



REPUBLIC OF TOGO
Work – Liberty – Homeland
National Council for the Fight against STI / HIV / AIDS

**National Report on Monitoring the Declaration of Commitment on HIV/AIDS
(UNGASS)**

Report on the core indicators

December 2005

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC(s)	Antenatal Clinic(s)
ARV	Antiretroviral
ARHS	Analysis of the Reproductive Health Situation
ATBEF	Association Togolaise pour le Bien Etre Familial (Togo Family Planning Association)
CAN	National Strategic Framework
CCCVT	Center for Confidential HIV Counseling and Voluntary Testing
CHR	Regional Hospital
CHU	Academic Hospital
CLAS / US	University of Lomé Coordinating Committee for the Fight against HIV/AIDS
CNAO	National Center for Orthopedic Equipment
CNTS	National Blood Transfusion Center
CRIS	Country Response Information System
DGSCN	General Directorate for Statistics and National Accounts
DRS	Regional Health Directorate
EU	European Union
FGM	Female Genital Mutilation
GNP	Gross National Product
GTZ	Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)
HCB	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
ILO/USDOL	International Labor Organization / US Department of Labor
LDC	Least-developed Countries
MDG	Millennium Development Goals
MTCT	Mother-to-Child Transmission
NAC	National AIDS Committee
NAC-STI	National Council for the Fight Against AIDS and Sexually Transmitted Infections
NAP	National AIDS Programme
NGO(s)	Nongovernmental Organization(s)
NHI	National Health Institute
PLHIV	Person Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PRSP	Poverty Reduction Strategy Paper
PSI	Population Service International (NGO)
SCRLS	Permanent Secretariat of the Regional AIDS Committee
SIDA 3	AIDS Control Support Project in West Africa - stage 3
SNSJA	National Health Service for Youths and Adolescents
STI	Sexually Transmitted Infection (STI)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Programme for Development
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URD	Population Research Unit
VCO	Vulnerable Child or Orphan
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

CONTEXT AND JUSTIFICATION

Introduction

At the end of the UN General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001, the governments of 189 member states adopted the Declaration of Commitment on HIV/AIDS. This Declaration reflects a worldwide consensus on a comprehensive project framework to reach the Millennium Development Goals, i.e. stopping and reversing the onslaught of the HIV/AIDS pandemic by the year 2015.

The Declaration of Commitment calls on governments:

- to involve all partners (business, civil society, private sector) at the highest level
- to focus on prevention in all actions
- to set up the crucial elements of effective action in the areas of care, support and treatment
- to adopt effective measures to ensure respect of the rights of those affected by HIV/AIDS
- to increase protection for the vulnerable
- to bring special support to orphans and children who are affected by HIV/AIDS
- to reduce the social and economic impact
- to continue research and development activities
- to develop and to take initiative by implementing special strategies for the fight against HIV/AIDS in areas affected by conflict and natural disasters
- to make sure that the resources supplied for worldwide action for the fight against HIV/AIDS are substantial, long-term and result-oriented.
- to maintain the current momentum and to monitor the progress made

Conscious of the need for a multi-sectoral initiative, the Declaration of Commitment supports responses at global, regional and national level to prevent new cases of HIV infection, to broaden access to care and to mitigate the impact of the epidemic.

In addition, the Declaration also calls for careful monitoring of the progress made in implementing the commitments made.

In order to accomplish the above, a series of core indicators was developed to evaluate progress in implementing the Declaration of Commitment.

These indicators and their reporting to the UN General Secretariat are a formal requirement of the Heads of State who also proposed the timetable for reporting: 2003, 2005, 2006.

This report, which covers the period from 2003 to 2005, is the result of a joint effort by the Permanent Secretariat of the National Council for the Fight against AIDS (NAC) together with national and international partners for the gathering of quantitative and qualitative data for the purpose of evaluating the level of progress made on these commitments.

The following core indicators were evaluated:

- national commitment and action indicators;
- national knowledge and behavior indicators;
- national HIV/AIDS programs impact indicators.

This report is based on the following research method:

- Creation of a small technical group under the leadership of the Permanent Secretary of NAC in charge of identifying key persons to be interviewed, coordinating data collection, input, writing the report and organizing the workshop for the validation of this report.
- Gathering of data for the indicators related to the commitments made and initiatives undertaken at national level and to the impact of national programs;
- Gathering of data on the knowledge and behavior of young people in the area of HIV/AIDS through a survey of the urban and the rural population conducted by the Population Research Unit (URD) of the University of Lomé
- Organizing a workshop to validate the report drafted by the technical group.

The indicators measured are presented in the table in the Appendix.
This report is divided into six chapters.

After a brief general country overview, we will present a brief overview of the current status of the HIV/AIDS situation in Togo in Chapter I; Chapter II contains a general overview of the epidemic. In Chapter III, we will present the national response to the epidemic. In Chapters IV and V we will address the main obstacles encountered and the support required from the country's development partners. And finally, in Chapter VI, we will develop a framework for monitoring and evaluation.

GENERAL COUNTRY OVERVIEW

1. GEOGRAPHICAL DATA

Togo is in West Africa. It is bordered by Benin to the East, Ghana to the West, the Atlantic Ocean to the South and Burkina Faso to the North. The country is roughly rectangular, approximately 700 km long and 150 km across at its widest, covering a surface area of 56,785 km². It has 50 km of coastline on the Atlantic Ocean.

Togo is divided into five administrative and economic regions comprising thirty districts.

- Coastal Region, with 6 districts;
- Plateau Region, with 9 districts;
- Central Region, with 4 districts;
- Kara Region, with 7 districts;
- Savanna Region, with 4 districts.

2. SOCIO-DEMOGRAPHIC AND CULTURAL DATA

2.1 Population

In 2005, Togo had an estimated population growth of 2.6% and a population of 5 212 000 inhabitants, with half the population below the age of 15. 51.3% of this population are women. The urban population was an estimated 35% in 2005, compared with 25% in 1981, which is when the last General Population and Habitat Census was conducted in the country.

2.2 Education (Schooling and literacy)

The net percentage of children attending primary schools across the entire country was 76.8% in 2003/2004. The in-school population is not evenly spread across the country, with the lowest rate in the northern part of the country (Savanna Region: 58.9%).

The adult literacy rate (15 years and over) was 68% for men and 38% for women in 2005, which shows a major gender gap.

2.3 Marriage

An analysis of the reproductive health situation (ARHS 2003) revealed wide-spread early sexual relationships in Togo. The age at first marriage is 20 for men and 17 for women, with an extremely high prevalence of early marriage in rural areas.

Polygamy is authorised by law, based on the code of practice of the people and the family. Approximately 54% of married women in Togo are in a polygamous union. Other ritual practices have been revealed by research studies in the area of social science, above all certain traditional practices called *sonorate* or *levirate*, excision, circumcision and ritual infibulation, which are all factors that are conducive to spreading HIV.

2.4 Religion

The majority of the population are animists. Christians and Muslims account for 28.3% and 12.1% of the entire population respectively. The majority of Christians are Catholic (48.4%), while 22.8% are Protestant. In addition, various other Christian churches (charismatic churches) have evolved since the arrival of democracy at the beginning of the 1990s.

Religious communities undertake initiatives in the area of health by setting up and running rural health centers and hospitals. These include the pediatric hospital of Tantigou in the Savanna Region; the Hélotia Health Center (Kéran) and Aledjo Kadara dispensary (Bafilo) in the Kara Region; the secondary hospital of Pagala (Blitta) in the Central Region; the Baptist Hospital in Kpélé Tsiko, the Bethesda Hospital in Agou Gnogbo and the DATCHA Hospital in the Plateau Region; and finally, the Saint-Jean-de-Dieu hospital in Afagnan in the Coastal Region.

3. HEALTH DATA

As far as the health situation is concerned, Togo is divided into six regions or health districts. The capital Lomé is a health district in itself. The health system is structured as a pyramid with three levels.

- The base of the pyramid represents the peripheral level. This is the operational level comprising of 35 district Health Directorates corresponding to the 35 health districts, 30 district hospitals, 700 peripheral healthcare units and private healthcare services.
- The middle of the pyramid represents the intermediary level, corresponding to 6 health regions, each of which comprises of a Regional Health Directorate and its affiliated services, a regional hospital and private healthcare services for the region.
- The top of the pyramid represents the central or national level, corresponding to the Ministry and General Directorate of Public Health, its central directorates, departments and services, as well as special units at national level (CHU, INH, CNAO, CNTS and medical schools) and private healthcare services with a national vocation.

As far as human resources are concerned, there is one (1) doctor for every 12,470 inhabitants in Togo, one (1) midwife for every 9,330 women of child-bearing age and one (1) nurse for every 3,093 inhabitants, which are unevenly spread across the country.

Almost half of the country's healthcare workers are concentrated in the capital Lomé and its outskirts. The city, which accounts for approximately 25% of the country's entire population, has 53% of doctors, 42% of midwives and 26% of nurses; that is 33% of all medical and paramedical staff.

4. ECONOMIC DATA

The country's economic situation is extremely unstable. Togo belongs to the group of 'Least-Developed Countries' (LDC) in the world, with an estimated annual per capita income of 330 dollars and a per capita GNP of 410 dollars.

Togo's economy is predominantly based on agriculture (cotton, coffee, cocoa, maize, cassava, sorghum, rice, etc.), but it also has a mining industry which is predominantly based on phosphate-mining, which is located about thirty kilometres from the capital.

A decline in raw material prices and currency devaluation (of the Franc CFA) in 1994 with no accompanying measures in addition to Structural Adjustment Programmes and an ongoing social and political crisis have directly resulted in a substantial proportion of public international development aid (e.g. from the European Union) being suspended, severely affecting the country's economy.

The consequences of this situation are:

- an increase in both domestic and foreign debt;
- a sharp decline in people's purchasing power;
- growing poverty among the most economically vulnerable segments of the population, particularly women and youths;
- a strong propensity towards high-risk sexual behavior in order to survive, especially among young girls, etc.

The country's economy regresses as the epidemic spreads¹.

Box No. 1

As far as legislation is concerned, in addition to the law banning Female Genital Mutilation (FGM), which has been in force since 1998, the law on the protection of human rights in the area of HIV/AIDS has been approved by the National Assembly. It was voted in on 2 December 2005. These pieces of legislation represent a major contribution by national law-makers to the fight against the spread of HIV/AIDS in the country.

¹ Translator's note: not quite sure what was exactly meant here, but as far as I can see this makes the most sense...

