. The study found that malaria is shifting towards higher altitudes, and more tropical and subtropical regions will become more suitable for transmission⁴³. In West Africa, an additional 58.7 million people are expected to face a net increase in the risk of malaria by the 2030s due to rising temperatures, according to the most conservative estimate⁴⁴.

33. Malaria is endemic in all regions of Togo, with a year-round transmission season and a seasonal recurrence during the rainy period. In 2019, external malaria consultations represented 54.4% of all consultations in Togo⁴⁵. A review of malaria case data per health district from 2008-2017 determined that the maximum seasonal indices were observed during or shortly after a rainy season, and that the minimum seasonal indices occurred during the dry season, especially between January and April⁴⁶. There is also indication that in the north of the country, malaria transmission is highly seasonal, particularly for children under five⁴⁷. An academic study reviewed malaria-related data collected by CHWs in Togo monthly, in the context of a knowledge gap identified by Togo's National Malaria Control Programme (PNLP)⁴⁸. The CHWs are supervised by the heads of USPs to ensure data quality. Data is then reviewed and compiled at the regional level. The study data was collected from 6,000 CHWs' notes in all 944 Togolese USPs, then grouped in 43 Health Districts and 6 Health Regions. **Error! Reference source not found.** shows the number of malaria cases in 2017⁴⁹.

Table 1: Number of malaria cases per region and rate per 1,000 inhabitants in 2017⁵⁰

Region	Number of cases	Rate per 1,000 inhabitants
Centrale	171,996	228.81
Kara	192,973	206.02
Savanes	192,244	190.80
Plateaux	301,305	180.10
Maritime	277,061	129.21
National level total	1,204,192	159.88

34. As can be observed, the regions of Centrale, Kara and Savanes – which are the prioritised regions for this project – exhibit the highest rate of malaria cases per 1,000 inhabitants based on the CHW data. Moreover, the data collected shows that the incidence of malaria has increased in all regions, particularly Maritime, Centrale and Savanes. Between 2008 and 2017, the mean annual percentage of malaria cases rose by 13.7% nationally, with significant increases observed in Centrale (16.7%), Savanes (15.8%), and Kara (13.5%)⁵¹. This higher incidence can be explained by malaria's expansion into higher altitudes, but also higher detection rates⁵². This increase in annual average cases has increased in all groups: children under five (13% increase), pregnant women (10% increase) and persons over five years of age (14% increase)⁵³. Nevertheless, the most recent malaria indicator survey (MIS) conducted in 2017-2018, contrary to the trends reported above, showed a general decrease in incidence through time (2000, 2005, 2010 and 2015) in most regions, except in the northern Kara and Savanes regions, which showed incidence peaking in 2010 before decreasing in 2015⁵⁴. Studies that make projections of malaria incidence/ prevalence under climate change in Togo are equivocal. Results over Togo suggest relatively minor changes in risk over this period, with high-risk areas in the north of the country remaining high risk. The study suggests minor extensions (~0-2 months) of the malaria season, particularly in northern regions that are already highly seasonal⁵⁵.

Diarrhoea

35. Diarrhoea incidence is impacted by several environmental factors, which can influence both the survival, dispersal and replication of causative pathogens (viral, bacterial or parasitic), as well as the pathways through which people are exposed to these pathogens. There is a large body of evidence linking climate hazards to diarrhoea worldwide, including drought,

⁴³ F. Colón González, M. Odhiambo Sewe, & A. Tompkins (2021). *Projecting the risk of mosquito-borne diseases in a warmer and more populated world: a multi-model, multi-scenario intercomparison modelling study*. *Lancet Planet Health*, 5: 404-14.

⁴⁴ S. Ryan, C. Lippi & F. Zermoglio (2020). *Shifting transmission risk for malaria in Africa with climate change: a framework for planning and intervention*. *Malaria Journal*, 19:170.

⁴⁵ MSHP (2019). [Direction Générale des Études de la Planification et de l'Information Sanitaire](#).

⁴⁶ Thomas, A. et al. (2021). Seasonality of confirmed malaria cases from 2008 to 2017 in Togo: a time series analysis by health district and target group. *BMC infectious diseases*, 21(1), 1189.

⁴⁷ *Ibid.*

⁴⁸ *Ibid.*

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*

⁵¹ Bakai et al. (2020). Changes in registered malaria cases and deaths in Togo from 2008 to 2017. [International Journal of Infectious Diseases: IJID: Official Publication of the International Society for Infectious diseases](#), 101, 298-305.

⁵² Thomas, A. et al. (2021). Seasonality of confirmed malaria cases from 2008 to 2017 in Togo: a time series analysis by health district and target group. *BMC infectious diseases*, 21(1), 1189.

⁵³ *Ibid.*

⁵⁴ The DHS Program. (2017). Togo: Malaria Indicator Survey (MIS), 2017

⁵⁵ Fall, P., Diouf, I., Deme, A., Diouf, S., Sene, D., Sultan, B., & Janicot, S. (2023). Enhancing Understanding of the Impact of Climate Change on Malaria in West Africa Using the Vector-Borne Disease Community Model of the International Center for Theoretical Physics (VECTRI) and the Bias-Corrected Phase 6 Coupled Model Intercomparison Project Data (CMIP6). *Microbiology Research*, 14(4), 2148-2180.

flooding, heavy rainfall and temperature, with most of this evidence on temperature and rainfall⁵⁶. A recent systematic review and meta-analysis examining the relationship between climate hazards and childhood diarrhoea world-wide found a small but significant positive association between diarrhoea risk and both increased temperature and increased rainfall. This effect was exacerbated by poor WASH facilities⁵⁷. More locally to Togo, a recent study using data from ten West African countries found increased odds of diarrhoea associated with higher temperature, and a non-linear relationship with precipitation⁵⁸. A recent systematic review examined the potential future climate change-attributable diarrhoea burden globally⁵⁹. This study found that the majority of identified research predicted an increase in diarrhoeal diseases in the near (2020–2040), mid (2040–2060) and long term (2060+) future due to climate change. They also found that high baseline burden of diarrhoeal disease, as it is in Togo, was associated with larger increases in burden⁶⁰.

36. In Togo diarrhoeal disease is widespread, representing the fifth highest cause of death as of 2021 (World Health Organization, 2025b). Survey, diarrhoea prevalence in Togo is particularly high in children ages 6–11 months (23%) and 12–23 months (22%)⁶¹. Beyond this static prevalence picture, recent national surveillance data show a marked and accelerating trend in diarrhoeal disease incidence linked to increasing climate variability. Between 2018 and 2022, reported diarrhoeal cases increased sharply across the country, with the most pronounced rises observed in climate-vulnerable regions; cases increased by approximately 75% in Centrale and 74% in Kara over this five-year period⁶². These upward trends reflect the growing exposure of communities to climate-related drivers of diarrhoeal transmission, including flooding, heat stress, and deteriorating water quality.
37. The MSHPCSUA's statistical review from 2019 provides a district-level snapshot of diarrhoeal morbidity by type⁶³. The number of cumulative cases recorded that year illustrate the existing burden prior to the more recent intensification observed after 2019. The same statistical review found the following number of cases:

Table 2: Number of bloody diarrhoea and acute diarrhoea cases in Togo, per region, in 2019⁶⁴

Region	Bloody diarrhoea cases	Severe diarrhoea cases	Total cases (absolute number)	Total rate per 10,000 people
Savanes	1532	0	1532	15.2
Kara	1757	123	1880	19.9
Centrale	1439	160	1599	21.0
Plateaux	2152	175	2327	13.8
Maritime	561	219	780	3.6
Lomé Commune	88	23	111	1.1
National total	7529	700	8229	N/A

38. As can be seen in Table 2, two types of diarrhoeal diseases were recorded. The region of Plateaux, followed by Kara, have the highest number of absolute cases in 2019. The highest rates of bloody diarrhoea and severe diarrhoea cases together, per 10,000 people, are the regions of Centrale, Kara and Savanes, the same regions with the highest incidence of malaria. In terms of recorded deaths, only three deaths for bloody diarrhoea were recorded that year, two of them in the Savanes region⁶⁵.
39. At the national level, the last decade showed mixed results for disease control: malaria and diarrhoea mortality rates decreased, reflecting progress from robust strategies in prevention, diagnosis, treatment, and surveillance in endemic areas. while morbidity rates increased. However, despite this success, morbidity cases have increased, leading to

⁵⁶Carlton, E. J., Woster, A. P., DeWitt, P., Goldstein, R. S., & Levy, K. (2016). A systematic review and meta-analysis of ambient temperature and diarrhoeal diseases. *International Journal of Epidemiology*, 45(1), 117–130.

Levy, K., Woster, A. P., Goldstein, R. S., & Carlton, E. J. (2016). Untangling the Impacts of Climate Change on Waterborne Diseases: a Systematic Review of Relationships between Diarrhoeal diseases and Temperature, Rainfall, Flooding, and Drought. *Environmental Science and Technology* (1520–5851 (Electronic)).

Flückiger, M., & Ludwig, M. (2022). Temperature and risk of diarrhoea among children in Sub-Saharan Africa. *World Development*, 160, 106070. <https://doi.org/https://doi.org/10.1016/j.worlddev.2022.106070>

⁵⁷ Gunsa, Gorfu & Cumming, Oliver & Getahun, Alemayehu & Freeman, Matthew & Ambelu, Argaw. (2024). Rainfall and Temperature Influences on Childhood Diarrhea and the Effect Modification Role of Water and Sanitation Conditions: A Systematic Review and Meta-Analysis. *International Journal of Environmental Research and Public Health*. 21. 823. 10.3390/ijerph21070823.

⁵⁸ Dunn, G., & Johnson, G. D. (2018). The geo-spatial distribution of childhood diarrheal disease in West Africa, 2008–2013: A covariate-adjusted cluster analysis. *Spatial and Spatio-temporal Epidemiology*, 26, 127–141. <https://doi.org/https://doi.org/10.1016/j.sste.2018.06.005>

⁵⁹ Alyssa G Miller et al 2025 *Environ. Res. Lett.* 20 053008, DOI 10.1088/1748-9326/adccd8

⁶⁰ *Ibid.*

⁶¹ Direction Générale de la Statistique et de la Comptabilité Nationale (DGSCN) (2015). *Troisième enquête démographique et de santé (EDST-III 2013-2014)*. Ministère togolais de la Planification, du Développement et de l'Aménagement du Territoire, Ministère Togolais de la Santé.

⁶² DHIS2 (2023). *DHIS2 in Action* [Data Set]. Data extracted 03.2023.

⁶³ Direction Générale des Études de la Planification et de l'Information Sanitaire (2019). *Annuaire des Statistiques Sanitaires du Togo*. Ministère de la Santé et de l'Hygiène Publique.

⁶⁴ *Ibid.*

⁶⁵ *Ibid.*

significant negative social and economic consequences, including economic losses from days lost of work due to sickness, higher health care expenditures and overall poorer quality of life.

Preterm birth

40. Rising temperatures and extreme heat events are now widely recognised as threats to maternal, infant and child health. Exposure to high temperatures during pregnancy has a range of physiological effects, including a reduction in placental blood flow⁶⁶ and an inflammatory response that may trigger early labour⁶⁷. PTB (delivery < 37 completed weeks' gestation) is the leading cause of neonatal and under-5 child mortality worldwide⁶⁸. Complications of PTB are the sixth leading cause of mortality in Togo, with 33.7 deaths per 100,000 population in 2021⁶⁹. The rate of PTB in Togo was estimated to be 13.3% of all live births in 2010⁷⁰.
41. There is strong evidence that short-term exposure to high ambient temperatures increases the risk of PTB⁷¹. A recent systematic review and meta-analysis of heat exposure impacts on maternal, foetal, and neonatal health revealed increased odds of PTB per increase in temperature 0-4 weeks before delivery and increased odds during a heatwave versus non-heatwave period. The vast majority of studies have been conducted in high-income countries, but there is some evidence to suggest that the heat-PTB impact is stronger in lower-middle-income countries.
42. Few studies have been conducted in sub-Saharan Africa. McElroy et al (2022) documented a strong tendency towards an increased risk of PTB with daily maximum temperatures >20°C using data from 14 Low- and Middle-Income countries, including Benin and Nigeria. The association with maximum temperature was not statistically significant and diurnal temperature range showed a stronger association with PTB⁷².
43. Although most studies focus on the short-term effects of heat exposure in the week or month preceding delivery, accumulating evidence suggests that high temperatures in early and mid-pregnancy may also be important. Several studies report larger effect sizes when heat events occur more than four-weeks before birth, with a recent meta-analysis finding 1.37-fold higher odds of PTB (95% CI: 1.08-1.74) at higher temperatures during these longer-lag⁷³.

Table 3: Neonatal and infant mortality rates, in 2019⁷⁴

Indicator	Number	Unit of measure	Lower bound	Upper bound
Neonatal mortality rate	24.9	Deaths per 1,000 live births	19.2	32.1
Neonatal deaths	0.4	% of under-five deaths	0.3	0.4
Stillbirths	5,878	Number of stillbirths	5,043	6,878
Stillbirth rate	20.7	Stillbirths per 1,000 total births	17.3	24.8
Neonatal deaths	6,930	Number of deaths	5,360	8,928
Infant deaths	11,074	Number of deaths	9,010	13,617

44. Togo faces persistent and severe challenges in maternal, infant and child health, exacerbated by socio-economic and geographic disparities. The maternal mortality ratio is estimated at 349 deaths per 100,000 live births in 2023⁷⁵. Childbirth remains risky, as the most common direct causes of maternal death include postpartum haemorrhage (47%), eclampsia or hypertensive disorders (24%), and sepsis/infections (13%), yet only 12% of maternal deaths are reviewed through formal audit processes⁷⁶.

⁶⁶ Wang, Y.-Y., Li, Q., Guo, Y., Zhou, H., Wang, Q.-M., Shen, H.-P., Zhang, Y.-P., Yan, D.-H., Li, S., Chen, G., Zhou, S., He, Y., Yang, Y., Peng, Z.-Q., Wang, H.-J., & Ma, X. (2020). Ambient temperature and the risk of preterm birth: A national birth cohort study in the mainland China. *Environment International*, 142, 105851. <https://doi.org/https://doi.org/10.1016/j.envint.2020.105851>

⁶⁷ Chersich, M. A.-O., Pham, M. D., Areal, A., Haghighi, M. M., Manyuchi, A., Swift, C. P., Wernecke, B., Robinson, M., Hetem, R., Boeckmann, M., & Hajat, S. (2022). Associations between high temperatures in pregnancy and risk of preterm birth, low birth weight, and stillbirths: systematic review and meta-analysis. *The BMJ* (1756-1833 (Electronic)).

⁶⁸ Lakhoo, D. A.-O., Brink, N. A.-O., Radebe, L., Craig, M. A.-O., Pham, M. D., Haghighi, M. M., Wise, A., Solarin, I., Luchters, S., Maimela, G., & Chersich, M. A.-O. (2025). A systematic review and meta-analysis of heat exposure impacts on maternal, fetal and neonatal health. *Nature* (1546-170X (Electronic)).

⁶⁹ *Ibid.* WHO 2025.

⁷⁰ Blencowe H, Cousens S, Oestergaard MZ, Chou D, Moller AB, Narwal R, Adler A, Vera Garcia C, Rohde S, Say L, Lawn JE. National, regional, and worldwide estimates of preterm birth rates in the year 2010 with time trends since 1990 for selected countries: a systematic analysis and implications. *Lancet*. 2012 Jun 9 ;379(9832) :2162-72. doi: 10.1016/S0140-6736(12)60820-4. PMID: 22682464.

⁷¹ *Ibid.* Chersich et al., Lakhoo et al.

⁷² McElroy, S., Ilango, S., Dimitrova, A., Gershunov, A., & Benmarhnia, T. (2021). Extreme heat, preterm birth, and stillbirth: A global analysis across 14 lower-middle income countries. *Environment International* (1873-6750 (Electronic)). <https://doi.org/10.1016/j.envint.2021.106902>

⁷³ *Ibid.* Lakhoo 2025.

⁷⁴ UNICEF. (2019). Cross-sector indicators [Data set].

⁷⁵ *Ibid.* WHO 2025.

⁷⁶ Douaguibe, B., Ajavon, D. R., Koffi, W., Tongou, P., Kambote, Y., Bararmna-Bagou, F., Mawougbe, R., & Aboubakari, S. (2023). Review of Maternal Deaths in Two Health Regions of Togo: About 69 Cases (Epidemiological and Sociodemographic Aspects). *Open Journal of Obstetrics and Gynecology*, 13(10), 1722–1729. <https://doi.org/10.4236/ojog.2023.1310145>

B.1.4 Prioritised project areas

45. Togo is comprised of five distinct regions. To determine the project areas, a risk assessment and regional prioritisation was carried out to select the most vulnerable regions. The process operationalised the IPCC AR6 risk assessment framework for i) hazard; ii) exposure; iii) vulnerability indicators for the recent temporal scale taking into consideration malaria under 5, diarrhoeal disease under 5, and preterm birth health outcomes⁷⁷. The variables and the methodological approach utilised for the development of the composite risk index are available in Annex 2.a Climate Rationale. The final list of regions for the proposed GCF project include those achieving the highest total risk index. As ranked by the calculated risk index, the three regions with the highest index are the northern regions of Centrale, Kara and Savanes. The project will focus on these three regions to increase the potential replicability and scale up of project impacts in the remaining districts of the targeted regions.

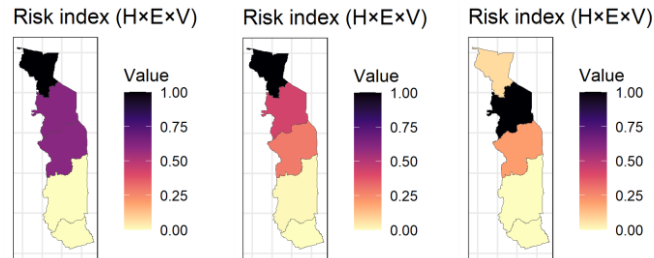


Figure 7 - Risk assessment (aggregation of component indices to region level) for malaria in children under 5, diarrhoeal diseases in children under 5, for preterm birth.

B.1.5 Epidemiological modelling

46. Further analysis was conducted to assess projected climate change impacts to the prioritised health outcomes. The epidemiological modelling utilised full historical (1950–2014) and projected (2015–2100) NASA NEX CMIP6 climate data for the two SSPs, giving model runs spanning a 150-year time series. The model utilised national DHIS2 system for all prefectures and the full period available in the study window and specific socio-economic and vulnerability covariates for each health outcome. After model training, checking and validation, the final models were projected onto historical and future climate scenarios using static covariates fixed at their training-period values. A comprehensive overview of the methodological approach is available on Annex 2.a Climate Rationale.

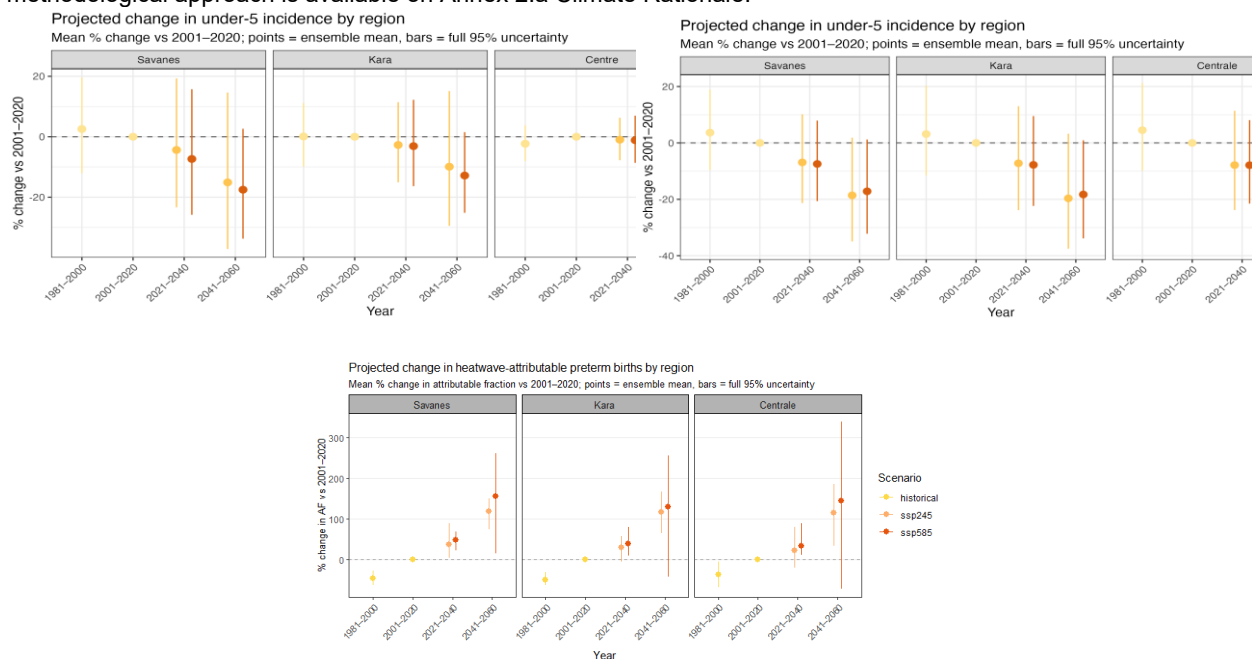


Figure 8 - Projected changes in malaria in children under 5, diarrhoeal in children under 5 and heatwave-attributable preterm births incidence in the priority regions. Points are ensemble mean values relative to the 2001–2020 period mean.

47. Modelling results show that malaria risk is driven by changes in the length of the transmission season associated with hot, humid and thermally variable conditions, while very high mean temperatures tend to be limiting. Projections suggest gradual declines in incidence in already hot lowland and northern areas, but possible increases or slower declines in cooler, higher-

⁷⁷ IPCC, 2022: Climate Change 2022: Impacts, Adaptation, and Vulnerability. Contribution of Working Group II to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change [H.-O. Pörtner, D.C. Roberts, M. Tignor, E.S. Poloczanska, K. Mintenbeck, A. Alegría, M. Craig, S. Langsdorf, S. Löschke, V. Möller, A. Okem, B. Rama (eds.)]. Cambridge University Press. Cambridge University Press, Cambridge, UK and New York, NY, USA, 3056 pp., doi:10.1017/9781009325844.

elevation parts of the centre of the country as they warm towards more suitable thermal conditions. While there is a trend for net declines in climate suitability, these do not remove malaria risk in northern Togo; instead, they redistribute it in space and time. The synthesis shows that short periods of hot, humid and thermally variable conditions, particularly at a one-month lag, will continue to drive transmission, while some cooler highland and fringe areas may become relatively more suitable as they warm.

48. In the case of diarrhoea, total precipitation is positively associated with incidence, consistent with the wet-contamination pathway, while warmer conditions and periods with more hot days show generally protective associations. Projections indicate a long-term climate-driven decline in diarrhoeal incidence, slightly stronger than for malaria, but with non-trivial probabilities of increases in some prefectures and seasons, particularly in Kara and Centrale and during the early rainy season. This means that climate change may lower average diarrhoeal burden but still leave children in northern Togo highly vulnerable to rain-driven spikes, especially in settings with weak WASH and health systems.
49. Epidemiological modelling confirms that heatwaves already increase PTB risk and that this burden will grow under future climate change. The meta-analysis shows that heatwaves contribute small effects in multiple months of pregnancy (lags 0-8), which accumulate to produce an overall increase in PTB risk. Current heatwave-attributable fractions are modest, but roughly double or more by mid-century, reaching 3–4.5% under both SSP2-4.5 and SSP5-8.5, with increases spread across nearly all prefectures.
50. The results on malaria and diarrhoea highlight that while overall trends show decline, incidence will still remain high with potentially altered seasonality and geographic distributions and high risk to the most vulnerable populations. Therefore, reliable surveillance is crucial for the identification of new incidence patterns, flexible planning and timely alert and response. Resilient health facilities to flood, droughts and heatwave events are crucial for reliable healthcare provision.
51. In the case of PTB increased risks from heatwaves further highlights the need for improved thermal comfort in health facilities and heat-proofing medical cold chains. Finally, the limited resources available to the public health system make the case for communication and behavioural campaigns to increase the effectiveness and efficiency of the means employed. Table 4 summarises key adaptation interventions for the three CSHO.

Table 4: Key adaptation interventions for the three CSHO in Togo

Suggested Adaptation Intervention	Rational	Expected Adaptation Benefit
Malaria		
Surveillance and response to prepare for altered seasonality and geographic distributions	Modest net declines in suitability but redistribution in space/time; cooler highland areas becoming suitable as they warm	Anticipate more concentrated transmission; flexible, climate-informed micro-planning
Reduce barriers to diagnosis (rapid and laboratory analyses) and treatment (including vaccination)	Longer travel times are associated with higher incidence; under-ascertainment is likely in remote areas	Effective diagnosis and treatment in hard-to-reach areas
Strengthen routine surveillance through sentinel sites and improved diagnostics	Need to reliably detect climate-driven shifts in incidence and seasonality	Reliable detection of epidemiological shifts; proactive identification of transmission patterns
Identify high-risk areas into routine vector-control programmes and maintain strong coverage	Small climate-driven increases in suitability could cause substantial case increases if immunity is low and care is weak	Consolidate potential gains and prevent resurgence
Implement alert systems integrating climatic indicators and climate-informed communication campaigns	Need to anticipate periods and places of heightened transmission	Proactive anticipation of transmission peaks
Diarrhoea		
Flood- and drought-resilient WASH infrastructure in public buildings	Manage wet-season and extreme-event risk; vulnerability is linked to structural WASH deficits	Withstand heavy rainfall and dry spells
Reduce barriers to diagnosis (rapid and laboratory analyses) and treatment (ORS, zinc)	Longer travel times are associated with higher incidence; under-ascertainment is likely in remote areas	Effective diagnosis and treatment in hard-to-reach areas
Reinforce behavioural interventions for hygiene and breastfeeding	Behaviours and crowding are drivers; breastfeeding and hygiene are protective	Reduce overall burden; "no regret" strategies that pay off during extremes

Extend surveillance, service reach and improve diagnostic specificity	Lower reported diarrhoea in remote areas suggests under-ascertainment	Ensure emerging risks in remote areas are not missed; improved analysis and forecasting
Preterm Births		
Develop and implement passive cooling techniques for health facility construction	Mitigate thermal stress for pregnant women; ensure facilities remain functional during heat extremes	Improved thermal comfort for patients and staff; functional health facilities
Introduce and scale heat-stable medication and improve the Logistics Management Information System	Cold-chain storage is vulnerable during heatwaves and power outages	Resilience of the supply chain; availability of essential commodities when needed
Awareness raising on heat impacts on Maternal, Infant and Child Health integrated into Antenatal care visits	Behaviour change is critical; vulnerable populations may have limited access to formal care	Improved hydration, resting, and cooling behaviours among pregnant women
Improve data availability baseline and capacity for modelling	Need for precise characterisation of heat-related risks and surveillance	Baseline for targeted early warning systems

B.1.6 Related ongoing and forthcoming projects with synergies

52. The table below **summarises** climate projects relevant to Togo, drawing specifically from the projects listed in the FS (Annex 2, *Table 42* (Adaptation) and *44* (Cross-cutting and Mitigation)). The selection focuses on projects that demonstrate the strongest alignment and potential synergies with the core Components and Outputs of the proposed project.

Table 5: Existing and relevant climate change projects in Togo

Information	Objective and results	Potential synergies
Adaptation		
Title: SAP48 Strengthening the resilience of vulnerable communities within high climatic and disaster risk areas in Togo Budget: USD 27 million Duration: 5 years Donor: GCF Agency: West African Development Bank (BOAD)	The project aims to improve the preparedness capacities of national institutions and strengthen the resilience of local communities to climate change and disaster risks by reinforcing the existing early warning system and training vulnerable populations in Togo. The proposed actions fall into the following four components: - improving knowledge and understanding of disaster risks; - strengthening governance to better manage disaster risks; - investing in disaster risk reduction for resilience; - strengthening disaster preparedness, response and recovery capacities.	The SAP48 project has significant synergies with Components 1 and 4 of this project. In particular, Output 1.2 will support the staff capacities of ANAMET; Output 1.3 will support the capacity needs of the National Civil Protection Agency (ANPC) for disaster risk management; Output 1.4: will contribute to the financial sustainability of ANAMET; Output 2.1 will strengthen the interinstitutional cooperation between ANAMET, ANPC, and other actors; Output 2.2 will strengthen ANAMET hydrometeorological system, data management and forecasting capacity; Output 2.3 will support community-based warning networks; Output 2.4 will strengthen capacity for community and institutional readiness and response; and Output 3.1. will set-up early warning triggers. The project will further improve the capacities of ANAMET (Output 1.1); capitalise on ANAMET's improved capacities to support enhanced epidemiological modelling (Output 1.2); it will utilise the strengthened ANPC capacity to deliver early warning systems (Output 1.3); improve the preparedness of health sector to other climate induced disasters (Outputs 2.1 and 2.2.); and capitalise on the local communities' readiness to improve the response of health-related health risks warnings (Output 4.2). Coordination will ensure no duplication between interinstitutional cooperation for the MHEWS and the climate-health specific focus of this project.

