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Assessing the core capacities of the Togolese health system to deliver universal health coverage

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ABSTRACT

Background: The Togolese government has been committed to ensuring universal health coverage since 2012 through a stepwise process. Multiple reforms have been implemented to achieve universal primary healthcare, in line with the World Health Organization's recommendations and the Alma-Ata commitment.
Aim: This paper assesses the core capacities of the Togolese health system to deliver UHC and, as a corollary, identifies potential gaps and requirements in HSS necessary for implementing UHC.
Results: The country spends 6.7% and 5.6% of GDP on total and current health expenditures, respectively. The Domestic General Government Health Expenditure (GGHE-D) accounts for only 2.6% of the government's total budget, 9.8% of current health expenditure, and 0.54% of GDP. The health system relies heavily on funding from foreign agencies, which accounts for 15.8% of current Health expenditure. The private sector accounts for the largest share of financing (70.6%), with 65.9% of current health expenditures paid out of pocket. The health insurance scheme accounts for only 8% of current health expenditures and covers approximately 7.5% of the population. In this system, there is one (1) physician for 16,191, one (1) nurse for 6430, and one (1) midwife for 10,069 inhabitants. Most medical products are imported, and the country faces a brain drain phenomenon among its healthcare staff.
Conclusion: The Togolese health system's financing and stewardship are weak, inequitable, and unsustainable. This extends to the rest of the health system, including service provision and resource generation, which makes achieving universal health coverage very challenging.

1. Introduction

A health system includes the actors, resources, and institutions related to regulating, financing, and providing health actions (any activities that aim to improve or maintain the population's health) [1]. According to Skolnik [2], p. 273, the "[h]ealth systems are the vehicle through which health services are delivered." The concept of UHC is closely linked to that of Health System Strengthening (HSS), to the extent that HSS comprises the means (i.e., policy instruments), while UHC is a way of framing the policy objectives [3]. In 2005, the World Health Organization (WHO) stated that its members were committed to achieving universal health coverage. It recognizes that health for all should be an aspirational target for every country and a vital framework for the United Nations system. Universal health coverage has been identified as potentially the third global health transition, following public health improvements, such as primary sewage and sanitation, and the epidemiological transition that reduced the toll of communicable diseases [4]. Two priorities for pro-poor financial risk protection, as set by the World Health Organization, are to significantly reduce, or preferably eliminate, out-of-pocket fees for health services and to provide protection against impoverishment and catastrophic expenditures. It encourages countries to protect against catastrophic health expenditure, defined as spending more than 10% of income on health-related costs [5]. Recently, international debates regarding financing and health equity have focused primarily on mechanisms to promote fairness in financing contributions. Along with health status, responsiveness to the population's expectations and fairness in financing contributions are the core performance indicators of the health system [1], as health

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disparities are a significant concern in public health [2].

The Togolese government has been committed to ensuring universal health coverage since 2012. Through a stepwise process, multiple policies and reforms have been made to improve healthcare access for all populations. An ardent desire to improve protection against healthcare costs and enhance equity of access to healthcare services lies at the core of many health sector financing initiatives in the Republic of Togo. Assessing the core capacity of one's health system is a critical aspect of the health sector's governance, grounded in data-driven decision-making. However, since the introduction of some reforms in the health sector, no study has been conducted to evaluate the actual core capacity of the health system to achieve UHC. As a result, providing the actual insights could guide national policy and program development. This paper aims to assess the capacities of the Togolese health systems to deliver UHC, and as a corollary, to determine possible gaps and requirements in terms of HSS necessary to implement and facilitate progress toward UHC.

The details about the macroeconomic and social context, as well as the health status context, of recent years in Togo provide an understanding of the social and health environment, the macroeconomic and budgetary constraints that Togo faces, and potential choices relating to the financing of its health system.

2. Context and conceptual framework

2.1. Health status context

Like other low-income countries, Togo is undergoing an epidemiological transition, presenting a double burden of disease, characterized by, on the one hand, a high prevalence of infectious diseases and, on the other hand, the emergence of non-communicable diseases primarily linked to a marked evolution in lifestyles.

Togo's life expectancy is lower than that of middle- and high-income countries. Both infant and maternal mortality are high, as well as pregnancy-related mortality. Table 1 shows the key health status indicators of general life expectancy at birth, female life expectancy at birth, male life expectancy at birth, inequality in life expectancy (%), maternal mortality ratio (deaths per 100,000 live births), under-5 mortality rate (per 1000 live births), and infant mortality rate (per 1000 live births).

2.2. Conceptual framework

The concept of Universal Health Coverage has its roots in the WHO Constitution, adopted in 1948, which declares health as one of the fundamental human rights, and in the Global Strategy for Health for All, launched in 1979. According to the World Health Organization, "[t]he goal of universal health coverage is to ensure that all people obtain the health services they need - prevention, promotion, treatment, rehabilitation, and palliation without risk of financial ruin or impoverishment, now and in the future" [6], p. 5. For Joseph Kutzin and Susan P. Sparkes [7], p. 12, "[u]niversal health coverage means that all people can receive needed health services of sufficient quality to be effective without fear that the use of those services would expose the user to financial hardship." This concept is associated with three dimensions: population coverage (or in-width coverage), health package coverage (or in-depth coverage), and cost coverage (or in-height coverage) [2].

Table 1
The Key Health Status Indicators and their values for 2022.

Indicators	Values
General Life Expectancy at Birth	61.6
Female Life Expectancy at Birth	62.2
Male Life Expectancy at Birth	60.9
Inequality in Life Expectancy (%)	27.7
Maternal Mortality Ratio (deaths per 100,000 live births)	399[a]
Under-5 Mortality Rate (per 1000 live births)	71[a]
Infant Mortality Rate (per 1000 live births)	42[a]

Data (except [a]) from UNDP. 2024. "Human Development Report 2023-2024." E.24.III.B.2. 1 UN Plaza. New York, NY 10017 USA: UNDP. https://report.hdr.undp.org/the-reasons-behind-the-current-gridlock.

[a] These figures come from INSEED. 2024. "Statistique de production, production économique." Institut national de la statistique et des études économiques et démographiques. 2024. https://inseed.tg/.

To summarize, universal health coverage refers to a sustainable and efficient health system that provides high-quality health services nationwide. That implies technical, financial, and geographical accessibility of the health service without hurdles. Financing accessibility is achievable through fairness in the financing contribution and other equitable measures. Consequently, universal health coverage hinges on the health system's performance [2].