Box No. 2

Demographic core indicators

Population data	Year	Estimate	Data source
Total population (in thousands)	2005	5 212	DGSCN
Percentage of the population of women of child-bearing age (12 - 45 years old)	2005	25	DGSCN
Percentage of the population aged 15 - 24	2005	40.1	RD/UL CAP youth survey, 2005
Percentage of the population aged 15 to 24 living in urban areas	2005	37.2	URD/UL CAP youth survey, 2005
Percentage of the population aged 15 to 24 living in rural areas	2005	43.1	URD/UL CAP youth survey, 2005
Female population aged 15 to 24 (in thousands)	2005	532.94	DGSCN
Annual growth rate (%)	2005	2.6	DGSCP
Percentage of the urban population	2005	35	DGSCN
Annual growth rate of the urban population	2000-2005	4	UN Population Division
Gross birth rate (per 1000 life births)	2004	37.9	UN Population Division
Gross mortality rate (per 1000)	2004	14.7	UN Population Division
Maternal mortality rate (per 100 000 life births)	2000	570	Health in the World, Report 2004, WHO
Life expectancy at birth	2004	52	Health in the World, Report 2004, WHO
Fertility rate	2003	5.08	ARHS 2003
Child mortality rate (per 1000 life births)	2000	83	Health in the World, Report 2004, WHO
Child-youth mortality rate	2000	141	Health in the World, Report 2004, WHO

Socio-economic core indicators			
Socio-economic indicators	Year	Estimate	Data source
Annual per capita income (in US-\$)	2004	330	GDP Committee of DGSCN
Per capita GNP (in US-\$)	2004	410	GDP Committee of DGSCN
Per capita GDP (in US-\$)	2005	373	GDP Committee of DGSCN
Proportion of public health expenditure (in %)	2003	5.2	Directory of Health Statistics 2003
Male adult (15 years and over) literacy rate (in %)	2005	68	DGSCN
Female adult (15 years and over) literacy rate (in %)	2005	38	DGSCP
Net school attendance rate for boys (in %)	2002	83.4	UNFPA
Net school attendance rate for girls (in %)	2002	74.3	UNFPA

**METHODS USED FOR COLLECTING DATA FOR THE
CORE INDICATORS**

The National Report 2005 submitted by Togo on the monitoring of the UNGASS-Declaration is the result of a participatory process which consisted of the following stages:

- Creation of a small technical group, under the leadership of the Permanent Secretary of the National AIDS Committee (NAC) and comprising the National AIDS Programme (NAP), the Head of Statistics, Study and Research of the Ministry of Health, the Monitoring and Evaluation Officer of NAC, the PS/NAC-STI Monitoring and Evaluation Officer, the UNAIDS Monitoring and Evaluation Officer, the UNICEF HIV/AIDS Administrator and the President of the Network of PLHIV Associations. This group was in charge of identifying key people to be interviewed, coordinating data collection, input, writing the report and organizing the workshop for validating this report.
- Gathering of data on indicators related to the commitments made and initiatives undertaken at national level as well as indicators on the impact of national programs. Data was gathered from specific sites, either by interviews or from annual activity reports. This procedure was carried out by research staff from the public sector, private sector and from civil society (see table opposite). Data collection took from two to five days, depending on the indicators.
- Evaluation of national knowledge and behavior indicators through a survey of the urban and rural population conducted by the Population Research Unit (URD) of the University of Lomé from 17 to 21 December 2005.
- Entering of the first data into the CRIS during the Regional Workshop which was jointly organized by the UNAIDS Regional Office (Dakar) and the UNAIDS Office/Togo in Lomé from 6 to 8 December. This workshop brought together representatives from the Monitoring and Evaluation Units of the National Councils for the Fight against HIV/AIDS from five countries (Benin, Burundi, Ivory Coast, Gabon and Togo). Any missing data that was collected later was entered in the system by the Monitoring and Evaluation Unit of PS/NAC.
- Organizing a workshop for validating the drafted report by the technical group.

Table No. 1: Breakdown of data collection teams by indicator

Area	Indicators	Data collection team
National Commitment and Action		
1. Amount of national funds disbursed	Amount of national funds disbursed by governments in low- and middle-income countries	Mr BONFOH, Accountant at PS/NAC* Mr MEDESSI, Accountant and Administrator at NAP Mr FIATY Yao Hétsu, Budget Director (MEFP)
2. National HIV/AIDS policy	National Composite Policy Index	DJOKE Kossi, DISER AGBOGAN Yawo, Programme Assistant at PS/NAC

Area	Indicators	Data collection team
National Programs: Education, workplace policies, STI case management, blood safety, prevention of mother-to-child transmission, antiretroviral combination therapy coverage, and services for orphans and vulnerable children (1)		
1. Education	Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year	Mr EDOH, AIDS Unit of the Ministry of Technical Education and Vocational Training * Mr TAGONE, AIDS Unit of the Ministry of Primary and Secondary Education Mr GBEGNON, Population Study and Research Unit, AIDS Unit of the University of Lomé
2. Workplace policy	Percentage of large enterprises/companies which have HIV/AIDS workplace policies and programs	Dr AKAYA, ILO/USDOL Project* Mr SOWOU, Employers Mr TSIKPLONOU, Trade Unions Mr BINGUITCHA, Work Inspector

Area	Indicators	Data collection team
National Programs: Education, workplace policies, STI case management, blood safety, prevention of mother-to-child transmission, antiretroviral combination therapy coverage, and services for orphans and vulnerable children (2)		
3. Treatment of STIs	Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled	Mme TCHAMDJA, SIDA 3* Mr DEVOTSU, NAP Mr GNANSA Atinédi, Head of Communications Division at PS/NAC
4. Prevention of MTCT	Percentage HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	Dr TCHAMA, Project Manager Prevention of MTCT at NAP* Dr OCLOO, Deputy Administrator HIV/AIDS at UNICEF

Area	Indicators	Data collection team
National Programs: Education, workplace policies, STI case management, blood safety, prevention of mother-to-child transmission, antiretroviral combination therapy coverage, and services for orphans and vulnerable children (3)		
5. Antiretroviral treatment (ARV)	Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy	Dr PELE Takouda, Deputy Director, monitoring of ARV patients, CAMEG Dr DEKU, Epidemiological Surveillance, monitoring / evaluation and ARV at NAP* Mr AKOUETE Folly, "Espoir Vie" (NGO), Togo Mrs. DJAHLIN Bernice, Programme Administrator, PS/NAC
6. Orphans and vulnerable children	Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	Mrs. DIKENI-KERIM, AIDSS* (NGO) Mrs. SIMON Céline, ACS (NGO) Mrs. ALI Bossa, Director of Childhood Protection, Ministry of Social Affairs
7. Blood safety	Percentage of transfused blood units screened for HIV	Mrs. ABUDU Akofa, Senior Laboratory Engineer at the National Center for Blood Transfusion* Mr Blaise SEDOH, Togolese Red Cross

Area	Indicators	Data collection team
Impact indicators		
Reduction of HIV prevalence	Percentage of young women and men aged 15 to 24 who are HIV-infected	Dr PELEI Takouda, Deputy Director, monitoring of ARV patients, CAMEG
Treatment for HIV: survival after 12 months on antiretroviral treatment	Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	Dr DEKU, Epidemiological Surveillance, monitoring / evaluation and ARV at NAP *
Reduction of MTCT	Percentage of infants born to HIV-infected mothers	Mr AKOUETE Folly, "Espoir Vie" (NGO), Togo Mrs. DJAHLIN Bernice, Programme Administrator, NAC

Note: * team leader

CHAPTER I – STATUS AT A GLANCE

The first case of AIDS was recorded among a group of female sex workers in Lomé in 1987. HIV infection has spread among the world's population at an exponential rate ever since, with the sexually active population most severely affected.

A total number of 17,600 cases were officially recorded between 1987 and 2005, with just over 80% of these falling into the 19-49 year olds group. The gender ratio male / female is 0.8; this can be explained by early sexual relationships among young girls.

82.4% of all cases are transmitted through heterosexual intercourse, while 6.5% are transmitted through mother-to-child transmission. Other paths of transmission are, above all, blood transmission (transfusion of contaminated blood, multiple use of contaminated syringes and medical sharps, etc.), which account for 11.1%.

A breakdown according to place of residence shows that 67.07% of cases of AIDS are in urban areas and 32.3% in rural area.

Seroprevalence among pregnant women - according to a sentinel HIV surveillance survey conducted in antenatal clinics in 2003 was an average of 4.8% (n= 3 845), although there were differences between urban and rural environments (6.81% and 2.43% respectively).

Seroprevalence was higher among female sex workers: 53.9% (n=386) in Lomé and 13.3% (n=315) among their clients in 2003.

In 2004, the prevalence of HIV among the entire sexually-active population (aged 15 to 49) was 4.5% (n= 4 623), reaching 6.7% in the coastal region, compared with 2.38% in the central region.

According to EPP/SPECTRUM, the number of PLHIV was estimated at 137,270 in 2005.