Title: Support the strengthening of national capacity to deliver climate, hydrometeorological and early warning services in selected sectors and communities Budget: USD 2.4 million Duration: 5 years Funder: WBG Agency: World Bank Group (WBG), GFDRR (Climate Risk and EWS – CREWS)	The CREWS project aims to improve Togo's EWS for drought, floods, and other severe climate events by building the capacity of national services, particularly ANAMET and the ANPC. Support includes training on advanced forecasting and standardising warning dissemination.	This project strongly aligns with Output 1.1 of the proposed project by supporting the technical capabilities of ANAMET for climate services, providing access to advanced forecasting tools and capacity development for refining flood warning procedures.
Title: FP205 Infrastructure Climate Resilient Fund (ICRF) Budget: USD 765.075 million Duration: 10 years Funder: GCF Agency: Africa Finance Corporation (AFC)	The ICRF promotes large-scale investment in climate-resilient infrastructure across 19 countries, targeting transport, energy, economic zones, and digital infrastructure. It supports technical assistance and climate risk assessment.	Potential synergies include the ICRF's complement to the proposed project by strengthening the overarching enabling infrastructure (energy, ICT, and data systems) essential for climate-resilient health service delivery.
Cross-cutting and Mitigation		
Title: FP105 BOAD Climate Finance Facility to Scale Up Solar Energy Investments in Francophone West Africa LDCs Budget: USD 141 million Duration: 7 years Donor: GCF Agency: BOAD	The programme aims to accelerate mitigation by scaling up solar energy investments in six Francophone LDCs (Benin, Burkina Faso, Guinea-Bissau, Mali, Niger, Togo). It promotes the large-scale deployment of solar technologies (PV and CSP) to decarbonise the energy mix and improve energy access.	Planned solar PV plants in Blitta (20 MW) and Dapaong (30 MW) will enhance energy reliability in the GIZ-GCF project's target regions (Centrale and Savanes), creating potential synergies. Stable, low-carbon electricity is crucial for sustaining cold chains for medicines and vaccines and powering the digital health EWS (Outputs 1.1 and 3.2).
Title: FP211 Hardest-to-Reach Budget: USD 250 million Duration: 12 years Donor: GCF Agency: Acumen Fund Inc.	The project expands access to off-grid solar energy for vulnerable populations in 16 sub-Saharan countries, including Togo. It supports small-scale renewable energy enterprises targeting last-mile communities and improving energy access.	The expansion of off-grid solar systems supports household-level access to reliable power, enabling communities to receive EWS alerts via mobile and radio. It also enhances communication and health information dissemination, improving preparedness and resilience at community level (Output 1.3 and 4.2).
Title: FP219: Staple Crops Processing Zone, Promoting Sustainable Agricultural Value Chains Budget: USD 271.7 million (USD 40.7 million to Togo specifically) Duration: 5 years (2025-2030) Donor: GCF Agency: African Development Bank (AfDB)	The project strengthens climate resilience and reduces GHG emissions in agricultural value chains across Togo, Senegal, and Guinea. In Togo, its activities are focused on the Kara region. It invests in sustainable water management, agro-processing, and Climate Information and Early Warning Systems (CIEWS) for agriculture.	The project is highly complementary as it targets the Kara region and addresses determinants of health (food and water security). It invests in CIEWS for agriculture, providing data and infrastructure that can be leveraged by the GIZ-GCF project's public health EWS (Output 1.1).
Title: FP223 Project GAIA Budget: USD 1.5 billion Duration: 30 years (2023-2054) Donor: GCF Agency: MUFG Bank, Ltd.	GAIA is a blended finance platform prioritising adaptation (70% of its portfolio) in health, water security, resilient infrastructure, and ecosystem services. It provides long-term debt finance to sovereign and sub-sovereign entities to implement climate-resilient investments.	GAIA's focus on health and infrastructure aligns with the GIZ-GCF project's goals of enhancing resilience of health systems, WASH facilities, and energy-efficient infrastructure. It can serve as a financing channel for scaling up climate-resilient health and WASH infrastructure (Outputs 2.1 and 3.2).

B.2 (a). Theory of change narrative and diagram (max. 1500 words, approximately 3 pages plus diagram)

B2a.1. Theory of change (ToC) and project goal

53. The following diagram shows the ToC for the project, which illustrates the change pathway and interactions of different elements of the intervention logic proposed by the project. As shown in the theory of change diagram, the project has established an integrated self-supporting approach, addressing the identified barriers and risks.

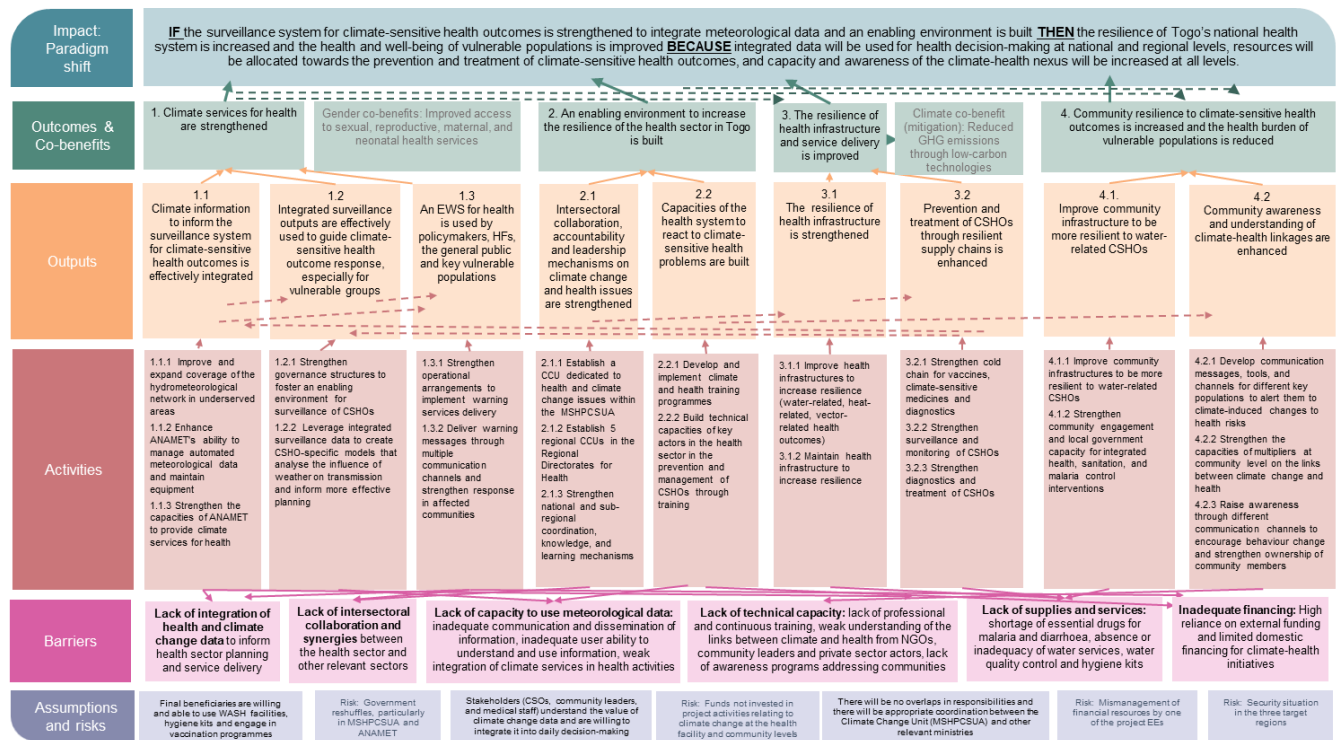


Figure 9: Theory of Change

54. **Goal:** The goal of the project is to strengthen climate services for health; increase the climate resilience of the health sector, the health infrastructure and service delivery; and enhance the resilience of communities to climate related health outcomes, including their capacity to manage associated health burden.
55. **Goal Statement:** IF the surveillance system for climate-sensitive health outcomes is strengthened to integrate meteorological data and an enabling environment is built THEN the resilience of Togo's national health system is increased and the health and well-being of vulnerable populations to climate-sensitive health outcomes is improved BECAUSE integrated data will be used for health decision-making at national and regional levels, resources will be allocated towards the prevention and treatment of climate-related health outcomes, and capacity and awareness of the climate-health nexus will be increased at all levels.
56. The series of activities, outputs, and outcomes (detailed in section B.3) drive the ToC diagram, goal, and goal statement by addressing the barriers and risks described below.

B.2a.2. Identified Barriers

57. The barriers that the project will address in the targeted areas and the overall national health sector enabling environment in the health sector include economic, financial, technical, institutional, knowledge and information barriers:

Table 6: Overview of barriers that this project will address

Barrier	Description	GCF project Outputs
Governance and institutional	Fragmented intersectoral collaboration and coordination: - Limited intersectoral collaboration and coordination across sectors and non-operationalisation of the One Health approach, hindering comprehensive climate-sensitive health responses. - Lack of clear mandate and institutionalisation for climate-health initiatives (e.g. the Climate-Health Task Force is informal, temporary, and lacks	Output 2.1 – Institutional mechanism for intersectoral coordination on climate and health established and operationalised (i.e., CCU).

	dedicated staff), hindering long-term action and effective decision-making.	
Information and data	Lack of capacity to use meteorological data: • Absence of high-performance weather prediction tools. • Data collection system with inadequate geographical coverage and obsolete equipment and management system with outdated processes. Lack of integration of health and climate change data: • Lack of integration of climate data in the DHIS2 health sector's information system, hindering analysis, planning, and evidence-based decision making.	• Output 1.1 – Climate information system strengthened for integration of meteorological and health data (i.e., DHIS2) to support more effective information management and decision-making. • Output 1.2 – Integrated surveillance system upgraded to ensure the data is actively used by developing specific CSHO models and creating maps for targeted interventions, bridging the gap between data collection and data-driven response. • Output 1.3 – EWS health installed to provide real-time weather data. • Output 3.2 – Sentinel sites for more robust case surveillance
Capacity	Lack of technical capacity of staff: • Limited national expertise in interpreting and communicating meteorological and climate-health data to end-users. • Reliance on unpaid or undertrained volunteers for technical tasks in ANAMET. • Weak integration of climate services in daily health operations and limited user capacity among health professionals and communities. • Absence of climate-health modules in academic and professional curricula. • Underdeveloped health research, characterised by insufficient national coordination and planning for health research, coupled with limited context-specific literature, restrict evidence-based planning and interventions.	• Output 1.1 – Improve management capacity of ANAMET • Output 1.2 – Integration and operational analysis of climate services • Output 1.3 – Climate informed evidence-based decisions and EWS • Output 2.2 – Capacity of health professionals and institutions to use meteorological and climate information is strengthened by integrating climate-health knowledge and training programmes into the education system. • Output 4.2 – Community awareness and understanding of climate-health linkages enhanced.
Technical and resources	Lack of supplies and services: • Degraded meteorological observation network with limited geographic coverage and no decentralised maintenance system. • Health infrastructure standards (Ministry of Health norms from 2025) fail to integrate climate resilience. • Absence or inadequacy of essential services, including irregular access to quality water and energy for HFs and communities. • Severe shortage of biomedical technicians and absence of structured maintenance pathways for facilities and cold chains. • Frequent shortage of essential medication and medical supplies needed to treat CSHO.	• Output 1.1 – Improve geographical coverage through the installation of new and maintenance of existing hydrometeorological equipment. • Output 3.2 – Strengthened prevention and treatment of CSHO through improved supply chains for essential medicines, enhanced surveillance and monitoring and improved health infrastructure. • Outputs 3.1 and 4.1 – Investment in climate-resilient construction of HFs and WASH services for communities.
Financial	Inadequate financing: • Heavy reliance on external funding due to insufficient state budgetary resources, resulting in weak financial management and limited overall capacity to mobilise finance for climate-health initiatives.	• Output 1.1 – ANAMET's financial autonomy improved finance and maintenance capacity to ensure long-term self-sufficiency, complementing SAP48 financial revenues securing efforts. • Output 2.1 – Permanent CCU within MSHPCSUA established to secure budget allocation and strengthen domestic resource mobilisation. • Cross-cutting – Capacity building in financial management and resource mobilisation for MSHPCSUA and ANAMET staff.

B.2 (b). Outcome mapping to GCF results areas and co-benefit categorisation

Outcome number	GCF Mitigation Results Area (MRA 1-4)				GCF Adaptation Results Area (ARA 1-4)			
	MRA 1 Energy generation and access	MRA 2 Low-emission transport	MRA 3 Building, cities, industries, appliances	MRA 4 Forestry and land use	ARA 1 Most vulnerable people and communities	ARA 2 Health, well-being, food and water security	ARA 3 Infrastructure and built environment	ARA 4 Ecosystems and ecosystem services
Outcome 1	☐	☐	☐	☐	☐	☒	☐	☐
Outcome 2	☐	☐	☐	☐	☐	☒	☐	☐
Outcome 3	☐	☐	☐	☐	☒	☒	☒	☐
Outcome 4	☐	☐	☐	☐	☐	☒	☐	☐

If any co-benefits have been identified in section B.2(a), fill in the Co-benefit table below to map each co-benefit to the corresponding category as defined in the FP guidance note.

Co-benefit number	Co-benefit					
	Environmental	Social	Economic	Gender	Adaptation	Mitigation
Co-benefit 1: Improved access to sexual and reproductive maternal, and infant health services	☐	☒	☐	☒	☐	☐
Co-benefit 2: Reduced GHG emissions through low-carbon technologies	☒	☐	☐	☐	☐	☐

B.3. Project/programme description (max. 2500 words, approximately 5 pages)

58. The proposed project is designed to **strengthen Togo's national and local capacity to respond to the growing health impacts due to climate change** through an integrated approach that combines institutional strengthening, technological innovation, resilient infrastructure, and community engagement.
59. It targets the three most climate-vulnerable northern regions – Centrale, Kara, and Savanes – covering 16 districts and approximately 2.9 million people. Focusing on the prevention and control of climate-sensitive health outcomes such as malaria, diarrhoeal diseases, the project also addresses the effects of extreme heat on maternal, infant and child health. It delivers systemic resilience and community-level adaptation through a set of interlinked, mutually reinforcing components.
60. Building on the systemic vulnerabilities identified in the Feasibility Study (Annex 2), the project moves beyond isolated interventions in infrastructure, community engagement, or coordination by pursuing an integrated strategy that combines institutional strengthening, data integration, capacity enhancement, and climate-resilient investment activities for a transformative impact. The proposed investments were selected after an option analysis was conducted on alternative technologies assessing among others their feasibility and impact on Environmental and Social Safeguards (ESS) (See Annex 2, Section 5.6, Table 37 and Annex 2c: Construction Study). This approach addresses the interlinked technical, institutional, and financial barriers that constrain the resilience of Togo's health system to climate change. By strengthening interoperability between national systems such as those maintained by ANAMET and the DHIS2, reinforcing governance through the CCUs, and enhancing the reliability of health infrastructure and cold chains, the project establishes a coherent and synergistic framework that builds long-term adaptive capacity and enables scalable national resilience.
61. The project components, outputs, and activities are fully consistent with the financing breakdown (Section C.2), the Results Frameworks (E.5), and the detailed activity descriptions (E.6).

Component 1: Strengthening the surveillance system for climate-sensitive health outcomes

62. This component addresses the infrastructure, institutional, and technical capacity gaps that currently prevent the establishment of proactive health surveillance mechanisms in Togo. By integrating climate and health data, enabling epidemiological forecasting and projections, and integrating these into the existing MHEWS, the system transitions toward predictive, evidence-based risk management. This enables timely interventions and strategic resource allocation while bridging the gap between data collection, analysis, and response. Technical barriers addressed include fragmented data systems, limited predictive modelling capacity, and the absence of climate-health-informed EWS.

Output 1.1: Climate information to support the surveillance system for climate-sensitive health outcomes is effectively integrated

63. This output will address ANAMET's infrastructure, institutional, and human capacity gaps, enabling the use of climate and meteorological data for evidence-based decision-making at the climate and health nexus. The output will improve the climate data collection system by expanding the network with additional Automated Weather Stations (AWS) and rain gauges and ensure the functionality of existing equipment through repair and maintenance. Maintenance response times will be improved through the development of a decentralised maintenance unit in Kara and the establishment of digital maintenance protocols. The output will also strengthen ANAMET's technical, managerial, and functional capacities (in climate and health, monitoring and evaluation (M&E), and financial management to improve its effectiveness and efficiency.

Activity 1.1.1 Improve and expand coverage of the hydrometeorological network in underserved areas

64. This activity aims to improve the availability, reliability, and geographical coverage of real-time meteorological data in Togo by strengthening the national network of observation infrastructure, providing the essential technical foundation for early warning systems. ANAMET sets the technical priorities while the ANPC contributes to site prioritisation based on vulnerability. For equipment and infrastructure under the activity, GIZ, acting as EE, oversees the procurement, construction, and installation of assets. GIZ is also responsible for drafting technical specifications, launching competitive and transparent international or local procurement tenders, and signing contracts. After completion and installation, ownership and maintenance responsibilities are formally transferred to the respective national institutions via co-signed handover protocols. Specifically, ANAMET will fully assume ownership and maintenance responsibilities after a structured transfer process for Automated Weather Stations (AWS) and rain gauges. Initial eligibility criteria for all sub-activities are detailed in Section 5.5 of Annex 2.

65. **Sub-activity 1.1.1.1: Purchase and installation of automated weather stations and rain gauges (EE: GIZ):** Observation capacity will be strengthened through the purchase and installation of 4 of synoptic-grade (SYNOP) AWS (compliant with World Meteorological Organisation (WMO) standards). The AWS will include standard meteorological sensors (temperature, humidity, pressure, wind, and rainfall), and real-time data transmission (General Packet Radio Service or satellite, GPRS), compatible with WMO's OSCAR/Surface and GTS/SYNOP or WIS 2.0 systems. This sub-activity also includes the procurement and installation of 50 rain gauges in underserved areas in the three targeted regions.

66. **Sub-activity 1.1.1.2: Repair and rehabilitation of existing AWS and rain gauges (EE: GIZ):** A technical audit will identify stations in need of rehabilitation, determining necessary repair components (e.g., sensors, modems, power supplies). Based on the audit findings, a prioritised list of interventions will be established, required spare parts will be procured, and technical services initiated. Repair teams will be dispatched to the field, with logistical support of local stakeholders, to carry out on-site rehabilitation. 15 meteorological stations and 82 rain gauges will be repaired.

Activity 1.1.2 Enhance ANAMET's ability to manage automated meteorological data and maintain equipment

67. This activity will strengthen the technical and operational capacities of ANAMET to ensure the sustainable maintenance of equipment, establishing a robust, decentralised system with rapid intervention capability. It will be implemented through the development of a decentralised unit in Kara and a digital solution to rationalise the maintenance and operational hydrometeorological equipment monitoring.

68. **Sub-activity 1.1.2.1: Establishment of a decentralised unit in Kara (EE: ANAMET):** A decentralised technical hub will be established in Kara to improve the maintenance, repair, data collection, and analysis of meteorological stations across the Centrale, Kara, and Savanes regions. The project will support this by constructing a workshop building and outfitting the maintenance workshop with diagnostic and repair equipment and secure spare parts storage.

69. **Sub-activity 1.1.2.2: Establishment of digital maintenance protocols and monitoring of hydrometeorological infrastructure and equipment (EE: ANAMET):** A digital maintenance protocol and monitoring system utilising a comprehensive stocktaking of all existing gear will be established, with technical manuals stored in a centralised digital database and relevant staff will be trained in its operation. The core of this system is a maintenance requirement protocol, informed by equipment profiles (ID, model, purchase date, last maintenance) which will be integrated into a digital action plan detailing specific maintenance, calibration, and corrective actions. It will feature Standard Maintenance Procedures (SMPs) and integrate spare parts stock management with automatic notifications to facilitate proactive planning and procurement.

Activity 1.1.3 Strengthen the capacities of ANAMET to provide climate services for health

70. The activity will ensure that meteorological data are leveraged to inform the health sector's decision-making, strengthening ANAMET's technical and operational capacities to deliver reliable and sector-specific climate services, particularly for public health.

71. **Sub-activity 1.1.3.1: Capacity development and dissemination of climate and health bulletins (EE: ANAMET):** ANAMET staff (from Climatological and Agrometeorological Divisions) will be equipped with specialised knowledge on the Togo-specific climate and health nexus (malaria, diarrhoea, heat impacts). Training will include a dedicated section on risk communication to translate complex data into clear, actionable messages. The sub-activity will support the development of rigorous guidelines and templates for the monthly climate and health bulletins, followed by dedicated support for initial production.

72. **Sub-activity 1.1.3.2: Strengthening of managerial, organisational, and intersectoral coordination capacities (EE: ANAMET):** ANAMET's operational processes, including M&E, ESS, Gender and Sexual Exploitation, Abuse, and Harassment (SEAH) policies, and Financial Management (FM) will be strengthened. The sub-activity will involve hands-on process operationalisation, beginning with a stocktaking of documentation and defining clear roles. Training for ten key ANAMET personnel will cover the practical application of these requirements, including ESS screening tools and SEAH code of conduct/Grievance Redress Mechanisms (GRM), and FM procedures.

Output 1.2: Integrated surveillance outputs are effectively used to guide climate-sensitive health outcome response, especially for vulnerable groups

73. This output establishes the analytical backbone of the climate-resilient health system, ensuring that epidemiological forecasting and projection are generated and translated into actionable insights for HFs and policymakers. It addresses critical baseline weaknesses – fragmented surveillance and the absence of systematic linkages between climate and health data – to enable the transition from reactive management to proactive, risk-informed public health planning.

Activity 1.2.1: Strengthen governance structures to foster an enabling environment for surveillance of climate-sensitive health outcomes

74. This activity strengthens the institutional and technical foundations needed to integrate meteorological and health data into a coherent and adaptable system for epidemiological modelling. It involves a comprehensive landscape analysis, reinforcing the institutional framework through formal agreements (Standard Operating Procedures – SOPs), and creating "digital bridges" (interoperability architecture and pilot integrations) for secure, seamless data exchange.

75. **Sub-activity 1.2.1.1: Conduct a data landscape analysis and institutional mapping (EE: GIZ):** A centralised climate-health data inventory will be created by consolidating datasets from health, meteorology, and other sectors (assessing quality and suitability for modelling). The institutional mapping will clarify governance structures, mandates, and complex information flows among key ministries and agencies (e.g. MSHPCSUA, ANAMET, ANPC). Findings will inform requirements for data sharing agreements and interoperable systems.

76. **Sub-activity 1.2.1.2: Strengthening the institutional set up (EE: GIZ):** Meteorological, health, and socioeconomic data will be institutionally integrated, anticipating future dataset expansion. This entails updating official policy documents and formalising collaboration (MSHPCSUA, ANAMET). The sub-activity will develop new SOPs for clear, consistent data collection workflows.

77. **Sub-activity 1.2.1.3: Strengthening collaboration mechanisms (EE: GIZ):** Coordination mechanisms at both national and sub-national levels will be established, including a Climate & Health Data Sub-Group under the One Health Platform. Four annual workshops between ministries and partners will be held to address interoperability barriers and infrastructure needs, fostering joint ownership for datasets integration.

78. **Sub-activity 1.2.1.4: Establishing the technical interoperability architecture & assurance (EE: GIZ):** The data separation between MSHPCSUA's DHIS2 and ANAMET's climate data will be bridged by establishing technical connections (Application Programming Interfaces - APIs), common standards (data definitions), and strict governance rules. This is enabled by an Interoperability Reference Pack, a Security & Compliance Toolkit (validated with the National Cybersecurity Agency – ANCy and the Independent Authority for the Protection of Personal Data – IPDCP the relevant national agencies), and two pilot integrations (ANAMET data pipeline into DHIS2, and analytics tools embedded in DHIS2 dashboards). To guarantee long-term operational viability, the project will also deliver an Operations & Capacity Pack encompassing monitoring runbooks, service-level agreements (SLAs), and training for national technical staff.

Activity 1.2.2: Leverage integrated surveillance data to create CSHO-specific models that analyse the influence of weather on transmission and inform more effective planning

79. This activity builds on established integrated data systems (1.2.1) to support advanced epidemiological modelling for climate-sensitive health outcomes (malaria, diarrhoea, heat), enhancing the capacity of MSHPCSUA and partners. It focuses on creating and applying of predictive models using climate and health data to forecast CSHO patterns for both the short-term (EWS) and the long-term (strategic) allocation and expands to integrate Antimicrobial Resistance (AMR) surveillance data into DHIS2 under the One Health approach.

80. **Sub-activity 1.2.2.1: Establish academic exchanges and partnerships (EE: GIZ):** The role of Togolese universities (notably West African Science Service Centre on Climate Change and Adapted Land Use - WASCAL and the University of Lomé – UoL) in climate-health modelling will be strengthened through structured academic exchanges and formal Memoranda of Understanding (MoUs) with regional and international partners, creating a locally available pool of expertise.

81. **Sub-activity 1.2.2.2: Strengthen climate- and weather-health modelling capacities (EE: GIZ):** Robust weather-health predictive models for malaria, diarrhoea diseases and heat-related outcomes will be developed. This sub-activity will operationalise two distinct modelling approaches: short-term models (forecasting sub-seasonal/seasonal CSHO surges for immediate intervention) and long-term models (integrating climate projections for future CSHO burden scenarios). All models will be integrated and hosted within the DHIS2 platform.

82. **Sub-activity 1.2.2.3: Enhance interpretation and application of models in real-world settings (EE: GIZ):** A standardised framework for systematically interpreting and validating model outputs against DHIS2 data will be developed to establish thresholds and triggers for action. A dedicated manual of interpretation will be developed and disseminated across MSHPCSUA personnel to strengthen national capacity for continuous model assessment and refinement.

83. **Sub-activity 1.2.2.4: Strengthen AMR data integration into surveillance systems (EE: GIZ):** AMR data integration into DHIS2 will be strengthened by revising existing surveillance tools (human, animal, and environmental) to include AMR indicators alongside climate variables. The DHIS2 platform will be configured for capturing, analysing, and visualising this integrated AMR data, with resulting evidence informing evidence-based MSHPCSUA decision making and systematically fed into the national AMR technical working group (TWG) and the One Health coordination mechanisms.

84. **Sub-activity 1.2.2.5: Develop scale-up roadmap for climate- and weather-health modelling (EE: GIZ):** The scalability of modelling efforts will be ensured by a detailed roadmap to implement epidemiological modelling at a national level. The roadmap will leverage lessons learned from the initial three targeted areas, assess the current state of critical components (data availability, interoperability, analytical capacity), and prioritise investment pathways that maximise the effectiveness of the national modelling platform.

Output 1.3: An EWS for health is used by policymakers, HFs, the general and key vulnerable populations

85. This output ensures the full operationalisation and institutional embedding of the H-EWS, transforming predictive intelligence (from Output 1.2) into timely, validated alerts that drive actionable public health responses. It establishes the governance, technical platform, and communication pathways necessary to deliver clear, equity-sensitive warnings to national decision-makers, HFs, and the most vulnerable communities, thereby integrating health risks into Togo's national MHEWS.

Activity 1.3.1: Strengthen operational arrangements to implement warning services delivery

86. This activity establishes the operational core of Togo's H-EWS, moving the existing system from analysis to action. It focuses on establishing the governance framework and SOPs to define roles, setting and validating the alert thresholds, and developing the digital platform required to automatically generate and route validated alerts seamlessly within the MHEWS infrastructure.
87. **Sub-activity 1.3.1.1: Establishing the governance framework for Health Early Warnings (EE: MSHPCSUA):** The governance and coordination backbone for the H-EWS will be established. Stakeholders (MSHPCSUA, ANAMET, ANPC, Red Cross) will validate their institutional responsibilities through joint workshops. SOPs and technical guidelines will be developed to define the full alert workflow (data input to handover for dissemination), harmonised with the national MHEWS to seamlessly integrate health alerts into national disaster risk management structures.
88. **Sub-activity 1.3.1.2: Defining thresholds and integrating data for health alerts (EE: GIZ):** The operational trigger logic for the H-EWS will be established by defining specific alert thresholds that convert multi-source data into actionable warnings (malaria, diarrhoea, and heat impacts). Thresholds will be defined, validated against historical outbreaks, and embedded in automated algorithms. The sub-activity harmonises and integrates data from surveillance, predictive models (1.2.2) into the H-EWS procedures. The use of vulnerability data ensures alerts are equity-sensitive, targeting high-risk groups.
89. **Sub-activity 1.3.1.3: Developing the digital platform for health alerts (EE: GIZ):** A digital platform necessary for a functional H-EWS will be established for generating and routing alerts. The platform will ensure seamless interoperability between the DHIS2 analysis and the national MHEWS. Automated workflows will manage the entire alert cycle: detecting thresholds, routing alerts through the governance chain (1.3.1.1) for validation, and forwarding them for dissemination (1.3.2).
90. **Sub-activity 1.3.1.4: Building capacity and ensuring sustainability of the H-EWS (EE: MSHPCSUA):** This sub-activity focuses on building the human and institutional capacity essential for sustained H-EWS operation. It involves training national and regional staff on the entire alert cycle, covering data interpretation, threshold validation, and crucial inter-sectoral coordination. Simulation exercises will be conducted to test workflows under realistic conditions, providing critical feedback to refine the governance framework (1.3.1.1).

Activity 1.3.2: Deliver warning messages through multiple communication channels and strengthen response in affected communities

91. This activity addresses the critical gap between national alerts and community action, ensuring warnings are effectively understood and used locally. It develops and operationalises the communication and community-response component of the H-EWS, focusing on transforming national alerts into clear, culturally resonant, and actionable messages that trigger timely protective behaviour.
92. **Sub-activity 1.3.2.1: Co-developing a practical communication approach for Togo's Early Warning System (EE: GIZ):** A practical communication approach will be co-designed with partners such as WASCAL, IDOS and non-governmental organisations (NGOs) and validated through participatory processes (ensuring cultural appropriateness), developing a clear EWS communication strategy and toolkit with message templates and language guidance. Field campaign tests in pilot districts will evaluate comprehension and response timeliness. The final output is a national EWS communication strategy harmonised with the governance framework that will be the operational reference for ANPC, MSHPCSUA, ANAMET, and other relevant stakeholders.
93. **Sub-activity 1.3.2.2: Strengthening community capacity to understand and act on early health warnings (EE: GIZ):** The "last-mile" connection will be strengthened by creating a dedicated gender-sensitive EWS training module integrated into the broader climate-health training package (4.2.2). This module will equip local multipliers (NGOs like the Togolese Red Cross, CHW, local leaders) with essential skills for last-mile communication and rapid community mobilisation while adhering to cultural inclusion and gender standards.