This study relies on Murray and Frenk's framework for assessing health system performance [1], which identifies three goals intrinsic to health systems, each with five components: health average level, health distribution, responsiveness average level, responsiveness distribution, and fairness distribution. According to this framework, to achieve the UHC, every health system organization must perform four basic functions: stewardship, financing, provision, and resource generation [1]. The stewardship function organizes, supervises, and ensures the effectiveness and efficiency of the three other functions according to this framework. It is about the overall system design, priority settings, performance assessments, intersectoral advocacy, regulations, and consumer protection [1]. The financial function aims to collect a sufficient amount of funding, ensure strategic pooling, and efficient purchasing to protect the population against financial hardship. Meanwhile, the service provision function aims to provide quality health services that are available, accessible, and affordable throughout the nation [1]. Regarding the resource generation function, its primary objective is to train, recruit, and retain high-quality health professionals, while also continuously developing or importing high-quality medical technologies and products [1]. Moreover, its goal is to implement a high-quality health information system, whose data are used for evidence-based decision-making and for assessing the system itself. All lead to a strong health system (good health status, responsiveness, and fairness in financing contributions), which is critical in achieving the UHC. Consequently, every government grapples with the critical problems of designing, implementing, evaluating, and reforming the institutions and organizations that facilitate these functions. Fig. 1 presents the conceptual framework that undergirds this study.

3. Methods

It is qualitative health-system assessment complemented by secondary analysis of routine quantitative data. Four sources of data collection methods were adopted. The study was based on a critical review of existing data and documents, interviews with the key health system stakeholders, Focus Group Discussions (FGDs) with nine specialists responsible for implementing the UHC, and the authors' experience supporting the UHC policy making and implementation in Togo.

The main question we intended to answer was: How far are the core health system capacities in Togo to deliver UHC? To achieve this, we focused on the primary foundational and institutional bases that facilitate the implementation of the UHC policy, as well as the challenges and bottlenecks hindering progress toward UHC. We used a set of interview guide questions to collect the views and experiences of implementers.

The implementers of the Universal Health Coverage were all stakeholders involved in the National Health System. We used four sets of interview guide questions. The first one was for implementers involved in health system financing at the Ministry of Health for at least five years (the Health Financing Division), the Direction of Budget and Finance of the Ministry of Economic and Finance, and the Social Security Agencies. The second targeted those involved in health service provision for at

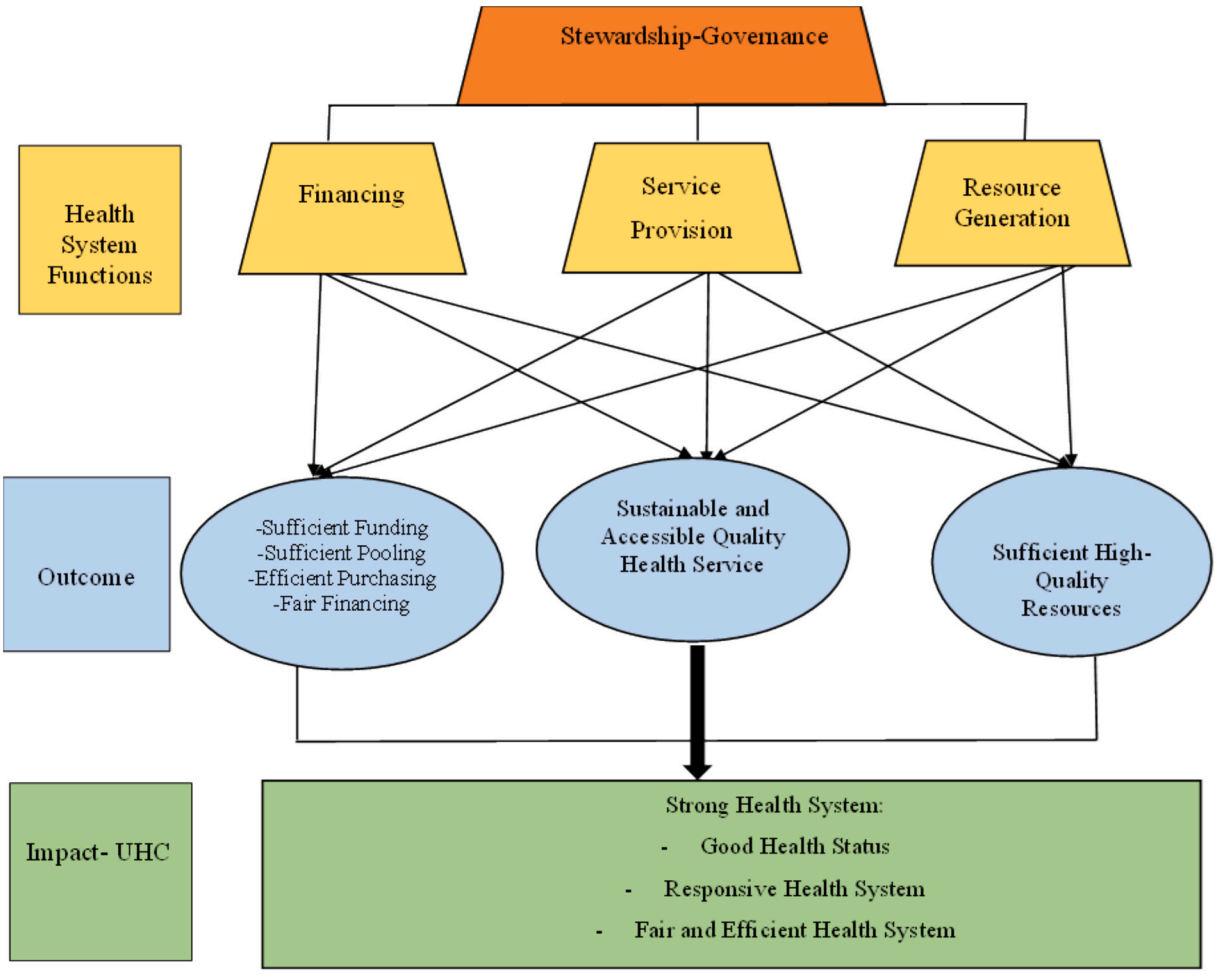

Fig. 1. The conceptual framework of the study.

least five years, under the Direction of the Sanitary Action Directorate of the Ministry of Health. As for the third one, it aimed to collect data on health resource generation for at least five years, from the Direction of Pharmacists and Medical Products and the Division of Health Information System of the Ministry of Health, from the Ministry of Higher Education, and from the authorities representing the Universities, Schools, and Hospitals involved in health staff training. Finally, the fourth set of interview guide questions aimed to collect data on health system stewardship from the Division of Health Regulation of the Ministry of Health, the Ministry of Commerce, the Social Security Agencies, and the Consumer Associations.

Moreover, we extensively utilized strategic documents, thereby deriving 'textual meaning' from the collected data, as social science researchers value the use of documents [8], p. 115, [9]. The institutions' official strategic documents and annual reports from 2021 to 2023 were collected. These documents were obtained following ethical approval and authorization from the Ministry of Health (325/2024/MSHP/SG/DGEPIS/DEPP/DER). Currency data in XOF was converted to USD using an exchange rate of 1 USD per 600 XOF.