**CHAPTER II: GENERAL OVERVIEW OF THE HIV/AIDS
EPIDEMIC**

1. HIV PREVALENCE

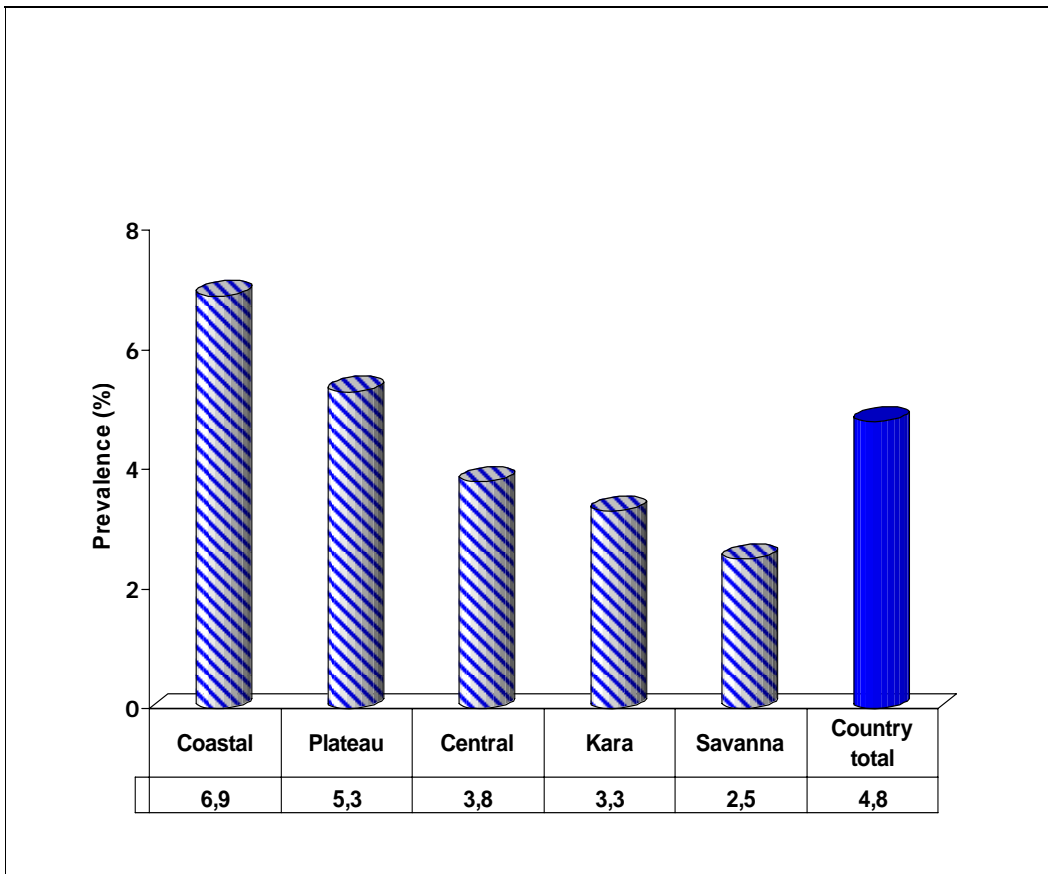
1.1 Among the population as a whole

No survey on the prevalence of HIV among the population as a whole has ever been carried out in Togo since the pandemic began. However, according to UNAIDS estimates from 2004, this prevalence was 4.1%. Hence, the number of PLHIV (adults and children) was estimated at about 128,980, according to the same source.

1.2 Epidemiological surveillance data

1.2.1 HIV prevalence among pregnant women in sentinel sites

Diagram 1: Seroprevalence of HIV by region in Togo for 2003, sentinel surveillance among pregnant women in antenatal clinics



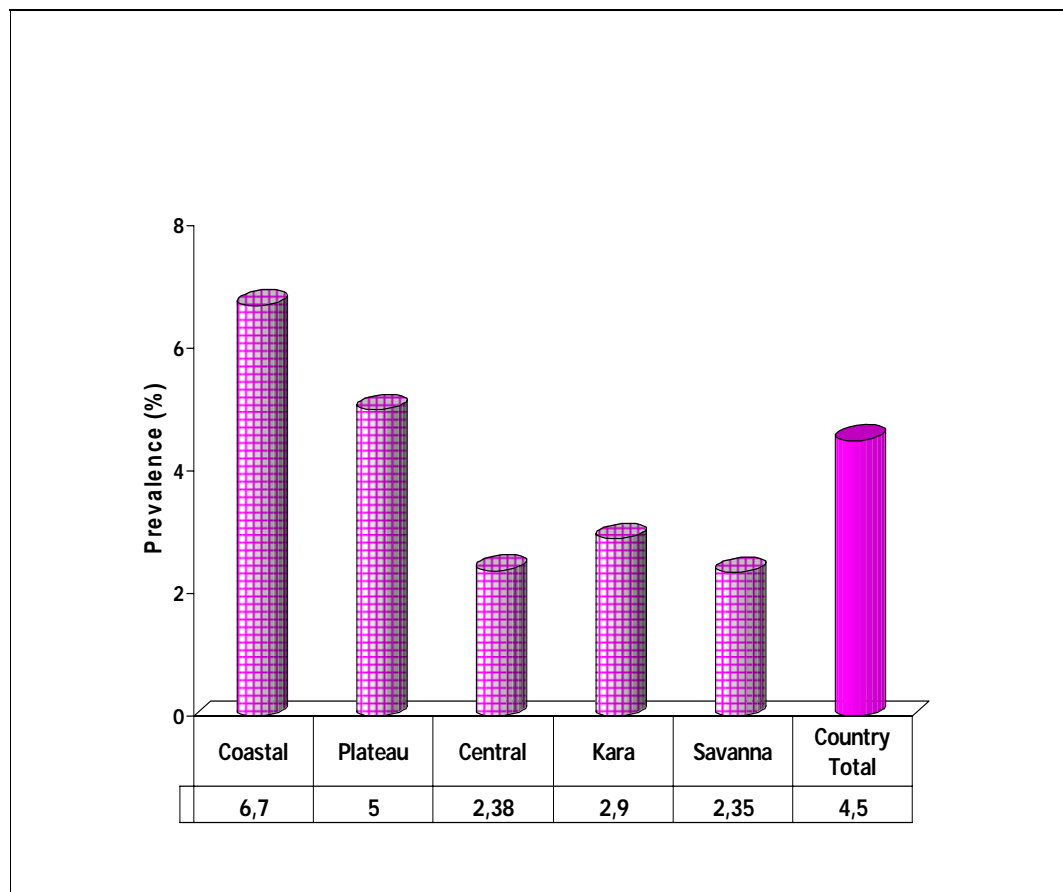
Source: NAP Annual Report 2003

Lomé, the capital, is in the Coastal Region and accounts for 20% of the country's total population.

There is a decline in the prevalence of HIV from the Southern (Coastal) part of the country towards the Northern part (Savanna Region).

Epidemiological surveillance data for 2004 revealed similar trends. Diagram 2 indicates the seroprevalence of HIV by region among women in antenatal clinics.

Diagram 2: Seroprevalence of HIV by region in Togo for 2004, sentinel surveillance among pregnant women in antenatal clinics



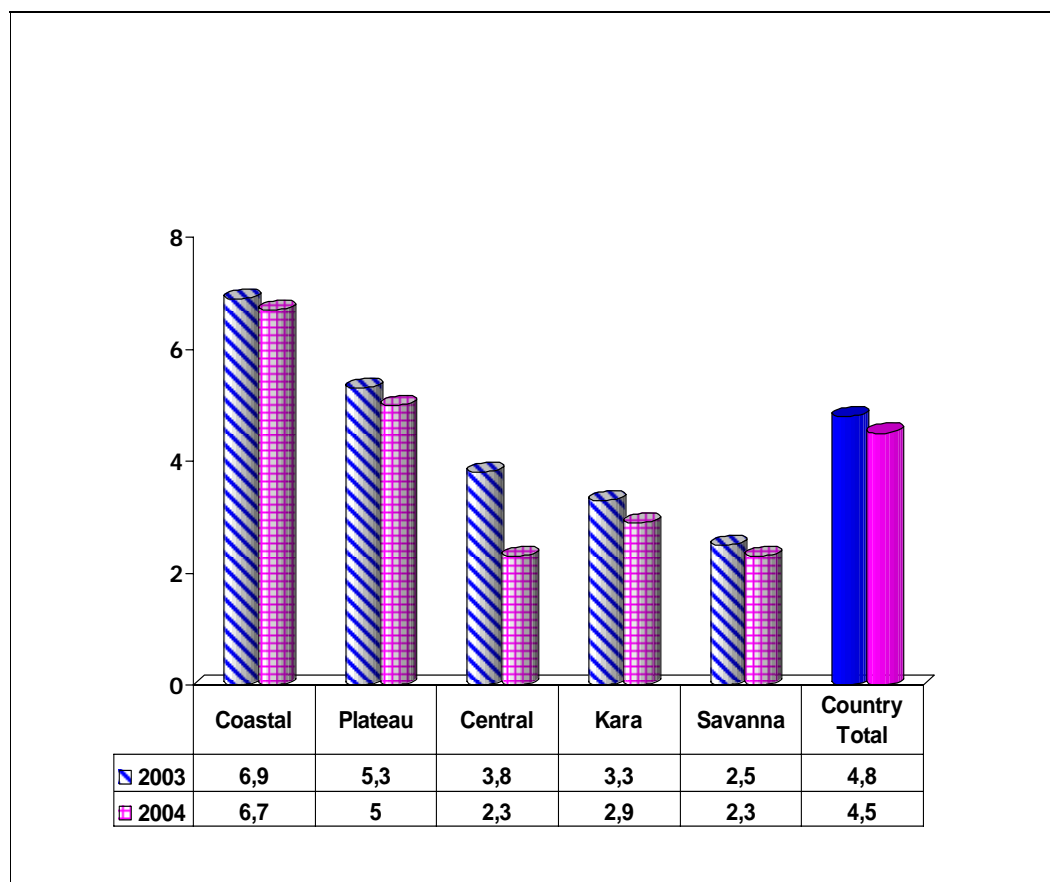
Source: NAP Annual Report 2004

The survey on seroprevalence in sentinel sites could not be carried out in 2005 due to lack of funding.

Over the whole of the two years, and considering the seroprevalence surveillance in sentinel sites among pregnant women only, the epidemic seems to have remained stable among this group.

Diagram 3: Seroprevalence of HIV by region in Togo for 2003 and 2004,

Sentinel surveillance among pregnant women in antenatal clinics



Source: NAP Annual Reports 2003 and 2004

1.2.2 HIV Prevalence among Specific Groups

- **Armed Forces**

A survey on the seroprevalence of HIV carried out by the Central Directorate of Health Services of the Armed Forces among members of the forces in 2002 revealed a prevalence of 12 to 16%.

- **Female sex workers and their male partners**

A survey was carried out by the 'SIDA 3'-Project in Lomé in 2003. This survey monitored HIV/STI prevalence and sexual behavior among female sex workers and their male partners. The survey covered 402 female sex workers aged 12 to 60 and 407 partners aged 15 to 65. The survey revealed that the HIV epidemic was highly concentrated among the female sex workers, with a prevalence of 53.9% (n=386), while it was average among their male partners, with a prevalence of 13.3% (n=315). These prevalence rates are 11 times and 3 times higher respectively than the prevalence for the population as a whole, measured on pregnant women.

Among the female sex workers HIV prevalence increased with age, with the group of female sex workers aged 40 years and over being most affected.

The table below is a summary of HIV prevalence among female sex workers by age group.

