



Togo

FY2013

Control of Neglected Tropical Diseases

Annual Work Plan

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Acronyms and Abbreviations

ALB – Albendazole

CAMEG – la Centrale d’Achats des Médicaments Essentiels Génériques et des consommables médicaux

CDD – Community drug distributor

DISER – Division d’Informations Statistiques, Etudes et Recherche

FEFO – First to expire, first out

FHI360 – Family Health International 360

GSK – GlaxoSmithKline

HDI – Health & Development, International

IEC – Information, education and communication

IVM – Ivermectin

LF – Lymphatic filariasis

M&E – Monitoring and evaluation

MDA – Mass drug administration

MDP – Mectizan Donation Program

MOH – Ministry of Health

NTD – Neglected tropical diseases

PHU – Peripheral health unit

PZQ – Praziquantel

SAE – Severe adverse event

SOP – Standard operating procedure

STH – Soil-transmitted helminths

TAS – Transmission assessment survey

TIPAC – Tool for Integrating Planning and Costing

UNICEF – United Nations Children’s Fund

USAID – United States Agency for International Development

WHO – World Health Organization

Executive Summary

FY 2013 is the fourth year that integrated control of neglected tropical diseases (NTDs) is being implemented in Togo with USAID funding through HDI. In FY 2013, the following activities are planned:

Support Togo's NTD Planning Process

- HDI will continue to cede leadership in the planning process to the Togo MOH

Mapping

- No additional mapping is needed

Nationwide MDA for schistosomiasis, onchocerciasis, and soil-transmitted helminths

- Community based distribution platform
- Schistosomiasis – Target 33 of Togo's 40 districts and more than 1.9 million people
 - Implementation unit is the peripheral health unit
 - School age children (SAC) in areas with prevalence <10% will be part of the target group in the southern half of the country (Maritime and Plateaux regions) in keeping with new WHO guidelines; this target group was treated in the north in 2012.
- Onchocerciasis – Target 32 districts and more than 2.5 million people
 - Implementation unit is the district
- Soil-transmitted helminths – Target 28 districts and more than 1.5 million school age children
 - Implementation unit is the district
- Praziquantel, ivermectin, and albendazole will be given simultaneously
- Goal is to coordinate training, implementation, and data collection with the distribution of albendazole and vitamin A by the Nutrition Program/UNICEF to children under five years of age

Training

- Cascade training of more than 10,000 people
- Emphasis on supply chain management and identification, management and reporting of severe adverse events

Community Mobilization and IEC

- Radio spots, town criers, national media, banners, meetings with leaders, and flip charts will be used

Supervision

- Joint effort by MOH and HDI
- Emphasis on ensuring appropriate treatment packages being delivered in each implementation unit, accurate treatment records at all levels, and careful tracking of drug inventories

Supply Chain Management

- Utilize Supply Chain Management Capacity Building Plan to strengthen SCM
- TA for training to improve SCM still desired

Management of severe adverse events

- Reporting is in accordance with Togo's pharmacovigilance policies, and includes reporting to FHI360 headquarters, GlaxoSmithKline, and Mectizan Donation Program

Program Monitoring and Evaluation

- The program will use existing M&E framework and tools supplied by FHI360
- Program assessment includes the results of the FY 2012 coverage survey and the annual program review; training and implementation will be revised based on findings from the program assessment
- Transition to post-elimination activities

- The LF transmission assessment surveys in March and May 2012 confirm no ongoing transmission of LF
- Nationwide surveillance for LF is ongoing, with focus on international border areas
- Onchocerciasis situation analysis is planned as part of requested technical assistance

Short term technical assistance requests

- Two new TA requests for FY 2013
 - Training on use of TIPAC
 - Training on how to calculate projected drug needs (to be provided by HDI to MOH)
- Some uncompleted requests from FY 2012 remain
 - Coverage survey TA is underway
 - Onchocerciasis situation analysis will follow after coverage survey is completed
 - Training on supply chain management, implementation of environmental mitigation measures, and M&E for MOH personnel are priority unfinished activities

Financial Management

- Monthly financial reports submitted to FHI360 within 30 days of the end of the reporting period.
- MOH receives all flow down financial regulations through the subaward granted to them.
- HDI will comply with financial sampling of records by FHI360 following the MDA and will take any corrective action as indicated by FHI360 after the sampling reviews.
- Skills improved within HDI and the MOH through Deloitte and Touche training

Facilitation of collaboration and coordination between MOH, HDI and other partners

- HDI will continue to advocate for increased government and donor support of the program
- Activities are integrated with the Nutrition Program, UNICEF, and Sightsavers whenever possible
- Stakeholder meeting will be held in early 2013

Cost Efficiencies

- Cost savings have been achieved through integration of training, transportation of drugs, and field work for three NTDs and across other programs and partners
- Cost savings have been achieved because this program is now established and MDA tools (IEC materials and dose poles) are now available in all geographic target areas.