To complement the assessment of health-system functions with evidence on service performance, we extracted selected national routine indicators from Togo's 2022 DHIS-2-based annual health statistics. Indicators were selected according to their relevance to service coverage and data availability and included reporting performance, service utilization, immunization, maternal and child health, malaria, tuberculosis, HIV, nutrition, adolescent health, and noncommunicable diseases.

We compared the reported indicator values with national program targets, where available, and examined geographical variation as an indicator of differences in service availability and effective coverage. Routine data were interpreted cautiously because variations may reflect differences in reporting completeness, denominator quality, case detection, and actual service performance.

For each of the four health-system functions defined by Murray and Frenk, financing, service provision, resource generation, and stewardship, we examined indicators identified by national stakeholders as relevant to system capacity and progress toward UHC. Data triangulation across documents, interviews, focus groups, and direct observation was used to strengthen the credibility of the findings.

The study took place in Lomé, Togo, from December 2024 to March 2025. The discussion's voice recordings were stored on hard drives. Data analysis relied on NVivo and Zotero's reference management. We coded using a direct approach by selecting text and then coding it to an existing or new node. The results are presented according to the four functions of the Murray and Frenk framework: financing, service provision, resource generation, and stewardship.

Each of the four Results subsections that follow draws directly on the corresponding set of interview guide questions described above: the financing subsection integrates interviews with the Health Financing Division, the Directorate of Budget and Finance, and the Social Security Agencies; the service-provision subsection integrates interviews with the Sanitary Action Directorate; the resource-generation subsection integrates interviews with the Directorate of Pharmacists and Medical Products, the Division of Health Information Systems, and training-institution authorities; and the stewardship subsection integrates interviews with the Division of Health Regulation, the Ministry of Commerce, the Social Security Agencies, and the Consumer Associations.

Findings from these interviews and FGDs are woven into the narrative alongside the quantitative and documentary data in each subsection, rather than reported separately.

4. Results

4.1. Function of financing

The following table presents the general health financing indicators for Togo in 2021. For analysis purposes, it is helpful to divide health system financing into three subfunctions: revenue collection (fund-raising), fund pooling (risk pooling), and service purchasing [1]. Table 2 presents Togo's general health financing indicators for 2021.

4.1.1. Revenue collection

In Togo, resource mobilization is based on multiple prepayment mechanisms: tax revenue, social contributions, and private insurance premiums. However, current health expenditure consists of two-thirds of out-of-pocket expenditures. The mechanisms for collecting taxes by the State are classic. The structure responsible for collecting tax revenue is the Ministry of Economy and Finance through two (02) revenue authorities (Customs and Taxes Agencies). The Togolese government has undertaken reforms, establishing the one-stop shop for foreign trade and the Togolese Revenue Office (OTR) since 2013 to improve tax revenue mobilization.

There are no specific taxes or fees allocated to the health sector. Under the finance law, the tax services collect multiple products generated by tax regulations. A part of the general tax revenues, which form the state budget, is allocated for the operating and investment budget allocation of the Ministry of Health and other ministries that have health in their attribution (the defense ministry). The share of the budget allocated to the Ministry of Health is determined by the budgetary framework letter, taking into account the constraints imposed by tax revenue forecasts.

Employment-based insurance is the most important single category of insurance coverage. National Health Insurance Institute (INAM) and National Social Security Fund (CNSS) are the structures that manage social health insurance in the country. The National Health Insurance Institute insures public sector workforce professionals, while the National Social Security Fund insures private professionals and the informal sector. These social insurance institutions set compulsory rates by income. The contribution rate is 10% of the salary for active agents (5% for employees and 5% for employers) and 5% of the pension for retired agents. The Finance Department automatically deducts these contributions from employees' salaries for active civil servant agents. The National Retirement Fund (CRT) also ensures the retention of 5% of the pension from retired civil servants and transfers them to the National Health Insurance Institute. These amounts, once retained by employers, are paid monthly into the INAM and CNSS bank accounts (via public treasury for INAM). Regarding the private sector, employers automatically deduct these contributions and transfer them to the National Social Security Fund. Regarding the informal sector, rules and policies should be established by the National Social Security Fund, taking into account certain specificities. Until now, the agricultural sector has been taken into account. The conditions set do not foster most peasants, and as the contribution is voluntary, it is challenging to enroll them.

There are multiple private and mutual health insurance companies, each with its own mechanism for collecting social security contributions and premiums. Some health insurance and mutual health insurance companies use community rating, while others prefer experience rating. The primary insurers are Sanlam Assurance, Sunu Assurance, GTA Assurance, Fidelia Assurance, and NSA Assurance. These private insurance companies set voluntary insurance rates based on risk instead of income. Foreign development agencies are the second most important source of funding for the Togolese health system, after households, and before the public administration. Finally, nongovernmental organizations also contribute to funding the health system. Table 3 shows the relative contribution of each entity for 2021.

4.1.2. Fund pooling

Ten institutions primarily ensure risk pooling: (1) the Ministry of Health and Hygiene, (2) the Ministry of Defense, and (3) the Welfare Ministry, which pool funds from public administration and 97% of the transfers from foreign agencies; (4) the National Health Insurance Institute (INAM, for civil servants) and (5) the National Social Security Fund (CNSS, for private employees), which pool funds for social insurance; and (6) Sanlam Assurance, (7) Sunu Assurance, (8) GTA Assurance, (9) Fidelia Assurance, and (10) NSA Assurance, the private and mutual health insurance agencies responsible for voluntary insurance. Table 4 lists these ten institutions, with consistent naming, alongside their respective shares. Together, these ten institutions account for only 33.1% of current health expenditure, while 65.9% is out-of-pocket. The remaining contributions are the foreign assistance direct payment (0.5%), the private sector direct payment (0.3%), and the non-government direct payment (0.2%). Social insurance covers 508,499 persons (6.28%), while private insurance covers 101,547 persons (1.25%). Therefore, only 7.5% of the population is covered by insurance schemes. Fig. 2 illustrates the relative share of pooled funds in current health expenditure.

In addition, Togo implemented Assur FNFI in 2015, a microinsurance product for the informal sector, and in 2017, a medical assistance program for students in public establishments called School Assur. This program covers healthcare for each student up to $ 50. It is important to note the absence of a national framework for coordinating and monitoring the implementation of all these health insurance mechanisms. This does not facilitate a more accurate assessment of progress. Table 4

Table 2
The General Health Financing Indicators of Togo for 2021.