Component 2: Building an enabling environment to increase health sector resilience

94. Component 2 institutionalises climate resilience across Togo's health sector by strengthening governance, policy frameworks, and human capacity. It addresses fragmented intersectoral collaboration, limited technical expertise, and the absence of formal climate-health mandates and dedicated financing mechanisms. By embedding climate-health leadership within existing structures and integrating climate science into training systems, this component ensures that climate-informed decision-making and response capacity are sustained and effectively mainstreamed across all levels of the health system.

Output 2.1: Intersectoral collaboration, accountability, and leadership mechanisms on climate change and health issues is strengthened

95. This output formalises climate-health governance by embedding leadership mechanisms within the MSHPCSUA and decentralising coordination to regional levels. It establishes and operationalises CCUs at the national and regional (within the Regional Health Directorates - RHD) levels. Furthermore, it focuses on partnerships and learning by formalising strategic external collaborations through MoUs with key national agencies (ANAMET, the Ministry of Environment, Forest Resources, Coastal Protection, and Climate Change - MERFPCCC) while integrating the new CCUs into multi-sectoral

platforms like the One Health initiative to ensure continuous knowledge exchange and embed climate risk management across sectors.

Activity 2.1.1: Establish a Climate Change Unit dedicated to health and climate change issues within the MSHPCSUA

96. This activity establishes a dedicated CCU to act as the central coordination body, systematically integrating climate change considerations into the health system. Its key functions include leading adaptation and mitigation strategies, coordinating national efforts, and serving as a liaison with intersectoral partners (MERFPCCC, ANPC). The CCU will also represent Togo in international platforms like the WHO Alliance for Transformative Action on Climate and Health (ATACH). For equipment under the activity GIZ as an EE is responsible for drafting technical specifications, launching competitive and transparent international or local procurement tenders, and signing contracts. After completion, ownership and maintenance responsibilities are formally transferred to MSHPCSUA. Specifically, MSHPCSUA will fully assume ownership and maintenance responsibilities for equipment and material resources for the CCU. Initial eligibility criteria for all sub-activities are detailed in Section 5.5 of Annex 2.
97. **Sub-activity 2.1.1.1: Formal establishment of the CCU (EE: MSHPCSUA):** Following stakeholder consultations, the MSHPCSUA will draft the Ministerial decree and legal/institutional framework to grant the CCU official recognition and a clear mandate. This framework will include a detailed organogram, defined job profiles, ring-fenced a MSHPCSUA budget line, and provision for essential equipment, culminating in the official launch of the fully integrated and operational CCU.
98. **Sub-activity 2.1.1.2: Capacity strengthening of the CCU (EE: GIZ):** The CCU will receive operational, technical, and managerial capacity development based on a comprehensive capacity needs assessment (including a KAP survey). The training will target CCU staff, MSHPCSUA directorates, and key sectoral partners (ANAMET, ANPC) through modular sessions, mentoring, and regional peer exchanges, focusing on climate-health knowledge, adaptive management, and multi-sectoral coordination.
99. **Sub-activity 2.1.1.3: Operational and strategic partnerships (EE: GIZ):** Collaborations through MoUs and cooperation protocols with key national (ANAMET, ANPC, MERFPCCC) and regional (e.g., West African Health Organisation - WAHO) actors will be formalised. The developed partnership coordination mechanism will ensure the CCU operates within a strong collaborative ecosystem, leveraging external expertise and aligning with national and international climate-resilient health systems agendas.
100. **Sub-activity 2.1.1.4: Provision of equipment and material resources for the CCU (EE: MSHPCSUA):** Based on a needs assessment, all necessary office infrastructure and specialised equipment will be procured and installed, including IT hardware and equipment to enable timely field access, supervision, and rapid response to remote, hard-to-reach areas during emergencies.

Activity 2.1.2: Establish 5 CCUs in the Regional Health Directorates

101. The activity will decentralise climate-health governance in Togo by establishing five regional CCUs within the RHDs. These regional CCUs will act as operational hubs, staffed and equipped to translate national strategies into local action, guiding Health Districts, health facilities and CHWs in implementing climate-sensitive activities. They will serve as key coordination points with partners like ANAMET and ANPC on EWS ensuring the systematic integration of adaptation into regional health planning. Site selection criteria are detailed in Section 5.5. – Annex 2. DISEM will prepare and screen regional lists of centres, while the final prioritisation will be conducted jointly by DISEM, GIZ, the Project Steering Committee (PSC), and regional representatives, ensuring a participatory, evidence-based, and needs-driven selection process.
102. **Sub-activity 2.1.2.1: Institutional set up and operationalisation of Regional CCUs (EE: MSHPCSUA):** The legal and institutional establishment and official launch of regional CCUs within the five RHDs will be supported. A regional CCU framework (aligned with the national CCU structure), will be developed and validated, including mandates, staffing, SOPs, and coordination frameworks. Each CCU will be embedded in existing regional planning mechanisms, and formal approval from the relevant ministries - MSHPCSUA, Ministry of Finance and Budget (Ministère des Finances et du Budget, MFB), will ensure legal status and integration into performance-based management systems.
103. **Sub-activity 2.1.2.2: Capacity building and technical support (EE: GIZ):** Tailored capacity development will strengthen the technical, managerial, and operational capacities of regional CCUs. Structured training programmes will cover climate-health fundamentals, regional climate risk assessments, data management, disaster risk reduction (DRR) coordination, One Health integration, and climate-health surveillance. Heads of CCUs will receive tailored coaching and all activities will include cross-cutting themes such as gender and SEAH, equity, and culturally appropriate community engagement.
104. **Sub-activity 2.1.2.3: Provision of operational tools and equipment (EE: MSHPCSUA):** CCUs will be equipped with the necessary tools, communication equipment based on regional risk profiles and operational needs. Packages include IT infrastructure, epidemiological surveillance and data tools, and basic emergency response kits. Maintenance plans and equipment use protocols will also be provided.

Activity 2.1.3: Strengthen national and sub-regional coordination, knowledge, and learning mechanisms

105. The activity institutionalises coordination, learning, and knowledge-sharing on climate and health at a national level. It strengthens the capacity of the national and regional CCUs to engage effectively in multi-sectoral national, regional and global health platforms, reinforcing Togo's engagement in key bodies like Economic Community of West African States (ECOWAS), WAHO, and WHO's ATACH to secure ownership, coherence, and sustainability.
106. **Sub-activity 2.1.3.1: Strengthening MSHPCSUA and CCU's strategic engagement in national multi-sectoral platforms (One Health, National Adaptation Committee) through institutional mapping, role clarification, and technical support (EE: GIZ):** The MSHPCSUA and its CCUs will be supported in their strategic participation in key national coordination platforms, including the One Health Platform and the National Adaptation Committee. A Strategic Engagement Plan will be developed and validated to formalise roles and policy influence, guiding sustained cross-sectoral collaboration and ensure that climate-health becomes a sustained national policy and research priority.

107. Sub-activity 2.1.3.2: Organisation and/or participation in inclusive national, regional, and international conferences, negotiations and fora (EE: GIZ): Togo's role in global climate-health dialogues will be enhanced by supporting inclusive national forums and facilitating strategic participation in high-level international events like United Nations Framework Convention on Climate Change – UNFCCC's Conference of the Parties – COP, WHO's ATACH, Clim-HEALTH Africa. At the national level, it will convene technical and research-policy workshops, involving government, academia, Civil Society Organisations (CSOs) (including youth and women), and the private sector. Technical support will be provided to national delegates to ensure high-quality, policy-aligned contributions to global agendas.

108. Sub-activity 2.1.3.3: Promotion of regional knowledge exchange and joint learning (EE: MSHPCSUA): Togo's position as a regional hub for climate-health knowledge exchange will be supported. It will facilitate South-South cooperation, support the documentation and dissemination of national lessons learned, and organise joint learning missions with peer countries to exchange good practices and co-develop adaptation approaches.

Output 2.2: Capacities of the health system to react to climate-sensitive health problems are built

109. This output contributes to the project scaling-up and sustainability by establish a sustainable national pipeline of climate-health expertise. It focuses on institutionalising advanced knowledge through developing a Climate and Health Master's Programme at the WASCAL and integrating related modules into midwifery and medical assistant curricula. Moreover, it supports continued learning of the existing workforce, health professionals and CHW in essential skills like interpreting climate-health bulletins, validating EWS alerts, and applying response protocols at both HF and community levels.

Activity 2.2.1: Develop and implement climate and health training programmes

110. This activity will create a comprehensive, integrated formal education ecosystem for climate and health. It will establish a Master's Programme in Climate Change and Health at the WASCAL while integrating the health impacts of climate change into medical curricula. All components promote intersectoral and participatory research and ensure the integration of gender, One Health, and AMR principles.

111. Sub-activity 2.2.1.1: Develop a Climate and Health Master's programme (EE: GIZ): A Master's Programme in Climate Change and Health at WASCAL will be established by supporting curriculum development, institutionalisation, faculty training, and student scholarships. In parallel, WASCAL will receive help to mobilise additional funding and strengthen its regional networks. The programme will guarantee relevance by aligning student research with national and regional climate-health priorities.

112. Sub-activity 2.2.1.2: Adapt medical support curricula by integrating climate change and health (EE: GIZ): Pre-service medical training curricula will be updated to systematically integrate climate-health linkages, AMR, and the One Health approach across national training institutions (School for Medical Assistants, National Schools for Medical Auxiliaries and National Schools for Midwives). Curricula, teaching methods, and learning materials will be reviewed and updated in close collaboration with WAHO focal points and national stakeholders. Teaching staff will be trained to apply the updated content and pedagogical approaches to strengthen effective delivery across institutions.

113. Sub-activity 2.2.1.3: Promote intersectoral and participatory research on climate and health, encouraging collaboration between academic, governmental, and community actors (EE: GIZ) Intersectoral and participatory research will be fostered by strengthening collaboration among academic institutions, government agencies, and community stakeholders. Participants will be sponsored to attend key conferences and organise national conferences in Togo to stimulate regional dialogue, consolidate multi-sectoral partnerships, and generate collaborative research initiatives.

114. Sub-activity 2.2.1.4: Support for research proposal submissions (EE: GIZ): A dedicated capacity-building programme will provide hands-on technical support to researchers and professionals to design, write, and submit high-quality, interdisciplinary research proposals on climate and health, with emphasis on mobilising resources from relevant grant opportunities (such as Wellcome Trust).

Activity 2.2.2: Build technical capacities of key actors in the health sector in the prevention and management of climate-sensitive health outcomes through training

115. This activity strengthens the technical capacity of health professionals and CHW to anticipate, prevent, and manage CSHOs. It operationalises the use of climate and health data across all levels of the health system through an integrated, blended learning approach that combines in-person and digital formats to maximise reach and promote sustainable learning.

116. Sub-activity 2.2.2.1: Developing innovative blended learning formats (EE: GIZ): Interactive eLearning modules and blended training formats will be developed to make climate-health education accessible and continuous. Courses will be hosted on a national digital platform, piloted and refined based on feedback. Materials and maintenance guides will be formally transferred to national partners to ensure long-term adaptability and use.

117. Sub-activity 2.2.2.2: Training national and regional health personnel (EE: GIZ): National and regional health staff will be trained to integrate climate data into CHSO surveillance and health planning. Training will combine classroom and online learning with practical exercises, case studies, and scenario planning, supported by mentoring and peer-learning networks to ensure integration of climate data into routine health surveillance.

118. Sub-activity 2.2.2.3: Training community health workers (EE: MSHPCSUA): CHWs' ability to detect, report, and respond to climate-sensitive health outcomes will be strengthened using climate-health bulletins (sub-activity 1.1.3.1) and local risk information. Training will combine short in-person sessions with mobile-based learning modules adapted to literacy levels.

Component 3: Climate-resilient and low-carbon infrastructures, technologies, and supply chain

119. Component 3 focuses on strengthening the core infrastructure and operational capacity of health service delivery of Togo's health system to withstand and adapt to climate shocks (heat stress, heat-related supply disruptions). It ensures that HFs remain functional and sustainable through climate-resilient construction, energy-efficient technologies, and robust

maintenance and supply systems. By integrating low-carbon solutions and digital tools into infrastructure and logistics, this component enhances the continuity of essential services, particularly for women, children, and vulnerable populations in climate-sensitive regions.

Output 3.1: The resilience of health infrastructure is strengthened

120. This output enhances the resilience and functionality of Togo's health infrastructure by embedding climate adaptation, preventive maintenance, and sustainability principles into the national health system. It improves water and energy resilience, thermal comfort, and protection from vectors through the rehabilitation, extension, and construction of climate-resilient facilities.

Activity 3.1.1: Improve health infrastructures to increase resilience (water-related, heat-related, vector-related health outcomes)

121. This activity strengthens the climate resilience of up to 15 USPs-I and USPs-II in Centrale, Kara, and Savanes through integrated adaptation measures addressing water-, heat-, and vector-related health risks. It includes the rehabilitation, extension, or construction of facilities (including maternity and neonatal wards) with climate-adapted and gender-sensitive designs. The activity contributes to integrating resilience standards into national norms and builds local construction capacity. For equipment and infrastructure under the activity GIZ as an EE is responsible for drafting technical specifications, launching competitive and transparent international or local procurement tenders, and signing contracts. After completion and installation of equipment, ownership and maintenance responsibilities are formally transferred to MSHPCSUA. Specifically, MSHPCSUA will fully assume ownership and maintenance responsibilities for rehabilitated and newly constructed wards in USP I and II, and the procured health facility equipment. Initial eligibility criteria for all sub-activities are detailed in Section 5.5 of Annex 2.

122. **Sub-activity 3.1.1.1: Consolidation of infrastructure norms and co-revision of health facilities' master plans (EE: GIZ):** National guidelines for climate-resilient health infrastructure (integrating standards for water-, heat-, and vector-borne CSHO resilience) will be developed through co-development workshops with experts and national authorities. The resulting framework and master plans guide all new construction and retrofitting.

123. **Sub-activity 3.1.1.2: Assessment and selection of health facilities (EE: GIZ):** HFs will be prioritised for rehabilitation or construction using jointly agreed technical, social, and climate criteria. Site selection will ensure maximum impact, considering vulnerability, accessibility, population demand, and infrastructure condition. The process will be participatory and evidence-based, involving the Direction of Health, Infrastructure, Equipment, and Maintenance (DISEM), GIZ, and regional representatives, with a list of eligible facilities and a clear prioritisation framework to guide investments as the outcome.

124. **Sub-activity 3.1.1.3: Capacity building on construction techniques and resilience measures (EE: GIZ):** Hands-on training for local workers and artisans in resilient construction techniques, targeting communities near project sites, will be developed and delivered. This will contribute to build a pool of skilled labour in electrical, solar, water, sanitation, and general construction trades, with a focus on women's participation.

125. **Sub-activity 3.1.1.4: Rehabilitation of health facilities and construction of resilient maternity blocks in USP-I and II (EE: GIZ):** Construction and rehabilitation works, using low-emission construction material, will deliver fully functional facilities able to withstand water-related impacts (together with partners such as BORDA), heat and vector risks, following national standards and utilising participatory oversight (DISEM, GIZ, community management committees – COGES).

126. **Sub-activity 3.1.1.5: Procurement of health facility equipment (EE: GIZ):** Upgraded facilities will be equipped with standardised, high-quality technical equipment. End-users will receive training in safe and effective equipment use, and all assets will be integrated into maintenance plans (3.1.2).

Activity 3.1.2: Maintain health infrastructure to increase resilience

127. This activity strengthens the institutional, human, digital, and financial foundations for maintaining health infrastructure and biomedical equipment, ensuring the long-term functionality and climate resilience of HFs. Aligned with the National Strategy for the Maintenance of Health Infrastructure and Equipment (2025-2030), the activity translates strategic intent into practical, operational reforms that strengthen governance, empower Regional Maintenance Centres (RMCs), and professionalise the maintenance workforce.

128. **Sub-activity 3.1.2.1: Strengthening gender transformative professional training and in-service training (EE: GIZ):** This sub-activity enhances pre-service and in-service systems to develop a skilled, gender-inclusive maintenance workforce. A new polyvalent "Health Maintenance Skills" module (covering electricity, plumbing, refrigeration, and basic biomedical maintenance) will be developed, institutionalised, and integrated into the Technician's Certificate curriculum, in collaboration with national training institutions. It will be piloted in three training centres to certify technician students for inclusion in a national technician registry. Concurrently, an in-service capacity building programme will strengthen maintenance competencies in HFs, offering regional refresher training for biomedical engineers and on-site sessions for end-users. A national recognition framework will be introduced to institutionalise professional standards and promote gender-balanced participation in the health maintenance workforce.

129. **Sub-activity 3.1.2.2: Strengthening partnership engagement for maintenance (EE: MSHPCSUA):** Collaboration between the public sector, private health providers, and biomedical industry actors will be strengthened to improve sustainability of maintenance services. It will begin with a diagnostic of existing and potential public-private partnerships (PPP), followed by the creation of a multi-actor task force to define strategic directions and engagement modalities. These partnerships are expected to enhance local technical capacity and promote shared responsibility for quality maintenance.

130. **Sub-activity 3.1.2.3: Support gender transformative and climate-sensitive operationality of maintenance in the health facilities (EE: GIZ):** Three RMCs will be operationalised as functional hubs for the national maintenance system. The centres will be equipped with diagnostic tools, spare parts, information systems, and logistics support, enabling them

to coordinate, plan, and execute maintenance interventions, including cold chain systems. In addition, a national quality monitoring and supervision framework will be developed to institutionalise continuous improvement and accountability. Eligible health facilities will need to be located in the targeted areas, have a validated maintenance plan, have designated maintenance focal points, and be up to date with contributions to the regional maintenance fund (please also see Annex 2 – Section 5.5).

131. **Sub-activity 3.1.2.4: Support digitalisation of maintenance processes (EE: GIZ):** A national Computerised Maintenance Management System (CMMS) will be established to manage operations across infrastructure and biomedical equipment. The platform will integrate equipment inventories, maintenance schedules, and performance indicators into a single digital dashboard. Training programmes and user guides will be provided to ensure long-term sustainable use of the platform.
132. **Sub-activity 3.1.2.5: Support a financing mechanism for the Regional Maintenance Fund (EE: MSHPCSUA):** A financing mechanism for the maintenance of health infrastructure and equipment will be established through the operationalisation of the Regional Maintenance Fund (RMF). Under the framework of the National Strategy for Maintenance of Health Infrastructure and Equipment 2026-2030,⁷⁸ key actions include developing the regulatory framework, establishing a transparent governance structure, mobilising diversified resources, and implementing a digital platform for fund monitoring. A pilot phase will test the mechanisms in selected regions, generating evidence to inform national scale-up. Ultimately, this will ensure predictable financing for maintenance activities, helping maintain the long-term functionality and climate resilience of health infrastructure.

Output 3.2: Prevention and treatment of CSHOs through resilient supply chains is enhanced

133. This output strengthens the ability of Togo's health system to prevent and treat CSHO by ensuring that essential vaccines, diagnostics, and medicines remain available, potent, and accessible even under climate stress. It establishes low-carbon, climate-resilient supply chains; integrates reliable cold chain and logistics systems; and improves diagnostic, treatment, and laboratory capacity to manage malaria, diarrhoeal diseases, and maternal emergencies.

Activity 3.2.1: Strengthen cold chains for vaccines, climate-sensitive medicines and diagnostics

134. This activity aims to ensure that Togo's health system can safely store, transport, and monitor vaccines, diagnostics, and climate-sensitive medicines, including the new R21 malaria vaccine. The activity will upgrade stationary cold chain infrastructure, expand modern and low-emission transport, and integrate real-time monitoring with the national electronic Logistics Management Information System (e-LMIS). For equipment under the activity, GIZ as an EE is responsible for drafting technical specifications, launching competitive and transparent international or local procurement tenders, and signing contracts. After appropriate installation or integration, ownership and maintenance responsibilities are formally transferred to MSHPCSUA. Specifically, MSHPCSUA will fully assume ownership and maintenance responsibilities for cold chain and energy infrastructure, and cold chain transport equipment. Initial eligibility criteria for all sub-activities are detailed in Section 5.5 of Annex 2.
135. **Sub-activity 3.2.1.1: Survey and strengthen cold chain and energy infrastructure (EE: GIZ):** Cold chain assets will be inventoried from national to community levels, assessing climate risks and registering them in the DHIS2-based system. Selected sites will be equipped with solar-powered refrigerators/freezers, voltage stabilisers, and hybrid PV-battery systems. A cloud-connected temperature-monitoring system will provide real-time alerts, and reference laboratories will receive solar backup and integrate into the monitoring platform.
136. **Sub-activity 3.2.1.2: Improving cold chain transport and distribution of medicine products (EE: GIZ):** Modernised transport will ensure safe last-mile delivery. High-performance cold chain backpacks, climate-friendly vehicles, and electric motorcycles will be deployed with reusable thermos-loggers connected to the cloud platform. Drivers and logistics staff will be trained on packing, temperature control, safe operation, and battery care, with site-level charging and maintenance routines established.
137. **Sub-activity: 3.2.1.3: Support to national e-LMIS roll-out (EE: MSHPCSUA):** By supporting the transition from paper-based systems to a fully functional e-LMIS, this sub-activity will strengthen Togo's health supply chain. It will finance core digital infrastructure and a phased roll-out prioritising climate-vulnerable HFs and ensuring interoperability with cold-chain data. Training will build national capacity for system management, improving stock visibility, reducing losses, and supporting more climate-resilient delivery. Initial eligibility criteria for the training are detailed in Section 5.5. – Annex 2.

Activity 3.2.2: Strengthen surveillance and monitoring of climate-sensitive health outcomes

138. This activity aims to enhance Togo's surveillance system for CSHOs by expanding and diversifying sentinel sites, piloting fever clinics, and improving the data quality. It integrates epidemiological, entomological, parasitological, and climatological monitoring to enable earlier detection, better analysis, and targeted responses to malaria, diarrhoeal diseases, and emerging febrile illnesses. The PNLP and the Directorate for Disease Control (DLM) lead the coordination, technical guidance, and site selection. For equipment under the activity GIZ as an EE is responsible for drafting technical specifications, launching competitive and transparent international or local procurement tenders, and signing contracts. After appropriate installation or integration, ownership and maintenance responsibilities are formally transferred to MSHPCSUA. Initial eligibility criteria for all sub-activities are detailed in Section 5.5 of Annex 2.
139. **Sub-activity 3.2.2.1: Extension of epidemiological sentinel sites for malaria (EE: MSHPCSUA):** The network of malaria sentinel sites will be expanded to additional HFs across diverse ecological zones. Sites will be equipped for weekly case reporting, and staff will be trained in data collection, trend analysis and diagnostic quality assurance.
140. **Sub-activity 3.2.2.2: Expansion towards entomological and parasitological sentinel sites for malaria (EE: MSHPCSUA):** Selected sites will monitor mosquito populations, species variation, and insecticide resistance, while

⁷⁸ MSHPCSUA (2025). *National Strategy for Maintenance of Health Infrastructure and Equipment 2026-2030*.

reinforcing parasite surveillance. Technicians and laboratory staff will be trained to conduct routine vector and parasite monitoring, with data feeding into national surveillance systems for resistance tracking.

141. **Sub-activity 3.2.2.3: Expansion toward climatological sentinel sites for diarrhoeal diseases (EE: MSHPCSUA):** Sentinel sites will monitor environmental and ecological factors, such as rainfall, temperature, and water quality, alongside disease trends. Health and environment officers will be trained to interpret these data and integrate them with diarrhoeal disease and AMR monitoring. Environmental sensors and standardised reporting will link local observations to national DHIS2 and early warning platforms.
142. **Sub-activity 3.2.2.4: Pilot of fever clinics in sentinel sites (EE: MSHPCSUA):** Fever clinics will be established in selected sentinel facilities to triage febrile patients and strengthen the detection of malaria, dengue, typhoid, and emerging infectious diseases. Personnel will be trained in case management and syndromic surveillance, contributing to real-time monitoring and support the national EWS.
143. **Sub-activity 3.2.2.5: Strengthening of monthly data quality reviews at district and regional levels (EE: GIZ):** District and regional teams will receive coaching, digital tools, and simplified support aids to improve routine data quality, analysis, and reporting. Monthly review meetings will consolidate lessons, identify gaps, and build analytical capacity.

Activity 3.2.3: Strengthen diagnostic and treatment of climate-sensitive health outcomes

144. This activity aims to improve access to accurate diagnostics and effective treatment for climate-sensitive health outcomes, including maternal emergencies. It strengthens laboratory systems, introduces rapid and confirmatory diagnostics, integrates climate-resilient treatments, and modernises supply and laboratory information systems.
145. **Sub-activity 3.2.3.1: Institutionalise diagnostics and strengthen laboratory systems for climate-sensitive health outcomes (EE: MSHPCSUA):** The use of rapid diagnostic tests and confirmatory microscopy will be expanded across USPs, reinforcing laboratory quality systems, and establishing molecular testing for antimalarial resistance and AMR. It will update national diagnostic algorithms, linking laboratory outputs to DHIS2 for surveillance and early warning.
146. **Sub-activity 3.2.3.2: Strengthening access to essential medicines and preventative service (EE: MSHPCSUA):** Climate-resilient treatments, such as heat-stable carbetocin for maternal health and ORS and zinc for diarrhoeal disease will be promoted. Health workers will be trained, and pharmacovigilance systems established to improve treatment effectiveness, reduce climate-related morbidity.
147. **Sub-activity 3.2.3.3: Regional access to essential climate-relevant medicines (EE: GIZ):** Efforts will focus on strengthening reliable and affordable access through progress towards multi-year supply agreements with African manufacturers and enhanced collaboration within ECOWAS pooled procurement mechanisms.

Component 4: Enhancing community adaptation and engagement

148. Component 4 brings the project's system-level investments to life at the community level, fostering locally led adaptation and social resilience. It empowers households, community structures, and local authorities to understand, anticipate, and respond to climate-health risks. By improving access to safe water, sanitation, and vector control, and by promoting behaviour change and social mobilisation, it directly reduces the incidence of climate-sensitive health outcomes. The component strengthens community governance and participation, ensuring that adaptation measures are inclusive, gender-responsive, and sustained through local ownership.

Output 4.1: Improve community infrastructure to be more resilient to water-related climate-sensitive health outcomes

149. This output strengthens the resilience of communities in Centrale, Kara, and Savanes against water-, vector-, and climate-related health risks by improving WASH systems and supporting integrated malaria control. It combines investments in climate-resilient water and sanitation infrastructure in schools and kindergartens with capacity-building to ensure sustainable management and adoption of hygiene and vector-control practices.

Activity 4.1.1: Improve community infrastructure to be more resilient to water-related climate-sensitive health outcomes

150. This activity aims to strengthen the resilience of schools and kindergartens in the target regions against water-related health risks by improving WASH systems. It integrates clean water access, climate-resilient sanitation, and hygiene promotion to reduce CSHO exposure and enhance community health, aligning with broader health infrastructure investments (3.1.1). The GIZ, MEN and local communities will select sites according to their proximity with prioritised HFs, high student populations and demonstrated critical gaps in water and sanitation services. For equipment under the activity, GIZ as an EE is responsible for drafting technical specifications, launching competitive and transparent international or local procurement tenders, and signing contracts. After appropriate completion and installation, ownership and maintenance responsibilities are formally transferred to Ministry of Education (MEN). Specifically, MEN will fully assume ownership and maintenance responsibilities for rehabilitated water supply systems in schools and improved sanitation facilities in schools. Initial eligibility criteria for all sub-activities are detailed in Section 5.5 of Annex 2.
151. **Sub-activity 4.1.1.1: Rehabilitate water supply systems in schools (EE: GIZ):** Climate-resilient water supply systems will be rehabilitated or installed. Boreholes will be equipped with hybrid solar and manual pumps, elevated storage tanks, and connections to sanitation blocks, prioritising schools with the greatest need and integrating climate-smart design features.
152. **Sub-activity 4.1.1.2: Implement improved sanitation facilities in schools (EE: GIZ):** Together with partners such as BORDA, outdated latrines will be replaced with modular, precast sanitation blocks designed to be safe, inclusive, and climate resilient, including gender-sensitive features and menstrual hygiene provisions.
153. **Sub-activity 4.1.1.3: Build capacity for WASH infrastructure management in schools (EE: GIZ):** Institutional capacity for sustainable operation and maintenance of school WASH infrastructure will be strengthened. This sub-activity will define clear management roles, develop practical tools, and deliver training for school and municipal actors, ensuring integration into local governance frameworks.

154. **Sub-activity 4.1.1.4: Promote WASH innovations for community behaviour change (EE: GIZ):** Hygiene, sanitation, and menstrual health practices will be promoted through awareness campaigns and market-based approaches. This sub-activity will foster partnerships with local private actors to distribute affordable, innovative WASH products, supporting lasting behaviour change and health resilience. The activity will be carried out with partner such as DMI and Lionne.