Proposed Plans for Additional Support to the NTD Program

- HDI is seeking funds to provide surgery to the 11 women with trichiasis identified during the HDI trachoma cluster survey in early 2011, and additionally to the estimated 550 other people suffering from trichiasis in the three districts in the 2011 cluster survey for trachoma

Background

FY 2013 is the fourth year of integrated neglected tropical disease (NTD) control in Togo with USAID funding through HDI and the second year through assistance from FHI. Many partners have contributed to the success of Togo's Integrated Program for the Control of NTDs: the National Malaria Control Program, the Global Fund, Plan-Togo, UNICEF, the National Nutrition Program, Sight Savers, World Health Organization, US Centers for Disease Control and Prevention, Mectizan Donation Program, Children Without Worms, IMA World Health, Croix Rouge, and Handicap International. Togo successfully piloted integrated NTD mapping and integrated MDAs in one district starting in 2005 with support from the CDC.

Table 1: NTD program in Togo – integrated NTD activities by disease

Disease	Number of endemic districts (baseline)	Number of non-endemic districts (current)	Number of districts needing mapping*	Number of districts with ongoing MDA		Number of districts needing MDA, but MDA not yet started	Number of districts where MDAs have been stopped
				USAID-funded	Others		
Schistosomiasis	35	5	0	35**	0	0	0
Soil-transmitted helminthes	28	12	0	28	4†	0	0
Lymphatic filariasis	7	40	0	0	0	0	7‡
Onchocerciasis	32	8	0	32	0	0	0
Trachoma	0	40	0	0	0	0	0

*The five districts of Lomé commune were not mapped because existing data suggest these diseases are neither transmitted nor found frequently enough in Lomé through importation to justify MDA treatments.

**All 35 districts that are endemic for schistosomiasis have ongoing MDAs, but two of those districts (Assoli and Dankpen) will not have MDA in 2013 because all endemic areas received treatment in 2012 and they do not have any peripheral health units (the implementation unit for schistosomiasis) where the prevalence is $\geq 50\%$; see details regarding PHU-level implementation for praziquantel below (first bullet at end of Background), in the footnote to Table 2, and in Annex 3 (the Togo Disease Workbook for the 2012-2013 Work Plan).

†The second round of mass treatment in the four districts with high prevalence of STH will be supported by UNICEF.

‡Lymphatic filariasis was eliminated before USAID support began.

Schistosomiasis, onchocerciasis, and soil-transmitted helminths (STH, primarily hookworm) are endemic in Togo (Table 1, Annex 2). Nationwide mapping (excluding Lomé) was conducted for schistosomiasis, trachoma, and soil-transmitted helminths in 2009. Schistosomiasis is endemic in all 35 districts outside of Lomé and STH are endemic in 28 districts; the prevalence of active trachoma is below 1% in all districts. Onchocerciasis is present in 32 districts; mass drug administration (MDA) with ivermectin has been ongoing for more than fifteen years in some areas, but onchocerciasis persists in pockets and technical assistance is being arranged to conduct a situation analysis to understand why and to plan a strategy to address this problem.

Seven districts were endemic for lymphatic filariasis (LF), but LF transmission has been interrupted in Togo and the last MDA for LF occurred in 2009. Post-MDA surveillance for LF continues nationally and in March and May 2012 transmission assessment surveys verified that there is no ongoing transmission of LF; Togo is seeking WHO certification of elimination of LF.

In 2010, Togo conducted an integrated MDA for schistosomiasis, onchocerciasis, and STH in the northern 15 districts. The 2011 MDA was the first nationwide integrated MDA for NTDs, and it also included distribution of long-lasting insecticide treated bed nets to every household through the National Malaria Program, the Global Fund, and Plan-Togo, and the distribution of albendazole and vitamin A to all children less than five years of age through UNICEF and the National Nutrition Program.

In FY 2012, Togo's main activity was to implement, nation-wide, integrated mass drug administration of praziquantel, albendazole, and ivermectin. As of the writing of this work plan the final data on numbers of people treated are not yet available, but more than 1.6 million people were targeted with praziquantel, 1.3 million school age children were targeted with albendazole, and more than 2.5 million people were targeted with ivermectin. More than 10,000 people were trained.

In FY 2012, technical assistance was requested to assist with sampling for a national survey of MDA coverage as part of Togo's monitoring and evaluation plan; the survey has not yet been implemented. An individual was also identified by RTI/Envision who will assist the onchocerciasis program in conducting a situation analysis; this technical assistance will begin once the results of the coverage survey are available.

A Togolese statistician has been hired and seconded from HDI to the Ministry of Health's Division for Statistical Information, Studies, and Research (DISER), the division tasked with data management and analysis for the MoH, including for NTDs. This person has helped to complete medication applications, develop drug distribution guides for supply chain management, develop the database for MDA data, and analyze MDA data, thereby increasing the MoH's self-sufficiency in these activities.

Several unique aspects of Togo's NTD Program must be kept in mind while reading this document.