	Amount ($US in millions)	Per capita ($us)	% THE	% budget	% GDP
Total Health Expenditures (THE)	523.4	65.75	100	32.2	6.7
Current Health Expenditures (CHE)	442.6	55.48	84.4	27.2	5.6
Capital Health Expenditures (CHE)	80.8	10.3	15.6	5	1
Households' Health Expenditure (HHE)	291.5	37.2	55.7	17.85	3.6
Domestic General Government Health Expenditure (GGHE-D)	43.5	5.4	8.3	2.6	0.54
Foreign Assistance via Government Health Expenditures (FAVGHE)	67.8	8.4	13	4	0.84
Total public Health Expenditures (GGHE+FAVGHE)	111.3	13.8	21.3	6.65	1.38

Data from Compte national sanitaire du Togo: https://p4h.world/app/uploads/2024/08/p4h_Rapport-CS-2020-2021_Togo.x23411.pdf

Table 3
Entities and their relative contribution for 2021.

Funding origin	%CHE
Household (out of pocket)	65.9
Transfer from Foreign Agencies	15.8
Domestic General Government Health Expenditures (GGHE-D)	9.8
Private Sector (Enterprises)	4.7
Social Insurance	3.6
NGO	0.2
Total	100

Data from Compte national sanitaire du Togo: https://p4h.world/app/uploads/2024/08/p4h_Rapport-CS-2020-2021_Togo.x23411.pdf

Table 4
The Relative Share of Pooling Funds with the Details of Other Financing Structures.

Pooling institution	%CHE
Household (out of pocket)	65.9
Public Administration (GGHE-D + FAVGHE):	25.1
-Health Ministry	
-Defense Ministry	
-Welfare Ministry	
Private Insurance:	4.4
-Sanlam Assurance	
-Sunu Assurance	
-GTA Assurance	
-NSA Assurance	
-Fidelia Assurance	
Social Insurance	3.6
-CNSS	
-INAM	
Direct Transfer from Foreign Agencies	0.5
Direct Transfer from the Private Sector	0.3
NGO	0.2
Total	100

Data from Compte national sanitaire du Togo: https://p4h.world/app/uploads/2024/08/p4h_Rapport-CS-2020-2021_Togo.x23411.pdf

presents the relative share of pooling funds, along with details of other financing structures.

4.1.3. Health services purchasing

Health services in Togo are purchased by the same ten institutions responsible for pooling funds (Section 4.1.2), plus households as direct out-of-pocket payers, for a total of eleven purchasing entities. Households are the primary purchasers of health care through out-of-pocket payment; the Ministry of Health and Hygiene exercises its purchasing function through the budget allocation rules in force; the Defense Ministry purchases through army medical services; the Ministry of Social Protection purchases through welfare services; and the National Health Insurance Institute (INAM) and the National Social Security Fund (CNSS) purchase on behalf of their insured populations, while the five private and mutual health insurance companies (Sanlam Assurance, Sunu Assurance, GTA Assurance, Fidelia Assurance, and NSA Assurance) purchase on behalf of their respective policyholders.

Employment-based insurance, such as the INAM and CNSS, provides payments to healthcare professionals and hospitals based almost entirely on fee-for-service payments, using customary criteria. As state agencies for social insurance, INAM and CNSS offer the same healthcare packages with an 80% coverage rate on a reimbursement basis. All public healthcare services, as well as volunteer private healthcare providers, sign partnership conventions with these agencies to become provider organizations. Healthcare professionals also, through professional associations, sign partnership conventions to be provider professionals. Table 5 presents the purchasing institutions and their respective shares.

4.2. Function of health service provision

The organizational structure, the government health sector's capacity, and the private sector's availability are critical in discussions of universal coverage policy, as they affect the extent to which the intended extension of coverage can be a practical reality. The health system is organized according to a pyramidal structure with three (3) levels: central, intermediate, and peripheral or operational. The central level includes the minister's office, the general secretariat, general and central directions, national specialized programs, divisions, and attached services. It is responsible for strategic design. Its primary role is to define health policies and standards, as well as to monitor and control activities. The six (6) regional health directions represent the intermediate level. It ensures structural arrangement. It supervises, monitors activities, and inspects operational-level structures. The peripheral level constitutes the operational level of the health pyramid. It is made up of 39 health districts. Its role is to implement health policy and directives.

The healthcare system has a classic three-level structure: primary, secondary, and tertiary. Primary care is structured around three levels: Community Health Workers (ASCs) provide care by delegation at the family and community level and are called upon to play the role of interfacing between the community and health services, Peripheral Care

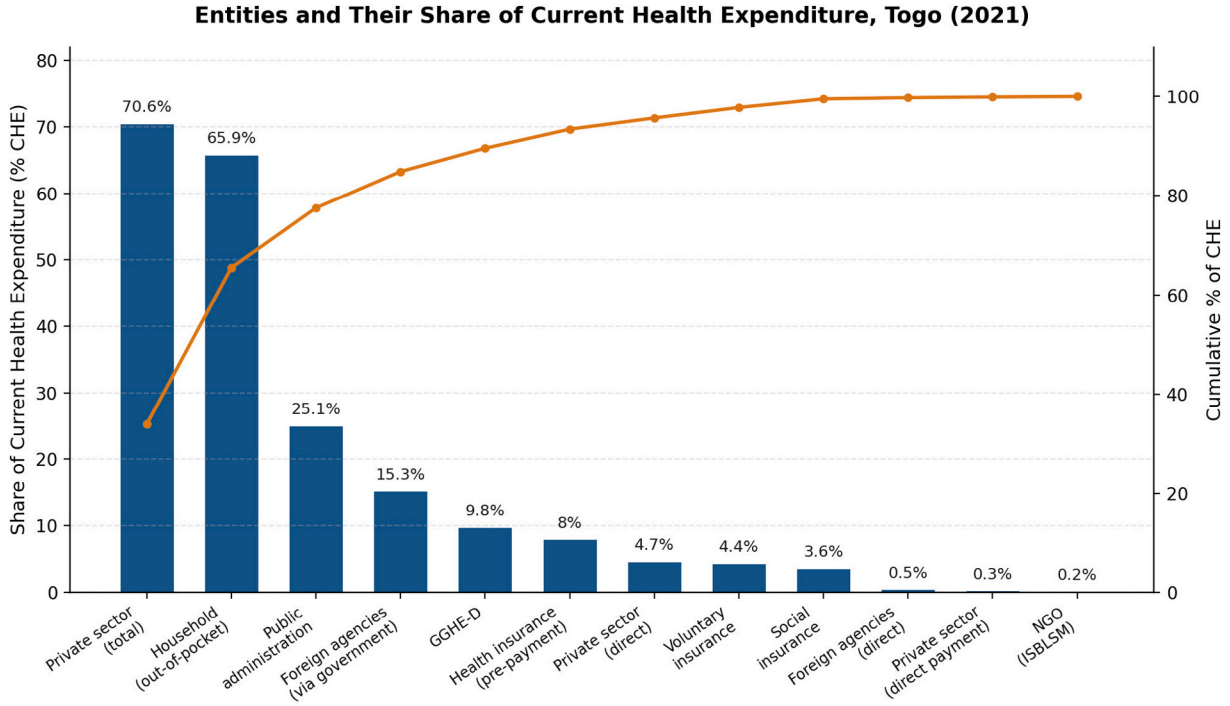

Fig. 2. Entities and Their Share of Current Health Expenditure (% of CHE; left axis) and Cumulative Share (right axis), Togo, 2021. Data adapted from Compte national sanitaire du Togo, Table 1 https://p4h.world/app/uploads/2024/08/p4h_Rapport-CS-2020-2021_Togo.x23411.pdf

Table 5
The purchasing Institutions and their Relative Share.