Table No. 2: HIV Prevalence among female sex workers by age group (n=386)

Age	Numbers	HIV +	Prevalence
12-20 years old	76	26	34.2 %
21-30 years old	185	86	46.5 %
31-40 years old	90	66	73.3 %
40 years and over	35	30	85.7 %
Total	386	208	53.9 %

Source: Monitoring surveys of HIV/STI prevalence and sexual behavior among female sex workers and their male partners carried out by the SIDA 3-Project in Lomé in 2003

The same trends were revealed among their male partners (table no. 3)

Table no. 3: HIV prevalence among male partners of female sex workers by age group (n=315)

Age	Numbers	HIV +	Prevalence
15-20 years old	57	0	0.0 %
21-30 years old	169	21	12.4 %
30 years and over	89	21	23.6 %
Total	315	42	13.3 %

Source: Monitoring surveys of HIV/STI prevalence and sexual behavior among female sex workers and their male partners carried out by the SIDA 3-Project in Lomé in 2003

A new evaluation is currently underway which will be extended to the other parts of the country.

- **Among blood donors**

HIV tests carried out on blood bags obtained by the National Blood Transfusion Center from blood donors in 2005 show a prevalence of 3% among this group.

Table No. 4: prevalence of HIV, Syphilis, Hepatitis B and Hepatitis C among blood donors by age group

Age	Number of donors	Donated blood tested positive	
		HIV	Prevalence
15–24 years old	4951	129	2.6
25-49 years old	3845	145	3.8
≥ 50 years old	329	5	1.5
Total	9125	279	3.0

Source: CNTS Activity Report 2005

- **Tuberculosis patients**

An HIV prevalence survey among tuberculosis patients is underway. According to the first trends recorded by the National Tuberculosis Control Programme (PNLT), one tuberculosis patient in four (25%) was reported HIV-positive.

2. REPORTED AIDS CASES

The data available on the number of cases of AIDS which have been diagnosed and reported is broken down neither by age nor gender. This is aggregated data for the country as a whole. From 1987 to 2005, there was an aggregated number of cases of 17,600.

3. PREVALENCE OF STIs

3.1 Among the population as a whole

The prevalence of STIs among the population as a whole is not known. The data available from the Directorate of Statistics, Study and Research of the Ministry of Health was obtained from health structures, whose reporting completeness is 95%.

In 2004, 17,222 cases of STIs were recorded by health structures. This is aggregated data.

3.2 Among sex workers and their male partners

The prevalence of STIs among female sex workers and their clients is summarised in tables 5 and 6 below.

On the whole and for all STIs (Gonorrhoea and Chlamydia) female sex workers and their male partners are exposed to the same risk of infection.

Table No. 5: Prevalence of STIs among female sex workers by age group (n=337)

Age	Number of female sex workers	Tested positive			
		Neisseria gonorrhoeae	Prevalence (in %)	Chlamydia trachomatis	Prevalence (in %)
12-20 years old	57	13	22.8	14	24.6
21-30 years old	167	22	13.2	10	6.0
31-40 years old	81	13	16.0	1	1.2
40 years and over	32	5	15.6	1	3.1
Total	337	53	15.7	26	7.7

Source: Monitoring surveys of HIV/STI prevalence and sexual behavior among female sex workers and their male partners carried out by the SIDA 3-Project in Lomé in 2003

Table No. 6: Prevalence of STIs among male partners of female sex workers by age group (n=321)

Age	Number of male partners of female sex workers	Tested positive			
		Neisseria gonorrhoeae	Prevalence	Chlamydia trachomatis	Prevalence
15-20 years	57	1	1.8 %	2	3.5 %
21-30 years	175	2	1.1 %	13	7.4 %
≥ 31 years	89	1	1.1 %	3	3.4 %
Total	321	4	1.2 %	18	5.6 %

Source: Monitoring surveys of HIV/STI prevalence and sexual behavior among female sex workers and their male partners carried out by the SIDA 3-Project in Lomé in 2003

3.3 Among blood donors

The prevalence of Syphilis, Hepatitis B and Hepatitis C among donor groups is relatively low.

Table No. 6: Prevalence of STIs among blood donors by age (n=9125)

Age	Number of donors	Blood of donor tested positive					
		Syphilis	%	HBV	%	HCV	%
15–24 years old	4951	46	0.09	498	0.1	182	0.03
25-49 years old	3845	46	0.01	427	0.1	170	0.04
≥ 50 years old	329	4	0.01	9	0.02	12	0.03
Total	9125	96	0.01	934	0.1	364	0.03

Source: CNTS Annual Report 2005

4. SOCIO-BEHAVIORAL AND ECONOMIC DETERMINING FACTORS

The principal determining factors for the spread of HIV in Togo are as follows:

- high sexual activity among the young population; multiple sex partners;
- failure to perceive the risk and denial of the disease;
- poverty and high economic and financial vulnerability of women
- increase in sex work (prostitution) among Togolese women (an increasingly young population of sex workers);
- high mobility of female sex workers in the country or sub-region;
- growth of financially vulnerable segments of the population, such as young girls working as housemaids, porters, bar staff, tailor and hairdresser apprentices, high-school and university students, single women etc.);
- high illiteracy among women (63%);
- low condom use among youths;
- high domestic migration and rural exodus in particular;
- a rather high prevalence of Sexually Transmitted Infections (STIs)
- stigma of people living with HIV (PLHIV)
- lack of care for people infected with HIV/AIDS;
- school drop-out and withdrawal of girls from school, both for social and for economic reasons;

- the custom of dowry for the release for apprentices (tailors and hairdressers in this case);
- harmful traditional practices (various traditions such as levirate or sonorate, passing into adulthood, leaving widowhood, infibulation, excision and circumcision, etc.);
- multiple partners (multiple sex partners)

In addition to all these socio-economic and cultural factors there are other obstacles to the fight against HIV/AIDS, above all:

- lack of institutional support (problem of lack of access to services involved in the fight);
- social and cultural constraints: importance of tradition, customs and rituals; AIDS being perceived as belonging to the realm of magic or the supernatural (which does not help access to care in public health facilities);
- growing influence of traditional healers;
- development of new information and communication technology which induces forms of high-risk sexual behavior (videos and porno websites);
- importance of religion (refusal of condom use by some religious groups), etc.

**CHAPTER III- NATIONAL RESPONSE TO THE HIV/AIDS
EPIDEMIC**

1. SUMMARY OF THE NATIONAL RESPONSE TO THE EPIDEMIC

In view of this situation as well as the social and economic consequences of the epidemic, the response, both by the government and by the community, directly resulted in:

- the mobilization of resources by the government for increasing public awareness of the disease and for the purchase of testing and diagnosis equipment in 1987;
- a committee for the fight being set up, development and implementation of three plans for short and medium-term intervention, covering successive periods between 1987 and 1995;
- intensification of the fight against HIV/AIDS between 1996 and 1999, based on greater political and financial commitment by the government, with changes in organizing the fight against HIV/AIDS brought about by the national program for the integration and decentralization of activities in the fight against HIV/AIDS/STIs.

Since 1999, we have seen a strengthening of the multi-faceted nature of the strategy for the fight against HIV/AIDS. During this phase, the development process of the National Strategic Framework (CAN) for the Fight against HIV/AIDS/STIs was first initiated, based on strategic planning, enabling contribution from the various actors of the fight against the epidemic.

The National Strategic Framework (CAN) for the fight against AIDS gives guidance for all current and future interventions in the fight against HIV/AIDS and STIs in Togo. It is structured around several main strategic areas and priority fields of action that were identified by analysis of the situation and response. Its implementation brought a large number of private and public-sector actors on the national scene, undertaking initiatives in different areas across the entire country. A special organizational structure was set up across the entire country to meet the challenges related to the synergies and complementarity of these various actors, as well as achieving efficiency in implementing their initiatives and ensuring good coordination of the fight against AIDS. The National Strategic Framework (CAN) for the fight against STI/HIV/AIDS provided a major opportunity for mobilizing additional resources in a context of national economic recession, mainly from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria.

The health sector has a preponderant role in the fight against HIV/AIDS. Initiatives undertaken in this sector are aimed at strengthening prevention and monitoring of the epidemic as well as capacities for providing medical care for persons infected with and affected by HIV. We are currently witnessing the first improvements in the care of PLWHA in Togo, thanks to the development of specific programs and initiatives for ensuring low-cost ARV treatment as well as an increase in the number of voluntary testing centers and campaigns to encourage people to use them.

As far as other sectors outside the health sector are concerned, there has not been much progress in setting up the structures for coordinating, developing and implementing action plans for the benefit of those working in government departments, except for the Defense sector which has succeeded in developing initiatives in the area of prevention, counseling, testing and treatment of STIs. In addition, campaigns to increase awareness and educate young people attending school have been implemented in the Education sector. Similar initiatives are being carried out by the Ministry of Youth in out-of-school environments. Many government departments have defined focal points for the fight against HIV/AIDS, but the development of genuine sectorial action plans for the fight against HIV/AIDS has not been conclusive. Even today, some ministry departments are probably unaware that the Strategic Framework for the fight against HIV even exists.

In spite of the completion of a certain number of remarkable initiatives, much remains to be done to ensure that activities are implemented and coordinated effectively.

2. INDICATORS OF NATIONAL ACTIONS AND COMMITMENTS

2.1 National commitment

Togo's commitment to the fight against HIV/AIDS began in 1987, both in terms of knowledge of the infection and at institutional level.

At institutional level, the National AIDS Committee (NAC) was set up in 1987. Subsequently, a National AIDS Programme (NAP) was established by the Ministry of Health. The NAC did not survive the dynamism of the NAP, which has been in charge of STI/HIV/AIDS prevention and care actions since 1987.

The NAC has used all its available resources in its attempts to reverse HIV/AIDS trends in Togo. However, given the extent of the epidemic, the structure in place has proved inadequate. Moreover, the disease has come to be seen as a development problem rather than strictly a health issue. As a result, the NAP was faced with institutional problems which led to the restructuring of the organizational framework for the fight against HIV/AIDS in Togo in 2000.

In view of the requirements of the new and more dynamic structure for the fight against HIV, the Togolese government adopted the strategy of the Joint UN Programme on HIV (UNAIDS), which is oriented towards a multi-sector and a multi-disciplinary approach in the fight against the epidemic. Today, the NAC is no longer responsible for coordinating the fight against STI/HIV/AIDS in Togo. This task has been delegated to the NAC.

The National AIDS/STI Council (NAC-STI) was set up by Presidential order in October 2001². It is presided over by the President of the Republic. It is made up of politicians (members of the government and national parliamentarians) and representatives from civil society and the private sector (doctors, businessmen, traditional leaders, religious leaders, traditional therapists, members of NGOs/Associations, PLHIV, trade unionists, etc.)