Activity 4.1.2: Strengthen community engagement and local government capacity for integrated health, sanitation, and malaria control interventions

155. This activity enhances the capacity of local governments and communities to plan, coordinate and implement integrated health, sanitation, and malaria control actions. Efforts focus on reinforcing local governance, participatory planning, promoting environmentally safe vector control, and ensuring sustainable management of WASH infrastructure.

156. **Sub-activity 4.1.2.1: Pilot innovative and environmentally safe-anti-larval intervention (EE: GIZ):** Integrated, eco-friendly approaches will be trailed to reduce mosquito breeding. In partnership with local NGOs like the Togolese Red Cross, CHWs will be trained in larval source management, and the promotion of repellent plants (e.g. citronella) households will test the introduction of affordable mosquito screens, developed with local producers.

157. **Sub-activity 4.1.2.2: Develop or update communal hygiene and sanitation plans incorporating malaria prevention and control (EE: GIZ):** Local governance will be strengthened by supporting municipalities to develop or update communal plans that integrate vector control measures. A participatory approach will support the identification of sanitation gaps and map breeding-risk zones, serving as key tools for resource mobilisation and intersectoral integration.

158. **Sub-activity 4.1.2.3: Strengthen communal coordination of health, sanitation, and vector control interventions (EE: GIZ):** Communal mechanisms for coordinated implementation will be reinforced. Local health committees will monitor infrastructure, while municipal teams (supported by the National Institute of Hygiene) conduct joint water-quality monitoring. Coordination with CCUs (4.2.1) will ensure that local actors have both the mandate and skills to sustain integrated interventions.

Output 4.2: Community awareness and understanding of climate-health linkages are enhanced

159. This output establishes an integrated, evidence-based communication ecosystem that connects national strategies with community realities. By strengthening the foundations for Social and Behavioural Change (SBC) (4.2.1), building the capacity of trusted local multipliers (4.2.2), and scaling inclusive mass communication campaigns (4.2.3), the project will empower households to understand, anticipate, and act on climate-sensitive health risks, fostering ownership and sustained community resilience.

Activity 4.2.1: Develop communication messages, tools, and channels for different key populations to alert them on climate induced changes to health risks

160. This activity will revise and extend Togo's SBC Climate and Health Toolkit, ensuring it is inclusive, linguistically accessible, and adaptable. It will strengthen national communication on climate-health risks through participatory evaluation, translation into local languages, and ongoing monitoring.

161. **Sub-activity 4.2.1.1: Evaluate and refine the SBC Strategy and Toolkit (EE: GIZ):** An independent participatory evaluation of the developed SBC Strategy will be conducted with partner institutions such as IDOS, frontline multipliers, and communities. Findings will improve usability, cultural relevance, and behavioural impact, serving as a validated national reference.

162. **Sub-activity 4.2.1.2: Develop a translation and communication guide for climate-health concepts (EE: GIZ):** A guide will be produced to make climate-health messages clear and culturally resonant across Togo's main languages in consistence with Annex 6c Local Communities Plan (LCP). In collaboration with partners such as the University of Kara, participatory workshops with linguists and community representatives will co-create local expressions, metaphors, and pre-translated early warning messages.

163. **Sub-activity 4.2.1.3: Evaluate, monitor impact, and adapt the SBC Climate and Health Strategy: (EE: GIZ):** A framework to monitor communication reach, behavioural change, and message effectiveness will be established with partners such as WASCAL and IDOS. Regular feedback will guide annual reviews and updates to keep the SBC Strategy adaptive and aligned with evolving climate-health risks.

Activity 4.2.2: Strengthen the capacities of multipliers at community level on the links between climate change and health

164. This activity will equip community-level multipliers (CHWs, teachers, religious leaders, and CSOs) with the knowledge and tools to communicate climate-health risks and promote adaptive behaviour. Multipliers will be trained to deliver locally relevant, culturally resonant message, integrating EWS-linked communication for timely community mobilisation. See Section 5.5 on initial eligibility criteria in Annex 2 – Feasibility Study for more information on the selection criteria for the community-level multipliers.

165. **Sub-activity 4.2.2.1: Develop and deliver localised training programme for community-level multipliers on climate-health risks (EE: MSHPCSUA):** Participatory, practice-based training programmes will build technical knowledge (malaria, diarrhoea, including the promotion of exclusive breastfeeding as a key preventive measure, heat stress, maternal, infant and child health, WASH-related illnesses) and communication skills. Training modules will use methods like storytelling and interactive drama for low-literacy audiences. A Training-of Trainers (ToT) component will create a regional cadre to sustain capacity building.

166. **Sub-activity 4.2.2.2: Develop and provide multipliers with tailored communication materials and tools to engage their communities (EE: GIZ):** Together with partner such as the University of Kara and DMI, a modular, audience-specific

communication toolkit will be produced (flipcharts, posters, comics, audio scripts), adapted into three local languages using co-developed metaphors. Toolkit user trainings and distribution will be carried out with NGOs like the Togolese Red Cross.

167. **Sub-activity 4.2.2.3: Coordinate and implement interpersonal communication campaigns through multipliers (EE: MSHPCSUA):** Structured interpersonal communication (IPC) campaigns will be established using trusted methods (home, visits, school sessions), coordinated through established regional Community SBC Communication (SBCC) Action Plans (8 plans developed) to ensure aligned outreach. Four community sensitisation campaigns will be implemented annually, with at least one campaign directly linked to the EWS (1.3.2) to facilitate rapid community mobilisation against climate-sensitive health risks. Field usability testing and structured feedback will be carried out with partners such as WASCAL or IDOS.

Activity 4.2.3: Raise awareness through different communication channels to encourage behaviour change and strengthen ownership of community members

168. This activity will enhance national awareness of climate-induced health risks and promote protective behaviours through an inclusive, multi-channel communication campaign. Using both traditional and digital media, it will translate complex technical information into engaging messages that empower communities to act, supported by feedback loops to refine messages over time. This activity will be carried out with partners such as DMI.
169. **Sub-activity 4.2.3.1: Storyboarding, production, and pre-testing of campaigns (EE: GIZ):** One integrated communication campaign will be designed, produced and pre-tested. All campaign materials will undergo pre-testing and be adapted into local languages to ensure cultural resonance and accessibility across diverse groups. To ensure critical coordination, there will be links to the EWS for rapid activation, and alignment with WASH communication priorities (4.1.1) for integrated public health messaging.
170. **Sub-activity 4.2.3.2: Rollout, monitoring, and adaptive feedback (EE: GIZ):** The integrated campaign will be disseminated through coordinated traditional and digital channels (partnerships with radio stations, digital platforms, community networks). Annual monitoring and evaluation will assess message reach, recall, and behavioural impact, feeding lessons into update SBC materials.

B.4. Implementation arrangements (max. 1500 words, approximately 3 pages plus diagrams)

B.4.1 Project management, implementation and execution structure

Role of GIZ as Accredited Entity (AE)

171. In its capacity as an AE, GIZ will assume oversight responsibility of the project, as defined in the Accreditation Master Agreement (AMA) between the GCF and GIZ. GIZ will administer project proceeds on behalf of the GCF and will provide oversight, guidance, and quality assurance of ANAMET and MSHPCSUA as Executing Entities (EEs) through its relevant head office units, as well as accompany monitoring and ensure regular reporting.
172. In order to implement the project, GIZ will enter into the following legal arrangements (see
173. *Figure 10*):
- The commission by the German Federal Ministry for Economic Cooperation and Development (BMZ) to implement the GCF project.
 - The Funded Activity Agreement (FAA) between GCF and GIZ as the basis for the transfer of GCF proceeds to GIZ.
 - Grant agreements (i.e. subsidiary agreements) with MSHPCSUA and ANAMET (as Executing Entities) based on GIZ's standard operating procedures for grant agreements.
 - The grant agreements will also secure the co-financing of the Government of the Togolese Republic channelled through MSHPCSUA and ANAMET.
 - An internal task assignment from GIZ AE to GIZ EE for the implementation of the project.
 - Grant agreements with other partners as required for the implementation of the project activities equally based on GIZ's standard operating procedures for grant agreements.

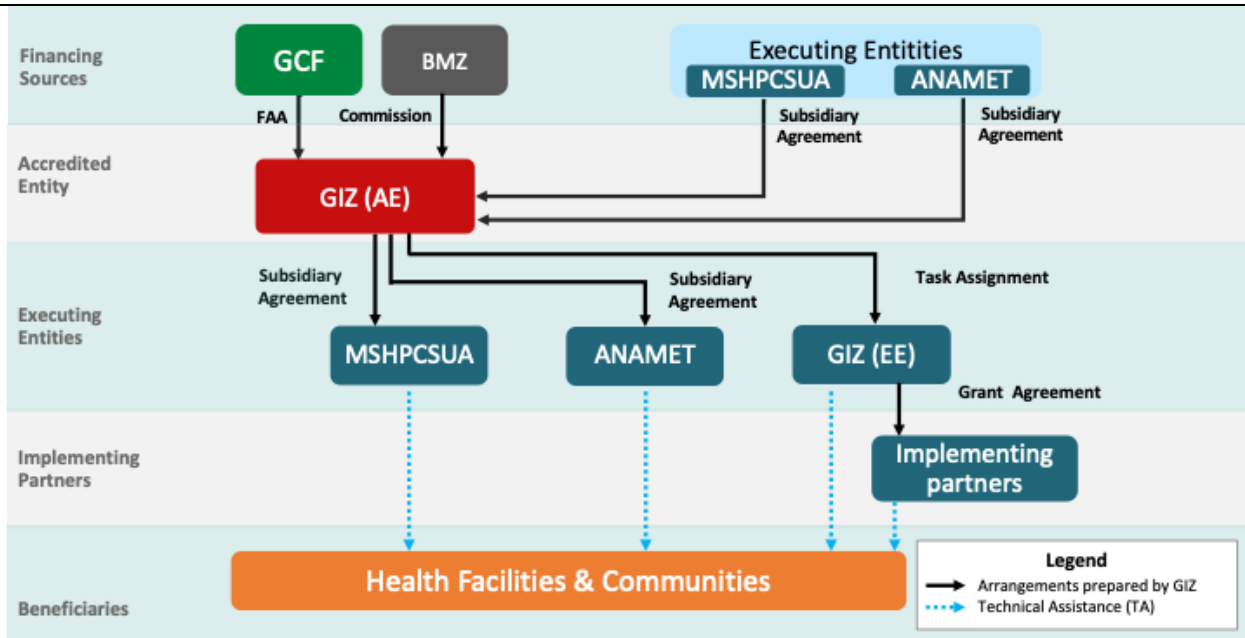


Figure 10: Legal arrangements

Role of GIZ as an Executing Entity

174. GIZ has been operating in Togo since 2012 and currently employs approximately 286 staff members, most of them being Togolese nationals. GIZ technical assistance in the four sectors amounts to around EUR 352 million (2012-2025). In its capacity as an EE, GIZ will lead and provide overall management of the Technical Assistance (TA) to the Project at the national and sub-national levels. It will be responsible for:

- Managing the project budget of GIZ (EE);
- Liaising with the GIZ Togo Office based in Lomé regarding budget and finances, monitoring and reporting, staff and appraiser contracts;
- Reporting to BMZ regarding the Ministry's financial contributions to the project, as well as the overall progress of project implementation;
- Coordinating project implementation with the co-financing development partners and their projects and counterparts, as well as other donors and projects operating in the same technical and/or geographical area;
- Liaising with, and reporting to, the Project Steering Committee (PSC);
- Coordinating with, and reporting to, line ministries involved in the Project and the GCF NDA in Togo, the Ministry of Environment, Forest Resources, Coastal Protection, and Climate Change (*Ministère de l'Environnement, des Ressources Forestières, de la Protection Côtière et du Changement Climatique - MERFPCCC*);
- Establishment and management of the national Project Management Unit (PMU), as well as the management of regional PMUs;
- Concluding grant agreements with other partners as required, potentially with, but not limited to, the pre-identified implementing partners (IPs) like Bremen Overseas Research and Development Association (BORDA), German Institute of Development and Sustainability (IDOS), and the West African Science Service Centre on Climate Change and Adapted Land Use (WASCAL). IPs will have no discretionary authority concerning the implementation of concerned sub-activities; all such discretionary authority is retained by GIZ as the Executing Entity. Further, IPs will not channel funds to other parties. The content of grant agreements provides for full adherence to the AE's AMA and FAA.
- The following minimum eligibility criteria will apply to Implementing Partners (IPs) that are not pre-identified in this FP: Positive result of Commercial and fiduciary due diligence assessment prior to engagement; evidence of operational capacity for operations in Togo; and technical expertise to effectively implement assigned activities under GIZ as EE. Concluding cooperation agreements with private sector partners that will contribute to the project's goals, prospectively, but not limited to, the pre-identified partners CIMTOGO SA and LIXIL corporation (for details see section B 5.5 Private Sector Engagement).
- Taking decisions pertaining to the activities that GIZ is executing as an EE.

B.4.2 Other Executing Entities

175. The following Executing Entities (EEs) have also been selected because of their comparative advantages and experience for implementing specific works relevant to responsible activities. GIZ, as the AE, conducted a thorough enhanced due diligence assessment with all Executing Entities which will receive GCF proceeds. The AE assessed and ensured the legal personality of the Executing Entities to enter into a legally binding agreement with GIZ and their ability to receive and properly manage funds. EEs will retain the final authority to make decisions pertaining to the activities that they execute.

- **Ministère de la Santé, de l'Hygiène Publique, de la Couverture Sanitaire Universelle et des Assurances (MSHPCSUA)** will act as EE for activities for which it has the mandate and/ or proved to have a comparative advantage. MSHPCSUA will co-chair the PSC and will be responsible for the overall multisectoral coordination between the relevant ministries. MSHPCSUA will play a leading role in project delivery and will act as the EE for some of the activities under all components of the project.
- **Agence Nationale de la Météorologie (ANAMET)**, the national meteorological agency, will act as EE for activities for which it has the mandate and/ or proved to have a comparative advantage. ANAMET will be a member of the PSC. ANAMET will play a leading role in project delivery and will act as the EE.

B.4.3 Flow of Funds

176. Figure 11 below depicts the overall flow of funds for the project.

- **GCF–GIZ:** GCF proceeds will be forwarded to GIZ as the Accredited Entity, which will have legal and financial fiduciary responsibility for the implementation of the project. GIZ will lead the PMU and ensure the implementation of the transfer of funds to the EEs and the monitoring and evaluation of activities. The GCF and GIZ will enter into a Funded Activity Agreement (FAA), under which GIZ shall administer the relevant GCF proceeds to be used for the financing of the project, in accordance with the FAA and AMA. Accountability on the use of financial resources will be facilitated through the review of annual and bi-annual project reports, as well as through audit and monitoring reports.
- **GIZ–EE:** Executing Entities ensure the execution of the specific project activities and are therefore accountable for the delivery of the associated outputs. GIZ, as the AE, will sign Subsidiary Agreements with the other EEs defining their respective responsibilities.

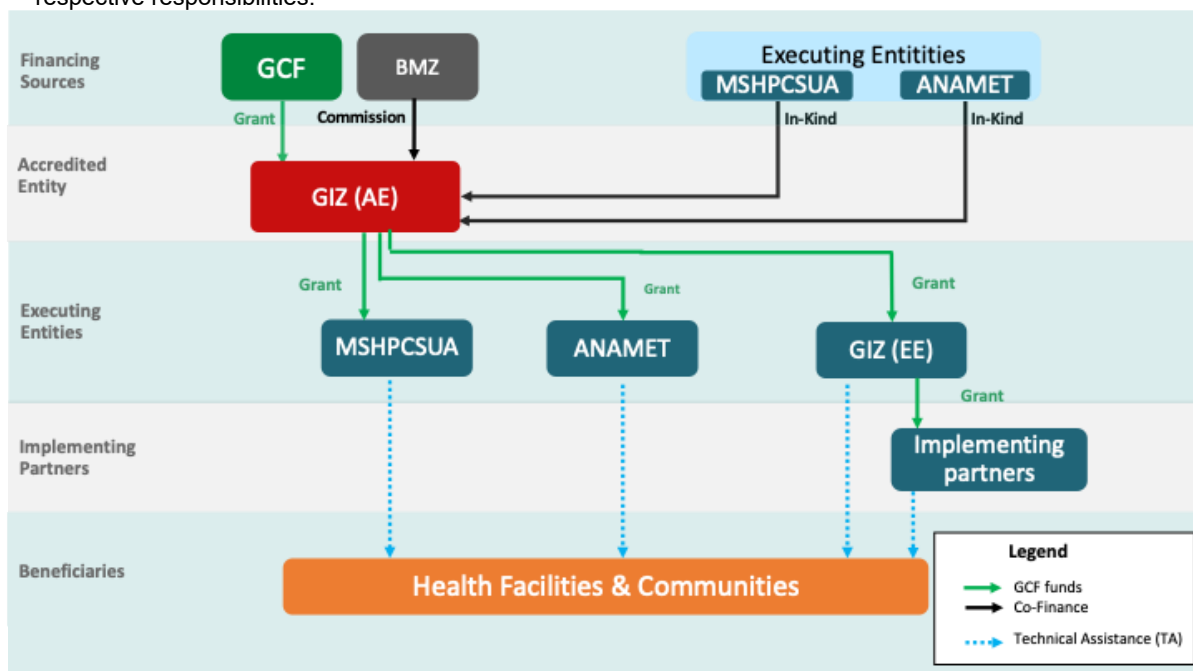


Figure 11: Overall flow of funds for the project

B.4.4 Governance and Management

177. As visualised in Figure 12, project steering and management will be ensured by a Project Steering Committee (PSC) and a Project Management Committee (PMC), both assuming complementary roles.

178. Responsible mainly for political steering, members of the PSC will include relevant government institutions and key project partners: MERFPCC, MSHPCSUA, ANAMET, the Ministry of Development Planning (Ministère de la Planification du Développement - MPD) along with the German Federal Ministry for Economic Cooperation and Development (BMZ) and GIZ in its role as AE.

179. The MERFPCC, both the climate change authority of Togo and the National Designated Authority (NDA) for the GCF, will chair the PSC and will be responsible for managing and overseeing the proposed project and continuation of interventions after the end of project duration. GIZ will serve as the secretariat of the PSC.

180. Decisions of the PSC will be taken by consensus. Key responsibilities of the PSC will be to:

- Provide overall guidance for project implementation.
- Provide feedback and validation of annual work plans, in consideration of annual reports and project evaluations.
- Ensure project progress and coherence with the (evolving) international and national policy context.
- Stay informed of project adherence with Annex 6b Environmental and Social Management Framework (ESMP), Annex 7b Stakeholder Engagement Plan (SEP), Annex 6c Local Communities Plan (LCP) and Annex 8b Gender Action Plan (GAP).
- Support the coordination of project activities across different line ministries and between the private and public sectors and civil society.

181. Based on the guidance and decisions of the PSC, the **Project Management Committee (PMC)** will serve as the main body for management and implementation of the project. The PMC will serve as a bridge between the political orientation of the project provided by the PSC and ensure the day-to-day management of the project. It will further provide orientation to the Project Management Unit (PMU). The PMC will hold documented quarterly meetings where project progress and emerging issues will be discussed and addressed. If needed, thematic working groups may be established to facilitate in-depth coordination of cross-cutting activities, such as those related to safeguards, gender or interventions at the municipality level.
182. Additionally, the PMC will have the following responsibilities:
- Implementing the decisions and recommendations of the PSC.
 - Providing oversight of the PMU.
 - Coordinating and ensuring timely execution of activities by each Executing Entity as outlined in the Annual Operating Plan, regularly updating the PSC and fostering a common understanding between the two Executing Entities regarding the theory of change and its integration across all project activities.
 - Supervising technical and budgetary project progress, and aligning with approved plans, budgets and indicators.
 - Promptly mobilising technical expertise from Executing Entities and other stakeholders upon identification of project implementation issues.
 - Facilitating harmonious collaboration with stakeholders for each of the project components and identifying the tasks and additional requirements that must be addressed in relation to the project.
 - Facilitating information flow from the project beneficiaries to the PSC.
 - Monitoring the implementation of, and adherence to, the ESMP, GAP, SEP, LCP.
 - Overseeing the progress of indicators managed by each Executing Entity in the monitoring system.
 - Assessing and consolidating insights and experiences from the project.
183. Member institutions of the PMC will include:
- GIZ, MSHPCSUA and ANAMET: Executing Entities.
 - MERFPCCC: a key national project partner, both as the authority responsible for climate change and in its role as NDA.
184. As and when necessary or desirable, extended PMC meetings can also be organised, involving PMC members and additional invitees – from the public and private sectors and from civil society – to address specific technical, geographical or sectoral issues.
185. The **Project Management Unit (PMU)** will consist of a dedicated GIZ team of professionals led by a Project Leader and including (inter alia) a Deputy Project Leader, a Finance Manager, a Gender, ESS and M&E (GEM) Specialist, a Communications Specialist and technical advisors.

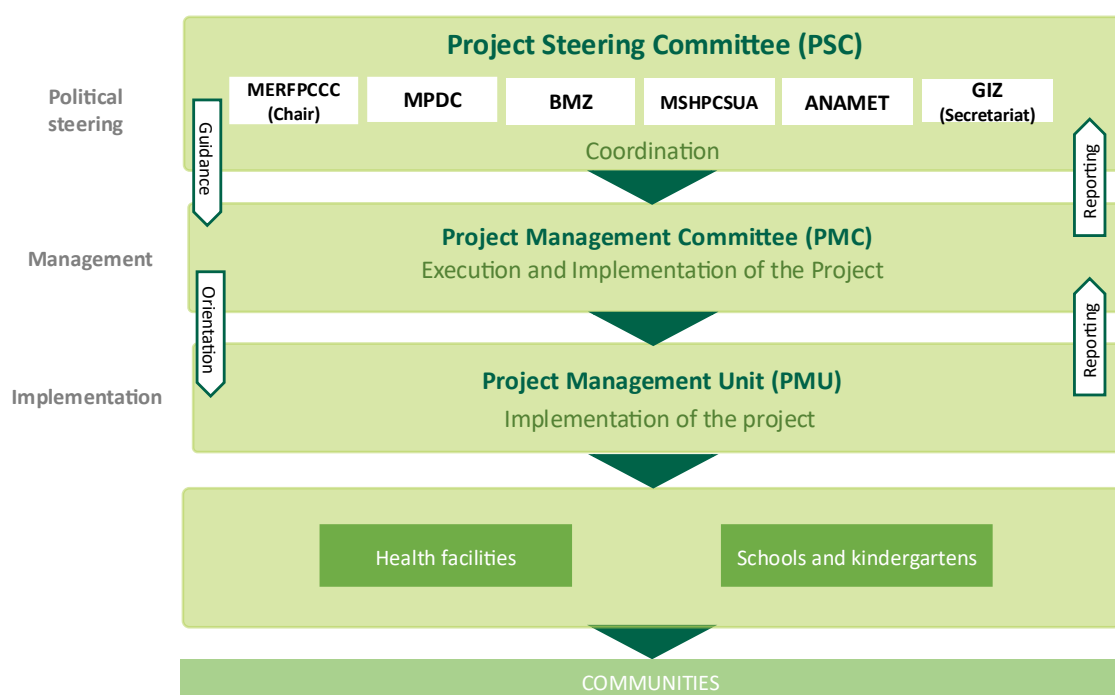


Figure 12: Project governance and management

B.5. Justification for GCF funding request (max. 1000 words, approximately 2 pages)

B 5.1 Alignment with GCF USP-2 and government policies

186. The proposed project is aligned with, and supportive of, Togo government policies (see Section D.5) as well as GCF's Updated Strategic Plan 2024-2027 (USP-2), notably Targeted Results 3 (**CIEWS**: 50 to 60 developing countries particularly vulnerable to the adverse effects of climate change protected by new or **improved early warning systems**.), 6 (**Infrastructure**: 45 to 60 developing countries supported by GCF to develop or secure **low-emission climate resilient infrastructure**, through systemic and/or country-driven resilience planning, funding and/or de-risking of investments), 9 (**Adaptation**: 40-70 approved proposals for **adaptation projects**, including for locally-led adaptation action)⁷⁹.

B 5.2 Additionality

187. The Government of Togo has identified the health sector as one of the most vulnerable to climate change and is committed to strengthen its resilience. However, key institutions including the MSHPCSUA, ANAMET (project EEs) and other relevant institutional stakeholders (ANPC, WASCAL etc.) face significant gaps in terms of governance and interinstitutional cooperation, personnel and institutional capacity, technical and climate resilient physical infrastructure, and availability of climate information. The project will support through a series of coordinated activities the institutionalisation of governance structures, support knowledge transfer to national bodies, acquisition of technical infrastructure and climate-proofing physical infrastructure and support the operational integration of climate and other relevant data for an improved climate informed health early warning system. Moreover, the government has a very limited fiscal space to support this kind of investments as highlighted in section D 4.2 leading to investments that are donor-driven, reactive, and therefore unable to bring about the transition needed for a paradigm shift in the sector.
188. The Climate Rationale, which underpins the project design, provides robust evidence demonstrating the climate impact in the burden of the targeted CSHO in Togo. Climate models (CMIP6) project temperature increases in Savanes, increases in relative humidity and heatwaves, while epidemiological modelling shows decline in incidence and altered disease transmission patterns for a malaria and diarrhoea diseases and increase incidence of preterm birth. These findings confirm the climate-related health burden in the northern regions – Centrale, Kara, and Savanes – and justify the project's focus on strengthening health system resilience to climate variability and change.
189. Project activities supported by GCF proceeds are capitalising on existing infrastructure, developing synergies, while clearly supporting climate additionality. The project builds on the current institutional, physical and technical infrastructure of ANAMET, MSHPCSUA, and ANPC. The project will expand on the existing ANAMET hydrometeorological system (Output 1.1.); capitalise on the institutional coordination and technical infrastructure of the MHEWS under ANPC (Output 1.3) (including the utilisation of TogoAlert+, the national MHEWS alert system); utilise the existing data and modelling capacities of the MSHPCSUA DHIS2 (Output 1.2); increase climate resilience of public health system facilities (Output 3.1); improve on the existing protocols, procedures and human resources capacity to strengthen climate-sensitive health outcomes diagnosis and treatment (Output 3.2).
190. Moreover, it avoids overlaps and develops synergies with existing projects, more notably with GCF SAP 48. The project will strategically address existing infrastructure gaps in close cooperation with the BOAD, ANPC and ANAMET to enhance synergies both during the project development and the project implementation phase (see Annexes 7a and 7b). The project will also support institutional coordination within the MSHPCSUA (Output 2.1) and develop linkages with key stakeholders at a national, regional, and international level (Output 2.2.). Output 4.2 will support the fourth element of a MHEWS,⁸⁰ ensuring community preparedness to respond to the warnings received, with a specific focus on health.
191. Lastly, physical investments address climate related risks and impacts across multiple levels – within the public healthcare system through measures enhancing resilience to heat, droughts, and cold chain disruptions (Outputs 3.1 and 3.2), and at the community level through flood- and drought-resilient WASH infrastructure and strengthened vector control for climate-sensitive health outcomes (Output 4.1).
192. Consequently, GCF support is required to systematically remove the identified barriers in Section B2.a2 and move towards an integrated proactive planning that mainstreams climate adaptation in the health sector through evidence-based decision-making.

B.5.3 Proposed financial instruments

193. Togo is an LDC with high economic vulnerability to climate change and persistent poverty. Fiscal space is limited, and access to financing at all levels remains inadequate (see section D.4.3). The following
194. **Table 7** summarises the assessment of suitability financial instruments considered.

Table 7: Comparative assessment of financial instruments and suitability

Financial instrument considered	Assessment
Domestic budget reallocation	Budget already operates within tight fiscal space ≈7–9%. Reallocation would still fall short of the ~€49 million climate-resilience CAPEX required.

⁷⁹ GCF (2023). [Strategic Plan for the Green Climate Fund, 2024-2027](#)

⁸⁰ UNDRR (N/A). [Definition: Early Warning System](#)

	Domestic budget allocation contributes to project co-financing.
Commercial bank loans / PPP	Project activities are characterised by distributional goals and limited revenue profile that is not attractive to Commercial bank loans / PPP.
Social impact bonds / blended repayable instruments	Project investments are characterised by negative financial Net Present Value (NPVs) under all repayable scenarios. Instruments will shift affordability pressures into future outcome payments.
Insurance / contingency funds	The financial instrument is not suitable for supporting the project's upfront investments. It may, however, provide complementary support after the initial investment phase
Philanthropy / NGOs	Smaller, short-tenor, project-specific and donor-driven. Unable to support transformational change and lead to a paradigm shift.
Sovereign concessional loans (multilateral/bilateral)	Concessional sovereign loans for the specific activities would not produce revenues streams robust enough for the loans to be serviced (see Annexes 3a and 3b).
Grants	Grants offer the necessary concessionality without adding fiscal pressure or crowding out other sources. Grants are aligned with the public-good nature of the interventions and the absence of revenue streams.

B.5.4 Concessionality

195. Concessionality is fully passed to beneficiaries as there is no on-lending or repayment. Funds flow via Subsidiary Agreements from the AE to EEs and will be administered in accordance with the FAA and AMA. Accountability on the use of financial resources will be facilitated through the review of annual and bi-annual project reports, as well as through audit and monitoring reports. Procurement and construction additionally incorporate resilient standards and specifications further ensuring concessionality.