Pooling institution	% CHE	Purchasing institutions
Households (out of pocket)	65.9	Households
Public administration (GGHE-D + FAVGHE)	25.1	Health Ministry Defense Ministry Welfare Ministry Sanlam Assurance
Private Insurance	4.4	Sunu Assurance GTA Assurance NSA Assurance Fidelia Assurance
Social insurance	3.6	CNSS INAM
Direct transfer from foreign agencies	0.5	Foreign Agencies
Direct transfer from private	0.3	Private Institutions
NGO	0.2	NGOs
Total	100	Multiple purchasing institutions

Data from Compte national sanitaire du Togo: https://p4h.world/app/uploads/2024/08/p4h_Rapport-CS-2020-2021_Togo.x23411.pdf

Units (USP) from which local activities are carried out with a fixed strategy and toward the populations, and district hospitals which constitute the first reference level. In the strategic option of strengthening primary health care (PHC), the Peripheral Care Units (USP) are called upon to serve as a framework for providing integrated, continuous, and global care. At the same time, the district hospital plays a significant role as a referral resource, manifesting itself in four circumstances: when a sophisticated technique, expert opinion, specialized intervention, or hospitalization is necessary.

The Regional Hospitals, the Regional Orthopedic Apparatus Centers (CRAO), the Regional Blood Transfusion Center (CRTS), and various regional specificities lead the second level of reference and recourse. Tertiary health care is provided in the University Hospital Centers (CHU), the specialized reference hospitals, the National Orthopedic Apparatus Center (CNAO), the National Institute of Hygiene (INH), and the National Center of Blood Transfusion (CNTS). They constitute the national reference centers.

This organization brings together a dense network of public and private structures, including 2152 health facilities as of 2022. These are 03 University hospital centers (tertiary care), 04 private specialized hospitals (tertiary care), 06 regional hospitals (secondary care), 107 private specialized hospitals (secondary care), 32 district hospitals (primary care), 1923 Peripheral Care Units (primary care), and 77 nursing homes (primary care). The public sector accounts for 36.14% of healthcare provision, while the private sector is the leading provider of care, comprising 63.86% of the total. This distribution is as follows: 48.10% for the liberal private sector, 13.26% for the religious private sector and NGOs, and 2.50% for associations and communities [10]. Furthermore, a significant portion of healthcare and services is provided by traditional medicine practitioners (PMTs). In July 2022, Togo had 4634 PMT, which corresponds to a ratio of 6 PMT per 10,000 inhabitants [10]. Traditional medicine constitutes an important segment of healthcare provision, particularly in areas where public health facility coverage is low or for the most vulnerable population groups. Various priority public health programs have been implemented to combat the disease burden. These are mainly the Expanded Immunization Program (EPI), the national programs to combat communicable diseases, chronic non-communicable diseases, the trauma disability and community-based rehabilitation program (PITR/RBC), the health program of reproduction, as well as emergency management programs, including the Public Health Emergency Operations Center (PHEOC).

4.3. Function of resource generation

4.3.1. Health professionals and health workforce generation

In the health system of Togo, clinician professionals are made up of Medical Specialized physicians, Generalist Physicians, Dentists, Public Health Specialists, Physician Assistants, Pharmacists, Pharmacist Assistants, Midwives, Midwife Assistants, Laboratory Technicians, Nurses, Nurse Assistants, Sanitation and Hygiene Technicians, Health psychologists, Functional rehabilitation staff, health services administrators, and allied health practitioners. Public health professionals specialize in various disciplines and work in diverse settings, ranging from governmental public health agencies to non-governmental organizations, as well as educational institutions and private healthcare facilities. Table 6 presents the different ratios of the technical staff in 2022.

Health-worker education and regulation are central to resource generation. Togo trains most core professional categories domestically, but gaps remain in selected specialties and in the production, equitable deployment, and retention of qualified personnel. These constraints reduce the effective availability of services, particularly outside urban areas, and therefore limit equitable progress toward UHC.

4.3.2. Pharmaceutical products, blood products, vaccines, supply, and food security

National production of pharmaceutical products is primarily ensured by four (04) approved manufacturers: DO Pharma, TONG MEI, GGIA Laboratory, and Galenic Production Unit (UPG). They primarily supply generic drugs to wholesale pharmaceutical establishments. Regarding distribution, two types of wholesalers complement each other. The Pharmaceutical wholesaler-depository establishments are companies whose activities include storage for the wholesale sale of pharmaceutical products from one or more manufacturers. Pharmaceutical wholesaler-distributor establishments are companies that engage in purchasing, storing, and wholesale distribution of pharmaceutical products. Togo has six (06) approved wholesale distributors: The Central Purchasing of Essential Generic Medicines of Togo (CAMEG-TOGO) and its branches. The private circuit is provided by five (05) wholesale distributors: UNIPHART, UBIPHARM, TEDIS PHARMA, SOTOMED, and CPA. These structures can only order health products with a Marketing Authorization (AMM) issued by the Minister responsible for health. They are required to place their orders with approved laboratories or their representatives. Pharmacies must obtain their supplies from wholesale distributors. Exceptionally, they can act as occasional importers, with special authorization from the health authorities, for health products that do not have marketing authorization in the territory but are prescribed to patients. Community pharmacists only dispense units of products (retail sale) to patients on prescription.

Table 6
The Healthcare Professional Staff Ratios in 2022.

Healthcare professional categories	Number	Ratio
Specialized doctors	341	23740/Specialized Doctor
Generalist doctors	159	50915/ generalist Doctor
Physician assistants	1058	7652/Assistant
Dental surgeons	7	1156500/Dental Surgeon
Nurses	1259	6430/Nurse
Nurse assistants	775	10446/Nurse Assistant
Midwives	804	10069/Midwife
Midwife Assistant	757	10694/Midwife Assistant
Pharmacists	19	426079/Pharmacist
Pharmacist assistant	57	142026/Pharmacist Assistant
Laboratory technicians	607	13337/Technician
Health psychologists	64	126492/Psychologist
Functional rehabilitation staff	255	31747/Person
Hospital support staff	2942	2752/Person
Total of Qualified Personnel	9104	889/Qualified Professional

Data from Compte national sanitaire du Togo: https://p4h.world/app/uploads/2024/08/p4h_Rapport-CS-2020-2021_Togo.x23411.pdf

The National Pharmaceutical Supply System (SNAP), established in 2014, organizes the public-sector supply chain from product selection and procurement to storage, distribution, prescribing, and dispensing. Its relevance to UHC lies in its ability to ensure the continuous and equitable availability of affordable essential medicines. Fragmented responsibilities and dependence on imported products remain important risks for access, quality, and financial protection.