- Because of the focal nature of schistosomiasis, Togo's Ministry of Health chose the peripheral health unit (PHU) as the implementation unit for schistosomiasis.
- In PHUs targeted for MDA with praziquantel every other year (those where the prevalence of schistosomiasis is 10-49%), treatment occurs in the north in even years and in the south in odd years.
- Togo has committed to treating all school age children with praziquantel twice during their primary school years in areas where schistosomiasis is present but prevalence is <10%. This treatment will occur every two years, concurrent with treatment of middle-prevalence areas, namely, in even years in the north and in odd years in the south.

Goals for the year 2013

Goals for FY 2013 are as follows.

- A second round of MDA will be conducted for onchocerciasis and STH in high prevalence areas in Nov 2012.
- Togo will implement nationwide MDA for onchocerciasis, schistosomiasis, and STH in May 2013 (see Table 2).

- LF surveillance and morbidity management activities will continue (see Monitoring and Evaluation section).
- The situation analysis of the onchocerciasis control program will be conducted with technical assistance as requested in the FY 2012 Work Plan.
- There will be continued support of the MOH as it improves its capacity for data management, monitoring and evaluation, and supply chain management, all of which were strengthened in 2012.

Main Activities

HDI will support the Ministry of Health (MOH) with the following essential activities:

Support NTD Country Program Planning Process

Togo will be in year two of their five-year (2012-2016) Strategic Plan for NTD control. The MOH has led the planning, management, and implementation of the integrated MDAs in 2011 and 2012. HDI will support the MOH in continuing this leadership in FY 2013 in the following ways:

- The Togo MOH will determine the target geographic regions and populations for MDA and will develop the treatment projections for 2013 using Togo's five-year Strategic Plan, WHO treatment guidelines for NTDs, and population data from the Togo census as well as from enumerations conducted by the community drug distributors in 2011 and 2012. Rather than leading the MOH in this role, HDI will review the MOH's plans and calculations as the MOH takes the lead in all of these activities. HDI has worked with the MOH in FY 2012 to enhance their ability to generate target population estimates and medication needs.
- HDI will assist the MOH in developing the Annual Work Plan through an iterative process of discussing plans and reviewing Work Plan drafts, incorporating incoming data from the field and the most recent MDA in the process.
- Operational micro-planning begins in the months prior to the MDA at bi-weekly central-level meetings; an HDI representative is present at all of these meetings. HDI will continue to work with government on assuring appropriate planning and supply chain management.

Mapping

- There are no remaining gaps in disease mapping and no mapping is planned.

Scaling up NTD National Program¹

- The integrated MDAs for Togo reached national scale in 2011 and will continue at national scale in 2013. All 35 districts where at least one of the target NTDs is prevalent will be treated.
- For schistosomiasis, the target population now includes school age children in areas with prevalence <10% to reach the WHO target of treating children in low prevalence areas twice during their primary school years. This target group was treated in the northern half of the country in 2012; in 2013 this target group will be treated in the southern half.
- For STH, there will be a second round of treatment (in November, 2012) for school age children in four districts where the prevalence of STH is ≥50%. This will be the first year of implementation of a second round of albendazole; although a second round had been

¹ The Disease Workbook Form containing treatment projections for the 2013 MDA is incorporated into this work plan as an annex.

scheduled for November 2011, it did not take place because the national MDA scheduled for May 2011 was delayed and November was too soon for a second round.

Mass Drug Administration

MDA Strategy

- Timeline: The national integrated MDA will take place in May 2013 and will occur over three weeks (including all re-visits to houses where residents are initially not home). Microplanning and production of necessary tools will occur in February, community mobilization and IEC will begin in March, and training of trainers and training of drug distributors will occur in April. The second round of treatment for calendar year 2012 is scheduled for November; four districts will receive a second round of treatment with albendazole and areas previously identified as having a high prevalence of onchocerciasis will receive a second round of ivermectin.
- Target populations: Details of the target populations are given in Table 2. The latest target population calculations use enumeration data from the 2011 and 2012 MDAs.

Table 2. Target districts and estimated target populations for 2013 MDA

NTD	Age group targeted	Frequency of distribution	Distribution platform(s)	Number of districts or sub-districts ^a	# of people targeted
Schistosomiasis	School age children and adults	Once per year (prev $\geq 50\%$)	Community-based	160 PHUs from 27 districts	1,416,308
Schistosomiasis	School age children only	Once every two years (prev 10-49%)	Community-based	240 PHUs from 35 districts	335,013
Schistosomiasis	School age children only	Once every two years (prev $< 10\%$)	Community-based	99 PHUs from 28 districts	181,994
Onchocerciasis	Entire population age 5 years and older	Once per year	Community-based	21 districts ^b	1,728,347
Onchocerciasis	Entire population age 5 years and older	Twice per year	Community-based	11 districts ^b	900,379
Soil-transmitted helminths	School age children	Once per year (prev 20-50%)	Community-based	24 districts	1,505,132
Soil-transmitted helminths	School age children	Twice per year (prev $\geq 50\%$)	Community-based	4 districts	208,352

^a Schistosomiasis treatment is implemented at the peripheral health unit (PHU) level, based on the prevalence of schistosomiasis at the PHU level, so the estimated number of people to be treated is equal to the sum of the people in the targeted PHUs. Details on target populations can be found in the END in Africa Disease Workbook Togo 2012-2013, included with this work plan.

