



# Togo

## FY 2015

Control of Neglected Tropical Diseases

Annual Work Plan  
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## **Acronyms and Abbreviations**

ALB – Albendazole  
APOC – African Programme for Onchocerciasis Control  
BCC – Behavior Change Communication  
CAMEG – Centrale d’Achats des Médicaments Essentiels Génériques et des consommables médicaux  
CDC – United States Centers for Disease Control and Prevention  
CDD – Community Drug Distributor  
DISER – Division d’Informations Statistiques, Etudes et Recherche  
DSA – Disease Specific Assessment  
DQA – Data quality assessments  
FHI 360 – Family Health International 360  
FOG – Fixed Obligation Grant  
FY – Fiscal Year  
HDI – Health & Development, International  
IEC – Information, Education and Communication  
IU – Implementation unit  
JSI – John Snow International  
LF – Lymphatic Filariasis  
M&E – Monitoring and Evaluation  
MDA – Mass Drug Administration  
MOE- Ministry of Education  
MOH – Ministry of Health  
NOCP- National Onchocerciasis Control Program  
NTD – Neglected Tropical Diseases  
PCT – Preventive chemotherapy  
PHU – Peripheral Health Unit  
PZQ – Praziquantel  
SAC – School-Age Children  
SAE – Severe Adverse Event  
SCM – Supply Chain Management  
STH – Soil-Transmitted Helminths  
TAS – Transmission Assessment Survey  
TIPAC – Tool for Integrated Planning and Costing  
UNICEF – United Nations Children’s Fund  
USAID – United States Agency for International Development  
WASH – Water, Sanitation and Hygiene  
WCBA – Women of child-bearing age  
WHO – World Health Organization

## **Executive Summary**

Fiscal year (FY) 2015 is the sixth year that integrated control of neglected tropical diseases is being implemented in Togo with United States Agency for International Development (USAID) funding through Health & Development, International (HDI). In FY 2015 the following activities are planned:

### **Strategic Planning**

- Togo will be drafting a new five-year strategic plan in late 2015 to replace the one that expires in 2016. In FY 2015, HDI will assist with preparatory activities for developing the plan. Togo is also transitioning from onchocerciasis control to elimination, and this will be an important focus of activities in FY 2015.

### **Neglected Tropical Diseases (NTD) Secretariat**

- HDI supports the NTD secretariat by supporting planning meetings, stakeholder/microplanning meetings, program review, and USAID's work planning meeting, and by providing capacity-strengthening assistance in a considerable number of ways as partially enumerated below.

### **Advocacy**

- HDI will provide assistance to the MOH in developing an advocacy plan (existing personnel time will be used for this activity and no additional funding will be needed).

### **Social Mobilization**

- Social mobilization will continue to utilize the highly effective town criers and local radio spots.

### **Capacity Building/Training**

- In FY 2015, HDI will place increased emphasis on the Togo MOH's ability to operate independently in all aspects of the program.
- More than 10,000 people will receive training on drug distribution, supply chain management, serious adverse event (SAE) reporting, educational messages, behavior change, and other aspects of the mass drug administration (MDA) activity.
- Field workers will be trained for disease-specific assessments and a coverage validation survey.
- Central level MOH personnel will receive training on how to generate useful outputs from the Tool for Integrated Planning and Costing (TIPAC) for program planning.
- MOH and HDI personnel will receive training from international experts to build Togolese capacity on supply chain management (SCM).
- HDI will work with MOH monitoring and evaluation (M&E) personnel to strengthen MOH capacity to capture, interpret and utilize data to improve program performance.

### **Mapping**

- A national epidemiological survey for onchocerciasis will provide updated prevalence data for onchocerciasis, which were last obtained on a national level in 1974.

### **Mass Drug Administration**

- Togo will maintain 100% geographical coverage of areas requiring MDA.
- The practice of treating only villages with fewer than 2000 people for onchocerciasis will be reviewed in light of Togo's move toward elimination of onchocerciasis.
- Information, education and communication (IEC) materials will be used to disseminate information on NTD prevention and treatment, and on good sanitation and hygiene practices.
- April 2015 MDA:
  - Schistosomiasis – Target is 33 of Togo's 40 districts and more than 2.3 million people (more than 1 million school age children and nearly 1.3 million adults at high risk):
    - Implementation unit is the peripheral health unit (PHU).
    - High risk adults will be treated in moderate and high prevalence PHUs.
  - Onchocerciasis – Target is 32 districts and nearly 2.8 million people:

- Implementation unit is the village.
  - Practice of treating only villages with fewer than 2000 people will be reviewed in light of the move towards elimination of onchocerciasis.
- Soil transmitted helminths (STH) – Target is 35 districts and more than 1.9 million school age children:
  - Implementation unit is the district.
  - More than 1.4 million women of child-bearing age (WCBA) will be treated if the United Nations International Children’s Emergency Fund (UNICEF) is able to supply medication.
- Praziquantel, ivermectin, and albendazole will be administered simultaneously.
- October 2014 MDA:
  - Onchocerciasis – Target is 11 high-prevalence districts, funded by the MOH of Togo.
  - STH – Target is 4 districts where the prevalence of STH is  $\geq 50\%$ .

#### **MDA Challenges**

- A group of migrant workers was identified that is typically absent during the MDA and poses a risk of importation of onchocerciasis and lymphatic filariasis (LF); a plan has been developed to treat these workers for onchocerciasis and test them for LF.
- Efforts must be continued to ensure that the correct number of drugs are sent to each locality.
- Suboptimal use of the flip charts was identified during the 2012 coverage survey; the importance of using the flip charts is reinforced during the training.

#### **Drug and Commodity Supply Management and Procurement**

- Togo will continue to submit drug requests using the World Health Organization’s joint request form for medicines for preventive chemotherapy.
- Serious adverse event reporting is emphasized during training.
- Short term technical assistance will be requested for training in advanced SCM.

#### **Supervision**

- Supervision will continue to be a joint effort by MOH and HDI.
- Issues identified during the MDA are specifically addressed during training and preparation for the subsequent MDA.

#### **Short-Term Technical Assistance**

- The MOH requests technical assistance for training on the TIPAC and SCM, as well as assistance with surveillance for onchocerciasis elimination.

#### **Monitoring and Evaluation**

- Conduct data quality assessments to assure the availability of reliable and meaningful data to inform programmatic decisions.
- Implement disease-specific assessments (DSAs):
  - Conduct the third transmission assessment survey (TAS) for LF.
  - Conduct DSAs for schistosomiasis and STH at integrated surveillance sites to revise treatment strategies for these diseases.
  - Implement a national epidemiological survey for onchocerciasis to ensure that all pockets of onchocerciasis have been identified and to launch the switch to elimination.
  - Continue with routine epidemiological surveillance for onchocerciasis in high risk areas.
- Continue with post-MDA passive surveillance for LF.
- Conduct a coverage validation survey.

#### **Looking Ahead**

- There is a gap in funding for LF morbidity management and trichiasis surgery.
- There is a gap in funding for entomological surveillance for onchocerciasis.

## **COUNTRY OVERVIEW**

### *Government and regional structure of Togo*

Togo is divided into six regions containing a total of 40 districts, of which 35 are outside the capital, Lomé. Togo has a decentralized health system, with regional and district offices, and the 40 districts are in turn served by more than 600 peripheral health units (PHUs). Each PHU typically serves between one and ten villages. This health system structure is important for understanding the door-to-door community-based distribution platform used for the integrated mass drug administrations (MDAs) for neglected tropical diseases (NTDs). The implementation unit for distribution of preventive chemotherapy varies according to the target disease; implementation occurs at the district level for soil transmitted helminths (STH), at the PHU level for schistosomiasis, and at the village level for onchocerciasis.

