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Country note**

Togo

Summary

The Executive Director presents the country note for Togo for a programme of cooperation for the period 2002 to 2006.

The situation of children and women

1. Togo covers an area of 56,600 square kilometres, with an estimated population in 2000 of 4,629,000, 60 per cent of which is under 20 years of age. Despite the social and political problems that followed the elections in 1998 and 1999, there have been some positive achievements relating to women and children. The country ratified the Convention on the Elimination of All Forms of Discrimination against Women in 1983, and the process of harmonization with Togolese legislation is under way. The Convention on the Rights of the Child was ratified in 1990 and a start has been made on the implementation of the recommendations of the Committee on the Rights of the Child on the basis of the initial report; in particular, the children's code is in the process of being adopted and the Children's Parliament was set up in August 2000.

2. Owing to the low level of tax revenue, the suspension of part of the multinational assistance since the end of 1992, and the absence of a programme with the Bretton Woods institutions, the economy is characterized by an excessive burden

* E/ICEF/2001/2.

** An addendum to the present report containing the final country programme recommendation will be submitted to the Executive Board for approval at its second regular session of 2001.

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of public debt amounting to $1.81 billion (22 per cent internal debt and 78 per cent external debt). Debt servicing amounted to $67 million in 1999. This has resulted, inter alia, in a reduction in public and private investment and a deterioration in basic social services. Almost three quarters of the population is living below the poverty level. Togo is one of the countries with a low human development index (0.471) and is ranked 145th out of 174 countries (1998).

3. Malaria is still the main cause of mortality. The rate of HIV/AIDS infection continues to increase dangerously: the rate has risen from less than 1 per cent in 1987 to 5.9 per cent of the general population in 1999. Dracunculiasis and poliomyelitis are in the process of being eradicated. The consumption of iodized salt increased from 1 per cent in 1996 to 71 per cent in 1998, and the campaign against vitamin A deficiency has been integrated into the vaccination campaigns.

4. The infant mortality rate has remained almost unchanged over the decade (81 per 1,000 live births in 1988 and 80 per 1,000 in 1998) and the infant and child mortality rate declined from 158 per 1,000 live births in 1988 to 146 in 1998. Malaria is still the main cause of infant and child mortality (34 per cent in 1998), followed by diarrhoea (31 per cent) and acute respiratory infections (10 per cent). One quarter of the children under three years of age are underweight, and only 31 per cent of children have been fully vaccinated. Fifteen per cent of infants (4 to 6 months) are exclusively breastfed. According to the school statistics for 1998/99, barely 3 per cent of pre-school-age children have access to kindergartens. The majority of parents do not have all the necessary knowledge to ensure the integrated development of their children. The school enrolment rate was 77 per cent in 1999 for primary education (80 per cent for boys and 74 per cent for girls). The repeater rate was 29 per cent at the primary school level in 1997. The school drop-out rate in 1997 was 17 per cent (19 per cent for girls, 16 per cent for boys). These poor standards are primarily due to high direct costs, the poor quality of education and the lack of teaching materials and qualified staff. Child labour has become widespread, but the country has very little information about children in need of special protection measures.

5. The demographic health survey (EDST-98) showed that the maternal mortality rate declined from 640 per 100,000 live births in 1990 to 478 in 1998. The main causes are still haemorrhaging, septicaemia, eclampsia, dystocia and abortion. The indirect causes, aggravated by early pregnancy, are primarily anaemia and malaria. The high number of births not attended by health professionals (49 per cent) continues to pose a health risk for both mother and child. Forty-eight per cent of Togolese women are illiterate, compared to 23 per cent of men. They have little access to education, technical and vocational training and information. The role of women is not valued. Women have no access to the land and little access to credit, and they are responsible for almost all household tasks.

Lessons learned from past cooperation

6. The mid-term review and EDST-98 emphasized the need for joint efforts, for greater intersectoral collaboration, and for an enhanced partnership with non-governmental organizations, communities and other development partners. With a view to putting the above lesson into practice: (a) in the Savanes region, the partnership with the non-governmental organization the Association in Support of

Community Health Activities has made it possible, within the framework of the Bamako Initiative, to strengthen the capacities and efficiency of the management committees, as well as to ensure the continuity of health services and stabilize their costs; (b) UNICEF has assisted in the preparation of regional health development plans, thus contributing to decentralization; (c) the increase in the rate of access to education, through the partnership with the non-governmental organization Aid and Action, has made it necessary to improve the quality of teaching; and (d) special groups for assessment/analysis and decision-making have made it possible for women to participate effectively in the microplanning process. These groups, where men and women participate on an equal basis, help to foster a local development dynamic that transcends socio-cultural barriers.

7. There are still, however, constraints, such as the poor coordination between the central and regional levels and the lack of reliable information for monitoring. The challenge for the new programme is to support institutional reinforcement for local governance, which will make communities more responsible.