^b In the 32 districts targeted to receive ivermectin, only villages with fewer than 2000 people are treated. Twice yearly treatment is conducted in areas with historically high prevalence of onchocerciasis.

- Treatment will be according to WHO guidelines with the following exceptions:
 - There is currently no funding to procure albendazole to treat women of child bearing age, as is recommended in WHO guidelines. If funding can be secured for purchase of the albendazole this target group will be added to the MDAs, as there would be no additional cost in terms of the distribution platform.

- In districts warranting treatment for onchocerciasis, ivermectin is only distributed in villages with fewer than 2000 people, rather than the entire population. This has historically been the Onchocerciasis Control Program's standard procedure, based on an old study conducted by the OCP demonstrating that villages with more than 2000 people receive fewer black fly bites and have a significantly reduced risk of infection with onchocerciasis compare with people in villages of population less than 2000.
- Geographic targets: In 2010, the three northern regions (Kara, Savanes and Centrale) were targeted and treated. In 2011, the two southern regions (Plateaux and Maritime) were added to the MDA. In 2013, all five regions are targeted. For schistosomiasis, those PHUs which are targeted with praziquantel every other year (prevalence from 10-49%) are treated in even years in the north and odd years in the south.
- Drug distribution platform: Drugs are delivered through community-based distribution for all target populations. The coverage survey to be conducted in September 2012 includes questions to determine whether community-based distribution is effectively reaching all age groups, particularly school age children who attend primary school. If it is determined that this target group is not being effectively reached and treated then modifications will be considered to improve coverage rates.
- Praziquantel, ivermectin, and albendazole will be administered together; that is, there will be no delay between treatments with praziquantel and ivermectin because all areas targeted with both drugs have previously received both drugs.

Training

- Togo utilizes a training-of-trainers approach to train personnel at all levels involved in the implementation of MDA. Including CDDs, more than 10,000 people will be trained (Table 3). Most personnel involved have participated in prior MDAs.

Table 3. Training Events - New Personnel and Refresher

Training Group	Topics	Number to be Trained/Retrained			Number Training Days	Location of training(s)
		New trainees	Refresher trainees	Total		
MOH/MOE at Central Level	Supervision skills; how to train trainers	0	18	18	2	Lomé
Trainers	Supervision skills; how to train trainers	0	102	102	2	District Headquarters
Supervisors/PHU nurses	MDA procedures; training of community drug distributors	0	626	626	2	District Headquarters
Supply chain managers	Supply chain management skill	0	0			
Community drug distributors	IEC and drug distribution procedures	100*	10,000	10,100	2	Peripheral Health Units

* Approximate number of Peace Corps volunteers

- The National Coordinator for NTD Control, the National Coordinators for the individual NTD programs and the HDI team conduct the training of regional and district supervisors. These supervisors in turn train the level below them, the peripheral health unit (PHU) nurses. The

regional and district supervisor/trainers consist of the regional and district medical directors, the regional NTD Focal Points, and the district NTD Focal Point persons.

- For the training-of-trainers session for PHU nurses, a nurse from the dispensary of each of the PHUs requiring MDA is trained on the implementation of the MDA at their respective district headquarters. These nurses return to their PHUs and conduct the annual retraining of the CDDs from that PHU on implementation of the MDA. Training for the nurse trainers occurs no more than two weeks before MDA, and training of the CDDs occurs within one week of the MDA. Annual re-training emphasizes the practical aspects of MDA implementation. Training curriculum contents are being updated accordingly.
- Most of the CDDs have participated in at least one MDA prior to 2013. All CDDs receive a refresher training immediately prior to the MDA on the correct administration of the drugs. The training of CDDs is the final step of the cascade training for the MDA. This step includes provision of an individual treatment guideline for each CDD highlighting the drugs that should be distributed in their village(s) and the target population for each of those drugs. Use of the dose poles is also reviewed during the training.
- In 2013, an effort will be made to engage Peace Corps volunteers in community mobilization and IEC activities, and to this end they will be included in training activities.
- Supply chain management will be specifically addressed in the training manual and at all levels of the training cascade.
- Training on identification, management, and reporting of serious adverse events will be included at all levels of the training cascade.

Community Mobilization and IEC

- Radio spots and town criers will advertise the upcoming MDA several weeks prior to its start. National media, banners, and meetings with leaders will also be used.
- The CDDs and Peace Corps volunteers engage the local communities and use flip charts to educate target populations about the prevention and treatment of NTDs before and during the MDA.
- HDI, in conjunction with the MOH, will produce a success story to share with stakeholders.