### *Major NTD donors in Togo*

Fiscal year (FY) 2015 is the sixth year of integrated NTD control in Togo with United States Agency for International Development (USAID) funding through Health & Development, International (HDI) and the fourth year through assistance from Family Health International 360 (FHI 360). Led by the Togo Ministry of Health (MOH), many partners and programs have contributed to the success of Togo's Integrated Program for the Control of NTDs. In addition to USAID, major NTD donors include (in alphabetical order):

- African Programme for Onchocerciasis Control (APOC) – provides continuing support for epidemiological and entomological surveillance for onchocerciasis.
- Hope Education Foundation – conducted mapping for STH and *S. mansoni* in Lomé region (5 districts) in November, 2013.
- Mectizan Donation Program – provides ivermectin for MDA for onchocerciasis.
- MOH Togo – supports a second round of ivermectin distribution in 11 districts.
- National Nutrition Programme – provides vitamin A for preschool children.
- Sightsavers – supports surveillance for onchocerciasis.
- United Nations International Children's Emergency Fund (UNICEF) – provides and distributes albendazole for preschool children throughout the country (and provided albendazole for distribution to women of child-bearing age (WCBA) in 2013).

The World Health Organization (WHO) office in Togo has provided important logistical support. Other organizations that have partnered with the NTD Program in the past, or are likely to partner with the NTD program in the near future, include Children Without Worms, IMA World Health, Croix Rouge, Handicap International, the United States Centers for Disease Control and Prevention (CDC), National Malaria Control Program, the Global Fund, and Plan-Togo.

### *History of USAID support*

USAID funding for integrated NTD work in Togo began in the latter part of FY 2009. In FY 2010, USAID provided funding for the nationwide integrated mapping of schistosomiasis, STH and trachoma followed by integrated MDA for schistosomiasis, onchocerciasis and STH in the northern three regions of the country (Savanes, Kara and Centrale). Funding was also provided for LF post-MDA surveillance activities and lymphedema morbidity management. In FY 2011 funding was expanded, and with the additional support of the National Malaria Control Program, the Global Fund through Plan-Togo, UNICEF and the National Nutrition Program, Togo conducted a nationwide integrated MDA for schistosomiasis, onchocerciasis and STH, including vitamin A and albendazole for pre-school children and bed net distribution to all households. USAID also funded LF surveillance and lymphedema morbidity management (training, soap and supplies for lymphedema care) in 2011. In FY 2012, USAID additionally

supported preventive chemotherapy for schistosomiasis in children living in PHUs with a prevalence of schistosomiasis from 1-9%. In FY 2013, support for integrated MDA continued, with the addition of praziquantel treatment for high risk adults in areas of moderate prevalence (10-49%), and LF surveillance continued, but funding for LF morbidity management ceased.

Other activities supported by USAID include a transmission assessment survey (TAS) for LF in FY 2012, to confirm interruption of LF; a coverage validation survey in 2012 (FY 2013); and an onchocerciasis program review in FY 2013 (to make recommendations for accelerating prevalence reduction in the few remaining villages with persistent high prevalence of onchocerciasis and for moving to onchocerciasis elimination in other areas). USAID has also supported trainings for accountants and on the Tool for Integrated Planning and Costing (TIPAC), as well as travel to international meetings to present data on Togo's successes.

#### *National NTD Program Overview*

Togo is currently operating off a five-year strategic plan for 2012-2016, although the NTD landscape has changed considerably and certain goals in that plan have evolved since 2012. Togo MOH control and elimination strategies for the targeted NTDs are as follows (see also Table 1):

*Lymphatic filariasis:* Lymphatic filariasis transmission was effectively interrupted in 2009, with the last MDA for LF occurring in 2009. All LF activities in Togo now focus on surveillance to prevent reintroduction (USAID-funded) and morbidity management (currently unfunded). The goal is to obtain WHO verification of elimination in Togo. The necessary data will be available by the end of FY 2015, but the actual date of verification will depend on WHO's final decision regarding verification in the context of ongoing MDA for onchocerciasis with ivermectin. The strategy is to continue with post-MDA surveillance in all districts in Togo and provide care for lymphedema patients and surgery for hydrocele patients.

*Onchocerciasis:* The onchocerciasis program has a long history beginning with larviciding in 1974, the addition of ivermectin treatment in selected communities in 1988, expansion to widespread community-directed treatment with ivermectin (CDTI) in 1997, and finally integration of ivermectin MDA with MDA for other NTDs starting in 2010. Reported and measured coverage for ivermectin has been very high, and there are only a handful of communities that are known to have a prevalence of onchocerciasis >5%. Based on the results and recommendations of an external assessment of the onchocerciasis program, conducted in 2013, the goal is to switch from control to elimination. The strategy is to reduce prevalence to below 5% in the remaining 20+ villages with onchocerciasis through MDA, continue with information, education and communication (IEC) and behavior change communication (BCC) and strengthen case management and support for the blind. In addition, the MOH will continue with routine epidemiological surveillance and will implement a national epidemiological survey in all onchocerciasis endemic districts to ensure that all pockets of onchocerciasis have been identified before the National Onchocerciasis Program's move to elimination.

*Schistosomiasis:* Nationwide schistosomiasis mapping (excluding Lomé) was conducted in 2009 and MDA started in 2010 according to WHO treatment thresholds. The mapping provided data on the prevalence of schistosomiasis at the PHU level (a total of 30 children in each PHU were tested for *S. mansoni* and *S. haematobium*). Because of the focal nature of schistosomiasis, the decision was made to select the PHU as the implementation unit, to best target those people at risk and to minimize over- and under-treatment of individuals. Mapping of *S. mansoni* was conducted in Lomé in 2013 and demonstrated prevalence below the WHO MDA treatment threshold. The goal now is to reduce the prevalence of *S.*

*haematobium* and *S. mansoni* in school age children (SAC) to below 10% in all areas. The strategy is to continue MDA according to disease prevalence in the PHU, continue with IEC and BCC and promote water, sanitation, and hygiene (WASH) principles. A disease-specific assessment (DSA) for schistosomiasis, combined with STH testing at integrated surveillance sites, will be used to evaluate the treatment strategies for schistosomiasis.

*Soil transmitted helminths*: As with schistosomiasis, the first national STH mapping (excluding Lomé) was conducted in 2009 and MDA was started in 2010 according to WHO treatment thresholds. UNICEF has been treating pre-school age children nationwide for STH since before 2009. STH mapping of Lomé was conducted in 2013 by an implementing partner (Hope Education Foundation) and showed the prevalence of STH was below the WHO MDA treatment threshold. The goal now is to reduce the prevalence below 20% in all areas. The strategy is to continue with MDA according to disease prevalence, continue with IEC and BCC and promote WASH principles. As with schistosomiasis, a DSA for STH at integrated surveillance sites will be used to revise the treatment strategies for STH.

*Trachoma*: Trachoma has never been targeted with MDA in Togo, nevertheless, mapping of the northern, dry half of the country in 2009 revealed that the prevalence of active disease is <1%. The goal is to maintain the prevalence of active trachoma below 1% and prevent those with trichiasis from progressing to blindness. The strategy is to promote appropriate WASH practices for prevention and to identify and treat persons with trichiasis.