B.5.5 Private Sector Engagement

196. The AE focused on engaging the private sector to assess potential collaboration and contribution to project activities. A Call for Expression of Interest (EOI) was launched to identify potential partners with an interest to support the project's social and environmental goals. The received submissions covered proposals in distinct sectors: health infrastructure and sanitation, cold chain logistics and medical supply, and medical equipment supply. Furthermore, the project held direct exchanges and meetings with several other potential partners, covering sectors such as Water, Sanitation, and Hygiene (WASH), telecommunications/digital devices, e-mobility, sustainable construction, cold chain, menstrual health, and health system infrastructure services. These efforts resulted in two planned private sector cooperations which shall be formalised in cooperation agreements. The first one involves CIMTOGO SA, a Heidelberg Materials subsidiary, which is currently developing production capacity for CO₂-reduced cement in Togo and is willing to support capacity-building for local artisans. The second one focuses on improved access to WASH services for vulnerable groups and will be supported by the Japanese-based LIXIL corporation. Potentials with other private sector actors will be further explored during project implementation.

B.6. Exit strategy (max. 500 words, approximately 1 page)

B.6.1 Institutional anchoring

197. Institutional ownership is ensured through the project's support for the transition of the informal Climate-Health Task Force into a permanent Climate Change Unit within the MSHPCSUA at the national level, along with the establishment of corresponding CCUs at the regional level. The CCUs will be institutionalised with formal legal status and permanent staff, ensuring their long-lasting capacity.

198. Regional CCUs will support the decentralisation of this effort and ensure that national strategies are translated into locally relevant actions. Furthermore, the EWS will be anchored within existing national institutions including the ANAMET (for the collection and analysis of climate data), the MSHPCSUA (for the integration of data sources, platform hosting and epidemiological forecasting and projections), and the ANPC (for EWS system protocols, communication). The project will actively support capacity development before formally handing over the tools and processes, with signed agreements transferring governance and monitoring responsibilities to these institutions.

B.6.2 Sustainable financing

199. Sustainable financing is ensured through maximising the utilisation of already existing infrastructure and processes (e.g. DHIS2) and ensuring adequate and sustainable funding for additional investments. Hydrometeorological equipment, data collection and analysis processes are embedded within ANAMET whose financial strategy and sustainability is supported by the GCF SAP 48 project. Epidemiological forecasting and projections will utilise DHIS2 which is already operational in

Togo, expanding its capacities and improving the quality of data utilised. Institutional interventions such as the establishment of CCUs will be supported by their integration in the MSHPCSUA organisational structure and permanent budget.

B.6.3 Operations and maintenance of investments

200. To ensure the operation and maintenance of the hydrometeorological equipment, the project will establish an ANAMET maintenance centre in Kara equipped with the necessary tools and a digital maintenance management system. ANAMET will formally take over responsibility for the operation and maintenance of physical and digital infrastructure. HFs and community infrastructure will be supported for a 12-month defects liability period. After the completion of this period, the maintenance responsibilities will be formally transferred to local representatives of the MSHPCSUA. Similarly, the MSHPCSUA will be explicitly responsible for the maintenance of all equipment procured for the CCUs after the project's implementation is complete.

B.6.4 Longterm capacity and scaling-up

- 201. A dedicated scaling-up roadmap will guarantee that project lessons learned are being capitalised. Building on the experience gained from implementing the different components of the EWS, the roadmap will set out a pathway of investments (e.g. AWS expansion, sentinel sites expansion, integration of additional CSHO epidemiological modelling) to maximise effectiveness, outreach, and efficiency for a national-level climate informed health EWS.
- 202. Sustainability will further be supported by developing national capacity for a long-term paradigm shift. High specialisation knowledge and skills will be supported by the targeted training of MSHPCSUA, ANAMET, and WASCAL personnel for data management and integration, epidemiological forecasting and projection, and results interpretation. A Climate and Health Master's programme at WASCAL will support the development of a cadre of local climate health experts produced within the country, reducing the need for external consultants.
- 203. Capacity development on construction and resilience measures and strengthening of professional training for maintenance will also be supported under Output 3.1. These investments will guarantee that there is available know-how for the implementation of the climate resilience norms of HFs, maintenance of medical equipment (Output 3.2) and community interventions (Output 4.1).
- 204. A localised network of community leaders will ensure health communication and responsive resource mobilisation. Training of CHWs and certified community-level multipliers will ensure local climate change awareness and knowledge.

C. FINANCING INFORMATION						
C.1. Total financing						
(a) Requested GCF funding (i + ii + iii + iv + v + vi + vii)	Total amount			Currency		
	37.6			million euro (€)		
GCF financial instrument	Amount	Tenor	Grace period	Pricing		
(i) Senior loans	NA					
(ii) Subordinated loans	NA					
(iii) Equity	NA					
(iv) Guarantees	NA					
(v) Reimbursable grants	NA					
(vi) Grants	37.6					
(vii) Results-based payments	NA					
(b) Co-financing information	Total amount			Currency		
	12.33			million euro (€)		
Name of institution	Financial instrument	Amount	Currency	Tenor & grace	Pricing	Seniority
BMZ	<u>Grant</u>	<u>6.4</u>	<u>million euro (€)</u>	<u>Enter years</u> <u>Enter years</u>	<u>Enter%</u>	<u>Options</u>
MSHPCSUA	<u>In kind</u>	<u>5.79</u>	<u>million euro (€)</u>			
ANAMET	<u>In kind</u>	<u>0.14</u>	<u>million euro (€)</u>			
(c) Total financing (c) = (a)+(b)	Amount			Currency		
	49.93			million euro (€)		
(d) Other financing arrangements and contributions	205.No other financing arrangements and contributions are envisioned by the project.					

C.2. Financing by component							
Component	Output	Indicative cost million euro (€)	GCF financing		Co-financing		
			Amount million euro (€)	Financial Instrument	Amount million euro (€)	Financial Instrument	Name of Institutions
Component 1	1.1	3.881	3.528	Grants	0.252	Grants	BMZ
					0.101	In-Kind	ANAMET
	1.2	1.536	1.430	Grants	0.106	Grants	BMZ
	1.3	1.288	1.083	Grants	0.129	Grants	BMZ
					0.076	In-Kind	MSHPCSUA
Component 2	2.1	3.646	3.125	Grants	0.256	Grants	BMZ
					0.265	In-Kind	MSHPCSUA
	2.2	3.689	2.622	Grants	1.027	Grants	BMZ
					0.040	In-Kind	MSHPCSUA
Component 3	3.1	15.919	12.482	Grants	2.698	Grants	BMZ
					0.739	In-Kind	MSHPCSUA
	3.2	7.830	3.127	Grants	0.516	Grants	BMZ
					4.187	In-Kind	MSHPCSUA
Component 4	4.1	5.081	4.543	Grants	0.538	Grants	BMZ
	4.2	3.388	2.817	Grants	0.300	Grants	BMZ
					0.271	In-Kind	MSHPCSUA
Project Monitoring		1.378	1.338	Grants	0.040	Grants	BMZ
PMC		1.692	0.900	Grants	0.536	Grants	BMZ
					0.039	In-Kind	ANAMET
					0.217	In-Kind	MSPCSUA
Contingencies		0.603	0.603	Grants	-	-	-
Indicative total cost (Million Euro)		49.93	37.6		12.33		

C.3 Capacity building and technology development/transfer (max. 250 words, approximately 0.5 page)	
C.3.1 Does GCF funding finance capacity building activities?	Yes ☒ No ☐
C.3.2. Does GCF funding finance technology development/transfer?	Yes ☒ No ☐
206.The project will contribute to the transfer of technology through the improvement of epidemiological modelling for climate-sensitive health outcomes in three target areas. This improvement involves integrating diverse data sources via tailored IT solutions (1.2.1) and applying enhanced modelling techniques (1.2.2). The initiative will introduce, for the first time operationally in Togo, climate-driven modelling capable of short-term forecasting and long-term projections. The outputs will be used to support the national MHEWS (Output 1.3). The overall requested GCF funding amount for these activities amounts to 2.5M EUR.	

D. EXPECTED PERFORMANCE AGAINST INVESTMENT CRITERIA

This section refers to the performance of the project/programme against the investment criteria as set out in the GCF's Initial Investment Framework.

D.1. Impact potential (max. 500 words, approximately 1 page)

D.1.1 Impact potential - Adaptation

207. The “Building the resilience of Togo's national health system and vulnerable communities to climate-sensitive health outcomes” project will **benefit 4,013,183 persons (directly 1,841,389 and indirectly 2,171,794), of which approximately 51% are women.**

The adaptation impacts of the project are summarised in

208. *Table 8.* Full details on the calculation of beneficiaries are provided in Annex 2d, and the methodological approach is detailed in Section 8.1.2 of the Feasibility Study (Annex 2).

209. Thereby, the project will substantially **contribute to GCF's USP-2 targets 3 (CIEWS), 6 (Infrastructure) and 9 (adaptation)**⁸¹.

Table 8: IRMF indicators and target beneficiaries

IRMF Indicator	Beneficiaries / Targets
<i>ARA 1: Most vulnerable people and communities</i>	
Core 2: Direct and indirect beneficiaries reached	Direct: 716,669 ; Indirect: N/A, of whom 51% are women
Supplementary 2.1: Beneficiaries adopting improved and/or new climate-resilient livelihood options	Total: 709,735, of whom 51% are women
<i>ARA 2: Health, well-being, food and water security</i>	
Core 2: Direct and indirect beneficiaries reached	Direct: 1,841,389 Indirect: 2,171,794 of whom 51% are women
Supplementary 2.4: Beneficiaries (female/male) covered by new or improved early warning systems	Total: 1,841,389 of whom 51% are women
<i>ARA 3: Infrastructure and built environment</i>	
Core 3: Value of physical assets made more resilient to the effects of climate change and/or more able to reduce GHG emissions	10,177,501 EUR
Core 2: Direct and indirect beneficiaries reached	Direct: 4,635; Indirect: N/A, of whom 51% are women

210. The project will increase the resilience of 4,013,183 beneficiaries (51% women) in the targeted areas and communities of the project through the adoption of improved climate resilient livelihood options (reduced work absenteeism from climate-sensitive health outcomes⁸²), improved EWS (for climate-sensitive health outcomes), and improved infrastructure (improved resilience of HFs and WASH infrastructure). Of the total beneficiaries, an estimated 1,841,389 will receive a targeted adaptation benefit through a functional and improved EWS for malaria and diarrhoeal diseases under Component 1, which also contributes to the enabling environment Core indicator 6 through the adoption of new technologies for climate-sensitive health outcome forecasting and projection modelling. Component 2 contributes to the enabling environment Core indicators 5 strengthening institutional framework for the integration of climate in the public health system and 8 through improved epidemiological surveillance, training and research on the climate and health nexus and the engagement in regional and international fora. A total of 282,144 beneficiaries will be supported by Component 3, receiving a targeted adaptation benefit through improved health facility infrastructure and prevention and treatment of climate-sensitive health outcomes reducing their sensitivity to climate-health risks. Component 4 will support 1,249,903 beneficiaries through improved climate resilient community infrastructure and environmental management for vector control contributing to reduced economic losses and reduced sensitivity to health risks, while the communication campaign will contribute to the appropriate community-level response to early warning system alerts and the adoption of good practices.

211. The project will benefit 2,171,794 indirect beneficiaries (51% women) - excluding the direct beneficiaries - as a result of non-targeted adaptation benefit from the functional and improved EWS. Indirect beneficiaries include 2,171,794 receiving adaptation benefits from improved institutional health coordination (Outcome 2).

⁸¹ GCF (2023). *op. cit.*

⁸² Lukwa, Akim & Mawoyo, Richard & Nelwin, Karen & Aggrey, Siya & Alaba, Funke. (2019). Effect of malaria on productivity in a workplace: the case of a banana plantation in Zimbabwe. *Malaria Journal*. 18. 10.1186/s12936-019-3021-6.

D.2. Paradigm shift potential (max. 500 words, approximately 1 page)

D.2.1 Potential for scaling up and replication

212. Scaling up and replication are integral part of the project, ensuring that clear scaling up pathways will be in place before the end of the project implementation period. Under activity 1.2.2, a roadmap to scale-up climate and weather modelling will be developed detailing to define an actionable pathway for expanding climate-informed HEWS to the national level. Moreover, by establishing local capacities for epidemiological modelling and the integration of climate and weather, environmental, epidemiological, and social determinants of health data under the DHIS2 system (1.2.2), forecasting and projection can be replicated for additional climate-sensitive health outcomes. Furthermore, the consolidation of infrastructure norms for HFs (3.1.1) and of health equipment maintenance (3.1.2) also facilitates scaling up climate resilience in health infrastructure nationwide. Lastly, developing capacity for manufacturing mosquito screens (4.1.2) will accelerate replication nationwide.

D.2.2 Potential for knowledge sharing and learning

213. Knowledge sharing and learning are supported through academic, technical and operational knowledge exchange and learning. At the formal education level, Output 2.2 will enhance local expertise by developing climate and health academic programmes. These activities will develop local capacity on the health and climate nexus, as well as the technical expertise needed for the sustainability of project physical interventions. At the operational level, knowledge transfer on epidemiological modelling will be supported through training of MHSPCSUA and academic personnel (1.2.2) from international academic institutions with a strong track record in the field. These operational knowledge transfer will ensure the interventions' sustainability, replicability and scaling-up. The project will institutionalise coordination, learning, and knowledge-sharing on climate and health in Togo (2.1.3) strengthening its position as a contributor through South–South exchanges, and technical workshops. Togo contributions will include sub-regional exchanges with peers such as Senegal, Malawi, and Benin; participation in regional platforms such as the ECOWAS, and WAHO; continental initiatives e.g. AU; and global dialogue. Lastly, Output 4.2 combines evidence-based approaches with implementation providing key lessons learned for community-level awareness and response campaigns

D.2.3 Contribution to the creation of an enabling environment

214. The project contributes to the development of an enabling environment by operationalising policies and systems that improve interinstitutional cooperation, streamline operating procedures, and enhance effectiveness through clear guidelines. Under Output 1.1, maintenance SOPs for hydrometeorological equipment will be developed. Output 1.2 focuses on SOPs for the integration of data from multiple sources and institutions to support a methodologically robust health EWS (Output 1.3). Finally, Output 4.2 will drive behavioural change concerning climate-health risks through improved communication, awareness-raising, and the capacity strengthening of community multipliers.

D.2.4 Contribution to the regulatory framework and policies

215. Paradigm shift is achieved through strengthening the institutional capacity and governance, by addressing systemic deficiencies in governance and a lack of stable funding by creating a formal, dedicated structure within the health ministry. A central component of this is the establishment of a CCU (activities 2.1.1 and 2.1.2) to overcome the informal and temporary nature of existing structures. This institutionalisation is also a direct response to financial barriers, as it is designed to help mobilise regular funding and reduce reliance on unstable external sources. This approach fosters strategic partnerships and an enabling environment by strengthening institutional coordination and capacity development. Moreover, under 1.2.2 the national Antimicrobial Resistance Plan will be updated to include climate-sensitive diseases surveillance and revise epidemiological surveillance tools.

D.2.5 Contribution to climate-resilient development pathways in the health and wellbeing sector

216. The project is designed to build a climate-resilient, accessible, and sustainable health system in Togo by addressing key barriers through a multi-pronged strategy. This approach focuses on comprehensive planning, data integration, and capacity development to anticipate and respond to climate-related health risks, particularly those associated with heat and precipitation. It will achieve this by strengthening policy and governance, developing the health workforce, improving service delivery via resilient infrastructure and enhanced diagnostics, and fostering intersectoral partnerships. The project also promotes community action and awareness and systematically facilitates knowledge transfer for broader impact and gender equality.

217. The project leverages data and technology for informed decision-making, recognising that robust, integrated data is foundational for a climate-resilient health system. It transforms the health information system by first ensuring the DHIS2 platform can integrate hydrometeorological and climate data, capitalising on the improved hydrometeorological data collection and data management (Output 1.1). The project will ensure the climate, weather, epidemiological and social determinants of health data are actively used by integrating them into health surveillance systems (1.2.1) and using them for climate-sensitive health outcomes forecasting and projections (1.2.2). The project also strengthens operational arrangements for an EWS, providing HFs with appropriate anticipatory alerts for the rationalisation of short-term resource allocation and long-term strategic planning (Output 1.3).

D.3. Sustainable development (max. 500 words, approximately 1 page)

D.3.1 Environmental co-benefits

218. The project will lead to environmental co-benefits beyond the adaptation of the public health sector to climate change. In particular, it will contribute to improved water and wastewater management, pollution reduction, and improved environmental monitoring. Improved infrastructure (Outputs 3.1, 4.1) will not only reduce the risk of contamination through reduced open defecation, but through a climate resilient approach, including reduced resource utilisation (water), proper wastewater collection and management, and the removal of potential contamination threats (e.g. safe decommissioning and of infrastructure and of equipment and residuals' management). The project will also strengthen environmental monitoring in the target areas by assessing the water quality of 120 community water sources (Output 4.1) and by integrating environmental quality control into the surveillance of diarrhoeal diseases (Output 3.2).

D3.2 Economic co-benefits

219. The project will strengthen productive employment at a local and national level. More specifically, the project will support the training of the local construction workforce on resilient construction techniques, increasing their employability and improving construction standards in the country (Output 3.1 and 4.1). Moreover, it will provide technical expertise and opportunities for career development through targeted technical capacity development for highly specialised personnel (e.g. epidemiological modelling and data management) (Output 1.2).

220. The project will also support academic and technical education (Output 2.2) through the development of health and climate curricula and the integration of health equipment maintenance in existing technical and vocational training, increasing the supply side for green jobs.

D3.3 Gender-sensitive development benefits

221. Through its activities, the project will advance gender equality by prioritising the needs of women, mothers, infants, and children. It will improve access to menstrual health and hygiene (MHH), promote gender-sensitive infrastructure standards, and strengthen gender equity in the health and climate workforce through targeted, inclusive training opportunities. The project will also reduce women's unpaid caregiving burden by lowering the incidence of malaria and diarrhoeal diseases, increase women's access to antenatal and reproductive health services through climate-resilient facilities, and enhance women's participation in community early-warning systems, vector-control committees, and health-related decision-making processes.

D3.4 Contribution to SDGs

222. The project directly supports the following Sustainable Development Goals:

- SDG 3: Ensure healthy lives and promote well-being for all at all ages
- SDG 5: Achieve gender equality and empower all women and girls
- SDG 6: Ensure availability and sustainable management of water and sanitation for all
- SDG 9: Build resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation
- SDG 13: Take urgent action to combat climate change and its impacts

D.4. Needs of recipient (max. 500 words, approximately 1 page)

D.4.1 Climate risk and vulnerability

223. As described in Section B1, Togo's health sector is exposed to diverse climate-related hazards, particularly related with communicable (malaria and diarrhoea) climate-sensitive diseases and non-communicable (maternal, infant and child) health risks. Climate change will have disproportionate impacts on vulnerable households and communities, including pregnant and post-partum women, newborns, infants and children, disabled persons, and poor households. Annex 2a Climate Rationale provides a detailed analysis in the climate risks and vulnerabilities in Togo, as well as the methodological approach used to prioritise the targeted regions. The project supports the resilience of the public health system through activities in the target areas and the overall institutional strengthening of the health governance (adaptation impact potential D.1.2).

D.4.2 Economic and social needs of the targeted population

224. Togo remains classified among the world's LDCs, with persistent challenges in human capital, poverty reduction, and resilience to climate change. The Human Capital Index (HCI) is 0.43, meaning a child born today will reach only 43% of their potential in health, education, and nutrition as an adult⁸³. Poverty remains widespread, particularly in rural areas (58.8%), and is even high in the target regions of Centrale (59.9%), Kara (58.2%), and Savanes (65%), where women are disproportionately affected due to limited access to education, healthcare, and economic opportunities. With a current warming trajectory of 3°C, the costs occurring from the impacts of climate change could be 20% of Togo's GDP by 2050⁸⁴.

225. Food insecurity remains a major concern, with Togo ranked 80th out of 127 in the 2024 Global Hunger Index (GHI), scoring 18.6 – classified as “moderate”, but showing slight signs of improvement compared to 2023. The Savanes and Kara regions are among the most food-insecure in the country⁸⁵. Moreover, the project will lead to reduced work absenteeism for the active population supporting livelihoods⁸⁶.

226. Climate-sensitive health risks are also increasing: from 2008-2017, malaria cases rose by an average of 13.7% nationally, with high incidence in the target regions of Centrale (16.7%), Savanes (15.8%) and Kara (13.5%)⁸⁷. Diarrhoeal cases also surged between 2018-2022, rising by 75% in Centrale and 74% in Kara⁸⁸. The maternal mortality rate remains high at 349 deaths per 100,000 live births (2023), well above the SDG 2030 target of 70⁸⁹.

D.4.3 Absence of alternative sources of financing

⁸³ WBG (2024). [Togo- Vue d'ensemble](#).

⁸⁴ Burke et al. (n.d.). Large potential reduction in economic damages under UN mitigation targets. *Nature*, 557, 549–553.

⁸⁵ WFP (2022). [Annual Country Report: Togo](#).

⁸⁶ Lukwa, Akim & Mawoyo, Richard & Nelwin, Karen & Aggrey, Siya & Alaba, Funke. (2019). Effect of malaria on productivity in a workplace: the case of a banana plantation in Zimbabwe. *Malaria Journal*. 18. 10.1186/s12936-019-3021-6.

⁸⁷ Bakai et al. (2020), Changes in registered malaria cases and deaths in Togo from 2008 to 2017. [International Journal of Infectious Diseases: IJID: Official Publication of the International Society for Infectious diseases](#), 101, 298-305.

⁸⁸ MSHP (2019). [Direction Générale des Études de la Planification et de l'Information Sanitaire](#); DHIS2 (2023). *Op. cit.*

⁸⁹ WHO (2025). *Op. cit.*

227. Estimates of the annual investment required for climate change adaptation in Togo range from 1.5% to 4.2% of GDP, underscoring both the significant financing needs and the constrained fiscal capacity of the Government to meet these needs⁹⁰. Moreover, according to the NDC, 35% of adaptation investments are required for the “human settlements and health” sector (Annex 2 – Section 3.1).
228. The health sector financing is characterised by improved trends - the real budget tripled from in 2015 to 2023 - but the percentage of the total budget for the health sector remains below the 15% target of the Abuja Declaration⁹¹. The latest estimation for the percentage is 9.0% (2023) with the latest verified figure at 7.3% (2019), both lower from the world average of 9.9% (2023)⁹². Of the total budget of the health sector during the period 2017-2022, 40.7% came from the State’s own resources, 33.7% from technical and financial partners; and only 25.6% from revenue generated by HFs, highlighting the dependence on technical and financial partners⁹³. Moreover, a total of 37% of the budget needs to be allocated to reducing maternal, infant and child mortality; family planning and adolescent health (23%) and fighting communicable diseases (14%), highlighting the importance of the project⁹⁴. Health direct payments borne by households account for 66% of healthcare expenditure in 2019, more than double to the WHO recommended standard of an average of 30% or less, showcasing the important burden that health poses to households⁹⁵.
229. In terms of financial inclusion, 57% of adults in Togo own an account and 37% of adults had a mobile money account (2024) and based on the Global Findex Database, though significant gaps exist in terms of gender (45% of women vs 70% of men) and urban and rural population (53% vs 66%)⁹⁶. Moreover, even though 78% mentioned that they have borrowed money, only 13% borrowed money from a formal bank or using a mobile money account, highlighting that access to financial products remain very low, with the majority of the population relying on informal sources, such as family, friends, and “tontines” (rotating savings and credit associations)⁹⁷. Therefore, there is minimal risk of crowding out public or private investments.

D.4.4 Institutional needs

230. At the institutional level, significant gaps remain in public health governance and the multi-hazard early warning system. Despite the efforts led to integrate climate change considerations in public health governance, there are still gaps in terms of lack of clear mandate and institutionalisation in the MSHPCSUA, inadequate intersectoral collaboration – including the lack of operationalisation of the One Health approach – and knowledge exchange at the national and international levels. While there is progress in the incorporation of technologies like the integration of the Climate Health Analytics Platform (CHAP) and the Climate App in DHIS2, there is no integration of climate and meteorological data, while the quality of epidemiological data is not robust enough to allow predictive modelling.
231. ANAMET is currently facing significant gaps within its hydrometeorological system, specifically concerning network coverage; data quality and management; forecasting capacity; and robust processes for monitoring, knowledge management and learning. These deficiencies will be collaboratively addressed through this project and the GCF SAP48 project, from which ANAMET is designated to benefit.
232. The GCF SAP48 project will also strengthen the Togolese multi-hazard EWS and ANPC both in terms of the enabling environment and technical capacities. Nevertheless, there are still gaps that need to be addressed concerning the integration of the climate and health nexus in the EWS. Currently, the SOPs for the health alerts are being developed, but do not include considerations on climate-sensitive diseases and will be limited to multi-hazard impacts on HFs and direct health impacts. The project will support the integration of communicable climate-sensitive diseases throughout all pillars of the EWS (data collection, analysis, notification and response).

D.5. Country ownership (max. 500 words, approximately 1 page)

D.5.1 Coherence with existing National Climate Strategy, policies and commitments

233. The project is aligned with the Togo NDC (2021 – Axis 4), the National Adaptation Plan (NAP), in which health is included as a priority area, and national policies and strategies, including the National Climate Change Adaptation Plan, the National Adaptation Plan for the Health Sector (PNAS), the National Health Policy (PNS), the National Plan for Health Sector Development (PNDS), the 2023-2026 National Malaria Control Programme, the National Action Plan for the Implementation of the National Framework for Climate Services (NFCS), the National Civil Protection Policy (PNPC). Additional information on the coherence with the National Climate Strategy, policies and commitments can be found in Sections 3.1 and 3.2.8 Annex 2 – Feasibility Study.

D.5.2 Capacity of AE and EEs to deliver

234. GIZ, with its headquarters in Germany, serves as AE, and GIZ, with its management structure in Togo, will serve as an EE. GIZ has a demonstrated experience implementing a GCF project and has shown they have sufficient capacities to deliver.
235. GIZ is one of the largest international providers of capacity development and technical assistance on climate change worldwide. GIZ as AE already developed and submitted several funding proposals to GCF. An overview of GIZ projects under implementation can be found on the GCF’s website.
236. Additional national EEs will be MSHPCSUA and ANAMET.

⁹⁰ International Monetary Fund. African Dept. (2024). Togo: Selected Issues. IMF Staff Country Reports, 2024(300). Retrieved Oct 23, 2025, from <https://doi.org/10.5089/9798400291227.002>

⁹¹ GIZ. (2022). ProSanté II: Project Progress Report.

⁹² *Ibid.*

⁹³ MSHP (2022). [Plan National de Développement Sanitaire \(PNDS\) 2023-2027](#). Ministère de la Santé et de l’Hygiène Publique.

⁹⁴ GIZ (2022). *op. cit.*

⁹⁵ *Ibid.*

⁹⁶ Klapper, L. et al. (2025). [The Global Findex Database 2025: Connectivity and Financial Inclusion in the Digital Economy](#). World Bank.

⁹⁷ *Ibid.*

237. MSHPCSUA has been acting as an Executing Entity under a variety of donor-funded health projects, including those financed by the World Bank (WB), the Islamic Bank of Development (IsDB), GAVI, Kreditanstalt für Wiederaufbau (KfW), GIZ and Bpi France/Natixis. Under these initiatives, the Ministry has been responsible for channelling funds to regional and district-level institutions (e.g., USPs, Health Districts, and RHD), as well as private sector service providers and final beneficiaries such as pregnant women, newborns, and children, and other vulnerable populations. These projects include, among others:

- Quality Essential Health Services Project for Universal Health Coverage (2021-2026) – WB, USD 70 million: Strengthens health system performance and service delivery.
- Health System Strengthening and Primary Health Care Project (2024-2027) – IsDB, USD 42.8 million: Enhances national governance and primary healthcare structures across all regions.
- Programme for Health system strengthening - sexual and reproductive health and rights (KfW-SRDR) Phase I-IV, 2017-2032) – KfW, EUR 59 million: Upgrades emergency obstetric and neonatal care infrastructures and services, particularly in the Kara region, with GIZ serving as the implementing agency and coordinating technical cooperation with the MSHPCSUA.
- Rehabilitation of University Hospitals in Kara and Lomé (2023-2026) – Bpi France/Natixis, EUR 103 million: Finances upgrading, rehabilitation, and equipment procurement for tertiary hospitals.
- Expanded Vaccination Programme (2017-2021) – GAVI, USD 250 million: Supports a nationwide initiative, for which the MSHPCSUA implements specific components, including cold-chain strengthening and vaccine delivery support.

238. ANAMET is the beneficiary organisation of the GCF SAP48 project under implementation. ANAMET has acted as a sub-implementing partner in the following projects:

- Integrating Flood and Drought Management and Early Warning for Climate Change Adaptation in the Volta Basin – Volta Flood and Drought Management (VFDM) – World Meteorological Organisation
- CREWS - Strengthening National Capacities for Early Warning in Togo – World Meteorological Organisation
- FSRP (Food System Resilience Program) – World Bank
- Project to strengthen meteorological services – Public Investment Program (PIP)
- Strengthening of technical capacities and meteorological infrastructure in Togo Project – BOAD
- Strengthening the resilience of vulnerable communities within high climatic and disaster risk areas in Togo - Project – BOAD

239. Additional information on the AE and EEs' capacities to implement the project are provided in Section B.4.

D.5.3 NDA approval process

240. The project has secured the NDA's support. The No-Objection Letter (NoL) is provided in Annex 1.

D.5.4 Engagement with stakeholders during project preparation and implementation

241. Annex 7a contains detailed information about the meetings undertaken during project preparation, including dates, attendees, gender breakdowns and meeting notes.

242. The Stakeholder Engagement Plan (SEP) is provided in Annex 7b.

Information Disclosure

243. The project will meet the requirements of the GCF Information Disclosure Policy and Section 7.1 of the GCF's E&S policy.