The NAC-STI is decentralized at regional and district levels where the highest local authorities are in charge of coordination.

The following tasks have been delegated to the NAC-STI: defining the political guidelines, mobilizing resources, evaluating the efficiency of the fight against STI/HIV/AIDS, approving annual budgets and action programs.

The Secretariat of the NAC-STI is accountable to a National Coordinator who has the following tasks and responsibilities: promoting a multi-sectoral approach towards implementing the Strategic Framework, ensuring the coordination of resources mobilized, promoting access to treatment, promoting and coordinating research, writing six-monthly reports on the activities carried out within the National Strategic Framework (CAN) and organizing regular meetings with partners.

The NAC-STI is recognized by all actors and partners as the country's only national authority for coordinating the fight against AIDS, although it should be noted that out of all the programs and projects supporting the fight against AIDS in Togo, the projects funded by the Global Fund and the UN System Programme for the national response are the only ones which were fundamentally based on the National Strategic Framework (CAN) and which have underlined the preponderant role of the NAC-STI.

² Translator's note: later on it says that the CNLS was established in October 2003. Is it possible there is a mistake in the dates? 2001 or 2003?

It should be noted that apart from the commitment made by the President of the Republic and the government, the highest levels of State - a commitment marked by the first step to strengthening the institutional framework with the creation of the NAC-STI, its Secretariat and technical bodies, the various advocacy activities conducted with the support of the Theme Group, extended to the country's development partners - there has also been a certain commitment on the part of the private sector and civil society - in this case NGOs - associations, traditional leaders, trade unionists, religious leaders and employers in the fight against HIV/AIDS (awareness seminars, round-table discussions, training workshops, setting up of AIDS units etc.).

2.2 National programs and actions

2.2.1- Funds disbursed by the government of Togo for the fight against HIV/AIDS between 2003 and 2005

The funds released by the government for the fight against HIV/AIDS between 2003 and 2005 are summarized in the table below. These funds are broken down into two main categories: (i) funding and equipment and (ii) program support. There is no data available on the breakdown of funds for "program support" by area of intervention, such as prevention, clinical care and ARV therapy etc.

Table No. 7: Breakdown of funds disbursed by the government of Togo for the fight against HIV/AIDS by area of intervention and by year

Areas of intervention	Amounts disbursed (in F CFA)			Total
	Year 2003	Year 2004	Year 2005	
Funding and equipment	10 000 100	10 000 100	10 000 100	300 000 300
Program support	400 275 150	450 000 100	299 999 700	1 150 274950
Total	410 275 250	460 000 200	309 999 800	1 180 275250

Sources: Directorate of Budget, Ministry of Trade, Finance and Privatization, NAC-STI, NAP

2.2.2 National policies for the fight against HIV/AIDS: "Composite National Policy Index"

According to the Constitution of the Fourth (IV) Republic, adopted on 27 September 1992 and amended in 2002, access to health care is a fundamental human right for all citizens of Togo. In accordance with this Constitution, national health policies aim to guarantee a state of health to all citizens that enables them to enjoy a socially and economically healthy life.

The health policy thereby places greater emphasis on the fight against HIV/AIDS, by way of multi-sectoral initiatives.

a) The National Strategic Framework for the fight against STI/HIV/AIDS

The National Strategic Framework for the fight against HIV/AIDS (CAN) 2001-2005 was developed in Togo in March 2001; it covers various sectors, including Health, Education, Employment, Transport, Armed Forces as well as Women and Youth, which explains its multi-sectoral approach.

It sets out several strategic areas, including voluntary counseling and testing, promotion and distribution of condoms, prevention and treatment of STIs, blood safety, prevention of Mother-to-Child transmission (MTCT), breastfeeding, care and treatment. These strategies are aimed at the following target groups: women and young girls, youths and high-risk populations, such as women working as porters, housemaids, orphans and vulnerable children as well as sex workers and migrants. The National Strategic Framework has also included poverty and development-related issues through more general operations on poverty and HIV/AIDS, gender and HIV/AIDS, human rights and the involvement of PLHIV.

In the same way, the problem of HIV/AIDS has been mainstreamed into all national policies and development programs.

The Poverty Reduction Strategy Paper (PRSP), the MDG monitoring document, the UN Development Assistance Framework document as well as the Common Country Assessments have mainstreamed HIV/AIDS-related issues into their strategies for prevention, care and support, mitigating the impact of HIV and AIDS, reducing gender inequalities and the reduction of income-related inequality.

Planning under the National Strategic Framework is effective at national level and considerable efforts were made for its implementation between 2003 and 2005, thanks to the awareness and the firm commitment of high-level State authorities, as well as support from the Global Fund and other partners during this period.

b) Political support

As far as political support is concerned, the NAC-STI, a national institution responsible for coordinating in-country initiatives for the fight against AIDS, was established on 11 **October 2003**³. It is made up of representatives from different sectors. The Council is presided over by the President of the Republic; the first Vice-President is the Head of government and the second Vice-President is the Minister of Health, together with the support of other members of government, national parliamentarians, traditional, religious and community leaders, regional delegates, civil society and PLHIV. The Council works through a Permanent Secretariat under the leadership of a team of seven members appointed by Presidential decree. The members meet once a week and their mandate consists of promoting interaction between the Government, the private sector, civil society and PLHIV.

c) Prevention

In the area of prevention, strategies for promoting information, education and communication (IEC) on HIV and AIDS are being developed, while active programs for the promotion of specific information on HIV and AIDS by the media are being implemented.

Programs for condom social-marketing, blood safety, antenatal screening for syphilis, prevention of MTCT and programs aimed at ensuring safe injections at healthcare centers are also being set up.

These strategies are aimed at young people, in both school and out-of-school environments, drug users, female sex workers and their partners, prison inmates, cross-border migrants as well as migrant parts of the population, refugees and displaced persons.

Activities specifically aimed at young people, which are the most vulnerable population, have been developed for promoting education on sexual and reproductive health, with a focus on

³ Translator's note: sorry, but I'm getting slightly confused with all those CNLS councils or committees: earlier on it said that CNLS was established in October 2001. Is this the same or yet a different one? I do assume it is the same...so is it possible that there is a mistake with the date? 2001 or 2003? See page ...

HIV and AIDS. Education on HIV is included in the curriculums at secondary schools and universities as well as training centers, enabling youths to obtain information on these issues. In other words, there is now stronger commitment to the fight.

Altogether, commitment has increased: efforts in implementing prevention programs were greater in 2005 than in 2003. This can mainly be explained by the commitment of all actors and from all sectors and the increase in resources allocated to the response.

d) Human Rights

Based on the Constitution of the Fourth (IV) Republic of Togo, adopted on 27 October 1992 and amended in 2002, access to healthcare is a fundamental right for all citizens of Togo. In accordance with this Constitution, several texts and laws are being voted to protect the rights of those infected with or affected by AIDS. The law on Female Genital Mutilation (FGM), in force since 1998, and the law on the protection of human rights in the area of HIV/AIDS, which was voted in on December 2, 2005, are also part of this philosophy. The latter is particularly aimed at protecting the individual, the family and society from infection with HIV/AIDS and at ensuring the respect for human rights of PLHIV and their protection against discrimination and stigmatization in particular. It is an anti-discrimination law which takes into account gender and equality and which is aimed at protecting all vulnerable groups, such as youths (in this case, girls), members of the armed forces, prison inmates, porters, housemaids and invalids. It even defines strategies to be applied to each target group.

e) Care, treatment and support

Within the framework of treatment for AIDS and opportunist infections, Togo has developed strategies for promoting care and comprehensive support for HIV and AIDS, based on the development of standards in this area. The following activities are being implemented: HIV screening in blood for transfusion, treatment of opportunist infections (OI), antiretroviral treatment, nutritional care, treatment of STIs, family planning services, psycho-social support for PLHIV and their families etc.

In terms of support, strategies aimed at catering for the needs of orphans and vulnerable children are being initiated by NGOs.

2.3 National programs and behavior indicators

2.3.1 HIV education in schools based on life-skills

HIV/AIDS education in schools started in 2003-2004, with the development of training programs for teachers first, then for children.

The data obtained from the Ministry of Primary and Secondary Education and the Ministry of Technical Education and Vocational Training on the one hand and from the Regional Directorates of Education and Inspectorates on the other hand, covers 493 schools of a total 1,221 of all levels and sectors, which means that 40.37% of schools have teachers who are trained in HIV/AIDS education, based on life skills.

State schools were favored for teacher training for purely tactical reasons: 427 out of 493 schools, i.e. 86.61% are state schools.

According to the technical report on the progress of the intensification of the fight against HIV/AIDS dated 1 April 2005, 11,200 guides were developed between 2004 and 2005 and are available across all regions and in all the schools which have included HIV/AIDS education in their curriculums. In addition, a decentralized training course run by a national pool of 51 instructors provided training for a large number of teachers across all regions in 2005. To date, 1,444 teachers have been trained.

Although it is difficult to say whether all the teachers who have been trained have actually given lessons on HIV/AIDS over the last year, especially as there are no specific HIV/AIDS classes, this system integrates elements of HIV/AIDS education with subjects like history or geography, French, life science or earth science in secondary schools and with law in technical or professional training institutions.

Lecturers in higher education have not received any training on HIV education based on life-skills.

However, in universities (University of Lomé and University of Kara), there are student associations called HIV/AIDS clubs. Members of these associations are trained either by other sister associations or by NGOs working in those areas, or by the National Program. Their purpose is to increase the awareness of the epidemic among their fellow students.

On 13 December 2005, the Committee for the Coordination of the Fight against HIV/AIDS of the University of Lomé (CLAS/UL) was officially set up. This Committee, which brings together all the student associations related to the fight against HIV/AIDS of the University of Lomé (UL), is in charge of coordinating all initiatives for the fight against HIV/AIDS within the University of Lomé.

2.3.2 Fight against HIV/AIDS in the workplace

The ILO / USDOL Project of the International Labor Office (ILO) and the US State Department for Labor supports companies and businesses in implementing policies on the fight against HIV and AIDS in the workplace. However, only 8 out of 107 companies have actually defined a policy and developed programs for the fight against HIV/AIDS.

These programs include:

- nomination of a Focal Point or creation of a joint committee on HIV/AIDS, with an operating budget.
- information and education activities in the area of HIV infection prevention.
- condom social-marketing
- medical care
- fight against discrimination and stigmatization in the workplace.