**Table 1: Snapshot of the status of the NTD program in Togo**

A	B	C	D	E	F		G	H	I
Disease	Total No. of Districts in Togo	No. of districts classified as endemic	No. of districts classified as non-endemic	No. of districts in need of initial mapping	No. of districts under a 'current MDA schedule' (prior to work plan discussions)		No. of districts in need of MDA at any level, but MDA not yet started, or prematurely stopped (prior to work plan discussion)	No. of districts requiring DSA*	No. of districts where criteria for stopping district-level MDA has been achieved
					USAID-funded	Others			
Lymphatic filariasis	40	8 <sup>a</sup>	32	0	0	0	0	Pre-TAS: 0 TAS: 8	8 <sup>e</sup>
Onchocerciasis		32	8	0	32	11 <sup>c</sup>	0	32 <sup>f</sup>	0
Schistosomiasis		35	5	0	35 <sup>b</sup>	0	0	35	0
Soil-transmitted helminths		40	0	0	35 <sup>g</sup>	35 <sup>d,g</sup>	0	35	0
Trachoma		0	40	0	0	0	0	0	0

\* DSA=disease specific assessment

<sup>a</sup> LF transmission has been interrupted in Togo, but Togo is still collecting the necessary data to submit a request for WHO validation of elimination of LF. There were originally 7 LF endemic districts but due to redistricting in 2012 one of the original LF endemic districts was divided into 2 districts, giving a total of 8 endemic districts now.

<sup>b</sup> All 35 districts that are endemic for schistosomiasis have ongoing MDAs. Treatment is based on prevalence at the peripheral health unit (PHU) level; high prevalence ( $\geq 50\%$  prevalence) PHUs are treated every year while PHUs with moderate (10-49% prevalence) or low prevalence (1-9% prevalence) are treated every other year. Treatment of moderate and low prevalence areas occurs in even years in the northern three regions and in odd years in the southern two regions (excluding Lomé). The low prevalence areas are treated every two years rather than every three years to maintain a simpler two-year cycle of treatment nationwide rather than the six-year cycle of treatment that would be required if low prevalence areas were treated every three years while moderate prevalence areas were treated every two years. Consequently, in FY 2015, all but two of the 35 endemic districts (Assoli and Dankpen, in the north of the country) will have MDA for schistosomiasis in 2015. In Assoli and Dankpen all endemic areas received treatment in 2014 and they do not have any PHUs where the prevalence is  $\geq 50\%$ ; see details regarding PHU-level implementation for praziquantel below in the MDA section and in Appendix 5 (the Togo Disease Workbook for Work Plan FY 2015).

<sup>c</sup> The second round of MDA in the eleven districts with a high prevalence of onchocerciasis is supported by the MOH of Togo

<sup>d</sup> Children under five years of age are treated with albendazole through UNICEF.

<sup>e</sup> Transmission of LF was interrupted in 2009, prior to USAID support, and the country is now in a post-MDA surveillance phase.

<sup>f</sup> Additional funding is needed to support expanded epidemiological surveys for onchocerciasis as Togo moves towards elimination of onchocerciasis.

<sup>g</sup> The five districts in Lomé region all have a prevalence of STH below 20% and so, although endemic for STH, are not targeted for MDA.

## Goals/Deliverables for the year 2015

Goals for FY 2015 are as follows:

- Togo will implement nationwide MDA for onchocerciasis, schistosomiasis and STH in April 2015 (see also Table 3). Targets are:
  - Onchocerciasis – 2,792,104 people;
  - Schistosomiasis – 2,362,000 people (1,078,715 SAC and 1,283,285 high risk adults);
  - STH – 3,393,178 people (1,920,667 SAC, funded by USAID, and 1,472,511 WCBA, distribution funded by USAID and medication provided by UNICEF<sup>1</sup>);
  - 100% geographic coverage of at-risk areas.
- A second round of MDA for calendar year 2014 will be conducted for onchocerciasis (11 districts, funded by Togo's MOH) and STH (four districts, funded by USAID) in high prevalence areas in October 2014. Targets are:
  - Onchocerciasis – 929,929 people;
  - STH – 211,726 SAC.
- LF surveillance activities will continue (see Monitoring and Evaluation (M&E) section).
- An LF Transmission Assessment Survey (TAS) will be conducted in February/March 2015. This is the third and final TAS since stopping MDA in 2009.
- LF morbidity management (hydrocele surgery and continuation of the lymphedema project) will continue if external funding can be secured.
- Disease specific assessments for schistosomiasis and STH will be conducted at integrated surveillance sites in February/March 2015 to evaluate treatment strategies for schistosomiasis and STH after five years of MDA.
- Routine epidemiological assessments for onchocerciasis will be conducted as well as a national surveillance activity to ensure that all areas with onchocerciasis have been identified in preparation for Togo's planned transition from onchocerciasis control to elimination.
- A coverage validation survey will be conducted in three new districts (distinct from those assessed in 2012); in Tandjoaré district, which has had difficulties with MDA implementation and achieving equitable coverage; and in villages presenting a challenge to onchocerciasis elimination.
- Coordination and integration of National Onchocerciasis Control Program (NOCP) activities with the integrated NTD Program activities will be enhanced through use of a new, unified list of target areas for treatment that includes target populations for all target diseases at the village level, as well as unified data analysis (begun in FY 2014).
- The NTD Program will continue to collaborate with WASH by disseminating IEC materials and BCC messages during the MDA for NTDs.

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<sup>1</sup> UNICEF generously provided albendazole for WCBA in 2013. There was no funding for the medication in 2014. We are hopeful that medication will be available for 2015 and this will be discussed further with UNICEF. HDI will also assist in discussions with UNICEF and the MOH to identify a distribution platform for treatment for STH among SAC in Lomé.

## **PLANNED ACTIVITIES**

### **Strategic Planning**

Togo has a five-year strategic plan for the integrated control of NTDs (2012-2016) in place. However, the NTD landscape and certain goals and activities have evolved since the plan was drafted in 2012, and the plan will expire in 2016. HDI will work with the MOH to conduct a mid-term evaluation of the present strategic plan in preparation for the eventual development of a new five-year strategic plan, 2016-2020. This new five-year strategic plan will include updated goals and strategies for onchocerciasis elimination, updated strategies for onchocerciasis surveillance, a timeline for applying for certification of LF elimination (which will be affected by progress with onchocerciasis elimination), and the integration of other national programs, such as noma, buruli ulcer, malaria, and WASH with integrated MDA for NTDs.

For the strategic planning activities listed above, HDI support will consist of personnel time only, and no USAID funds are targeted for this activity outside of the routine support for HDI personnel.

Togo is also making a move from control to elimination in the onchocerciasis program; HDI will assist the MOH in developing a comprehensive epidemiological surveillance plan to ensure that the disease burden is being reduced in the remaining high-prevalence villages and that the surveillance system would detect any resurgence of disease (there have been a few villages in which the prevalence increased after having previously been reduced to, or near to, zero). Epidemiological studies in FY 2015 will include both the routine epidemiological surveillance in a rotating selection of 30 high risk onchocerciasis villages that has been ongoing for years, as well as a national survey to establish that there are no unidentified pockets (hotspots) of onchocerciasis. The last national mapping of onchocerciasis prevalence occurred in 1974.