Grievance Redress Mechanism

244. The GRM is detailed in the Stakeholder Engagement Plan (SEP) in Annex 7b.

D.6. Efficiency and effectiveness (max. 500 words, approximately 1 page)

D.6.1 Adequacy and justification of GCF funding

245. GCF resources are essential to overcome the identified barriers to health sector adaptation in Togo, especially given the sector's heavy reliance on external funding and the insufficient state budgetary resources. The requested GCF grant, and co-financing is indispensable to enable investments at a significant scale and enabling environment interventions that lead to a resilient health sector. On the contrary, without GCF support, the investments will remain fragmented, donor driven, and reactive without the necessary momentum to bring about a paradigm shift. The project interventions have a clear additionality and avoid crowding out other sources of financing, while addressing institutional, technical, and financial barriers.

D.6.2 Efficiency and effectiveness

246. The GCF investment represents a cost-effective, efficient investment for the adaptation of the Togolese health sector to climate change. The total project financing is 49.94 M EUR (GCF Requested amount 37.6M EUR, Co-financing 12.34M EUR) and the project will result in 1,841,389 direct and 2,171,794 indirect beneficiaries during the 5-year implementation period. The project has the following cost per direct and indirect beneficiaries:

- For the GCF proceeds 9.37 EUR/ beneficiary.
- For the overall project budget 12.44 EUR/ beneficiary.

247. The project cost is comparable to the average 10.5 USD/beneficiary ratio for other GCF projects in the health sector.

248. The Economic and Financial Analysis corroborates the justification of the project. The project KPIs are an Economic Net Present Value of 11.6 million Euros, Economic Internal Rate of Return (EIRR) 10 % and a Benefit-Cost Ratio (BCR) of 1.3. The robustness of the results is further supported by the sensitivity analysis that includes $\pm 20\%$ cost/benefits scenarios and assesses social discount rates between 2,4,6,8,10 and 12%. The EIRR remains above the social discount rate for all scenarios with 6% discount rate and all but the extreme negative scenarios for social discount rate of 8%. The methodology and assumptions utilised for the analysis are detailed in the Annexes 3a and 3b and include: (i) social discount rate of 6%, (ii) analysis of EWS, improved HFs infrastructure, and community resilience investments (iii) and economic benefits reduced morbidity and mortality, avoided losses from climate change induced disasters, avoided costs for water purchase, avoided electricity costs, avoided GHG emissions, avoided costs from vaccines losses.

D.6.3 Best available technologies and practices

249. The project employs the best available technologies and practices for epidemiological surveillance, forecasting and projections taking into consideration meteorological, climatic, environmental, epidemiological, and social determinants of health data. Epidemiological forecasting and projections will inform evidence-based decision making for short term resource allocation and longer-term strategic planning in the health sector. Health informed alerts will be channelled through the existing ANPC MHEWS system capitalising on existing nationally available infrastructure and capacity and in line with WMO and United Nations Disaster Risk Reduction (UNDRR) best-practice guidance. Health and community infrastructure, as well as cold chains investments incorporate resilience and gender-sensitive design standards contributing to the avoidance of carbon lock-in. Community-led behaviour change communication will utilise gender-responsive and culturally appropriate models as validated by beneficiary consultations (see Annexes 7a, 6c).

E. LOGICAL FRAMEWORK

This section refers to the project/programme's logical framework in accordance with the GCF's Integrated Results Management Framework to which the project/programme contributes as a whole, including in respect of any co-financing.

E.1. Project/Programme Focus

Please indicate whether this proposal is for a mitigation or adaptation project/programme. For cross-cutting proposals, select both.

- ☐ Reduced emissions (mitigation)
☒ Increased resilience (adaptation)

E.2. GCF Impact level: Paradigm shift potential (max 600 words, approximately 1-2 pages)

Assessment Dimension	Current state (baseline)		Potential target scenario (Description)	How the project/programme will contribute (Description)
	Description	Rating		
Scale	There is limited evidence of a pathway toward a quantifiable impact of adaptation in the health sector. Togo remains vulnerable to climate change impacts, being the 14 th and 17 th country with the highest disability-adjusted life years (DALYs) ⁹⁸ per 100K inhabitants for diarrhoeal diseases and malaria, respectively, in 2021 ⁹⁹ . HF's remain vulnerable to climate-induced disasters, including heatwaves and droughts.	<u>Low</u>	As a result of the project intervention, the health sector will increase its capacity to tackle climate-sensitive health outcomes and infrastructure will be less vulnerable to climate change impacts. Epidemiological surveillance, forecasting and projection tools will allow for evidence-based short-term resource allocation and longer-term strategic planning. An operational Early Warning System will increase the MSHPCSUA's, health professionals' and communities' preparedness to address climate change health risks. Capacity for diagnosis and treatment, resilient cold chains and health professional with knowledge, appropriate attitudes and practices will lead to higher effectiveness in addressing climate-sensitive health outcomes. Communities will have the awareness and knowledge to respond locally reducing their exposure and vulnerability to malaria and diarrhoeal diseases.	The project will catalyse transformational improvements in data collection (Outputs 1.1, 3.2), integration and analysis (Output 1.2) for the climate and health nexus; it will also create a robust epidemiological forecast and projection operational and strategic tool (Output 1.2); and it will improve the health aspects of the MHEWS (Output 1.3). It will increase the resilience of physical infrastructure for the health sector (Output 3.1); strengthen services delivery and resilience through cold chains, diagnosis and treatment (Output 3.2); improve community WASH infrastructure and environmental management for vector control (Output 4.1); and develop community capacity for the adoption of climate-resilient practices and behaviours (Output 4.2)

⁹⁸ WHO. (n.d.).

⁹⁹ IHME. (2015). [GBD Compare \[Data Set\]](#). Seattle, WA: Institute for Health Metrics and Evaluation, University of Washington. Retrieved Octobre 2025.

Replicability	Availability of climate information and technical and institutional barriers limit the ability to replicate climate-resilient technologies and practices. The health-sector infrastructure remains vulnerable, and limited and uncoordinated improvements could not be replicated. Limited awareness and knowledge at the community level hinders the adoption of climate resilient practices and behaviours.	<u>Low</u>	The project will lead to the integration of improved systems that will increase the climate resilience of the health sector. A robust and interoperable system integrating multiple data sources will allow for scaling up forecasting and projection, in terms of geographic area or CSHOs, seamlessly incorporating results into the MHEWS and decision-making processes. Construction norms will be replicated across all new, retrofitted, or maintained healthcare facilities across the country, multiplying the adoption of climate-resilient technologies and practices. Improved CSHO diagnostic capacity will support diagnosis across the country, and climate-resilient cold chains will provide effective immunisation and treatment. Communities will have the awareness and options to adopt climate-resilient practices to reduce exposure to CSHO pathogens.	The project will support the setting up of a baseline for epidemiological forecasting and projections, ensuring the interoperability and analysis of multiple data sources (Output 1.2). It will capitalise on lessons learned, providing a comprehensive investment roadmap to improve the effective and efficient replication of modelling as an evidence-based decision tool (Output 1.2). The project will also ensure that institutional arrangements and processes are in place to incorporate results into the MHEWS (Output 1.3), allowing for the replication of further health-related risks integration. Construction norms (Output 3.2) will allow for the replication of healthcare infrastructure, and will offer a replicable model, most notably for education. Lastly, empowered communities (Output 4.2) with awareness and knowledge about climate change risks will acquire a set of transferable skills and practices across several sectors.
Sustainability	Several good-practice policy frameworks and institutional arrangements are already in place and embedded across key stakeholders. These include the National Plan for the Adaptation of the Health Sector, the National Plan for the Development of the Health Sector, the National Health Plan, and the National Programme Against Malaria. These instruments are operational and provide coordination platforms bringing together the MSHPCSUA, international partners (including WHO and UNICEF), academia, civil society organisations, other sectors, and regional governance structures.	<u>Medium</u>	The project will shift the health sector to a high-climate-resilience equilibrium. Capacity development at the MSHPCSUA will set the stage for long-term support of public health outcomes. Improved, evidence-based decision-making will allow for long-term adaptive management to ensure that the public health system can provide comprehensive diagnosis and treatment of CSHOs beyond the GCF funding period. Increased knowledge and capacity of health professionals, and highly trained, dedicated personnel for planning at the MSHPCSUA level, will create a self-sustaining transformation of the sector. Strong leadership and governance, an informed and knowledgeable health workforce, integrated health information systems, resilient chains for the provision of essential products and technologies, quality service delivery, and ring-fenced financing will keep the sector in a state of high climate resilience.	The project will support the self-sustaining transformation of the health sector in Togo, increasing its climate resilience. Long-term institutional support for the sector is created through institutionalisation for coordination, including the CCUs (Output 2.1), capacity building for the MSHPCSUA and key stakeholders in the country (Output 2.2), including interinstitutional cooperation at the national, regional, and international levels. The project's approach to climate-resilient infrastructure improvement norms, which are gender-sensitive and adjusted to local conditions, coupled with targeted construction capacity development (Outputs 3.1, 4.1), will maintain resilience beyond the funding period. Enhanced knowledge and skills across the sector and in communities (Outputs 2.2, 4.2), combined with improved and climate-resilient access to diagnostic and treatment options (Output 3.2), will enable robust and long-term resilience to CSHOs and other health-related climate risks. The project's comprehensive

	However, while the One Health platform has been formally established, it is currently inactive. In parallel, the MSHPCSUA has created a Climate-Health Task Force to coordinate responses to climate-related health risks, but important institutional, technical, and resourcing gaps limit its effectiveness. In addition, the ANPC has been strengthening both the physical infrastructure and institutional coordination mechanisms for early warning systems, including with the GCF project SAP 48).			interventions to all health system resilience components will set in motion a system that can support the long-term sustainability of project results.
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E.3. GCF Outcome level: Reduced emissions and increased resilience (IRMF core indicators 1-4, quantitative indicators)

GCF Result Area	IRMF Indicator	Means of Verification (MoV)	Baseline	Target		Assumptions / Note
				Mid-term	Final ¹⁰⁰	
<u>Total beneficiaries</u>	<u>Core 2: Direct and indirect beneficiaries reached</u>	Project monitoring and evaluation reports quality assessed by the AE. DHIS2 Data	0 Total 0 direct 0 indirect 0 male 0 female	1,605,273 Total 736,556 direct 868,718 indirect 787,649 males 817,624 females	4,013,183 Total 1,841,389 direct 2,171,794 indirect 1,969,123 males 2,044,060 females	Direct beneficiaries receive targeted support and adaptation benefits from Outputs 1.3, 3.1, 3.2, and 4.1. Indirect beneficiaries receive adaptation benefit from Outputs 1.3, 2.1, 2.2, 3.1. Indirect beneficiaries include the rest of the population that does not directly receive notifications but are less exposed to risks through local governance and healthcare preparedness. As beneficiaries overlap the total number of beneficiaries excludes overlaps between beneficiary groups. For more information on the beneficiary calculations and methodology, please see

¹⁰⁰ The final target means the target at the end of project/programme implementation period. However, for core indicator 1 (GHG emission reduction), please also provide the target value at the end of the total lifespan period which is defined as the maximum number of years over which the impacts of the investment are expected to be effective.

						Section 8.1.2 of Annex 2 Feasibility Study and Annex 2d Beneficiary calculations.
<u>ARA1 Most vulnerable people and communities</u>	<u>Core 2: Direct and indirect beneficiaries reached</u>	MSHPCSUA records, DHIS2 Data, national population and housing census. Survey Project monitoring and evaluation reports quality assessed by the AE	0 Total 0 direct 0 indirect 0 male 0 female	286,667 Total 286,667 direct 0 indirect 139,678 males 146,990 females	716,669 Total 716,669 direct 0 indirect 349,195 males 367,474 females	Direct beneficiaries for ARA1 receive targeted support from Outputs 3.1, 3.2, and 4.1 and have a measurable adaptation benefit of reduced days of work absence leading to more secure livelihoods (improved adaptive capacity). As beneficiaries overlap the total number of beneficiaries excludes overlaps between beneficiary groups.
	<u>Supplementary 2.1: Beneficiaries (female/male) adopting improved and/or new climate-resilient livelihood options</u>	MSHPCSUA records, DHIS2 Data, national population and housing census. Project monitoring and evaluation reports quality assessed by the AE	0 Total 0 direct 0 indirect 0 male 0 female	286,667 Total 286,667 direct 0 indirect 139,678 males 146,990 females	716,669 Total 716,669 direct 0 indirect 349,195 males 367,474 females	No Indirect beneficiaries are accounted as there is no measurable adaptation benefit to non-targeted population. Assumptions: All active population in the targeted areas has access to the improved healthcare services through universal healthcare coverage leading to timely diagnosis and improved treatment of the targeted CSHO. Gender split for direct and indirect beneficiaries is according to the 2022 census data and woman account for 51% of the beneficiaries. Note: Active population corresponds to ages between 15-65 of both sexes. For more information on the beneficiary calculations and methodology, please see Section 8.1.2 of Annex 2 Feasibility Study and Annex 2d Beneficiary calculations.
<u>ARA2 Health, well-being, food and water security</u>	<u>Core 2: Direct and indirect beneficiaries reached</u>	Mobile provider subscriptions, ANPC TogoAlert+ monitoring, national population and housing census. Project monitoring and evaluation reports quality assessed by the AE	0 Total 0 direct 0 indirect 0 male 0 female	1,605,273 Total 736,556 direct 868,718 indirect 787,649 males 817,624 females	4,013,183 Total 1,841,389 direct 2,171,794 indirect 1,969,123 males 2,044,060 females	Direct beneficiaries for ARA2 receive targeted support from Outputs 1.3, 3.1, 3.2, and 4.1. As beneficiaries overlap the total number of beneficiaries excludes overlaps between beneficiary groups. Direct beneficiaries from Output 1.3 have the adaptation benefit of receiving health-related EWS alerts (reduced exposure). Indirect beneficiaries include the rest of the population that does not directly receive notifications, but through local governance and

	<u>Supplementary 2.4:</u> <u>Beneficiaries (female/male)</u> <u>covered by new or improved</u> <u>early warning systems</u>	Mobile provider subscriptions, ANPC TogoAlert+ monitoring, national population and housing census. Project monitoring and evaluation reports quality assessed by the AE	0 Total 0 direct 0 indirect 0 male 0 female	1,605,273 Total 736,556 direct 868,718 indirect 787,649 males 817,624 females	4,013,183 Total 1,841,389 direct 2,171,794 indirect 1,969,123 males 2,044,060 females	healthcare preparedness are less exposed to risks. Direct beneficiaries from Output 3.1 have the adaptation benefit of receiving more climate-resilient healthcare services (reduced sensitivity). Direct beneficiaries from Output 3.2 have the adaptation benefit of improved diagnosis and treatment of targeted CSHO (reduced sensitivity). Direct beneficiaries from Output 4.1 have the adaptation benefit of reduced exposure to CSHO (reduced exposure). Assumptions: At least one of the multiple available means of EWS notification remain operational. For assumptions and justification on the EWS improvements, please see Annex 2d. The EWS effectively covers 63% of the population in the targeted areas ¹⁰¹ . Note: Baseline is 0 for the improved EWS Gender split for direct and indirect beneficiaries is according to the 2022 census data (51% women). For more information on the beneficiary calculations and methodology, please see Section 8.1.2 of Annex 2 Feasibility Study and Annex 2d Beneficiary calculations.
<u>ARA3 Infrastructure and built environment</u> <u>Choose an item.</u>	<u>Core 3: Value of physical assets made more resilient to the effects of climate change and/or more able to reduce GHG emissions</u>	Project monitoring and evaluation reports quality assessed by the AE. Project financial reporting, Verification visits	0 EUR	3,053,253 EUR	10,177,501 EUR	Assumptions: 30% of sites will be rehabilitated by project mid-term.
	<u>Supplementary 2.6:</u> <u>Beneficiaries (female/male)</u> <u>living in buildings that have</u>	Mid-term and final evaluation survey.	0 Total 0 direct 0 indirect	1,854 Total 1,854 direct 0 indirect	4,635 Total 4,635 direct 0 indirect	Direct beneficiaries for ARA3 receive targeted support from Output 4.1. Direct beneficiaries from Output 4.1 have the adaptation benefit of having access climate

¹⁰¹ Effectiveness is estimated based on message delivery success rate, message comprehension, and capacity to respond.

	<u>increased resilience against climate hazards</u>	Project monitoring and evaluation reports quality assessed by the AE.	<i>0 male 0 female</i>	<i>903 males 951female</i>	<i>2,258 males 2,377female</i>	resilient WASH in schools and houses with improved protection from vectors. No Indirect beneficiaries are accounted as there is no measurable adaptation benefit to non-targeted population. Assumptions: 40% of sites will be rehabilitated by project mid-term. Gender split for direct and indirect beneficiaries is according to the 2022 census data (51% women). For more information on the beneficiary calculations and methodology, please see Section 8.1.2 of Annex 2 Feasibility Study and Annex 2d Beneficiary calculations.
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E.4. GCF Outcome level: Enabling environment (IRMF core indicators 5-8 as applicable)

Core Indicator	Baseline context (description)	Rating for current state (baseline)	Target scenario (description)	How the project will contribute	Coverage
<u>Core Indicator 5: Degree to which GCF investments contribute to strengthening institutional and regulatory frameworks for low emission climate-resilient development pathways in a country-driven manner</u>	A Climate-Health Task Force was created within the MSHPCSUA in 2019 for the coordination of climate action within the Ministry, but multiple commitments, lack of financing and absence of intersectoral coordination and cooperation hinder its effectiveness. Moreover, there is no coordination platform at the regional level.	<u>medium</u>	Coordination within the MSHPCSUA and with key stakeholders like the ANPC, ANAMET, MERFPCCC, and Division of Integrated Surveillance for Health Emergencies and Response (DivSIUR) at both national and regional levels will be ensured by dedicated and properly trained MSHPCSUA personnel. The MSHPCSUA has established operational and strategic partnerships with these national and regional stakeholders, including ECOWAS, WHO/ATACH being able to tap to significant resources for operational and strategic evidence-based decision making.	The project will support the establishment of one national (2.1.1) and five regional (2.1.2) Climate Change Units within the MSHPCSUA. These units will ensure coordination both within the ministry and among different stakeholders. To build capacity, the Climate Change Units at both national and regional levels will be trained and equipped to fulfil their roles. Additionally, the project will support key strategic partnerships through engagement in national and regional multi-sectoral platforms and participation in conferences (2.1.3).	<u>National level (one country)</u>

<u>Core Indicator 6: Degree to which GCF investments contribute to technology deployment, dissemination, development or transfer and innovation</u>	Despite having a solid foundation in digital health surveillance through its DHIS2 system, Togo has only made pilot innovations in climate integration. While tools such as the DHIS2 Climate App and the Climate and Health Analytics Platform (CHAP) have shown promise in using meteorological and health data to assess malaria risks and guide interventions, they remain limited in scope. These tools are only partially integrated, are limited to malaria, don't yet inform operational and strategic decisions or cover other climate-sensitive health outcomes.	medium	A functional and improved EWS for malaria and diarrhoeal diseases will be informed by enhanced modelling. This modelling will integrate meteorological, climate, epidemiological, and social determinants to provide short-term case forecasts and long-term projections. The technologies used for data integration and analysis will enable evidence-based decision-making for both operational resource allocation and strategic planning.	The project will contribute to epidemiological modelling by integrating multiple databases (under 1.2.1). This improved modelling (under 1.2.2) will cover malaria and diarrhoeal diseases in the three targeted areas. For the first time at an operational level in Togo, the project will implement a type of modelling that allows for short-term forecasting and long-term projections based on meteorological and climate projection data.	<u>Multiple sub-national areas within a country</u>
<u>Core indicator 8: Degree to which GCF investments contribute to effective knowledge generation and learning processes, and use of good practices, methodologies and standards</u>	Surveillance of climate-sensitive diseases in Togo remains limited, despite improvements such as the establishment of malaria sentinel sites in 2017. Additionally, the quality and timeliness of current data can't support operational Early Warning System (EWS) forecasting and projections. Moreover, even though Togo developed a national strategic plan for health research for 2015-2020, its implementation has been weak. This is due to a lack of consistent, cross-sectoral dialogue involving academia, civil society, and development partners. Lastly, the country's participation in regional health and climate events has been intermittent	medium	A comprehensive network of sentinel sites in the targeted areas will employ well-trained personnel with the necessary equipment. This will allow for the implementation of good practices and the provision of robust, timely, and high-quality data to inform epidemiological modelling. Furthermore, cross-sectoral dialogue and improved national awareness will enable operational research on the climate and health nexus, leading to effective knowledge generation and learning. Consistent participation by the MSHPCSUA and key stakeholders in national and regional forums will contribute to the dissemination and exchange of these good practices.	The project will support the strengthening of surveillance and monitoring of climate-sensitive diseases (3.2.2). It will do this by extending epidemiological sentinel sites for malaria, expanding to include entomological and parasitological sites for malaria, and establishing ecological sentinel sites for diarrhoeal diseases. The project will also strengthen monthly data quality reviews and reporting at the district and regional levels. Furthermore, the project will develop a Climate and Health Master's program, adapt medical curricula to integrate climate change and health, and promote research collaboration among academic, governmental, and community actors (2.2.1). It will also improve the technical capacities of key health sector actors on climate-sensitive diseases by integrating climate change into existing Health Training Programmes and by training health personnel and CHWs (2.2.2). Lastly, it will support participation in regional and international platforms and conferences (2.1.3).	<u>Multiple sub-national areas within a country</u>

E.5. Project/programme specific indicators (project outcomes and outputs)

Project/programme results (outcomes/ outputs)	Project/programme specific Indicator	Means of Verification (MoV)	Baseline	Target		Assumptions / Note
				Mid-term	Final	
Outcome 1: Climate services for health are strengthened	Togolese HEWS operationally capable to issue evidence-based CSHOs risk alerts.	MSHPCSUA, ANPC documentation, ANPC TogoAlert+ monitoring Data Project monitoring and evaluation reports quality assessed by the AE.	0 MHEWS with capacity to issue evidence-based CSHOs risk alerts	0	1	Assumptions: HEWS does not face critical disruptions. All dissemination channels continue to be accessible. No major climate disasters occur that significantly disrupt project implementation. No major health crises or pandemics disrupt in-person project activities.
Output 1.1: Climate information to inform the surveillance system for climate-sensitive health outcomes is effectively integrated	Number of fully operational AWS meeting WMO standards installed at priority positions.	ANAMET technical reports Equipment commissioning records Project monitoring and evaluation reports quality assessed by the AE.	0 AWS installed	4	4	Assumptions: No major climate disasters occur that significantly disrupt project implementation. No major health crises or pandemics disrupt in-person project activities. Equipment procurement proceeds on schedule. Equipment / technology supply chains remain stable and there are no major cost escalations.
Output 1.2: Integrated surveillance outputs are effectively used to guide climate-sensitive health outcome response, especially for vulnerable groups	Number of CSHOs decision making supported by operational epidemiological modelling.	MSHPCSUA documentation Project monitoring and evaluation reports quality assessed by the AE.	0 CSHOs	1	3	Assumptions: No major climate disasters occur that significantly disrupt project implementation. No major health crises or pandemics disrupt in-person project activities. DHIS2 MSHPCSUA system does not face critical disruptions.
Output 1.3: An EWS for health is used by policymakers, HFs, the general and key vulnerable populations	Number of updated operational protocols incorporating improved CSHO	ANPC documentation, ANPC TogoAlert+ monitoring	0 updated documents (1 non-updated)	1 updated document	1 updated document	Assumptions: MHEWS does not face critical disruptions. Notes:

	surveillance and modelling in the Togolese MHEWS.	Project monitoring and evaluation reports quality assessed by the AE.				Protocols refer to the operational documents that guide health-related alerts under the Togolese MHEWS. To be “updated” the document should incorporate improved CSHOs surveillance, modelling and modelling interpretation.
Outcome 2: An enabling environment to increase the resilience of the health sector in Togo is built	Population supported by improved climate-health MSHPCSUA governance at both national and regional level.	MSHPCSUA documentation Project monitoring and evaluation reports quality assessed by the AE.	0 persons	2,023,875	8,095,498	Assumptions: MSHPCSUA commitment is not altered due to major health crises or pandemics. No major disruptions leading to critical MSHPCSUA reallocation needs occur.
Output 2.1: Intersectoral collaboration, accountability and leadership mechanisms on climate change and health issues is strengthened	Number of CCUs with MSHPCSUA allocated budget and staff operational at a national and regional level.	MSHPCSUA documentation. Project monitoring and evaluation reports quality assessed by the AE.	0 CCUs	1	4	Assumptions: MSHPCSUA commitment is not altered due to major health crises or pandemics. No major disruptions leading to critical MSHPCSUA reallocation needs occur. Notes: “Operational” refers to CCUs that are staffed, equipped and with a ring-fenced budget.
Output 2.2: Capacities of the health system to react to climate-sensitive health problems are built	Number of curricula in national midwifery and medical assistant schools incorporating the climate and health nexus.	Documentation of approved curricula Project monitoring and evaluation reports quality assessed by the AE.	0 curricula	0	2	Assumptions: Academic and Technical and Vocational Education and Training (TVET) institutions’ commitment to engage with the climate and health nexus persists. No major cost escalations leading to strategic planning change of academic and TVET institutions.
Outcome 3: The resilience of health infrastructure and service delivery is improved	Population covered from climate resilient health services.	MSHPCSUA documentation, DHIS2 data Project monitoring and evaluation reports quality assessed by the AE.	0 persons	112,858	282,144	Assumptions: No major climate disasters occur that significantly disrupt project implementation. No major health crises or pandemics disrupt in-person project activities. Equipment / technology supply chains remain stable and there are no major cost escalations.
	Services related to CSHO improved in project supported USPs	Survey to assess improved service delivery	0 % of the surveyed population	30%	60%	Assumptions: No major climate disasters occur that significantly disrupt project implementation.

		Project monitoring and evaluation reports quality assessed by the AE.				No major health crises or pandemics disrupt in-person project activities. Equipment / technology supply chains remain stable and there are no major cost escalations. Handover of the USPs will take place in Y4.
Output 3.1: The resilience of health infrastructure is strengthened	Population having access to climate resilient USPs.	MSHPCSUA documentation, DHIS2 data Project monitoring and evaluation reports quality assessed by the AE.	0 persons	53,795	134,488	Assumptions: No major climate disasters occur that significantly disrupt project implementation. No major health crises or pandemics disrupt in-person project activities. Equipment / technology supply chains remain stable and there are no major cost escalations. 15 USPs (12 USPs-I, 3 USPs-II) covering 8,088 and 11,380 population respectively. Handover of the USPs will take place on Y4
Output 3.2: Prevention and treatment of CSHOs through resilient supply chains is enhanced	Population having access to improved diagnosis and treatment of CSHOs.	MSHPCSUA documentation, DHIS2 Data Project monitoring and evaluation reports quality assessed by the AE.	0 persons	59,062	147,655	Assumptions: No major climate disasters occur that significantly disrupt project implementation. No major health crises or pandemics disrupt in-person project activities. Equipment / technology supply chains remain stable and there are no major cost escalations. 15 USPs (12 USPs-I, 3 USPs-II) Handover of the USPs will take place on Y4.
Outcome 4: Community resilience to climate-sensitive health outcomes is increased and the health burden of vulnerable populations is reduced	Population living in communities with improved resilience to CSHO.	Survey Project monitoring and evaluation reports quality assessed by the AE. Field visits.	0 persons	1,218	4,635	Assumptions: No major climate disasters occur that significantly disrupt project implementation. No major health crises or pandemics disrupt in-person project activities. Equipment / technology supply chains remain stable and there are no major cost escalations.

Output 4.1: Improve community infrastructure to be more resilient to water-related CSHOs	Population residing in communities with climate resilient communal infrastructure or benefiting mosquito screens	National population and housing census. Project monitoring and evaluation reports quality assessed by the AE. Field visits.	0 persons	1,218 persons benefiting from WASH 633 persons benefiting from mosquito screens	3,045 persons benefiting from WASH 1,590 persons benefiting from mosquito screens	Assumptions: No major climate disasters occur that significantly disrupt project implementation. No major health crises or pandemics disrupt in-person project activities. Equipment / technology supply chains remain stable and there are no major cost escalations. 15 schools receiving WASH support with an average of 203 students per school 300 houses supported with screens with 5.3 members per household
Output 4.2: Community awareness and understanding of climate-health linkages are enhanced	Percentage of the population with improved awareness and knowledge to respond to health climate risks.	Quasi experimental methodology that can robustly assess improved awareness and knowledge (survey based) Project monitoring and evaluation reports quality assessed by the AE.	0 % of the surveyed population	30%	60%	Assumptions: No major climate disasters occur that significantly disrupt project implementation. Access to communication means remains unhindered and widely available throughout the project implementation. The total catchment population of health areas will be reached i.e. 1,249,903 through social media, radio, telephone, interpersonal engagement.
Project/programme co-benefit indicators						
Co-benefit 1: Improved access to sexual and reproductive health	Number of women with improved access to quality sexual and reproductive health services	MSHPCSUA documentation. Project monitoring and evaluation reports quality assessed by the AE.	0	658,387	658,387	Number of women in reproductive age (15-49 years old) in the targeted Health Districts.
Co-benefit 2: GHG emissions avoided	Avoided GHG emissions in tCO ₂ eq	Annual ex-ante and ex-post analyses, electricity generation data from the project. Power generated from solar resource (GWh) and multiplied by the Firm Energy Combined Margin Grid	0	493.2 tCO ₂ eq	986.4 tCO ₂ eq	Assumptions: No disruptions in supply chains hinder the employment of the technologies. For specific calculations please see annex provided. Interventions include health electricity production from PV installations in HFs, electric motorbikes, and low carbon cement use.