2.3.3 Sexually Transmitted Infections: Treatment of STIs

Treatment of STIs is dispensed in all the country's healthcare facilities. In 2005, 17,222 cases of STIs were reported. Among those healthcare centers which reported cases of STIs, nearly 80 receive support from the 'SIDA 3' project through the development of guides and algorithms for care, support for staff training and for health center equipment and support for providing the drugs essential for patient care.

In 2004, 15,909 patients were monitored in appropriate services and units of intervention within the framework of the project, according to national regulations and procedures. 14,269 of these were female sex workers and 1,640 were partners infected with STIs. From January to June 2005, 9,873 clients infected with STIs were admitted to these centers. The efficiency of care for people with STIs in appropriate services and units of intervention was rated at 87% in 2004.

2.3.4 Prevention of Mother-to-Child transmission of HIV

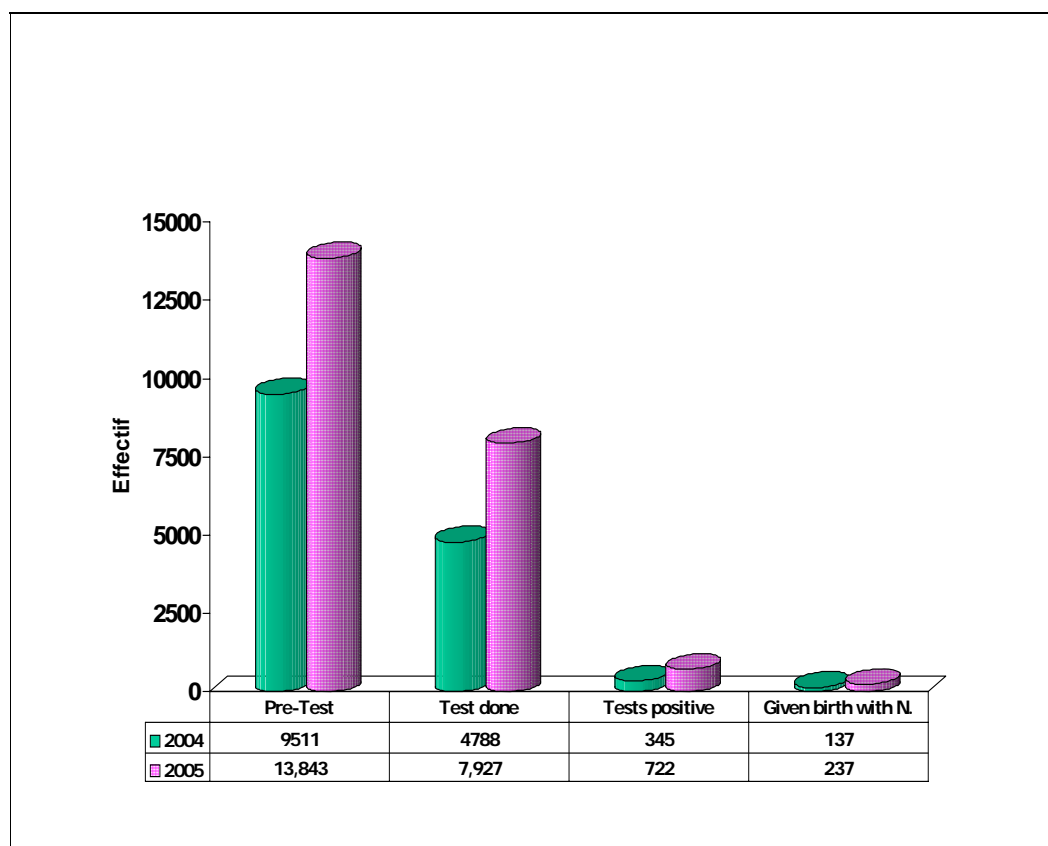
According to population forecasts for 2005 (DGSCN), the proportion of children aged 0 to 11 months was an estimated 4.5%. This proportion can be assimilated with expected pregnancies, so that the number of pregnant women can be estimated at 228,770 and 234,540 for 2004 and 2005 respectively.

In 2004, 9,511 pregnant women out of 11,911 admitted for a first antenatal consultation at MTCT prevention sites received pre-test counseling, i.e. 79.4%.

Of the 9,511 women who received pre-test counseling, half (50.3%) accepted the HIV test (4,788 women). 345 tests were positive. Only two out of five pregnant women who were tested HIV-positive received Nevirapine treatment for the birth.

In 2005, more pregnant women accepted pre-test counseling and actually took the test.

Diagram 4: Pre-test counseling and screening for HIV among pregnant women in antenatal clinics in 2004 and 2005.



Source: NAP Annual Reports 2004-2005

The monitoring of children born to HIV-positive mothers faces many difficulties. In 2004, 180 out of 217 babies born to HIV-positive mothers received Névirapine, 161 were breastfed, while 36 received substitute milk. 99 were regularly monitored and 6 of them underwent screening when they were 18 months old; 5 of them (83.3%) were HIV-negative.

Mother-to-Child Transmission of HIV: data from May 2002 to November 2005 (1)

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Data	Year 2002 (2 sites within 1 district)	Year 2003 (10 sites within 5 districts)	Year 2004 (15 sites within 7 districts)	Year 2005 (31 sites within 13 districts)
Number of talks on MTCT	-	1 367	1 286	5 684
Number of women admitted for a first antenatal consultation in these sites	4 218	7 681	11 971	15 350
Number of women having received pre-test counseling	1 560	6 245	9 511	13 843
Number of women having undergone screening for HIV following pre-test counseling	564	2 950	4 788 50,3 %	7 927 57,2
Number of women tested HIV-positive	73	166	345 7,2 %	722 9,1 %
Number of women admitted for post-testing	1 107	2 387	3 023	5 341
Number of sex partners screened	-	-	43	520
Number of sex partners tested HIV-positive	-	-	12	103
Number of HIV-positive women having received NVP	23	79	137	596
Number of HIV-positive women having given birth	17	53	351	693
Number of HIV-positive women having given birth under NVP	11 15.0 %	36 21.6 %	152 44.0 %	237 32.8 %

Mother-to-Child Transmission of HIV: data from May 2002 to November 2005 (2)

Data	Year 2002 (2 sites within 1 district)	Year 2003 (10 sites within 5 districts)	Year 2004 (15 sites within 7 districts)	Year 2005 (31 sites within 13 districts)
Number of children born to HIV-positive women	17	43	217	296
Number of children born to HIV-positive women who died	02	02	07	30
Number of children born to HIV-positive women having received NVP	09	43	180	277
Number of children exclusively breastfed (EMB)	13	40	161	228
Number of children on substitute milk	02	03	36	105
Number of children monitored	07	42	99	296
Number of children aware of their serological status at 18 months old	-	02	06	31
Number of children tested HIV-negative at 18 months old	-	-	05 83.3 %	28 90.3 %
Number of children on cotrimoxazole	-	-	-	270
Number of children on ARV	-	-	12	19

2.3.5 Confidential HIV Counseling and Voluntary Testing

One of the strategies taken on board in the fight against HIV/AIDS in Togo is confidential HIV counseling and voluntary testing. A Center for Counseling and Documentation was set up by the NAP in 2000 for counseling, documentation and screening services.

Within this framework, Centers for Confidential HIV Counseling and Voluntary Screening (CCCVS) are set up to provide confidential voluntary counseling and screening services.

Similar initiatives have been taken by some NGOs and other Associations around the NAP. Some twenty CCCVS have been set up by PSI-Togo and ATBEF, although these centers are not evenly spread across the country. 17 out of 35 health districts have CCCVS, 42% of which are in the area of Lomé-Commune.

In 2004, 12,728 persons, mainly young people aged 15-24 visited CCCVS; 8,823 out of these young people visited CCCVS in the Coastal area. The prevalence of HIV among those patients of these CCCVS is an estimated 13.7% for the same year, with a high prevalence in CCCVS in the Coastal Region (19.6%), compared with a low prevalence in those in the Savanna Region (5.1%).

2.3.6 Antiretroviral treatment

3,972 persons infected with HIV at an advanced stage are on antiretroviral treatment. Medical care is provided by NGOs and other associations and organizations.

2.3.7 Blood safety

The National Center for Blood Transfusion (CNTS) collects, processes and distributes blood and blood products. This center has a regional branch in Sokodé in the Central Region. From October 2004 to September 2005, 13,186 blood samples were collected. All of them, i.e. 100%, were screened for HIV, HBV and HCV. 387 samples out of 13,186 (2.93%) tested HIV-positive.

2.3.8 Knowledge and behavior of youths in the area of HIV prevention

HIV epidemics are mainly spread by way of transmission through sexual intercourse to successive generations of young people.

Hence, it is absolutely vital for young people to have good knowledge about HIV/AIDS, so that they can adopt their behavior to help reduce the risk of HIV transmission.

From 17 to 21 December 2005, a population survey was carried out among young people aged 15 to 24 in order to evaluate their knowledge, attitudes and practices as far as HIV prevention is concerned. The results of this survey are outlined below.

d) Knowledge

54.6% out of 6,153 interviewed had accurate and comprehensive knowledge of how to prevent the transmission of HIV, particularly:

(i) that risks are reduced by having only one faithful non-infected partner; (ii) that risks are reduced by using condoms; (iii) that a person may appear to be in good health and still be HIV-positive; (iv) concerning mosquito bites and HIV transmission; (v) HIV transmission and daily life with a person infected with HIV.

Boys gave more correct answers than girls (57.4% compared with 51.8%). The survey also revealed that knowledge was better in urban areas (56.0%) than in rural areas (53.7%).

e) Attitudes and behaviors

796 young people aged 15 to 24 out of the 6,153 who were interviewed (12.8%) said that they had had sexual intercourse for the first time before the age of 15. Early sexual relationships are much more widespread in urban areas (16.8%) than in rural areas (10.2%).

According to the results of this survey, boys are more likely to start sexual activity early than girls (14.5% and 11.1% respectively).

High-risk behavior, such as sexual intercourse with a casual partner outside marriage, was reported among 32% of boys and 12.6% of girls. The use of condoms during sexual intercourse with casual partners is not yet systematic among young people.

2.3.9 Condom use

In Togo, actions to improve public awareness of how to prevent HIV infection are carried out in all sectors and by several actors, including the Ministry of Education, the Ministry for Youth and Sports, the Ministry of Defense and War Veterans, NGOs and other Associations, trade unions, and above all, the Ministry of Health.