For the integrated DSAs for schistosomiasis and STH, HDI will work with the MOH to develop a sampling scheme that will preserve, as much as possible, the rich and detailed information on local prevalence of these diseases and will allow revision of the treatment strategies for these diseases.

### **NTD Secretariat**

HDI supports numerous NTD secretariat activities:

- One stakeholder/microplanning meeting per year, to consolidate stakeholder support for integrated NTD activities; inform participants about the objectives, targets, and process of the MDA; outline a general action plan for the campaign; review and refine the budget based on contributions from all partners; and identify synergistic activities or additional opportunities for integration of programs. Attendees will include the Secretary 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, the head of the Division of Sanitation and Environmental Health, representatives from the WASH Program, the Nutrition Program, the Malaria Program, the Ministry of Education (MOE), the Ministry of Social Action, and other partners (e.g. Plan Togo, etc.).
- One program review meeting to review the results, successes and challenges associated with MDAs, coverage surveys, DSAs, and/or to evaluate program progress against annual and longer-term strategic goals.
- One work planning meeting to meet with USAID, FHI360, HDI and in-country partners to develop the annual work plan for integrated NTD control activities that are supported by funding from USAID.
- A planning and budgeting meeting of all NTD programs based on outputs from the TIPAC.
- Four meetings (one per quarter) of the NTD secretariat for planning and coordinating NTD activities.

## **Advocacy**

HDI will provide assistance to the Togo MOH in developing an advocacy plan.

## **Social Mobilization**

Social mobilization prior to the MDA will continue to utilize town criers and local radio spots, which have been highly effective for publicizing the MDA. The 2012 coverage survey found that town criers were the most common source of information about the MDA, with nearly half of respondents having heard about the MDA from a town crier. Radio announcements were the third most common source of information about the MDA, after town criers and the community drug distributors (CDDs) themselves. Town criers will be trained on the appropriate social mobilization messages to be used during the 2015 MDA.

IEC materials used during the MDA will be updated and reproduced to create the full complement of copies needed in FY 2015, including tools needed for the increased number of CDDs (see below).

## **Capacity Building/Training**

In FY 2015, HDI will place increased emphasis on developing the Togo MOH's capacity to independently prepare for and implement all activities, as well as their ability to interpret and respond to data and information from the MDAs, the coverage survey, surveillance activities, and DSAs to improve the NTD program. The MOH will lead activities, and HDI will ensure that their own role is primarily supportive. Training in FY 2015 will pertain to implementation of the MDA and surveys: the coverage survey, LF TAS, schistosomiasis/STH integrated surveillance, and onchocerciasis epidemiological assessments.

In order to improve coverage and efficiency in the field, particularly as Togo moves towards elimination of onchocerciasis, the number of CDDs will be increased. This will reduce the amount of time and travel required of CDDs and will facilitate closer and more supportive interactions between the CDDs and the population. In 2011, Togo reduced the number of CDDs it used for integrated MDA to meet the needs of the malaria program and other partners during the highly integrated field activity that year, but an appropriate complement of CDDs needs to be restored. This will require additional training in FY 2015.

HDI personnel will continue to support training for MOH personnel to refine MOH skills in assessing and improving data quality, drug forecasting, developing the complex line-list of localities that constitutes Togo's treatment guide, and supply chain management (SCM).

The MOH is specifically requesting training on how to use the TIPAC to extract vital information for planning and forecasting. The individuals listed in Table 2 for TIPAC training have already been trained on providing inputs to the TIPAC and completing the spreadsheet, but they require assistance in how to utilize the spreadsheet to obtain maximally beneficial outputs for programmatic use.

Table 2: Training targets

Training Groups	Training Topics	Number to be Trained			Number of Training Days	Location of training(s)	Name other funding partner (if applicable, e.g., MOH, SCI)
		New	Refresher	Total			
<b>MOH/MOE at Central Level</b>	Supervision skills; how to train trainers, SCM skills	0	18	18	1	<i>Lomé</i>	None
<b>Trainers</b>	Supervision skills; how to train trainers, SCM skills	0	105	105	3	<i>Regional headquarters</i>	None
<b>Supervisors / PHU nurses</b>	MDA procedures; training of CDDs, SCM skills	0	632	632	3	<i>District Headquarters</i>	None
<b>CDDs</b>	IEC and drug distribution procedures for NTDs, and IEC for WASH	500	9,250	9,750	2	<i>PHUs</i>	None
<b>Field workers for coverage validation survey</b>	All aspects of survey implementation: household selection in the field, informed consent, interview techniques, data recording	0	16	16	2	<i>Lomé</i>	None
<b>Field workers for LF TAS #3</b>	All aspects of survey implementation: household selection in the field, informed consent, blood sampling and safe handling of biological specimens, interview techniques, data recording	0	35	35	1	<i>Lomé</i>	None

<b>Field workers for integrated DSA for schistosomiasis / STH</b>	All aspects of field implementation: field navigation, informed consent, laboratory techniques and safe handling of samples, data recording	0	25	25	2	Lomé	None
<b>Field workers for epidemiological surveillance for onchocerciasis</b>	All aspects of field implementation: field navigation, informed consent, laboratory techniques and safe handling of samples, data recording	0	25	25	2	Lomé	None
<b>NTD program coordinators, focal points for M&amp;E, and accountants (central and regional levels)</b>	Capacity building on use of the TIPAC to extract data and generate useful outputs for program planning	0	5	5	2	Lomé	Deloitte
<b>NTD program logistics coordinator (central and regional levels)</b>	Capacity building on logistics and supply chain management	0	5	5	5	West Africa (location to be determined)	USAID/Deliver
<b>NTD program coordinator and data managers (central level)</b>	Capacity building on capturing, interpreting and applying data to improve program performance	4	2	6	2	Lomé	None

*MOE=Ministry of Education; SCM=supply chain management; PHU=peripheral health unit; CDD=community drug distributor; IEC=information, education and communication; WASH=water, sanitation and hygiene; M&E=monitoring and evaluation*

Togo utilizes a training-of-trainers approach to train personnel involved in MDA implementation. More than 10,000 people will be trained (Table 2) and all personnel involved in conducting training sessions will have participated in previous MDAs. Annual retraining is held before the April MDA to refresh all

staff, particularly CDDs, on the correct administration of drugs and on any new or amended target populations or instructions for IEC and BCC. The training of CDDs is the final step of the cascade training for the April MDA and this step includes provision of an individual treatment guideline for each CDD highlighting the drugs that should be distributed in their village(s). Both supply chain management and training on the identification, management, and reporting of adverse events are included at all levels of the cascade training.

### **Mapping**

Togo completed mapping for STH and *S. mansoni* in Lomé district in November 2013. The national epidemiological survey for onchocerciasis will serve as a mapping update by identifying any unrecognized pockets of onchocerciasis and providing updated prevalence data for onchocerciasis, which is needed for advancing onchocerciasis activities in Togo and was last completed on a national level in 1974. There is not a standardized WHO protocol for this activity, but Togo will develop a national strategy for sampling and will use skin snips for disease testing.

### **MDA**

Togo reached 100% geographic coverage of areas requiring MDA in 2011 and has maintained 100% geographic coverage since then (see coverage map at end of work plan).

The drug delivery platform is community-based, door-to-door distribution. The implementation unit (IU) for STH is the district, the IU for schistosomiasis is the PHU, and the IU for onchocerciasis is the village.