Supervision

- HDI staff will be present at the training of supervisors and will actively participate in supervision during the MDA.
- Primary responsibility for supervision lies with the districts. The PHU nurse is responsible for assuring effective roll-out of the MDA in their PHU. The district supervisor (three per district) visits PHU dispensaries, receives feedback from PHU nurses, visits any problem area identified by a PHU nurse, and selects a subset of CDDs to follow and assess. The regional supervisors visit any problem areas identified by district supervisors and make additional supervisory visits as necessary. HDI and national level supervisors (including those from the Division of Pharmacy, Laboratory, and Technical Equipment) make spot checks and visit problem areas as needed. The national level supervisors (including those from the Division of Pharmacy, Laboratory, and Technical Equipment) include representatives from each of the NTD programs.
- Supervisors monitor drug inventories during the MDA through communications from CDDs to PHU nurses to district level supervisors. Standardized supervision forms are used by all supervisors. Issues or bottlenecks that arise in terms of drugs or other supplies are addressed within the PHU, if possible (for example, if a drug shortage for one CDD can be resolved by drawing surplus drugs from another CDD in the same PHU). Greater issues can be resolved by

having the PHU nurse contact the district supervisor to arrange for inter-PHU movement of drugs or other supplies within the district.

- At the end of the MDA, a team of supervisors travels to each district and collects the treatment reporting forms and all unused drugs after validating stock against inventory records. They review forms for consistency and accuracy while in each district and ensure that any errors or omissions are corrected before forwarding the forms to the next level. The supervisory team brings copies of the PHU-level forms to Lomé. After data have been entered and analyzed, the supervisors review reported geographic, epidemiologic and programmatic coverage and investigate any unusual findings.

Supply Chain Management

- All drug requests for FY 2013 have been submitted (see Table 4). Inventory from the 2012 MDA was not available at the time that drug requests were submitted so any surplus from the 2012 MDA will be used in 2013 and drug requests for 2014 will be reduced to account for this remaining stock. Projections in 2013 should be the most accurate yet, as this is the first year that we have had enumeration data from the CDDs for every PHU that is targeted for treatment. The Togo MOH also played a greater role in developing drug projections for 2013, and hopefully HDI's only role in 2013 will be to review and validate projections for 2014.
- Projected drug needs for 2014 will be submitted in June 2013, with drugs provided by the same sources as shown in Table 4.

Table 4. NTD Medicines Estimated for the year 2013

Drug	Source of drug	Quantity of drug requested	Date of Application (Month/Year)	Requested delivery date (Month/Year)
IVM	Donation by Merck/MDP	Information pending	Information pending	02/13 for April MDA
ALB	Donation by GSK/CWW	1,884,832	07/2012	10/12 for Nov MDA, 02/13 for April MDA
PZQ	Purchase through USAID funding	5,541,443	06/2012	03/13 for April MDA

- As in previous years, drugs will be delivered from Lomé to each region by the MOH. Each district then collects its supply of drugs from the regional warehouse under the direction of the regional focal point person. Each public health unit (PHU) collects its supply of drugs from the district and distributes the drugs to individual CDDs.
- At each step, drugs are dispatched with an inventory form stating the name of each drug, the quantity being distributed at that level (district, PHU, or village), the date the drugs are being distributed to that level, and the expiration date. The signatures of both the person delivering and the person receiving the order are included at each transfer point. At the end of the MDA the inventory form must be returned to the next level up with an indication of how many doses of each drug were used, along with any unused drugs. Supply chain management and accountability of drugs has been excellent in Togo, but efforts will be made to cultivate greater

expertise within the MOH by identifying a person from the MOH who can receive training on supply chain management along with the HDI-Togo logistics coordinator who has been overseeing these activities.

- Unused drugs are returned to the district level by district transport, and collected by central level vehicles and returned to Lomé; however, ivermectin is stored at the regional level. Unused drugs that can be used in the next MDA are stored at CAMEG in Lomé. Damaged drugs are collected and incinerated according to official national procedures.
- Although the supply chain in Togo has been effective at providing drugs where they are needed, at all levels of supply chain management there is room for capacity building and improved supply chain management. HDI will review the Supply Chain Management Capacity Building Plan for END in Africa with pertinent people in the Togo MOH and will assist the MOH in implementing the recommendations for Togo obtained through the supply chain management rapid assessment led by END in Africa's logistics advisor. This can include developing standard operating procedures (SOPs) for handling drugs before and after the MDA. Additionally, short term technical assistance regarding supply chain management was requested in 2012, and HDI will work to coordinate implementation of this assistance in FY 2013.

Management of Serious Adverse Events

- All Serious Adverse Events (SAE) are reported immediately by the government of Togo to HDI, and HDI will notify the Project Director for END in Africa at FHI360 Headquarters and appropriate medication donation programs within 24 hours of receipt of the information. Identification, management, and reporting of SAEs are taught at the trainings. Adverse events are reported through established channels as previously done. The CDD refers the patient immediately to the PHU dispensary. Serious cases are hospitalized at the district hospital. From the dispensary or hospital, the case is reported to the district supervisor and regional supervisor and details of the case are sent by email or fax. This approach is in accordance with Togo's national system of pharmacovigilance. The regional supervisor reports the SAE immediately by phone to the HDI office in Lomé and the MOH.

Program Monitoring and Evaluation

Monitoring and Evaluation of MDA

Timeline:

- The program will use the existing M&E framework and tools supplied by FHI360. The timeline for completion and reporting of the MDA deliverables is shown in the Timeline at the end of this document.