The National Blood Transfusion Center oversees the management of blood product supply, storage, and distribution systems. There is a Regional Blood Transfusion Center in each health region. The Expanded Immunization Program ensures a stable vaccine supply, adequate storage, and efficient distribution. In 2024, the country established a national plan to combat the sale and distribution of adulterated and substandard medical products. Moreover, the National Food Security Agency of Togo has been working for food security in Togo since 2008. It builds up stocks of foodstuffs purchased from local producers, provides food assistance to victims of natural disasters or conflicts, and supports the processing or export of surplus food.

4.3.3. Health data collection and database, and knowledge generation

Togo uses DHIS-2 across all health districts and produces annual health statistics with district-level disaggregation. However, variable completeness and timeliness, inconsistent metadata, and limited analytical capacity constrain the routine production and use of performance indicators. Available outcome indicators, including life expectancy, maternal mortality, under-five mortality, and infant mortality, indicate persistent health-system challenges, but they do not substitute for service-coverage measures. Togo uses DHIS-2 to compile routine health-service information and produces annual health-statistics reports with program and subnational data. Available routine information includes outpatient and inpatient activity, epidemiological surveillance, and other measures of health-service performance. These sources enable examination of selected dimensions of effective service coverage even when a complete national UHC Service Coverage Index cannot be calculated. The inability to routinely compute the UHC Service Coverage Index and financial-protection indicators, therefore, represents both a measurement gap and a stewardship weakness. Table 7 presents selected indicators of health-service performance in Togo, 2022.

Table 7
Selected indicators of health-service performance in Togo, 2022.

Indicators	Coverage in 2022
DHIS-2 reporting completeness/timeliness	89.9%/80.8%
The utilization rate for curative care	56.4%
DTP3 or pentavalent vaccine coverage	88.6%
The percentage of pregnant women who had at least 4 prenatal care contacts	50.9%
Proportion of maternal deaths subjected to an audit (review)	53.24%
Percentage of births attended by skilled personnel	72.5%
Maternal mortality due to direct obstetric causes in health facilities	1.18%
Percentage of pregnant women who received at least three doses of sulfadoxine-pyrimethamine (IPTp) during pregnancy	61.5%
Proportion of women who underwent a Cesarean section and received the subsidy	91%
Proportion of severely acutely malnourished children under 5 years of age receiving care	30.39%
Percentage of public health facilities offering services tailored to adolescents and young people (specially designed and equipped spaces, trained staff, activity reports)	2%
Malaria incidence (per 1000 population)	275
Incidence of Tuberculosis (p.100,000 population)	33
Anti-tuberculosis treatment success rate for new and relapse patients (cured plus treatment completed)	86.7%

Data from [1] "Ministère de la Santé, de l'Hygiène Publique, de la Couverture Sanitaire Universelle et des Assurances," Ministère de la Santé, de l'Hygiène Publique, de la Couverture Sanitaire Universelle et des Assurances. Accessed: Oct. 07, 2026. [Online]. Available: https://transports.gouv.tg/wp-content/uploads/2025/05/Rapport-annuel-de-performance-2023_MSHP_VF.pdf

In 2015, Togo developed a national health research strategic plan to guide health research interventions from 2015 to 2020, including social protection issues [11]. The implementation of this plan was suboptimal due to weak national coordination of health research and insufficient funding. However, the creation of the ministerial decree by the Bioethics Committee for Health Research (CBRS) and the research work conducted during this period are noteworthy.

4.4. Function of stewardship

4.4.1. Overall system design

The quality of governance is a critical determinant of outcomes in the health sector [2,12,13]. The design, implementation, evaluation, and reform of the organizations and institutions that facilitate financing, service provision, and resource generation for the health system are carried out under the leadership of the Ministry of Health and Hygiene. The strategic design of health financing is the responsibility of the entire government, as outlined in a strategic development plan. The structural arrangement falls under the purview of the Ministry of Health and Hygiene, as well as the Ministry of Economics and Finance. Different authoritative organizations and institutions are responsible for implementation management. The strategic design of health service provision is also the responsibility of the entire government, as outlined in a strategic development plan. The structural arrangement for service provision is performed exclusively by the Ministry of Health and Hygiene. Different mandated organizations and institutions are responsible for implementation management. Finally, the Ministry of Health and Hygiene leads the strategic design of resource generation through the Health Development Plan. The Ministry of Health and Hygiene, in collaboration with the Ministries of Higher Education and Research, Vocational Training, and Commerce, as well as other Relevant Ministries, ensures the structural arrangement. Different authoritative organizations and institutions are responsible for implementation management.

4.4.2. Priority settings

Based on the principles of the Paris Declaration on the effectiveness of development aid, particularly the principle of ownership, and the Accra Agenda, the Togolese government established a 2018–2025 strategic development plan, which was later revised and became the Government Roadmap 2025 in 2020. This Agenda proposed a new integrated national vision around three (3) strategic axes, the first of which aims to strengthen inclusion and social harmony and consolidate peace. The first pillar of this axis aims to provide identity and ensure coverage of health and access to essential services for all.

Based on this Government Roadmap 2025, the Ministry of Health and Hygiene set up the National Health Development Plan 2023–2027 with five axes: Health system and community health, the use of essential health services, including nutrition by mothers, children, young people and adolescents and the elderly, the fight against diseases and control of social and environmental determinants, the responses to epidemics and other public health emergencies, and the protection against financial risk linked to the use of health services.

4.4.3. Performance assessments

A fundamental ingredient for providing strategic direction and assuring a level playing field is to evaluate the performance of institutions and organizations in charge of revenue collection, risk pooling, service purchasing and provision, and resource development [1]. The Ministry of Economics and Finance is responsible for assessing the performance of the Togolese Revenue Office every quarter in terms of tax generation and the funds generated through donations from agencies and non-governmental organizations. The respective Ministries are in charge of evaluating the risk-pooling public agencies: The National Health Insurance Institute and the National Social Security Fund. Service provision performance falls under the exclusive purview of the Health Ministry,

which collaborates with higher education ministries and professional training institutions to evaluate resource generation.

4.4.4. Intersectoral advocacy

Improving health requires a multi-sectoral approach, which requires a set of concerted and coordinated interventions that should mobilize a wide range of actors and organizational entities. Intersectoral approaches aim to address the health risk factors and the determinants of health [2]. All governmental departments account for the health implications of their plans, policies, and programs. The One Health Platform was formally established on August 29, 2023, to facilitate coordination among different departments. At the international level, Togo's health system relies on technical expertise and financial support from the United Nations Agencies and other multilateral organizations, bilateral institutions, and international nongovernmental organizations.