Generally speaking, 62.2% of youths used condoms during their last sexual relationship with a casual partner. Condom use is more wide-spread in urban areas (73.8%) than in rural areas (55.7%).

▪ Distribution of (male and female) condoms

A condom social marketing and distribution programs is being set up across the entire country, with various activities promotion condom use.

This programs involves three main promoters: Population Service International (PSI), Family Health Division (DSF) and the Togo Family Planning Association (Association Togolaise du Bien-Etre Familial, ATBEF). They provide large stocks of male and female condoms to healthcare facilities, networks and the NGOs/Associations that provide the link with the communities and regions.

Peer educators have been used to set up condom distribution circuits. Outlets selling condoms and providing advice, run by these peer educators, are being opened by NGOs/Associations and PSI-Togo across all regions.

These distribution channels distributed 9,779,980 condoms in 2002; 10,376,119 in 2003 (7,823,984 of which were distributed by PSI-Togo); (7,777,083 male condoms and 46,901 female condoms), 8,023,729 units were distributed in 2004, 7,742,929 of which were distributed by PSI-Togo (7,687,984 male condoms and 54,945 female condoms).

In order to initiate young people in the use of condoms, PSI-Togo is promoting certain condom brands, such as "Protector Plus", "Panthère", "Condom Jeune Rebel" for male condoms, and "Fémidon" and "Protectiv" for female condoms.

**CHAPTER IV: MAJOR CHALLENGES FACED AND
ACTIONS NEEDED TO ACHIEVE THE UNGASS GOALS /
TARGETS**

1. CHALLENGES

1.1 In achieving the goals and targets

The national response to HIV/AIDS is still punctuated with various obstacles of different kinds, making it difficult to achieve the goals and targets fixed at UNGASS.

- Inadequacies in implementing the "three leading principles"

The National Strategic Framework 2001-2005 is the recognized standard framework for action for the response to HIV/AIDS in Togo, in which all sectors are involved. This framework, which was developed and adopted according to a participatory approach involving all the different groups of actors concerned both at national and regional levels, has no budget and neither has it been transposed into an operational plan; in addition, most of the objectives are not specifically quantified. Nonetheless, it remains the sole reference for all the actors and partners involved in the national response.

The NAC-STI, a multi-sectoral organization for coordinating the fight, has been operational through its Permanent Secretariat since 2002. However, this Permanent Secretariat has neither a proper head office (its current office is too small and inappropriate), nor adequate operational capacities (in terms of human resources, logistics and financial resources), nor the autonomy of action required for fulfillment of its tasks.

The same is true for the decentralized structures of the NAC-STI, i.e. the regional and local (district) committees for the fight against AIDS and their relevant secretariats.

In addition, some of the NAC-STI instruments, such as the Commission on Science or on Ethics, have not yet been set up.

These factors combine to result in inadequate coordination between the different actors, partners and their initiatives in the area of STI/HIV/AIDS at national level.

Finally, there is, as yet, no standard system for the monitoring and evaluation of the national response to HIV/AIDS. Nonetheless, this process is now underway.

- Socio-political and economic environment

As a result of the socio-political and economic crisis, which has affected the country for several years, and the suspension of funding cooperation with the major financial backers, it has not been possible to mobilize sufficient resources to take effective action in all the areas of intervention of the national response. Thus, several sources of funding granted to most of the countries of the sub-region for the fight against STI/HIV/AIDS have not been granted to Togo (e.g. the MAP-Project of the World Bank).

In addition, the high level of poverty related to the country's overall economic recession, means that an increasing number of citizens are exposed to high-risk sexual behavior, such as multiple partners, unprotected sexual intercourse, etc.), above all among certain segments of the population like single women, young girls (at school or in apprenticeships), housemaids, porters, bar staff etc..

- Socio-cultural traditions involving certain traditional or religious rituals, which are still widespread in the country, unfortunately contribute to the spread of HIV/AIDS.
- The lack of harmonization between strategies of intervention of different actors in the field, also poses a major obstacle to the fulfillment of the goals and objectives.
- The complex, diverse and cumbersome procedures of development partners and the fact that they are not mastered by those working at national level are a real obstacle

to the use of the few financial resources mobilized for the national response to the pandemic.

1.2 In gathering data for the indicators

The principal factors hindering the collection of data on the indicators for monitoring and evaluating the national response to HIV/AIDS in general and the UNGASS indicators in particular are as follows:

- the fact that there is no operating national database on HIV/AIDS and STI; the CRIS, which has recently been established, is not yet operational;
- little research, few studies and surveys on HIV/AIDS and on the attitudes and behaviors related to HIV/AIDS carried out at national level;
- no system for the centralization and compilation of activity reports and research/survey reports from all the actors and partners involved in the response at PS/ NAC-STI.

Hence, the data for several indicators is rather patchy, out of date or not broken down (according to age, gender, private/public sector, urban/rural environments etc.), or even virtually inexistent. This is, for instance, the case for data on child orphans and other vulnerable children or data on knowledge and behavior

2. Actions needed to achieve the goals and targets

These measures consist, above all, of:

- intensifying measures for HIV prevention, with specific strategies for the most vulnerable and at-risk groups;
- improving medical as well as psycho-social care for PLHIV;
- improving treatment of STIs;
- harmonizing the intervention strategies of actors and partners involved in the response;
- continuing and reinforcing application of the "three leading principles" through:
 - a participatory review of the National Strategic Framework (2001-2005) which is currently underway and which will lead to a new National Strategic Framework (2006-2010) with realistic and feasible objectives, a budget and operational plans;
 - strengthening the institutional capacities of PS/ NAC-STI and SCRLS in order to enable them to complete their missions effectively;
 - boosting operation of the NAC-STI and its meetings;
 - continuing the process of establishing a standard national system for the monitoring and evaluation of HIV/AIDS.
 - strengthening epidemiological surveillance;
 - carrying out research, studies and surveys on HIV/AIDS and on knowledge, attitudes and behavior related to the infection at national level;
 - making the CRIS operational;
 - increasing substantially the government's financial commitment and mobilizing sizeable resources from national economic operators and development partners in order to meet the requirements of the response effectively;
 - launching a process of deliberation on the harmonization and simplification of procedures, in order to ensure better use of funding; this process is to be carried out in consultation with all technical and financial partners and with representatives from civil society.

**CHAPTER V: SUPPORT REQUIRED FROM THE
COUNTRY'S DEVELOPMENT PARTNERS**

Support from the country's development partners is much needed to address the following priority issues:

- Strengthening of technical, logistical and human resources of PS/NAC-STI, SCRLS, NAP and other actors, including civil society;
- Support and effective commitment in applying the three leading principles, the "3 Ones" in terms of coordination and monitoring-evaluation;
- Supporting the process of harmonizing the intervention strategies of the actors and partners involved in the response;
- Stepping up measures for HIV prevention, based on the relevant UNAIDS policy focus document;
- Improving both medical and psycho-social care for PLHIV, child orphans and other vulnerable children;
- Improving treatment of STIs;
- Technical and financial support for carrying out research, studies and surveys on HIV/AIDS and on knowledge, attitudes and behaviors related to the infection at national level;
- Participatory review of the National Strategic Framework 2001-2005;
- Developing and implementing the new National Strategic Framework 2006-2010;
- Support for establishing the single basket system for better coordination and synergy in the mobilization of resources and their rational use in the response to HIV/AIDS;
- Continuing implementation of the single system for monitoring and evaluation;
- Making the CRIS operational at national, regional and peripheral levels;
- Support for mobilizing and accessing technical and financial resources at home and abroad (MAP/World Bank, BAD etc.);
- Launching of measures and initiatives aimed at harmonizing and simplifying procedures, in order to ensure better use of funding;
- Support in integrating the fight against HIV/AIDS in all strategies, initiatives and programs set out in the Poverty Reduction Strategic Paper (PRSP).

Support required from the country's development partners

Efforts made by the government and private actors in Togo will not suffice to contain the epidemic. Support from international partners in development is necessary to improve initiatives in the fight against HIV/AIDS in sensitive areas, such as blood safety, screening, medical care, training of those involved as well as the fight against poverty.

The joint Project of UN System agencies in Togo and the Global Fund will, no doubt, help strengthen local initiatives in the fight against HIV/AIDS. However, it is also important to back monitoring / supervision activities and the evaluation of other actions (instructor training, retraining and logistical support) should be strengthened.

In addition, partners from outside Togo, in this case United Nations System agencies, must help to simplify procedures, since national leaders often find that their initiatives are blocked by "red tape" in some agencies.

CHAPTER VI: FRAMEWORK FOR MONITORING AND EVALUATION

4.1 General overview

All the different actors and partners currently have their own mechanisms for monitoring and evaluating initiatives in the fight against HIV/AIDS in Togo. There is, as yet, no National System for Monitoring and Evaluation, operating under a budget.

It should also be noted that there is currently no operating mechanism in place for the transmission of reports from actors and partners to SP/NAC-STI.

Moreover, the results of monitoring and evaluation surveys carried out by partners and other organizations are not shared systematically, which means that there is no accurate data available to provide a regular picture of the overall HIV/AIDS situation in the country and the progress made by initiatives undertaken in the fight against the epidemic.

Once the National Program for Monitoring and Evaluation (PNSE) has been implemented, it will be possible to standardize this system. This is why the Monitoring and Evaluation Theme Group mentioned in Chapter II is so important.

There is a Monitoring and Evaluation Unit within PS/NAC-STI (Division for Planning and Monitoring-Evaluation). However, it is still in its early stages and has very limited resources and technical capacities, although it is supposed to be the central point of the national system for monitoring and evaluation.

Finally, it should be pointed out that hardly any training has been provided for actors in the area of monitoring and evaluation.

4.2 Current process

The process of implementing a standardized system for monitoring and evaluation began in April 2005 with the harmonization of the national program indicators, coordinated by NAC-STI. However, this process has not yet been completed. A National Program for Monitoring and Evaluation (PNSE) has yet to be developed, validated and implemented, integrating appropriate mechanisms and strategies for data collection, analysis, dissemination and use.

Hence, the implementation of a national information system and a national database on STI/HIV/AIDS is a major issue for Togo in the immediate future.

The plans for making the CRIS operational at national, regional and peripheral level follow the same logic: a small group of leaders in the area of monitoring and evaluation were trained to use the software by UNAIDS in Lomé from 29 August to 2 September 2005. This training must be passed on to all of the different levels mentioned above.