Data Management:

- Data collection utilizes the established community registers that are familiar to the CDDs. Treatment and drug inventories from the CDDs are compiled by PHU nurses into PHU-level treatment and drug reporting forms.
- PHU-level data forms are double-entered into a database created by the Division d'Informations Statistiques, Etudes et Recherche (DISER) in the MOH. Data quality is determined by assessment of data uniqueness, accuracy, internal consistency, and completeness. Spot check of data from randomly selected sites is conducted in which the original data sheets are compared with the data files. Data are screened for outliers; outliers are inspected manually and a decision on how to handle each outlier is made individually and using outside data sources if needed. This activity will be led by the statistician seconded to DISER with back up from the HDI technical lead.

Program Assessments and Transition to Post-MDA Elimination Strategy

Program Assessment

- A coverage survey is planned for September 2012 to validate coverage rates reported through the July MDA. Results from the coverage survey will be critical to help 1) either confirm that program implementation is proceeding as believed or identify areas where it is not (to initiate processes to strengthen problem areas), 2) assess coverage in the three geographic areas where onchocerciasis prevalence is persistently high to inform next steps for onchocerciasis control, and 3) understand whether the household distribution platform is effective for reaching the target populations, especially school age children. Additionally, community response to the MDA will be solicited. A report containing results of the coverage survey will be completed and circulated to the MOH, donors, and other interested parties in November, 2012.

Program Review and Feedback to the Community

- The annual program performance review will be held at the central level. This meeting will be informed by the results of the MDA and the coverage survey.
- Results from the 2012 MDA will be used to 1) validate drug inventory and identify areas where there were drug shortages or surpluses, 2) identify any areas where drug distribution was not in accordance with population targets, 3) amend training in 2013 to improve any issues identified in #1 and #2, and 4) verify the names, populations, and endemicities of PHUs that were redistricted since preparation for the 2012 MDA took place (peripheral health units are periodically merged or new ones created according to local needs).
- Drug inventory data are compared with drug counts. Inconsistencies are investigated by HDI personnel and any supply chain issues are addressed before the next MDA.
- Programmatic coverage rates are calculated from the treatment data. Areas of low (<85%) or high (>100%) programmatic coverage are examined to determine what may have led to such results. If necessary, adjustments in population estimates will be made in preparation of the next year's treatment projections.
- Irregularities or gaps in treatment algorithms, drug supply chain management, and data collection are examined by a joint MOH/HDI team and problem areas are specifically addressed during training prior to subsequent MDAs.
- The Togo MOH feels that an important part of the MDA process is to provide community feedback on the results. Results of the MDA will be disseminated to the communities through religious and traditional community leaders and radio spots. Communities will be able to see how their performance compares with the performance of all other communities in the area. Community response to this feedback will be assessed in the supplemental questions to the coverage survey.

Transition to post-MDA elimination strategy

- LF has probably been eliminated from Togo since 2009 when MDAs for LF were stopped, and LF is therefore no longer a target disease for integrated MDA. HDI continues to support the MOH in implementing post-MDA surveillance for LF as recommended by the WHO.
- The second post-MDA transmission assessment survey (TAS) was conducted in March and May 2012; all seven districts previously endemic for LF were evaluated and the results showed that there is no longer transmission of the disease, three years after the last MDA for LF. However, continued integrated MDA for onchocerciasis and STH in these seven districts previously endemic for LF affects the interpretation of these results and may delay official certification of LF elimination in Togo if the 2015 TAS is conducted under the same conditions.

- Ongoing LF surveillance includes the following activities. Every month at least one laboratory technician in each district collects thick blood films drawn at night from patients with suspected malaria; these blood films are also examined for *Wucheria bancrofti* microfilariae. In 2013, due to the creation of five new districts in Togo, the number of laboratories conducting this surveillance will increase to 46. In addition, along border areas not served by these laboratories, where the risk of LF transmission is high due to the presence of LF in neighboring countries, nurses in 19 peripheral health centers are trained to collect capillary blood on filter paper three times a year in 20 adults living in their catchment area. These filter papers are sent to Lomé where they are tested for Ag Og4C3 by the laboratory of the National Institute of Hygiene.
- Identification of any case of LF triggers an investigation in the community where the case lives and works. Further analyses are conducted as necessary, and the positive case is treated with albendazole and ivermectin.
- TA has been requested to conduct a situation analysis of onchocerciasis control in Togo; this is the necessary first step in determining whether Togo is near elimination of onchocerciasis and where and when Togo should change from control activities to primarily surveillance activities. The onchocerciasis program continues to conduct skin snip surveys to track the prevalence of onchocerciasis in pre-determined areas; this work is made possible by support from Sightsavers.
- The prevalence of active trachoma is less than 1% in Togo. While trachoma is no longer a target disease for MDA, HDI continues to support IEC on the importance of facial hygiene. Togo has developed a strategic plan for elimination of trachoma, including a schedule for conducting trichiasis surgeries for patients.