		Emission Factor IFI grid emission factor ¹⁰² .				
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E.6. Project/programme activities and deliverables

All project activities should be listed here with a description and sub-activities. Significant deliverables should be reflected in annex 5 implementation timetable. Add rows as needed.

Please number the activities as shown below to indicate association of activities to the related outputs provided above in section E.5. Similarly, please number sub-activities as shown below to associate to the related activity.

Activities	Description	Sub-activities	Deliverables
Activity 1.1.1 Improve and expand coverage of the hydrometeorological network in underserved areas	The activity focuses on strengthening the availability, reliability, and geographical coverage of real-time meteorological data in Togo. It expands and improves the national network of AWS and rain gauges and ensuring the proper maintenance of existing equipment. The system is providing the foundation needed for early warning systems and improved climate services.	Sub-activity 1.1.1.1: Purchase and installation of automated weather stations and rain gauges Sub-activity 1.1.1.2: Repair and rehabilitation of existing AWS and rain gauges	Sub-activity 1.1.1.1 1 technical procurement file, including specs, supplier selection report, and delivery certificates developed 4 new AWS procured, installed and delivered 50 rain gauges procured, installed and delivered Sub-activity 1.1.1.2 1 national technical audit report with rehabilitation needs and field logs developed 15 AWS and 82 rain gauges repaired and restored to real-time operational status, with maintenance teams having at least 40% female technicians - At least 40% of technicians participating in rain gauge and weather station repair and maintenance activities are women.
Activity 1.1.2: Enhance ANAMET's ability to manage automated meteorological data and maintain equipment	The activity strengthens the technical and operational capacities of ANAMET to effectively manage automated meteorological stations and ensure the sustainable maintenance of equipment. It facilitates the creation of a robust, decentralised system designed for rapid intervention to guarantee station availability. This is achieved through two key steps: supporting the development of an operational decentralised unit in Kara and creating a digital solution to rationalise the monitoring and maintenance of all hydrometeorological equipment.	Sub-activity 1.1.2.1: Establishment of decentralised unit in Kara Sub-activity 1.1.2.2: Establishment of digital maintenance protocols and monitoring of hydrometeorological infrastructure and equipment	Sub-activity 1.1.2.1 1 building to host the maintenance workshop, storage areas, and logistics constructed taking into consideration gender needs 1 fully operational Decentralised Maintenance Centre with workshops, storage areas, and logistics capacity for rapid interventions equipped Sub-activity 1.1.2.2 1 fully operational digital solution for maintenance protocols and monitoring developed 30 (ANAMET, ANPC) technical personnel trained for data upkeep, maintenance protocols, stock availability and proactive planning
Activity 1.1.3 Strengthen the capacities of ANAMET to provide climate services for health	This activity will leverage meteorological data to inform the health sector's decision-making. It will strengthen ANAMET's technical capacities to deliver high-quality actionable health and climate bulletins. Additionally, the activity will reinforce ANAMET's organisational and managerial capacities especially	Sub-activity 1.1.3.1: Capacity development and dissemination of climate and health bulletins	Sub-activity 1.1.3.1 3 sets training material on climate and health nexus science, risk communication, health and climate bulletins developed 15 participants of ANAMET personnel trained 15 monthly bulletins delivered. At least five (≥ 5) staff members only from ANAMET's technical divisions (Agrometeorological, Synoptic,

¹⁰² https://unfccc.int/sites/default/files/resource/Harmonized_IFI_Default_Grid_Factors_2021_v3.2_0.xlsx

	focusing on M&E, ESS, Gender and SEAH, and Financial Management	Sub-activity 1.1.3.2: Strengthening of managerial, organisational, and intersectoral coordination capacities	Climatological, Forecasting, and Instrumentation) will be trained on climate and health nexus science, risk communication, and the development of health and climate bulletins. Sub-activity 1.1.3.2 • 1 set training material on M&E and Risk Management, ESS, SEAH, and FM developed • 10 ANAMET personnel trained • 1 log of ad-hoc support provided
Activity 1.2.1: Strengthen governance structures to foster an enabling environment for surveillance of climate-sensitive health outcomes	The activity integrates climate, meteorological and health data into a coherent system for epidemiological modelling and evidence-based decisions. It includes a data landscape analysis and institutional mapping, reinforces the institutional setup through clarified mandates and strengthens collaboration mechanisms embedded in formal protocols and agreements. Moreover, it establishes a technical Interoperability Architecture between the data systems. The resulting framework ensures that climate and health information can effectively support evidence-based planning and EWS.	Sub-activity 1.2.1.1: Conduct a data landscape analysis and institutional mapping Sub-activity 1.2.1.2: Strengthening the institutional set up Sub-activity 1.2.1.3: Strengthening collaboration mechanisms Sub-activity 1.2.1.4: Establishing the technical interoperability architecture and assurance	Sub-activity 1.2.1.1 • 4 data managers trained (2 health MSHPCSUA, 2 meteorological ANAMET) and 2 stakeholder (ANPC, GIZ) staff on data landscape analyses and institutional mapping • 1 report on prioritised technical and institutional requirements developed • 1 consolidated implementation-readiness note developed Sub-activity 1.2.1.2 • 3 MoUs between MSHPCSUA and stakeholders signed • 1 set of SOPs for data collection developed • 10 data managers and technical staff trained on SOP processes and institutional mandates • 1 cooperation agreement between MSHPCSUA, WASCAL-UoL and a university with a strong track record on climate-sensitive diseases modelling signed Sub-activity 1.2.1.3 • 1 Climate & Health Data Sub-Group established under the One Health Platform • 1 annual coordination forum between ministries, agencies, and development partners held • 10 institutional stakeholders trained on collaboration protocols and technical data integration Sub-activity 1.2.1.4 • 1 Interoperability, Security and Compliance Framework established • 1 Climate-health data interoperability and dashboard pilots implemented • 1 Operations & capacity institutionalisation completed
Activity 1.2.2: Leverage integrated surveillance data to create CSHO-specific models that	This activity leverages established data systems to support advanced epidemiological modelling for climate-sensitive diseases, building the capacity of MSHPCSUA and the University of Lomé. It focuses	Sub-activity 1.2.2.1: Establish academic exchanges and partnerships	Sub-activity 1.2.2.1 • 3 MoUs signed between Togolese universities and regional/international universities • 6 faculty members participated in short-term academic exchanges

analyse the influence of weather on transmission and inform more effective planning	on creating predictive models that use climate (ANAMET) and health (DHIS2) data to forecast disease patterns for both short-term actions (EWS, outbreak preparedness) and long-term strategic planning (resource allocation, impact assessments). Antimicrobial Resistance (AMR) surveillance data will be integrated into DHIS2, providing the essential groundwork to assess climate change impacts on AMR under a One Health approach.	Sub-activity 1.2.2.2: Strengthen weather-health modelling capacities Sub-activity 1.2.2.3: Enhance interpretation and application of models in real-world settings Sub-activity 1.2.2.4: Strengthen AMR data integration into surveillance systems Sub-activity 1.2.2.5: Develop scale-up roadmap for climate- and weather-health modelling	Sub-activity 1.2.2.2 • 5 professionals trained in short-term and long-term predictive/projection models for malaria and diarrhoea • 6 operational models for short-term effects (3) and long-term scenarios (3) of weather to malaria, diarrhoea and heat integrating developed Sub-activity 1.2.2.3 • 1 calibrated and validated standardised framework of interpretation • 2 manuals of interpretation developed • 4 health partners from MSHPCSUA and WASCAL-UoL trained to conduct model assessment and adaptation Sub-activity 1.2.2.4 • 1 synthesis report on climate-AMR linkages produced • 1 national AMR Action Plan updated to incorporate climate-sensitive surveillance and decision-making developed Sub-activity 1.2.2.5 • 1 scale-up gender-responsive roadmap validated
Activity 1.3.1: Strengthen operational arrangements to implement warning services delivery	This activity establishes the operational core of Togo's Health Early Warning System (Health EWS), transforming integrated climate and health data into timely, actionable alerts. It establishes a governance framework and SOPs that define roles and embed health alerts within the national MHEWS. Second, it defines and validates thresholds for triggering alerts using multi-source data, ensuring consistent and equity-sensitive criteria. Third, it develops a digital platform to automate data aggregation, apply thresholds, and generate validated alerts, linking seamlessly with the wider MHEWS infrastructure.	Sub-activity 1.3.1.1.: Establishing the governance framework for Health Early Warnings Sub-activity 1.3.1.2.: Defining thresholds and integrating data for health alerts Sub-activity 1.3.1.3.: Developing the digital platform for health alerts Sub-activity 1.3.1.4.: Building capacity and ensuring sustainability of the Health EWS	Sub-activity 1.3.1.1 • 1 governance framework for H-EWS validated and endorsed by MSHPCSUA, ANAMET, ANPC • 1 national SOPs for alert workflows finalised and disseminated • 1 H-EWS annex integrated into national MHEWS procedures Sub-activity 1.3.1.2 • Alert thresholds for malaria, diarrhoeal diseases, and heat impacts defined and validated by MSHPCSUA and ANAMET incorporating gender-responsive vulnerability criteria Sub-activity 1.3.1.3 • 1 digital platform for H-EWS operational and linked to national MHEWS • Automated alert generation and validation workflows being functional Sub-activity 1.3.1.4 • 120 staff at national and regional level trained on H-EWS alert workflows • Digital helpdesk and refresher course for EWS established
Activity 1.3.2: Deliver warning messages through multiple	The activity develops and operationalises the communication and community-response component of the H-EWS. It focuses on transforming national	Sub-activity 1.3.2.1: Co-developing a practical communication approach for Togo's EWS	Sub-activity 1.3.2.1

communication channels and strengthen response in affected communities	alerts into clear, culturally resonant, and actionable messages that trigger timely protective behaviour. This is achieved by co-developing a practical EWS communication approach and toolkit that maps alert pathways and tests messages for clarity and trust. Moreover, the activity develops a training model for local interpretation and response to H-EWS information deployed under output 4.2.	Sub-activity 1.3.2.2: Strengthening community capacity to understand and act on early health warnings	• 1 H-EWS communication methodology & toolkit developed and validated • 1 H-EWS communication strategy for Togo finalised Sub-activity 1.3.2.2 • 1 EWS training module developed (to be delivered into the multiplier training package of 4.2.2) • 3 regional joint training sessions delivered (together with 4.2.2) reaching at least 500 multipliers (CHWs, teachers, Red Cross volunteers, local leaders) who will also be trained on EWS.
Activity 2.1.1: Establish a CCU dedicated to health and climate change issues within the MSHPCSUA	The activity establishes a dedicated CCU under the MSHPCSUA. The CCU will act as the national coordination body, systematically integrating climate change considerations into the health system. Its key functions include leading the planning and implementation of adaptation and mitigation strategies, coordinating national efforts, and serving as a liaison between the health sector and intersectoral partners like Ministry of Environment and ANPC. The CCU will also represent Togo in international platforms like the WHO ATACH alliance. The activity includes institutionalisation, capacity development, establishment of partnerships, and acquisition of infrastructure.	Sub-activity 2.1.1.1: Formal establishment of the CCU Sub-activity 2.1.1.2: Capacity strengthening of the CCU Sub-activity 2.1.1.3: Operational and strategic partnerships Sub-activity 2.1.1.4: Provision of equipment and material resources for the CCU	Sub-activity 2.1.1.1 • 1 ministerial decree officially establishing the CCU within the MSHPCSUA issued, mandating a composition of ≥50% women and ≥10% women in leadership and decision-making positions • 1 institutional framework document for the CCU adopted by the MSHPCSUA Sub-activity 2.1.1.2 • 1 institutional capacity development plan validated and adopted by MSHPCSUA • 25 staff trained on technical and managerial topics, comprising an absolute target of ≥50% women • 2 regional peer learning or exchange visits completed Sub-activity 2.1.1.3 • 3 formal cooperation agreements to inform (MoUs/protocols) signed with strategic institutions under Output 1.2 • 1 strategic partnership and donor engagement plan, including a coordination mechanism, is developed Sub-activity 2.1.1.4 • 1 CCU with complete office setup (including IT) equipped • 1 operational 4x4 utility vehicle delivered and registered for CCU
Activity 2.1.2: Establish 5 CCUs in the Regional Health Directorates	The activity will decentralise climate-health governance in Togo by establishing five regional CCUs within the RHDs. These regional CCUs will act as operational hubs, staffed by designated personnel and equipped with necessary resources. Their mandate is to translate national strategies into local action, guiding Health Districts and CHWs in implementing climate-sensitive activities. They will also serve as key coordination points with regional	Sub-activity 2.1.2.1: Institutional setup and operationalisation of regional CCUs Sub-activity 2.1.2.2: Capacity development and technical support	Sub-activity 2.1.2.1 • 5 CCUs established through legal documents, with the formal assignment of personnel across these units comprising an absolute target of ≥30% women • ≥ 1 of the 5 regional CCUs will be headed by a woman from the assigned personnel, with the required technical, managerial, and leadership skills

	partners like ANAMET and ANPC on EWS and disaster risk reduction, while collecting and reporting local climate-health data to strengthen national surveillance (DHIS2). The activity includes the formal establishment of the CCUs, the capacity development of the staff and the provision of necessary equipment and resources.	Sub-activity 2.1.2.3: Provision of operational tools and equipment and	Sub-activity 2.1.2.2 • 15 members of the 5 CCUs trained in technical, administrative and management skills • 10 regional peer-learning workshops conducted Sub-activity 2.1.2.3 • 5 regional CCUs equipped with complete office setup (including IT)
Activity 2.1.3: Strengthen national and sub-regional coordination, knowledge, and learning mechanisms	The activity institutionalises coordination, learning, and knowledge-sharing on climate and health at a national level. It strengthens the capacity of the national CCU and regional CCUs to engage effectively in multi-sectoral national, regional and global health platforms. The activity will position Togo as an active contributor by promoting regional knowledge exchange through joint learning missions and participation in key regional bodies like ECOWAS and WAHO. At the international level, Togo's engagement in platforms such as WHO's ATACH will be reinforced, securing ownership, coherence, and sustainability across local, regional, and global climate-health agendas.	Sub-activity 2.1.3.1: Strengthening MSHPCSUA and CCU's strategic engagement in national multi-sectoral platforms through institutional mapping, role clarification, and technical support Sub-activity 2.1.3.2: Organisation and/or participation in inclusive national, regional, and international conferences, negotiations and fora Sub-activity 2.1.3.3: Promotion of regional knowledge exchange and joint learning	Sub-activity 2.1.3.1 • 1 Strategic Engagement and Coordination Plan for CCUs validated by MSHPCSUA • 1 Capacity Development Programme for One Health, National Adaptation Committee, and CCUs delivered to 15 staff • National CCU participated in 3 climate-relevant coordination platforms Sub-activity 2.1.3.2 • CCU/MSHPCSUA participated in 5 regional or international conferences and fora on climate change and health • 2 national research-policy exchange fora conducted Sub-activity 2.1.3.3 • 5 lessons learnt products produced and disseminated regionally • 1 regional or international event co-hosted by MSHPCSUA in Togo • 3 joint learning missions conducted
Activity 2.2.1: Develop and implement climate and health training programmes	The activity will develop and implement comprehensive training on climate and health at the university and professional levels. It will create a Climate Change and Health Master's degree medical support curricula, and update curricula to embed climate-health, AMR, and One Health. It will promote intersectoral research by sponsoring conference attendance and organising national conferences. Finally, it will establish a capacity-building programme to support researchers in writing and submitting high-quality research proposals for funding.	Sub-activity 2.2.1.1: Develop a Climate and Health Master's programme Sub-activity 2.2.1.2: Adapt medical support curricula by integrating climate change and health	Sub-activity 2.2.1.1 • 1 integrated and validated Master curriculum, including (online) teaching tools • 13 students (1 cohort) successfully complete the master's programme in Climate and Health. Sub-activity 2.2.1.2 • 2 medical curricula updated, integrating climate change, AMR, and One Health concepts (revised didactic and pedagogical approaches) • Updated teaching materials are produced to reflect the revised curricula • 4 training sessions delivered for medical school teaching staff • 4 specific gender-responsive measures adopted in the admission and retention strategy

		Sub-activity 2.2.1.3: Promote intersectoral and participatory research on climate and health, encouraging collaboration between academic, governmental, and community actors.	Sub-activity 2.2.1.3 • 2 national conferences in Togo focused on climate and health research organised
		Sub-activity 2.2.1.4: Support for research proposal submissions	Sub-activity 2.2.1.4 • 1 set of training materials research proposal development developed • 4 capacity-building workshops (80 trainees) for researchers on proposal design and grant writing delivered
Activity 2.2.2: Build technical capacities of key actors in the health sector in the prevention and management of climate-sensitive health outcomes through training	The activity strengthens the technical capacities of health professionals at central, regional, and local levels, including CHWs, across the Centrale, Kara, and Savanes regions. The activity will implement a blended learning approach, combining in-person, hands-on training with digital and remote tools. Health workers and CHWs will receive practical training focused on how to prepare, interpret, and apply climate-health bulletins using weather data. The initiative involves four key sub-activities: integrating climate aspects into existing health training programmes, developing innovative blended learning formats, training national and regional health personnel, and the integrated training of CHWs.	Sub-activity 2.2.2.1: Developing innovative blended learning formats Sub-activity 2.2.2.2: Training national and regional health personnel Sub-activity 2.2.2.3: Training of community health workers	Sub-activity 2.2.2.1 • 30 trainers trained in 3 ToT sessions to build capacity, ensuring an absolute target of ≥30% women (minimum 9 out of 30 trainers) Sub-activity 2.2.2.2 • 150 of national and regional health personnel trained, with at least 80% of nationally trained female health professionals demonstrating adequate knowledge of Respectful Maternity Care, humanised childbirth approaches, and the use of carbetocin Sub-activity 2.2.2.3 • 150 CHWs trained
Activity 3.1.1: Improve health infrastructures to increase resilience (water-related, heat-related, vector-related health outcomes)	This activity strengthens the climate resilience of HFs in Centrale, Kara, and Savanes by implementing integrated adaptation measures against heat, and vector-borne diseases. It includes the rehabilitation or construction of up to 15 USPs-I and USPs-II with climate-adapted designs for maternity and neonatal wards. The activity integrates resilience standards into national norms, builds local construction capacity, and ensures, functional facilities. Upgrades focus on flood- and heat-resistant designs, improved drainage, passive cooling, and mosquito control. These measures enhance health system performance and protect vulnerable groups, including women and children, under climate stress.	Sub-activity 3.1.1.1: Consolidation of infrastructure norms and co-revision of health facilities master plans Sub-activity 3.1.1.2: Assessment and selection of health facilities Sub-activity 3.1.1.3: Capacity building on construction techniques and resilience measures	Sub-activity 3.1.1.1 • 1 set of resilient health infrastructure guidelines developed • 25 personnel members trained in the application of the guidelines (15 technical personnel and health facility managers and 10 technical personnel from the Regional Departments) Sub-activity 3.1.1.2 • 1 prioritisation framework for the selection of HFs developed • 1 list of eligible and selected HFs validated by PSC Sub-activity 3.1.1.3 • 1 training programme developed • 225 core team of construction / Maintenance personnel trained, with priority selection Sub-activity 3.1.1.4

		Sub-activity 3.1.1.4: Rehabilitation of health facilities and construction of resilient maternity blocks in USP-I and II Sub-activity 3.1.1.5: Procurement of health facility equipment	• 100% of construction plans developed or updated under the project are based on participatory needs assessments and comply with person-centred care standards by the end of the project and undergo validation by COGES, local women representatives, medical staff and project team in the design phase. • 15 HFs rehabilitated or extended or newly constructed considering climate resilience ○ At least 60% (9 out of 15) have separate maternity wards in accordance with the revised standard ○ 100% (up to 15 facilities) provide gender-responsive, inclusive and confidential climate-sensitive health services ○ 100% demonstrate effective use of accessibility features by patients with reduced mobility • At least 30 staff members (2 per upgraded facility) trained on survivor-centred GBV/SEAH case management and referral protocols • 3 operation and maintenance (O&M) plans developed (1 per region, covering the 15 HFs) Sub-activity 3.1.1.5 • 15 USP equipped
Activity 3.1.2: Maintain health infrastructures to increase resilience	The activity strengthens the institutional, human, digital, and financial foundations for maintaining health infrastructure and biomedical equipment, ensuring long-term functionality and climate resilience by operationalising the National Maintenance Strategy (2025-2030). The activity includes enhancing gender-transformative professional training by integrating a "Health Maintenance Skills" module into the Technician's Certificate curriculum and providing in-service training. It strengthens public-private partnerships for maintenance sustainability. It operationalises three Regional Maintenance Centres (RMCs) with updated tools and support, establishes a national CMMS, and supports the operationalisation of a RMF with clear governance and financing.	Sub-activity 3.1.2.1: Strengthening gender transformative professional training and in-service training Sub-activity 3.1.2.2: Strengthening partnership engagement for maintenance Sub-activity 3.1.2.3: Support gender transformative and climate-sensitive operability of maintenance in the health facilities Sub-activity 3.1.2.4: Support digitalisation of maintenance processes	Sub-activity 3.1.2.1 • 1 BT-level Technical Training module on maintenance in HFs developed • 20 BT students certified and included in a national technician registry, supported by targeted awareness-raising campaigns aiming for an absolute target of ≥25% female participation • 1 national recognition framework for maintenance staff implemented in 50 HFs • 200 end-user training sessions delivered Sub-activity 3.1.2.2 • 1 Public-Private Maintenance Partnership (PPMP) Task Force established • 1 MoU between the MSHPCSUA and the private sector signed Sub-activity 3.1.2.3 • 3 RMCs established Sub-activity 3.1.2.4

		Sub-activity 3.1.2.5: Support a financing mechanism for the Regional Maintenance Fund	• 1 national digital inventory of health facility equipment and infrastructure completed and validated • 1 GMAO system deployed (with software, licenses, server hosting, digital devices) operationalised • 6 GMAO training programmes delivered (1 for 20 principal users and 5 regional workshops for 100 users) Sub-activity 3.1.2.5 • 1 strategy for resource mobilisation developed • 75 staff members trained (45 regional and 30 prefecture levels)
Activity 3.2.1: Strengthen cold chains for vaccines, climate-sensitive medicines and diagnostics	This activity strengthens the cold and supply chains for vaccines - including the new R21 malaria vaccine -, medicines, and diagnostics. It maps and upgrades stationary infrastructure across all levels using solar-powered refrigerators/freezers and hybrid energy systems. The activity modernises the transport fleet with high-performance cold-chain backpacks, refrigerated vans, and electric vehicles for last-mile delivery. It also rolls out a cloud-connected temperature-monitoring platform and integrates cold-chain data into the national electronic Logistics Management Information System (e-LMIS) to enable real-time alerts and efficient maintenance/resupply.	Sub-activity 3.2.1.1: Survey and strengthen cold chain & energy infrastructure Sub-activity 3.2.1.2: Improving cold chain transport and distribution of medical products Sub-activity 3.2.1.3: Support to national e-LMIS roll-out	Sub-activity 3.2.1.1 • 1 assessment package of cold chain & energy infrastructure validated • 15 USP with stationary cold chain upgraded • End-to-end temperature monitoring operational Sub-activity 3.2.1.2 • 1 cold chain transport system in place (vehicles, backpack, trained personnel) Sub-activity 3.2.1.3 • 1 national e-LMIS system in place and validated • 5 trainers trained, aiming for an absolute target of ≥30% female participation
Activity 3.2.2: Strengthen surveillance and monitoring of climate-sensitive health outcomes	This activity enhances Togo's climate-sensitive health outcomes surveillance system for earlier detection for malaria and diarrhoeal diseases. It expands the network of epidemiological sentinel sites for malaria and diversifies surveillance to include entomological, parasitological, and climatological sites (for diarrhoeal diseases). The activity includes piloting fever clinics to improve syndromic detection and strengthening monthly data quality reviews at district and regional levels through capacity building and digital innovation.	Sub-activity 3.2.2.1: Extension of epidemiological sentinel sites for malaria Sub-activity 3.2.2.2: Expansion towards entomological and parasitological sentinel sites for malaria Sub-activity 3.2.2.3: Expansion towards climatological sentinel sites for diarrhoeal diseases Sub-activity 3.2.2.4: Pilot of fever clinics in sentinel sites	Sub-activity 3.2.2.1 • 15 new epidemiological sentinel sites operational • 60 health professionals trained on malaria surveillance, aiming for an absolute target of ≥30% female participation Sub-activity 3.2.2.2 • 6 entomological and parasitological sentinel sites operational • Protocols for insecticide resistance and parasite monitoring validated Sub-activity 3.2.2.3 • 6 climatological sentinel sites operational • 20 health and environmental officers trained on integrated climate-health surveillance, aiming for an absolute target of ≥30% female participation Sub-activity 3.2.2.4 • 15 fever clinics established and equipped in sentinel sites

		Sub-activity 3.2.2.5: Strengthening of monthly data quality reviews and reporting at district and regional levels	• 60 health personnel trained and deployed, aiming for an absolute target of ≥30% female participation Sub-activity 3.2.2.5 • 6 districts in data improvement supported (focal point coaching, monitoring meetings) • All project-supported surveillance systems configured to report sex-disaggregated data on climate-sensitive health outcomes • 30 data managers trained on Electronic Data Quality Review (eDQR), including the mandatory provision of one female-only training session for women staff of ministerial data units (DSNISI) to build leadership and confidence • Gamification dashboards in DHSI2 operational in the 3 regions • By end of project, 100% of the project-supported surveillance systems (epidemiological, entomological, and climatological sentinel sites) regularly produce report including report sex-disaggregated data on at least 3 priority climate-sensitive health
Activity 3.2.3: Strengthening diagnostics and treatment of climate-sensitive health outcomes	This activity improves access to accurate diagnostics and reliable treatment for climate-sensitive health outcomes (malaria, diarrhoeal, post-partum haemorrhage). It institutionalises rapid and confirmatory diagnostic tools and strengthens laboratory quality systems and molecular capacity for resistance tracking. The activity institutionalises climate-resilient treatments and establishes a forecast-to-procurement process to secure steady, affordable regional access to essential medicines.	Sub-activity 3.2.3.1: Institutionalise diagnostics and strengthen laboratory systems for climate-sensitive health outcomes Sub-activity 3.2.3.2: Strengthening access to essential medicines and preventative services Sub-activity 3.2.3.3: Regional access to essential climate-relevant medicines	Sub-activity 3.2.3.1 • 1 operational procedure validated and disseminated including gender-responsive patient communication • 900,000 rapid diagnostic tests available in the targeted areas for 3 years Sub-activity 3.2.3.2 • Heat-resilient essential medicines available in the 3 regions • 1 set of Pharmacovigilance guidelines developed and disseminated • 2 studies of therapeutic efficacy of anti-malaria drugs published Sub-activity 3.2.3.3 • 10 HF's supplied with climate-relevant medicines through regional procurement agreements
Activity 4.1.1: Improve community infrastructures to be more resilient to water-related climate-sensitive health outcomes	This activity strengthens WASH infrastructure in educational facilities against water-related health threats and diarrhoeal diseases. It improves water supply systems; improved, inclusive, and climate-resilient sanitation facilities. Furthermore, it builds capacity for infrastructure management and promotes WASH innovations for sustainable community behaviour change, including hygiene and menstrual health practices.	Sub-activity 4.1.1.1: Rehabilitate water supply systems in schools Sub-activity 4.1.1.2: Implement improved sanitation facilities in schools Sub-activity 4.1.1.3: Build capacity for WASH infrastructure management in schools	Sub-activity 4.1.1.1 • 15 schools with drinking water supply systems installed/rehabilitated Sub-activity 4.1.1.2 • 15 schools with improved sanitation blocks installed/rehabilitated • 5 Decentralised Wastewater Treatment Systems (DEWATS) treatment facilities installed Sub-activity 4.1.1.3 • 1 WASH in Schools framework developed

