glaas | UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water

Togo

DEMOGRAPHIC AND ECONOMIC ESTIMATES

Population (2012)[a]	**6.64 M**
Urban population (2012)[a]	**2.56 M**
Rural population (2012)[a]	**4.09 M**
Population growth rate (2012)[a]	**2.59%**
Gross domestic product USD (2012)[b]	**3.81 billion**

[a] World Population Prospects: The 2012 Revision, UNDESA 2013.
[b] World Development Indicators, World Bank 2013.

HEALTH ESTIMATES

Infant mortality / 1,000 live births (2012)[c]	**62**
Under 5 mortality / 1,000 live births (2012)[c]	**95.5**
Life expectancy at birth (2012)[d]	**58 yrs**
Diarrhoea deaths attributable to WASH (2012)[e]	**2377**

[c] Levels & Trends in Child Mortality. Report 2013, UNICEF 2013.
[d] World Health Statistics, WHO 2014.
[e] Preventing diarrhoea through better water, sanitation and hygiene, WHO 2014.

SANITATION AND DRINKING-WATER ESTIMATES

Use of improved sanitation facilities (2012)[f]	**11%**
Use of drinking-water from improved sources (2012)[f]	**61%**

[f] Progress on Drinking-Water and Sanitation – 2014 Update, WHO/UNICEF 2014.

WHO/FWC/WSH/16.37

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UN WATER

World Health Organization

Sanitation, drinking-water and hygiene status overview

At the 2014 Sanitation and Water for All High Level Meeting (SWA HLM), the Government of Togo made six commitments for improving the water, sanitation and hygiene sector. The commitments covered areas such as coordination and human resources.

Togo has stated that establishing a sector coordination framework is one of the priority actions in order to operationalize its sectoral approach and, consequently, implement resource mobilization strategies in the sector. Therefore, two of Togo's SWA commitments centered on coordination. They are:

- The Ministry of Health will cooperate with the Ministry of Planning, Development and Land Planning, the Ministry of Primary and Secondary Education and the Ministry of Rural Infrastructure to include actions related to the elimination of open defecation and CLTS in the 2014-2016 Priority Action Programme for the SCAPE (Accelerated Growth and Jobs Promotion Strategy) and in the 2015 National Health Development Plan; and
- The Ministry of Rural Infrastructure will cooperate with the Ministry of Health, the Ministry of Primary and Secondary Education, the private sector, and civil society to effectively establish this sector coordination framework.

Additionally, several cooperation and coordination structures between the actors have been put in place in recent years. The main ones are: the Country Water Partnership of Togo (PNE-TOGO) WASH Cluster, the National WASH Coalition, Actors Network of Water and Sanitation Togo, and the focus group of partners of the EU Water Facility. All of these structures are formal; however the operationalization of these frameworks has not been effective. For example, meetings are not consistently organized.

The Government of Togo also made an SWA commitment for human resources—to build the human resource capacity of hygiene and sanitation departments to overcome the malfunctioning of, and weaknesses in, the administration and management of the water, hygiene and sanitation services. To achieve this, the government intends to build the capacity of actors to effectively and sustainably implement the PANSEA (Water Sector Investment Programme) by 2017, increasing staff numbers (60 category A and B officials), and strengthening human resource capacity between now and 2016.

Human resources in Togo are currently constrained by financial resources for staffing and recruitment practices. In addition to the SWA commitment, the government plans to conduct an analysis of the human resources situation to better understand the needs of the sector.

Highlights based on country reported GLAAS 2013/2014 data[1]

I. Governance

The Ministry of Rural Infrastructure has the lead for both drinking-water and sanitation services. The Ministry of Health leads hygiene promotion initiatives and has a number of responsibilities in sanitation and water. Several coordination mechanisms exist, including a committee developed specifically for WASH.

LEAD INSTITUTIONS	SANITATION	DRINKING-WATER	HYGIENE PROMOTION
Ministry of Rural Infrastructure	✔	✔	
Ministry of Health			✔

Number of ministries and national institutions with responsibilities in WASH: **12**

Coordination between WASH actors includes:
- ✘ All ministries and government agencies
- ✔ Nongovernmental agencies
- ✘ Evidence supported decisions based on national plan and documentation of process

PLAN AND TARGETS FOR IMPROVED SERVICES	INCLUDED IN PLAN	COVERAGE TARGET (%)	COVERAGE TARGET YEAR
Urban sanitation	✔	83	2015
Rural sanitation	✔	55	2015
Sanitation in schools	✘		
Sanitation in health facilities	✔		
Urban drinking-water supply	✔	69	2015
Rural drinking-water supply	✔	63	2015
Drinking-water in schools	✘		
Drinking-water in health facilities	✘		
Hygiene promotion	✔		
Hygiene promotion in schools	✘		
Hygiene promotion in health facilities	✔		

There are specific plans implemented addressing the issues of reliability/continuity of urban and rural water supplies.

SPECIFIC PLANS FOR IMPROVING AND SUSTAINING SERVICES[a]	EXISTENCE AND LEVEL OF IMPLEMENTATION OF MEASURES (Low → High)
Keep rural water supply functioning over long-term	
Improve reliability/continuity of urban water supply	
To rehabilitate broken public latrines	
Safely empty or replace latrines when full	
Reuse of wastewater or septage	
Ensure DWQ meets national standards	
Address resilience to climate change	

[a] Including implementation.

[1] All data represented in this country highlight document is based on country responses to GLAAS 2013/2014 questionnaire unless otherwise stated.

II. Monitoring

There is a high level of data availability reported for policy-making and response to WASH related disease outbreak. Difficulties in carrying out independent surveillance are reported to be due to a lack of staff.