For schistosomiasis, the baseline mapping was conducted at the PHU level, so accurate prevalence data are available for every PHU outside of Lomé. Due to the focal nature of schistosomiasis transmission, the PHU was selected as the implementation unit to better align treatment strategies with the populations at risk, and to reduce over- or under-treatment of populations that would occur through district-wide treatment strategies. In high prevalence PHUs ( $\geq 50\%$  prevalence) all persons age 5 years and older are treated every year (in accordance with WHO recommendations). In moderate prevalence PHUs (10-49% prevalence), all SAC and adult women are treated every other year (in even years in the north and in odd years in the south). Adult women are at high risk due to their daily household activities that put them in contact with water. Treatment for these at-risk women began in FY 2014. The policy of Togo's NTD program is to treat all SAC with praziquantel every two years in areas where schistosomiasis is present but prevalence is  $< 10\%$ ; this treatment occurs concurrently with treatment of moderate prevalence areas, namely, in the north in even years and in the south in odd years. USAID helps ensure gender equality and female empowerment by supporting the treatment of adult women who are at high risk of infection with schistosomiasis during their domestic duties in areas with moderate prevalence of schistosomiasis (10%-49% prevalence) and in areas with high prevalence of schistosomiasis ( $\geq 50\%$ ). This treatment can have the added benefit of reducing these women's susceptibility to HIV.

For onchocerciasis, a 2013 external technical review of Togo's onchocerciasis program (including surveillance activities and data, MDA targets and coverage) suggested that Togo is ready to begin transitioning from onchocerciasis control to elimination. This transition requires certain specific activities. First, the prevalence of onchocerciasis is believed to be low in most of the country, and this will be confirmed with an epidemiological survey in FY 2015. Once low prevalence has been confirmed, Togo will be ready to transition to onchocerciasis elimination. Historically, only villages with population  $< 2000$  have been treated through MDA because individuals in those villages were determined to be at high risk of blindness; however, with a shift towards elimination, this practice will be reviewed by Togo's

Onchocerciasis Control Program, and the target villages and populations may be amended. Results of the epidemiological survey will provide additional information for updating the treatment plan. Table 3 reflects the onchocerciasis target population based on the historical approach of only treating villages with population <2000.

IEC materials will be distributed everywhere as described in the section on social mobilization; CDDs will show and discuss flip charts with all households.

**Table 3: USAID-supported districts and estimated target populations for MDA in FY15 in Togo**

*Column definitions correspond to those found in the workbooks*

NTD	Age groups targeted (per disease workbook instructions)	Number of rounds of distribution annually	Distribution platform(s)	Number of districts to be treated (as of May 2014)	Total # of eligible people targeted (as of May 2014)
LF	--	0	--	0	0
Onchocerciasis	All persons age 5 years and older	1 or 2, depending on prevalence	Community MDA, door-to-door	32	2,792,104
Schistosomiasis	SAC or all persons age 5 years and older (based on prevalence), high risk adults (HRA) in high and moderate prevalence areas	1 round annually if prevalence $\geq 50\%$ or 1 round every two years if prevalence $< 50\%$	Community MDA, door-to-door	33	2,362,000 (1,078,715 SAC and 1,283,285 HRA)
STH	SAC and WCBA	1 or 2, depending on prevalence	Community MDA, door-to-door	35	3,393,178 (1,920,667 SAC and 1,472,511 WCBA)
Trachoma	--	0	--	0	0

### MDA Challenges

Overall, epidemiological and program coverage have been excellent in Togo, and above the minimum target levels (Table 4). Nevertheless, there are a few challenges that have been identified that have adversely affected coverage.

There are two issues that have represented challenges in calculating coverage. First is the definition of the population at risk (particularly with respect to onchocerciasis, but also for schistosomiasis), which makes the reported epidemiological coverage appear low in the disease workbooks. Second is the fact that the reported programmatic coverage in the disease workbooks uses the target populations calculated from the previous year's MDA as the denominator. The epidemiological coverage issue can be resolved by using the same geographic areas for calculating the population at risk and the target population, and the programmatic coverage issue can be resolved by updating the workbook with the



enumerated population estimates from the MDA in which the treatments were given, and then calculating programmatic coverage.

A second issue relates to preventive chemotherapy (PCT) for onchocerciasis. During field supervision during the April 2014 MDA, it was determined that there are groups of migrant workers who reside in the area only at certain times of the year and may not be present during the MDA. These untreated individuals may be importing onchocerciasis and may constitute untreated reservoirs of onchocerciasis that may sustain ongoing transmission throughout a much larger population. Similarly, these individuals could import LF into Togo from neighboring countries where transmission is still ongoing. In FY 2015, Togo will address these issues by implementing a special ivermectin distribution among the migrant workers as soon as they arrive in Togo to work, around November of each year, and testing a sample of them for LF.

Through the coverage survey in 2012, some people reported that they did not receive treatment because there were “not enough drugs”. Careful analysis of the drug distribution guide (showing how many tablets should go to each PHU) shows that appropriate numbers of tablets were designated for the PHUs in which those residents lived, so there was a problem either with the number of tablets actually sent to those PHUs, or in the number of tablets distributed to each village within those PHUs. The results of the FY 2014 MDA will be closely examined to identify any similar problems and to work with MDA supervisors to prevent such difficulties in the FY 2015 MDA. Problem areas will be closely examined during the next MDA. In addition, some CDDs may not be reporting drug shortages and replenishing supplies. During the CDD training, the trainers will emphasize the importance of doing everything possible to ensure that all eligible and willing individuals receive treatment and supervision will be strengthened to detect drug shortages in a timely fashion.

Another issue identified through the 2012 coverage survey was that in one of the three districts surveyed, the coverage for girls was lower than for boys, although coverage for both was well above target coverage levels. This gender inequality has been addressed during the most recent MDA trainings by emphasizing the importance of identifying and treating girls. The FY 2015 coverage survey will help confirm that this issue has been resolved. When new CDDs are needed in future MDAs, HDI and the NTD program in Togo will actively advocate for the recruitment of more women CDDs during community meetings for selection of CDDs.

Additionally, the coverage survey demonstrated that in one of the three districts surveyed the previous year’s distribution plan was used, resulting in the non-treatment of high risk adults in certain areas. This was a one-time problem related to the absence of a key manager in that district; the manager was replaced and no further problems have been identified there.

Suboptimal use of the flip charts for IEC and BCC was also identified in the coverage survey. Just over 50% of those interviewed during the coverage survey reported having been shown a flip chart. This was particularly concerning because the coverage survey also demonstrated that those who *did* report being shown a flip chart did in fact have better knowledge of disease transmission and methods for preventing infection. The training now emphasizes the success of the educational component of the MDA, and the significant impact that CDDs can have on the health and lives of the populations they serve. The flip charts should be shown to everybody and the pictures explained in order to capitalize on this educational opportunity in every household visit.

Unfortunately, even among those who were shown a flip chart, knowledge of good health and hygiene practices and disease prevention was low. A one-page field sheet for CDDs highlights the key educational messages that CDDs should be conveying when they show the flip charts. This will hopefully simplify and clarify the messages, and thereby strengthen the educational component of the MDA. Spot checks of CDDs during supervision of the April 2014 MDA suggest that flip charts are being shown and discussed, but the results of the FY 2015 coverage survey will provide better data on this activity.