Short term Technical Assistance Request²

The MOH requires additional assistance to achieve timely and complete reporting of required M&E deliverables, however, HDI is providing assistance to train the new statistician in this area.

There are two new requests for technical assistance in 2013: training on the TIPAC (the workbook to aid in identifying funding gaps for the Integrated NTD Program, #1 in Table 5) and training on how to complete drug request forms (#2 in Table 5).

Table 5 also lists technical assistance request from the FY 2012 Work Plan that has not yet been completed. The justifications for these requests can be found in the FY 2012 Work Plan and as an appendix to this Work Plan. Completion of these activities from the FY 2012 Work Plan will be contingent upon the TA and funding for these requests.

Table 5. Technical Assistance Requests

Task	Technical skill required	Number of Days required
1. Training on the TIPAC – how to complete it, how to use it, how to interpret it	Strong knowledge of the TIPAC workbook, and knowledge of information sources useful for completing the TIPAC.	Two days
2. Training on how to complete the drug request forms	Knowledge of drug request forms and knowledge of the specific issues associated with calculation of drug needs in Togo.	One day (this TA can be provided by HDI)

² Technical assistant is contingent on fund availability and prioritization requests.

3. Conduct a systematic review of existing onchocerciasis program data to confirm and identify geographic areas of persistent elevated prevalence of onchocerciasis (three areas are currently known) and next steps for control in these areas. Assist in evaluating need for reinforcing control activities in border areas.	Strong knowledge of onchocerciasis control. We would like the technical assistant to review existing data at the onchocerciasis control program office in Kara and conduct field visits to selected areas of high prevalence of onchocerciasis to assess community and environmental factors possibly affecting program effectiveness (such as vector control strategies, or geographic coverage measured through MDA coverage rates, etc.)	6-8 weeks in Togo, PAPERWORK FOR REQUEST SUBMITTED – TIMING CONTINGENT UPON COMPLETION OF COVERAGE SURVEY
4. MDA coverage validation survey - design phase – consultation is needed to review proposed study design including sampling	Expertise in designing NTD coverage surveys	IN PROGRESS
5. Conduct training on M&E for the integrated NTD program and for M&E personnel from pertinent individual NTD programs and develop a set of integrated monitoring and evaluation indicators.	Knowledge of appropriate indicators for M&E of integrated NTD programs and ability to train MOH personnel on M&E	1 week in Togo or at regional NTD Program training on M&E
6. Creation of a peer-reviewed publication of the results of the 2011 MDA, including the results of the post-MDA survey conducted by the Togo MOH	Experience writing peer-reviewed publications and knowledge of literature related to program process evaluation and review.	Email/phone correspondence and 1 week in Togo
7. Training of MOH and HDI personnel on supply chain management strategies	Expertise in supply chain management	Less than 1 week
8. Environmental mitigation and management	Implementation of environmental mitigation measures and monitoring activities	Less than 1 week

Financial Management

- The HDI NTD Program Accountants at Headquarters and in Togo have several years of experience working with funding from USAID and are familiar with the regulations. Every month a field budget is proposed and approved, within the bounds of the approved award budget. Each month, each budget line is compared against the actual budget, and each entry verified in Togo is reviewed and approved by Headquarters to ensure compliance with USAID regulations. The Program Manager reviews each month's financial report to again verify that expenses are in accordance with the work plan. Monthly financial reports with program narrative reports are submitted to FHI360 within 30 days after the end of the reporting period. Additionally, several individuals from HDI-Togo and HDI-Headquarters attended a training provided by Deloitte and Touche in Togo in November 2011.
- The MOH receives all flow down financial regulations through the subaward granted to them. They will also be instructed to review USAID reporting requirements and regulations. Additionally, MOH staff attended the training session provided by Deloitte and Touche in Togo in November 2011.
- Upon completion of the MDA, the original receipts flow from the MOH system to HDI for review and recording in HDI's accounting system together with the supports for each entry.

- HDI will comply with financial sampling of records by FHI360 following the MDA and will take any reasonable corrective action as indicated by FHI360 after the sampling reviews. FHI360 also has direct, view-only access to the financial accounting system and can carry out any inspection or analysis desired at any time.