4.4.5. Regulations

The Directorate of Medicines and Pharmaceuticals is the national drug regulatory authority, whose mission is to design, implement, and monitor policies and programs in the field of pharmacy and medicines. There is no formal authority agency to regulate food and medical technologies. The right to health is recognized by the Togolese constitution as in most countries worldwide [14], stipulating in Article 13 that the State must guarantee the physical and mental integrity, life, and security of all persons living on the national territory [15]. The main laws regulating the health system use the rights-based approach [2].

Togo's health system is primarily regulated by Law N°. 2009-007 of May 15, 2009 [16], which establishes the public health code of the Togolese Republic. Law n°0.2021–012 of June 18, 2021, relating to the Labor Code [17], also regulates the health system. The Labor Code governs labor relations between workers and employers carrying out their professional activities within the territory of the Togolese Republic, as well as between these employers and the trainees or apprentices placed under their authority. Law N°. 2011-006 of February 21, 2011, on the Social Security Code [18], defines the provisions governing the general compulsory social security system in Togo. Law N°. 2010-004 on the Water Code [19] establishes the general legal framework and the basic principles of integrated water resources management in Togo. Law N°. 2020-007 of June 26, 2020, relating to school feeding [20] aims to guarantee, ultimately, for each student in primary education, particularly students located in the most vulnerable areas, access to sufficient and balanced school nutrition and to promote the development of local production. Decree N°. 2017–011/PR of January 31, 2017 [21], relating to disaster risk management, establishes the creation, responsibilities, organization, and operation of the National Civil Protection Agency (ANPC). Law N°0.2015–010 [22] establishes the penal code of the Togolese Republic, which determines crimes and misdemeanors and sets the penalties applicable to their perpetrators.

4.4.6. Consumers protection

The Togolese Public Health Code protects consumers. Book 2, Title 2, and Chapter 4 regulate nutrition and consumer health protection. Thus, the prevention and treatment of nutritional deficiencies, as well as the prevention and treatment of nutritional excesses, are within the scope of the Togolese health system. Measures aimed at reducing the incidence of all forms of malnutrition and promoting better nutrition for individuals and communities are the responsibility of the health system. The code prohibits any production, importation, possession, sale, or free transfer of unhealthy, expired, or spoiled food products. Consumer health protection is ensured through controls and inspections, supplemented by selective surveys and laboratory analysis. These controls apply to all foodstuffs, whether in their natural or manufactured state, and whether produced locally or imported. These controls cover the entire agri-food production chain. The Ministry of Health ensures that restaurants maintain healthy conditions through its licensing process. However, the country lacks a specialized agency to regulate food and drugs. Consumer protection falls under the purview of the Ministry of Health and Public Hygiene, the Ministry of Justice, the Ministry of Commerce, and the Consumers Association. Moreover, like other African countries, Togo faces the problem of adulterated and substandard medical products.

5. Discussion

This study aims to provide an overview of Togo's health system, focusing on its four main functions, and to assess the challenges associated with the government's goal to achieve universal health coverage in the coming years. Some data are missing. For instance, there is a lack of information about overlapping coverage, as some households have both private and social insurance. Some pregnant women and students also benefit from Woezou, school Assur, and private and social assurance. It is a cause of non-optimal resource utilization due to the parallel implementation of programs aimed at the same end goal. These overlaps make interpretation challenging. However, the results of this study provide an overview of the health system's capacity to achieve universal health coverage.

Togo's health outcomes remain suboptimal, as reflected in this study by life expectancy and maternal, infant, and under-five mortality indicators. These outcomes should be interpreted as the cumulative result of weaknesses across the four system functions rather than as isolated statistics. Limited public financing, high household payments, unequal access to qualified personnel, insufficient coordination and weak performance-monitoring capacity jointly restrict the effective coverage and quality of essential services. Arhin et al. [23], found that on the average infant mortality rate in Sub-Saharan Africa, between 2000 and 2019, was approximately 60 for every 1000 live births per year, Seychelles, Mauritius, Cabo Verde, and Botswana recorded the lowest values of infant mortality rate while Sierra Leone, Central Africa Republic, Liberia and Angola had the highest values. In Benin, the inadequate coordination of social protection policies and strategies results in multiple overlaps between the AM-ARCH project and scheme, such as the Special Regime for Civil Servants regarding the benefit package in 2021–2022 [24].

The financing profile is inconsistent with rapid progress toward UHC. Although total health expenditure represents 6.7% of GDP, domestic government health expenditure is only 0.54% of GDP and 2.6% of the national budget, while out-of-pocket payments represent 65.9% of current health expenditure. In 2021, the government of Liberia allocated 14% of its budget to health, close to the Abuja Declaration's recommendation of 15% of national budgets to the health sector [25]. However, according to the same authors, domestic general government health expenditure accounted for only 48% of the total publicly available health budget, while the remaining 52% came from donor funding [25]. In Cameroon, healthcare financing in 2021 relied predominantly on out-of-pocket payments, which represented around 72% of total health expenditure [26]. Oumorou et al. [26], p. 9, wrote, “Public investment in health remains critically insufficient, with health spending accounting for only 2.86% of total government expenditure and approximately 3.5% of GDP, well below the 15% target set by the Abuja Declaration”.

Achieving universal health coverage requires more a total amount spent. Adrian et al. wrote, “[a]lthough there is no consensus to determine the funding needs for UHC, a recent study showed that targets that aim to include 5% of GDP, 15% of government expenditure and USD 86 per capita, are interesting benchmarks” [27, p.9]. The central issue is therefore not only the total amount spent, but who pays, how funds are pooled, and whether purchasing arrangements direct resources toward priority services and underserved populations. Heavy reliance on household payments exposes families to financial hardship and weakens equitable access.

Only 7.5% of the population is covered by insurance arrangements, while prepayment represents a small share of current health expenditure. Or, there is evidence that financing healthcare via social health

insurance and other compulsory financing mechanisms improves health system efficiency [23]. Therefore, this narrow and fragmented pooling base limits cross-subsidization between healthy and sick, rich and poor, and formal and informal populations. Expanding enrolment without consolidating pools and strengthening strategic purchasing may increase administrative complexity without adequately improving financial protection or service quality. Considering that general government health financing has a significant positive association with health system efficiency [23], the finding regarding Togolese general government health financing is a critical bottleneck to universal health coverage.

The combined findings point to a mutually reinforcing set of constraints. Fragmented financing reduces purchasing leverage; weak purchasing and uneven workforce distribution limit service availability and quality; and insufficient routine performance data make it difficult to identify gaps, allocate resources, and hold institutions accountable. These interactions, rather than any single deficit, explain why current reforms may not translate automatically into effective UHC.