**Table 4: Explanation of low USAID-supported program and epidemiological coverage**

*Epidemiological coverage targets are defined below.*

*Programmatic coverage targets are  $\geq 80\%$  eligible population*

NTD	Total number of districts treated in FY14	Epidemiological coverage targets	Number of districts that did not meet coverage targets in FY14	Reason(s) for poor district performance	Proposed remediation actions
Lymphatic filariasis	0	$\geq 65\%$ epi coverage	Epi: --	--	--
			Program: --	--	--
Onchocerciasis	32	$\geq 65\%$ epi coverage	Epi: 0	--	--
			Program: 0	--	--
Schistosomiasis	28	$\geq 75\%$ epi coverage of SAC	Epi: 0	--	--
			Program: 0	--	--
Soil-transmitted helminths	28	$\geq 75\%$ epi coverage of SAC	Epi: 0	--	--
			Program: 0	--	--
Trachoma	0	$\geq 80\%$ epi coverage	Epi: --	--	--
			Program: --	--	--

### Drug and Commodity Supply Management and Procurement

Togo has an effective and accurate process for quantifying drug needs. Every village is enumerated during every MDA, and the drug needs for a given year are determined by taking the larger of the two most recent population estimates for each village (adjusted to account for population growth) and summing those figures at the appropriate geographic levels to determine drug needs. Togo submitted WHO's joint request form for medicines for preventive chemotherapy for FY 2014 and will do so again in FY 2015. Drug procurement needs for FY 2015 are shown in Table 5.

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 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, the lot number, 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.

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 Centrale d’Achats des Medicaments Essentiels Generiques et des consommables medicaux (CAMEG) in Lomé. Damaged drugs are collected and incinerated according to official national procedures. Togo uses the “first to expire, first out” approach to drug utilization, and there have not been instances of drugs expiring before use.

As mentioned in the section on MDA challenges, through the 2012 coverage survey some people reported that they did not receive treatment because there were “not enough drugs”. Careful analysis of the drug distribution guide (showing how many tablets should go to each PHU) shows that appropriate numbers of tablets were designated for the PHUs in which those residents lived, so there was a problem either with the number of tablets actually sent to those PHUs, or in the number of tablets distributed to each village within those PHUs. The results of the FY 2014 MDA will be closely examined to identify any similar problems so that trainers can work with MDA supervisors to prevent such difficulties in the FY 2015 MDA.

MOH and HDI personnel are requesting advanced training on SCM through short term TA from JSI or another END Africa partner.

**Table 5: HDI Drug and Commodity Procurement (USAID-specific)**

Drug/commodity	USAID support mechanism (e.g., ENVISION, END)	Quantity (tablets/tubes) to be procured	Date of application (MM/YR)	Expected delivery date of drugs (MM/YR)
ALB	WHO/GSK donation	2,345,632 <sup>a</sup>	06/2014	02/2015
PZQ	END in Africa (JSI/RTI)	7,104,587	03/2014	02/2015
ICT Cards	HDI	26,000	10/2014	12/2014
Kato Katz kits	HDI	54 kits <sup>b</sup>	10/2014	12/2014
Urine filtration kits	HDI	216 kits <sup>c</sup>	10/2014	12/2014

*ALB=albendazole, PZQ=praziquantel, <sup>a</sup>for school-age children, MDA rounds 1 and 2, <sup>b</sup>400 specimens per kit, <sup>c</sup>100 specimens per kit, JSI=John Snow International*

#### *Serious adverse events*

Identification, management, and reporting of serious adverse events (SAEs) are taught at the trainings. The CDD refers the patient immediately to the PHU dispensary. Serious cases are to be hospitalized at the district hospital. From the dispensary or hospital, any case is to be reported to the district supervisor and regional supervisor and details of the case are to be 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 at the central level.

To ensure complete reporting of all SAEs to all appropriate parties, HDI is responsible for reporting SAEs to parties outside of Togo. HDI will notify the Project Director for END in Africa at FHI 360 Headquarters and relevant medication donation programs by email within 24 hours of learning of any SAE. When the

new WHO guidelines on management of SAEs are available, the recommended measures will be incorporated into the Togo system for managing and reporting SAEs.

In 2015, HDI will assist with editing training manuals and guides for drug distributors to simplify and clarify instructions to the CDDs on correct identification, management, and reporting of SAEs. An additional one-page summary sheet of key CDD activities has been developed for CDDs to take into the field in FY 2015, and this includes instructions on the identification and management of SAEs.

### **Supervision**

As occurred for the April 2014 MDA, HDI staff will support the NTD program in conducting supervision by being present at the training of supervisors and actively participating in supervision in the field during the MDA in FY 2015. 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 supervisors (three per district) visit PHU dispensaries, receive feedback from PHU nurses, visit any problem areas identified by a PHU nurse, and select 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, as well as representatives from each of the NTD programs) make spot checks and visit problem areas as needed.

Drug shortages are communicated from CDDs to PHU nurses to district level supervisors. Issues or bottlenecks that arise in terms of drugs or other supplies are addressed within the PHU, if possible (for example, drug shortage for one CDD can be resolved by drawing surplus drugs from another CDD in the same PHU). Larger scale 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, but to date there have not been supply issues above the level of the PHU.

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 quantity of stock remaining against the amount recorded on 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, epidemiological and programmatic coverage and investigate any unusual findings. HDI ensures that WHO distribution guidelines are adhered to by carefully reviewing the drug distribution guide (showing how many tablets should be delivered to each PHU) and by reviewing the MDA data to make sure that the correct populations were treated with the correct drugs in each village and PHU. Any areas where treatment guidelines were not followed will be contacted through the supervisory chain and, if needed, drug distributors will revisit those areas and correct treatments will be given.

An in-country onchocerciasis expert will be engaged to provide field support for onchocerciasis field activities as well as oversight of MDA activities in high risk onchocerciasis villages. A consultant from outside Togo will be engaged to assist with supervision of DSAs.

### **Short-Term Technical Assistance**

The MOH requests technical assistance for capacity building on the TIPAC as well as for improving SCM skills. An external consultant with experience with onchocerciasis surveillance and elimination will be

engaged to provide guidance on appropriate surveillance and monitoring and evaluation for onchocerciasis as Togo moves towards elimination. An external consultant will also be engaged to assist MOH and HDI personnel in overseeing the field work for the integrated DSA for schistosomiasis and STH, and for the epidemiological surveillance for onchocerciasis.

**Table 6: Technical Assistance request from END in Africa**

Task-TA needed (illustrative example below)	Why needed	Technical skill required	Number of days required and anticipated quarter
Capacity building in use of the TIPAC	<i>To build capacity on generating useful outputs for program planning from the TIPAC</i>	<i>Experience with using the TIPAC to generate outputs for program planning</i>	<i>5 (first quarter)</i>
Training of MOH and HDI-Togo personnel on SCM strategies*	<i>To build capacity in SCM, above and beyond basic SCM skills</i>	<i>Expertise in SCM</i>	<i>7 (first quarter)</i>

\*This TA was requested in FY 2014, through the USAID/DELIVER Project, but was never completed.