Facilitate Collaboration and Coordination

- HDI will continue to support engagement of the NTD program with other partners and programs. MDAs typically involve the Nutrition Program/UNICEF, and in the future may again involve the Malaria Program or other programs. Coordination of these activities is achieved through weekly or biweekly meetings with all partners who plan to implement field activities at the same time through a shared platform. In addition, key partners are invited to a session of the Work Planning meeting in August so that activities can be coordinated most effectively, and a draft of the FY 2013 Work Plan will be shared with them for their feedback.
- The Togo MOH, through the NTD coordinating body, has been highly effective at coordinating donor support and pooling available resources to achieve MOH goals. In 2011, none of the partners participating in the nationwide integrated MDA had sufficient funds to implement their activities nationwide alone, and only through the leadership and coordination of the MOH was the highly integrated nationwide campaign made possible.
- A stakeholder meeting will be held in early 2013. Attendees will include the Director General for health, the coordinator of each NTD program, the focal point for the Integrated NTD program, the regional director for all six regions in Togo, district directors, representatives from the Nutrition Program, the Ministry of Education, and the Ministry of Social Action, and other partners (e.g. Malaria Program, Plan Togo, partners involved in WASH activities, etc.). The goals of the meeting are to inform participants about the objectives, targets, and process of the MDA, outline a general action plan for the campaign, develop detailed work plans for principle activities, and review and refine the budget based on contributions from all partners.
- In FY 2013, HDI will continue to advocate for increased commitment from the government and donors in support of the NTD Program by disseminating the achievements of the program and using the program's success to leverage commitment at the annual stakeholders meeting and elsewhere. HDI will focus on identifying and supporting champions of integrated NTD control. HDI will specifically advocate for increased direct support from the government of Togo by highlighting that program sustainability is improved when domestic commitment is strong.
- HDI and the MOH are working with the US Peace Corps program to involve Peace Corps volunteers in community mobilization and IEC activities.
- The approved Work Plan will be translated into French and disseminated to all stakeholders electronically and will be available at any relevant meetings.

Cost-efficiencies

- Cost savings have been achieved through integration of training, transportation of drugs, and field work for MDAs for three diseases, as well as through the creation of multi-year registers to track drug inventory and distribution for all drugs and of integrated, durable and reusable IEC materials. These cost efficiencies will continue in the upcoming MDAs.
- In FY 2013, HDI will strive to achieve cost efficiencies by coordinating training and field work with the Nutrition Program/UNICEF when they distribute albendazole to children under five years of age.

- Cost savings have been achieved because this program is now established and MDA tools (IEC materials and dose poles) are now available in all geographic target areas.
- Further cost efficiencies may be achieved by streamlining training when the program becomes more routine, and possibly by improving data transfer so that fewer forms are needed and/or necessary forms are streamlined.

Proposed Plans for Additional Support to National NTD Program (will be considered on a case-by case basis)

HDI is seeking funds to provide surgery to the 11 women with trichiasis identified during the HDI trachoma cluster survey in early 2011, and additionally to the estimated 550 other people suffering from trichiasis in the three surveyed districts. Sight Savers is being approached for funding. HDI is also seeking funds to continue supporting the LF lymphedema management program.

Cost Share

Financial contributions from HDI and the Togo government (detailed in the budget) total \$134,421 and include MOH contributions of staff at central, regional and district levels for the project (particularly for supervision), PHU nurses, other public health personnel involved in the project (e.g. accountants), community drug distributors' time, and vehicles for distribution of supplies and for supervision.

Travel Plans

Two HDI headquarters personnel will travel to Togo for the May MDA training and/or field work. One headquarters staff person will attend the February 2013 annual performance review meeting and two headquarters staff personnel will attend the August 2013 performance review meeting and work planning session.

Staffing

There have been no changes in staffing since 2012. Dr. Anders Seim is Executive Director of HDI. At headquarters level, Stephanie Richard is the Project Manager for the Togo Integrated Control of NTDs Project, Dr. Rachel Bronzan is the Technical Lead, and Brent Bell is the Accountant. Dr. Gabriel Anthony is the Resident Representative of HDI in Togo for the project, Kokou Emmanuel Abalo is the in-country Accountant, and Michel Datagni is the in-country Logistics Manager.

Environmental Monitoring Plan

This program makes every effort to limit its impact on the environment. Dose poles, laminated flip charts, and village registers used in the MDA are durable and reusable. Reports will be circulated electronically whenever feasible. Short-term technical assistance was requested from FHI360 on environmental mitigation measures and monitoring activities. Damaged drugs will be collected and incinerated at the regional level.

Timeline

Timeline of Major Activities: Togo integrated NTD program Oct 2012 – Sep 2013

2012-2013	MONTH (OCTOBER-SEPTEMBER)											
ACTIVITY	O	N	D	J	F	M	A	M	J	J	A	S
Finalize drug applications (for 2014)									X			
MDA		X ¹					X ²					
Microplanning for 2013 MDA begins			X									
Finalize and print out training materials			X									
Training of central, regional, district trainers							X					
Training of PHU nurses							X					
Training of CDDs							X					
Community mobilization						X	X					
IEC						X	X					
Coverage survey	X											
M&E – Post-MDA review meeting									X			
M&E – Generate coverage reports									X			
M&E – Finalize and distribute coverage reports		X								X		
Dissemination of MDA results back to the community		X								X		
LF surveillance	X	X	X	X	X	X	X	X	X	X	X	X
Stakeholder meeting												X
Annual performance review meeting with all MOH NTD program personnel ³											X	
Work Planning meeting (with FHI360 and USAID, for FY2014 and FY2015)								X				
TA for onchocerciasis situation analysis				X ³								
Semi-annual reports						X						X

¹ – November MDA – albendazole and ivermectin in highest prevalence districts

² – April MDA – ivermectin (donated by MDP), albendazole and praziquantel nationwide as indicated

³ – Onchocerciasis TA will occur after completion of the coverage survey, likely in early 2013