Proposed country programme strategy

8. The preparation of the strategy document was coordinated by the Ministry of Planning and Development, in conjunction with the other ministries, United Nations agencies, non-governmental organizations and other development partners. It was guided by the country development programme, which focuses on poverty eradication, the Common Country Assessment (CCA), the main guidelines of the United Nations Development Assistance Framework (UNDAF), the two Conventions and the programme of the World Health Organization (WHO). Within the UNDAF preparatory groups, UNICEF was responsible for education and the rights of the child and, with WHO, for essential social services.

9. The aim is to contribute to the achievement of national objectives relating to the realization of the rights of children and of women, especially those most vulnerable. The objectives are: (a) to support the implementation of provisions relating to the promotion and implementation of the rights of children and women; (b) to contribute to the reduction in infant, infant and child, and maternal mortality rates, and to strengthen the prevention of HIV/AIDS in general and, in particular, among young people and adolescents, as well as mother-child transmission; (c) to enhance basic education by improving school enrolment, attendance and completion rates and by promoting the integrated development of the young child, as well as parental education; and (d) to strengthen the involvement of communities, in particular families, women and children, in decision-making and action.

10. The country programme strategies for 2002-2006, identified on the basis of causal analysis and in accordance with the Government's strategies, are: (a) capacity-building for communities, families and institutions at all levels, in order to enhance appreciation and analysis of the problems and to take specific action to implement the rights of children and women; (b) support for the Government in strengthening the political, legal and institutional framework and the development of activities for women and children in need of special protection measures; (c) the provision of high-quality essential services for children and women, with particular attention to the most disadvantaged; and (d) communication to influence the

behavioural aspect of the problems identified and to create an environment conducive to the well-being of children and women.

11. The new programme, like the preceding one, will be implemented in three regions (Savanes, Kara and Maritime), covering eight prefectures, including the Golfe prefecture, with an estimated population of 2.2 million. It comprises four programmes, two sectoral (health and nutrition, and basic education) and two cross-sectoral (community capacity-building and communication, monitoring and evaluation). The latter would have a national dimension, while the others would be carried out at the regional level. The three regions were chosen because of their low levels of school enrolment, particularly for girls, and their social and health indicators, and the high incidence of poverty in those regions. This programme will also make it possible to consolidate the actions already carried out with a view to ensuring greater impact and continuity. The Golfe prefecture was included because of the increasing number of children in need of special protection measures and the rural exodus of girls, in particular to Lomé.

12. The *health and nutrition programme* will help to reduce infant and infant and child mortality, maternal mortality and moderate and severe malnutrition; and to eliminate vitamin A and iodine deficiencies. It will support Togo's efforts: (a) to sustain the Vaccine Independence Initiative; (b) to implement the national reproduction health policy for women by strengthening emergency obstetrical services, essential neonatal care and primary health care through the Bamako Initiative; and (c) to control HIV/AIDS by targeting pregnant women in areas with high infection rates in order to reduce mother-child transmission.

13. The *basic education programme* will help to strengthen school enrolment in general, and of girls in particular, and to improve the performance of the educational system through capacity-building for teachers; the revision of the curricula; and the setting up of a system to monitor school performance and assess the quality of the teaching and the provision of teaching materials, with particular attention to the regions which are most disadvantaged for the education of girl children. The psychosocial and emotional development of young children and the knowledge and abilities of parents will be enhanced.

14. The aim of the *community capacity-building programme* is: (a) to strengthen the capacities of communities, women and children to enhance participation, planning and decision-making at all levels; (b) to improve the home environment (education, literacy education, microcredit) and increase access to high-quality essential social services (health, nutrition, water/sanitation); and (c) to have the community detect and handle problems relating to child protection (traffic, registration of births, HIV/AIDS).

15. The aim of the *communication, monitoring and evaluation programme* is: to promote an environment and behaviour conducive to respect for and the realization and protection of the rights of children and women; and to encourage participatory and dialogue approaches with adolescents and women in order to ensure better control of priority problems such as HIV/AIDS, early pregnancies and maternal health. The programme will also make it possible to strengthen the system of data collection and analysis for the better implementation of development policy as well as integrated research activities and the implementation of the integrated monitoring and evaluation plan.

16. The 2002-2006 country programme is based on the strengthening of intersectoral collaboration and coordination at the local level. Intersectoral collaboration will be ensured through the community capacity-building programme, which will serve as a basis for sectoral project activities. In the light of the specific context of the country and in order to deal with possible changes in the situation, an emergency preparation plan will also be developed. The "cross-sectoral costs" budget will be used to finance key posts for implementation and to cover the general expenses of the programmes.

Estimated programme budget

Estimated programme cooperation, 2002-2006[a]

(In thousands of United States dollars)

	General resources	*Supplementary funds*	*Total*
Health and nutrition	2 980	1 700	4 680
Basic education	1 750	1 300	3 050
Community capacity-building	1 800	800	2 600
Communication, monitoring and evaluation	851	200	1 051
Cross-sectoral costs	750		750
Total	**8 131**	**4 000**	**12 131**

[a] These are indicative figures only which are subject to change once aggregate financial data are finalized.