Health's low budgetary share, which was only 3.9% of government expenditure in 2022 in Cameroon, has been attributed to structural and political economy factors, including limited legislative prioritization of health, fragmented policy coordination, and an underperforming revenue system [28]. By contrast, early in 2019, Burkina Faso's current health expenditure (CHE) per capita was $42.30 USD (compared to $65 USD for this study), with Government spending dominating health expenditure at 41.8% of CHE, followed by out-of-pocket payments (34.7%), external aid (15.8%), and voluntary health insurance contributions (1.9%) [29].

The workforce findings further illustrate the gap between nominal system capacity and effective service coverage. Togo has approximately 1.12 qualified health personnel per 1000 inhabitants, with particularly large shortages of physicians, nurses, and midwives. Shortages, urban concentration, and weak retention reduce geographical access, continuity, and quality of care. The policy implication is not simply to expand training, but to align production, recruitment, deployment, incentives, supervision, and retention with district-level service needs. N. A. Forbinake et al. [28] showed how Cameroon faces severe health workforce shortages, as of 2022, with a physician density (0.07 doctors per 1000 people), nurse/midwife density (0.56 per 1000 people), and only 1 specialist surgeon per 100,000 people.

The routine service indicators qualify the broader assessment of Togo's capacity to achieve UHC. The findings suggest that the health system can deliver and monitor selected priority interventions, but performance is not uniform across programs. Lower performance in some indicators may reflect a combination of workforce shortages, geographical barriers, medicine or commodity availability, referral limitations, demand-side constraints, and weaknesses in local management. The findings should not, however, be interpreted as definitive measures of service quality because routine contact indicators do not establish whether users received timely and effective care.

The DHIS-2 findings also demonstrate the relationship between information and the other health-system functions. Incomplete, delayed, or insufficiently disaggregated data weaken stewardship by limiting the identification of underserved populations, evidence-based allocation of resources, performance monitoring, and institutional accountability. Conversely, regular district-level analysis of service coverage, data quality, workforce availability, and medicine availability could enable decision-makers to target corrective action and monitor whether UHC reforms are reducing geographical and socioeconomic inequalities.

5.1. Strengths of the study

To our knowledge, this is the first attempt since the launch of Togo's stepwise UHC reforms in 2012 to assess core health-system capacities across the four functions of the Murray and Frenk framework: stewardship, financing, service provision, and resource generation. These functions are conceptually distinct from the WHO six building blocks. The study triangulates document review, key-informant interviews, focus group discussions, and field experience, allowing findings to be compared across sources and grounded in official institutional records.

5.2. Limitations of the study

The study used routine administrative indicators to complement the assessment of health-system capacity. Such data may be affected by incomplete reporting, inaccuracies in target-population denominators, differences in case detection, limited reporting from private providers, and variations in data-validation practices. Routine indicators primarily capture reported service contacts and may not fully measure service quality, continuity, unmet need, or effective coverage. The results should therefore be interpreted as an indication of health-system performance rather than as a complete assessment of UHC.

6. Recommendations

Critical challenges faced by the country in deciding on how to make progress toward universal coverage are how best to:

- **Improve health system financing**: Evaluate the possibility of raising tax rates on company profits, personal income, and indirect taxes to create a specific line for public health expenditures. These funds must be used to strengthen the health social insurance scheme, reduce the share of out-of-pocket payments in total health expenditure, and provide financial protection for the population in the informal sector. This is expected to significantly reduce financial hardship among the population.
- **Strengthen DHIS-2 and institutionalize data-informed UHC monitoring:** Establish a validated national and district-level UHC performance dashboard within DHIS-2, building on the routine indicators presented in Table 7. The dashboard should integrate indicators related to immunization, maternal and child health, malaria, tuberculosis, noncommunicable diseases, service utilization, workforce distribution, medicine availability, reporting performance, and financial protection. Regular data-quality reviews, district performance analyses, and feedback mechanisms should be institutionalized so that routine information is used to identify underserved populations, guide resource allocation, monitor inequalities, and strengthen accountability for UHC results.
- **Improve stewardship/governance:** Operationalize Universal Health Insurance (UHI) Regulatory Committee. This committee will ensure that evidence on various complementary financing options for the UHI is documented, based on an analysis of their evolution and objectives. It will work to integrate parallel free programs, which are sources of spending inefficiencies, into universal health coverage. Moreover, reducing the fragmentation of current financing arrangements by merging the two public agencies (CNSS and INAM) to create a National Social Protection Agency would improve governance and stewardship, thereby enhancing efficiency.
- **Resource Generation:** Create financial compensation as the fundamental market mechanism for regulating the supply of health professionals to recruit and maintain highly qualified staff. Also, establish an independent National Agency for Food and Drug Administration dedicated to guaranteeing the safety of food and drugs nationwide.
- **Strengthen intersectoral action, community empowerment, and regular performance review:** Build on the National Health Platform established in August 2023 to formalize intersectoral collaboration between the health, social protection, and finance sectors around UHC financing targets. Expand the role of Community Health Workers (ASCs) and Consumer Associations in local accountability mechanisms to strengthen community empowerment and demand-side engagement. Integrate the existing Public Health Emergency Operations Center (PHEOC) into routine health-system

strengthening rather than treating emergency preparedness as a parallel function. Finally, institutionalize an annual, National Health Plan-oriented sector performance review, using the same four-function framework applied in this study, to track progress toward UHC targets over time. One area where recent reforms already show tangible results is the Expanded Immunization Program's dedicated vaccine cold-chain and distribution system (Section 4.3.2); extending this model of ring-fenced, dedicated management to other essential-medicines categories could be a pragmatic entry point for broader supply-chain reform.

7. Conclusion

Togo has initiated important reforms toward UHC, but progress is constrained by interacting weaknesses in the four health-system functions. High out-of-pocket spending and fragmented pooling undermine financial protection; workforce shortages and maldistribution restrict equitable access; weaknesses in medicines, service delivery, and routine information limit effective coverage; and stewardship arrangements do not yet ensure coherent accountability across institutions. Progress, therefore, requires coordinated reform rather than isolated interventions, with priority given to greater public financing and pooling, strategic purchasing, district-responsive workforce policies, a reliable supply of essential medicines, and a strengthened DHIS-2-based performance system. Future research should assess the distributional effects and fiscal feasibility of these reforms.

Declaration of generative AI and AI-assisted technologies in the manuscript preparation process

During the preparation of this work, the authors used Grammarly and Zotero for proofreading and reference management. After using this tool/service, the authors reviewed and edited the content as needed and took full responsibility for the content of the published article.

CRediT authorship contribution statement

Dibeka Baman: Writing – review & editing, Writing – original draft, Visualization, Validation, Software, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Laurent Cleenewerck de Kiev:** Validation, Supervision, Formal analysis. **Kabiru Gulma:** Writing – review & editing, Validation, Formal analysis. **Bagnan Bato:** Writing – review & editing, Validation, Formal analysis.

Ethics approval and consent to participate

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Declaration of competing interest

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