### Monitoring and Evaluation (M&E)

The major components of M&E for FY 2015 are:

- Conduct data quality assessments (DQA) to assure the availability of reliable and meaningful data to inform programmatic decisions;
- Conduct the third TAS for LF;
- Continue with post-MDA surveillance for LF;
- Implement a nationwide disease specific assessment for STH and schistosomiasis to evaluate the treatment strategies for these diseases;
- Continue with routine epidemiological surveillance for onchocerciasis in 30 villages;
- Conduct a national epidemiological assessment for onchocerciasis to identify any unrecognized pockets of onchocerciasis and guide the transition from control to elimination of onchocerciasis;
- Revise onchocerciasis surveillance activities as necessary to ensure that there is a comprehensive surveillance system in place for onchocerciasis elimination;
- Conduct a coverage survey in three new districts (distinct from those assessed in 2012); in Tandjoaré district, which was included in the 2012 coverage survey but has had difficulties with MDA implementation and achieving equitable coverage; and in villages presenting a challenge to onchocerciasis elimination<sup>2</sup>.

The key change in strategy from FY 2014 is the transition from control of onchocerciasis to an emphasis on elimination.

<sup>2</sup> There are still villages in some districts that have onchocerciasis prevalence above 5% after over 17 years of MDA.

#### *Coverage survey in FY 2015*

A coverage survey is planned for FY 2015, to be conducted within 90 days of completion of the April MDA in three districts that are representative of the different ecological zones and cultures of Togo and in Tandjoaré district (which has had difficulties with MDA implementation and achieving equitable coverage), as well as in villages presenting a challenge for the movement towards onchocerciasis elimination. The results will be used to validate reported coverage, identify any issues related to drug distribution or IEC/BCC activities, and confirm that issues identified in the 2012 coverage survey have been addressed.

#### *Disease-specific assessments in FY 2015*

A situation analysis of onchocerciasis was conducted in 2013. The report of this technical assistance outlines, for each region, a time frame for moving to elimination of onchocerciasis. The onchocerciasis program continues to conduct skin snip surveys to track the prevalence of onchocerciasis in pre-determined areas; this work has historically been made possible by support from APOC and Sightsavers. As part of the move to elimination, this surveillance will need to be expanded to ensure that there is no recrudescence of disease (Table 7) and confirm that there are not undetected pockets of disease outside of areas currently being treated. The approach and methodology behind the ongoing surveillance for onchocerciasis that rotates around targeted villages approximately every three years will be reviewed. We will additionally conduct a national epidemiological survey for onchocerciasis in all endemic districts to confirm that there are no unidentified pockets of onchocerciasis in preparation for the move to elimination. This will be the first time that a comprehensive evaluation of the onchocerciasis situation has been conducted since 1974. An external consultant will be engaged to provide assistance on the onchocerciasis survey methodology, and a local consultant with extensive knowledge and experience with Togo's onchocerciasis program will provide field support for onchocerciasis field activities and oversight of high risk onchocerciasis areas during the MDA.

In FY 2015 Togo will conduct DSA for schistosomiasis and STH at integrated surveillance sites in accordance with WHO guidelines, measuring the prevalence and intensity of infection with schistosomiasis and STH in SAC (Table 7). This activity will employ urine examination for *S. haematobium* using urine dipsticks and urine filtration, and stool examination for *S. mansoni* and STH using Kato Katz assays. Data will be used to assess progress in the control of these diseases and also to evaluate the treatment strategies for these diseases. The results will provide the most definitive evidence of the success of the NTD program, which can be used to lobby both within and outside Togo for support to sustain these gains.

The LF component of this integrated disease-specific activity is described below under post-treatment surveillance.

**Table 7: Disease-specific assessments in FY 2015**

Disease	Location	Activity description	Expected Dates of Implementation	How results will be used to support MOH needs
LF	All eight previously endemic districts	Transmission assessment survey (third TAS post-MDA) – to be implemented according to WHO guidelines	February 2015	The data will confirm interruption of LF transmission in Togo and allow Togo to request verification of LF elimination by WHO*
Integrated disease specific assessment for STH and schistosomiasis	Nationwide	Assessment of STH and schistosomiasis prevalence at integrated surveillance sites. The assessment will utilize Kato Katz on stool samples and urine dipsticks and urine filtration on urine samples for schistosomiasis and STH.	February 2015	The data will be used to assess progress in control of STH and schistosomiasis and evaluate the treatment strategies for these diseases.
Onchocerciasis	30 villages in problem areas	Routine epidemiological surveillance to establish the prevalence of onchocerciasis in problem areas	February 2015	The data obtained will guide MDA activities and help guide interventions in problem villages.
Onchocerciasis	Select villages in all endemic districts	Epidemiological surveillance to identify any unrecognized pockets of onchocerciasis (the first such survey since 1974).	December 2014 to April 2015	The data obtained will identify any unrecognized pockets of onchocerciasis and serve as a new reference point as Togo moves towards elimination of onchocerciasis.

*\*Verification of elimination may be contingent upon cessation of ivermectin MDA for onchocerciasis.*

*Post-treatment surveillance in 2015*

HDI continues to support the MOH in implementing post-MDA surveillance for LF as recommended by the WHO. The final TAS is scheduled for 2015 (see Table 7), six years after the final MDA for LF. The TAS conducted in 2009 and 2012 confirmed that there is no longer transmission of LF in the eight districts that were previously endemic for LF, although it should be noted that there is ongoing MDA with ivermectin for onchocerciasis in these districts. Obtaining WHO certification will be contingent upon a successful TAS in 2015, and may also be contingent upon cessation of ivermectin MDA for onchocerciasis. Ongoing LF surveillance includes two distinct activities. For the first component of surveillance, on a monthly basis, laboratory technicians in 46 laboratories, at least one in each district, collect all thick blood films that were drawn from patients for the purpose of malaria diagnosis between the hours of 10pm and 3am; these same blood films are then examined for *Wuchereria bancrofti* microfilariae. A convenience sample of ten of these slides is sent to the central level for review each

month. The second surveillance activity is implemented by nurses in 20 peripheral health centers along border areas not served by the above-mentioned laboratories, where the risk of LF transmission is high due to the presence of LF in neighboring countries. The nurses are trained to collect capillary blood on filter papers three times per year from a random convenience sample of 20 previously untested adults living in their catchment area who come to the health center for care. These filter paper samples are sent to Lomé where they are tested for Ag Og4C3 specific to *W. bancrofti* by the laboratory of the National Institute of Hygiene. Additionally, a group of migrant workers from a neighboring, LF-endemic country was recently identified. These workers pose a risk of reintroduction of the *W. bancrofti* into Togo. A sample of these workers will be tested for *W. bancrofti* to assess the risk of reintroduction of the parasite into Togo.

Any case of LF identified through these surveillance activities triggers an investigation in the community where the case lives and works. More extensive testing is conducted and confirmed positive cases are treated with albendazole and ivermectin yearly for at least five years. From 2010 to 2012 there has been only one positive case.

Discussions have been held with neighboring countries, which are beginning to stop MDA for LF, to coordinate and implement synchronized surveillance.

#### *Data quality assessments*

Togo strives to assure the quality of its data in a number of ways. Data collection for the MDA 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. The new tally sheets for collecting gender-disaggregated data have performed well. PHU-level data forms are double-entered into a database created by the Division d'Informations Statistiques, Etudes et Recherche (DISER) in the MOH.

Considerable effort is exerted to ensure the quality of the data, so that reliable conclusions and trends about program performance can be drawn. 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, using outside data sources if needed. This activity will be supported by the HDI technical lead.

Starting with the April 2014 MDA, and continuing in FY 2015, population data from the current MDA will be compared with population data from the previous year. If there are dramatic differences in the enumerated populations this will be investigated to determine whether there has been a significant population movement or whether one of the years was inaccurately enumerated. The names and populations of all PHUs are also updated yearly after the MDA population enumeration.