MONITORING	SANITATION		DRINKING-WATER		HYGIENE
Latest national assessment	January 2011		January 2011		August 2012
Use of performance indicators[a]	●		●		●
Data availability for decision-making[a]					Health sector
Policy and strategy making	✔		✔		✔
Resource allocation	●		●		NA
National standards	NA		✘		NA
Response to WASH related disease outbreak	NA		NA		✔
Surveillance[b]	Urban	Rural	Urban	Rural	
Independent testing WQ against national standards	NA	NA	✘	✘	
Independent auditing management procedures with verification	NA	NA	✘	✘	
Internal monitoring of formal service providers	✘	✘	✘	✘	
Communication[a]					
Performance reviews made public	✘	✘	✘	✘	
Customer satisfaction reviews made public	✘	✘	✘	✘	

[a] ✘ Few. ● Some. ✔ Most.
[b] ✘ Not reported. ● Not used. ✔ Used and informs corrective action.
NA: Not applicable.

III. Human resources

Human resource strategies are not developed for sanitation and drinking-water. The most important constraints identified are the lack of financial resources and recruitment practices.

HUMAN RESOURCES	SANITATION	DRINKING-WATER	HYGIENE
Human resource strategy developed[a]	✘	✘	✔
Strategy defines gaps and actions needed to improve[a]			●
Human resource constraints for WASH[b]			
Availability of financial resources for staff costs	✘	✘	✘
Availability of education/training organisations	●	●	●
Skilled graduates	●	●	●
Preference by skilled graduates to work in other sectors	✔	✔	✔
Emigration of skilled workers abroad	●	●	●
Skilled workers do not want to live and work in rural areas	●	●	●
Recruitment practices	✘	✘	✘
Other			

[a] ✘ No. ● In development. ✔ Yes.
[b] ✘ Severe constraint. ● Moderate constraint. ✔ Low or no constraint.

IV. Financing

A financing plan is in place, although it is not fully implemented, and there is a reported insufficiency of funds to meet most MDG targets. There are also reported difficulties in absorption of domestic and donor commitments mainly due to the late disbursement of funds and procurement issues.

FINANCING

	SANITATION		DRINKING-WATER	
Financing plan for WASH	Urban	Rural	Urban	Rural
Assessment of financing sources and strategies[a]	●	●	●	●
Use of available funding (absorption)				
Estimated % of domestic commitments used[b]	●	●	●	●
Estimated % of donor commitments used[b]	●	●	●	●
Sufficiency of finance				
WASH finance sufficient to meet MDG targets[b]	✘	✘	●	✔

[a] ✘ No agreed financing plan. ● Plan in development or only used for some decisions. ✔ Plan/budget is agreed and consistently followed.
[b] ✘ Less than 50%. ● 50–75%. ✔ Over 75%.

WASH VS. OTHER EXPENDITURE DATA

Total WASH expenditure[1]	
2012	20.60 M.USD
Expenditure as a % GDP	
Education[2]	4.5
Health[2]	8.0
WASH[3]	1.0

[1] Reported WASH expenditure in GLAAS 2013/2014 converted using UN exchange rate 31/12/12.
[2] Expenditure as a % GDP – Average 2010–2012, sources UNESCO 2014, WHO 2014.
[3] WASH expenditure from country GLAAS 2013 response, GDP Average 2010–2012, World Development Indicators, World Bank 2013.
NA: Not available.

V. Equity

As a step towards addressing equity in access to WASH services, three disadvantaged groups are identified in WASH plans. Funds are reported to be largely directed to urban areas, however, the unserved are mainly in rural areas.

EQUITY IN GOVERNANCE

	SANITATION		DRINKING-WATER	
Laws				
Recognize human right in legislation	✘		✔	
Participation and reporting[a]	Urban	Rural	Urban	Rural
Clearly defined procedures for participation	✔	✔	✔	✔
Extent to which users participate in planning	✘	✘	✘	✘
Effective complaint mechanisms	✔	✘	✔	✘

[a] ✘ Low/few. ● Moderate/some. ✔ High/most.

DISADVANTAGED GROUPS IN WASH PLAN

1. Poor populations
2. Displaced persons
3. People living with disabilities

EQUITY IN FINANCE

Figure 1. Urban vs. rural WASH funding

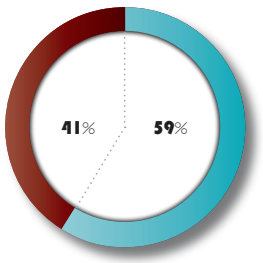
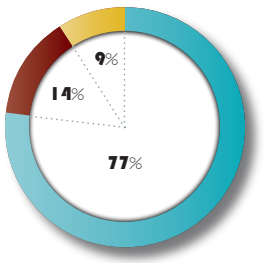


Figure 2. Disaggregated WASH expenditure



EQUITY IN ACCESS[1]

Figure 3. Population with access to improved sanitation facilities

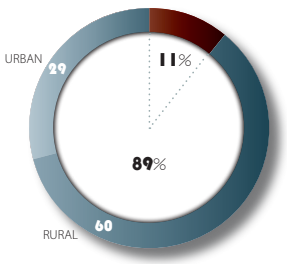
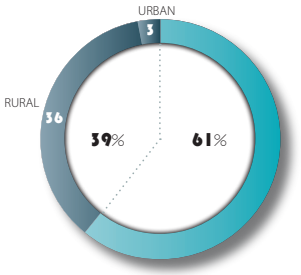


Figure 4. Population with access to improved drinking-water sources



[1] Progress on Drinking-Water and Sanitation – 2014 Update, WHO/UNICEF 2014.