		Sub-activity 4.1.1.4: Promote WASH innovations for community behaviour change	• 3 workshops on WASH facility management conducted (including participants from the 15 schools), aiming for an absolute target of $\geq 30\%$ female participation • 15 MH awareness sessions in the 15 targeted schools • 750 reusable sanitary pad kits distributed to girls in the 15 schools by trained multipliers • Formal agreement between the municipal emptying service in place for all schools signed Sub-activity 4.1.1.4 • WASH products distributed in 15 Sanimarkets • 15 functional selling points for MH products established • 3 training in the 15 Sanimarkets on Innovative WASH products delivered
Activity 4.1.2: Strengthening community engagement and local government capacity for integrated health, sanitation, and malaria control interventions	This activity strengthens the capacity of local governments and communities to manage integrated health, sanitation, and malaria control interventions and adapt to climate challenges. It pilots innovative and environmentally safe anti-larval interventions, including training CHWs and introducing mosquito screens for households. It supports the development or updating of eight communal hygiene and sanitation plans, ensuring they incorporate vector control measures. Finally, it strengthens communal coordination by reinforcing local HF committees and municipal capacity for water quality monitoring.	Sub-activity 4.1.2.1: Pilot innovative and environmentally safe anti-larval interventions Sub-activity 4.1.2.2: Development or updating of communal hygiene and sanitation plans incorporating malaria prevention and control Sub-activity 4.1.2.3: Strengthening communal coordination of health, sanitation, and vector control interventions	Sub-activity 4.1.2.1 • 1 training manual for CHW to include safe anti-larval interventions updated • 30 local providers selected and trained on mosquito screen production and installation • 16 community awareness and marketing campaigns on mosquito nets in the targeted areas delivered Sub-activity 4.1.2.2 • 80 municipal agents (10 per municipality) trained in integrated planning • 8 municipal hygiene and sanitation plans updated or developed Sub-activity 4.1.2.3 • 2 workshops on strengthening communal coordination of 15 local HF committees delivered ◦ $\geq 20\%$ women, and 10% of LCs have part of the local health committee
Activity 4.2.1: Develop communication messages, tools, and channels for different key populations to alert them on climate induced changes to health risks	This activity validates, localises, and adapts the SBC Climate and Health Strategy and Toolkit as a national reference. It starts with an independent evaluation of the draft strategy to assess its cultural fit, usability, and relevance among diverse user groups. It develops a Translation and Communication Guide to ensure climate-health information is clear, inclusive, and culturally resonant across local languages, linking directly to EWS triggers. The activity concludes by establishing a	Sub-activity 4.2.1.1: Evaluate and refine the SBC Strategy and toolkit Sub-activity 4.2.1.2: Develop a translation and Communication Guide for climate-health concepts Sub-activity 4.2.1.3: Evaluate, monitor impact, and adapt the SBC Climate and Health Strategy	Sub-activity 4.2.1.1 • 1 SBC Toolkit based on evaluation results revised Sub-activity 4.2.1.2 • 1 Translation and Communication Guide formally endorsed by the TWG and integrated into the national SBC Climate and Health Toolkit with the participation of ≥ 1 woman, 1 LC representative, and 1 representative of persons with disabilities in the development process. Sub-activity 4.2.1.3

	framework for monitoring campaign impact and conducting annual adaptation workshops to continuously refine the toolkit.		1 final consolidated evaluation and lessons-learned report feeding into the SBC Toolkit developed
Activity 4.2.2: Strengthen the capacities of multipliers at community level on the links between climate change and health	This activity strengthens the capacity of multipliers to communicate climate-health messages and promote resilient. It establishes a structured system to train multipliers on risks and interpersonal communication. The program develops and provides a modular communication toolkit in key local languages. Multipliers will implement co-ordinated IPC campaigns, guided by Community SBCC Action Plans, with at least one campaign annually linked to the EWS to enable rapid mobilisation.	Sub-activity 4.2.2.1: Develop and deliver localised training programmes for community-level multipliers on climate-health risks Sub-activity 4.2.2.2: Develop and provide multipliers with tailored communication materials and tools to engage their communities Sub-activity 4.2.2.3: Coordinate and implement interpersonal communication campaigns through multipliers	Sub-activity 4.2.2.1 20 trainers trained through ToT, ensuring an absolute target of ≥40% women 500 multipliers trained in climate-health SBCC approaches and impact measuring, with recruitment ensuring a final pool of ≥125 women and ≥2 representatives per local community Sub-activity 4.2.2.2 1 toolkit containing at least 4 audience-specific communication formats developed 3 toolkit translations in key local languages validated 4,000 toolkits distributed Sub-activity 4.2.2.3 8 Community SBCC Action Plans developed 4 community sensitisation campaigns with gender-responsive climate-health messaging and outreach strategies targeting women and vulnerable groups conducted annually across 8 target municipalities - At least 3 community awareness sessions conducted on GBV, SEAH prevention and safe reporting
Activity 4.2.3: Raise awareness through different communication channels to encourage behaviour change and strengthen ownership of community members	This activity increases public awareness and promotes protective behaviours via multi-channel, national communication campaigns. Translates the SBC Toolkit into narratives using traditional media (radio, print) and innovative digital approaches (influencers, social media). The campaigns are professionally produced, audience-tested, and localised into key languages. A rapid-response mechanism links the campaign directly EWS for immediate deployment of actionable messages during climate-health alerts.	Sub-activity 4.2.3.1: Storyboarding, production, and pre-testing of campaigns Sub-activity 4.2.3.2: Rollout, monitoring, and adaptive feedback	Sub-activity 4.2.3.1 1 integrated campaign produced in final media-ready formats - All campaign materials translated and adapted into local languages for rollout 1 comprehensive mapping and analysis of existing gender and positive masculinity campaigns, Sub-activity 4.2.3.2 1 integrated campaign in the targeted areas completed

E.7. Monitoring, reporting and evaluation arrangements (max. 500 words, approximately 1 page)

E.7.1 Monitoring, reporting and evaluation arrangements

250. Monitoring, reporting and evaluation arrangements (in addition to the ESMP and GAP) will comply with the relevant GCF policies, as stipulated in the AMA, FAA and project-related Financing Agreements and Implementation Agreements with Executing Entities and Implementation Partners, which EEs will extend to sub-grantees.

251. The project will apply a customised results-based M&E system. The M&E system will track project (sub-) activities, outcomes and impacts, as well as associated financial flows.

252. This system will be based on:

- GIZ Standard Operating Procedures ("GIZ's evaluation policy – principles, guidelines and requirements")

- Monitoring and evaluation plan (Annex 11)
- Integrated results management framework and logical framework
- Implementation Timetable (Annex 5)
- Requirements of GCF's Annual Performance Report
- Procedures and requirements of project partners and stakeholders in Togo

253. The GIZ GCF Oversight Unit will approve the monitoring system and ensures quality control of reports to the GCF.

E.7.2 Recruitment of M&E staff

254. GIZ EE will dedicate a staff member for monitoring to set up the monitoring system and to coordinate contributions by all project partners/EEs to the system.

E.7.3 Independent evaluation

255. GIZ AE's Corporate Unit Evaluation will conduct a **mid-term evaluation and a final evaluation** of the project.

256. GIZ evaluations are carried out by GIZ's independent evaluation unit. This unit is steered by a corporate unit that is separate from operational business and reports directly to the Management Board. Moreover, evaluations are conducted with the support of external evaluators.

257. GIZ applies the 'Evaluation criteria for German bilateral development cooperation' (2006, revised 2020) on a standard basis in project evaluations. These are based on the six evaluation criteria agreed by the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD): relevance, effectiveness, efficiency, overarching development results (impact), coherence and sustainability.

258. Additionally, to the six OECD DAC evaluation criteria, the following five GCF criteria will be evaluated: Gender equity, country ownership, innovativeness in results areas, replication and scalability as well as unexpected results.

259. **Regarding GCFs' Evaluation Principle:** Impartial, objective and unbiased and relevance, use and participation: All provisions for upholding the GCF evaluation principles described in Chapter V (a-d) of the Evaluation Policy are followed (see DAC standards and DeGEval evaluation standards). In line with the UNEG norms, evaluation team members selected by GIZ must not be directly responsible for the policy setting, design or management of an evaluation project.

260. **Regarding GCFs' Evaluation Principle:** Credibility and Robustness: As a matter of principle, GIZ takes care to use an appropriate combination of quantitative and qualitative methods of empirical social research in evaluations. The mix of methods is adapted to the object of the evaluation and the evaluation questions. To ensure robust evidence, GIZ uses a theory-based approach as a minimum standard for its central project evaluations. The contribution analysis has proven to be a suitable design. The aim of contribution analyses is to collect empirical evidence on whether and to what extent contributions to observed changes can be associated with a project. Furthermore, the analyses should increase the understanding and knowledge of what works, what does not work and why.

261. Projects will be rated based on the six OECD/DAC and on the GCF evaluation criteria. Each of the OECD/DAC and GCF criteria is rated on a scale of 1 to 100. Using a points system serve to increase the transparency of ratings, whilst enabling better comparability between individual projects.

262. An Interim Independent Evaluation Report and a Final Independent Evaluation Report will be submitted to the GCF as per timeline agreed in the funded activity agreement (FAA).

263. Results from the mid-term evaluation should be reflected within the project design, to influence upscaling, and improve overall project implementation (adaptive management).

E.7.4 Data collection and frequency

264. GIZ EE will coordinate data collection for implemented activities through the responsible EE in charge of leading the monitoring activities at local level. It will supervise and guide the monitoring and evaluation and will aggregate monitoring reports based on local partner inputs at least every six months and make a summary report available to GIZ's AE unit at head office, again at least every six months.

F. RISK ASSESSMENT AND MANAGEMENT

F.1. Risk factors and mitigations measures (max. 3 pages)

Selected risk factor 1: Security situation in the Savanes Region

Category	Probability	Impact
<u>Other</u>	<u>Medium</u>	<u>High</u>

Description

The security situation in the Northern Savanes region has been volatile since 2021, when armed jihadist organisations from Burkina Faso and Benin started sporadic cross-border attacks on Togolese security forces. Implementation preparation will take the fragile security situation into consideration. In very high-risk areas, no project implementation is planned.

Mitigation Measure(s)

Potential delays or adjustments to implementation modalities may be required in case the security situation deteriorates. Continuous monitoring of the security situation by the Safety and Risk Mitigation Office (SRMO). Regular coordination with the local GIZ antenna. Strengthened coordination with local authorities and security forces (e.g., the Emergency Plan for Strengthening Resilience in the Savanes Regions - PURS). Regular updating of contingency plans for potential security incidents. Continuous monitoring and adjustment of the project's implementation modes and timeline based on security assessments."

Selected risk factor 2: Gaps in coordination between key ministries and agencies

Category	Probability	Impact
<u>Governance</u>	<u>Low</u>	<u>Medium</u>

Description

Misaligned coordination or conflicting agendas among ministries and agencies could severely limit project effectiveness, creating administrative bottlenecks and resource fragmentation. The project's approach requires precise cross-sectoral coordination and clear delineation of roles and responsibilities.

Mitigation Measure(s)

The project supports inter-sectoral coordination through its cooperation between ministries and agencies to promote alignment in agendas and priorities and maximise synergies. The project was developed through extensive consultations with all relevant national and international stakeholders that informed the project design. A robust stakeholder engagement strategy will further ensure that the project will engage with all key stakeholders throughout project implementation.

Selected risk factor 3: Lack of managerial and financial capacity of national EE ANAMET and double-counting and double-dipping risk

Category	Probability	Impact
<u>Technical and operational</u>	<u>Low</u>	<u>Medium</u>

Description

ANAMET has a current lack of managerial and financial capacity. While the institution disposes of an independent legal structure since 2022 (secured by decree) and its highest governance body, the Board of Directors, has been nominated in December 2025, improved internal processes remain in draft form, but largely unimplemented. Consequently, ANAMET still lacks robust capacity with regards to budget allocations, financial management and auditing functions. Moreover, ANAMET will be a beneficiary institution (though not an EE) under the GCF-funded project (SAP048), this creates a double-counting and double-dipping risk if clear segregation of financial records, budgets, and expenditures between the two projects is not in place.

Mitigation Measure(s)

Exchanges with the German side in November 2025 and later follow up indicate that the Togo government actors (including Ministry of Transport and Presidency) are currently addressing the issue of the Board of Directors. Preparatory internal steps are under way to plan the support and mitigation measures (e.g. audit of progress before conclusion of Grant Agreement with ANAMET). The AE and ANAMET will apply strengthened financial management and internal control measures and will ensure clear coordination with SAP048. The AE to ensure clear segregation of financial records, budgets, and expenditures between the two projects will support the acquisition and deployment of dedicated financial and administrative management software, which will be used to generate separate financial reports, as this is not currently supported by the utilised software provided by Togo's Ministry of Economy and Finance. The AE will maintain close fiduciary oversight throughout implementation (see section G.3.1).

Selected risk factor 4: Interventions complexity		
Category	Probability	Impact
<u>Technical and operational</u>	<u>Low</u>	<u>Medium</u>
Description		
The planned project activities and especially the infrastructure construction and rehabilitation measures are complex, since they include a variety of types of interventions, a wide geographically area, different types of resilience measures, engagement with local availability service providers and ESS risks.		
Mitigation Measure(s)		
Project interventions and construction activity planning in the FP development phase was done in close cooperation with EEs, GIZ's construction unit (HQ) and the project development team. It entailed a careful analysis of intervention sites during a mission on the ground, while continuous assessment of eventual implementation, reputation and liability risks was and is ensured. ESS documents include appropriate consideration of E&S risks and fit-for-purpose mitigation measures.		
Selected risk factor 5: Risk of money laundering, terrorist financing, prohibited practices and sanctions		
Category	Probability	Impact
<u>Prohibited practices</u>	<u>Low</u>	<u>Medium</u>
Description		
Without strict oversight, project proceeds can be diverted for illicit purposes. This may include money laundering, terrorist financing, or other prohibited practices or other misuse of funds.		
Mitigation Measure(s)		
The UN sanction list will be screened to ensure that no EE, implementation partner or subcontractor is listed. GIZ as AE will determine the Procurement and Consultant Guidelines, which have been reviewed and accepted by GCF during the accreditation process. GIZ's guidelines will ensure high standards to mitigate potential risks. Project procurement will be transparently documented, as per the Procurement Plan in Annex 10a to the FP. Moreover, EEs have been assessed, and they have processes and personnel capacity for the transparent financial management, project monitoring and reporting, which will be supported and strengthened to ensure compliance with GCE policies requirements. Monitoring of the use of funding will be regularly conducted according to the rigorous GIZ international financial management rules and regulations.		
Selected risk factor 6: Risk of social conflicts due to discrimination of certain groups (e.g. gender inequality/exclusion of LCs)		
Category	Probability	Impact
<u>Reputational</u>	<u>Low</u>	<u>Medium</u>
Description		
The project may create social conflicts if certain groups of society do not have equal opportunities to benefit from project activities, for example due to gender inequality the access of women could be limited, or LCs are not adequately integrated.		
Mitigation Measure(s)		
The project has been designed through participatory practices, including with feedback from women local communities with traditional livelihoods, including distinct community women (see Annex 7a). Participatory processes will continue to be implemented throughout the project implementation (e.g. see Annex 7b) ensuring that feedback will be provided to reflect on project implementation. Project activities are gender-sensitive and specific targeted activities to strengthen gender equality and social inclusion, while safeguarding the rights of women and LCs, are included within the ESMP (Annex 6b), GAP (Annex 8b) and the LCP (Annex 6c). The project though the LCP will proactively involve women and LC (see Annex 6c). The project has developed a GRM that will be communicated to all beneficiaries in culturally appropriate ways, in local languages and through preferred mediums (see Annex 7b - SEP). The GRM mechanisms will be available to all those that have a grievance or complaint to file, including beneficiaries and project implementation staff. Specific SEAH guidelines will be implemented and all personnel that will be involved in the implementation process will follow a SEAH training.		
Environmental and social risks are considered in the Environmental and Social Impact Assessment (ESIA, Annex 6a), and Environmental and Social Management Plan (ESMP, Annex 6b). Gender-specific risks are considered in the Gender Assessment and Gender Action Plan (Annexes 8a and 8b, respectively).		

G. GCF POLICIES AND STANDARDS

G.1. Environmental and social risk assessment (max. 750 words, approximately 1.5 pages)

265. Further information is provided under the ESIA, the Environmental and Social Management Plan, and the Local Communities Plan (Annex 6a, 6b, 6c, respectively).

266. Table 9 below provides an overview of the ESS triggered by the proposed project.

Table 9: E&S Risk Assessment (Source: Annex 6b)

ESS	E&S Risks	Mitigation measures
ESS 1	Risk level: Moderate Triggered: Yes Executing Entities (EEs) do not establish and operationalise a functional ESMS, including effective stakeholder engagement and grievance redress mechanism. ESS focal points within the Executing Entities are not formally designated and sufficiently trained to implement the ESMP. Activities in the Savanes region may expose project personnel, partners, and beneficiaries to security threats associated with the deteriorating security situation.	• Functional Environmental and Social Management System. • Reinforcement of ESS focal points' capacities within EEs. • Strengthen security and safety arrangements in Savanes (e.g., continuous monitoring from the GIZ Risk Management Officer, prior travel clearance).
ESS 2	Risk level: Moderate Triggered: Yes Contractors and suppliers may not fully comply with or provide sufficient oversight of applicable national labour laws and international labour standards Contractors and suppliers may lack awareness of gender equality, SEAH prevention and protection of vulnerable workers.	• Require contractors to adhere to labour rights and standards (including compliance checks during ground supervision missions). • Sensitise construction contractors and suppliers on human rights and gender issues.
ESS 3	Risk level: Moderate Triggered: Yes Biomedical and solid waste generation from health facilities, construction and demolition waste, e-waste and wastewater from the facilities and interventions are not treated properly leading to environmental contamination, degradation of soil and water quality. Infrastructure improvements may increase energy demand, reliance on fossil-fuel-based and increased GHG emissions. Inadequate sanitation systems and wastewater management may lead to faecal contamination. Inadequate borehole design and maintenance compromising groundwater quality and aquifers. Rehabilitation of existing water infrastructure or drilling of new boreholes may lead to increased water consumption.	• Improve general and biomedical waste management procedures (including a protocol for managing end-of-life equipment). • Ensure proper construction waste management and disposal of hazardous waste (including conducting hazardous materials/asbestos surveys). • Ensure low-carbon infrastructure design, renewable energy system design and low-carbon material use. • Promotion of renewable energy systems and energy efficiency measures. • Measures for air quality improvement (dust suppression) during construction works. • Measures for safe faecal sludge and wastewater management. • Safe and sustainable borehole siting, construction, and maintenance. • Water-level monitoring infrastructure (piezometers or automated loggers) will enable continuous tracking groundwater levels
ESS 4	Risk level: Moderate Triggered: Yes Construction and rehabilitation activities create unsafe conditions for workers and communities. Infrastructure rehabilitation and health campaigns fail to adequately account for climate-related hazards and disease prevention, increasing community health risks. Contractors, suppliers, and project workers fail to respect human rights and SEAH prevention measures due to a lack of awareness and enforcement. Infrastructure design and service delivery do not adequately address the specific needs of women,	• Measures for appropriate occupational health and safety, including traffic management plans around construction sites. • Measures to improve community health and environmental awareness • Sensitise construction contractors and suppliers on human rights and gender issues. • Measures to strengthen human rights and to improve access to health services for women and vulnerable groups (e.g., ensuring infrastructure accessibility and applying the humanised childbirth approach).

	persons with disabilities, and other vulnerable groups.	
ESS 5	Risk level: Low to moderate Triggered: Yes • Construction and rehabilitation works will only be undertaken on sites owned by public partners, and no land acquisition will take place under the project. Nevertheless, public status or boundaries may not be fully documented or recognised by communities, leading to tensions or delays if consultations are insufficient.	• Ensure activities will take place where physical and/or economic displacement will not occur, and in Government land(s) with secure, undisputed land tenure by clarifying the land tenure status of intervention sites. • Transparent consultations to confirm land status and community consent. • Advise MSHPCSUA and ANAMET on land tenure regularisation.
ESS 6	Risk level: Low Triggered: Yes One Health decision-making fails to integrate biodiversity and ecosystem considerations if the Climate Change Unit and ESS focal points are not actively engaged in the One Health Platform and policy discussions. Health facility infrastructure improvements lead to localised habitat degradation, heat stress and cumulative ecological impacts if biodiversity assessments and nature-based solutions are not integrated into planning and rehabilitation	• Consider one health considerations in policy and strategic planning in Togo. • Biodiversity assessment and inclusion of revegetation interventions in infrastructure rehabilitation activities.
ESS 7	Risk level: Low Triggered: Yes Local communities with semi-nomadic livelihoods, including Fulani pastoralists and other mobile groups, may not adequately benefit from project activities if customary institutions and traditional leadership structures are not adequately included in project governance and consultation processes	• Build capacity in Free, Prior, and Informed Consent (FPIC), the GRM, and gender-related subjects. • Inform local communities about the GRM and ensure their capacity to file grievances. • Apply the humanised childbirth approach to respect cultural norms and improve local women's self-determination during delivery. • Prepare communication messages, tools, and channels adapted to local communities (e.g., language translation, referencing for local cultural and spiritual belief systems). • Train traditional healers from local communities as multipliers for climate-health messages. • Monitoring & Reporting on the implementation of the Local Communities Plan.
ESS 8	Risk level: Low Triggered: Yes Modern medicine and vaccination activities face community resistance and reduced trust if traditional beliefs and local cultural norms are not sufficiently understood or respected. Field teams, contractors, and suppliers may undermine community trust or disturb culturally significant sites if project implementation and engagement activities are not culturally appropriate.	• Improve acceptance of conventional/ modern medicine without undermining traditional health practices • Enhance cultural sensitivity of EEs and contractors (including change find procedures).

G.2. Gender assessment and action plan (max. 500 words, approximately 1 page)

267. The Gender Assessment (GA) identifies persistent gender inequalities across governance, data systems, service delivery, and social structures that increase the vulnerability of women and marginalised groups to climate-sensitive health outcomes. These gaps are rooted in structural barriers such as patriarchal norms, unequal representation, weak institutional capacity for gender mainstreaming, and insufficiently inclusive infrastructure and communication systems. The Gender Action Plan (GAP) outlines targeted measures to ensure that climate and health interventions systematically address these inequalities and contribute to women's empowerment and social inclusion. Detailed results of the

project's GA and the GAP are provided in Annex 8a and Annex 8b, respectively. Main takeaways are summarised in Table 10.

Table 10: Overview of gender gaps and recommended measures

Gender gap	Recommended measures
Insufficient gender-informed decision-making and tracking of vulnerabilities	- Gender-sensitive M&E system that systematically collects gender-disaggregated data and community-level data to explicitly reflect the needs of women and vulnerable groups in service delivery, ensuring of project indicators are disaggregated by sex and vulnerability status to monitor gender and SEAH mitigation measures. - Systematically integrate gender- (and where relevant, Local Community-) specific analysis into all baseline studies, needs assessments, and updates of strategic documents carried out under the project. - Develop a gender-responsive roadmap for implementing climate- and weather-health epidemiological modelling at the national level to document which data will benefit from disaggregation.
Weak institutional coordination and leadership	- Regular coordination meetings between Gender Focal Points of the EEs to ensure alignment on gender priorities and harmonised approaches. - Mandate at minimum equal gender representation in the composition of the national CCU and women representation in the leadership/decision-making positions the national CCU and ensure equal participation of women and men CCU staff in technical and managerial training - Strengthen the capacity of GFPs and relevant project staff through targeted gender trainings to promote a shared understanding of equity principles.
Safeguarding and Grievance Redress (GRM) risks	- GBV and SEAH complaints are processed in the Grievance Redress Mechanism (GRM) in a gender and culturally sensitive way, ensuring anonymity and protection of complainants and survivors. - Mandate that all of project staff, workers, and implementing partners review, sign the Code of Ethics and Conduct (CoEC), and receive gender-responsive SEAH training.
Unequal access to resilient infrastructure and technology.	- Standard construction plans integrate person-centred care considerations, including adequate room confidentiality, properly equipped delivery rooms, separate sanitary facilities, and accessible pathways. - Aim for female participation among construction providers and artisans, and ensure participation of female technicians in hydrometeorological repair and maintenance activities.
Exclusion of women from technical training and education	- Implement a gender-responsive admission and retention strategy for the Master's programme incorporating measures (e.g., flexible criteria, mentoring, financial support). - Enforce female participation across all professional, medical, and ToT cohorts .
Ineffective communication and community engagement	- Practical, gender-responsive patient communication support guides for health workers, providing locally adapted examples for explaining diagnoses to different population groups. - Ensure the direct participation of at least a woman, an LC representative, and a representative of persons with disabilities in the co-design of translation and communication guides. - Guarantee the participation of at least a quarter of women and at least two representatives per LC in the training of community multipliers
Specific risks to adolescent health and hygiene	- Organise menstrual health awareness sessions involving female teachers and local multipliers. - Integrate a gender-responsive menstrual health component into WASH facility management training and the management model. - Provide subsidised reusable sanitary pad kits to girls and establish functional menstrual hygiene selling points to support income-generating activities.

G.3. Financial management and procurement (max. 500 words, approximately 1 page)

G.3.1 Financial management

268. The financial management of the project will follow GIZ's internal rules and regulations. GIZ has bank accounts with Deutsche Bundesbank and Commerzbank. GIZ will not open a specific bank account for the GCF project but will ensure that all funds provided are clearly identifiable and distinguishable from GIZ's other funds by setting up separate cost units exclusively for the funds disbursed by the GCF for each funded activity (ledger accounts). Funds received and expenditures incurred will be booked to the respective cost unit according to generally accepted accounting principles and procedures accepted by the German Government. As a general principle, GIZ disburses funds to recipients in accordance with the progress of the project. The Executing Entities (GIZ, MSHPCSUA, ANAMET) have to report on the proper use of funds and defined progress as a prerequisite for any further disbursement. Independent external auditors will perform annual financial audits of the project in line with International Auditing Standards.

269. Taking into consideration the identified project risks, GIZ will take mitigation measures from a financial management and fiduciary standpoint to ensure appropriate risk management. Mitigation measures will ensure that EE's fiduciary oversight will be tailored according to their capacity and identified gaps. EE's fiduciary capacity will be regularly assessed during the project implementation period, and the assessment will inform the AE's oversight intensity.

270. At the beginning of each year, an annual plan is prepared, which expresses which activities are to be implemented in the coming year. These annual plans need to be approved by the PMU. Each implementation partner will report on the use of budgets to GIZ as an EE.

G.3.2 Procurement

271. Goods, works and services under the project will be procured by the AE and the EEs in line with their respective implementation responsibilities. GIZ, in its role as Accredited Entity (AE) and Executing Entity (EE), will carry out procurement in accordance with the applicable German and European public procurement rules, as operationalised through GIZ internal procurement procedures. National EEs will carry out procurement under their respective subsidiary agreements with GIZ and in accordance with the GIZ Procurement Guidelines for recipients of financing (see Annex 10b). These guidelines constitute the contractually agreed minimum standards for procurement by recipients of GIZ financing. In addition, the EEs must comply with all applicable statutory regulations under national public procurement law. The EEs are responsible for the award and processing of contracts under their part of the project and must ensure that all procurement steps are appropriately documented. Further information on procurement for external EEs can be found in the Procedures for Controlling Procurement (Annex 19).

G.4. Disclosure of funding proposal

☐ No confidential information: The accredited entity confirms that the funding proposal, including its annexes, may be disclosed in full by the GCF, as no information is being provided in confidence.

☒ With confidential information: The accredited entity declares that the funding proposal, including its annexes, may not be disclosed in full by the GCF, as certain information is being provided in confidence. Accordingly, the accredited entity is providing to the Secretariat the following two copies of the funding proposal, including all annexes:

- full copy for internal use of the GCF in which the confidential portions are marked accordingly, together with an explanatory note regarding the said portions and the corresponding reason for confidentiality under the accredited entity's disclosure policy, and
- redacted copy for disclosure on the GCF website.

The funding proposal can only be processed upon receipt of the two copies above, if containing confidential information.

H. ANNEXES

H.1. Mandatory annexes

- ☒ Annex 1 NDA no-objection letter ([template provided](#))
- ☒ Annex 2 Feasibility study
 - 2a – Climate rationale
 - 2b – Theory of change
 - 2c – Construction study
 - 2d – Calculation of beneficiaries
- ☒ Annex 3 Economic analysis in word and spreadsheet format
 - 3a – Economic and financial analysis
 - 3b – Economic and financial valuation summary
- ☒ Annex 4 Detailed budget plan ([template provided](#))
 - 4a – Detailed budget plan
 - 4b – Notes and assumptions
- ☒ Annex 5 Implementation timetable ([template provided](#))
- ☒ Annex 6 E&S document corresponding to the E&S category (A, B or C; or I1, I2 or I3):
([ESS disclosure form provided](#))
 - ☒ 6a – Environmental and Social Impact Assessment (ESIA)
 - ☒ 6b – Environmental and Social Management Plan (ESMP)
 - ☒ 6c – Local Communities Plan (LCP)
- ☒ Annex 7 Summary of consultations and stakeholder engagement plan
 - 7a – Summary of consultations
 - 7b – Stakeholder engagement plan (SEP)
- ☒ Annex 8 Gender assessment and project-level gender action plan ([template provided](#))
 - 8a – Gender assessment (GA)
 - 8b – Gender action plan (GAP)
- ☒ Annex 9 Legal due diligence (regulation, taxation and insurance)
- ☒ Annex 10 Procurement plan ([template provided](#))
 - 10a – Procurement plan
 - 10b – GIZ Procurement guidelines
- ☒ Annex 11 Monitoring and evaluation plan ([template provided](#))
- ☒ Annex 12 AE fee request ([template provided](#))
- ☒ Annex 13 Co-financing commitment letters ([template provided](#))
 - 13a – Co-financing commitment letter BMZ
 - 13b – Co-financing commitment letter MSHPCSUA
 - 13c – Co-financing commitment letter ANAMET
- ☒ Annex 14 Term sheet (including a detailed disbursement schedule)

H.2. Other annexes as applicable

- ☒ Annex 15 Evidence of internal approval ([template provided](#))
- ☒ Annex 16 Map indicating the location of proposed interventions

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| ☐ | Annex 17 Multi-country project/programme information (template provided) |
| ☒ | Annex 18 Evaluation report (for proposals based on up-scaling or replicating a pilot project) |
| ☒ | Annex 19 Procedures for controlling procurement by third parties or executing entities undertaking projects financed by the entity |
| ☒ | Annex 20 First level AML/CFT (KYC) assessment |
| ☐ | Annex 21 Operations manual (Operations and maintenance) |
| ☐ | Annex 22 Assessment of GHG emission reductions and their monitoring and reporting (for mitigation and cross cutting-projects) ¹⁰³ |
| ☐ | Annex X Other references |

* Please note that a funding proposal will be considered complete only upon receipt of all the applicable supporting documents.

¹⁰³ Annex 22 is mandatory for mitigation and cross-cutting projects.