Results from the 2014 MDA will be used to 1) identify areas where there were drug inventory imbalances, either shortages or surpluses, 2) identify any areas where drug distribution was not in accordance with population targets, and 3) amend training in 2015 to improve any issues identified in #1 and #2. In addition, inconsistencies between drug inventories and treatment records will be investigated by the MOH in collaboration with HDI personnel and supply chain issues will be addressed before the next MDA. Irregularities or gaps in treatment algorithms are examined by a joint MOH/HDI team and problem areas are specifically addressed during training prior to subsequent MDAs. Areas of poor



coverage will be investigated; the current year's coverage will be compared with past years to see if an area is consistently underperforming. Poorly performing areas will be brought to the attention of those who supervise and/or implement drug distribution in those areas.

#### *M&E challenges*

There are several challenges related to M&E activities in Togo. The first relates to calculation of the population at risk, the population requiring PCT, and the target population for MDA. The distribution of albendazole for STH control does not present any difficulty as the IU is the district and the target population is clearly defined. For schistosomiasis, the IU is the PHU. In working with partners and funders, Togo has defined the population at risk differently at different times. Given the focal nature of schistosomiasis transmission, and the PHU-level prevalence data on schistosomiasis that were generated during the baseline mapping in 2009, we propose to declare here that the population at risk be retained as all persons living in a PHU catchment area where the prevalence of schistosomiasis is >0%. The population requiring PCT is then determined from WHO recommendations, and is all persons that WHO recommends should be treated in an area with a given prevalence of schistosomiasis (Table A2.2, *Preventive chemotherapy in human helminthiasis*, WHO 2006). In Togo, the target population is then equal to the population requiring PC, because Togo targets all SAC and any adults believed to be at high risk.

For onchocerciasis, the situation is more complex. Togo categorizes districts as endemic or non-endemic, but within those districts only treats villages with population <2000, as discussed earlier. The population at risk, however, should not be limited to just those villages, given that the vector can fly many miles from its breeding site. We propose to define the population at risk as the total population of the districts in which onchocerciasis is found. The target population would then remain all persons age five years and older living in villages with population <2000. The population requiring PCT should be agreed upon across all partners.

The second challenge related to M&E involves determination of the denominators for calculating coverage. We have made a commitment to use the enumerated populations from the same MDA from which the treatment (numerator) data come, and to update the target populations before calculating the coverage of the nationwide April MDA. For the second round, although the different yet overlapping implementation units and target populations for onchocerciasis and STH create a complex mosaic of new and old data in 13 of Togo's 40 districts, we will nevertheless make every attempt in FY 2015 to use the enumerated population from the second round to update the denominator before calculating coverage for those villages treated in the second round.

#### *Other M&E activities*

A convenience survey/rapid evaluation is conducted by supervisors immediately following the MDA while supervisors are still in the field to assess any specific successes or failures of implementation. Findings are used to immediately correct any identified distribution errors and to improve training and implementation in subsequent treatment rounds.

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 of the coverage survey.

## Planned Fixed Obligation Grants to local organizations and/or governments

Table 8 lists the four fixed obligation grants (FOGs) to the Togo MOH that are planned for FY 2015.

**Table 8: Planned FOG recipients**

FOG recipient (split by type of organization)	Number of FOGs	Activities
Togo MOH	4	<ul style="list-style-type: none"> <li>• Social mobilization activities and training of nurses and CDDs in advance of the April MDA</li> <li>• Planning and implementation of the April MDA, including the development of a detailed distribution plan, and submission of a final report of the MDA.</li> <li>• October MDA in highest prevalence areas</li> <li>• Convenience survey/rapid evaluation during MDA</li> </ul>

## Summary of NTD partners working in country

Table 9 lists other partners in Togo who are working to prevent or treat NTDs in Togo.

**Table 9: NTD partners working in country and summarized activities**

Partner	Location	Activities	Is USAID providing financial support to this partner?
UNICEF	All 40 Districts in Togo	Provide albendazole for pre-school age children nationwide	No
National Nutrition Programme	All 40 Districts in Togo	Provide vitamin A for pre-school age children nationwide	No
APOC (African Programme for Onchocerciasis Control)	All 32 onchocerciasis districts	Provide funding and technical assistance for epidemiological and entomological surveys for onchocerciasis	No
Sightsavers	All 32 onchocerciasis districts	Provide funding and technical assistance for epidemiological and entomological surveys for onchocerciasis	No
WHO (World Health Organization)	Central level	Act as consignee for MDA drugs donated to Togo	No
Hope Education Foundation	Lomé district	Conducted mapping of STH and <i>S. mansoni</i> in Lomé district, developing and testing school-based educational curriculum to prevent infection with STH	No

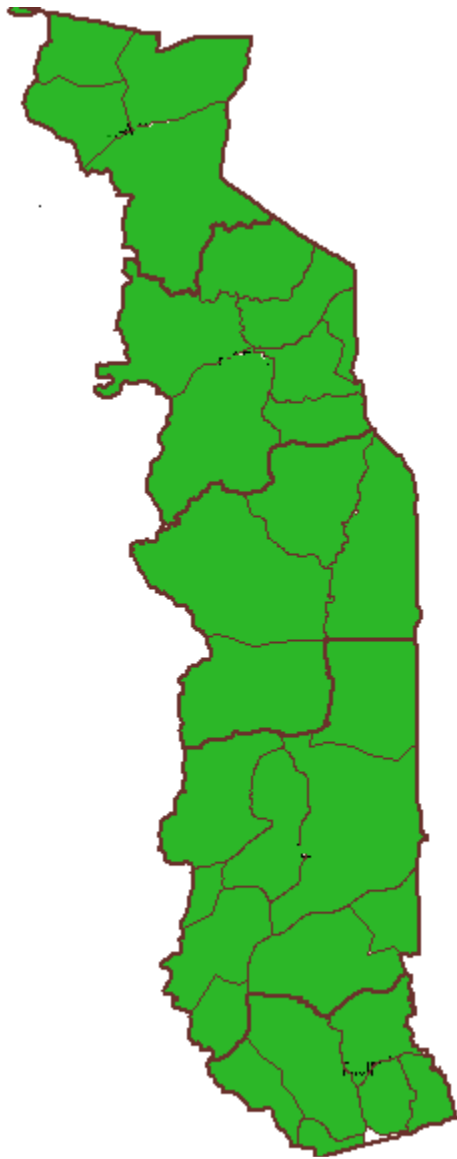
## Looking Ahead

Togo would like to continue LF morbidity management for lymphedema, as well as treat cases of hydrocele, to definitively eliminate LF transmission and disease from Togo. Funding is also desired for entomological surveys for onchocerciasis.

**Table 10: Remaining gaps to be addressed**

<b>Identified gap or activity</b>	<b>Would external support be needed –funding or technical (outside of existing partners)?</b>	<b>Estimated time needed to address activity</b>	<b>Estimated cost to carry out activity</b>
LF morbidity management	Funding	Ongoing	\$40,000/year
Trichiasis surgery	Training and funding	Two years	\$100,000
Hydrocele surgery	Training and funding	Two years	\$100,000
Onchocerciasis entomological survey	Supplies, training and implementation	Yearly	\$7,500/year

Figure 1: USAID NTD support map



All 35 districts outside the capital, Lomé, will receive USAID funding in FY 2015 for both MDA and disease-specific assessments