4.3 Necessary support

The overall process of developing the national system for monitoring and evaluation with respect to the application of the three leading principles requires both technical and financial support.

The strengthening of the institutional capacities of the Monitoring and Evaluation Unit of PS/NAC-STI (in terms of human resources, logistics and financial resources as well as technical skills) is a vital necessity in order to make it truly operational and to enable it to fulfill its role as a cornerstone within the standard national framework for monitoring and evaluation. The impact of such efforts will be limited, unless accompanied by actions in support of the monitoring and evaluation units to be established within SCRLS, NAP and civil society.

To ensure effective operation of the CRIS, adequate technical investments are required (widespread use of the software program, organization, IT equipment) for all the actors concerned and at all geographical levels (national, regional and peripheral levels).

Developing the technical skills of those involved, through training in the area of monitoring and evaluation, is just as much a priority to make sure that the entire national system for the monitoring and evaluation of the response to HIV/AIDS operates effectively and efficiently.

APPENDICES

Appendix 1: Consultation/preparation process for the National Report on Monitoring the Declaration of Commitment on HIV/AIDS

The National Report 2005 submitted by Togo on the monitoring of the UNGASS-Declaration is the result of a participatory process which consisted of the following stages:

- Creation of a small technical group under the leadership of the National Coordinator of PS/NAC-STI and comprising the NAP Director, the Head of the Statistics, Study and Research Department of the Ministry of Health, the PS/NAC-STI Monitoring and Evaluation Officer, the UNAIDS Monitoring and Evaluation Officer, the UNICEF HIV/AIDS Administrator, the President of the Network of PLHIV Associations.

This group was in charge of identifying key people to be interviewed, coordinating data collection, input, writing the report and organizing the forum for the validation of this report.

- Gathering of data on indicators related to the commitments made and initiatives undertaken at national level and to the impact of national programs. Data was gathered from specific sites, either by interviews or from annual activity reports. This procedure was carried out by research staff from the public sector, private sector and from civil society (see collection schedule and teams).
- Evaluation of national knowledge and behavior indicators through a survey of the urban and rural population conducted by the Population Research Unit (URD) of the University of Lomé from 17 to 21 December 2005.
- Entering of the first data into the CRIS during the Regional Workshop which was jointly organized by the UNAIDS Regional Office (Dakar) and the UNAIDS Office/Togo in Lomé from 6 to 8 December. This workshop brought together representatives from the Monitoring and Evaluation Units of the National Councils for the Fight against HIV/AIDS from five countries (Benin, Burundi, Ivory Coast, Gabon and Togo). Missing data that was collected later was entered in the system by the Monitoring and Evaluation Unit of PS/NAC.
- Organizing a workshop to validate the report drafted by the technical group.

Appendix 2

LIST OF PERSONS INTERVIEWED BY TYPE OF QUESTIONNAIRE

A- National Composite Policy Index.			
Part A: Strategic Plan; Political Support; Prevention; Care and support; Monitoring and Evaluation;			
Part B: Prevention, Care and Support.			
No of order	Full name	Position	Structures
1	Abi Tchao TAGBA	National Coordinator	PS/NAC-STI
2	Wiyaoou Kpao ADOM	Director	NAC
1- B- National Composite Policy Index - Part B of the Human Rights questionnaire			
No. of order	Full name	Position	Structures
1	Mawuto DZIDZOLI	MP; Member CNDH Coordinator of the AIDS Network at the National Assembly	National Assembly (Parliament)
2	Baloukina-Eza NIMON	MP; Deputy Coordinator of the AIDS Network at the National Assembly	National Assembly
3	Imam El Hadj MENSAH Kassim	Acting President of CNDH	CNDH
4	Mrs. Kabaiyah KPATCHA TCHAMDJA	Matrimonial Judge	Court of Lomé
C- National Composite Policy Index.			
Part B of the "Participation of Civil Society" questionnaire			
No. of order	Full name	Position	Structures/ Associations
5	Koffi VIDZRAKOU	Executive Director of the Association	ATBEF
6	Komi TSOLENYANU	Network Chairman	TOCAHSO
7	Rémy AFIADEMANYO	NGO Chairman	'Vivre Mieux'
8	Blaise SEDOH	National HIV/AIDS Coordinator	Togolese Red Cross
9	Makénnibè POROSI	Network Director	UONGTO
10	Komi Alex ABALO	NGO Director	'Espoir Vie' – Togo
11	Simplice ANATO	NGO Director	'Arc-En-Ciel'

Appendix 3

- Broadening the partners and development of multi-sectoral policies

Summary of partner support for the National Strategic Framework against AIDS (1)

Agencies	Principle initiatives	Cost in FCFA	Period	Geographical areas covered
PLAN – TOGO	Youth Program	265 414 600		Regions: Central and Plateau regions
	PLAN – TOGO sub-total	265 414 600		
WHO	Blood safety	93 756 724	2003-2004	Nationwide
	Women's Program (with a focus on protection)	13 657 963		
	Strengthening the institutional framework	36 300 000		
	Epidemiological Surveillance	28 050 000		
	General public awareness campaigns	8 250 000		
	Care for PLHIV	130 485 300		
	Treatment of STIs	11 000 000		
	Research	64 350 000		
	Prevention of MTCT	37 966 500		
WHO sub-total	423 816 487			
GTZ	General public awareness campaigns	35 147 365	2003-2004	Dapaong Lomé-Commune Central Region
	Condom Social Marketing	7 172 000		
	Care for PLHIV	25 652 263		
	Treatment of STIs	5 024 296		
	Research	15 000 000		
	Migrant Programs	5 973 770		
GTZ sub-total	93 969 694			
UNDP	Strengthening the institutional framework	104 610 000		Nationwide
	Advocacy	79 750 000		
	Mobilizing Civil Society	79 706 000		
	Youth Programs	53 339 000		
	General public awareness campaigns	15 345 000		
	Support for Monitoring and Evaluation	52 250 000		
	385 000 000			

Summary of partner support to the National Strategic Framework against AIDS (2)

Agencies	Principle initiatives	Cost in FCFA	Period	Geographical areas covered
SIDA 3/ACDI	Treatment of STIs	148 236 800	2002-2006	Regions: Coastal Region, Lomé, Plateau R., Kara, Central Reg., Dapaong;
	Epidemiological Surveillance	52 900 000		
	Research	47 500 000		
	HIV/AIDS prevention among sex workers and their clients	198 242 500		
	SIDA 3/ACDI sub-total	446 879 350		
EU	General public awareness campaigns	110 000 000	2002-2006	Lomé Commune 5 Coastal Region Nationwide
	Care for PLHIV	66 000 000		
	Treatment of STIs	9 350 000		
	Blood safety	222 750 000		
	Research	25 850 000		
	Women's Programs	119 900 000		
	EU sub-total	553 850 000		
UNFPA	General public awareness campaigns	52 093 800	2002-2006	Regions: Coastal Region, Plateau Region, Kara, Savanna Region
	Blood safety	11 000 000		
	Youth Programs	38 260 750		
	Women's Programs	39 778 750		
	Condom Social Marketing	85 800 000		
	UNFPA sub-total	226 933 300		
UNICEF	Strengthening the institutional framework	8 250 000	2002-2006	Regions: Lomé Commune, Coastal Region, Plateau Region, Central R., Kara, Savanna Region
	General public awareness campaigns	52 250 000		
	Care for PLHIV	41 250 000		
	Treatment of STIs	33 000 000		
	Research	11 000 000		
	Youth Programs	57 750 000		
	Women's Programs	28 600 000 000		
	Prevention of MCT	165 000 000		
	UNICEF sub-total	26 968 500 000		

Summary of partner support to the National Strategic Framework against AIDS (3)

Agencies	Principle initiatives	Cost in FCFA	Period	Geographical areas covered
UNAIDS	Strengthening the institutional framework	62 150 000		
	General public awareness campaigns	45 375 000		
	Care for PLHIV	24 750 000		
	Youth Programs	16 500 000		
	UNAIDS Sub-total	148 775 000		
French Cooperation	Support for blood safety (CNTS)	181 000 000	2002 - 2006	Nationwide and Lomé Commune
	Support for Voluntary Screening for HIV (CCD)	36 000 000		
	Support to NGOs	40 000 000		
	Information and Communication	31 000 000		
	French Cooperation Sub-total	288 000 000		
Global Fund	Condom Social Marketing	116 119 183	2003 - 2006	Nationwide
	Care for PLHIV	3 017 154 870		
	Blood safety	118 904 465		
	Youth Programs	676 867 192		
	Prevention of MCT	377 010 225		
	Sex worker programs	390 541 750		
	Capacity-building	325 655 675		
	Global Fund Sub-total	5 022 134 177		

Bibliography

'SIDA 3' Project, 2003: Report of the first survey on the monitoring of the prevalence of STI/HIV and of sexual behavior among female sex workers and their male partners / clients in Lomé, p 25.

Report of the National Workshop on the Prevention of Mother-to-Child Transmission of HIV in Togo, April 2003.

Population Service International, 2002: Study on the monitoring of behaviors related to STI/HIV/AIDS within the Armed Forces of Togo, p. 24

NAC, 2001: National Strategic Framework for the Fight against STI/HIV/AIDS 2001-2005, p. 65

URD, CAP Youth CAP Survey 2005

NAP 2005: NAP Annual Report 2005

CAMEG, 2005: CAMEG Annual Report.

Ministry of Technical Education and Vocational Training, AIDS Unit Activity Report, 2003-2004

Ministry of Primary and Secondary Education, AIDS Unit Activity Report, 2003-2004

National Center for Blood Transfusion, Annual Reports 2004-2005

Prevention of mother-to-child transmission of VIH (PMTCT) in Togo: sites running in June 2005

Regions	PMTCT sites
Savanna	Mango hospital Dapaong CHR Dapaong PMI Nadjodi USP Cinkassé CMS
Kara	Kara CHU Tomdè CHR Kara PMI Bassar hospital Kabou CMS Kantè hospital
Central	Sokodé CHR Sokodé clinic Bon Secours clinic
Plateau	Atakpamé CHR Atakpamé PMI Agbonou CMS Anié CMS Gléi USP Akparè USP Kpalimé hospital Kpalimé PMI Goudévè CMS
Coastal	Tsévié CHR Tsévié PMI Adjido hospital Anèho clinic Vogan hospital
Lomé-Commune	District 1 (CSL) District 3 (regional hospital) Tokoin CHU
National total	31

